Local Health Planning to Meet the Needs of Communities

Marion Wilson

6th National Rural Health Conference
Canberra, Australian Capital Territory, 4-7 March 2001
Local health planning to meet the needs of communities

Marion Wilson, Nicole Bennett, Jenny Grosvenor, Therese Jones, Mid West Area Health Service

INTRODUCTION

This paper aims to give an overview of the strategies and processes used to engage local communities and service partners in rural health service planning. Previously, community engagement in service planning has predominantly been tokenistic and has not occurred in any comprehensive way. To place a template on each community on what its health issues are and what service model would best meet those needs, would result in gaps in service provision, inefficiencies and perhaps duplication of resources as often Health is not the sole service provider. It also disempowers the community where health gains are sought.

Underpinning this discussion are the core concepts of a broad social view of health, community development, community participation and building social capital. These are all recognised through the Alma Alta, which outlined the primary health care philosophy, and then further through the Ottawa Charter.

This “warts and all” account of service planning in the Mid Western Area Health Service (MWAHS) is an attempt to share our recent experience to put the rhetoric into practice. It is recognised that health planning with local communities is an evolving and dynamic process. Our experience, will hopefully further inform efforts to move towards an inclusive, consultative model for health planning in which communities can have a real say, as recommended by the NSW Health Council (2000) and the Sinclair Report (2000).

There have been some encouraging outcomes from our efforts. These include: the securing of extra funding, significant structural and clinical practice change, increased community participation, and a real shift in service provision to include vulnerable and marginalised target groups (eg carers, Aboriginal communities, and those with a disability).

BACKGROUND INFORMATION

Mid Western Area Health Service

Population profile

Like many rural areas, the MW AHS has a widely dispersed, predominantly aging and socioeconomically disadvantaged population of around 176 000. The Area covers
59,835 square kilometres, encapsulates 13 local government areas (LGAs) and contains 6.8% of the State’s population. Towns range from large regional centres such as Orange and Bathurst to isolated townships such as Hill End and Lake Cargelligo.

The Area has a significant Aboriginal population, this being 3.2% of the total MWAHS population, compared to 1.6% for the State (1996 Census). Adverse economic and social factors relate to poorer levels of health in some communities. There are projected changes in the structure of the population due to aging and net outward migration in the 15–34 year age group as they seek education and employment opportunities outside the Area.

The economy is mainly agri-based (wheat and sheep and orchards), with some significant mining activities (eg gold mining). The agricultural industry contributes 10% of the output of the State. As with many rural communities, the area has been adversely affected by changes in the commodity market and a succession of unfavourable seasons and industry downturns.

Mid Western Area Health Service profile
There is a complex array of services which includes 22 acute hospitals, a major psychiatric centre, 3 multi-purpose service sites (4 more to be commissioned), and 31 community health centres. Bathurst and Orange are the two major hospitals providing a range of specialist and retrieval services. It would be a fair comment to say that the previous focus of service delivery has been around the “bricks and mortar” rather than the community’s health needs.

Health Service management structures are generally devolved to the local government areas (LGA). Each LGA has a Health Service Manager who is operationally responsible, for both hospital and community health services, through the Area.
Operations Manager, to the Chief Executive Officer and the Area Health Service Board.

There are a number of Area wide programs that have the responsibility for management and co-ordination of direct services. These include Public Health Unit, Aboriginal Health, Alcohol and Other Drugs, Women’s Health, HIV/AIDS, Needle Exchange, Sexual Assault Services and Child Protection. A health improvement network provides co-ordination for programs that address the main health issues of the Area such as heart health, injury prevention, cancer and aged care. All of these Area programs, including local health planning, are co-ordinated from the Executive Directorate of Services Development.

The organisational chart below describes the management and program structures in Mid Western Area Health Service.

**PLANNING PROCESSES IN MWAHS**

Past and present

Previously, the overwhelming influence on health service planning, has been NSW Health and Area Strategic Direction documents. These documents were not well informed of local issues where priorities are sometimes different. Often the health priorities at the local level went beyond traditional injury and illness issues such as domestic violence, transport, the degradation of the natural environment, culturally appropriate services and the lack of social support systems. These health priorities also vary across the Area from town to town, village to village, settlement to settlement and could rapidly change. These changes include government elections, the withdrawal of a service from a community, the use of technology for service provision, a factory closing, a poor harvest season, a change in a government housing or funding policy, a
suicide or injury of someone in a small isolated community and the price of a commodity rapidly changing like petrol. Service planning was not localised or flexible to meet the communities’ needs.

The focus of service planning was also based on “curative treatment”. There was no comprehensive attempt for services to have a prevention and health improvement focus. Community engagement in service planning occurred in isolated teams at a local level, with inadequate resources and “part of an accreditation quality process”.

The local health planning process attempts to address this imbalance as well as increase local participation in communities experiencing change. The aim of local health planning is to support each local health service and community in developing a health improvement plan. The plan is to state where it wants the health of its local community to be in 3 to 5 years time and the role of the local Health Service and others in doing something to achieve this within available resources. The local health plan aims to inform business planning of the health service and other partners.

The chart below gives a diagrammatical representation of where the local health plan fits in with other strategic health documents in Mid Western Area Health Service.

![Diagram of local health planning process](image)

### Putting local health planning into action

The local health planning process in Mid Western Area Health Service began during 1999 in three pilot sites. They were Health Services ranging in size from small, medium and a large regional centre. To support and facilitate the process, MWAHS has put in place infrastructure and developed tools.
A planning schedule was developed to provide a framework and guide for local health services and their communities. These are often referred to as the “bones”.

Presentations to local planning groups have seen the development of representing this schedule in a pictorial analogy of a river system.
How each local health service and community progresses through the schedule isn’t made too prescriptive either. As each local health service embarks and progresses through each step, the underlying principles or “flavour” and “meat” to the bones should be incorporated as illustrated below.

These charts may seem patronising and too simplistic. However, when the health service tries to engage the community in its planning, it is important that the language is dejargonised, appropriate and meaningful. Therefore, it is imperative that presentations and tools are developed with this aim in mind. Health service staff, however have also appreciated the use of different language and tools.

Mid Western Area Health Service has also developed a “Planning Toolkit” for local planning teams. The “Planning Toolkit” is a guide on the process of planning health improvement across the continuum of care in a community. Referring back to the river system analogy, it is a map for the planning team to get through the river system and out to the sea.
The “Planning Toolkit” provides suggested worksheets and group processes in answering the health improvement planning questions (NSW Health).

<table>
<thead>
<tr>
<th>The team will need to answer the following questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the problem(s) / issue(s)?</td>
</tr>
<tr>
<td>2. Which of these are the priority issues?</td>
</tr>
<tr>
<td>3. What is the best thing to do?</td>
</tr>
<tr>
<td>4. What are we doing now?</td>
</tr>
<tr>
<td>5. Are we doing the best thing?</td>
</tr>
<tr>
<td>If not, why not?</td>
</tr>
<tr>
<td>6. What should we plan to achieve in the next five years?</td>
</tr>
<tr>
<td>7. What has to be done in order to get there?</td>
</tr>
<tr>
<td>8. How will we know if its worked/working?</td>
</tr>
</tbody>
</table>
Planning team leaders, usually a Health Service staff member with good leadership and group skills, attend an Orientation Day into local health planning and the use of the Toolkit.

Each planning team comprises of, wherever possible:

- a health professional in the field;
- a health professional not in the field or a different service setting;
- a target group member;
- a community representative/other service providers;
- a health council member;
- a mental health worker; and
- a hospital employee from a support service with an interest in the issue.

The planning teams are formed around local priority issues or population groups, depending on the process adopted by the local community. Generally speaking, the larger the community (eg >10 000 population), planning teams around population groups are formed to identify issues and priorities.
To help manage and drive the process, each local Health Service and local community has formed a Steering Committee. The local Health Service Manager and Community Health Manager have key leadership roles on the Committee.

These are some of the local resources and tools developed to support local health planning. However, other necessary and important influential structures and mechanisms exist within Mid Western Area Health Service.

An Area Executive Director is responsible for the overall process of local health planning that informs Area Policy. The role has seen the establishment of an Area Local Health Planning Advisory Group and three planning positions to help facilitate the planning process across the Area. Two of the positions are offered as a temporary secondment to staff as a capacity building strategy.

Local health planning has also been incorporated into Performance Management for local Health Service Managers and is included in the Performance Agreement with NSW Health.

The establishment in 1998 of local Health Councils has provided a link for the Health Service and its communities. The Health Councils participate in an Orientation Program to the health service including a module on conducting community needs assessments. Health Councils have helped provide local community consultation and data. The local health planning process also provides the Health Councils opportunities to participate in the planning.

The Area with the Aboriginal and Torres Strait Islander communities have established an Area Partnership with local Partnerships also formed. The Partnership has provided information on local health issues for their communities.

Other activities in the Area that support the local health planning process include:

♦ health promotion skills (VETAB accredited course) for staff;
♦ Quality Management Training Program; and
♦ publication of public/population health documents giving local health data.

Progress to date

Although there were initially three pilot sites, progress to date is not a reflection of who started first. Six sites out of a potential of sixteen communities/Health Services have developed draft plans. Two of the sites are now at the review stage. Six of the remaining ten have conducted a community needs assessment and determined priorities ready for planning.

In determining community needs, public forums, surveys and discrete focus groups with target groups were held. The Health Councils have played a key role in the community consultation. Community data packages have been compiled for each community as a resource for planning teams.

In determining strategies, access to Area Program knowledge and resources have been important. This has resulted in changes to the communication and co-ordination of
Area Program activities in some of the local health services. The silos that existed between Area Programs and local health services are starting to be dismantled.

Outcomes

The Health Service is currently mapping the issues across the Area to identify commonalities to further inform Area Program planning.

However, the issues identified in communities have ranged from illness (eg cardiovascular disease, mental illness, cancer, asthma, post natal depression) to population groups (eg young children, Aboriginal health, young mothers in villages, disability) to risk factors (eg alcohol and other drugs, physical activity, domestic violence, child abuse, transport, unemployment, lack of social supports, no information on services available) to service issues (eg unco-ordination of services, lack of outreach services, culturally inappropriate services).

Issues, once identified and prioritised, and have resulted in action in many places. Some of the action required has not meant the need for extra dollars but implementing simple but effective resources or ways of doing things in service delivery. Examples of this include the development of health and welfare service directories in small towns. These directories became very much a community driven project with community groups informing the Health Service what and how the layout should be, so as to be useful and relevant. It also informed the community what services were currently available to the community, even if the actual service wasn’t behind four walls and wearing a uniform. With this knowledge base the community were able to participate further in the planning.

Focus groups, held with young at risk mothers in one community, has identified the need for these directories to be available to mothers once they left the hospital after the birth of a child. They voiced their say in needing to know what support was out there once they were at home. The directory was stated to be more valuable and useful than a basket with talcum powder.

Other outcomes include the formation of a inter agency community planning group that has secured funding for the establishment of a family care cottage that will provide short-term stay Tresillian services to at risk target groups. It is envisaged that this project and services will be further developed across the Area especially with the Families First government initiative soon to be introduced in the Area.

Involving and consulting the communities has resulted in other changes. One small community has introduced a men’s clinic in an appropriate location and time. Another community now accesses a free immunisation clinic and women’s clinic. Local politics between service providers were re-examined and re-negotiated when target groups within the community were given opportunity to have their say in the planning.

Another local Health Service is looking at how to address the issue of diabetes resource support within their community by initially accessing Area resources with a long-term goal of using local resources.
The Area Health Service was able to successfully consult and negotiate with one community, the closure of underutilised public beds in a private facility and thus free up resources to provide more community-based services.

The following list summarises some other outcomes from the planning process.

♦ Multi-disciplinary approach to providing Youth Clinics in high schools.

♦ Health Service involvement in advocating for a Women’s Refuge in a community.

♦ Outreach and consultation with small villages and settlements.

♦ Men’s health community nights.

♦ Local health services addressing the co-ordination and advocacy of those with a disability using the Health Service across the continuum of care.

♦ Implementation of an Area Men’s Health Program.

♦ Day care and activities program for a variety of target groups in a community including those who have left school with a disability or particular learning disabilities. The Health Council will present the issue to a Multi-purpose Service Planning Committee, in a community where the delivery of such a program may involve partnerships and co-ordination of services other than the Health Service.

♦ Awareness and involvement in planning of the Health Service with other organisations and groups such as local government, environmental groups and business groups. These links, assisted by the establishment of Health Councils, may become further instrumental when action on issues on recruitment of health professionals to rural areas and unemployment, transport and information technology are further developed.

♦ Formation of mental health carer support groups.

♦ The proposed formation of community support networks within some small outlying communities for young families accessing services in larger regional centres. These community networks could provide transport, childcare and farm minding support. It is envisaged that accessing these networks would become part of the service provision and practices of the services located in the larger regional centres. A Health Council conducting focus groups with young families in outlying villages recently identified the concept. This is the type of information that informs local health planning.

Evaluation

The approach to evaluation by Mid Western Area is one of Action Research. This has been due to the process being new, as well as allowing for the process to be empowering for all parties, that is local health services, the local managers and staff, as well as the communities. This approach has been seen to allow for the process to recognise the existing strengths and gaps of the local health services and communities,
allow for local issues to be addressed, as well as provide opportunities for community development approaches.

A formal evaluation at an Area Health level has not been completed. There is a commitment by the Area Executive to do this in the very near future with the option of obtaining external expertise being explored. However, local documentation and information regarding the processes, critical reflections and changes made are available.

Some general observations however could be made at this point in the local health planning. It has challenged our thinking in what we measure as success and how we measure success.

More research, or perhaps our access to, indicators on social capital is needed. Qualitative research methods are also an integral part of the process and improving our skills in this area has also been required. We often can do the “number crunching” quantitative methods well, or at least with ease, to meet an agenda.

When observing the variation in our progress, many factors could be suggested to have had an impact. These factors have been from within and outside the organisation. For example:

- NSW Evaluation of Rural Health Councils Phase 1 Report.
- Ministerial Committee reports
  - NSW Health Council (Menadue Report)
  - Advisory Committee on Smaller Towns (Sinclair Report).
- Rural access and implementation to Information Technology.
- Restructuring of rural health services in NSW from Districts to Area Health.
- Staff recruitment freezes.
- Planning occurring in silos within the Area Health Service eg community health service planning distinct from hospital-based planning and distinct from Area Program planning.
- Commitment and leadership skills of the local Health Service Manager.
- Health Improvement and planning skills of local planning teams.
- Planning resources available at local sites.
- Multi-purpose service planning processes occurring concurrently within some local communities.
- Local communities calendar of events.

This list may be extended when a more formal evaluation is undertaken.
CONCLUSION

Therefore, to say we have achieved “xyz” and thus end our project of local health planning would be to deny that the process is dynamic and that each community is unique. We continue to stop and reflect where we have come, learn lessons from each other, make changes and try something different.

Hopefully this paper and this Conference will widen our scope for learning from others experiences. Our communities will learn something from your experience that you are willing to share.

There is a real opportunity for rural Australia to put into place the rhetoric of the primary care philosophy and the Ottawa charter because of the varying sizes and uniqueness of the communities, because social issues and social capital is intrinsic to the health of those communities because partnerships are so important, we need to work together because resources are so thin on the ground, and because the increasing reality of accessing tertiary levels of services a distance away from your community means that prevention and health improvement becomes a common sense strategic approach to health.

By learning and sharing with each other we can put our models and issues to State, national and international forums and bodies so that rural Australia is recognised in putting the primary care philosophy and Ottawa charter into action.

AUTHORS

Marion Wilson has worked in primary care services at State and area level. Her focus has been in enabling rural communities to participate in and help develop local health services through health promotion practice, planning, and community consultation. Marion’s academic background has ranged from generalist nursing to community development and health management. She has represented NSW Health and local health services at various State, national and international forums. Marion lives with her husband Barry on a small farm in central western New South Wales.