Using Evidence Based Needs Assessment to Lead Change in a Small Rural Community

Frank Evans, Mary Hoodless

5th National Rural Health Conference
Adelaide, South Australia, 14-17th March 1999
Proceedings
INTRODUCTION

The National Rural Health Strategy (1996), states that it is vital that health care providers understand the links between the health needs of rural Australians and the direct causative and underlying factors that contribute to the relative poor health of rural communities. Multi-Purpose Services (MPS), being highly flexible services, are well positioned to achieve this link between need and service provision. In order to achieve this the Upper Murray Health & Community Services (UMH&CS) developed and implemented a model of evidence based needs assessment, combining a socio-demographic, epidemiological and community consultative approach based on national and local priorities. The need for a high prevention, high support based model was identified, being most evident in terms of the increasing rates of illness and disability associated with ageing, rural living and socio-economic status. In addition, the need for acute services was identified through case studies and the community consultation which involved a high level of information exchange through community meetings. The community valued health promotion and support services in the home ahead of local access to ‘hospital’ services, and in particular wanted to retain diagnostic and minor surgery and maternity services (Evans, et al, 1997). As a result of this UMH&CS Board made a commitment to maintain maternity and surgical services and allocated up to $130,000 for capital works and skills maintenance to provide safe, high quality surgical services in Corryong. Despite this significant commitment to acute services the ‘down grading’ of the maternity and surgical services was put forward by Corryong’s three General Practitioners as the reason for leaving Corryong at short notice. This action required UMH&CS to take responsibility for general practice services in Corryong and Khancoban and a quality service has been maintained, despite what has been described as a critical shortage of rural doctors in Victoria and public statements from the Rural Doctors’ Association and the North East Victorian Division of General Practice that quality, Australian doctors would not be attracted to the town.

This paper builds on the above discussion and describes how UMH&CS, as an MPS, has been able to combine an evidence based service mix with community identified priorities, to lead change consistent with the primary health care strategies espoused by the Ottawa Charter and the National Rural Health Strategy as revised from time to time (AHMC,1991; AHMC,1993; AHMC,1994; AHMC,1996). The paper describes how this has been achieved whilst providing...
local access to an appropriate range of acute services. It is argued that the change process has been hampered by significant resistance from strong rural lobby groups such as the Rural Doctors’ Association of Australia (RDAA). In addition to this, ill informed comments and press releases from the National Rural Health Alliance (NRHA) added to the misinterpretation of events in Corryong at both a local and national level. The intention of this paper is not to lay blame, as there is no blame to be laid. Rather, it is intended to highlight the need to acknowledge and deal with the differences that have arisen between rural doctors and rural health services undergoing reorientation to a service with a primary health care, population health focus.

THE RURAL DOCTORS’ ASSOCIATION OF AUSTRALIA & MULTI-PURPOSE SERVICES

Rural health has received prominence over the past decade. An enormous amount of literature now exists on rural health status and rural health service provision. However, prior to 1990 little was known about the health of rural Australians (Humphreys and Rolley, 1991, p.ix). The formation of the Rural Doctors’ Association of Australia heralded a new era for rural health. The RDAA was able to focus the attention of the Australian Health Ministers’ Conference (AHMC) on rural health through the Australian Health Ministers’ Advisory Council (AHMAC) Rural Task Force. Three important government initiatives that can be attributed to the lobbying power of the RDAA were the introduction of the Rural Health Support Education and Training (RHSET) program, support for 1st National Rural Health Conference and ultimately the formation of the non-government, National Rural Health Alliance (Charter cited in Craig, 1991, p.i). In his opening address to the 1st National Rural Health Conference, the Federal Minister for Health, Brian Howe, (1991,p.19) acknowledged the role of the Rural Doctors’ Association in putting rural health on the national agenda. The Minister also used this address to flag a commitment to develop integrated processes and structures between all three levels of government and stated his personal commitment to the development of more versatile service types. In addition to espousing the benefits of the MPC program, the Minister flagged the need for, and Commonwealth commitment to, increased funding flexibility to improve the range of service provision to rural communities based on social justice principles. In effect the Minister flagged a commitment to what would become known as the MPS Program (Howe, 1991,pp. 20-21).

In June 1990 AHMC recommended that the Australian Health Ministers’ Advisory Council (AHMAC) set up a special sub committee to look at the problems of rural general practice and make recommendations to overcome the problems. The AHMAC Rural Health Care Task Force was established by AHMAC. The terms of reference of this committee were broadened by AHMAC to address the broad issues in rural health care in addition to general practice. The main recommendation of the Task Force was to propose a consultative mechanism and process for the development of a national rural health strategy
for consideration by the AHMC in 1991. The outcome was support for an RDAA sponsored 1st National Rural Health Conference as the vehicle for the development of a National Rural Health Strategy. The National Rural Health Strategy was essentially the vehicle for establishing and progressing the MPS program. Multi-Purpose Services were described by the first and subsequent National Rural Health Strategies as flexible and integrated health services capable of responding to the health needs of rural communities based on primary health care principles (AHMC, 1991; AHMC, 1993; AHMC, 1994; AHMC, 1996).

The MPS program has been supported by both Federal and State Labor and Coalition Governments, the National Rural Health Strategies and National Rural Health Conferences and has seen budgetary support over time increase the program from an initial seventeen pilots in 1992, to approval and funding for a total of one hundred and twenty MPS in the 1998/99 budget (Commonwealth Department of Health and Family Services, 1998, p.1). The development and introduction of the MPS program was a bold and innovative initiative. The program requires agreement between the Commonwealth, States and individual communities to a level of funding originating from a number of different program sources. The minimal reporting requirements and locally determined service mix means that both levels of government effectively delegate their purchasing responsibilities to the community through the MPS community board of management. As such the ability of an MPS to be successful is dependant on its ability to provide services that meet the genuine needs of the community within a framework of community participation. Given the level of support for the program it would have been reasonable to expect that the major challenges for the MPS program would be the joint State and Commonwealth funding and management arrangements required to set up the overall program and the process required to determine the funding pool for individual services. In fact the Commonwealth and the States have overcome these potential problems through a commitment to the program and flexible funding arrangements. Despite success at this level, the literature and anecdotal evidence suggests the introduction of the MPS program, in Victoria at least, has been an extremely difficult process with varying degrees of success due, in the main, to stakeholder resistance at a number of levels. (Wolley, 1997, pp.272-273; Sheehan, 1997, pp.70-74; Centre for Ageing Studies et al, 1995, p3; Keating & Calder, 1997).

EVIDENCE BASED NEEDS ASSESSMENT

The National Rural Health Strategy Update 1996 identifies key issues for rural health services. One issue relates to health care needs. The Strategy states that it is vital that providers understand the links between the health needs of rural Australians and the direct causative and underlying factors that contribute to the relative poor health of rural communities. The Strategy draws attention to the need for integrated, flexible funding models that can facilitate the development of services with a primary health care, population health focus.
UMH&CS as a Multi-Purpose Service represents an integrated, flexible service with the ability to shift resources to meet community needs. MPS have a responsibility to their State and Federal governments to adopt a primary health care, public health approach to service delivery that maintains a population health focus. Our challenge was to develop further our needs based model of service planning to achieve a high level of allocative efficiency within a framework of social justice and equity. UMH&CS utilised an evidence-based approach to its second comprehensive needs assessment, required to continue in the MPS program. The second attempt utilised case studies to identify the health and community service needs of the Upper Murray community. UMH&CS combined the use of demographic and epidemiological profiles and the identification of effective and cost effective services in conjunction with community consultation, including key stakeholders and general practitioners, to identify community priorities for service provision. In other words UMH&CS objective was to improve allocative efficiency through the identification of interventions that would produce the best results in terms of individual or community health gains (Evans et al, 1997, p.13).

Results of the needs assessment were interesting in that evidence was produced to support a reorientation of the service based on primary health care principles, whilst acknowledging the need for local access to acute services. Of equal interest was the consistency of the evidence produced from both the quantitative and qualitative aspects of the research. The community valued health promotion and community and home based support services, ahead of hospital services. The needs assessment proved that in the Upper Murray at least, individuals are capable of making informed choices that reflect their needs (Evans, et al, 1997, p.13). The needs assessment resulted in the Board of Management approving additional resources for: health promotion; community development; public and environmental health; counselling; and home care services. In addition to this the Board allocated funds for GPs and Midwives, to maintain an under utilised maternity service and capital funds to upgrade theatre and sterilising infrastructure to maintain minor surgical services. The Board did not approve a major capital works program that would have enabled an additional 15-20 major operations per annum. This information was made public through a mail out to individuals who participated in the consultation and through the local newspaper via a series of press releases and was received without incident.

GENERAL PRACTITIONERS LEAVE CORRYONG

It was not until some months later, when the local doctors refused to accept the change in service mix and threatened to leave the community, that community resistance emerged. With support from the local member for parliament, the doctors organised a community meeting, attended by approximately 500 people. At the meeting the doctors said they would be leaving the community and would not stay until replacements were found. (Corryong Courier, April 8, 1998, p.1). What was in essence a significant improvement in service mix was put forward
by the doctors as an unacceptable reduction in acute services. The doctors were represented by an Industrial Officer of the RDAA, who claimed that suitable doctors would not be recruited to replace the existing doctors due to the lack of acute services. This meeting was the beginning of a six month campaign by a small, yet powerful lobby group, supported by the RDAA, to attempt to force the MPS to provide major surgery in sub-standard facilities, without appropriate support services or post operative specialist support. The same RDAA Industrial Officer went on to publish an article in *Bush Alert*, the rural newsletter of the Royal Australian College of General Practitioners, entitled “How to Destroy a Country Practice” (Graham, 1998, p.5). The article claimed that the first step in destroying a country practice is to implement:

…a policy (MPS) dreamed up by Health Bureaucrats and adopted by Government with no consultation with rural people and certainly NOT with rural Doctors. The premise: aging population = predominant emphasis on aged care services and community health. Therefore reduce range of acute services and acute beds (Graham, 1998, p.5).

The fact that UMH&CS has supported a maternity service providing 15-20 deliveries a year with a $20,000 - $30,000 recurrent training fund and a $100,000 theatre upgrade for approximately 150 operations a year, was lost in the adverse publicity (Corryong Courier, April 22, 1998, p.1; Corryong Courier, April 8, 1998, p.5). The National Rural Health Alliance (NRHA) made public statements citing the “Corryong Situation” as a reminder of the need to support rural doctors (Tattam & Vale, 1998). Subsequent to all three local doctors leaving UMH&CS assumed responsibility for general practice services, took over the management of the medical clinic and has employed three highly qualified, Australian trained doctors to provide general practice services to the community (Border Mail, September 2, 1998).

RURAL DOCTOR RESISTANCE TO MPS INITIATIVE

Corryong is not the only Victorian community to experience resistance from rural doctors as it implemented MPS and attempted to reorientate it service. Sheehan, 1997, (p.69) states that the Apollo Bay community realised in 1993 that its hospital was in jeopardy under casemix funding. Sheehan describes a community that embraced the MPS program through a steering committee that was comprised of representatives from all the major health and community service providers in the district. Sheehan claimed the steering committee was committed to developing a flexible, integrated health service capable of meeting the needs of the community (1997, p.70). The change process in Apollo Bay was not without its difficulties. Sheehan states that assuming the pilot would enjoy the full support of total community was:

…perhaps the greatest error in judgement Apollo Bay made...it was without doubt the resistance to accept this new model by the two longest servicing Medical Practitioners in town that contributed to much of the angst and dissension within the community. This culminated in a bitter dispute between these doctors, their supporters and the protagonists of the MPS.
The outcome of the dispute was that the doctors remained in the community though resigned from their VMO positions. The CEO and his family left the community following a period where he and his family required professional security precautions following serious threats to their safety.

Alpine Health located in Myrtleford, Mt Beauty and Bright, has also experienced significant community resistance to the program, led by local medical officers. Following the appointment of interim management in 1998, an attempt was made to reshape the service and achieve a higher level of service integration. Once again this led to a series of community meetings where the local medical practitioners dominated the debate citing a down grading of acute services as unacceptable and that they would leave the community if they could not continue to use all their procedural skills (Border Mail, October 12, 1998, p.9). The head of the North East Victorian Division of General Practice and the Secretary of the RDAA, only weeks after resigning as President of the Board of Alpine Health MPS, publicly criticised the MPS model in his role as RDAA Secretary, stating that, “the doctor shortage in the rural Victorian town of Corryong should sound a warning to small communities across Australia where multipurpose health management is being considered.” The RDAA Secretary went on to say that, “The idea (MPS) is to save money by grouping them (services) together and thereby keeping the whole thing running, but the problem is that the multipurpose system focuses on aged care and neglects acute care services” (Vale, 1998).

CONCLUSION
The MPS program has been well supported financially and is the product of good policy driven by powerful rural lobby groups and forward thinking bureaucrats. Unfortunately it is the same rural lobby groups and in particular the RDAA, that have contributed to the difficulties experienced in implementing the program in Victoria, despite continued strong political and bureaucratic support for the MPS initiative. The expansion of the program continues despite the lack of a comprehensive evaluation and a strong resistance to the program from many service providers and communities (Border Mail, 20 April 1998; Australian Doctor 19 June 1998, Australian Doctor 10 July 1998; Graham, 1998, p.5; Keating & Calder, 1997). UMH&CS needs assessment has produced evidence to support the recommendations of the National Rural Health Strategies and National Rural Health Conferences as they relate to flexible integrated service models with a primary health care, population health focus. However, the dichotomy that exists between the needs of service providers, and in particular rural doctors, and the changes required to develop integrated, flexible, rural health services requires meaningful and urgent action. It is not enough to advocate for collaborative planning and decision making, as the issues as described above are more fundamental and must be acknowledged as such. It is imperative that, within a blame free context, the causative factors underpinning this dichotomy are identified, acknowledged and acted upon. It is recommended that the NRHA, being the peak, non-government, rural health body, take a lead role in this process.
REFERENCE LIST

Woolley,T., 1997, Balancing the What We Want With The What We Need, in Proceedings of the 4th National Rural Health Conference, Canberra, National Rural Health Alliance.