

## ORIGINAL RESEARCH

# Developing sustainable models of rural health care: a community development approach

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*Submitted: 10 July 2007; Resubmitted: 14 November 2007; Published: 7 December 2007*

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*Rural and Remote Health 7: 818. (Online), 2007*

Available from: <http://www.rrh.org.au>

## ABSTRACT

Globally, small rural communities frequently are demographically similar to their neighbours and are consistently found to have a number of problems linked to the international phenomenon of rural decline and urban drift. For example, it is widely noted that rural populations have poor health status and aging populations. In Australia, multiple state and national policies and programs have been instigated to redress this situation. Yet few rural residents would agree that their town is the same as an apparently similar sized one nearby or across the country. This article reports a project that investigated the way government policies, health and community services, population characteristics and local peculiarities combined for residents in two small rural towns in New South Wales. Interviews and focus groups with policy makers, health and community service workers and community members identified the felt, expressed, normative and comparative needs of residents in the case-study towns. Key findings include substantial variation in service provision between towns because of historical funding allocations, workforce composition, natural disasters and distance from the nearest regional centre. Health and community services were more likely to be provided because of available funding, rather than identified community needs. While some services, such as mental illness intervention and GPs, are clearly in demand in rural areas, in these examples, more health services were not needed. Rather, flexibility in the services provided and work practices, role diversity for health and community workers and community profiling would be more effective to target services. The impact of industry, employment and recreation on health status cannot be ignored in local development.

**Key words:** Australia, community development, model of care.



## Introduction

Rural/remote dwellers have higher morbidity and mortality rates than urban dwellers, and restricted access to health services<sup>1,2</sup>. Access is impeded by limited availability of services, higher costs, workforce shortages and transport problems, coupled with a disintegrating rural infrastructure<sup>3,4</sup>.

The complexity of healthcare provision is frequently acknowledged as a problem in addressing a population's health status. Issues identified include limited collaboration across sectors; vertical funding and organisation of health services; multiple program evaluation criteria; and short-term and inadequate funding<sup>5,6</sup>. Complex policies and processes are differentially applied across the nation and there exists a lack of understanding of community context and culture<sup>7,8</sup>. Investigations into solutions are also vertically focussed and do not incorporate an holistic approach to understanding health service delivery. Efforts to improve rural health status have largely been reactive, time limited, poorly coordinated and focussed on particular professional groups or type of disease. This has resulted in uneven levels of service provision poorly related to need<sup>9</sup>.

The relationship between place of residence and socio-economic status has been examined. Social geography began with Mayhew's 1861 account of the relationship between crime and other variables such as access to education<sup>10</sup>. This work remains current and is the basis of the World Health Organisation's report, *The Social Determinants of Health*<sup>6</sup>. It argues that life chances and health status are closely linked to an individual's environment. This knowledge should influence the provision of health services and the application of health policy in Australia. However, Vinson notes that a community's internal relations and peculiar characteristics can modify (for better or worse) the most well intentioned policy or program aimed at improving the health and welfare of a population<sup>10</sup>.

To unravel these complex problems, a localised approach was adopted that valued community context and culture; and examined treatment, prevention, formal and informal support and education activities in two Australian rural locations. This project aimed to identify the peculiarities of two communities, noting the impact of health care on these, or vice versa. The project used a community development approach within a case study methodology. The objective was to determine the impact of policy processes and uneven service provision, and to identify innovation and collaboration that can inform new models of healthcare delivery.

### *Needs analysis – a community development strategy*

In western countries, community development has a history in social practice rather than health practice, in spite of being acknowledged as a healthcare strategy<sup>7,11</sup>. In Australia community development approaches are more often the province of local government or community service agencies than state or federal health departments. Community development, however, offers a strategy to develop new models of health service provision that can take an holistic view of health, promote inter-sectorial collaboration, identify and evaluate innovation, and incorporate local context and culture, providing it is methodologically and ethically sound. The following section outlines the initial stage in the community development approach: needs analysis.

*Needs identification* and *needs analysis* are two steps of a community development strategy, usually referred to collectively as needs analysis, which can identify problems faced by a target group<sup>9</sup>. The target group is linked by one or more defining characteristics, such as age, sex or location. Needs identification involves collecting information about the target group's circumstances, problems and resources. It involves making a value judgement about the relative importance of the identified needs and the way these might be met<sup>9</sup>. The findings of a needs analysis are vital for service planning because they can identify service gaps and barriers, service users, document ongoing disadvantage and provide



leverage for advocacy activities<sup>9</sup>. This is a platform for community development activity.

In community development work, the idealised approach is to facilitate the community's needs identification and analysis, subsequently allowing that community to develop suitable ways of meeting the needs<sup>12</sup>. While the ideal process is explicit, the value-laden prioritising of needs is less clear. The clues to whose needs are valued over others can sometimes be found in the definition of the target group or the definition of the issue. For example, Stevens describing needs assessment processes in the British National Health System noted a difference between the need for health care and the need for health<sup>13</sup>. The distinction is made because those who need health 'have problems with no realistic treatments'; whereas, those who need health care 'can benefit from treatment or prevention services'<sup>13</sup>. In this example, the target group whose needs are prioritised are health-service users with identifiable conditions or diagnoses that fit within a medical model of action.

Value judgements are also found in the way certain needs are prioritised over others. The word need has a moral or ethical association that implies a responsibility of others to act if the needy cannot do so. To manage the vast range of possible or potential needs of any target group, and limited resources, a system of assessing priority is required. Kretzman and McKnight<sup>14</sup> suggest that an asset-based needs assessment framework is less judgemental. However that framework assesses strengths, and this project's aim was to identify contextual deficits in health and welfare services<sup>13</sup>. The literature on needs identification commonly uses Bradshaw's typology of need allocating different weight to each of the four categories: (i) felt; (ii) expressed; (iii) normative; and (iv) comparative need, in the analysis<sup>15</sup>.

'Felt need' is the wish list of the target group<sup>9</sup>. There is a tendency in the literature to place less importance on this type of need because it is perceived to develop a list of wants that may not address the identified problem. For example, training needs assessments will ask about skill development

required to complete tasks, rather than identifying the training workers feel they need, which may not directly support the work of the employer<sup>16</sup>. Felt need may be called 'demand' because it is what people want or are willing to use if it was provided.

'Expressed need' is the measurement of the targets group's need, via waiting lists for example<sup>9</sup>. This can also be called demand. Evidence of expressed need relies on professionals keeping waiting lists, promoting particular courses of action, and may be affected by media campaigns. It is also affected by the cost of services and what people are willing or able to pay<sup>13</sup>. 'Felt need' may not be recognised as demand because it is unexpressed or devalued. Expressed need is demand identified and controlled by professionals. However, once need is referred to as demand the moral imperative disappears. 'Normative need' is that identified and expected by professionals or experts in the field<sup>9</sup>. It is shaped by their values and training about the way needs should be met. Finally, 'comparative need' involves comparing target groups in different areas to each other. This presumes a judgement is formed about whose needs are greater, or assessing what action to meet need is possible. Normative need and comparative need are related to supply: this is what is, or could be, provided.

Stevens suggests that supply has nothing to do with need but is easier to measure<sup>13</sup>. Supply is historically developed and may link to political imperatives and campaigns or funding and staff available at a particular time. Normative needs will be shaped by the professional opinions and work practices of those supplied to participate in the needs identification process. Comparative needs will be shaped by historical funding allocations and service development successes and failures. In the public sector, and to some degree the private sector, political campaigns, funding and work practices will be visible factors in the policies developed to meet identified needs.

To manage the tensions between an ideal community development approach, types of need, value judgements in prioritising needs and multiple target groups, a triangulated



approach to healthcare needs analysis was developed for the present project. The approach is described and the project findings relevant to the needs analysis are reported here. The project's findings on policy implementation and disadvantage will form subsequent articles.

## Methods

The project received approval from the Charles Sturt University Ethics In Human Research Committee (approval number 2007/140). A case study approach entails an in-depth investigation of an area of interest. In this case, people and services bounded by a geographical location. The project was an instrumental case study of a bounded system<sup>17</sup>. The aim was to identify what is similar about each case and also what is unique. Each case site was instrumental to understanding the issue of rural health service provision, not simply the intrinsic conditions of the site<sup>18</sup>. Both qualitative and quantitative data was collected in a case study approach to build a picture of the case, applying the conceptual framework in analysis.

*Needs identification* involves a comprehensive investigation of a community's social, cultural and physical environments; available infrastructure, existing services and supports and the collaborative relationships that exist between service providers. Several processes and types of information built the community profiles including census and global information systems (GIS) data, meetings, interviews, focus groups and documents.

Felt needs were defined as any statements by research participants who live in the community about anything they believed would improve their health or wellbeing, service gaps, access problems, networks and supports.

Expressed needs were defined as reports by health and community service workers of waiting lists and requests for services that could not be met. Also noted were records of need identified by community and government planners,

lobbyists and media. Needs reflected in policy directives or goals were also defined as expressed needs.

Normative needs were defined as statements by research participants who were health and community service workers about the needs of their service users in the case study community, and about any difficulties encountered in service provision.

Comparative need was defined as the difference in need between the two case study sites identified by census data, GIS mapping of facilities and infrastructure and participant reports of past development and funding of services, services available, service gaps and problems. Also noted were positive views of the community, services, networks and facilities.

### *Sample*

The two research sites were in central west New South Wales and named 'Seventy' and 'Thirty'. The towns were chosen because they were superficially unremarkable small rural towns with health and welfare services including a hospital, community health centre and community agencies. Neither has a large Aboriginal or immigrant population, no major tourist attractions or industries and neither are remote from a regional centre.

Seventy had a population of approximately 1750, and Thirty had approximately 1550 residents according to local government statistics. The 2001 census statistics used in this project record Seventy and Thirty as having 1512 and 1563 residents, respectively. Both towns are in the same local government area (LGA) with the main council services located in Thirty. Seventy is on the edge of the LGA and the southern side of the town is in the adjacent LGA.

Each town is surrounded by several smaller villages with populations ranging from 50 to 800 residents in an agricultural region. The nearest large regional centre to each town (population 40 000) is 38 km from Thirty and 72 km from Seventy. Another town of 8000 residents is



approximately 35 km from Seventy, providing shopping, sporting and some health and welfare services to Seventy residents.

## *Data collection*

GIS data mapped town facilities and infrastructure, population health data and socio-economic disadvantage trends to specific localities within a community. Services, community facilities, businesses and industry were identified. Examination of community profiles from national census data identified socioeconomic indicators of each community. This was compared with Vinson's report on Australian disadvantage<sup>19</sup>.

Policy and funding documents from several health-focussed state and commonwealth departments mapped the parameters of health and health-related service provision available to the community. Interviews were conducted with policy advisers and managers about the role and implementation of policy in rural areas, including what services were intended to be delivered, how and where.

Qualitative semi-structured interviews and focus groups were undertaken with existing community groups to identify felt, expressed, normative and comparative needs. Existing community groups were those that met regularly for work and social purposes. Groups participating included the service group Rotary, mothers' groups, a toddlers' playgroup, school staff meetings, and health and welfare workers' staff and interagency meetings. It was central to the methodology that the participating groups had community knowledge, not necessarily specific health or welfare needs or experience.

Participants were asked about their experiences of health services, what unmet needs they had, and what they hoped would be available in the future. Service providers were asked an additional question about innovative service delivery models.

Interviews were conducted with four individuals and eight focus groups and were held in each town during March, April and May 2007. A total of 128 community members participated in the qualitative data collection, 57 from Thirty and 71 from Seventy. Focus groups were held with existing community groups at their usual meeting place and time. This included local health and community service workers. An additional seven participants who provided health and health-related services, and policy development or implementation were interviewed about service provision in each town. Interviews and focus groups were recorded as minutes and on a digital voice recorder. Minutes and files were transcribed into Microsoft Word documents.

## *Data analysis*

*Needs analysis* involves identifying policy and funding impacts, service gaps, potential collaborations, evaluating innovative projects and prioritising the identified needs based on community characteristics. The analysis is informed by primary healthcare goals of improving all the population's health via health promotion and prevention activities and access to treatment; community development processes including identifying felt, expressed, normative and comparative needs; and by prioritising the needs stated by community members.

The research team examined the data for statements about need, service deficits and problems from the perspective that health care is a basic human right and that ease of access is the key to upholding that right. The researchers were also keen to note any innovative and/or successful means of service delivery and positive aspects of health care in the case study towns. However, consistent with the methodology, examples from the case study sites were seen to be instrumental to health service delivery in rural areas, not just intrinsic to the site.

Statements from the transcribed interview and focus group records were separated into the four needs categories in a deductive analysis and stored in NVIVO.



## Findings

### *Felt needs*

The two communities felt needs were similar but varied across age groups. Overall participants valued the health services they had locally and perceived them as effective, although some gaps were identified in treatment services and community facilities. Mental health services were most frequently identified as inadequate and ineffective. A number of research participants were concerned about suicide among depressed farmers. Support for young people with mental illness was described by participants as 'non-existent'.

Children and elderly people were reported to have the greatest need for health services. Services frequently noted as needed for children included speech pathology and occupational therapy. For elderly people podiatry was specifically noted. Parents had difficulty accessing assessment services for children locally, usually because positions were vacant or limited to part time. Treatment services were described as even more limited. If a child had a disability or required specialist intervention it was frequently not available locally but supplied by a regional or urban service provider. Sometimes these providers visited the town, or children were expected to travel to them.

Following a diagnosis, parents were often unsure of the best means of intervention or what options were available to them from a range of providers in other areas:

*I knew [son] had a problem. He's nearly four and we've just been told he's autistic after two years of trying to find out. I don't know what to do now, what that means. There's services, but they're not here and they do different things. What's best?*

Elderly people experienced similar problems, often requiring treatment in regional centres or urban areas for serious and chronic conditions related to aging. This group appears more

likely to travel for treatment services that are never available locally, specialist medical advice and procedures and cancer treatment, for example. While aged care residential facilities were well regarded, elderly people outside these services stated they did not like to ask for services or know what to ask for.

Many people with high needs for information, emotional and financial support and treatment for chronic conditions said they did not put pressure on service providers, agencies or government departments to address their needs. Reasons given for this were a lack of skills, energy and other resources to do it. However, it was also because of stoicism and the attitude well expressed by one woman (and echoed by others) of *I'm not a wantier*.

Transport was identified as a need for some groups and at some times. Transport for work and social events was identified as a need for young people, and the risk of motor vehicle accidents was a concern for parents. Travelling to access work, social activities, school, shopping and so on is an accepted part of living in a rural area. However, schedules are frequently planned around expected trips to minimise costs and travel time.

Illness was described as a drain on financial and emotional resources. Unexpected and/or frequent travel for treatment services increased costs and required significant time away from work or caring responsibilities. Some people reported limited personal resources for this. Some participants reported accessing urban services to be additionally stressful because of their unfamiliarity with and nervousness in the city. For example:

*I chose to have radical surgery in [nearby town] rather than spend weeks going to Sydney for radiotherapy. I couldn't afford that, I didn't want to do it so I had the surgery. Maybe not the best option, but I'm still here aren't I?*



Most participants valued their local doctors, expressing concern that they might leave the town and not be replaced. While stating, 'we're lucky to have two [doctors in town]' participants did not say they needed another one. When asked in several focus groups if they did need another doctor, responses indicated this was impossible to consider. For example: 'We've got two, some other places haven't got any. We're doing all right'.

A frequently noted need was return of local control of health services. Many participants attributed their current good health services to past actions and planning by the (now disbanded) local hospital board. For example:

*Ever since we lost the hospital board we've lost a lot of things. No one cares what happens locally and there's no way of being involved. If we still had the Board no one would take the hospital.*

Other felt needs that were frequently reported were development of industry to replace diminishing agricultural holdings, employment and recreational opportunities for young people and exercise facilities. Lack of recreational facilities was frequently identified as problem in the case study towns. Several participants noted that facilities had closed because of insurance costs, and that sporting teams, particularly for young people, no longer existed. For example:

*We used to have soccer, rugby, netball - all those for all age groups, now there's only one rugby team this season and we all travel for kids sport.*

*We had a gym for a while but it cost too much to run. Even the motel resort place out the road that used to let people use the pool and equipment stopped because of insurance costs. Tennis was a place to get together but we couldn't collect enough to cover the costs. It's all about risk.*

## **Expressed needs**

Expressed needs were identified in participant statements. However, they were difficult to clarify or quantify. For example, references were made to long waiting lists, heavy workloads and limited time and resources, particularly for proactive interventions. A speech pathologist working primarily with children noted:

*We're all generalists. We do a bit of everything. Children could benefit most by an early intervention strategy that means a team of people working together but I'm the entire team and I only work five days a fortnight. I do my best to fit people in but it's not ideal.*

Waiting lists are not formalised or accessible. They are kept by the person providing the service and only exist if there is a person in the position. No record is kept of requests for service that cannot be provided. A health service manager stated:

*We started providing a service at [town]. There was nothing much to do at first but it built up. When she [health worker] left, a gap existed and people wanted it filled. Sometimes when you provide a service you set up an expectation that wasn't there before and might not be there in a year if we don't fill the position.*

A research participant from a Division of General Practice believed that one way of recording expressed need would be via data from GPs. Information about chronic conditions, for example, is sometimes but not routinely reported because 'they're [GPs] too busy'. One research participant stated: 'I heard our doctor had 3000 patients on his books'. This was confirmed as 'likely' by the Division of GP participant.

The demand for GP services was noted by many research participants and expressed in waiting times. A GP visit in both towns required an appointment several weeks in



advance and a waiting time of three or four hours in the surgery. One participant noted:

*You have to book in being sick and wait anyway. If he gets called up [to] the hospital that will be the day gone in the waiting room.*

## **Normative needs**

Normative needs were frequently expressed as a need of health and welfare workers rather than a need of the population. For example, it was assumed the community needed the services of the agency and the unmet need was described as more work hours or funding for positions or more people to fill vacant positions. Generally the health workforce perceive they are being asked to 'do more with less'. The need to be addressed was the 'less,' which referred to work time, professional support, additional staff and their deteriorating buildings.

The community's needs were generally identified by the speciality or focus of the worker. For example, a disability support worker stated 'young disabled people need appropriate support services' and a family worker stated 'we need more support for families with young children'.

Government departments funding health and welfare agencies require services to be provided in certain ways, called service models. The model directs the type of activity the worker does and the amount of money it should cost the funding body. For example:

*We have to do social support, that's the big thing we have to report on - units of support. That means there is some things we can't do. If a client asks us to do some shopping for them, we can take them shopping but we can't shop from a list. If they need that they have to go to HACC [another agency serving the same client group].*

However, the workers are not sure if their local population's needs match those identified by the funding body based on a state or nationally defined need. For example:

*I: What are the health needs of this community?*

*P: We need to target obesity, that's the current health focus*

*I: how many people in town are obese?*

*P: I don't know*

Some service gaps reflected system problems. For example:

*The hospital in [town] should refer them to us so we can follow up. Half the time I see someone down the street and they say 'my sister's out of hospital now. Are you going to see her?'*

Health workers reported some problems in matching client needs with the service they provided. This was usually expressed as a need. For example, 'they need to parent better', 'they need to be able to read and write', 'they need financial counselling' or 'they need someone to go there everyday to feed the kids and get them to school'. Often the need was identified as the responsibility of some other profession or a service option that did not exist. Many of the challenging needs identified were linked to a number of problems, including long-term unemployment, disability, mental illness, substance abuse or dependency and limited or no literacy.

Health worker research participants discussed the increasing complexity of cases, noting that fragmented funding and services made it difficult to support clients even when services existed. Workers reported collaborating locally by sharing information and trying to work together, but there was agreement that some problems were unable to be resolved. For example:



*It's not just the kid with the developmental delay who I see, it's mum with one too and Dad drinks and they've got no money but they could get an American Express card and a plasma screen TV. We all know that family, and the others like them. Where do you start?*

People who did actively advocate for their children or themselves and those who used multiple public services but remained socially disadvantaged were sometimes regarded as welfare dependant and overstating their needs. For example:

*They know how to work the system. They come here because there's no jobs and they can stay unemployed no questions asked.*

One exception was noted in the findings of normative needs. A community worker stated:

*Transport is not needed. Professionals always say transport is needed but there's heaps of transport.*

## **Comparative needs**

Many Seventy residents perceived Thirty to 'get more' than Seventy does. This perception arises because the local council sits in Thirty. Many Seventy research participants expressed anger about this, citing lack of an aged care hostel and limited representation on the council as evidence of being 'ignored'. For example:

*We send them off all enthusiastic [elected local councillors] and next minute there's nothing. It was the same in the last council before the boundaries changed. We're on the edge [of the LGA] and at the end of the line.*

*We're the biggest town in the council and we get nothing.*

Community profiles of each town from the 2001 census show similar levels of population, income, educational attainment, home ownership, ethnic and religious mix and family make-up<sup>20</sup>. However, Vinson's report into disadvantage by postcode found that Seventy was significantly more disadvantaged than Thirty<sup>19</sup>. Vinson's measures of disadvantage include, among others, reported child abuse, early school leaving, long-term unemployment, imprisonment and low income. The southern part of Seventy is in a different LGA from other parts, complicating any statistical picture of the population.

A closer examination of the 2001 census statistics revealed Seventy has 80 more single parent families than Thirty does, and that Seventy has approximately 200 more people on incomes below \$200 per week. There is no public housing in Thirty. There is public housing in Seventy and a number of families are reported to be living in the caravan park. Thirty's caravan park has '2 or3' permanent residents, described as elderly single men.

Research participants from Thirty reported little or no disadvantage in the town, perceiving that disadvantaged people moved to the smaller villages surrounding the town and further from the regional centre because rents were cheaper. Research participants from Seventy perceived some unemployment and substance abuse to exist in the town, and noted people moving from other larger towns. This was often attributed to the drug and alcohol residential rehabilitation centre established approximately 15 years ago that can accommodate up to 20 people. Workers from this centre noted that most people attending the centre had been in jail and had multiple problems to address. However, while approximately 30 of their graduates continued to live in the community, the majority of people attending the centre leave the town after leaving the centre.

The centre's ex-residents were not perceived to need any particular health services. Current residents were described as frequent users of the town's treatment services, particularly the doctor and the pharmacist. They were also noted to need employment (including literacy) and social



skills, although these were not provided by the centre because of funding cuts, or from elsewhere in the town.

Public and private health services in Seventy are highly regarded by research participants. They described a large community health centre that provided eighteen different types of services or interventions from resident and visiting workers. The services are provided in the centre, by outreach to smaller villages, in the hospital and during home visits. The town also has a hospital served by the two local GPs that participants described as meeting their needs for general treatment and assessment of illnesses and injuries. A number of research participants reported the GPs undertaking special training to meet gaps in service provision. For example:

*...he's a frustrated psychiatrist. Mental health is no good so he did a course and now he does all that stuff and the other doctor does the family stuff.*

The health centre provided comprehensive primary health services to the elderly population including social and physical activity groups. Seventy also has a 'men's shed'. This is described as a facility for unemployed and retired men to meet and engage in self-directed activities that usually involve making things from wood. The shed is funded and supported by the council, but research participants report the planning and establishment is the result of a community health worker's efforts.

Thirty had a devastating flood in 2004 from which the community is still recovering. As well as an emotional cost described by research participants, the flood damaged health service sites and subsequently limited services. Community health centre staff described the premises at the hospital as inadequate in mid-2007, although community nursing and some allied health services continue to operate.

Thirty research participants were mostly positive about the health services in the town, although many noted a long-standing and well known dispute between the local GPs that is perceived to have a negative effect on services in the

town. The effects are said to include nursing staff leaving the hospital and townspeople seeking care outside the town. A number of participants also reported being sent to a regional centre after presenting at the hospital for treatment.

Childcare was identified as a need in Seventy but not in Thirty, although that town had more young families recorded in 2001 census statistics, and no long day-care facilities. Both towns had a preschool operated by a community management committee. Thirty has a highly regarded dentist. Seventy has not had a dentist since the last dentist died 10 or 12 years ago. Thirty had some facilities, such as wheel chair ramps, for people with a physical disability. Research participants stated this was because one woman lobbied strongly for the facilities because she has a son in a wheelchair.

The Area Health Service provided data on hospital separations during 2006 (discharges or deaths) showing a higher number of separations from other hospitals for Thirty residents, while Seventy residents appear more likely to be treated locally. A comprehensive analysis of factors affecting these data, such as type of disease treated, has not been conducted.

## Discussion

Local health and community services in small communities are primarily the result of historical decisions about funding allocations. While there is an expectation of treatment services, particularly in towns that have a hospital, other prevention and support services are gratefully received but rarely demanded. It is likely that many felt needs will not be addressed because the people who are the neediest are the least able to advocate for themselves. Some may also consider it culturally unacceptable to demand assistance from public funds. The research participant who 'chose' to have radical surgery instead of treatment in Sydney did not have the resources to weigh both options equally. His need for treatment became a problem of supply not demand.



Actions to meet needs are determined by people passionate enough to work for them. Their voices might be heard in lobbying, fund raising, committee membership, funding submissions lodged, or participation in management, planning and service delivery processes. The result of action is a drug and alcohol rehabilitation centre or a men's shed or wheelchair ramps in the footpath, for example. These are not consistently supplied according to some system of allocation, nor are they supplied because one community needs them more than another. Expressed needs are an unreliable source of information because they only measure demand for the services that exist or recently existed. If there is no expectation of a service there is no demand for it. There is an expectation of GP services and the need expressed in waiting times was consistent in both case study towns. What interventions are subsequently required is unknown. The possibility of those interventions being provided by someone else, such as a nurse practitioner or mental health worker, cannot be assessed.

Inconsistent or non-existent record keeping about unmet requests for service limits the validity of expressed needs. The likelihood that those in small rural towns will travel to access services dilutes the expression of need. If travel is required and the need becomes financial assistance rather than service provision, recording or measuring the need again becomes problematic. Community transport services and travel assistance schemes measure supply not the needs of all who travel for services.

Normative needs capture the work practices of health and community workers. There is a tendency to assess need according to the client group serviced and therefore somewhat unreliable. For example, the community workers who perceive no need for transport services work with single elderly people who are the main users of the community transport and hospital transport services. The transport needs noted as felt needs of other age or ability groups in the community are not visible to them, nor are the transport needs of elderly people who are cared for by family.

Health and community workers frequently described needs for more working hours or more workers. They could clearly identify ways they could improve their service delivery in the community, particularly by being proactive not reactive. These practices could be assumed to have a positive impact on the communities' health status. However, some more immediate needs could not be met. These needs were often related to the worker's reason for interaction with someone, but not within their role to meet.

Identifying a need for support, for families, for example, is one part of a process and does not determine the type of support that might be delivered. Availability of a type of service depends on what is supported by funding bodies and the ability of local services or the community to implement them. While holistic assessment and working together are generally agreed on principles of the local agencies and workers, competition policy and strict reporting requirements linked to service models are singular and inflexible systems of funding. This approach is not concerned with meeting local need. Nor is a cost-efficient service necessarily an effective one.

The findings of comparative needs highlight differences in services unrelated to need. This is not surprising given the inflexibility of funding and service models and the historical development of services. What is highlighted, however, is the way distance affects service use and potential need. Research participants from Thirty were mostly willing to travel to access specialist services, for work opportunities and to get anything they couldn't get locally.

While only 30 km more distant from the same regional centre as Thirty, Seventy had a more active health centre, a more active hospital, more specialist community services and more reports of problems related to transport and access to specialist and support services. It also had more socioeconomic disadvantage and reported crime, more limited employment opportunities, more reported need for services and concern about the future.



## Conclusion

The overall picture developed from the needs analysis is one of poorly resourced limited services patching up the health of their community as best they could. Active and effective services rely on the energy and experience of the workers, while the community is grateful for anything they can get and unlikely to demand more.

There is no systematic way of profiling a community and identifying their needs, consequently services and facilities vary. The part-time, fragmented services trying to do everything cannot be sustainable for the funding bodies, in spite of the limited resources allocated to them. Nor are they sustainable for the individuals in the positions who may be isolated and frustrated at the limitations they experience.

While some services, such as mental illness intervention and GPs, are clearly in demand, more health services are not needed. Rather flexibility in services provided and work practices, role diversity for workers and community profiling to target services would be more effective. More importantly, as isolation from regional centres increases, the community's need for industry, employment and recreational activities may do more for health than health services could.

There are two solutions suggested for developing and implementing models of health care. The first solution is to identify needs more effectively. This requires consistent and concerted efforts to collect community information in a systematic way. If all healthcare providers are involved in profiling the health and welfare needs of the population, the needs can be effectively assessed and inform planning processes.

The second solution to healthcare provision is more significant and broader. The application of human rights standards to rural healthcare provision can remove political imperatives and lobbying from the funding process. Ideally this means developing long-term healthcare plans based on human rights principles that will be supported by all levels

of government. This leadership model will provide structure and guidance. It will not require the most disadvantaged members of communities to lobby for care they are entitled to.

## References

1. Campbell A, Manoff T, Caffery J. Rurality and mental health: an Australian primary care study *Rural and Remote Health* **6**: 595. (Online) 2006. Available: [www.rrh.org.au](http://www.rrh.org.au) (Accessed 26 November 2007).
2. Welch N. 2000 *Understanding of the determinants of rural health*. (Online) 2000. Available: [http://nrha.ruralhealth.org.au/cms/uploads/publications/03\\_welch\\_00.pdf](http://nrha.ruralhealth.org.au/cms/uploads/publications/03_welch_00.pdf) (Accessed 5 March 2005).
3. Alston M. From local to global: making social policy more effective for rural community capacity building. *Australian Social Work* 2002; **55**: 214-226.
4. National Rural Health Alliance. *Health and rural infrastructure. Inquiry into Infrastructure and the development of Australia's regional areas*. Submission to House of Representatives Standing Committee on Primary Industries and Regional Services. Canberra: NRHA, 2005.
5. WHO. *Community participation in local health and community participation*. (Online) 2005. Available: <http://www.euro.who.int/document/e78652.pdf> (Accessed 6 July 2006).
6. WHO. *The Social Determinants of health: The solid facts*, 3rd edn. (Online) 2003. Available: <http://www.euro.who.int/document/e81384.pdf> (Accessed 6 July 2006).
7. Australian Primary Health Care Research Institute. *APHCRI home page*. (Online) 2003. Available: <http://www.anu.edu.au/aphcri/> (Accessed 6 July 2006).



8. Mahmood M, Moss J, Karmiliani R. Community context of health service development: Implications for health sector reform in Pakistan. *Eastern Mediterranean Health Journal* 2003; **9**: 464-471.
  9. Alston M, Bowles W. *Research for social workers*, 2nd edn. Sydney: Allen & Unwin, 2003.
  10. Vinson T. *Community adversity and resilience: the distribution of social disadvantage in Victoria and New South Wales and the mediating role of social cohesion*. Richmond, VIC: Jesuit Social Services, 2004.
  11. Kahssay HM, Oakley P (Eds). *Community involvement in health development: a review of the concept and practice*. Geneva: World Health Organization, 1999.
  12. Ife J. *Community development: creating community alternatives - vision, analysis and practice*. Melbourne: Longman, 1995.
  13. Stevens A. *Health care needs assessment*, vol 2: the epidemiologically based needs assessment reviews. London: Radcliffe, 2005.
  14. Kretzman JP, MacKnight JL. *Setting the direction of community assessment*. (Online) 2007. Available: [http://www.acphd.org/AXBYCZ/Admin/DataReports/07\\_step3\\_direction.pdf](http://www.acphd.org/AXBYCZ/Admin/DataReports/07_step3_direction.pdf) (Accessed 30 October 2007).
  15. Bradshaw J. A taxonomy of social need. *New Society* 1972; March: 640-643.
  16. Bee R, Bee F. *Learning needs analysis and evaluation*. London: Chartered Institute of Personnel and Development, 2003.
  17. Stake RE. *The art of case study research*. Thousand Oaks, CA: Sage, 1995.
  18. Stake RE. Qualitative case studies. NLY Denzin (Ed.). *The Sage handbook of qualitative research*, 3rd edn. Thousand Oaks, CA: Sage, 2005; 443-466.
  19. Vinson T. *Dropping off the edge: the distribution of disadvantage in Australia*. Canberra, ACT: Jesuit Social Services/Catholic Social Services, 2007.
  20. Australian Bureau of Statistics *Population Census 2001*. Available: [www.abs.gov.au](http://www.abs.gov.au) (Accessed 30 October 2006).
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