A FORMATIVE AND PROCESS EVALUATION OF A SERVICE DEVELOPMENT GROUP: AN ANALYSIS OF THE WAIKATO HOSPITAL BOARD'S REVIEW OF MATERNITY SERVICES

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Abstract

This study is a formative and process evaluation and analysis of what occurred before and during the Waikato Hospital Board's Review of Maternity Services. An historical perspective of the Service Development Group (SDG) approach to health planning is presented together with information about the establishment of the SDG and review process. Nine objectives were proposed which were to: establish the reasons behind the Board's decision to review existing maternity services; describe what happened during the review period; describe the reasons for the Board's decision to use a SDG to review maternity services; assess the effectiveness of evaluation research techniques for this study; describe participants' attitudes toward the SDG; examine the interaction and co-operation between the various committees involved in the review; attempt to measure the amount of satisfaction with the SDG exercise as perceived by participants; draw conclusions about the value of the SDG and make recommendations for future Service Development Group exercises.

Three major research techniques were used. Analysis of archival data gave an historical perspective of the Board and its maternity services, while questionnaires were used to gather information from the three groups involved in the study an: 11 member Service Development Group, the 6 member Board's Steering Committee, and several committee members of each of the 7 SDG nominating organisations. Interviews with the SDG and the Board's Steering Committee members provided in-depth qualitative information. One questionnaire was administered to SDG members after pre-testing. It was then adapted for use with the Board's Steering Committee and committee members of the SDG nominating organisations. The research was sequential with preliminary data analysis being completed before interviews were conducted with SDG and Steering committee members. There were no refusals for interviews or questionnaires. Data analysis consisted of descriptive statistics and qualitative interpretation which highlighted the emergence of global trends and allowed comparison between groups.

Nine themes emerged from the questionnaire and interview data. The SDG approach was positively supported as was the combination of professional and community representation in health services reviews. Full discussion and agreement on terms of reference for any SDG should involve all participants. Other findings concerned the members' role as nominated representatives, support for the SDG's work and its ability to effect change, and concern with the methods of the general administration of the SDG. Issues concerning group size and parochial interests of individuals and groups were elaborated as were the SDG's feelings toward the power of the Board's Steering Committee. An awareness of cultural issues surfaced as a result of the SDG's work.

Advantages of the participant role of the researcher and benefits of in-depth qualitative analysis are discussed. There is a critical appraisal of the methodology and directions for future research are discussed. Major recommendations arising from the research were that the SDG approach is a worthwhile method for health services reviews, that all potential SDG members should be appointed before commencement of meetings, and that skilled public relations and communications programmes should be used. Terms of reference require careful consideration, SDG membership should be limited to preferably less than 11 people, a key person is required to act as facilitator, and an awareness of cultural issues is necessary. It was concluded that evaluation research techniques were useful and successful when employed to monitor and assess the SDG process.

A prescriptive model for service development groups is proposed in the final chapter. The model presented would be aplicable to any SDG involved in a service planning task. It is a model for planning, implementing, monitoring and evaluating the impact of the service development group. Consideration is given to the way that diverse cultural and social viewpoints can be accommodated in the deliberations of SDG's. The overall objective of the model presented is participatory democracy atempted through community involvement in planning.

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CHAPTER 1

HISTORICAL PERSPECTIVE OF THE SERVICE DEVELOPMENT GROUP APPROACH TO HEALTH PLANNING

A Service Development Group (SDG) approach was used by the Waikato Hospital Board to assist with a review of maternity services. This study uses evaluation research techniques in an attempt to understand the processes which occurred.

Library and computer (Australian Medline Network and Dialog) searches were made to locate information about the use of service development group techniques in New Zealand and internationally. Few examples parallel to the New Zealand experience were found. Those with relevance to the present study are described toward the end of this chapter. Reasons for the Waikato Hospital Board's review of maternity services will be given in Chapter Two. An explanation of health reviews which have used the service development group approach is presented in this chapter. Recent events which formed the background to the approach for the Waikato Hospital Board's review of maternity services are elaborated.

REORGANISATION OF HEALTH SERVICES IN NEW ZEALAND

For over one hundred years there have been discussions about the reorganisation of health services in New Zealand. There have been commissions, inquiries, reports and papers as well as the occasional reorganisation, which in turn have led to yet another round of reports inquiries and papers (Editorial, New Zealand Hospital Journal, 1976). Similar structural approaches are reported as occurring in Britain, Australia and Canada (Anderson, 1975; Brunton, 1984; England, 1978; Foskett, 1980; Malcolm, 1976, 1981; Smith & Tatchell, 1979; Tydeman & Mitchell, 1978).

One of the major attempts to reorganise health services in New Zealand was the White Paper A Health Service for New Zealand, produced by the Labour Government in 1974. As part of the introduction to the White Paper on the reorganisation of health services the Minister of Health, Hon. T M McGuigan stated:

> "In the past 25 years there has been a vast change in medical technology. Sophisticated methods of diagnosis and treatment have replaced the simple method of the 1930's. The age of the general practitioner who did a modicum of surgery and obstetrics, often in his [sic] surgery or in the patient's home,

> has passed. The isolation of settlements in the past led to a widespread dispersal of health services and facilities. Because of modern transport services and communications networks, most skilled activities can now be concentrated in hospitals, where they can be carried out largely by specialists, in conditions designed to provide greatest safety for the patient. Highly specialised techniques and equipment require highly skilled staff and efficient use of resources. Much of advanced modern medical technology must be located in regional centres to ensure economic usage of skilled staff. Care, however, cannot begin and end at the door of the hospital, but must provide for people in the environment in which they live and work. The community orientation of health services demands a community based service". (A Health Service for New Zealand, 1974, p 7-8).

Health, in reality hospital planning and development prior to the introduction of the White Paper, was determined primarily in terms of beds. The need for which was determined by "loose" demographic projections, patient/nurse dependency studies, and hospital board capital development plans. Hospital boards and their officers had considerable experience in design planning, yet very few gave thought to rational service planning (Brunton, 1984).

SERVICE DEVELOPMENT GROUPS

The "White Paper", as it became popularly known, was modelled on the National Health Service approach in Great Britain. It proposed the establishment of fourteen regional health authorities in New Zealand by 1 April 1978. The proposals and public submissions on them were considered by the Legal and Administrative Consultative Group (1976), who recommended that service development groups, representing each clinical and front line service, be the foundation unit of organisation and planning under the proposed new regional health authorities. Service development groups were to include people of each discipline and agency connected to the service. A further recommendation was that the service development group concept should be tested in "pilot" or trial situations.

Conceptually, the term "pilot" meant that groups of people with a common health service interest would be brought together to discuss issues relevant to that specific health service area (Malcolm, 1981). The service development group approach emerged from the attempts to improve health service through administrative reform. Those attempts were prompted by such problems as inequalities in the distribution of care and resources, the imbalance between institutional and community care and between curative and preventative care, increasing costs, fragmented services and the absence of planning mechanisms or suitable organisational structure (Barnett, Malcolm, Rayner, Smith & Wright, 1984).

In 1977 a Special Advisory Committee on Health Services Organisation (SACHSO) which was set up by the government developed the idea of service development groups. These were seen by SACHSO as offering a number of advantages:

1. They would provide a link between a planning authority and the workforce in each service.
2. They would develop co-ordinated service plans through having representatives of the public, private and voluntary sectors serving on them.
3. They would become innovators by encouraging new health-promotion strategies in the light of changing techniques.
4. They would assist in the allocation of resources by highlighting the claims and priorities of particular services, and promoting responsible approaches to cost control and use.

Service development groups were to identify local health needs and problems, establish plans for the future (both immediate and long term), propose strategies for achieving those plans, and monitor subsequent developments (Legal and Administrative Consultative Group, 1976).

Service development groups appeared to have the potential to give detailed consideration of the type of services needed by communities, thus differing from the traditional methods of hospital planning, which had revolved around the "number of beds" required as the major determining factor. In the traditional approach, community needs,

demographic trends, changing requirements (for example styles of child birth, out patient care, health education, prevention of disease) were often not given thorough consideration (Brunton, 1984).

THE NEED FOR PILOT SCHEMES

One influence which contributed to a broader health planning perspective was the publication of comparative data which suggested that in international terms New Zealand was generously provided with hospital beds (A Health Service for New Zealand, 1974; Brunton, 1984; Legal and Administrative Consultative Group, 1976). SACHSO followed a consultative approach and proposed that "service" planning be tested by "Shadow Service Development Groups" in pilot schemes in Northland and Wellington. In both areas, especially in Northland, observers (Malcolm 1982; Wright, 1980) stated that the proposals were received with apprehension, even hostility because the public believed health services would be reduced. Despite that, the service development group concept appeared to gain credibility (Brunton, 1984; Malcolm, 1982).

One of the main features of the pilot schemes was the minimal initiating structure - advisory committees with no authority or funding with an instruction from SACHSO to try the service development group concept. They were consultative bodies which seemed to succeed because of the democratic participative approach (Malcolm 1982; Wright, 1980). The apparently successful outcome of the two pilot schemes was because it was believed that they conformed very closely to sound planning and organisational theory (Wright, 1980). The service development group approach is an arena in which varied perspectives about a particular service can be co-ordinated and channelled toward common objectives.

SACHSO produced a discussion document, Proposed Northland Pilot Scheme in 1977. To test the proposals put forward in the discussion document SACHSO decided to establish two pilot schemes, one in a rural area, the other in an urban area. Northland and Wellington were chosen. The Northland Health Services Advisory Committee was established in 1978; the Wellington Health Services Advisory Committee commenced its task in May 1979 (Northland Health Services Advisory Committee, 1981; Wellington Health Services Advisory Committee, 1981; Wright, 1980).

In Northland, the Health Services Advisory Committee established "shadow" pilot service development groups. These groups were to develop procedures and to identify and assemble the data necessary for service planning. They were to be accountable to the Northland Health Service Committee (which was in turn accountable to the Minister of Health) which co-ordinated their work.

"Shadow" service development groups were established in Northland for: Health of the Elderly; Primary Health Care; Mental Health; Dental Health; Public Health and Environmental Protection; Specialist and Hospital Services. Each group developed independent terms of reference and produced individual reports. Unfamiliar concepts had to be explored. Service planning was new and most groups had to define this service and its boundaries. The exercise proved to be of great value in crystallizing policy in various areas of health study in Northland and enabled health workers to define areas of need and explore practical avenues of solution.

Another of the concerns was the potential for the formation of a Northland Area Health Board. It was envisaged that the shadow service development groups would form the nucleus of definitive service development groups to serve the Board if an Area Health Board was formed (Shadow Service Development Groups. Reports to the Northland Health Services Advisory Committee, June 1981). On 1 September 1985, Northland became an Area Health Board under the terms of the Area Health Boards 1983 Act.

The Wellington Health Services Advisory Committee commenced its task in May 1979. Like the Northland counterpart the terms of reference were to test the propositions put forward by SACHSO. One of the terms of reference for the Wellington Health Services Advisory Committee was to:

> "initiate the establishment of Service Development Groups to develop the procedures and information for service planning" (Wellington Health Services Advisory Committee Appendix 1981, p. 21).

Shadow service development groups were established in May 1979 by the Wellington Health Services Advisory Committee in five areas: Primary Health Care, Dental Health, Health of the Elderly, Mental Health, Public Health and Environmental Protection. All of these groups formed individual terms of reference but the reports were published collectively (Shadow Service Development Groups. Reports to the Wellington Health Services Advisory Committee, 1981). The selection by SACHSO of a large metropolitan area such as Wellington showed an awareness that approaches to designing health services appropriate for that area might be different to those required by a rural community (Northland). The groups also considered the future formation of an Area Health Board in Wellington, although that has still to happen.

SERVICE PLANNING

Other examples of service planning occurred in the Nelson and Hawke's Bay Hospital Boards. In 1977 the Nelson Hospital Board proposed a Service Planning and Review Committee to bring forward proposals on objectives and future strategies of the Board's services. This committee was charged with establishing multi-disciplinary inter-agency service advisory groups to advise it on topics such as geriatrics, medicine, child and maternal health, ambulance services, mental health and community medicine (Wright, 1980). The service advisory groups met irregularly. There were no terms of reference or clear direction. Lack of reliable information and adequate data were reasons given for the eventual failure of the advisory groups.

When the Nelson Hospital Board Service Planning and Review Committee reviewed the situation in 1980 it agreed that the service planning concept was still valid and recommended that two new service advisory groups be established. These were Community Accident and Emergency and Community Services for the Disabled and were based on the assumption that there would ultimately be an area health board in Nelson (Wright, 1980). Nelson Hospital Board and Health District formed into an Area Health Board in October 1985. There appear to be no further published reports of the Nelson Service Planning and Review Committee (personal communication, Pauline Barnett, Department of Health Consultant to the Nelson Area Health Board, 4 November 1985).

Service advisory groups were established by the Hawke's Bay Hospital Board Service Advisory Groups for two reasons:

1. Difficulties were being experienced in the Board's psychiatric unit so a Psychiatric Service Management Group was established in 1977;
2. In 1977 the new Medical Superintendent-in-Chief suggested the establishment of service advisory groups which would reflect the service development group concept as put forward by SACHSO. Groups were established for mental health; geriatric; child health and obstetric services. Group members were approved by the Board.

Support staff for the Hawke's Bay Advisory groups was provided by university students and Temporary Employment Project workers. Hawke's Bay service advisory groups did not prepare publications but conducted workshops and seminars. Group reports were presented to the Hospital Board meeting (Wright, 1980). Information presented by Wright (1980) about Nelson and Hawke's Bay was obtained during interviews and discussions with staff and committee members associated with each programme.

Another branch of service development activity occurred in the Christchurch-North area of the Canterbury Hospital Board. Public health expenditure in this area in 1979/80 was more than $140 million, and services were provided by more than six hundred and fifty autonomous agencies, groups and individuals. Co-ordination of all these services was a major motivating factor leading to the establishment of service development groups. The process differed from the SACHSO model of service planning where a service development group was central to the planning process. In the Christchurch-North Canterbury area the focus was on the overall development of a service in which service development groups were important but not necessarily the dominant or even the principal contributors (Barnett et al. 1984; Wright, 1980).

In Christchurch a service approach to health planning was evident from the early 1970's (Wright, 1980). Initially service development groups in Canterbury were restricted to hospital board personnel, but gradually membership was expanded to include the private sector and representatives of relevant professional disciplines. Some attempt to

evaluate the process of the work of four service development groups (Community Mental Health Planning; the Establishment of a Geriatric Co-ordinating Centre; The Establishment of a Primary Health Care Unit; and planning for Alcohol Detoxification Services) was made using case studies, interviews and questionnaires. A number of recurrent themes emerged from the data collected. These were the importance of well developed communications networks; the attitudes of agencies involved; the impact of national policies; the availability of resources, particularly personnel and finance; the provision of adequate back-up; the commitment to a service planning approach; the frustration associated with lack of implementation of recommendations, and the need for an overall planning structure. It appeared that there was some commitment to the concept, and service planning was viewed as a viable approach which required a defined organisation structure and an unbiased overview body to receive, consider and implement recommendations where appropriate (Barnett et al. 1984).

Malcolm (1981) stated that the service development group approach implemented in Northland, Wellington and Christchurch seemed to be offering a definitive strategy for the solution of health planning problems. It was an innovation of international significance as it had shown that a democratic participative model could work and lead to a desire for change arising out of a network process.

INTERNATIONAL PERSPECTIVES

Some examples of similar types of health services research and planning are worthy of mention in the present study. The countries involved are Canada. Scotland, Britain, Venezuela and Australia. Of these the only example with direct relevance is the Illawarra Health Board in Australia. New Zealand borrowed some of the major concepts from Great Britain and slowly developed its own style. Australia duplicated the Northland Area Health Board scheme in the Illawarra.

Canada. Canada. as a whole. and its federated provinces have enacted major social legislation to improve the health and well-being of its citizens. A planning process which involved research and evaluative systems was used to assist provincial and federal decision makers to select the most appropriate options. A medical care data base was used

to help identify apparent needs and gaps. It was proposed that there should be a regular national health survey, the development of health status indicators, the identification of high risk segments of the population, better use of national data banks, and a research emphasis upon diseases of national concern and population life style (Anderson, 1975).

Scotland. In Scotland health services reorganisation involved a concept of planning under the umbrella of the National Health Service (NHS), Scotland. The Scottish Health Service Planning Council was developed. It provided a unique forum where representatives of the Health Department, Universities, Health Boards and National Consultative Committees met together to discuss and advise on future development of the NHS in Scotland. As well, policy and programme planning working groups (geriatrics and mentally handicapped) and specialist and support services working groups were set up. The former were concerned with advising on the development of professional skills and the latter on the provision of basic facilities and resources in ways which would meet the needs of different client groups. Concern was for health outcomes and community involvement in health care (Hunter, 1975).

Britain. The National Health Service in Britain was reorganised in 1982 and uncertainty still exists about the way some of the new management arrangements are working (Barnett, 1983). New District Health Authorities have been established and Management Advisory Service trials undertaken. In particular, the Management Advisory Service (MAS) in the Oxford/South Western Region was concerned with the organisation of clinical services as well as the management of institutions and overall management performance. The MAS was financed by the Department of Health and Social Security. It was independent of regional and district management but responsible to a supervisory board which had membership drawn from members of the regional and district health authorities of Oxford and the South Western regions including an independent member.

An illustration of the work undertaken was presented in the first four studies by MAS. These were:

1. Review of Management of Waiting Lists,
2. Review of Utilisation of Trauma and Orthopaedic Services,
3. Examination of the Capital Planning System,
4. Examination of the Allocation of Units of Medical Time (Barnett, 1983).

Community involvement (as demonstrated in the service development group approach) was not so apparent in the MAS trials. Barnett (1983) noted that because MAS was outside the normal channels and lines of accountability the MAS role was to persuade and change attitudes of local authorities and clients to ensure acceptance of new ideas and policies.

Venezuela. A reorganisation of the health care system was undertaken in Caracas Barrio (Rakowski & Kastner, 1985). Decentralisation and simplification of the bureaucratic process was the major aim. More authority was delegated to the local level in order to speed up the bureaucratic process to achieve regionalisation of the health care system. The plan was clearcut on paper, yet the transition to regionalisation appeared to be incomplete and generated some new bureaucratic obstacles. In complete contrast to the situation in New Zealand, one of the problems encountered in Venezuela was the practice of sending women to the central maternity hospital which was so overcrowded that women were assigned two to a bed. Women claimed to have received inadequate care at district maternity hospitals and requested referral to the overcrowded central maternity hospital for treatment and delivery. Regionalisation enabled the question of the women's needs to be approached. Professionals defined the issues and the strategies to follow. Although information was made public through newspapers, radios and television a great deal of confusion still exists regarding lines of authority and responsibility (Rakowski & Kastner, 1985).

Australia. In New South Wales, the Illawarra Health Service was established in December 1985. The Illawarra region comprised 250,000 people in three local government areas and contains the major city of Wollongong. It is largely a coal mining and steel producing district. The Illawarra District selected and followed the model advocated by the Northland Advisory Committee in New Zealand for the operation of an

Area Health Board. A structure characterised by service directors, service development groups and a high level of community participation has evolved. Community members, both lay and professional, are represented on service development groups and community advisory Councils. Overall, the Northland Model has been readily applicable to this multi-cultural, multi-lingual coastal community. An advisory officer for the community health section of the Northland Area Health Board visited the Illawarra Area Health Board in 1985 to see how the Australian version was operating two years after its inception. Snelgar (1985) reported that the Board had experienced some anxiety which resulted from different groups being amalgamated with the curative hospital service at one end of the scale and the preventive health programme of the Department of Health at the other. This was an issue which was common to Northland as well but for both areas the main objective was continuing health care. It was believed that the setting up of service development groups would be the mechanism to overcome anxiety and change attitudes. The success of service development groups depended on administrative planning and research support to carry out the preparation required between meetings. Another impressive feature was the amount of money and resources set aside for evaluating the success of the programmes. Snelgar (1985) stated that in New Zealand evaluations are done if there was any money left over but in Australia money was set aside for programme evaluation. Similar "pilot" studies are underway in three other areas in New South Wales. One is in the heavy growth areas to the south west of Sydney, one in the Blue Mountains to the west of Sydney, and the other on the far north coast (Brennan, 1985).

To summarise international findings some aspects of the New Zealand experience can be seen in the examples from Scotland and Britain although the situation is not really resolved in those countries. Canada's example presents a broad spectrum approach to health service planning. Problems with maternity services in Venezuela were outlined to contrast with the situation existing for the Waikato Hospital Board. Australia provides the most similar model with the service development group approach of the Illawarra Health Service's reorganisation.

Rigid insistence on a service development group approach may not always be the most suitable strategy for all health care/problem areas. In

the Waikato area, for a sensitive topic such as maternity services, it seemed appropriate as it allowed private, public and voluntary agencies to have input. Parents Centre, National Council of Women, Maori Women's Welfare League and Plunket Society representatives could contribute equally with midwives, medical specialists, a general practitioner and Health Department nominees. The plan prepared drew on combined, yet varied knowledge and experience of maternity services in the Waikato area, thus emphasising the difference between the expert top-down method and the democratic-participative approach. The service development group process is a way of finding solutions to existing problems affecting health services. It allows good communication, effective co-ordination, understanding of community needs and the organisational responses to these. Chapter Two describes the Waikato Hospital Board's area and the development of the maternity services review which used a service development group approach to assist with trying to solve a health services planning difficulty.

CHAPTER 2

WAIKATO HOSPITAL BOARD'S REVIEW OF MATERNITY SERVICES

In Chapter Two a general description of the Waikato Hospital Board district, geographic and demographic features, plus reasons for the Board's review of maternity services are given. The service development perspective on health planning is outlined in detail, using the example of the Waikato Hospital Board's Review of Maternity Services.

THE WAIKATO HOSPITAL BOARD

The Waikato Hospital Board serves a geographic area ranging from Mercer in the North Island of New Zealand to Taupo County (see Map 1 P 223). It extends from the West Coast to the Kaimai Ranges and Rotorua District in the east and is dissected by the Waikato River from Port Waikato to Lake Taupo. The area covers one-eleventh of the area of New Zealand and contains one-tenth of the population, 336.143 in 1986 (Waikato Hospital Board, 1985-1986 Annual Report). The Board is one of the largest in terms of both area and population and covers a diverse range of physical and cultural features. It includes the densely settled farmlands of the Waikato, the sparsely populated and rugged areas of the King Country and the exotic forest plantations of the Volcanic Plateau. The Board's area incorporates twenty local authorities (six counties, three districts, ten boroughs and Hamilton City). All of the Waikato United Council and parts of the Tongariro, Thames Valley United Council and Bay of Plenty United Councils are also included.

Hamilton City with a population of 103,800 (1985 estimate. Government Statistician, personal communication, 27 May 1985) is the largest urban area and is located in the densely settled Waikato. Rotorua in the south-east is the second largest urban area with a population of 62.000 (1985 estimate, Government Statistician, personal communication 27 May, 1985). Other main centres are Taupo and Tokoroa in the Volcanic Plateau area, and Te Kuiti in the Waitomo District. The road network is extensive in the Waikato area but is poor for most of the west coast and other areas, other than the main highways going south and east.

The Board's population is concentrated in the northern half of the Board's area with about fifty percent of the population living north of Cambridge and Te Awamutu. Only six percent of the Board's population lives in the Otorohanga and Waitomo Districts. Taupo County and Taupo Borough cover a large part of the Board's area but account for only nine percent of the population.

Twenty eight percent of the Board's population are found in Hamilton and fifteen percent in Rotorua with a further twenty six percent dwelling in the remaining townships. About thirty percent of the Board's population live in the rural areas of the counties and districts. For New Zealand as a whole, nine percent of the population are Maori but for the Waikato Hospital Board the figure is eighteen percent (Sceats & Pool, 1986). The Waikato Hospital Board administered fourteen maternity hospitals in 1985 (see Map 2 P 225). There are one hundred and five operating public maternity units in New Zealand and many of these are in rural areas (Rosenblatt, 1984).

Births

The total number of births occurring at the maternity hospitals in the Board's area has been steadily declining since the 1960's, but the number of births at Waikato Hospital has increased during that time. In 1963/1964 births at Waikato Hospital accounted for thirty percent of all births in the Board's area and this increased to forty-two percent in 1983/84, whereas births at most other maternity hospitals have decreased (Waikato Hospital Board, 1984). The change in the pattern of births in the hospitals over a period of twenty years is shown in Table 2.1.

Table 2.1
Number of Births in the Waikato Hospital Board's Maternity Hospitals

Region	1963/64	1973/74	1983/84
Waikato	1,875	2,563	2,748
Rotorua	1,196	1,409	1,289
Tokoroa	444	537	426
Cambridge	217	238	122
Huntly	412	295	113
Matamata	322	228	139
Morrinsville	267	163	131
Otorohanga	221	114	64
Putaruru	261	176	100
Taupo	357	275	166
Te Aroha*	187	119	78
Te Awamutu	443	313	194
Te Kuiti	334	263	199
Turangi	-	167	79

*Te Aroha Hospital was closed for almost two months February/March 1984.

Reasons for the decrease in births at district hospitals and increase at Waikato Hospital are: (a) there has been a rural exodus balanced by rapid growth in Hamilton (Sceats & Pool, 1986); (b) Obstetric Regulations (1975) set criteria which meant that some pregnant women were classified as being "at risk", in which case they were transferred to Waikato Hospital before the birth to allow the immediate access to specialist obstetric and resuscitation services. Even though the woman and infant may subsequently be transferred back to a district hospital, only the place at which the birth occurred is permitted to count the delivery, which is the measurement used for comparing work loads between hospitals. For example, a woman living in Turangi may receive all her antenatal care there, but may be transferred for obstetric reasons for delivery at Waikato Hospital (a "Level 3" obstetric hospital - see Appendix 1 for a description of the different levels of care provided in obstetric hospitals in New Zealand). Mother and baby would be returned to Turangi Hospital as soon as possible for postnatal care. Even so, Waikato Hospital would count the Turangi woman's delivery in Waikato Hospital's statistics.

In 1981 a seven-bed maternity hospital at Te Aroha (which falls within the Waikato Hospital Board's area) was forced to close because of a shortage of professional nursing staff, causing considerable public concern. The temporary closure led to a public meeting and a petition of 1,000 signatures against the closure of the unit. It was also closed for a short period during 1982, again because of nursing shortages. A subsequent application by the Waikato Hospital Board to close the maternity hospital on a permanent basis was not granted by the Minister of Health. Instead, a letter to the Board (22 June 1982, see Appendix 2) stated that the Minister was unable to make a decision on the Board's application to close the Te Aroha Hospital ward until he had an understanding of how Te Aroha "does or does not fit into the pattern of maternity services provided by the Board." In the same letter the Minister requested that the Board carry out a comprehensive study of its maternity services. It appears then that the closure of Te Aroha Hospital was the major reason for the review.

There were two other potential reasons for the review. It was known that the Board had 109 maternity beds above the guideline figures of 0.5 beds per 1,000 population (Department of Health, 1977). At the same

time, financial constraints were being imposed on the Board by the government which meant that any savings which could be effected by any means would assist with the overall budgetary management.

COMMUNITY INVOLVEMENT

Although there are no formal records, the Board's Administration Officer during that time recalled that members of the Board discussed fully the way in which the review should be undertaken (E. Penn, 1983, personal communication). One of the important aspects of these discussions was a decision that there should be community involvement in the review. The Administration Officer was asked to seek the advice of the Department of Health's Management Services Research Unit in Wellington to assist in writing an outline of a plan that could be followed for a review of maternity services. A visit to Wellington plus extensive reading enabled the Board's Officer to formulate a planning programme (E. Penn, 1983, personal communication).

At a Board meeting held on 13 September 1982, a draft plan document was reviewed. The planning document set out a method for a way that the maternity services review could be carried out. It was agreed that the Board should proceed with the proposed planning programme (Draft Obstetric Service Plan, Waikato Hospital Board Minutes, 13 September 1982, pages 540-547; see Appendix 3).

At a meeting held on 21 September 1982 (between representatives of the Board and representatives of the Waikato United Council - a co-ordinating body of local government which is a local authority and can exert some power over regional schemes), the Chief Executive of the Hospital Board stated that over the next five years a reduction of $6 million dollars would occur in the Board's maintenance grant. Such a reduction must affect the level of services that could be provided. It was also recorded that:

> "As a result of these factors and because the maternity services at some hospitals were under-utilised, the Board has agreed to proceed with an obstetric/maternity service plan. The brief did involve a reduction in present services which could be provided if a reduction of 10% or 15% were required" (Waikato Hospital Board Minutes, 11 October 1982, p. 43).

The Draft Obstetric Service Plan proposed that two committees be set up. The first was called the "Board's Steering Committee", which was to assist in the evaluation of objectives within financial restraints, maintenance and quality of services and existing policies. The Steering Committee's purpose was to advise and guide the Service Development Group (SDG). It had power over the Service Development Group and was to be made up by the Chairman of the Board, two Board members, the Medical Superintendent-in-Chief, the Chief Executive and the Chief Nurse. The second committee was to be called the "Service Development Group" and it was to be made up of representatives of providers and users of the service. An explanatory note stated that:

> "During the last decade in New Zealand, it has been realised that to plan health services effectively, there must be cognisance of all the inputs to the service within a structured planning approach. From this realisation has evolved the 'service planning' approach which has found particular application in the testing of the Wellington and Northland pilot schemes for health services reorganisation in those areas. It has also become an accepted planning practice for the North Canterbury, Tauranga, Auckland, Otago and Wellington Hospital Boards" (Waikato Hospital Board Minutes, September 1982, p. 544).

A definition of "service planning" was given as "planning by the providers", but the essence of service planning (Malcolm, 1981; Wright, 1980) is that provision is made for individuals and groups with an interest in a particular service to contribute to the process. A recent Health Services Development Draft Strategic Plan for the Wellington region provides a useful summary (Wellington Hospital Board, May 1985). Service development plans are seen to comprise: assessment of a Board's regional features and population profile, identification of factors which determine the need for health care services together with determination of the key problems and issues affecting the provision of health care. The current financial level of service provision, policies, objectives, priorities, long term strategies, plans for the development of individual services as well as short term operational plans are also included in service development plans.

The Waikato Hospital Board accepted the idea of involving "providers and users" of maternity services. A general objective was also agreed upon. The Service Development Group (SDG) should set objectives for a future maternity service based on the group's analysis of what an "ideal maternity service" should be. Suggestions for future strategies for the delivery of services throughout the Board's area were requested.

The SDG was set up in October 1982, with the following membership:

Chairman of Obstetrics and Gynaecology, Waikato Hospital Board
Director of New Born Unit, Waikato Hospital
A practising midwife from a district hospital
The Board's advisor on Obstetric Nursing Services
Research and Development Officer (Waikato Hospital Board employee)
Representative from:
- General Pracitioners
- Parents Centre
- Plunket
- National Council of Women
- Public Health Nurse
- A Board member (to be shared by the two members on the Steering Committee)
- Maori Women's Welfare League (appointed February 1983)

The representative from the general practitioners was to be a member of the Medical Association and the practising midwife appointment was made by the Chief Nurse in consultation with the relevant Nurses' Association special interest group.

DESCRIPTION OF THE POSITION OF THE RESEARCH AND DEVELOPMENT OFFICER

The present author applied successfully for the new position as Research and Development officer. The position was considered to be of a project nature of a finite period though it was included in the Board's permanent establishment, July 1984. The position description stated a summary of the principal duties:

(a) to institute an ongoing plan of action to study the nature and extent of services currently being provided by the Board;
(b) to collect, analyse and interpret data and information required for service planning using approved data collection techniques;
(c) to liaise with senior Board staff and other related organisations in investigating and studying development proposals;

(d) to prepare periodic reports as required on aspects of the planning and development of services for consideration by the Board's executive;
(e) to attend meetings of the Board or other committees convened for service planning purposes;
(f) to initiate action to prepare a maternity services and allied health services plan for the Waikato Hospital Board.

Overall, the Research and Development Officer, although listed in the SDG's membership, was also the administrator, facilitator and provider of information for the group. That role meant that some influence over the direction of the review was made possible through the type of information which was supplied. As well, the Research and Development Officer was responsible for supplying relevant demographic information and hospital statistics, drawing graphs, producing photographs, illustrations, maps and designing questionnaires. Two major reports were drafted for the Service Development Group and Board's Steering Committee. Later the Research and Development Officer was responsible for the final production and distribution of the reports, especially the Service Development Group Report (1983). Another duty was the production of a pamphlet which presented the substance of the report. This meant that as many people as possible had access to the information. A second report, the Waikato Hospital Board Review of Maternity Services - Maternity Service Plan, December 1984, represented the combined views of the Board's Steering Committee and the SDG and was published as a report of the Waikato Hospital Board.

The Waikato Hospital Board's review of maternity services had been in progress for three years at the time the present study was conducted. The Research and Development Officer was involved with all facets of the review so that all the background reporting involved in this thesis was based on participant involvement.

DESCRIPTION OF THE WORK OF THE SERVICE DEVELOPMENT GROUP

The first meeting of the SDG was held in October 1982, the second in November 1982. At these two meetings the SDG arrived at the following objectives for the "Review of Maternity Services."

Objectives of the Service Development Group

1. Definition of an "ideal maternity service."
2. To identify, collect, receive, assemble and evaluate the data required for planning a co-ordinated maternity service over the Board's area.
3. To review present services and prepare a plan within twelve months which will include philosophies, strategies and future programmes for maternity services which -
   - will provide an adequate level of service to people of the Waikato Hospital Board area,
   - reduce present expenditure by 5%,
   - indicate the effects of the 5%, 10% and 15% reduction in expenditure.
4. To identify hospitals where closure appears to be justified and/or alternative functions can be undertaken without significant physical alterations (Service Development Group Report, 1983, p. 4).

The Board accepted the SDG's objectives and added the following terms of reference, which were financially based and service orientated: (a) the group was asked to produce a service plan which would produce five, ten or fifteen percent reductions on the expenditure on maternity service, which was $11.9 million as at 1 April 1982; (b) identification of a particular hospital where functions in addition to the present maternity service might be undertaken; (c) the possible closure of a maternity hospital; (d) the possibility of the transfer of the management of a particular maternity hospital in whole or in part to an alternative group (Waikato Hospital Board Minute Book, 12 December, 1982).

The SDG decided that, as a first task, a definition of an "ideal maternity service" should be made, after which there should be an examination of what the Board actually provided. A statement which outlined an "Ideal Maternity Service" was devised and minuted in December 1982. The basic premise was that:

> "An "Ideal Maternity Service" provides facilities which minimise the risk to mother and baby antenatally, during and following delivery, and provides for the care of the mother and newborn infant in such a way as to enhance family relationships. The

Service Development Group's view is that this service will usually be provided in hospitals - organised on a regional basis" (Service Development Group Report, September 1983, p. 8. See also Appendix 4 for the total definition).

The next phase of the review was for the members of the SDG to visit each of the Board's fourteen maternity hospitals. During 1974-75 the Maternity Services Committee of the Board of Health had reviewed all maternity hospitals in New Zealand. These had been inspected "in company with the sister in charge and the route followed was that which would be taken by a mother in labour" (Board of Health Report Series: No 26, 1976 p. 6). The Board's Research and Development Officer suggested that a similar approach should be adopted for the SDG's visits to the maternity hospitals. The idea of a standardised approach was accepted, which meant that an attempt was made to give all places and clinical areas equal attention. Background information (Board of Health Report Series: No 26, 1976; Driscoll, 1982; Oakley, 1980; Ward, Forster & Lee, 1981) indicated that points which the SDG should evaluate were matters such as: standards of care; antenatal, delivery, postnatal and resuscitation facilities; staff availability; environment; state of buildings, access to transport (public, private and ambulance), alternative commmunity or professional uses for the hospital, effect of the loss of a maternity hospital on a town and loss of other amenities as a result of possible closure. A check list was compiled to provide a framework for comparative analysis and overall evaluation (see Appendix 5). As the SDG's work proceeded, the check list expanded as other important areas were highlighted and added (Board of Health Report Series: No 26, 1976; Minutes of a meeting of the Service Development Group held 30 November 1982; Service Development Group Report, September 1983).

As the SDG's visits proceeded, members of the various organisations and professions brought a range of views to the assessment. Nominees were able to discuss relevant areas of concern with health professionals not usually easily accessible to them. Health professionals from each area visited were able to meet the members of the SDG and express a "local" viewpoint.

Visits to the fourteen hospitals took place between December 1982 and April 1983. Sometimes two or three places were seen on the same day. Preparation of the visits included prior correspondence with the staff at the hospitals and invitations to the local medical practitioners to meet with the members of the review party, to facilitate discussion of local viewpoints. On the day of the visit the group held a short meeting at which they discussed what had been observed. Community organisation representatives seemed to take special note of the adequacy of antenatal and parent education procedures and facilities. Nurse members were particularly aware of nursing practice and attitudes. One medical practitioner was interested in architectural features (safety of stairs, access to buildings, work-flow patterns) and another medical doctor noted "family-oriented atmospheres" when they occurred. These points were recorded, providing a source of information when later consultation took place (Minutes of the Service Development Group 1982, 1983).

When the visits were completed, the SDG settled into a pattern of regular meetings in order to produce a report within twelve months, as the terms of reference had stated. Twenty-five full meetings of the group and numerous sub-committee meetings were held between October 1982 and September 1983. It was agreed that the report would be published as a discussion document (Service Development Group Report, September, 1983).

After it was made public, the report attracted media attention (newspapers, radio and television), with emphasis on the recommendations which named five hospitals for possible closure. To ensure wide distribution of the report's recommendations, a pamphlet was produced to help inform those who did not have a full document available to them. The pamphlets were widely distributed to libraries, county offices, hospitals and organisations.

All interested people were invited to offer submissions about the recommendations of the report. Seventy-five submissions were received and four petitions (with 19, 17, 20 and 3,500 signatures) which were all against the SDG's recommendations. There were only two submissions which lent support to the recommendations of the report.

As well as defining "An Ideal Service", touring the hospitals, discussions and production of a report, the SDG was involved in a study entitled Survey of Womens' Attitudes to a Level 3 Hospital (Driscoll & Brockelsby, 1983). This study was conducted under the auspices of the SDG, and gained information concerning the "perception of care" from women who had been transferred for "at risk" obstetric reasons to Waikato Hospital. A structured questionnaire was administered to 130 women aged between 14 and 39. The results indicated that nearly all the women were happy with the care they had received during pregnancy, delivery and postnatally. Some methodological difficulties were experienced when designing the research and the subsequent analysis. The Research and Development Officer drafted the questionnaire, and the SDG examined it prior to administration. Questions about socio-economic status and religion were deleted by the SDG because some members disapproved of asking such questions. This meant that some information for analysis was lost. This illustrates some of the difficulties of conducting scientific research which required the agreement of such a varied committee. Other background research which has been conducted because of the review of maternity services includes: Time/Travel Analysis for Maternity Hospitals in the Waikato Hospital Board (Driscoll, Brockelsby, Coutts & Kirkland-Smith, 1984); Patterns of use of the Delivery Suite Area at Waikato Women's Hospital (Driscoll, 1984); General Practitioner Data-Analysis of the Number of Deliveries Conducted by each General Practitioner in the Waikato Hospital Board's Area (Addendum to the Report of the Waikato Hospital Board, 1985); Demographic Profile of the Waikato Hospital Board (Brockelsby, 1985); and compilation of newspaper clippings about the review of maternity services.

At the end of 1983 the SDG was invited to take part in a series of public workshops attended by the Board members and the Steering Committee. These began in May 1984, centering on the SDG's recommendations. The meetings were a continuation of the public relations exercise. Further information was collected and collated at the workshop meetings, some of which attracted as many as five hundred participants. Completion of the public meetings marked the stage in the review when the SDG held a meeting (10 October 1984) with the Board's Steering Committee at which both committees were able to express views concerning the exercise.

This overview of the SDG and the work it did for the Waikato Hospital Board, attempts to describe an exercise which involved private and public sector interests in health planning. The exercise was concerned with maternity services, but the model could be used for any specialty health service. The Board's review of maternity services was designed and initiated without any documented evidence that evaluation procedures were considered necessary. Evaluation research techniques were appropriate for the present study as they assisted with analysis and clarified aspects of the review. Aspects of evaluation research methods will be discussed in Chapter Three.

C H A P T E R 3

E V A L U A T I O N R E S E A R C H

The service development group process has been promoted as a way of finding solutions to existing problems affecting health services, since the process can provide good communication, effective co-ordination and understanding of community needs (Barnett, Malcolm, Rayner, Smith & Wright, 1984; Malcolm, 1981; Snelgar, 1985). Service development group approaches are written into New Zealand legislation (Area Health Boards Act, 1983), so evaluation of the process has become an important issue on a national basis. The Area Health Boards Act (1983), came into force on the 1st day of April 1984. The functions of an area health board are generally to promote and protect the health of the residents of its district, and, towards that end, to consult and co-operate with individuals and organisations including voluntary agencies, Departments of State and territorial authorities concerned with the promotion and maintenance of health. Part II of the Act, (sections 29 and 30), describes service development groups and their functioning within area health boards. The Act directs area health boards to appoint (from time to time) sufficient service development groups, consisting of two or more persons, to advise the board in accordance with policy directions on the full range of health services in the public, private and voluntary sectors within its district.

Evaluation research methods, because of the versatility of approach and combination of quantitative and qualitative research techniques, were identified for this research as the most appropriate to find "what really happened" or "what was going on" underneath and surrounding the "public profile" of the Waikato Hospital Board's formal review of maternity services. Early evaluation research relied heavily on quantitative methods (Bernstein, 1976; Freeman & Sherwood, 1977; Riecken & Boruch, 1974); however qualitative research methods have now become important (Cameron, 1980; Robinson, R., 1984; Thomas, 1983). Some of these studies are referred to in later discussion. For the present project it was decided that a combination of quantitative and qualitative data could prove worthwhile. Time spent in the setting before the study was commenced allowed a thorough understanding of the context in which this research project was initiated.

The topic revolves around the Waikato Hospital Board's review of maternity services. The Service Development Group (SDG) and the Board's

Steering Committee undertook that exercise. Although the present research shares the same topic it is an evaluation of the review process itself, rather than a review of maternity services. It was anticipated that findings from this research would be helpful to hospital boards setting up service development groups or to those making the change to Area Health Boards.

Most of the literature reviewed is from North American studies; however, examples from New Zealand evaluation studies have been used. Raeburn and Seymour (1979) described the organisation of a comprehensive community development project which managed to avoid political pressures. Thomas (1982; 1983) examined theories of evaluation research and also helped supervise studies by Garnham (1983) and Snelgrove (1983). Garnham (1983) reviewed a service programme dealing with child abuse, while Snelgrove (1983) evaluated social services concerned with children and families. These studies will be discussed to illustrate some of the aspects of evaluation research as applied in New Zealand.

HISTORICAL BACKGROUND/DEVELOPMENT OF EVALUATION RESEARCH

Evaluation research has developed into an independent field of enquiry during the last twenty years. Most of the development has occurred in the USA (Levine, 1981; Robinson, R., 1984). Publicly funded projects drew attention and there have been demands for assessments/evaluations of programmes which used large amounts of public money. Examples of such programmes are (1) a study of the effectiveness of capital punishment as a deterrent to crime (the White report; Robinson, R., 1984) and (2) an investigation of the effects of early childhood training on the intellectual, cognitive and emotional development of disadvantaged children (the Westinghouse Head Start programme; Robinson, R., 1984). Government projects centering on such sensitive topics increased the public's interest in the evaluation studies. A demand for public accountability was fuelled by a lack of substantial results from the early evaluation studies. The problem appeared to be that evaluation researchers were rarely able to conclude that a programme had had even modest success in achieving its major goals (Mullen & Dumpson, 1976; Robinson, R., 1984).

Nevertheless, evaluation research has survived as a worthwhile activity, becoming a component part of public programmes. It was estimated that the U.S.A. government spending on evaluation had reached the billion dollar mark by 1976 (Rossi, 1979). Other western countries such as Canada, France, the United Kingdom, West Germany and Sweden have shown similar patterns of development (Levine, 1981).

Academic backgrounds of evaluators include education, psychology, sociology, medicine, statistics, anthropology, politics, law and science. Merging of different perspectives and methodologies has meant new approaches to the problems raised by evaluation could be developed (Robinson, R., 1984). These approaches will be discussed later.

Programme evaluation has been promoted as a way to provide the methodologies and information needed to help implement reforms in public administration; however, judicious use of scarce funds and human resources was advocated as interest in evaluation studies increased (Rutman, 1980). A variety of approaches has emerged which includes programme planning, budgeting systems, zero-based budgeting, management by objectives and cost benefit analysis. Such technical tools and procedures are expected to make the budgeting, planning and management process more rational.

ASPECTS OF EVALUATION RESEARCH

Technical, political and social activities contribute to evaluation research. Each of these aspects will be discussed separately.

Technical Aspects of Evaluation Research

Evaluation research requires an understanding of the programme requiring assessment, and decisions about the most suitable research techniques to use. A study of interest in the present context and which offered guidance for some of the technical aspects of the present study was the National Medical Care Expenditure Survey (NMCES; Berk, Wilensky & Cohen, 1984). While the NMCES study was conducted on a large scale compared to New Zealand research, it was a useful precedent and aspects provided a model for the present study. The NMCES study was designed to provide a comprehensive profile of how health services are used and paid for in the U.S.A.

Described as one of the most ambitious data collection efforts ever conducted by a government health agency, the survey employed a series of methodological procedures. Data was obtained in three stages. The first was a household survey of 14,000 randomly selected households. For the next stage respondents received a computerised summary of the data obtained during the earlier household survey. Comment and feedback were requested about the survey summary. The third stage consisted of supplementary surveys which were conducted with physicians, personnel in health care facilities, and with employers and insurance companies responsible for their insurance coverage. The complex survey design employed in NMCES created an opportunity to examine the usefulness of a wide range of survey procedures. The series of procedures were expensive in terms of time and money; however, NMCES stated that they proved to be cost-effective and furthered the survey objectives. Additional surveys are in progress but so far the study has appeared to be more useful for the poor, the elderly, and those who have been in hospital, than it does for the rest of the population (Berk, et al. 1984). The NCMES study has been useful as a model allowing some guidelines for the present, less ambitious, study about a service development group process used to review health services.

Political Aspects of Evaluation Research

Evaluation is more than just a technical activity. It is also a political one. Research is designed to aid the process of policy formation, programme design and management which makes it a political activity (Rossi, Freeman & Wright, 1979). Political activity means that evaluations are conducted within contexts in which there are many interested parties with interest in the outcomes of the efforts. The major impetus for rational policy making and programme development has been political and pragmatic. Leadership in the evaluation research field has been given by politicians, planners and executives. It is the political atmosphere that makes it possible to conduct evaluations of ongoing social programmes (Rossi, et al. 1979). Outcomes of a political process may be viewed as balancing the viewpoints of the representatives of a variety of interested parties, with the outcome of an evaluation being merely one more argument on one side or another. Information from evaluation research can contribute to the political decision making process. Rossi et al. (1979) comment that to imagine that evaluators

have a special place in the political decision making process that amounts to a veto over decisions, would strip the decision makers of their prerogatives. It can be expected that evaluation outcomes will play the role of an expert witness on the degree of effectiveness of a programme.

Levine and Levine (1977) provided an unusual example of politics and evaluation which made use of archival data to illustrate issues of evaluation. It concerns the 1915 controversy over the introduction of the "Gary" educational system, which was introduced and promoted by the administration of Mayor Mitchel into two New York schools. The superintendent of the schools was resentful of the interference in his work and ordered an evaluative study of the Gary plan. An educational psychologist (B R Buckingham) was given the evaluation task, which he undertook using his own newly developed academic achievement tests to compare the two Gary organised schools with six schools organised on the "Ettinger" plan and eight traditionally organised schools. Buckingham's (1916) report criticised the proponents of the Gary system who had made premature statements about its superiority to the other forms of schooling.

As soon as Buckingham's report appeared so did the rebuttals, particularly a detailed critique by Howard W Nudd (1916), Executive Director of the Public Education Association (published in the New York Globe, The New York Times, School and Society and the Journal of Education). The president of the Board of Education, and the Superintendent of Schools, found it advantageous to cite Nudd's interpretation of the Buckingham report up to a year and a half later, while at the same time there was continued pressure from the mayor's office to extend the Gary plan throughout the New York schools and to make any increase in the education budget contingent on the wholesale adoption of the Gary system (Levine & Levine, 1977). An evaluation study may have some very general impacts on decision making by changing the grounds of political argument, but more realistically the results of evaluation will be but one of the elements in decision making (Rossi, et al. 1979).

Raeburn and Seymour (1979) described a simple model with general application to the planning and evaluation of community programmes. It was a systems approach emphasising wholeness and the interrelatedness of parts, which consisted of seven procedural steps: overview, need assessment, goal setting, resource organisation, action, reviews and outcome statements. Application of this systems model was used in "The Birkdale Project" (Raeburn & Seymour, 1977). Birkdale and Beachhaven are two adjoining suburban areas (with populations of mainly young families) located in Auckland, New Zealand. The project arose as a result of the concern of local school principals about growing social problems in the area and Raeburn and Seymour were invited to organise a programme to plan and evaluate a community project which would provide fresh directions. They decided to use the systems model and to let the nature of the needs articulated by the community determine what was done. The overall objective of the project was to promote the well being of the community of Birkdale and Beachhaven. To ensure that the project remained free of political pressures it was decided to obtain all money for projects by local fund raising efforts. Step two of the model had revealed a number of clear priorities, notably those relating to facilities or services for preschoolers, mothers at home during the day, school children, teenagers, elderly people and depressed and anxious people. From the needs thus identified goals were specified and handled by 17 specific projects (for example Birkdale Creche Project for preschoolers). Each project was evaluated by telephone interviews of a sample of project users. Results showed that 87% had "favourable" or "very favourable" attitudes towards the project as a whole. Local and central government started to take an increasing interest in the Birkdale Project and subsequently made substantial financial contributions toward its operation. Raeburn and Seymour (1977) appear to have adhered to a simple research model, used community resources and when the evaluation proved the model to be successful, attracted the interest and financial support of local and central government.

Both the "Gary" plan (Levine & Levine, 1977) and the "Birkdale" project (Raeburn & Seymour, 1977) illustrate the way in which evaluations can influence decision makers to support a project or influence distribution

of finance because of the contribution to the information base about a particular topic. Groups and individuals can affect the way in which evaluation results will be used by policy makers and individuals (Rawls, 1971, p 4).

The effectiveness of an organisation is often a sociopolitical question concerning individuals' needs and the amount of importance placed on satisfying demand (Pfeffer & Salancik, 1978). Sometimes evaluators can be of more service to administrators, patients or colleagues by conducting two politically influential studies on different programmes instead of only one "conclusive" study on one programme (Rutman, 1980). It may be necessary for the evaluator (especially in health evaluations) to use suggestive evidence as satisfying the immediate demand which may have become an important aspect of the evaluation. Scientific interests may argue that one study carried out thoroughly is more important than quick satisfaction of the needs of administrators. However, practical experience (Garnham, 1983; Snelgrove, 1983) can provide a common sense and careful approach in which both social justice and scientific interest are taken into account. Immediate feedback to the administrators involved may pave the way for further and ongoing evaluation research. This idea could be part of an overall strategy.

Consideration of the "personal" and "political" aspects of evaluation is a recurring theme in the literature (Dawson & D'amico, 1985; Finney & Moos, 1984; Patton, Grimes, Guthrie, French & Blyth, 1975). It has been predicted that programme sponsors, managers and staff will regard positive evaluations favourably and react with hostility to negative ones, as it will appear as if it was only their activities that were judged by the evaluation report (Rossi, et al. 1979). Anticipation of such reactions makes it possible to reduce or avoid the amount or intensity of conflict. Patton (1979) has emphasised the importance of taking account of the issues of conflict, power struggles and interpersonal animosities. Studies and reports which do not produce the results and answers which funding bodies have expected or anticipated, are often not published, labelled "Confidential", or conveniently forgotton about (J. Johnson, personal communication, September 1983). Negative responses, such as a reaction to setting up of evaluation procedures in organisations, have to be anticipated. Staff may feel

threatened because of their lack of knowledge of evaluation procedures and because of the fear of discovering that deficiencies in services will be revealed. Provision of feedback and reassurance can do much to reduce negative reactions, as was found by Snelgrove (1983) in her study of a children's trust in Hamilton, New Zealand.

Using evaluation findings to influence the decisions of politicians, administrators and funding agencies can be the source of another problem. It has been argued that evaluation studies should do more than pass or fail a programme. They should provide a rational basis for making decisions about that programme (Katz, 1978; Posavac & Carey, 1980; Suchman, 1967). That argument grew from dissatisfaction with the lack of utilisation of the results of evaluation studies. House (1977) described a particular instance in which evaluation results were not used:

> "The project staff claimed to know already everything we found out and to have addressed themselves to the problem ..... I got the impression that their idea of service consisted of us documenting to an outside audience (which we never reported to, except through them) their successes. When we continued to uncover what we thought was a balanced picture containing many problems (like all projects) they were unenthusiastic" (pp 98-99).

It has not always been possible to trace policy decisions to particular evaluation findings. Evaluation may be useful to policy makers, but not determine policy decisions. Utilisation of evaluation findings has been examined as a topic in its own right to try to understand the issues involved (Robinson, R., 1984). The issue of result utilisation as the basic purpose of evaluation emphasises the interface between politics and evaluation. It seems that decision making is synonymous with the allocation of money, position and authority (House, 1977). Robinson, R., (1984) believes:

> "The role of the evaluator is therefore necessarily political and evaluators have a duty to enter the political area and to ensure that this distribution of basic goods in society is

> "just" ..... The political factors in evaluation exemplify the need to see evaluation as intimately involved in relationships between people, many of whom hold different motives, interests and amounts of power" (pp 149-150).

Clearly the political aspects of evaluation research have been important and are involved in the present research. Two political issues relevant to the present study were (1) position and (2) authority. In New Zealand health services are administered in a hierarchical system with medical doctors given power through position, status and salary. The three groups questioned in this study all had medical doctors in their membership who were aware of the power and authority which their positions carried. Therefore it was important to design questionnaires which gave all participants the same opportunity to express viewpoints. A further dimension of evaluation research were the social aspects.

Social Aspects of Evaluation Research

Evaluation research has been described as "... research which attempts to assess the effectiveness of a service, program or organisation" (Thomas, 1983, p 2). Thomas describes the various models of evaluation which have been developed, stating that they have been influenced by the type of service being evaluated. It must be asked, however, is it the service, programme or organisation being evaluated or the people involved in the various settings? People make services, programmes or organisations happen and it is a depersonification which reduces peoples' activities to "services, programmes or organisations".

The language of evaluation research presents a mystique through labels and concepts which can have the effect of confusing both professional and lay people. The search for precision and trying to make it a true science has had the effect of making it less clear to the people evaluators are trying to help or influence. Although not a lot of evaluation research has been done in New Zealand, it has become apparent that straight forward language, verbal and illustrative examples have been helpful to busy decision makers (Barnett et al. 1984). Terminology

such as "quantitative" and "qualitative" or titles such as "research design for generalising from multiple case studies" (Greene & David, 1984) may be a psychologist's shorthand, but many evaluations would be more useful to decision makers if the language was more explanatory.

As psychologists move into settings where human services have been evaluated, control over experimental variables may be undesirable or impractical (Munoz, Snowden & Kelly, 1979). Robinson, R., (1984) states that human behaviour is affected by factors other than just the programme under consideration. It has been assumed (Parlett & Hamilton, 1976; Weiss & Rein, 1977) that programme actions are specified in a context independent model. In practice there is no social intervention programme which will be unaffected by participants or clients who may have interpersonal difficulties, differences in perception of a situation or at some times feeling of being unwell or tiredness. Facilitation of service development groups or other groups which allows good interaction and discussion may help to obtain satisfactory outcomes for social intervention programmes.

A study by Snelgrove (1983), A Survey Conducted for the Hamilton's Children's Trust: Providing Evaluation Services for Social Services Concerned With Children and Families, highlighted some of the reservations concerning evaluation. Reservations expressed by the staff of the organisation were: 1) "Evaluation goes against our ideology of self actualisation and self-accountability" (p 20). Snelgrove's interpretation was that intangible goals may be difficult to develop into behavioural objectives. 2) "Evaluation violates our ground rule of client confidentiality" (p 20). Record keeping can be organised to exclude or protect client names and associated client concerns. Reassurance regarding maintenance of confidentiality should be given. 3) "Evaluation is too costly in terms of staff time and money" (p 20). To save costs volunteers and clerical staff can be involved in the collection of data. Involving experienced staff in the preparation of brief, well designed forms in order to collect useful information is cost effective (Snelgrove, 1983, p 20). Snelgrove recommended that organisations should be approached with sensitivity about the topic of evaluation and a good background given for the reasons for establishing evaluation studies.

It has been more common in the 1980's for evaluation studies to embrace many purposes and designs (Robinson, R., 1984). The use of various designs and methodologies within a single evaluation study may provide the richness necessary to handle the complexities of the task being undertaken. No one data technique will accommodate all the issues inherent in most programme evaluations.

MODELS OF EVALUATION RESEARCH

> "Evaluating the effectiveness of organisations requires selecting the appropriate criteria. Many approaches are available, but to find the most useful approach, the evaluator should first answer critical questions in assessing organisational effectiveness" (Cameron, 1980, p 66).

Often organisations are evaluated on the basis of criteria which justify what has already been done. Such an approach may lead to narrow perspectives that will not contribute to long-term organisational survival. Four major approaches to evaluating organisational effectiveness are described as "goal model", "system resource model", "participant (client) satisfaction model" and "process model" (Cameron, 1980). These models provide useful guidelines for systematically assessing the effectiveness of an organisation. The same models can be used for understanding and assessing the effectiveness of social intervention programmes, the work of committees or service development groups. Each will be described and relevance for the present research assessed.

Goal Model

This approach defines effectiveness in terms of how well an organisation accomplishes its goals. Usually this perspective focuses attention on the outputs of an organisation. The goal model has been most useful when organisational goals are clear, consensual, and measurable (for example, a sporting contest where the goal is to win). One problem with the goal approach is that some organisations have effects in ways that do not coincide with their intended goals. An example (Cameron, 1980) of this model was Nestles, whose explicit goal was to provide nutritional aid to babies in third world nations. It became so effective at replacing mother's milk with formula that the company was boycotted because it was

viewed as "being a perpetrator of widespread malnutrition and starvation in underdeveloped third world countries" (Cameron, 1980, p 68). One might add that one of the goals of the company was to make money, but presumably the company never set out to cause nutritional problems although it was many years after these criticisms were made before Nestles did anything about their marketing of formula milk. The goal approach views an organisation as an entity developed and controlled to serve the purposes of key people - owners, managers, and those inside and outside the organisation who have some controlling power in defining the operative purposes of the organisation (Seashore, 1983). Aspects of the goal model approach have been used in the present research and will be emphasised in later analysis. The approach provided useful guidelines for systematically assessing the way in which the service development group reached some decisions.

System Resource Model/Human Resource Model

This approach to organisational effectiveness judges the extent to which an organisation acquires needed resources - that is, the greater the amount of the needed resources an organisation can obtain from the external environment, the more effective it can be (Cameron, 1980). Even if an organisation has acquired optimal resources, it may also be ineffective if it is not adaptable to change. It is also not only a question of how many resources are available but how they are used. For the present research the concept of the "human resource model" was more applicable. Keeley (1984) believed the first question that organisational evaluation must answer, is what objects people value. Participants in complex organisations do co-operate despite disagreements over the value of goals and the value of resources they may expect organisations to provide. It is essential to recognise disagreements if respect for people and their separate interests is to be maintained. In order to co-operate effectively, participants cannot disagree over everything; there has to be some element of common value that distinguishes organisations from other groups such as sports crowds. Resource based theories propose that it is agreement on multipurpose means that binds many social systems together.

Some evaluation studies have involved programme staff and so increased knowledge bases. Involvement of programme staff increases the chance of the information being used .... "Producing data is one thing: getting

it used is quite another," (House, 1973, p 174). Leviton and Hughes (1981) concluded that client involvement in research studies could enhance the use of information. They argued that client involvement in study activities gives evaluators a better chance of relating research information to user needs, and of communicating that information smoothly and efficiently, thus keeping the evaluator's credibility high by gaining the advocacy and involvement of key people. However, the present study did not really examine that issue, as it sought to gain an understanding of the processes involved and attitudes of the Service Development Group members, Board's Steering Commitee and committee members of nominating organisations toward the service development group approach.

Evaluation of the service development group approach used in the Waikato Hospital Board's Review of Maternity Services has required adoption of the "human-resource model". The research concentrated on finding out what the members of the SDG, their nominating organisations and the Board's Steering Committee thought about the service development group approach. Analysis of the value of involving all the various groups in the research and the effect on promotion of similar future evaluation programmes were considered with the assistance of the "human resource model". For example, the SDG participants did not disagree over everything, so there must have been some element of common value which linked them together (Keeley, 1984). These aspects of the system resource model are discussed later.

Participant Client Satisfaction Model

Another approach to effectiveness is the participant satisfaction model, which was the major model used in this research. It defines effectiveness as the extent to which all of the organisation's strategic constituencies are satisfied (Cameron, 1980; Keeley, 1978; Pfeffer & Salancik, 1978). A strategic constituency is any group of people with some interest in an organisation. These can be resource providers, users of the organisation's products or services, producers of the organisation's output, groups whose co-operation is essential for the organisation's survival or those whose lives are affected by the organisation (Cameron, 1980). Cameron stated that the effectiveness of an organisation can be based on how well it is able to respond to the demands and expectations of its strategic constituencies.

The applicability of the participant (client) satisfaction or strategic constituencies approach is limited, as the approach assumes that organisations are effective to the extent that they minimally satisfy constituency demands. Organisations can be effective when strategic constituencies are not satisfied; however, it is generally acknowledged that the viewpoints of strategic constituencies (clients) are critical in assessing effectiveness. Identifying the appropriate constituency can be a problem (Cameron & Whetton, 1983). It has been found that different constituencies hold different preferences for effectiveness for an organisation. This incompatibility has led some authors to suggest that the preferences of the most powerful constituency should be identified (Pfeffer & Salancik, 1978). Effectiveness of an organisation can be viewed as a sociopolitical question concerning "who wants what and how important is it that the demand be satisfied" (Pfeffer & Salancik, 1978, p 87).

The participant (client) satisfaction model or strategic constituencies approach was applicable to the present research and as a model raised questions about which groups of clients were to be satisfied in the review of maternity services - the hospital administrators, politicians, professional staff, the general public or parents? Hospital administrators were anxious about managing a deficit budget and viewed some district maternity hospitals as under utilized and not cost-effective. Politicians became involved in order to help communities protect established services, whereas professional staff tried to protect their jobs. Submissions from small town communities indicated they did not want change and parents wanted to be reassured that services would be available when needed. For everyone concerned in the review, identification of the appropriate constituency may have been a problem. Depending on a particular perspective there must have been a difference in the perception of which needs were the most important. Board employees involved in the committees may have found that Board interests were most important to meet whereas the Parents Centre and Plunket representatives may have been parents' advocates. Participant (Client) Satisfaction Evaluation Models assisted by providing guidelines for assessing the way in which the SDG reached some of their decisions. Later analysis based on findings from this study will attempt to clarify some of these issues.

Process Model

A further approach to effectiveness has focused on the internal processes and operations of the organisation. Effective organisations are viewed as those with an absence of internal strain, members are highly integrated into the system, internal functioning is smooth and typified by trust and benevolence toward individuals, and information flows smoothly in all directions (Cameron, 1980). In the process approach organisations are viewed as more effective if they have a greater degree of the "healthy" characteristics described above and less effective if they possess a lesser degree of those characteristics. Exceptions in applicability of the process approach occur when long-term adaptation and innovativeness are enhanced through conflict and the presence of unused resources (organisational slack). An example of this (Cameron, 1980) was a football team which had a lack of team discipline, fights among players, and between players and coaches, threatened firings, turnover in key personnel and lack of cohesion, yet won the main competition for two years. "Inefficiency sometimes produces effectiveness" (Cameron, 1980, p 69). The process model describes effective organisations as those that operate smoothly. Exceptions to the process model allow understanding of other ways in which organisations function. As this evaluation attempted to determine the effectiveness of the service development group approach questions were formulated about how SDG members felt about the exercise at various stages of the review and in what ways the method could be improved in the future.

Relevance of Models for Present Research

Multiple perspectives have been required to understand organisational effectiveness. If the SDG can be conceptualised as an organisation, the "Goal Model" provided a framework to help with understanding of how the SDG functioned. The "System Resource/Human Resource Model" meant there was client involvement in the research and thus offered the potential of resulting information being used. Also applicable was the "Participant Satisfaction Model", as the model raised questions about which groups of clients (if any) were being satisfied. The "Process Model" helped by making it clear to the researcher that questions about the effectiveness

of the service development group approach needed to cover aspects of community appreciation and participation. Overall the models described were useful when trying to understand ways in which the SDG had functioned and the potential usefulness of the approach.

CATEGORIES OF EVALUATION RESEARCH

Arising from the perspectives, aspects and models of evaluation research already outlined, six broader categories of evaluation arise (Evaluation Research Society, 1980). These are: 1) front-end analysis, comprises activities that take place prior to the installation of a programme (needs assessment); 2) evaluation assessment, which includes activities undertaken to assess whether other kinds of programme evaluation efforts should be initiated; 3) formative evaluation, which includes the process of testing or appraising an ongoing programme in order to make modification or improvements; 4) impact evaluation or finding out how well an entire programme works; 5) programme monitoring, which includes a wide variety of activities which provide information about services delivered and people involved; 6) and meta-evaluation entails evaluation of the evaluation, and may take a variety of forms, ranging from critiques of evaluation reports, to reanalysis of original data, to collection of new information. Two categories which are directly relevant to the present study, formative evaluation and programme monitoring, will be discussed.

Formative Evaluation and Programme Monitoring

These types of evaluation involve the process of testing or appraising an ongoing programme in order to make immediate modifications or improvements. This includes preliminary planning, field testing, needs assessment and establishing an active role for the evaluator. They provide information for decision making on specific aspects of the programme (Campbell, 1974; Evaluation Research Society, 1980; Thomas, 1982). The research design should allow immediate revisions of unworkable aspects of a programme. Formative evaluation is a matter of common sense because many of the errors of planning are visible (Campbell, 1974). It includes the process of testing or appraising the processes of an ongoing programme in order to make immediate modifications and improvements (Thomas, 1982). Concepts of formative evaluation were directly applicable to the present research as they

related to the development, progress and change occurring within the SDG. Questionnaire findings were used to show the shift in attitudes and thinking of SDG members over the period of this research. Interview formats were developed and changed after preliminary questionnaire results were tabled. Formative evaluation concepts were also applicable to the role of the evaluation researcher as "a participant observer" (Attkisson, Brown & Hargreaves, 1978).

The research was designed to assess what was actually happening in the programme how administrative systems and service delivery systems were working and how well the service delivery activities matched the aims and objectives of the programme (Thomas, 1982). These types of evaluation may include active participation by the evaluator in the further development and tailoring of the programme.

Some methods of programme monitoring were covered in the present research, and questionnaires were designed to inquire about administrative systems as well as service delivery systems. Questions examined SDG members' perceptions of their own work and role and how well the project matched the set terms of reference and served community needs. Programme monitoring provided a useful conceptual framework to help with understanding the evaluator's role as well as that of the SDG, Board's Steering Committee and nominating organisations. It allowed some clarification of a complex analytical problem and will be referred to in subsequent discussion.

The role of the formative evaluator is seen as one of active participation, but not always such active participation is required for programme monitoring as the researcher may be standing back from the project in order to observe adequately (Thomas, 1982). For both categories qualitative information gathering procedures are required (Patton, 1979; Trend, 1979). Formative evaluation techniques and programme monitoring constitute the main approach of this thesis. Their relevance to the study will become clearer in the next chapters about methodology, presentation of results and overall analysis.

GOALS OF THE RESEARCH

(1) To report the reasons why the Waikato Hospital Board decided to review its established maternity service.

(2) To attempt to give an overview of what occurred during the review period.

(3) To describe the reasons for the selection of a community based SDG to conduct the Board's review of maternity services.

(4) To assess the effectiveness of evaluation research techniques and the appropriateness of using them to try to understand what the service development group approach meant to the people closely involved, as well as to the communities with an interest in the exercise.

(5) To try to gain information from the SDG, the Board's Steering Committee and selected community groups, regarding their attitudes toward the exercise.

(6) To examine the ways in which the various committees involved in the review interlocked.

(7) To attempt to measure the amount of satisfaction with the SDG exercise, as perceived by the SDG members, the Board's Steering Committee members and the committee members of the SDG member's nominating organisations.

(8) To make conclusions about the effectiveness of the service development group process.

(9) To make recommendations which may assist other agencies that contemplate undertaking a similar type of review exercise.

Evaluation research techniques have provided a scientifically formulated basis for this study. Understanding the concepts allowed boundaries to be drawn to the research design. For instance: What was the purpose of the study?; What research techniques would provide the information being sought?; Should quantitative or qualitative research methods be employed?; Who were the key people involved? With a complex research problem it was important to use a methodology which was tailored to meet the research goals and objectives. Evaluation research techniques kept the design structure manageable and allowed maximum information to be gained. Because of the importance placed on qualitative information in the formative evaluation and programme monitoring categories, the research proceeded in that mode with assistance from some quantitative

data produced from questionnaire inquiry. The restrictions of a recognised research methodology prevented the boundaries of the inquiry from becoming unmanageable for a single evaluator. An approved and acceptable research structure assisted the researcher to keep the task manageable.

The methodology employed three major methods: (1) Archival data, 2) Questionnaires, (3) Interviews. Explanation for the rationale for using these methods is provided in the next chapter. The general methodological approach was exploratory and investigative. The first questionnaire designed was for use with the SDG. Questionnaires used with the Board's Steering Committee and Nominating Organisations were developed using a similar format and questions to the SDG questionnaire. The goals of the research, particularly Goals 5, 6 and 7, provided the reasons for asking questions about SDG ideas, knowledge and appreciation of the SDG's work by community and other groups, terms of reference for the SDG, effective communication, positive and negative outcomes and potential value of the service development group approach for reviewing health services. Major themes identified from preliminary tabling of questionnaire data were used as a basis for interviews with SDG and Steering Committee members.

C H A P T E R 4

M E T H O D

OVERVIEW

Three major methods were used in this research. They were:

1) Analysis of archival data which allowed an historical perspective of the Waikato Hospital Board and its maternity services to be gained;
2) Questionnaires were used to gather information from the three groups of people involved in the study. These were the Service Development Group (SDG), 11 members, Waikato Hospital Board Steering Committee, 6 members and several committee members of the seven SDG nominating organisations;
3) Interviews were conducted with the SDG and Waikato Hospital Board Steering Committee to gain qualitative information to supplement the questionnaire findings. Individual membership of the various groups is described later in this chapter.

Archival information included analysis of Waikato Hospital Board minute books, general records and documentation about maternity services and the formation of the SDG. Detailed information about service planning was found in the Health Planning and Research Unit in Christchurch. An international computer search for further references was conducted using DIALOG and Australian MEDLINE. The first questionnaire designed in this research was that for administration to the SDG using the research goals discussed in Chapter 3 as a framework for construction of the questions. Pretesting the questionnaire was conducted with two female research assistants who were involved in the review of maternity services. Questionnaires used with the Waikato Hospital Board Steering Committee and the committee members of the SDG nominating organisations adapted and built on the questionnaire administered to the SDG. The pattern of the research was sequential, as each section of the research was completed before the next commenced (see Appendix 9 for the timetable of the research). Questionnaires were mailed to the SDG in early November 1984 with a return date of two weeks later being given. All questionnaires were ultimately returned by early January 1985. Preliminary data analysis was performed, after which semi-structured interviews were held with SDG members to further discuss themes emerging from the questionnaires.

When SDG interviews were completed, a questionnaire specially re-designed for administration to the Board's Steering Committee was mailed to participants in February 1985. No date was specified for the return, but all questionnaires were completed by the end of March 1985.

After preliminary analysis of the information, interviews were conducted with the Board's Steering Committee during April and May 1985. These interviews were conducted informally with an unstructured format. The next stage was commenced on 5 June 1985 with the mailing of a questionnaire designed for use with committee members of the SDG nominating organisations. A request was made for return by 22 July 1985 but collection was not completed until October 1985. Preliminary data analysis was carried out during November 1985. Although the numbers of people involved in the three groups asked to answer the questionnaires were small, all questionnaires administered were completed even though the last group took five months to complete. Care and patience with follow up techniques were required to ensure that result.

Methods used for data analysis are outlined later in this chapter. These include descriptive statistics and qualitative data to represent findings. Reasons for not relying on statistical techniques for analysis are given, even though such methods as chi-square analysis and the Fisher exact probability test were considered.

Respondents

Chapter 2 introduced the SDG and Board's Steering Committee, the two groups involved in the Waikato Hospital Board's Review of Maternity Services. Those two groups, together with the committees of the organisations which nominated representatives to the SDG, made up the samples which were surveyed for this study. A detailed outline of the members of each sample is presented below.

Board's Steering Committee (six members)

All of the Board's Steering Committee members were professional people; two medical doctors, two nurses and two accountants. There were four female members, two of whom were not married, while the other two members were both married men. All were European, the approximate average age was 53 years.

Composition of the group was:
Chairman of the Board
Two Board Members
Medical Superintendent-in-Chief
Chief Executive
Chief Nurse

The Chairman of the Board was a married woman aged about 52 years with a family of five adult children. Her background included an accounting degree, some nursing training and involvement in various community committees. She preferred to be called "Chairman", rather than "Chairperson". As well as this elected position, she was employed part time for an accounting firm in a country district.

The two Board members were both women. One was 65 years of age, single and a practising general practitioner in a country area. She was also a member of the SDG. The other was aged between 45-50 years, a married woman with adult children and a qualified nurse working as a nursing tutor at the Technical Institute.

The Medical Superintendent-in-Chief was a man aged between 60-65 years, married with adult children. His title meant that he was the most senior medical doctor working for the Board.

The Chief Executive was a man aged about 45 years, married with two young children. As Chief Executive he was the principal administrator for the Board and formed a tripartite management team with the Chief Nurse and Superintendent-in-Chief. His background was accountancy but he had a career commitment to hospital administration.

The Chief Nurse was a female university graduate aged about 45 years, single and the most senior nurse working for the Board.

Nominating Organisations for the Service Development Group (seven committees). Seven organisations selected by the Waikato Hospital Board nominated a person to serve as a member of the SDG. These organisations were the New Zealand Medical Association (Waikato Branch); Parents

Centre (Waikato); Plunket Society (Waikato); National Council of Women; Department of Health (Hamilton District); Maori Women's Welfare League (Waikato); New Zealand Nurses' Association.

The New Zealand Medical Association is the professional organisation representing medical practitioners. Nearly all New Zealand's medical practitioners belong to this organisation, which publishes a bi-monthly journal.

Parents Centre is a national organisation which was formed in Wellington in 1951. Concerned with parent education and support pre-and postnatally, it has been innovative and creative in its approach to birth techniques, breast feeding and child rearing practices (Ritchie & Ritchie, 1978). Current membership stands at 8,552 families.

The Plunket Society of New Zealand is a national organisation established in 1907 by Sir Truby King to "help the mothers and save the babies." It trains "Plunket Nurses" who work with mothers and babies. A social network is also provided for the mothers. Membership is about 60,000 members nationwide with 121 branches and seven sub-branches.

National Council of Women is politically powerful as it is made up of representatives from most of New Zealand's women's organisations. Established in 1896 by Mrs Kate Sheppard, it is an incorporated society with a contributing membership of 250,000 people from 43 nationally organised societies.

The Department of Health is responsible for public health in New Zealand. Whilst it does not administer hospitals, it has a responsibility in almost all other health areas. Traditionally, public health nurses have helped care for many rural and Maori babies.

Maori Women's Welfare League is a national organisation concerned with Maori women's issues. It has a membership of approximately 3,000 and has a recognised voice on behalf of Maori women.

The New Zealand Nurses' Association is a professional organisation which speaks for nurses in New Zealand. It has a membership of nearly 30,000, publishes a journal and has Interest Sections for various specialties of nursing; for example, midwives,; psychiatric; mental health sections.

The Service Development Group (eleven members)
Only three of the eleven members of the SDG were not health professionals. Two were not married. There were three male and eight female members, one member was Maori, the rest European. The approximate average age was 48 years.

Composition of the group was:
Chairman of Obstetrics and Gynaecology, Waikato Hospital Board
Director of New Born Unit, Waikato Hospital
A practising midwife from a district hospital
The Board's advisor on Obstetric Nursing Services
Research and Development Officer (Waikato Hospital Board employed)
Representative from: General Practitioners
Parents Centre
Plunket Society
National Council of Women
Public Health Nurse
A Board member (to be shared with the two members on the Steering Committee)
Maori Women's Welfare League

The Chairman of Obstetrics and Gynaecology for the Waikato Hospital Board was a man aged about 60, married with an adult family, who practised obstetrics and gynaecology both in a public and private capacity.

Director of the New Born Unit at Waikato Hospital was a man aged about 40, married with a young family, who practised paediatrics both publicly and privately.

The practising midwife from a district hospital was a married woman with an adult family, aged about 50.

The Board's advisor on Obstetric Nursing Services was a single woman aged 45 years, and a practising midwife.

Research and Development Officer (the researcher) was a Hospital Board employee who acted as facilitator for the SDG. She was a university graduate in psychology and a registered nurse, married with three children and aged 39 years.

The representative from general practitioners was a man aged 45, married with a teenage family. He practised medicine (including obstetrics) in a country area.

Parents Centre representative was a married woman aged 34 with three young children. She had previous experience as a school teacher.

Plunket's representative was their principal nurse advisor for the Waikato District. She was aged 52, widowed with three adult children and two grandchildren.

National Council of Women's nominee was selected on a national basis and was the organisation's junior national vice president. She was aged 52, married to a farmer with an adult family. A university graduate, she was also a Piako county councillor with previous experience as a secondary school teacher.

The Public Health Nurse was a senior nurse from the Department of Health's office in Hamilton. A married woman aged between 45 and 50 years with an adult family.

Representation by a Board Member was always provided by the female general practitioner previously described in the Board's Steering Committee's membership.

Maori Women's Welfare League nominated one of their members from the Te Aroha District. A married woman, aged about 45, with adult and teenaged children, she also worked as an adult educator.

MEASURES

Archival analysis, questionnaires and interview formats were used as the research measures. Each will be discussed separately.

Archival Analysis

Since its inception (1886), the Waikato Hospital Board has kept records of meetings, properties purchased and staff appointed. For the present research the minute books of the Board meetings were searched for relevant information. Furthermore, four files had been kept for the Board containing all documentation concerning maternity services. Information about formation of the SDG was also kept on the files. Another source of information was the research diaries kept by the researcher. They included some informal material not usually kept on the Board files, sent by other Board officers about the work of the SDG as well as results of telephone conversations and observations of interactions between group and committee members. Newspaper clippings about the Waikato Hospital Board's Review of Maternity Services were collected in three scrapbooks, which provided yet another useful record.

Information used by the SDG included statistics about hospital admissions and numbers of births and was obtained from two sources: 1) registers kept in each hospital; and 2) formal returns produced from information forwarded from the Board's hospitals by the National Health Statistics Centre. The SDG used this information in its decision making.

Formal information such as the Obstetrics Regulations, 1975; Area Health Boards Act, 1983; Board of Health Reports was obtained from the Waikato Hospital's Medical Library and Government Bookshops. The Department of Health in Wellington and the Health Planning and Research Unit in Christchurch were both visited and their libraries searched for literature. Detailed information about health planning and service planning was found in the Health Planning and Research Unit in Christchurch. As a check that relevant information about the topic had been gathered, an international computer search for further references was conducted using DIALOG and Australian MEDLINE Network.

Sample Survey Research : Questionnaires

Three groups were surveyed using questionnaires especially designed for use with each group.

Service Development Group Questionnaire

A questionnaire was designed for use with the SDG (see Appendix 5), using the "Goals of the Research" discussed in Chapter 3 as the framework for construction of the questions. The questionnaire attempted to find out how individuals had felt about the work of the SDG, if they felt that all had equal opportunity to contribute during the exercise, if the contribution of community representatives was as important as that of the professional people, and whether they thought the SDG's work had been appreciated by local body authorities, politicians and other relevant organisations.

There were 34 questions, 26 of which had a Likert type response format with a choice of answers with a request to "tick the most correct answer for you" or to "tick the answer that applies." Eight questions were open-ended allowing original responses. The formats are demonstrated in Appendix 5, 6 and 7. Both a multiple-choice format as well as an open ended format was used in an attempt to obtain information as efficiently as possible. An example of a multi-choice format can be seen in the SDG questionnaire (Appendix 5) Question 12, which asked "Did you think your task as a nominated representative was..." The question presented a range of five responses from "very easy" to "not easy at all" and respondents were asked to tick one response category only. It was an attempt to find out how people felt about their involvement in the project. Some questions were left in an open-ended response format to enable a wider variety of responses to emerge. These were questions such as Question 25 which asked "With your knowledge and experience of a service development group exercise, have you any comment on other or additional factors which should be taken into account for a future service development group?" Respondents were given five lines in which to provide a response. Coding the results to the open-ended questions was carried out by identifying the major themes and quantifying the responses. Where no themes emerged and issues needed further clarification they were followed up during interviews, the next phase of the research.

With a format such as this, quantitative and qualitative data were obtained. When the questionnaires were completed some preliminary data analysis was carried out.

Board's Steering Committee Questionnaire

A questionnaire was designed for administration to the Board's Steering Committee (see Appendix 6). There were 18 questions, 12 of which had a multi-choice response format. Six questions were open-ended, while ten questions were repeated from the SDG questionnaire. These were numbered 7-15, 17 and 18. Questions were designed to try to discover how the Board's Steering Committee felt about the work of the SDG and if the Steering Committee felt there was value in involving a service development group in health research. The format of the response categories for the questions followed the same pattern as that used for the SDG questionnaire. Response categories were designed to try to gain insights about what was going on, and how respondents were feeling about the project. Preliminary tabling of data was undertaken using the same method described for the SDG data. Identification of the major themes emerging from the data enabled the researcher to isolate priority issues for further discussion during interviews with Steering Committee members.

SDG Nominating Organisation's Questionnaire

The third questionnaire had a similar format to those designed for the other two groups (see Appendix 7). Of the 20 questions used, 12 offered selected response scales, and eight were open-ended, allowing for a descriptive response. The ten questions which were repeated from the SDG questionnaire in the Board's Steering Group questionnaire were also used in the questionnaire to the committees of the nominating organisations. These were numbered 4, 5, 8-12, 15, 18, 19. Questions were designed to find out what the nominating organisation had thought about the SDG exercise. Questions were also asked about how the nominating organisations perceived the public response to the SDG's work. For instance, respondents were asked if their organisation thought that the SDG's work was known and appreciated by the community in general (Question 4 Appendix 7). A multi-choice response format offered four options from "very much appreciated" to "not appreciated at all". Another question relevant to community representation was "What

comment would you like to make about methods of ensuring future representation of community representatives in health services planning?" (Question 13A Appendix 7). An open-ended response format allowed respondents a free choice in their answers.

INTERVIEW TECHNIQUES

Service Development Group

Semi-structured interview formats were designed for use with members of the SDG (See Appendix 8). The interview questions were designed to amplify some of the themes which arose from the open-ended responses to the more formal questionnaire. Interviews were held during January 1985. At the time of interview a verbal report about the questionnaire results was given. Interviews were based on themes which had arisen in the questionnaire data. The major issues arising from the questionnaire results appeared to concern: 1) the SDG's terms of reference; 2) conflict of roles - community and professional; 3) feelings of bitterness toward the Board's Steering Committee; 4) difficulty in working without being part of the Hospital Board structure; 5) the job as a nominated representative not being easy; 6) non-appreciation by communities and local body representatives; 7) the reasons for SDG members working well together; and, 8) that the SDG approach was valuable in reviewing health services. After gaining approval from SDG members, notes were taken during the course of each individual interview.

Board's Steering Committee

Interviews were also conducted with each of the Board's Steering Committee members during April and May 1985. They were unstructured, notes being taken afterwards because interview time was limited. Three issues were discussed. These were (1) the terms of reference used for the review, (2) chairperson's selection and (3) acceptance of community input in health services planning.

Nominating Organisations

Committees of the nominating organisations were not interviewed, as it was physically impossible to do so.

PROCEDURE

Pretesting

The pretest stage of this project was helpful for selection of the questionnaire best suited to the aims of the research. Two questionnaires suitable for use with the SDG were pretested. They were: 1) a questionnaire designed specifically by the researcher for the present project, which used a mixture of structured and open-ended questions; and, 2) a questionnaire designed by Donna Lynn Smith (1981). A senior health administrator from Edmonton, Canada, she was worked with the Health Planning and Research Unit in Christchurch, New Zealand. Her questionnaire attempted to assess the needs, problems, achievements and frustrations of service planning groups in Christchurch. It used fact finding questions and a 1 to 5 scoring scale (Barnett et al., 1984).

Two female research assistants with university social sciences training, who had been involved with the Board's review of maternity services, agreed to assist with pretesting the two questionnaires. They were asked to check carefully if they understood the wording of questions. Their responses to both questionnaires were studied by the researcher and supervisors. Although the numerical scale of Smith's (1981) questionnaire was adequately answered, it did not supply the in-depth information of the researcher's questionnaire. Smith's questions focussed on clinical matters rather than social aspects. The researcher's format used structured and open-ended questions, providing both quantitative and qualitative information which was better suited to the aims of the project. Therefore, it was decided to proceed with the researcher's questionnaire.

Administration of the questionnaire to the Service Development Group

On 10 November 1984 each member of the SDG was mailed a copy of the questionnaire (see Appendix 5). A covering letter explained the reason for the research and requested that respondents answer the questions as they applied to the individual's experience as a member of the SDG. It was also requested that the completed questionnaire be returned by 26 November 1984. A stamped addressed envelope was supplied.

The questionnaire was confidential. Respondents were told in the covering note that the information which they provided might be useful for formation and establishment of future service development groups to assist with health service research. Each participant was given a code number which was marked on their questionnaire. This allowed the researcher to know which questionnaire had been returned and to categorize responses into the groups to which respondents belonged; for example, community or professional representatives.

Procedures for collection of questionnaires from the SDG

Return of questionnaires by the SDG was slow, so another letter requesting completion and return was sent to SDG members. This was successful apart from one member, who was sent another copy of the questionnaire, and telephoned before completion of the questionnaire was achieved during January 1985. This now meant that research with the Board's Steering Committee could be started.

Administration of the questionnaire to the Board's Steering Committee

(5 members, the SDG member was not asked to participate as she had not taken part in Steering Committee work at the time the questionnaires were administered.)

The questionnaire previously described (see Appendix 6) and specially prepared for administration to the Board's Steering Committee was mailed to participants on 22 February 1985. A stamped addressed envelope was supplied to assist with return. However, no date for the return of the questionnaire was stated, nor was any statement of confidentiality or anonymity made. (It was hoped that this group of people would co-operate with the research).

Procedures for collection of questionnaires from the Board's Steering Committee

Three members of the Board's Steering Committee returned their questionnaires by mail within seven days, two members contacted the researcher by telephone and arranged for their completed questionnaires to be collected. All of these questionnaires were returned within one month.

Administration of the questionnaire to the committee members of the seven organisations which nominated SDG members

The questionnaire (see Appendix 7) designed for use with committee members of the SDG nominating organisations was mailed to the president or senior person of each organisation on 5 June 1985. A covering letter explained the purpose of the research and requested that the questionnaire was discussed at the next committee meeting, completed and returned as soon as possible or by 22 July 1985. A stamped addressed envelope was enclosed for that purpose. Some groups such as the New Zealand Nurses' Association and Maori Women's Welfare League completed the questionnaire as a group and others (the New Zealand Medical Association and National Council of Women), designated a spokesperson to complete the questionnaire on their behalf.

Procedures for collection of questionnaires from the Nominating Organisations

It took from June to October 1985 to complete collection of the nominating organisations' questionnaires. Some difficulties were experienced with some organisations because of the timing of their committee meetings. Follow-up letters and telephone calls were used. Care needed to be taken with the manner of requesting completion to ensure co-operation of the committees.

DATA ANALYSIS

Preparation for data analysis included consideration of various methods of statistical analysis. The question was posed as to the meaning and dimensions of understanding that statistical analysis would give to the study. Small numbers meant that the significance of the findings came from the figures themselves, making statistical analysis pointless to the exercise. After careful consideration and consultation the researcher decided that:

1) descriptive statistics and qualitative data would be used to represent the findings; qualitative data gave meaning to the small numbers by providing illustrative examples.

2) the small numbers involved precluded the use of such statistical techniques as chi-square analysis or the Fisher exact probability test;
3) the interest in global trends and comparison between groups can be best reflected in tables and in-depth qualitative data.

C H A P T E R 5

S E R V I C E D E V E L O P M E N T G R O U P R E S U L T S

QUESTIONNAIRE RESULTS

This chapter presents results from the questionnaire and interviews of the eleven Service Development Group (SDG) members. Not every question was answered by every SDG member so the number of respondents varies for some tables. The Waikato Hospital Board had accepted the idea of involving providers and users of maternity services to assist with a review of maternity services and had set terms of reference which were financially based and service oriented. SDG members added their own objectives to the terms of reference (see p22 Chapter 2). The SDG comprised three community representatives and eight professional representatives (four medical doctors and four nurses). To allow trends to emerge, data are tabled under two headings, community representatives and professional representatives. Professional representatives have been subdivided into two headings, doctors and nurses, in order to show differences between them.

Tables in Chapter 5 represent information supplied by SDG members about their perceptions on issues such as the functioning of the SDG, public and professional attitudes toward the SDG, positive and negative outcomes of the SDG's work, comments about the terms of reference, suggestions for future SDG's and the potential value of SDG's for reviewing health services. A report of interviews with SDG members concludes Chapter 5. The first table discussed is Table 5.1 which illustrates SDG members' reaction to being selected to represent a community or professional organisation.

Table 5.1

SDG Members' Reaction to Being Selected as a Representative for an Organisation

Reaction	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4	Nurses (N=4)
Very pleased	2	-	1
Pleased		4	2
Not very pleased	1	-	-
Not very pleased at all	-	-	1

Responses show two community representatives and one nurse stated that they were "very pleased" about being selected to represent their organisation, four doctors and two nurses were "pleased", while one nurse was "not very pleased at all". No reason was given for the negative response. Over 80% of the sample were very pleased or pleased to be invited to be selected as their organisation's nominee to be an SDG member. The next table (Table 5.2) shows how SDG members viewed their individual selection to serve as members of the group.

With one exception, SDG members believed their individual selection to the SDG to be "very appropriate" or "appropriate". One community representative stated that selection was "not very appropriate". Closer examination of that person's questionnaire responses shows it was only toward the end of the project that that member felt accepted as a member of the group. The feeling of not being appropriate may have been caused because it took some time for that person to feel part of the SDG.

Table 5.2
Appropriateness of Selection to the SDG

Reaction	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Very appropriate	1	2	3
Appropriate	1	2	1
Not very appropriate	1	-	-
Not very appropriate at all	-	-	-

SDG members were asked if they had wondered how they would find time for the exercise. Table 5.3 illustrates the responses.

Table 5.3

Lack of Time to Take Part in the SDG Project

Response	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Yes	1	3	3
No	2	1	1

Six professional people and one community representative were concerned about how they would find time for the exercise. Notes which they added when completing the questionnaire described practical difficulties such as busy timetable, travel distance, time away from work and difficulty with day time meetings as the main reasons. Participants were also asked if they were concerned about how the exercise was going to be managed (Table 5.4). The question related to doubts that some SDG members had expressed about combining lay and professional people in a meeting situation. There were worries that the lay people would not be able to contribute as fully as it was anticipated the professional people would.

Table 5.4

Concern Over Exercise Management

Response Category	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Yes	3	3	3
No	-	1	1

Only two people in the SDG (both health professionals) did not wonder how the exercise was going to be managed. All the other members of the group had doubts about the future management of the SDG.

Responses to a question which asked about how well each SDG member felt they had managed to convey their organisation's ideas provided information that all except two participants believed they had represented "well". Although two responses from community representatives indicated perceptions that early representation had been less than satisfactory, greater confidence was expressed about the quality of representation toward the end of the review.

SDG members were asked about knowledge and appreciation shown by the community in general, and selected community groups' knowledge and appreciation of their work. Groups such as Parents Centre and the National Council of Women were representated in the membership of the SDG. In addition the SDG was asked about local body representatives, parliamentarians, Young Farmers, Federated Farmers and Women's Division of Federated Farmers, because it had become apparent to the researcher that these additional groups had become very involved and interested in the Waikato Hospital Board's review of maternity services. Table 5.5 illustrates the responses to questions about those various groups' knowledge and appreciation of the SDG's work.

Table 5.5

Knowledge and Appreciation of the SDG's Work

Appreciation	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
By the Waikato Hospital Board			
Very much appreciated	-	-	-
Appreciated	3	3	2
Not appreciated	-	1	2
Not appreciated at all	-	-	-
By the Community in General			
Very much appreciated	-	-	-
Appreciated	-	-	1
Not appreciated	3	1	2
Not appreciated at all	-	2	1
By Parents Centre			
Very much appreciated	-	-	-
Appreciated	3	2	3
Not appreciated	-	-	-
Not appreciated at all	-	-	-
By local bodies and parliamentarians			
Very appreciated	-	-	-
Appreciated	1	1	-
Not appreciated	2	3	3
Not appreciated at all	-	-	-

Table 5.5 (continued)

Knowledge and Appreciation of the SDG's Work

Appreciation	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
	By Young Farmers, Federated Farmers, Women's Division of Federated Farmers		
Very appreciated	-	-	-
Appreciated	2	1	2
Not appreciated	1	2	-
Not appreciated at all	-	-	-
	By National Council of Women		
Very appreciated	1	-	-
Appreciated	2	-	2
Not appreciated	-	2	1
Not appreciated at all	-	-	-

Table 5.5 reflects the level of knowledge and appreciation by the community and other agencies, such as farmers' groups and politicians, felt by SDG members in relation to their work. Eight of the eleven members of the SDG believed that the Waikato Hospital Board appreciated the SDG's work. One doctor and two nurses thought the work was "not appreciated" by the Board. Only one SDG member (a nurse) chose the response category "appreciated" for the community's knowledge and appreciation of the SDG's work. Three community representatives, one doctor and two nurses thought that the SDG's work was "not appreciated at all" by the community in general. All SDG members who responded to the question about Parents Centre agreed that the work of the SDG was

"appreciated" by Parents Centre. There were no negative responses. The positive effect of Parents Centre representation in the SDG may be indicated by this result.

Only two representatives; (one community, and one medical doctor) stated that local body representatives and parliamentarians had appreciated the SDG's work. The remaining eight respondents all stated that they felt their work was "not appreciated". In contrast, five of the respondents believed that farmers' groups had "appreciated" the SDG's work. One community representative and two medical doctors thought rural groups had "not appreciated" the SDG's work. This result may indicate that SDG members felt greater appreciation from rural groups than they did from local body politicians and parliamentarians.

All of the community representatives and two nurses believed that National Council of Women's members had knowledge of and had appreciated the SDG's work, but two doctors and one nurse did not agree, selecting the "not appreciated" response category as appropriate. Both Parents Centre and National Council of Women had a representative member as part of the SDG, which may have accounted for the favourable perception of knowledge and appreciation of the SDG by those two community groups.

SDG members were asked if they thought that all members of the group had an equal chance to contribute to the exercise. Analysis of the responses is presented in Table 5.6.

Table 5.6
Perceptions of Opportunity to Contribute to the SDG

Contribution	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
All the time	1	1	-
Most of the time	1	2	3
Occasionally	1	1	1
Not at all	-	-	-

Table 5.6 shows that one community representative and one doctor thought they had the opportunity to contribute "all the time". One community representative, two doctors and three nurses stated "most of the time". One community representative, one doctor and one nurse thought they had "occasionally" had an equal chance to contribute.

SDG members were asked if they thought their work had acted as a catalyst to make changes to maternity services (Table 5.7). One SDG member (a community representative) thought that the SDG's work had acted "very much" as a catalyst to make change to maternity services. Two community representatives, one doctor and three nurses responded "in some ways", but four professional representatives (three doctors and one nurse) stated the SDG's work had acted "not very much" as a catalyst to make changes to maternity services.

Table 5.7
SDG's Work Acting as a Catalyst to Make Changes to Maternity Services

Catalyst	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Very much	1	-	-
In some ways	2	1	3
Not very much	-	3	1
Not at all	-	-	-

Table 5.8 is derived from responses to the open-ended question: "Have you any comment to make about the terms of reference set by the Waikato Hospital Board, for the Service Development Group?" The responses have been organised into the four major themes which arose. Respondents had more than one opportunity to answer, which is indicated in the table when numbers are more than the stated N.

Table 5.8

Comments About the Terms of Reference set by the Waikato Hospital Board

Terms of Reference	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Too Specific	-	2	2
Inflexible	-	2	2
Vague	1	1	-
Negative	3	4	3

Elaboration of the four themes includes the following information:

1) Specific. Four responses from professional representatives (two doctors and two nurses) indicated that the terms of reference were too specific and that more general terms of reference were necessary to cover the whole group.

2) Inflexibility. Four responses from professional representatives indicated that they believed that the terms of reference were inflexible. One nurse stated "we were not able to meet the terms of reference because of our lack of power, for example we identified standards which were not acceptable to the Steering Committee." That comment indicated that the nurse representative believed that any change was unlikely. Another professional representative (a doctor) illustrated the inflexibility with the following comment: "The financial situation changed by the terms of reference remained unaltered. We were still instructed to find 5, 10 or 15% savings."

3) Vague. Another theme outlined by SDG members was that the terms of reference were vague. One doctor answered "the terms of reference were very vague from the outset and altered during the exercise." The idea of vagueness is in direct contrast to the notion of the terms of reference being too specific. Further illustration is offered by the comment of a nurse who stated: "The purpose of the terms of reference seemed to change from a necessary to unnecessary exercise."

4) Negative. Ten responses (all participants apart from one nurse) stated that the terms of reference were negative. A community representative responded that, "the Board's stated need for financial cuts meant that negative planning occurred." Other comments included, "we met the terms of reference and objectives. There was too much emphasis on cost savings which conflicted with the idea of the development of a suitable service to continue into the next century," (nurse).

Summary

Ten of the eleven SDG members gave similar responses regarding the terms of reference and the need for financial cuts. One member commented that the emphasis on cost savings conflicted with the idea of the development of a service to continue into the next century. The question was restated during subsequent interviews because the researcher wanted to know how the situation could be improved for future SDG's. It will be discussed again in following chapters.

Table 5.9 shows that eight of the ten respondents would be willing to take part in a future SDG exercise.

Table 5.9

Participate in Another SDG Exercise

Willingness	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=3)	Nurses (N=4)
Very willing	2	-	1
Willing	1	2	2
Reluctant	-	1	1
Very reluctant	-	-	-

Two community representatives and one nurse would be "very willing" to take part in a future SDG exercise. One community representative, two

nurses and two doctors would be "willing", but one doctor and one nurse would be "reluctant" to take part in a future exercise. No reasons were given for these responses. Participants were asked to list any additional factors would should be taken into account for a future SDG exercise. The range of responses is demonstrated in Table 5.10.

Table 5.10
Additional Factors Which Should be Taken Into Account for a Future SDG

Additional Factors	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Stick to agreed procedures	2	-	-
Skilled Chairperson	2	-	-
Separate minute secretary	2	3	1
Agreed procedures	2	3	-
Clear guidelines/ terms of reference	2	3	3
Smaller SDG	-	2	3
Adequate Time	-	1	2
Adequate remuneration	-	1	-
Use ad hoc groups/ community consultation	2	-	2

Table 5.10 groups a wide variety of responses to the open-ended question: "With your knowledge and experience of a Service Development Group exercise have you any comment on other or additional factors which should be taken into account for a future Service Development Group?" The table shows the three major themes which arose from the answers. These were that there should be 1) a separate minute secretary, 2) agreed procedures, and 3) clear guidelines and terms of reference.

Other interesting themes were that future service development groups should be smaller and employ ad hoc group/community consultation. One medical doctor attempted to summarise the SDG exercise with the comment that "the group was too large, the time too long and the expense allowance too small."

Table 5.11 shows data obtained during November 1984, which was the month when the SDG completed work for the Board. At that time six professional representatives (three doctors and three nurses) and one community representative thought the task was "now finished". Two community representatives thought there was still unfinished business, qualifying their concern with worries about transport difficulties for young families and the effect of separation for mothers from families should a district maternity hospital close.

Table 5.11
Feelings About Completion of the Task

Task	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=3)	Nurses (N=4)
Now finished	1	3	3
Business unfinished	2	-	1

SDG members were asked if their group should be allowed further time for deliberations. Results are illustrated in Table 5.12.

Table 5.12

Need for Further Time Allowance

Agreement	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Strongly agree	-	-	1
Agree	2	2	-
Disagree	1	2	3
Disagree strongly	-	-	-

Table 5.12 shows that almost half of the sample agreed that the SDG should be continued to allow it to have further time for deliberations while the rest of the SDG did not believe further time was needed. No reasons were given for the need for further time and no further tasks for the SDG were suggested.

Six major trends were obtained in response to the question "List the positive outcomes of the SDG." These were 1) community participation and communication, 2) clear identification of problems, 3) the concept of an "ideal maternity service", 4) exposure of the Waikato Hospital Board's business, 5) awareness gained of hospital business, and 6) effected change.

The six major trends identified that were supported by all participants: 1) Community participation and communication was valued by all SDG members. One community representative stated, "the SDG as a whole were positive towards the hospitals and their expectations, as well as to the community and their needs. It was a useful communication with communities." 2) They were able to identify problems in the areas of maternal health, attitudes of hospital staff and Hospital Board politics. 3) The concept of an "ideal maternity service" was believed to have set a standard for hospitals. 4) The exposure of the Waikato

Hospital Board's business meant that the Board's problems were revealed to the public with the SDG gaining insights into the functioning of the Board's business. 5) An awareness was gained of hospital business, but the health professionals in the SDG believed that a greater awareness was gained of how "we as professionals are viewed by consumers and by those who work in small community settings who represented organisations involved in the exercise" (doctor). 6) That the SDG "effected change", was illustrated by comments such as "the group effected changes, for example, permission was gained to change a delivery theatre at Waikato Hospital into a homely styled delivery room" (nurse). Other comments indicated pleasure at being involved in planning for a Hospital Board and being able to put forward positive proposals.

Table 5.13 shows the six major negative outcomes identified from the responses to the question "List the negative outcomes of the activities of the SDG."

Table 5.13
Negative Outcomes of the Work of the SDG

Negative Outcomes	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Time wasted	3	4	4
Difficult to keep to plan of action	3	2	2
Too much paper work	2	4	4
Parochial interests	3	2	3
Changes made by Board's Steering Committee	2	2	4
Viewed as a threat	3	-	-

Community representatives listed comments which illustrated that the SDG exercise was viewed as a threat. They believed the SDG exercise caused closing of ranks in almost every town because small towns thought that their small maternity hospitals would be closed because of the SDGs work.

As well as positive and negative outcomes SDG members were asked to list any unexpected outcomes of the SDG's work. The major ideas are grouped in Table 5.14.

Table 5.14
Unexpected Outcomes of the SDG's Work

Unexpected	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=3)	Nurses
Knowledge of health services increased	3	-	
Idea of a new hospital at Ngarua	3	3	-
Continual delays caused procedural difficulties	-	2	-

All of the community representatives stated that they had gained knowledge of health services. One of the SDG's suggestions (to build a new hospital at Ngarua) was viewed as an unexpected outcome by three community representatives and three medical doctors. Two doctors mentioned unexpected delays in the SDG's work. Nurse representatives did not supply any unexpected outcomes and no further elaboration was given at any time.

An attempt was made to find out about the potential value of the SDG approach when reviewing health services. Table 5.15 lists the responses.

Table 5.15
Potential Value of the SDG Approach for Reviewing Health Services

Response	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Very valuable	3	-	4
Valuable	-	3	-
Not very valuable	-	1	-
Of no value at all	-	-	-

All participants answered the question about the potential value of the SDG approach for reviewing health services. Three community representatives and four nurses endorsed the approach as being "very valuable", three doctors thought it was "valuable". One doctor thought the approach was "not very valuable" but he did not elaborate. Despite the one negative response, the result indicates a willingness by group members to involve community and professional people when reviewing health services.

Table 5.16 shows that all the community representatives, three doctors and one nurse (representing over 50% of respondents) had gained "personal satisfaction" from being involved in the SDG.

Table 5.16

Gains From Being Involved in the SDG

Gains	Community Representatives (N=3)	Professional Representatives	
		Doctors (N=4)	Nurses (N=4)
Personal satisfaction	3	3	1
Knowledge of other groups	3	3	4
Acquaintances/ contacts	1	1	-
Friends	1	1	-

Most of the participants stated they had gained knowledge of other groups represented in the community. Two SDG members had gained acquaintances/contacts and two stated they had gained friends. Responses to this question could possibly indicate that the rewards for the group came from the process of working with other groups.

SUMMARY OF QUESTIONNAIRE RESULTS

Major issues arising from the questionnaire results appeared to concern; 1) the SDG's terms of reference; 2) a perceived conflict of roles - community and professional; 3) feelings of bitterness toward the Board's Steering Committee; 4) difficulty in working without being part of the Hospital Board structure; 5) the task as a nominated representative not being easy; 6) non-appreciation by communities/local body representatives; 7) cohesiveness of the SDG; 8) the SDG's ideas being worthwhile; and 9) the value of the service development group approach for reviewing health services. The next step in the research was to explore the major issues that had been identified, by conducting interviews with each SDG member.

REPORT OF INTERVIEWS WITH SERVICE DEVELOPMENT GROUP MEMBERS

During January 1985, SDG members were interviewed (see Appendix 8 for interview schedule). The purpose of the interviews was to elaborate further on the major themes identified in the questionnaire survey.

The major themes which eventuated are listed and discussed in relation to the three groups of participants: a) Community representatives; b) Doctors; and c) Nurses.

1) Terms of reference (listed Chapter 2 page 22)

Question: "In your view were the terms of reference fair?" (The question was designed to elicit whether people thought the terms of reference were reasonable.)

a) Community representatives

"In the very beginning I couldn't work out what it was all about. It all seemed very 'high powered' but I seemed to manage". This response does not answer the question directly, it is an indication that the whole exercise was not understood at the start. Another member said: "I didn't really feel very happy about being chosen to take part", again not answering the question but an expression of feelings about the terms of reference.

b) Doctors

One direct answer to the question reflected the views of the other doctors "No they were not fair. No member of the group had the courage to speak against them. They just followed and obeyed what the Board had set down. We should have looked to expand the terms of reference."

c) Nurses

Comments made about the terms of reference indicated a certain amount of dissatisfaction. Examples given were, "Yes the terms of reference were fair but they seemed to change. They were really not flexible enough" and "They were fair as a starting point. It would have been better if the two groups - the Board and the SDG had met and decided on the terms of reference together".

Summary

The quotations selected give some indication of the differences in understanding of the purpose of terms of reference. The question asked SDG members to examine the usefulness of the terms of reference. SDG members also questioned their initial acceptance of the terms of reference set by the Board. It could be postulated that the terms of

reference influenced the investigation, discussions and outcomes for the group. The comment by a doctor that "no member of the group had the courage to speak against them" showed that this member thought that the terms of reference had required further discussion. In the early stages the group members did not know each other. They had not formed support networks, no informal discussion had taken place.

2) Conflict of Roles

Question: "Did you think that there was conflict between community and professional roles?"

a) Community representatives

Community representatives did not give a clear answer to the question about conflict between community and professional roles. Instead they answered in a more general manner commenting on inadequacies of the SDG process. Comments such as "we needed representation from younger women and country representatives. I felt such a responsibility representing women of my age" and "general impression is one of the Board being set against the district, they are quite convinced of that at a local level" showed the conflict which SDG members felt about their membership "role" in the group. Rather than representing in the most appropriate way that they could, there seemed to be a feeling of responsibility for people not included in the SDG.

b) Doctors

Four comments are listed as they showed some of the difficulties encountered by SDG members, and the challenge to traditional roles.

> "No I could have done the job in a couple of days but we need-d the community input".
>
> "Hopeless having people like the Department of Health and Plunket representatives involved. They really had little to offer.
>
> Maori representatives offered little. Had to have the professionals there".
>
> "Lay group had to go along with the professionals. So many issues needed professional guidance".
>
> "No, I liked the community approach".

c) Nurses

A conflict of roles was made very clear by the nurses' comments. It seemed that their professional 'nurse' role did not allow them to represent women at the same time.

"The two groups were diametrically opposed - that is the professional and community. In my heart I felt for the mothers and babes but as a professional I really could not condone those hospitals with so few births, - some of those old nurses are so set in their ways".

"Seemed to be for some. Should not have been a problem".

"Tremendously difficult. I was on the group as a country midwife but I wanted to speak for women".

"Yes some professionals represented community groups, for instance Plunket. A plunket mother would have been more suitable. That professional should have realised that fact and got out in the beginning."

3) Feelings toward the Board's Steering Committee

Question: "Many SDG members expressed feelings of bitterness toward the Board's Steering Committee. Have you any comment to make about that?"

a) Community Representatives

A number of comments were made which expressed feelings of frustration. For instance one representative commented,

"I felt a bit angry I guess. I would have liked them to have had broader vision, they had pre-made up their minds".

Another said "There was very little interaction with the Steering Committee".

b) Doctors

Doctors made a lot of comments. These can be summed up in the following excerpt:

"Some members of the Steering Committee still don't understand the impact of the SDG and how the SDG managed to do such a good job. The Steering Committee were very powerful".

These professional people could not combat the powerful Board's Steering Committee.

c) Nurses

The most resentful and critical comments were made by the nurse members.

"The Steering Committee were 'real jubes'. It didn't matter what we wanted it was always going to be the Superintendent-in-Chief's way."

"I felt it was very male dominated, but so was the Service Development Group"

"I wish I had the guts to say I didn't think that the way the Superintendent-in-Chief was ruling the Steering Committee was fair. His views were very narrow. He had no lateral vision at all".

Summary

The immediate issues appear to revolve around the control of power in the two committees. The communication process was not satisfactory and the SDG members expressed feelings of being "ordered" by the Steering Committee and powerlessness.

4) Hospital Board Structure

Question: "Did you think it was hard to work without being part of the Hospital Board Structure?"

a) Community Representatives

Comments which indicated that it was hard to work without being part of the Hospital Board structure were:

"Hidden agendas all the time. We were a sop. Going through the the motions - Bit of window dressing".

"Unwritten rules - I charged ahead and said it - nurses were very inhibited - just muttered".

All of these remarks seem to say that these SDG members thought it was hard to feel that they were being taken seriously.

b) Doctors

The responses from the medical people also indicated that it was hard to work without being part of the Hospital Board structure. The Chairperson of the SDG remarked that the Chief Executive had tried to keep him informed of the Board's thinking and the financial situation but because of work commitments only brief meetings were achieved.

c) Nurses

Nurses also agreed with the view that it was hard to work without being part of the Hospital Board structure. They made statements such as:

"Yes, unless you were part of the system"

"I didn't seem to be able to offer much. This disappointed me and I really didn't know the reason".

"I think the Hospital Board structure is even tighter, more bureaucratic than the Health Department. Everything seems to be done "by the book".

5) Task as a Nominated Representative

Question: "Eight of the Service Development Group said that their job as a nominated representative was not easy. Have you any comment about this?"

a) Community Representatives

At the time of interview community representatives had little to say about their task as a nominated representative not being easy. Two comments of interest were:

"The nurses were inhibited by the doctors. They used to get me to say things. Seemed frightened to speak out".

"Took me a long time to settle in because I was asked to be part of the group after they had started."

b) Doctors

Doctors commented on the task as a whole rather than their own role. Comments were:

"Probably the first time some of them have ever done a job like this".

"Enjoyed being a member even if it was a bit tedious. Could have knocked the job off in two or three days with a colleague - and say the Parent Centre representative. The National Council of Women's Representative was useful".

c) Nurses

From the two comments given, nurses appeared to be a little uncomfortable in the role as an SDG member.

"I suppose I ended up representing as a nurse. I did write in the beginning and suggest they (the Board) used a Plunket mother".

Another nurse stated

"I thought it was a good project and a worthwhile idea. I came in after two meetings were held. Never caught up really".

Summary

The responses to this question show the confident approach of the doctors. Feelings of being unsure of the correct direction to take were expressed by two nurses. It seemed that the community representatives in their view, became the spokesperson for the nurses although nurses did not seem to think so. The job was not easy for some because the SDG's work was commenced before all members were appointed.

6) Non-Appreciation

Question: "What were the reasons for the non-appreciation by communities/local body representatives?"

a) Community Representatives

A range of responses was given by community representatives which included:

"I don't really know." "Hard to say, we needed more country representatives".

A more specific answer was:

"Ultimate decision must rest with the government. The general impression is one of the Board being set against the districts. Te Aroha councillors really feel this and attribute negative statements to all Board members".

b) Doctors

Comments were incisive and indicated that communities and local body representatives viewed the maternity services review as threatening to the local hospital. People in each district were prepared to fight hard to prevent possible closure of their hospital.

"Oh they were only interested in 'their place'".

"All fighting to preserve what they had"

"Districts had 'wants' not 'needs', Didn't listen".

c) Nurses

A variety of responses were provided by this group which provided reasons for non-appreciation of the SDG's work by communities and local body representatives:

"Suspicion of us, misunderstanding, I would like to know if there is any change of attitude"

"They didn't understand what it was all about. Hard to make people aware of what was going on"

"Board didn't explain well enough"

"Everybody protects their own place. I think the Board will be very lucky if this Labour government allows any of those Hospitals to close".

Summary

The overall viewpoint is that of the SDG being seen as opposed to the community. The SDG and the review were held in suspicion by local authorities. At the same time there was a belief that the Board had not explained the SDG exercise "well enough" to outsiders.

7) Cohesiveness of the SDG

Question: "Seven members of the Service Development Group thought that the group worked well together. Have you any further comments?"

a) Community Representatives

The only comment made was:

"We got to know each other when we shared cars on our visits to the hospitals".

b) Doctors

The doctors made two assessments. These were that it was:

"A pretty good sort of a group" and "The nurses were not put down by the doctors."

c) Nurses

Comments ranged from appreciation of the group to disappointment about the Maori Women's Welfare Leagues representative being ignored. Nurses stated:

"Good group of so many different interests."

"Yes, and not too much time wasted."

"Yes, but the Maori women's representative just got ignored".

At SDG meetings the Maori women's representative expressed the views of Maori women and organised a meeting for SDG members with the Tainui Maori Women's Welfare League at the Te Puna Marae. In spite of these positive effects there was no mention in the SDG's report about Maori birth practices or the importance of taking cultural issues into account when planning for maternity services.

Summary

There seemed to be a general consensus of being a "pretty good sort of group", who grew accustomed to each other because of attendance at meetings. One doctor commented on doctor/nurse relationships and one nurse worried that the Maori representative had been ignored.

8) Worthwhile Ideas

Question: "One SDG member thought "All the group's ideas were worthwhile", nine SDG members thought "most ideas worthwhile", while one member thought "some were worthwhile". Have you any further comment?"

a) Community Representatives

The Parents Centre representative reported that she had been pleased to have been asked to give advice about provision of a family-oriented delivery room at Waikato Women's Hospiital. A delivery theatre at that hospital had been changed to a less clinical environment because of those efforts.

b) Doctors

Doctors believed that the SDG's ideas had stimulated "a good deal of discussion". They agreed that the idea of a new central hospital at Ngarua was excellent and believed the Board's Steering Committee had "slammed that idea without allowing it sufficient thought."

c) Nurses

Nurses agreed that the SDG had had very good ideas which had not been taken seriously enough. The Board's Steering Committee had "wiped the group's ideas in a mindless fashion." The idea of a new central hospital at Ngarua was supported as a good suggestion which should still happen.

Summary

The questionnaire and interview of SDG members occurred a year after the SDG's report was released. It is interesting to note that a community representative was used on a consultant basis by hospital authorities and that both the doctor and nurse representatives still believed that the SDG's ideas merited practical application.

9) Valuable Approach

Question: "Six of the SDG thought that the SDG approach was valuable for reviewing health services. Do you want to comment on that?"

a) Community Representatives

Support for the SDG approach was apparent from the comments:

> "Definitely" and "We modified the views of the professionals", which seemed to emphasise the importance of a community based SDG.

b) Doctors

Doctors also supported the SDG approach, making interesting observations such as:

> "We needed the lay input - the Board needs to be seen to be including the community these days. People like the National Council of Women's representative were valuable".
>
> "Next time, don't want a large group. Pre-write a document, then consult and modify where necessary. The Government seems to want these service development things".

c) Nurses

Support for the SDG approach with ideas for future groups was given by the nurse members. Two comments were:

"Yes, I agree that the approach was valuable. I would have liked more feedback from the marae visit. Maori culture had different feelings about birth and death".

"Liked the combination of different groups although the SDG was too large. It was better than what has happened before but needed more time".

Summary

As no negative comments were recorded it appeared that the SDG approach was considered to be valuable for reviewing health services. Requirements for a future SDG exercise are spelled out, for instance group size and the request for more time. An awareness about cultural issues surfaced.

OVERVIEW OF QUESTIONNAIRE AND INTERVIEW RESULTS

Major issues identified from the questionnaire results included the SDG's terms of reference, the conflict of community and professional roles, feelings of bitterness toward the Board's Steering Committee, difficulty in working without being part of the Hospital Board structure, the task of a nominated representative not being easy, non-appreciation by communities and local body representatives, cohesiveness of the SDG, value of the SDG's ideas, and that the service development group approach was valuable in reviewing health services. Interviews with SDG members were held to explore those issues in greater depth and comments supported questionnaire results. There was support for the concept of community involvement in health services planning through the service development group method. Disappointment was expressed about the negative way in which the SDG's suggestion of a new central hospital at Ngaruawahia had been received. There was comment about the way in which the SDG had been perceived to ignore the views of the Maori Women's Welfare League representative. Additional comments were made which could possibly assist a future service development group. These were consideration of appropriate terms of reference, group size, awareness of cultural issues and a request for more time for any exercise. Many of these issues were explored with the Board's Steering Committee. Those results are presented in the next chapter.

CHAPTER 6

BOARD'S STEERING COMMITTEE RESULTS

QUESTIONNAIRE RESULTS

Chapter 6 presents results from the questionnaire and interviews of the Board's Steering Committee members. The Steering Committee's purpose in the review of maternity services was to assist in the evaluation of objectives within financial restraints, maintenance and quality of services, and existing policies. It comprised the Chairman of the Board, two Board members, the Medical Superintendent-in-Chief, the Chief Executive and the Chief Nurse. This chapter illustrates how the Steering Committee felt about the work of the Service Development Group (SDG). Support for involvement of a SDG in health services research is examined. Table 6.1 lists the amount of knowledge and appreciation which the Steering Committee believe various community groups had for the SDG. Other tables illustrate additional factors which should be taken into account for a future service development group. Issues discussed include positive and negative outcomes of the SDG under review.

The first question which the Steering Committee was asked sought to discover the level of support for the idea of using a service development group approach to review maternity services for the Board. Four of the five participants indicated strong support for the idea of using a service development group approach to review maternity services but one member did not support the idea at all but gave no reason for the viewpoint. A second question asked steering committee members if they felt they had had sufficient opportunity to present their viewpoints to the SDG. Four members believed they had sufficient opportunity while one member felt they had only "occasionally" had the opportunity to present viewpoints to the SDG.

A positive response was received to a question about involvement of service development groups in any future review of health service areas. Four members approved of involvement, only one disapproved. No reason was given for the negative response. An open ended question was asked to attempt to gain further information about the benefits of involving community representatives in the Board's review of maternity services.

Four Steering Committee members believed that community representatives should be involved throughout the exercise while only one member believed involvement should be when any plan for a particular health service had been completed. Overall, comments recorded that community involvement added knowledge and information from the wide range of interests held by local people. A comment that "there is a modification of the professional view and the need to identify the actual reason for the professional stand," indicated an awareness of the influence of the professional viewpoint and the influence of community representatives in "modifying the professional view". Another member commented that "community expectations should be identified in health planning," demonstrating the need for a broadly based approach for health services planning.

Responses to the next question asked illustrate the value which the Steering Committee gave to the SDG's ideas. All of the Board's Steering Committee stated that most of the SDG's ideas were worthwhile. The response is interesting when compared with the answers given to the previous question, which showed one committee member thought community representatives should only be involved "when the plan has been completed".

Information was sought about the Steering Committee's views of the knowledge and appreciation that the community in general and selected community groups had about the SDG's work. Groups such as Parents Centre and the National Council of Women were represented in the SDG, but the Steering Committee was also asked about local body representatives, parliamentarians, Young Farmers, Federated Farmers and Women's Division of Federated Farmers. Because of media attention it became apparent to the researcher that a wide range of groups had become involved in the Waikato Hospital Board's review of maternity services. Information gained about the Board's Steering Committee's views about all of these groups and their knowledge and appreciation of the SDG's work is presented in Table 6.1.

Table 6.1

Board's Steering Committee View on Knowledge and Appreciation of the Service Development Group's Ideas

Response	Waikato Hospital Board	Community in general	Interest Groups such as Parents Centre	Local Body Representatives and Parliamentarians	Young Farmers, Federated Farmers, Womens Division of Federated Farmers	National Council of Women
Very much appreciated	1	-	-	-	-	-
Appreciated	3	3	5	4	3	5
Not appreciated	1	2	-	1	2	-
Not appreciated at all	-	-	-	-	-	-

Table 6.1 shows that one member (a Board member) of the Board's Steering Committee believed the SDG's work had been "very much appreciated" by the Waikato Hospital Board. Three members stated "appreciated" and there was one negative response from the Superintendent-in-Chief. Three committee members thought the SDG's work was "appreciated" by the community in general but two did not agree. All responses showed that the Steering Committee felt the SDG's work was welcomed by Parents Centre and National Council of Women (groups which had SDG members). Four members thought that local body members and parliamentarians "appreciated" the SDG's work with one disagreeing. A similar pattern evolved with rural groups. Young Farmers, Federated Farmers and Women's Division of Federated Farmers were seen to have "appreciated" the SDG's work but two stated "not appreciated" (these last two groups did not have SDG members). Overall the table indicates that groups which had representation on the SDG were viewed by the Board's Steering Committee as appreciative of the SDG's work. Information provided in Table 6.1 allows an understanding of the Steering Committee's perception of the effectiveness of the SDG by key members of the public.

Responses to a question which asked if the Steering Committee believed the SDG's work had acted as a catalyst to make changes to maternity services showed that two of the Board's Steering Committee members believed that the SDG's work had acted as a catalyst "in some ways" to make changes but two members stated "not very much", and one the Superintendent-in-chief, "not at all".

Steering Committee members were asked to comment about the terms of reference set by the Waikato Hospital Board for the maternity services review. Responses derived from an open-ended question seem to suggest some confusion or discrepancy between members' opinions of the terms of reference. Three participants who believed the terms of reference had been specific made comments such as "Terms of reference should be specific and there should be no deviation" and... "objectives should be clear cut and achievable." Answers from the other two participants, the Chief Executive and Board Chairperson which indicated that they thought the terms of reference were ambiguous were, "In hindsight they could have been more explicit" and "They were somewhat ambiguous - due to a degree of ambivalence within the Board. That made it difficult for the SDG to be clear about their objectives."

The answers given regarding the terms of reference seem to indicate a polarisation of views amongst Steering Committee members and emphasise the importance of clearly understandable terms of reference for any future service development group.

Table 6.2 provides further information about any additional factors which SDG and Steering Committee members said should be taken into account for a future service development group.

Table 6.2
Additional Factors Which Should be Taken Into Account For a Future Service Development Group

Steering Committee Response	Frequency
Smaller size service development group	3
Clear terms of reference	2
Regular exchange of ideas with management	2
"Stricter" chairperson	1
Involve professionals first, public later	1

The five issues mentioned are discussed below.

1) Smaller size for the service development group

Three participants believed the service development group should have less than the eleven members who made up the SDG for the maternity services review. One stated "Smaller number of members with formal input from special interest groups" while another answered "Smaller size - role more explicitly stated when set up - how long the group should function and any continuing monitoring role should be spelled out".

2) Clear terms of reference

Two Steering Committee members mentioned, without elaborating on, the need for "clear terms of reference".

3) Regular exchange of information with management

This view was held by two Steering Committee members. One participant emphasised the need for regular exchange of information with management. He believed that "Management cannot be divorced from the activity. Regular interchange is required and/or representation."

4) Stricter chairperson

Comment was made about the qualities needed for the chairperson. One participant thought that stricter "chairmanship" of service development group meetings was required. Further comment about the chairperson indicated that more skill should have been used in order to involve all members in the group's discussions.

5) Involve professionals first, public later

Two comments indicated the need for early professional involvement. These were: (i) "I believe that a service development exercise should be by the professional in the first instance. Involve the public later." (ii) "'Public' representatives need not be involved in the service development group - it depends on what service and why they are thought to be necessary or not."

The Board's Steering Committee were asked about any positive outcomes or achievements of the SDG. These are listed in Table 6.3.

Table 6.3
Positive Outcomes of the SDG

Steering Committee Response	Frequency
Created public awareness of Board's willingness to encourage community participation	5
Wide representation of community views	4
Agreement on an "ideal" service	3
Met objectives of the brief	3
Original ideas	2

Responses indicate an awareness of the value of community involvement in planning for a health service. Creating public awareness of the Board's willingness to encourage community participation was mentioned by all respondents. Three (participants) commented on the importance of the development of the concept of an "ideal" service, four others thought that the SDG had offered a "wide representation of community views", and three members stated that the SDG had met the "objectives of the brief". Two participants commented that the SDG had provided original and creative ideas about delivery of maternity services, especially the suggestion to build a modern family-orientated maternity hospital at Ngarua, which would be central to Morrinsville, Te Aroha and Matamata and allow closure of the older existing maternity hospitals at the latter three towns.

Table 6.4 lists responses to an enquiry about the negative outcomes of the SDG.

Table 6.4
Negative Outcomes of the SDG

Steering Committee Response	Frequency
Too much emphasis on wording and literary style	2
Narrow in approach to alternative uses	2
Unrealistic outcomes	1
Expensive in time and resources	1
Ignored important aspects of health planning	1
Generated public opposition to change	1

Table 6.4 shows that two members of the committee thought there was "too much emphasis on wording and literary style" by the SDG in minute and report writing. Two participants commented that the SDG had been narrow in approach to alternative uses of maternity hospitals for other purposes, meaning that non-medical uses could not be envisaged. There

were also comments about "unrealistic outcomes", "generated public opposition to change", "expensive in time and resources," and "ignored important aspects of health planning". Comments on unrealistic outcomes, and generating public opposition to change, referred to the SDG's suggestion of a new purpose-built maternity hospital at Ngarua, which drew intense public and media criticism because of Ngarua's lack of population and associated civic amenties such as water supply and fire services. Some Steering Committee members felt the exercise had been expensive in time and resources because of the number of people involved, which necessitated twenty six full meetings and numerous sub-committee meetings. One participant had emphasised that important aspects of health planning had been ignored and qualified the statement by stating that demographic, geographic and transportation issues had been overlooked.

A question was asked to allow the Board's Steering Committee the opportunity to state the positive actions which they believed they had demonstrated in relation to the SDG. Table 6.5 illustrates the information which was provided.

Table 6.5
Positive Actions of Board's Steering Committee in Relation to the SDG

Steering Committee Response	Frequency
Approve final report and recommendations	3
Channeling activity in productive directions	2
Very little	1

Three positive actions of the Board's Steering Committee in relation to the SDG were listed. These were:

i) Approve final report and recommendations

Three participants commented that a positive action was to approve the SDG's report and recommendations. The Board's Chairman expressed the following "To discuss and draw together the Service Development

proposals and the entrenched positions of executive officers and Board members and approve a final report and recommendations." The comment indicates that a positive action was seen as the achievement of agreement about the report from Board members and staff.

ii) Channeling activity in productive directions

Two comments indicated that the Steering Committee members felt that they had helped channel SDG activity in productive directions. They were: 1) "After data collection, and recommendations of the SDG, the Board's executive rehashed the whole exercise and added another dimension to the outcome. The Board and Executive (Steering Committee) should have the responsibility to make final recommendations." and 2) "Some channelling of activity in more productive directions, but effectiveness limited by both lack of clear ideas about how and where it was meant to be "steering", and ambivalence regarding steering versus undue influence."

iii) Very little

One participant stated that there had been "very little" positive action by the Steering Committee to the SDG. He stated: "The exercise was experimental and the two groups should have had more time together. The SDG were not well supervised by the Steering Group."

SUMMARY OF QUESTIONNAIRE RESULTS

The Board's Steering Committee appear to have supported the idea of the SDG approach for reviewing health services. Knowledge and appreciation of the SDG's work was perceived as highest amongst community groups when there was a nominee from a particular group as a member of the SDG. Important issues appeared to be formulation of the terms of reference, the chairperson's selection and community involvement in health services planning. The next stage in the research was to discuss those issues during interviews with each member of the Board's Steering Committee.

REPORT OF INTERVIEWS WITH THE BOARD'S STEERING COMMITTEE MEMBERS

Interviews were conducted in order to gain further information about three themes which had arisen from the questionnaire results. These were 1) the terms of reference used for the review; 2) chairperson's selection; 3) acceptance of community input in health services planning.

1) Terms of reference (see Chapter 2, p 22) were discussed and participants made some interesting comments during the discussion. One participant stated that the terms of reference had been "not quite effective in that too many people wanted to pursue particular points of view". Another comment was: "Although the outcome was perhaps tainted by the requirement to save money, it's pointless to plan ignoring resources. Despite what many people have said the SDG are absolutely convinced on professional grounds some services should close. Presumably this would have been so irrespective of the tight terms of reference." A third participant believed that the terms of reference "were not strictly adhered to".

Comments provided seem to indicate a realisation that the terms of reference had not accommodated the SDG members' requirements but perhaps had been tailored to meet the Waikato Hospital Board's needs. The comment about the outcome of the SDG exercise being tainted by money will be discussed in Chapters 8 and 9. The last comment that the terms of reference "were not strictly adhered to" fits in with the first comment about there being a lack of effectiveness and people wanting to pursue particular points of view. Such comments demonstrate the need for clearly understood terms of reference for any future service development group exercise.

2) Selection of the Chairperson

There was little comment regarding the method of the chairperson's selection. One participant thought that SDG meetings should be controlled by a "strong chairman". All members said the selection was simply a Board decision, there was no elaboration on this issue.

3) Acceptance of community involvement in health services planning

Considerable discussion resulted from the introduction of this topic. Some comments recorded were:

> "Opportunity for representatives to see and understand a particular health service from a broader viewpoint. Opportunity to bring community viewpoint."

"They felt the Board was interested in their views and had the opportunity to contribute. Community input validated the assessments made by Board members and senior staff."

"If closure of services are contemplated, public consultation is required under Department of Health policies."

"Public representation need not be included on the Service Development Group. It depends on what service and why they are thought to be necessary, or not."

Those comments appear to reluctantly acknowledge the value of community involvement in health services planning. It is interesting to note that two participants stated that community input can act as validation for assessments made by the Board and senior staff. A useful contribution was "It depends on what service and why community input is thought to be necessary, or not". The subject of community involvement in service development groups will be discussed further in Chapters 7 and 8 of this thesis.

OVERVIEW OF QUESTIONNAIRE AND INTERVIEW RESULTS

Questionnaire and interview results showed support for the concept of the service development group approach when reviewing health services. Questionnaire findings showed that knowledge and appreciation of the SDG's work increased if a community group was represented in the SDG's membership. Issues which were discussed during interviews included formulation of the terms of reference, the chairperson's selection and community involvement in health services planning. Comments indicated the need for clearly understood terms of reference. All Steering Committee members stated the chairperson's selection was a "Board decision" though one person wanted a "strong chairman". Community involvement in service development groups and health services planning appeared to be accepted with some reservations.

Chapter 7 presents findings from a questionnaire administered to committee members of the organisations selected to nominate people to be members of the SDG.

C H A P T E R 7

S E R V I C E D E V E L O P M E N T G R O U P

N O M I N A T I N G O R G A N I S A T I O N S ' R E S U L T S

QUESTIONNAIRE RESULTS

Results from the questionnaire circulated to committee members of the Service Development Group (SDG) nominating organisations are presented in this chapter. The seven organisations that participated were the National Council of Women of New Zealand, Parents Centre (Hamilton Branch), the Maori Women's Welfare League, the New Zealand Medical Association (Waikato Branch), the New Zealand Nurses' Association (Hamilton Branch), the Department of Health (Hamilton Health District) and the Plunket Society of New Zealand (Hamilton Branch).

Table 7.1 illustrates participants' responses to a request for information about appropriateness of the SDG nominating groups. The question stated "Your organisation was asked to nominate a representative to serve as a member of the Service Development Group which assisted with the Waikato Hospital Board's Review of Maternity Services. Did your group think that the selection of nominating groups for the Service Development Groups was appropriate?"

Table 7.1
Appropriateness of Selection of SDG Nominating Groups

Response	Frequency
Very appropriate	2
Appropriate	4
Not very appropriate	1
Not very appropriate at all	-

The majority of groups believed the selection had been appropriate. The Maori Women's Welfare League and the Plunket Society stated that the selection had been "very appropriate"; only one group, the New Zealand Medical Association responded "not very appropriate". No further elaboration was given but the researcher wondered if the question had been understood as the New Zealand Medical Association representatives played a full and active role in the SDG's work.

Committee members of the nominating organisations were next asked if there had been sufficient opportunities for nominees to represent their organisations' ideas. Table 7.2 shows that three groups responded "all the time" and three groups believed "some of the time", but one group (the New Zealand Nurses' Association) stated "not at all". No reasons for the nurses' response were given.

Table 7.2
Opportunities for Nominee to Represent Organisation's Ideas

Opportunity	Frequency
All the time	3
Some of the time	3
Occasionally	-
Not at all	1

Participants commented about the SDG's ideas in response to a question "On the whole what did your organisation think of the Service Development Group's ideas?" Four organisations (the Maori Women's Welfare League, National Council of Women, New Zealand Medical Association and Plunket Society) thought that "most" of the SDG's ideas "were worthwhile". Two groups (Parents Centre and the Department of Health) stated that "some were worthwhile". One group (the New Zealand Nurses' Association) did not answer, but added a comment that "As a group no one opinion could be identified."

Table 7.3 illustrates the answers to a question about "knowledge and appreciation" of the SDG's work. It has the same format as Tables 5.5 (Chapter 5) and 6.1 (Chapter 6) but includes another group which had not previously been considered; in addition to community groups, participants were asked if they believed the SDG's work was "known and appreciated" by health professionals.

Table 7.3

Nominating Organisations' Views About Knowledge and Appreciation of the SDG's Work

Response	Waikato Hospital Board	Community in general	Health Professionals	Local Bodies and Parliamentarians	Young Farmers, Federated Farmers, Womens Division of Federated Farmers	National Council of Women
Very much appreciated	2	-	-	-	-	2
Appreciated	3	2	5	2	4	3
"Don't know	-	-	2	2	2	2
Not appreciated	-	4	-	1	1	-
Not appreciated at all	-	1	-	-	-	-

Table 7.3 reflects the level of "knowledge and appreciation" by the Waikato Hospital Board, health professionals, the community in general, farmers' groups and politicians, agreed on by committee members of the nominating organisations in relation to the SDG's work. Two committee members thought the SDG's work was "very much appreciated" and three others stated that it was "appreciated" by the Waikato Hospital Board. The response to the same question in relation to the community in general was that two participants thought the SDG's work was "appreciated", but four others stated "not appreciated" while one thought the SDG's work was "not appreciated at all". This response could indicate the apprehension felt by the community to the SDG's work. It was previously identified in Table 5.13 (Chapter 5) that the SDG's work was "viewed as a threat" by small towns.

The general finding was that the SDG's work was appreciated by health professionals, farmers' groups and the National Council of Women, but two nominating organisations indicated they were unable to answer this question. The positive responses regarding knowledge and appreciation of the SDG's work by the National Council of Women were similar to responses by the SDG (Table 5.5) and the Board's Steering Committee (Table 6.1) to the same question.

Responses to an open-ended question which invited comments about the terms of reference set by the Waikato Hospital Board for the SDG have been organised into the three themes which arose and are set out below. Similar themes emerged in the answers to this question as for the SDG and the Board's Steering Committee. All groups seemed to agree that the terms of reference were very important and need to be clearly thought out for a specific task.

1) Adequate. Three responses appeared to indicate that the terms of reference were adequate. The Department of Health representative stated "They were clear and adequate". Another response (National Council of Women) was "Adequate for the most part but in fact they left the Service Development Group with a negative brief ie, asked to consider reductions, while still hoping to set an ideal". The Plunket Society Committee member thought they were "very comprehensive but could have been more clearly set out".

2) Not seen. Two groups, the Maori Women's Welfare League and the New Zealand Nurses' Association stated that they "doubted" or were "unsure" that they had seen the terms of reference. A reason for these answers may be that the questionnaires to nominating organisations were administered in June 1985, but the terms of reference were distributed in November 1982. It is possible that these groups elected new committees in the intervening period.

3) Negative. Parents Centre and the New Zealand Medical Association commented on negative aspects of the terms of reference. Parents Centre made a general comment which reflected a feeling of powerlessness: "Nationally Parents Centre has lobbied against closure of small maternity hospitals. As it was a foregone conclusion that a number would close in the Waikato area and one of the Service Development Group's tasks was to decide which ones, we were powerless to make the kinds of suggestions we felt were in the best interests of consumers". Although the National Council of Women had stated the terms of reference were "adequate", they also believed the Board had provided the SDG with a somewhat "negative brief" because of the direction to consider reductions to maternity services.

The analysis of the responses to an open-ended question which asked about methods of ensuring future representation of community representatives in health services planning showed all groups, apart from the New Zealand Medical Association, offered suggestions of ways of continuing community representation.

Parents Centre emphasised the need for community representation, stating: "We feel that community representation is vital, if the ratio of community representatives to "authorities" or "experts" is too low, then it is little more than a token gesture". Support for that statement was offered by the New Zealand Nurses Association, who stated "Our group felt the need to ensure that both urban and rural communities were represented". A view which did not support community representation came from the New Zealand Medical Association. They stated "public representation is a very noble ideal - generally we don't find it useful in medical matters". The implications of these statements will be further discussed in subsequent chapters.

Participants were asked to list any other groups that deserved to be included in the representation. Only three ideas were stated. These were for representation from local bodies, more consumer involvement and for the inclusion of people such as fifth and sixth form high school students. The request for a person who would "directly represent local bodies" was qualified by the comment that representation from Borough or United Councils "may have allayed adverse reactions of some of these". Fifth and sixth form students "should have had representation as future consumers".

A question about methods of ensuring health professionals' representation in health services planning provoked interesting responses. Comments were made which were not directly relevant to the question. There seemed to be agreement that health professionals required representation, but some groups continued to worry about consumer representation. The Plunket Society stated "Health professionals cannot always represent consumer views adequately". National Council of Women recorded "Health professionals need to be represented, but care needs to be taken that hospital health service hierarchies are not transferred to planning. Where senior doctors override other professionals' views articulation skills need to be present in juniors! More users, if articulate, could counter this trend." Concern about consumer representation was expressed, even when answering a question about ensuring professional representation. That theme will be discussed in subsequent chapters. Information provided when participants were asked if they thought that any future review of a health service area should involve a service development group showed that three groups (Maori Women's Welfare League, National Council of Women and Plunket Society) thought that service development groups should "definitely" be involved in future health services reviews. All the other groups also believed that a service development group and should be involved. There were no negative responses.

Benefits gained from involving community representatives in the review of maternity services were listed in response to an open-ended question. (See Table 7.4)

Table 7.4

Benefits Gained from Involving Community Representatives in the Review of Maternity Services

Response	Frequency
Broader viewpoint	3
Sharing viewpoints	4
Views of women	2
Awareness of social problems	2
Maori viewpoint	1

The Maori Women's Welfare League commented on the benefits, suggesting there is a need for "A broader awareness of maternity services, an appreciation for the communities where services were not being fully utilised and an interest in alternative uses as they would affect Maori families." The Department of Health, Plunket Society and New Zealand Nurses' Association emphasised that involvement of community representatives meant that there was a "broader viewpoint". National Council of Women stated that "Views of women are essential in any discussion of the health services and the senior medical representatives were men. Users of maternity services are obviously women so need to be represented by community groups". Parents Centre shared that perspective when they commented "Consumers of maternity services are in a vulnerable position as a majority feel there is no choice but to present themselves to the public system. Their voices must be heard."

The next question in the research asked "How much should community representatives be involved in the health planning process?" Information gained is shown in Table 7.5.

Table 7.5
Involvement of Community Representatives in the Health Planning Process

Response	Frequency
All the time	4
Regular consultation	3
Occasional consultation	1
Not at all	-

Four groups believed that community representatives should be involved in the health planning process "all the time", three groups thought there should be regular consultation. One group (the New Zealand Medical Association) selected "occasional consultation" as the appropriate response category. Involvement of community representatives in health services planning will be discussed in further chapters.

Committee members of the SDG nominating organisations were asked to list the positive outcomes or achievements of the SDG in the Waikato Hospital Board's review of maternity services. Table 7.6 presents an analysis of the main responses.

Table 7.6
Positive Outcomes of the SDG

Response	Frequency
Combination of community and professional viewpoints	3
Compilation of relevant information	2
Allowed a range of feelings to be expressed	1
Ideal of a family centred approach	1

The Department of Health, Maori Women's Welfare League and the National Council of Women all expressed appreciation for the "positive" combination of community and professional viewpoints. The New Zealand Nurses' Association believed that the SDG approach had allowed nurses to express a wide range of feelings concerning the review of maternity services, especially for the nurses who worked in hospitals threatened by closure. Plunket Society observed that "It meant that a great deal of data has been compiled that should provide a good baseline for the Hospital Board for future development of services." Parents Centre re-emphasised the "ideal" of a family centred approach for maternity services.

Five major themes eventuated in response to the invitation to "list the negative outcomes of the work of the SDG in the Review of Maternity Services." (1) Parochial interests were listed by the Department of Health, National Council of Women and New Zealand Nurses' Association. National Council of Women stated: "A parochial attitude was immutable anyway so there was a certain futility about the SDG's work." The Department of Health's comments inferred parochialism when they stated: "Often members protected their own interests and not the cohesive interest of the whole." (2) Closure decisions were stated as negative by the National Council of Women, New Zealand Nurses' Association and Parents Centre, who stated bluntly: "The decision to close some small maternity hospitals." (3) Difficulty of combining voluntary organisations and professional groups was mentioned by the Maori Women's Welfare League who stated that there had been difficulties for voluntary organisations meeting with professionals "who did the review as part of their work. Our one representative did not get much chance to "sound" off her ideas." (4) Loss of public confidence was described by one group (National Council of Women) who believed that the "SDG's credibility was strained and the public lost confidence in the Service Development Group and the Board because of the Board's decision to publish the SDG's report before all planned steps were taken." There was some confusion about when community consulation should take place. Some SDG members believed it should happen before publication of the SDG report, not after, which had occurred. National Council of Women and

the New Zealand Medical Association commented about lack of co-operation by the Board with SDG recommendations. The Medical Association observed: "Too much work for final outcome, too little evidence of the Board's co-operation with the Service Development Group's recommendations."

Table 7.7
Negative Outcomes of the SDG

Response	Frequency
Parochial interests	3
Closure decisions	3
Board's lack of co-operation with SDG's recommendations	2
Difficulty of combining voluntary organisations and professional groups	1
Loss of public confidence	1

Comments listed in Table 7.7 provide valuable information for future service development groups. The importance of public and interpersonal relationships in such an exercise will be discussed in the next chapter.

OVERVIEW OF QUESTIONNAIRE RESULTS

Major themes arising from the questionnaire results appeared to be 1) the value of the SDG's ideas; 2) appreciation of the work of the SDG from groups with SDG representation; 3) non-appreciation of the SDG's work by community groups without SDG representation; 4) ambivalence about the suitability of the SDG's terms of reference; 5) the importance of wide community representation in health services planning; 6) a requirement for ensuring health professionals representation; 7) agreement about involvement of service development groups in future health services' reviews; 8) criticism of participants with parochial interests; and 9) some difficulties expressed about combining professional and voluntary groups as members of the SDG. All these themes will be explored in the next chapter.

CHAPTER 8

DISCUSSION

Chapters, 5, 6 and 7 presented questionnaire and interview data collected in the present research. In this chapter nine major themes emerging from these data will be discussed and implications elaborated:

1) support for the service development group approach;
2) feelings of adequacy as a nominated representative;
3) appreciation of the SDG's work;
4) catalyst for change;
5) terms of reference;
6) administration;
7) feelings towards the Board's Steering Committee;
8) parochial interests;
9) cultural perspectives.

1. SUPPORT FOR THE SERVICE DEVELOPMENT GROUP APPROACH

SDG members' questionnaire responses demonstrated unanimous agreement about five aspects of the service development group approach which appear to provide sound reasons to support the service development group method. These were:

Community participation and communication. The SDG perceived itself as being positive toward the Board and its hospitals, as well as toward local communities and their needs. Those views suggested that such a balanced perspective would not have eventuated if the SDG had not involved the combination of community and professional representatives who had attempted to understand the complexity of the issues involved. The SDG saw itself as a way of maintaining effective communication between the people and the Board.

Chapter 1 provided the historical perspective of the SDG approach to health planning. In 1977 SACHSO (the Special Advisory Committee on Health Services Organisation) developed the idea of service development groups and recommended that they would enhance co-ordinated planning by having representatives of the public, private and voluntary sectors serving on them. Merging of lay and professional viewpoints can be a way of finding mutually satisfactory solutions in health services planning (Barnett et al., 1984; Malcolm, 1981; Wright, 1980).

It was a new initiative for the Waikato Hospital Board to involve community representatives in health planning, as they did in the maternity services review. Evaluation of the value of community representation was attempted in the present research. Participants answered questions during questionnaire and interview inquiry about the value of community representation. When asked about methods of ensuring representation of health professionals on service development groups, responses included pleas for continued representation by community groups.

Service development group approaches were viewed as potentially valuable for future reviews by ten of the eleven SDG members (Table 5.15), indicating a willingness to involve community and professional people when health services reviews are contemplated. Subsequent interviews with SDG members provided information which also supported the service development group approach. Community representatives emphasised the need for a community based service development group because they believed they had modified the professional viewpoint. Health professionals had come to realise that, although women appreciated professional care, they also needed the love and warmth of their partners and families, that they needed a homely, welcoming environment in which to give birth and unless there were extenuating circumstances they (particularly Maori women), wanted to have their babies in their home town. Medical and nursing representatives agreed that not only was lay input required it was "valuable". Comment was made that the Government "seems to want these service development things". At the same time that the SDG was involved in the Waikato Hospital Board's review of maternity services, the Government enacted the Area Health Boards Act, 1983, which directed that Area Health Boards appointed service development groups (from time to time) to advise hospital boards about aspects of provision of health services.

Interviews with the Board's Steering Committee provided confirmation of the need to include community representatives in planning. Community input was believed to have facilitated the maternity services review because public consultation was required by the Department of Health if closure of services was contemplated. A further comment was made that

"public representation was not always required in service development groups as it really depended on the type of service and the reasons for needing public involvement". It could be argued that services such as renal dialysis, anaesthetics or surgery, which are technically and professionally demanding, may not require community representation, because lay people may not have the expertise to contribute to these areas. However, questions from lay representatives could offer fresh insights which go against conventional wisdom yet may ultimately help toward decisions about provision of the best possible services. Nominating organisations (apart from the New Zealand Medical Association) emphasised the need for continued community representation. Parents Centre observed that community representation was vital and asked that the ratio of community representatives to experts be kept in balance.

Analysis of the membership of the SDG showed that there were three community representatives and eight health professionals. Such an imbalance must have presented a daunting challenge to the three women who represented the community when presenting their community-oriented views to an audience of four doctors and four nurses. In retrospect, it must be stated that they did manage to convey their ideas. However, the idea of equal representation is worth consideration by those responsible for setting up service development groups. Groups structured in that way may facilitate different approaches and perspectives for health service planning.

The New Zealand Nurses' Association stated there was a need "to ensure that both urban and rural communities were represented". There are important differences between the maternity services needs of urban and rural women in New Zealand. Rural women often experience difficulties in the areas of transport, child care and domestic support as well as needing additional help with the farm work - a role many carry out during pregnancy. As well as this, they are often isolated, with little emotional support. Urban women also experience difficulties with transport, child care and emotional support, but few carry out tasks such as milking the cows, cooking for shearing gangs or driving tractors and heavy machinery during pregnancy. Local communities needed reassurance that service development groups had members that different sectors were able to identify with and who represented their interests.

The implications of the theme about community and professional representation are that representation from the community as well as professional arenas is widely favoured and considered valuable in health services reviews. The service development group approach was believed to have allowed the expression of a "wide range of feelings" concerning the review of maternity services. Interview responses indicated that the majority of SDG members believed they had made up "a good group", representing many different interests. Steering Committee members agreed that it had allowed representatives to understand "a particular health service from a broader viewpoint" and "an opportunity to bring a community viewpoint". Positive responses about the combination of representatives provided evidence that it is possible for community and professional people to work together in a health services review.

Ability of a service development group to identify problems in the areas of maternal health, attitudes of hospital staff and hospital board politics. As mentioned in Chapter 2, one of the first tasks of the SDG was to define an "ideal maternity service" (see Appendix 4). The "ideal" set standards for the way a modern maternity service should be carried out. Relaxed "homely-styled" delivery environments were advocated as a way of helping women to relax during labour and facilitate delivery (Oakley, 1980; Service Development Group Report, 1983). The SDG observed that change to more relaxed settings was not apparent in all the Board's hospitals (Minutes of the SDG, 1982). Setting a standard which was endorsed by the Board meant that the SDG had understood Hospital Board politics and made change acceptable. Hospital boards are traditionally very formal, adhering to strict meeting procedure and considering any decisions or changes very carefully. SDG members had listed their formal objectives. The objectives were accepted by the Board. Once the concept of the ideal service was formed it was accepted by the SDG, the Steering Committee and then ultimately the Board. Once the ideal concept had been processed through all those committees it was accepted as policy. If the SDG had tried to impose the concept or politicise it they would not have been successful. Approval by the Hospital Board, an elected local body authority, was required. Questionnaire responses (see pages 72-73)

showed that SDG members listed their ability to change delivery theatres into "homely-styled delivery rooms" as one way in which they had identified a problem in the area of maternal health and provided a solution.

Formulation of the SDG's concept of an "ideal maternity service" (See Appendix 4). This was the first objective and task the SDG carried out. Completed in December 1982, it was later accepted by the Steering Committee and the Board and provided a basis for analysis of services for the review. There appeared to be general acceptance by all groups surveyed that the "ideal" concept had provided worthwhile standards to use when planning for future maternity services.

Public nature of the review. Many SDG members had no prior knowledge and contact with the Waikato Hospital Board. Responses to an open ended question about positive achievements of the SDG indicated that SDG members believed the insights they had gained and shared with nominating organisations about the functioning of the Board to have been a positive outcome for the SDG. Perhaps the involvement of the SDG in the review of maternity services was a successful public relations initiative because it broke down barriers. The SDG allowed public accessibility to a local body authority.

Increased awareness of consumers' perceptions of health professionals. One member of the SDG (a medical doctor) stated that he had gained an awareness of how "we as professionals are viewed by consumers". As a consequence of the SDG's discussions, views were modified and attitudes softened, which allowed consensus decisions to be reached. Community representatives were advocates for family involvement in the birth and post-natal periods whereas health professionals were more concerned with safety aspects.

Four out of the five Steering Committee members supported the idea of using a service development group approach to review maternity services for the Board (no reason was given for the one negative response). Steering Committee members all agreed that the SDG's ideas had been worthwhile and gave unanimous support to the Board's willingness to encourage community participation through the involvement of a service development group.

All of the SDG nominating organisations were in favour of the service development approach for health planning. There was agreement that involvement of health professionals was necessary, but consumer views could only be presented by lay representation. Reasons given were that the users of the maternity services were obviously women so needed to be represented by community groups. Parents Centre and National Council of Women had tried to represent women's views. Health professionals tended to be unaware of the consumer at times, except as receiver of their service and wisdom. The voice of the consumer had little chance to be heard. Often the emphasis on "cost effectiveness" neglected to consider the human cost. Consumers of maternity services are in a vulnerable position, as a majority feel there is no choice but to present themselves to the public system. It was questioned if the consumers' view was understood.

Six of the seven nominating organisations thought that the SDG's ideas had been worthwhile. (The New Zealand Nurses' Association did not respond to the question.) As these organisations included both professional and community groups, the overwhelming support expressed for the service development group approach must be viewed as a strong endorsement for the method.

2. FEELINGS OF ADEQUACY AS A NOMINATED REPRESENTATIVE

SDG members were selected by nominating organisations as people who had sufficient knowledge and experience to be able to contribute to the review of maternity services. Some found the task difficult, two went so far as to state that they had not been pleased to be selected as the representative, but did not elaborate further. A community representative and a nurse representative commented that they were selected after the SDG had started work and because of that it had taken a long time to settle in. Neither felt they had ever really caught up. The Research Officer appointed to work with the SDG, was employed after the first meeting had taken place. In retrospect, the whole exercise may have benefited by the earlier appointment of the Research Officer so that preparation of background information for the SDG could have been completed before meetings were commenced.

Professional representatives expressed some ambivalence about their role as SDG members. Plunket Society had nominated a nurse, but she had questioned her suitability, suggesting that a "Plunket mother" should have been selected. During the interview she reflected the belief that she had represented a nursing perspective rather than the viewpoint of a mother with a young baby. Medical doctors believed they could have accomplished the task very quickly if it had been solely their domain, but agreed that the community representatives had been useful.

Difficulties were expressed over "combining professionals with non-professionals. It was the consumer view that was required yet so many of the matters concerned depended on the opinion of professionals" (medical doctor). Major implications of this theme are that if people are to feel adequate in their role as service development group members they should be willing to participate, be thoroughly briefed and provided with sufficient background information to enable them to commence on equal terms. Also the climate needs to facilitate participation. Meeting rooms should provide a good working environment. People must be able to see and hear each other. The SDG did not find the Waikato Hospital Board Boardroom conducive for group discussion so agreed to shift to a small room at the Waikato Women's Hospital for SDG meetings.

Selection of people to serve as members of service development groups requires careful thought and sensitive application. All members should be selected before any meetings have commenced so that nobody feels as if their nomination and subsequent contribution was an "after-thought". The Maori Women's Welfare League representative was the last person included in the group and as subsequent data showed (interview reports, Chapter 5, p85) that a nurse member of the SDG felt that the Maori Women's representative's views "just got ignored". Acceptance of Maori cultural issues could well have been enhanced if Maori representation had not been an after-thought. These issues are discussed in greater detail in Chapter 9.

3. APPRECIATION OF THE SDG'S WORK

Responses to a question regarding "knowledge and appreciation of the SDG's work" were illustrated in Tables 5.5, 6.1 and 7.3. Responses were based on each participant's perception of the way that various

professional and community groups had viewed the SDG. The major trends emerging were that it was perceived that the SDG's work was "appreciated" by the Waikato Hospital Board, Parents Centre and the National Council of Women, but it was "not appreciated" by the community in general. Each of the groups that had "appreciated" the SDG's work had members as part of the SDG and were conversant with the process of setting up the SDG and its task. In contrast, the community in general had little information apart from negative news stories about possible hospital closures being the result of the review.

Major implications for future reviews seem to be that the Board needs to keep the public fully informed of all issues involved in an attempt to lessen community concern. It could be postulated that the positive attitude of the Board, Parents Centre and National Council of Women toward the SDG was formed because those groups were involved. Broader representation may assist future reviews, but that may not always be the most practical solution. Although the Board had stated that it was a public exercise, skilled public relations and communications may have facilitated the review. Early notification about the review and the implications of possible closures of maternity hospitals came from direct media reports from Board meetings. More careful management may have involved a sequence of prepared press releases planned to present all aspects of the review. Such an approach may have gained public co-operation, especially if some of the Board's problems had been discussed more fully. For such initiatives as fund raising for medical equipment, public goodwill is always needed. With care, some of those feelings of goodwill could have been used in the maternity services review. As it was, only feelings of public antagonism were gained regarding the proposed review. No positive views about the review were expressed by the public in the news media.

4. CATALYST FOR CHANGE

Over half of the SDG, almost half of the Steering Committee and all of the Nominating Organisations believed that the SDG's work had acted "in some ways" as a catalyst to make changes to maternity services. Examples of changes that occurred during the review period were the introduction of family-oriented delivery rooms; a far wider choice of the position which the women wanted to adopt during the birth process;

relaxation of some hospital rules and regulations about visitors and about who could attend the birth. The idea of the SDG acting as a catalyst for change is interesting. Explanations of why the SDG functioned as a catalyst could relate to the interest that was created by the SDG's visits, and the overall review. Ideas included in the "ideal concept for maternity services", and the sharing of information between professional and community people generated informal agreement for change providing the evidence that the SDG was a "catalyst for change" outside of any formal recommendations. As a direct result, the Parents Centre representative had been pleased to be asked to advise on changes to a delivery theatre at Waikato Hospital to make the room a family-oriented delivery room. It was also a direct reflection of the esteem that the Parents Centre representative had gained because of her contribution to the SDG.

The implication was that service development groups can effect change because of members' interest and involvement. This was a positive finding and a serendipitous result which showed that change can occur outside the set terms of reference.

5. TERMS OF REFERENCE

Questionnaire responses about the terms of reference set by the Board for the SDG provided both positive and negative viewpoints, but information gained during interviews allowed some further analysis to be undertaken. SDG members expressed frustration and dissatisfaction with the terms of reference and expressed a belief that the Board and the SDG should have met and decided on the terms of reference together. The Board pre-set the terms of reference, which had been agreed to at the start of the review and before all members had been appointed. At that stage members did not know each other and there was no group process operating. They were nervous, in strange surroundings and in the early stages not sufficiently informed or confident enough to ask for changes or argue about terms of reference with the Board. Once the SDG and the Board had agreed on the terms of reference, there was no option for any change available. At a later stage they realised that the terms of reference had dictated the outcomes of the review, hence the feelings of frustration and dissatisfaction because they felt their options had been dictated. A member of the Board's Steering Committee observed that the

outcome of the exercise had been affected undesirably by the need to save money, but that the SDG had eventually made its recommendations on professional (rather than financial) grounds. The same ambivalence was expressed by the nominating organisations, with half believing the terms of reference were adequate and half thinking they had been negative because the SDG had been asked to consider reductions to a service. Two groups (New Zealand Nurses Association and Maori Women's Welfare League) were unsure that they had even seen the terms of reference, which further supports the need to improve the communications aspect of such exercises.

The implications are that the terms of reference were accepted by the SDG yet, if studied carefully, provided the answer to the review which the SDG had been asked to carry out. In asking the SDG to identify at least one hospital for closure and savings of 5, 10 or 15 percent, the only outcomes to the review that the Board wanted or could expect were negative solutions. Perhaps the SDG should have questioned the terms of reference at an early stage or sought to have had the negative aspects removed. More flexible terms of reference should have been requested. Because the terms of reference provided the guideline for the review, there should have been more time given for discussion and agreement before commencement of the task.

6. ADMINISTRATION

Issues about administration of the SDG (previously outlined in Tables 5.10 and 6.2) provided some guidelines for the future. Both the SDG and Steering Committee believed that any future service development group should be smaller than the eleven people who made up the SDG for the maternity services review and should employ ad hoc group/community consultation. There have been efforts to specify the "ideal size" for problem-solving groups. Slater (1958) concluded that groups of five were the most effective for dealing with tasks that involved the collection or exchange of information or making a decision based on the evaluation of that information. Osborn (1957) suggested that the optimum size for brainstorming groups was between five and ten. Smaller groups may be more satisfying for participants because more time is available for each person to express opinions but the addition of a few more members may add different skills and assist in finding better

solutions. Some tasks may only require one person whereas other tasks will require several individuals (Hackman & Vidmar, 1972; Robinson, M. 1984; Steiner, 1972). Group size has both positive and negative influences on group process (Cartwright & Zander, 1968; Shaw, 1981; Swap, 1984). Large groups mean that a wide range of capabilities, knowledge and skills are available to the group. There is the opportunity to meet a wide range of people. Conversely shy people can hide in a large group. As the size of the group increases, time available for each member to contribute decreases and relatively fewer group members participate in activities. Members in a large group are more likely to conform to group pressures. A group of more than 12 is believed (Gibb, 1951; Marrow, 1957) to make the work impersonal, making the individual feel like a lone hand again, believing that any opinion voiced would not count. Once a group becomes larger than 12, members tend to form sub-committees. Marrow (1957) stated that small groups were more creative than large ones. The more time a group spent in discussion the greater the likelihood of achieving concensus decisions.

The SDG agreed that there should be clear terms of reference, agreed procedures and a skilled chairperson. A separate minute secretary was recommended because it had not always been possible for one person to keep minutes, provide information and act as the group's facilitator. Regular interchange of information with management was advised by Steering Committee members.

Responses to an open-ended question about additional factors which should be taken into account for future service development groups showed there was general agreement about the need for improvement to the administrative procedure. Definite implications arose. These were that the size of service development groups should be less than the eleven who had served on the SDG for the review of maternity services. Supplementary information should be sought from ad hoc groups and through consultation with community groups.

The nature of the task, rather than knowledge of preferred group size, appears to have provided guidance about the size of service development group required. Recent examples of different sizes of groups for the Waikato Hospital Board have been a Service Planning Group for Dental

Services with a specialised membership of eight people and a Service Planning Group for the Elderly with a wider representation of seventeen members. Dental services planning was considered to be a simple task by Hospital Board adminstrators. Service planning for the elderly was expected to be more complex because of a shortage of accommodation for an increasing geriatric population. The Service Planning Group for Dental Services completed its assignment in four full day meetings. It has a completed report which was scheduled for publication in April 1987. Work is still in progress for the Service Planning Group for the Elderly. Two meetings have been held but already the group has assigned responsibility for compilation of the planning document to a sub-committee of four people. Six meetings of the large group are planned but four additional meetings of the sub-committee have already taken place. Theories of group size are understood by psychologists but not necessarily by hospital administrators.

7. FEELINGS TOWARD THE BOARD'S STEERING COMMITTEE

SDG questionnaire responses indicated feelings of frustration about the Board's Steering Committee's power to alter the SDG's work "without due consideration of the SDG's carefully researched and discussed decisions". Interview enquiry yielded unanimous views that the Steering Committee had lacked broad vision, had "pre-made up their minds" and that even the professional members of the SDG could not combat the powerful Board's Steering Committee.

Individual members of the Steering Committee were leaders in fields which encompassed local body politics, medicine, nursing and financial administration. They were accustomed to authority, executive power and decision making. Members of the SDG were also prominent people in their professions or organisations who were used to decision making. As a group the SDG had not anticipated being controlled (or "steered") by a small, but powerful committee. Health professionals in New Zealand follow the structural model which stems back to the work of Fayol (1949). Staff in hospitals work in a bureaucratic, hierarchical span of control which assumes the right to give orders and the power to exact obedience. It was inevitable that the SDG with a membership of eight health professionals and three lay people would obey the chain of command principle and accept and obey the authority held by the Steering Committee who were the Board's top executive officers.

Subsequent questionnaire and interview inquiry provided information that SDG members had felt frustrated by some of the actions of the Steering Committee. A particular frustration noted was that the terms of the brief had implied that there would be on-going discussion with the Steering Committee. That did not occur and there seemed to be a feeling of disappointment that the two groups had not had the opportunity to share information. One implication of this theme is that the work of any service development group will be facilitated by open and friendly communication between management and the service development group.

8. PAROCHIAL INTERESTS

Parochial interests were spontaneously mentioned by a majority of all participants in response to open-ended questions and during interviews. There was an impression that the Board was "set against the districts" and that hospitals would be closed. Districts were seen as "having wants not needs" and not being prepared to listen. Three nominating organisations believed that individual SDG members had protected their own parochial interests and not the interests of the whole group. Those SDG members who were associated with districts where hospitals were threatened by closure, were perceived to have "responded rather differently from those whose hospitals' future was not uncertain". Even when factual information showed hospitals (and staff) were under-utilised, reasons were always found by local communities, hospital staff and some SDG members to support keeping facilities open. Discussion of parochial interests was also related to the financially oriented terms of reference which requested recommendation of closure of at least one district maternity hospital. The implication is that service development groups should look at a particular service as objectively as possible. If the idea of closure of a service arises it should be a consequence of the service development groups close examination of provision and the future development of that service. In that way there may be less need to protect local interests.

9. CULTURAL PERSPECTIVES

A request for more information about Maori culture was discussed by nurse members of the SDG during interviews. As SDG members they had attended a meeting of the Tainui Regional Council at the Te Puna Marae and on that day the meeting had been curtailed because of the accidental

death of a Tainui member's relative. The New Zealand Nurses Association had written on their questionnaire that it was apparent that "Maori culture had different feelings about birth and death". Cultural issues were introduced to SDG members by the Maori Women's Welfare League representative, but nurse representatives believed these had been ignored by the SDG.

Maori women living in the Board area belong to the Tainui Federation of Tribes. The Maori Women's Welfare League representative explained to the SDG that Maori people believed babies should be born close to their homes, that the whenua (placenta) should be buried in a traditional site which could be a rock or a hollow in a tree or a specially chosen place. Later the iho (dried portion of the umbilical cord) should also be buried in the same place as the whenua. That ritual makes a link with the land and is very spiritual and important for Maori people. The origins of birth and the end of human life as we know it are involved in these rituals.

Maori people value privacy. The lower part of the body is especially private and women find it hard to cope with teams of doctors peering at them in gynaecological examinations. They find it offensive that nurses use the same towels, face-washers and bowls to wash the top and lower parts of the body of hospital patients. Health is spiritual and consists particularly of trust, love, nurturing and warmth (Barham, 1987).

Although these particular issues were explained more than once to the SDG, there was no reference or discussion about the importance of cross cultural needs in health services made in any of the maternity services reports. Not every Maori woman will want the whenua (placenta) taken home and buried but the implications are that the opportunity to do so should be made available by hospital staff. Staff participation in cross cultural education in-service training courses should be encouraged. The SDG's report would have been more comprehensive if there had been an additional section which discussed particular needs of Maori people, who comprise eighteen percent of the Board's population, and a higher percentage of its maternity service clients.

SUMMARY

Nine themes have been identified and the implications of each theme discussed. Three gained very positive support. They were: 1) support for the service development group approach; 2) combination of professional and community representation in health services reviews and; 3) terms of reference for any future service development group should be given adequate time for discussion and agreement by all participants. Other issues which arose concerned the role as a nominated representative, appreciation of the SDG's work and its ability to effect change and the general administration of the SDG. Parochial interests of individuals and groups were discussed as were the SDG's feelings toward the power of the Board's Steering Committee. An awareness of the importance of considering cultural issues surfaced which has implications for the way any future service development group decided to work.

The next and concluding chapter will discuss the extent to which the aims of the present research were achieved, the limitations of the methodology and recommendations for future service development groups and association evaluation research.

CHAPTER 9

ACHIEVEMENT OF AIMS AND FUTURE DIRECTIONS

A framework for evaluation was required for this study. No single approach to the evaluation of effectiveness can be appropriate in all circumstances. It was decided to use Cameron's (1980) model of organisational effectiveness because it provided questions which could be used to try to understand the ways in which the SDG had functioned. Evaluating the effectiveness of organisations requires the selection of appropriate criteria (see Ch 3). In order to find the most useful approach, the evaluator should first answer critical questions about the assessment of organisational effectiveness (Cameron, 1980). The critical questions asked were (1) How well did the SDG accomplish its goals? (2) Did the SDG acquire needed resources? (3) Was there evidence of client satisfaction? (4) What were the internal processes and operations of the SDG? The four major approaches which were used to define and assess organisational effectiveness in the present study are listed below:

1) The goal model, which allows evaluators to focus on the outputs of an organisation. The closer an organisation's outputs come to meeting its goals, the more effective it is.

2) The human resource model or system resource approach. Under this approach the organisation's effectiveness is judged by the extent to which it acquires needed resources. That is, the more needed resources an organisation can obtain from its external environment, the more effective it is.

3) The participant satisfaction model. This approach defines effectiveness as the extent to which all of the organisation's strategic constituencies are at least minimally satisfied with it.

4) The process model which focuses on the internal process and operations of the organisation. Effective organisations are those with an absence of internal strain, where members are highly integrated into the system, internal functioning is smooth and typified by trust and benevolence toward individuals and where there is a free flow of information. Organisations are more effective if they possess a higher degree of these cohesive internal characteristics, and less effective if they do not have so many of these characteristics (Cameron, 1980).

The present study attempted to create meaning from confusion and complexity (Pfeffer, 1981), by establishing objectives which would act as a guide throughout the formation of the research, overall process and end analysis. These objectives (see Chapter 3) provided a conceptual framework for questionnaire and interview research and in this chapter will provide the format for a discussion of the results. Statistical methods of data analysis were not appropriate for the small sample sizes involved in this research. However, in-depth qualitative analyses have facilitated and enhanced the ability to draw conclusions from the information collated.

Assessment of the extent to which aims were achieved, a critique of the methodology and the methods used for analysis will be discussed. Implications of the results, some serendipitous findings, and recommendations for future service development groups are outlined. Suggestions are made about methods for further research and emphasis is placed on the importance of monitoring and evaluation for health services reviews.

AIM 1: TO ESTABLISH THE REASONS BEHIND THE BOARD'S DECISION TO REVIEW EXISTING MATERNITY SERVICES

Archival research methods assisted with achievement of this aim. Searches of Board minutes, newspaper clippings, Department of Health's Planning guidelines for hospital beds and services (1977), and discussion with the Board's Executive Officers provided reasons for the Waikato Hospital Board's decision to review its maternity services. These were: demographic changes such as the trend toward smaller families, the guidelines of the Obstetric Regulations (1975), oversupply of maternity beds in all of the Board's maternity hospitals, financial constraints and the temporary closure of Te Aroha Maternity Hospital due to shortage of nursing staff.

For a period of three to four years before the initiation of the maternity services review the Superintendent-in-Chief stated that he had been recommending closure of at least two underutilised district maternity hospitals. Pressure caused by the need for provision of other health services and a shortage of financial resources made it necessary to review the way existing services, facilities and finances were being used. However, the management problems of Te Aroha Maternity Hospital provided the major reason for the Board to write to the Minister of Health and request permanent closure of that hospital. In declining the request, the Minister used the issue as a stimulus to ask the Board to conduct a review of all its maternity services (see Appendix 2). Overall there were a number of contributing reasons for the review but the Minister's letter appears to have been the catalyst that caused the Board to decide to review its Maternity Services.

Achievement of Aim 1 involved acquiring resources such as information about the supply and use of maternity services. Only a thorough examination of all the available information allowed the researcher to conclude that it was the power of the Minister's request that had caused the Board to initiate a formal review. However, it also showed that it was only a trigger as there were many other basic reasons. These have been identified and are outlined above.

AIM 2: TO DESCRIBE WHAT HAPPENED DURING THE REVIEW PERIOD

A comprehensive account of the Waikato Hospital Board's review of maternity services was given in Chapter 2. The public exercise which was undertaken by the SDG and Waikato Hospital Board support staff involved collecting information from many sources. In the prescriptive model of the SDG process which is developed in Chapter 10, major concepts about SDG work are elaborated. In that way an in depth understanding of SDG process is developed.

The major stages of the review will now be summarised. Aim 2 was achieved because the Waikato Hospital Board's review of maternity services was a public exercise which alowed access to all the documentation kept by the Board, the Service Development Group (SDG), the Steering Committee, the Hospitals Advisory Council and newspapers. Their records allowed a full description of the review period to be given. The Waikato Hospital Board's review of maternity services was a separate exercise to determine obstetric needs undertaken for the Board by the SDG and the Steering Committee.

Commencement of the Review

The Board agreed to proceed with the programme as set out in the Draft Obstetric Service Plan (see Appendix 3). The plan proposed that there should be two committees: (1) the Board's Steering Committee, made up of Board members and executives who were to assist in the evaluation of objectives within financial constraints, maintenance and quality of services and existing policies; and (2) a service development group, which was to comprise representatives of providers and users of the maternity services and whose task was to assist in the review of maternity services according to terms of reference set by the Board (see Chapter 2). Having accepted the general principles of service planning, the Board set up its SDG in October 1982 with membership from professional, public, private and voluntary organisations. Terms of reference were formulated by the Board from which the SDG was to form its own objectives.

Definition of an "Ideal Maternity Service"

As stated in the previous chapter, questionnaire and interview responses showed that the SDG was aware that it had been asked to carry out a review within financial limits, but it decided that its first task should be to define an "ideal maternity service" (see Appendix 4). Many in the group stated at the time they were interviewed that the definition of an "ideal maternity service" was the SDG's major achievement. In setting an "ideal", the SDG set a standard that was simultaneously professional, safe and client-oriented in approach.

SDG members were united in their approach to the review. Sufficient time was taken to ensure that the "ideal" definition embraced ideas which were potentially worthwhile and feasible for families and health professionals. They pursued that "ideal" philosophy throughout all the activities which they undertook. Recommendations were made after careful consideration and discussion. The widespread opposition from local authorities and the general public to the SDG's report was disappointing to the SDG, but perhaps inevitable, because the recommendations to close five district maternity hospitals overshadowed the worthwhile concepts which the "ideal maternity service" espoused. It was unfortunate that there was little publicity about the potential benefits of the SDG's ideal concept, as greater emphasis on that may have altered the public's negative perception of the SDG's work.

The importance of communication networking, consultation, participatory democracy and the importance of articulating them through skilled public relations programmes and the use of a professional facilitator are developed and elaborated in Chapter 10. All these aspects become parts of a prescriptive model for SDG process which is described in the next chapter.

Integration of the SDG's and the Steering Committee's recommendations in the Waikato Hospital Board's Report. Review of Maternity Services - Maternity Service Plan, December 1984, resulted in a request by the Chairman of the Board to the Minister of Health to allow the Board to implement the plan and recommendations. Information about the implementation of the maternity service plan is included in this chapter (rather than in Ch 10) because all questionnaire and interview enquiry for the present research had been completed some time prior to the Minister releasing the Hospital's Advisory Council's Report. Therefore it was not possible to follow up on the effects of the implementation of the plan but it is relevant to give some information on the review cycle. The SDG was not involved in this process but the recommendations of their Exposure Draft plan were the foundation of a Maternity Service Plan. It is interesting to note that throughout the process of review by the

Board's Steering Committee, the public submissions, workshops and the visit of the Hospitals Advisory Committee there were no changes from the original SDG recommendations. An account of the process which occurred follows.

Request to Implement the Maternity Service Plan

The Board wrote to the Minister of Health on 31 July 1985, requesting permission to implement the Maternity Service Plan as set out in their 1984 report. The letter specifically requested permission to close or reduce the maternity function at four hospitals. On 2 October 1985, the Hospitals Advisory Council considered a request from the Waikato Hospital Board for the consent of the Minister of Health under Section 55 of the Hospitals Act 1957 to: (1) close Turangi Maternity Hospital; (2) withdraw maternity inpatient services from Putaruru Maternity Hospital; (3) withdraw maternity inpatient services from Te Aroha Hospital; (4) close Otorohanga Maternity Hospital. The Hospitals Advisory Council is a statutory advisory body to the Minister of Health set up under the Hospitals Act 1957 which has the Director-General of Health (ex officio) as Chairperson. The Hospitals Advisory Council appointed an investigating committee to review a request for a hospital closure. The chairperson of an investigating committee is the nominee of the New Zealand Hospital Boards' Association and committee members are health professionals in the specialty under investigation.

Visit of the Hospitals Advisory Council Committee to the Waikato Hospital Board District

During January 1986, the two-person committee visited the Waikato Hospital Board district. They investigated all of the Board's hospitals where maternity services were offered as well as visiting the neighbouring Boards of Thames and Taumarunui. Public meetings were held in Hamilton and at every place where a change or closure of maternity services had been requested by the Waikato Hospital Board. Relevant documentation and statistics held by the Board were also studied by the committee.

Release of the Hospitals Investigating Committee's Report

In July 1986 the Minister of Health released and supported the Investigating Committee's report which had been endorsed by the Hospitals Advisory Council. The recommendations were:

"1 that the council recommends to the Minister of Health that he decline to grant his consent to the closure of Turangi maternity Hospital;

2. that the council recommends to the Minister of Health that he grant his consent to the withdrawal of maternity inpatient services from Putaruru Maternity Hospital;

3. that the council recommends to the Minister of Health that he grant his consent to the withdrawal of maternity delivery services from Te Aroha Hospital but decline to consent to the removal of postnatal facilities;

4. that the council recommends to the Minister of Health that he should grant his consent to the closure of Otorohanga Maternity Hospital; and

5. that the council clarify its policy on additional or alternative use of hospital facilities as a factor to be considered by committees investigating proposals for closure or restricted operation of those facilities" (Hospitals Advisory Investigating Committee for the Hospital Advisory Council, July 1986).

The findings received wide media coverage. Despite protests from some areas, the Board has worked toward implementation of the recommendations. Otorohanga and Putaruru maternity Hospitals were closed by 1 December 1986 and Te Aroha Maternity Hospital was open for ante- and post-natal patients only - women being required to travel to neighbouring hospitals to have their babies.

AIM 3: TO DESCRIBE THE REASONS FOR THE BOARD'S DECISION TO USE A SERVICE DEVELOPMENT GROUP TO REVIEW MATERNITY SERVICES

Pressure was being felt by the Board about financial constraints and too many maternity beds, as well as a request from the Minister of Health to review its maternity services. Influences on and approaches to health

services and hospital planning were discussed in Chapter 1. One of the major influences on health services reorganisation has been the then Labour Government's White Paper A Health Service for New Zealand (1974). Prior to the "White Paper", planning was determined in terms of numbers of hospital beds. The "White Paper" was modelled on the National Health Service approach in Great Britain. It proposed fourteen regional health authorities for New Zealand by 1 April 1978. Although that did not eventuate, another similar proposal was developed by a Legal and Administration Consultative Group (1976), which recommended that service development groups should be established for each clinical and front line service and thus become the foundation unit of organisation and planning under the proposed new regional health authorities. All these approaches included consumer representation on deliberative committees. This offered the Board assurance that their thinking was up to date.

As discussed in Chapters 1 and 2, the service development group approach implemented in Northland, Wellington and Christchurch seemed to offer a definitive strategy for the solution of health planning problems. Malcolm (1981) commented that the service development group approach was an innovation of international significance as it demonstrated that a democratic participative model could work and that a desire for change could evolve from such a process.

One reason for the use of a service development group approach was, therefore, the recent history of health planning in New Zealand. A second reason which may have influenced the Board was that the service development group approach had already been used in Northland and Wellington with reasonable success. A third reason may have been the appointment of a new Chief Executive from the North Canterbury Hospital Board who had knowledge and experience of service development groups. The Waikato Hospital Board decided to use a service development group approach because of a succession of events which seemed to come together and provide sufficient evidence to warrant the approach.

There was agreement by the Board that there should be community involvement in the review. A suggested plan (Draft Obstetric Service Plan, 1982), which involved using a community based service development group to review maternity services, was endorsed by the Chief Executive, then formally approved by the Board. No alternative courses of action were offered or suggested at the decisive Board meeting (Waikato Hospital Board Minutes, 13 September 1982). The way in which the service development group process was used by the Waikato Hospital Board has been described in earlier chapters. However, it is pertinent to reiterate in this overview that service development group approaches have now been written into New Zealand legislation in the Area Health Boards Act (1983). As stated in Chapter 3, the present research is an evaluation of the maternity services review process rather than a review of maternity services themselves.

AIM 4: TO ASSESS THE EFFECTIVENESS OF EVALUATION RESEARCH TECHNIQUES FOR THIS STUDY

Evaluation research techniques described in Chapter 3 were chosen by the researcher to help in the process of understanding what the service development group approach meant to the people closely involved as well as communities with an interest in the exercise. Participant involvement by the author meant that research techniques were required which would both help to make the research project manageable for one evaluator and clarify the issues. Evaluation research techniques appeared to meet those requirements.

Examples of the Ways in Which Various Aspects of Evaluation Research Have Assisted This Study

Technical aspects. A study of the National Medical Care Expenditure Survey (NMCES; Berk, Wilensky & Cohen, 1984) provided some useful guidelines for the present study because it showed evaluation research techniques were useful and adaptable for a complex research design and worthwhile for a large study. The present research was on a comparatively small scale but it was fairly complex, so the NMCES example acted as a useful model for the present project.

The NMCES project had used surveys with different groups of potential clients which allowed comparison of different aspects of medical care expenditure It was decided that questionnaires administered to the three groups involved in the present programme would provide the information needed for analysis of the service development group process and so allow a comprehensive profile about the functioning of a service development group.

Political aspects. Research designed to aid the process of policy formation, programme design and management can be classified as a political activity when evaluation studies are carried out in contexts where people are vitally interested in the outcomes of the activities. Evaluation research provides information which contributes toward the political decision-making process (Levine & Levine, 1977; Raeburn & Seymour, 1979; Rossi et al. 1979). The present study was fraught with difficulties, with pressure coming from the Steering Committee and local communities, as well as internal pressure caused by protection of parochial interests by some SDG members.

Although it was never stated, the researcher gained the impression that the Steering Committee viewed the SDG as a difficult but necessary way of achieving an unpopular task. It could be suggested that the SDG was a political tool used by the Steering Committee. Local communities vented their anger at the findings and recommendations of the SDG but as some members of the SDG were drawn from local communities, the anger was modified. SDG members attempted to protect their individual and community interests while steadily becoming more unified as a group. Although protection of parochial issues was often mentioned in questionnaire and interview responses, the SDG's commitment to the group and its outcomes became apparent. SDG members realised that the group's work could influence professional decision makers about the delivery of future maternity services. In fact, changes toward less technical and more homelike obstetric environments occurred with the implementation of SDG recommendations, so that the SDG became part of the overall political process.

Models of Evaluation Research

As previously explained at the beginning of this chapter the goal model (approach) helped the researcher to develop an awareness about the types of questions required to obtain information from participants about how effective the SDG was in attaining its goals. The SDG had targets such as the concept of the "ideal maternity service" and a sincere wish to help make the delivery of maternity services more cost-effective. Use of this approach highlighted areas where difficulties had occurred and how achievement of the goals was impeded. One instance was the restrictive terms of reference which had limited the SDG's objectives. The goal model also helped show that the SDG's work had had some effects that were not intended. For example, questionnaire and interview responses demonstrated that support for the combination of community and professional views which had not been anticipated. This was an unexpected effect that showed up through using the goal model as a means for analysis because it raised the issue of "whose goals are being met?"

The human resource model assisted with understanding the ways that the SDG had been used by the Board to carry out a difficult task. The SDG brought a broad knowledge base to the review and the potential for worthwhile recommendations as a result of client involvement (House, 1977; Leviton & Hughes, 1981). The human resource model can be used to judge the extent that an organisation is effective in acquiring needed resources from the external environment (Cameron, 1980). It may be harsh to comment that the Board "used" the SDG to carry out a difficult task but the approach of the human resource model helps in trying to understand what occurred. Resource based theories propose that it is agreement about differing needs and methods of achieving those that links many social systems together (Cameron, 1980; Keeley, 1984). If the Board was not able to change maternity services by resolution from a Board meeting they had to find another method. Appointment of the SDG was a means to finding a method of effecting change. SDG members were willing to work on maternity service issues, but at the same time they helped facilitate a change in provision of services and allocation of finance.

Application of the human resource model also helped to show that the Board did not really use the potential of the SDG effectively. With the mix of community and professional membership, the SDG has an inbuilt

capacity to allow many client oriented changes to be made. The SDG created the "ideal" for maternity services. Parts of the ideal were implemented but new ideas of ante and post-natal care were acknowledged but mostly dismissed by the powerful Board Steering Committee. An example was the SDG acceptance of the public demand for home delivery (see Appendix 4) but those ideas were never followed up or investigated for possible implementation by any Board agency. This example illustrates that the Board was effective in acquiring the human resource of the SDG as a new method for exploring a health service.

The participant satisfaction model produced a guideline for designing questions used to assess which people were likely to be satisfied or unsatisfied with the review of maternity services. Effectiveness is defined as the extent to which strategic constituencies of organisations are satisfied by the review or programme (Cameron, 1980; Keeley, 1978; Pfeffer & Salancik, 1978). Perhaps the only strategic constituency that was fully satisfied was the Board, as all other groups involved lost to a certain extent, especially doctors, nurses, domestic workers, gardeners, pharmacists and florists who lost aspects of their employment or business. At the time of this report (March, 1987) it would appear that the group which lost the most and were least satisfied were young parents, who could not be expected to understand all aspects of the review. Social intervention programmes will be affected by the people involved in the project. Aspects of evaluation research which need to be taken into account include assurance of confidentiality of client information and respect for the procedures and protocols of institutions or organisations where research is undertaken (Finney & Moos, 1984; Patton et al. 1975; Snelgrove, 1983). Involving staff in evaluation studies can be useful and cost-effective for the programme because interest in obtaining successful outcomes is increased and unsuccessful aspects are more easily understood.

The process model describes effective organisations as those that operate smoothly (Cameron, 1980). In order to use the process model the SDG was conceptualised as an organisation and examined to see how smoothly it had operated. Questions were formed to allow responses about the way SDG

members perceived the functioning of their group and the overall effectiveness of the service development group approach. Members believed that they were a "good" group and the researcher observed that the cohesiveness of the SDG increased with each meeting. However, if their work had not been for a limited period of time, they may not have been able to continue to exist as a group without setting fresh and more acceptable objectives. As a group, the SDG had become unified and natural leaders had emerged. These leaders (the Parents Centre representative and a paediatrician) were finding the terms of reference increasingly restrictive. They shared a mutual and serious commitment to the protection and care of infants and their families. The researcher believes that, given time, they would have convinced the SDG and the Board that relaxation of the terms of reference was necessary to allow useful results and implementation of the "ideal concept". Insufficient time elapsed for the SDG to reflect on the useful role they had played. Understanding of the functioning of the SDG was enhanced by using the process model as a guideline.

It can be seen that all of the models provided some help but two were most helpful for analysing and understanding what the service development group approach had meant to SDG participants and local communities. These were the goal model and the participant satisfaction model which helped the researcher to assess the achievements and community perception of the SDG.

Categories of Evaluation

There are six categories of evaluation, of which two (formative evaluation and programme monitoring) were relevant to the present study (Campbell, 1974). The concept of formative evaluation related to the development, progress and change occurring within the SDG, while programme monitoring provided a framework which assisted with understanding the role of the evaluation researcher as a participant observer (Attkisson, Brown & Hargreaves, 1978). For both categories, qualitative information gathering procedures were required (Patton, 1979; Trend, 1979). Shifts in attitudes within the SDG were observed by the researcher and examined further during interviews. Interview information provided insights into aspects of the relationships occurring between SDG

members and the three groups involved in the study. The participant observer role was important because it allowed observation of verbal and non-verbal behaviour which was discussed during subsequent interviews. When the Steering Committee and the SDG had their last meeting they did not amalgamate but sat strictly in their own groups. That observation further confirmed questionnaire and interview findings about the lack of cohesiveness between the two committees. The additional dimension of participant observation involved in the process model allowed the researcher knowledge and insights which helped faciliate the various stages of the study. Evaluation research techniques were useful and effective in the process of understanding what the service development group approach meant to people closely involved as well as communities with an interest in the exercise.

AIM 5: TO DESCRIBE PARTICIPANTS' ATTITUDES TOWARD THE SDG

Understanding participants' attitudes about the SDG employed the strategic constituencies or participant satisfaction model (Cameron, 1980). Cameron (1980) states that in this approach, the effectiveness of an organisation is judged by how well it responds to the demands or expectations of its strategic constituencies. The theme of participatory democracy was revealed as important in the SDG process. The methodology used to gather information from the SDG, Board's Steering Committee and selected community groups about their attitudes toward the use of a service group development involved three major techniques. These were: analysis of archival data, questionnaires and interviews. Major findings were discussed in the previous chapter. There was unanimous support from the SDG and their nominating organisations and, in terms of the participant satisfaction model, qualified satisfaction among the Steering Committee with the idea of using a service group development approach for reviewing maternity services. Subsequent questions and interviews showed general support by participants for representation from the community in health services reviews.

As an illustration of this model, the SDG and nominating organisations were satisfied that the SDG's work had acted as a "catalyst for change" to maternity services whereas the Steering Committee were only minimally satisfied. Changes occurred because of the involvement of the SDG and

the interest in maternity services and professional practice which was created. The SDG's ideas about family-oriented delivery rooms have been introduced in all the Board's maternity hospitals. In 1986 a refurbished family-oriented delivery room was opened at Te Kuiti Hospital's maternity unit. The Board's architect reported that the ideas had been gained from the SDG and the Board's review of maternity services. Questionnaire and interview responses from the present study showed that a majority of respondents thought that combining professional and community viewpoints had been a positive outcome of the service development group approach because it allowed people to share ideas in an open forum. That finding must be considered to be a worthwhile outcome of the present research.

Protection of parochial interests was another theme introduced by over half the participants. SDG members were perceived to have put their own needs first. Community representatives wanted to retain hospital services in local districts. Professional people emphasised the quality of care provided for women at local maternity hospials in an effort to retain local services and ensure the continued use of facilities and maintenance of employment. Overall, SDG members were more interested in trying to protect the interests of their own district than they were in facilitating the work of the SDG. This fact has been mentioned in other studies concerning social programmes and educational initiatives (Levine & Levine, 1977; Rossi et al., 1979). The researcher believes that interviews with the nominating organisations should have been carried out. They would have provided more in-depth information about the effect on districts and the social costs to people should maternity services be changed or closed.

Facilitation of service development groups has been helped by insights gained during the present research regarding the SDG for maternity services. The researcher has subsequently been involved in service planning exercises concerned with dentistry, psychiatry, intellectual handicap and the elderly. Knowledge gained from the present study has been used when setting terms of reference for service planning groups, although group size is still subject to political considerations of the public and board administration. Ensuring that relevant organisations have representation may mean large service development groups are formed.

The researcher has learnt that as well as the major tasks it is important to have a key person (facilitator) available to help service development group members with details such as transport expenses, parking, general information about secretarial assistance, photocopying, meals and location of lavatories. That person should also be accessible to answer queries and supply information outside of meeting times. Attention to these matters makes service development group members feel worthwhile and positive about the task being attempted. This attention to SDG's personal comfort is part of the general facilitation of the group and was equally important to the professional people as to the lay members.

AIM 6: TO EXAMINE THE INTERACTION AND CO-OPERATION BETWEEN THE VARIOUS COMMITTEES INVOLVED IN THE REVIEW

Political aspects of evaluation research were useful when attempting to understand the degree of co-operation between the three main groups involved in the review. Many staff members were involved in aspects of the review and had the potential to shape the review's directions and outcomes.

Co-operation varied between the different groups. Interviews with SDG members showed that many had feelings of frustration and resentment toward the Board's Steering Committee. The Steering Committee had a wide brief to advise the SDG about matters of finance, service delivery and policy. However, it seemed that there was little useful interaction between the Steering Committee and the SDG. Community representatives commented on the rigidity of the Steering Committee's approach while professional representatives worried about the use of power. The hierarchical chain of command in hospitals in New Zealand allocates most power to the position of Superintendent-in-Chief. Comments made by both doctor and nurse members of the SDG confirm that the hierarchical model and use of power was applied to the SDG and its work. SDG members felt powerless to deal with it. In the interaction that did take place between the Steering Committee and the SDG, the Superintendent-in-Chief used the power attributed to his position to make sure that decisions made were consistent with his thinking. Although some issues were only minor, this negativism resulted in feelings of resentment and anger from the SDG. Frustration was caused because the Board's Chairperson had

asked the SDG for innovative suggestions regarding maternity services. In response, the SDG recommended amalgamation of Te Aroha, Morrinsville and Matamata Maternity Hospitals into one hospital sited in the Ngarua area. Ngarua is central and equidistant from the three townships mentioned (See Map 1). Reasons given for the proposal were that it would secure modern family-oriented facilities for the future, and relieve staffing problems. SDG members were dismayed by the Steering Committee's negative reception of the idea of the new hospital. Steering Committee views were endorsed by Te Aroha's mayor who attacked the proposal as "absolutely stupid" because Ngarua was without facilities such as drainage or water supply. There was no fire brigade, and doctors, nurses and other staff would have to travel 19 km to work from the area's towns (Waikato Times, 3.10.83 and 5.10.83).

Interviews with the Board's Steering Committee brought further insights about interaction and co-operation between committees. One member from the Steering Committee stated that there had been "very little" positive reaction by the Steering Committee to the SDG. The Steering Committee's comments appear to indicate that more interaction and understanding between the groups may have benefited the review. The power relationships existing between the two groups meant effective communication was impossible. There were ideas that one committee was meant to "steer" the other, but any attempts to do so were met with resentment and frustration from the SDG.

Evidence that there was interlocking between the SDG and their nominating groups can be assumed from the positive answers and additional comments which the SDG nominating organisations offered throughout their questionnaire responses. The Maori Womens' Welfare League, National Council of Women and Plunket Society all emphasised that service development groups should "definitely" be involved in future service reviews. All the other nominating groups also believed that service development groups should be involved. From the positive responses to questions about involvement of service development groups in future service reviews, it must be interpreted that there had been effective communication between SDG members and nominating organisations.

Indications are that hospital boards that use community-based service development groups in service planning exercises will benefit from the communication network which will be established between the Board, organisations and the community at large.

It has been demonstrated that there was little interaction or co-operation between the SDG and the Steering Committee, only a struggle for, and against, maintenance of power relationships. There was evidence that there was good communication and interaction between the SDG and all their nominating groups.

AIM 7: TO ATTEMPT TO MEASURE THE AMOUNT OF SATISFACTION WITH THE SDG EXERCISE AS PERCEIVED BY THE COMMUNITY

The participant satisfaction model (Cameron, 1980; Keeley, 1978; Pfeffer & Salancik, 1978) was used to understand the extent to which key organisations' strategic constituencies were satisfied. Participants were given the opportunity to list (1) the positive outcomes of the SDG, and (2) the negative outcomes of the SDG as well as to comment on the terms of reference set by the Waikato Hospital Board for the SDG. The response formats were open-ended to allow different ideas from each of the three groups. Analysis of the responses enabled conclusions to be made about the amount of satisfaction with the service development group exercise.

Facilitation of community participation and communication were listed by all SDG members as positive outcomes by the SDG. The SDG felt that their report had made information about maternity services available to the general public and allowed interactive comment. Conceptualising an "ideal" for maternity services was also counted as an achievement. Members of the SDG believed that the ideal standard which they had set for their own work was worthwhile and they hoped the standard would be applied in both the Board's and other New Zealand maternity hospitals.

All groups consulted commented about the positive way in which community and professional people had worked together as members of the SDG. In retrospect, little acknowledgement was given to the SDG for its work by the Board or the general public, yet its foundation work continues to gain credibility as a health service planning initiative in New Zealand.

The researcher has been asked to speak about the example of process and faciliation of the maternity services SDG at Department of health national seminars for health planners in 1987 and 1988. Planners and managers who attend come from hospital boards, health development units, private and voluntary agencies. Satisfaction was expressed by members of the SDG who were pleased that they had been able to participate in a community exercise. Gaining insights into the functioning of a hospital board and being involved in some of the planning were valued. However the SDG were given little reason to believe that their work had been appreciated, was useful or far sighted. SDG meetings finished when their report was completed leaving some members feeling discarded by the Board. More attention to the public relations aspects between the Board and the SDG may have prevented these negative feelings.

Responses from the Steering Committee about positive outcomes of the SDG's work indicated an awareness of the value to a health service of community involvement. Creating public awareness of the Board's willingness to encourage community participation was listed as a positive outcome by all participants, so acknowledging the public relations function of the SDG for the Board.

In contrast to positive outcomes and satisfaction, there were some major dissatisfactions noted by all groups. These were: parochial interests, restrictive terms of reference, closure decisions and subsequent loss of public confidence. There appears to be a public expectation that hospital boards supply but do not withdraw services. Suggestions of possible maternity hospital closures caused people to worry that further hospital and other general services such as rail, bus and courthouses would be lost to townships. This is evidence of participant dissatisfaction. Criticism of the "terms of reference" for the SDG occurred repeatedly throughout this study. The National Council of Women commented that the terms of reference had been adequate, but in fact had left the SDG with a negative brief, because they had been asked to consider reductions while still hoping to set an ideal.

AIM 8: TO MAKE CONCLUSIONS ABOUT THE VALUE OF THE SERVICE DEVELOPMENT GROUP PROCESS

Two models, goal and participant satisfaction (Cameron, 1980) proved to be the most useful to allow analysis and conclusions to be made about the value of the service development group process. An example of an SDG goal and achievement would be their setting an objective of creating a model for an "ideal maternity service" and completion of that task (see Appendix 4). Participant satisfaction was evidenced by questionnaire responses which demonstrated that SDG and Steering Committee members had valued the combination of community and professional views in the review of maternity services. The human resource and process models allowed some clarification about the way resources had been obtained and the influence of the SDG review on traditional hospital administrative structures. Responses from participants indicated that the service development group approach was valuable for reviewing health services. The combination of professional and lay perspectives had resulted in fresh ideas and innovative approaches for maternity services. A good example was the implementation of the SDG's idea of family-oriented delivery rooms which can be observed at Te Kuiti's Maternity Hospital. The traditional austere delivery rooms are no longer used (they have been converted to a physiotherapy unit) and the space once used for a large, lonely nursery for newborn babies has been converted to a welcoming delivery room. Soft pink carpet, matching drapes, a lazy-boy lounge chair, bean bags and a low seat designed for a seated birth position welcome prospective parents. According to a nurse who works in the unit mothers seem to have easier and shorter labours, with less need for perineal sutures when their babies are born in the new room. Next door a more traditional but new delivery room with linoed walls, floor, and plenty of technology on show is only used when the carpeted room is occupied. Carpets have been introduced to the corridors of the post-natal wards and the researcher noted the happy faces of staff and mothers when visiting this unit during May 1987.

These changes resulted from the impetus caused by the review of maternity services and the work of the SDG. It was also interesting to note that 33% of the women attending Te Kuiti Maternity Hospital lived in Otorohanga where the maternity hospital was closed as a result of the SDG's work. There are no recorded complaints from these families about having to travel south to have their babies, which could possibly be due

to the relaxed family-oriented atmosphere which they had encountered at Te Kuiti Hospital. In addition, the SDG's idea of a visiting midwife (who is the previous principal nurse of Otorohanga Maternity Hospital) to carry out post-natal care appears to be working to the benefit of families and the midwife.

The importance of the "lay input" from the community representation in the SDG should not be underestimated. Throughout the review community representatives advocated that there should be provision of maternity environments best suited for families, and not for the convenience of health professionals. Health professionals believed the review had provided an opportunity for both professional and community representatives to understand a particular health service from a broader viewpoint. A process of change in group interaction occurred within the SDG which was observed by the researcher. Seating at meetings was strategically changed by the research and development officer to encourage wide communication within the SDG and to break down the traditional medical and nursing hierarchical patterns that were operating within the group. After a while community and professional members mixed freely. It was encouraging for the researcher to help facilitate the work of the SDG which, it was hoped, would help improve obstetric service provision for families.

This evaluation study has shown that service development groups are worthwhile for assisting with health service reviews. The development of ideas created in such diverse groups with the incorporation of lay and professional controls will help to provide acceptable and cost-effective solutions.

AIM 9: TO MAKE RECOMMENDATIONS FOR FUTURE SERVICE DEVELOPMENT GROUP EXERCISES

A major challenge in the present research was to discover the most useful methods for distinguishing what were the important aspects of the service development group approach in order to make recommendations for the future. The present research was designed not only to study the process of service development group functioning and people's perceptions of its effectiveness, but also to make recommendations for any other

agencies planning a similar type of exercise. Six recommendations were derived from the findings of the present study and the researcher's participant involvement.

The recommendations are listed below:

1) That the service development group approach or community involvement and participatory democracy is recommended as a worthwhile method to assist with reviews of health services because it involves people in the prescription of their own services and ensures understanding and co-operation. There are some service areas where community involvement may have its limitations. An example would be where complex medical technology is involved such as renal dialysis or cardiac surgery, although consumer involvement would still be necessary to represent client perspectives that health professionals do not always consider. There could be difficulties with service accessibility, personal expense, family care problems, fear of the procedures or misunderstanding of of the process.
2) That all service development group members are selected before meetings commence so that nobody feels at a disadvantage.
3) That skilled public relations and communications exercises should be employed to help facilitate and communicate the information and thus increase the general public's understanding about such reviews.
4) That adequate time should be given to allow discussion and agreement about any terms of reference before commencement of the task so that SDG members do not feel they are being controlled and directed.
5) That service development groups should be small in numbers of personnel to ensure optimal SDG performance; for example 5 to 10 people would comprise an efficient working group. These aspects are discussed in greater detail in Chapter 10.
6) That a key person should be available to act as a facilitator for the group. Community psychologists or people with social science training would be able to carry out this role.
7) That cultural issues should be taken into account. Biculturalism and multiculturalism are complex matters that require careful study and consideration. A professional facilitator should be able to assist the SDG with relevant research and information sources.

CRITIQUE

Several aspects of this research require consideration. They are:

1) design of the questionnaires; 2) importance of interview information; 3) participant observer role of the researcher; 4) benefits of in-depth qualitative analysis; 5) social cost aspects; 6) future research. Each will be examined separately.

1) Design of the Questionnaires

The methodological approach was exploratory and investigative, employing three major methods: (1) archival data, (2) questionnaires, (3) interviews. Archival data provided background information, while questionnaire and interview data provided the in-depth information needed for qualitative analysis. However, there were some questions where further elaboration of responses was needed. The structured response formats did not provide the same in-depth information as the open-ended questions. Final analysis of questionnaire results showed the need for further information about some response sets. For instance, one member of the Steering Committee did not support the idea of using a service development group for reviewing maternity services. The response format for the question had not required any further explanation of the given answer. As all other participants had supported the idea of a service development group approach, some explanation of the one dissenting response would have been helpful. Examples of responses which required further elaboration occurred in each of the three questionnaires. Greater allowance for commentary may have elicited further information from respondents.

Questionnaires and interviews were useful for the present study although there were limitations in the depth of information and insights that were obtained. Another approach which could have been taken would have been filming the SDG at committee meetings. This would have provided video feedback and allowed the committee some self appraisal of their level of interaction. It would also have recorded valuable data regarding non-verbal behaviours of the SDG which the researcher could have incorporated into the present study. Other techniques which may have been used include small group discussion with the committees, local authorities and with relevant consumers. Moreover if the study had continued over an extended period of time, a systematic examination of outcomes could have been undertaken, thus enhancing the evaluation of the usefulness of the SDG approach.

2) Importance of Interview Information

SDG and Steering Committee members were interviewed after the questionnaire enquiry was completed. Interview information from the SDG and Steering Committee provided valuable qualitative information and penetrating insights for this evaluation. The committee members of nominating organisations were not interviewed because the task was physically impossible for the single researcher involved in this study. Interviews with nominating organisations' committee members may have provided further insights about aspects of the review such as biculturalism and socio-economic difficulties. This demonstrates that more researchers would have allowed the study greater completeness.

3) Participant Observer Role of the Researcher

Overall, the participant observer role of the researcher was beneficial for carrying out evaluation research on the service development group approach to review maternity services. Although this research project is dated as having begun 1 July 1984, the researcher had been employed by the Board since the second meeting of the SDG (held 16 November 1982) and enjoyed a working relationship with all the groups that were involved. To avoid confusion between the Board's review of maternity services and the present study, the researcher explained to the SDG that she was going to conduct a separate evaluation study of the review. SDG members understood that the evaluation programme was to be supervised by staff from the Psychology Department at the University of Waikato. Goodwill and co-operation were evident at all times from SDG members. In turn, the researcher was aware of the need for objectivity and consideration of ethical matters.

Questions could be asked about limitations which the participant observer role may have put on the researcher's ability to collect objective data. Social scientists are trained to be objective and to approach research settings free from, or aware of, any bias. Possibly the only bias that the researcher had was to facilitate the review of maternity services for the Board; there were no pre-conceived ideas of outcomes. The Board had not allowed finance for a formal evaluation of the review so the incorporation of a post-graduate study could be considered to have been fortunate for the researcher and the Board. Other studies and researchers may not be so fortunate, a theme which is developed at the conclusion of this thesis.

4) Benefits of In-depth Qualitative Analysis

Small numbers involved in this research meant that statistical analysis was not appropriate to the exercise. Findings have been described and supported with in-depth qualitative data. When the research was designed, it was realised that descriptive analysis was more appropriate than fine-grained statistical analysis. Qualitative analysis has added a richness to this study and allowed insights and perspectives which have been exciting and constructive. As mentioned, any limitations of the analysis have been caused by the design of the response formats for the questionnaires, which limited the amount of information for interpretation.

5) Social Cost Aspects

A topic not developed in the research was how the maternity services review and possible findings would affect communities and what participants thought about these social cost aspects. Questions related to social policy and economic issues would have been worthwhile. For instance, did it matter to the SDG that women and families may be disadvantaged if hospitals closed and how did that compare with the government's social policy? Since the introduction of the Social Security Act in 1938 and the accompaning health care benefits, there has been an acceptance that New Zealand people have access and a right to free health care. The Waikato Hospital Board's review of maternity services showed a diminishing demand for maternity services. It did not establish any new health service demands, because that was outside the SDG's brief. A whole facet which was really overlooked was the economic and social cost factors which were associated with either keeping small maternity hospitals open or closing them or trying to provide alternative services. There was a whole range of issues to be considered such as loss of employment, transport costs, loss of business for the local pharmacist and florist, loss of a health presence in a township, possible loss of general practitioners and the question of acceptance of change by a local community. A hospital in a small town creates a nucleus of business, local pride and social cohesiveness. Possible loss of a hospital would not be acceptable to local communities. Future studies may be able to account for these aspects in much greater depth.

6) Future Research

Major findings and recommendations from this study provide some guidelines for future research. Service development groups have now been legislated as requirements for Area Health Boards in New Zealand. Evaluation and monitoring is advised as an integral part of any such exercise. Recommendations suggested for further research are that a team of researchers study several service development groups simultaneously. A team approach to evaluation would allow intensive collection and analysis of information in an efficient time framework. Evaluation findings would be current and useful for ongoing exercises.

Evaluation is time and labour intensive. For such tasks it may be preferable to employ social scientists on a consultative basis. The present study involved a researcher from inside the organisation; however, it may be that future research and evaluation could be carried out on a contract basis. Contracting research specialists would ensure freedom from any pressure from interested parties. It can be difficult to be both researcher and employee because some research projects may result in findings which the employer finds difficult to accept or rejects. Subsequently the employer may discontinue the project and the employment of the researcher. It is also difficult to maintain objectivity while facilitating a group. The insider perspective can be influenced by personalities or environmental factors. Competent evaluation studies free from influence or bias may assist in helping to achieve health service changes acceptable to health service professionals and the community in general.

The present study was possibly a little ambitious for one researcher. Time limitations meant that basic sociometric and leadership information about the SDG is sparse. Systematic observations using a standard schedule such as Bales Interaction Process Analysis would have been useful to help understand the small group interaction processess that were occurring. More time should also have been spent in allowing the SDG members to get to know each other. Closer examination should also have been made of the SDG's working environment and an attempt to change the situation should have been made by discussing the issues within the chairperson. A more neutral venue of convenience to all participants may have been utilized.

Information collected for this study has provided evidence which endorses the Board's decision to involve a service development group in the review of maternity services. Community and professional thinking was combined to produce a reasonable plan for future maternity services. Some themes developed which deserve concluding comment. The Superintendent-in-Chief was criticised for using power in a way that frustrated the SDG. However, in 1987 a new Superintendent-in-Chief was appointed (due to retirement of the incumbent). Immediately after that appointment new guidelines for service planning groups were developed. There was a belief that the people who had been involved in the review of maternity services were "martyrs" and that future reviews would have strict time frameworks and be less open to the community.

In retrospect it must be stated that the community representatives involved in the maternity services review brought a freshness of thought which contrasted with traditional ideas. Professional representatives showed their integrity in being prepared to listen to and examine new perspectives for health care services. The combination of community and professional views was the key factor that made the service development group approach worthwhile.

The findings from the present study and the researcher's close observation of SDG process have allowed an understanding of the generic aims of service development groups and the attempts toward participatory democracy in health service planning. In the following chapter a prescriptive model for service development group process is presented. Propositions of group leadership and group process conditions conducive to the successful functioning of service development groups are discussed. Political, bureaucratic and community conditions likely to enhance or inhibit the performance of service development groups and the likelihood of domination by hierachical bureaucracies are outlined and information is presented to help ensure successful service development group exercises.

CHAPTER 10

A PRESCRIPTIVE MODEL FOR SERVICE DEVELOPMENT GROUPS

The Waikato Hospital Board's Review of Maternity Services, the involvement of a Service Development Group (SDG), and the way that the SDG assisted with that exercise, has been the focus of the present research. This focus has involved a case study examination of a health service review, particularly an attempt at participatory democracy with the inclusion of community representatives in the SDG.

Many issues affect planning for health and other human services. In this final chapter, it is intended to formulate a prescriptive model of service development groups which may assist and guide future planning initiatives. Existing social and cultural values will always prescribe the political formation of SDGs but with community and lay involvement in the SDG planning process it appears there is some account taken of public concerns. Key issues, principles and priorities which should focus the direction of future planning and decision making will be discussed.

PROCEDURES REQUIRED TO SET UP AND MONITOR IMPLEMENTATION OF AN SDG

In New Zealand, health is a service industry for which there is legislation that health planning reviews should be assisted by service development groups (Area Health Board Act, 1983). In general, for any organisation wishing to set up a service development group there should be a clearly defined reason for doing so. This chapter presents an overview of the procedures required to establish and monitor a SDG programme.

Members should be selected before meetings commence. It was found in the SDG exercise for maternity services that adding a member after the group had started its work was not conducive to smooth functioning because of the period of adjustment that was required. Group membership should be selected on the basis of what people can bring personally and contribute to the group, and not just because they represent a specified organisation, even though that background may be useful. People who have a sensitivity for others, the ability to listen and question are valuable in an SDG.

It is important to appoint a skilled facilitator to work with the group. Ensuring that there is adequate time given for discussion and agreement about the SDG terms of reference before commencement of the task is essential. Specific preferences of the people that the plan is being prepared for should be taken into account. The experience of the present study has illustrated that Maori people have different feelings about events surrounding birth and death than European people. Skilled public relations and communications exercises should be employed to ensure dissemination of information to the target audiences (see Chapter 9). The SDG concerned with maternity services felt let down that the good work which they had done was not appreciated by the general public. If a skilled public relations programme had been planned it may have been possible to gain positive effects and feedback from the public about the SDG's work.

At the beginning of the maternity services review the researcher was given little information or guidelines about the work that was to be conducted. The work for the review, the present academic research and subsequent service planning initiatives have allowed development of a prescriptive model for service development group initiatives. The model is illustrated in Figure 1, p 161. Major components of the model are described as being inputs, or outputs, to allow an understanding of the contribution of each part in SDG proces.

An effective service development group with an equal community and professional representation is a way "... by which communities decide on their own needs and priorities, acquire knowledge, and develop and gain access to resources and support systems to meet those needs ... The process implies strengthening of existing communities from within, in contrast to the organisation of communities by outside forces" (Davey & Dwyer 1984, p 8).

GENERIC AIMS AND METHODS OF SERVICE DEVELOPMENT GROUPS AND WAYS OF ACHIEVING PARTICIPATORY DEMOCRACY

Service development group comprise a group of people with a balance of lay and professional represention. These participants are selected through the process illustrated in Figure 1, because of the special

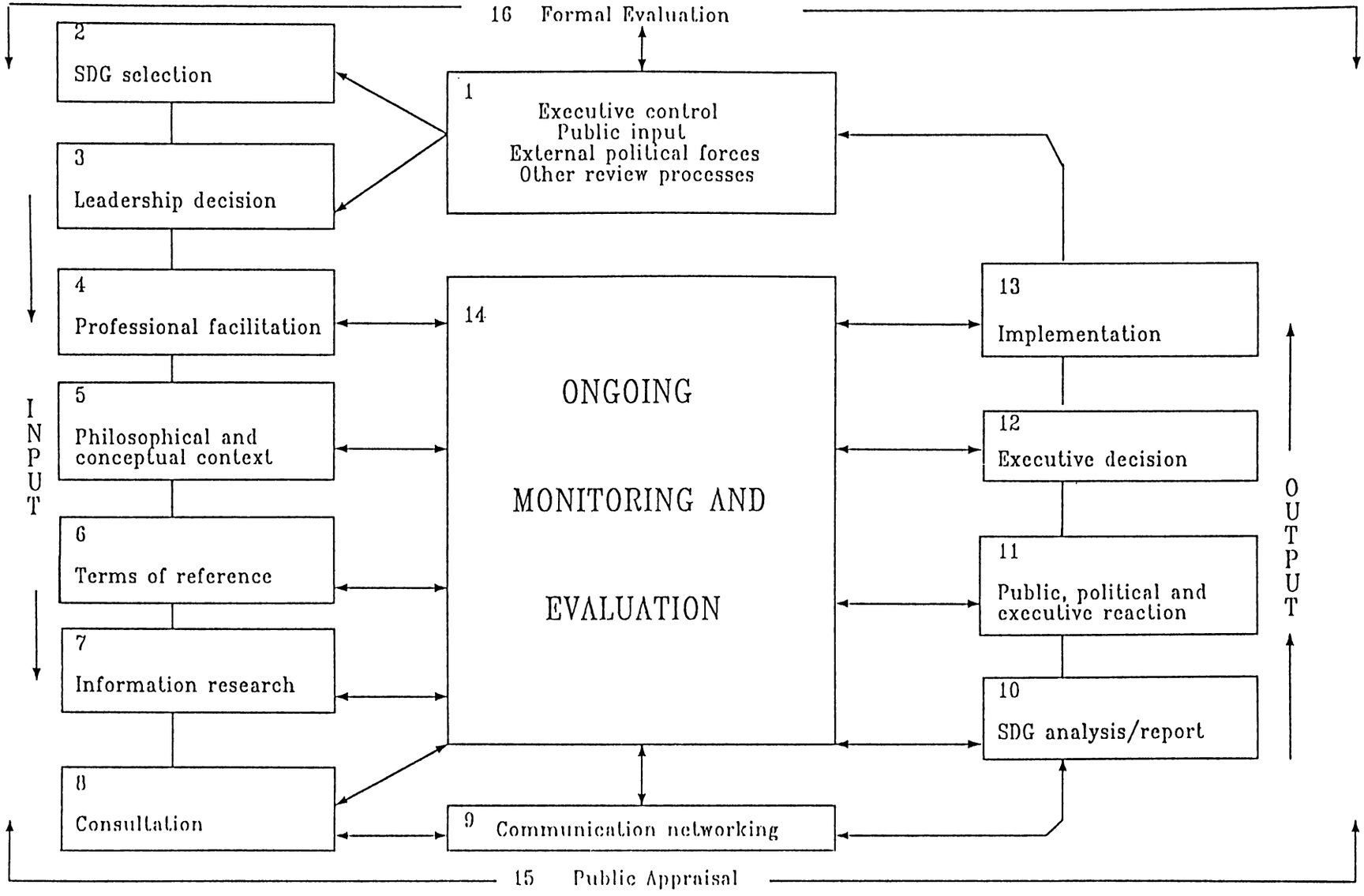
knowledge which they possess for a specific task, to meet together for the purpose of planning for delivery or improvement or cancellation of a service. This thesis has dealt with health care issues, but the service development group approach could be used for a range of services such as transport, electricity, local authorities, education, sport or leisure clubs. The ideal is participatory democracy, but the methods of achieving this, or gaining public understanding of the process, are less well understood.

The dynamics of group process have allowed understanding that more than seven or eight people will form cliques. It is known that between five to eight members will make a good working size group (Hackman & Vidmar, 1972; Osborn, 1957; Robinson, M.1984; Slater, 1958; Steiner, 1972). Group size is a matter of prolonged debate when service development groups are being set up, with political, parochial and emotional reasons taking precedence over selection of a group of people for a specific task. The SDG's group size and task should be explicitly stated at commencement, and the mode of operation communicated so that the undertaking is understood by participants and observers. Deficiencies in organisational effectiveness were described in Chapter 9 and specific recommendations for future SDGs given.

When the Waikato Hospital Board set up the SDG for maternity services, there were no guidelines for how the SDG should operate. The facilitator was appointed after the group had started its work. Composition of the group was never analysed until the present research was undertaken. Membership was on the basis of representation of politically powerful lobby groups for that service. The ratio of professional to lay people was 8 to 3. A prescriptive model used for the appointment of service development groups which would ensure participatory democracy will now be described for the benefit of any other group coming into this situation.

Figure 1 represents a model for service development group process. The model illustrates a process of inputs and outputs commencing with Executive Control which is box 1.

Figure 1
A Model for Service Development Group Process



INPUTS

1. Executive Control. SDG formation is dependent on a combined process of executive control from the Board or executive team, public input, external political forces and other review processess. The combination of pressures leads to the desire for, and setting up, of the SDG.

2. SDG selection process. Conceptually the model follows a democratic consultative approach. It recognises that results from a political process will be required to provide the reason for the review and envisages that the request, pressure or desire, for the review will come from the recipients or providers of a service. The service development group membership selection process requires public input to ensure participatory democracy will occur through appropriate selection of members. There will be executive involvement and control with possible influence from outside forces such as politicians who may seek the advice of constituents. That could also apply to the choice of a chairperson.

3. Leadership decision. The chairperson of the SDG can be pre-selected by the executive. Ideally the SDG should choose its own leader so increasing the opportunity for a democratic process to occur.

4. Guidance by a professional facilitator. An essential member of the SDG team who assists both chairperson and the SDG is the facilitator. Once selection is made the SDG should be assisted by a professionally trained facilitator to guide the group process and assist with formation of concepts and philosophies. Assistance will be required with background research and collection and interpretation of relevant information. This can include population statistics, geographical information and analysis of census figures.

Other major tasks shown in Figure 1 which will require professional assistance are as follows:-

5. Philosophical and conceptual context. Understanding of issues such as social change, changes in relation to government policy, social policy and regional responsibilities comprise the philosophical context in which the SDG has to work. Examination of issues such as equity, accessibility, accountability, allocation of personnel, financial and facility resources is also included. Allocation of financial resources has to be put in a suitable priority to accommodate human need and technological advances (Waikato Hospital Board, 1987). Arising from the philosophical and conceptual context are the terms of reference for the project.

6. Terms of reference. The aims and objectives of the SDG exercise are spelt out in the guideline provided by the terms of reference established for the SDG task. These may be set by an executive or by agreement of the executive and the SDG. Terms of reference dictate the scope of the project, therefore it is critical that sufficient time is allowed to set the best possible goals for the task.

7. Information/research. This includes information research about the topic, understanding unique characteristics such as demography, cultural concerns, geography, economic factors, and target groups. It may also include commissioning research on specific topics and ensuring the production of scientific reports. Once this information is gathered a discussion process will be required with users and providers of the service.

8. Consultative process. This means that there is consultation with users, providers and the financiers of the service. Management issues such as cost-effectiveness must be addressed at this stage. During this process there may be the need for a service development group to play a mediator role between professionals, administrators, voluntary agencies, and the public in order to develop the best options for the service. Testing proposed ideas or recommendations is carried out through a networking process which is discussed in the next paragraph.

INPUT AND OUTCOME

9. Communication networking. This means that information about many aspects of the SDG's work is made available for public and executive consideration. The process may be carried out by formal or informal methods of communication such as reports, media releases or discussion groups. Networking will be required to test any service development group ideas, recommendations or plans. Communication networking assumes that an adequate consultative programme is established to allow both the public and executives to combine views toward final recommendations which then become subject to public and executive implementation. Some mediation and conciliation may be required at this stage. This stage is both input and outcome related as a two way process of information exchange occurs.

As a consequence of the SDG process, associated research may be produced such as social surveys, especially questionnaires regarding peoples' attitudes toward specific services or perceptions of services presently provided. Production and publication of background papers and research reports ensures a contribution to the broader planning process. These reports will be used by the SDG but may also have wider application at a local or national level. The next stages describe the outputs of the SDG process.

OUTPUTS

10. SDG analysis: proposals, report, recommendations. Completion of the SDG's analysis and overview of all of the inputs to their study will be marked by the construction of a report, proposals and possible recommendations which will be circulated for public and executive analysis and review at administration and public meetings. The SDG's work will now be available for public and executive scrutiny.

11. Public, political and executive reaction. The review of the SDG's plan, proposals and recommendations allows time for oral and written submissions about any proposed changes. Allowance should be made for any changes to be made to the suggested proposals. Publication of any plan should be followed by a set amount of time during which written

submissions can be received or oral submissions heard. These should be considered by the SDG and the executive and any changes agreed upon before production of a final report. The professional facilitator has a role to play in this process to ensure concensus decisions and that monitoring and evaluation of the process and achievement of objectives is continued. Once the final submission phase is completed the SDG's work is available for executive decisions by the same people who helped appoint the SDG membership.

12. Executive decisions. These should be made by the executive when all of the stages described are completed, generally the SDG does not play a part in this process, although it is possible that the chairperson or members of the SDG may be consulted. After the decision making phase, responsibility for implementation becomes the executive's task.

13. Implementation. Final recommendation and implementation becomes the task of the executive and budget planners. Once implementation is progressing, the whole process may revert to public and executive review of the planning process and SDG involvement. Depending on the amount of public interest in the project this is a stage where the media has an important part to play in reporting progress of implementation. Throughout the whole process which has been described it is important that ongoing monitoring and evaluation of the SDG process will have taken place. Ways that this can be assured will now be described.

14. Ongoing Monitoring and Evaluation. Ongoing monitoring and evaluation of the SDG process is shown in the model as being linked to boxes 4 to 15 the only exceptions being Executive control (box 1), SDG Selection (2) and Leadership selection (box 3). Reponsibility for ongoing monitoring and evaluation of the process lies with SDG members, the chairperson and the professional facilitator. Internal checking of performance variables will ensure that all tasks are carried out. It is closely linked to public appraisal which results from the communication networking process.

15. Public appraisal This is shown in Figure 1 as underpinning the whole planning process. The constant awareness, interaction and monitoring should ensure optimum results and successful co-operation for any planning process. Public appraisal is dependant on formal and informal communication networking which is linked in the model to ongoing monitoring and evaluation of the total process. Community goodwill is important for facilitation of the SDG process because the SDG will only be as effective as the composition of its membership and communication networking allows.

16. Formal evaluation/audit of the SDG process stands alone in the model as an "ideal" as it is believed that evaluation or "auditing" of SDG work for human services should be carried out independently. Figure 1 shows that formal evaluation is linked to executive control, public input, external political forces and other review process which demonstrates the degree of responsibility and accountability which exists in this planning model. Formal evaluation could be carried out by: 1) external professional people on a consultancy basis; 2) an academic exercise such as this thesis; 3) an audit commissioned by government sources and carried out by government research staff. Independent formal evaluation reports contain information which can be useful for decision making and formation of future SDG's. The model illustrates that the SDG will be involved in ongoing monitoring and evaluation, however, it is not believed that formal evaluation should be a task for the SDG. Reasons for an independent evaluation process are discussed in greater detail later in this chapter.

SOCIAL AND CULTURAL VALUES: THE ATTEMPT TO BRING DEMOCRACY INTO PLANNING

Participatory democracy has become an increasing value in the broader social situation. Public participation, client orientation, and consultation in planning for services, give attempts to allow people to be more involved in the management of their lives and chosen lifestyle (Bates and Linder-Pelz, 1987; Bernard, 1974; Campbell, 1983; Driscoll, 1985; Flexner, 1987; Gibbs, Fraser and Scott, 1988; Oakley, 1980; Ray, 1980; Waikato Hospital Board, 1987).

The social and historical background of many of New Zealand's institutions and bureaucratic systems have meant that most New Zealanders have come to believe that a wide range of health and other services will be available, as of right, when they want to use them. The belief is a result of political and social developments in New Zealand since the late 19th century onwards, particularly the landmark social security policies of the 1930s and 1940s (A Health Service for New Zealand, 1974; Gibbs, et al., 1988).

In addition to the present research another attempt to review health services in New Zealand was carried out by a task force that could be described as the ultimate SDG is contained in the Gibbs Report (1988). Its philosophical base regarding the provision of health services appeared to contain elements of the democratic-participative approach (Malcolm, 1982; Wright, 1980). The Gibbs Report (1988) recorded that the redistribution of resources by government in the pursuit of equity had been a perceived objective of New Zealand governments. In reality, successive governments had felt constrained to limit expenditure on health and other social services, while providers of the services had found themselves less than capable of keeping pace with technological and other developments apparent in most advanced nations (Gibbs et al., 1988). In an attempt to resolve some of the apparent difficulties facing the supply, equitable distribution and funding of health services in 1987 the Minister of Health, (Dr M Bassett) had asked three citizens to form a "Task force" to conduct an enquiry into health services in New Zealand. No information was given for the reasons for selection of the three people involved, one woman and two men. These were: a former hospital board chairperson, a leading industrialist and a professor of medicine. They were assisted by at least fourteen people as support staff. In the Gibbs report recognition is given to significant alterations in social structures.

> "Patterns of urbanisation, increased mobility, smaller families and the growing number of households where both parents work have broken the once traditional networks which cared for the elderly and disabled. The degree to which this dislocation has increased the demands now made of the health

> system was never envisaged by those who planned it in the 1930's and 1940's. Many other measures which seemed appropriate for that time have become unsuitable for the specific preferences of Maori, Pacific Island and other people in society" (Gibbs et al, 1988, p 2).

A third planning attempt was the Waikato Hospital Board Strategic Plan 1987 was written in order to focus direction and plan strongly for future Board services. It evolved from a planning process undertaken by the Board's three chief executive officers and three support staff. The plan discusses strategic priorities, policy objectives, organisation, population, health status, finance, external issues and planning imperatives.

Effects of social change are described in the Waikato Hospital Board Strategic Plan 1987 when it says:

> "Regional high levels of youth unemployment, stresses related to the restructuring of the economy, increased mobility and disruption of families, may raise the incidence of psychiatric and behavioural disorders, and increase the level of smoking and alcohol and substance abuse. These will require counselling and intervention services to be extended outside the major centres" (p 10).

All of the consequences of social change need taking into account when planning for health services.

Cultural diversity in New Zealand has caused increasing tensions regarding consideration of specific cultural requirements. It is apparent that there are different views about biculturalism and multiculturalism, and which comes first in the priority order when allocation of resource is being decided. Many people believe that under the principles of the Treaty of Waitangi, Maori people have an historic right to appropriate services funded through the health system, participation in decision making, resources allocated to their own

development programmes, the availability of Maori food and medicines, and the use of Maori as an alternative language. Others believe that the allocation of resources, delivery of services, and training programmes for staff, should reflect the increasingly diverse nature of New Zealand society (Waikato Hospital Board, 1987). Some believe that New Zealand must achieve biculturalism before multiculturalism can be attempted (Dyall & Keith, 1988; Garlick, personal communication, December 1987). A response to individual and community needs which takes account of different cultural perspectives should be a generally held objective by health providers. Service development groups should take into account bicultural and multicultural issues. In the next section, ideas about methods of achieving participatory democracy in planning will be outlined.

When the SDG concerned with maternity services carried out its work the reports were greeted with howls of public protest. The Gibbs Report attracted the same initial criticism. Some aspects of the Gibbs report may be implemented because the Government financed the venture and it would be expected that politicians would need to support it.

Participatory democracy/or public participation in planning means that there is more confidence by the general public in what is planned. The public must also see that democracy is operating. This is an important aspect of the model presented. Accountability has become a watchword used by groups of citizens when they demand that they should be consulted on a continuing basis by agencies, departments and politicians, to ensure that services or goods are provided as needed and in ways that fit the priorities of the people whose needs they are meant to serve (Bates & Linder-Pelz, 1987). When people are accountable for something it means "... they owe a duty to those to whom they are accountable" (Bates & Linder-Pelz, 1987, p 160).

APPLICATION OF THE PRESCRIPTIVE MODEL TO THE SERVICE DEVELOPMENT GROUP PROCESS

As an example of the usefulness of the prescriptive model for service development group process it is proposed to test the model against the process used for the SDG in the maternity service review, the Gibbs

Report and the Waikato Hospital Board Strategic Plan. In this way the model could be used as a means for prediction of likely outcomes. Figure 2, pp 171-172, presents a grid type framework which uses the concepts of the Model for Service Development Group Process (Figure 1) as a basis for analysis.

The analysis demonstrates where the principles of participatory democracy have applied in the three planning models tested. Executive control is apparent in all three models, with more apparent application in the Gibbs and Waikato Hospital Board Strategic planning initiatives. Some evidence of participatory democracy is demonstrated in the SDG selection process, but not in the other two planning models. Again the SDG for maternity services was the only group to have the specific appointment of a professional facilitator. The SDG and the Waikato Hospital Board both worked in the philosophical and conceptual context of the Board's Role and Mission Statement. Labour Party philosophy and government policy direction provided the contextual philosophical base for the Gibbs Report. Provision of information and associated research was undertaken for the maternity services SDG by the professional facilitator, by the government support team for the Gibbs study and carried out by committee members for the Waikato Hospital Board strategic planning exercise.

The analysis demonstrates that the SDG had wide consultation and communication networking, the Gibbs report some, and the strategic planning process had none. The example illustrates the weaknesses of the SDG planning process, particularly the pre-selection of the SDG chairperson by the Board and executive, terms of reference being set by the Board and executive and the ongoing monitoring and evaluation being carried out on a casual, ad hoc basis. Both the SDG plan and the Gibbs report were made available for public submissions. There was no public involvement in the Waikato Hospital Board strategic planning process. For all three plans, executive decisions were made at the highest possible level, as was implementation of recommendations for the SDG plan and the strategic plan, with eventual involvement and assistance of all relevant staff in the organisation. Recommendations from the Gibbs report have yet to be implemented. Some attempt at overview and public

Figure 2
Application of the prescriptive model for SDG process

CONCEPTS OF THE MODEL FOR SERVICE DEVELOPMENT GROUP PROCESS	SDG USED FOR THE WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES	GIBBS REPORT	WAIKATO HOSPITAL BOARD STRATEGIC PLAN
1. Executive control Public Input External political forces other review process.	Set SDG in motion. The trigger for the SDG exercise.	No public input, all executive control.	Total executive control.
2. SDG selection process, participatory democracy.	SDG membership selected by the Board. Nomination of some members by selected professional and voluntary groups! Some evidence of participatory democracy.	Three person committee selected by two cabinet ministers confirmed by prime-minister. No public participation.	Six member committee selected by Board's triumvirate Management team. No public participation.
3. Leadership decisions	Chairperson preselected by Executive.	Chairperson selected by the Prime-minister	Chairperson self selecting out of the executive group.
4. Guidance by a professional facilitator.	A social scientist was employed to be involved with the SDG.	A support team of fourteen government employees were seconded to work with the committee.	No facilitation.
5. Philosophical and conceptual context.	Provided by the guiding principles of the Board's Role and Mission Statement.	?The Social philosophy and manifestos of the Labour Party.	Guiding principles of the Board's Role and Mission Statement.
6. Terms of reference	Set by executive	Set by cabinet.	Set by executive.
7. Information/research	Conducted for the SDG by the social scientist.	Supplied by the support team.	Carried out by the six member committee.
8. Consultative process	Wide consultation with users and providers of the service.	Some consultation mainly with providers of ther services.	No consultation.

Figure 2 (Continued)

CONCEPTS OF THE MODEL FOR SERVICE DEVELOPMENT GROUP PROCESS	SDG USED FOR THE WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES	GIBBS REPORT	WAIKATO HOSPITAL BOARD STRATEGIC PLAN
9. Communication networking	Wide communication networking.	Communication networking in the form of "press leaks."	No communication. Final report not open to submissions.
10. SDG analysis: proposals, reports recommendations.	SDG report, draft exposure document open to public submissions.	Report open to public submissions.	Final document, not available for submissions of any type.
11. Public, Political and executive reaction.	Oral and written submissions.	Written submissions.	No submissions.
12. Executive decisions	Made by the Board.	Made at Ministerial level.	Made by Board with Executive advice.
13. Implementation	Carried out by Board Administrators and alll staff.	Final outcome not known.	Carried out at operational level by Board executive and plannings groups and all staff.
14. Ongoing monitoring and evaluation	Some attempt by SDG members. Carried out by professional facilitator.	Some attempt by support staff.	Some attempt by Executive Staff carrying out the task.
15. Public appraisal.	Some attempt at SDG overview, public appraisal via the media.	Media overview and public appraisal.	No overview.
16. Formal evaluation/audit of the SDG process.	Independent university study. Audit by outside firm of accountancy management consultant.	NIL	NIL

appraisal of the SDG work and Gibbs study has been achieved through independent university study and public review through media communication, but there has been no overview of the strategic plan. Formal evaluation and audit by external consultants has been carried out on the SDG's maternity service review but there has been no evaluation or audit of the Gibbs report or Waikato Hospital Board Strategic Plan.

Use of the theoretical model for service development group process as a framework for testing the strengths and weaknesses of three health planning initiatives has illustrated positive aspects and weaknesses of all three planning approaches. The SDG for maternity services illustrated a democratic participative model, the Gibbs report had some consultation and public participation, whereas the Waikato Hospital Board had no client involvement at all. Recommendations from the maternity services review have been implemented successfully. It is believed that client involvement in the SDG's work assisted with the successful outcomes. It is too soon to discuss the outcomes from the other two plans, but it could be predicted that implementation of any recommendations will not be so easily accepted by the public because of the lack of client involvement, consultation and communication networking. Overall the planning process used by the SDG for maternity services appears to have been the most successful of the three reviews because of the participative democratic approach.

GROUP LEADERSHIP AND GROUP PROCESS CONDITIONS CONDUCIVE TO THE SUCCESSFUL FUNCTIONING OF SDGs

Leader/member relationships are critical for the type of group process that is achievable within the service department group structure. Fiedler's (1978) contingency theory of leadership emphasized that there was no one successful type of leader. Fiedler's theory was selected because it concerned issues of leadership and the environment groups worked in. The four basic components of Fiedler's model were:-

1) the personality of the leader - task versus person orientation;
2) leader/member relations;
3) task structure, and
4) position power.

There is a need to examine ways of exchange between leaders and followers. Leaders and followers must be viewed as interacting in order to understand group behaviour.

More recent contigency theorists have tried to look at the situation from the perspective of leaders, followers and the environment in which they operate (Diener & Liden, 1986). The perceptions that group members make about the chairperson's behaviour will affect the way that the group works and in turn alter the leader's performance as well. The most basic conclusion of Fiedler's research was that there was no such thing as a good leader for all situations. "A leader who is effective in one situation may or may not be in another" (Fiedler, 1969, p 42). One important fact is the basis of the leader's authority. This may come from either the chairperson being appointed by an outside authority or being elected by the members. Hollander's (1984) research suggests that an elected leader will create a greater sense of responsibility in followers.

The SDG process described in the present study showed that representation was from groups who had professional and community justification for SDG membership. Seniority, clinical experience and loyalty were the possible reasons that the chairperson was appointed by the Waikato Hospital Board. No opportunity was given for the SDG to elect the chairperson. Natural leaders for the SDG eventuated (as described in Ch 9) and were effective in gaining direction for the SDG. As stated in the critique (Ch 9), greater attention should have been given to observing the power relations among SDG members and between them and the Steering Committee.

Leaders of groups have two major functions. The first is the identification of the group's goal and moving the group toward the goal, while the other concerns maintenance of satisfactory relationships between the leader and other group members (Fodor, 1978; Katz & Kahn, 1978; Stogdill, 1974; Weick, 1978). A good leader must pay attention to reactions of the group members. Good leadership is typified by the ability to take in messages of various types from various sources and to reflect an understanding of those messages in subsequent behaviour (Diener & Liden, 1986; Weick, 1978). Leadership is a lively process

because there is a constant interchange between leaders and followers, each influencing the other in an ongoing process (Katz & Kahn, 1978).

Fiedler, Chemers and Mahar, (1976) developed a leadership training program called "leadermatch", which helped leaders define and create situations in which they were most effective. When a leader was not effective Fiedler (1978) believed it was more fruitful to try to change the leader's work environment than to try to change the leadership or personality style. Others have debated the validity of this approach (Diener & Liden, 1986). It may be effective in its own terms, but not in the groups' terms. It is important that the environment suits the group and not just the leader. If the environment suits the leader but not the group it may be necessary to appoint another leader.

The chairperson of the SDG was a senior male obstetrician and gynaecologist for the Waikato Hospital Board, who also consulted privately in obstetrics and gynaecology. It was apparent that he was used to working with "the speed of a surgeon's knife" to accomplish a task quickly and competently. Some members of the SDG expected and reacted well to the precise (and humourless) manner in which SDG meetings were held. The "medical" style of leadership was aided when agreement was reached that SDG meetings would be held in Waikato Women's Hospital in a meeting room on level 9, the same floor in which the chairperson's hospital office was located. The meeting room was pleasant but smelt of hospitals and gave the health professionals access to their "bleeps" (call system), telephones and an excuse to continue to wear their uniforms and trappings of office. Community representatives must be commended for working in such an environment, which for them may have seemed like a visit to the doctor. It must be stated that the chairperson was always readily available to clarify, communicate and summarize when requested. In contrast, some members of the SDG were quiet during the discussion process. Insights were gained during visits to the wash room where informal discussions occurred which encouraged the researcher to act as coach to the community members to help them to combat the clinically powerful environment in which meetings were being held. The findings from the present study indicate that the "ideal" chairperson should be elected by the SDG or could be a genuine non-voting independent chairperson facilitating all viewpoints. It is

important that the meeting place should be "neutral." Understanding the effect of the leader's role and the potential part to be played in SDG functioning should be given careful consideration during the Chairperson's selection process

THE ROLE OF THE PROFESSIONAL FACILITATOR

Throughout the SDG's work for the maternity service review the researcher acted as a professional facilitator. The role was not formally recognised but it became apparent to the researcher that as well as the SDG needing leadership they also required professional facilitation. The professional facilitator should ensure smooth functioning of the group, provide background information, conduct associated research and ensure that personal comfort and general administration matters are taken into account. If a professional facilitator is available to assist with SDG work more cost effective use of time and personnel resources should be anticipated.

POLITICAL, BUREAUCRATIC AND COMMUNITY CONDITIONS LIKELY TO ENHANCE OR INHIBIT SDG PERFORMANCE

The idea of accountability in health planning has been previously discussed in this chapter in terms of accountability being a popular watchword. Bates and Linder-Pelz (1987) discuss the idea that it does not occur to most people that they could, or should have participated, years before, in the planning and development of those services which are provided by governments. It is impossible to elect representatives who can understand all or even most of the electorate and therefore there can be no accountability to the electorate (Bates & Linder-Pelz, 1987). Politicians and administrators are viewed as people in power concerned with their own interests and those of their own social class, neglecting the less powerful people (Bates & Linder-Pelz, 1987). The idea of SDG's with built in consumer sovereignty and participatory democracy is a significant step toward ensuring that planning of services is carried out by consumers and providers.

When people are in the crisis of an illness they are not usually capable of defending themselves or demanding participation. When the crisis is over they want to forget the painful experience as quickly as possible

(Bates & Linder-Pelz, 1987). When illness and frailty intervene in the lives of these people their options are severely limited (Russell & Schofield, 1987). The health care system is a set of power relations in which some occupations systematically experience greater control over their own arena of work than others. For instance, doctors experience the greatest control over both patients and other health care workers (Russell & Schofield, 1986). Nurses and hospital boards also have some control. Patients have the least. The SDG planning process is an attempt to counteract this lack of control. However, Russell & Schofield (1986) argue that satisfaction is increased with successful outcomes and they believe the chances of successful outcomes are maximised by greater control on the part of patients. Better management will occur "... in an atmosphere of participation - of activity and interaction - rather than of patient passivity and 'expert' control. To achieve such a situation requires a redistribution of power within the 'health care system' and between health workers and sick people" (Russell & Schofield, 1986, p. 205).

For some of the reasons stated by Russell & Schofield, SDGs must not become controlled by hierachical bureaucracies. If monitoring and evaluation is carried out both as a continual process and as a formal evaluation (see Figure 1) conditions likely to enhance the performance of service development groups should develop. There will always be the possibility of hidden agendas, political influences and parochial loyalties. The professional facilitator has a key role in producing optimum conditions for the service development group process, ensuring that monitoring and evaluation take place and that the group's objectives are met. If the guideline of the theoretical model portrayed in Figure 1 is followed, the SDG should not deteriorate into a political lobby group.

GENERIC PERFORMANCE CRITERIA FOR SERVICE DEVELOPMENT GROUPS

Service development group performance criteria have been derived from the shared practical experience of others (Barnett, 1983; Barnett, et al. 1984; Malcolm, 1981; Williams, 1984; Wright, 1980). Service development groups have now been legislated for in the Area Health Board Act 1983 but no specific guidelines or performance criteria have been

created to accompany the act. The researcher derived a method of facilitating service development groups which was non-specific for any one task but has assisted in guiding subsequent groups. The following are guidelines for ways of carrying out the tasks inherent in the model for service development group initiatives (see Figure 1). The professional facilitator should ensure that service development group process or analysis involves the following factors.

Commitment by boards and authorities to the service development group's work must come from the top - there must be client orientation and "top" executive commitment. Professional facilitation is required to ensure the transmission of information. In Figure 1 the professional facilitator is shown as being appointed directly after the SDG have been selected. It may even be preferable to appoint the facilitator before the SDG is selected. The facilitator will help to ensure establishment of the group process, initiation of the collection and supply of relevant information, and access to needed resources. A planning framework must be constructed to ensure the work necessary to develop a plan or recommendations is carried out. Performance variables can be assessed by examining the application of the terms of reference to the project.

Performance variables relate to the concepts illustrated in Figure 1 and can be assessed by questioning whether the goals and objectives (terms of reference) of the project have been established and communicated. Other questions would be derived to seek to establish whether information research and consultation and communication networking had taken place. It should be established whether plans and procedures for monitoring and evaluating the process have been set in place and are being carried out. Outcomes of the SDG's work are reports, plans and recommendations which are all performance variables.

Contributing factors to SDG performance can be described as the initiatives which help to ensure that there is facilitation of SDG process. These factors include setting dates for the completion of each stage of the task and guarding against lack of co-operation, blocking of progress or withholding of information. Other contributing factors to

performance are the ability to be flexible, to modify, or amend as necessary. The planning framework and methodology should foster SDG creativity. Reports, plans and recommendations should be used and not left to lodge on office shelves or the whole service development group exercise will be viewed as a time wasting exercise.

At the start of any service development group exercise it would help to have an informal social gathering for group members to allow them to become acquainted before beginning the task. In this way some of the artificial barriers would be broken down. An attempt at some information sharing or self disclosure about interests and background might also be useful. It is important for the facilitator to understand the gender, age, cultural, knowledge and background differences existing in the group so that personal embarrassments are not allowed to occur.

To try to gain insights into the group process the Bales Interaction Process Analysis (Bales, 1958) standard schedule could be used to record systematic observations of the group. Some studies of leadership style could also be useful (Fiedler, Chemers & Mahar, 1976; Katz & Kahn, 1978). Group performance in the SDG context could be assessed by evaluation research techniques such as questionnaire inquiry, video feedback and group discussion. The professional facilitator could conduct a series of semi-structured interviews about group interaction which would also allow feedback about SDG performance.

Formal Evaluation

The present study has described an attempt at an "in-house" evaluation study. Such an experience has indicated that evaluation of human service programmes should also be conducted from outside the organisation responsible for conducting the programme. If allocation and use of financial resources requires an independent audit then allocation and use of human service resources also requires an overall evaluation or audit from an independent and professionally expert source. In-house checks can be carried out to ensure that the programme is in place, that it has set terms of reference and an effective membership. However, funding for evaluation should be budgeted for from the start and not be the after-thought which mostly occurs at present.

ACCOMMODATION OF DIVERSE CULTURAL AND SOCIAL VIEWPOINTS IN SERVICE DEVELOPMENT GROUP WORK

Service development groups are a system of participatory democracy. The model proposed in Figure 1 p 161 takes into account the principle that service development groups are to be aware of the diversity of groups in the broader community. Professional facilitation of the groups is essential to help with group process and recognition that cultural and spiritual values may differ, that the "known" way many not always be correct. There is a need to accommodate diverse viewpoints and to try to meet the needs of different groups on a democratic basis. Planning for any service must always allow for cultural differences and requirements whether it be for housing, education, health or transport.

The professional facilitator is required to work at both the micro (SDG) and macro (community) level. A practical way of achieving effective accommodation of diverse cultural and social viewpoints would be to hold service development group meetings in community centred buildings. A change of environment for meetings sometimes makes a real difference in the way that people operate and communicate. Meetings about health could be held at the local council chambers and meetings about local body affairs at schools.

It is essential that the purpose and objectives of the service development group are communicated to the diverse cultural and social groups within the community, for whom the study or review is being carried out. A skilled communicator or public relations expert will be required to assist with this process. Interaction and consultation between the service development group and the public should be within time constraints, although some time should be allowed for hearing oral submissions. Not every person is capable of making a written submission about matters which may be personal, sensitive and emotional. Language barriers must be accommodated and provision made for interpreters where necessary. If it is perceived that the service development group is making an attempt to understand diverse cultural and social viewpoints, the public network process which will arise from the process will assist with the work of the review.

The same process is required to keep members of any organisation or controlling body informed of the SDG's progress. In this way the process gains access to support systems from 'within' set structures as well as 'outside' in the wider community. Figure 1 illustrated that an output of any SDG is the consultative process between users, providers and financiers of a service before any plan is supported and only after executive and public analysis.

CONCLUSION

The importance of lay representation, participatory democracy, professional facilitation, consultation and communication networking for successful and cost-effective outcomes to any planning process is emphasised. Client orientation in planning and design has been found to produce useful solutions for health services (Bishop, 1987; Driscoll, 1987; Flexner, 1987; Slemint, 1987). There should be application of business planning practice techniques (Gibbs et al. 1988; Williams, 1984) to health planning. These new and different techniques will require understanding and subsequent implementation. Services for people are just as critical as is the correct budget balance for financial services yet the financial service tends to be viewed as more important than the human service.

This study has presented an evaluative analysis of a service development group set up to review maternity services for the Waikato Hospital Board. Chapter 10 has used that example as a case study approach to develop a prescriptive model for service development groups. If the prescribed model and performance criteria are adhered to, then community involvement and participatory democracy in service planning should be achieved. Adherence to the model and criteria outlined in this chapter will enhance the achievement of community involvement and democracy.

APPENDIX 1

CATEGORIES OF LEVELS OF CARE FOR HOSPITALS PROVIDING MATERNITY AND NEONATAL SERVICES

CATEGORIES OF LEVELS OF CARE FOR HOSPITALS
PROVIDING MATERNITY AND NEONATAL SERVICES

4.6 DEFINITION OF LEVELS OF CARE

Although we do not recommend defining regions, we believe it will be useful to make some further definition of levels of care so that appropriate standards (for example, of equipment and staffing) can be developed.

The Obstetric Regulations 1975 defined certain levels of obstetric services, namely obstetric unit, maternity unit, and maternity aftercare unit. The Bonham—Mackay report (5) gave a more complex grade classification of obstetric services. Neither of these systems is now suitable for special care services for the newborn. A more suitable classification is that proposed in the North American report (1) which has now been accepted for Australia (48). A similar system has been proposed for the United Kingdom (4) although terminology differs.

The American report classifies services into three levels : primary or Level I, secondary or Level II, and tertiary or Level III. This gives a good basis for a New Zealand classification, although modification is needed for New Zealand conditions. In particular, units that do not meet minimal criteria for emergency care need a separate classification, and we propose that they be classified as Level O.

The system following has already been used in the recent report of the Committee on Obstetric Equipment (24).

Level O: General practitioner unit not attached to a general hospital and without immediate cover by specialist obstetricians or paediatricians.

Level I: Unit attached to a general hospital, with facilities for caesarean section, but which lacks specialist paediatric services.

Level II: Unit with specialist obstetric and paediatric services, where the majority of complicated obstetric problems and certain neonatal problems are provided for.

Level III: Regional centre responsible for the most comprehensive and intensive level of obstetric and newborn care.

In the terminology of the Obstetric Regulations 1975 a "maternity unit" corresponds to either Level O or Level I of the classification proposed here, and "obstetric unit" to Level II or Level III.

The UK House of Commons Report (4) uses the terms "regional centre" and "subregional centre", which are presumably at least approximately equivalent to Level III and Level II respectively of the North American classification.

(Board of Health Report Series No. 29 1982, p. 23-24)

The Waikato Hospital Board has a mixture of these facilities. The provision of Level 0 Hospitals depends on adequate screening and referral of "at risk" mothers to the nearest appropriate unit.

APPENDIX 2

CORRESPONDENCE: MINISTER OF HEALTH'S LETTER TO THE WAIKATO HOSPITAL BOARD, 22 JUNE 1982

OFFICE OF THE MINISTER OF HEALTH

WELLINGTON, NEW ZEALAND

RECEIVED AT BOARD OFFICE
24 JUN 1982

22 JUN 1982

The Chief Executive
Waikato Hospital Board
PO Box 934
HAMILTON

Dear Mr Fargher

As advised in my telegram I have decided to defer any decision on your board's application to close the Te Aroha Hospital maternity ward until the board carries out a complete review of obstetric services provided by the board. As the board does have a number of small maternity hospitals in its region and appears to have 100 maternity beds more than is required according to bed guideline figures, I feel there is a need for the board to carry out a comprehensive study of its maternity services. I am certainly unable to make a decision on the board's application to close the Te Aroha Hospital maternity ward until I have an understanding of how Te Aroha does or does not fit into the pattern of maternity services provided by the board.

I believe this review should be carried out in conjunction with officers from the Department of Health and I suggest you contact the Director-General of Health on this point. The completed study is to be referred to the Hospitals Advisory Council for consideration and recommendation to me. I will then decide on the board's application to close the Te Aroha Hospital maternity ward. In the meantime the maternity ward is to stay open.

Yours sincerely

A G Malcolm
Minister of Health

APPENDIX 3

DRAFT OBSTETRIC PLAN

OBSTETRIC/MATERNITY SERVICE PLAN

1. INTRODUCTION:

The Board has been requested by the Department of Health to undertake an overall review of obstetric/maternity services in its area. It is intended that the review proceed on a consultative basis using the service planning approach. Formal community comment will be requested once information has been collated and objectives set for an overall service.

To act as planners, a Service Development Group (SDG) will be formed, membership being representatives of the Board's staff with expertise in this specialty, general practitioners, and allied voluntary groups. The function of the SDG will be to identify the type of service at all levels which the Board should provide in its area of administration. Once objectives for the services have been defined, the group membership will be extended to include the Steering Committee appointed by the Board who will assist in the evaluation of objectives within financial restraints, maintenance and quality of servicesand existing policies.

The community will be advised of the recommendations of the SDG for the delivery of obstetric/maternity services throughout the Board area and will be asked to comment regarding their own particular area. Finally, the SDG will prepare a service plan which will review present programmes and needs, and propose strategies and future programmes for consideration by the Board.

2. PROCESS:

The process for the review will consist of five phases as shown in the following diagram:-

(Appendix A gives defined details of each phase)

To co-ordinate all aspects of the review, it is intended to appoint a Research and Development Officer.

3. PHASE 1 - PRE-PLANNING

The Research and Development Officer will be responsible for the pre-planning stage which requires the collation of data which will become the basis of a management information system. Data will include factors relating to population, health status, health resources, utilisation of present services, quality of care and safety factors.

4. PHASE 2 - SETTING OBJECTIVES

A Service Development Group will be appointed representative of the providers and users of the service, to set objectives for the service based on an ideal, review existing policies against objectives and suggest future strategies for the delivery of services throughout the Board's area.

It is recommended that the membership of the group comprise:-

- Director of O&G Waikato Hospital
- Director of Paediatrics, Waikato Hospital
- A practising midwife from a district hospital
- The Board's Advisor on Obstetric Nursing Services
- Representative(s) from the General Practitioners
- Representative from Parents Centre
- Representative from Plunket
- The Research and Development Officer.

It is envisaged that the Director, O&G will liaise with the local Obstetrics Committee which has recently been formed.

5. PHASE 3 - EXPOSURE DRAFT

Once objectives have been set, the group will be extended to include the Board's steering committee, i.e., the Chairman, Dr Marshall and Mrs Loveridge, Chief Executive, Superintendent in Chief and Chief Nurse.

The Service Development Group will review the objectives in terms of the constraints, the quality of care and statutory/Board policies. A draft document will be prepared with all relevant information, together with defined future goals and objectives for the Board's obstetric and maternity services.

This document will become the 'Exposure Draft' which will be made public and forwarded to all community organisations. At this stage, community organisations will be requested to make submissions on the provision of services within their community and any alternative uses of facilities.

6. PHASE 4 - ALTERNATIVES

This phase will comprise two stages. Firstly, the Service Development Group will consider all submissions from the community and the various alternatives available in order to provide a 'package' for each community which will fit into an overall service plan for obstetric/maternity services. It may be necessary in this phase to co-opt to the Service Development Group community leaders and/or Hospital Board staff with expertise in other specialties, and the area Board Member.

The second stage will be to advise the communities of the 'package' and, if necessary, to hold public meetings to gain acceptance of the proposals.

7. PHASE 5 - SERVICE PLAN

The SDG in the final phase compiles all the 'packages' into an overall service plan for obstetric/maternity services for submission to the Board for approval to action.

8. CONCLUSION

A service plan for obstetric and maternity services will determine the adequacy of the present services offered and set the direction of future goals.

To ensure that the service plan covers all aspects of provider and consumer opinion, it is considered that a Service Development Group should be formed. Initially, the providers of the services will set objectives within terms of quality of care and standards of practice. Once these objectives are set, the consumer, through representative community organisations, will be canvassed for their ideas of community requirements.

The resultant service plan will enable the Board to provide obstetric/maternity services in the future, confident that both professional and client needs are being met.

* * *

PHASE 3 : EXPOSURE DRAFT

Essentially this will provide a document with all relevant information and some ideas as to future goals and objectives. It will not be a final document but rather an exposure of the possible objectives with supporting data, inviting comment or alternatives to be proposed. It will be produced by the Steering Committee in consultation with the Service Development Group or other appropriate bodies.

PHASE 4 : ALTERNATIVE COURSES OF ACTION:

Specification of various alternatives and their feasibility.

Stage 1: Design of proposals, analysing possibilities with terms of costing,
staff levels,
present funding,
resources available.

Stage 2: Evaluation of the alternatives by projecting the consequences of the various plans compared to targets set by objectives.

Consideration of:
Submissions from Community Organisations.
Submissions from Professionals.
Board Members.

PHASE 5 : SERVICE PLAN:

The service plan will:

- Advise on the provision of future maternity/obstetric services;
- Recommend strategies and programmes;
- Suggest alternative uses for buildings not required for obstetric/maternity services;
- Set standards for professional skills;
- Set priorities to assist in the allocation of resources.

* * *

E.M. Penn,
Administration Officer.

August 1982.

APPENDIX 4

THE SERVICE DEVELOPMENT GROUP'S DEFINITION OF AN "IDEAL MATERNITY SERVICE"

THE SERVICE DEVELOPMENT GROUP'S DEFINITION OF AN "IDEAL MATERNITY SERVICE" 1

An "Ideal Maternity Service" provides facilities which minimise the risk to mother and baby antenatally, during and following delivery, and provides for the care of the mother and newborn infant in such a way as to enhance family relationships. The Service Development Group's view is that this service will usually be provided in hospitals - organised on a regional basis.

Regional Service

For the purpose of explanation the Service Development Group has agreed to the following definitions of levels of hospitals in the region.

Definitions of Levels of Hospitals

The Service Development Group used the following definitions:-

Level 0	District Hospitals, General Practitioner care only, and low risk deliveries only.
Level 1	Hospitals where an obstetrician or surgeon is available for emergency caesarian sections but no paediatric services are available. These are not referral centres, and should deliver low risk pregnancies only.
Level 2	Hospitals which are limited referral centres where there are Obstetricians and Paediatricians and where there are some neo-natal intensive care facilities.
Level 3	Hospitals which are major referral hospitals for an area and include special care services both for obstetrics and for the newborn including a neonatal transport service. This area extends beyond the Waikato Hospital Board area - (to include Gisborne, Thames, Taumarunui, Tauranga and Whakatane).

(Definitions adapted from "Special Care for the Newborn," Board of Health Report No. 29 p. 23-24 - 1982.)

A Regional Service provides a mixture of these facilities. The provision of a limited number of community-based (Level 0) maternity hospitals is dependent on adequate screening and referral of the at-risk mothers to the appropriate unit. The promotion of in-utero transport is a most important part of an "Ideal Regional Service."

1 This could also be called an "Ideal Perinatal Service."

Maintenance of Standards

To maintain acceptable medical and nursing standards and utilisation of buildings and services the Service Development Group believes 100 deliveries per annum is a minimum figure for a Level 0 hospital.

Preparation for Parenthood

Areas which concern parents and identified by the Service Development Group would include:
socio-economic circumstances; awareness of cultural diversity; psychological and emotional needs of families; adequate preparation for labour and delivery; promotion of breast feeding and enhancement of family life. These are all important factors in a successful and happy outcome to pregnancy.

The Service Development Group recognises that every woman should have the right to a doctor of her own choice provided that practitioner satisfies the criteria of the Regional Obstetric Standards Review Committee.

The Family Experience

An "Ideal Maternity Service" meets the needs of the woman and her husband or partner and should include the following options.

- Access to adequate antenatal care and education.
- Familiarity with the hospital where she will deliver.
- The opportunity to meet with nursing and medical staff at the hospital.
- Delivery in an environment which does not appear clinical, and preferably in the room in which she has laboured.
- The presence of support people (husband, partner, friend, parents and other children) if so desired.
- Consideration of individual requests, such as choice of delivery position, low lights and immediate contact with the baby providing the safety of mother and baby is not prejudiced.

Home Delivery

An "Ideal Maternity Service" recognises that there is a small demand for home confinement and this may increase to some extent if a district loses a maternity hospital. With adequate selection of the mother and properly supervised care by experienced well qualified doctors and midwives who are adequately equipped, home confinement is recognised as having a low risk.

The Service Development Group sees practical difficulties at present which limit the acceptability of this service.

APPENDIX 5

QUESTIONNAIRE FORMAT: SERVICE DEVELOPMENT GROUP

WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES

SERVICE DEVELOPMENT GROUP

It would be appreciated if members of the Service Development Group would answer the questions contained in the attached questionnaire. Your answers will assist with the formation and establishment of future Service Development Groups which may assist with health service research. This questionnaire is confidential. Please answer all questions as they apply to your experiences as a member of the Service Development Group.

Please tick the most correct answer for you.

WHEN YOUR NOMINATING GROUP SELECTED YOU AS THEIR REPRESENTATIVE;

1. were you
   - very pleased _____
   - pleased _____
   - not very pleased _____
   - not pleased at all _____

2. did you feel your selection was appropriate:
   - very appropriate _____
   - appropriate _____
   - not very appropriate _____
   - not very appropriate at all _____

3. did you wonder how you would manage the time for the exercise:
   - yes _____
   - no _____

4. DID YOU HAVE ANY PRACTICAL DIFFICULTIES ATTENDING THE MEETINGS?
   Please describe _____

_____

_____

_____

5. DID YOU WONDER HOW THE EXERCISE WAS GOING TO BE MANAGED:

Yes_____

No_____

IN GENERAL, IF YOU REPRESENTED A COMMUNITY GROUP, DID YOU THINK THAT YOU MANAGED TO CONVEY YOUR GROUP'S IDEAS:

6. At the start of the review;

Very well_____

Well_____

Not very well_____

Not well at all_____

7. Throughout the review;

Very well_____

Well_____

Not very well_____

Not well at all_____

8. Towards the later stages of the review;

Very well_____

Well_____

Not very well_____

Not well at all _____

IN GENERAL, IF YOU REPRESENTED A PROFESSIONAL GROUP, DID YOU THINK YOU MANAGED TO CONVEY YOUR GROUP'S IDEAS:

9. At the start of the review:

Very well_____

Well_____

Not very well_____

Not well at all _____

10. Throughout the review:

Very well_____

Well_____

Not very well_____

Not well at all _____

11. Towards the later stages of the review:

Very well_____

Well_____

Not very well_____

Not well at all _____

12. DID YOU THINK THAT YOUR TASK AS A NOMINATED REPRESENTATIVE WAS:

Very easy_____

Easy_____

Not easy_____

Not very easy _____

Not easy at all _____

13. HOW DID YOU THINK THE SERVICE DEVELOPMENT GROUP WORKED TOGETHER AS A GROUP:

Very well_____

Well_____

Not very well_____

Not well at all _____

14. ON THE WHOLE WHAT DID YOU THINK OF THE SERVICE DEVELOPMENT GROUP IDEAS:

All were worthwhile_____

Most were worthwhile_____

Some were worthwhile_____

None were worthwhile_____

DID YOU THINK THAT THE SERVICE DEVELOPMENT GROUP'S WORK WAS KNOWN AND APPRECIATED:

15. By the Waikato Hospital Board:

Very much appreciated_____

Appreciated_____

Not appreciated_____

Not appreciated at all_____

16. By the community in general:

Very much appreciated_____

Appreciated_____

Not appreciated_____

Not appreciated at all_____

BY INTEREST GROUPS; for example

17. Parent Centre:

Very appreciated_____

Appreciated_____

Not appreciated_____

Not appreciated at all_____

18. Politicians: for example; local body representatives, parliamentarians:

Very appreciated_____

Appreciated_____

Not appreciated_____

Not appreciated at all_____

19. Rural Groups for example; Young Farmers Federated Farmers, Women's Division Federated Farmers:

Very appreciated_____

Appreciated_____

Not appreciated_____

Not appreciated at all_____

20. National Council of Women:

Very appreciated_____

Appreciated_____

Not appreciated_____

Not very appreciated_____

21. DID YOU THINK ALL MEMBERS OF THE GROUP HAD AN EQUAL CHANCE TO CONTRIBUTE:

All the time _____

Most of the time_____

Occasionally _____

Not at all_____

22. DO YOU THINK THAT THE SERVICE DEVELOPMENT GROUP'S WORK HAS ACTED AS A CATALYST IN ANY WAY TO MAKE CHANGES TO MATERNITY SERVICES:

Very much_____

In some ways_____

Not very much_____

Not at all_____

23. HAVE YOU ANY COMMENT TO MAKE ABOUT THE TERMS OF REFERENCE, SET BY THE WAIKATO HOSPITAL BOARD, FOR THE SERVICE DEVELOPMENT GROUP:
Please comment:

_____

_____

_____

_____

_____

_____

_____

24. WOULD YOU BE WILLING TO PARTICIPATE IN ANOTHER SERVICE DEVELOPMENT GROUP EXERCISE:

Very willing_____

Willing_____

Reluctant_____

Very reluctant_____

25. WITH YOUR KNOWLEDGE AND EXPERIENCE OF A SERVICE DEVELOPMENT GROUP EXERCISE HAVE YOU ANY COMMENT ON OTHER/ADDITIONAL FACTORS WHICH SHOULD BE TAKEN INTO ACCOUNT FOR A FUTURE SERVICE DEVELOPMENT GROUP?
Please comment:

_____

_____

_____

_____

_____

_____

_____

26. DO YOU FEEL THE WORK OF YOUR GROUP IS:

1) Now finished _____

2) Still has unfinished business (please specify) _____

_____

_____

27. DO YOU FEEL THE WORK OF YOUR GROUP SHOULD BE CONTINUED AS A MEANS OF MAINTAINING EFFECTIVE COMMUNICATION BETWEEN PEOPLE AND THE HOSPITAL BOARD?

Yes _____

No _____

28. DO YOU AGREE THAT THE GROUP SHOULD BE CONTINUED TO ALLOW IT TO HAVE FURTHER TIME FOR DELIBERATIONS:

Strongly agree_____

Agree_____

Disagree_____

Disagree strongly_____

29. LIST THE POSITIVE OUTCOMES OR ACHIEVEMENTS OF THE SERVICE DEVELOPMENT GROUP:

_____

_____

_____

_____

_____

_____

30. LIST THE NEGATIVE OUTCOMES OF THE ACTIVITIES OF THE SERVICE DEVELOPMENT GROUP:

_____

_____

_____

_____

_____

31. LIST ANY UNEXPECTED OUTCOMES FROM YOUR SERVICE DEVELOPMENT GROUP:

_____

_____

_____

_____

_____

32. HOW POTENTIALLY VALUABLE IS THE SERVICE DEVELOPMENT GROUP APPROACH IN REVIEWING HEALTH SERVICES:

Very valuable _____

Valuable _____

Not very valuable _____

Of no value at all _____

33. WHAT HAVE YOU GAINED FROM BEING INVOLVED IN THE SERVICE DEVELOPMENT GROUP: (Tick all answers that apply)

Personal satisfaction _____

Knowledge of other groups represented on the committee _____

Friends _____

Other rewards (Please specify) _____

34. ANY FURTHER COMMENTS?

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. Please return by Monday 26 November, 1984. A stamped addressed envelope is provided.

I will contact you at a later date regarding the results of this questionnaire

_____ Sharon Dinnell

APPENDIX 6

QUESTIONNAIRE FORMAT: BOARD'S STEERING COMMITTEE

22 February 1985 REF. SD:CB

MEMBERS OF THE BOARDS STEERING COMMITTEE

WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES
SERVICE DEVELOPMENT GROUP

Enclosed please find a questionnaire which relates to my post-graduate study/evaluation of the Service Development Groups.

I would be grateful if you could complete the questions.

I will contact you at a later date as to a suitable time to collect the questionnaire.

Thank you.

Sharon Dimmock

RESEARCH & DEVELOPMENT OFFICER

WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES

MEMBERS OF THE BOARD'S STEERING COMMITTEE

Questionnaire about the research process involved during the Board's review of maternity services.

1. WHEN THE IDEA OF A SERVICE DEVELOPMENT GROUP APPROACH WAS FIRST INTRODUCED DID YOU SUPPORT THE IDEA?

   Very much _____

   In some ways _____

   Not very much _____

   Not at all _____

2. DO YOU BELIEVE THAT YOU HAD SUFFICIENT OPPORTUNITY TO PRESENT YOUR VIEWPOINT TO THE SERVICE DEVELOPMENT GROUP?

   All the time _____

   Most of the time _____

   Occasionally _____

   Not at all _____

3. DO YOU THINK THAT ANY FUTURE REVIEW OF A HEALTH SERVICE AREA SHOULD INVOLVE A SERVICE DEVELOPMENT GROUP?

   Definitely _____

   Yes _____

   No _____

   Not at all _____

4. WHAT BENEFITS WERE GAINED FROM INVOLVING COMMUNITY REPRESENTATIVES IN THIS PLANNING EXERCISE?

   Please describe _____

   _____

   _____

   _____

   _____

5. ON THE WHOLE WHAT DID YOU THINK OF THE SERVICE DEVELOPMENT GROUP'S IDEAS?

All were worthwhile _____

Most were worthwhile _____

Some were worthwhile _____

None were worthwhile _____

6. OVERALL DO YOU THINK THAT THE SERVICE DEVELOPMENT GROUP'S WORK WAS KNOWN AND APPRECIATED:

7. By the Waikato Hospital Board:

Very much appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all ____

8. By the community in general:

Very much appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all ____

BY INTEREST GROUPS; for example

9. Parent Centre:

Very appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all ____

10. Politicians: for example; local body representatives, parliamentarians:

Very appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all ____

11. Rural Groups for example; Young Farmers Federated Farmers, Women's Division Federated Farmers:

Very appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all ____

12. National Council of Women:

Very appreciated _____

Appreciated _____

Not appreciated _____

Not very appreciated _____

13. DO YOU THINK THAT THE SERVICE DEVELOPMENT GROUP'S WORK HAS ACTED AS A CATALYST IN ANY WAY TO MAKE CHANGES TO MATERNITY SERVICES:

Very much _____

In some ways _____

Not very much _____

Not at all _____

14. HAVE YOU ANY COMMENT TO MAKE ABOUT THE TERMS OF REFERENCE, SET BY THE WAIKATO HOSPITAL BOARD, FOR THE SERVICE DEVELOPMENT GROUP?
Please comment:

15. WITH YOUR KNOWLEDGE AND EXPERIENCE OF A SERVICE DEVELOPMENT GROUP EXERCISE HAVE YOU ANY COMMENT ON OTHER/ADDITIONAL FACTORS WHICH SHOULD BE TAKEN INTO ACCOUNT FOR A FUTURE SERVICE DEVELOPMENT GROUP?
Please comment:

16. HOW MUCH SHOULD COMMUNITY REPRESENTATIVES BE INVOLVED IN THE HEALTH PLANNING PROCESS?

All the time _____

On a consultative basis ___

On an ad hoc basis _____

Not at all _____

17. PLEASE LIST WHAT YOU BELIEVED WERE THE POSITIVE OUTCOMES OR ACHIEVEMENTS OF THE SERVICE DEVELOPMENT GROUP:

18. PLEASE LIST THE NEGATIVE OUTCOMES OF THE ACTIVITIES OF THE SERVICE DEVELOPMENT GROUP:

19. IN RELATION TO THE SERVICE DEVELOPMENT GROUP WHAT WERE THE POSITIVE ACTIONS OR ACHIEVEMENTS OF THE BOARD'S STEERING COMMITTEE:

Thank you for taking the time to complete this questionnaire.

Sharon Driscoll

APPENDIX 7

QUESTIONNAIRE FORMAT: SDG NOMINATING ORGANISATIONS

Waikato Hospital Board

REF.

5 June 1985

Dear

WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES

I am conducting an independent post-graduate study whinh is being supervised by the University of Waikato with the knowledge of the Waikato Hospital Board. It would be appreciated if you would discuss the enclosed questionnaire at your next committee meeting and return it to me as soon as possible or by 22 July 1985. A stamped addressed envelope is enclosed for that purpose.

Your answers may assist with the formation and establishment of future Service Development Groups assisting with health service research.

Thank you for your help.

Yours faithfully

Sharon Dimock

RESEARCH AND DEVELOPMENT OFFICER

Encls.

MARLBOROUGH PLACE, HAMILTON, N.Z. CORRESPONDENCE TO: CHIEF EXECUTIVE P.O. BOX 934 TELEPHONE 394-679

WAIKATO HOSPITAL BOARD REVIEW OF MATERNITY SERVICES

1985

1. Your organisation was asked to nominate a representative to serve as a member of the Service Development Group which assisted with the Waikato Hospital Board's Review of Maternity Services. Did your group think that the selection of nominating groups for the Service Development Group was appropriate?

Very appropriate _____
Appropriate _____
Not very appropriate _____
Not appropriate at all _____

2. Were there sufficient opportunities for your nominee to represent your organisation's ideas?

All the time _____
Some of the time _____
Occasionally _____
Not at all _____

3. On the whole what did your organisation think of the Service Development Group's ideas?

All were worthwhile _____
Most were worthwhile _____
Some were worthwhile _____
None were worthwhile _____

Does your organisation think that the Service Development Group's work was known and appreciated:

4. By the community in general:

Very much appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all _____

5. By the Waikato Hospital Board:

Very much appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all _____

6. By Health Professionals:

Very much appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all _____

BY INTEREST GROUPS; for example

8. Politicians; for example local body representatives, parliamentarians

Very much appreciated _____

Appreciated _____

Not appreciated _____

Not appreciated at all _____

9. Rural Groups for example Young Farmers; Federated Farmers; Womens Division Federated Farmers

Very much appreciated _____
Appreciated _____
Not appreciated _____
Not appreciated at all _____

10. National Council of Women

Very much appreciated _____
Appreciated _____
Not appreciated _____
Not appreciated at all _____

11. Does your organisation think that the Service Development Group's work has acted as a catalyst in any way to make changes to maternity services?

Very much _____
In some ways _____
Not very much _____
Not at all _____

12. Has your organisation any comment to make about the Terms of Reference set by the Waikato Hospital Board for the Service Development Group?

Please comment:

13A. What comment would you like to make about methods of ensuring future representation of community representatives in health services planning?

13B. For instance were there other groups that deserved to be included?

14. Please comment about methods of ensuring health professionals' representation in health services planning.

15. Does your organisation think that any future review of a health service area should involve a Service Development Group?

Definitely _____

Yes _____

No _____

Not at all _____

16. What benefits were gained from involving community representatives in the review of maternity services?

Please describe:

17. How much should community representatives be involved in the health planning process?

All the time _____

Regular consultation _____

Occasional consultation _____

Not at all _____

18. Please list the positive outcomes or achievements of the Service Development Group in the review of maternity services.

19. Please list the negative outcomes of the work of the Service Development Group in the review of maternity services.

20. Any further observations that you would like to make would be very welcome. Please list.

Thank you for taking time to complete this questionnaire.

APPENDIX 8

INTERVIEW FORMAT: SERVICE DEVELOPMENT GROUP

INTERVIEW SCHEDULE

Fair Guidelines

In your view were the Terms of Reference fair?

Conflict of Roles

Did you think that there was conflict between community/professional roles?

Feelings

Many Service Development Group members expressed feelings of bitterness toward the Steering Committee. Have you any comment to make about that?

Political Process

Do you think it was hand to work without being part of the "inside ring-of knowledge" or hospital board structure?

Representation

Majority of responses said that their job as a nominated representative was not easy. Could you comment about that?

Appreciation

What were the reasons for the non-appreciation by communities?/local body representatives?

Group Process

Most of you thought the group worked well together. What was the reason for that?

Most of you thought the group had good ideas. What was the reason for that?

Six of the group thought that the Service Development Group approach was very valuable in reviewing health services. Do you want to comment on that?

General matters

1. Final report accepted by Board incorporates many of the Service Development Group's recommendations. Do you believe that the Board could/would have made the same decisions without the Service Development Group's contribution?

2. What was your (personal) response to the final document.

APPENDIX 9

RESEARCH TIMETABLE

Research Timetable

1) SDG Questionnaire Administered 10 November 1984

2) SDG Questionnaire Received/Collected 5 January 1985

3) SDG Interviews Conducted January 1985

4) Board Steering Committee Questionnaire Administered 22 February 1985

5) Board Steering Committee Questionnaire Received/Collected 30 March 1985

6) Board Steering Commmittee Interviews Conducted April/May 1985

7) SDG Nominating Organisations Questionnaire Administered 5 June 1985

8) SDG Nominating Organisations Questionnaire Received/Collected July-October 1985

M A P 1

A R E A A D M I N I S T E R E D B Y T H E
W A I K A T O H O S P I T A L B O A R D

Map 1


AREA ADMINISTERED BY THE
WAIKATO HOSPITAL BOARD
WAIKATO RIVER
TE AROHA
HUNTLY
RAGLAN
PIAKO
WAIKATO
MORRINSVILLE
NGARUA
HAMILTON
MATAMATA
CAMBRIDGE
WAIPA
MATAMATA
TE AWAMUTU
PUTARURU
ROTORUA
OTOROHANGA
OTOROHANGA
TOKOROA
TE KUITI
ROTORUA
WAITOMO
TAUPO
LAKE TAUPO
TAUPO
TURANGI
LOCAL AUTHORITY DIVISIONS USED IN
DEMOGRAPHIC ANALYSIS

MAP 2

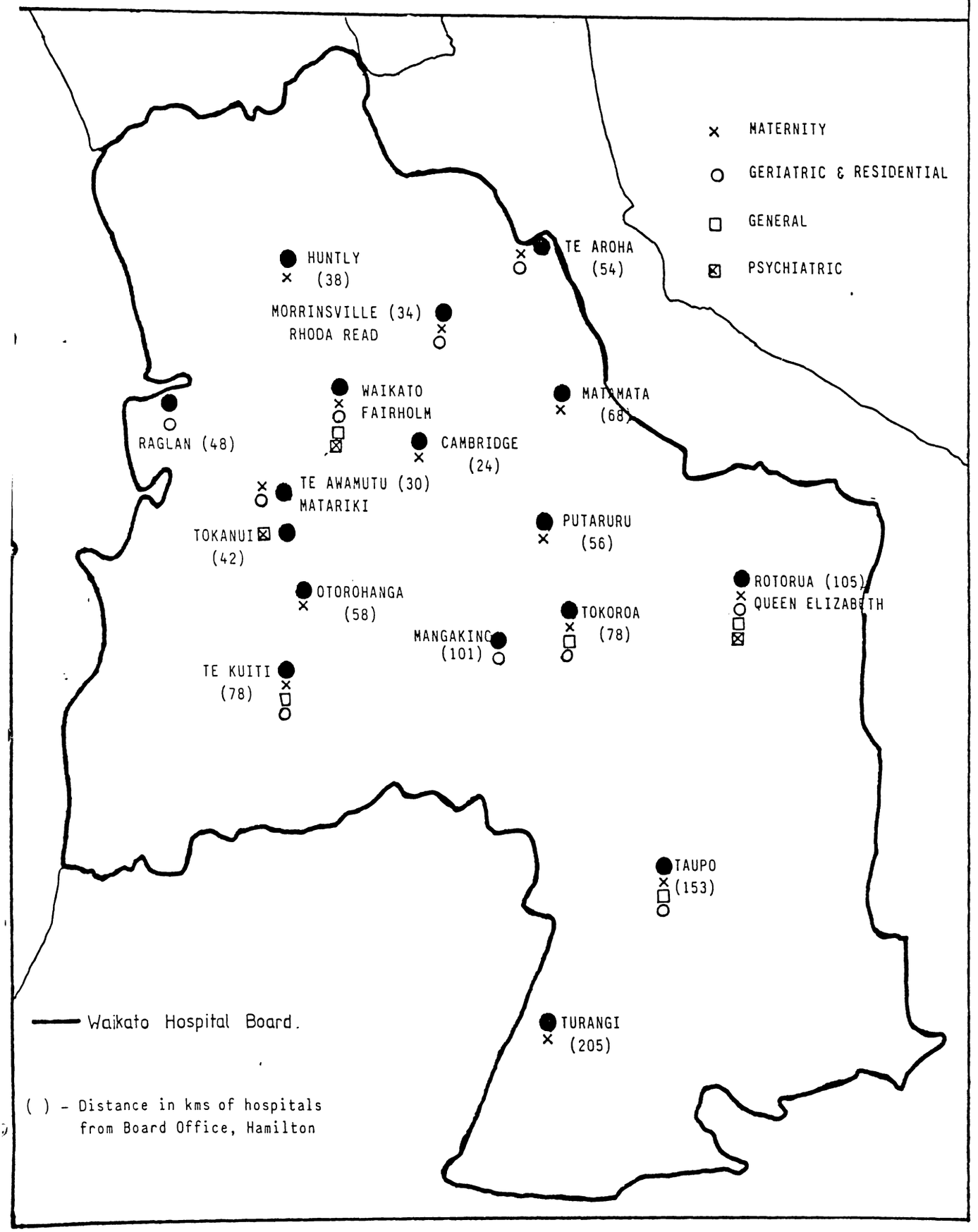
INSTITUTIONS ADMINISTERED

BY THE

WAIKATO HOSPITAL BOARD

Map 2

INSTITUTIONS ADMINISTERED BY WAIKATO HOSPITAL BOARD



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