



# Leaky margins crossing borders: the need for intersectoral collaboration to build healthy remote and rural communities

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## Abstract

This paper presents a Queensland research project using individual interviews and a survey to explore opportunities and threats in building sustainable communities in the bush. The research formed part of a submission by the Queensland Council of Social Services to the Blueprint for the Bush planning process. The research highlights the interconnectedness of environment, economic and social infrastructure and explores themes developed during the research. Core issues such as transport, the use of information and communication technology, workforce, service integration and the need for flexible funding pools have direct impacts on the health and wellbeing of remote and rural communities. Allied health professionals are well placed to provide a leadership role in building social and community capital through linking systems and organisations from different sectors. This paper argues for allied health professionals to establish local networks to both support their practice and decrease professional and personal isolation that can sometimes occur in remote and rural communities.

## Introduction

In October 2005 the Queensland Government embarked on the development of a ten year strategy to improve the social capacity of rural and remote communities across the State. The Queensland Council of Social Services was funded by the Department of Communities to undertake a state-wide consultation process within a very tight timeframe to inform the development of practical short and medium term strategies. The author was engaged by QCOSS to develop a position paper around five main areas relating to social infrastructure. The five main areas were:

- ▷ innovative cross-program and cross government service delivery;
- ▷ distance, isolation and travel;
- ▷ communication and information technology opportunities;
- ▷ workforce development and retention; and
- ▷ building communities' change capacity.

The process developed a number of recommendations for consideration by the government in planning for better social services in rural and remote Queensland communities. By linking the systems of support offered by SARRAH and other government and non-government allied health organisations, this paper proposes that allied health professionals assume a greater role in enhancing community health and well being by becoming more active in support of local social services.

Traditionally State and Commonwealth Governments have created funding and service silos across the human services sectors with education being separated from vocational training, hospitals and community health centres being separated from health related services such as sexual assault and pregnancy help and child protection services separated from justice and family supports. The fragmentation of funding programs combined with the highly politicised context of social service delivery is exacerbated by issues particular to rural and remote communities in decline. Isolation, travel and infrastructure costs are all greater in rural communities than in metropolitan areas. Successive state and national governments have failed to maintain basic social infrastructure as rural communities decline. As evidence of the results of poor attention to social infrastructure examine the extreme effects of the cyclone in the Innisfail area of Queensland on old buildings and public amenities.

## Method

As part of the submission to the Blueprint for the Bush development process, a snowballing interview technique was used to collect both issues and examples of effective and sustainable social services in rural and remote Queensland. A total of seventeen respondents completed interviews based on a survey instrument developed around the five core

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categories. The survey instrument was developed by a state-wide reference group and took between 30 and 90 minutes for respondents to complete. The surveys were conducted by telephone and responses were categorised around the five previously described headings. Information was then linked to previous submissions to government made by a range of social service organisations from rural Queensland. Recommendations were developed supported by brief rationale. This paper draws on the information gathered during this process and links the findings to create a vision for increasing allied health professionals participation in working across the range of sectors that comprise social services.

## Findings and discussion

The following key underlying assumptions were substantiated by the research. Especially significant is that social services in remote and rural communities are not adequately funded in recognition of increased costs caused either by isolation or by the process of providing services to a range of isolated remote or rural communities. In spite of small and ad hoc funding programs and complex reporting arrangements to different funding bodies, non-government organisations make a valuable contribution to community service delivery. Clients of non-government agencies are presenting with more complex issues and problems and social service caseloads are increasing and not decreasing even if population is declining. Because of the underlying shift to regional and metropolitan centres, it is difficult to attract and retain staff to community organisations due to the salary and employment conditions. The salary and employment conditions, particularly in relation to short term projects and grants are not comparable to similar public or private sector positions. The cost of providing services has increased and with current petrol prices are like to increase exponentially. These significant cost increases can be directly related to increased scrutiny, quality assurance, accountability and compliance requirements set by the Government. Reporting requirements are significant and greatly reduce organisations capacity to undertake direct service delivery.

In Queensland efforts have been made to support social services and rural communities by integrating public sector access in the form of QGAP office. The research supports the premises that any attempts at integration and collocation must consider individual community differences. One size does not fit all and models devised in central Brisbane do not necessarily have direct applicability to rural and remote communities. The QGAP transactional services have been well accepted in some communities and have provided real access to a range of government products which would not usually be available without considerable travel. An example highlighting complexity of service amalgamation comes from Mackay where concerns about infrastructure funding, including rent, led to a process of linking organisation with similar philosophies of supporting women. The incomplete project has taken four years with the aim to amalgamate a number of related women's services so that safe and appropriate accommodation can be established. By combining rent and other core expenses the four services could create economies of scale and improve their business bargaining position, but "ownership" issues have provided challenging to overcome. Other attempts to combine a range of local senior citizens services and organisations in south-west Queensland have been equally difficult to achieve, even with individual acknowledgement of service viability issues.

Non-government organisations established in rural communities have significant social history, and much of the social infrastructure was created during rural wool boom years. The buildings are now dated and need major renovation to comply with modern safety and accessibility requirements. Even if the population of the community is in decline, the ownership of the facility or resources remains important because of the historical context of long term family links to the enterprise. Other concerns were raised during consultation about wasted high quality education infrastructure not being utilised in communities where school enrolments are declining. Examples were given particularly from remote communities where a range of social services and community supports are provided from school facilities.

As remote and rural populations decline and the proportion of residents who are retired changes, the demographic of management committees in non-government organisations also changes (Humphreys et al 1996, Barr, 2005). In some communities great difficulty is experienced in attracting suitably skilled volunteers to assume management committee positions, in others a few core strong volunteers assume key positions on a number of community based organisations and in other communities a growing number of healthy retirees has ensured a revitalisation of management committees. In some rural communities there may be a need to amalgamate organisations completely and in others the need may be to form cooperative networks.

Human services must be considered in the context of the economic and environmental issues impacting on remote and rural communities. Devolved government and the processes of regionalising public service management has been shown to be effective and sustainable within an Australian context, therefore governments need to be vigilant that resources do not gather at the centre and become too metro centric. Decisions impacting on local communities must

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involve the people who live in those communities. Meaningful engagement means localised action and a requirement for devolved government and a breaking down of traditional public service silos.

Research has shown that the capacity of communities to respond to change effectively largely depends on the quality of relationships between individuals, leaders and groups (CROCCS 2003) as well as a range of economic and access issues. Any strategies being supported by centralised government that aim to improve social capacity, must take into consideration strategies in facilitation, participation and interaction between individuals and community organisations around a range of activities. Queensland community development workers have agreed that a developmental process to support collective and individual change is required (Rogan, p 13)

An example of the successful linking of key agencies and individuals around common goals is provided in the Central Highlands Human Services Group. The human services group is a sub group of the Central Highlands Regional Resource Use Planning Cooperative (CHRRUP). The human services sector group takes regional issues, concerns and successes into other planning processes and also advocates for the community across government. The current issues being worked on by this group include: housing needs, rapid growth associated with the resources boom; Citrus Canker outbreak and foster care and Child Protection. A brochure developed by CHRRUP entitled "A community response to Loss and Change" is about to be released and highlights the effectiveness of this locally based and formalised network (CHRRUP, 2005)

Supporting Social Capital and recognising the unique qualities of each region, is best described by the World Health Organisation. It states that social capital is the 'Glue' which holds together the fabric of any community. With this 'Glue' communities are linked through distinct networks and their individualism, and the diversity of these communities. Within the Collaborative Community Management Models Project; A Partnership Project (2004:15p.3.2) there is a broad discussion around sustainability and capacity building, and the links that are created through regional organisations and their ability to contribute to their unique region, town and communities. The project recommends that sustainable and lasting positive social change is best supported with locally collaborative projects.

The recently released Queensland Health Systems Review (Final Report September 2005) makes a number of recommendations which reflect the need for an improved emphasis on the development of social capital within and around the health system. In particular the government needs to rebuild community trust through an ongoing process of meaningful engagement, consultation and transparent reporting. Specifically, the role of District Health Councils needs to be enhanced and there needs to be improved access to community based care arrangements (p. 341).

### Allied health professionals and social leadership

This paper makes three main points in relation to encouraging allied health professionals to assume greater social leadership roles within Australia's rural and remote communities. The assumptions have been developed from research such as that completed by Hodgson and Berry in the early 1990s and Rosalie Boyce's work which commenced in the early 1990s and continues today about allied health identity. Furthermore the author's own management and clinical experience in working with allied health professionals across Australia for the last fifteen years informs the argument.

The first characteristic of the allied health professions is their pervasiveness through social service systems. More than any other group of professions, allied health professionals work with all levels of society in almost all aspects of modern human existence. That is, although the concept of allied health professional focuses on the many and varied roles that a diverse group of professions contribute to Australia's health and well being, the same professions also have significant roles within the education, vocation, housing, disability, child care and welfare sectors. For example teams of allied health professionals are used to support children and families in schools just as they are involved in return to work and employment programs. As educated middle-class citizens, allied health professionals enjoy many of the privileges that come from having access to adequate resources and a healthy lifestyle. They are linked to the dominant social class yet work with people from all aspects of our society. They work with people experiencing the violence associated with poverty in a wealthy society and see the consequences of social breakdown and isolation because not only are the consequences often experienced in terms of compromised health and well being but also in all the aspects of other social services where allied health professionals work or are used as consultants. Allied health professionals are therefore well placed to assess the impact of poor social policy and where social services are failing. As members of the privileged middle class, they also understand the structures and systems that cause the problems.

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The second key factor of allied health professionals is their motivation to join and maintain their roles within the health workforce. Allied health professionals like to make a difference and are motivated by altruism. They like working with people, are ideas people and have essential skills in motivating others. Allied health professionals lead the health system in applying practical strategies to improve health and wellbeing and are also often at the cutting edge of applying new technology. These personal characteristics make allied health professionals ideal candidates for becoming involved in the development and maintenance of social services in the non-government sectors. Allied health professionals should be volunteers on the management committees of neighbourhood, housing and childcare agencies. They should be providing advice on outcomes, learning and aspects quality improvement to family welfare agencies. Allied health professionals know about money and how to access the social systems and can make a real difference to other aspects of our society than in direct health service provision.

Politics is the third aspect of allied health professional life that makes them well suited to challenge the status quo. Allied health professionals work within a system where the politics of the medical and nursing professions means that the work environment is laden with the pitfalls of contested terrain. Allied health professionals are trained and socialised in to supporting their patients and clients in environments where there are many competing demands.

The challenge is that as a group allied health professionals are not generally party politically active and avoid overt power struggles where they may be described as aggressive or even worse as self interested. That is why allied health professionals hardly ever take industrial action and why they are so often overlooked when rewards for productivity and effectiveness are handed out. "Allied health professionals are "nice" people who work hard and provide good value for money (if you can get them)..." are comments made to the author by senior members of the Australian College of Health Service Executives. There are major examples though, of how effective allied health professionals are when they overcome the cringe factor of being politically active and are supported to participate outside their areas of comfort.

Services for Australian Rural and Remote Allied Health (SARRAH) has over ten years experience of empowering and supporting its members to become involved in challenging the status quo and developing better health policy. Admittedly the organisation has achieved such success not on its own but by forming partnerships and alliances with other passionate groups and organisations. At SARRAH Summits in Canberra, after a day's planning, members walk the corridors of Parliament House and lobby politicians to respond the clearly identified rural and remote community needs. Praise and information as well as concerns are usually welcomed. The Summits have been particularly effective in empowering individual members and enhance an understanding of Australia's political system. SARRAH provides an excellent vehicle for training allied health professionals to become more socially active within the health care system, but must now encourage and develop process to expand allied health professionals influence in overt and visible ways across the entire social service system.

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