Original Article

Strengthening Primary Health Care: Building the capacity of rural communities to access health funding.

Authors:

Dr. John McDonald (Senior Lecturer in ural health)
Leann Brown (Director of the Centre for Rural and Regional Health)
Angela Murphy (Postgraduate student in rural health)

Centre for Rural and Regional Health
University of Ballarat
Mt. Helen Campus
PO Box 663
Ballarat, Victoria, 3353.

Correspondence to:

Dr. John McDonald
Senior Lecturer in Rural Health
University of Ballarat
Mt. Helen Campus
PO Box 663
Ballarat, Victoria, 3353.
Telephone   (03) 5327 9629
Facsimile   (03) 5327 9840
Email   j.mcdonald@ballarat.edu.au

Strengthening Primary Health Care: Building the capacity of rural communities to access health funding.

ABSTRACT: *Present health funding models can place onerous pressures on rural health services. Staff may lack the time, resources, access to data, and the expertise needed to complete complex and lengthy funding submissions. This present study describes an innovative capacity-building approach to working with Victorian rural communities seeking to access health care funding through the Regional Health Services Program. This approach used several strategies: engaging stakeholders in targeted rural communities, developing an information kit and running a workshop on preparing submissions to the Regional Health Services Program, facilitating community consultations, and providing ongoing support with submissions. Six rural communities were supported in this way. Four have been funded to date, with a combined annual recurrent budget for new primary health care services of over $2.5 million. Each community has developed a service delivery model that meets the particular needs of their local area. This capacity building approach is both effective and replicable to other health funding opportunities.*

KEY WORDS: *capacity building, health funding, primary care, rural communities.*

INTRODUCTION

Rural communities have traditionally seen their bed-based hospitals as the foundation of the local health service. Rural health services are currently being reformed in response to improved medical treatments, economic imperatives, and a greater emphasis on health promotion and early intervention. For example, programs such as Multipurpose Services and Healthstreams allow the pooling of funding from different sources for health and aged care services to provide a more flexible, coordinated and cost effective service delivery model to meet local needs. Key principles of the national rural health policy also indicate the direction of the

redevelopment. There is expected to be a stronger focus on primary health care, public health approaches, enhancing community capability, and encouraging genuine community participation in determining health needs and setting priorities.[1] Needs-based, flexible funding at all levels of government is a key mechanism for achieving these reforms.

Health funding models can, despite their intentions, actually exacerbate rural disadvantage and isolate communities from involvement in their health services. While the Commonwealth has increasingly moved towards needs-based funding, there is ongoing debate about the problems involved in defining and measuring need, and with the marginalisation of community consultation in favour of quantitatively-driven, centralised, expert solutions to local needs.[2] On the other hand, submission-based funding tends to favour metropolitan areas. For example, capital cities have been found to receive a disproportionately higher share of Home and Community Care funding despite the greater cost of service delivery in rural areas and the relative lack of alternative services.[2]

This paper describes an innovative, capacity building approach funded by the Commonwealth Department of Health and Aged Care. The project involved staff from the Centre for Rural and Regional Health at the University of Ballarat working with six targeted rural communities to assist them to submit competitive applications to the Regional Health Services Program. The approach, processes and outcomes are reported here.

REGIONAL HEALTH SERVICES PROGRAM: AN OVERVIEW

The Commonwealth's Regional Health Services initiative aims to improve the health and well being of people in rural communities with populations of less than 5,000. The 1999/2000 Federal Budget provided a total of $42.8 million over four years to establish at least 30 Regional Health Services in rural communities throughout Australia. The aim of the program is to enhance primary health care through:

- devising locally-based solutions to local health problems;

- a multi-sectoral approach that extends beyond acute care, general practice and residential care;

- flexible, innovative, integrated solutions;

- improved access to health services; and

- collaboration between all levels of government.[3]

The Commonwealth has designated target regions that have been identified as areas of need. Communities in these regions can apply for funding for either service planning or service delivery; the six communities involved in this project applied for the latter. Submissions for service delivery demand a needs-based approach. Applicants are required to prepare a community profile of the region, analyse current health service data and health workforce data, identify the priority health needs of the community (including analysis of population-based health data), and determine access issues facing the region. The submission also requires a service delivery proposal that demonstrates how the identified health priorities will be addressed, together with demonstrated evidence for the effectiveness of the proposed approach. The proposal needs to incorporate a detailed project plan, budget costings, evidence of sound organisational and financial management, and additional supporting documentation. It is expected that strong community involvement and consultation with key stakeholders underpins the

development of the submission and the implementation of a funded service delivery project. Overall, the submission process can take several weeks to a few months. The final submission document is usually around 30 or more pages.

PROBLEMS FOR RURAL COMMUNITIES IN ACCESSING HEALTH FUNDING

Rural communities face a number of challenges when preparing competitive funding submissions. Previous research indicates that submission-based planning produces inequitable allocations reflecting rural disadvantage in opportunity, skill and access to information.[2,4] Staff in rural health agencies generally carry heavy workloads and thus have comparatively little time available to invest in submission writing.[4] Moreover, smaller agencies, typically found in the more rural and remote areas, do not have the critical mass of staff to allow them much capacity to pursue tenders.[5] Submission writing demands a significant skill base including community profiling, needs assessment, statistical analysis and service planning; the generalist nature of rural health practice sometimes means that these skills are underdeveloped.[4] The difficulties facing rural health staff in accessing and utilising reliable information technologies are also well known.[6] However, submissions often assume ready access to computerised data bases (such as the Australian Bureau of Statistics, the Cochrane Collaboration, and electronic research journals). Finally, when tenders are let on a regional rather than local community basis, inter-agency tensions and inter-town rivalries can hinder collaborative regional approaches.[7]

The Regional Health Services funding model has been criticised for having "too much bureaucratic language for the normal community submission writer to follow" and for having the potential for "division and competition rather than putting the dollars to services and community benefit on a needs basis".[8] These criticisms highlight the level of detail required in the submission, and the complexity of engaging a range of community representatives and service providers in the submission process. The task is particularly difficult for targeted, high need communities where there are typically few health staff available to lead the submission process. In response to some of these concerns, the Commonwealth Department of Health and Aged Care funded the Centre for Rural and Regional Health at the University of Ballarat to work with six targeted communities in the Grampians Region of Victoria to prepare competitive submissions for the Regional Health Services Program. The Centre is multi-disciplinary and has adopted an inter-sectoral approach to addressing health issues. The Centre's community membership scheme has attracted significant numbers of service providers from the health, welfare and education sectors. Joint forums are regularly held, and several collaborative research projects and developmental activities are taking place.

BUILDING CAPACITY TO PREPARE COMPETITIVE SUBMISSIONS

Community capacity refers to the attributes of communities that determine their capacity to identify, mobilise, and address social and public health problems.[9] Capacity building aims to foster the conditions that strengthen the attributes of communities that enable them to plan, develop, implement, and maintain effective community programs.[10] With regard to this present project, community capacity building aimed to

(1) overcome the barriers of professional isolation, staff shortages, poor access to data and other evidence-based literature, and lack of experience in needs-based funding submissions and (2) provide resources, training and ongoing support to enable targeted rural communities to prepare competitive funding submissions.

There were five overlapping stages to the five-month project. Stage one involved consultation with Commonwealth staff and key health services staff in the targeted communities. These discussions clarified the types and levels of resources, training and support required to build community capacity in relation to the requirements of a Regional Health Services funding submission. Stage two involved the development of a tailored 'Funding Submission Information Kit'. Key sections in the kit included:

- an overview of the research process, including evidence-based health care and relevant resources;

- an outline of relevant Commonwealth/state policies and programs, and strategies to ensure coordinated service planning and delivery between levels of government;

- models and methodologies of needs assessment;

- how to prepare a community health profile;

- strategies for community consultation; and,

- guidelines and processes for preparing a competitive submission.

Stage three involved the design and delivery of a full-day workshop with 18 representatives from the six targeted communities. The morning session included a presentation on the Regional Health Services Program by Commonwealth staff, followed by an overview of the 'Funding Submission Information Kit'. Participants then worked in the six groups to identify their progress with the submissions, key issues and barriers in preparing a submission, what resources and support they required, and

the ongoing role of staff from the Centre for Rural and Regional Health. In the afternoon session, Centre staff consulted on an individual basis with the groups to plan their activities over the following weeks.

Stage four – consultation within each of the targeted communities – is fundamental to the Regional Health Services Program and was pivotal to the success of this project. While there is widespread acknowledgment of the advantages of community participation in the development and management of health services,[11] it is evident that sustainable, positive outcomes using this approach can be elusive.[12] In many ways, the philosophy and structure of the Australian health care system compromises the ability of communities to participate in health policy development and decision-making.[13,14] Therefore, each of the six communities necessitated individual consultative mechanisms to identify community needs and health priorities. The chosen mechanisms were influenced by several factors including: perceived levels of community agreement about the health needs and priorities; the number and diversity of existing service providers and the relationships between them; current models of service delivery and the degree of local "ownership" of the health services; the geographical area and the number of towns involved; and whether a lead agency had been identified to prepare the submission. The Centre for Rural and Regional Health worked with staff from key agencies to jointly facilitate the consultative processes.

The final stage involved collaboration on the preparation of the submissions. Staff from the Centre were able to access statistical databases available through the University to enable detailed and up-to-date community profiles to be written. These staff also drew upon their expertise in evidence-based health care to develop a methodology for meta-analysis of health data and existing community needs analyses.

Literature searching and retrieval via the University's electronic databases permitted a strong evidence base to be assembled for the proposed approaches. Through exploiting these resources, the target communities gained enhanced capacity to prepare competitive submissions.

OUTCOMES AND BENEFITS OF THE PROJECT

At the time of writing, five of the six target communities had submitted applications to the Regional Health Services Program. Ministerial approval has been given for funding four of the five applications (one is still being considered). Funding has been approved for three years and the combined annual recurrent budget for these new primary health care services is over $2.5 million. Positions funded include community health nurses, social workers and youth workers, physiotherapists, occupational therapists, community transport services and pharmacy services, resulting in a greatly enhanced primary health care system. These staff will be delivering a range of programs and services targeting the prioritised health needs in each community such as: health promotion programs on cardiovascular disease and diabetes; injury prevention programs; individual counselling and support services for young people; and physiotherapy for older people. The direct benefits of this project for health services in the five communities are readily evident. Enhanced access to multidisciplinary services will result in improved health outcomes. The added benefit is the increased critical mass of health staff working in the small communities. Staff from the lead agencies who worked on the submissions have gained invaluable skills and experience in submission writing. The project has strengthened the communities' capacity to address health problems.

The project also created and consolidated relationships between local communities, health services and the University. Staff from the Centre for Rural and Regional Health gained a much better understanding of the regional communities, their health priorities, and workforce issues. Professional relationships were forged with staff from health agencies which has resulted in plans for joint professional development workshops and potential research projects. Collaboration between communities and universities, such as the completion of a community needs assessment, has been shown to be mutually beneficial.[15] While the Centre is not funded as a University Department of Rural Health (UDRH), it is clear that UDRH's can be effective partners in rural health education, training and research.[16]

Some challenges remain for the funded communities. Difficulties arise with the recruitment and retention of nursing and allied health staff in rural areas; some innovative strategies are being trialed by the communities and the outcomes will be evaluated. Further, the capacity of this project to equip the rural health practitioners with the skills and resources to prepare competitive submissions for other funding pools is unknown. Finally, community involvement in the implementation and review of the services is crucial, but is also known to present some challenges.[12]

CONCLUSION

This paper examined the disadvantages facing rural health staff in preparing competitive funding submissions. Small, under-resourced health services find the task particularly onerous. A collaborative, capacity building approach proved very effective

in strengthening the resources of the communities to research their own needs, consult

with key stakeholders, and develop a detailed, evidence-based, service delivery

proposal. The level of funding allocated to the communities is testimony to the quality

of the submissions. Given this achievement, there appears to be considerable scope for

mutually beneficial partnerships to be cultivated between universities and their regional

communities. Sustainable partnerships demand that universities no longer treat

communities as passive subjects of research or merely as markets for their educational

products. This project also demonstrated that the Commonwealth and states should

carefully consider the appropriateness of submission-based funding models for

disadvantaged communities and poorly resourced rural health services.

ACKNOWLEDGEMENTS

REFERENCES

1. National Rural Health Alliance. *Healthy Horizons: A framework for improving the health of rural, regional and remote Australians*. Canberra, 1999.
2. Barber J. Rural disadvantage in the distribution of South Australian Home and Community Care funding. *Australian Journal of Social Issues* 1998; 33(3): 231-239.
3. Commonwealth Department of Health and Aged Care. *Policy Framework. Commonwealth Regional Health Services Program: Enhancing primary health care in rural communities.* Commonwealth of Australia, 2000.
4. Wood R., Malko-Nyhan, K. A picture of locational-occupational diversity: An analysis of the needs of rural and remote healthcare workers when writing RHSET applications. *Australian Journal of Rural Health* 1998; 6: 118-125.
5. House of Representatives Standing Committee on Family and Community Affairs. *What Price Competition? Report on the Competitive Tendering of Welfare Service Delivery*. Commonwealth of Australia, 1998.
6. Coordinating Unit for Rural Health Education in Victoria. *Information technology: Access and utilisation by rural allied health practitioners*. Victoria, 1999.

7. McDonald, J. (1999) *When the Market Fails: Competitive tendering for welfare services in rural areas.* Rural Practice: A celebration. Paper presented at the Rural Social Work Action Group Conference. University of Ballarat.

8. Anonymous. Regional Health Services - The Answer? *PARTYline. Newsletter of the National Rural Health Alliance* December 2000; 7: 4-5.

9. McLeroy K. Community capacity: What is it? How do we measure it? What is the role of the Prevention Centres and CDC? Paper presented at the *Sixth Annual Prevention Centres Conference*, National Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Atlanta, 1996.

10. Poole D. Building community capacity to promote social and public health: Challenges for universities. *Health and Social Work* 1997; 22(3): 163-171.

11. Baum F. *The new public health: An Australian perspective*. Melbourne, Oxford University Press, 1998.

12. Wakerman J., Field P. Remote area health service delivery in central Australia: Primary health care and participatory management. *Australian Journal of Rural Health* 1998; 6: 27-31.

13. Butler C., Rissel C., Khavarpour F. The context for community participation in health action in Australia. *Australian Journal of Social Issues* 1999; 34(3): 253-265.

14. McBride T., Hulme A. Continuing uncertainties for Victorian municipal health plans. *Australian Journal of Primary Health – Interchange* 2000; 6(2): 6-18.

15. Kulig J., Wilde I. Collaboration between communities and universities: Completion of a community needs assessment. *Public Health Nursing* 1996; 13(2): 112-9.

16. Walker J. Partnerships to improve rural and remote health care. *Australian Journal of Public Administration* 1999; 53(8): 72-76.