Royal Flying Doctor Service field days: supporting access to primary health care for people living in remote north Queensland utilising a capacity building approach

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Introduction

Models of health service delivery in rural and remote areas are shifting away from medical models towards more collaborative and integrative primary health care models which focus on community participation in identifying health needs and strengthening community capacity to promote and maintain health (Macdonald, 2000; Harvey, Williams & Hill, 2005). Thus, capacity building has become an important underpinning element of health delivery in rural and remote areas. Despite this shift there are few documented examples of the delivery of primary health care approaches that service remote areas in Australia, especially those which receive a fly-in, fly-out service (Humphreys, Hegney, Lipscombe, Gregory & Chater, 2002).

This paper will examine the Royal Flying Doctors Service (RFDS) field day program as a means of strengthening community capacity for health and supporting access to primary health care in remote areas of north Queensland. This paper has the potential to provide information that could inform the structure and implementation of capacity building activities within a primary health care framework in other remote areas of Australia and internationally.

Background

Across a range of indicators, people in rural and remote Australia experience poorer health than people living in urban areas. For example, they experience higher mortality rates due to injury, diabetes and coronary disease and as a result rural and remote life expectancy is lower (National Rural Health Policy Sub-committee and National Rural Health Alliance, 2002). These disparities exist across all ages and cultural backgrounds. Indigenous Australians, who comprise a large proportion of the population of remote Australians, experience the poorest health status of all Australians (Smith, 2004).

A factor that can make promoting health more challenging is the attitude to health of people living in rural and remote areas. In general, rural Australians have a comparatively narrow understanding of health primarily viewing it as the absence of disease or any form of disability which will inhibit their capacity for work and to remain productive (Harvey, et al. 2005; Elliot-Schmidt & Strong, 1997). In addition to this, ‘newcomers’ or ‘new services’ often experience scepticism, with a preference for trusted established service providers and approaches (Elliot-Schmidt & Strong, 1997). Other factors such as a culture of stoicism, self reliance and concerns for confidentiality mean people may be reluctant to access health services, particularly those related to broader health issues such as psychosocial health (Harvey, et al. 2005; Welch, 2000). These factors contribute to the challenge of improving health in rural and remote communities and the introduction of new models of service delivery such as the RFDS ‘field days’.

Isolation and distance experienced by those in remote areas such as station properties and national parks make the above mentioned issues even more challenging. A study by Greenwood and Cheers (2003, p.6) involving fifteen women living on isolated pastoral stations in South Australia, found that as custodians of the RFDS medical chest, women had responsibility for managing problems and injuries on the property but that many were unprepared and had “little knowledge to assist them to manage such events”. The women on station properties in the study experienced isolation and loneliness particularly during critical times such as the birth of a baby.

The challenge in developing effective health promotion strategies is further complicated by the widely differing health needs of diverse rural and remote communities, which include Aboriginal
communities, mining communities, tourist centres and traditional farming communities (National Rural Health Policy Sub-committee and National Rural Health Alliance, 2002). Each has distinct health issues and health risks and therefore primary health care programs need to be flexible and innovative in order to maximise individual and community capacity for health (Wass, 2000).

National rural health policy has highlighted the need to shift towards a primary health care approach to service delivery in rural and remote areas (National Rural Health Policy Sub-committee and National Rural Health Alliance, 2002). This policy supports the shift in emphasis from more traditional medical models towards more integrative and flexible models which focus on community participation in identifying health needs and strengthening community capacity to promote and maintain health. The United Nations Declaration of Alma Ata, that supported a primary health care approach, put forward that “health is a basic human right” and that the best way to achieve this is “through affordable, accessible, appropriate and sustainable health services and addressing underlying causes of illness” (World Health Organization, 1978, p1). It emphasises the need for community participation in order to identify and address health needs and to collaborate with other sectors to maximise individual and community capacity for health (Wass, 2000). Health promotion is a central theme to primary health care aimed at building this community capacity (Smith, 2004).

The concept of building community capacity to enable communities to promote and maintain their own health has become a key underpinning issue in recent debates surrounding public health (Bush, Dower & Mutch, 2002). Capacity building has various definitions but for the purpose of this paper it has been defined as the ‘increase in a community group’s ability to define, assess, analyse and act on health (or other) concerns of importance to their members’ (Labonte and Laverack, 2001a p.114). Capacity building develops self-determination and is particularly suited to overcoming the challenges of distance and isolation which typify health promotion in remote areas. It also fits with the values of self reliance, independence and productivity held by rural communities (Harvey, et al., 2005). Labonte and colleagues (2002) suggested that building community capacity will translate into improved individual and community health and that these improvements are more likely to be sustained. Finally, the flexible nature of the capacity building approach enables activities to be designed based on the specific needs of each remote community.

The RFDS is well known in rural and remote Australia as the provider of aero medical retrieval and transport services, remote medical consultation and provision of RFDS medical chests. More recently, RFDS in Queensland has expanded to include women’s health, child and family health, mental health, Indigenous community liaison and development and health promotion. The RFDS in Cairns, one of eight RFDS bases in Queensland, services 600 000 square kilometres from Torres Strait in the north through to Normanton in the west and south to Mackay. In 1998, a RFDS strategic workshop identified the need for services to extend beyond biomedical approaches to include health promotion (RFDS Qld Section, 1998). This realisation of the need to reorient services combined with a review of clinics provided the drive to redesign medical and child health services delivered at stations, national parks and roadhouses to the ‘field day’ format.

Field days are based on capacity building principles with a focus on prevention and promotion and are co-ordinated by a health promotion officer. People travel from surrounding properties, usually within a one to two hour radius to attend the field day which involves a morning session devoted to health education, information sharing, practical demonstrations and skill development followed by an afternoon medical and child health clinic. RFDS staff and local communities work together in scheduling field day locations and identifying health topics of interest. An extensive range of health issues have been covered including preventing farm injuries, stress management, relationships, diabetes prevention, cancer prevention and detection, physical activity, nutrition and responding to emergencies. Each site has a local field day co-ordinator who plays a critical role in networking with others in the community, discussing issues with neighbours and liaising with the RFDS health promotion officer. This is a voluntary role which is typically held by the wife of the property.
Methodology

During 2006 RFDS conducted a qualitative explanatory study into the development of community capacity associated with RFDS field day program. The methods used in this research include in-depth interviews with field day participants, field day co-ordinators and RFDS staff. In addition, a focus group was conducted with RFDS staff and documents pertaining to RFDS field days reviewed as secondary sources of data for the study. The in-depth interview questions were developed around the four themes of capacity building including networks and partnerships, problem solving, infrastructure and knowledge transfer put forward in Bush, Dower and Mutch’s Community Capacity Index (2002). These dimensions were used to guide conversation with study participants about their perceptions of the development of community capacity for health associated with the conduct of field days.

In analysis of data, a thematic analysis was used as the main approach to develop an in-depth description and explanation from the analysis of the themes discovered in the data (Wadsworth, 1997; Neuman, 2003). Both interviews and focus group were transcribed with the data being organised into themes based on the identified capacity building dimensions in order to provide insight into community capacity for health associated with RFDS field days (Neuman, 2003).

Summary of outcomes

The three themes identified during the data analysis which collectively describe the development of community capacity associated with the conduct of field days are:

- network partnerships
- knowledge transfer
- problem solving.

Field days were found to have helped to develop linkages and partnerships with others in their community. Respondents explained that the quality and comprehensiveness of these links had improved because of field days. Respondents went on to suggest that this had led to an increased sense of community, increased participation, and trust and sharing. The findings also revealed that the improved partnerships had extended outside the community to include improved links between the community and the external organisations, in particular RFDS. It was also identified that capacity for leadership had increased as a result of field days.

With regards to knowledge transfer the research revealed that field days had supported the development of knowledge transfer. This transfer of knowledge was reported to have increased between community members; from community members to external organisations; and from external organisations to the community. Knowledge transfer was viewed as the development of knowledge; exchange of this knowledge and the use of this knowledge.

The study also revealed that respondents believed there was increased problem solving capacity. This was described by respondents as increased capacity to solve problems regarding both specific health issues and program issues. For example, respondents felt they were better able to assess and manage health issues.

In summary field days are contributing to building capacity for health in the remote communities that have been involved in field days. Importantly, as Labonte and colleagues (2001b) suggest that much of the knowledge, skills and confidence developed through one program can often be transferable to other initiatives.

This study has contributed to increasing understanding of community capacity in the rural and remote setting. The four domains of the Community Capacity Index (CCI) identified by Bush, Dower and Mutch (2002) which were used to guide data collection and initial data analysis have been expanded upon to make for a richer, more detailed model of community capacity, one that is more representative.
of the uniqueness and remoteness of the field day context. Furthermore, this study has demonstrated the practical application of developing community capacity within a rural and remote context.

Field days have also provided a framework for building community capacity within the primary health care context. Field days demonstrate the shift in the way RFDS health services are delivered in these communities, away from the traditional medical model of care towards a primary health care model that focuses on building community capacity. Prior to the commencement of the field day program many communities in this study had previously been involved in a medical model of care, one that was individually focused, treatment orientated, expert driven and success measured narrowly through quantitative means. This research has shown that field days are an effective means of building community capacity within a primary health care model, one that focuses on self reliance, community participation, intersectoral collaboration, integration of health services and responding to the expressed needs of the community. This study, therefore has provided an example of the ability of an organisation to move towards a more comprehensive model of primary health care utilising a capacity building approach.

Conclusion and recommendations

In summary, research has revealed that RFDS field days are assisting to build community capacity for health in remote communities of north Queensland. In particular, field days have assisted to develop linkages and partnerships both internally and externally; they have improved the community’s ability to transfer knowledge; and have increased problem solving capacities. Furthermore, it is likely that much of the knowledge, skills and confidence developed through the field day program may be transferable to other initiatives.

The need for primary health care services in rural and remote communities to build community capacity to articulate and address community health issues is well documented. This study has provided a documented example of the shift away from a medical model of care towards a more comprehensive primary health care model, one that embraces the capacity building approach. The study therefore, provides a template for developing locally relevant primary health care using a capacity building approach. It is recommended that this model could serve to inform the structure and implementation of primary health care programs in other remote locations of Australia and internationally, particularly those which receive a fly-in fly-out service.

Finally, there is a need for funding bodies and policy makers to recognise the challenges, resources and time required in utilising a capacity building approach to primary health care and to adequately fund and support programs accordingly. It is not until decision makers have literature by which to understand and judge capacity building approaches that they will truly support extending primary health care beyond service delivery. This research supports argument for the need for these types of primary health care models to be recognised and resourced by funding bodies.

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References


**Presenter**

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