Provider and consumer perceptions of allied health service needs

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Abstract

The study reported in this paper compared data from 20 separate focus groups, representing providers and consumers of health services in the Grampians region, Victoria, on their perceptions of the allied health service issues in that region. The results of the study indicated that providers and consumers raised many similar issues in regard to allied health services – access to allied health services, service delivery, social and rural issues – but discussed the issues from different perspectives. The provider discussion was concerned with service delivery issues and the consumer discussion was focused on broader social issues which affect health.

Introduction

Historically, policy-makers have often relied on the perceptions and opinions of health care providers in determining strategic plans for health policy and services. In the last decade, consumers have begun to question the assumption that providers know best in regard to health care services for the community. Today's consumer has increased expectations of providers in regard to the quality of health care, including participation in decision-making about resource allocation (Dwyer 1989). In a National Health Strategy (1993) paper, it was argued that the health system must involve its consumers at all levels if it is to be responsive to its community, reduce inequalities and use resources effectively and efficiently.

The study reported in this paper considered health care needs from a social policy perspective. Need is regarded as socially constructed, based on the context of the need, attitudes and values of the individuals expressing the need (Lightfoot 1995). Research into the perceptions of providers and consumers about health care needs has revealed some discrepancies in the views of the two groups

(Howard 1982; Cameron 1992; Summers 1992). This study compared the data from separate focus groups, representing providers and consumers of health services in the Grampians health region, in regard to perceptions of the community's allied health services needs. The following disciplines were classified as allied health for the purposes of the study: dietetics, occupational therapy, podiatry, psychology, physiotherapy, speech pathology and social work.

The Grampians health region in Victoria covers an area of 48 112 square kilometres and has a population of 204 208 (Bauer 1996). The major urban area is the provincial city of Ballarat, 110 kilometres from the capital city of Melbourne. There are several smaller cities in the region and the majority of the population growth is on the fringe of these cities. Surrounding the urban areas are smaller rural townships and farming communities. At the time of the study there were nine cities and towns, including Ballarat, in which allied health staff were employed. The allied health staff from these cities and towns provided visiting services to the surrounding communities.

Method

Twenty focus group discussions were held across the nine cities and towns. The groups consisted of 10 pairs of groups, with each pair of groups comprising a group representative of service providers and a group representative of consumers. One pair of groups was conducted initially as a pilot group to test the interview schedule.

The researcher liaised with health and welfare personnel in the local cities and towns to develop lists of possible participants for the focus group discussions. Invitations to the groups were initially issued in the form of a letter, with telephone follow-up. Table 1 summarises the categories of provider and consumer groups, the number of participants invited, and the number attending the focus group discussions.

Table 1: Categories of provider and consumer groups, number of participants invited, and the number attending the focus group discussions

	Number of participants invited	Number of participants attending
Categories of provider		
Hospitals	25	23
Shires/home care services	24	11
Accommodation facilities	12	5
Specialist services	32	16
Children's services	11	3
Other	10	2
Subtotal	**114**	**60**
Categories of consumers		
Service clubs	36	12
Social service groups	17	6
Religious groups	28	8
Schools	14	4
Community groups	11	6
Self-help groups	16	12
Others	13	5
Subtotal	**135**	**53**

The development of a participant list, with the assistance of local health and welfare personnel, also allowed the researcher the opportunity to fulfil selection criteria requirements for focus groups (McMillian 1989). The selection criteria for focus group participation were experience in regard to the topic, a willingness to participate as either a provider or a consumer of health services, living in the same geographical location (consumers) and working for the same employer (providers).

The measure used in this study was an interview schedule containing questions to elicit information about current and needed allied health services in the area. Prompts and probes were used to gain data on the ease and difficulty in using and providing services, knowledge of available allied health services, the level of

services to meet consumer needs, the effect of service cost on consumer use of services, and children and carer service needs.

The focus groups were conducted at the local hospitals. A relaxed atmosphere was created to enhance interaction and the free flow of ideas and opinions, vital for the success of focus groups. This was achieved by the organisation of furniture, provision of refreshments and the leadership style of the facilitator. The group discussions were two hours in length. The number of participants in the individual group sessions was between four and ten people (providers), with a median number of six, and between three and thirteen people (consumers), with a median number of five. In this study the researcher/facilitator was an allied health professional working in the Grampians health region, with proven skills in group processes and a good knowledge of the methodology. The groups were audio-taped for the purpose of transcription and data analysis. The 'cut and paste' technique was used to summarise the data and to shape and identify issues. A semantic approach to content analysis of the dialogue was undertaken. This approach involved analysing the positive and negative characteristics of an issue to determine the direction. The researcher was aware that using only one person's judgement in the data analysis stage does leave scope for subjectivity and potential bias. Time limitations, however, precluded the use of more independent coding of the transcript.

Results

Access to allied health services

Providers and consumers identified a number of access issues which affect allied health service provision. Both providers and consumers perceived that communities had a poor knowledge of allied health services in relation to their availability and roles. This perceived lack of knowledge was believed to be exacerbated by the limited availability, and hence visibility, of the allied health services. The groups noted that lack of service availability leads to a lack of education and promotion of allied health roles. The focus groups stated that additional information outlets for community services data, including allied health services, were needed.

Provider and consumer groups described smaller communities as receiving minimal or insufficient allied health services. Both groups identified the negative consequences of the limited availability of publicly funded allied health services as a low rate of general practitioner referral, a low rate of self-referral and the high utilisation of non-specialist health and welfare services.

Both providers and consumers identified inadequate transportation as a major barrier to accessing allied health services. The focus groups identified concerns with transport and stated that the problems existed with public and personal modes of transport, in regard to time, cost and convenience.

Prohibitive financial costs were mentioned in the provision of domiciliary services to overcome consumer difficulties with transport and for some consumers in accessing allied health services. This related to the accumulative cost of travel, a user service cost and often an equipment cost. Rural poverty was an important factor identified at the root of this problem.

Special groups identified by provider and consumer groups with access problems to allied health services were school-aged children and carers. Provider and consumer groups perceived access to speech pathology services for school-aged children to be inadequate. They also identified a number of other speciality health services which were lacking for the school-aged population. Carers were perceived by both groups to have special unaddressed needs in relation to respite services. Both groups commented that carer guilt, and hence hesitation in accessing services, exacerbated the problem.

Service delivery

Service delivery issues identified by providers and consumers were the benefits of local management of allied health services and the provision of local support staff to assist professional allied health staff in providing more effective allied health services. Both groups identified communication between providers as an area that needed improvement, particularly between providers in Melbourne and those in the Grampians. The general practitioner was recognised as the vital link between the community and providers. The groups commented that funding cuts had affected service delivery.

Social issues

Provider and consumer groups both identified a number of social issues that were believed to affect an individual's health status. Limited counselling services for depression, financial assistance, alcohol and drug abuse and domestic violence were perceived to contribute to social problems in the region. Youth depression and suicide were mentioned as particular issues of concern in both provider and consumer groups. Specific groups such as youth and younger disabled males were perceived to have special needs in terms of socialisation which were not being addressed.

Both groups recognised some issues unique to rural areas, in particular, the inequitable distribution of public services in rural areas and the difficulty in recruiting and retaining allied health staff to rural positions.

Discussion

Providers recognised many concerns for the community, but either did not elaborate on the issues or discussed them from a service delivery perspective. Consumers recognised the same health issues as providers but discussed the issues from a personal perspective, elaborating on practical difficulties they were having with services. The essence of the difference between the discussions of the two groups was that one group's discussion was theoretical (providers) and the other group's discussion was practical (consumers). Lightfoot (1995) described this difference as a consequence of the differing focus of the two groups – the consumer groups focused on outcomes, while the provider groups focused on the means of achieving satisfactory services.

Access to allied health services

When discussing the lack of and poor access to community knowledge of allied health services, consumers were concerned with the location of information, and the practical problem of consumer reluctance to seek assistance due to their strong desire to maintain independence. Providers did not discuss why consumers had a poor knowledge of allied health services, but instead focused on the methods they had used to inform the community about their services. Consumers were discussing outcomes, providers the means of achieving such outcomes.

Providers recognised that smaller communities received minimal allied health services and that there were difficulties with the distribution of public services in rural areas. When discussing inequitable services, consumers recognised the flow-on effect of a reduction in services, the movement of young people to larger towns, the lack of younger people to support the older population, and consequent further isolation of the older population. Consumers also discussed the practical problems for individuals caused by inadequate services, such as the cost of travel, time delays in treatment and utilisation of non-specialist practitioners. Consumers expressed frustration and anger with the limited services. The discussion by both groups of the factors related to the limited availability of allied health services reinforced the conclusion that consumers had a broader perspective on health than providers.

Consumer discussion of access to allied health services for special groups such as school-aged children and carers also highlighted the broader perspective of consumers in their discussion of health issues, compared to providers. Consumers discussed the effect of limited access to allied health services on children and families, whereas providers discussed this in relation to children and providers only. Consumers also included young mothers as a group in need of respite services, whereas providers only considered as carers those people who look after the aged or persons with a disability.

Service delivery

The discussion of service delivery issues further highlighted the difference in the perspectives of the two groups. Consumer groups recognised some issues that affected service delivery such as funding cuts, poor communication between providers, and lack of support staff to assist allied health staff. Providers devoted more time to discussing service delivery issues and were more detailed in their discussion of the impact of these issues on services. Providers discussed the impact of the de-institutionalisation and community re-integration policy on generic service providers. This was said to be especially difficult for allied health staff who lacked knowledge and skills in working with people who have a psychiatric or intellectual disability. This difference in discussion emphasises that providers placed more importance on cost-efficiency and technical expertise in their discussions of health issues and consumers were more focused on the personal aspect of health.

When discussing the difficulty in recruiting and retaining allied health staff in rural areas, again providers focused on the effects on service delivery such as pressure on existing staff, lack of peer support and limited career advancement. Consumers recognised the problem, but linked it to general difficulties in attracting professional staff to rural areas.

Social issues

The focus group discussions of social issues which affect health further highlighted the different perspectives of the provider and consumer groups. Both groups recognised depression, isolation and stress as having a negative impact on an individual's health, but the consumer group went on to discuss the impact on the family and community. Providers tended to recognise social issues as affecting special needs groups such as the aged or persons with a disability. Consumers discussed the social issues in relation to the aged or persons with a disability, as well as youth and young mothers. It could be concluded that

consumers had a broader perspective on health than providers, emphasising social determinants of health, and that conclusion was supported by this study.

Limitations of current research

Limited generalisation of results to the general population has been noted as a weakness of focus groups, hence caution needs to be exercised in generalising the results in this study to other regions and other aspects of health service provision (Basch 1987; Stewart & Shamadasani 1990). Generalisation is limited also by the sample of participants in the study.

The researcher developed an invitation list of participants who belonged to organised groups in the community, and then either mailed a written invitation to them or contacted them by telephone. This excluded some groups and limited opportunity for participation for individuals not belonging to organised groups such as a religious group, social support group or community group. Prior to the conduct of four of the nine focus groups, advertisements were placed in the local newspapers to invite the general public to participate in the groups; this generated only one participant. Consumer representation may have been limited by the use of the selection method. Usually, only participants contacted and willing and able to articulate in public attended.

Representation from smaller communities may have been reduced due to the need to travel to larger centres to participate in the focus groups. Inequity in access to transport was a factor discussed in this study and may also have affected consumer participation in the study.

The use of the focus group forum may have limited consumer representation and participation. Consumers may be unfamiliar with the structure of the data gathering session, techniques used to gain information, and the language used in the sessions, thereby reducing their willingness or ability to participate. Specific groups of consumers may have been disadvantaged by the focus group forum, for example, people with communication problems, difficulty with concentration or interpersonal skills, children, frail aged people and people with a chronic illness.

Some of the focus groups had fewer than six participants, the recommended minimum size for such groups.

A number of the above-mentioned limitations were to some degree minimised by the large number of focus groups conducted in this study, but consumer participation and representation in similar studies could be improved by overcoming some of the identified limitations.

Conclusions

This study into allied health needs in the Grampians health region, using separate focus groups for providers and consumers, highlighted the differing views and perspectives that the two groups have on health issues. The provider discussion was concerned with service delivery issues and the consumer discussion was focused on broader social issues which affect health. Both groups recognised many similar health issues but the discussion of the issues revealed the underlying different values and experiences of the two groups in relation to health needs. Lightfoot (1995) has described this as 'felt' and 'expressed' needs by the community and 'normative' needs by the experts, the reflection of different contexts of need, and the attitudes and values of the individual determining the need.

The fact that divergent views were revealed in the study supported the literature on community participation, namely, that when identifying, developing and implementing health needs strategies, those concerned in the outcome should be involved in the decision-making process. If only one perspective is considered, the result will be a narrower focus, omission of lateral problem-solving options and, possibly, the maintenance of the status quo.

This study highlighted the possible importance of separate provider and consumer consultations to ensure that consumers felt comfortable expressing their views. A National Health Strategy (1993) paper noted that consumers experienced more barriers to participation in community consultations than did providers. The power differential between the two groups and preconceived attitudes of providers are two examples of barriers. A third and significant barrier to consumer participation, evident in this study, is consumer reluctance to participate in reviews due to disillusionment with such government-sponsored reviews and the subsequent lack of action following. This suggests that government departments and agencies need to consider their motivation for conducting need assessments if they want consumers' long-term commitment to involvement in such assessments.

Future research is suggested in separate provider and consumer consultations to gain additional data into the divergent perspectives of health needs of the two groups. Further, exploration of consumer participation in strategic planning would assist in the evolution of health policy towards its stated goal of an outcome focus. The consumer health outcome perspective would allow for a focus on strategies which contribute to health, rather than to providing health care. This would involve strategies and resources other than health resources in areas such as housing, education and employment. Therefore, consumer and

provider participation are required in a broad range of human service areas, notably, the areas that produce health and strategic planning which will minimise structural problems in the community.

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