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Rural health at a crossroads: tailoring local services for diverse communities

Every rural community has its own unique circumstances and set of health care challenges. What works well in one place is unlikely to replicate in another.

We also know that rural people are less likely to access their share of the health pie – this is something we need to see addressed.

There is an important conversation under way about how best to serve our diverse rural communities, and the need for integrated networks of medical, nursing, and allied health staff.

The Association of Salaried Medical Specialists is active in this discussion, and we hope this Research Brief makes a useful contribution.

The document was produced by our Research and Policy team. While the conclusions reached are those of the Association, we wish to thank Rural Health Medicine specialist Dr Jennifer Keys for her valuable feedback on the draft.

Ngā mihi,

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Introduction

People living in rural areas and small towns in New Zealand face greater barriers accessing healthcare services than people in urban centres. Barriers include long travel distances to access healthcare, higher costs, impacts of isolation, and wider socioeconomic factors.

The delivery of healthcare to rural communities is also challenging because of difficulties recruiting medical professionals to live and work in these areas. Many rural areas of New Zealand face significant shortages of doctors and other health professionals. These factors combined mean people living in rural New Zealand are likely to have high levels of unmet health need.

We take the view there is no one-size-fits-all model for rural hospitals in New Zealand. Nevertheless, we believe aiming for a medical workforce that creates networks of rural hospital medicine specialists supported by base and tertiary hospital specialist colleagues and well-resourced transport systems is the best strategy. We encourage greater investment in the specialist workforce as a

tangible step towards improving services in rural hospitals. We further support efforts to ensure those doctors working in rural areas can work sustainably, safely, and in a manner that enables them to maintain their professional scope and collegial connections.

In this Research Brief, we provide a background to the subject of rural hospital medicine. We explain how rural hospital medicine developed as a specialty and how it fits with rural generalism. We present case studies of different rural hospital services in New Zealand and conclude by providing some recommendations.

Key messages:

1. People in rural areas do not receive equitable access to hospital and health care services.
2. Rural hospitals suffer from significant shortages of appropriately qualified doctors.
3. More doctors are needed to work in rural hospitals and rural general practice.

A sustainable, flexible model of service delivery by rural hospital medicine specialists working in supportive networks with other medical specialists should be promoted.

Key terms

- **Medical generalism** - a field of medicine where doctors qualify to practise generalism within their speciality, such as a general physician or general surgeon. A generalist can also have a broad set of skills and expertise and provide care across specialty boundaries. The generalist doctor in New Zealand is usually found in general practice.[1]
- **Rural generalism** - a broad scope of medical care in the rural context that encompasses primary, emergency, and hospital-based care, as well as advanced skill sets, a population health approach and teamwork.[2]
- **Rural hospital medicine** - a broad, horizontal field of practice that intersects with many medical specialties, other health practitioners, and community services. [3]
- **Rural hospital** - a non-metropolitan hospital staffed by suitably trained and experienced staff, who take full clinical responsibility for a wide range of clinical presentations. While resident specialists may also work in these hospitals, cover may be limited in scope or less than full-time. (Ibid)
- **International Medical Graduate (IMG) -** A doctor who obtained their primary medical qualification in a country other than New Zealand. Sometimes called an overseas trained doctor. IMGs are supervised by doctors who hold vocational registration in the area of medicine the IMG is appointed to work in until they gain vocational registration.[4]
- **Rural New Zealand** - A combined category including four of the seven Statistics New Zealand Urban/Rural Profile areas: Highly Rural/Remote Areas, Rural Areas with Low Urban Influence, Independent Urban Areas, and Rural Areas with Moderate Urban Influence. The rural population is the population living in these areas. The Ministry of Health reports that one in four New Zealanders live in rural areas or small towns. Statistics New Zealand calculates that 16.3 percent of the New Zealand population live in rural areas and 10 percent in small urban areas.[5] [6]

Rural health

The provision of health services to communities in rural areas and small towns in New Zealand is a critical challenge. In sparsely populated regions people often travel long distances to receive health care, sometimes without access to public transport.

Bidwell (2001)[7] suggests issues with rural health can be divided into two main categories: 'intrinsic' and 'contingent'. Health services are intrinsically more difficult to deliver in rural areas where there are lower population densities and less infrastructure than non-rural areas. Contingent problems affecting rural health in New Zealand include demographic change (out-migration and ageing population), the closure of public and private sector services, higher than average rates of poverty and unemployment, higher rates of accident or injury-related mortality and morbidity, and the maldistribution of healthcare professionals, especially doctors. Bidwell notes that "when the population is spread thinly, doctors are spread even more thinly". (Ibid, p2.)

There are also equity concerns in rural health provision. In rural areas, larger proportions of Māori live in high deprivation categories (NZDep quintile five - high deprivation) than Māori in urban areas. There is a direct correlation between rural areas with high levels of deprivation and the proportion of Māori living in these communities.[8]

People who live in rural areas also face challenges receiving the same level of medical care as people living in urban areas. A recent study shows, for example, that rural and remote communities, particularly those with more Māori and older adults, have poorer access to advanced emergency medical services.[9] Evidence suggests that rapid access to advanced level emergency medical and trauma care reduces mortality and likelihood of disability. (Ibid)

While the deployment of telehealth technologies can be an effective way to deliver care to patients in rural communities, it is not a panacea. Telehealth is not always acceptable or accessible for patients and many prefer an in-person appointment. In addition, enabling and supporting clinicians to influence the model of telehealth used in their services is crucial if it is to be successful.[10]

Comparisons between rural and urban populations suggest that while life expectancy rates are very similar between urban and rural populations, access to health services is strongly influenced by degrees of remoteness[i]. Research suggests that long travel distances to get to health services can act as a barrier to health care. The National Health Committee (NHC) found in their 2010 report on rural health care provision that people with disabilities and older New Zealanders have more challenges accessing health care when they live in rural locations.[11]

In addition to the access challenges faced by rural populations, it is often difficult to recruit and retain suitably qualified individuals who are willing to work in remote areas and who have the requisite skills to provide the breadth of services required. The World Health Organisation (WHO) has identified rural workforce shortages as a significant barrier to universal, equitable health coverage. Drivers of rural workforce shortages identified by the WHO include the trend toward medical specialisation, demographic shifts in the medical workforce, changing work priorities of

[i] There is ongoing research about (mis)classification of rural versus urban areas in New Zealand and the consequences of this in terms of health outcomes. Research by Fearnley, Lawrenson and Nixon (2016) suggests that re-classifying people who use rural medical services will tell a different story in terms of life expectancy and other indicators. Source: Fearnley, D., Lawrenson, R., & Nixon, G. (2016). 'Poorly defined': unknown unknowns in New Zealand Rural Health. The New Zealand Medical Journal, 129(1439), 77–81. There is also data which shows that for Māori, living rurally is a multiplier for poor survival (discussed further in this *Brief*.)

younger doctors, changing attitudes toward owning a general practice, and negative perceptions of both rural and general practice.[12]

As noted by the NHC, health professionals working in rural contexts are frequently required to provide a wide range of services to meet the health care needs of the rural population in any one given area. The NHC also noted the impact of wider trends in health care towards specialisation. A consequence of increasing specialisation is that many services are limited to regional centres. Access to specialist services and distances required to travel to secondary and tertiary services are a significant barrier for many people in rural areas. The NHC stated that the need for more secondary services in rural hospitals and specialists in the regions to run outpatient clinics would provide better access for rural populations.[13]

The Government's 2018 inquiry into mental health and addiction also noted that recruiting mental health staff to work in rural areas is challenging. The inquiry panel found that often only crisis services are provided, with limited opportunity to undertake preventative work, such as services for suicide prevention and postvention, rehab and detox, and maternal mental health. The inquiry noted that slow or no internet connection, limited cellphone coverage and poor roads in rural areas can also limit access to mental health and addiction services and support.[14]

A medical workforce with a focus on generalism has been internationally and domestically recognised as an effective way of delivering health services, particularly in rural and remote areas.[15] In New Zealand, rural communities have traditionally been served by a mix of rural general practitioners, rural nurses and rural hospital doctors.

The next section of this brief explains rural generalism and describes the development of General Practice and Rural Hospital Medicine in New Zealand within the context of rural hospital generalism.

Rural generalism

The commonly accepted definition of rural generalism is taken from the Cairns Consensus Statement on Rural Generalist Medicine. This statement was drafted at the inaugural world summit on rural generalist medicine in 2013 where it was acknowledged the provision of health services in rural communities requires a strong generalist approach and, in particular, skilled doctors who can provide a broad scope of clinical care alongside other health care workers.[16]

Rural hospital generalism is a subset of this broader concept of rural generalism.[17] In New Zealand, rural hospital generalists have included General Practitioners (GPs), Medical Officers working under general registration, Registrars and Rural Hospital Medicine specialists. It is worth noting that, in 1995, the recognition of general practice as a vocational scope limited the work GPs could undertake in rural hospitals. An important factor in the Medical Council's decision to recognise General Practice as a scope of practice was that the existing training programme did not adequately prepare rural GPs to provide rural hospital services see (Box 1).[18] In response to serious rural hospital workforce shortages and the lack of any training pathway, rural hospital medicine (RHM) was recognised by the Medical Council as a vocational scope of practice in 2008 with the expectation it would improve the recruitment and retention of rural hospital doctors.[19] The scope of practice of RHM is oriented to the provision of secondary care (see Box 2).

Box 1: General Practice vocational scope

The scope of General Practice is recognised as a clinical specialty oriented to primary care. It is personal, family, and community-oriented comprehensive primary care that includes diagnosis, continues over time and is anticipatory as well as responsive.[20]

No dedicated rural training stream was built into the general practice training, which left individual practitioners and hospital services vulnerable.[21] Between 1999 and 2005, the number of rural GPs working in rural hospitals halved, reflecting the changing professional boundaries, increasing specialisation of urban hospital care with a move to community-based care, and the changing regulatory environment. Ibid

Box 2: Rural Hospital Medicine vocational scope

Rural hospital medicine (RHM) is determined by its social context, the rural environment, the demands of which include professional and geographic isolation, limited resources, and special cultural and sociological factors. It is invariably practised at a distance from comprehensive specialist medical and surgical services and investigations.

A broad generalist set of skills, knowledge and attitudes are needed to deliver optimum patient outcomes in rural hospitals. Unlike rural general practice, rural hospital medicine is oriented to secondary care and is responsive rather than anticipatory and does not continue over time.[22]

There are similarities between rural hospital medicine doctors and general practitioners. In both scopes, the doctor needs a deep knowledge of a broad range of clinical issues and a wide range of skills.

The scope of RHM was envisaged as being tied to its context: the rural hospital with no or very limited other specialist cover.[23] Further, it was intended that vocational registration would not allow an RHM trained doctor to practise independently in a metropolitan hospital; they would only be able to do so as general registrants under the oversight of a relevant specialist. In addition, the scope would not allow independent practice in primary care. Ibid

Recent research on the first 10 years of the RHM training programme found there were 29 graduates in that time, with 26 currently practising. Of these, 24 (92%) are practising in a rural location, mostly in rural hospitals. Half are also working in an additional scope.[24] A survey of RHMs in 2018 found that 55 percent of respondents were also registered in general practice.[25] The RHM training programme is gradually increasing in size. Twenty-six registrars joined the programme in 2021 and a Prior Specialist Pathway has been established for experienced specialists in other scopes who want to train to work as RHM specialists.[26]

Alongside the relatively small growth in RHM specialists, data shows a continuing decline in rural GP numbers in New Zealand and a rural general practice workforce that is under severe strain (see Box 3). Some researchers have noted that the shortage of rural GPs is being eased by the dual pathway in Rural Hospital Medicine and General Practice that many RHM registrars have taken up. A study of the Queensland Rural Generalist Program (QRGP), however, found that the dual pathway programme may be attracting trainees to rural hospital medicine at the expense of rural primary care. As a consequence, it has been mooted that rural practices not associated with a hospital may

be disadvantaged in finding doctors in the long term. The QRGP study reported that the programme, directed at both rural hospital and rural general practice workforce needs, can result in 'leakage' from general practice to hospital focussed workforce needs. The study highlighted the risk that once exposed to advanced skills training, trainees may leave the general practice pathway. They further state the incentive of a higher remuneration working in the rural hospital setting as another factor in 'leakage'. [27]

Box 3. Key findings from the 2018 rural general practice workforce survey[28]

Between 2017 and 2018 rural general practices reporting a current vacancy increased from 35 percent to 39 percent. At the same time, 36 percent of rural GPs intended to retire in the next five years; 60 percent of these doctors have already started to reduce their hours. Rural GPs are working longer hours. Almost two thirds (62 percent) are working more than 36 hours per week compared to 48 percent for urban-based GPs, and 26 percent of rural GPs felt they were burnt out.

Twice the number of rural-based GPs (22 percent) than urban-based respondents identified themselves as short-term employees or contractors. Added to this, IMGs made up nearly half (46 percent) of rural GPs.

The severe shortage of rural-based medical practitioners extends to rural hospitals and has been revealed in surveys of the workforce in this sector over many years. The next section discusses the high need for locums and IMGs in many rural hospitals.

Locums and IMGs

The results of a survey of the Rural Hospital Medicine workforce in 2018 showed that over one quarter (27 percent) of rural hospitals have two or more vacancies and over half (53 percent) had a least one vacancy. These proportions may be higher given the percentage of 'don't know' answers (17 percent). [29] As a consequence of medical workforce pressures, many rural hospitals are reliant on locum doctors to fill gaps and maintain rosters. Locums are doctors who work in a freelance capacity when a hospital is short-staffed. Locums command a higher hourly rate of pay than permanent staff and incur accommodation and travel costs for the employing hospital. The situation can create high turnover of staff and significant recruitment costs.

The NZ Rural Hospital Network has called for the establishment of a national locum agency for rural hospital doctors to focus on recruiting overseas trained doctors. This may have perverse consequences. The Network acknowledges that the long-term goal is permanent placement of New Zealand trained rural doctors, but it believes that increasing the pool of locums in the short to medium term is critical to mitigating the impact of the rural health workforce crisis.[30]

Findings from recent surveys show a high number of IMGs working in rural hospitals. The Medical Council's 2019 medical workforce survey showed that over half (52.9 percent) of RHM doctors are IMGs; and the 2018 survey of the rural hospital medicine workforce found more than a third (37 percent) of RHMs working in rural hospitals are IMGs.[31] [32] The proportions of IMGs in RHM is slightly higher than the proportion in medical specialties overall (approximately 42 percent). The high numbers of IMGs in rural settings may have implications for the stability of the rural hospital medicine workforce, as many IMGs do not stay in New Zealand for long periods. Just over 60 percent

leave in the first two years after they register. While this may not apply to those specialised in RHM, it is nevertheless an issue that may require monitoring.

The survey of rural hospital medicine doctors found that more than a quarter (29 percent) rated themselves as burnt out. (Ibid., p18.) Data from ASMS' 2020 burnout study, soon to be released, shows 64 percent of RHM specialists report personal burnout (2nd highest) and 55 percent report work-related burnout (4th highest). Factors relating to working in rural areas, such as isolation, loneliness and lack of collegiality can lead to feeling burnt out.

The next section describes rural hospitals in New Zealand and provides examples of where rural generalist workforce models have been adopted. These examples highlight the importance of the rural context and suggest that solving the provision of health in rural communities is not a one-size-fits-all solution.

The importance of context

Rural communities are diverse and have different needs depending on their location and relative distance to large centres. While there are commonalities in rural settings such as isolation and unmet need, approaches to the provision of health care must be tailored to local circumstances.[33] The rural generalist model must be adapted to the specific needs of different contexts. On this point, the Royal Australian College of General Practice (RACGP**)** notes "that which succeeds in one jurisdiction may not work or replicate in another".[34] In a similar vein, the New Zealand Health and Disability System Review noted: "the challenges faced by each rural community are determined by local population characteristics and geography, so the solutions would need to be local".[35]

Rural hospitals in New Zealand are classified as either Level 1, 2 or 3. Level 1 rural hospitals have visiting medical cover, Level 2 hospitals have on-site medical cover during normal working hours, and Level 3 rural hospitals have on-site 24-hour medical cover. The hospitals in New Zealand classified as rural hospitals are listed in table 1.

Table 1: New Zealand rural hospitals

Level 1:	Whangaroa, Te Aroha, Morrinsville, Ōpōtiki, Te Puia Springs, Stratford, Taihape, Kaikōura, Maniototo, Chatham Islands
Level 2:	Hokianga, Dargaville, Matamata, Te Kuiti, Wairoa, Dannevirke, Tākaka, Buller, Reefton, Gore, Balclutha
Level 3:	Kaitaia, Thames, Tokoroa, Taumaranui, Hāwera, Greymouth, Ashburton, Oamaru, Queenstown, Dunstan

See map of New Zealand rural hospitals attached to this report.

Funding to rural hospitals for postgraduate rural hospital medicine clinical training from the Health Workforce Directorate of the Ministry of Health recognises these levels. A 2018 survey of the RHM workforce found two-thirds (67 percent) of respondents worked in a Level 3 rural hospital. Another 19 percent worked in a Level 2 hospital. Very few RHMs worked in a Level 1 rural hospital.[36]

There is considerable variation both within and across these levels in relation to services provided, staffing, diagnostic and other support services. There is also a mix of staffing with some hospitals relying on rural GPs, while some have predominantly RHM specialists.[37] Some of the variation

reflects historical developments, as well as responses to the needs of rural communities based on their geography and social and cultural composition. No single blueprint will fit all needs.

In the next section we describe three examples of rural hospitals that have adopted rural hospital medicine initiatives. They illustrate why the model works well for some hospitals but may be less suitable in others.

Rural hospital examples

Ashburton Hospital has adopted an RHM model and has proximity to a supporting tertiary hospital and specialist medical services in Christchurch (see Box 4). Nevertheless, the local population has lost several on-site hospital services that were previously available closer to home. The transition from a secondary specialist hospital to a rural generalist model helped ensure the survival of Ashburton Hospital which, in 2008, struggled to replace and recruit general surgeons, physicians and anaesthetists. The hospital is now classified as rural Level 3. Six RHM SMOs and eight RMOs now make up the medical workforce, supported by specialist consultants from Christchurch. Greater workforce stability has been reported with less reliance on locums. The hospital no longer offers acute or elective surgery and there are fewer beds. An increase in demand for rural hospital emergency and urgent care services has been noted, resulting in part from the rural health workforce crisis in rural general practices.

Box 4. Ashburton hospital

Population served	34,800
Services	Medical, Maternity
Beds	53 – 5 maternity, 21 acute medical, 19 rehab, 8 acute assessment
Distance to referring hospital	Around 1-hour drive to Christchurch

The RHM initiative works differently on the West Coast due to its geographic isolation and sparse population. Visiting for consultant specialists is harder due to difficult terrain and travel times (see Box 5). It was suggested that telehealth would reduce the need for travel by patients and consultants. While there has been success in paediatrics, a study found that utilisation of telehealth for emergency care has not had the uptake expected.[38]

A rural generalist medical workforce model is being implemented at Grey Hospital (Te Nīkau), a Level 3 rural hospital. Under the model it is envisaged that acute 24/7 services will be provided by West Coast rural hospital doctors with generalist skills working with other West Coast and Christchurch-based hospital specialists as part of the Transalpine Health Service model. However, Lawrenson et al noted in 2015 that while RHM Fellows were filling positions at Grey Hospital (and Wairau) they were "working out of scope" and needed a collegial relationship.[39]

The expectation is that the changes being implemented will reduce the use of locums, lead to more senior doctors working in general practice, strengthen continuity of care, and improve long-term sustainability.[40] There is no evidence to support the proposed model at this stage. Grey Hospital

currently has a mixed model with a range of specialists, including RHMs, anaesthetists, surgeons, O&G, and other. We wonder if this type of mixed model is better suited to a remote setting such as the West Coast. While RHM specialists are trained to deliver a broad range of services, we suggest that limitations on their scope of practice require other hospital specialists to be working on site at Te Nīkau to ensure the safe, high quality service provision expected from a secondary hospital in a remote location.

Box 5. Grey hospital (Te Nīkau)	
Population served	32,600
Services	Medical, surgical, critical care, paediatrics, maternity, ED, urgent care, 24-hour access to radiology and laboratory services. There may be limited specialist cover. Acute inpatient beds.
Beds	56 – 6 maternity, 32 inpatient general, 4 critical care, 2 paediatric, 8 emergency, 4 acute medical observation
Distance to referring hospital	3+ hours drive to Christchurch

Taupō Hospital is a level 3 hospital that is staffed by a stable medical workforce of rural hospital medicine and emergency medicine specialists supported by visiting medical teams from Rotorua Hospital.

The hospital provides a primary birthing facility for women with low-risk pregnancies run and staffed by midwives. Maternity patients who can't give birth at Taupō are referred to Rotorua Hospital. Rotorua Hospital is a secondary maternity unit. Women who have more complex maternity needs are cared for in partnership with input from specialists at Waikato or Auckland and on occasions where appropriate care will be transferred to a tertiary centre.

Box 6. Taupō Hospital	
Population served	34,000
Services	Surgical, Medical, Maternity
Beds	34 – 5 maternity, 17 acute inpatient, 1 Chemotherapy unit, 8 day ward, 2 ED observation, 1 ED
Distance to referring hospital	Around 1 hour to Rotorua; around 2 hours to Waikato Hospital

Hokianga Health (Hauora Hokianga) is an example of a rural generalist model being the right fit with rural hospital medicine and general practice covering the whole practice scope. The key features of the service are breadth of practice, integrated community to clinic to hospital care, no patient fees, and community ownership. The model has enabled the strengthening of clinical practice and wider quality systems and standards.

The RHM initiative is well suited to the social and environmental context of Hokianga Hospital in the Far North (see Box 6). At this stage, however, it is considered too early to determine the impact the initiative will have on the workforce in the long term.[41]

Box 7. Hokianga Hospital

Population served	7,200 (70% identifying as Māori)
Services	Acute medical inpatient, accident and emergency, maternity, urgent care
Beds	26 – 12 aged care, 4 maternity, 10 acute medical
Distance to referring hospital	1 hour 40 drive to Whangārei

The rural hospital medicine workforce model is being adopted as an answer to the rural medical workforce crisis. The above examples illustrate the variable needs and different models used in different rural settings. The next section identifies some key actions to address the current workforce crisis in rural New Zealand.

Toward a sustainable workforce model for rural hospitals

Rural communities face challenges receiving the same level of medical care as people living in urban areas. However, they should expect similar health and disability outcomes for their communities. The Government has an obligation to support rural hospitals with funding and staffing models that support access to safe, high quality services.

The RHM pathway is producing a medical workforce particularly suited to rural hospitals. This was the aim of the specialty and where it works best. In certain circumstances, however, a mixed rural hospital medical workforce is appropriate. RHMs have a broad scope and achieve good outcomes especially when RHMs are part of a networked system of medical care, characterised by supportive relationships with local specialist colleagues.

The New Zealand Rural Hospital Summit in 2020 highlighted the rural workforce crisis and agreed it requires a coordinated national approach through a rural health workforce plan. The Summit considered this was critical to building a workforce able to offer rural people equitable access to health services. It has also called for the development of a 10-year rural health strategy in partnership with iwi and rural communities to provide leadership, accountability, and a robust basis for service commissioning.[42] In ASMS' view, these proposals should be actioned to set a clear future direction that will enable rural health workforces, including GPs, RHMs, and other medical specialists to work together to achieve desired outcomes for rural populations.

Further, we note the current number of RHM specialists is insufficient to address the serious shortages in many rural hospitals and we argue the need for targeted funding to train more of these doctors. The lack of research on rural health and rural hospital work in New Zealand has also been raised by several commentators.[43] [44] [45] [46] Recently, the Health and Disability System Review noted that formal evaluation of rural hospitals is limited.[47] The Review Panel reported that: "Clearly, the health system needs to have a better understanding of the form, structure, and function of diverse

rural hospitals and their contribution to health service delivery and have a strategy for their development". (Ibid., p188.) The review recommended that rural service planning should recognise the unique challenges of geography and distance.[48] Given the number of New Zealanders who rely on rural hospitals, ASMS agrees that urgent priority should be given to investigating and addressing the issues affecting them, particularly workforce and funding.

Conclusion and recommendations

This document highlights the difficulties accessing health services in rural areas and the challenges recruiting and retaining doctors to work in rural hospitals. It also considers particular issues for Māori in rural areas and the importance of accounting for context when developing workforce and service models. ASMS makes the following recommendations to achieve better outcomes for rural communities in New Zealand:

- National health planning and funding which recognises the specific requirements of rural health care.
- A Māori Health Authority with full commissioning rights, which includes oversight of rural health.
- Urgent centralised development of a Health and Disability workforce plan, with key targets for medical training and progression to address equity and diversity of the medical workforce as well as distribution by geography, rurality, and specialty.[49]
- Co-ordination, publication, and maintenance of a medical workforce census by the Ministry of Health to inform and address rural doctor shortages.
- Rural training programmes which are designed to grow and retain RHM specialists.
- Funding of the experiential component of the current RHM training programme as well as the development of a New Zealand specific examination rather than the current reliance on an Australian exam.
- Health employers, the Ministry of Health, professional colleges, and unions work together to design recruitment and retention strategies to support clinicians to train, work and remain in rural settings.
- Parity between vocationally registered salaried doctors working in rural tier 1 and hospital services, with incentives to remain in these settings, including access to continuing medical education and professional learning and development, financial support, and extra leave.
- Design rural health care models with input from qualified clinicians, unions, and community representatives.
- Further develop telehealth for locally based multi-specialty health workforce in rural areas.
- Free primary care access for rural communities.

Source: Royal New Zealand College of General Practitioners

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