R U R A L H E A L T H -

N E W S T R U C T U R E S - A N E W V O I C E

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A Study Presented to the Kellog Rural Leadership Course
Lincoln College, Canterbury 1989

Ruddenklav, Veronica (1989)
Rural health- new structures
a new voice

C O N T E N T S

Section 1

SECTION ONE

INTRODUCTION

The problem of providing services for people is an ever present, ever compounding one in New Zealand. The decisions relating to who needs what, how those needs can be filled and how much money should be used to do so are complex, made more so by the fact that needs change. In the last five years the structure of services filling those needs has changed in many areas including health and local government and this has affected services provided. Some services, like health are essential and for rural people affect the structure and the viability of their communities. These communities have undergone enormous change in the last five years leading to problems for the decision makers as costs rise and resources are stretched. In order to inform the decision-makers to enable them to make best and most appropriate use of those resources, rural people require a mechanism to convey the health issues particular to their sector and have them well recognised. They need a channel for effective advocacy.

It is the purpose of this study to explore the channels for effective advocacy of rural health issues with particular reference to the Southland example.

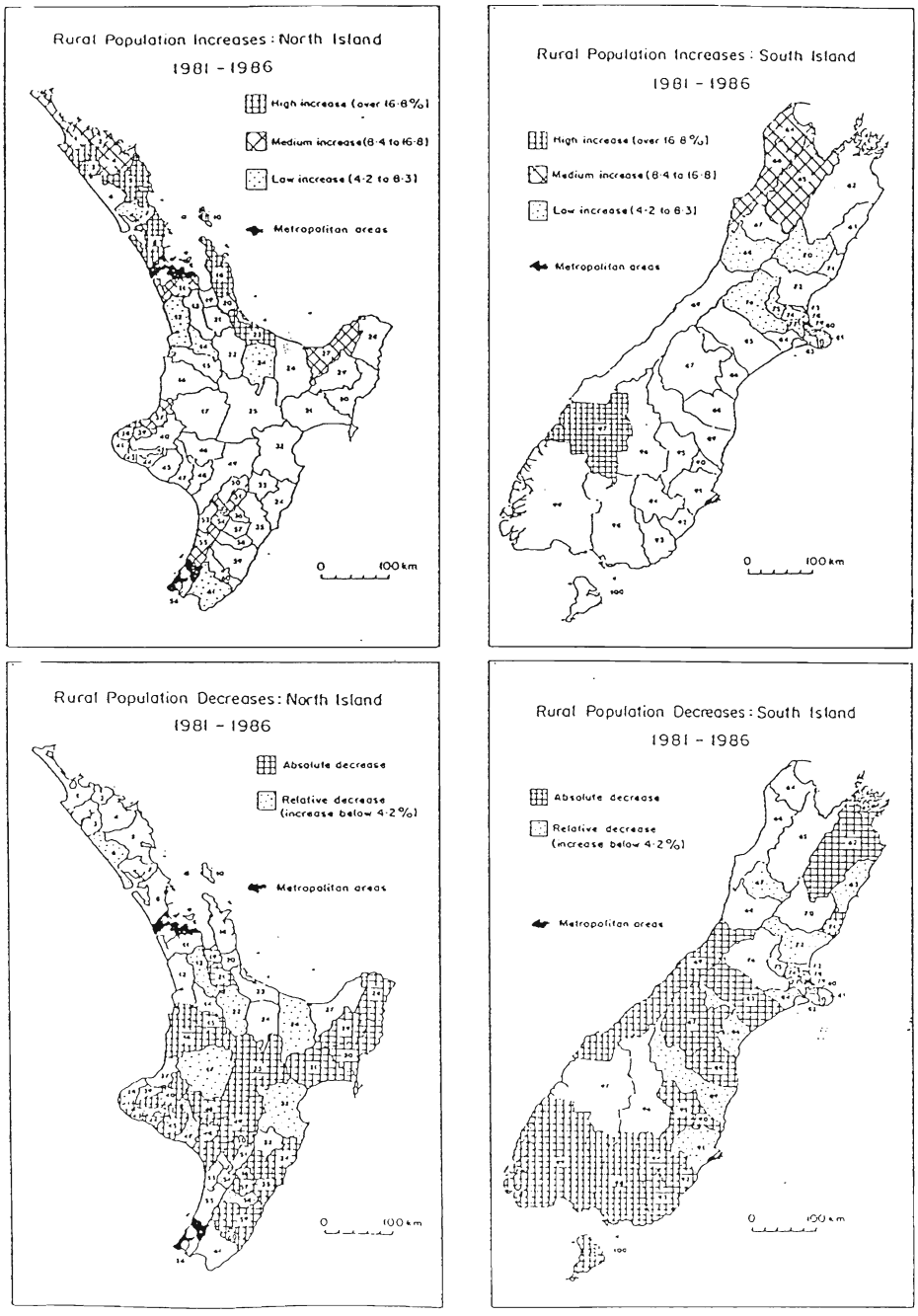
Section 2

SECTION TWO

RURAL COMMUNITIES - WHAT IS HAPPENING?

Rural Depopulation

More than a century ago almost half of New Zealand's population was considered to be rural. Now that figure is only 16.3% (Population Monitoring Group 1986). The extent of rural depopulation is shown in Cants (1986) analysis of the rates of population change throughout New Zealand between 1981-1986 (Figure 1).



The decline in population is extensive, particularly in Southland. Regional population projections for the next 30 years show that the trend will continue (Population Monitoring Group 1985). This depopulation is both a cause and a consequence of major problems in rural areas.

"Below a certain level of population, a community cannot support essential services and that effect is spiralling, so that lack of facilities becomes a cause of further out-migration". (Barker and Brown 1980).

A study of Eketahuna showed that the closure of the district high school in 1960 began a chain of events over the next 17 years including the closure of five primary schools, a local factory, the saleyards, a department store, and the departure of the chemist and resident vet. Corporatisation saw the Ministry of Works, the Post Office, Power Board and Pest Destruction Board all cease operation of depots in the area. Finally in 1977 the maternity hospital closed (Glendinning 1978). In a relatively short period many basic and necessary services were removed from Eketahuna taking with them, population.

... With the departure of all but a skeletal residual population the rural services, schools and social structure suffered. In many areas they collapsed completely. Isolated rural communities were deprived of residents because of inadequate services and insufficient residents deprived them of adequate services. With each person who left life become more difficult for those who carried on.... (Glendinning 1979)

Effects Of Economic Restructuring

On The Regions

This pattern is being repeated in rural areas throughout the country and is being exacerbated by recent national economic restructuring. With the effects of inflation, government changes in policy - floating of the dollar and removal of SMP's, interest rate changes and disturbing inflation costs many farmers are in a real financial predicament. Unable to meet mortgage repayments, they marched on Parliament, restructured debts and fought for survival. Some cases led to farmers having to walk off their land.

The economic restructuring for those who were not in such a critical financial position led to a massive decrease in on-farm spending - 18% in Goods and Services in 1985/86 followed by a further drop of 6% in 1986-87 (Taylor 1987). The flow-on effect of this was severe in the regions particularly in the rural towns.

"The financial plight of the provinces is being shared by the people of Invercargill. More than 1,000 jobs have been lost in Invercargill and similar reports are coming in from other centres" stated the Mayor, Eve Poole in the opening address at the Southland Federated Farmers Conference in May 1986.

The Government policy of corporatisation also contributed to the rural dilemma as the Eketahuna study showed. As inefficient services were removed and jobs lost so were services and people.

"The indications are that in New Zealand economic restructuring will lead to further rural depopulation and service withdrawal, to the detriment and perhaps complete demise of rural communities" Heenan 1989.

The rate and extent of the changes caused considerable stress to the individuals as he/she struggled to adapt to the impact of them. The livelihood of rural people was in jeopardy, farm size became bigger, extra labour units were laid off and off-farm employment was sought to help pay the mortgage. The whole way of life changed as many individuals struggled to cope with family, farm work and off-farm work as well as grave financial concerns. The resulting psychological pressure on rural people was enormous.

"Rural New Zealand is in crisis. Most rural people are having to adjust to a new economic reality. I am particularly concerned about their low mental and social readjustment". (Glendinning 1986).

Summary

The structural changes in rural New Zealand in the last five years have been extensive. With the loss of services through economic restructuring and the variability of livelihood and employment the rural life is no longer a sought after one and rural areas are losing population to the urban areas. Those left behind are faced with a changed way of life and a markedly different community structure.

Section 3

SECTION THREE

RURAL HEALTH ISSUES

For rural people, health issues have always been important. Their health status and the provision of services for health care in their area are recognised as an integral part of the fabric of their communities. But does health in rural areas have particular characteristics? That is the question that must be asked if the channels of advocacy on rural health issues are to be discussed.

What Does Research Say About Rural Health Issues?

In 1987 the Health Research and Development Unit of the Department of Health in Wellington began a three stage project on rural health issues, the first stage of which was to collate literature relating to it. (The second stage was a comparative study of urban/rural health statistics and the third, a regional analysis of mortality and morbidity rates).

Literature Review Summarised

The review collated research relating to rural health and grouped it into categories. It summarised overseas literature on the subject with the findings of Fearn (1985) a British study which found:

- high levels of illness in rural areas.
- trends for health services in rural areas to become increasingly centralised and less accessible.
- the general practitioner to be the focal point of rural health care delivery.
- accessibility to hospital care a major problem in rural areas.
- that the further people are from hospitals the less likely they are to use them.

Fearn advocated the provision of a more localised system of health with the provision of health services adapted to local needs.

New Zealand Research

The review (Rural Health Literature Review 1987) found quite an amount of research had been done in New Zealand though some had never been properly reported appearing only as magazine articles. However there have been four national

surveys including rural health though only one (J Pryde 1981) focusing specifically on the topic. These surveys highlighted regional variations in the distance people must travel to health services, in services available and the influence climatic and geographical factors had on the location of service and health status in the area.

Regional studies undertaken in five areas of New Zealand (Appendix 1) highlighted the problems of availability, accessibility and acceptability of services while various community studies looked at specific health issues in specific rural areas. Again access to and availability of services was highlighted. Rural/urban comparative studies do not show any rural specific illness apart from poisoning from agricultural chemicals and incidence of brucellosis and leptospirosis.

The closure of small hospitals and the difficulties of attracting general practitioners into their rural areas are the major health issues for rural medical practitioners. Health Service research also showed physical social and professional isolation to be a problem for rural doctors along with the difficulties of taking a holiday or study leave.

Summary

Existing research shows the particular characteristics of rural health issues to be:

- availability, accessibility and appropriateness of services and the need for greater flexibility in their provision to rural areas.

- the regional variation in needs.

- the problems of attracting medical practitioners to rural areas.

- the effects of service loss.

- the variability in the quality of research carried out on rural health issues.

Edmonston concludes from her research "What seems to be required are well-planned, quality, small scale community based research studies as these could provide information directly relevant both to the local authorities and local communities for immediate action and future planning purposes (Health Literature Review 1988).

Occupational Health In Rural Areas

The research identifies some characteristics particular to rural areas. There are other notable ones not mentioned within it. One of these is occupational health ie health issues related to what happens in the workplace. These issues are not easily separated from community health issues in the rural context.

On-Farm Fatalities

Tables from the Accident Compensation Commission reveal that of all on-farm fatalities in New Zealand between 1980-1986 nearly one in four or 25% involved a child under 15 years of age (Figure 4).

NEW ZEALAND FARM FATALITIES

CAUSE OR AGENCY

(-) = Children under 15 years

Year	Total	Tractor	Drowning	Machine	Vehicle	Firearm	Animal	Burn Chemical	Electricity	Tree	Other
1980	38 (9)	13	5 (3)	2(1)	2(0)	1	3	(1)	4(1)	1	5(3)
1981	47(17)	13(1)	12(10)	1(0)	4(2)	1	5(2)	-	5(1)	1	5(1)
1982	43(10)	17	4 (4)	0	4(2)	3(1)	5(2)	-	3	4	3(1)
1983	29 (9)	17(4)	2 (2)	1	8(3)	-	-	-	-	1	-
1984	44(13)	13(3)	9 (7)	(2)	9(1)	5	1	1	1	2	1
1985	29 (5)	11	3	0	4(1)	2(1)	4(3)	1	-	1	3
1986	23 (4)	7	3 (1)	1	3	3(1)	3(1)	-	-	1	2(1)

Claims registered with ACC so far in 1989 for injuries from tractors not on roads show that of 455 claims, 16 involve under 15 year olds and 27 persons over 65. Figure 5.

TRACTOR SAFETY

TRACTOR INJURIES (NOT ROADS) — CLAIMS REGISTERED WITH A.C.C. IN 1989 FY

AGE	SEX	CLAIMS	% CLAIMS	TOT. COST (YTD)	% TOT. COST	AVG. COST
54	M	50	10	67,613.30	8.69	13,522.66
34	M	49	10	60,753.02	7.81	12,150.60
29	M	40	8	43,161.90	5.54	8,632.38
24	M	39	8	52,740.07	6.78	10,548.01
39	M	36	7	136,381.65	17.53	27,267.33
49	M	35	7	57,538.98	7.39	11,507,79
59	M	32	7	56,098.89	7.21	11,219.77
44	M	32	7	154,826.10	19.90	30,965.22
19	M	32	7	19,116.43	2.45	3,823.28
69	M	22	4	29,976.20	3.85	5,995.25
64	M	16	3	26,792.13	3.44	5,358.42
74	M	13	2	11,281.93	1.45	2,256.38
19	F	7	1	4,907.03	0.63	1,635.67
14	M	6	1	2,519.31	0.32	629.82
39	F	5	1	4,807.37	0.61	1,602.45
34	F	5	1	9,343.28	1.20	3,114.42
79	M	5	1	3,295.24	0.42	1,098.41
49	F	5	1	2,467.61	0.31	822.53
24	F	4	0	3,073.46	0.39	1,536.73
9	M	3	0	363.40	0.04	121.13
29	F	3	0	3,246.21	0.41	1,623.10
44	F	3	0	2.521.57	0.32	1,260.78
4	F	3	0	3,102.24	0.39	1,034.08
4	M	2	0	2,358.79	0.30	1,179.39
54	F	2	0	4,219.92	0.54	2,109.96
9	F	2	0	275.95	0.03	275.95
14	F	1	0	1,014.87	0.13	1,014.87
59	F	1	0	0.00	0.00	0.00
84	M	1	0	13,799.70	1.77	13,799.70
74	F	1	0	161.12	0.02	161.12
		455	86	777,757.76	99.87	

These figures will not include statistics for anyone not eligible for compensation ie principally non-earners ie persons under 15, over 65. It can therefore be assumed that the figures are the tip of the iceberg particularly for this age group.

All of these figures bear out the fact that occupational health hazards in rural areas also involve family members because the workplace is also the home and recreational environment of the worker's family. This is unique in occupational health in New Zealand.

Education about occupational health in rural areas is difficult because unlike the industrial situation, workers are not grouped together and as education must also include family members, community networks are essential for programmes to be effective.

Environment

Another health issue which has particular characteristics in rural areas is the environmental one. The farmer has a unique opportunity to determine its effects through decisions he makes on agricultural chemicals and his handling of them.

Agricultural Chemicals

National Poisoning Statistics 1984

Age Group	Male	Female
0- 4	19	22
5-14	2	-
15-24	5	3
25-54	31	1
55+	5	1
All	63	27

Figure 6

Figure 6 shows that agricultural chemicals pose a risk not only to the agricultural worker but also the non-working members of the family. 48% of notifications involved children under 15 years of age.

Summary

While some aspects of occupational health are common to all work situations the rural situation is unique because:

- the work place is also the home environment for the worker's family.

- the process of education must involve the rural community to spread the message.

- occupational health and community health are interwoven in rural areas.

Section 4

SECTION FOUR

STRUCTURE OF HEALTH SERVICES

Introduction

Research shows that there are characteristics of health issues which are particular to rural communities. The structure of those communities has changed dramatically in the last five years. So too, has the structure of the health services provided for them. The changes in health service structure were a response to a change in emphasis in health, a need to refine a system of health care which had become too costly, lacked co-ordination between sectors and did not allow for community consultation.

Background To The Changes

Definition Of Health

The dictionary defines health as the condition of the body or a soundness of body. That definition formed the basis of the provision of Health Services in New Zealand for nearly 100 years. However in recent times, two documents highlighted a major philosophical change in thinking about health. They were the Alma Ata Declaration and the Ottawa Charter.

The Alma Ata Declaration 1978 (Appendix 2) was a declaration by the World Health Organisation on Primary Health Care which New Zealand signed.

It declared:

- that health, in a full sense is a basic human right.
- that people have the right and duty to take part in planning and organising of their health care.
- that primary health care should be available, accessible and appropriate for everyone.
- that primary health care includes health promotion and prevention of diseases as well as treatment for illness and disease.
- that primary health care involves many areas of life.

(Department of Health Leaflet 1988)

Ottawa Charter (Appendix 3)

Was a declaration from an international conference in Canada on health promotion. It resulted from many countries having adopted the Alma Ata declaration.

The Ottawa Charter outlined the basic conditions for health, emphasised that all aspects of our lives affect it, that education is essential to enable people to take more responsibility for it and that all sectors including Government, private organisations, community groups and families must work together to reach the best health for everyone - "Health for all by the year 2000". It redefined health as "a state of complete physical mental social and spiritual well-being, not merely the absence of illness or disease". (Ottawa Charter).

Summary

These two documents emphasised that health involved the whole person and that every section of the community must be involved in decision making about it. They acknowledged the need to have health issues considered in the public decision making process and most importantly encaptured the change in perspectives. Health was to be no longer solely treatment orientated. It became a tool essential for living to be achieved through partnership involving the individual, the health professional and the public decision-makers. The era of social and community health was underway.

A CHANGED STRUCTURE

Introduction

With a change to a social and community perspective the structure for health services was no longer appropriate. It was not geared to consultation, co-ordination and equity but had become exceptionally costly as vast improvements in treatment services had been absorbed.

A new structure was required which recognised a change in emphasis from:

sickness to wellness
imposed to empowered
hierarchical to partnership
individual to community.

Background

For decades the Health Care System had been structured with two distinct arms in each regional area.

1. Hospital Board

Which was elected by the people, was essentially clinical in orientation and was responsible for the provision of hospitals and associated treatment services as well as hospital-based community services eg District Nurses. It received population-based funding from central government for running expenses eg salaries but had to apply to Central Government for capital item funding.

2. The District Office of the Department of Health

Were essentially epidemiological in orientation and were responsible for health protection and promotion and primary health care services. However it had little influence over how these services were delivered to the public. Their funding was messy; some came from Central Government to be administered by the office and some came direct to them to be allocated as they saw fit.

Main Problems

Who provided the services and the way they were funded divided the responsibility between Central Government, District Offices of the Health Department and the Hospital Boards. There was a great deal of confusion over who was responsible for what. Moreover, the Minister had limited powers to intervene in regional matters and communities were constrained by having to work with central government. Co-ordination between the public, private and voluntary sectors providing health care was not required. The community had no opportunity to influence their health care apart from a vote every three years.

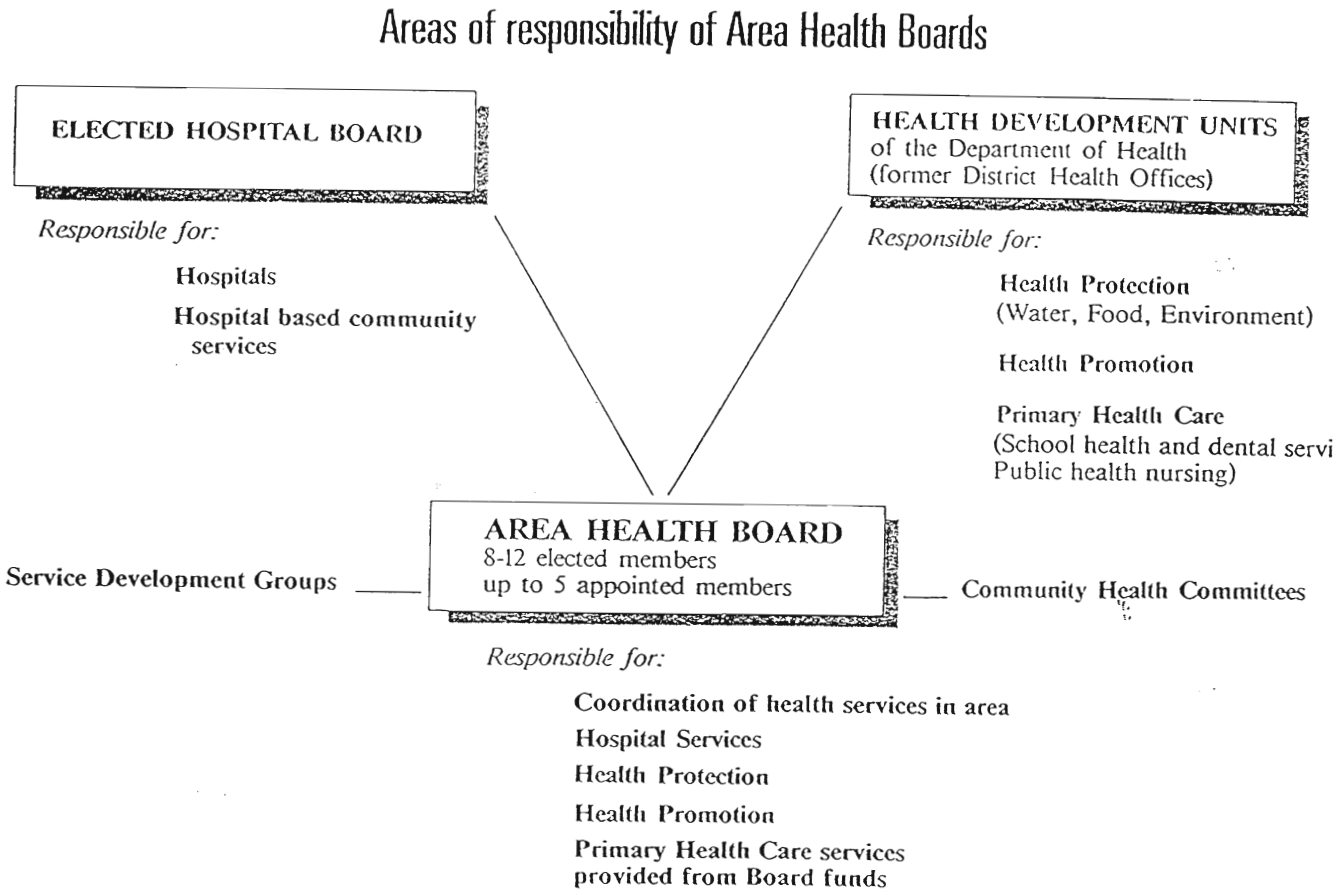
Summary of Problems

- responsibilities confused.
- lack of co-ordination of provision of services.
- no mechanism for community consultation.

NEW STRUCTURE OF HEALTH SERVICES

Introduction

In response to all the problems inherent in the old structure and in recognition of a changed perspective on health care, the Area Health Board Act was passed in 1983 which heralded the beginning of the amalgamation of Hospital Boards and Health Departments into new regional authorities - Figure 8.



Nationally the health services were restructured with lines of accountability, monitoring systems and advisory roles. The Minister of Health would set national policy and have direct links to the Health Council, a forum for discussion between Government and Area Health Boards and the Ministry of Health which would have a monitoring and advisory role. Legal complications have prevented the Ministry from being established to date (Otago Daily Times September 1989).

The New Regional Structure of Health Services

Under the Act, Area Health Boards were to be established, with service development groups as the voice of health workers and community committees as the voice of the people.

Area Health Boards

The responsibilities, functions and duties of the Boards are outlined in the Act. Section 9 states:

9. Primary objectives of boards - The primary objectives of an area health board in its district shall be as follows:

   (a) To promote, protect, and conserve the public health, and to provide health services:

   (b) To provide for the effective co-ordination of the planning, provision, and evaluation of health services between the public, private, and voluntary sectors:

   (c) To establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education, and treatment services.

Section 10 states:

The functions of an area health board shall be as follows:

- to investigate and assess health needs in its district.

- to plan future development of health services in its district and towards that end:

   i) to consult as appropriate with any regional or united council in the district and

   ii) to support, encourage and facilitate the organisation of community involvement in the planning of such services.

Each region will develop a local structure under the terms of the Area Health Board Act. Already regional variations on the theme are appearing but every Area Health Board will employ a Chief Executive to implement its policies - Figure 9.

A NEW STRUCTURE FOR THE NEW ZEALAND HEALTH SERVICES

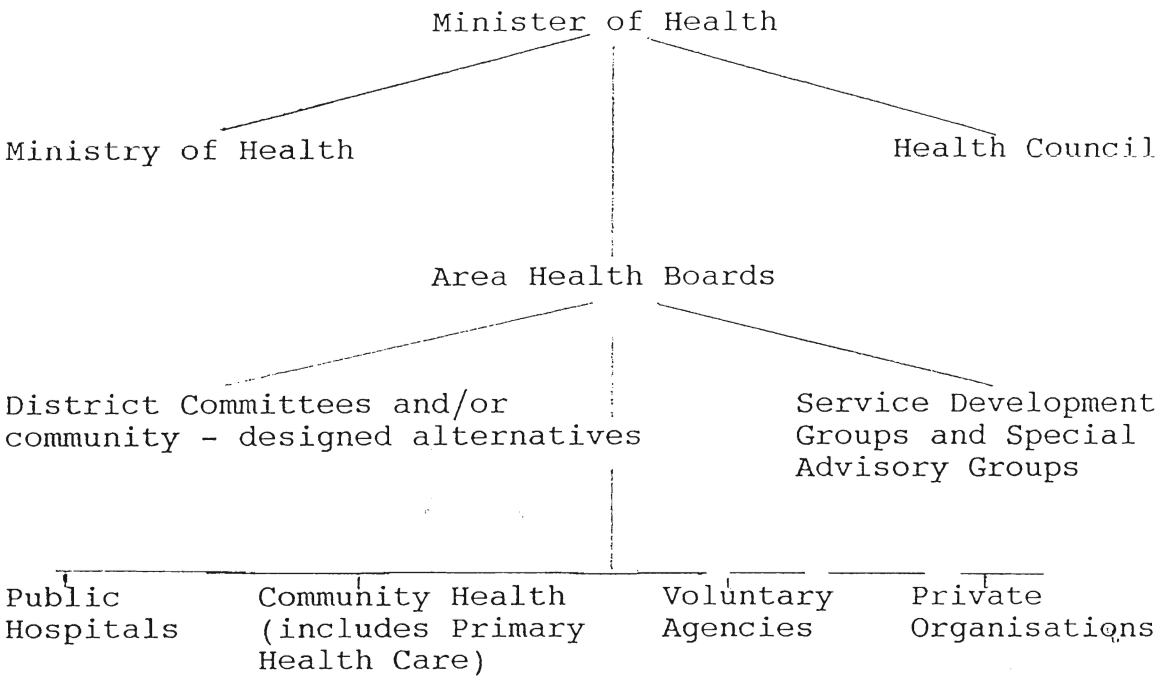


Figure 9

Community Committees

To assist the Board with the flow of information, Community Committees may be established. Boards may also allocate funds to them so they can provide services. These committees are elected on an ad hoc basis at public meetings and are confined to a geographical area. They do not have a planned approach nor do they hold any power but they are a useful management tool in that they can reflect the opinions of the people (Appendix 4).

Service Development Groups

May be established to advise on policy directives related to a particular issue or service and will be called together for that express purpose and disbanded when it is complete - Appendix 5. The Act specifies which issues must be dealt

with by Service Development Groups and allows for the establishment of them to deal with other issues as well.

Summary of Changes in the Structure of New Zealand Health Services

The structure has changed so that:

- services can be provided and co-ordinated regionally.
- services can be more responsive to local needs.
- services can reflect the broadened definition of health.
- the community can have a much greater part in the decision making process.

"The new structure will be responsive to community needs, ie accessible, affordable and appropriate; efficient and effective with clear objectives, a coherence of purpose and clear lines of responsibility" (David Caygill 1987).

It is important that the end result of the changes which are occurring is a system which is better suited to the needs of consumers" Helen Clark (1989).

Section 5

ADVOCACY FOR THE PEOPLE - THE SOUTHLAND EXAMPLE

Introduction

The structure of health services in New Zealand changed so that the system of health care would be more efficient and effective, more responsive to needs of the community and allowed for much greater community consultation about policy decisions and their implications. With the structure not yet 12 months old, insight into the happenings in Southland in the latter half of 1989 provides a commentary on the available advocacy mechanisms.

Background

The population of the Southland area is 103,000 of which 53,000 live in the major urban centre, Invercargill, and a further 8,000 in the secondary urban centre, Gore. (New Zealand Statistics 1986). What percentage of this population can be deemed rural depends on definition. New Zealand Statistics Department says it is communities of 1,000 or less therefore, by definition Riverton (1,704) is not rural and Tapanui (969) is. The reality is that there is no clear break between urban and rural in Southland; "towns and their surrounding rural areas are inextricably interwoven" - Cant 1986. It could reasonably be argued that at least 50,000 or close to 50% of the Southland Area Health Board region figure is rural, some would say the percentage is more. However, the importance of health issues pertaining to rural areas in the formulation of board policy can be readily acknowledged, and crucial to this is adequate and accurate information regarding the needs of those areas. So what channels of advocacy are there available to rural people in Southland.

Service Development Groups

In the Southland area the first of these is about to be set up. It is to be 'a group of health workers from either the voluntary, private or public sector appointed by the Board to advise on health and health services in each group service area (Handbook 1989).

There is provision in the Act for a Committee of the Service Development Group to be established to undertake any particular task delegated to it (AHB Act Section 29 Clauses 6/7) or "invite attendance from someone able to advise on a particular aspect of the issue". In Southland, a mental health service development group is being established. The implications of the adoption of the principles of normalisation of mentally handicapped people by the board has considerable implications for all such patients and their families within the area. However the problems of access and availability of support services in the community

are greater for those patients scattered in the rural areas. The provisions of Section 29 6/7 should be used to provide rural perspectives on the Mental Health Service Development Group.

Elected Representatives

The elected representatives can also advocate on behalf of rural people in the Southland region. There are 10 elected representatives in Southland and provision for up to five ministerial appointees. With the pace of change, though, both in rural communities and health services as well as the sheer physical extent of the area they serve, even the most earnest representative can only do so much.

Community Committees and Rural Advocacy

The other official channel for advocacy in the Southland Area Health Board structure is the Community Committee. The Southland Area Health Board has completed setting up nine community committees within its boundaries. As committees of the Board they have been elected at public meetings on an ad hoc basis and have a Board member seconded to each. They have come into being, in Southland, in the midst of budget allocation cuts and have therefore tended to attract members with sectorial interests. They are however "responsible to the Board in an advisory role for providing information on Health Services and health issues concerning that committee's areas". (J Braithwaite 1989).

Having not yet been in place six months the situation in Eastern Southland a distinctly rural area of Southland, (Figure 9) provided a view of the community committee's role as advocate for the rural people it served. In response to expected budget allocation cuts, the Southland Area Health Board proposed a cut in services to Gore Hospital. As the Board did not see the Eastern Southland Community Committee as a proper vehicle for the community consultative process, it neither informed nor met with it about these, nor asked its advice concerning the impact of such cuts in the area except through the presence of the seconded board member on the committee. The Community Committee considered the implications of the proposals to be extensive in their area, and being unable to meet with the full board for discussions, felt compelled to resort to the support of the law to show their concern. They became co-plaintiffs in a court action to have the Southland Area Health Board decisions reviewed. History will determine the outcome of that action.

The Question To Be Asked

Did the structure provide a channel of advocacy for the concerns of the Eastern Southland people?

Answer - partly.

Through their elected representative who was able to advocate on their behalf. However the usefulness of the Community Committee as a channel for advocacy must be of grave concern. The Southland Area Health Board did not see it as such - a motion is at present before the Board to have the committee disbanded (Southland Times October 1989) and the community did not see it as such since they felt compelled to use the law instead, or at least as well as. It needs to be said that the earnestness and goodwill of both the Southland Area Health Board and the Eastern Southland Community Committee are fully recognised and no blame of either party is intended to be laid but the example of what happened served to show that the new structure fell short for effective advocacy of rural needs. Given their present terms of reference and power base the Community Committees are not able to negotiate from anything other than a weak position. They do not provide an opportunity for the community to be involved in the actual decision making process but merely allow for consultation which popularly means 'seeking a reaction to a proposed course of action'. Community Committees to be effective advocates must be the authors of information on need which it must then properly present to the Board. That information, if it is to be used for decision making must be carefully gleaned from a variety of sources by the committee and used to lay out a plan. This should then be put to the Board and the committee ask for the things they believe to be needed. This would be effective advocacy.

Summary

- the elected representatives of the people can be effective advocates of the people.
- the service development have provisions to allow for their use for advocacy.
- the Community Committees in their present form in Southland fall short as effective advocates for rural needs.

Section 6

CHANGES IN LOCAL GOVERNMENT

Introduction

At present decisions relating to health services in Southland are made by one regional authority, the Southland Area Health Board. Despite the grave implications of some of these decisions for the well-being of the area as a whole, no other regional authority is presently part of that decision-making process. Like the structure of the health services, the structure of the regional authorities has undergone considerable change to enable each region to have more say in its direction and future (Gibbs 1970, Scott 1979) through the establishment of a system* to deal with the use of resources on a regional scale* incorporating regional planning schemes.

Background

As early as 1929, an amendment to the first Town Planning Act 1926 authorised regional planning schemes and the Town and Country Planning Act 1953 reinforced these provisions though did not make them mandatory. This led to few regional authorities actually functioning or being established. No further legislation affecting regional administration occurred till the Local Government Act 1974 which stated in its title:

"An Act to consolidate and amend law relating to the organisation of districts and functions of local authorities, to make better provision for the administration of those functions which can most effectively be carried out on a regional basis, and to make provision for the establishment of united councils, district community councils, and community councils".

Its stated objectives were:

1. That of reorganisation, preparation, and implementation of regional schemes.

2. The co-ordination of functions at regional level.

3. The establishment of united or regional councils.

Aburn 1979/83

The Local Government Commission had the responsibility of providing a pattern for all of that to happen. Considerable ongoing debate ensued focusing on the constitution, power and functions of the proposed authorities.

The Town and Country Planning Act 1977 clarified some of these areas and formalised the link between regional councils and regional planning, making planning a mandatory function of the Council.

The regional bodies who were to carry out the regional planning were not well resourced, territorial local authorities were uneased by the new legislation and the united councils were slow to assume the new role established for them and the 1977 legislation reconsidered all of these factors.

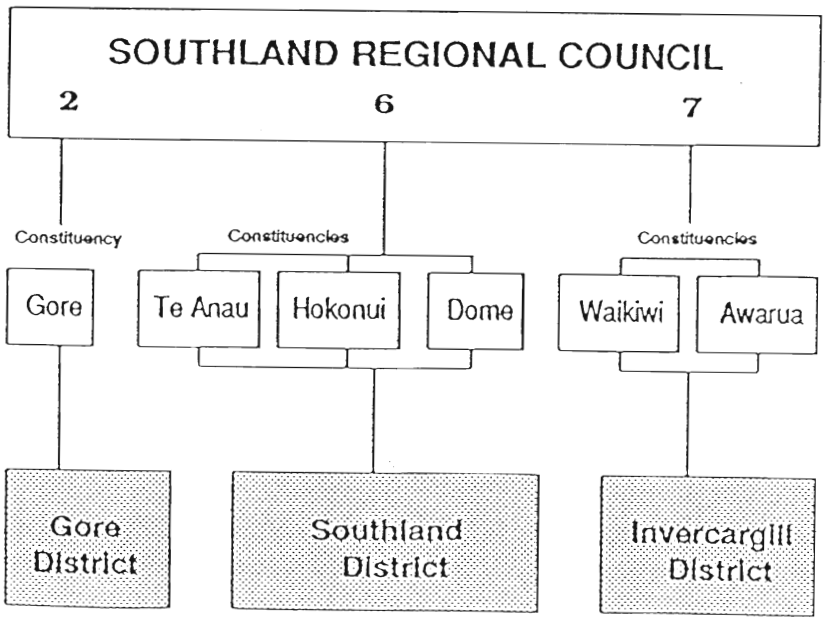
The Tribunal set up to do so was concerned 'that the Act only allowed for planning schemes to preclude certain developments taking place rather than encouraging determination of what was desired to take place within its region.

In 1988 however with the Local Government Amendment Act multi-function units of local government were established directly elected to be responsible for regional planning, with their main responsibility resource management with directly elected territorial authorities responsible for the functions of County Councils.

"The legal framework for regional planning in New Zealand provides considerable scope for innovation. As a process regional planning has the potential to express territorial will and to manage resources on a sustainable basis with equity and justice. (Forrest 1981, 1989)

Heenan 1989 says "Regional planning denotes a formal activity which organises the use of resources on a regional scale".

Southland - the new structure in Southland provided for a regional council made up of elected representatives from the constituencies within its area. (Figure 11).



Regional Council (15 members) would take over the responsibilities associated with resource management - the functions of the following bodies:

. Southland United Council

. Southland Catchment and Regional Water Boards

. Otautau and Waimatuku River Boards

. All noxious plants authorities

. All pest destruction boards

. Southland Harbour Board (except for recreational amenities).

A port company has already been established to run the commercial operation of the port at Bluff.

District Councils - 15 members and a Mayor. There would be three district councils established - Gore, Invercargill and Southland who would assume the functions of the Southland and Wallace County Councils, Winton Borough Council, Stewart Island County Council, Ohai Railway Board and the Reserves Board

"The new era heralds a change of great magnitude. It will encourage greater people participation, make representation more equitable and provide momentum for improved performance across the full spectrum of government activity" (Tom Shirley 1989).

Rural Services Committee - By law the Southland Regional Council must until 1995 establish and maintain a rural services committee responsible for:

(a) agricultural pest destruction; and

(b) noxious plants control; and

(c) any other functions considered by the Southland Regional Council to be of particular concern to the rural community.

The persons appointed shall be not less than two persons. These shall be persons:

(a) Who are not members of the Council (Southland Regional Council).

(b) Who in the opinion of the Council have knowledge that will assist the work of the committee (Local Government Commission).

Advocacy Channels in Local Government - Historical Model in Southland

The old Southland United Council recognised the responsibility it had as a regional planning authority to be involved in planning for a wide range of services within the region. In 1983, in co-operation with the Southland Hospital Board, County Council and Health Department in Southland, it funded researched, and produced a document, Health Priorities for Southland (1983) which dealt with the major health problems in the area and identified what might be done to solve them (Southland United Council 1983). The Principal Officer of the Southland United Council stated:

(a) "United Councils are well placed to be regional advocates - that is to ensure a properly researched, reasonable point of view is put forward to Government or any other body on any issue affecting the region.

(b) They are in a position to establish credibility not as a regional authority but as authorities on the region ....

(c) The United Council can function as regional educators to know and understand the changes that are taking place at national level and to interpret the likely affect of these changes on the region.

(d) They can be facilitators helping other organisations or individuals make things happen (Watt 1986).

This was a unique approach in its time and provides an excellent model for the incoming regional and district councils. The mechanism is present in the structure of the Regional Council in the form of the Rural Services Committee to take up responsibility for "any other functions considered by Southland Regional Council to be of particular concern to the rural community."

Summary

The system of local government in New Zealand has evolved to develop a mechanism for effective regional decision making and planning. Along the way, the functions, constitution and powers of the proposed bodies has been constantly reviewed but their value as planners of resources within their regions has been recognised and a structure developed to support this. This structure allows for a directly elected regional council to adopt a regional perspective in its decision-making, to be multi-functional and to involve appropriate sectors in those decisions affecting the region as a whole.

Section 7

SUMMATION

At present, decisions on health services in the Southland Region are made by one regional authority, the Southland Area Health Board. Health services are crucial to the viability of communities in Rural Southland and the viability of those communities is crucial to the region as a whole. The problems of health issues in rural areas is therefore one for all the regional authorities of the area not just the one responsible for the provision of health services, the Southland Area Health Board. The regional council of Southland has a major responsibility to promote the overall well-being of its area. To this end it must promote the retention of population through ensuring the best possible living conditions for them including the addressing of their particular health needs, for the strength of the region is in its people, without them the management of physical resources is meaningless.

It follows therefore that the Southland Regional Council should be used as an appropriate channel for advocacy of rural health issues.

Rural people themselves must recognise the characteristics of the health needs of their communities and understand the importance of having them effectively conveyed to the decision makers. Without effective advocacy, the future of rural communities cannot be assured.

A considerable amount of work will be required to affect this and justice cannot be done, to many aspects of it in this study.

SUMMARY OF PROPOSALS

1. THAT the Southland Area Health Board establish the characteristics of rural health particular to its region.

2. THAT in recognition of those, it appoint subcommittees to its Service Development Groups to address issues particular to rural communities.

3. THAT the existing form of Community Committees be recognised as a useful management tool but not necessarily a source of comprehensive advocacy for the people it serves.

4. THAT the Southland Area Health Board recognise the value of other regional bodies, in particular the Southland Regional Council, as a source of valuable information and perspective.

5. THAT the Southland Area Health Board use the provisions of the Area Health Board Act Section 10 i to formalise that relationship.

6. THAT the Southland Regional Council recognise the importance of health services for the rural communities which form over half the population of its region.

7. THAT it explore those issues under the terms of the Rural Services Committee.

8. THAT it formalise liaison with the provider of health services, the Southland Area Health Board.

LIST OF APPENDICES

Appendix One

1. Otago - An Evaluation of Health Care Services by Rural and Urban Women, Val Walton et al
   Unpublished 1985.

2. Southland Women's Health Survey
   Unpublished 1987

3. Northland - Primary Health Care in Northland. A Comparative Study of a Special Area and a Fee for Service Area Occassional Paper No. 28 Department of Health, Wellington (1986). Flight and Snelgar

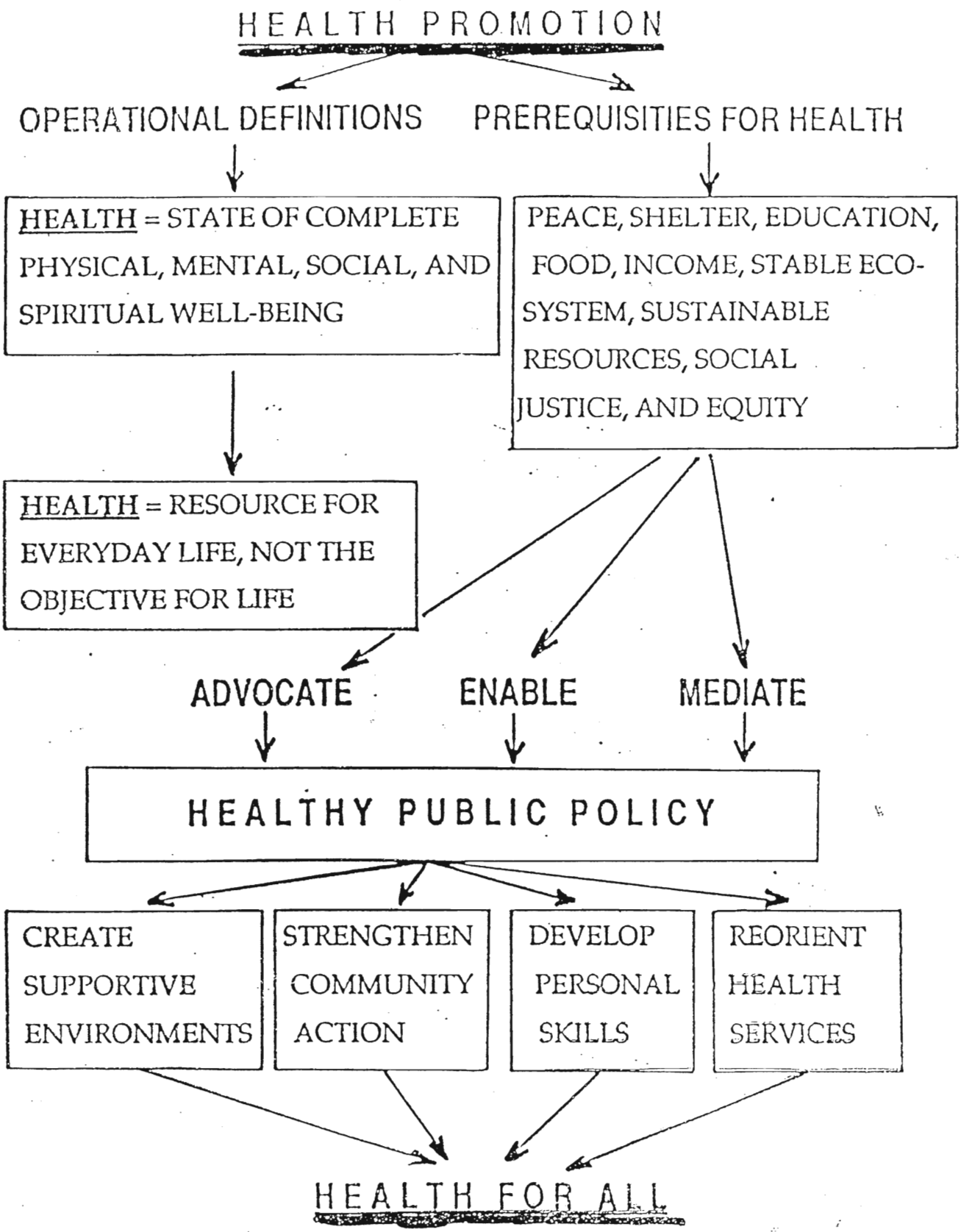
4. Teenage Pregnancy in the Waiarapa - An Assessment of the Availability of Contraceptive Service for Young People
   Unpublished (May 1986) K Hadley

5. Some Aspects of the Demography of the Waikato Board Report to the Waikato Hospital Board
   Unpublished 1984
   Cochrane and Pool

In 1978 the World Health Organisation made a "Declaration" on Primary Health Care. New Zealand signed this agreement.

main points in the declaration are:

- That health in a full sense, is a basic human right.
- That people have the right and the duty to take part as individuals and as groups, in planning and in organising their health care.
- Primary health care should be available to everyone and should be provided in ways acceptable to everyone and in places suitable to everyone.
- Primary health care includes health promotion, prevention of diseases, treatment of common diseases and injuries and provision of basic drugs.
- Primary health care involves many areas of life, including housing, education, social welfare and agriculture. All of these need to co-ordinate their work with health workers at national and local levels.


HEALTH PROMOTION
OPERATIONAL DEFINITIONS
PREREQUISITIES FOR HEALTH
HEALTH = STATE OF COMPLETE PHYSICAL, MENTAL, SOCIAL, AND SPIRITUAL WELL-BEING
PEACE, SHELTER, EDUCATION, FOOD, INCOME, STABLE ECO-SYSTEM, SUSTAINABLE RESOURCES, SOCIAL JUSTICE, AND EQUITY
HEALTH = RESOURCE FOR EVERYDAY LIFE, NOT THE OBJECTIVE FOR LIFE
ADVOCATE
ENABLE
MEDIATE
HEALTHY PUBLIC POLICY
CREATE SUPPORTIVE ENVIRONMENTS
STRENGTHEN COMMUNITY ACTION
DEVELOP PERSONAL SKILLS
REORIENT HEALTH SERVICES
HEALTH FOR ALL

The Ottawa Charter was presented at the first International Conference on Health Promotion in November 1986.

The main points of this charter are:

- The basic conditions for health are: peace, shelter, education, food, income, a stable ecosystem, enough resources, social justice and equity.
- All aspects of our lives affect health—politics, economics, culture, the environment, our behaviour, and our individual bodies.
- Health promotion works towards equality—people cannot reach their best level of health unless they are able to take control of the things which decide their health. This applies equally to women and men.
- Like the declaration on primary health care, the Ottawa Charter says that all sectors must work together in order to reach the best health for everyone. This charter goes further and says that this includes government and private organisations, finance, community groups and families. Health cannot be separated from other areas of life.

31. **Community committees**—(1) An area health board may from time to time appoint a community committee, consisting of 2 or more persons, in respect of any area within its district.

(2) Notwithstanding anything in subsection (1) of this section, in any case where the hospital district of the initiating hospital board or of any of the initiating hospital boards comprised, at any time on or after the 1st day of January 1950, 2 or more hospital districts, the area health board shall appoint a community committee for each of those former hospital districts unless, on the application of the board, the Minister waives compliance by the board with this requirement.

10. Community committees—(1) Section 31 of the principal Act is hereby amended by inserting, after subsection (2), the following subsections:

"(2A) The board may authorise any such committee—

"(a) To manage any undertaking or service within the functions of the board; or

"(b) To regulate and undertake, or to inquire into and report upon, such matters as the board thinks fit.

"(2B) The board shall have the same powers of delegation to any such committee as it has in respect of committees appointed under section 28 of this Act; and the provisions of subsection (2) of that section shall apply accordingly."

(2) Section 31 (4) of the principal Act is hereby amended by inserting, before the words "Every community committee", the words "In addition to performing any function required of it by the board under subsection (2A) or subsection (2B) of this section,".

(3) Any such committee may comprise persons who are not members of the board; but no person who is incapable of being a member of the board shall be capable of being a member of any such committee.

(4) Every community committee shall provide a forum for the various community groups working in the health field, and shall provide a liaison between such groups and the board.

(5) Members of a community committee shall be appointed for a term of 3 years, and may from time to time be reappointed.

(6) Every community committee may determine its own procedure.

Amendment
1988 No. 10(

29. Service development groups—(1) Every area health board shall from time to time appoint sufficient service development groups, consisting of 2 or more persons, to advise the board, in accordance with any policy directives prescribed by the board, on the full range of health services in the public, private, and voluntary sectors relevant to its district.

(2) Without limiting the generality of subsection (1) of this section, every board shall appoint sufficient service development groups to deal adequately with the following:

(a) Medicine (other than paediatric, geriatric, or psychiatric medicine):

(b) Surgery:

(c) Child health:

(d) Health of the elderly:

(e) Mental health:

(f) Dental health:

(g) Health protection:

(h) Health promotion:

(i) Primary health care.

(3) Notwithstanding anything in subsection (1) or subsection (2) of this section, on the application of any board the Minister may waive compliance by the board with the requirements of those subsections if he is satisfied that the board has established alternative planning procedures that are adequate to perform the functions of service development groups under this Act.

(4) Subject to subsection (2) of this section, a board may at any time discharge, alter, or reconstitute any service development group.

(5) Every service development group shall, unless sooner discharged by the board, be deemed to be discharged on the coming into office of the members of the board at the triennial general election of members next following the appointment of the group.

(6) A service development group may from time to time appoint a committee comprising 2 or more members of the group to undertake any task delegated to it by the group.

(7) A service development group may from time to time invite any person to attend any meeting or meetings of the group to advise the group on any matter.

(8) Every service development group may determine its own procedure.

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