Royal Australasian College of Surgeons

RACS AOTEAROA NEW ZEALAND REGIONAL AND RURAL HEALTH EQUITY STRATEGY

1 CONTEXT AND DEVELOPMENT OF THIS STRATEGY

This Strategy has been developed in conjunction with the RACS Rural Health Equity Strategic Action Plan and supplements it with Aotearoa New Zealand-facing actions using the relevant language and terminology.

The Rural Health Equity Strategic Action Plan was developed to address the inequity of surgical services currently experienced by people living outside major metropolitan areas in Australia and Aotearoa New Zealand. Developing an Aotearoa New Zealand specific strategy is an action item agreed by the College in the Rural Health Equity Strategic Action Plan. It is clearly acknowledged that the initial strategic initiatives outlined in the Rural Health Equity Strategic Action Plan are mainly Australian-centric, and the aim of this Strategy is to develop specific actions for the Aotearoa New Zealand context.

A wide range of Fellows and groups representing various specialties and areas of interest have contributed to the development of this strategy. The development process included holding a Regional and Rural Health Equity Strategy workshop for the Aotearoa New Zealand surgical community, presenting this Strategy and seeking feedback from interested RACS committees, specialty groups and workshop participants.

2 SUMMARY OF ACTIONS

An outline of the Aotearoa New Zealand-facing actions derived from the workshop and subsequent discussions and meetings are listed below. These are also summarised in Section 6. Timeframes for implementation have been suggested.

Recommended Actions	Proposed Timeline	Responsibility
Recommend to the Rural Health Equity Steering Committee (RHESC) to endorse 'regional' as the preferred terminology for Aotearoa New Zealand.	Short	Aotearoa New Zealand National Committee (AoNZNC) representative on RHESC
Recommend to the Rural Health Equity Steering Committee to endorse the definition of 'regional' to be as per Stats NZ Tatauranga Aotearoa Functional Urban Area classifications for large-, medium- and small-regional centres.	Short	AoNZNC representative on RHESC
Endorse data collection about Aotearoa New Zealand members that captures regional geographic information.	Medium	RHESC
Conduct a gap analysis study on the barriers and incentives to specialist surgeons working in regional and rural Aotearoa New Zealand.	Medium	RHESC
Share Aotearoa New Zealand Rural Health Equity workshop recommendations and strategy with the Transition Unit and Minister for Rural Communities (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).	Short	AoNZNC
Apply a Māori health lens as per the principles outlined in the Te Tiriti o Waitangi and Te Rautaki Māori to the Rural Health Equity Strategy.	Medium	Māori Health Project Officer / AoNZNC representative on RHESC

Board of Surgical Education and Training (BSET), Aotearoa New Zealand and binational Specialty Training Boards to consider reviewing SET curricula to ensure it supports regional and rural surgical practice.	Long	BSET
Consider the project findings arising from the RACS project on investigating and developing a rural facing surgical curriculum in Australia (funded via the Australian Department of Health) and if any relevant learnings could be applied to Aotearoa New Zealand context.	Medium	Specialty Training Boards and Committees
Ask the Board of Surgical Education and Training, Aotearoa New Zealand and binational Specialty Training Boards to consider expanding SET supervision to ensure it supports regional and rural surgical practice.	Medium	AoNZNC representative on RHESC / Specialty Training Boards and Committees
Support the integration of administrative processes for RACS Fellowship with vocational assessment with the Medical Council of New Zealand for SIMGs.	Short	RHESC / SIMG Assessment Committee
Develop SIMG welcome pack as outlined in the Rural Health Equity Strategy.	Medium	AoNZNC / AoNZNC representative on RHESC
Ask the Board of Surgical Education and Training, New Zealand and binational Specialty Training Boards to consider developing Hub and Node training networks as part of accrediting SET training posts including novel models of supervision with local supervision supplemented by remote or visiting supervisors spread across hub and node sites.	Long	AoNZNC representative on RHESC
Explore the Hub and Node network model with the Transition Unit.	Medium	AoNZNC representative on RHESC / AoNZNC
Regional and Rural Health forum be convened with Aotearoa New Zealand and binational specialist medical colleges.	Medium	AoNZNC representative on RHESC / AoNZNC
Share Aotearoa New Zealand Regional and Rural Health Equity strategy report and recommendations with the Council of Medical Colleges in New Zealand (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).	Short	AoNZNC
Aotearoa New Zealand National Committee to consider including a rural representative on their committee, and for this representative to be the RACS representative on the Hauora Taiwhenua, and the Division of Rural Hospital Medicine.	Short	AoNZNC
Aotearoa New Zealand National Committee and Rural Health Equity Steering Committee discuss the feasibility of Aotearoa New Zealand Regional and Rural Subcommittee.	Completed	AoNZNC representative on RHESC
RACS provides dedicated resources to implement the Aotearoa New Zealand Regional and Rural Health Equity Strategy.	Short	RHESC
Ensure there is representation for AoNZ Orthopaedic and General Surgery specialist societies equivalent to Australia on the Rural Health Equity Steering Committee	Completed	RHESC

3 INTRODUCTION

On Saturday 4 September 2021 RACS Rural Surgery Section (RSS) hosted a workshop to discuss the inaugural Rural Health Equity Strategic Action Plan and derive Aotearoa New Zealand-facing strategic initiatives exploring concepts on how to best support Fellows, Trainees and Specialist International Medical Graduates in Aotearoa New Zealand. This workshop addressed recommended action item 3.2 from the Rural Health Equity Strategic Action Plan under the Collaborate for Rural strategy to 'convene a New Zealand Rural Surgical Services Forum, developing a strategy bespoke to provincial and rural surgery in New Zealand'. It also provided an opportunity to discuss the potential impacts on rural and regional surgical services of proposed reforms aimed at transforming the delivery of healthcare in Aotearoa New Zealand.

Workshop participants included Aotearoa New Zealand National Committee executive and members, Aotearoa New Zealand-based Councillors, Māori Health Advisory Group, NZ Executive Directors of Surgical Affairs (EDSA), Andrew Connolly (Chief Medical Officer NZ Ministry of Health), representatives from the Australasian College of Emergency Medicine and the Australian and New Zealand College of Anaesthetists, Dr Allan Panting (retired regional orthopaedic surgeon and previous NZ EDSA), Specialist International Medical Graduates (SIMG), Dr Jeremy Webber (Clinical Director Rural Health, New Zealand Rural General Practice Network) and Dr Margaret Fielding (a surgically-trained rural general practitioner). Aotearoa New Zealand-based members of the RSS were given the option to register via the Rural Surgery Section newsletter.

The workshop was part of the Rural Surgery Section Committee meeting which was initially planned to be a face-to-face event in Queenstown. The workshop was planned for 2020 but was cancelled due to the COVID-19 pandemic. Due to the 2021 COVID-19 lockdown in Aotearoa New Zealand this workshop took place over Zoom.

4 SETTING THE SCENE

Invited speakers were asked to provide brief presentations to stimulate discussions on topics related to current policy issues and propose recommendations that could be adopted by RACS and its partner surgical societies and association and related Specialty Training Boards. The main discussion points arising from each of the presentations are outlined in the following.

Introduction to the RACS Rural Health Equity Strategy

- **Associate Professor Kerin Fielding, Councillor, Chair of the Rural Health Equity Steering Committee & Dr Bridget Clancy, Vice Chair of Rural Health Equity Steering Committee; and Chair of Rural Surgery Section**

The Rural Health Equity Steering Committee was established in early 2021 with the responsibility of managing the overarching principles outlined in the RACS Rural Health Equity Strategic Action Plan and prioritising the actions for implementation. The work to date has focused on establishing a governance structure with an Advisory Group and Global, Rural/Regional/Remote and Deployable (GRiD) Surgery Working Group; developing a monitoring and evaluation framework; reviewing training post accreditation standards and selection initiatives, as well as strengthening linkages to the Australian National Rural Health Commissioner, Regional Training Hubs, National Rural Health Alliance and other specialist medical colleges (RACMA, RANZCO, ANZCA, RACGP and ACRRM).

The lack of agreed definitions and classifications of rural, regional and remote has impeded data collection and reporting of outcomes. Statistics NZ Tatauranga Aotearoa has recently developed two classifications: Functional urban areas (FUA) and Urban accessibility. There is limited regular and comprehensive data on health disparities in the rural setting.

Challenges and opportunities facing rural health systems in Aotearoa New Zealand

➢ **Dr Chris Phoon, co-opted member of Rural Surgery Section**

According to the Ministry of Health NZ one in four New Zealanders live in rural areas or small towns. Data from the 2018 census suggests 11.6% of Aotearoa New Zealand's population lives outside FUAs, i.e. in rural areas, and 26.5% live in regional areas (Table 1 below).[1] Māori represent a higher proportion of the population living in small urban areas and rural areas.[2]

Table 1 Composition of FUA according to 2018 Census. Source: StatsNZ

Functional urban area type	Number of functional urban areas	2018 Census usually resident population					Percent of New Zealand
		Components					
		Urban cores	Secondary urban cores	Satellite urban areas	Hinterland (rural SA1s)	Functional urban area	
Metropolitan area	6	2,303,448	338,403	83,289	187,386	2,912,526	62.0
Large regional centre	11	541,038	42,324	38,124	105,525	727,011	15.5
Medium regional centre	14	245,535	-	29,592	46,872	321,999	6.9
Small regional centre	22	148,524	-	9,213	35,427	193,164	4.1
Total functional urban areas	53	3,238,545	380,727	160,218	375,210	4,154,700	88.4
Outside functional urban areas						545,055	11.6
Total New Zealand						4,699,755	100.0

The Ministry for Primary Industry presented a 'Rural Proofing Policy' which updated policy creation guidelines which were endorsed by cabinet and presented to the public on 13 June 2018.[3] It stated that the effectiveness of rural proofing on policy would be assessed through a proposed report to cabinet by June 2021. The rural proofing policy required government to add a rural lens to the normal policymaking process, to consciously remove any urban bias and think through potential rural implications of policies.

For the last 20 years, delivery of healthcare in Aotearoa New Zealand has been locally managed by 20 District Health Boards (DHBs). They have a statutory responsibility for both primary and secondary (hospital) care within a geographic area. Population Based Funding Formula (PBFF) is the funding 'capitation' formula the Ministry of Health uses to distribute the majority of health funding to DHBs each year.[4] The PBFF considers the population and demographics of those residing in each DHB catchment. The formula includes factors to compensate DHBs that service rural communities and areas of high deprivation. DHBs currently ensure that patients are seen locally and appropriately. General practitioners refer to their local hospital and specialists assess if services can be delivered safely close to home. Where services cannot be delivered by the home DHB, patients can be referred to another DHB, which charges the home DHB an interdistrict flow cost. A financial contribution is made to the cost of travel and accommodation for people who need to travel a long distance or very frequently to attend specialist hospital treatment.[5] At the DHB Board level the cost of this funding is a significant ongoing concern in setting annual budgets. Conversely, underestimation of inter-district flow costs often leads to relative disincentives for smaller centres to develop their own service and infrastructure, as it may be cheaper to maintain outsourcing to a local tertiary service.

In 2018 the Health and Disability System Review was commissioned by the Government. The scope of the Review was wide ranging with a particular emphasis on current and future equity in healthcare delivery.[6] The recommendations arising from the Review culminated in the announcement of health reforms in April 2021 by the Minister of Health Hon Andrew Little.[7] These reforms included:

- creation of a new Māori Health Authority to lead improvement in Hauora Māori (Māori health)
- merging all DHBs into a single entity to create Health NZ, a new Crown entity to lead, deliver, and provide consistency, oversight and accountability; to guide and co-ordinate health care in New Zealand
- refocussing the Ministry of Health's scope to health policy, regulation, advisory roles to Government
- creation of a new Public Health Unit to improve responses to major public health issues as highlighted by the COVID-19 pandemic
- develop a new long term "New Zealand Health Plan", which include reviewing where specialist services will be provided.

The report also called for introducing a two-tiered system:

- Tier 1 – community and primary care
- Tier 2 – hospitals and specialists services.

Regarding the surgical hospital level Tier 2, there is a need to:

- "identify national and highly specialised services and where they should be provided."
- develop more virtual sessions/telemedicine
- "operate as a cohesive network in an integrated and collaborative way with Tier 1"

The Transition Unit roadmap has given until July 2021 for consultation. It is intended that legislation will be passed in July 2022, with the new entities fully operational in September of that year.[8,9]

Potential benefits and drawbacks of reforms are highlighted in the following table:

Benefits	Drawbacks
- Centralised asset management and health infrastructure building - Nationalisation of surgical prioritisation thresholds - Common information technology management systems - Improved auditing of regional health outcomes, National Performance Management Reviews, National policies, health pathways, patient resources and guidelines on common conditions - Standardising agreements with private sector - Savings through national purchasing of equipment and supplies	- Barriers to care in the regions frequently relates to local issues - Greater distance between healthcare providers and senior management, possibly leading to additional health bureaucracy and clinician disempowerment - Loss of local community and hospital integration - Potentially diminished quality local service provision being replaced by telehealth/virtual clinics - Reduction in local political accountability - Urban rather than regional/rural focus

Introduction on government's proposed health reforms to the Ministry of Health, Māori Health Authority and Health New Zealand, and collaborating for equitable rural surgical care

➢ **Dr Andrew Connolly, Chief Medical Officer, Ministry of Health New Zealand**

The reforms aim to address health care inequities which are believed to be driven by the DHB system ("postcode lottery") while also strengthening the health system into a single nationwide service which provides consistent, high-quality health services for everyone, particularly groups who have been traditionally underserved. Population based funding has potentially disadvantaged some DHBs –

Southern and Tairawhiti being two quoted examples. The DHB model has good features but has not consistently realised equitable health care. The reforms aim to have national consistency for hospital and specialist services and local tailoring of primary and community care. This should improve care quality and equity, while ensuring the services are provided close to home reflecting the community needs. The establishment of the Māori Health Authority will significantly bolster the delivery of care to Māori whānau and communities.

As the implementation of these reforms is imminent, there are opportunities to ensure surgical training is targeted towards the local context. Curricula for, training posts and opportunities for Fellowships in rural settings are levers RACS could consider targeting in developing a surgical workforce which will have the necessary broad scope skill set and clinical networks to meet community need when they reach Fellowship.

A significant challenge for RACS is not having surgical voices heard and represented in the decision-making process. The previous initiative to develop a Hub and Node model proposed by the New Zealand Association of Plastic Surgeons to Health Workforce NZ was accepted in 2013 but then was not implemented.[10,11] This is further expanded in section 5.7. RACS and its surgical societies and associations will need to continue to engage with Health NZ. Action by RACS to draft and promote a rural surgery advocacy plan in the development of the NZ Health Plan by the Transition Unit was strongly encouraged by the Chief Medical Officer, who can help facilitate this.

Participant discussion included issues with patient transfer within and between DHBs. Transfer times are often prolonged. At times, relationships within DHBs and between DHBs can delay transfers. Comments were made about difficulties persuading tertiary centres to accept rural and regional patients. This might be improved by developing clinical relationships, which may be especially difficult for SIMGs, who may not have had the opportunity to develop relationships during training. Supporting and establishing official visitations and sabbaticals for SIMGs would be a good initiative. At SET level, Specialty Training Boards and Surgical Societies can reinforce relationships building activities.

> *"If you rotate rural focused trainees through the Cardiac Unit now, those conversations are easy when my current trainee becomes a rural surgeon." – Workshop Participant*

How the Te Rautaki Māori (Māori Health Action Plan) can be supported by an Aotearoa New Zealand Rural Health Equity strategy

- **Dr Alison Scott, RACS Māori Health Advisory Group**

Te Rautaki Māori (Māori Health Action Plan) is underpinned by six kaupapa (priority areas) and the Te Tiriti o Waitangi (The Treaty of Waitangi).[12,13] Equity specifically targets disparities amongst disadvantaged or underprivileged communities. There is a collective responsibility that Māori health equity is considered by all committees, planning bodies, governing boards, and health services.

Dr Scott also highlighted that the Aotearoa New Zealand Rural Health Equity Strategy must consider the principles of the Treaty of Waitangi. Dr Scott discussed aspects of Te Rautaki Māori that have made it successful and suggested the Aotearoa New Zealand Rural Health Equity Strategy incorporate the following priority areas:

- Pae Ora (Healthy Futures):
    - establishing Māori positions on governance boards and in decision making processes
    - supporting legislation, statements, proposals etc. that addresses positive health outcomes for Māori
    - addressing racism and unconscious bias
    - embedding Te Tiriti o Waitangi principles and mission statements into policy and education
- Kaupapa Here (Stronger Policy and Development):

    - ensuring policies that are reviewed and/or developed benefit the progression of Te Rautaki Māori and work toward improving health equity
- Mātauranga Māori (Māori Knowledge and Capability):
    - incorporating the Māori cultural knowledge and capability of non-Māori to improve Māori health
- Whakatipu (Workforce Development):
    - allocating and strengthening specific training positions for Māori
    - allocating adequate resources, i.e. funding, are sourced for the implementation of this project
- Rangahau Māori (Research Development):
    - capturing ethnicity data and addressing racism and unconscious bias
- Ngā Hononga (Partnerships):
    - fostering genuine partnerships with Ministry of Health and healthcare organisations, as well as Specialty Societies to enable collaboration on shared goals (conjoint statements, shared meetings, communications)

Similar to the governance structure of the Indigenous Health Committee, it is important to have separate entities to consider the unique challenges of Aboriginal and Torres Strait Islander and Māori people. Whilst there is already a dedicated Māori representative on the Rural Health Equity Steering Committee (Dr Maxine Ronald is the current member), stronger Māori representation would also be welcomed.

Whilst RACS recently launched the Australian Indigenous Surgical Pathway Program aimed at inspiring and supporting Aboriginal and Torres Strait Islanders on a surgical medical career, an analogous pathway for Māori SET aspirants is likely to be unsuitable. The Māori Health Advisory Group's opinion is this is not appropriate in Aotearoa New Zealand at present. There is strong advocacy for an environment that provides safe, equitable and sustainable pastoral care for Trainees. The creation of the tenth competency and more Directors of Surgery who are Māori may help make an analogous Surgical Pathway Program redundant.

The barriers and enablers in undergraduate rural medical student recruitment

➢ **Dr Margaret Fielding, GP and Rural Generalist from Wairoa**

Dr Fielding spoke about selecting medical students for rural intention/origin.
Recommendations from the presentation included:

- Establish the Otago Rural Medical Immersion programme more widely [14]
- Modify the selection criteria for those wanting to enter medicine
- Involve the Māori Health Authority with oversight of rural health
- RACS to establish links with the Rural Division of Hospital Medicine and the Māori Health Authority
- Doctors in small rural hospitals may need to be dual qualified.

A number of Specialty Training Boards have already adopted rural selection initiatives. An example is the New Zealand Society of Otolaryngology Head and Neck Surgery (OHNS), who award selection points for rural pre-SET work experience, have reduced selection points from postgraduate/academic qualifications (often only attainable in urban centres), and reduced the number of referees requirements to help SET aspirants apply from smaller rural units. Rural selection questions at selection interviews have been implemented as well. One-year training posts in rural centres are now offered to most SET OHNS Trainees.

Specialist International Medical Graduates (SIMG) experience in rural Aotearoa New Zealand

➢ **Ms Clare French, Locum specialist general surgeon in Masterton**

SIMGs are valued members of rural surgical teams. They are highly represented in many rural hospitals.[15] The Medical Council of New Zealand (MCNZ) permits SIMGs to work as locum and consultant surgeons without the need to be on a FRACS pathway. There is a common misconception

that SIMGs are transient (working holiday), but many stay long term at one hospital.[16] Although SIMGs bring diversity in knowledge and experience, they face barriers hindering their retention in the rural surgical workforce. These include:

- limited relationships with colleagues; isolated hospitals can exacerbate this
- limited opportunity to develop clinical networks/connection to help facilitate transfers, retrievals, collaboration and support
- limited career development as research, continuing medical education (CME) and teaching opportunities are concentrated in the urban centres
- impression of a culture of gatekeeping by AoNZ-trained specialists, MCNZ, specialist medical colleges and their societies and training boards, and Immigration NZ.

SIMGs often feel unwelcome and undervalued. Whilst it is imperative that surgical standards are maintained, the current processes around SIMG assessment including those of the MCNZ have been criticised as being unintentionally burdensome. Examples include frustration at repeating courses and exams for experienced surgical consultants.

It was recommended that retention of SIMGs could be improved with supports related to:

- Time and financial/logistical support for CME and collaboration between specialists at affiliated hospitals
- Stronger relationships between administration/ management of individual hospitals
- Systematic integration of SIMGs into governing bodies and colleges in advisory roles.

Australasian College of Emergency Medicine's approach toward rural health equity

- **Dr Jared Bayless, ACEM Rural, Regional, and Remote Committee**

Multiple specialties are focusing on rural health. ACEM's Rural Health Action Plan was published in June 2021.[17] In this Action Plan, the following major priorities were identified:

- Workforce distribution: attracting, growing and retaining the workforce through wellbeing and education needs
- Evidence: capturing data on the specialist's and patient's experiences
- Service Provision, Planning & Development: enhancing rural representation at policy and advocacy levels, and emergency medicine standards
- Collaboration: among trainees and specialists, within rural, regional and remote health practice community, and between rural and metropolitan clinical networks.

The collaborative alliance with rural health practitioners

- **Dr Jeremy Webber, Clinical Director Rural Health, New Zealand Rural General Practice Network (NZRGPN)**

Fellows of Rural Hospital Medicine are a subspecialty of General Practice, trained as part of Division of Rural Hospital Medicine within the Royal New Zealand College of General Practitioners (RNZCGP). This accredited training programme commenced in 2008 to deliver the vocational scope for doctors working within rural hospitals. Rural hospital doctors undertake shared care arrangements with urban-based specialists, involving the identification of serious illness at an early stage, arranging transfers, and managing complex care; and they are involved in community health initiatives. The MCNZ provides recognised specialist vocational registration to practitioners with a Fellowship of the Division of Rural Hospital Medicine (FDRHMNZ) qualification.
There is a considerable variation in New Zealand rural hospitals. The Division recognises three levels of rural hospital (shown in the map below):

1. Visiting medical cover once a day, no onsite laboratory, limited radiology
2. Onsite medical cover in working hours, some point-of-care testing, on-call radiographer
3. 24-hour medical cover, radiology and laboratory services, may have some specialist cover.

These locations do not generally have on-site surgical cover.

Figure 1. Map of New Zealand rural hospitals accredited for Rural Hospital Medicine training. Source: RNZCGP Division of Rural Hospital Medicine[18]

At present, the surgical representative on the Division of Rural Hospital Medicine within the is currently vacant pending RNZCGP structure change.

In May 2021, the vision for Hauora Taiwhenua Rural Health Network was proposed by the New Zealand Rural General Practice Network (NZRGPN) with the purpose of bringing together rural health networks in a collective initiative to advocate on behalf of rural health with one united voice. The initial networks to join are the NZ Rural Hospital Network, Rural Nurses New Zealand, Rural Health Alliance Aotearoa NZ, and Students of Rural Health Aotearoa, along with the Network's Treaty partners, Te Rōpū Ārahi. This proposed structure will allow various rural health groups to have their own voice on their specific issues, contribute to strong collective messages, and work together to plan and deliver the health services that

meet the needs of rural communities. This proposal was endorsed by NZRGPN members, with transition occurring in 2022.

5 EMERGENT KEY THEMES

5.1 Consensus on a definition of rural relevant to Aotearoa New Zealand

In Aotearoa New Zealand, there is no agreed definition of 'rural' for the purposes of health policy and research. Definitions for rural vary between sources and have evolved over time. Terms such as provincial are no longer widely used. Statistics NZ Tatauranga Aotearoa, in its 2004 report *New Zealand: An Urban/Rural Profile*[19], outlined the complexities involved in classifying an area as rural or urban and noted that there was no internationally recognised definition of a 'rural' area. It noted that standard urban/rural classification, particularly the rural categorisation, was judged to be inadequate as it was based purely on population size. The report also highlighted the lack of consistency between Aotearoa New Zealand and other countries, like Australia, as Aotearoa New Zealand (at the time) defined main urban areas as having 30,000 or more people, while the Australian definition lists a population centre of greater than 50,000 as regional (Modified Monash Model classification 2).

Evolving from the 2004 Urban/rural (experimental) profile (UREP), which explored the diversity of social and economic characteristics of people in all areas of the urban-rural spectrum, Statistics NZ developed two new classifications in 2020, recognising the connectivity between semi-rural areas surrounding urban areas to the urban areas:

- Functional urban areas (FUA): based on linkages between where a person resides and their activity space[20]
- Urban accessibility: distinguishes rural areas based on their degree of accessibility to urban areas.

More information on these classifications is outlined in the Appendix 2.

The preferred term by most Aotearoa New Zealand surgeons is regional rather than provincial or rural. This fits with Statistics NZ definitions. A preferred definition for the Rural Health Equity Strategy in Aotearoa New Zealand is the RACS Aotearoa New Zealand Regional and Rural Health Equity Plan. The term rural will continue to be used throughout this document pending future endorsement by RACS governance bodies.

There is lack of data collected about RACS members and their geographic distribution in Aotearoa New Zealand. The RACS Activities currently only reports published information about Australian members and their geographic classification.

Actions to consider:

5.1.1 Recommend to the Rural Health Equity Steering Committee to endorse 'regional' as the preferred terminology for Aotearoa New Zealand

5.1.2 Recommend to the Rural Health Equity Steering Committee to endorse the definition of 'regional' to be as per Functional Urban Area classifications for large-, medium- and small-regional centres.

5.1.3 Recommend to the Rural Health Equity Steering Committee to endorse data collection about Aotearoa New Zealand members that captures regional geographic information.

5.1.4 Conduct a gap analysis study on the barriers and incentives to specialist surgeons working in regional and rural Aotearoa New Zealand.

5.2 Opportunity to influence the New Zealand health reforms and government

There is a current opportunity to engage with the Transition Unit and the Minister for Rural Communities, Hon Damien O'Connor by initially forwarding copies of the Rural Health Equity Strategy to both offices.

Action to consider:

5.2.1 Share Aotearoa New Zealand Rural Health Equity workshop recommendations and strategy with the Transition Unit and Minister for Rural Communities (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).

5.3 Adopt and develop specific principles to an Aotearoa New Zealand setting in accordance with the Te Tiriti o Waitangi (Treaty of Waitangi) and Te Rautaki Māori (Māori Health Action Plan)

The plan should be reviewed to ensure that it is in accordance with principles of Te Tiriti o Waitangi, so it is appropriate for the Aotearoa New Zealand setting. Collaboration is highly recommended where initiatives are aligned toward achieving similar objectives. This can be demonstrated by organising joint meetings, coordinating joint research, co-signing statements and policy papers.

Action to consider:

5.3.1 Apply a Māori health lens as per the principles outlined in the Te Tiriti o Waitangi and Te Rautaki Māori to the Rural Health Equity Strategy.

5.4 Curriculum review supported

SET training should endeavour to ensure that at the completion of the program each Trainee is competent over the breadth of their surgical specialty. Whilst SET training provides a broad scope of practice within each surgical specialty, the importance of maintaining a generalist practice should be better promoted towards new Fellows. Establishing professional and non-technical skills and learning objectives that have a rural focus within the curriculum could help build confidence and competency in training specialists for rural settings. Encouraging the SET program to be based upon core surgical practice for each specialty would imply greater recognition of training in regional centres.

Actions to consider:

5.4.1 Ask the Board of Surgical Education and Training, Aotearoa New Zealand and binational Specialty Training Boards to consider reviewing SET curricula to ensure it supports regional and rural surgical practice.

5.4.2 Consider the project findings arising from the RACS project on investigating and developing a rural facing surgical curriculum in Australia (funded via the Australian Department of Health) and if any relevant learnings could be applied to Aotearoa New Zealand context.

5.5 SET training post accreditation policies governed by New Zealand and bi-national Specialty Training Boards to consider novel models for training and supervision

The current accreditation criteria tend to be more focused towards metropolitan units. As an unintentional consequence, rural and regional training posts are at a disadvantage. It is recommended that the accreditation standards of training should be more applicable to regional centres. An example is the requirement that supervisors must hold FRACS. Many rural centres do not have multiple RACS-trained surgeons which currently limits the possibility to create additional accredited training posts. It is important that the College recognises the quality of training and experience to be provided in any centre – this is not necessarily related to the surgical fellowship held by the supervising senior staff.

Some Aotearoa New Zealand and binational training boards and societies, such as the Board of Cardiothoracic Surgery and Board of Otolaryngology, Head and Neck Surgery, welcome proposals that include:

- creating cross-specialty training exposure to supplement rural and regional training rotations
- creating more rural posts dedicated to advanced Trainees to help retain new rural Fellows
- creating pilots for new Fellowships in rural surgery

Action to consider:

5.5.1 Ask the Board of Surgical Education and Training, Aotearoa New Zealand and binational Specialty Training Boards to consider expanding SET supervision to ensure it supports regional and rural surgical practice.

5.6 Invest in Specialist International Medical Graduate (SIMG) support

Initiatives that improve opportunities for SIMGs to develop clinical and collegiate relationships should be adopted by RACS, surgical societies and Specialty Training Boards. These can include:

- the development of a RACS welcome pack as part of a broader orientation/induction program to support the SIMG to the workplace
- official events organised by surgical societies to encourage networking and developing collegial relationships
- considering integration of SIMGs into governing bodies and medical colleges in advisory roles
- advocating for financial/logistical support for CME, MALT audit and collaboration between specialists at affiliated hospitals.

These are supported by commentary at the workshop:

> *"Local senior mentorship for SIMGs in our association would really help with this. Otherwise as an outsider it's very difficult to join the club and develop the networks."*
> *– Workshop Participant*

In contrast to Australia, where SIMGs are required to be on an assessment pathway to Fellowship in order to be gain specialist registration, there are dual pathways to attain vocational registration in Aotearoa New Zealand. The Medical Council of New Zealand (MCNZ) determines successful applications based on its criteria and advice received from the relevant Vocational Educational and Advisory Body (VEAB). RACS is the VEAB for its nine surgical specialties. As such there are a significant number of specialist surgeons in Aotearoa New Zealand who are not FRACS but are identifiable to the College via CPD, recertification and communication purposes.

It was recognised that SIMGs obtaining MCNZ specialist recognition face ongoing demands. There is a large number of applicants and extensive paperwork for each case. RACS needs to continue to support MCNZ registration processes and devote resources to these. The Rural Health Equity Strategy should support ongoing work to integrate MCNZ and RACS Pathway to Fellowship processes.[21,22]

Actions to consider:

5.6.1 Recommend to the Rural Health Equity Steering Committee and SIMG Assessment Committee to support the integration of administrative processes with the Medical Council of New Zealand.

5.6.2 Endorse the development of a RACS SIMG welcome pack as outlined in the Rural Health Equity Strategy.

5.7 Explore the concept of the Hub and Node model for supporting training, and rural isolated practitioners/surgical teams

A Hub and Spoke model is based upon centralisation of service decision-making by the manager/surgeon in a city (hub) planning service. A Hub and Node model has the hub

supporting devolved care in regional and rural hospital(s) by providing peer support, audit and review collaboration, education resources, acute cover to support the taking of leave and increasing the ability to undertake advanced procedures. It allows better patient centred care rather than service centred care. This model fosters improved collegial relations between the central hub and peripheral nodes.

> *"Strong nodes can decompress hubs to free up time - the Midcentral analysis for plastics showed that 74% of hub activities could be safely delivered at the nodes." – Workshop Participant*

In this model, rather than a metropolitan service delivering all care and surgeons visiting regional hospitals, a node (regional/rural service) is supported by a metropolitan base. Nodes are supported with CME and tertiary care. Both patients and clinicians may travel between hub and node hospitals to access and facilitate care. The hub should endeavour to facilitate the service, but this has been difficult in some areas. Issues include difficulties in attracting and establishing surgeons working in relative isolation, parochialism, subspecialisation, effective placement and funding.

> *"The hub needs to be supported, too, in making these collaborations possible — as much as it's tough out in the node, the hubs are overworked too and there's a real fear that extending themselves to collaborate with the nodes means the nodes will use that relationship to load more work on them." – Workshop Participant*

The model may also work for training. A training site is typically sited within the same health jurisdiction as the hub.

The Hub and Node model was proposed by New Zealand Association of Plastic Surgeons to Health Workforce NZ several years ago, was accepted but was not widely implemented.[23] Participants noted this model is working well in some areas.

> *"Supporting those more isolated nodes may make them more able to attract and retain surgical services"*
>
> *"Nervousness (my concern) currently is representation and/or the ability to achieve traction for what we need outside of the regional management hub."*
>
> *"Support networking builds trust and when referrals are needed it is easier. However at the management level it tends to favour the hub"*
>
> *"One of the keys to functional node / hub relationships is shared academic / collegial activities - there has to be an "us" rather than "them and us" culture. This will be easier if we are employed by Health NZ rather than different DHBs. The inherent culture of one employer has the potential to breakdown significant barriers."*
>
> *"Local service delivered by local surgeons, in the local community is the ideal outcome."*

Actions to consider:

5.7.1 Ask the Board of Surgical Education and Training, New Zealand and binational Specialty Training Boards to consider developing Hub and Node training networks as part of accrediting SET training posts including novel models of supervision with local supervision supplemented by remote or visiting supervisors spread across hub and node sites.

5.7.2 Recommend the Aotearoa New Zealand National Committee explore the Hub and Node network model with the Transition Unit.

5.8 Foster closer relationships with other specialist medical colleges in rural health equity initiatives

The Australasian College of Emergency Medicine, Royal Australian and New Zealand College of Psychiatrists, Royal Australasian College of Physicians have produced publications and papers dedicated to rural health equity. The Royal Australasian College of Medical Administrators are progressing similar plans. The Australian and New Zealand College of Anaesthetists and Royal Australian and New Zealand College of Obstetricians and Gynaecologists have diploma programs targeted towards rural procedural skills; however these are Australian focused.

The Council of Presidents of Medical Colleges (CPMC) has been a forum RACS has used to showcase the current Rural Health Equity Strategy. However, this group focusses on Australian issues. The Aotearoa New Zealand Rural Health Equity strategy should be showcased at the Council of Medical Colleges in New Zealand which is the collective voice of sixteen medical colleges in New Zealand.[24] There is interest to convene an actions-driven inter-college forum on rural and regional health in the future. The location could be in Aotearoa New Zealand in 2022.

Actions to consider:

5.8.1 Recommend that an inter-college Regional and Rural Health forum be convened with Aotearoa New Zealand and binational specialist medical colleges.

5.8.2 Share Aotearoa New Zealand Regional and Rural Health Equity Strategy report and recommendations with the Council of Medical Colleges in New Zealand (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).

5.9 Importance of rural representation in RACS structures and of RACS in rural organisations

It was recommended that a rural RACS representative be established within the Aotearoa New Zealand National Committee (AoNZNC), who would join Hauora Taiwhenua, the Division of Rural Hospital Medicine (currently vacant pending RNZCGP structure change) and other rural health networks in Aotearoa New Zealand.

The original Rural Health Equity Strategy recommendation of an Aotearoa New Zealand subcommittee of Rural Surgery Section committee requires further discussion by the Rural Health Equity Steering Committee and the AoNZNC. The preference is to recommend a rural representative on AoNZNC. The AoNZNC has a strong interest in regional and rural surgery and has resources to support recommendations.

Actions to consider:

5.9.1 Recommend that the Aotearoa New Zealand National Committee to include a rural representative on their committee, and for this representative to be the RACS representative on the Hauora Taiwhenua, and the Division of Rural Hospital Medicine.

5.9.2 Recommend that Aotearoa New Zealand National Committee and Rural Health Equity Steering Committee discuss the feasibility of Aotearoa New Zealand Regional and Rural Subcommittee.

5.10 Dedicated resourcing to implement

Funding is required to employ a dedicated Program Officer or equivalent. A Program Officer would be responsible for coordinating and supporting RACS in delivering the implementation of the Aotearoa New Zealand Rural Health Equity strategy.

Action to consider:

5.10.1 Recommend that RACS provides dedicated resources to implement the Aotearoa New Zealand Rural Health Equity Strategy.

6 SUMMARY OF ACTIONS ARISING FROM WORKSHOP AND DISCUSSIONS

Item	Actions arising for consideration
5.1.1	Recommend to the Rural Health Equity Steering Committee to endorse 'regional' as the preferred terminology for Aotearoa New Zealand.
5.1.2	Recommend to the Rural Health Equity Steering Committee to endorse the definition of 'regional' to be as per Functional Urban Area classifications for large-, medium- and small-regional centres.
5.1.3	Recommend to the Rural Health Equity Steering Committee to endorse data collection about Aotearoa New Zealand members that captures regional geographic information.
5.1.4	Conduct a gap analysis study on the barriers and incentives to specialist surgeons working in regional and rural Aotearoa New Zealand.
5.2.1	Share Aotearoa New Zealand Rural Health Equity workshop recommendations and strategy with the Transition Unit and Minister for Rural Communities (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).
5.3.1	Apply a Māori health lens as per the principles outlined in the Te Tiriti o Waitangi and Te Rautaki Māori to the Rural Health Equity Strategy.
5.4.1	Ask Board of Surgical Education and Training, Aotearoa New Zealand and binational Specialty Training Boards to consider reviewing SET curricula to ensure it supports regional and rural surgical practice.
5.4.2	Consider the project findings arising from the RACS project on investigating and developing a rural facing surgical curriculum in Australia (funded via the Australian Department of Health) and if any relevant learnings could be applied to Aotearoa New Zealand context.
5.5.1	Ask the Board of Surgical Education and Training, Aotearoa New Zealand and binational Specialty Training Boards to consider expanding SET supervision to ensure it supports regional and rural surgical practice.
5.6.1	Recommend to the Rural Health Equity Steering Committee and SIMG Assessment Committee to support the integration of administrative processes with the Medical Council of New Zealand.
5.6.2	Endorse the development of SIMG welcome pack as outlined in the Rural Health Equity Strategy.
5.7.1	Ask the Board of Surgical Education and Training, New Zealand and binational Specialty Training Boards to consider developing Hub and Node training networks as part of accrediting SET training posts including novel models of supervision with local supervision supplemented by remote or visiting supervisors spread across hub and node sites.
5.7.2	Recommend to the Aotearoa New Zealand National Committee explore the Hub and Node network model with the Transition Unit.
5.8.1	Recommend that an inter-college Regional and Rural Health forum be convened with Aotearoa New Zealand and binational specialist medical colleges.
5.8.2	Share Aotearoa New Zealand Rural Health Equity strategy report and recommendations with the Council of Medical Colleges in New Zealand (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).
5.9.1	Recommend that the Aotearoa New Zealand National Committee to have a rural representative on their committee, and for this representative to be RACS representative on the Hauora Taiwhenua, and the Division of Rural Hospital Medicine.
5.9.2	Recommend that Aotearoa New Zealand National Committee and Rural Health Equity Steering Committee discuss the feasibility of Aotearoa New Zealand Regional and Rural Subcommittee.
5.10.1	Recommend that RACS provides dedicated resources to implement the Aotearoa New Zealand Rural Health Equity Strategy.

7 MAPPING RURAL HEALTH EQUITY STRATEGY RECOMMENDATIONS IN AoNZ REGIONAL AND RURAL HEALTH EQUITY STRATEGY

The following tables map out Aotearoa New Zealand specific targets and deliverables in accordance with the recommendations outlined in the inaugural RACS Rural Health Equity Strategic Action Plan.

REPRESENT FOR RURAL

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
1. Rurality as a diversity element	1.1. Co-option for diversity, including geographic diversity 1.2. In specialties with rare rural members, a surgeon who is actively involved in rural outreach or rurally interested could be representative	RACS Specialty Training Boards; Specialty Societies and Associations	Adopt as is
2. Technology as a tool of inclusion	2.1. Allow remote participation in state and national educational events and research 2.2. Remote access to selection interviews 2.3. One College Digital Transformation enhancements to video-meetings and synchronous streaming of continuing professional development (CPD) events	RACS Specialty Training Boards; Specialty Societies and Associations	Adopt as is
3. Manage conflict of interest	3.1. Rural representation on all committees and boards involved in Surgical Education and Training (SET) 3.2. Conflicts of interest are recognised and managed during decision making as prescribed in RACS' policy	RACS Specialty Training Boards; Specialty Societies and Associations	Ensure there is representation for AoNZ Orthopaedic and General Surgery specialist societies equivalent to Australia on the Rural Health Equity Steering Committee
4. Foster a pro-rural culture focused on collectivism and peer co-operation	4.1. Recognition of rural achievements in internal and external media and communication 4.2. Recognition and emphasis of the "dual" training required of a rural surgeon, that is broad scope of clinical practice plus extra skills required of rural practice 4.3. Call out anti-rural cultures/behaviours at RACS and in workplaces (emphasise that rural surgery is not urban-lite or second best/less than surgery in urban settings) 4.4. Positive presentation of rural surgery to Trainees	RACS Specialty Training Boards; Specialty Societies and Associations	Adopt as is
5. Establish evaluation framework	5.1. Develop mechanism to gather data, evaluate and improve the rural initiatives	RACS Specialty Training Boards; Specialty Societies and Associations	Adopt as is

SELECT FOR RURAL

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
1. SET selection requirements and scoring criteria	1.1. Award selection points for 1.1.1. Rural origin 1.1.2. One or more years of rural medical school experience 1.1.3. One or more years of rural pre-SET work exposure. 1.2. Reduce points for items that require predominantly urban work experience 1.2.1. Higher degree qualifications 1.2.2. Referee recommendations and reports that are exclusively attainable from encounters in urban tertiary centres. 1.3. Remove or balance points selection criteria that disadvantage rural applicants.	RACS Specialty Training Boards	Adopt as is
2. Interviews	2.1. Virtual selection interviews or interviews in every state and territory. 2.2. Situational interviewing pertaining to equity of access and health outcomes for rural and other underserved communities.	RACS Specialty Training Boards	Adopt as is
3. Rural Selection Initiative, analogous to the Aboriginal and Torres Strait Islander Selection Initiative	3.1. Quarantined positions for rural selection applicants. This can be based on either: 3.1.1. 30% of positions for population parity 3.1.2. 14% for RACS parity 3.1.3. one position, for training programs with seven or less positions available. 3.2. For applicants reaching the minimum selection standard plus being of rural origin, 12 months of rural medical school and 12 months of pre-SET rural experience.	RACS Specialty Training Boards	Any initiative involving Māori must consider the Te Tiriti o Waitangi (The Treaty of Waitangi) and its principles.

TRAIN FOR RURAL

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
1. All trainees have rural work exposure.	1.1. Three levels of rural SET training exposure, related to the surgeon to population ratios in Australia and New Zealand: 1.1.1. Rural/Regional Training Networks (General surgery and Orthopaedic surgery program) 1.1.2. 12-month rural training posts (Otolaryngology Head Neck Surgery, Plastics and Reconstructive, Urology and Vascular Surgery programs) 1.1.3. Rural Focused Urban Specialist (Cardiothoracic, Paediatric and Neurosurgery).	RACS Specialty Training Boards	Consider Hub and Node network training models where trainees complete final SET training in rural posts. Consider specific centres dedicated to train regional/rural general surgeons (e.g. Invercargill, Timaru, Gisborne, Wanganui, etc.)
2. SET training posts are distributed according to community need for surgical care.	2.1. RACS works with Government Health Departments in Australia and New Zealand to identify a system for distributing training posts based on community need. 2.2. Rural representation on all committees and boards involved in SET training. 2.3. Conflict of interests recognised and managed during decision making.	RACS Specialty Training Boards	Adopt as is
3. Separate accreditation criteria for rural training posts recognising the unique value of rural training	3.1. Shift criteria that: 3.1.1. Require supervision based on number of FRACS employed to total Full-time Equivalent FRACS 3.1.2. Require certain case numbers to consider other metrics of experience not provided in urban practice (e.g. for first operator experience and direct consultant supervision, broader scope of experience). 3.2. Include holistic criteria for: 3.2.1. Adequate accommodation for Trainee and their family 3.2.2. Adequate internet access 3.2.3. Adequate days off at the start and end of rotations for relocation, and relocation support 3.2.4. Access to research facilities and mentors.	RACS Specialty Training Boards	Adopt as is, with consideration of novel supervision models including SIMGs as be supervisors of SET training.
4. Rural facing curriculum	4.1. All Trainees acquire the generalist skills required for rural practice. 4.2. The generalist curriculum would be the base curriculum with the rural curriculum overlaid, providing knowledge and experience to prepare practitioners with a broader scope of clinical practice that is often required in rural areas, and additional skills in outreach, inreach and health service management.	RACS Specialty Training Boards	Adopt any applicable findings arising from the STP support project on investigating and developing a rural facing curriculum. Consider if there are funding opportunities to adapt project findings.
5. Dual fellowship in primary specialty plus Global, Remote/Rural/Regional and Deployable (GRiD) Surgery	5.1. Establish GRiD faculty (see Retain for Rural for more) 5.2. Dual fellowship achieved concurrently with SET training and/or through post-SET fellowship positions.	RACS Specialty Training Boards	Consider including the Pasifika community (through the Pacific Islands Surgeons Association (PISA)) on the GRiD PFET and Faculty development.
6. Portability/preservation of entitlements across jurisdictions	6.1. Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions.	RACS Trainee Association	(not applicable)

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
		(RACSTA); State health jurisdictions	
7. Establish a Rural and remote career coordinator program	7.1. Enrol all rural interested trainees early in SET training with opportunity for later entry into program if rural intention emerges. 7.2. Trainee interview to determine career goals and trainee's motivation, negotiating an individual plan. 7.3. Information and connection hub on rural Fellowships, rural research opportunities, other peer groups and conferences. 7.4. Connecting Trainees with rural and specialty mentors.	RACS Specialty Training Boards; RACSTA	Adopt as is
8. Implement a Rural and Remote Central and Northern Australia Surgical Service Strategy (RCANS)	8.1. Convene a forum with remote surgical stakeholders including directors of surgery from remote surgical services, Australian and New Zealand College of Anaesthetists, Royal Australasian College of Medical Administrators and the Remote and Rural JMO stakeholders to progress the implementation of the Remote Central and Northern Australian Training Network. 8.2. Develop a Remote Central and Northern Australia (RCANS) selection initiative, by selecting junior doctors who are already living, working, and committed to a remote area.	RACS Specialty Training Boards; State health jurisdictions	(not applicable)

RETAIN FOR RURAL

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
1. Ongoing educational, professional, and personal support for rural surgeons	1.1. Establishment of faculty in Global, Remote/Rural/Regional and Deployable (GRiD) Surgery 1.1.1. Develop GRiD dual fellowship post-Fellowship (PFET) qualification 1.1.2. Surgeons to participate as faculty members, mentors, teachers, supervisors and trainers 1.1.3. Establish a RACS Annual Scientific Congress Section 1.1.4. Curation of GRiD library resource hub 1.1.5. Develop CPD offerings in line with GRiD faculty 1.2. CPD access for rural surgeons to be bolstered with 1.2.1. Remote access to participate in meetings and CPD events. Develop Technology as a Tool for Inclusion policy paper. 1.2.2. Review of current CPD content. 1.3. Revamp RACS Rural Surgery Section Online Information Hub 1.4. Collaborate with regulators to recognise and protect enhanced/broad scopes of practice for rural surgeons (development of GRiD PFET qualification). 1.5. Collaborate with Royal Australasian College of Medical Administrators and jurisdictions to develop a mediator model between rural surgeons and hospital administrators. 1.6. Advocate for safe hours contracts for rural surgeons, with the onus on hospitals to devise protocols for task substitution, transfer or locums and service level responsibility for safe rostering. 1.7. Foster a pro-rural culture within RACS.	RACS; Specialty Societies and Associations	Adopt as is
2. Financial sustainability	2.1. Advocate for financially sustainable models of remuneration for rural surgeons (salaried and Visiting Medical Officer models which acknowledge financial risk). 2.2. Portability of entitlements for GRiD fellowship surgeons crossing state borders for dual appointments or explore options for the coordination/pooling of entitlements for surgeons in border towns 2.3. Continue funding RACS Provincial Surgeon Fellowships for rural surgeons' CPD travel and accommodation. 2.4. Continue support and promotion of rural specialist programs (e.g. the Support for Rural Specialists CPD grants).	RACS; Specialty Societies and Associations; State health jurisdictions	(largely not applicable as the health system in AoNZ is predominantly public) Consider what CME opportunities are available for rural AoNZ surgeons.
3. Support for Specialist International Medical Graduates (SIMG) surgeons	3.1. Optimise application and assessment processes, and exam attainment, with a process for notifying relevant society of SIMG successful application 3.2. Develop an SIMG "welcome pack" for each society 3.3. Improve access to CPD opportunities and formalise professional networks for rural SIMGs with surgical colleagues in urban or larger centres.	RACS; Specialty Societies and Associations; State health jurisdictions	Adopt as is, with particular attention on supporting the integration of administrative processes with the MCNZ.

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
4. Accountable surgical services	4.1. Advocate for infrastructure and funding for rural surgical services 4.2. Foster a culture of collective responsibility for rural health equity 4.3. Foster a culture of supportive peer relationships across distances, aligned with referral and transfer pathways, with reciprocal responsibility. Accountable larger centres to partner with smaller rural and regional centres by support through telehealth, outreach, inreach, defined referral and transfer protocols, swaps for leave/CPD.	RACS; Specialty Societies and Associations; State health jurisdictions	Adopt as is

COLLABORATE FOR RURAL

Recommended Action	Deliverable	Stakeholders	AoNZ Targets
1. RACS adopts a framework for National Surgical Systems	1.1. Convene a meeting with the Royal Australian College of General Practitioners Rural, Australian College of Rural and Remote Medicine and nursing stakeholders to develop systems for interdisciplinary training in rural surgical skills including general practitioners with extended scope of practice in surgery. 1.2. Improve links with interdisciplinary teams, including general practitioners with extended scope of practice (anaesthesia and critical care, surgery, emergency medicine) and nurses with extended scope of practice. 1.3. Commence collaboration with other surgical team stakeholders via Council of Presidents of Medical Colleges to encourage development of rural health equity programs in all speciality medical colleges and via the National Rural Health Alliance. 1.4. Commence collaboration with regulators to enable fit for purpose scopes of practice for rural surgeons	RACS; Specialty Societies and Associations; National Rural Health Commissioner; RACGP Rural; ACRRM; Perioperative Surgical Nursing Assistants; transfer and retrieval services; Royal Australasian College of Medical Administrators; Australian Medical Council; Australian Health Practitioner Regulatory Agency and Medical Council of New Zealand	RACS to have a representative on the Hauora Taiwhenua, and the Division of Rural Hospital Medicine (as part of the New Zealand College of General Practitioners). Collaboration with other surgical stakeholders via the Council of Medical Colleges in New Zealand (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee). Recommend an inter-college Regional and Rural Health forum be convened with Aotearoa New Zealand and binational specialist medical colleges. Ensure collaboration with Transition Unit and Minister for Rural Communities (in support of advocacy efforts facilitated by the Aotearoa New Zealand National Committee).
2. Sustainable surgical services for Remote Central and Northern Australia (RCANS) Forum 2021	2.1. Convene a forum in 2021 to develop a strategy for Remote Central and Northern Surgical services. Topics of discussion: selection initiative, training networks, scholarships and return of service obligations. This work could work in conjunction with the ATSI SET pipeline project, led by the RACS Mina advisory group.	RACS; Indigenous Health Committee Mina advisory group; Specialty Societies and Associations; Australian Federal Department of Health; National Rural Health Commissioner; State/territory health jurisdictions; ANZCA; RACMA; Regional Training Hubs	(not applicable)
3. New Zealand Provincial and Rural Surgical System Strategy	3.1. Rural Surgery Section committee, with engagement of RACS New Zealand National Board, forms a New Zealand subcommittee (comprising four NZ members, RACS NZ councillors and representatives from NZ National Board). 3.2. Convene a New Zealand Rural Surgical Services Forum in September 2021, developing a strategy bespoke to provincial and rural surgery in New Zealand.	RACS; Specialty Societies and Associations; New Zealand District Health Boards	AoNZNC to have rural representative on its committee, and for this representative to be RACS representative on external rural stakeholder groups, such as the Hauora Taiwhenua, and the Division of Rural Hospital Medicine (above). Recommend that AoNZNC and Rural Health Equity Steering Committee discuss the feasibility of Aotearoa New Zealand Regional and Rural Subcommittee.

8 APPENDIX 1 - Workshop Participants

	Name (by alphabetical order)	Role / Organisation	Specialty	Location
1.	Alison Scott	RACS Maori Health Advisory Group	Paediatric	Christchurch
2.	Allan Panting	Former Aotearoa NZ Surgical Advisor for RACS	Retired Orthopaedic	Practised in Nelson for 35 years
3.	Andrew Connolly	Chief Medical Officer Ministry of Health	General	Middlemore
4.	Andrew Hill	Councillor	General	Auckland
5.	Andy Meighan	New Zealand Orthopaedic Association	Orthopaedics	Blenheim
6.	Brandon Adams	New Zealand Association of Plastic Surgeons	Plastic and Reconstructive	Tauranga
7.	Bridget Clancy	Chair Rural Surgery Section	ENT	Warrnambool, South West Vic
8.	Chetan Pradhan	Rural Surgery Section	General	South Australia
9.	Chris Adams	Chair New Zealand Association of Plastic Surgeons	Plastic and Reconstructive	Wellington
10.	Chris Phoon	Rural Surgery Section	Orthopaedics	Invercargill Southland Hospital
11.	Clare French	SIMG	Consultant general surgeon trained in the USA	Wairarapa DHB, Masterton
12.	David Waterhouse	New Zealand Society of Otolaryngology Head and Neck Surgery and ORL Training Board	ENT	Originally from Rural Northland, working in Whangarei and Kaitaia
13.	Gowan Creamer	New Zealand Association of General Surgeons	General	Waikato
14.	Graham Roper	Deputy Chair of NZNC Australia and New Zealand College of Anaesthetists	Anaesthesia	CMO West Coast DHB
15.	Gregory Robertson		General	Christchurch
16.	Jared Bayless	Australasian College of Emergency Medicine	Emergency medicine	Taupo
17.	Jeff Holman	SIMG	Orthopaedic	Masterton
18.	Jeremy Webber	Clinical Director NZ Rural General Practice Network	Rural Specialist, FACRRM	Taupo
19.	Julian Speight	Rural Surgery Section; past president New Zealand Association of General Surgeons and New Zealand Medical Assistance Team member	General	Invercargill
20.	Kerin Fielding	Chair Rural Health Equity Steering Committee	Orthopaedic	Wagga Wagga, NSW
21.	Kiki Maoate		Paediatric	Christchurch
22.	Magda Sakowska		General	Timaru
23.	Mark Stewart	New Zealand Association of General Surgeons	General	Nelson previous rural general surgery fellowship Darwin
24.	Mavis Orizu	SIMG	General	Invercargill

	Name (by alphabetical order)	Role / Organisation	Specialty	Location
25.	Maxine Ronald	Councillor	General	Whangarei
26.	Neil Price	Chair Board of Paediatric Surgery	Paediatric	Auckland, formerly of Invercargill
27.	Nicola Hill	Councillor, Workshop Convenor	ENT	Nelson
28.	Paul Manuel	SIMG	General	Invercargill Southland
29.	Phil Morreau	Councillor	Paediatric	Based in Auckland, operate and visit Kaiatia and Whangarei in Northland
30.	Philip Davis	Chair, Australian and New Zealand Society of Cardiac and Thoracic Surgeons	Cardiothoracic	Dunedin
31.	Philippa Mercer	Chair Aotearoa NZ National Committee RACS	General	Christchurch
32.	PJ Faumuina		ENT	Whanganui
33.	Richard Reid		General	Hamilton, trainer at Waikato
34.	Roberto Sthory	Rural Surgery Section	General	Gisborne
35.	Ros Pochin		General	Nelson
36.	Ruth Bollard	Councillor, Chair SIMG Assessment Committee	General	Ballarat, Vic
37.	Sally Langley	RACS President	Plastic and Reconstructive	Otautahi Christchurch, 30 years in Greymouth
38.	Sally Ure	Chair of NZNC, ANZCA	Anaesthesia	Wellington
39.	Sarah Rennie	Aotearoa NZ Surgical Advisor for RACS	General	Wellington, Locum
40.	Spencer Beasley	Aotearoa NZ Surgical Advisor for RACS	Paediatric	Christchurch & provide rural regions with specialist care locally
41.	Subhaschandra Shetty		ENT	Whangarei

9 APPENDIX 2

Geographic classifications

Functional urban areas (FUA) has been used by OECD and is defined as: 'a functional urban area consists of a city and its commuting zone. Functional urban areas therefore consist of a densely inhabited city and a less densely populated commuting zone whose labour market is highly integrated with the city'.[25]

FUAs consist of a densely inhabited city and a less densely populated commuting zone.[26] Figure 2 shows the FUAs around the country. They are categorised by population size:

- Metropolitan area - 100,000 or more residents
- Large regional centre – 30,000 – 99,999
- Medium regional centre – 10,000 – 29,999
- Small regional centre – 1,000 - 9,999

Rural settlements are smaller clusters outside of these areas. Medium regional areas are considered a good minimum proxy for the presence of services such as hospitals and supermarkets.

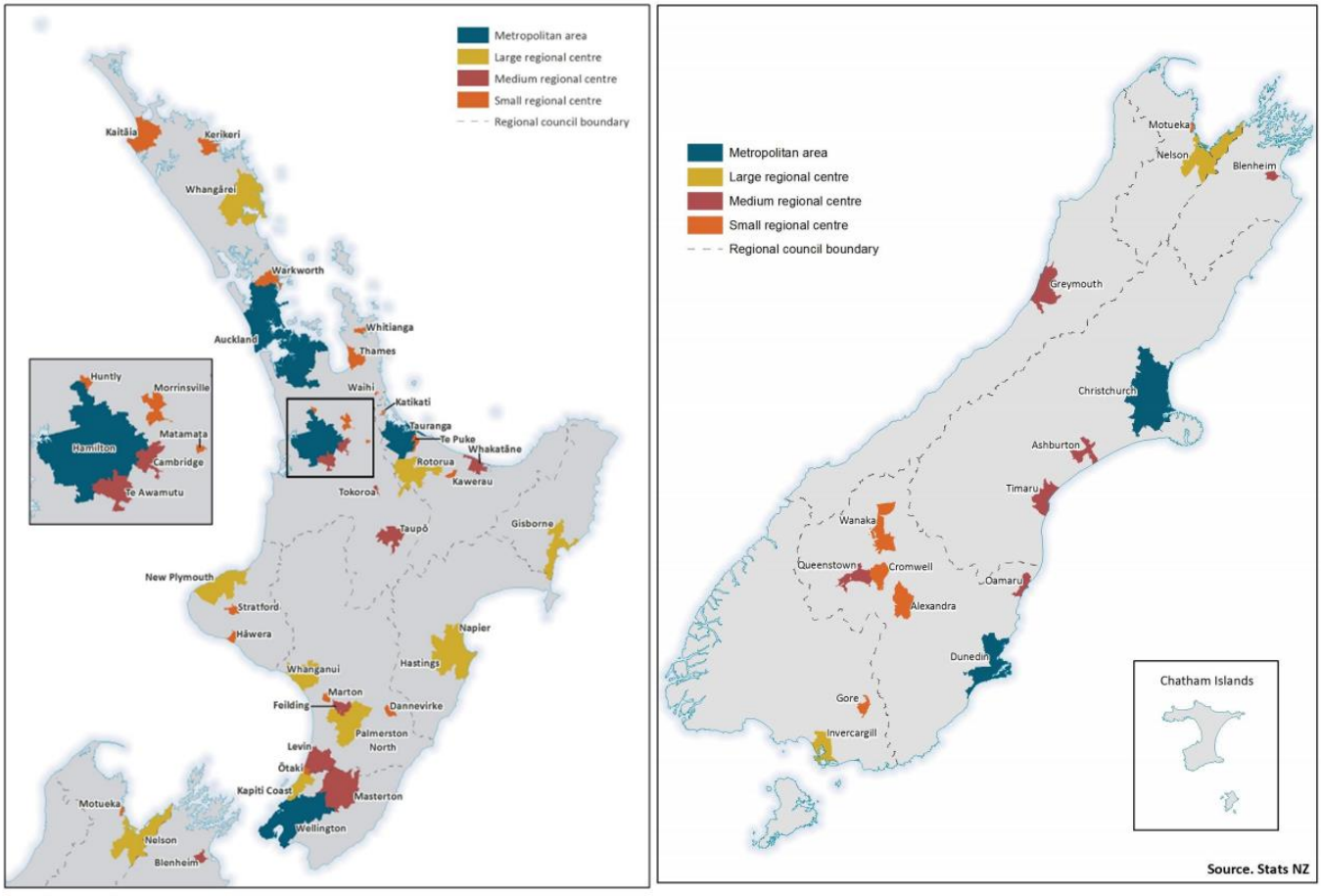

Figure 2. FUA by type in North and South Islands. Source: StatsNZ[26]

The other new classification is urban accessibility.[27] It measures potential urban accessibility or rural remoteness using estimated drive times. This type of classification is useful in measuring level of accessibility to healthcare, education, or other services usually located in larger urban areas.
This measure classifies remote as over 1 hour drive to urban facilities and very remote as 2 hours' drive. The map below shows that includes much of Aotearoa New Zealand's land area, including areas such as Northland/Te Tai Tokerau and East Cape/Te Tairāwhiti which have high Māori populations.

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