SECTION: GENERAL NEWS ARTICLE TYPE: NEWS ITEM AUDIENCE : 3,000 PAGE: 1
PRINTED SIZE: 515.00cm² REGION: NZ MARKET: New Zealand ASR: NZD 1,895 WORDS: 685
ITEM ID: 1202543491

20 NOV, 2019

Less floss, more candy

NZ Doctor, New Zealand

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Barbara Fountain

RuralFest! The name conjures up pony rides, petting zoos, bake-offs, dog trials and candy floss. For feisty rural health advocates looking to get some traction with politicians, RuralFest takes a more prosaic form.

This month's Wellington RuralFest meeting saw representatives from around 30 rural organisations put through their paces with quick-fire rounds of three-minute speeches before heading off for a shindig at Parliament.

The reps from the Rural Health Alliance Aotearoa New Zealand were meeting politicians with a view to getting some traction on the rural issues dear to their hearts, an undertaking as exacting as the most gruelling dog trial and, after you've spent many years lobbying for serious attention to rural health services and workforce training, one that requires footwork complex enough to qualify for the line-dancing showdown.

To the outside observer, rural health this year appears to have been stuck in a bit of a quagmire.

Last year, the two-horse race to create a national school for training rural health practitioners had Otago and Auckland universities in one stable with a proposal for a National School of Rural Health, and University of Waikato in the other with a graduate-entry rural medical school. This drove passionate debate and a sense of "action at last", but was quashed in November by health minister David Clark. The initiative belonged to his predecessor, National Party health minister Jonathan Coleman, and had never had budget allocated.

This year, to everyone's surprise, at the National Rural Health Conference in April, Dr Clark announced rural health training hubs; the Budget followed with $4.563 million over four years for rural workforce training and development. Fervour was reignited but, as time has passed and long-time rural training advocates now find themselves quizzed by management consultants undertaking a scoping project for the hubs, that fervour has somewhat diminished.

Scope this, I hear some mutter through gritted teeth.

Then there's PRIME – the vexed question of funding and support for practitioners answering callouts to medical emergencies in rural areas – pretty crucial to keeping rural communities safe. On that front, silence.

In his letter of expectations to DHBs last year, Dr Clark asked DHBs to make the needs of rural patients a priority, a call in keeping with the Government's rural-proofing policy.

It sounds good but belies the fact that officials struggle to identify "rural".

As University of Otago rural GP and rural training advocate Garry Nixon pointed out in 2016 research, nationally collated health data had Wanaka, Takaka, Twizel, Murupara, Wairoa, Ohakune and Dargaville included as "urban" while larger urban centres, including Timaru, Blenheim, Masterton and

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Whakatāne, were classified as "rural".

Dr Nixon was, earlier this year, handed a 30-month Health Research Council grant of $943,443 and the Herculean task of defining rural. It's somewhat late in the day but pretty critical.

Meanwhile, there's a tendency in some quarters to believe technology will solve many problems for rural health and, in other quarters, maybe that the problems will disappear as rural communities themselves disappear. But that is not happening. According to the interim report of the Health and Disability System Review Panel, over the next 20 years, rural areas are projected to grow slightly faster than other main urban areas (excluding Auckland).

The report also noted that people living in rural towns can have poorer health outcomes, including lower life expectancy, than people living in cities or surrounding rural areas, an effect that is accentuated for rural Māori and disabled people. All problems are likely to be exacerbated with population growth in the absence of well-planned rural health services.

The RuralFest put out a call for a rural health commissioner, a role that has been lauded in Australia.

Commissioners of all stripes have their strengths and weaknesses – the key strength being their public platform but the key weakness being resources, as all commissioners are subject to government largesse.

Before placing the burden of righting rural health upon one person, it would be good to get a tangible indication of what the Government really wants for rural health. ■

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