

**Title** How can rural health be improved through community participation?

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## Executive summary

Rural Australians generally experience poorer health than their city counterparts. Rural Australia is a vast geographical region, with significant diversity, where there is good health and prosperity, as well as disadvantage. The purpose of this issue brief is to provide evidence on how the health of rural Australians can be improved through community participation initiatives, which are currently being funded and delivered by health services and networks.

Rural Australians need innovative health services that are tailored to the local context and meet increasing healthcare demands, without increases to expenditure. There are community participation approaches supported by research that can improve existing practice. Avoiding duplication, including the current work of Medicare Locals and Local Hospital Networks, is important for ensuring good outcomes from community participation initiatives.

The following recommendations are made to improve practice:

- New ways to contract and pay for health services are needed, which use ideas developed with communities, within current budgets
- State and federal government competitive grants and tenders should prioritise proposals that demonstrate effective community participation approaches
- Community-based services, such as community health centres, Medicare Locals and Local Health Networks, have an important role to play in facilitating community participation, including:
  - Building partnerships between existing services and leveraging existing participation strategies, rather than developing new services or standalone initiatives – to leverage available funds and maximise outcomes
  - Employment of a jointly-appointed, paid community leadership position across existing community-based health services, to avoid duplication and overcome barriers of over-consultation and volunteer fatigue
- Formal and robust evaluation of initiatives is necessary to guide future policy and research

A national innovative online knowledge sharing portal is required to share best practice in rural community participation, save time and money on ineffective approaches, and to support the rural health workforce.

## What is the policy issue?

Rural people, one-third of Australia's population, generally experience poorer health than their city counterparts<sup>[1]</sup>. Rural Australia is a vast geographical region, with significant diversity; where there is good health and prosperity as well as disadvantage. The purpose of this issue brief is to provide evidence on how we can improve the health of all rural Australians, but particularly for people experiencing disadvantage.

Overall, rural Australians are more likely to experience poor health, and their life expectancy is up to four years lower than urban counterparts<sup>[1]</sup>. Preventable health conditions, including obesity and accidental injuries, are more prevalent in rural compared with urban areas; and there are higher rates of unhealthy behaviours, mainly risky alcohol use and tobacco smoking<sup>[1]</sup>. Suicide prevalence is high, particularly for young men and men aged over 85 years old<sup>[1]</sup>; as are rates of chronic diseases, including mental illness.

The distribution of health services in rural versus urban areas contributes to poorer health outcomes. Rural health services are generally small with fewer resources and infrastructure, but at the same time are expected to provide a broad range of services over a large dispersed area<sup>[2]</sup>. There are high demands placed on them because of fewer alternative options, high population needs and persistent workforce shortages<sup>[2]</sup>. In 2011, fewer available health professionals and limited access to specialist services resulted in an estimated \$3 billion shortfall in health service provision in rural Australia, primarily for dental, allied health and aged care services<sup>[3]</sup>. Access to timely and affordable health care for rural people is a national problem.

Commentators predict rural-urban inequities will worsen with new challenges to the health sector<sup>[4]</sup>. One reason for this is the increasing privatisation of health services, which makes it difficult for people on low incomes to access care. Health budgets are tightening, while ageing populations and the increasing burden of chronic disease are placing increasing demands on health systems and challenging current capacities<sup>[5, 6]</sup>. Recent national health reforms may go some way to improve the health of rural people. However, there is no evidence to date that they have made significant progress in addressing rural health priorities<sup>[2]</sup>. With ongoing rural health inequities and an uncertain fiscal future, it is becoming increasingly important that we find effective, affordable and sustainable ways of improving rural health.

## What is the proposed solution?

One way of tackling disparities without large increases in expenditure is to engage rural communities in redesigning health services, so they better address local needs. Community

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<sup>1</sup> We use the ABS (2011) definition of rural as "outside major cities", a geographical grouping that includes regional and remote, noting that health varies across these regions

participation<sup>2</sup> is a process of collective action, which takes full advantage of local assets and capacities, mobilising citizens to take control of health at the local level. Communities participate in a partnership with services to deliver health programs and initiatives. There are already instances of this occurring across Australia <sup>[7-10]</sup>.

National standards require health organisations to engage consumers and communities in service planning, design, evaluation and governance <sup>[11, 12]</sup>, and the majority of hospital and primary care networks are releasing community participation plans. 'Standard 2: Partnering with Consumers', found within the National Safety and Quality Health Services Standards, notes that consumer participation will improve the "safety and quality of care" <sup>[11]</sup>. Primary care reform requires that Medicare Locals coordinate primary health care services "with a greater focus on the specific needs of local communities" <sup>[13]</sup>. The aim of policy initiatives is to have consumers and communities participate in the delivery of health services they consume, and to mobilise communities to take action on local issues that impact on their health and wellbeing.

One of the challenges for health services executives charged with meeting these standards is that there is little guidance on how to *do* community participation so that it improves health outcomes <sup>[14-16]</sup>; this lack of evidence extends to the rural context <sup>[8, 17]</sup>. Experts suggest that community participation will improve outcomes for communities and health services when it is facilitated effectively, and argue that people have a right to be involved in decisions about publicly funded services <sup>[18, 19]</sup>. Drawing from the best available research, this issue brief provides recommendations on how to facilitate rural community participation to improve the health of rural communities.

Community participation in the rural context is enabled and challenged by a range of factors. There are numerous examples of successful community participation in Australia, particularly in Indigenous health, which demonstrate that it can be effective (see for example [westerndesertkidney.org.au](http://westerndesertkidney.org.au)). There are several reasons why, for instance, rural communities tend to have fewer services, therefore people have more incentives to participate in discussions about them <sup>[9]</sup>. Generally, rural communities have higher rates of community connectedness and volunteering <sup>[1]</sup>. There are longstanding traditions of community participation with small rural hospitals and health centres, particularly in times of threat and protest, or natural disasters <sup>[20, 21]</sup>. And, outside of mainstream health services, community participation has been integral to rural wellbeing through strong establishments such as the Country Fire Authority and the Country Women's Association.

Relying on strong rural community bonds alone, however, is not enough. Some rural citizens have no interest in contributing to discussions on how public healthcare services are delivered or run. Research has reported that ad hoc, informal or responsive involvement is enough in some communities; however, at the same time, some people have no desire to

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<sup>2</sup> We use Schmidt and Rifkin's (1996) definition of community participation in healthcare, "social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decision and establish mechanisms to meet their needs"

take on public healthcare responsibilities <sup>[22]</sup>. Initiatives that burden volunteers with additional responsibility run the risk of exploiting rural ‘goodwill’ and destabilising existing good community work.

Rural communities with changing demographics might encounter difficulties in facilitating community participation using traditional strategies, for example, a ‘town hall’ style meeting might be insufficient to understand broad community concerns because of the growing diversity of views and agendas. For example, ‘tree-changers’ (people who move inland from metropolitan cities seeking new life styles and opportunities within regional Australia) might have different ideas about local hospital priorities than farming families with young children, or newly-settled refugees. And finally, because rural people have past experiences of services being withdrawn, it is understandable that participation approaches implemented by public institutions may be met with suspicion and resistance.

There is little guidance for health services on how to effectively facilitate community participation in meaningful ways that results in positive outcomes. Without evidence, there is a risk that tokenistic methods or a ‘tick box’ approach will be used to meet legislation and standards on community participation. The challenge policymakers face is finding best practice approaches to community participation that can be implemented across rural Australia, which improve the delivery of services and health outcomes for rural people.

### **Best practice approaches to community participation**

The following strategies for effective community participation have been developed from research currently being conducted by the La Trobe University Rural Health School (refer to *Building Healthy Rural Communities Research* page 13 below for more details). A case study of community participation in Canadian food programs and initiatives, including a national food security network, a provincial-level food and farming alliance and several local community gardens and kitchens, reveal a number of effective participation strategies. The findings of this case study, together with preliminary findings from three rural Australian research initiatives, have been used to develop the strategies outlined in this issue brief. They are designed to improve community participation initiatives that are currently being implemented in rural health care services in Australia and to enhance outcomes for the organisation and the community.

#### **1. Gather local knowledge with local people**

A comprehensive understanding of local context is required to facilitate participation at a community level—a one-size-fits-all approach to community participation rarely works. Generic approaches underutilise local knowledge, social networks, assets and expertise, and fail to respect historical experiences, cultural context and local health conditions. The diversity of rural communities needs to be understood by examining the local context through a process of gathering experiential and tacit knowledge (lived experiences) as well as scientific knowledge.

The story of Warracknabeal, Victoria, demonstrates how national data can be an inaccurate depiction at the community level (see Box 1 below for more details). This example demonstrates that knowledge of the local context will contribute to more accurate health planning and prioritisation as well as increase awareness of local assets and attributes to support health initiatives, for instance, the availability of volunteers and neighbourhood safety.

### Box 1. Warracknabeal, Victoria

#### *Warracknabeal*

Warracknabeal is situated in the Yarriambiack Local Government Area (LGA), about 330 kilometres north-west of Melbourne. Warracknabeal is an affordable place to live, and the LGA has the second lowest median house price in the state, with over 97% of rental housing classified as affordable. This community has a high sense of belonging, trust, and safety; 45% of residents volunteer; membership of groups and parental involvement in schools is above the state average, and crime is low.

Unique to this rural area, population projections indicate an increase in young adult residents, possibly due to affordable housing costs, and availability of public schools (see [www.facebook.com/WarracknabealSecondaryCollege](http://www.facebook.com/WarracknabealSecondaryCollege)) and health services (see [www.rnh.net.au](http://www.rnh.net.au)). Unemployment (4.6% compared with 5%) and welfare dependence (8.8% compared to 9%) are below the state average, although, take home wages are low, and almost half of households live on less than \$650 per week (6<sup>th</sup> lowest of Victorian LGAs).

There are high demands on health services because of an ageing population and high prevalence of disability. The rate of primary health occasions of services is more than five times the state average. Despite cancer incidence being lower in rural than urban areas on a national level <sup>[1]</sup>, locally cancer incidence in males is double the state average, the highest incidence of all Victorian LGAs.

#### *Digital stories, Warracknabeal, 2012:*

Katie, nurse, challenges stereotypes to pursue her dream rural health career  
<http://www.patientvoices.org.uk/flv/0633pv384.htm>

Peter, feeling powerless due to illness draws from community for wellbeing  
<http://www.patientvoices.org.uk/flv/0632pv384.htm>

Norma, respecting elders and relationships in rural context  
<http://www.patientvoices.org.uk/flv/0630pv384.htm>

Understanding the local context through local knowledge and lived experiences, statistical information and other relevant sources will support community participation that takes full advantage of local assets and capacity.

## 2. A dynamic, multidimensional approach is more effective than a single method

To effectively facilitate community participation, health services should use a range of strategies that are integrated to form a broad organisational approach. In the Canadian case study, for example, participation strategies were used at all levels of community activities, operations and governance. This included policymaking with community conversations, newsletters to provide community updates, and webinars to share examples of good

practice with a larger audience. Multiple dynamic approaches were used, which meant they could be adjusted to suit the local context, energy levels and available funding. The intensity or demands required of the strategy could be changed—for instance, time, resource investment, efforts, skills, responsibilities and expectations of citizens and staff. Using multiple strategies did not necessarily mean more funding or resources were needed. Engagement from volunteers, interns and students and use of social media were key factors to a successful approach.

Another key to success in community participation is determining the right balance of strategies with the community. In Rochester, Victoria, for example, seeking input from existing, established community groups on local health service priorities was found to be more successful than beginning a new community reference group specifically for this service.

Table 1 outlines how multiple strategies can be integrated to form a broad organisational approach, based on a Canadian case study. High and low demand strategies were integrated to form a comprehensive approach, without a requirement for extensive financial or human resources.

**Table 1. Example of a multidimensional community participation approach integrating different strategies**

Participation strategy	Objective	Example
Inform	<i>Provision of information to community</i>	- Newsletter, website, calendar, household canvassing
Consult	<i>Seeking information from community</i>	- Online, written or photographic submissions - Feedback through community leaders
Involve	<i>Intentional strategies to engage community</i>	- Twitter feed, Facebook page - Skills workshops and social events - Interactive webinar
Collaborate	<i>Participating with community, cooperative</i>	- Community food hub e.g. food market, garden, kitchen - Social enterprise e.g. bike shop, meals on wheels, café - Story-making or art workshops - Students placements or internships - Online learning portal, open access resources - School nutrition programs - Community working groups
Empower	<i>Full decision-making by community</i>	- Participatory policy making, priority setting and strategic planning

Note: Modified from the International Association for Public Participation (IAP2) Public Participation Spectrum (see <http://www.iap2.org.au/resources/iap2s-public-participation-spectrum>)

### 3. Leveraging existing community assets and capacity

To encourage community participation with health services, it is important to leverage existing capacity rather than develop a new initiative in isolation. This approach recognises that good community participation may already be occurring and new initiatives are more likely to succeed and be cost effective if they build on what exists. For example, building a community garden on a health service site is a strategy that has been used in Canada and in Australia. It creates a social community space within existing health services, which provides new opportunities for health promotion and recreation while improving awareness and access to onsite primary health care programs<sup>[9, 23, 24]</sup>. This practical approach means that limited financial and human resources are used to capitalise on existing community activities or assets, energy and motivation. In this example, existing assets and capacity included the health service, spare public land, volunteer gardeners, and local community groups and business sponsors. Leveraging that aims to form new community partnerships between existing entities maximises value, capacity and outcomes for community participation initiatives. Examples of leveraging in Canada are provided in Boxes 2 and 3.

#### Box 2. Student-led Meals on Wheels by bike, Montreal

##### ***Student-led Meals on Wheels by bike, Montreal***

*In Montreal, Quebec, a youth-driven healthy food delivery program, a 'meals on wheels' by bike, makes use of local university partnerships for land use and for student volunteers who deliver healthy meals to elderly residents by bicycle - important for the city because of high rates of elderly residents living alone (see housing profile <http://www.fgmtl.org/en/vitalsigns2010/housing.php>). The outcomes are three-fold: improved access to healthy meals, youth vocational training in agriculture, hospitality and social care, and intergenerational social interaction through meal deliveries and events. The program is multidimensional and entrepreneurial, volunteers and members can choose what level and type of engagement they prefer, for example newsletter subscriber or board member, and volunteers schedule their own shifts in food preparation or deliveries. The organisation creates stronger neighbourhood connections; the building is a bustling hub for youth and an incubator for innovation, for example urban agriculture projects like bee-keeping, and a bicycle repair shop.*

*See <http://santropolroulant.org/>*

#### Box 3. Community agriculture, Halifax

##### ***Community agriculture, Halifax***

*Community participation in Halifax, Nova Scotia, utilises local connections with farmers, a community centre car park, and volunteer energy and labour for agriculture projects that have benefits for the broader community. See <http://www.youtube.com/watch?v=u34-x26kCYQ>*

### 4. Paid community leaders are fundamental

Employing community leaders to generate effective community participation with health services is fundamental. Employing a local person with valuable contextual knowledge and local relationships will contribute to the success of community participation initiatives, as well as reduce volunteer over-reliance and burden. Community leaders, also known in the

literature as 'community animators' or 'community organisers', are resourceful people who are well connected with linkages within and across neighbourhoods, and with local business and industry leaders. They are keen organisers who bring people together and facilitate participation in community activities. Their responsibilities include organising social events, evaluating local issues, providing education and advocacy, and maintaining stakeholder partnerships with business, health and education. Community leaders are strong advocates with contagious enthusiasm, who are trusted and respected by their community<sup>[25]</sup>.

In the Canadian case study, community food programs employed a local person who had a good understanding of the local context and existing relationships in the community, and who was able to organise and mobilise people. The majority of community leaders observed in the Canadian case study were paid staff, or volunteers paid an honorarium. Leaders were sought out and invested in through a leveraging and capacity building process. See Box 4 for an example of how community food animators were utilised for a national community participation initiative.

#### **Box 4. Community food animators**

##### **Community food animators talk food security**

Community food animators were responsible for holding 'kitchen table talks' during a national citizen consultation strategy implemented in Canada. This involved organising a meeting with citizens in their existing networks, and writing a submission on food security together. Online and written submissions were used to develop a robust policy platform for a national food strategy. See an advertisement from Ontario Health <http://www.ohpe.ca/node/11623> and the final report at Food Secure Canada <http://foodsecurecanada.org/policy-advocacy/resetting-table>

Community food animators are currently employed by FoodShare Toronto. See a description of their role at <http://www.foodshare.net/toronto-community-food-animators>

#### **5. Use specific strategies to include marginalised community subgroups**

Communities need to develop specific strategies that will enable marginalised subgroups to participate in community activities. Traditional community participation methods can marginalise and exclude people because of age, illness, disability, transport, language or culture. Employees of health and welfare services may have existing trust and legitimacy, and are well placed to develop strategies that encourage marginalised groups to participate. This could involve storytelling rather than surveys, or submitting photos rather than written responses. Methods should be developed in collaboration with relevant community members.

One example of where this has been done well is in Heathcote and Warracknabeal, rural communities in Victoria. In these places digital storytelling was used with different groups to share community experiences. Similar approaches have been used in Canada. In the Canadian community food programs, for example, leaders supported participation with newly settled migrants and people living in social housing by building community gardens together (see Box 5). Social media and webpages can be used with accessibility options to

provide information and to seek comment from people who find it difficult to attend face to face consultations, or in languages other than English.

#### **Box 5. Community gardening with new Canadians in Halifax**

##### **Community gardening with new Canadians in Halifax**

*See Herald Magazine, October 25, 2013; 'Rooted in the community'; gardening with new Canadians in Halifax had positive outcomes for community participants. The community garden is described by two Nepalese refugee women as a place to grow food to feed their families and to meet the local residents of Halifax.*

<http://thechronicleherald.ca/heraldmagazine/1162380-rooted-in-the-community>

#### **Box 6. Inclusive community participation in a Halifax community garden**

##### **Inclusive community participation in a Halifax community garden**

*This video provides a virtual, narrated tour of community gardens across the Halifax municipality, to demonstrate how food and gardening can be used as a vehicle for wide participation that has positive benefits for communities. In this example, food and gardening were used as strategies to include community subgroups that generally might find it difficult to participate. See video:*

<http://www.youtube.com/watch?v=6OEhMAq73Q>

### **6. Shared decision-making improves outcomes and experience for the community**

Involving the community in decision-making with health services staff is more effective than seeking isolated consultation feedback, as this may or may not provide relevant or practical ideas or outcomes. For example, involving community members in a budget and resource allocation meeting with finance officers and managers may result in more practical outcomes than seeking feedback through a survey. This is because community members are likely to find it difficult to provide practical solutions without appropriate information and explanations needed to make good decisions.

The value of the shared decision-making approach is supported by research on citizen juries and participatory budgeting <sup>[14, 22]</sup>. A good example of where shared decision-making works in practice is in 'co-production models' in Australia and the United Kingdom. In these models, service provision responsibilities are shared between management, service providers and service users, and lines between these groups are intentionally blurred <sup>[9, 26-29]</sup>.

In our Warracknabeal study we observed the value of shared decision-making with rural communities. We found that having health staff attend community meetings led to quick decision-making and practical ideas that could be implemented within current budgets. Similarly, across southern Ontario, cooperative working groups including parents, teachers, community food workers and council officials, deliver successful healthy food programs in schools. There are many examples of community programs that have staff and community members working cooperatively and sharing decision-making and other responsibilities to

complete various activities; for example, writing newsletters and online blogs (see for example, Sustain Ontario website [www.sustainontario.com](http://www.sustainontario.com) and Box 7 for an example from the school nutrition programs delivered across southern Ontario).

#### **Box 7. FoodShare Toronto Farm to Table school nutrition program**

##### **FoodShare Toronto Farm to Table school nutrition program**

This program uses a cooperative model of governance and demonstrates how sharing decision-making and other responsibilities with staff and community members has positive outcomes. See website for program description and a video: <http://www.foodshare.net/field-to-table-schools>

#### ***What are the challenges of community participation in rural areas?***

Our research points to two challenges associated with community participation with rural health services.

##### **Over-consultation and volunteer fatigue**

Over-consultation and volunteer fatigue often impact on community participation in rural places. We found that participation approaches that require a high level of community time and investment are challenging to implement over a prolonged period. This difficulty may increase with smaller populations, and has been confirmed in other rural studies <sup>[30, 31]</sup>. Participation strategies must be in the community's best interests over time <sup>[9]</sup>. Volunteer fatigue can be avoided by using a combination of high and low demand strategies; changing demand in terms of time, resource investment, efforts, skills, responsibilities and expectations of citizens and staff. For example, health services can use high demand options such as community priority setting meetings once a year, alongside low demand options such as ongoing social media information updates and online progress reports with feedback options.

Volunteer fatigue can also be counteracted by balancing paid staff and volunteer labour, and by offering incentives such as transport or food vouchers. In a Toronto-based community food initiative, volunteers at a food distribution centre were given a public transport pass and a box of fruit and vegetables to acknowledge their work. Health organisations are encouraged to regularly celebrate achievements by using social media and local news outlets to acknowledge awards, contributions and investments; food programs in the Canadian case study did this weekly via Twitter and Facebook.

##### **Sustainability of approach**

Our research shows that sustaining a consistent approach to community participation is more important than maintaining one particular strategy. High demand participation strategies, such as a community forum, might be more effective if they are used for short periods of time on a regular basis, rather than frequently. Strategies should not be prolonged if they are not in the community's best interests. For example, alternating community town hall-style meetings with an online webinar or a meeting in an aged care

home would maintain consistency of the participation approach, while also encouraging broader participation beyond the 'usual suspects' to different community subgroups. The challenge is to sustain a community participation approach that is dynamic and flexible in responding to local conditions, energy and motivations, and recognises that an extensive, long term participation strategy might not be the most effective or meaningful method of participation for communities<sup>[32]</sup>. Local conditions and objectives should determine indicators of success<sup>[9]</sup>.

### **What happens when you do it well?**

Our research demonstrates that community participation with rural health services can deliver social benefits to the community and improve health literacy.

#### **Social benefits**

Community participation is a social process that can lead to social benefits such as better relationships and community cohesion. Social benefits of community participation can be difficult to measure, but there are useful evaluation tools such as questionnaires designed to measure social capital<sup>[33]</sup>.

Social benefits reported by key informants in the Canadian case study included improved social connections, trust, belonging, cohesion, safety, and reduced social isolation, which confirms what other studies have found<sup>[24, 34-36]</sup>. It is too early to determine what the social benefits are from the rural community research initiatives underway as part of this study, however, the Warracknabeal study indicates new positive social connections as a result of attending community meetings. In other studies, researchers looking at rural communities and participation have reported improvements in infrastructure and access to funding to create social community spaces<sup>[17]</sup>. For example, Men's Sheds are a well-known social community space, created through participation, which support friendships and belonging in communities<sup>[37]</sup>.

There is good evidence that a higher sense of community 'belonging' is associated with good mental health<sup>[33]</sup>. This indicates that community participation that results in social benefits is one strategy that might be effective for tackling rural health priorities including reducing high rates of mental illness and suicide.

#### **Improved uptake of health information: health literacy**

Being health literate means having the ability to understand and utilise health information, and apply it when accessing services<sup>[38]</sup>. Health literacy is a particular requirement for effective use of electronic personal health records and online technologies for managing, accessing and navigating health services<sup>[39]</sup>. By communicating with services, communities can learn about the health system, the various programs offered, and about appropriate service access for health complaints. In this way, community participation with health services may prevent inappropriate service use; for example, emergency presentations for health complaints that could be managed by a General Practitioner.

In an extensive literature review, researchers reported that improved health literacy was linked with positive health behaviour change<sup>[40]</sup>. In our study, Canadian community food leaders described the importance of health literacy related to food and nutrition, and linked this with increased healthy food consumption and choices in shopping and meal preparation.

Community participation initiatives that include peer discussions and skill sharing, education sessions and workshops, and information distributed via social media, may improve health literacy. Further research, some of which is under way, is needed to explore methods of measuring health literacy so we can determine which are most effective. Our initial findings suggest cooperative methods that utilise shared decision-making combined with social media are likely to be effective.

## Key messages for policymakers

- New ways are needed to contract and pay for health services, using ideas developed with communities and within current budgets. Current funding models need to be more flexible to allow this. Solutions developed with communities do not necessarily need more funds, but the inflexibility in current funding arrangements means that they cannot be implemented easily<sup>[13]</sup>.
- State and federal government competitive grants and tenders should prioritise proposals that demonstrate effective participation approaches as outlined in this issue paper.
- Community health services, Medicare Locals and Local Health Networks have an important role to play in facilitating community participation by gathering local knowledge, mapping existing assets, and leveraging capacity at regional and local levels. This should include:
  - Building partnerships between existing services, which have established trust and legitimacy, and leveraging existing participation strategies, rather than developing new services or standalone initiatives. This will result in focussed investment of currently available funds, maximising outcomes.
  - Employment of a joint-appointed paid community leadership position across community health services, Medicare Locals and Local Health Networks, in order to avoid duplication of community participation initiatives, improve efficiency, and overcome barriers of over-consultation and volunteer fatigue. This position, similar to the ‘health animator’ model used in Canada, and the research leader in our rural community research initiatives, would be responsible for the coordination of community participation approaches within communities, and develop and facilitate a dynamic, multidimensional approach for the local area. This would meet objectives of the National

Primary Health Strategic Framework <sup>[12]</sup> for integrated community participation. Local knowledge is key to success for this position, therefore in large catchment areas, for instance Tasmania, more than one employee might be required. This person would be responsible for volunteer support, communication and social media strategy, education, capacity building and evaluation.

- Evaluation of community participation in health services should use tools to measure social benefits and health literacy, in order to collect evidence of outcomes that are relevant to rural health reform priorities<sup>[2]</sup>, see for example Community Capital Tool: <http://www.sfu.ca/cscd/community-capital-tool-launched.html>
- A national innovative online knowledge sharing portal is required, to share best practice in rural community participation, to support the rural health workforce, and save time and money on approaches that are not effective or efficient. This knowledge sharing website should be interactive and use social media including blogs, videos and webinars; with a particular emphasis on how to overcome challenges and barriers. A good example of an online knowledge portal is: <http://foodsecurecanada.org/resources-news>

## Building Healthy Rural Communities research

This issue brief contains research findings from the Building Healthy Rural Communities research program, currently in progress on the regional campuses of La Trobe Rural Health School, La Trobe University, Bendigo; led by a team of university researchers, service managers and six doctoral students. The research is a three year project, commenced in December 2012, which is investigating community participation in health service improvement. Findings reported in the current paper were selected from a scoping review, an international case study, and three northern Victorian community research initiatives.

### Scoping review

A scoping literature review by Kenny et al <sup>[17]</sup> located six studies (English, peer-reviewed) that describe effective participatory approaches to rural health service improvement; two were located in Australia; one in Tasmania <sup>[9]</sup>, and one in Victoria <sup>[10]</sup>; and four others were from North America. Several challenges to implementing community participation are highlighted; additionally, we note there is a shortage of rural research in this field.

### Case study

A case study of community participation in Canadian community food programs and initiatives was conducted in October 2013-January 2014. The purpose of this case study was to investigate an exemplary case of community participation, to examine best practices in community participation in Canada and identify 'what works'. Data were five key informant interviews with community food leaders in Toronto, Montreal and Halifax, 11 site visits

including guided tours of food programs and community gardens, and evaluation of documents, images, videos and social media. This is the first of three case studies in an ongoing doctoral research project on international community participation in democratic, high-income countries.

### *Community research initiatives*

Three community research initiatives are being conducted in partnership with rural health services. Each initiative is led by a doctoral student and involves regular community meetings and other strategies, such as a health seminar or community expo. Community participants include hospital chief executive officers, local leaders, interested citizens, health service staff, and academics from the research program. The group's objectives are to enhance community participation with the health service, and to formalise an approach that supports effective community participation in health service planning, design, delivery and evaluation. The health services include:

- Heathcote Health <http://www.heathcotehealth.org/>
- Rural Northwest Health <http://www.rnh.net.au/>
- Rochester and Elmore District Health Service <http://www.redhs.com.au/>

### *Limitations*

Research literature in this field is extensive and multidisciplinary, and difficult to synthesise; for example, community participation and consumer participation have different meanings<sup>[41]</sup>. Inconsistent terms used to describe rural (e.g. regional, remote), participation (e.g. engagement, consultation) and community (e.g. place, group of people) add to the complexity. In this issue brief, 'rural community participation' has been used as an umbrella term to aid communication of research findings for a broad audience. The quality of the research on rural community participation is limited by biomedical standards, consisting mainly of qualitative studies or small cohort studies which are relevant to the research topic, but do not easily lead to authoritative conclusions and recommendations for policymakers. The recommendations provided are based on the status quo of community participation policy in health services, and seek to improve current practices that are being implemented and funded across Australia.

The Canadian case study includes interviews with urban-based key informants, who were the best available experts in their field; selected for interview because they are known for developing best practice approaches to community participation in food programs and initiatives at national, provincial, and municipal levels. Two key informants were employed at a national level and coordinated community participation approaches across provinces and regions; three worked at a municipal level with some operations at a provincial level, for example policy advice or partnership development with regional food and farming industries.

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