Developing Social Capital: Community Participation in Rural Health Services

Roger Strasser, Paul Worley, Richard Hays, John Togno

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INTRODUCTION

It seems as we approach the 21st Century, that the only constant is change itself. In relation to health services, there is a world-wide trend towards community and home-based services, such that hospital and institution-based services are reserved for short term targeted interventions often involving specific technology. (1) (2) In rural areas changing practices in major industries like agriculture, mining and forestry combined with wider social and economic changes are causing considerable upheaval often described as ‘the rural decline’. (3) The combined effect of these changes often involves closure, down-grading or restructure of rural hospitals causing considerable angst in rural communities. (4) Often the restructuring of health services is centrally determined and occurs in a way which reinforces negative stereotypes in the rural culture of the city and government being distant and antagonistic. (5)

This paper draws on findings from several research projects undertaken by the authors, particularly focusing on sustainable rural health services. It explores the issues from the community’s perspective and also from the viewpoint of rural health care providers, particularly rural and remote GPs.

HEALTH SERVICE NEEDS IN SMALL RURAL COMMUNITIES

The first in a series of studies of Health Service Needs in Small Rural Communities began in 1993 with focus groups in three small rural communities in Gippsland. (6) The smallest community (population less than 500) had no official health services other than a visiting maternal and child health nurse one afternoon per week. The second community (population less than 2,500) had a community health centre and a nursing home (formerly a hospital) and a visiting medical service on weekdays. The third community (population approximately 2,500) had a hospital, community health centre, and resident medical practice. In each community there was a focus group involving local health care providers and a separate focus group involving members of the community. Findings from the focus groups were used to develop a questionnaire, which was used for a telephone survey of a larger sample selected randomly from a similar range of Gippsland communities. (7)
When asked about the meaning of health, there was a common theme in all focus groups of a positive sense of health involving full functioning and Well-Being. All groups identified a range of factors which affect health including physical, emotional, social, environmental, educational, transportation and financial service access. However, when asked what services were needed to maintain their health, all focus groups indicated that the first priority is a doctor and the second priority is a hospital, consistent with John Humphreys’ research. A chemist or pharmacy service was also seen as essential.

In exploring the background to this sense of priorities, it became clear that their security need was a strong driving force. People in small communities felt in need of a ‘safety net’ such that if they were unlucky enough to be seriously ill or injured there would be doctors and support facilities to ‘save them’. The importance of the hospital in economic terms to the community was emphasised also. Often the hospital is a major employer and purchaser of goods and services in the town. When asked what would be the effect of downgrading or closure of a hospital, a downward spiral was predicted. The view was that if the hospital closed, then doctors would leave and they would be followed by other professionals including teachers, lawyers and bank managers.

HEALTH SERVICE DELIVERY IN SMALL RURAL COMMUNITIES: THE PROCESS OF CHANGE

A subsequent Study in this series on Health Service Delivery in Small Rural Communities investigated the Process of Change. Six rural communities whose hospitals had been restructured were included in the Study. Three of those communities saw the change coming and worked with it and the other three used traditional political means to resist the change. Again the communities were tiny (population 500 or less), very small (population up to 2500) and small (population over 2,500). Quantitative and qualitative data were collected including financial statements and throughput figures together with in-depth interviews with key community and health service personnel in each study town.

Comparing the two groups of communities, the group that resisted the change had hospitals with part time CEOs who were based in another town and provided administration from a distance. The Boards of Management used traditionally political means to resist the change and provided special circumstances and fighting furiously to keep the hospital. In contrast the communities which went with the change tended to have local administration who read the need for change early and developed a working relationship with the Regional Office of the Health Department to explore options for restructuring. In relation to their staff, the group that resisted change did not involve their staff in establishing the new service such that there were sackings, relocations and redundancies. Those who chose to undertake retraining to work in the new service did so at
their own cost. By way of contrast, the communities that worked with the change kept their staff and the wider community informed, encouraged existing staff to seek positions in the new service and paid for these staff to retrain.

For both groups of communities the experience of change was extremely traumatic and in none of the communities was sufficient attention paid to the grieving process, mourning the loss of the community’s hospital. Both groups of communities continued to see access to doctor and hospital services as the highest priority. In the communities that resisted change the new service was established as an outpost of that run in another town and the community initially boycotted the new service. In those communities that went with the change the new service was administered within that town and supported by at least some sectors within the community.

In terms of outcomes the group of communities which worked with the change came out better. Both groups of communities suffered reductions in staff numbers and recurrent budget; however, these reductions were less in the communities that engaged with the change. In those communities that resisted change there was a perception of reduced emergency services and substitution of community health for acute health services. In those communities that worked with the change there was an expanded notion of health care with a sense of additional community health services complementing acute health services. (9)

GENERAL PRACTITIONERS IN TOWNS WITHOUT HOSPITALS

An effect of the restructuring of rural health services is that an increasing number of towns with general practitioners (GPs) but no hospitals. In 1996, a Study of the Support and Training Needs of Victorian GPs in Towns without a Hospital was undertaken. (10) A postal survey was sent to all Victorian GPs in towns without a hospital and a matched control group of GPs in towns of similar size with a local hospital. Response rates were 72 per cent of GPs with no hospital and 87 per cent of GPs with a local hospital.

In the towns without hospitals, emergencies were much more likely to come direct to the GP clinic when compared with the towns that had a local hospital. In addition about half the towns without a hospital also had no ambulance station. These differences were reflected in practice costs such that the practices in towns without hospitals were significantly more likely to have supplies and equipment to deal with emergencies which added to practice overheads. For example the practice telephone bills in towns without hospitals were almost double that of practices in the comparison group.

From this Study it is very clear that the nature of rural practice in a town without a hospital is substantially different from practising as a GP in a town with a local hospital. Where there is a hospital, the GP is provided with greater support – infrastructure support, professional support from other health practitioners and financial support as described. (10) It is clear therefore that where a rural hospital closes or is restructured, the nature of practice changes for the local general
practitioner(s). In this context it is not surprising that closure or downgrading of
the local hospital often is followed by the community's worst fear, which is the
departure of the local doctor(s). In fact, despite their initial assurances to the
contrary, GPs in five of the six Process of Change communities did leave after
restructuring of the hospital.

CHANGING PRIORITIES AND PREFERENCES OF RURAL PRACTITIONERS

The National Rural General Practice Study was the first comprehensive national
study covering all rural and remote general practitioners in Australia. (11) It was
undertaken in 1996/97 and drew on data from existing sources such as the
Australian Bureau of Statistics and the Australian Institute of Health and Welfare
together with a postal survey of all general practitioners in rural and remote
areas. There was a 72 per cent response rate to the survey which covered
professional issues, personal and social issues, personal background, patient
issues, recruitment and retention programs and changing health services.

Overall, the Study findings confirmed those of previous individual State-based
Studies in the early 1990s and showed that there had been relatively few
changes since those previous Studies. (12) It did show that the rural medical
workforce appears to be ageing, that the proportion of women is increasing and
that rural doctors' length of stay in rural practice is decreasing slightly. Whereas
in the early 1990s, the projection for rural doctor numbers was continuing
decline, the National Rural General Practice Study projected overall numbers in
rural practice staying about the same over the next five years.

One important finding from the National Rural General Practice Study was that
there are significant differences in priorities and preferences of women
graduates and recent graduates when compared with the whole group of rural
and remote GPs. In particular women and younger rural doctors rate practice
style and lifestyle issues like hours worked each week, practising public health,
availability of continuing medical education (CME), and availability of leave as
being significantly more important than their older and male colleagues. Clearly
conventional models of rural practice involving long hours on call, and the
emphasis on hospital-based procedural services is not necessarily attractive to
recent graduates and particularly female doctors.

MODELS OF SUSTAINABLE RURAL AND REMOTE GP SERVICES

This major national research project was undertaken in 1997/98 by a Monash,
Flinders and Queensland Universities team including the authors of this paper.
(13) Following an extensive national and international literature review, there
were 70 in-depth interviews with key stakeholders, national and international
consultations and 22 in-depth case studies. The case studies involved
communities in all parts of rural and remote Australia, some with successful
models of health services and others which were struggling. In all cases, the conventional model of health service delivery (including Medicare fee-for-service for GPs) was seen to be marginal or unviable.

The Study described eight different types of rural and remote communities depending upon degree of remoteness, existence of a local hospital, presence of local doctor and proximity to a larger centre. The eight community types were not mutually exclusive and in some cases the term ‘community’ was used to refer to a group of towns rather than just one town. Thirty-two criteria for sustainability were identified organised into seven categories. These categories were: practitioner related issues; administration, funding and financial arrangements of the services; the nature of service; community characteristics and infrastructure; characteristics of the catchment population; health service environment; and policy environment.

Three key features of sustainable rural health services were identified as follows:
1. Sustainable communities.
2. Sustainable self service structure and organisation.
3. Sustainable individual GPs.

Drawing together all the findings from this Project it became clear that sustainable rural health services depend on two critical factors:
1. Community participation and ownership.
2. An explicit agreement between the community and the GPs regarding general practitioner services, covering the GPs’ period of contracted service, the range of services provided and after-hours availability.

DISCUSSION

The findings of the Studies reported in this paper demonstrate the importance of understanding the different priorities and preferences of people in rural communities on the one hand and health care providers on the other in the process of developing and implementing rural health services. Although people in rural communities have a broad understanding of their health in terms of social wellbeing, their strong security need ensures a major focus on medical practitioner and hospital services. From the viewpoint of established general practitioners, a local hospital provides support and adds another dimension to their practice such that if it is removed the nature of their practice is substantially changed. Consequently it is important that GPs as well as other health care providers are active participants in restructuring and redeveloping health services.

Restructuring and redevelopment of health services in rural communities is painful and difficult for all those involved. Where hospitals have been restructured into other forms of health service, the outcomes are generally better where the community and local management are actively engaged in the restructuring process. This requires local leadership and involvement of health service staff.
Fostering community participation may require external facilitation for the local champions. In developing specific sustainable models of rural health services, the notion of ‘community’ may need to be broadened from that of an individual town to encompass a cluster of towns some of which have a strong history of rivalry, particularly on the football field. In addition, there is a need for systematic assessment of health service requirements, again involving the community so as to encourage a realistic understanding of appropriate service profiles and expectations of health care practitioners. The assessment must focus on the needs of the community, as distinct from the funding agency or health service providers.

The concept of social capital was introduced by Coleman in an attempt to link the perspectives of sociology with those of economics. In her 1995 Boyer lecturers, Eva Cox, described social capital as the social fabric or glue which binds us together to facilitate co-operation for mutual benefit. According to Bush by coupling the terms ‘social’ and ‘capital’, Cox attempted to give investment in the social fabric of society the status of other forms of capital, like financial capital, as a recognised form of investment:

"Usually capital is understood as that accumulated stock of wealth that when invested produces certain additional benefits to the owner of the stock in the form of financial gain. However, capital can also refer to the accumulation of other types of stock such as for example, physical and human resources. What distinguishes social capital from these other forms of accumulated stock is its public ownership and collective accumulation." 

In relation to health, research reports are beginning to appear suggesting a correlation between health status indicators and levels of social capital. Traditionally rural communities may be seen to have high stocks of social capital. This is reflected in high levels of social contact including through voluntary organisations and the strong sense of belonging. Particularly in smaller rural communities there is a community conception of the town as 'one big happy family'. In this sense the changes characterised by 'the rural decline' may be seen as having the effect of reducing the stocks of social capital in rural areas. In relation to health, many rural communities have accumulated considerable social capital through involvement with their local hospital. Often this has been translated into financial and physical capital through fundraising for buildings and equipment. Seen in this light, it is not surprising that rural communities experience externally imposed ‘restructure’ of their hospitals as stealing.

From the research findings reported in this paper, successful health service delivery in rural communities might be seen as like a 'three-legged stool'. Maintenance and improvement in health services requires strength in all three legs:

1. The health authority/agency.
2. The health care provider(s).
3. The community preferably articulated through a community representative organisation.
Community participation in developing health service models promotes a sense of ownership of the local health service, increases local knowledge and skills, and strengthens local relationships and networks. This encourages not only development of social capital within the community, but also a corporate health service memory which facilitates maintenance and continuity of services transcending idiosyncrasies and changes of health care providers. A contract between the community representative organisations and the doctor and other providers benefits all parties by facilitating the setting of limits to the providers practice while specifying services available to the community.

REFERENCES