Combined Networks Submission to The Panel, Government System Review of Health and Disability Services

Contributors to this Submission are Members of:

- New Zealand Rural General Practice Network https://rgpn.org.nz
- NZ Rural Hospital Network http://nzrhn.co.nz
- Rural Nurses New Zealand https://www.rnnz.org.nz
- Rural Health Alliance Aotearoa NZ https://rhaanz.org.nz

The Rural General Practice Network, Rural Hospital Network, Rural Nurses NZ and the Rural Health Alliance Aotearoa NZ represent a wide range of health, social service, agri-business and local government organisations living and working in rural NZ. This submission reflects the reality and experience of our combined membership who live and work in rural New Zealand. It applies Governments Rural Proofing Policy to the Review of Health and Disability Services.

We know that rural New Zealanders are a large and heterogenous population of around 650,000 people – the equivalent of NZ's second largest city. The diversity of cultures, ethnicity, age, gender, social deprivation, and health needs of rural New Zealanders matches any urban city, anywhere in the world. Yet in our experience, current urban centric funding and contracting models often result in services being delivered in the same urban centric way, disadvantaging many rural people.

Of all the geographic categories, NZs rural towns have the lowest socioeconomic status, highest proportion of Māori, highest avoidable and amenable mortality rates, and most likely the poorest access to health services. Equity, with respect to health outcomes and access to services, is a core value for health service delivery in rural NZ. Therefore, at the heart of this submission is the right of every rural person to have equitable access to health and social services that are:

- **Sustainable** – fully staffed and clinically, financially and socially sustainable.
- **Flexible –** to respond to the needs of their communities inclusive of age or gender, cultural and ethnic diversity. Able to respond to medical, clinical and technological developments and trends towards regionalisation of specialist health and social services.
- **Connected –** to communities and iwi; patients to services and services to patients; across professional groups and government agencies.
- **Connected –**New Zealand wide, fast, reliable and affordable internet and telecommunication networks.
- **Accessible** – geographically, close to the patient's home and able to meet the needs of patients in realistic timeframes, out of hours or in emergencies.

We thank the Panel for the opportunity to contribute to the Review and thank our members for their well-considered input to this submission.

Signed:

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GOVERNMENT SYSTEM REVIEW OF HEALTH AND DISABILITY SERVICES

Response to Submission questions

1. What are the most important values for our future public health and disability system?

A robust platform of data and research informs the allocation of resources and targeted initiatives to remove the impact of postal codes on health outcomes.

All people living in rural NZ are empowered to live a full and healthy life through:

- Mutually respectful relationships between whanau, iwi, communities and the health and disability system.
- High levels of health and mental health literacy.
- Equitable access to excellent health and social services that mirror the culture and diversity of their communities.
- Fully transparent and accountable service planning, delivery, and funding that recognise the realities of delivering services in rural centres and beyond to socially and geographically isolated people.

Health and social service professionals living and working in rural NZ are:

- Connected to their whanau and communities.
- A younger, happier, interprofessional workforce whose conditions of work are the envy of their urban counterparts
- Fully empowered to work confidently at the top of their scope of practice with easy access to support from specialist services as and when they need it
- Well remunerated and able to enjoy the sanctity of their personal lives and time.

Rural Whanau and Hapu are able to determine their own needs and how these are met.

2. Think about how the best health and disability system for NZ might look in 2030. How would that be different from the system we use today?

- Rural New Zealanders are formally recognised as a heterogenous population; a diverse range of cultures, ethnicity, age, gender and socio-economic status.
- A Rural Health Commissioner ensures cross Government, and cross agency transparency and accountability for the health and wellbeing of rural New Zealanders. The Commissioner coordinates the expansion of a multidisciplinary rural health workforce that is fully funded by Government. Robust data and research provides the platform for this.
- Rural Primary Care, Hospital and Community Services:
    - Are the centre of their community's health, social and behavioural needs
    - Are connected to their patients, other providers and specialist services wherever they are, through fast and reliable IT systems and connectivity
    - Are entwined in interprofessional under and post graduate rural health education programmes and are appropriately funded for this function.

RURAL PRIMARY CARE:

Works with the community to develop and deliver services that reflect the unique needs of that community.

Is the community's centre for all health and social service needs through well-resourced interprofessional teams, seamless flows between agencies, flexible service models and consultation processes.

Is connected to patients, community and residential care services, transport systems, health and social service providers, specialist services through fast, reliable and affordable internet connectivity and effective technology that empowers the patient at every level of engagement.

Is trained, funded and supported by specialist services and allied health professionals to care for rural people experiencing mental distress, illness or at risk of suicide.

Is not reliant on the goodwill of staff to work above and beyond their scope of practice or working day to respond to crisis, urgent care or routine needs of the community.

Is the preferred workplace for medical and social service graduates.

- Enter into long term contracts with funding bodies that empower rural providers, communities, iwi and whanau to develop and maintain models of care required to reach their high needs, distant communities, offer outreach and marae- based services. Contract deliverables and targets, national IT systems and infrastructure enable this.
    - Are able to connect people in their care to any service they need, regardless of what is provided locally – because the IT and service models are set up to make this easy – eg there are no Family Planning services in the Wairarapa yet the service could be co-provided through primary care providers.
- Funding mechanisms:
    - The current network and role of the 20 DHBs has been reconfigured to optimise local level engagement but also ensures the allocation and accountability for Vote Health funding is entirely separate from contracting for, and the provision of, services.
    - Reflect the disproportionately higher costs of delivering services in rural areas where lower volumes, and flexible service models are the norm and not constrained by urban centric national pricing frameworks, service specifications, or contract outputs and targets.
    - Conversely, monitoring and research tools provide evidence of the efficacy of investing in rural health services to the national health system.
    - Deliver a continuous programme of investment in technology and workforce capability that underpin patient centric pathways across and between local, regional and nationally provided services.
    - Resource the highly skilled rural generalist medical and allied health workforce to develop and maintain competency.

3. What changes could make our health and disability system more fair and equal for everyone?

- The National Transport Assistance Scheme is reconstructed to ensure that all rural New Zealanders have equitable access to the financial, logistical and personal support required to attend regional or national treatment centres
- Provide clarity of roles, certainty of service contracts, and adequate funding to address the challenges of providing emergency and urgent care in rural areas eg PRIME and emergency response services, ambulance and helicopter transfer; the impact of high seasonal demand in holiday or seasonal activities on otherwise low volume rural health services.
- A single health record connects providers and patients, enables rural primary care to be the centre of each patient’s care with seamless access to specialist services.
- People who live rurally have the same access to further investigations and treatment as their urban counterparts. Technology is used to support this.

4. What changes could most improve health for Maori

The crucial role that rural and/or iwi community organisations play in the wellbeing of whanau is woven into every level of the health and disability sector from locally based health promotion and education to service navigation, specialist care, high level strategic planning and sustainable funding models.

All rural health and social service providers have easy access to training and locally based iwi support so they can reach the highest standards of cultural competency.

Iwi are integrally woven into the rural health educational pipelines in order to attract, train and retain Maori in the rural health and disability workforce.

5. What changes could most improve the health for Pacific peoples?

The crucial role that rural Pacifica based community organisations and churches play in wellbeing of whanau must be woven into health service design and delivery, with long term and sustainable funding.

Pacifica groups are integrally woven into the rural health educational pipelines in order to attract, train and retain Pacific peoples in the rural health and disability workforce.

6. **What changes could make sure that disabled people have equal opportunities to achieve their goals and the life they want?**
   Specialist disability services or programmes are not available to many rural people, their families and communities they live in due to low volumes. However, they do have a wealth of other resources available: community groups, schools, sports facilities, country pubs and community halls – all under used. Balancing the tension between national standards for service provision that aim to protect people who live with disability from substandard programmes or exploitation, against the social wellbeing of that person is one that families and communities can resolve themselves.

   Programme and service models must be able to be adapted to utilise the resources that are available in rural areas, rather than be constrained by an urban centric service specifications and contract arrangements.

7. **What existing or previous actions have worked well in NZ or overseas? Why did they work, and how might they make things even better in the future?**
   - Whanau Ora models of care have worked well. As each rural community has its own unique character and resources available to it the principles of the Whanau Ora models could be applied to any of these.
   - The Northern Ontario School of Medicine provides evidence that recruiting rural people to health and social service professions and providing their training in rural communities builds a sustainable and competent rural workforce.
   - Scotland, Canada, Alaska, Australia – have all developed models of care that enable people to access the care they need close to home, via telemedicine, and medical workforce supported to work at the top of their scope of practice. The implementation of these models will require professional colleges, educational institutes, funding bodies and service providers to place a rural lens upon their processes.
   - Over the past two decades, Governments have invested in interprofessional workforce initiatives that are embedded in rural communities across Northern Ontario and Australia. This has significantly increased the capability and capacity of providers working in rural areas.
   - The Rural Health Commissioner in Australia works with Government to improve rural health policies, develop the interprofessional workforce, and champion the cause of rural practice.
   - Rural community-based research in Northern Canada has helped define rural communities needs and how these may be addressed.

8. **What are the most important changes that would make the biggest difference to New Zealanders?**
   Good policy starts with good data! Rhetoric alone is insufficient to drive improvements to the health and wellbeing outcomes of rural New Zealanders. The work to enable a consistent, clear and cross-government definition of 'rural' is an urgent priority.

   A system of monitoring health outcomes based on rurality, and aligned to ethnicity, age and deprivation will inform the allocation of resources and targeted response to need.

9. **Is there anything else you wish to add?**

   There is little doubt among rural communities that a person's access to health services, and consequently health outcomes, is linked to where they live.

   Government's Rural Proofing Policy is a platform from which this can be addressed, from which rural people and the organisations that represent them, are invited to every table, rather than having to lobby for their seat and their voice to be heard.

All layers of the health and disability sector should be formally committed, through contracting and monitoring systems, to applying the Rural Proofing Policy to the work that they do. A systematised approach such as those that are in place for other priority populations ensures this will occur.