A review of community consultation in the development of a multi purpose service in rural and remote Australia

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Abstract

This paper examines the role of community consultation and participation in the process of establishing a Multi Purpose Service (MPS) program in two towns in Western Australia. Information was gathered through written documents and semi-structured interviews with individuals who were integral to the process. Consumer involvement in health care is increasing, and while claims of being community driven underpinned the MPS program, our findings suggest otherwise. Conflicts of interest, a lack of representation, and misunderstandings about the meaning of community consultation were present throughout the process of implementation. Moreover, official reports either ignore or downplay these events. We conclude that more attention must be paid to the role of the community in the health reform agenda generally and the MPS program specifically.

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What is known about the topic?
Community consultation and participation are considered to be important components of health care planning.

What does this paper add?
This paper discusses the difficulties of ensuring effective consumer participation in local planning initiatives.

What are the implications for practitioners?
Before beginning a planning process, the role of the community and the meaning of consultation and participation should be clarified to assist in structuring effective, appropriate community involvement.

COMMUNITY CONSULTATION and participation in health care planning were enshrined in the World Health Organization's Declaration of Alma-Ata (World Health Organization 1978) and Ottawa Charter for Health Promotion (World Health Organization 1986). Since that time, their stated importance has become increasingly significant in health service delivery models and initiatives throughout the world (Jewkes & Murcott 1996; Rifkin 1996). Australia has followed suit and moved to consolidate community participation in

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health care at a national level (NRCCPH [National Resource Centre for Community Participation in Health] 2002; NRCCPH 2001). As this article illustrates, however, the principle of actively involving consumers at every stage of health service planning to ensure their success (NRCCPH 2001, p. 3) is not always realised in practice.

Community participation in health programs

There has been a significant growth in research that focuses on the ways community consultation has been incorporated into specific health services at the local level. This body of work abounds with examples of the disparity between institutional rhetoric and the reality of practice when it comes to health programs that claim to put the community first (Mull 1990; Tatar 1996; Zakus 1998; Wayland &

Crowder 2002). Such studies have made it clear that the process of community consultation and participation is particularly susceptible to becoming a tool that reinforces the vested interests of those in power, rather than one that leads to power sharing and a fundamental restructuring of the health care system (Heggenhougan 1984; Peterson 1994). As such, it has become a device that kindles public enthusiasm for, and promotes acceptance of, predefined and largely top-down objectives.

Discussions on the role of the community and its somewhat dubious relationship with health-related programs (Mooney 2000; Chapman 2000; Short 2000) suggest there is little agreement regarding this role in community consultation and participation in the health reform agenda. Those who are especially wary of giving too much weight to the community cite the public's relative ignorance about health and the intricacies of the health care industry, as well as their tendency to reflect media-biased perspectives that are narrow, if not reactionary, in nature (Leeder 2000; Chapman 2000). There are also considerable problems associated with defining communities and adequately measuring their values.

In response to these issues, others have highlighted the inherent biases of policymakers themselves when setting the health reform agenda (Aldrich & Mooney 2001). They suggest further that the community should be viewed as citizens rather than as a reflection of epidemiological indicators and patient satisfaction surveys. With this perspective, community values not only drive the health reform agenda but define the very nature of the health service. The aim is to give equal weight to issues other than those related to a strict focus on health status and the burden of disease. Such issues might include social equity and the very right of communities to choose for themselves (Mooney 2000; Aldrich & Mooney 2001). A critical need that has emerged from this debate is finding a way to balance community opinions and values with professional expertise, epidemiological data and other forms of evidence-based knowledge.

The Multi Purpose Service (MPS) program in Australia has evolved against this backdrop, where the community's role is widely acknow-

ledged as important but the exact nature of participation remains uncertain. It is necessary, then, to critically examine the ways in which community consultation and participation have been implemented in a program that claims to be community-driven, completely transparent and necessarily endorsed by all parties at every stage.

In this paper we focus on community consultation and participation during the process of establishing one MPS program to service two rural towns in Western Australia. The objective was for both communities to work together under a single board of management to deliver a range of health services in the most cost effective way. We specifically highlight these events and the experiences and perceptions of key community stakeholders during the process. In doing so, we critically examine ways in which government health authorities incorporate community consultation and participation into programs that are tailored to benefit people living in rural and remote areas. We show that the concept of community consultation and participation is interpreted ambiguously (Bragar & Specht 1973 in NRCCPH 2002, p. 8), with conflicting meanings and expectations as to its application in practice leading to divisiveness between community groups. We suggest that if community-driven initiatives like the MPS program are to be successful, they must incorporate a reconsideration of the role of the community and the process of consultation and participation.

The MPS program

In the 1990s, the commonwealth and state governments of Australia focused their attention on rural and remote health services, stating that many were economically inefficient, delivered in an ad-hoc, repetitious and unrelated manner, and not attuned to the changing health profile of their respective communities. Health services in these areas were encouraged to adopt a more flexible approach that would allow them to better address the needs of local communities (Hoodless & Evans 2001). To this end, the Multi Purpose Service program was developed and implemented in 1993. At its core,

the MPS program is a centralised management structure and accountability process for all health and aged care services in a specific region into which commonwealth and state funding can be pooled. The rationale behind this approach allows health services to target community needs without the burden of rigid program constraints and separate funding sources.

Community consultation and participation are an important part of the needs analysis component of the MPS program (Snowball 1994; National Rural Health Alliance 1996; Hoodless & Evans 2001). In fact, the Health Department of Western Australia (2000) states on its MPS website that "The development of an MPS is a community driven decision". It claims further that the program cannot proceed without the full participation and endorsement of both the community and local health services:

> Ongoing community consultation is essential to ensure all participants are fully informed and endorse each step of the process towards the MPS goal. It is paramount that the entire process is open and transparent and all points of view are given equal consideration.

Among the necessary requirements to develop and implement an MPS, community consultation and participation are particularly evident in the establishment of a local steering committee and the steps put forward for an overall needs analysis. These steps include a community survey, meetings with key stakeholders, public forums, and invitations for written submissions. Such actions are also considered important in fostering a sense of cooperation, trust and community ownership. It is important to note that the needs analysis also includes the collection of hard data such as demographic and epidemiological information and a description of the current health services and utilisation patterns.

Methods

Approval was granted by the ethics committee at the University of Western Australia to undertake this research and conduct semi-structured interviews with individuals and key stakeholders instrumental in the planning and implementation of the MPS. Eighteen people were interviewed (in some cases more than once), including those who worked for the pre-existing health services in both towns, local managers from the Health Department of Western Australia, local medical practitioners, members of the previous Wongabeena Health Service Board, members of the current amalgamated board, members from the MPS consultative committees and several community members who were closely involved in the process.

Archival material was also an important part of data collection. This information included correspondence between key stakeholders, reports and minutes from meetings held with government officials, media clippings and the official needs-analysis reports associated with the planning and implementation of the MPS in Diamond Head and Wongabeena (these are pseudonyms).

Data analysis involved the identification of: specific actions taken as a basis for community consultation and participation; and contradictions and conflicts that arose during the process. These broad themes were then examined in more detail and in terms of the following key factors: pre-existing local issues; perceptions of the MPS program; definitions of need; expectations and roles of self and others; and perceptions and constructions of different groups throughout the process. A final step involved a critical examination of the basic principles associated with the MPS program and an assessment of how these compared with the process.

Rural anxiety and inter-town rivalry as extenuating circumstances

It is important to highlight the backdrop against which the process of establishing an MPS in Wongabeena and Diamond Head occurred. While both towns are located in the same shire, they are separated from one another by over 100 kilometres. Diamond Head is geographically isolated from the rest of the shire's population centres but has become a very popular tourist resort and retirement centre. It is the largest town in the shire and had an estimated population of about 2000

when the MPS program was being considered. During peak tourist season, the town regularly absorbs an additional 7000 people. It was clear to health authorities that both the resident population and the number of tourists were going to grow significantly in the coming years. Before the MPS, a small Silver Chain nursing post and one general practitioner serviced the town's health needs.

Wongabeena is located in the midst of a relatively productive agricultural and pastoral area and caters to a well-established and more permanent resident population including an Aboriginal community. The estimated population of the town and immediate area was about 800 when the MPS program was being considered, with minimal growth. Historically, the town has also served as the hub for several smaller communities that make up the remainder of the shire's population. At the time of the MPS deliberations, Wongabeena was serviced by a small district hospital with several short stay acute beds and one general practitioner.

As regional resources became scarce, the rivalry grew between Wongabeena and Diamond Head, and one town's success generated resentment from the other. The level of anxiety was perhaps greater in Wongabeena, as its residents watched Diamond Head grow into a major tourist resort. Wongabeena fitted the profile of most rural towns in the region and shared similar concerns involving the sustainability and well-being of the community. The local health services became a source of pride and the community was extremely protective of them. Additionally, the visit by the Minister for Commerce and Trade for Western Australia to Diamond Head before the MPS deliberations to discuss health services issues heightened the level of anxiety in Wongabeena. Rumours spread about the closure of the local hospital, reinforced by reports on the radio and local newspapers. It was not until later that the State Health Minister confirmed that plans were under way to downgrade the town's hospital and reduce costs by cutting its staff in order to fund new health centres in Diamond Head and a nearby community. Documents from the regional development authority described the Wongabeena community as "shocked" in response "both at the announcement to downgrade the hospital and the failure of the Minister and the Health Department to consult with the Shire and the community". Residents were particularly displeased with the idea of upgrading services in Diamond Head "at the expense of their community and their hospital". Community concern was so great that 350 people attended a public meeting in Wongabeena to protest the decision.

For their part, residents of Diamond Head proposed expanding the town's nursing post to meet increased demand resulting from the growth of its year-round population as well as its exploding tourist population. The request was denied by government authorities, however, which set the stage for the establishment of an MPS program for the two communities.

These extenuating circumstances are important for various reasons. The anxiety and inter-town rivalry between Wongabeena and Diamond Head are not uncommon in rural and remote towns in Australia. People are aware of, and concerned about, the influence of top-down political and economic initiatives that are perceived to undermine the underlying fabric of their communities. This can result in an emotionally charged atmosphere characterised by widespread concern over the very existence of communities. Yet one would not know this level of concern existed by reading official needs-analysis reports, particularly when the needs are narrowly focused on epidemiological indicators and lists of predefined service preferences. This is unfortunate since rural anxiety and local politics have a major influence on the success of government programs. The process of establishing the MPS became immediately embroiled in local divisions and exacerbated an already tense and fragmented environment.

Examination of official reports

Community consultation and participation was part of the overall needs analysis, composed of four broad stages. These included a baseline analysis of pre-existing health data, interviews with health service providers, the formation of a local consultative committee, and various strategies employed to encourage input from the broader community.

The baseline analysis of pre-existing health data and interviews with health service providers were conducted in a similar manner in both communities. The former involved the collection of hospital admission, discharge and diagnosis information, epidemiological and population health data, and information related to transport and access patterns from local and regional health services. Interviews with health service providers focused on service utilisation, perceived needs, gaps in service provision, and ideas for future program development. The official needs-analysis reports from both communities demonstrate that the information collected was extensive and thorough.

The local consultative committees in Diamond Head and Wongabeena were established through similar processes. Close attention was paid to ensuring broad-based input from the community at large and that composition allowed for differences in age, gender, race/ethnicity and other socioeconomic factors. Diamond Head's committee was composed of eleven members, including representatives from the shire, hospital board, regional development commission, community at large and health care providers. Wongabeena's committee was composed of seven members, the full details of whom were not provided in the report. In contrast to Diamond Head, the selection criteria for Wongabeena's committee stipulated that its members could not be active health care providers. Government health authorities entrusted the committees from both towns with conducting consultation activities with their respective communities.

Community input in Diamond Head and Wongabeena was encouraged through a needs survey, a call for written submissions, and public meetings. It is worthwhile to briefly examine how these strategies played out in each town.

In Diamond Head, the needs survey was distributed to 800 households. A total of 183 surveys were returned, representing 513 residents or 34% of the permanent residents of the town. A similar survey was distributed to 700 households in the catchment area of Wongabeena's district hospital (excluding Diamond Head due to the separate survey). A total of 133 surveys were returned, representing 385 residents or 17% of the catchment area.

Given the number of returned responses, the survey results were probably not representative of the whole community, a fact the authors acknowledged in the Diamond Head report. Additionally, the survey questions were focused only on health and health services. Subsequently, the answers were compiled in a short list of priority areas in the following way: Acute care beds, Nursing home beds, Accident and emergency services … etc. Beyond this, community responses appeared in an ad-hoc manner throughout each report and as a means of reinforcing and supplementing epidemiological data and service utilisation patterns. Each report provided a similar half-page statement describing how needs were classified into various categories that clearly differentiate public opinion, statistical and/or pre-existing data and expert assessments regarding what is best for the community. However, no mention is made of the weight accorded to each category in the final analysis. The categories themselves are rendered almost useless given the consequences of the following statement, which is found in both reports: "… there is no reason to suppose that a need identified by three sources has a higher priority than a need that has been identified by only one source". Simply put, the importance accorded to each category is not clearly defined and there is no explanation as to how community opinions were balanced with professional expertise, epidemiological data and other forms of need.

In both towns, the call for written submissions was a dismal failure. Despite an advertising campaign that included newspapers, notices and radio spots, Wongabeena received only one submission, and Diamond Head, two.

The final strategy employed to encourage community input involved public meetings. The consultative committee from Wongabeena initiated twenty public meetings throughout the region. The needs-analysis report describes the meetings as "extremely well attended" and makes a "conservative estimate" of 200 participants. Despite the turn out for these meetings and the high level of discontent among Wongabeena's residents, the

community input is reported as a list of generic health needs. In fact, in the 70-page report the amount of space dedicated to community feedback from these meetings is less than half a page, although there are other occasional references to community input from these meetings throughout the report. A second round of public meetings was used to explain the MPS program and alleviate fears that community members might have. This effectively blurred the purpose of the community meetings between encouraging community input and influencing public opinion.

Public meetings were initially deemed unnecessary in Diamond Head. The needs-analysis report provides conflicting reasons for this. At one point, it states that meetings were not held because "… everyone was given adequate opportunity to have input through the survey form and written submissions". At another point, however, the same report suggests that no such meetings were held "because the committee considered that it needed to be able to present the findings of this report before doing so".

The conflicts

It was clear from our interviews that the process of establishing an MPS in Diamond Head and Wongabeena was fraught with controversy and strife. Both supporting and opposing groups emerged among the key stakeholders. As the resulting conflicts unfolded, community members became increasingly sceptical of the amount of information received and did not know who to believe.

Those in support of the MPS program were led by management staff from the Health Department of Western Australia, who focused much of their attention on issues of accountability, service utilisation patterns and epidemiological information. These staff operated under the assumption that the MPS was the only option, emphasising that without the transition to an MPS the communities "would not be able to get the services or keep the [current] services". Subsequently, the management staff "just worked slowly towards what they were aiming for all along". They acknowledged the obvious tensions that emerged regarding the

program, but tended to dismiss this as being generated by one or two people who were "stirring the pot". At the same time, however, there were indications that some of the Health Department staff felt removed from the process:

> No one told anyone what was happening or how it was going to happen and the staff didn't really have much input at all on how it was going to happen, so we just sort of learnt via the grapevine.
> — *Nurse, Wongabeena Hospital.*

Members of the consultative committees were generally in favour of the MPS program but were caught in a difficult and ambiguous position. They felt obliged to support the MPS because the Health Department presented the program as the only option to prevent losing existing services. This was particularly true of those individuals who sat on the committee from Wongabeena, some of whom suggested that changes to the health services were "forced" on them by the Health Department as a result of economic motives rather than community needs. With no other option to present to the community, committee members felt pressured to encourage support for the MPS program during the community consultation process. Their actions inevitably led to conflicts with the wider community, and they were keenly aware that many community members viewed them as a 'mouthpiece' for the Health Department and thus unable to represent the needs and concerns of the community. Committee members responded by labelling the community as unrealistic, disinterested or uncooperative.

As 'front men', the consultation committees were not only caught between the Health Department and the community, but also between the Health Department and health service providers:

> The biggest problem is [doctors] don't like being told by the government. And that is what the [committee] is – a mouthpiece for the government. I mean you've got your rules and regulations and your circulars and everything from the government and if you say 'you do,' you do or 'thou shalt not do' and you shan't do. Doctors, they want to be

able to bend the rules. And in a lot of instances, the [committee] cannot bend the rules.
— *Committee Member from Wongabeena.*

As with committee members, health service providers in both Diamond Head and Wongabeena were led to believe that the only option was a choice between the MPS program and the loss of existing services. Pre-existing health service providers were generally opposed to the establishment of an MPS and expressed particular concern over the loss of autonomy. Those in Diamond Head were well aware that the MPS program translated into a divestment of funding and local decision making and a structure that was potentially less flexible:

… the bureaucrats said "Look, you won't get a hospital, there is no Health Department money for that anywhere, not just here". The Government was closing country hospitals at that time; not building new ones … What we didn't really like was the loss of autonomy. Instead of being a Silver Chain Nursing Post where we basically got a budget and told to do what we thought was best … we became a health department run with all these bureaucrats telling us what they thought was best.
— *Silver Chain Nurse in Diamond Head.*

Health service providers at Wongabeena Hospital not only viewed the MPS program as a loss of autonomy, but as a general threat to the community. Sentiments ran extremely high in this regard:

In the end the whole community was being torn apart. Who was on whose side? It was becoming terrible. They felt fearful of what was happening to their health service.
— *Committee member, Wongabeena Hospital.*

The general practitioners expressed their reservations about the program:

There was the distinct impression that it was all going to happen whether we had input or not. One of the crucial points of MPS was supposed to be community consultation and

the involvement of local doctors and nursing staff, but we were not really welcomed with open arms. It was the traditional government approach. We know what is good for you. We had to push ourselves forward to get our say.
— *GP Diamond Head.*

I wrote to the Minister of Health and said that I had not found a single person in the community, professional or otherwise who had been consulted about this.
— *GP Wongabeena.*

Throughout the process of establishing an MPS, the communities were confronted with various perspectives and competing agendas. Community members expressed confusion, cynicism and felt they were misrepresented. As one individual put it: "The less information the community had the better". In this context, it would have been extremely difficult to conduct an effective process of community consultation and participation.

Conclusion

The Health Department of Western Australia defines community consultation and participation as central to the MPS program. The process of establishing an MPS must be initiated by the community, conducted in a completely transparent manner and endorsed by all key services and community stakeholders in an environment where all viewpoints have been given equal consideration.

It is clear from our study that the process of engaging the community in the above manner did not occur during the establishment of an MPS in Diamond Head and Wongabeena. In many ways, the line between consultation and persuasion was seriously blurred, so much so that issues of choice and empowerment became non-existent. Conflicting interests, role ambiguity and a lack of representation ran throughout the entire process.

This is not to denounce the MPS program in Western Australia. To the contrary, the program can attract a broader range of services to local communities and even offset the downgrading or

closure of country hospitals as a result of changing demographic trends, low use and dwindling populations (Snowball 1994). There are certainly many positive testimonials from communities throughout the State regarding the program (see National Rural Health Alliance 1996). For many services, the centralised management and accountability structure and pooled funding that the MPS program brings do in fact result in more flexibility and adaptability.

Yet we question the manner in which community consultation and participation occurred in this instance. For community-driven initiatives like the MPS program to be successful, the role of the community and the meaning of consultation and participation must be clarified and defined so that they can be effectively applied in practice. Facilitating a process that is underpinned by transparency and endorsed by all parties at every stage of implementation speaks to the level of ownership and empowerment that we actually want from rural and remote communities in Australia.

Acknowledgements

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