Te Kāwanatanga o Aotearoa
New Zealand Government

Rural Health Strategy

2023

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MANATŪ HAUORA
MINISTRY OF HEALTH

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Minister's foreword

I am proud to fulfil the commitment to develop the Rural Health Strategy (the strategy), the first health strategy for rural communities. The strategy sets the direction over the next ten years for improving the health of rural communities.

Improving rural health outcomes are key part of building towards pae ora and achieving equity for health outcomes in Aotearoa New Zealand, with one in five people living in rural communities, with one in four for Māori.

Rural communities' strengths, challenges, and outcomes have been overlooked in how health services are provided. From this point, there are clear expectations on health agencies and entities to deliver better options that work for rural communities, by taking into account the different characteristics and approaches needed. For rural Māori communities, solutions that are led by Māori leaders and the community are a vital part of tino rangatiratanga and changing the experiences and outcomes of Māori.

As we work to improve the health system, we know health can't solve these issues alone. There are opportunities for the health sector to strengthen outcomes by working across Government and with crucial players in rural communities.

The five priorities of the Rural Health Strategy set high level direction for change, with the forthcoming Government Policy Statement on Health in 2024 outlining specific changes towards change over 2024–2027.

While agencies have started to improve data and monitoring of rural communities' health outcomes, there is a way to go. Monitoring rural communities' equity to urban communities, as well as equity within rural communities will be crucial in monitoring progress towards the direction set by the strategy for all groups within rural communities.

For the rural health workforce, and those supporting them, I want to thank you on behalf of our communities for your dedication, perseverance and the important work you do. This is a pivotal time for the health of rural Aotearoa New Zealand, and we look forward to working with you to improve health outcomes in rural communities.

Hon Willow-Jean Prime
Associate Minister of Health

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Executive Summary

The purpose of this Rural Health Strategy is to set the direction for improving the health of rural communities over the next ten years.

Rural life is varied and changing. The health of rural populations is strongly linked to rural economies, the environment, infrastructure and community connectedness. Rural communities are resourceful – community organisations, iwi and hapū have an important role in promoting health in their communities and supporting rural people through challenging events.

However, rural communities have too often been overlooked in health system planning, delivery and monitoring. Rural people can face significant challenges accessing health care and experience worse overall health outcomes compared to urban populations. One in five New Zealanders and one in four Māori live in rural areas – it is critical that these challenges are addressed if we are going to achieve pae ora / healthy futures for all New Zealanders.

Our vision is for people living in rural communities to live long and healthy lives – supported by a health system that meets the varied needs of these communities and draws on the strengths and knowledge of rural whānau to achieve pae ora.

Achieving this vision will require us to work collaboratively with the communities our system serves. This includes iwi, hapū and Māori communities exercising tino rangatiratanga in the design and delivery of rural health services.

This strategy identifies five priorities that will give effect to this vision over the next ten years:

- **Priority One: Considering rural communities as a priority group**
  Health policies and planning are designed to meet the specific needs of rural communities – rather than expecting rural communities to fit into funding approaches and ways of offering care for urban settings.
- **Priority Two: Prevention, paving the path to a healthier future**
  Rural communities have building blocks in place to support healthier futures – stable jobs, good pay, quality housing, digital connectivity and resilience to climate change. Preventive health interventions such as screening, and promoting and protecting people's health and wellbeing are key areas of focus.
- **Priority Three: Services are available closer to home for rural communities**
  A wider range of service options will be available in the home or in the community, including from outreach options (such as mobile outpatients clinics and digital solutions).
- **Priority Four: Rural communities are supported to access services at a distance**
  Where it is not possible to access health services locally, coordinated support will be available to help rural people travel or use digital technology to receive care.
- **Priority Five: A valued and flexible workforce**

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The rural health workforce will be developed and supported to deliver the care that rural communities need – including kaupapa Māori approaches and extended health care roles and rural specialisations.

This strategy does not commit to specific actions, but sets the long-term direction for improving rural health in these priority areas. More specific actions will be made in the Government Policy Statement on Health and the New Zealand Health Plan / Te Pae Tata – which will set out measurable actions to advance the priorities over the next three years. Change will also require significant improvements in the monitoring of rural health data over time, so that we can understand what changes are having an impact and where we may need to change course.

This strategy has been developed by Manatū Hauora / the Ministry of Health and draws on conversations that we have had with rural communities as we consulted on the development of six new health strategies required under the Pae Ora Act 2022. It represents the start of a much longer conversation about ways to improve the health of rural communities that will need to take place over the coming years to ensure that the health needs and aspirations of rural communities are met.

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RURAL HEALTH STRATEGY

PURPOSE

The Rural Health Strategy sets the direction for improving the health, both physical and mental, of New Zealanders living in rural communities over the next ten years.

It is a key part of shifting the health sector towards building pae ora and achieving equity by reducing health disparities

VISION

Our vision is for all people living within rural communities to live long, healthy lives

We envision a future where the health system takes into account the different needs of rural communities, and the insights and strengths of rural whānau are used to improve wellbeing, address equity and achieve pae ora (healthy futures).

The Geographic Classification for Health (GCH)

There is a lack of data on rural health access and outcomes. This impacts our ability to know where to prioritise our resources to improve rural health.

The GCH provides a consistent way to measure rural health outcomes. The Geographic Classification for Health has three rural categories (R1, R2 and R3) based on distance to urban-centres, and relative size of population in the area.

The most remote and isolated rural communities are classified as R3. There are two urban classifications, one for the six main centres (U1) and one for provincial cities (U2).

FOCUS AREAS

Broader and integrated health options are supported in the community

A population health approach that protects and promotes health and delays ill health is adopted

Public health programmes are available and fit-for-purpose

Wellbeing of rural health workforce

Expand rural training pathways

Better recognition of broader roles within the rural health workforce

Training for broader and more flexible roles

Support for patient to access care can include digital support to reduce travel

Proactively assess access needs for people needing treatment or with long-term conditions

Reassess current system settings to address rural health needs

Tino rangatiratanga for rural Māori

The voice of rural communities is at the centre

Health system adopt approaches that work for rural communities

Better use of digital, mobile and outreach services

PRIORITY AREAS

Services are available closer to home for rural communities

Prevention, paving the path to a healthier future

Considering rural communities as a priority group

A valued and flexible rural health workforce

Rural communities are supported to access services at a distance

Commitment to Te Tiriti

The health sector is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi. As the kaitiaki and steward of the health system, the health sector has the responsibility to enable Māori to exercise authority over their health and wellbeing and achieve equitable health outcomes for Māori in ways that enable Māori to live, thrive and flourish as Māori.

Turning Strategy into Action

The Rural Health Strategy will provide direction for the Government Policy Statement on Health, the New Zealand Health Plan and Multi-Year Health Funding. These, along with locality planning, will shape action to improve rural health outcomes and rural communities will be a key part of this discussion.

Alignment across the Pae Ora Strategies

The Rural Health Strategy is part of a suite of six health strategies required under the Pae Ora Act. The priorities of these strategies are closely aligned and interwoven.

The New Zealand Health Strategy, Women's Health Strategy, and Hauora Māori Strategy provide direction for change for improving overall health outcomes, including for rural communities. Te Mana Ola - the Pacific Health Strategy and the Health of Disabled Persons Strategy provide direction for improving these population groups outcomes, including when they are in rural communities.

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Introduction

Purpose of the Rural Health Strategy

The Rural Health Strategy sets the direction for improving the health, both physical and mental, of New Zealanders living in rural communities over the next ten years.

This is the first New Zealand Rural Health Strategy. Rural communities have too often been overlooked in policy advice, priority setting, health service planning and monitoring health outcomes. As a result, settings have not met rural communities' needs, inequities in rural health outcomes have not been picked up in monitoring or addressed through policy.

The health system reforms aspire to remove geographic differences in health outcomes and better serve all communities, including rural. The Rural Health Strategy will provide the next step for the system to recognise rural communities' needs, set the direction and provide accountability for progress towards improving rural health outcomes.

The Pae Ora (Healthy Futures) Act 2022 (the Pae Ora Act) requires the Government to produce a Rural Health Strategy, including an assessment of the current state of health outcomes and health sector performance; an assessment of the medium and long-term trends that will affect health outcomes and health sector performance; and which sets out opportunities and priorities for improving the health sector, including for the health workforce.

The role of this strategy is to set long-term direction for improving rural health – it does not commit to precise actions for health entities. More specific decisions will be made in the Government Policy Statement on Health and the New Zealand Health Plan. These documents will set out specific actions and priorities for the next three years (from mid-2024, and for subsequent three-year periods). Planning and design of local services will also be guided by locality plans that rural communities and iwi-Māori partnership boards are part of developing.

This strategy is part of a suite of six health strategies required under the Pae Ora Act that are being published in 2023. The New Zealand Health Strategy takes a whole-population focus, and considers systemic issues, opportunities and priorities. These priorities are relevant to improving health in rural communities as well as nationally.

The structure of this document

Part 1 describes a long-term vision for rural health and key guiding approaches.
Part 2 provides an overview of rural communities and the current state of rural health.
Part 3 identifies the priority areas, and the changes needed within these areas to achieve our 10-year vision for improving the health outcomes of rural communities.
Part 4 describes the next steps for how these changes can be taken up and part of the health system people experience in future.

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Part 1: Our vision for rural health

Our vision is for all people living within rural communities to live long, healthy lives. We envision a future where the health system takes into account the different needs of rural communities, and the insights and strengths of rural whānau are used to improve wellbeing, address equity and achieve pae ora (healthy futures).

Achieving pae ora | healthy futures for all New Zealanders is a long-term challenge and requires a sustained effort that lasts across generations. This Strategy sets out the next steps towards this vision and focuses on what can be achieved, and what change is needed, over the next ten years.

Pae ora encourages everyone in the health and disability system to work collaboratively, to think beyond narrow definitions of health and to provide high-quality and effective health services. This includes a focus on:

- improving people's own health and wellbeing;
- supporting strong and empowered family networks and recognising the impact of family on health and wellbeing; and
- the impact of our communities and the places where we live, work and rest to our health and wellbeing.

In this vision, rural communities are valued and the needs of people in rural areas are considered across the health system. Rural communities are well-supported and are living in health promoting and well-connected environments to live, play, learn, work and age. Health and wellbeing services are accessible, culturally safe and more options are available closer to whānau, reducing the need for long and costly journeys, and time away from home. There is flexibility for regional differences between rural communities and differences in local needs across rural communities to be addressed as the community sees fit.

The health system is committed to working in partnership with Māori and taking an approach to health that is inclusive, respectful and honours te āo Māori. Māori communities have tino rangatiratanga to design and deliver the valued services and supports, including Kaupapa Māori, Māori approaches of rongoā and whānau-centred and Māori-led health care.

Achieving this vision requires government and health entities to work collectively and in collaboration with the communities our system serves, with iwi, hapū and Māori communities, and with the wider organisations that contribute to the health and wellbeing of whānau. This will enable all New Zealanders to live longer in good health, have improved wellbeing and quality of life, be part of healthy, inclusive and resilient communities, and live in environments that sustain their health and wellbeing.

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Commitment to Te Tiriti o Waitangi | the Treaty of Waitangi

The health sector is committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti o Waitangi | the Treaty of Waitangi (Te Tiriti). Regarding the text of Te Tiriti and declarations made during its signing, the Crown, as the kaitiaki and steward of the health system (under article 1 of Te Tiriti), has the responsibility to enable Māori to exercise authority over their health and wellbeing (under article 2) and achieve equitable health outcomes for Māori (under article 3) in ways that enable Māori to live, thrive and flourish as Māori (Ritenga Māori declaration).

The Crown's approach to meeting its obligations under Te Tiriti is outlined in section 6 of the Pae Ora (Healthy Futures) Act 2022. The legislation contains specific provisions intended to give effect to the Crown's obligations.

In particular, the health sector principles in section 7 of the Act guide the Minister of Health, Manatū Hauora | the Ministry of Health and all health entities in how they carry out their functions. The health sector principles incorporate key outcomes and behaviours derived from the principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal, including:

- **Tino rangatiratanga:** Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health services.
- **Equity:** Being committed to achieving equitable health outcomes for Māori.
- **Active protection:** Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options:** Providing for and properly resourcing kaupapa Māori health services. Furthermore, the Crown is obliged to ensure that all health services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership:** Working in partnership with Māori in the governance, design, delivery and monitoring of health services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

These principles[1] are central to achieving our vision of pae ora | healthy futures for Māori. Pae ora has a special meaning for Māori, and includes three inter-connected elements:

- **Mauri ora (healthy individuals)** seeks to shift the mauri (or life force) of a person from one that is languishing to one that is flourishing.
- **Whānau ora (healthy families)** is a fundamental philosophy for creating strong, healthy and empowered whānau. A strong healthy and empowered whānau can make the most significant difference to Māori health and wellbeing.

[1] The principles were recommended in the Waitangi Tribunal's *Hauora* report (Waitangi Tribunal 2019)

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- **Wai ora (healthy environments)** acknowledges the importance of Māori connections to whenua as part of the environments in which we live and belong – and the significant impact this has on the health and wellbeing of individuals, whānau, hapū, iwi and Māori communities.

Our commitment to Te Tiriti o Waitangi and priorities for hauora Māori are described in greater detail in the Hauora Māori Strategy published in parallel with this document.

Becoming a good Te Tiriti partner is necessary if we are to realise the overall aims of the Pae Ora Act and the Rural Health Strategy and see Māori living longer, healthier, and more independent lives. We aim to embed a dynamic health system which places Te Tiriti at the forefront of thinking and provides opportunities to improve health outcomes for Māori.

Reflecting rural voices

The development of the Rural Health Strategy has been informed by public and stakeholder engagement undertaken by Manatū Hauora across the suite of Pae Ora strategies. Between November 2022 and May 2023, Manatū Hauora received feedback and submissions across multiple different channels, including in-person and online engagements, regional wānanga, and social media. Further information on the process of engagement and key themes are included in a report on the engagement that is published alongside the strategies.

Key themes for rural health from engagement included:

- Concerns about access to care. Options restricted by workforce gaps and limited availability of services in rural areas (maternity, urgent care and emergency and mental health were highlighted as particular concerns).

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- There needs to be more local input into services available in the community – with more services available closer to home.
- While people were generally positive about their experiences in receiving care, they also experience challenges to get into the system to gain care they need – with difficult referrals and long wait-times. Lack of access to acute mental health support is a particular risk.
- Those making decisions do not consider the impact of these decisions and on rural communities – such as appointment times which don't work when travelling two or more hours.
- Rural communities want to see expanded prevention support, such as access to screening, health improvement practitioners and mental health promotion.

Some key themes for rural Māori communities from the Ngā Wānanga Pae Ora 2023 engagement included:

- Recognition, and resources to enable, rural Māori communities' right to tino rangatiratanga. This can be supported through partnerships with Māori, hapū, iwi and the role of IMPBs, and entities' commissioning decisions.
- Whānau-centred services, delivered through those community trusts, with solutions that bring together primary care, prevention and other services enable more proactive and effective support.
- Systems create burdens for whānau as the conditions and barriers they experience to seek help, including past interactions where they felt disrespected.

This strategy is based on what we heard from rural communities, stakeholders and the rural health sector.

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Part 2: Rural communities

Definition of rural communities

The Rural Health Strategy focuses on people who live in rural communities. This means it is based on geographic areas people live in rather than an individual's identity. Rural areas are generally categorised by the small and sparse population compared to cities, as well as the degree of isolation, in terms of distance from main centres.

Rural communities, or populations, in this strategy are defined using the Geographic Classification for Health, which has been developed for categorising rural and urban areas to monitor health outcomes[2]. This purpose aligns with the focus of the Rural Health Strategy, to set the direction for improving rural health outcomes, and to monitor. Other New Zealand rural definitions, such as Statistics New Zealand's focus also classify rural and urban areas based on population size and drive time to urban centre. However, the population and drive time thresholds used in the GCH framework were developed specifically with health services in mind.

The Geographic Classification for Health takes into account distances, in terms of travel times, from urban centres, where key health services are more likely to be located, in addition to the population within the surrounding communities nearby (see Appendix 1). The resulting classification of rural and urban areas was also informed by feedback from the health sector to ensure it 'makes sense on the ground'. Geographic based boundaries always have some contention as they are not definitive and have some subjectivity around exactly where the boundaries make sense. This results in some people living quite close to each other in different categories.

The Geographic Classification for Health has three rural categories (R1, R2 and R3) based on distance to urban-centres, and relative size of population in the area (see Appendix 1, the full map of New Zealand). The most remote and isolated rural communities are classified as R3. There are two urban classifications, one for the six main centres (U1) and one for provincial cities (U2). Population distribution by these classifications are shown in Figure 2.

Using this more distance-based approach instead of purely population-based approach, sees, for example:

- Taihape, classified as rural and R2, due to distance from main urban centres, instead of a small urban area.

[2] Whitehead J, Davie G, de Graaf B, Crengle S, Fearnley D, Smith M, Lawrenson, R, Nixon, G. *Defining rural in Aotearoa New Zealand: a novel geographic classification for health purposes* (2022) New Zealand Medical Journal, August 5, 2022, volume 135.

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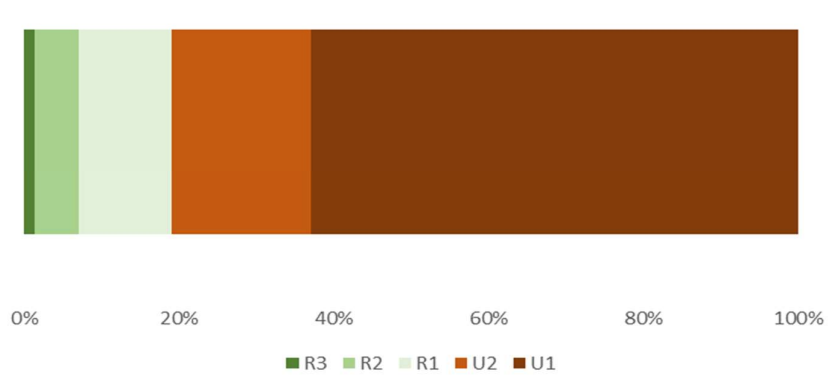
- areas around Rangiora are classified as part of a main urban centre with Christchurch, categorised as U1, given it is a short distance from Christchurch city centre, and hospital, rather than a mix of rural or smaller urban areas.

For monitoring outcomes and describing rural communities this geographic based definition will be used for rural communities by health entities. Te Pae Tata (interim New Zealand Health plan) already makes this commitment for Te Whatu Ora and Te Aka Whai Ora. However, when engaging rural communities or implementing initiatives for rural communities there are reasons to have flexibility. For example, mental health promotion to rural communities may be focused on rural areas, but there is also scope to focus on people outside these specific geographic boundaries for engagement and delivering services, such as promotion that targets primary industry workers who may also live or work in urban areas.

In 2022, around one in five (19%) of the New Zealand population lived in rural areas. Most of the people in rural communities are in areas that border urban areas, or are relatively large rural centres (R1 category). Within this group, R1, comprised 12% of the population, with R2 at 6% (this group are either further away than R1 or have smaller populations than R1), and within R3, the most remote rural areas, has only around 1%.

The proportion of people living in rural communities has been stable within census data from 2006 to 2018 (19%), and in 1996 it was slightly higher at 21%. Further data on population breakdowns within rural communities uses population estimates from the 2018 Census instead of 2022 population estimates.

Figure 2: New Zealand population share by Geographic Classification for Health rural and urban categories, 2022



For countries with similar population to New Zealand[3], Finland (30%) and Sweden (25%) have higher rural populations, while Norway (18%), Denmark (18%) and Scotland (17%) have similar rates to New Zealand, and Ireland a bit less (14%). For Australia, 28% live outside main centres, but this mostly represents regional communities, with 2% in remote areas in a much larger country with a higher population.

[3] While different approaches to define rural communities are used internationally they generally use comparable population size and travel distance thresholds.

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Groups within rural communities

In the 2018 Census, Europeans are the largest ethnic group in rural areas (82%), followed by Māori, (22%)[4]. Asian (4%) and Pacific peoples (3%) make up a small share of people within rural communities. Rural communities have a higher proportion of Māori than urban populations, with around one quarter of rural people identifying as Māori, compared to 17% nationally. The proportion of the Māori population that live in rural communities has fallen slightly since 1996. However, the proportion of people in rural communities that identify as Māori has been increasing, as it has for total New Zealand population.

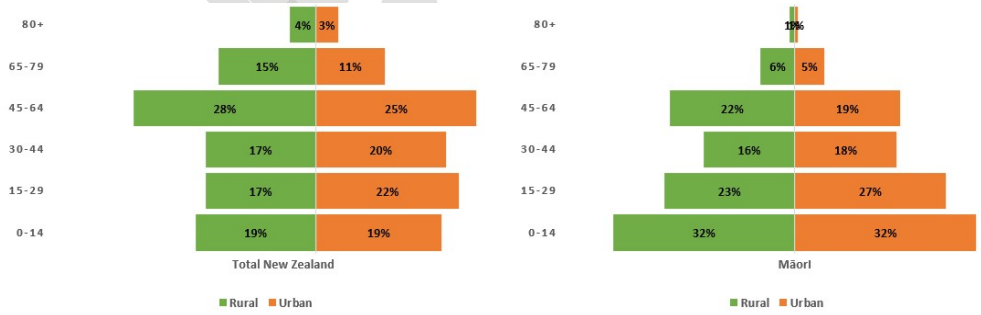
The rural population is split between male and female evenly, at 50%, with urban areas having slightly more females, at 51%. However, Pacific peoples in rural communities are more likely to be male, at 54% – likely reflecting the rural migrant Pacific workforce, which is predominantly male.

People aged between 20–39 years are less likely to live in rural areas than other age groups, as young people leave rural areas for education and employment opportunities (see Figure 3). Women are more likely to exit rural communities for study and work when young adults. Between the ages of 15–29 years women drop to 47% of rural communities. The share of children within rural areas is similar to urban areas.

Older people are more likely to live in rural communities than other age groups – around a quarter of people aged over 65 live in rural communities (making up 20% of the total rural population in 2018). Kaumātua are even more likely to live rurally, with 34% of the total Māori population over 65 years living in rural areas.

The share of older people in the rural population has increased as the population ages, and will continue to grow. Between 1996 and 2018 the rural population over 65 years grew from 13% to 20%. This increase was higher than for urban areas. The older-age dependency ratio (over 65 years to number of working age) is 50% higher for rural communities than urban communities at 35 per 100, compared to 23 per 100 in urban areas. The higher dependency rate also reflects the lower share of younger adults in rural communities.

Figure 3: Age distribution for rural and urban, total New Zealand and Māori, 2018



[4] This is for 'total response' ethnic group. Under the 'total response' ethnicity approach, people can be counted in more than one ethnic group, as they identify with more than one ethnicity. The sum then of Ethnic groups will add to more than 100%.

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In rural communities there are also more women than men, reflecting women's longer life expectancy. However, the higher share of women in older age groups is not as large as in urban areas. For example, in urban areas around 60% of people 80 years and older are women. In rural areas this is 55%. This could reflect a trend of older rural women moving to urban areas with extended family, or for better access to care or support.

Two-thirds of the total rural population and 86% of the rural Māori population live in the North Island. Waikato (21%), has around one-fifth of the total rural population, followed by Northland (12%), Otago (12%) Canterbury (11%) and Manawatu-Wanganui (9%). The regions with higher composition of rural communities are the West Coast (all communities are considered rural), followed by Northland (around 60% of population live in rural communities), followed by Tasman, Otago, Southland and Waikato (around 40%-50% of the population live in rural communities). Māori are the largest ethnic group within the rural areas within the Gisborne region (74%) and rural Bay of Plenty region (54%). Within Northland and Hawkes Bay regions, Māori are around 40% of the rural communities.

Ethnic diversity is growing in rural communities

Ethnic diversity is not as high in rural communities as in urban centres. In rural communities, 5% of people identify as Asian and 3% as Pacific peoples, well below the population share for these groups nationally (16% and 7% respectively). However, the ethnic diversity of rural communities is starting to grow, particularly among Pacific peoples, Indians and Filipinos.

From 1996 to 2006, the population of Pacific peoples living rurally was stable and low, at around 1% of rural communities. From 2006 to 2018, the population of Pacific peoples living rurally doubled. Rural Pacific peoples grew from 4% to 6% of the total Pacific peoples population. Rural areas in Waikato, Northland and Manawatu-Wanganui comprise around 60% of the rural Pacific peoples population. Rural towns with significant populations of Pacific peoples include: Tokoroa, Taupo, Levin, Ashburton and Oamaru[5].

Outside the Pacific community, the largest rural ethnic communities in 2018 Census were Indian, Filipino, Chinese, and other European ethnicities, including Dutch and German. Indian and Chinese rural populations represent only around 3% of the total population share for these groups. There has been a significant increase in the Filipino rural population in recent years, with links to primary industry employment. In Ashburton, Selwyn, Waimate, Southland district and Hurunui, Filipino students comprise 5%-7% of school enrolments. The wider Filipino population however is predominantly urban – with around 85% living in urban areas. Dutch, German and Latin American populations have rural population shares that are more comparable to the European and Māori populations.

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Refugee resettlement will also increase ethnic diversity in rural areas over the next ten years. Ashburton (with recent groups from Afghanistan) and Levin (with some initial groups from Colombia) are rural areas with refugee resettlement[6].

Increasing diversity from migration can revitalise local economies and provide additional labour, but can also come with challenges and experiences of racism for new migrant communities.

Temporary population groups: seasonal, itinerant workers and tourism

Rural communities also host people who are living temporarily in the regions, such as short-term migrant workers in the primary industries, and people who move around rural areas for work, such as shearers. It is important that these groups can have their health needs met while in rural communities; however this can be challenging due to eligibility for services (for those on work visas less than two years), not being enrolled with general practices in the area, and long work days.

Tourism (including regional holiday homes) is also playing a growing role in rural economies and health outcomes. Tourism can help maintain the viability of rural communities, boost local economies and allow visitors support the local economy through temporary work. However, tourism can also reduce local housing supply and affordability for local people. Health services are also affected by seasonal influxes or visitors: Central Otago, Coromandel and Taupō have significantly higher populations during holiday periods. This can put pressure on health services, present challenges for the workforce and can mean that the longer-term care needs of long-term residents are delayed – particularly in small rural areas.

Disabled people in rural communities

There is limited data on disabled people with within rural communities. The New Zealand Health Survey 2021/22 indicates that a similar share of disabled people and the total New Zealand population live in rural communities - around 19%. Women were more likely than men to have a disability in rural communities, similar to national data. However, the focus of the disability questions in the New Zealand Health Survey are more limited than the Disability Survey approach, and do not cover all disabilities or impairments. A significant proportion of the disabled community are not therefore present in this data including those with mental health and addiction issues, those with neurodivergence and those with disabling but variable conditions such as musculoskeletal injuries or Chronic Fatigue which can lead to significant disability at various times in someone's life.

Living rurally can greatly impact experiences of disabled people due to the potential for isolation and distance from key supports. While some disabled people may move to rural areas for cheaper housing, building up social networks can take time.

Access to disability supports can be more limited in rural areas, and people are more reliant on family. Specialists (such as speech therapists) may not be available and digital options to access are limited.

[6] These regions were established as resettlement locations when the Refugee Quota was increased to 1,500 people per year.

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While many health and wellbeing services are able to support greater access to services by using remote and digital technologies, these are not always appropriate or accessible for disabled people with a range of impairments and who in some case, are further distanced from services through the use of technology.

Rainbow communities

There is not a lot of research that documents the experience of rainbow[7] people in rural communities. An estimated 4.4% of New Zealanders identified as being part of the rainbow community in 2021, and this was estimated to be lower in rural areas, at 3.5%[8]. In time, we will have better data to tell a richer story about the lives of rural rainbow communities.

As is the case more generally, the rainbow community in rural areas faces unacceptable levels of discrimination and inequities in everyday life. While anecdotally, rural communities can offer warm and supportive environments, it may be different for younger members of the rainbow community, especially those who are exploring gender and sexuality and who do not have easy access to a diverse range of role models. A report from ten years ago identified that rural towns can be isolating and unsafe for young people exploring identity[9], and a more recent survey showed that one in eight rainbow people had moved to towns or cities to feel safer expressing their identity.

While rainbow communities are diverse, there are some commonly reported health issues, including anxiety, distress and depression[10]. There is also a need for health specific services for rainbow communities, such as gender-affirming care and support for people with variations of sex characteristics. Rainbow communities can face barriers to accessing healthcare and avoid seeing a doctor because they are worried about disrespect or mistreatment in rural areas:

> *"We both went to our doctor while we were still living up in Kerikeri, we went together, asked the doctor about taking hormones. And he pretty much had no idea what we were talking about, had to search it up. And then he said that he would send a referral to the nearest endocrinology place, which was in Whangārei. I think it was either 2016 or 2017 and (we) still haven't heard back." - Transgender man.*

It is critical that we remove barriers to accessing health services and improve inclusiveness for rural rainbow communities. With greater training, upskilling and support, the rural workforce can create welcoming and inclusive services, where the needs of the rainbow people are understood and respected.

[7] Rainbow is an umbrella term that covers a diversity of sexual orientations, gender identities and expressions, and sex characteristics and is used in place of LGBTQIA+. It is a diverse population group with a range of experiences and includes people who identify as gay or lesbian, bisexual, queer, asexual, intersex, transgender, non-binary, takatāpui and MVPFAFF+.

[8] Statistics New Zealand, Household Economic Survey data for the year ended June 2021. Rural and urban definitions were based on Statistics New Zealand definitions and estimates for rurality were based on survey data. StatsNZ note the challenges of accurately counting rainbow communities, and there may be extra challenges in rural areas.

[9] Ministry of Youth Development (2015) Supporting LGBTI Young People in New Zealand.

[10] Statistics New Zealand, Household Economic Survey data for the year ended June 2021

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Living and working in rural communities

Health and wellbeing of rural communities needs to be considered within the broader context of living and working in the rural communities. The rural population is not homogenous, and the needs and aspirations of those living in rural areas, such as rural Northland and rural Southland, can vary. Yet whānau connection, housing, transport, employment, culture and the environment have long-standing impacts on the health and wellbeing of rural communities. Sustainable and prosperous rural communities are dependent on all these factors, as well as access to health care.

Community connectedness and trust

Community, social support, and cohesion are important contributors to health in rural areas. Conversely, loneliness and isolation adversely impact physical and mental health. Grass roots community organisations, iwi and social groups play a big role in welcoming people to rural communities, offering manaaki or "rural hospitality", and fill the gaps where government support is inaccessible or under-resourced. They also offer vital social connections at marae, sports clubs, and through activities such as community meals or 'surfing for farmers' such as through the regional Rural Support Trusts.

Schools also play an integral role in the social cohesion of rural communities. Limited educational opportunities, particularly for secondary school students, forces rural young people to seek education outside of their community. This limits the connection these young people then have with their communities. In addition, the closure of rural primary schools, which often also serve as community centres or meeting points, have negative impacts on experiences of social connectedness for children, parents and the wider community.

The strong social networks and sense of responsibility for collective wellbeing in rural communities has been evident in recent extreme weather events and the COVID-19 response. Many great examples of health innovation that utilise community strengths and promote knowledge-sharing have emerged within rural communities.

Access to formal child and elder care in rural areas varies enormously. Rural women often provide care for children, older people and families. Caring roles can be isolating and the quality of relationships with family and close neighbours may impact on women's wellbeing.

> *"Rural women are often isolated and over-burdened as a result of limited support and remoteness of location. This can lead to neglect and further deterioration in their health and wellbeing".* Rural Women NZ submission.

Nationally, around 1 in 3 women experience intimate partner violence at some stage in their life[11]. While the prevalence of family and sexual violence in rural areas is not well known, experiences of isolation and lack of available support services is likely to rural women at a greater risk of experiencing family and sexual violence. Rural women can

[11] Fanslow, J., Hashemi, L., Gulliver, P., McIntosh T. (2021). A century of sexual abuse victimisation: A birth cohort analysis, Social Science & Medicine, Volume 270,113574, https://doi.org/10.1016/j.socscimed.2020.113574.

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find it more difficult to leave relationships and homes, as this often means leaving the community as well. The impacts of family and sexual violence on women are further outlined in the Women's Health Strategy.

Support for older people – Kaumātua

For kuia and kaumatua, the option to age in place in the communities they are connected to is important. They can face access issues to care and losing the ability to drive – has a significant impact on their independence, and more reliant on family or community. When supports for ageing in place at home cannot adequately support older people, and residential care options are not available, older people may have to leave the area – sometimes separating couples and families. In addition, the Lack of specific palliative or dementia care facilities or support, can put pressure on families, or health professionals in general roles to provide care.

Many Māori and Pacific whānau prefer to care for their elders at home rather than in aged residential care – and need quality and affordable housing options. Where older people do not have wider whānau in their community, papakāinga housing options for kaumātua have been developed by some iwi.

Mātauranga Māori

Rural Māori face significant unmet health needs and face inequities in access and quality of care. Māori health in rural communities is poor for a range of complex reasons, including racism and discrimination and the impact of wider socio-economic factors including poverty and poor hosing, and rural Māori have not yet enjoyed the benefits of the health reforms (as set out in the Hauora Māori Strategy).

Despite these challenges, rural Māori communities are resilient and often use networks and systems to support whānau and wider communities. Early in the COVID-19 pandemic, iwi, hapū and marae responses were based on mātauranga Māori and mana motuhake, offering support to meet multiple needs to stay safe and connected. Rural whānau Māori have amplified efforts to revitalise te reo and mātauranga in recent years.

Continuing these efforts to build the culture and mātauranga of rural Māori communities is essential to enable Māori who live in rural communities to live well for longer, to be part of strong and thriving communities and continue to be well connected to whenua in a way that builds and sustains wellbeing.

Housing

Quality, safe and affordable housing is a challenge for rural communities. The housing stock is in general older in rural communities and is not built to modern healthy homes standards. Old, cold, damp and mouldy housing leads to ill health and preventable hospitalisations. People in rural areas are more likely to live somewhere that lacks a toilet, kitchen sink, or bath or shower, than people in urban areas. Māori in rural areas were considerably more likely than the total rural population to live in a dwelling that lacked these basic amenities. Improvements in rural housing will greatly improve health outcomes.

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There are a range of factors that contribute to housing challenges for rural communities. Homelessness in rural communities has been growing and Census data shows the Far North District had one of the highest numbers of homeless people in the country. The causes of homelessness are complex, but are partially due to 'stressed renters' relocating to areas with cheaper housing.

For workers, including the rural health workforce, finding suitable and available housing is a challenge – and many people are reliant on employer-led ownership or renting arrangements. This is particularly challenging for people on short-term work or training placements, including health students. It is common for employers in rural communities to include housing, or to secure housing, as part of employment package – this can be an important part of filling workforce gaps.

Increasing housing supply in rural areas is often not seen as key focus. While there is plenty of space available, asset value is generally lower than in urban areas and construction infrastructure can be more limited, making it challenging to attract investors and developers. There is some work underway to address this – including MAIHI Ka Ora – the National Māori Housing Strategy, which is creating space in our housing system to ensure Māori can remain connected to their people, their whenua and their whānau.

Declining rates of home ownership particularly impact the housing security and affordability for older people as they exit the workforce. Depending on housing options in specific rural areas, this could either result in older people leaving the communities they consider to be their home, or for areas with lower cost and available housing, be seen as options for older people to move into.

Food security

Rural communities, despite being key in producing some key food products, can face issues with availability of food within their community. This is due to limited local commercial options, or distance to access food in larger shops, and to afford food due to financial pressures. For those that do face financial pressures there can also be more limited local charitable support, such as food banks. More food purchase planning takes place for those in more remote communities. However, if you have financial pressures doing larger shops in cheaper options further away, with higher transport costs, are less viable options.

Food security can be higher concern for some older people, as they are more likely to be on modest incomes and may have more issues around transport options. For families with children, some benefit from food in schools (outlined further within health and wellbeing within rural communities).

There can also be more limited range of foods, which can affect new migrant groups looking to maintain their cultural food options.

Transport

Rural communities are reliant on transport networks to get to work, school, access health, or get supplies from town. These networks can be precarious, and when a single bridge or road is affected, there are significant impacts on people's daily lives,

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and ultimately their ability to continue living in certain areas (as seen in the aftermath of cyclone Gabrielle). Alternative transport options tend to be maintained to a lower standard, and public transport is often inadequate or non-existent – leaving people reliant on their own transport or seeking help from others. Waka Kotahi is looking to prioritise resilience within its investment options, but some areas have limited options and inherent risk to impacts of extreme weather and climate change, due to the geography of the area.

Having resilient infrastructure includes options for air, such as helipads, that are key need for emergency care, or provide access for health and other essential needs when other transport links are damaged.

Digital connectivity

The COVID-19 pandemic has accelerated the availability and necessity of digital technology use when accessing social and health services. However, there is a digital divide between urban and rural households, which is more pronounced in remote areas. Some people in remote rural areas are still unable to reliably access the internet or have limited or intermittent connectivity, especially in sparsely populated geographic areas such as Northland or the West Coast. Addressing the technical challenges of getting internet to our regions can be costly (such as satellite-based solutions), exacerbating the digital divide.

A lack of digital connectivity limits rural communities access to online health and social services, but also isolates rural communities from a range of online options, such as connecting with family and video streaming services.

For people to have the option of using digital health services across the country, it is important that the necessary infrastructure and supports are put in place to improve digital equity in rural areas. Areas of focus for improving digital equity include:

- Improving digital connectivity. The Ministry for Business, Innovation and Employment (MBIE) has launched several rural-focussed initiatives. Some iwi groups are also active in supporting connectivity for their communities. However more work is needed to ensure there is equity in the quality of digital connectivity across the country and are reliable and resilient.
- Supporting people with the financial costs associated with digital health. This includes access to digital devices and any data costs.
- Supporting people and communities to develop digital literacy, so that they have the confidence to utilise digital health services, when this works for them

When there is connectivity, people often lack digital devices or capability to use technology. During the COVID-19 pandemic, there was increased support to provide digital access to groups missing out from education (for families with children) and from MSD. This also supported digital access to health information for COVID-19 and for online appointments during this period. This support for digital inclusion is now more limited.

Environmental factors and climate change

The conditions in and around our homes, schools, playgrounds, and workplaces, or rivers and beaches all have an impact on healthy whānau and communities. The

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environment impacts on our wellbeing, and the quality of our drinking water, the air we breathe and exposure to hazardous substances affect rural health. Sustaining a healthy environment is central to keeping the rural population well and to preventing avoidable deaths due to preventable environmental health issues.

Wai ora, the importance of people's connection to the environment to their wellbeing, is important for rural communities, especially rural Māori living in their tūrangawaewae. Many people within rural communities live off the land and water within their communities and often have strong intergenerational connections to their place. Environmental change, including to the built environment, in their place can impact wai ora.

Rural communities are disproportionately affected by climate change in several ways, with direct and indirect effects on rural health:

- Rural areas are more exposed to climate-related events than urban areas, such as droughts, flooding and sea-level rise. The wellbeing toll of these events is immense and expected to worsen as they become more frequent.
- These events affect rural livelihoods as well as homes, and exacerbate already poor health outcomes. Around half of those impacted by the loss of safe drinking water in Cyclone Gabrielle were Māori and over half were living in the most deprived areas. A lack of access to safe drinking water and sewage can be another stress on flood-wearied communities.
- Greater resiliency in infrastructure, including water and digital infrastructure, is needed to serve basic health needs in the face of climate change.
- Transformational change will be required to balance investment in coastal protection versus supporting coastal retreat to ensure the safety and viability of rural coastal settlements.
- Rural communities are more prone to being cut off from vital support networks and economic activity in the aftermath of severe weather, such Cyclone Gabrielle. The cumulative financial and personal effects of severe events and uncertainty about the future puts strain on mental health.

Rural adaptations and mitigations to climate change can help rural communities to become more sustainable and resilient. Providing solar panels provides a more affordable energy option to rural communities, especially kaumatua who won't face large bills for heating. They also support more local renewable energy and provide more resilience to risks from infrastructure. Solar panels were beneficial in the aftermath of Cyclone Gabrielle, where solar-connected homes were able to continue using basic appliances.

While adaptions and mitigations can help lessen the impacts, preparation for managing the impact of more frequent events affecting rural communities will be needed, including support for community-based organisations, Proactive planning and adaptation in this regard are essential steps towards safeguarding our communities against the impacts of climate change.

Sustainable communities

The sustainability of rural communities and the availability of health services within these communities is intrinsically linked. As health and social services lessen, people

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are dissuaded from living in certain areas and may choose to move – particularly those looking to start a family, older people, or those with specific health needs. Struggling health services and communities can also find it hard to recruit health workers, compounding the problem – as schooling, digital connectivity and wider employment options (for family members) all contribute to the decision to live rurally.

Rural communities are based strongly around rural economies, particularly the primary industries (including farming, forestry and fishing), directly or indirectly providing a livelihood to communities. However, primary industries are vulnerable to weather and international markets. Conversely, industrial growth has the potential to revitalise rural communities. For example, a new medicinal cannabis company being established near Ruatoria (called Hikuranga enterprises) has the potential to boost to employment, and increase the population and business activity, and then also community facilities.

More limited education and employment opportunities also dissuade young people from staying in rural areas. More work is needed on attracting young people to roles in rural communities that support their life aspirations, and could include health careers. This should also include opportunities in local employment for young disabled people, such as supported work experience and transition to work supported placements.

As well as economic growth, maintaining and enhancing health and social infrastructure is important to attract people and businesses to communities. The Resource Management Reforms, led by the Ministry for the Environment, have increased opportunities to embed health and wellbeing in future spatial planning, and, over time, this will lead to health-promoting environments.

Health and wellbeing in rural communities

Information and knowledge are necessary for evidence-based decision-making in health. However, high-quality information for rural communities has been limited in the past, and the picture of outcomes is now building. This section sets out the current state of rural communities' health and wellbeing, based on available data. Improving rural health monitoring and reporting will be a key priority for health agencies in the reformed system.

Rural communities have higher levels of deprivation

Higher levels of socioeconomic deprivation are associated with poorer health. Deprivation, as measured in the census through the New Zealand Deprivation Index, is a combination of communication, income, employment, qualifications, home ownership, support, living space and transport[12]. Rural communities have a higher share of their population living within areas considered to have the highest deprivation (top quintile), than the main urban areas. Deprivation is felt hardest in remote rural areas, with around 40% living in areas categorised as within the group most deprived. In comparison, people in larger rural centres or closer to urban areas have similar deprivation levels to provincial urban areas.

[12] There is limited data on social inequity such as child poverty and housing affordability measures for rural communities, as many of these are based off survey data that does not produce robust rural results.

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The Ministry of Education's equity index[13], which is also used as part of targeting the Ka Ora, Ka Ako food in schools programme, suggests that families with children in rural areas are more likely to have more socio-economic challenges. Of rural-based students[14], 41% were in schools that received the Ka Ora, Ka Ako programme in 2023. For Māori rural-based students, this is around two-thirds, and over 70% for Māori students in the most remote rural schools. This is higher than students in urban-based schools (24% of total urban-based students and 48% of Māori urban-based students).

Overview of rural health outcomes

Rural communities have poorer overall health outcomes than those living in urban centres. They have more communities with higher health needs including Māori, older people, and still a comparable share of children to urban areas.

Uptake of some prevention initiatives and diagnostic access indicates some rural communities do not access care that prevents or identifies issues early. Barriers include distance, availability, or the approaches available did not meet their needs.

Distance to access care, or the ability to get into care in the community, such as GP practices with long delays for appointments or inability to enrol, can lead to health issues not being picked up or addressed as early as they could. Distances to services could also impact treatment options and lessen the ability to have whānau near when getting treatment.

Amenable mortality rates for Māori communities are higher than the total New Zealand population, and rural Māori communities' rate of amendable mortality is higher than their urban counterparts. Further work is needed to understand the interactions between deprivation, rurality and ethnicity in shaping health outcomes.

Further details on rural health outcomes are in Appendix 2.

Improving reporting on rural health outcomes

Health agencies are currently working towards adapting data sets to monitor and publish health data for rural communities using the Geographic Classification for Health. Over time, this will build the evidence base for rural health outcomes and health care experiences. It will also be part of evidence based and feedback loops to inform our approaches – including through monitoring this Rural Health Strategy and evaluating rural health approaches.

When building this data and evidence base, we will need to include a focus on different population groups within rural communities. This includes Māori, other ethnic communities including Pacific peoples, disabled people, the rainbow community and

[13] The Equity Index (EQI) he EQI is a statistical model that estimates the extent to which students face socio-economic barriers to achievement at school using 37 variables linked to school achievement. The information that this model provides allows the Ministry of Education to better target equity funding. The higher EQI number indicates that a school has students facing more or greater socio-economic barriers. For further information see: **https://www.education.govt.nz/our-work/changes-in-education/equity-index/faq-equity-index/**

[14] This analysis of rural and urban schools classifies them into the Geographic Classification for Health using the school's address and applying that to all enrolled students.

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other groups with higher health needs. The evidence base will also include the wider determinants of health, including housing and socio-economic impacts.

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Part 3: Priorities for rural health

The New Zealand Health Strategy, Women's Health Strategy, and Hauora Māori Strategy provide direction for change for improving overall health outcomes, including for rural communities. Te Mana Ola - the Pacific Health Strategy, and Health of Disabled People Strategy provide direction for improving these population groups outcomes, including when they are in rural communities. Many of the priorities in other strategies also support rural communities as they are about improving the system and experience for everyone, or they support populations in rural communities that have multiple identities, such as rural Māori or rural disabled people.

Key areas of focus in other strategies that apply to the rural health context, includes the health adopting a learning culture (priority 4 in the New Zealand Health Strategy). Ending racism and discrimination in the health system will require collective action at every level. In future, health services will be able to monitor and acknowledge where system inequities lie and have a proactive approach to dismantling systemic racism. This is further outlined in Outcome 3 of the Hauora Māori Strategy.

The priority areas for the Rural Health Strategy set a ten-year direction for health in pursuit of our long-term vision of pae ora | healthy futures. Each of the priorities has been chosen based on an assessment of the evidence base and feedback from people and communities. Collectively, the priorities span a range of areas that highlight the key opportunities for change in our health system. They indicate the types of change needed to re-balance the system towards people, whānau and communities, to develop new services and approaches, and to change how agencies, and people delivering care work together. Our priorities reinforce each other and are inter-linked in a number of ways. Action in one area is likely to have a broader impact in others.

The priorities in the Rural Health Strategy relate specifically to how rural communities are served by health system. Many of these consider practical and operational changes within the system, as well as the policy decisions to make the changes happen.

The priorities for this first Rural Health Strategy set the direction for changes that specifically improve outcomes for rural communities:

- Making sure the needs of rural communities are considered in planning and service decisions (priority 1).
- Prevention: Paving the path to a healthier future (priority 2).
- Shifting the balance towards more services being closer to home, through local provision, services coming to the community or telehealth (priority 3).

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- Better support for when whānau do need to access care outside their community (priority 4).
- Growing and supporting the rural health workforce and expanding their capabilities to deliver the care needed by the community closer to home (priority 5).

Overview of Rural Health Strategy priorities

Priority 1: **Considering Rural Communities as priority group**	**Priority 2:** **Prevention: paving the path to a healthier future**	**Priority 3:** **Service options are available closer to home for rural communities**	**Priority 4:** **Rural communities are supported to access services at a distance**	**Priority 5:** **A valued and flexible rural health workforce**
Planning and decisions to consider and factor in the needs of, and impact on, rural communities	*Shifting focus to prevention and addressing wider influences on health*	*Improve access to services within rural communities from local entities, or from those outside the community via outreach and digital options*	*When health care at a distance, financial support for travel or digital options to reduce travel are supported*	*Build a workforce with broad capabilities to meet health needs within rural communities to provide a wider range of care closer to home*
Adapt "rural proofing" framework for health decisions	Addressing the building blocks that make and keep people well	Broader health services available locally	Proactively identify and assess access needs	Increased support for rural health training pathways, and the new workforce better reflects population served
Reassessment of existing settings that contribute to approach that does not work for rural communities and contribute to limited access or poorer outcomes	A population approach and prevention to keep rural people healthy	Outreach services including outpatient clinics, diagnostics or mobile screening	Access support offered includes travel costs, digital support to enable remote care options, and could link to other supports, such as mobility aids or interpreting	Recognition of broader rural roles, clinical frameworks and task sharing. Support for training to broaden and maintain capability
Voice of rural communities input their needs through locality plans and Iwi Māori Partnership Boards	Cross-agency work on factors that impact health and sustain prevention	Digital options are expanded and supported for patients, whānau and workforce	Approach would support ease of use for patient and whānau in receiving help	Wellbeing of workforce

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Priority 1

Considering rural communities as a priority group

Why is this a priority?

Around one in five New Zealanders live in rural communities, and for Māori that is one in four. Ensuring that a policy option or approach works for this significant part of our population is crucial for achieving equity and overall health outcomes. Many existing systems and policies are largely designed for urban settings, with a lack of consideration for the needs and circumstances of rural communities. Rural areas are not smaller urban areas – they have different strengths, needs and community characteristics – and different options and approaches are needed.

In spite of this, many legacy funding and service delivery approaches follow a generic approach that have been designed for urban populations and have not been developed around what works best for rural communities. Given the specific challenges in rural communities, including sustaining services and the economics of provision to smaller, sparser groups, different approaches must be considered to achieve good health outcomes.

Many resilient rural communities work towards sorting out what their communities need, despite resource or support gaps. They are already innovative by necessity. However, the health sector should not rely on the "bank of aroha" or the strength and resilience of rural communities to make up for a lack of consideration of rural needs in health planning and resourcing.

What will the future look like

Rural communities will be recognised across the health system as a priority in planning and decision-making. The impact on and needs of rural communities would be part of:

- new health initiatives or approaches, to consider how these will reach rural communities, such as cervical cancer screening through HPV testing;
- assessing priorities for new technology, to include potential for higher benefits to rural communities of new technologies, such as use of monitoring devices[15] or sensors or new diagnostic approaches;
- decisions on commissioning health services for rural community, informed by locality plans;

[15] For example, monitoring of real-time glucose levels for diabetic patients that enables both patient and health workers receiving this data would have greater benefits for rurally-based patients.

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- continuous improvement processes, so that gaps in rural health outcomes are identified and assessed routinely to target support where needed.

Meeting Māori rural communities' needs better also requires strong leadership from Māori communities. This will be supported through iwi-Māori partnership boards, locality planning and more generally through Māori voice in decision-making. We expect to see mātauranga Māori approaches in rural models of care where services focus on the broad needs of the whānau and which include options such as rongoā.

Improvement in meeting rural community needs will also be supported by a coordinated and aligned approach across wider government services. This will recognise that inequity in rural needs not only relates to health but to other sectors, such as disability, education or social services. Common issues and barriers can also be overcome by developing solutions together.

By supporting what works better for rural communities, health outcomes for rural communities and wider New Zealand, will also benefit. For example, being offered digital options, could improve health outcomes for other groups across New Zealand.

What needs to change

Improved approaches for how rural communities' needs are considered across the health system – from policy and operational decisions, cross-agency work on determinants to monitoring.

The impact of Cabinet policy decisions on rural is currently supported through the Ministry for Primary Industries "Rural proofing" framework. This framework means:

- understanding the different needs of rural communities;
- identifying the impacts of policies on them;
- ensuring the policy outcomes are fair and equitable.

Health agencies should adapt this approach to a health context, and support sector decision-makers to apply it in considering the impact of decisions and planning on rural communities. This needs to be systemic and supported through existing processes to ensure decision-makers at all levels have tools and systems to make the change in their thinking and approaches.

Approaches that work for rural communities should be part of designing key system settings, not as an ad-hoc rural addition, when later there are clear gaps. This would span a range of areas including funding models, but also include more operational choices such as appointment scheduling and co-ordination for those with multiple chronic conditions, or the screening options or collection of self-tests for an area with postal limitations. Better meeting rural community needs can also be supported by better collaboration across government entities around service planning and delivery for rural communities.

The voice of rural communities should be central to developing approaches that work for them. This will build on the opportunity of locality planning to develop new mechanisms to reflect and respond to the diversity of rural voices.

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For rural Māori, approaches that are driven by their communities are critical for supporting tino rangatiratanga and mana motuhake in the design, delivery and monitoring of health services, and for being effective towards improving health outcomes and achieving equity. This requires the health system to recognise and strengthen rural Māori leadership, including through the work of Iwi-Māori Partnership Boards.

For example, during the COVID-19 pandemic kaupapa Māori approaches that focused on supporting all whānau needs were highly valued when reaching people and getting uptake was crucial. However, many of these approaches can also support wider health and wellbeing challenges, have not had the same respect from the system.

> "*Our marae are really important to us. We were valued during COVID, but that is changing back to the old ways. It's silly because it works*" Ngā Wānanga Pae Ora 2023 participant.

Current system settings should be reassessed when they contribute to gaps in health needs for rural communities. Considering rural needs will mean reassessing the role of existing system settings in contributing to persistent service gaps in multiple rural areas, and determining what needs to change for these to lessen in the long-term.

This should consider not just the immediate impact of unequal settings – for instance, when people in small towns in rural communities cannot enrol in general practice, or where key care roles cannot be recruited such as midwives or aged care support – but also the underlying commercial, funding and workforce factors that can create issues for rural communities. While there are always likely to be some challenges in providing healthcare to rural communities, there are opportunities to look at different approaches to prevention, models of care and supporting the workforce.

For urgent care and emergency care, health agencies, ACC and the sector need to re-assess options and approaches in rural areas that can be sustainable and still meet community needs. The complexity of this task is high around resource needs, transportation, range of workforce needs, integration across community care and emergency response, and the range of different strengths or capabilities within local areas. Different options may work in different communities.

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Priority 2

Prevention: Paving the path to a healthier future

Why is this a priority?

When rural whānau don't have the things they need, like warm, safe homes and healthy food, it affects their health. When people in rural areas worry about making ends meet, and their income is unpredictable, it puts a strain on health and wellbeing. The health system needs to change the way things are done, to keep people well, prevent illness and support rural communities so everyone can thrive. Schools, marae, volunteer organisations and sport clubs are the social glue in small places. These get-togethers, lending each other a hand, and kindness of rural communities is vital to pae ora. There are many challenges, and there are plenty of reasons to be optimistic about the future.

The ability to achieve pae ora in rural areas is dependent on social, cultural, structural, economic and environmental factors. Creating healthy rural communities needs the right building blocks in place, including stable jobs, good pay, quality housing, resilience to climate change and education. It also needs leadership to build connections and additional support for people facing challenges or hardship.

A population health approach that protects and promotes health and prevents or delays ill health and injury, is crucial. By addressing the underlying factors that impact people's ability to live and work well in rural areas, we are shifting the focus to prevention and taking an approach that promotes pae ora in its deepest sense:

> "*Having basic needs met is fundamental to health. Being able to afford to go to the doctor, to feed the family, to have access to and afford housing, and to have paid work*". Whānau voice findings.

Change is possible, but it requires a different way of working. There are initiatives across government targeting these housing, education, digital connectivity, employment and environment issues, but the focus on wellbeing is uneven and there are opportunities for better coordination and strengthened impacts. Rural communities need a joined-up approach to address issues of wellbeing right across the full range of initiatives and policies. This will support rural communities to live well from birth, childhood and adolescence, right through to adulthood and old age.

The COVID-19 pandemic highlighted the importance of preventing disease, promoting healthy behaviour, and working across sectors to address the drivers of ill health. Action to address COVID-19 pandemic demonstrated how the sustainability of the healthcare system is best supported by keeping people well. When organisations and communities work together to improve living conditions and wellbeing, we are all collectively safer and healthier.

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What will the future look like

Creating thriving communities and keeping whānau well requires preventive action at every level. Effective prevention – keeping rural people healthy throughout their lives and avoiding early death – requires action across a continuum, including to:

- reduce the impact of environmental and social factors that negatively affect health;
- reduce risk factors and increase protective factors to prevent a disease in those who are well;
- detect health issues early and manage diseases to prevent or reduce long-term effects. This includes screening people to identify disease early;
- minimise the day-to-day impact of a disease or ill health.

Case study: Tertiary prevention

Ngati Hine Health Trust remotely monitors patients who have had a Cardiovascular Disease (CVD) event from home. They provide patients with a monitoring plan and devices that allows people to log daily vital signs and symptoms of deteriorating health. Patients receive feedback, access to coordinated treatment, educational material and the ability to communicate virtually with their assigned Whānau Ora Navigator.

When we increase the focus on keeping people well, rural communities will thrive and will be an attractive place to live, learn, work, play and age. Over the longer term, health outcomes will improve, life expectancy gaps for rural Māori will reduce and we will have easy and local access to the prevention solutions that the community sees as necessary.

The health system will support communities to deliver on their aspirations, strengths and under the leadership of iwi, hapū, whānau and communities. The health sector will be supported to lead by example and use the levers it has, including procurement, to support rural communities. The experiences and voices of rural communities, iwi, hapū and whānau will be heard, and their priorities respected by those making the decisions.

What needs to change

Shifting the focus towards the prevention of ill health in rural communities will require many of the same cross-government and cross-sector actions identified in the New Zealand Health Strategy and other strategies. In particular, the advent of locality planning provides an opportunity for a specific rural focus that drives priorities and commissioning decisions for health and wider public services, and can support a greater focus on prevention.

A population health approach that protects and promotes health and delays ill health is adopted. Prevention efforts for rural communities should be locally co-ordinated, culturally safe and sustained over the long term. The health sector will report on the outcomes of the investment in prevention for rural communities.

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Public health programmes are available and fit-for-purpose. For the health sector, a greater focus on preventing, reducing and delaying health needs in rural communities might include:

- Improving access to a wide range of public health programmes in rural communities, including health protection, health promotion and preventive interventions such as screening.
- Ensuring availability of screening and immunisation in all rural communities, with a focus on children and women with caring commitments. Approaches may target seasonal workers, and those with limited mobility or transport options.
- Locally-led mātauranga Māori solutions and access to rongoā, tikanga based solutions, culturally and clinically safe health services.
- Prevention solutions for rural Māori are driven by approaches that the community want and are effective, such as whānau ora.
- Improving experiences for disabled people in rural communities through deliberate design that responds to environmental, sensory and care needs for them and for their family and whānau.
- Monitoring, analysis and reporting of the impact of the determinants of health on the rural population drives research and action.
- Data becomes easily available to strengthen community action in setting priorities, making decisions, planning and implementation.
- Reviewing funding approaches to support sustainable investment in prevention in rural communities, across a range of settings and at every stage of life.

Across wider sectors, it will be necessary to strengthen collaboration between services, agencies and communities to address shared issues. This should consider how to ensure rural communities, and in particular Māori, are able to drive priorities and inform service design and delivery. Community co-design approaches are likely to need to be adapted to be most effective in rural communities.

Case study: Buller Flood Recovery

The Buller Flood Recovery team led work in 2022 to check in on those affected by floods living in the Buller district. The team included a range of local government and health staff, iwi and social service agencies. The results of the survey indicated a reduced quality of life amongst those affected by flooding that was linked to decreased levels of physical activity, weight gain, increased use of alcohol and tobacco and other drugs, and a small proportion who reported an increase in gambling. The survey also highlighted women, Māori, those in one adult households, those renting and those living with extended whānau or friends were among the most likely to be struggling. This has informed Council planning and is an excellent example of the necessity of whole communities to work together to navigate long-term social and economic recovery and climate change adaptation.

Rural health can also adopt the lessons learnt from the practice of "health in all policies", both internationally and locally, most notably in Christchurch and the wider Canterbury region. Health in all policies is a structured approach to working across sectors and with communities on a range of public policy in a way that promotes trusting relationships and engages stakeholders to systematically to consider the implications of decision making on population health and equity. A health in all

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policies approach can be utilised to address health inequities, the wider determinants of health, and climate change. The approach aligns with the United Nations Sustainable Development Goals, as adopted by the UN General Assembly. Utilising a health in all policies approach leads to increased collaboration and efficiency and the consideration of health and equity across sectors.

Support for health in all policies will be provided nationally, as noted in the New Zealand Health Strategy, to drive engagement with central government agencies. A commitment to using health in all policies across the country will ensure that local initiatives are well supported by best practice. Existing tools and case studies will be expanded to build capacity across health sector to work collaboratively. Health will partner with local government to support councils to better meet their legislative requirements for supporting wellbeing. Finally, support for the use of health impact assessments and other tools to enable health in all policies will be resourced.

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Priority 3

Services are available closer to home for rural communities

Why is this a priority?

Access to services is the key problem for rural communities: the further someone lives from a health service, the less likely they are to access that service. For example, urban people were around 1.5 times more likely to have a computed tomography (CT) scan than those living in rural areas that did not have a CT scanner.

Health services need to be designed and delivered in ways that work better for rural communities. Often the focus for services is on building capability in central locations instead of having them closer to where people live, or designing models that help people access services from their home.

"Keep me well, and keep me close to home", Hauraki locality whānau voice

The opportunity for rural communities is not just about access to health services, but about the design of new integrated services that address health and wellbeing in the rural context, including for rural Māori. Innovation and collaboration are often part of the necessity of living and working within rural communities. While there are many positive approaches for health within rural communities, often these are supported in an ad-hoc way by the system and opportunities for wider benefits are missed.

While remoteness and distance will always be the reality of living in rural areas – having more local options can reduce the impact.

What will the future look like

Rural communities will have broader options for services that support their health, delivered by locally-based entities. Primary and community care, other community-based services, including kaupapa Māori services, and rural hospitals will provide patient and whānau-centred models of care that support continuity of care for rural communities.

People will have increased local access to community health services, medicines, more diagnostic options and services such as follow-up injections for arthritis, or less complicated repeated cancer treatment options. Health services will be delivered in ways and places that best support access for rural communities, for example nursing visits at a playgroup or screening at a community event. Mobile outpatient clinics and community outreach services will be better utilised to provide key services such as diagnostics and specialist care services.

These broadened service options will depend on health needs of the community, the capabilities to deliver it, especially from the workforce, and relate to priorities raised in

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locality planning. For Māori rural communities, local options could include marae-based clinics and mātauranga Māori services.

Integrated healthcare

Golden Bay Community Health, based in Tākaka, combined the resources from previous "isolated islands of services" including old hospital, aged care, district nurse and GP practice to provide integrated services for their community. The community trust owns the facilities, but they are run by Nelson Primary Health Care. While there is strong value to the community in its services, some are from community and workforce effort where not all is supported by funding.

The community benefits from having access to broader health care – lessening the need to choose between travel to Motueka or Nelson or not finding out what is wrong or getting treatment. They provide maternity through to palliative care and offer urgent care for the community. Outreach services and outpatient clinics also visit to provide additional services to the community. Opportunities for more links to specialists, including via medical telehealth, and local services, such as aged care, are actively looked at to support more care and services closer to home and to sustain the community. The community knows where to get support, has more continuity of care, and links to specialist support through its community provider.

They have broadened their workforce roles, such as rural nurse roles, and have clinical nurse educator to grow skills and provide career growth to retain staff. They are generally able to maintain a workforce across different parts of their service and from and have sufficient scale to make the cover rosters manageable.

This integrated approach provides more equitable health care close to home, managed locally with specialist oversight, when needed.

Digital options are not the panacea for access issues, but they are part of the solution. Digital access such as telehealth will be part of a standard offer for patient and whānau choice, when this is appropriate, with the right support provided to facilitate the appointment. Urban-centres would need to have processes and tools to support this offer, and patients also supported with health workers locally, if needed for the consult.

The focus on closer to home also aligns with the *Oranga Hinengaro System and Service Framework* that provides direction for the mental health and addiction system and service. It includes a focus on locally networked mental health and addiction services. Smaller areas, including rural and remote areas, will tailor services, balancing local circumstances, workforce availability and the appropriateness of mixing people of different ages and needs. Smaller local services may have multi-purpose teams and multi-skilled staff and will be able to access advice and support from regional services.

What needs to change

Rural communities need to be supported to have more service options available in their community. This requires increasing both:

- the range of services available in the community through integrated models that support health and wellbeing;

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- mobile outreach or digital options from main centres into rural communities, to deliver services to meet a range of community's needs, including being accessible to disabled people.

Integrated health options should be developed as a desired model. To support more integrated models and expanded services within rural communities, there will need to be changes to the current funding approach for services and an integrated commissioning approach at the community level. More flexible funding and planning arrangements that focus on broader service needs will need to be developed.

The development of the Government Policy Statement on Health and Te Pae Tata, with input from early locality plans, will provide an opportunity to progress these options. This could also include options for support to extend facilities and high-end equipment needed for a broader range of services to be covered locally. The expansion of services and development of models for rural communities will need to take place within the context of constraints that apply to all groups, including resourcing and workforce availability. Decisions will have to set priorities for initial actions and consider how to address the most substantial inequities or provide the greatest health benefit to rural populations.

Expanded options in communities should build upon people and capabilities within rural areas by recognising and resourcing local-led options. For areas where there is high community need, such as mental health, health professionals should be supported to develop extended roles or capabilities to enable them to continue and expand their role within the community. Supporting the rural health workforce build broader capabilities, and better links to the urban-based workforce, are reflected in priority 5.

Enabling options and choices for rural communities would provide Māori communities more options to deliver on tino rangatiratanga, and Māori providers and iwi would need to be supported to expand services with te ao Māori approaches, including rongoā Māori.

Digital, mobile and outreach health services are better utilised to bring care to rural communities. There will need to be stronger commitments to improving and increasing outreach or mobile services including:

- more outpatient or specialist clinics in rural communities, including those led from a range of health professionals
- additional mobile services, including minor surgery, Te Waka Wahine Hauora – the Women's Health Bus, or diagnostic tools[16]
- the expectation that a telehealth option is offered to rural patients, when the type of consult, with limited direct treatment makes this feasible;
- locations within rural areas for digital support where this works for the community based on connectivity, and services available, such as a community hub, or a health care provider;
- ensuring approaches are responsive to the different needs of rural communities including being accessible to disabled people.

[16] Another benefit of the mobile services is that they can also provide back-up for diagnostics, workforce gaps or seasonal population surges.

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Digital health options in rural communities should allow for care-in-place in an accessible location (either at home, residential care, or in the community), with different types of providers across the health system.

Case study: Pokapū o te Taiwhenua Network

The Pokapū o te Taiwhenua Network is a pilot network of health and wellbeing community providers, community members, primary care and specialist care supporting digital inclusion and digital health equity in Te Manawa Taki region, around Lakes District.

The network offers video appointment facilitation, where clinical or non-clinical facilitators from the local workforce can support patients based on their needs. The kaupapa is aimed at providing whānau with the "right care, at the right place at the right time with the right technology and the right facilitation". This includes options such as:

- access to video appointments in their home or at local community hubs
- providing in-person clinical support, with blood pressure, oxygen and other health vitals reported back via technology to specialist on the video link
- providing digital literacy support.

The video consultations are described as 'a one-on-one kōrero [between you and your health provider], with a screen in the middle of you'. This allows health professionals to form a relationship with their patients through digitally-enabled face-to-face contact.

By taking out the need for hours of travel and waiting rooms, especially for those with mobility issues, these digitally-facilitated appointments are slotted into patient's schedules with very minimal impact on the rest of their day. People can still go to work, care for their mokopuna, and participate in sports and recreation.

Enabling care to be received at home or in the community, ensures that patients receive care in a space that is safe and comfortable, and allows practitioners understand patients' health in the context of where they live. Remote-based interpreters are also able to join video-consultations where necessary, to help facilitate conversations between patient and provider. Patients are also enabled to include their whānau in the consultations, either in-person in their home or dialled in remotely to the conference call.

Although the provision of local health services has potential to greatly improve access and continuity of care in rural areas, consideration needs to be made of both:

- the potential for negative interactions with one local option making people hesitant about other local services; and
- the notion that 'everyone knows everyone' in rural communities can dissuade people from seeking care. Perceived risks of the community finding out personal information can be a barrier to accessing support, in particular for sexual or mental health issues; experiences of family violence; or information regarding sexual and/or gender identity.

"You can't access sexual or mental healthcare if your local GP is your family friend." - Representative of the Rainbow sector

While these aspects will need to be considered in the broadening of services locally, the option to access urban-based services or digital solutions, such as telehealth options for abortion services, may provide an option outside their local community when they would prefer to do so.

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Priority 4

Rural communities are supported to access services at a distance

Why is this a priority?

There will always be a need for people living in rural communities to receive health services from parts of the health system outside their community, some very long distances away. Some specialist services may be hours away from home, making access harder for rural people. The impact of this distance, as well as compounding other barriers, and be a factor in them not seeking care. When travelling large distances to specialist services or treatment, rurally based patients do not only have to factor in direct travel costs for them and their whānau, but the wider impact on work and family roles of being away from home for periods of time. Sometimes, the costs or lack of options to cover work or home life will seem insurmountable and people will opt to not access health as a result.

When essential health services cannot be provided within reasonable travel distance, for instance for reasons of quality, safety and efficiency, including in ability to sustain the workforce, the system needs to support people and families that have barriers to care.

People who do not access care when needed may build up issues that leads to more ill-health and poorer outcomes. We know that distances create a higher impact on the time away from home and costs for people living in rural communities. We also know there are many people in rural communities, like urban areas, that also struggle with finances, and some rural areas have high levels of deprivation. Those more affected by the impact of distances include disabled people needing health support, those with long-term health conditions, and those facing more financial pressures.

As Māori are more likely to live in rural communities, especially in more remote areas, traveling for care can have more impact on rural Māori. The data for first specialist appointments show that Māori, in both rural and urban areas, have higher rates (10 percentage points higher than European) of not making it to their first appointment. It is not clear the degree to which people agreeing to a first specialist appointment, are impacted by living in rural communities.

Around 10% of routine hospital admissions for Māori are out of their region, with the majority of these for tamariki and rangatahi[3]. The financial costs of travel can impact the ability of their whānau to support them, and place additional stress on work and care responsibilities. Higher distances from centralised liver cancer treatment for Māori (over 40% live 2.5 hours away), and lack of travel support, are linked to lower survival rates as this could delay access to care, and reduce whānau support available[4].

There is likely to be significant unmet need for support for travel, including from some who are eligible for support from the National Travel Assistance (NTA) programme but

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have difficulty in accessing it. In 2018, around 2% of people accessing specialist services received support from the NTA programme. This rate of access is likely to be significantly below the level of need, given the proportion of rural families with distances to travel and whanau, including older people, with financial challenges.

What will the future look like

When people need to access services at a distance from their home community, their needs will be assessed, and they will proactively receive appropriate support to help them access care. For people with some long-term conditions, about to undertake intense period of treatment, or as part of pregnancy, they can have an initial assessment of their access needs.

The assessment of support for those needing to access services at a distance will look at both transport options and opportunities to reduce the need for travel to health professionals. This will include the use of digital devices, wearables and other appropriate options that would support telehealth and remote monitoring, to reduce the need for travel to in-person appointments and improve management of their conditions.

The access assessment could also include actions to address other barriers to people accessing care at a distance, including a need for interpretation for ethnic communities and other types of communication support. An assessment of needs for support will also be aligned with other assessments, if needed, such as for home care, disability support or equipment.

Where people receive support to access care outside their community, this should be easier for people to receive. It should provide payment upfront when needed, not retrospectively when this puts the pressure on people to meet any costs initially. For example, some types of lower-level support, such as a small amount in petrol vouchers to offset travel to appointments, should be easy to claim for eligible people, with simpler approaches and clear rules for access.

What needs to change

The health system needs to shift, from expecting people to overcome difficulties to reach the services they need when outside their community, to offering proactive support that better responds to people's circumstances. When people need to travel distances for care, this should be managed and supported so that people follow through with the care they need and have less stress making arrangements.

Achieving this change requires a full re-assessment of existing options to support people to access services when not within a reasonable distance, or where the needs and situation of the person and whānau would risk poorer health outcomes.

This change would look to **proactively identify access needs for people with long-term health conditions or those about to undertake a significant period of**

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treatment. It should include support for travel for them and their whānau, where appropriate, and consider options for digital support.

A new approach would also need to be in partnership with the Ministry of Social Development and ACC, given they also support access to health services. It would also involve Whaikaha, given disabled people may have additional support needs to factor in for travel and digital options.

The design of a new approach should consider how any support is administered and funded. Access criteria for a new approachshould recognise the high and growing costs of transportation and should be less restrictive on qualifying distances. For instance, of those living on the West Coast, currently only those in Karamea or south of Franz Josef could access support to travel to Christchurch as standard under the National Travel Assistance programme.

A new approach to assessing access supports should also include provision of interpreting services for speakers of other languages. For rural communities, with growing diversity from ethnic communities, this will be an increasing issue for accessing local services and well as those outside their community.

Increasing support for digital options will also reduce the necessity for travel and the burdens associated for people and whānau. To be successful for digital supports for access, and digital options in priority 3, these will require effective infrastructure for digital connectivity, as well as devices and the skills and confidence to use them – whether in a person's home, or at a provider or community hub, depending on local options.

While there are rural connectivity initiatives looking to improve coverage, there are significant parts of rural areas with limited, intermittent or no coverage. Increasing satellite-based services may fill some of these technical-based gaps in the near future, but current subscription plans can be barrier for lower-income households.

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Priority 5
A valued and flexible rural health workforce

Why is this a priority?

The health workforce is the system's most valuable asset, and a critical part of delivering all our priorities for rural communities.

Within rural communities, there are significant issues recruiting and retaining people to the health workforce. Current high rates of people who trained overseas, or those on short contracts, make it more reliant on international inflows and contractors. Acute shortages and an ageing workforce, especially for GPs, create a significant risk in meeting the health needs of rural communities now and in the future.

Although rural health roles and lifestyles in rural communities can be attractive, retaining people in rural health roles can be challenging. The characteristics of rural communities, such as lack of adequate housing, isolation, lack of digital connectivity or employment and school options for their families can be issues. In addition, added burdens and additional work hours are often placed on the rural-based workforce. The 2022 RNZCGP workforce survey found that rural GPs were three times as likely as urban GPs to have after hours commitments on a weekly basis.

Tackling attraction and retention challenges will be essential to enabling a rural health workforce that is robust and flexible to adapt to support broader care options closer to home for rural people, and to meet range of needs and the high variation from a smaller population base. It also requires that the health workforce, as a whole, that is more supportive of the rural health workforce – by being responsive, collegial, and understanding the impact of service availability for rural communities.

We need more people trained in New Zealand, or already working here, to choose to work in rural health settings. Part of this, is having more people training that may be more likely to choose rural settings. This can be because they are from rural areas, or undertook long-term placements in rural settings to learn about the roles available. The other part of is also attracting people into rural settings and retaining the workforce through valuing rural health roles and improving workforce experience and wellbeing. Having a work life balance is increasingly important for attracting and retaining younger age groups in the workforce.

Rural communities have a higher share of Māori people than urban areas, especially kaumatua. Their health inequities can be better addressed through a culturally safe and more representative workforce. This includes recognition of the role that tohunga and other practitioners play in keeping whānau well. The rongoā workforce will need support to grow and develop. Broader health care choices are especially important where there is deep and intergenerational distrust of the health system.

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"My mother goes to Māori health centre in Whanganui. (She) won't go closer to home – because (there are) no Māori doctors there. (She) drives 35 minutes to get service... Plus ...Māori model of care. Addressed as 'auntie' – because from same iwi." – engagement participant at Central Field Days

What will the future look like

The New Zealand Health Strategy has set out that to protect, promote and improve the health of New Zealanders, achieve equity in health outcomes and build towards pae ora (healthy futures), we need:

- A workforce that is available to meet service and population needs
- A workforce that is equitably accessible to provide choice and timely care
- A responsive workforce that is culturally safe, representative of and flexible to population health needs
- A productive workforce that is motivated and empowered
- A quality workforce that delivers safe, effective and efficient care and are partners with Māori

All of these features will strengthen the rural health workforce.

There will be more health workers in rural areas, who are supported to maintain health and wellbeing and are incentivised to stay in rural areas. More of the people who are trained in New Zealand will choose to work in rural health settings, reducing the reliance on migration or short-term contracts. This will be supported by better training pathways for rural-based people, and more exposure to long-term rural placements during training. With more places across health professions and from range of providers, there will be better co-ordination of support for rural-based entities receiving students to manage and align placements.

Training pathways will provide opportunities for existing workers based in rural areas, such as kaiāwhina, to develop, extend of grow into other roles. The rural health sector will train their local health workforce by providing opportunities for career progression. There will be increased flexibility around tasks to better utilise the health workforce that is available within different rural communities and to provide a better range of home-based supports.

The rural health workforce will support broader coverage of health needs, including kaupapa Māori approaches. Support for workforce teams to build their skills will include those parts of the rural workforce that are delivering mātauranga Māori services.

Flexible roles to support the needs of whānau

Imagine your kuia just got home from the hospital after a hip replacement. She needs a lot of care, including wound checks, mobility assessments, and help getting to the bathroom. In the city, she would probably have to see different health professionals for different tasks, which can be exhausting and time-consuming for everyone involved.

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But in rural communities like Arahura on the West Coast, the patient needs are met differently. Using skill sharing, a district nurse, physiotherapist, occupational therapist or rural nurse specialist might go and see your kuia, each able to give all the care that she needs in one visit. The framework ensures that she receives safe and coordinated care without so much disruption to her recovery.

This interdisciplinary approach to healthcare has major benefits for rural communities. It focuses on putting patients and whānau first and improving health outcomes by promoting allied health professional skill-sharing. It means that rural health professionals can deliver comprehensive care to more rural people closer to home. With this approach, rural communities can receive the same quality of care as urban areas, making it easier for your kuia and others like her to get back to their daily lives.

What needs to change

To move towards having a valued and flexible rural workforce, a range of changes need to progress. We need to improve the wellbeing of the workforce, including through valuing their roles by through better recognition in professional frameworks, and better support for rural pathways and ongoing training to support broader health coverage.

We need to provide more recognition and visibility of the broader range of skills and capabilities needed in rural health settings. This should be through professional rural scopes or career paths, clinical frameworks and in the training options available. This would include expanding rural scopes to wider groups of health workers including the allied health professions[17]. These broader rural scopes could also include the teaching and mentoring needed for supporting student placements or upskilling teams.

The development of robust clinical frameworks[18] will support flexible rural roles while ensuring clinical safety and accountability. The supportive framework allows the best models of care for the community to be provided safely and sustainably in rural contexts. This requires working culture to be positive and trusting, including with those based in main centres whose collaboration is critical.

For example, the rural obstetric model in Te Nikau Hospital, Greymouth supports rural generalists to train and maintain safe obstetric practice including local delivery of caesarean sections, while also working in their generalist medical roles. This means the care team looks different to urban models but provides high-quality care.

Recognition of rural roles can also support retention as it demonstrates value and career progression. Recognition, when linked to roles and skill needs, or time periods of continuity in rural health roles, could also link to remuneration support directly

[17] Within medicine, there is the rural generalists model, and rural hospital medicine as training path, and for nursing rural nurse specialists as career option, however, more is needed in these and other professions to recognise and value the skills and capabilities.

[18] A clinical framework outlines training and certification requirements as well as maintenance of standards. This can demonstrate that services, while differently configured in rural areas, are operating according to the framework that considered safety, quality and managed risk within a rural context.

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through pay or Kiwisaver contributions. Often there are ad-hoc financial arrangements or exemptions to maintain a workforce in rural areas. More standard approaches as part of a career pathway model could demonstrate more effectively how rural-based roles are valued and supported.

Rural training pathways need to be expanded for all health professions. More people need to choose to work in rural health roles. Part of this is having more people training that may be likely to choose rural settings[19]. We need to increase people from rural communities transitioning into health careers, including those already working in rural health workforce, and expand the availability of long-term immersion placements, involving both rural hospital and community settings, and to include broader range of health professions.

Key areas to improve for rural placements include:

- Integrated rural training pathways for all health professions.
- Better co-ordination – so hosts and students can plan and there is alignment across system to make best use of training spaces available.
- More support for those hosting rural placements – this could be around supporting the role of managing the placement, or costs of hosting.
- Support for students to access rural placements – travel and accommodation support may need to be considered or targeted at students.
- Removal of inconsistencies across students in different programmes or disciplines – all are studying towards valued roles in the health system that should have parity in support for placements (for example, medical trainee interns receive financial support for their final year with significant work placements, but there is no direct support for midwives in a similar situation).

Improving co-ordination of student placements across the whole system is already being looked at in partnership with education agencies.

Expanding admission support for rural students, including those from diverse rural backgrounds, across limited entry programmes and supporting the attraction of rural students into health pathways is important. However, a priority should be supporting those already rural-based and settled, including those that are part of the sector, such as kaiāwhina roles or those who volunteer as first responders, to pathway into other health roles. The first focus could be for health pathways with shorter training time or existing available training, and could include allied health roles, such as paramedics, mental health roles, as well as midwife and nursing roles.

People already living in rural areas and interested in these pathways will likely be women, and many may have families and financial commitments to meet. For this group, having training options 'for rural, in rural' can have a significant impact. Options

[19] This can be because they are from rural areas, or undertook long-term placements in rural settings to learn about the roles available. While placements can increase graduates that go on to take-up roles in rural areas, many of these students will still take up career pathways in urban centres. The groups going into urban-based roles can still benefit rural health, as having a broader workforce that experienced rural contexts means more urban-based clinicians that have better understanding of the context of rural health workforce.

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that enable them to train in rural areas while in employment, with work-based or digital options, or to financially support them for any block training or placements outside their community in urban areas, would improve their ability to transition. These pathways could also provide employment and training opportunities for young people in rural communities, especially rangatahi, rather than leaving for employment in urban areas.

We need to develop broader and more flexible roles across the rural workforce. Building-up integrated and expanded service options in rural communities requires a workforce to be supported to train for extended roles, and upskill or maintain capabilities, including when there are increasingly recognised rural-specific roles. Having digital capability is also important to be confident to offer digital or telehealth options. The broader training should also have kaupapa Māori training options for supporting a hauora Māori workforce.

With the shift to a more preventative and proactive public health approach, more inter-personal skills, such as supporting people to manage their conditions or change behaviour, will be required to support wider health and wellbeing. Broadening rural workforce teams, such as through health improvement practitioners and health coaches, is an example of how the workforce has been undertaking different tasks.

Ensuring there is support from urban centres for rural training or upskilling is important. While some training options could be online and utilise daily practical experiences, or be provider-based, others may involve time spent in urban centres to build or maintain specific skills or extended roles. These collaborative relationships between rural and urban-based workforces need to be there for the provision of broader services as well.

Health improvement practitioners

In Oamaru, Sione was determined to conquer his diabetes despite the barriers in his path. His GP referred him to a dedicated Health Improvement Practitioner (HIP). Sione's HIP understood that to truly make a difference, she needed to build a bridge of trust with Sione. She learned about his unique cultural background, comprehending the challenges he faced in accessing healthcare services.

The HIP and Sione crafted a care plan that aligned with Sione's values, focusing on vital aspects such as diet, exercise, and consistent medication. She encouraged him to actively participate in diabetes education programs and community events, reminding him of the strength that lies in shared experiences.

With newfound confidence and armed with knowledge, Sione took charge of his health like never before. He diligently monitored his blood sugar levels, adhered to his prescribed medication, and embraced healthier lifestyle choices. Sione's transformation was remarkable, both physically and emotionally.

This approach has continuity of care as HIP are part of a team, but enables broader use of different workforce skills from an expanded team to support better outcomes.

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Training support for the rural workforce should apply across the public-funded system[20]. This could include costs of training and potentially associated costs, such as travel or support to backfill if training is required in main centres or facilities, depending on the training needs.

We need to support a culturally safe and representative workforce in rural areas. We want to have a workforce that looks like and can relate to the people that they serve. Increasing the cultural safety of the workforce is required across the health sector, especially for delivering culturally safe solutions to rural Māori communities. Having specific recruitment pathways for rural Māori will be key to growing the rural health workforce and reducing health inequity for rural Māori. Having a workforce that can also support te ao Māori options will be an important part of growing rural Māori health workforce.

While ethnic diversity is generally lower in rural areas, it is growing with Pacific people, Indian and Filipino communities. The rural health workforce needs to have cultural considerations in its interactions, including use of interpreters. The workforce also needs to be better equipped to respond to the needs of rainbow communities in rural areas.

We need to improve wellbeing in the rural workforce.

Growing the workforce and being more valued through recognition of rural roles will take some pressure and burdens off the rural workforce and lessen burnout and fatigue.

In addition to the overall volume of work, there are other tasks that take toll and also lessen time for patients. Some of these involve administration, follow-up, or monitoring results. These have grown with patient expectations, including for more customised support and communication, and with clinical expectations with more monitoring options. These trends are likely to continue.

Changes that are focused on lessening the burdens of these tasks, such as monitoring can be more effective for workforce and patient. For example, there could be regional task-based support, such as for monitoring, following up with patient or process for referral. Also, having digital tools and systems that make tasks easier for those having to monitor or assess results, or action referrals would make a difference to workloads tied up with these growing tasks.

[20] While some training support responsibilities are set out through employment contracts with health entities, the support also needs to be part of system settings to cover public-funded health workforce.

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Rural Health Strategy

Purpose

The Rural Health Strategy sets the direction for improving the health and wellbeing, both physical and mental, of New Zealanders living in rural communities over the next ten years. It is a key part of shifting the health sector towards building pae ora and achieving equity by reducing health disparities.

Vision

Our vision for rural health in New Zealand is one where all rural communities are empowered to achieve their full potential for health and wellbeing. We envision a future where every aspect of the health system takes into account the unique needs of rural communities, and the insights and strengths of rural whānau are used to improve their pae ora.

Priority 1: Considering rural communities as a priority group

Sandra (age 85) has lived in Milton all her life. As she's gotten older, she's developed more complex conditions. Her eyesight is poor, and she relies on public transport to get around. Appointments at Dunedin are coordinated so she goes in once and gets everything sorted. Sometimes she has home support.

Priority 2: Prevention, paving the path to a healthier future

Wiremu (age 5) and his whānau live near Kaitaia. They live in a home that is warm, dry and newly insulated following an iwi-led housing improvement scheme. Wiremu and his sister are safely able to walk to school. His mum and nana can access breast and cervical screening which is available at a visiting marae-based clinic.

Priority 3: Services are available closer to home for rural communities

Tereapii (age 35) is a mother of two, working full-time at South Waikato District Council in Tokoroa. Her and her sisters no longer need to take days off work to take Mum up to Hamilton for daily dialysis. There is a dialysis machine in the South Waikato Pacific Islands Community Trust and she is cared for by staff she has known most of her life.

Priority 4: Rural communities are supported to access services at a distance

Daniel (age 15) lives with his whānau in Westport and has muscular dystrophy and needs a range of specialist support to manage his condition. Daniel had an access assessment to see how he and his whānau can be best supported to access appointments either in person or through digital options. This ensures there's a plan to support Daniel and his family with financial costs to travel or digital options at home.

Priority 5: A valued and flexible rural health workforce

Kiri (age 40) started out working as kaiāwhina in Te Kaha and has two children. Kiri was supported to become a nurse while also being financially supported and able to take her of her children, by increasing her skills on the job and attending training at a Kaupapa provider. As a nurse, Kiri is able keep kaumātua safe and respected in their rohe. Kiri's training pathway from kaiāwhina to nurse has encouraged others in her community to also have a career in health that supports their community and provides good financial support to their family.

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Part 4: Delivering our commitment to change

Turning strategies into action

One of the objectives of the health system reforms is to better align and integrate the accountability arrangements that set direction and priorities for health agencies. The reforms put in place a new approach that aims to ensure clarity and coherence, from long-term strategic objectives to shorter-term priorities and expectations.

This new approach provides clear roles for key documents, underpinned by statutory requirements in the Pae Ora (Healthy Futures) Act:

- Health strategies are intended to set a long-term (ten years) direction for improving health and identify priorities and opportunities for the health system. The strategies provide a vision and indicate the types of change necessary over the medium and long term. Strategies do not make commitments to particular actions or require health entities to undertake specific activities – instead they describe potential choices and issues to be considered, to inform the decisions that the Government will make on what actions are taken forward, and when. Health entities must take the strategies into account in carrying out their responsibilities.
- The Government Policy Statement (GPS) sets out the specific priorities and expectations for the health system over a three-year period. It is the key document for Government to set its priorities, confirm actions for entities and funding for the health system, and detail how success will be measured. The GPS will reflect the long-term direction of the strategies, and include more detailed actions for health entities in the short-term that work towards the strategy aims. The GPS is agreed by Ministers, and health entities must give effect to it.
- The New Zealand Health Plan (NZHP) | Te Pae Tata is a three-year national service plan, that specifies the service priorities and areas for improvement that will achieve Government's expectations in the GPS. The NZHP includes more detailed plans for health services, programmes and enablers that show how the health entities will meet priorities within the funding available. The NZHP is developed by health entities and approved by Ministers.

These documents work together to set a consistent direction for the health system, which is then developed into more specific actions and costed service plans that span a multi-year period, as illustrated in Figure 4 below.

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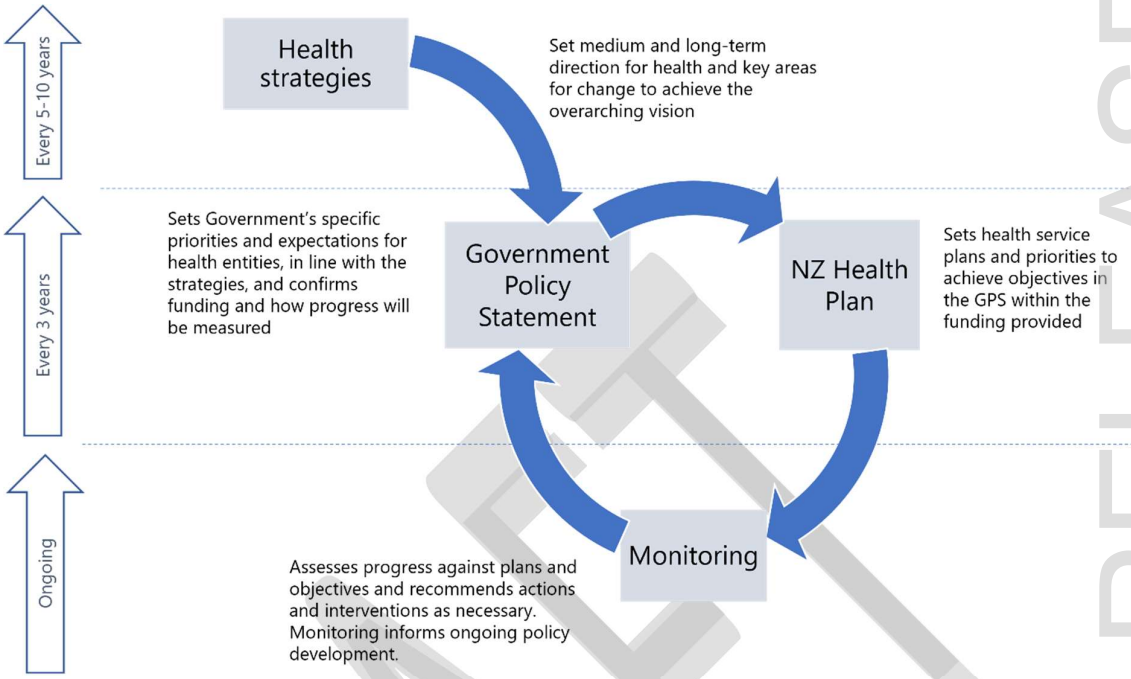
Figure 4: System architecture of the health system post-reforms



This new approach provides a clear pathway for translating strategies into action, and monitoring and evaluating the impact of strategies and the performance of agencies. The role of health strategies is critical to providing the long-term vision and priority areas that inform decisions on the other documents.

As the Government determines the first three-year GPS for 2024-2027, and in subsequent cycles, the strategies will be turned into clear expectations and actions that will provide the opportunity to achieve the changes set out.

Programme needed for change

For this strategy to make a difference, we need to take a different approach and consider the forces that drive change, and the underlying barriers that have held back progress in some places.

Critical to our approach is recognising that change in a complex system cannot be driven by changing structures, rules and policies alone. Each of these contribute to setting a direction and framing the environment, but do not always tackle the inherent factors that influence how people work and how decisions are made: the culture and values of our workforce and system.

The key areas for change are outlined in each Rural Health Strategy priority. Manatū Hauora will need to assess progress towards these, and plan a work programme to support next steps.

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Monitoring progress

The health strategies set a direction towards achieving pae ora | healthy futures for all New Zealanders, and include goals to eliminate health inequities and improve health outcomes. Monitoring progress towards this vision requires a long-term approach to measuring key health outcomes.

The GPS will set requirements for measures and indicators that will be used to monitor and assess the progress of the health system as a whole, and of individual entities, in achieving these goals. These measures will combine more enduring and long-term system-level outcomes that are closely linked to the strategies, as well as more specific measures that reflect three-year priorities and help drive action in areas prioritised in the GPS. They will support Manatū Hauora, in its stewardship role, to track delivery of the strategies and report on the impact on outcomes over time. There will also be a significant monitoring role for Te Aka Whai Ora and Iwi Māori Partnership Boards and to ensure that local services are accountable and responsive to Māori needs and aspirations.

Ensuring high-quality data will be essential to monitoring outcomes. This is particularly the case for monitoring inequities between population groups, which require a breakdown of data to make comparisons and develop insights.

Ongoing evaluation

In addition to monitoring the intended outcomes of the strategies to account for the success of their delivery, it is also important to ensure ongoing evaluation of the strategy direction itself to assure that this remains appropriate.

Over the coming years as the strategies are developed into firm actions in the GPS and NZ Health Plan and then implemented, it will be necessary to invest in ongoing research and evaluation to continue to build our understanding of the direction and evolve it where needed. This may include:

- Evaluating the impact of the Pae Ora (Healthy Futures) Act, the effectiveness of its implementation and lessons for the system structure.
- Evaluating the new accountability approach, the roles of strategies, the GPS and NZ Health Plan, and the effectiveness of their delivery and alignment in achieving system goals.
- Evaluating the process undertaken to develop the health strategies, to draw insights on the benefits of different engagement approaches, analysis and development.
- Evaluating actions taken in the spirit of continuous quality improvement.

These areas for evaluation will be developed further to support a refreshed approach to research across the health system.

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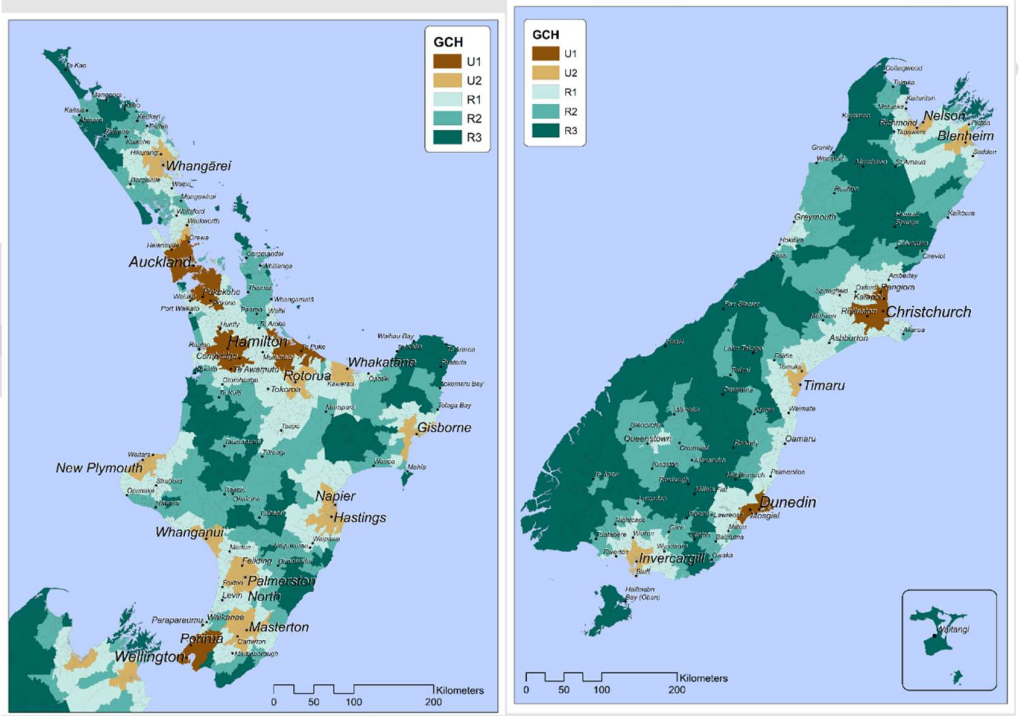
Appendix 1: Geographic Classification for Health

Geographic Classification for Health by two factors, distance and population size

Population size thresholds	Drive-time thresholds				
	Urban		Rural		
	Urban 1 (U1)	Urban 2 (U2)	Rural 1 (R1)	Rural 2 (R2)	Rural 3 (R3)
Major urban (Population ≥100,000)	≤25 min		>25 to ≤60 min	>60 to ≤90 min	>90 min
Large Urban (30,000 – 99,999)		≤20 min	>20 to ≤50 min	>50 to ≤80 min	>80 min
Medium Urban (10,000-29,999)			≤25 min	>25 to ≤60 min	>60 min
Small Urban (1,000 – 9,999)				≤25 min	>25 min

Maps of New Zealand by Geographic Classification for Health



Further information about the development of the Geographic Classification for Health is available on the University of Otago's website**:** https://blogs.otago.ac.nz/rural-urbannz/ or in Whitehead J, Davie G, de Graaf B, Crengle S, Fearnley D, Smith M, Lawrenson R, Nixon G. *Defining rural in Aotearoa New Zealand: a novel geographic classification for health purposes* (2022) New Zealand Medical Journal, August 5, 2022, volume 135.

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Appendix 2: Rural Health outcomes

Further work on rural health outcomes

This section provides a high-level overview of rural health from available information. However, there are many gaps. Health data for rural communities needs to be as systemic part of health data produced and reported by the health sector.

From the data published here, as well as in other health research, highlights the additional challenges and poorer outcomes rural communities experience in general, especially rural Māori. However, the experiences and outcomes for rural communities differ by region and population groups.

Access to healthcare is more challenging in rural areas

If health care options are not available close to where people live and work, people are less likely to use them as distance is a barrier.

> *"If it is not at our fingertips then we just tough it out, there are more important things to worry about" Hokonui locality, engagement participant*

Rural communities, especially some more remote areas, have challenges accessing health care due to where and how care is made available, with health options being available in main centres.

During engagement, significant concerns were raised about the availability of maternity care, mental health and urgent or emergency care. While primary care practices are generally accessible, getting appointments can take time. Oral care, pharmacy and other allied health options like physiotherapy and occupational therapy can also be limited. Availability of mental health supports were also key concerns for people within rural areas, and addressing this is part of priority 3.

Access to urgent care has declined in some areas due to issues around funding options and the burden current models place on the rural workforce. While trained local volunteers, local clinicians on call and air ambulances are some options currently supporting rural communities, there are concerns around access to urgent care options that are sufficiently staffed and resourced to provide safe and timely responses. In many communities there are gaps in support, or reliance on small groups within the workforce to cover too much in addition to existing roles.

Workforce pressures also play a role for clinical staff where staffing levels mean they can't support travel and maintain services. There are also issues transporting patients' long distances, as this impacts the rural-based ambulance and clinicians' availability to support others, or return home. Non-urgent patient transport alongside emergency needs also creates complexity to manage resources and staff, while maintaining services.

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> *"If my daughter has an asthma attack it will depend if there are enough nurses on so they can transport us to Waikato hospital with a nurse, otherwise I will have to drive her myself, alone, unless there is enough risk to call air ambulance that brings its own clinical staff". Participant in Waikato engagement.*

Some of these local emergency services rely on fundraising by local rural communities to keep them going. This can be a sense of pride for rural communities to fund services themselves. However, it also means services are partly dependent on resources within local communities rather than their health needs. Communities with less financial resources may be less likely to raise funding. These communities are also likely to have higher Māori populations with higher health needs, increasing inequity in care. Urgent care and emergency care are outlined as an area where change is needed within priority 1.

For maternity care, there are significant shortages and gaps in many rural communities. Of midwives registering a location of work, 11% worked in rural areas[21], while 18% of 0–4 year-olds live in rural communities. Digital options for some maternity services, such as lactation consultants, are not utilised as much as they could be, sometimes due to funding barriers. Some expectant mothers have to make hard choices about where to be in the lead-up to birth, and choose between what is best for pepe and any existing children.

> *"Would be nice to have our babies here. I'm choosing to go to Nelson because that's where my support is. It's three hours away." Participant in rural mothers' group*

Access to general practice

To access a doctor or nurse from a general practice, often wait times can be weeks or a month, or in some communities no local access for new people with closed enrolments. As at July 2022, around 25% of rural practices were not taking new enrolments[22], including in the rural towns of Kaitaia, Stratford, Dannevirke and Motueka. Rural communities have far fewer alternative options (such as urgent care clinics) than people in urban centres. For rural, they could look to access telehealth from other providers, if this could meet the purpose of the visit, or they will need to enrol outside their community.

Where people cannot enrol, or cannot get to see the doctor or nurse, this may mean they do not seek care when they should, and may resort to emergency care or have delayed diagnosis. Ensuring there is coverage in rural areas, especially remote areas, where urban services are far away is crucial for supporting health and wellbeing in rural communities.

Of rural people enrolled in a general practice, 12% travelled more than 30 minutes to their enrolled practice. Regions with rural populations more likely to have higher travel times to general practice included Bay of Plenty, Gisborne, the West Coast and Otago regions. Of those traveling over 30 minutes, two-thirds were driving to urban-based practices, which could partly reflect commuting. In three regions, Southland, Otago and

[21] This included around 1 in 10 midwives working in rural communities also working in urban areas.
[22] GPNZ, *PHO Closed Books Stocktake Report 2022*, July 2022

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Northland, rural people traveling over 30 minutes were more likely to be traveling to a rural-based GP practice than an urban GP practice.

The 2021/22 New Zealand Health Survey found similar rates of unmet need for a GP, and of transport being a barrier to accessing a GP, between rural and urban populations. There were also similar rates of people in rural and urban areas who identified cost as the reason for not attending a GP or picking up a prescription.

In 2022, 58% of rural people enrolled in general practice benefited from zero or low-cost access (current maximum $19.50 fee payment for adults in 2023). This was through zero fees for children under 14, low-cost access through the practice or from a community service card. This is slightly higher than the 53% in urban communities. Urban Pacific peoples and rural Māori have the highest rates of benefit from zero or low-cost access, at around 85%, followed by rural Pacific peoples with 77%, and urban Māori with 76%. European and Māori within rural communities benefit at higher rates from zero and low-cost access than their urban counterparts, (54% to 43% for European and 84% to 76% for Māori). This pattern was the reverse for Pacific and Asian people, with higher rates of people benefiting in urban areas. These higher rates of access to zero fees or low-cost access may have helped reduce unmet need for GPs due to cost, despite rural communities more likely to be in high deprivation areas.

Rural communities are more likely to be enrolled in health services

Of the rural people who have interacted with health services, 96% are enrolled in a general practice, slightly higher than the urban population. Rural health system users are under-represented in the unenrolled population, at 14% of total unenrolled. This partly reflects older age distribution within rural communities, as younger adults who are less likely to be enrolled are underrepresented in rural communities. The enrolment percentage does not capture people who have not recently accessed any health services.

Rural ethnic groups most likely to be unenrolled are Pacific people and Asian groups within rural communities, at 13%, three times the rate for all rural people, and higher than their urban counterparts unenrolment rate. This may reflect the fact that some recent migrants are ineligible for publicly funded primary care. Rural communities within the Bay of Plenty, Otago and Tasman regions had higher rates of unenrolled people who had used health services.

Rural Māori in the most remote areas were more likely than Māori in urban or other rural areas to be unenrolled (7% compared to 4%–5%). Māori were also slightly under-represented in health service users compared to their share of the total population, indicating some were not accessing public-funded health care. Lower share of health service users applied across urban and rural areas for Māori, but again, this was more pronounced for Māori in the most remote rural communities.

Hospital Services are further away

Over a quarter of the rural communities from Northland, Gisborne, and West Coast travel over 90 minutes to a secondary-tertiary hospital, while over half of rural communities in Otago travel 2 hours or more[23]. By comparison, Tasman and Waikato

[23] Distances are based on driving times in good road conditions with no impact from traffic.

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are the only urban areas where more than a quarter of people travel over 20 minutes to a main hospital (in driving distance, excluding traffic).

Having mobile outpatient clinics, or other outreach options, even if there are significant needs for service from rural areas, is often dependent on specific clinicians or administrators promoting this, rather than an expectation to consider community needs and access. Similarly, digital options, such as telehealth, are not standard offerings across the system for the patient and whānau when feasible. When digital options are offered, it is often driven by specialists or administrators keen to adapt, or rural-based groups pushing for telehealth. Some current digital options are part of pilots or special targeted initiatives, rather than standard practice.

Support to access services outside the community

Current supports within the health system for patients to access health care are outdated and focus on travel only, not digital options, and have restricted eligibility criteria that is not flexible to respond to people with high needs.

Introduced in 2005, the National Travel Assistance Scheme (NTA) provides financial assistance to those who need to travel long distances or travel frequently to access government-funded health services. In some circumstances, the Ministry of Social Development (MSD) can also support travel to health through special needs grants or a disability allowance.

NTA currently has many shortcomings, as outlined in a 2018 review that made recommendations to improve the system. Identified issues included restrictive eligibility, with regional differences on how exceptions are used[24], payment provided after the costs are paid upfront, insufficient financial support to cover costs of accessing services, as rates have not been reviewed since 2009, and outdated and time-intensive process to gain via paper forms and post.

Many volunteer groups, often around specific health conditions such as cancer volunteer groups, support people with transport. Accommodation is also supported by charities, included those linked to hospitals. However, the availability depends on the area and what capacity of the groups.

The lack of consideration about the impact on rural people when coordinating hospital-based appointments can also exacerbate issues. While these issues affect other populations, rural patients with complex conditions have additional struggles to get to multiple appointments and to access different specialist services. This poor coordination results in additional travel, unnecessary overnight or multi-night stays and at times missing appointments all together. Bureaucratic process within departments and lack of co-ordination are a barrier to asking for better appointment times.

Further data related to the uptake of NTA for rural communities and looking at frequency and duration of travel for some treatment or management plans would provide further insight to inform the policy work needed for a new support system, related to priority 4.

[24] Some areas, such as in Northland, support transport to first specialist appointments (currently outside the National Travel Assistance coverage), and will provide support in advance of other appointments, as they know this can be insurmountable for their population, often from remote rural communities.

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Wait times for elective treatment

Average wait times for elective treatment have risen across the health system since the beginning of the COVID-19 pandemic. By the end of 2022, two out of every five patients who have been given a commitment for treatment are not being treated within 4 months. These are comparable between rural and urban populations. There is a slightly higher proportion of people waiting more than 4 months for treatment in the most remote rural areas; although this may have more to do with wait times in the regions with the majority of the most remote populations[25], rather than their remote location.

A further area for more rural health data is treatment pathways and outcomes of care, and the equity of these between rural and urban, and within rural communities.

Rural health outcomes by areas

Immunisation and screening

Access to services can mean rural people do not have the same uptake of prevention, or options that mitigate health conditions, including through early diagnosis.

- Rural Māori (56%) and rural European (75%) children have lower rates of being fully vaccinated by age 2, with both around 5 percentage points lower than their urban counterparts. For Pacific and Asian children, the rural and urban rates were similar.
- For Māori children in the most remote rural areas, immunisation rates were lower, with just under 50% fully vaccinated.
- Māori children in rural areas within Northland, Gisborne and Bay of Plenty had the lowest rates. Northland accounted for 25% of rural Māori children not fully vaccinated.
- For immunisation in-line with the Measles, Mumps and Rubella (MMR) schedule at 2 years, the rural and urban patterns are similar to overall childhood immunisation.
- For immunisation in-line with the whooping cough (pertussis) schedule at 2 years, the rural and urban differences are smaller, with around 90% of both groups being fully vaccinated (88% for rural; 91% for urban).

A priority around early detection will be to have cancer screening data by rural areas and ethnicity to assess reach and uptake of these initiatives. Especially with the upcoming changes to cervical cancer screening, and the shift in priority 3 to have services closer to home.

> *"There is variable access to screening services. In many areas, the Breast Screening Bus only visits a rural town every two years, in others, it is unreliably available. Women who are not able to get to an appointment during its scheduled times in their town are expected to travel to an urban centre for a mammogram that takes no more than 15 minutes. This is not*

[25] For example, around two-thirds of most remote rural group are in Northland, Waikato and Southern areas.

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> *an easy option for women with young children, or those who cannot arrange or afford transport.*" Hauora Taiwhenua Rural Health Network submission.

Access and use of diagnostic tools for rural communities is another area to improve ongoing data reporting by health entities. This could look at travel times, and uptake of use by rural communities. Part of this would also be monitoring progress on options to support diagnostic access closer to home under priority 3, including through mobile options, outreach or through other approaches with new technology.

Lifestyle and risk factors

In the New Zealand Health Survey 2021/22:

- rural men have the higher rates of physical activity than urban men or women – with those having more active jobs in primary industries likely to contribute to this;
- rural men had higher rates of hazardous drinking than men in urban areas or women, and rural areas account for disproportionate amount of deaths and serious injuries from alcohol-related crashes;
- people living in rural communities were more likely to be regular smokers, than their urban counterparts. Smoking rates in rural communities have been falling, as they have overall;
- the use of e-cigarettes, or vaping, has risen over recent years, but is similar for people living in rural and urban areas.

In addition, the higher rates of rural men being employed in industries with more workplace accidents, increase the risk of workplace injury for rural men. In 2020, the agriculture, forestry and fishing industry held the highest incident rate of work-related injury claims, at 188 claims per 1,000 FTEs. Males accounted for 78% of these claims.

Oral health

Rural communities need oral health services that promote, improve, maintain and restore oral health throughout the life course. Oral health outcomes and access to services in rural areas is generally poorer than urban areas. Children in Northland and the rural regions around Rotorua, in particular, are less likely to be caries-free at age five when compared to the national average.

> *"I have been supporting a young person to get access to dental care. There is nothing available in the Gore district and we could not find anything in Invercargill either. The options available were Queenstown, Central Otago, Milton or Dunedin. That is a huge barrier if you are a single parent on a low income. Dental care is expensive, but it becomes more unattainable if you have to travel 1-2 hours one-way to access it. You need access to transport, there are additional fuel costs and potentially having to take time off work to attend". Hokonui Locality Plan.*

Rates of community water fluoridation is much lower in rural areas. Work is underway to improve community water fluoridation where feasible. As the older rural population increases, so will oral health needs (particularly as more older people now have their own teeth). The health system will need to find ways to support local and in-home care for older people.

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Innovative approaches are needed to tackle oral health inequities for rural communities that are focussed on prevention, and are accessible and appropriate for rural people.

Mental health and substance-related harm

Rural communities persistently experience poorer mental health outcomes than the general population. This is likely due to both challenges in accessing specialist mental health support, as well as the social, economic, environmental and cultural factors impacting rural communities.

Rural communities have endured a number of events in recent years that have affected livelihoods and mental wellbeing (M. Bovis, the recent floods, Cyclone Gabrielle and droughts in parts of the country). These events can cause significant disruption to peoples' normal lives and will be contributing to stress and uncertainty. In January 2023, around 70% of respondents to the Federated Farmers Farm Confidence survey indicated economic conditions were impacting rural mental wellbeing. The main three concerns for farmers related to climate change action policies, debt and interest payments and regulation and compliance costs.

Over 2016–2018, the rate of suicide in rural communities for men was on average 40% higher than men in urban areas[26]. For women in rural communities the suicide rate was on average 20% higher that of women in urban areas. For young people aged 15–24 years, the rate of suicides in rural communities was on average 20% higher that of their urban counterparts. A higher proportion of suicides in rural areas involve firearms than urban areas – possibly reflecting easier access to firearms in rural areas. There is no specific factor that accounts for the differences between rural and urban. Suicide is complex. There are a wide range of factors that interact to influence a person's risk of suicide, and these factors influence and change people in varying ways throughout their lives.

Rural communities' relationship with alcohol also influences mental health outcomes. Local councils report high acceptability of alcohol use in rural areas. There is a documented perception that drink driving laws are less likely to be enforced in rural areas. Rural communities may be less likely to access health services for alcohol-related conditions, and experience higher rates of alcohol-related health loss and premature death. There is growing evidence that additional alcohol outlets in rural areas have a greater impact on violence in comparison to those in urban environments. These impacts on rural communities must be considered when implementing alcohol control strategies.

The actions in *Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing,* the Government's long-term plan for transforming New Zealand's approach to mental wellbeing have the potential to benefit rural communities. They have a focus on increasing the availability of local community-led supports and addressing barriers to support including access to, and use of, digital technology. Integrated Primary Mental Health and Addiction Services have been rolled out to general

[26] Rural and urban suicide data is based on the Statistics New Zealand definition from the Rural/Urban (experimental) profile, developed in 2004. This differs from Geographic Classification of Health used for other measures. Suicide rates were age-standardised to WHO world standard population.

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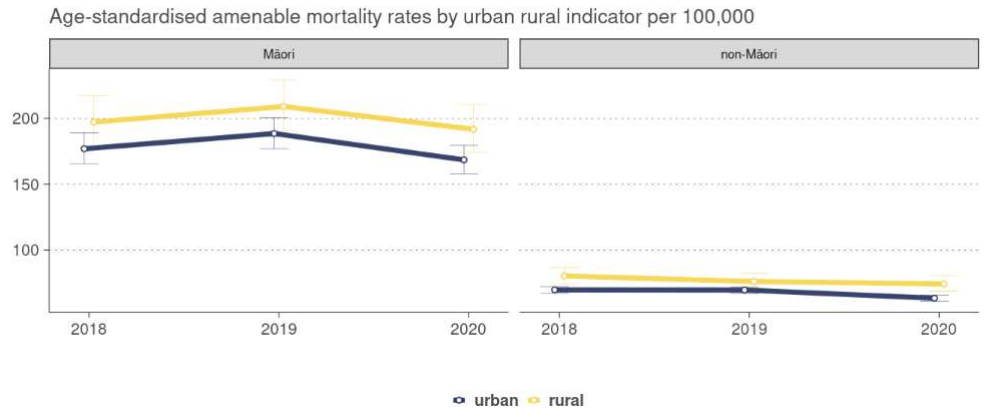
practices across the country, with rural areas a priority. As at March 2023, part way through these being rolled out, they are available in practices with around 70% of enrolled rural population. While there is growing accessibility to mental health and addiction services within primary care settings in rural areas, acute and specialist services are mainly limited to urban areas, with additional issues around wait-times and workforce gaps.

Inequity in mortality data for rural people

Age-standardised Māori mortality, in both urban and rural communities, are significantly higher than non-Māori. Non-Māori mortality rates are similar between urban and rural, as are mortality rates for urban and rural Māori.

However, Māori in rural communities have a higher amenable mortality rate than urban Māori – as the rate is around 10% higher over 2018-2020. For non-Māori amendable morality, there were no significant difference between urban and rural areas. Amenable mortality, a subset of all-cause mortality, is defined as deaths under age 75 years that could potentially be avoided, given effective and timely healthcare[27]. Māori mortality, both urban and rural, have around one-third categorised as amendable, compared to under one in five for total New Zealand mortality.

Figure 2: Age Standardised amenable mortality rates, by urban and rural, per 100,000



Source: Ministry of Health, mortality data

Research indicates that for younger age groups, amendable mortality rates are comparatively higher in rural areas, as well as provincial areas, than in main urban centres. But this comparative difference reduces in magnitude as age groups increases[28]. Males also have higher amendable mortality rates than females in both rural and urban areas.

[27] Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75). The definition used is from Ministry of Health (2018) *Amenable Mortality SLM Data.* Amenable mortality was also focus of recent research in Crengle S, Davie G, Whitehead, J, de Graaf B, Lawrenson R, and Nixon G. (2022) *Mortality outcomes and inequities experienced by rural Māori in Aotearoa New Zealand,* The Lancet – Regional Health Western Pacific, Vol 28 November 2022.

[28] Nixon G, Davie G, Whitehead, J, Miller R, de Graaf B, Lawrenson R, Smith M Wakerman J Humphreys J and Crengle S *Comparison of urban and rural mortality rates across the lifespan in Aotearoa/New Zealand: a population-level study*, J Epidemiol Community Health Published Online First: 09 June 2023. doi: 10.1136/jech-2023-220337

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The higher amenable mortality experienced by rural Māori, compared to their urban counterparts, suggests that there are additional challenges for rural Māori. Amenable mortality relates to quality of healthcare provided. The inequities experienced by rural Māori will need further research to understand which factors, which may vary by cause of death. Inequities could be related to determinants, such as deprivation, or access to care, early detection, or the treatment experience, or higher accident fatalities, such as from forestry work or road accidents.

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