

“A GREAT LITTLE HOSPITAL”

Inside New Zealand's Rural and
Community Hospital System



May 2026



EXECUTIVE SUMMARY

Our rural hospital network holds significant untapped capacity that can decompress services across the entire New Zealand health system. This is especially important as we look toward sustainable ways of meeting the growing volumes and complexity of health needs in Aotearoa. However, this potential is currently obstructed by staffing shortages. Investing in improved staffing configurations will be the most effective lever in lifting productivity and better serving our rural communities' health needs.

Key findings:

Rural emergency departments are under pressure

Emergency department presentations have increased by 4.7% year-on-year along with patients who did not wait for treatment, which leaped by 20% during this same period. This directly reflects shortages in medical staffing during periods of high pressure.

Many rural hospitals have untapped capacity

Many rural hospitals operate well below the 85% best-practice threshold for bed utilisation, indicating an efficiency gap in the use of hospital resources. This is corroborated by a productivity indicator: cost weighted discharge. Both point to an opportunity for lifting rural hospital capacity. With sufficient medical staffing, these facilities can decompress overcrowded metropolitan hospitals.

Demand for diagnostic services is growing

Radiology and laboratory volumes are rocketing upward, reflecting increasing pressure on these services nationally. Current models of service provision are outdated and can no longer keep up with demand. A shift to 7-day service provision is required to sustainably meet needs.

Recommendations:

1. Invest in medical staffing: Fully fund rural training programmes, implement workforce supports, and ensure fair remuneration that reflects the demands and challenges of rural practice.

2. Shift to 7-Day service models: Transition allied, scientific, and technical workforces from “on-call” rosters to 7-day rosters to maximise return on investment for expensive infrastructure and reduce staff burnout.

Background to this report

Between November 2025 and March 2026, we undertook research to examine how our rural and community hospital network was holding up.

During 2024 and 2025 medical staffing was perilously low in some of these hospitals at both the resident doctor, as well as the senior medical officer level. Whether the staffing issues arose at Taupō Hospital, Timaru Hospital, Wairau Hospital, Kenepuru Hospital, or Whakatāne Hospital, the situation was always roughly the same – not enough doctors employed to cover emergency departments and acute workload, especially overnights and on weekends.

We also saw sustained pressure on the allied, scientific and technical health workforces over this time, particularly for our two key diagnostic workforces – medical imaging and medical laboratory. This was especially apparent in parts of the country like Northland, Gisborne, and Otago – including the Queenstown Lakes area – which are seeing steady population growth.

New Zealand's population is spread across an archipelago bisected by mountain ranges, lakes and rivers, forests and rugged coastline. This means our smaller, rural hospitals play a crucial role in ensuring every New Zealander gets the care they need, close to home.

Too often the narrative of health and healthcare in Aotearoa is dominated by the perspective of our major metropolitan hospitals. To get a better understanding of what was occurring in our rural and community hospitals we requested data from Health New Zealand | Te Whatu Ora ('Health NZ') under the Official Information Act and surveyed NZRDA and APEX members who work in rural or community hospitals (see Appendix for methodology details). The resulting information and our observations are presented in this report.

Definitions

Rural and community hospitals – Broadly we looked at Health NZ's small hospital network, including rural hospitals as well as some of the small provincial and community hospitals. This meant that as well as looking at Kaitiāia, Ōamaru and Ashburton hospitals, we also looked at Whanganui, Timaru and Wairarapa hospitals.

NZRDA – New Zealand Resident Doctors' Association is a trade union of 3,000 resident medical officers including trainee interns, house officers, registrars and fellows. Resident medical officers are doctors who have finished medical school and are completing training as general practitioners and other specialists.

APEX – The Association of Professionals and Executive Employees represents over 6,000 allied, scientific and technical health professionals including psychologists, laboratory scientists, medical imaging technologists, pharmacists, and physiotherapists - 5 critical groups to improving performance in these communities.

INTRODUCTION

Rural hospitals are the unsung heroes of New Zealand’s health system

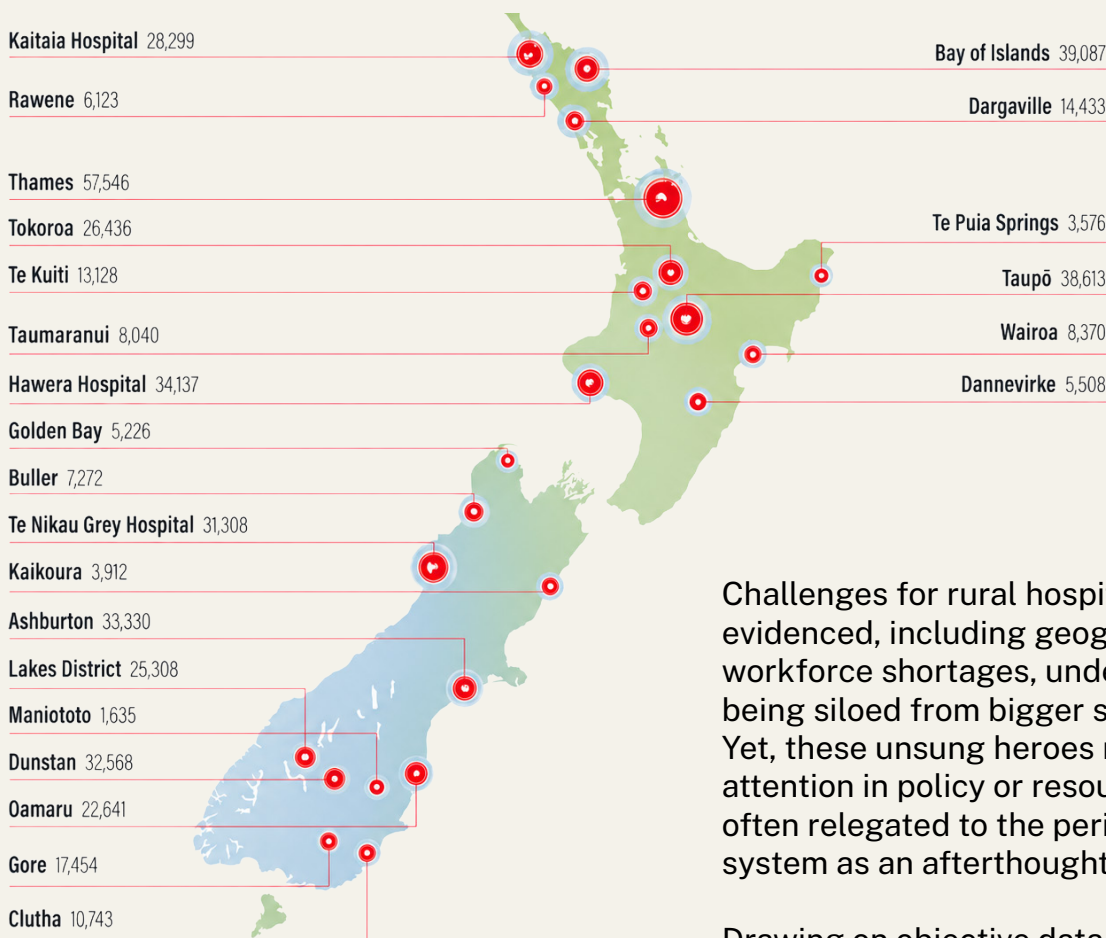
Rural hospitals are ‘anchor institutions’ within their communities. Beyond providing critical health services, they are often sizeable employers within their region and one of the largest influences on the community’s health, economic, and social wellbeing.^{1,2} In Aotearoa, where rurality can be a key determinant of unmet health need and preventable mortality^{3,4,5,6} – particularly for Māori and older populations^{7,8,9} – these hospitals provide an essential safety net for the around 15% of our population.¹⁰

Access to rural hospital services enable patients to be treated and cared for within the familiarity and comfort of their own communities, supported by their whānau.¹¹

This means rural hospitals are not just ‘mini’ versions of their larger, urban counterparts. They serve specific purposes within their communities that cannot be replicated by service provision at urban sites. We concluded that the trends demonstrated in this report present a compelling case for improving support for small hospitals and paying greater attention to how we can invest in staffing and expansion of services, to lift the overall capacity of our rural hospital network.

While definitions of ‘rural hospital’ vary, they often deliver integrated services that straddle the boundary of primary and secondary care. As such, we use ‘rural hospital’ as a shorthand to refer to rural and community hospitals inclusively, in this report.

Indicative catchment populations of 24 rural hospitals



Challenges for rural hospitals are well-evidenced, including geographic isolation, workforce shortages, under resourcing, and being siloed from bigger sites.^{8,12,13} Yet, these unsung heroes receive little attention in policy or resourcing decisions; often relegated to the periphery of the health system as an afterthought.

Drawing on objective data from Health NZ and the lived experience of our APEX and NZRDA members, this report traverses the terrain to build a realistic portrait of rural hospitals across Aotearoa.

Figure 1: Map of NZ showing catchment served by different hospitals, sourced from Hauora Taiwhenua | Rural Health Network – Rural Health New Zealand Snapshot 2024

RURAL HOSPITALS ARE GREAT PLACES TO WORK

What attracts our health workforce to work rurally

Different factors influenced our Allied, Scientific, and Technical (AST) and resident doctor members’ decision to work at their rural hospital, as shown below. This is likely driven by tenure and the nature of the role.

On average, 92% of AST members had worked in their hospital for a year or longer, whereas most resident doctors had only moved to the rural hospital recently, often as a requirement of a training programme. Around two-thirds (65%) of resident doctors had worked in the hospital for less than a year.

AST staff were primarily drawn to the rural “lifestyle” and “quality of life”, citing benefits like the beaches, weather, tight-knit communities, and better work life balance. On the other hand, most compelling for resident doctors was the ability to train and practice within a broader scope, often with greater patient variety and increased role autonomy than would be available at larger centres.

Across all professions connection – to the team, to patients, and to the community – was also cited as important. This included being able to have the flexibility and time to connect with patients on a deeper level and being able to “give back” to the community that raised them.

Factors most influencing decision to work at their rural hospital

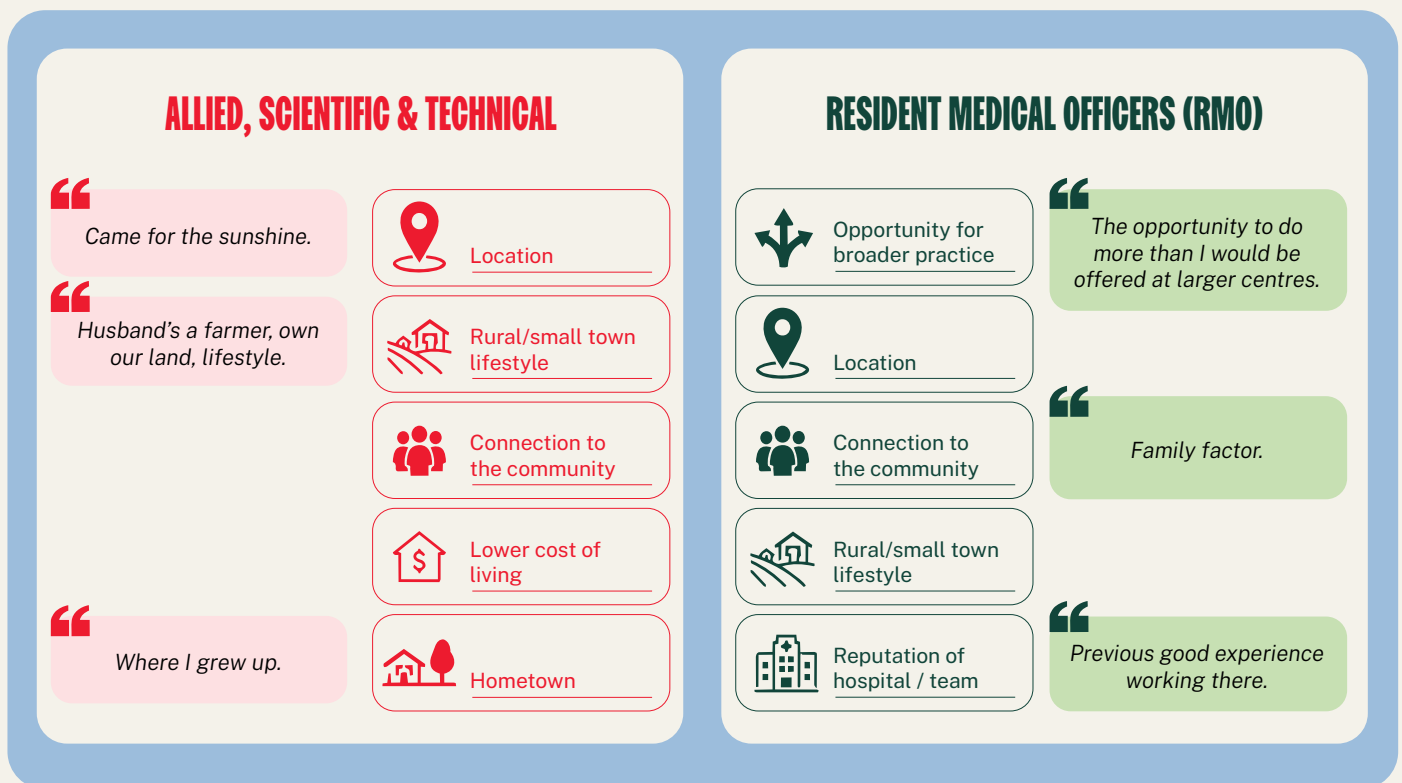


Figure 2. Most influential factors in deciding to work rurally

BUT WORKING RURALLY HAS ITS CHALLENGES

Emergency Departments (EDs) are under pressure

ED presentations increased over a two-year period

The importance of EDs in providing timely life-stabilising and lifesaving services cannot be understated, especially in geographically remote areas. They also serve an important role in offloading the system for stretched primary care services as well as providing 24/7 access. While many rural hospitals across the country do not have an ED, the data we received shows that between July 2023 and June 2024 12 rural hospitals saw 160,509 ED presentations, increasing over the following year (July 2024 to June 2025) to 168,066 ED presentations.

This is a year-on-year increase of 4.7%, representing an additional 7,557 ED presentations across the 12 hospitals.

Notable increases in ED presentations are apparent in seven of these rural hospitals, with a slight reduction or relative stability across the remainder. Kaitāia and Bay of Islands hospitals in Northland stand out as having experienced a surge in presentations.

Table 1. Year-on-year comparison of total ED presentations across 12 rural hospitals

Hospital	Jul '23 to Jun '24	Jul '24 to Jun '25	% change
Kaitāia	9,808	11,997	+22.3
Bay of Islands	11,080	12,622	+13.9
Taumarunui	8,439	9,121	+8.1
Hāwera	15,227	16,388	+7.6
Thames	18,239	19,508	+7.0
Te Nīkau Grey	11,392	12,083	+6.1
Te Kūiti	2,570	2,725	+6.0
Taupō	17,900	18,465	+3.2
Wairoa	3,665	3,492	-4.7
Whakatāne	25,719	25,397	-1.3
Timaru	21,979	21,801	-0.8
Tokoroa	14,491	14,467	-0.2

Yet patients are not always waiting for treatment

Between July 2023 and June 2024, 7,204 patients were triaged in ED but did not wait ('DNW') for treatment. By the following year, this number grew to 8,654 patients: a 20% increase.

All but one rural hospital – Hāwera – saw a year-on-year increase in DNWs. Thames, Te Kūiti, and Te Nīkau Grey hospitals especially stand out in terms of relative increases. Notable increases are also seen at Tokoroa, Whakatāne, and Timaru hospitals.

Long ED wait times are clearly a barrier to accessing care and an indicator of unmet need. A significant number of these patients are likely to present again at ED when their condition has further deteriorated, increasing their likelihood of requiring intensive care and risk of mortality, when they do.¹⁴

Table 2. Year-on-year comparison of total DNWs across 12 rural hospitals

Hospital	Jul '23 to Jun '24	Jul '24 to Jun '25	% change
Thames	86	568	+560.5
Te Kūiti	3	15	+400.0
Te Nīkau Grey	17	72	+323.5
Taumarunui	161	290	+80.1
Taupō	255	447	+75.3
Bay of Islands	159	227	+42.8
Tokoroa	861	1,118	+29.8
Whakatāne	1,992	2,584	+29.7
Wairoa	28	33	+17.9
Kaitāia	255	289	+13.3
Timaru	1,367	1,414	+3.4
Hāwera	2,020	1,597	-20.9

What is driving increased ED presentations?

One of the vulnerabilities of small hospitals is a lack of slack in staffing models and rosters for sickness or absence. A small number of vacancies can create a large hole in service delivery. So, while demand on ED services is growing across the country, this is being felt more acutely in rural hospitals.

Medical staffing shortages in particular can quickly drive up wait times, lead to ED overcrowding, and generate significant patient safety risks. Often, even one doctor being away sick toppled the whole system. Staffing ratios and hours were also frequently mismatched. Members told us:

“ [We’re] often unable to acutely admit patients in a timely fashion. Overnight patients can wait a while for acute issues as there is only one RMO for the whole hospital (90 beds).

– Wairau

“ We have excess RMOs in the daytime, and at times, critical understaffing out of hours. Our ED weekends (2x long days 8am – 10.30pm) are clearly in breach of the [collective agreement]. The roster ought to be changed to have better cover in the evenings and at the weekends too.

– Ashburton

Shortages of ED doctors had wider flow-on impacts, with hospitals “almost needing to close services at times”. Another member told us:

“ When we are understaffed, the whole hospital is impacted. From theaters not having enough assistance, slower ward rounds, delayed discharges, delayed clerking of patients from ED, longer working hours due to staying late to finish jobs, to being unable to attend protected teaching time.

– Wairau

Many rural hospitals have untapped capacity

Data on two broad measures of hospital workload – monthly bed utilisation and cost weighted discharges – suggest our rural and community hospital system is not being well utilised overall.

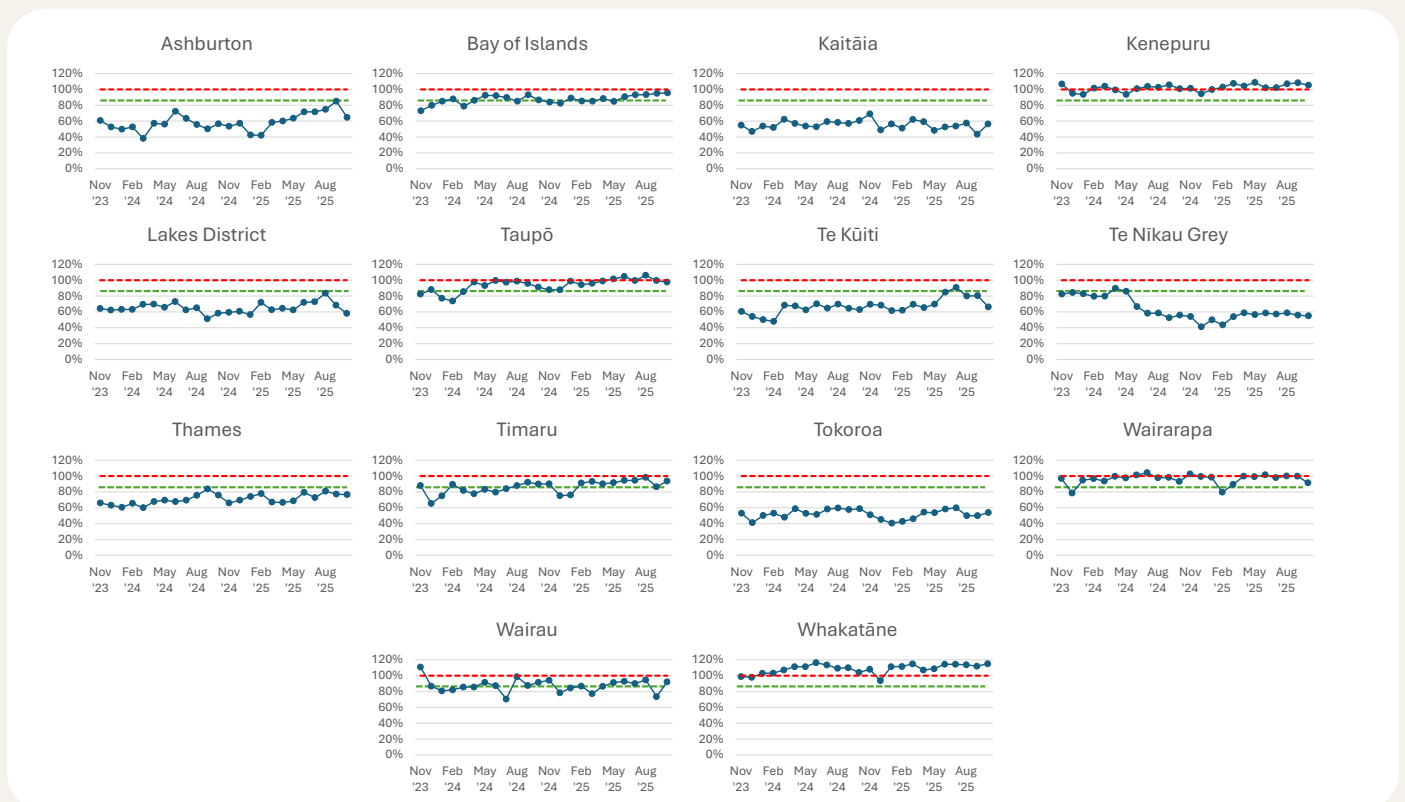
Rural hospitals tend to have lower bed utilisation rates

Bed utilisation reflects the percentage of hospital beds used across a defined period. Across 41 Health NZ hospitals nationally*, the average utilisation between November 2023 and October 2025 was 87.1%. This reflects very high utilisation and a lot of pressure on the health system.

Hospitals cannot function at 100% bed occupancy – spare capacity is needed so that patients can flow through the system. This is especially important in rural hospitals with fewer beds, to preserve ‘surge capacity’ in responding to unforeseen events.⁸ As such, 85% bed occupancy is often recommended as best-practice to maintain patient safety.¹⁶

The average bed utilisation across rural and community hospital networks was 79.5% – well below the national average and under the recommended best-practice threshold.

Figure 3: Monthly bed hospital utilisation across 12 hospitals between Nov 2023 and Oct 2025



*Excluding Franklin Memorial Hospital in Waiuku, Auckland which closed in August 2024

Table 3: Average bed utilisation across rural hospitals

Hospital	Bed utilisation %
Tokoroa	52.10%
Kaitāia	55.30%
Ashburton	58.80%
Te Nīkau Grey	63.40%
Lakes District	65.00%
Te Kūiti	67.10%
Thames	70.90%
Timaru	86.20%
Bay of Islands	87.40%
Wairau	87.60%
Taupō	93.90%
Wairarapa	96.30%
Whanganui	97.20%
Kenepuru	102.10%
Whakatāne	108.80%

Note: Bed utilisation data was not provided for Dargaville, Taumarunui, Hāwera, Wairoa, Westport (Buller), Kaikoura, Ōamaru hospitals.

While rates tend to vary across rural hospitals, Tokoroa, Kaitāia, Ashburton, Te Nīkau, Lakes District, Te Kūiti, and Thames hospitals were running well under capacity. Others exceeded the best-practice occupancy threshold, but two particularly stand out. Whakatāne and Kenepuru hospitals had average utilisation rates of 109% and 102% respectively, indicating overcrowding and increased risk of patient harm. This is concerning and warrants further investigation.

Cost weighted discharges indicate opportunities to lift capacity

Another blunt measure of hospital workload is to look at Cost Weighted Discharges (CWDs). CWDs account for how complex and expensive it is to treat a patient through to discharge. The more complex the treatment, the more hospital resources are used, reflected in a higher CWD.

Hospital level comparisons reflect more granular year-on-year fluctuations, with hospitals like Dargaville (-14%), Tokoroa (-13.3%), Taupō (-9.3%), and Kaitāia (-8.2%) experiencing notable decreases in CWD.

We looked at CWDs over two years across twelve rural hospitals, involving a total of 78,765 patients. These hospitals discharged 39,978 patients between July 2023 and June 2024, and 38,788 patients over the following twelve-month period, reflecting a slight decline of 1%.

Table 4. Year-on-year comparison of total case weighted discharges across 12 rural hospitals

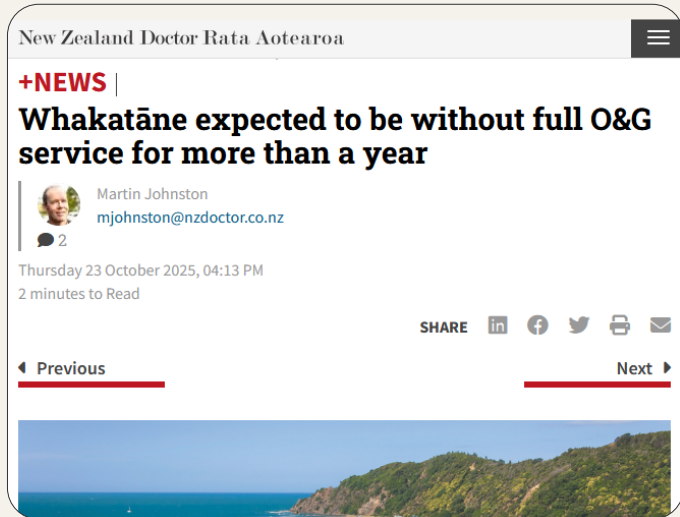
Hospital	Jul '23 to Jun '24	Jul '24 to Jun '25	% change
Dargaville	906.5	779.6	-14.0
Tokoroa	1,359.8	1,177.4	-13.4
Taupō	2,175.5	1,973.6	-9.3
Kaitāia	2,195.8	2,016.6	-8.2
Timaru	10,160.3	9,728.3	-4.3
Whakatāne	10,202.3	9,825.8	-3.7
Bay of Islands	2,325.2	2,279.2	-2.0
Te Nīkau Grey	4,535.3	4,510.8	-0.5
Hāwera	590.8	619.7	4.9
Thames	4,530.9	4,784.7	5.6
Taumarunui	564.0	604.4	7.2
Te Kūiti	431.2	487.3	13.0

What does this tell us about rural and community hospital capacity?

Based on bed utilisation rates alone, it may appear that rural hospitals are less busy. However, nearly all hospitals with lower bed utilisation rates saw a year-on-year increase in ED presentations, except for Timaru. In fact, many hospitals with the lowest bed utilisation rates and decreasing CWD have had long-standing issues with medical staffing shortages.

Staffing shortages are a key explanatory factor behind the underutilisation of rural hospital capacity. If we do not have sufficient staffing, beds cannot be filled safely, hospital resources cannot be used efficiently, and productivity takes a dive.

However, this gap represents a significant opportunity. By addressing staffing deficits, we can unlock this existing capacity to decompress larger hospitals and ease pressure off the entire health system.



Media links

- [Dargaville Hospital loses its only full-time doctor](#)
- [The doctor-less north: Stroke patient seen by telehealth at Kaitiāia Hospital](#)
- [Far North doctor shortage now 'acute', clinical manager warns](#)
- [Taupo clinicians plan for emergency hospital shutdown amid critical staff shortages](#)
- [Timaru Hospital resident doctor expected to do work of three, union says](#)
- [Whakatāne expected to be without full O&G service for more than a year](#)
- [Bay of Islands Hospital unable to take new admissions amid doctor shortage](#)
- [Doctor shortage nearly saw Grey Hospital close doors, health advocate warns](#)

There is an increasing demand for diagnostic services

The data also paints a picture of increasing pressure on diagnostic services – our laboratory and radiology departments.

Pressure on laboratory services is growing

While we were unable to source national data on laboratory services, Health NZ provided us with data for the Northland region alone.

Northland lab data tells a story of a region under pressure

A total of 60,729 lab tests were ordered across Kaitiāia, Dargaville, and Bay of Islands hospitals between November 2023 and October 2025.[†] This includes blood cultures (3,701), full blood counts (51,719), and urine tests (8,903).

This represented a 4% growth in laboratory test volumes between the 2024 and 2025 period. This is largely driven by Bay of Islands, with volumes at Kaitiāia remaining relatively static and a slight decrease (by 3%) at Dargaville Hospital as shown below.

Radiology is also seeing a massive expansion

In parallel, we are also seeing substantial increases in radiology volumes. Between January 2024 and October 2025, 426,198 radiology scans were performed across 19 rural and small hospitals around the country. The figure below shows a clear trend upward. Since the announcement of the diagnostic boosts late last year, we predict scan volumes will continue to increase off the chart.[‡]

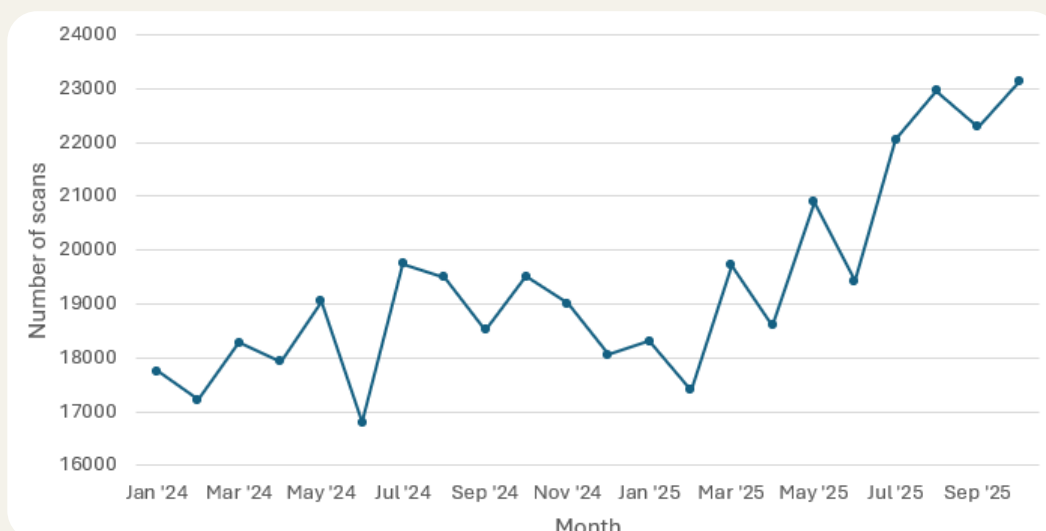
[†] Numbers are slightly overstated due to the inability to exclude all GP and outpatient requests. The laboratory test data has been limited to data available for blood and urine samples.

[‡] The Minister announced in September 2025 a \$65 million Diagnostic Improvement Plan that would deliver an additional 64,000 radiology procedures. A month later, the \$108 million upgrade to diagnostic infrastructure across 14 public hospitals was also announced.

Table 5. Year-on-year comparison for lab test data across Northland rural hospitals

Hospital	Nov '23 – Oct '24	Nov '24 – Oct '25	Percentage change
Kaitiāia	11,209	11,216	0%
Bay of Islands	13,795	15,186	10%
Dargaville	4,724	4,599	-3%

Figure 4. Total radiology events per month across Northland rural hospitals



When looking at total scan volumes, the busiest rural and community hospitals were Whakatāne, Thames, Wairau, Wairarapa, and Te Nīkau Grey. However, looking at the relative increases between the two years (January to December 2024 against January to October 2025), once again Dargaville (195% increase); Bay of Islands (159% increase); and Kaitāia (132% increase) feature at the top of the list.

Table 6. Year-on-year comparison for radiology scan data rural hospitals

Hospital	2024 total	2025 total (until Oct)	% change
Dargaville	352	1,039	+195.2
Bay of Islands	1,510	3,910	+158.9
Kaitāia	1,408	3,270	+132.2
Kenepuru	9,939	11,101	+11.7
Wairarapa	20,014	21,418	+7.0
Wairoa	8,257	8,581	+3.9
Kaikoura	1,126	1,089	-3.3
Ōamaru	1,539	1,486	-3.4
Ashburton	14,437	13,367	-7.4
Taumarunui	5,386	4,963	-7.9
Lakes	14,020	12,625	-10.0
Te Kūiti	3,267	2,861	-12.4
Hāwera	9,079	7,924	-12.7
Thames	26,233	22,778	-13.2
Whakatāne	34,166	29,528	-13.6
Wairau	25,308	21,506	-15.0
Taupō	13,985	11,618	-16.9
Te Nīkau Grey	20,744	17,116	-17.5
Tokoroa	10,621	8,627	-18.8

Why are we seeing these findings?

Laboratory and radiology test volumes indicate our Northland hospitals are experiencing a high level of demand for diagnostic services. The region is on track to being one of the fastest-growing populations in the country, particularly for those 65 and older.¹⁷

These findings are part of a larger national trend of growing demand for diagnostic services, reflecting the increasing complexity of patient health needs with an ageing population. While pressure on hospitals may be influenced by the entry or exit of private providers nearby, overall, the findings reflect growing demand on our rural hospital diagnostic services.

STAFFING IS THE KEY TO LIFTING RURAL HOSPITAL CAPACITY

Rural and community hospitals have shown remarkable agility in adapting to growing patient volumes and complexity, despite their under resourcing. However, we cannot rely on this resilience alone to sustainably meet the future health needs of our rural communities.

Our findings point to an interesting paradox: despite ED presentations and wait times growing, many rural hospital beds lie empty. Despite staff working to the point of exhaustion, productivity – in the form of cost weighted discharges – is declining. Both are a direct consequence of staffing shortages.

To reverse these trends, we need to shift to staffing configurations that will have the greatest impact on harnessing untapped capacity and lifting productivity. This hinges on two key interventions:

1. Investing in rural medical staffing

Sufficient medical staffing remains the rate limiting step in providing timely hospital admissions, care, and discharges. Rural doctors play a vital role in managing bottlenecks; being able to safely refer stable, lower acuity patients to their GPs for follow-up care when hospital admissions or transfers are unnecessary. Facilitating this ‘step-down’ care has the added benefit of decompressing services in larger hospitals.

However, medical shortages undermine efficient hospital flow and timely discharges, with added costs such as expensive locum coverage. When “very obvious gaps in the system go unfilled” for extended periods, it creates a vicious cycle of burnout and turnover. Members told us:

“ In Q4 last year: House Officers (HOs) working an extra approximately 10 hours per week (beyond roster pattern) to fill the deficit of vacancies, without compensation or acknowledgment. Many have grown disenfranchised with the hospital following this.

– Whakatāne

“ Lots of locums required to staff ED in particular, leading to frustration from SMOs as difficulty signing off results/continuity.”

– Wairarapa

These are not merely anecdotes. The Royal New Zealand College of General Practitioners’ most recent workforce survey shows over one in four (26%) rural hospital doctors are considering leaving New Zealand to practice overseas.¹⁸ This same survey highlights the reality that training and working in rural hospital medicine, or even practising rurally, remains less attractive than other speciality programmes.

We urgently need investment in the training, recruitment, and retention of our rural medical workforce. While financial incentives (e.g., rural allowances and bonding schemes) have their place, we must also ensure there is support for doctors to gain exposure, train, and work rurally. This includes fully funding rural hospital training programmes and fair remuneration that recognises the clinical and professional challenges of rural practice. Targeted recruitment and retention strategies have also been called for, especially for Māori and Pacific clinicians, to reflect the demographics of rural communities being served.¹⁸

We are therefore calling for commitment to funding the training and staffing of doctors working rurally, to fully unlock the capacity of our rural hospitals and better serve our rural communities across the country.

2. Shifting to a 7-day service model

Demand on clinical services – particularly diagnostics, outpatient, and mental health – continues to grow. While our rural and community hospitals have adapted as best they can, traditional models relying on on-call after hours rosters are outdated and no longer serve our communities nor our workforce.

“ Crazy on-call rosters when on the weekend on-call you are working effectively 12 days in a row with no sleep days apart from nine hour break. Would like to at least have enough staff for a p.m. shift in the weekend.

– Wairarapa

“ We only have 3 or 4 people on the on-call/weekend roster. If you have worked all day then get called in multiple times overnight fatigue can affect your judgement, especially as one person does Friday through to Monday 8am, no 9 hour breaks available. I fell asleep at the wheel driving home after a callout one night. We provide the best service we can to clinicians, but sometimes this leaves me running on empty.

– Taumarunui

Clearly a step change is needed to deliver these services sustainably. Funding clinical services to a continuous 7-day model would alleviate pressure on services, while improving productivity and cost-efficiency. This is not a radical concept; NHS hospitals in England have been operating a ‘seven-day service’ for acute and emergency care, for over a decade.¹⁹ The logic is simple: given the high fixed costs of hospitals, infrastructure left idle during nights and weekends is a waste of expensive resources.²⁰

A 7-day model would involve moving our allied, scientific and technical workforces from ‘on-call’ rosters for after hours and weekends (often at much higher overtime rates) toward 7-day rosters, with rotating days off. While this requires investment in additional FTE, costs would be partially offset by a reduced reliance on premium overtime rates, as well as reductions in outsourcing of services.

There is a clear efficiency argument to be made for expanding rosters to 7-day service provision, rather than continuously adding infrastructure that is only used to capacity five days a week.²¹ This is especially true for diagnostics services. Efficiency gains can also be realised by expanding key support services such as pharmacy, physiotherapy, social work, and other professions involved in post discharge care and rehabilitation over the weekend;^{22,23} freeing up hospital beds for those with the greatest clinical need.

Patients benefit by being seen, treated, and discharged quicker, all while reducing hospital costs and freeing up valuable resources.²⁴ From a workforce perspective, 7-day rostering better balances the workload across a greater clinician FTE base, reducing the risk of burnout and turnover.

To be clear, we are not proposing an indiscriminate expansion of all services across all rural hospitals. This shift must be driven by patterns of need within the local communities. If implemented, an expanded 7-day service model will look different across different hospitals, scaled to demand, and supported by the necessary infrastructure investment. Some members examples included:

“ If the social work service was available over the weekend, it would be a game-changer.

– Timaru

“ Ultrasound. This is critically understaffed – especially in Kaitāia. It has been for years with the midwives having to refer to a service approximately 100km away.

– Kaitāia

“ For radiology we could have ultrasound everyday rather than 3 days a week.

– Thames

It is essential that any expansion to a 7-day model is grounded in ergonomic scheduling principles and rolled out in a way that meets the needs of both the service and the workforce.²⁵

The Rural Health Hub: A one-stop shop

These staffing levers would work to boost rural hospital capacity in a way that met the specific health needs of local communities. Ideally, this would be supported by an extension of ambulance, outpatient, and mental health services, whilst being closely integrated with our primary care teams. This would shift the delivery model from secondary care toward an integrated ‘Health Hub’ that offered co-located services run by multidisciplinary teams.

Many existing rural and community hospitals already have existing facilities and infrastructure that can be leveraged for such an expansion. However, where it is impractical to expand services within existing hospital footprints, other health sites nearby (such as general practices or other clinics) can be used as an anchor for the Hubs – scalable to community needs.

Work on the Health Hub, including proof of concept, is well underway, and will be published as a separate report. Nonetheless, investment in rural hospitals offers fertile ground for transforming the Health Hub service model into a reality, delivering more integrated care closer to home and decompressing secondary services.

LIFTING CAPACITY OF THE WHOLE SYSTEM

Unlocking the full capacity of rural hospitals strengthens the whole system

This report observes broad patterns about our rural and community hospital network. Yes, it finds that emergency departments and diagnostic services are under pressure from increased demand. But it also finds that these hospitals are both great places to work, and relatively underutilised, when compared to major urban hospitals. Indeed, there is scope to significantly increase patient care in rural hospitals, provided we get the medical and allied staffing configured correctly.

We think these trends present a compelling case for improving supports for small hospitals and paying greater attention to how we can expand services and upgrade infrastructure, whilst strengthening integration with primary care and releasing capacity for more training of medical and health practitioners.

It might be tempting to think that the problems for Ashburton Hospital only affect Ashburton, but healthcare is a tightly interwoven system. If patients cannot be treated and cared for at Ashburton, they will ultimately have to be transported to and cared for in Christchurch Hospital. Costs rise accordingly.

So not only do these hospitals provide care for their local communities, they also keep patients in their community and from spilling into the metropolitan hospitals, where pressure on services and demand for hospital beds is highest.

Getting more out of the hospital network requires a focus on using existing capacity better, as well as investing in expanding capacity in high demand hospitals. We support a renewed focus on improving support for rural and community hospitals, with the knowledge that this matters both to the local communities as well as the health system's overall productivity and resilience.

The people who work here are passionate about their communities and have many great ideas about what is working well, and what needs to be improved. This report confirms the view that empowering small hospitals, within a well-integrated local, regional and national system, is a vital precondition of dealing with the ongoing 'postcode lottery' of regional inequity in health services, as well as maximising value added outcomes.

These "great little hospitals" remain the backbone of our healthcare system and require continued focus and careful consideration from decision makers and funders.

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APPENDIX: METHODOLOGY

In November 2025, we requested data on rural hospitals from Health New Zealand | Te Whatu Ora under the Official Information Act. The parameters of data provided were as follows:

ED presentations and Did Not Waits (DNW)

ED attendance and DNW numbers were provided for selected facilities. The latest information which was complete enough to provide for reporting was to June 2025.

Hospital bed utilisation

Bed utilisation data was provided for selected facilities, with Health NZ distinguishing between:

- Occupancy – percentage of beds in use at a specific point in time, and
- Bed utilisation – the percentage of beds used across a defined period.

Hospital discharges and Cost Weighted Discharges (CWD)

CWD data for publicly funded discharges were provided for select facilities. Health NZ defines CWD as:

The cost weight is a score that provides a weighting of how this discharge compares to the average case mix hospital discharge. For example, a cost weight of 0.5 means that this event is half the cost of the average event. These numbers can be turned into an estimated cost by multiplying them by the unit price/national price for that financial year.

The latest information which was complete enough to provide for reporting was to June 2025.

Laboratory services

While we requested data on tests ordered for hospital inpatients, we were informed this would require significant manual collation. Only lab data for the Northland region was able to be provided, with the caveat that numbers did not exclude all GP and outpatient requests.

Radiology services

Scan volumes were provided by modality, including CT, MR, Ultrasound, X Ray, DEXA, Fluoroscopy, Interventional Radiology, Mammography, Nuclear Medicine, and PET scans.

The national radiology dataset was established in January 2024, so earlier data was not available. Data for Westport and Timaru was not yet available.

Other data not provided or held

We also requested data on patient transfers to other hospitals but received a response that this information was not centrally held.

The data held across different hospitals, as well as specific collection methods and date ranges, varied considerably making exact comparisons difficult. With these limitations in mind, we have done our best to piece together the most accurate and current picture of rural hospitals across the country.

Between February and March 2026, we also surveyed APEX and NZRDA members who worked in rural or community hospitals across the country. A total of 353 respondents completed the survey.

We have drawn on these collective responses to corroborate OIA data and used select quotes to illustrate key ideas.

Familiarity, Isolation, Intensity • Unproductive, isolating but well-meaning • **Challenging yet rewarding** • Healthy work environment • **All one team** • Stressful, defeating, BUSY • **Crisis work, providing a “band aid” primarily** • Was great before • **Friends. Good. Fun** • Inadequate. Stressful. Busy. • **Caring, patient-focused, teamwork** • Sometimes very challenging • **Fulfilling, fun, friendly** • Community, small and slow • **Busy, interesting, good people** • Great place to work. • **Satisfying variable rewarding** • It is ok • **No MRI problematic** • Challenging. Rewarding. Frustrating. • **It’s pretty good** • Community, diverse, grassroots • **Support from all colleagues** • Family, overstretched, underpaid • **Small** • Lack of resources • **Proud Enjoy Team** • Connections caring team • **Challenging, demanding, rewarding** • Great community environment • **Frustrated, depressed and apathetic** • High level of post code tested service • **Hardworking, professional, undervalued** • Negative impact of psychological well-being • **Variety, independence, lifestyle** • Challenging, understaffed, strained • **Team, skilled, personable** • Underinvested, understaffed, undertrained • **Unpredictable, relaxed, stressful** • People try best in limited circumstances • **Flexible, sustainable and enjoyable** • Challenging, change, satisfying • **I love it!** • Community, accessible, enjoyable • **Nice then chaos** • Rewarding, interesting, fun • **Enjoyable Challenging** • Friendly Relaxed • **Rewarding, busy, multi-disciplined** • Varied interesting busy • **Work-life balance and no traffic jam** • Community, Multidisciplinary and problem solving • **Great but overwhelming** • Mostly good, considering • **Consistently steady workload** • Outdated, manageable, peaceful • **Appreciated, friendly, satisfying** • Busy, interesting, tiring • **Busy lonely tiring** • Busy, teamwork, flexibility • **Busy, gratifying and joyful** • Family, dedicated, grateful • **Friendly but restricted care** • Importance of teamwork • **Friendly, resourceful, managing** • Interesting Busy Hometown feel • **Friendly like family** • Fun Frantic Caring • **Helpful, fun, accommodating for patients and staff** • Community focused but challenging • **Rewarding, community, generalist** • Community, lack of resources or services in the community. • **Rewarding, challenging, busy** • It’s hard but we have been made to manage with a lack of resources • **Connection, not-fit-for-purpose a difference** • **Good. Draining.** • **Tiring Happy** • **Diverse** • Community, connection, team • **Stressful, interesting, learning environment** • Friendly. Good. Sufficient. • **Community, friendly, busy** • Stressful, challenging, unfulfilling • **Enjoyable, frustrating, understaffed** • Challenging but rewarding • **Community, forgotten, undervalued** • Busy, Challenging, frustrating • **I enjoy it** • Challenging, fun, family • **It’s a lifestyle!** • Interesting, variable, progressive • **Close, respected, forgotten** • Mixture of work • **Satisfied** • Perfect Community. Isolation. Self-sufficient • **Small scale Amateurish Convenient** • Community, people, empathy • Friendly • **Community, challenging, holistic** • I’m still here • **Team, potential, frustration** • Rewarding, challenging, enjoyable • **Peaceful Meaningful and satisfying** • Familiar, friendly, low stress • **Community, fast care, lucky** • Outdated X ray machine • **Intimate, friendly, rewarding** • Messy, sometimes fun • **Collegiality, exposure, Aotearoa** • Previously was good • **Rewarding, demanding, relentless** • Humbling fun roller coaster • **Good team vibes** • It’s fine. The facilities in place for us RMOS these things make working here a lot smoother. • **Multi-cultural. Mutual support** • Best decision ever • **Isolating but fun** • Friendly, community-focused • **At the moment “f*** this place”** • Wild wild west • **Friendly, fun, close-knit team** • Busy, friendly, horrendous roster • **Dedicated, strained, busy** • Make it work • **Friendly, broad scope, community** • Teamwork, broad, enjoyable • **Interesting, challenging, friendly** • Very long hours • **Educational, challenging, collegial.** • Satisfactory, Slow paced • **Challenging, empowering, fulfilling** • Collegial, rewarding, supportive • **Welcoming, caring, community** • Wonderful friendly community • **Rewarding, satisfying and living.** • Community essential understaffed • **Busy, understaffed, pressure** • Patience, empathy, service • **Not bad considering** • Close relationship with nursing and doctor staff • **Crazy busy unsustainable** • Local, friendly, under resourced • **Busy hard** • Rewarding, interesting, taxing • **Friendly adequate** • Great working environment • **Despite all that it’s a great little hospital.** • Seriously burnout • **Busy friendly team** • Diverse Challenging Compact

**DESCRIBE WORKING
 AT YOUR HOSPITAL
 IN THREE WORDS**

Uninformed-management • Whanaungatanga, variety, contribution • **Teamwork, friendly, valued** • Jack all trades • **Teamwork, relaxed, patient centred** • Pressure, gratifying, making **Challenging** • Satisfying