Ensuring Rural Communities Get Great Health Outcomes

Hauora Taiwhenua Rural Health Hub
Fieldays Mystery Creek, Hamilton
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Host

- Grant Davidson – Chief Executive, Hauora Taiwhenua Rural Health Network

Participants

- Hon Matt Doocey – Minister, National
- Daniel Eb – The Opportunities Party
- Hon Dr Ayesha Verrall – Labour
- Steve Abel – Green Party

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Grant (CEO, Hauora Taiwhenua – Rural Health Network): As an introduction, my name's Grant, and I'm the CEO of Hauora Taiwhenua, the Rural Health Network, and we advocate on behalf of the health of rural communities across New Zealand.

And we all know the state of rural health. We, as a rural community, have some of the worst health outcomes of any group of people in New Zealand. We have higher suicide rates, we have higher preventable deaths, and Māori in rural communities are the worst group of all. So we are really seeking answers and commitments to a government or coalition government that will do better for us going forward.

I'm sure Matt Doocey here on behalf of National will tell us what they've got planned. We were really disappointed that rural got no mention in the health budget this year, other than Waikato Medical School, which we were proudly at the launch of today in terms of their clinical community placements. But the first graduate of that is at least eight years away. So we've got problems right now, not just in GPs, but in nurses, midwives, healthcare workers, and all other professions giving to health and rural communities. Pardon?

Just ringing out. Matt. Can someone check the time? They won't be qualified at that stage. They'll still be doing their fellowships. So — post-graduate. Yeah. Four starts in 2028, then add four, then add two, then add two, and we'll have a qualified GP specialist. So my maths was perfect. But I appreciate you checking. Right. So enough from me. Let's... Well, we started quite well. So — such a strong point to start on — what we're going to do is —

Audience member: Are you always this grumpy?

Grant: Yeah, I'm absolutely. I was born grumpy, but I'm optimistic.

So what I'm going to do is get each of these beautiful people to introduce themselves. Then we're going to give them an opportunity to speak for no more than three to five minutes on their promise and what they're going to do to go forward. Then we're going to go to a Q&A session, and we'll take questions from anyone out there in the audience. Right. So first of all, we've got Matt Doocey

representing the National Party. He's currently the Minister of Rural Health and the Minister of Mental Health. We've got Daniel Eb, who's the Deputy Leader of the Opportunity Party and speaking today on behalf of health. We've got Ayesha Verrall, the spokesperson for Labor, Steve Abel, the spokesperson for Greens. Mark Patterson should be turning up for New Zealand First. He's just late. We offered Te Pāti Māori and ACT the opportunity to be here, and they declined to participate.

So who wants to go first?

Ayesha Verrall (Labor Health Spokesperson): Well, kia ora, everybody, and thank you to Hauora Taiwhenua for having us here today. This is a really special event and one of a series of events run by Hauora Taiwhenua that really put the spotlight on rural health, which is just fantastic.

I'm from a small town. I'm from Te Anau, two hours from the nearest hospital. Did my medical training at Otago. I've lived and practiced at Wellington Hospital as a medical specialist there, and now I've been an MP for six years and really proud to be Labor's health spokesperson.

And I had reason to go back to Te Anau 18 months ago when my dad passed away. He had melanoma, and he was sick for about three months before he died. And looking after him in Te Anau, I saw all the amazing things that a small town does to care for its people. The care workers who looked after Dad were students that he had taught, and they knew him and took care of him just wonderfully. I was able to help with his medicines, with his care, with his nursing, and it was a big job. And one day, I fell asleep on the couch, and I had forgotten to go to the pharmacy and pick up his medicines. But Cindy, my classmate, knocked on the door, woke me up, and she had brought Dad's medicines because she's now the town pharmacist. Those are the things that happen in small towns where we look after people. But gosh, it's a lot to overcome all the other things that rural people have to do to access healthcare. In our case, driving two hours to get to the nearest hospital for that. So I'm very aware of the challenges that rural clinicians and patients face in seeking care.

Labor wants to make one of the things that's difficult — accessing care — easier across the country, and that's the affordability of healthcare. That's our focus. Right now, the whole country is in a cost of living crisis. The government promised to make it better, but it's getting worse. We face challenges with fuel costs, with cost of food, and the cost of all our bills. Six hundred and fifty thousand people — just think of that — 650,000 people say they can't afford to go to the doctor. They miss out on care because they can't afford to go. Stuff reported just two days ago that in the South Island, one in three New Zealanders say they don't go to the doctor, and cost and other barriers is a big part of that.

We have to change that. We can't go on as a country saying that so many people can't access basic medical care. And when people don't access medical care, everyone in the community pays the price because it means more costly hospital treatments, it crowds up our emergency departments, it clogs up our waiting lists. This is why fixing this problem is something Labor's committed to. That's why we'll fund three free GP visits when you need them, and that's funded on our Medicard, which is a commitment that you'll see us talk about more and more in the coming months. It'll keep people well and free up our emergency departments.

We have a solid plan to deliver on this promise, and I want to tell you four things about it. Step one is a program to free up 4.5 million GP visits — to free up capacity so they can focus on patients rather than paperwork. That means supporting them with technology and also grants so that where they don't have the space to see more patients, we'll support them to expand their premises.

The second really important part of our plan is fixing the broken general practice funding model. Right now, general practice funding is bad, and the government is making it worse. Dozens of rural clinics are at risk of closing because of cuts to their capitation funding that are being discussed now. Labor will fix this once and for all. It has been a 30-year problem, but we will fix it by introducing a fairer and more transparent way of funding called independent pricing. A pricing authority will set a national rate for GP funding that reflects a practice's real cost, and we all know rural practices face higher costs. When the rate goes up, Health New Zealand would be obliged to fund it. So Labor will protect your services and your community.

Step three is to train more doctors. I was thrilled to meet one of the doctors that I trained when I was working at Wellington Hospital in here today. He's now a lecturer at Auckland University and brought his med students along with him today. I was so proud as Minister of Health in 2023 to approve the training of 50 more medical students. The government has funded 50 more and the Waikato Medical School is to come, and I'm sure Matt will speak about that. So those extra clinicians to take up a place in our health system are on their way.

And step four is to get these doctors and other skilled practitioners into your communities. So for areas that need more doctors, Labor's got a family doctor loan scheme. It'll provide them with interest-free targeted loans to support new GP clinics to open and help local practitioners stay in your community. So we're going to back locals to keep doing the work they love in rural communities.

Fixing the health system will be at the heart of the next Labor government. We'll build a health system that keeps people well, not just treats them when they're sick, and no matter where you live. Free doctor's visits, shorter wait times, care closer to your home for everyone.

Grant: Thanks, Ayesha. How come that doctor's got a blue shirt on?

Ayesha: It's Auckland Blues.

Grant: Auckland Blues. Thank you. That's good. I didn't make my students join the Labor Party, but maybe I should. Let's pass over to Dan next.

Daniel Eb (Deputy Leader, Opportunity Party): Kia ora, everyone. Daniel Eb. I'm the Deputy Leader of the Opportunity Party. Firstly I'd like to mihi to Hauora Taiwhenua for holding space for this important kōrero.

I'm new to the health sector, and so while reading all the strategy documents was really important, I also needed to get some stories from the front line of what actually health feels like out in our rural community. So I talked to a rural health nurse who's been practicing for 45 years in Golden Bay, and when I asked her, "Tell me in one sentence the state of rural health," she said, "I don't need a sentence. I can give you one word: burnout."

And so the rest of that conversation was about what happens when we have particularly a rural health system that doesn't focus on prevention but relies on emergency treatment in our hospitals. It was about what happens when we have an old model that is still in place when rural populations age to a higher degree than our urban populations do and the distance is obviously incredibly difficult to travel.

And the overall feeling I got from that conversation was this deep sense of frustration. In 45 years, she has seen so many strategy documents come. She has seen governments change time and time again, and she referred to these things as paper changes. The papers that they stick up on the front at the entranceway at the reception change, but the actual fundamentals of how they run their clinics doesn't necessarily change — or doesn't change as much as it needs to, to meet these kind of demands.

There were absolutely some bright spots in that conversation. She talked about an integrated health facility in Golden Bay that really was a step change in how they delivered services. She talked about a surgical bus that took surgeons and specialists to rural people instead of rural people having to travel two hours to come to a hospital. But I got the distinct impression that these innovations weren't enough to get ahead of some of the foundational challenges that haven't really been responded to.

As a new party, I think it would be quite easy for me to throw a bit of shade at some of the existing parties, but I don't think this is an individual government problem. Minister Doocey, I'm sure you're doing as much work as you can — likewise, keep doing it though.

What I think this is emblematic of is a political system that's failing to deliver meaningful change where we need it to. This is successive governments that can't seem to get a handle on the problem. And so my big question that I would like to ask on this panel is: if health is such a taonga, if health is so important to us, if it's so important to all of our communities, why is it a political football? Why do these things keep changing?

I was going to read through the four points on our health policy plan. You already talked about three of them at least — I was copying your notes. Training more doctors is on there. It's a lot of the same stuff, and I'm going to assume that a lot of the same things are on Minister Doocey's list as well.

The main thing that headlines the Opportunity Party health policy is a deep commitment to a 10-year cross-party plan for health. That is the umbrella under which all of this shared tactical initiatives that we all want to do — training more primary care providers, integrating AI to reduce the administration burden, using telehealth to keep health closer to home rather than putting people out into hospitals, and increasing funding — we'll do a 30% increase in capitation over three years to actually fund our providers properly.

I think maybe the big thing that is potentially a little bit different on the Opportunity Party side is we are a party of massive nerds. We love efficiency, and so we are a huge advocate of more preventative services. We know from international evidence that every $1 that we invest in prevention now saves us $13 further down the line. That's what we're interested in, and so we would roll out a nationwide health prevention platform that focuses on health coaching around some of our really big issues like cardiovascular disease, obesity, diabetes, and we would ensure that every Kiwi has access to an annual checkup, either through Māori or community services. But again, nothing I'm telling you now is exclusive to the Opportunity Party.

What's missing is the ability for the red team and the blue team to actually properly get together, put politics aside on health and commit to a shared vision, and most importantly, stick to it. And I think that's the fundamental thing that the Opportunity Party brings to politics. We can be that constructive force. The child in the family that keeps mum and dad together is basically what we are aiming to run on this election. Kia ora.

Grant: Thanks, Dan. What we might do is keep the microphone heading this way. So we'll give Matt Doocey the opportunity to talk now. Probably the last time you'll be able to talk when the Chiefs beat the Crusaders this weekend in Hamilton, and then are defeated again by the Hurricanes next weekend in the final. So over to you, Matt.

Matt Doocey (Minister of Rural Health and Mental Health, National Party): It's going so well, Grant, until you brought the rugby into it. Go the Crusaders, I say. Be a good game tomorrow night. Anyway, rugby will be the winner of the day. Oh, I'm going to eat into it by talking about the rugby, am I?

Just to respond really to what Dan was talking about — an agreement in health. I think it's that classic New Zealand statement, yeah, nah. Look, I don't disagree that the more joined up, the better, because the reality is our three-year parliamentary cycles can interrupt long-term policy settings. I see my good friend Chlöe Swarbrick in the tent today as well. Myself and Chlöe and Louisa Wall at the time from Labor set up New Zealand Parliament's first cross-party mental health group for that reason of taking long-term policy settings. But on saying that, when you think about what an election is, it's a battle of ideas, right? It's a contest of ideas, and quite rightly, you want to see what are the new ideas in health that will drive the health system forward for the next term. So some of it, yes, we can come together, but other of it, we do need to think how we differentiate ourselves as well.

On behalf of the National Party, and specifically when we think about rural health, I, like others, want to acknowledge the role of Grant and Fiona and Mark and others from Hauora Taiwhenua, and what great and tireless advocates you are for rural health as well.

Quite clearly, we have got to do better, and that's something I think every party here will be passionate about delivering. For me, there's a few things I want to step through in my introductory comments.

First and foremost, we've got to think about how we prioritize rural health and what are we actually doing that's going to deliver that prioritization. Something this government has done is around the introduction of what's called the GCH, the Geographical Classification for Health. Now, you can't manage something you're not measuring. So as Mental Health Minister, I introduced New Zealand's first mental health targets. I'm no target fundamentalist, but what it allows — one week access for primary mental health and addiction support, three weeks for specialist mental health and addiction support — is the ability to benchmark our performance against an expected level of service the country expects from their health system.

Now with the ability to measure rurality, when we generate those reports — and across the physical health target reports as well — I'm not happy with the national average. We can drill into not only the 20 health districts, but we can drill into rurality and urban population groups like Māori, Pasifika, Asian, and also age demographics. So hypothetically, we can go into Northland Māori rural, Northland Māori rural young people, and as you'd probably expect, performance can drop away around access of service. And that leads to a different conversation to an arm's-length entity, which is Health New Zealand, who have the operating statute to operate independently, to set expectations that they want and need to roll out services in those areas that aren't getting access.

I raise that because it's a very different philosophical point between myself and Ayesha. Their approach around postcode lottery was around centralization, and Wellington knows best. Ours is the opposite, where we're pushing back out into the regions. From 1st of July, local decision makers will make decisions on local service delivery, local workforce decisions, and budgetary decisions, because we fundamentally believe the closer the decision to the frontline, especially in our rural communities, will make the difference.

Second area I want to skip through is around workforce. My firm belief is one of the biggest barriers to timely support in New Zealand for physical and mental health support is too many workforce vacancies. So we've got to grow the health workforce. But how we also do that is bring health workforce education as close to home as well.

I point you to a couple of initiatives. We've heard briefly about the Waikato Medical School. We made the announcement today, the rolling out of the first ever whole-of-country clinical placement map, to ensure that our doctors are going into the rural communities, because the data shows if they go in, they get a good experience, hopefully fall in love, they'll stay there. So that's why the third medical school is unashamedly focused on rurality and primary care. But we're also rolling out what's called rural training hubs. That's gathering up the four Ps: pathways, placements, pastoral support — which is a big one if you're coming from outside a rural community and you want to get settled — and a program lead. We want people in our rural communities to be able to access the education so they can go into the local health workforce.

The final point I'd make on that — the Wairarapa one — I met a lady who was traveling three and a half hours to go to Napier to train as a nurse with her kids, to put them in nursery. Now through the training hub, she'll be able to access that education closer to home. Thanks, Grant.

Grant: Thank you. Thanks, Matt. Finally, Steve from the Greens.

Steve Abel (Greens Health Spokesperson): Kia ora koutou. Thank you very much. It's good to be here.

Look, I'm a tree guy. I thought that this was about heath. I thought this was about the heath over there. Not health. I don't know anything about health.

Actually, that's not entirely fair. I am filling in for my dear colleague, Huhana Lyndon, who's our health spokesperson. But we all encounter and engage with the health system. We are a party that believes in the holistic nature of our society, that we are a species that is part of nature, and all of the things are connected. So we care very much about health as much as we do about the environment.

I had an interesting experience as a child. When I was three years old, I found myself in hospital for six weeks with rheumatic fever, and I got a mitral valve murmur to thank for it. And we're acutely aware of the social determinants of health impacts. So when we look at the need for affordable dry housing for all New Zealanders, when we look at the need for good access to nutritious food for all New Zealanders, these are things that are not ambulances at the bottom of the cliff. These are the things that help us have a healthier society.

And primary healthcare is a high priority for us. So I met my doctor a few months ago, and he was ashen-faced at how exhausted everyone in his team were with just doing the GP work in the local community. We are very much committed to properly funding and supporting general practice and primary healthcare.

We already made a commitment to free doctor's visits. We also made a commitment last term to free dental care. Dental care is a major impact on overall health, and it's also a determinant that indicates socioeconomic disadvantage in terms of how your dental health is.

We're committed to putting our money where our mouth is. We believe that New Zealanders genuinely expect us to have an affordable, accessible public health system, and it is not one size fits all, and the rural community is an example of that. We need a health system that actually caters to that rural community. We've committed to mobile diagnostic units so that there's rural access to that. We've committed to better funding for workforce, for expertise to be in rural communities and deal with the issues that are faced there at the health level.

If we're serious as a nation about protecting the integrity of our public health system and making sure that it generally works for everybody, we have to be willing to pay for it and fund it. And what we've seen over subsequent years is governments unwilling to put in the sufficient money that our health system needs to be world-class. People having to wait for hours to get medical care at a hospital. Understaffing of our medical system, where health workers are absolutely strung out — is not the way that we get the best outcomes in terms of health delivery or in terms of wellbeing for our population. So rest assured, a Green government will make sure there is proper funding of our health system and there is proper catering to the needs of rural people who are not being well-served by the way our health system currently functions. Thank you.

Grant: Thank you, Steve. So what we're going to do now is open the floor to questions, and we'll give each of the representatives an opportunity to briefly answer those questions. And we don't want political rhetoric and marketing. What we want is some clear, straightforward answers, and I'll try to keep them on track. So while you dream up your questions, I'll just ask the first one, and I've got a whole bunch waiting.

So first question — we've heard a lot about workforce, and we can train extra people, and there are some in training. We're talking about the whole comprehensive care team in primary care: nurses, healthcare assistants, doctors, midwives. At the moment, once they're trained, we lose them overseas. We lose heaps overseas. If you go to Australia as a trained GP, you can earn up to three times as much — by being willing to deal with flies, heat, and red dust. But once they're over there and they meet partners and put down roots, they don't come back often.

What are we going to do to retain the public money that's been put into the trained workforce — to keep them in New Zealand? We passed up pay parity, so our nurses working in communities are getting 13% less than if they work in a hospital system in the big cities, and yet we need them more in the country. And doctors, even on the capitation system, generally can't pay themselves as much as they do in the big cities where they don't have to do after-hours care, et cetera. So I really want to know what you're going to do to retain the workforce if we do train them.

Steve Abel: I think the number one thing — and it doesn't just apply to health, it applies across the board — is that we need to make sure the conditions for people working in the health system are good. That the hours are reasonable, that you're supported by a fellow workforce, you're not understaffed. That's a major issue in health. And that people are appropriately remunerated. And if we're trying to attract people into rural areas, we need to make sure that there's a good reason for people to want to go to those areas and stay there. Security of employment, appropriate remuneration, and proper resourcing so that the facilities are up to scratch and the workforce is sufficient to the job at hand.

We visited the Queenstown Hospital — myself and Chlöe Swarbrick and Huhana a few weeks ago — and it was just striking how much the people working in that facility achieved with, frankly, an

infrastructure that needed to have been invested in 20 years ago. We need to make sure we properly invest in infrastructure and make this place a place that people want to stay and want to come back to.

Ayesha Verrall: I worked in Australia my second year as a doctor, and I worked in Singapore as well, both very impressive health systems. I came back to New Zealand because it's wonderful. It doesn't have the same pay rates, but I can have a life here that is like a life I can't have anywhere else.

New Zealand will not be able to compete with Australia for wages. We can offer better wages, absolutely, and Labor always prioritizes that. But we can never totally match Australia. What we need is to be able to offer our workers the fundamentals of a good life here in New Zealand. That's why Labor is focused on jobs, health, homes, action on the cost of living. When those things are in place, then we can get — I'm sure our people will choose to stay here because it is the best country in the world.

The thing I wanted to make clear as well is that we retain our locally trained health workers 70% over 10 years, doctors and nurses. You look at the Medical Council and Nursing Council stats. So while some look for solutions in immigration — and we'll always need immigration to some extent — training our own people is the way in which we build a workforce that stays and is much more likely to be retained here.

And then finally, retention is all very good, but you have to get in the door. I am so upset about the fact that we now have unemployed graduate nurses in this country. 800 nursing graduates could not get jobs. That is because basically the government's got a cap on the number of nurses that they're employing. These people that have given so much to training in our health system. So that is an area where government has to do better because we need those people. They are the people, locally trained, who will stay on in our health system.

Matt Doocey: It's an interesting comment that Ayesha made around nursing graduates, and I think the challenge is real. We need to step up and respond to that. But I just point to my experience doing the Rural Health Roadshow, going around 13 rural and remote locations. We were in areas like Kaitaia in Northland, where they did have jobs available for nursing graduates, but they weren't applying for them. So the reality is, there is pressure in some areas more than others, and the reality is, some will need to travel to gain employment. And that I think is something that most of us have experienced over the course of our lives as we develop our careers as well.

Look, the issue is real that people do go overseas, primarily to Australia. What I find interesting — I was talking to a clinical psychologist who asked me why we weren't paying enough in comparison to Australia, as if it was just sort of a stroke of the pen. I said, "Well, it's all relative to our economy. Where are you heading to?" And she said, "Western Australia." And I just point to what Western Australia does in their economy that we don't do here — around mining and other industries that bring real income to their local economies, so they can command those wages for their public sector. And that's what we want to do in the National Party: grow our economy so we can afford to pay our hardworking public sector workers more as well.

History shows — and I was one of them, Ayesha said she was one of them — a lot of our health workforce does go overseas. The data shows that most of them come back. But yes, there is a group who potentially don't feel like they have any other choice but to go overseas because of some of the

pressures they face economically in New Zealand. So it is right to focus on ensuring we have better entitlements and terms and conditions. But I think as Steve alluded to as well, a big part of it is burnout and workforce vacancies. People do leave when they're covering too many workforce vacancies.

So it is a joined-up approach: how we open up the training pipelines to ensure we've got an increasing number of new graduates coming through, how we ensure we've got better terms and conditions for retention, and also opening up pathways around clinical leadership and supervision later on in careers. There's a question with the 120 placements coming out of Waikato Medical School — making sure they have the right supervision. It does show that if we can get them in those clinical leadership roles, they stay longer.

The final point I'd make is, again, you can't manage what you don't measure. The Auditor-General was critical of the last government for having no standalone mental health workforce plan. We published ours in our first year of government. That's why we've got 11% more frontline mental health and addiction workers now since coming into office. Child and adolescent mental health, 19%. So if you do have a plan, you can deliver it.

Daniel Eb: Just have a show of hands — who knows someone that has emigrated either to Australia or somewhere else in the last two years, particularly young people? Okay, that's half, two-thirds.

The loss of our health workers is the same thing that's happening in our engineering sector, in our business sector, in education sectors. We are hemorrhaging our young people because they do not see a future here in New Zealand, and we have to ask some really fundamentally hard questions why that is.

At the Opportunity Party, we think one of the primary issues is that we have built an entire economy around housing. That's where all our money flows, that's where all our capital gets locked up in. And as a result of bad incentives and bad policies that were made 20-odd years ago, we're now living in a period of time where housing costs seven, eight, nine times average incomes. And every dollar that should be going into business innovation or someone who wants to go and study or train instead gets locked up into paying rent and paying mortgages. And so that rural health nurse in Golden Bay who I talked to — the second thing she said after burnout was: when new people come, their rentals suck, and generally, they get kicked out of housing really quickly, and that can be the thing that tips them over to leave.

So to some degree, I think both Steve and Matt are kind of right. We have to have baseline standards that ensure that people can work well, that they are protected at work, and that they have the resources that they need. But you're right, we have to pay for that through economic growth. We don't think that opening up all and sundry to mining is the way to go. We take a pragmatic approach to mining in the right place at the right time, with large degrees of local involvement. The decision to dig must be made by those communities. We think that the way to actually get sustainable long-term economic growth is to change the settings in the housing market so that money actually flows to where it's supposed to go — to innovators, entrepreneurs, communities. And that's where we'll get the economic growth that can then pay for the standards that actually keep people here. We have a tax system that does just that, by the way. Thank you.

Grant: Okay. Questions. It's also okay to ask a yes/no question, and we'll ask them to commit to a yes/no.

Audience member (rural GP, Te Kuiti): So how do all your parties' health policies address equity both as a Te Tiriti obligation, but actually equity between rural and urban? Because Labor's three GP visits free — well, that's fine if you've got the GPs available to do that. So how does that address the inequity that exists in the rural workforce? But at the same time, Matt, you talk about increasing the mental health frontline workforce. In a rural community that I work in, in Te Kuiti, I can't see that. My patients are still struggling to even access counseling and psychologist support there. If we have someone in acute crisis, to get a crisis team worker down, that's three hours, five hours. Sometimes we have to transport them to Hamilton. So how are you actually, in your policies, addressing the equity both for Māori — because we know significant Māori populations live in rural communities — but also that rural/urban divide?

Matt Doocey: Yeah, look, very good question. And in a nutshell, you've really encapsulated the real pressures of living and, it looks like for yourself, working in healthcare in our rural communities.

The first point I'd make is pointing back to the data around the targets. I've actually been able to dig into the rural communities geographically as well as rurality and urban and population groups like Māori to actually understand the performance that they are experiencing, and expect Health New Zealand to be responding and ensuring resources flow into that area to bring them up to that expected level of service.

When we came into office, the mental health and addiction ring-fence was $2.4 billion. It'll go close to topping $3 billion this year. Crisis — which you've talked about — is a big area that we want to focus on, not only rolling out the mental health co-response teams to pair up with police to ensure that when you ring 111 for a mental health crisis, you get a mental health response, not a criminal justice response. But last year, we announced $61 million to roll out 40 new crisis and assessment team workers.

Nothing here is a silver bullet, I accept that, but it's just making sure that we've got the right problem definition and ensuring that we're investing more targetedly, because it can't always be just more money at a macro scale. It's got to be: where are we actually targeting that funding to ensure we can measure a lift of performance?

The final point I'd make is, my experience of working in the New Zealand health system and the British NHS, there's always that tension between efficiency and equity. I'd argue the NHS is a highly equitable system. But they've got 75 million taxpayers who pay an extra tax, and quite literally, they do hose a lot of money to cover the cracks. And then in New Zealand, I think with a low tax base, we've got an efficient system, but there's real equity issues. And so we've got to make sure that we do focus on that issue of equity.

But just to point out — in the NHS experience, free at the point of entry. So everyone says highly equitable, but try and get into a GP in the UK — it would be a lot worse than New Zealand, and that's a free one. So whatever health system, there are tensions. I think you can get a bit too into the philosophical discussion. It's ensuring that we've got targeted intervention that ultimately addresses the issues you're raising.

Ayesha Verrall: Thank you. I'll go to some of the things I mentioned in my opening remarks. In addition to the three free GP visits, we do want to support rural clinics, and some of the ways in which we can do that is through independent pricing, which is ending the take-it-or-leave-it negotiation between the government and clinics and saying instead, an independent authority specified in legislation will set the amount that clinics are paid based on evidence and need. And we all know rural clinics have higher costs because of the large population over a large area that they serve.

The second thing is we'll support clinics with freeing up more visits. We're very happy to partner on technology and making sure there's enough space available in clinics to do that. Where that's a barrier, government will work with you to address it.

Third thing is, in addition to training more doctors, we want them to take up spaces in rural practice. And to do that, we'll have a family doctor loan guarantee scheme so that in places where there aren't enough doctors, they can buy into a new practice there at a low — initially no, and then low — interest loan.

But I want to make a bigger point. When we move our proposal for three free GP visits, we'll be making one of the biggest injections of a pro-equity policy in New Zealand health I can think of. Can you name anything more than that, that would be more pro-equity than saying to the 650,000 New Zealanders who can't afford healthcare, that they can get seen? I can't. And it'll be great for Māori, great for people with disabilities, and great for rural people as well.

Daniel Eb: One of the broad strategies we have is a workforce agency that will not just apply to health, but across the entire economy, where we recognize the gaps in our workforce — your point about how long it takes to train somebody — and we encourage people from high school through to their study into areas where we know we're going to have gaps in workforce. And this is the sort of thing — workforce planning — that's not unusual. It's done in many parts of the world, and we used to do it here. We don't do it here now. We need to be more intentional about that.

And we need to make sure that the cost of getting your education to becoming a healthcare worker or professional is supported and paid for by the government, because it is in the public good. So we, as a principle, believe in lowering the cost of tertiary education. Rather than having people coming into their careers as a health worker with a massive debt on their shoulders, and then having really tough conditions to try and eke out a living in where they don't feel supported, they don't feel valued, and they don't feel like what they are giving to us as a society is truly recognized and appropriately rewarded.

Those are just some of the things. But a lot of the things that Ayesha referred to are similar to what the Greens would do as well to really make sure we have a functional, accessible, and sustainable health system for all.

Steve Abel: As part of our Honouring Te Tiriti policy platform, we support devolving a lot of healthcare services down to culturally relevant local providers. We think people should be able to access healthcare in a way that's culturally relevant to them. That makes a big difference in addressing inequities, particularly for Māori.

In terms of addressing inequities specifically for rural populations, we want to transition to a needs-based capitation model as much as possible. And to reiterate my earlier point — and I kind of disagree with Matt here — macro funding does matter. You can't keep chopping up and restructuring,

trying to eke out efficiencies. At some point, you've got to put money on the table, and frankly, health in general is underfunded. So we have to lift our funding model, so we will commit to that 30% increase in capitation over three years. Kia ora.

Grant: Thank you all. Alex.

Alex (rural GP, Coromandel): Tēnā koutou. Thank you very much for the comments so far today. I'm a rural GP in Coromandel, and I just want to echo what Steve was saying about workforce planning — it's really vital. And I've got a specific question for you all around that.

We have designed now a rural-specific GP training pathway. When can we get that actually up and running and operationalized? It's ready to go.

Grant: So when Alex is talking about a rural GP fellowship, that's specific training to train people on the extra skills required to be a general practitioner in a rural isolated area. And to make that a happening thing, it would cost $70,000 per general practitioner to put them through the program. Will you commit to funding 10 as a pilot per year?

Audience member: This is a stitch-up. I could see it coming. There you go. A million bucks a year and we're going to get a much stronger workforce out in rural areas. Will you do it?

Matt Doocey: Yeah, look. First thing to say is — well done for the work in the space. And look, we're aware of it, and it is under consideration, but clearly not going to announce anything today. But the principled point is not only do we need to grow the number of GPs in New Zealand, but also we need to ensure that we've got a better pathway for rural GPs and ensuring we roll out more of the generalism model. So those are three principal points that we would agree to, but we're just probably not at the point of making that announcement from the proposal from the GP College today. Other than — you do point forward in the direction of where things need to go, and of course, we saw that today with the Waikato University announcement.

Daniel Eb: Yeah, I'd largely echo those core principles. Personally, I'm new to the health sector. I'm not familiar enough with that program to provide any additional comment beyond that.

Ayesha Verrall: That sounds like a great initiative. The college has briefed me on it as well. It is the sort of thing I'd like to support. I have one slight reservation that I want to mention. I was minister after Andrew Little. He worked really hard on getting GP training places. I would say I would give credit to the current government in terms of the focus on general practice postgraduate training. They've had initiatives there as well.

I feel all of us — both the sector and the politicians — we focus on the little bits, the next step. Workforce is a generational issue. I do think a longer-term approach to getting everyone in the room

on something like that would be my first step on the general practice workforce, and that sounds like a great idea to showcase.

Daniel Eb: Yeah, that sort of idea is right in the realm of what we've committed to do, which is have specialist training for people in rural sectors. We believe in targeted strategies that actually meet the needs of people where they're at, and that sounds like an excellent idea along those lines. So — how soon can we make it happen? Oh, about six months. Just got to change the government.

Grant: Thank you. That was a perhaps, perhaps, perhaps, and a yes.

Audience member: This is a question specifically for Ayesha Verrall. She was at the August 13th, 2021 vaccine ministers meeting, which was left non-minuted and non-diarized, where everyone there decided to keep information on myocarditis out of the public communications. Do you have anything to say to the people who died from myocarditis after deciding not to let the New Zealand public know that that was a side effect of the COVID vaccine?

Ayesha Verrall: My first visit to Fieldays was during COVID, and it's tough for everyone to think about what our country went through during that time. But I have recollections of what we did on myocarditis. Actually, we ran one of the best public information programs on myocarditis in the world. And Medsafe had a monitoring program that was much better than many other countries, and the risks of myocarditis were made public and communicated clearly. A lot of people could have died in New Zealand but didn't because of the actions we took during COVID, and I know a lot of people in the audience today are health workers who participated in the COVID-19 response. I really thank you for your service on that.

Audience member (Prostate Cancer Foundation): I just wanted to ask the panel today. Much of the rural workforce is male, and yet we don't really see much focus on men's health. And we hear a lot about women's health. Every other day, there's another announcement on breast or cervical cancer. We don't really hear much about prostate cancer, which is one of the most diagnosed cancers in New Zealand now, and in fact, worldwide. And also, there's been the release of a landmark report that we at the Prostate Cancer Foundation contributed to, produced by Movember, into the real state of men's health in New Zealand. I wondered whether that report and men's health in general — we have a women's health strategy, we do not have a men's health strategy — whether this is going to impact on your policies as you go into the election and whether there's going to be any kind of focus on men's health specifically within your policy settings.

Matt Doocey: We were going so well before I got myself into trouble. But anyway, we're in a political panel. I'd slightly disagree with you, with respect. I'm actually probably forming the view, especially in rural, that actually we probably need to elevate the voice of rural women more. I think at times we have been a bit focused on rural men's health. That's not to undermine the valuable points you raise and clearly for the great work that you do around prostate cancer.

And I think it's incumbent on any government of the day to step up around that Movember report. So that's something we're actively looking at. Some of my colleagues might not know, but I think they're looking at bringing the report to Parliament over the next couple of months, and we'll do a cross-party event because I think it's important in an election year that all the parties step up and say what they might do in response to that report as well. But yeah, my first point is I think actually when you talk to the Rural Women's Network, I think there is a reality that we probably need to do a bit more in the rural women's space.

Daniel Eb: Yeah, I think it's an interesting approach. We call ourselves an evidence-based party. Evidence is really important to us, and so anything like that, we try to take a step back and say, "What are we actually trying to achieve here?" If the evidence points to a sort of identity-based approach and that's going to get the best results, let's do that. If something points to maybe taking more of a family health approach — and the best way to remove prostate cancer risk is actually to go through kids, potentially — let's do that. So I think we quite quickly get into these ideological rat races where everything has to kind of fit existing belief sets. Let's look at data and evidence first and make our decision off the back of that and kind of screw ideology. It doesn't really serve us that well in the long run.

Ayesha Verrall: Yeah. Thanks for your question, and I just appreciate the Foundation's advocacy on prostate screening, and we continue on the Health Select Committee to look into the evidence there.

I started by talking about my dad and his illness. He died of melanoma, and he was a mountain climber in his youth before he had kids. He used to climb in the Southern Alps. He told me stories about how he'd just get incredible sunburns climbing back in, I guess, the '60s or the '70s, and wake up with his face stuck to his sleeping bag because of the peeling and blistering. Always an outdoors man — ran marathons, ran the Kepler Track, ran the Routeburn Track, hunting, fishing. That was his life outdoors, and I imagine that was his risk of melanoma. And melanoma is twice as likely to kill men than women as a result, and we all know what we can do about it, and people still die. And not only do they die, they have long experiences in the healthcare system that are also very costly. If I get my wish on November 7th, that would be something I'd like to take action on.

Grant: Sorry, Andrew.

Andrew: Well, it was my mum that died of melanoma, so I don't know what you're talking about.

Grant: No, you can make light of it now. Bloody awful disease, melanoma, I can tell you.

Steve Abel: Look, I would say the principle — I really respect what Movember does and the stuff around prostate. The principle that we need to find how to communicate to people who are at risk of particular illnesses goes across the board. Whatever your demographic, whatever your sex, whatever your postcode, whatever your ethnicity — we need to be intentional and targeted about how we reach those people and those demographics who are most at risk of certain diseases and illnesses. That just makes sense. I don't think it's an either/or. So the principle is good. Let's find out how we get to those communities and those groups of people and get those diseases dealt with.

Grant: Thank you. I made a commitment to finishing on time, and I know Minister Doocey's got another commitment. I've got three questions, so you're just going to raise your hand if you support these before we close off.

Rural hospitals across New Zealand — there are about 28 of the major ones and some others that are aged care centres. They're funded at a significantly different level: community rural hospitals versus the Health New Zealand rural hospitals. Will you commit to looking at equitable funding for rural hospitals? Yes or no?

All panellists: Yes.

Grant: For rural people to access health, often they have to travel to cities for specialist appointments and even to their doctor's appointments. The National Travel Assistance Scheme is woefully underfunded in terms of mileage rates and even access. Will you look at revising the NTAS so there's equitable access for rural folk to get to their appointments?

Matt Doocey: What will we do? Will we do it or look at it? You know we've increased it twice in two years now.

Grant: I know you've increased it twice. It's still less than half the actual IRD rate for mileage rates.

Matt Doocey: What are you actually asking us to do?

Grant: Well, I'm actually asking you to fund it at a rate that will enable people to access the health that they're required to. Will we be prepared to look into it or actually do it?

Matt Doocey: Look into it and then act on the recommendations. I'll look into it. I can't make an announcement today that we'll do it.

Grant: Okay. Ayesha's scratching an itch.

Ayesha Verrall: Yeah, it was definitely scratching my itch.

Steve Abel: And the Greens will do it.

Grant: The final question. We're being told by the government the answer to all our woes is technology and AI. That comes down to the latest thing. Rural primary care are the least supported in terms of technology and introducing technology. Who will help rural practices and rural primary care get technology?

Could you take a photo? Hey, big round of applause to the panel for fronting up. Thank you all.