

**RURAL HEALTH: A CASE STUDY  
OF THE DANNEVIRKE  
COMMUNITY HOSPITAL:  
AN EXEMPLAR OF INNOVATION**

**Jan Lockett-Kay RCpN BA MBS**

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## EXECUTIVE SUMMARY

Rural communities can take pride in the way they have grasped opportunities to develop innovative health services at a time when the Crown is requiring relevant, responsive and affordable services.

This report begins with an outline of Government's rural health policy. The basis for developing the policy was the Crown's acknowledgment that it could no longer afford to provide health services without being able to limit liability. Open-ended, demand driven reimbursement regimes were incompatible with government's need to constrain expenditure and focus on health outcomes. Rural health service costs were increasing disproportionately to any population growth or improvement in health status.

The report tells the story of the Dannevirke health service which has been transformed from a 180 bed public hospital in its hey day, to a 9 bed rural health centre and an array of community services. The range of partnerships – the community with: MidCentral Health Ltd, health professionals in private practice, community trusts and other organisations - has resulted in a unique service which meets health needs in a way that is acceptable to the community and to the funder, the Health Funding Authority. The report describes the Crown Health Enterprise's exiting process, the community responses and the new service that emerged after extensive consultation.

The report concludes with comment on key issues essential for ongoing viability of the service. Of particular note is the need for effective community consultation and participation and effective public/private partnerships. The challenge for Dannevirke will be:

- to ensure it continues to attract health professionals who are able to enter into these partnerships,
- that community expectations for service delivery are affordable, and,

- that the coordination between services in Dannevirke and acute, high technology services provided for the region at MidCentral Health Ltd in Palmerston North remain compatible.

Rural communities are most effective in establishing innovative partnerships with health professionals and key stakeholders, thus ensuring essential and appropriate health services are provided in their community. The Dannevirke Community Hospital is an excellent example of this.

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# 1. INTRODUCTION

The essence of successful rural health policy is a commitment to rural New Zealanders getting the right services at the right time by the right people. Rural health services are an essential part of New Zealand's overall health services. While a small country in terms of size and population, New Zealand still has a wide variety of different communities with different circumstances and needs. Rural communities are no exception.

Milio (1981) puts forward a proposition that people's health is primarily the result of the environments in which they live and the patterns of behaviour they follow. Those patterns are shaped by environments and environments are shaped by public policy. Milio believes that it is the responsibility of government to make possible an attainable level of health for the total population. This responsibility includes the assurance that the public be involved in the policy and planning process. To effectively develop health-making policy, public policies must foster public interest and ensure that the policy making "machinery" is truly representative of the community: that is, it is seen to be of value to the community and have values that are those of the people.

As in most western countries health expenditure in New Zealand has risen rapidly over the last 50 years. However New Zealand spends less per head, in relation to GDP, than comparable countries and has a relatively low rate of growth in health expenditure compared with other OECD countries.

Reorganisation of the health services has been a topic of discussion since the publication of "A Review of Hospital and Related Services" in 1969. In 1988 the State Services Act introduced the system of general management into the total public service. Emphasis on policy and review functions and increased efficiency and effectiveness became a priority for the first time. From community elected hospital boards, to Area Health Boards to Crown Health

Enterprises and recently to Health and Hospital Services – the change is continuing.

In the early 1990s the Dannevirke community was faced with the situation where the health services provided were no longer affordable, the difficulty in recruiting skilled health professionals was having an impact on service delivery and infrastructure and fixed asset costs were prohibitive. Over time the public opinion gained intensity, various lobby groups mobilised and Dannevirke became centre stage for key health reforms.

This report outlines the policy objectives which guided the development of new initiatives in Dannevirke. It also supports the notion that Dannevirke, as a typical rural community, was most effective in establishing innovative partnerships with key health professionals and stakeholders to ensure essential and appropriate health services are provided in their community. The Dannevirke community now prides itself in having a community health service, which is exemplary.

My special thanks goes to Sharon Wards, Manager of the Dannevirke Community Hospital, for her willingness to share so much information about the hospital's development, philosophies, successes and community reactions.

## 2. RURAL HEALTH POLICY

In the Ministry of Health's publication, *Rural Health Policy: Meeting the Needs of Rural Communities* (Ministry of Health, 1999) the Government's Medium-Term Strategy for Health and Disability Support Services identifies key areas of priority (see Appendix 1). Four are particularly relevant to rural health:

- Public certainty about access, quality and security of services
- Well co-ordinated, integrated services that contribute to better health and disability outcomes
- Improved capability and adaptability of the health and disability sector
- Sustainability of the publicly funded health system

With major reviews and restructuring in recent years a key goal is raising public confidence in the level, mix, quality and structures of health and disability services.

The Government's policy for rural health and disability support services enables rural people to receive effective, appropriate front-line care in their own community, and have timely access to acute emergency services of an agreed standard of care within acceptable modern standards.

The Ministry argues that the increasingly specialised nature of clinical services, coupled with higher levels of technology now employed in medicine, mean that some services are best delivered through regional or national centres of excellence. Used creatively, new technologies, such as telemedicine, telephone triage systems and better transport systems, can

enable all New Zealanders to benefit from such services. The Government

has the expectation that the sector will use technology creatively to facilitate access to health and disability support services for isolated communities.

The Government supports the notion that there is diversity among rural communities and is keen to create opportunities for rural communities to develop local arrangements that suit their needs. Alliances and networks between providers at the primary level and between the primary and secondary levels are encouraged.

The Government's policy for rural health services aims to:

- enable rural people to receive effective front-line care in their own community,
- organise services around people and their needs, recognise the diversity of New Zealand's rural communities and their differing needs, and,
- create opportunities for rural communities to develop local arrangements that meet their needs

Community-based services and hospital services face similar issues in rural areas. The recruitment and retention of appropriately skilled professionals is a real issue along with ensuring that practitioners have a sustainable lifestyle for themselves and their families.

The Ministry advocates that rural health and disability support service providers must be innovative and flexible in their efforts to develop and maintain skills. New technologies are supporting significant advances in many areas – health is no exception. Likewise, different agencies working together can make the sum greater than the parts.



Other key aspects of the Health Funding Authority's (HFA) primary-care strategy currently under development are:

- a pragmatic focus on health outcomes, such as practice population programmes focused on prevention and early detection, management of chronic diseases and improvement of health status of those groups including Maori and Pacific people
- encouraging the involvement in primary practice of a wider range of providers, consumers, and contracting that allows new alliances to form
- focus on quality and on the right people providing the right care at the right place and in the right time
- recognising good features of the rural environment (for example, linkages between GPs and home-based services that may be transferable to urban areas)
- an enabling, flexible and innovative contracting framework that supports local solutions to local problems.

The HFA has been working with the Rural General Practitioner Network and other interested groups to develop a better way of recognising the increased costs associated with providing rural general practice.

A dependable, secure and certain public hospital sector remains at the heart of the Government's health strategy. This is made clear in the *Hospital Services Plan* (Ministry of Health, 1998). The plan responds to the need for greater certainty about the ongoing provision of hospital services, and places special emphasis on the needs of rural and provincial communities. It is part

of the Government's general health strategy, which is motivated by the ideal of timely access to good-quality, cost-effective health care for all New Zealanders. The plan sets out a framework that describes five kinds of hospital facilities. The plan outlines where services are currently provided and will continue to be provided until at least September 2001. The Government has made a firm commitment to maintaining the current distribution of services for that period.

A rural premium of \$15 million has gone into small publicly owned hospitals through the contracting process in 1998/99. This was the first time that there had been an attempt to develop a consistent and fair approach to a rural premium across the country. While it is not yet perfect, it is a step in the right direction towards a transparent and equitable rural premium.

Of this premium, \$6 million was allocated to hospitals that provide 24-hour acute cover but have a workload less than what is financially sustainable for that level of service. The remaining money was negotiated on a case-by-case basis, recognising each region's unique characteristics.

The health centre (or health clinic) model is becoming more common in rural areas. Health centres range from the very small to those that cover a significant range of services. Some go to the extent of having inpatient facilities. Typically, this type of facility provides an integrated range of services including primary and community health services. Health centres usually have a community service base (for example, providing public health nursing, district nursing, home help and mental health teams) with facilities for visiting specialists, and for treatment (for example, physiotherapy, public health and pharmacy services). Sometimes it will also have general practice and/or maternity beds.

There is a wide range of ownership structures. A number of health centres are run by public hospitals. In some places, local community groups or groups of health providers have developed health centres to replace small hospitals that were once run by the public health system. Some have been developed using the Community Trust Assistance Scheme. There are also partnerships between the public hospital and the local community. Despite initial community concern regarding this development, experience is increasing widespread support for these new health centres.

Over time, more health centres will develop as community initiatives come forward. The HFA is continually looking at developments in this area including, where appropriate, trials of new services with associated evaluations.

Many integrated care initiatives have been developed up and down this country (see Appendix 2). There are a range of initiatives that come within the understanding of what is meant by integrated care. At one end of the spectrum is the emphasis on improved co-ordination between services; at the other end it means taking the available budget and using it to purchase a whole range of services for a whole population so as to get the best outcome overall.

Integrated care in its various forms seeks to deliver health services to people and to communities in a co-ordinated way. It looks at the bigger picture when providing health care, so that the community's need for preventative and educational services are worked on as part of a constructive overall package. Integrated care aims to give both better co-ordinated and more health and disability support services within existing resources. Integrated care services may have the following features:

- coverage of a particular population

- a range of services
- more than one provider
- well developed, effective collaboration between providers
- the use of a single pool of funding.

Communities and local providers are able to consider a variety of integrated care arrangements, thus allowing local people to take the initiative in developing their own local services by working out the solutions that serve them best. Such approaches are expected to help communities to resolve some of the issues in maintaining effective health services experienced by rural communities.

Because rural communities tend to be small, they often already have some important ingredients for successful integration, such as existing relationships between key groups.

### **3. DANNEVIRKE COMMUNITY HOSPITAL**

For many decades the Dannevirke community prided itself in the excellent service provided by the public hospital “on the hill”. In its heyday the hospital was a busy 180 bed medical, surgical and maternity hospital (see Figure 1). Some community services were available and the several residential homes provided accommodation for surgeons and physicians. In the early 1970s a new purpose built psychopaedic facility was opened – a superb “state of the art” centre for long-term care. All buildings at the hospital were typical of the hospitals built around the 1930s - a number of double storied buildings, large boiler house, nurses home, tennis courts - all situated in expansive beautifully maintained grounds.

Over time, changes in the provision of medical and other health services resulted in a much reduced level of hospital services in Dannevirke. This trend was typical of many rural towns. A number of innovative strategies were developed to slow the decline in patient numbers. One such initiative was to offer non-acute or elective surgery at Dannevirke Hospital for people outside the region, thus providing an alternative to long waiting lists in, for example, Palmerston North. Dannevirke Hospital was a major employer in the town - and was very much the heart of the community.

Management frameworks of the past were largely devoid of business disciplines and did not incorporate policy objectives as a basis for service provision initiatives. The HFA has as its fundamental brief the allocation of available vote health funds in accordance with Government objectives (Ministry of Health 1999). It was rapidly becoming apparent to the Dannevirke community that their health services were being seen by Government as not sustainable or affordable. Increasingly services are provided at larger base hospitals where expert clinical support is readily available. With the range of

Figure 1: Dannevirke Public Hospital – closed September 1997



diagnostic procedures and tests available today and the trends towards specialisation among clinicians, it became more difficult for smaller rural hospitals such as Dannevirke to maintain staffing levels and expertise in areas other than low level, low risk nursing based services which are backed up by either physician or general practitioner. By the early 1990s it was apparent that Dannevirke health services had to change.

When MidCentral Health Limited announced its decision to cease provision of inpatient services at Dannevirke Hospital, the Central Regional Health Authority (RHA), now the HFA, had to consider whether those services should continue to be available to the people in the area, and where they should be located. The services in the exit notice were:

- Inpatient medical services
- Inpatient maternity services
- Continuing hospital level care for older people
- Intermittent/respice care
- Pharmacy
- Community referred radiology.

MidCentral Health saw that its role as a provider of health services in Dannevirke had changed. It considered that it was now more appropriate to provide specialist health services for Dannevirke residents from their Palmerston North site.

The HFA's management of this exit process had to be done in conjunction with MidCentral Health and the community affected by the change. As part of this process MidCentral Health agreed to continue to provide the service for six months. During this time the HFA had to decide what service arrangements would need to replace the services being exited.

The HFA's role was to identify what services were required, where they should be provided and who would provide them. This included identifying future service options, holding public meetings and inviting submissions from the community. As the HFA wanted to continue purchasing a similar range of services in the Dannevirke area, the community consultation process was used to determine how the services would be provided and the type of organisation(s) that would be sought to provide them.

Using the approach that had been useful in other similar change processes, Bill Bly, Tararua District Mayor helped establish a task force of local health providers. The task force's role in the process was invaluable. This forum enabled people to discuss health service options and ensured that community interests were met. It also ensured that information was shared openly with potential new providers of health services and the community.

The combination of government directed processes and the locally focussed task force ensured that the consultation process identified the critical issues of health service provision in the area. Submissions were received from a broad spectrum of the community. While many focussed on the range and continuation of locally available health services based at the existing site, a central theme was the importance of the need for stability in terms of the range of services and its providers.

This was an extremely difficult time for the community. The "Friends of the Hospital" were most active and worked very hard to maintain the status quo and save their hospital. For a reasonable period of time Dannevirke health services were frequently in the news – the "hands around the hospital" being a classic example of one way the "Friends of the Hospital" voiced their objections.

As plans commenced to initiate the exiting process there was, in the background, two general Practitioners, a Midwife and a Physiotherapist who began the task of preparing their proposal. Their motivation was very clearly



based on their firm commitment that the perceived “crisis” must, indeed, create an opportunity for desirable change and a favourable outcome for the community. One of the most critical drivers for their initiative was to ensure Dannevirke maintained a health service infrastructure which enabled them to retain and attract health professionals to the town rather than begin the down hill spiral experienced by so many rural communities.

Doctor Tom Gibson provided the initial vision for the group and together with his medical colleagues, a midwife, physiotherapist and lawyer put in an endless number of hours over the coming months preparing their business case and working through the formidable “red tape” in preparing the submission for the Central RHA. Because of the political imperatives and the RHA’s need to have minimal risk associated with any new concept, the greatest hurdle this group had to overcome was to convince the RHA that a privately owned limited liability company was a feasible option and did not put a public health service at risk. A number of other rural areas facing the same issues as Dannevirke invariably opted for a community trust arrangement.

In September 1996 the five directors of the limited liability company were rewarded for their innovative proposal with the awarding of a five-year, fixed price contract with the RHA for the provision of:

- Inpatient medical services
- Inpatient maternity services
- Intermittent/respice care
- Community referred radiology.

The Central RHA contracted to other providers for the delivery of continuing hospital level care for older people and pharmacy services. It was now time for construction of the building to commence and planning for the operationalisation of their proposal.

With an extremely high level of local and national interest construction commenced in March 1997. The new Dannevirke Community Hospital was officially opened on 17 October 1997 amidst great fanfare (see Figure 2). The old Dannevirke Hospital closed its doors at this time.

The building is a model of innovation and not only meets the current needs but is designed in such a fashion as to lend itself to easy alteration - thus ensuring the facilities can remain responsive to future demands. The building comprises a general hospital ward, a maternity service, X-Ray and ultrasound facility (during business hours), private physiotherapy and medial laboratory. MidCentral services are all located within the same building. This means most people can see their General Practitioner / Specialist, have an X-Ray, make their physiotherapy appointment and have their blood test taken within the one location. The six general practice medial beds are available to all people in the community who require low level medical care that can be managed by their own general practitioner. These beds also cater for patients who require palliative or hospice type care. The three maternity beds and delivery suite is available for those mothers who choose to have their babies in Dannevirke. Mothers can also be transferred to the Dannevirke facility following delivery of their baby in Palmerston North. All patients receive 24-hour care from a registered nurse and/or midwife.

Catering services are supplied from a local restaurant. Inpatient care, medical X-Rays, maternity ultrasound and maternity care are provided free of charge to all people. Charges are made for non-medial X-Rays, non-maternity ultrasound and ECGs. MidCentral Health leases facilities to provide a number of support services such as Mental Health, Alcohol and Drug Dependence Services, Community Health Services and Outpatients Specialist Clinics. Surgeons and physicians from Palmerston North visit regularly. A private physiotherapy practice, HomeCare 2000 and Medlab also operate within the complex.

Four of the town's six General Practitioners are located in premises adjoining the community hospital and all GPs are contracted to the hospital.

Figure 2: Dannevirke Community Hospital – opened September 1997



The facility fulfils 80% of the community's needs. Accident and Emergency services are not provided nor are inpatient services for children under the age of 16. Three Rest Homes provide hospital care for older people.

There are some important initiatives and exciting plans for the ongoing improvement of the health services to the community. One area identified for improvement is the community services provided by MidCentral Health. Currently General Practitioners refer to MidCentral Health Community Services based in Palmerston North. The referral is then forwarded to the Community Health Nurses based in Dannevirke, however there is no direct contact between the District Nurses in the town and the GPs. This can result in inappropriate, inefficient and untimely provision of care.

The Dannevirke Community Hospital Manager, Sharon Wards, says the best advertisement for the hospital is happy staff. She places great emphasis on a strong consumer or customer focus, believing they are the best judges of how well the hospital is meeting community and HFA obligations. Sharon Wards says 'If you keep your staff happy, then your patients will be happy too.' She also places very high value on good community relations and readily makes herself available to speak to groups and individuals who want to know more about the hospital or have an issue to discuss.

Sharon Wards says local solutions are important for local problems as no rural community is the same as another. However opportunity to share ideas and experiences are important. With that in mind Sharon set about establishing the Rural Health Network. The network's inaugural conference was held at Dannevirke in August 1998. Delegates included managers, nurses, GPs and allied health professionals from both public and private sectors. The conference developed a forum for sharing information about rural health services and best practice in the changing health environment.

## 4. CONCLUDING COMMENTS

When a comparison is made of the current government policy guidelines and the sequence of events that unfolded at Dannevirke one must agree that the new community hospital reflects the policy requirements identified by the government in the late 1990s.

The Dannevirke Community Hospital is an exemplar of rural health innovation. It admirably reflects the attributes and essential characteristics outlined in the policy document (Ministry of Health, 1999). The facility provides certainty of access; it is well co-ordinated and demonstrates integration of services across primary and secondary care and between the public and private sector. Above all, it has a strong customer focus and is affordable.

The Dannevirke Community Hospital is one of many recent new service initiatives. Integration of health services can offer ways to achieve the ultimate win/win situation – better, less-stressful outcomes for the patient and better use of the taxpayers' health dollar. The Government wants to encourage community and provider partnerships with various government agencies in developing innovative care proposals. The approach adopted by the Government incorporates the flexibility needed for local solutions to local issues to come forward.

At the time that MidCentral Health issued an exit notice public confidence in the government and its health policies was very low. The HFA was aware of this, needed community input and cooperation and needed the outcome to be successful. There were many tensions to be managed:

- The community's demand for services and the HFA's assessment of need
- Distorted perceptions of the value of the old hospital
- The fundamental principal that health care should be accessible, free and not rationed
- The cost of technology and the availability of this technology in Dannevirke

- Difficulties experienced with recruiting appropriately skilled staff
- The impact of hospital closure on every aspect of Dannevirke life –as a provider of health services, as an employer and as a source of income for local businesses.

The rural sector is and will remain an essential part of the economic and social fabric of New Zealand. Rural health and disability service requirements must continue to be met – they are an essential part of New Zealand’s overall health services policy framework. Delivering services to the dispersed rural New Zealand population has always presented particular challenges.

The Dannevirke initiative is a superb example of partnership between the public and private sector. However because of the accountability the HFA has to the government as funder, its the willingness to share a reasonable amount of the risk is questionable. In order to bring about change the RHA and the HFA have clearly been the party with the greatest amount of negotiating power. Funding and purchasing bodies in the future must ensure that this inequitable power base does not result in the shareholders of innovative services such as the Dannevirke Community Hospital deciding that their return on investment does not warrant continued commitment. Recreating yet another new service in Dannevirke in the future without the support of these shareholders and the lack of an existing public facility may prove rather difficult.

Finally the expectation the HFA places on the level of commitment and personal investment of health professionals is worthy of comment. In order for the new rural service to succeed in Dannevirke there was an extraordinary level of commitment on the part of the health professionals who had the vision. This very high level of personal investment and inequitable sharing of risk poses, I believe one of the greatest threats for the long-term viability of such a partnership. New entrants may decide that the level of investment - both capital and personal – is a disincentive.

## 5. REFERENCES

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## APPENDIX 1

Government's Medium -Term Strategy for Health and Disability Support Services as detailed in the *Rural Health Policy: Meeting the Needs of Rural Communities* (Ministry of Health, 1999) are:

- Public certainty about access, quality and security of services
- Timely, equitable and nationally consistent access to elective services
- Acknowledging the special relationship between Maori and the Crown
- Decreased long-standing disparities in health status
- Improved mental health
- Improved child health
- Improved disability support services
- Greater emphasis on population health approaches
- Well co-ordinated, integrated services that contribute to better health and disability outcomes
- Intersectoral collaboration between public agencies – education, health and welfare – and various providers to achieve social policy objectives
- Improved capability and adaptability of the health and disability sector
- Sustainability of the publicly funded health system



## **APPENDIX 2:**

**INNOVATIVE RURAL HEALTH INITIATIVES** – identified in *Rural Health Policy: Meeting the Needs of Rural Communities* (Ministry of Health, 1999)

### **Teleradiology**

The use of telephone and computer technology to gain access to radiology services provides significant opportunities to rural hospitals and health centres. Reading x-rays and CT scans remotely can be of particular value in determining whether or not a patient must be transported to another centre or not. It can also be of assistance where it is not feasible to have an onsite radiologist.

Difficulty in recruiting a radiologist led **Coast** Health Care Ltd to contract with a Christchurch-based radiology service allowing urgent x-rays to be scanned through to Christchurch and a consultation provided within 20 minutes. A radiologist and a sonographer visit Greymouth Hospital weekly. This initiative has increased the quality of radiology services and reduced the need to refer West Coast people to Christchurch.

### **Patea and District Medical Community Trust**

The Patea community used to struggle to keep one GP. Now the town has a two-GP service plus access to the after-hours service at Hāwera Emergency Department.

The community worked towards solving the problem itself. It formed a community trust in 1991, rallied together public donations, and now, eight years later, its medical centre caters for 2733 patients.

The practice is self-supporting and works in well with the health centre, which was built for the use of all community health groups in 1995 through the trust and Taranaki Health Ltd joint venture.

‘Now the doctors work at the Hawera Emergency Department to make up the other part of their income, which means they have a good working relationship with the Taranaki Emergency Services.

‘If the Trust had not been formed we would not have had GPs in Patea. It’s working really well – a true success story.’

### **Rural Nurse led services at Takapau**

The Takapau Health Centre was nurse Anne Lloyd’s dream. ‘Sadly, Mrs Lloyd passed away a few months after the centre was opened. Her dream has developed into a valuable community asset providing a range of nurse-led health services,’ says nurse practitioner, Ingrid Cheer.

Today there are approximately 4000 contacts made each year via telephone, face-to-face consultations and group activities.

‘Our focus is on picking up health problems early, maintenance of health, and health promotion and screening. We also work towards empowering patients and helping them get access to other services. Working in closely with other health providers is crucial to the centre’s overall functions.’

The centre, managed by the Takapau Community Health Charitable Trust, now has one full-time and one part-time multi-skilled registered nurse working, as well as a voluntary administrator. There is also an outreach clinic in Norsewood.

Operating in a large, rural, isolated community where there are few other locally based health services and limited public transport, the centre co-

ordinates visiting health professional clinics, provides regular clinics such as hearing, asthma, podiatry, cervical screening and CPR classes, and uses internet services to ensure ready access to information. The service has a licence to sell a small range of pharmaceuticals, and has equipment such as blood glucose meters, wheelchairs and crutches available. There is also transport assistance to GPs and other health services via the Friends of the Health Centre (a voluntary group).

‘The community’s support never ceases to amaze me and at times it is most humbling,’ says Ingrid. ‘I believe it’s been a success because the community feels it owns the centre. Local control and local solutions to local problems in a depressed area are huge attributes to community morale.’

### **Opotiki Health Facility**

The Opotiki Health Facility was opened by Health Minister Wyatt Creech in March 1999. The health facility is owned by the community, Pacific Health Ltd and the Whakatohea Trust Board. Replacing the old Opotiki hospital, it provides health services for the Opotiki District – around 10,000 people.

‘A vision that was created five years ago has at last become a reality. It is a pleasure to see this valuable community asset up and running,’ says Ron Dunham, Chief Executive Office of Pacific Health Limited.

‘It is an important community asset, allowing people access to health services in an area where those services are quite hard to access,’ Heather Thompson, health facility co-ordinator says. ‘While the old hospital was a beautiful site and was loved and revered by the community, it was just not economical.’

‘The community wanted to retain the old hospital, but there has been a shift of emphasis to retaining services within the community. To do this we needed a facility which provides all the same services, but as a more economic unit.’

The new health facility provides GP services, physiotherapy, midwifery and maternity services and a range of specialist outpatient services. The facility has five beds for maternity and hospital care.

### **Kaitaia Maternity Service**

The Kaitaia Maternity Service incorporates all the maternity services in the region spreading from Mangamuka to North Cape. The majority of the region's roads are unsealed and access to some areas is difficult during the winter months. The service has to deal with these problems, as well as significant population factors like having a high percentage of Maori women (45% of the women aged 15–44 years) and a high proportion of young families, many of them on low incomes.

'We didn't want to create competition in this area,' says Donna Mayes, Kaitaia Maternity Services manager. 'GPs and practice nurses have a long history of working together and we wanted to continue that relationship, ensuring that our service met the needs of rural women. We wanted to make a service where the midwives and GPs had security of income, collegial support working as a team, and flexibility in how the services were delivered.'

The midwives provide antenatal care, and do home deliveries as well as look after the maternity service at the hospital. GPs provide the medical backup throughout the pregnancy as need and choice demands. The maternity service provides senior midwife cover at the Kaitaia hospital maternity unit and Northland Health provides support staff. The service also works in closely with community groups such as Plunket, Ringa Atawhai and iwi-based health groups.

'We are too isolated to operate in a competitive environment. Our drive was to get focused on how to meet the needs of women and we made a decision to

leave the politics behind. Our satisfaction is in seeing women in the region receiving good care,' says Donna.

### **Balclutha Health Facility**

Balclutha's integrated Healthcare Facility opened its doors to the community in December 1998. Brian Dodds, the chairman of the board of Clutha Health Incorporated, says it has been a challenging task bringing the community around to accepting the new facility as the key health service.

In December 1991 a campaign to fight for the retention of surgical services at Balclutha hospital started. Three years later these remaining surgical services closed down and the Hospital Support Committee rallied to find alternatives which would secure sustainable health services in the Balclutha.

'In the beginning we were all fighting for what we had; then we stepped back and thought, "shouldn't we be looking to the future?" There was divided opinion on it. Concern about whether or not, as a community, we should be taking on the responsibility for the provision of health services,' says Brian.

In August 1997 the group presented a business plan, centred on a new facility in Balclutha, to the community and members of the committee spoke to as many community organisations as possible to gain the support they needed to get the project under way.

'It's been a big change for the community to accept but we are confident that the quality and range of services which the new facility offers will do much to overcome the remaining opposition.'

Now the focus is on ensuring the continuing provision of the best health services by drawing together local health personnel and through better co-ordination and co-operation improving the services to the community.

Clutha Health Incorporated has been formed to own the facility on behalf of the community. It is an incorporated society with a board membership of 10 (five of whom are elected, while three are appointed by the people who work in the facility, one by the Clutha District Council and one by the Minister of Health). The incorporated society, in turn, has appointed a board of five directors to the Clutha Community Health Company Limited, which holds the contract to provide health services.

The facility includes seven general inpatient beds, two observation beds, four inpatient beds with specialist geriatric supervision, a maternity facility ward, two postnatal beds and two more beds to cope with overflow, five suites for general practices, x-ray services, a laboratory, physiotherapy, and an outpatients department where visiting clinicians and speciality nurses will conduct clinics. District nurses, occupational therapists and a medical social worker will also work from the facility.