WINSTON CHURCHILL MEMORIAL TRUST of AUSTRALIA

REPORT by Robyn Grigg
2008 Fellow

To study community managed medical services in rural and remote areas

“We make a living by what we get; we make a life by what we give.” Sir Winston Churchill

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Date
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1. INTRODUCTION AND ACKNOWLEDGEMENTS

Communities, health providers and governments are searching for innovation and new models for the provision of health services in rural and remote Australia. The engagement of communities ensures relevance to the needs of individual communities and a stronger more sustainable basis for implementation.

My 2008 Fellowship visit to Canada and Scotland is summarised in this report through a description of the main themes and common threads from many interviews, workshops and documents and projects that were generously shared by my hosts.

My Churchill Fellowship trip has been an exciting, invaluable and extremely eventful experience and the results of this Fellowship have only been possible thanks to:

- The Winston Churchill Memorial Trust for an opportunity to learn and explore and return with even more enthusiasm.
- My referees, Dr Dennis Pashen for supporting my application and providing several of my initial contacts, and Dee Elliott for her inspiration and support.
- Dr Keith MacLellan, Dr Michael Jong, Carol Brice-Bennett, Josée Gauthier, and Professor Jane Farmer for their hospitality and generously sharing their time, homes, intellect, staff, and passion for community participation in primary health care services.
- My son Mitchell for carrying my luggage and being my “left hand” man throughout the journey after I slipped on ice on the first day, and my husband Gilles for his boundless patience and good humour.
2. EXECUTIVE SUMMARY

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The objectives of my fellowship were to investigate research, structures, finance and networks that build community ownership and participation in primary health care services. The people and services I met with were in rural and remote settings in Canada and Scotland and included indigenous and non-indigenous communities.

Community development and ownership are central imperatives in a primary health care approach. In the Australian Primary Health Care Research Institute's "Systematic Review of Primary Health Care Delivery Models in Rural and Remote Australia 1993-2006. (Wakerman et al, September 2006) the discussion of community "readiness" to manage change and participate in service development highlights a number of what is termed "enabling" factors. Many of these have been recurring themes in the conversations, research, documents, and projects during my fellowship tour and I will refer to them in this report as they provide a useful framework for analysis. The conditions that enable ownership and engagement include community commitment, identification of local health needs and strategies, a community champion and consistent leadership, community capacity to be involved in the governance of services, and an accountable auspice and structure for funding.

Equitable access to primary health care in rural and remote communities has become more and more difficult to attain in Australia and other similar countries. Workforce shortages, more specialised services and training, the expense of infrastructure, and centralised systems for the delivery of health services are all challenging service providers and communities to innovate and find solutions. I particularly asked people what it was that "triggered" or raised the level of motivation for communities to be involved as it is often a challenge for community development facilitators to engage and inspire community participation.

The Churchill Fellowship tour provided an opportunity to review the similarities related to remoteness, geography and community engagement. The opportunity to establish networks and to learn about the community managed initiatives in countries with similar challenges to Australia was one of the most significant aspects of my fellowship. There are strong themes in common in all the conversations and projects that indicate there is a framework that could be applied to the evaluation, design and implementation of community models of primary health care.

Governance models and structures which can support community led health service provision, programs or planning exist however, there are a range of systemic barriers that prevent or hinder community initiative and ownership. Centralisation and specialisation are significant trends in service development and provision and this is contrary to the needs and context of rural communities. Communities need open parameters within which to create generalised and integrated responses to their needs. They require the strength of a system of governance and decision making that reflects the scale and profile of the local community. Governments will need to reform and accommodate regional community based solutions if they are to equitably and efficiently address rural and remote health.

Dissemination
The fellowship has provided me with a number of themes that I would like to pursue through further research and to present to my professional networks in community and economic development. I will be presenting at conferences and will undertake further interviews in Australia with academics and health practitioners who have an interest in community led models of primary health care. Some of the contacts I made with universities overseas have expressed an interest in developing collaborative projects and I will ensure that I make relevant introductions with universities in Australia to support this. Due to restraints caused by my accident there were contacts that I had made in Canada that I will follow up with at a later date to continue to develop my research and make further links with interested colleagues.
High lights

- Heard wolves howling on a crisp clear and cold night in Shawville.
- Watched the ice flow by on the St Lawrence river from the warmth of my little log cabin in Rimouski.
- Dined at home with the doctor and his excited enthusiastic and dedicated band of student doctors in Happy Valley-Goose Bay.
- Looked out across the frozen ice in the far north of Labrador... breathtaking silence and cold beauty.
- Toured a small part of Labrador with a wonderful woman who has a knowledge of the local people and the heritage and culture that enriched my experience and thinking.
- Participated in a full day workshop on issues relating to access to health services in rural and remote Québec... en français!
- Drived through the remote north west of Scotland and saw it through the eyes of a local community development officer who loves her country and its people..... inspirational and contagious love of community!
- Saw the health system from the inside out after my untimely and painful "ice" experience on Mont Royal, and met a whole bunch of health professionals who weren't even on my itinerary.
3. PROGRAM ITINERARY AND INTERVIEWEES

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<tr>
<th>Dates</th>
<th>Place</th>
<th>Institutions/ contacts/ Activities</th>
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| 1-5 Dec | Shawville, Quebec | Dr Keith MacLellan and staff at medical centre in Shawville  
Society of Rural Physicians Canada |
| 10 Dec | Happy Valley Goose Bay, Labrador | Dr Michael Jong Vice President Medical Affairs, Labrador- Grenville Health Authority  
Presentation at Labrador Health Centre. Participants included:  
Nurse Specialist Early Childhood Development, Labrador Health Secretariat; Clinical Coordinator LGHA; Vice President Medical Services, LGHA; Chief of Staff, LGHA; Hospital doctors, and Director Aboriginal Health Programs, LGHA.  
Delia Connell, Vice President of Community, Children’s services and Aboriginal Affairs, Labrador Grenfell Health  
Executive staff of Labrador-Grenfell Health  
Tour of Labrador Health Centre  
Dinner with Cathy and Dr Michael Jong and medical students on placement at hospital |
| 11 Dec | North West River Labrador | Carol Brice- Bennett, Director of Aboriginal Health Programs Labrador-Grenfell Health Authority  
Presentation to community health workers of the Labrador Health Secretariat (Health Canada) and Labrador-Grenfell Health at Innu community of Sheshatshiu, located 35 kms from Goose Bay.  
Participants:  
Nympha Bryne, Mushuau Innu from Natuashish; Patricia Kemuksigsiak; Eugene Hart (youth support officer in schools); Michelle Parsons; Amy Goudie; Connie Stewart (youth counsellor and suicide prevention); Elizabeth Dawson; Anne Aberdeen; Carol Brice-Bennett.  
Tour of Sheshatshiu and adjacent Metis community of North West River, cultural museum, new housing development. |
| 12 Dec | Happy Valley Goose Bay Labrador | Michelle Kinney, Deputy Minister Health and Social Development, Nunatsiavut Government, Happy Valley Goose Bay  
Stanley Oliver, Deputy Mayor Happy Valley- Goose Bay Town Council and Executive Director of Labrador Friendship Centre  
Dr Linda Turner Social Work St Thomas University, Frederickton, New Brunswick |
<p>| 15-19 Dec | Rimouski, Quebec | Josée Gauthier, Conseiller scientifique, Services aux Communautés rurales, éloignées et isolées. Institut national de santé publique Québec |</p>
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<th>Date</th>
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<tr>
<td>15-19 Dec</td>
<td>Rimouski, Quebec</td>
<td>Workshop on research findings for organisational primary health care service models and access to services required by rural and remote communities in Quebec</td>
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<tr>
<td>5 - 9 Jan</td>
<td>Montreal</td>
<td>Jean-Pierre Girard Cooperative Institute, Sherbrook University</td>
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<td>6 Jan</td>
<td>Montreal</td>
<td>Dr Mary Richardson, Solidarite Rurale du Quebec</td>
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<td>7 Jan</td>
<td>Montreal</td>
<td>Centre de santé et de service sociaux de la montagne</td>
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<tr>
<td>20 Jan</td>
<td>Inverness, Scotland</td>
<td>Dinner meeting with Prof Jane Farmer, Amy Nimegeer, Artur Steinerowski, Kate Stephen</td>
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<tr>
<td>21 Jan</td>
<td>Inverness</td>
<td>Prof Farmer, UHI Millennium Institute Highland Research and Development Day</td>
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<tr>
<td>22 Jan</td>
<td>Inverness</td>
<td>Met Gill Keel, Head of Public Engagement with NHS Highland at UHI Millennium Institute</td>
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<tr>
<td>23 Jan</td>
<td>Lochinver</td>
<td>Kate Stephen and Amy Nimegeer, Community Development and Research Staff from UHI. Travelled to communities participating in O4O EU project and Remote Service Futures projects. Interviews during the course of the day</td>
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4. MAIN BODY – People, Examples and Themes Explored

This report is not an academic analysis of the models or case studies but is a travelogue and collection of ideas and discussion themes. It is organised around a description of the principal locations visited, key contacts, a local example, a synthesis of the main themes from discussions in each location, and some related information links and references.

I hope it also conveys the enthusiasm of the people I met, who do such wonderful work and are analysing their efforts and the possibilities for the communities they live in and work with.

4.1 Far reaching impact from Shawville, Quebec

This little town on the south western limits of Quebec was full of surprises. Here I met a highly experienced rural doctor who has been one of the leaders in advocacy for rural medicine in Canada over many years. A rural physician in practice in Shawville Quebec, Dr Keith MacLellan is also a Past President of the Society of Rural Physicians of Canada and was a representative on the Ministerial Advisory Council on Rural Health 2001-2002.

The town of Shawville is also the administrative “hub” for the Society of Rural Physicians of Canada (SRPC). The SRPC is the national voice of Canadian rural physicians with an aim to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities. The SRPC is a voluntary professional organization representing over 1,300 of Canada’s rural physicians and comprising 5 regional divisions spanning the country.

The administrative team at the SRPC office is small in number but they are a testament to what can be achieved. Small numbers of organised people (professional groups as well as general community) can have considerable influence through advocacy at national levels. It may not take lots of money but does require commitment and organisation.

4.1.1 Local Example 1 - “Reachout Program proposal”

The Shawville community is one of many that have found practical ways to take a lead and work together with health professionals. The Pontiac region has developed a proposal for a “Reachout Program” to strengthen the connections formally between the Ottawa University, Ottawa hospital and community hospitals through regional education and community engagement. The proposal has been developed to redress the widening gap in abilities to care for critically ill patients between large urban hospitals and regional community hospitals abilities to care for critically ill patients. “Fly in fly out” models are frequently not feasible due to the geography and weather in Canada and the level of knowledge, competence and confidence of.

The “Reachout Program” is about caring for intensive care patients from the Pontiac Hospital and all of the smaller community hospitals in the Ottawa Valley linked with the tertiary care centre intensive care unit. The Lions Club and Rotary Club raised $20,000 and then they approached the Ottawa Tertiary care ICU with the locally identified needs (what each community wants will be different). They offered to give the money they had raised provided it was allocated and accounted for the identified community project. This is an example of the community taking control, raising the money, and not being so
helpless or “needy” and using the resources of volunteers and local services to determine an education need to be able to take care better of critically ill patients. The community thereby is directing the services and the teaching to meet local priorities.

The Reachout proposal identifies the need for a contractually binding long term commitment to build the capacity of health professionals in the regions through education. The close involvement of the community at all stages of the development of this program is also critical to its success.

4.1.2 Theme 1 - Generalism not specialisation – A rural and remote imperative

The conversations with Dr Keith MacLellan captured some of the advocacy and policy issues that are current in Canada and Australia. This included workforce shortages in rural and remote areas, attempts to innovate through service design, professional and governance structures, resources and potential partners in primary health care services.

The definition applied to rural and remote is an important base line for research and for advocating for the needs of communities. The rurality index that Dr MacLellan has applied for surgical research is an index developed in terms of procedural skills. http://www.ncbi.nlm.nih.gov/pubmed/16921665

The terms “remote” and “isolated” can be value laden and a technical means of defining and analysing access to services is critical in service advocacy, development and planning.

The majority of graduates coming out of medicine are now declaring specialities eg palliative care, emergency etc. There is a world movement towards colleges of general practitioners declaring that general practice is a specialty area of expertise and more specifically that rural and remote general practice is a specialisation. According to Dr MacLellan, a generalist is somebody whose competencies are defined by the community and its public health needs. So if you legitimise and validate that with the community, effectiveness is not about making rural comparisons or even family practice rural medicine comparisons, it is in generalism. That way the needs will define what type of doctor is required.

The previous Canadian Government commissioned two separate reports of relevance to rural and remote health: “Beyond freefall: halting rural poverty” Final Report of the Standing Senate Committee on Agriculture and Forestry, June 2008 and “Rural Health in Rural Hands”: Ministerial Advisory Council on Rural Health November 2002. These reports raised strategic directions for the engagement of communities but they have not been implemented by the new government in Canada. The seven broad areas of focus recommended by the Ministerial Advisory Council on Rural Health were: Building Healthy Communities, Infrastructure for Community Capacity-building, Intersectoral Collaboration, Rural Health Research, Health Information Technology, Health Human Resources, and Aboriginal Health.

Section 4 of the Senate report on rural poverty, proposes the continued use of the “healthy communities’ approach. It affirms the importance of recognising that the major determinants of health span a broad range of issues and prerequisites are equitable access to “peace, food, shelter, clean air and water, adequate resources, education, income, a safe physical environment, social supports etc. It indicates the framework for “healthy communities” is based on what communities can achieve for themselves with a bit of assistance from higher levels of government” (p xix Executive summary).

The healthy communities approach also reinforces the concept of generalism at a community planning level. The relationships that need to be developed across government jurisdictions are numerous and small rural and remote communities do not have the capacity to work across the specialty areas of government departments. A different generalised, regional development approach is required.

Local capabilities need to be built up but this can’t be done unless the community invests in it and unless there is an accountable structure for the management of funds. The Ministerial Advisory Council recommended that local infrastructure be built up to be able to accountably access and receive funds.
The trend in society is towards specialisation and away from rural; because in rural, every little community is different. What is needed is community capacity building at the local level for health. The federal government needs to support local community volunteer centres/sectors to do local needs assessments, local research, and generalist training locally. This was also recommended by the Ministerial Advisory Council.

Conversations with Dr MacLellan:....a train of thought....

......Rural health revolves around the concept of the "generalism" of the entire rural workforce
.............................."Generalism" is characterised by defined competencies
The competencies are defined by the communities needs and accredited by peers
......................All rural communities are different and will need different defined competencies
..............................There is currently no Canadian rural community capacity to determine, develop and support defined competencies in health and health care
..............................Therefore rural communities will continue to lose the capability of caring for ill patients, delivering babies and improving the health of their populations to the inexorable specialisation and centralised trends of modern, so-called “advanced” society – no matter how many well funded “rural health projects” are implemented.

4.2.3 References and information links

Pontiac Hospital, Shawville

“Rural Health in Rural Hands”: Ministerial Advisory Council on Rural Health November 2002
www.srpc.ca/librarydocs/rural_handsrbr.pdf


Building on Values : the future of Health care in Canada. RJ Romanow, 2002
www.cbc.ca/healthcare/final_report.pdf

4.2 Understanding access and equity for rural and remote health services – Rimouski, Quebec

My visit to Rimouski was a wonderful opportunity to practice my French, and I hope I didn’t lose too much in translation. My contact Josée Gauthier, from the National Institute of Public Health Quebec (INSPQ), organised an agenda that would allow me to hear the outcomes of the research with which she has been involved. I attended a one day forum of community representatives and service providers, government representatives, academics, and health professionals.

The Forum presented research findings on a collaborative research project with the following objectives:

- Assess the influence of geographic remoteness on the timing, content, and intensity of various levels of services for tracer conditions.
- Identify specific considerations for measuring accessibility and continuity of services in rural, remote, and isolated communities.
- Determine whether specific organizational characteristics emerge in primary care in relation to the prevailing geographic remoteness between various levels of services
- Assess the contribution of professional co-operation (especially between nurses and physicians) to improve the accessibility and continuity of services provided to rural, remote, and isolated communities
The workshop outlined the distribution of primary health care services in Quebec and provided an analysis and definition of rural and remote based on the communities remoteness from services, distance and travelling times. The workshop also considered the key concepts in the studies including “access”, rural and remote communities, models, experience of health services, and the system of provision. Participants discussed issues pertaining to the place of the family physician within models of primary care service delivery, the experience and confidence of people in their health care, the nature of collaboration between health professionals as a factor of geography, access to services as related to geographic location.

I interviewed one of the participants at the workshop, Dr Mary Richardson. Mary is currently working with ‘Solidarité rurale du Québec” which has a rural development research and advocacy role across the province. Quebec has been dynamic in communities taking control of their health care needs. They are not always successful but there is certainly a lot going on with the creation of health cooperatives and alternative social economy models.

4.2.1 Local Example 2 –Solidarité Rurale du Québec

Solidarité rurale du Québec was formed as a provincial entity following a conference in 1991 in a situation of crisis in rural areas. There was a call of alarm about the decline in rural communities and a demand for action. Solidarité rurale follows up on the National Rural Policy (1991) and ensures it is implemented. They make statements/ positions on certain issues at a policy level. In 1997 they were given the official status of an advisor to the Quebec government on rural issues and they are very proactive in making public statements and advocating to government.

They are constantly keeping abreast of issues in the rural context, eg agriculture, migration, health etc. They have one full time researcher (at present the main focus is on migration in and out of rural communities and also economic development). They also oversee approx 108 rural development agencies. It is a membership based coalition which includes municipalities, farmers organisations etc.

4.2.2 Local Example 3 - la Coopérative de santé et de solidarité de Sainte-Félicité

My hosts had scheduled for me to meet with representatives from the Health Cooperative at Sainte-Félicité but circumstances did not allow it. I have included them as an example however as there was a brief article about them whilst I was in Quebec and they exemplify the cooperative movement that I am studying. « Le Soleil » published on 08 décembre 2008 an article, « Un démarrage fulgurant pour la coopérative de santé de Sainte-Félicité » (A brilliant start for the health cooperative at Sainte-Félicité). http://www.cyberpresse.ca/le-soleil/actualites/les-regions/200812/07/01-808175-un-demarrage-fulgurant-pour-la-cooperative-de-sante-de-ste-felicite.php

The health care cooperative in Sainte- Félicité has only been operating for one year but in this time has exceeded its membership target by 40%. The service is in a municipality with only 1,200 people and the cooperative employs 3 staff (a nurse, a doctor and a secretary) and now has 1,000 members. There is to be a second doctor commencing in February 2009.

4.2.3 Theme 2 – perceptions of isolation – who is remote?

Research by Josée Gauthier (INSPQ) and Jeannie Haggerty’s (University of Sherbrooke) research team has raised some interesting paradoxes and themes by analysing the geographic context as well as the organisational parameters and the individuals’ experience of care. There are some suggestions that the experience of the health care system is more positive in rural and remote contexts as smaller communities have characteristics that are conducive to collaboration between agencies and service “streams”. It is interesting to consider a positive analysis of the rural and remote situation and the strengths of local communities in terms of flexible contexts for collaboration, positive perceptions of access and community support for innovation.
Regardless of the perceptions, there are stark differences in the level of service infrastructure and also in the health outcomes for people in urban and rural or remote settings.

4.2.4 References and information links

www.inspq.qc.ca

Canadian Health Research Foundation - project summary
http://www.chsrf.ca/funding_opportunities/ogc/2003/gauthier_e.php

www.solidarite-rurale.qc.ca

4.3 Health Cooperatives a structured community response to need – Sherbrooke, Quebec

Jean-Pierre Girard is an International Health Cooperative Organisation (IHCO) board member, an advisor on collective health enterprises, and a lecturer and researcher associated with the IRECUS (the Research and Education Institute for Cooperatives University of Sherbrooke). Jean-Pierre is passionate about the cooperative and preventive approach to provide the members of a given community a powerful means to collectively take charge of their overall health.

According to a survey conducted in 2007 by the IHCO, there are over 117 cooperatives offering health services in Canada and 66% of these are based in Quebec. http://www.ica.coop/ihco/newsanddoc.html

The University of Sherbrooke is also putting into practice what it has learned through research and extensive liaison through IRECUS. It has now established a health cooperative founded within a university setting with membership gathered from students, university personnel, and a range of other associated members. The cooperative has a priority focus on health promotion and prevention.

4.3.1 Theme 3 – How can this be fair? -a question of equity and a matter of responsibility

The right to accessible, quality and equitable services is fundamental to health care service provision in both Australia and Canada. There are many factors which can mitigate the management of this from a government or a local level. However, it is interesting to watch the outcomes when a government makes a decision to close a hospital, or a town loses its general practitioner, and a community rallies and re-establishes an equivalent service. This has been the response in a number of communities in Quebec and communities are applying a cooperative structure to achieve it.

There was lively debate at the workshop I attended and in the media whilst I was in Quebec with regard to the increase in the number of health care cooperatives that are forming and having success. The more cooperatives establish as local independent structures for service provision, the more the implications for provincial systems of taxation, insurance and program financing will come under scrutiny and debate.

A letter was published by a group of Mayors the Municipal Region of Councils of Nicolet-Yamaska in October 2008. http://www.lecourriersud.com/article-263090-Lettre-ouverte-du-conseil-des-maires-de-la-MRC-de-NicoletYamaska-a-Jean-Charest.html The mayors identified the loss of family physicians due to retirement and the closure of hospital emergency facilities as creating critical problems for access to health services in rural and remote areas. They cite the establishment of health care cooperatives as being positive in the sense that communities have taken responsibility in addressing the issue in rapid and effective ways. However they also highlight that this could evolve into competitive and inequitable actions between towns and regions, that it does not put pressure onto the province to fulfil its obligations.
of service provision, and that it introduces additional layers of consumer payment via provincial taxes, municipal contributions, cooperative membership and then additional payments for service.

4.3.2 References and information links

www.cedworks.com publication of community controlled health care in Canada Vol 18 no, 3 Autumn 2007 special edition "Making waves"

International Health Cooperative Organisation
http://www.coop.org/ihco/index.html

University of Sherbrooke Health Cooperative
www.USherbrooke.ca/coopsante

4.4 Governance on the horizon - Labrador

To even begin to understand Labrador you have to discover its many layers and segments of government.

"Being a leader in Labrador is complex". I spoke with Stan Oliver a local Deputy Mayor and the Executive Director of the Labrador Friendship Centre. "We have three indigenous groups all at different stages of self government, a Federal Government with certain jurisdictions, a Provincial Government with other jurisdictions, and two large Municipalities who have another set of concerns and jurisdictions." The population of Labrador was estimated to be 26,300 in 2007 with an area of 296,860 sq km.

Stan Oliver talked of the struggle and long term commitment that he and others have had in order to stand up for the rights of the indigenous people to negotiate fair benefits from large scale resource developments, for self governance for indigenous groups, and for community engagement in community planning and infrastructure development.

I met with Delia Connell, the Vice President for Community, Children’s Services and Aboriginal Affairs at Labrador-Grenfell Health. Delia is working with the Innu communities and the Nunatsiavut Government to transition the provision of health services. The focus is on building the capacity of local communities and ensuring that they are ready to deliver programs that meet their needs. Delia particularly mentioned the establishment of a post-undergraduate social work degree in partnership with the aboriginal communities and St Thomas University. The program is ensuring that the skills of local people are developed and culturally appropriate programs are designed.

My guide and host during my stay in Happy Valley- Goose Bay was Carol Brice-Bennett, the Director for Aboriginal Health Programs with the Labrador-Grenfell Health Authority. Carol’s knowledge of the region and its people has grown during more than 35 years of visiting and living in the local community and she has published many reports and books on Innu and Inuit culture, health and the history of Labrador. She has a deep attachment to this land and its people, and my visit was very much enriched by Carol’s enthusiasm and attention to all aspects of my stay. Carol introduced me to local store owners, cooked my first meal of caribou, drove me to North West River/ Sheshatshiu, we dined with health workers in their homes, visited the cultural museums and health facilities and talked about the many aspects of the life and history in Labrador.

The reason I came to Labrador was that I had met Dr Michael Jong in Australia. He has welcomed many people to Labrador and has a well earned reputation for building the capacity of the local health system through education and training. Dr Jong has lived in Happy Valley- Goose Bay for more than 24 years. His love of the community and area is clearly “infectious” as he has managed to inspire and increase the number of doctors in this remote and beautiful part of the world at a time when many small communities struggle to attract and retain doctors. The Faculty of Medicine at Memorial University in St John’s, Newfoundland conducts an 8 month residency in family medicine at the Labrador- Grenfell
Health Centre. There is also an outdoor survival skills program allowing doctors to learn from native elders in their own environment.

There was an air of excitement and enthusiasm when I talked with the Nunatsiavut Deputy Minister for Health and Social Development, Michelle Kinney. It took a long time to negotiate a land rights agreement and the formation of the government which was established on 1 December 2005; and yet you would think it only happened months ago for all the enthusiasm to create, innovate and make a change. It is an inspiration and a testament to the long term commitment of this nation and its people.

My visit to Sheshatshiu and North West River was a real treat and I was fortunate to meet some of the health workers in the Innu community there. We discussed the youth and suicide prevention programs that they are implementing and found a great deal in common with the way in which we are working in Australia.

4.4.1 Local example 4 – Nunatsiavut government

Following a land claims settlement in 2005 with Inuit (meaning ‘people’) in northern Labrador, a new territory called Nunatsiavut (meaning ‘our beautiful land’) was established along with a separate governance structure. The Nunatsiavut Government has its own constitution and is making decisions and establishing the infrastructure to deliver their services. At this time they have Ministers with portfolios in Health and Social Development, Education and Economic Development, Land and Natural Resources, and Youth Elders and Recreation. Not all services are delivered by the government at this time and decisions are being progressively made about the transition of programs from the Provincial Government. The decisions are based on their capacity and readiness to deliver services and programs and the infrastructure and resources that are available.

My meetings were mainly to discuss the health and social programs that are being developed. The emphasis at this stage has been on consultation with the communities and setting priorities. It is also about training local people to take on professional health roles through a variety of education programs offered in the region. To this end a nurse access program, supporting the training for a dentist, a social work program, and a new mobile mental health team project are all examples which are ensuring that local people have the skills and competencies to work with the communities.

I also visited an Innu (Indian) community called Sheshatshiu located 35 kms from Happy Valley- Goose Bay. The Innu and Inuit organisations have good relations and are collaborating on developing a number of health and social programs with Labrador-Grenfell Health. Innu at Sheshatshiu and at Natuashish (located on the northern coast) compose the Innu Nation, an organization negotiating a land claims settlement with the Canadian government. For the purpose of this Local example I have focussed on the Nunatsiavut Government.

4.4.2 Theme 4 – Building a foundation for change

There are “foundation” conditions that assist a community to make the significant changes that have come about in Labrador. I will highlight four that were raised in the interviews and workshops I had whilst in Goose Bay:

- Commitment – it’s a long journey
  The time that it takes to ensure that social change comes about is extensive, both in leading up to the decision to reform or make a dramatic change such as the creation of a new government, and the time after to implement and redefine. It is clear that the beliefs and values of the people individually and as a collective are essential ingredients in sustaining the change. I was interested to find that although three years have passed since the Nunatsiavut territory was established, there is still a level of enthusiasm that could almost be described as elation and a certainty that there is hope for improved health in the communities.
• Education and training - in the community
The education and training of health professionals within rural and remote communities was a recurrent theme during my visit. Research is indicating that training and educating health professionals in rural and remote areas is likely to contribute to their decisions to work in rural and remote communities. The Nunatsiavut government’s approach has been to negotiate with Provincial authorities and various universities to design and deliver curriculum that is directly responsive to the needs of the local communities. This has occurred in nursing and social work fields, as well as in teacher education, which contribute significantly to the recruitment and retention of staff within the region.

• Leadership – it’s a lot to do with style
The leadership model and its implications for making the changes was also raised in many of my discussions whilst in Happy Valley- Goose Bay. The Nunatsiavut officials have invested time and energy in consultation and organising the networks and structures for consensus decision making. This has taken some time but will provide the vehicle for involving Inuit in the development of their own solutions and opportunities. There is a Regional Health Plan and all communities have their own local health plan to guide them and ensure agreement about priorities.

• Health needs assessment – clarity of purpose
The identification of needs is a base line for any action. The Nunatsiavut communities have recently participated in a national Inuit Health Survey which was conducted by the Centre for Indigenous Peoples’ Nutrition and Environment (CINE) at McGill University, and supported by various Canadian agencies. They achieved 100% participation levels and Inuit in this region and in other territories now have the means to make comparisons about their health status and it enriches the information they had already gathered through their own planning and consultation process. The design of educational and training programs for health workers based in the communities also provides the means for more detailed studies and research as part of the education programs. This further enhances the design and development of programs and responses to priorities in the community.

4.4.3 References and information links
Labrador Friendship Centre: http://www.lfchvgb.ca/home/2

National Association of Friendship Centres: http://www.nafc-aboriginal.com/history.htm

“Practice makes Perfect”, The Ambassador, Volume 14 Issue 2. Article about Dr Michael Jong


Nunatsiavut Government: www.nunatsiavut.com

Innu: www.innu.ca
4.5 Knowledge transfer – Inverness, Scotland

Inverness, Scotland

The north of Scotland is a dynamic and very friendly part of the world. I was fortunate to be there for the Highland Research and Development day at the UHI Millennium Institute in Inverness. It was an opportunity to meet with a range of health professionals and to attend workshops on community engagement in health services and health research projects in Scotland. UHI Millenium Institute is actively building its research capacity and identifying collaborative partnerships. I attended a workshop that had a number of local examples of community engagement in medical practices; one through an arts and design process for a new medical clinic in Fort William and the other was based on training patients to be volunteer consultation administrators and advocates with other patients to gauge satisfaction and identify improvements in patient communications and relations.

My contact in Inverness was Professor Jane Farmer, Co-Director and Chair of Rural Health Policy and Management at the Centre for Rural Health which is a collaborative venture between the University of Aberdeen (www.abdn.ac.uk) and the UHI Millennium Institute (www.uhi.ac.uk). Jane has a number of projects that are about building the capacity of local communities to plan for and redesign their health services. In particular I was briefed on a knowledge transfer project and an older persons community development project.

There is nothing like a long drive in the countryside to give a context for where people live and to gain a sense of the parameters for community development. Driving from Inverness to Lochinver with project managers from UHI, Amy Nimegeer and Kate Stephen, was such a treat. My guides Kate and Amy demonstrated their love of Scotland through a wonderful commentary of anecdotes, stories, and interesting facts about the environment, the history and the local communities.

I met with Gill Keel Head of Public Engagement, a role which includes providing leadership for, and management of, NHS Highland’s corporate communications and public involvement teams. Gill advises the Board on evolving requirements and practice in relation to involving patients and the public in NHS services.

4.5.1 Local example 5 – Rural Futures

Remote Service Futures is a knowledge transfer partnership project focussed on involving stakeholders including community members, the National Health Service, Councils, voluntary services, etc. in engagement to envision different ways that services might be provided in the future. The project includes working with communities to gather the information that is pertinent to service planning including current expenditure, service and community profiles, community infrastructure (transport etc). This may seem a straight forward exercise, but as for most systems, unless the data and budgets are aligned, configured and produced at a locational level (with the same geographic boundaries across program and budget lines), it is highly complex to report to a community.

The project has also developed resources to facilitate discussions, consultation and planning with communities. It is important to find processes, languages, and techniques that allow people from a range of backgrounds to plan together and to simulate the reality of the scenarios.

Projects of this nature importantly focus on gaining the trust of participants, establishing agreed communications, and ensuring relationships are developed to encourage open discussion of issues sensitive to the community or the public sector. The project commenced in February 2008 and is therefore still in the early stages of development.

4.5.2 Local example 6 – Older for Older Project

Professor Jane Farmer is the project leader for “O4O” or older people for older people. This is a 3 year project (2008 – 2011) and is funded by the European Union Northern Periphery Programme with support from the organisations within each of the partner countries Scotland, Northern Ireland, Sweden,
Finland, and Greenland. The project is in response to the increasing proportions of older people in the European population. The "peripheral" regions participating in the project have a higher proportion of older people than in their central and urban regions and there are increasing demands on attracting and maintaining skilled people and transport to provide services. The project is based on community development principles and building the capacity for older people to develop their own local solutions and opportunities.

Kate Stephen is the project manager for O4O in Scotland and she outlined a number of the initiatives and ideas that the communities are working on. They include "Neach Cobhair," a volunteering service for small household jobs in South West Ross; a door-to-door bus service in Tongue, Sutherland, and a film featuring the life stories of people in Ardersier, Inverness-shire. All are drawing on the enterprise, needs, wishes and enthusiasm of local people as they seek to forge a future for their communities by helping themselves and each other.

Kate took me to visit Lochinver, where they are consulting local people on the kind of place that would tempt them to leave their homes if they could no longer live on their own. They are working with a local steering group on feasible housing options for the area in the future.

4.5.3 Theme 5 – The transfer of knowledge – pivotal “commodity” in relationship transactions.

Information is a fundamental “commodity” in relationship transactions. There is increasingly an accountability requirement and an imperative for relationship development with communities both within the public sector and with private sector investment in regions. It is interesting to examine the scope, details, and consistency of data collection and what information is disseminated and to which audience. In terms of understanding accountability of public expenditure to local communities and providing useful evaluation measures at a local level, there appear to be significant systemic barriers.

Developing a framework for community ownership, the legislative means to finance and commit to implementation, and the systems to communicate, report and account for public expenditure at local levels would require a significant refocus on how the business of government is conducted.

4.5.4 References and information links

UHI Millenium Institute, Inverness.  www.uhi.ac.uk/home

“Remote service futures” working with communities and stakeholders in service design” Jane Farmer, Amy Nimegeer. Rural Futures: Dreams, Dilemmas, Dangers” Compilation, 2008 University of Plymouth, UK.

Older People For Older People project:  www.o4os.eu
5. CONCLUSIONS

Rural and remote communities have significant relationships with “external brokers or facilitators” such as universities, governments, financers, and private companies. The principles, structures and agreements from the early stages of developing these relationships with rural and remote communities should be negotiated clearly with terms of relative responsibility and expectation.

Governance models and structures which can support community led health service provision, programs or planning exist however, there are a range of systemic barriers that prevent or hinder community initiative and ownership.

Centralisation and specialisation are significant trends in service development and provision and this is contrary to the needs and context of rural communities. Communities need open parameters within which to create generalised and integrated responses to their needs. They require the strength of a system of governance and decision making that reflects the scale and profile of the local community. Governments will need to reform and accommodate regional community based solutions if they are to equitably and efficiently address rural and remote health.

6. RECOMMENDATIONS

- Further research is required into evaluation frameworks for community led health service provision
- Investigate options and governance structures for community led health initiatives in rural and remote contexts including more legislative “agility” from governments to support community leadership.
- Information and training for rural and remote communities and government departments to promote “generalist models” for health service provision.