We all benefit from caring about rural health

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They say that innovation happens in difficult circumstances. Sir Ernest Rutherford is famously attributed with the quote that has become an archetypical expression of New Zealand values: '*We haven't the money, so we've got to think*'. In this issue we have a focus on rural healthcare, an activity that happens in the difficult circumstance of having to operate in our national healthcare system that is designed (naturally) to address the needs of most people, most of the time. Specifically, and naturally, it is not designed to prioritise service for the 7.1% of New Zealanders who live in highly rural or remote areas, or rural areas with low urban influence.[1] This leaves rural New Zealand in the tantalising position of having to innovate for healthcare. Innovation requires creativity, wisdom, and a lot of work and delivers leadership beyond the sector that produces it in the first place. We all benefit.

Dr Jo Scott-Jones in a guest editorial acknowledges the work done by some of this issue's authors, and makes a call for more measurement of the health and healthcare issues of rural New Zealand.[2] These issues are not just about money (financial issues are probably shared more widely), but they start with definitions,[3] cover resource and infrastructure, and extend into policy. Wong,[4] Fearnley,[5] and Gibbons[6] articulate and measure some of the challenges in rural health and these authors, along with Atmore,[7] Pelham,[8] and Mayne[9] also offer solutions.

Wong and Nixon[4] analysed the 2014 workforce survey of the Royal New Zealand College of General Practitioners and warn that the rural medical workforce is still very dependent on overseas-trained and male doctors nearing the end of their careers. A solution Pelham and colleagues found was inter-professional education in rural New Zealand for our future healthcare providers.[8] There, educators have a lot of wisdom to share, the teamwork concept is demonstrated in action, and the experience is positive for both students and communities. Teamwork solutions are reinforced in Atmore's editorial reporting solutions for rural healthcare in Scotland where they added new non-traditional roles to the healthcare teams.[7]

The additional costs of providing healthcare in rural settings are challenging for health system planners and funders, but we do not often hear of the costs for rural people to use these services. Fearnley and colleagues[5] measured the cost of accessing hospital outpatient clinics for people in their rural Central Otago community and found that free hospital care was uncomfortably costly for many people (out-of-pocket expenses averaged $182 for care delivered locally and $732 if people had to travel to Dunedin). Mayne's experiences in rural Waikato are also salutary. A single patient caused his practice to reassess the way they cared for patients with skin lesions. An audit of their revised care arrangements showed not only '*better, sooner, more convenient*'[10] care, but also less costly care. The new procedures had an overall public and private cost that was less than 20% of the cost of earlier, less functional, care delivery. Another way to save costs is not to order redundant tests: consider, for example, exercise treadmill tests.[11]

Next September, we are planning a Special Issue of the Journal of Primary Health Care to highlight new ways of doing things (as in Mayne's practice). If you have further stories, commentaries, or research along these lines, please do consider writing about it for this Special Issue. Doolan-Noble and colleagues explain more in their Viewpoint article.[12]

Tomlin and colleagues report research of potential importance for policy at all planning and organisational levels of the health system.[13] This paper shows how, by adapting an algorithm developed in Scotland and using New Zealand's health databases, the researchers figured out

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people's likelihood of an acute hospital admission in the next 12 months. The theory is that if we knew who was going to need to be acutely admitted to hospital we could pre-emptively wrap these people in a cocoon of relevant community care that would help them to stay out of hospital.

Rounding out this issue we have clinical papers identifying the need for careful consideration of care after hospitalisation for acute coronary syndromes,[14] showing that patients and providers have quite high levels of agreement about the level of self-management support received and provided,[15] and another showing that meaningful tasks are needed to engage patients in stroke rehabilitation.[16] Henning *et al.* discuss an ethical challenge that will become familiar (if it is not already so), with a rural flavour.[17]

And the last word for a rural health innovation that works? Manuka honey![18]

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