

# Planning with rural communities: to hit and not to miss

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## INTRODUCTION: SETTING THE SCENE

Why is it that planning strategies which work well in one community fall flat in others? How can communities plan successfully? And how can a planner tell which methods of consultation will be accepted by a community?

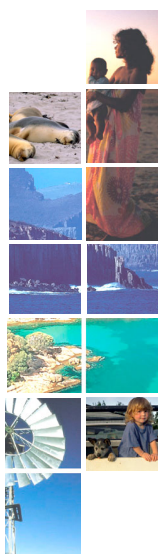
These are constant questions for those working with communities to establish health and community service priorities and needs. Dealing with the tricky aspects of developing a successful approach to health service planning in rural communities is a topic of long-standing interest to health care providers and communities alike.

This paper concentrates on the outcomes of various strategies for community consultation as they were used in the planning project which led to the establishment of a regional health service in Central and Southern Yorke Peninsula (South Australia). The planning work was done with a limited budget, a short timeframe, a dispersed community and in a climate of cynicism about health service planning. These problems contributed to the thinking about consultation methods.

I have used this planning project as a case study to illustrate aspects of the “how to pick what works well” questions. This paper builds upon work presented at this forum (the 2001 National Rural Health Conference) and presents some more recent perspectives.

## A LITTLE ABOUT THE APPROACH OF THIS PAPER

This paper is presented as a case study, a descriptive method often used in health service planning and evaluation. A case study can take one of three forms: intrinsic, in which the research comes to better understand a particular case; instrumental, in which a case is examined to give insight into an issue or theory; and collective, in which a number of cases are studied jointly to investigate a specific issue or condition (Stake 1994). In this instance the instrumental approach is taken. The value of a case study to chronicle events or to try out or test a circumstance or issue (Marshall and Rossman 1989) supports this choice. A key flaw of case study research is to mistake a case study for a sample and then infer outcomes for populations based on this sample. To avoid this flaw, this discussion centres on a specific community and generalises only in regard to methods, not outcomes.



## PLANNING STRATEGY OPTIONS

A number of authors provide advice on the planning strategies which might lead to high levels of community input and why community consultation strategies should form an integral part of planning work. Several relate to planning for Regional Health Services (RHS), the focus of this case study, or Multi Purpose Service (MPS) work.

The consultative approach to this planning study was chosen to avoid the criticism that the process of “needs assessment” can be a tool of limiting service in a health sector dominated by market models and “efficiencies” by becoming a means to target (Stehlik and Chenoweth 2001). The options chosen went beyond needs assessment to include participation in all aspects of the conduct and management of the planning study.

Too often, during the process of health priority determination, community consultation becomes a thinly designed health needs analysis with little consideration for the fundamental principles of communication. For consultation is about communication—a basic process of sharing information to reach common understanding. (Hall, 2001:1)

In a “how to” style paper, Hall (2001) argues that community input leads to innovation and service change and that participation needs to be full and open to be real. She suggests some strategies for participation including:

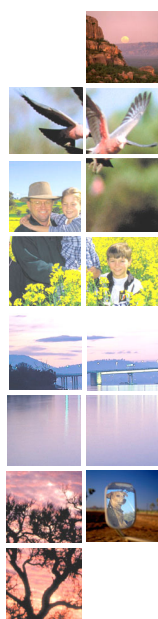
- public meetings
- staff forums
- publications
- surveys.

Ley et al (2001) used a people-initiated referendum to test the view of people about the introduction of an MPS which was a major health reform for their community. The leadership in this process came from the community. They also used health surveys as a tool for consultation and subsequent health forums (with independent facilitation) to discuss the issues arising from the health surveys. A strategic plan was developed, the summary of which was distributed to all local households to complete the feedback loop. They well describe the practical reality of the “forum style” of consultation:

The priorities... were not based on a democratic vote by all community members, but on the perceptions and judgments of the small percentage of the people, relatively well-informed about their community and its health care needs, who wanted to put forward how they saw things. (Ley et al, 2001:7)

In another piece describing consultation on the MPS issue, Hooper (2001) described a needs analysis which was connected to community consultation. She described the use of a petition (her term was a “signature register”) to support their proposals. Although this is called a community survey, it was more a process to gain approval for a predetermined initiative.

Wilson (2001) took a social participation and community development frame of reference in her study of local health planning. She noted the positive outcomes from the process to be:





While the primary interest in this paper is the consultation strategies and outcomes of the planning, it is important to note that the project was successful in meeting the strategic goals of:

- refocusing primary health care resources towards priorities identified by consultation and other recognised community needs;
- consolidation of primary health care service providers into more flexible delivery teams; and
- an expansion of primary care services to meet identified community priority needs. (Wakefield Health 2002)

The service delivery model chosen on the basis of the RHS research and planning was based on a capacity-building approach aimed at developing skills in the community to support improved health outcomes. This capacity-building approach was also a key element in the planning strategies.

These planning strategies also fostered the development of a closer management relationship between existing government and community providers of health, aged care and community services within the community. The process of planning brought local service providers together with a new energy for collaboration.

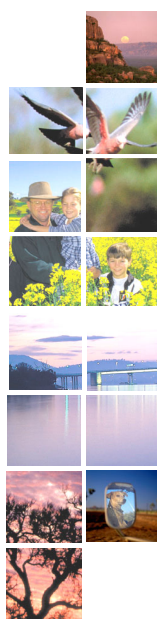
The process for consulting the community and stakeholders about the potential for an RHS was undertaken during December 2001 and January 2002. There were four stages of the process – from establishing a working steering committee to completing the proposals, and these are described below. All stages of the process engaged local people and local service providers. It was this engagement, which operated at a number of levels throughout the study, that saw local leadership emerging. This work continued a consultative tradition established by Wakefield Health planning strategies (Wakefield Regional Health Service 2000a and 2000b)

An initial contributor to the leadership outcomes was the management decision to use local staff rather than consultants to do the planning work. It was felt that local staff would be more able to ensure the knowledge, planning skills and capabilities developed during the study remained within the community and that the value attributed to input by “locals”, rather than “experts”, would ensure a high degree of unanimity about the final strategies.

### Stage one: getting started

The planning study was started by Wakefield Health, the state government regional body which manages funding, monitoring and planning for a specific area of rural South Australia, including the Yorke Peninsula. As the planner, my role was to provide advice on the framework for the study and then work with the “community” to complete the project. Wakefield Health was funded by the Commonwealth Department of Health and Ageing (Rural Health Branch) to assess the contribution that an RHS could make to improved primary health care outcomes.

But how best to achieve this “working with the community” rather than to exhibit a token effort?



The approach used consultation at every level of the process – initial data collection and issue identification, priority setting, identifying the proposals to meet the identified needs/approaches, and managing the process. Community participation was also a key element in the service design finally agreed.

The Steering Committee, which had oversight of the study, was formed from the group of people attending an initial community meeting. Invitations to this meeting were sent to health, aged care and community service organisations, from government, community-based and the private sector, within the study area. All those who attended the meeting (23 people) indicated their wish to be active in the process. They formed the Steering Committee and elected a chairman from within their membership. This group provided support to the planner undertaking the study. Each of the meetings was an opportunity to discuss the progress of the work, the issues arising from it, and possible service models and ideas to meet the emerging needs.

A media and information campaign was planned for January 2002. Given the short time frame for the study (December 2001 – end February, 2002), it was imperative that information about the issues be distributed widely. An initial story in the local newspaper (*The Country Times*) in late December provided early advice of the study process and the consultative way it would be conducted. This was to give local people the opportunity to plan to attend a meeting in their community and to open the way for the community and household survey which was to be distributed during January.

Full-page advertising provided a complete timetable and included locations of the community meetings, an overview of the RHS program and information about primary health care in an attempt to ensure the scope of the work was understood. A short question sheet was also included in the advertisement as a “tear out/send in” opportunity for those unable to attend a meeting or who missed out on a survey, giving them the chance to have their say about the issues and priorities.

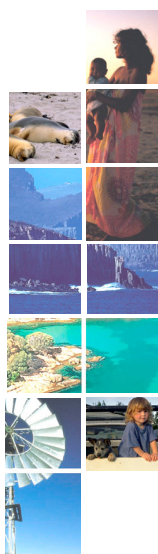
A leaflet about regional health services was produced and circulated at meetings, sent along with letters to households about the survey and was provided to anyone who asked for more information.

These marketing strategies combined to let people know about the issues and about the opportunities for participation.

## Stage two: using consultation to gather data

Community meetings were arranged as a way for local people to be involved in the planning process. The study areas is characterised by dispersed communities. While it was not possible to hold a meeting in every small town, it was important to provide as much access as possible. Shopping and business travel patterns were used to select the locations which were most likely to be easy for people to get to. Locals were encouraged (through media advertising and fliers on community notice boards, etc) to attend any meeting that suited them – it was not necessary to go to the one closest. Some meetings were held in the daytime, and others in early evening to give a spread of times for people to choose from. In all, more than 50 people attended the meetings which were held in 7 towns.

The focus of discussion at the community meetings was information-sharing and gathering, with an outline of the planning process and the regional health service



program given at the outset of each meeting. Participants were invited to identify the primary health care services which worked well for them, areas where access and service could be improved, and the gaps in services. The process was aimed at gaining an understanding the issues as they were perceived by local people.

A household and community survey was developed and pilot tested as the primary instrument for collecting data from individuals. It was distributed in two main ways: a letter to households randomly selected from the address list held by the District Council of Yorke Peninsula; and through people collecting a copy from a community location and returning their completed survey to a “drop box” at a community location. These locations included chemists, caravan parks, medical practices, council offices and local supermarkets. Copies of the survey were also available at the community meetings and some questions in the survey were repeated in the newspaper advertising. The “drop boxes” in community locations proved a very successful innovation and were a way of local businesses and services to show their interest and support for the planning work.

In all, almost 500 people responded to the survey – about half from each of the household mail-out and the various community input opportunities. Given the very strong response, the data provided details on the full range of issues under investigation and contributed to the data pool of value to health services in the region beyond the RHS planning process.

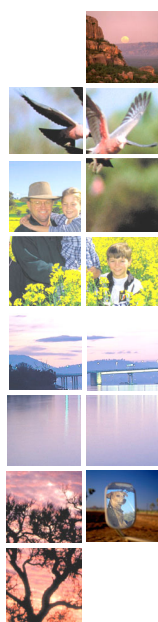
Service provider consultations were the third community-based planning strategy. The primary service provider consultation was a workshop held after the community meetings had been conducted. The aim was to bring data from the community to service providers so it could be considered alongside the provider perspective.

Invitations to this meeting were sent to all members of the Steering Committee and to managers/service providers in health, aged care and community services organisations throughout the study area. Organisations which had service delivery staff visiting the study area were also invited to be represented. The meeting attracted more than 30 service providers.

### Stage three: identifying priorities

Priority-setting exercises were undertaken at each stage of the consultation process. These exercises engaged members of the wider community, service providers and those involved with the management of services. They were undertaken in the following way:

- Survey: Respondents were asked to identify their three health priorities. Their responses were collated along with the responses from those who used the newspaper article as the vehicle for their response.
- Community meetings: Each participant was asked to provide, in writing, up to three priorities (issues, concerns, service gaps, etc) and their proposed solution. This was done by providing each person with three file cards upon which to write. They were not asked to share the priorities with other participants. As part of the workshop process, participants were also asked what worked well, what could work better, and what were the gaps in order for them to identify issues and concerns. This information was then used for group priority setting.



- Service provider workshop: Participants were given the same opportunity as those at community meetings to indicate, in writing, their personal priorities and issues (with the three file card process). During the workshop, participants worked in groups of four to six to identify priorities and to discuss possible solutions, from the service provider perspective. These priorities were shared to develop a common list.

The key stakeholder process was the fourth consultation element. It brought the elements of the planning study together and enabled overall priority setting. The priority-setting processes identified priorities in three main areas: about medical services; about primary health care services and issues; and about wider community concerns. Issues of governance, accountability and management were also topics for discussion at the key stakeholder process.

Key stakeholders were presented with data from the consultation processes and discussed the interface between the RHS study and other local projects (for example, at the time planning work for the Aboriginal Primary Health Care Access Program was also being done). The priorities from the community survey, the consultation meetings and the service provider workshop were reported. This ensured participants shared an understanding of the issues for local people and were informed of the strategies local people thought would work.

Discussion groups at this workshop developed the initial service plans and delivery mechanisms which formed the basis of the proposals.

### Stage four: developing the proposals

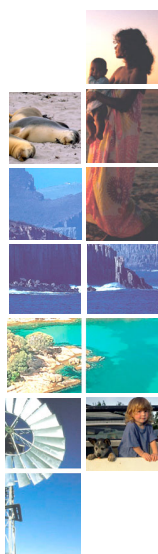
The Steering Committee worked with the planner to develop the proposals. These discussions also covered issues of governance and management. Decisions about the fund-holder and the service provider were made by the Steering Committee after discussion between members and their respective organisations.

## THE LEARNING FROM THIS PLANNING PROCESS

The planning process had attempted to ensure a dispersed rural community, concerned about access to health services but cynical about consultations, could determine the priorities and services which would meet their identified needs.

Debriefing and discussion were used by the Steering Committee members and those conducting the consultations to review the strategies which had been employed. The community meetings were expected to be the most successful strategy because they were seen to have been successful in the past. This confidence was misplaced. The community meetings did not attract large numbers, and many who came voiced their dissatisfaction and cynicism with attending because of their past experiences. One way of attempting to alleviate the cynicism was to ensure participants that they would receive a copy of the issues and priorities – thus responding to their concern that they were asked for a view but did not have it respected by knowing how their view was used. Delivering on this undertaking was vital to the success of the project.

The Steering Committee did not expect this strong response to the household and community survey. Again they were wrong. Had the survey not been done it is



reasonable to conclude that significant data and views would have remained uncollected. The success derived from the multiple methods used to administer the survey – having it available in a range of locations, making it easy for people to return (using reply-paid and community “drop boxes”) and providing it at all the community meetings. Success also accrued from the public discussion and dissemination of the survey results as they were received.

The approach whereby one form of consultation built on the other forms meant that the final plan had strong support and was widely understood.

The key outcome of the planning study was that local leadership emerged. This was entirely an unintended outcome. The task had been to provide the background data and possible operational models to establish a successful regional health service. This task was achieved because the submission for funding was successful and the RHS established.

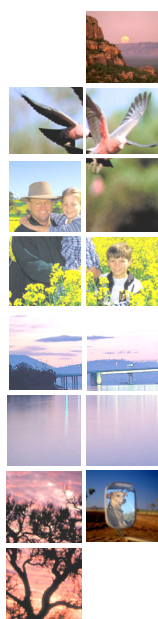
The leadership element arose in two ways. Firstly, the Steering Committee selection process ensured those in the community who wanted to take a key role in the planning were immediately given the opportunity. The committee agreed to form the nucleus of the advisory group to the RHS when it was established so that continuity and the transfer of skills and knowledge gained through the planning process were ensured. Secondly, the RHS plan included proposals for identifying and supporting “community champions” who were local people prepared to learn more about primary health care and to communicate this to their communities. The plan included proposals to fund the training and support of community champions and they were expected to be drawn from different age groups, cultural backgrounds and location.

The learning in this aspect is that embedding the planning work in the community results in strong local leadership. This leadership can be translated into support for the planning outcomes, not just the planning process.

And to return to the opening questions ...

The essence of the experience outlined in this brief case study is that selecting a range of methods is more likely to result in high level input from communities than relying on a single strategy. A culture of open discussion with key stakeholders and community members during the set-up phase of consultation greatly assists in the identification of suitable methods. Local knowledge, from service providers and communities, should contribute to the pool of advice before methods are defined. This can be difficult, particularly in a climate where funders often require a clear definition of method before funding decisions are made. Documenting the success of others who use multiple methods and engage the community in the decision-making processes in funding applications, can assist funders to support these more open processes.

Note: at the time of writing this paper, the author was Manager, Strategic Planning and Service Development, Wakefield Health.



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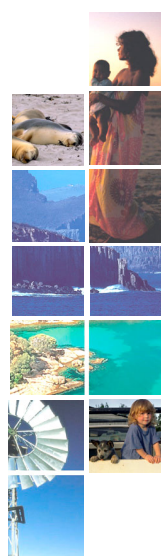
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## PRESENTER

**Meredith Hodgson** is the Regional General Manager for the Mid North Regional Health Service in rural South Australia. Her role is to lead the planning and funding of public health services including hospitals and community health services.

Meredith has a background in strategic planning and service development for rural health services. Major projects in which Meredith participated have included reviews of acute clinical services and planning studies for the development of Regional Health Services and primary care initiatives under the Aboriginal Primary Health Care Access Program. These projects were conducted with local communities and the close involvement of local health services.

Meredith has held the positions of Chief Executive Officer, Relationships Australia (SA) and Executive Director, Northern Suburbs Family Resource Centre. Both were leadership roles in community service organisations with a focus on enhancing the capacity of workers and communities to build services and develop positive



relationships. She also brings experience from private consulting and academic teaching to her new role.

Meredith has submitted her PhD thesis to complete her studies at the University of South Australia. The thesis investigates the way in which senior managers maintain their personal values and beliefs in challenging funding and policy environments. She holds a Master of Policy and Administration and Honours in Sociology. Her academic work reflects her interests in management and leadership, community service planning and social justice.

Meredith splits her living between Port Pirie in the mid-north and the vineyard and winery business in Eden Valley, which she shares with her husband Richard.

