

# Understanding social capital to support a primary health care approach in a socially fragmented region

Sue Kilpatrick<sup>1</sup>, Stuart Auckland<sup>1</sup>

<sup>1</sup>University of Tasmania

## Abstract

The Tasmanian health system is experiencing considerable change as it shifts toward a primary health care approach with associated restructuring of rural health services. These changes will impact significantly on small isolated and socially fragmented communities such as those on the west coast of Tasmania. This paper examines how understanding social capital can support a shift towards the community participation principles that underpin a primary health care approach. Drawing on findings from the West Coast Health Development Project the paper explores the links between social capital, community participation and governance within the context of a primary health care approach. Accepting that social capital together with physical and human capital are integral assets within communities, the paper examines how the nature of social capital influences and shapes community participation in local health service planning through the work of community health advisory bodies such as the West Coast Community Advisory Committee (CAC). Findings from the study revealed a lack of connectedness between the west coast communities and with the health policy reform agenda. This was exacerbated, in part, by a lack of understanding by community and health service stakeholder groups of:

- the key principles of community participation
- community values and attitudes towards health services
- the role of social capital in health policy reform.

The paper highlights the importance of understanding the key elements that help build social capital as a precursor to creating a more conducive climate for community participation in local health care reform.

## Introduction

The new Tasmanian Health Plan emphasises a primary health care approach, in line with international best practice<sup>1</sup>. It signals the restructuring of many rural services away from inpatient facilities toward multi-purpose community health centres<sup>2</sup>. The shift in emphasis is justified by the need to slow the increasing burden of chronic disease so as to improve future health outcomes, and reduce the associated escalating pressure on health budgets. One of several facilities earmarked for restructuring in the Health Plan is on the isolated west coast of Tasmania. The proposed restructure of the west coast health facility has implications not only for its immediate community but also for other rural communities across the west coast.

This paper draws on findings from the West Coast Health Development Project undertaken by the University Department of Rural Health, Tasmania for the Tasmanian Department of Health and Human Services in 2006 to examine how understanding social capital can support a shift towards the community participation principles that underpin a primary health care approach. Findings from the

Project provide the basis for a review of existing community based health support structures on the west coast.

## Background

Primary health care, according to the landmark Alma Ata Declaration<sup>3</sup> is first level of contact with the health system, universally accessible and delivered close to where people live and work. It is part of social and economic development and incorporates community participation in decisions<sup>4</sup>. Communities needs to be engaged in order to encourage participation<sup>5</sup>, and they should be empowered through community health development that builds social capital and the capacity of community to participate in planning and controlling health care<sup>4, 67</sup>.

Case studies of Australian rural communities have found that an understanding of rural place, including social capital, is a pre-requisite for effective health development. Community in these studies is a whole of population that shares a common identity derived from a common physical proximity. Understanding facilitates alignment between health programs and community expectations, values and norms. It assists in identifying and incorporating social capital and other community skills and assets, as well as providing information about health needs and priorities<sup>8-10</sup>.

We define social capital after Falk and Kilpatrick<sup>11</sup> as being both accumulated and drawn upon in interactions between individuals, between individuals and groups and between groups. It is the networks, norms values and related trust that facilitate or 'oil' collective action for mutual benefit. The quality or efficacy of social capital available for different purposes varies. For example, a community may offer excellent support for its elderly but not be able to resist closure of its school. By its very nature, social capital belongs to the group or collective. It has been seen as consisting of both vertical (bridging or weak) and horizontal (bonding or strong) ties. Intercommunity (or weak) ties that cross various social divides, such as between the health service and client groups, are needed to balance strong horizontal ties, for example those between groups within a rural locale, which otherwise can become a basis for the pursuit of narrow interests and exclusion of some<sup>12</sup>.

Knowledge and experience of the consumer participants and the commitment and planning of the organisation are critical to the success of consumer participation in health<sup>13</sup>. Staff and consumers should have broad knowledge of specific issues, there should be shared understanding of goals, values and priorities and of the roles of the participants (consumer and staff)<sup>14</sup>. Much of the community participation literature talks of partnerships between communities and health services, suggesting some degree of equality of power in the relationship is desirable<sup>15-18</sup>.

Government can choose the kind and extent of community participation it encourages and permits<sup>1</sup>. The process of engagement is a community development process which should recognise community diversity while building cohesion<sup>19</sup>. Common expectations and agreed goals should be established early<sup>20</sup>. The community engagement process should be consistent with established community ways of working and level of community efficacy<sup>6</sup>. It takes time to build relationships and trust<sup>21</sup>.

Social capital for the purpose of community participation in health, from this literature, belongs to both the community and the health service, which can be defined to include local organisations and State level agencies. Some elements reside within communities and within the health service, for example, bonding ties and extent of community cohesion. Others reside across the partners, for example the extent to which vision is shared and the degree of trust between the community and the health service.

A review of research on social capital and capacity for joint working in rural communities identified elements of social capacity that reside variously in communities, industry, agencies and the State, and which can be developed<sup>22</sup>. These elements are consistent with the literature reviewed above and form a useful framework for analysing the quality of the social capital available to rural communities and their health services for the purpose of implementing a primary health care approach.

- Norms and values, including a shared vision, trust, identity and reciprocity
- Knowledge and skills, including knowing how to access resources
- Skills in working together and with others, including leadership
- Interactional infrastructure, including networks, communication sites and procedures<sup>22, 23</sup>

## The west coast of Tasmania

Community for the purposes of this study is the west coast of Tasmania local government area. Its population of 5000 is concentrated in five small towns about 45 minutes apart by car<sup>24</sup>, separated by mountainous terrain that is difficult or impossible to traverse in adverse weather. Mining, fishing and tourism are the main industries. The town profiles are changing as the mining industry waxes and wanes and populations, apart from one tourism-based town, are in decline. Despite being among the highest income earners in Tasmania, at least one third of the west coast population receives some form of welfare benefit. This significant dichotomy is masked by lack of differentiation in housing and living conditions, with all residents living in similar housing regardless of income<sup>25</sup>. Educational attainment is substantially below the average for Tasmania<sup>24</sup>.

The west coast is connected to the rest of Tasmania only by poor roads, very limited bus services and infrequent, expensive light aircraft services, meaning emergency medical retrieval can be delayed and difficult and access to tertiary health services time consuming and expensive. At the time the project was conducted there were two inpatient facilities and two nursing centres in the region. Four of the towns were serviced by full or part time General Practices. Allied health services were delivered into the region from Burnie the nearest large centre, but suffered from staff shortages and discontinuity of service according to senior health department bureaucrats and local clients.

In an effort to better engage with local communities the Tasmanian Department of Health and Human Services had established a Community Advisory Committee (CAC) with one representative selected by the health service from each of the region's five towns. The CAC comprised representatives from a senior mining company staffer, a local government elected councillor, a private health practitioner, three other community representatives and the senior health department officer in the region.

## Methodology

The project assessed the existing health care capacity and physical and social characteristics of the west coast community. We undertook documentary analysis including analysis of recent reviews and community consultation reports prepared by the state government, interviews with senior local and state health staff (approximately four) and community leaders (approximately four) and a focus group with six members of the existing CAC. In view of recent community consultation by the state health department it was not deemed necessary to conduct further community interviews. Manual coding of notes taken by the researchers<sup>26</sup> against the above framework was employed in analysing the data for

the quality of the social capital available to the west coast community and the health service for the purpose of implementing a primary health care approach.

## Findings

### Norms and values

The region had a shared identity derived from isolation and cultural notions of separateness from the rest of Tasmania combined with inequity in a range of government services and a heritage of shared hardship. There were pressures on a cohesive regional identity, however, related to five discrete, previously self-reliant towns. The data revealed that the community had no vision for health care and had generally not considered health services beyond an awareness of what was currently available.

At the time of the project, the health department was attempting to coordinate and consolidate a range of previously loosely connected services on the ground in the five towns and others delivered by outreach by several government, not for profit and private providers. Related to this, the health service's vision for health outcomes, the suite of services and service delivery modes was at a very early stage of development when the study was conducted in 2006.

There was a lack of trust of the health service by the community, evidenced by interviewees' perceptions of inequitable treatment in health services compared with other Tasmanian communities, uncertainty about the future of local services, for example on the part of the CAC members, and a loss of confidence in allied health services indicated by client interviewees. Allied health services were delivered by outreach from the nearest larger centre, but were inconsistent due to staff shortages which meant many last minute cancellations and constant change of the practitioners providing the services service according to senior health department bureaucrats and local clients.

In summary, norms and values were shared by the community and the health service to only a very limited extent. The related aspects of shared vision, trust, identity and reciprocity were weak for the purpose of joint participation in a primary health care approach.

### Knowledge and skills, including knowing how to access resources

There is a strong history of volunteer involvement evidenced by organisations in the community and dependence on volunteers for provision of some essential services (e.g. ambulance, emergency services and transport). Recent difficulties in recruiting sufficient volunteers were attributed by our interviewees to an ageing population and a shift in the mining industry to workers who live outside the region and travel in for long shifts over a compressed period.

There were community perceptions that the bureaucracy did not to understand the issues the west coast faced. The inability of the health services, especially public and not-for-profits, to provide a consistent, reliable service highlighted problems with accessing resources.

The health services in the area had been based around a well established hospital in one of the population centres. At the time of the project the health service was in transition to a new hospital and a new system of service delivery that had implications for the whole region. Whilst there were very strong connections to the established hospital many residents interviewed recognised the need for a new system of service delivery but were concerned with possible implications to their community. Coupled with this, residents of the region and health workers perceived that they were not adequately informed of the future plans for health service delivery, were not adequately consulted and not involved in any decision making processes. This created a level of distrust about government consultancy

processes that continued to the time of the project. This made it difficult to engage the community in the project as they had no expectation that their views would be heard.

### **Skills in working together and with others, including leadership**

Cultural notions of separateness, inequity and a heritage of shared hardship often resulted in parochialism and community militancy that was counter-productive to change. That the CAC representation was based on town of residence rather than skills or particular interest within health exacerbated differences and feelings of distrust. However, there were articulate, capable, community-oriented leaders and activists in the west coast whose energy and commitment could be a driving force for change.

The CAC was unsure of its responsibilities and how to go about meeting them. Members lacked experience and skills in their roles, for example in how to develop strategic and communication plans and how to liaise with the community.

The state health department and its local service had provided only a partial orientation to the health service to the members of the CAC. Analysis of health service provider interviews suggested that this was due to time pressures and a feeling that the CAC was a lower priority than sorting out service delivery. There was also a feeling expressed by some senior health service bureaucrats that the health department should not be seen to be interfering with the work of the CAC. This situation created a vacuum which restricted community input.

The health department appointed a local health manager who was committed to the health service in the region, however as local skilled support for this leader was limited, the health manager was extremely busy with operational issues and change management within the service. Perhaps for this reason, we saw little evidence of a considered approach to working together on the part of the health service or the community.

### **Interactional infrastructure, including networks, communication sites and procedures**

The West Coast Council is the key 'political' body in the eyes of residents and is the major focus for communication within the community and with external stakeholders.

The CAC is a formal site for interaction around health; however partly for the reasons discussed above, it was relatively isolated from the health service. While its governance procedures and operational guidelines had been established, the CAC was not clear on how these should work in practice. Face-to-face CAC meetings were difficult at times because of the poor roads and bad weather, but electronic communication alternatives were not used due to difficulties of access or limited knowledge of their capacity and use.

There was little evidence of joint planning or visioning by the health services and the CAC. CAC meetings were often attended only by the local health manager and senior state government people from outside the region. Non state government services did not attend, despite government funding for some non government services to cover aspects of a holistic primary health care system in the region. Under the new west coast health service model the senior government health service manager was proposed to represent all State health services. There was no other formal or informal interaction between CAC members and the local health services.

It could be argued that networks for interaction for a primary health care approach were restricted within the community, within the combined local health services and between the community and the health service.

## Discussion

We found several community and health service social capital factors<sup>11</sup> that negatively affected community participation in health care decisions. Norms and values were shared by the community and the health service to only a very limited extent. The related aspects of shared vision, trust, identity and reciprocity were weak for the purpose of joint participation in a primary health care approach. Networks within the region, while perhaps effective for other purposes, were not effective for engagement around primary health. Knowledge of health needs and services, and the ability to access resources within and outside the region were inadequate for a primary health care approach. The region lacked the maturity to effectively engage in a partnership with the externally driven state health service according to established indicators, particularly local leadership, shared vision, trust, and knowledge, use and valuing of community's resources<sup>7</sup>. Community and health staff in the region did not have sufficient skills, understanding of, or time to adequately engage in a partnership<sup>14, 27</sup>. Despite attempts by the State health department to engage the community through the CAC, the interactional infrastructure<sup>23</sup> was not sufficiently resourced.

## Conclusion

Project recommendations centred on improvements to the Community Advisory Committee. To enable effective community engagement to occur the state health department should take a leadership role in clarifying the role of the CAC, restructuring its membership and developing its skills and connections to the health service and community groups. Specifically the department should:

- establish the role and functions of the CAC, including working with the CAC to develop a strategic plan and communication strategy
- include representatives with special health interests that crossed the boundaries of the five towns
- work with the CAC to upskill representatives on meeting procedures and incorporate sustainable, participatory governance practices in CAC operations
- promote the work and value of the CAC with local health service staff and develop the attitude, knowledge and skills required by key local health service staff to engage and work with the CAC
- assist the CAC to engage the west coast business community and other groups within the community.

Following our work on the west coast there was a review of the terms of reference and membership of the CAC. As a result of this review membership of the committee now includes health providers (non Health West employees). The role of the CAC has been reassessed to provide comment and advice to the Health West Service rather than seeing itself as a committee that directs local health policy. The CAC is now represented on the health advisory group for the larger region of which the west coast is a part. This will open up further opportunities for development and enhancement of social capital for the west coast.

There are lessons from the study for others attempting to engage remote communities in primary health care. Remote communities are not necessarily cohesive or ready to participate effectively in primary health care to the extent advised by the World Health Organization<sup>6</sup>. Health systems should pay attention to building the social capital resources of the community and local health services to facilitate community participation in local health care reform.

## References

1. Kilpatrick S. Multi-level rural community engagement in health. *Australian Journal of Rural* 2009;17:39-44.
2. Department of Health and Human Services. *Future health: Tasmania's health plan*. Hobart: Department of Health and Human Services, Tasmania; 2007.
3. World Health Organization. Declaration of Alma-Ata; 1978; Available from: [www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)
4. World Health Organization. Declaration of Alma-Ata. 1978.
5. Taylor J, Wilkinson D, Cheers B. *Working with communities in health and human services*. Melbourne: Oxford University Press; 2007.
6. World Health Organization. *Community participation in local health and sustainable development: Approaches and techniques*. European Sustainable Development and Health Series. 2002.
7. Kilpatrick S, Auckland S, Johns S, Whelan J. Building capacity for rural health: The role of boundary crossers in coalition maturity for partnerships with external agents. In: Doyle L, editor. *Building stronger communities: Research informing practice*. London: NIACE; 2007. p. 220-36.
8. Taylor J, Wilkinson D, Cheers B. Rural Places and Community Participation in Health Services Development. In: *Proceedings of international conference on engaging communities, 2005 14-17 August; Brisbane*.
9. Johns S, Kilpatrick S, Whelan J. Our health in our hands: Building effective community partnerships for rural health service provision. *Rural Society* 2007;17(1):50-65.
10. Nathan S, Harris E, Kemp L, Harris-Roxas B. Health service staff attitudes to community representatives on committees. *Journal of Health Organization and Management* 2006;20(6):551-9.
11. Falk I, Kilpatrick S. What is social capital? A study of interaction in a rural community. *Sociologia Ruralis* 2000;40(1):87-110.
12. Woolcock M. Social capital and economic development: toward a theoretical synthesis and policy framework. *Theory and Society* 1998;27(2):151-208.
13. National Resource Centre for Consumer Participation in Health. Information series: Methods and models of consumer participation. Health Issues Centre; 2004 11 September 2006]; Available from: <http://www.participateinhealth.org.au/clearinghouse/>
14. Berkowitz B. Collaboration for health improvement: models for state, community and academic partnerships. *Journal of Public Health Management and Practice* 2000;6(1):67-72.
15. Eyre R, Gauld R. Community participation in a rural community health trust: the case of Lawrence, New Zealand. *Health Promotion International* 2003;18(3):189.
16. Arnstein S. A Ladder of Citizen Participation *Journal of the American Planning Association* 1969;35(4):216-24.
17. Rifkin S. Paradigms lost: toward a new understanding of community participation in health programs. *Acta Tropica* 1996;61:71-92.
18. Department of Human Services. *Doing it with us not for us. Strategic direction*. Melbourne: State Government of Victoria; 2006.
19. Boxelaar L, Paine M, Beilin R. Community Engagement: For Whom? In: *Proceedings of international conference on engaging communities, 2005 14-17 August; Brisbane*.
20. De Weaver L, Lloyd D. The Language of Community Engagement in a Regional and Indigenous Context. In: *Proceedings of international conference on engaging communities, 2005 14-17 August; Brisbane*.
21. Putland C, Baum F. How can health bureaucracies consult effectively about their policies and practices? Some lessons from an Australian study. *Health Promotion International* 1997;12(4):299-309.
22. Cocklin C, Dibden J, Kilpatrick S, Higgins V, Sass J, Snell D, et al. *Social capability in rural Victoria: The food & agriculture and natural resource management sectors*. Bendigo: The State of Victoria, Department of Natural Resources and Environment; 2001.
23. Kilpatrick S, Loechel B. Interactional infrastructure in rural communities: matching training needs and provision. *Rural Society* 2004;14(1):4-21.
24. Australian Bureau of Statistics. *2006 Census QuickStats : West Coast (M) (Local Government Area)*. Australian Bureau of Statistics; 2007 [cited 2008 30 April 2008].
25. Vause L. Who cares for our health? In: *7th National Rural Health Conference, 2003 1-4 March; Hobart*.
26. Denzin N, Lincoln Y. *Handbook of qualitative research*. 2nd ed. Thousand oakes: Sage; 2000.
27. O'Meara P, Chesters J, Han G-S. Outside—Looking In: evaluating a community capacity building project. *Rural Society* 2004;14(2):126-41.

## Presenters

**Sue Kilpatrick** is Pro Vice Chancellor (Rural and Regional) at Deakin University, and Immediate Past Chair of the Australian Rural Health Education Network (ARHEN). Her research interests are rural health and community sector systems, community participation in health, social capital, rural workforce including training, and rural leadership. She is particularly interested in application of evidence-based best practice of the processes through which regional/rural communities and health and community services develop effective partnerships to help their regions prosper and to build community capacity as well as improve health outcomes.

**Stuart Auckland** has extensive experience in rural community development, having worked as project manager for a diverse range of community-developed initiatives within both the government and non-government sectors. Stuart's initial work was in the area of natural resource management prior to moving to rural health in 2000. Stuart is now Community Health Development Coordinator of the University Department of Rural Health. His research interests are: university community engagement, integrated health service models, capacity building and community empowerment/leadership, and managing partnerships, networks and alliances.