

# Rural Places and Community Participation in Health Services Development

Taylor J<sup>1\*</sup>, Wilkinson D<sup>2</sup> & Cheers B<sup>3</sup>

<sup>1</sup> Manager Research and Enterprise, Spencer Gulf Rural Health School, University of South Australia and Adelaide University, South Australia, Australia<sup>#</sup>

<sup>2</sup> Deputy Head School of Medicine, University of Queensland, Queensland, Australia<sup>#</sup>

<sup>3</sup> Director, Centre for Rural and Regional Development, University of South Australia, South Australia, Australia<sup>#</sup>

## Abstract

This paper explores the relationships between rural places and community participation in health service development. Community participation in planning for health programs and services is fundamental to effective and accessible primary health care. However, there have been ongoing challenges for health professionals engaging with communities in these activities. One reason for this is that the terms 'community' and 'participation' are commonly used without reference to concepts or theory about communities. Community participation is rarely conceived of, or undertaken as, development of place.

This paper, using an interactional perspective of 'community', adds a theoretical perspective to understand more about how and why communities of place become involved in health service development. PhD research explored community-initiated community participation in organising hospital and general practice services in three small rural communities in Australia. It was found that community participants understood community participation as social interactions embedded in a community of place related to the betterment of the community. From this understanding three concepts about community participation in health activities emerge:

- Community participation as development of place
- The value of the community participation processes to the community
- Community participation consistent with community values and attitudes.

An understanding of the relationships between community functioning and community participation is essential for health professionals working with communities and for communities themselves. It may important in developing community-based initiatives in other fields such as social care and environmental management.

## Keywords

Community participation, community of place, community engagement

---

<sup>#</sup> Contacts: <sup>1</sup> Phone +61 8 8647 6127, Fax +61 8 8647 6164, email [judy.taylor@unisa.edu.au](mailto:judy.taylor@unisa.edu.au)

<sup>2</sup> Phone +61 7 3365 5450, Fax +61 7 3365 5522, email [david.wilkinson@uq.edu.au](mailto:david.wilkinson@uq.edu.au)

<sup>3</sup> Phone +61 8 8647 6047, Fax + 61 8 8647 8185, email [brian.cheers@unisa.edu.au](mailto:brian.cheers@unisa.edu.au)

## Introduction

In Australia, many rural and remote locations have, by necessity, become involved in supporting their health services (Collins 2001). For many years, financial and in-kind support to building programs, accepting governance responsibilities on hospital and health services boards, donating time for maintenance and refurbishment, and fund raising to buy medical equipment, has been commonplace. An empirical study of two rural and a remote community in Australia iterated with an extensive literature review found that rural community participants understood place, community development, and community participation as intertwined. People participated because of a desire to contribute to the community. This is in advance of information available in the health field. In health, much of the work about health improvement is conducted without reference to theory or concepts about rural places. This paper argues that understanding rural places is a pre-requisite to effective health development.

The research used a multiple, embedded case study design (Yin 1998), purposively sampling three communities in country South Australia which had exhibited extensive community participation in their general medical practices and health services. Data was of three types:

- Semi-structured interviews with community members, general practitioners and health practitioners, rural medical workforce consultants, and government officers, who understood the community participation in each community
- Analysis of community history texts, records of health service meetings, and annual reports
- Non-participatory observation of community participation as it occurred 'in situ' in each of the three locations.

Data was analysed, after entry into N6,<sup>1</sup> producing categories about forms of participation, reasons for it, and issues involved in each community. Then the patterns of community participation were analysed across communities looking for similar and contrasting patterns. Patterns that were constant across the communities were further explored to develop concepts about community participation. Further analysis was undertaken to test whether or not these concepts were consistent with theory and concepts about rural communities and connections between communities and place from community sociology.

Literature about community participation in health, dating back to its origins in the 1970s with the Declaration of Alma Ata, was reviewed with three main approaches to community participation becoming apparent:

- The contributions approach considers participation as voluntary contributions to a development project, rather than decision-making about the project. Professional

---

<sup>1</sup> N6 is a software package marketed by QRS that enables data to be analysed into categories and relationships between categories.

developers, usually external to the community concerned, lead participation (Oakley and Marsden 1984).

- The instrumental approach defines health as a commodity rather than as a process, and those who use the commodity as consumers. Consumer and/or community participation is an intervention designed to achieve health outcomes in the most equitable and effective manner. Participation is usually led by professionals (Rifkin 1986, 1996).
- The community empowerment approach seeks to empower and support individuals and groups to take greater control over issues that affect their health. It includes the notions of personal development, consciousness-raising, and social action (Williams and Labonte 2003).

Of course the concept of community participation is not specific to health development. As a principle it underpins rural and remote community development (Cheers 1998), and social development (Midgley et al. 1986). Some of the most significant conceptual work about community participation occurs in the rural development literature according to Rifkin (2001). However, health services development and health planning, rarely uses this conceptual work. Therefore this research, locating the concept of community participation in the broader context of rural, social, and economic development theory and practice, was unusual.

### **Current conceptions of community engagement in health services development**

There are three issues with the current conception of community engagement in health and health services development. These are:

- the instrumental approach to community engagement
- the lack of connectedness between existing community participation and health service reform agendas
- health service reform understandings of 'representativeness' in participating in health planning.

### ***The instrumental approach to community engagement***

Unfortunately the term 'community engagement', as it is used in the health field in Australia, has come to mean communities engaging with health professionals, on their terms, rather than the reverse. Health professionals generally determine the agenda for consultation; decide who will be consulted with, and the timeframe for consultations. Health service reform strategies, such as the Generational Health Review in South Australia (Department of Human Services 2003), often include community participation as a strategy. However engagement in health activities, unlike in some other disciplines (Haslin and Brown 2004), is often about getting health consumers or community leaders on-side in order to effectively target high priority areas for health services. Consultations about needs and priorities, health services development, and the delivery of programs start with structures and processes designed by local health administrators in accord with state and sometimes national priorities. This is a

very worthwhile intention and one that none of us would argue with, but a rather instrumental approach to health services development.

The first issue then in current conceptions of community engagement is the instrumental approach generally taken by health professionals. In practice, this type of engagement may achieve the instrumental ends required by health professionals, but rarely does it achieve a strong and effective developmental partnerships that meets both health professionals' and community's needs (Rifkin 1996). Even if there is a reasonable level of involvement health professionals may struggle to get the most frequent users of their services and marginalised groups involved in these consultations. The groups of people whose health is of concern, including those from different ethnic and cultural backgrounds for example, are rarely part of these consultations. Health professionals may perceive the community to be 'apathetic' about health issues, or reluctant to become involved.

This may be an accurate perception — it may be the case that community people regard health professionals and in particular general practitioners as the ones charged with the responsibility to deliver health care. In Australia, the relative strengths of the health care system and access to services through Medicare may result in an expectation that health care issues will be dealt with by professionals (Butler et al. 1999). The research into community participation in organising rural general medical practice that is the basis of this paper, found instances of community people involved in developing health services but little involvement in health care issues. The quote below illustrates this point.

“Personally I try and stay out of health care issues. That is what the doctors do in their own way. I reckon my role and the board role is to put the practice in place, make it financially viable — make it sustainable and leave it up to the doctors to do that stuff.”  
(Health services board member)

Perhaps because what is perceived as a lack of interest in, or knowledge about health care issues, community participation and community engagement in health activities starts with health professional rather than community members. Health professionals define the group to be targeted, the 'community' to be consulted, and the outcomes that are required. An example of this comes from one of the communities studied.

“In the health care planning that we are currently undertaking we take our plans to the [health services] Board first. We tell them what we would like to do and how we would do it and if our operating budget covers that service or whether we are going to apply for funds.” (Health service CEO)

The study of rural community participation in organising rural general medical practice found extensive participation in each of the three communities in health service development. These communities, over long periods had spent time, money, and provided in-kind support to their hospitals, aged care facilities, and health services.

“There has been a lot of community support to the hospital and the aged care facility over the years, a lot of community money, so that feeling is still there of community ownership. It may be diminishing somewhat. One time there wasn't so much government support for these things [hospitals and health services] and the community has to make a big contribution before they could get any government help. This is not the case to the same degree. There is still a lot of voluntary support the auxiliary, the board members are honorary members, and we help with the old people, all this is this is a community contribution. There is a sense of ownership and contribution.”  
(Hospital board ex-chairperson)

In working in rural communities where there is active community involvement in health services development there are problems with an instrumental approach to community participation. If health professionals engage with communities around their own agenda, without acknowledging the existing community structures, motivations and the ways in which the community functions, the result may well be a lack of synergy between the existing activities of community members and the plans of health administrators for community engagement.

***A lack of connectedness between existing community participation and health reform agendas***

Secondly, the value of community activities that are related to health improvement or health services development that happen naturally, as part of community life, are often ignored. For example, in relation to the recruitment of general practitioners in rural and remote areas of Australia, many rural and remote communities, because of serious rural medical workforce issues, contribute significantly in order to attract a doctor. They may contribute funds from community reserves augmented by donations to purchase housing, practice accommodation, and medical equipment. In-kind support such as helping maintain the buildings, introducing the doctor and his or her family to the community, baby-sitting, and providing governance arrangements for the practice, are not uncommon. Communities contribute because they value general practitioner services and know that the viability of the community is intimately related to the presence of those services in their community. This is community initiated participation in helping to organise health services, and as such, may be overlooked.

What health professionals are often looking for is participation in the initiatives that they are proposing. Policy officers, discussing community participation in one of the rural communities studied, talked about how complex it was to get the community involved in the plans they had for a new way of delivering health services.

“There are some things that are starting to come together and there are some things that we have put in place around the [new health service] that will force a coming together. There are so many issues. I don't think that there was strong community participation in the [new health service] proposal. We were prepared to overlook the lack of community participation because of the need for funding in the area, to strengthen the health providers to allow them to go to the community.” (Policy officer)

### ***Health reform understandings of ‘representativeness’ in community participation***

The third issue is the way in which ‘representativeness’ is understood by health administrators and those who facilitate structures to inform health service development and the community level. Generally when being appointed, community board members understand that they are being a representative of their community. For example, when giving advice about health matters or needs and priorities on a local hospital board, they may regard themselves as representing community needs and aspirations (Taylor 2004). However, there are often questions as to whether these community-elected people do actually represent the views of all the groups in the community particularly marginalised groups (Abelson 2001; Frankish et al. 2002). Health administrators in Australia argue that structures such as local hospital or health services boards may not be representative — people might be representing themselves rather than the interests of particular groups that are disadvantaged with regard to health (Department of Human Services 2003). These different perspectives can and must be debated in order for community representation to be valued and understood.

### **Addressing issues with community engagement**

Some of the issues with community engagement outlined above can be addressed if health professionals have a better understanding of the community to be engaged with. People who live in rural or remote communities in Australia generally have no problem in defining their community. Local people usually define the community geographically and include the ways in which they relate to the community to fulfill needs. A participant in the study about community participation in rural communities defined it in the following manner.

“What’s the community? Well it’s [place name] and then the little towns around. I live between two towns — my farm is at [place name] but I use [place name] for business, and go to Church there. We all depend on one another out here — we all play football for the one team. We are all inter-dependent.” (Health services board member)

Health professionals, wanting to work with a community and not living locally, may not understand communities in this way.

“Community engagement, well we don’t really work with communities, we work with individuals on the health services board for example, and they don’t really represent the community, just the ‘business end of town’. There isn’t really a community any more — just people going about their business.” (Health policy officer)

Those people who are wanting to reform health services, or plan community health initiatives may be unsure if there is a ‘community’. They may be uncertain as to which groups are excluded and they often use evaluative terms to describe a community, dysfunctional, strong, and or inclusive, from their perspective. In their work, administrators may refer to groups of health consumers, or they may refer to a region constructed for the purposes of health services administration. Necessarily, distinct communities are amalgamated for the purposes of regional development or health care provision and this must occur in moving to a more regional focus in health services provision. However, rarely can this amalgamation of geographic areas be regarded as a community of place. Often people living in the locations within the region do not interact and do not understand themselves as part of the one ‘community’. Therefore, conducting health planning across regions involves understanding the different communities involved.

### **A community of place**

Using well established sociological theory to understand a community of place may help in defining the community that is to be engaged. There have been many theoretical approaches to defining and understanding community (Hillery 1955; McKnight 1997; McMillan and Chavis 1986; Warren 1978; Wilkinson 1991). The approach developed by Wilkinson (1991), an interactional perspective on community, developed from social field theory (Kaufman 1959; Wilkinson 1970) is used here. An interactional perspective on community conceives of a community of place as having three elements:

- A geographic locality
- A local society
- Locally oriented social actions.

### ***A geographic locality***

The first element of a community of place is that it is a geographic entity with more or less commonly agreed on boundaries where people live and meet their daily needs together (Wilkinson 1991). Boundaries may change according to what aspect of community functioning is described. For example, in discussing football, a community of place may include as the areas that have members and supporters of team. This may be different from the way the community is described when considering health services delivery. In order for a geographical

area to become a locality it needs to be demarcated by more or less locally agreed boundaries. The important factor is that residents can define the area that they regard the 'community' and that there is common agreement.

### ***A local society***

Within a community of place a local society enables residents to meet their business and social needs and provides access to services. "A local society is a comprehensive network of associations for meeting common needs and expressing common interests" (Wilkinson 1991, p. 2). There are many ways that social structures and networks can be organised and can connect people, but it is the existence of these local structures and facilities that enable interaction. In most Australian rural communities there is some form of local government, and boards or administrative structures to provide governance for health and social services, service and business organisations. In addition there are numbers of formal and informal interest groups and networks. Although the configuration of clubs and associations may look very different across the various communities, the presence of such social elements is critical to a definition of a community of place.

A community of place may have more than one local society. In some Australian towns with an Aboriginal or a Torres Strait Islander population, there may be two, three or four or more distinct local societies with identifiable social elements. These societies may interact and intersect or parallel each other and rarely come together. Each community may be different.

A local society is marked by several more or less distinctive social fields, such as the sporting groups and organisations through which individuals pursue their interests. A social field is dynamic and constantly changing as the needs of the community change (Pigg 1999). The way that the community comes together is through locality-oriented collective actions. People who live together in the same geographic area and think of themselves as a community do not necessarily constitute a community, unless they act together in a local society (Wilkinson 1991). Therefore a community of place is not just a geographic area; it is actually about social interactions, people who have relationships of various types for various purposes.

### ***Locality-oriented collective actions***

The interactional perspective of community focuses on the third element of a community of place — social interactions. Community interactions are the substance of community.

"One, community is a social unit of which space is an integral part; community is a place, a relatively small one. Two, community indicates a configuration as to a way of life, both as to how people do things and what they want. A third notion is that of collective action. Persons in a community should not only be able to, but frequently do act together in the common concerns of life" (Kaufman 1959, p. 9).

The defining feature of a community of place is the locally oriented social interactions that come about naturally as people go about their daily lives. Fundamentally it is not the sum of the formal structures that make up the community, although that helps — it is the people and their interactions. It is through interactions that connections are made and commitments to addressing common community problems or undertaking development come about. The following is an example of the types of contributions that have built the hospital and health services in a remote Australian community.

“I guess my motivation to contribute is about being local and being involved in everything. My grandmother was a member of the hospital auxiliary and did the cooking and mended the sheets and then my mother took that on. It is instilled in you to do things. My mother was very community minded — sixty years with Red Cross. It is a part of your way of life if your mother and father have modelled it.” (Health services board member)

It is common to place evaluative terms on the concept of a community of place. A community of place may be perceived as a ‘good thing’ and one that will lead to positive outcomes for people socially and economically if they are connected to the community. However, communities of place when defining them are just that — communities of place. In understanding any community of place there will be aspects of community functioning which are strengths or limitations in relation to some desired outcome. This is an important distinction. Any community, in its essence, is not dysfunctional, weak or strong; it is only when considering what is desired for or by the community that these terms make any sense.

Many rural and remote communities in Australia are communities of place. For example, they have a local society, locally oriented social interactions and a commonly agreed upon geographic boundaries. Using the concept of community of place enables analysis of the activities that occur in the community of place, the interactions, and the structures that may be important to health services development. Three concepts about rural community participation in health services development that evolve from this understanding of a community of place are now discussed. These concepts, evident in an empirical study and embedded in well established sociological theory, may be relevant in discussing rural community participation more broadly.

### **Community participation in a community of place**

From a community perspective, community participation in developing health services comes about because people, from different sectors in a community of place, come together to pursue a common task, or solve a common problem, which they perceive to be in the community’s interest.

“I guess just realising what a wonderful facility [hospital and general practice] we had got me involved. A lot of those facilities were under threat around the country and I wanted to do everything I could to make sure that we managed to keep, even develop what we have. I suppose that has always been where I have come from; I valued the services and I wanted them to continue.” (Health services chairperson)

In all three communities studied, community members participated in organising the general practice in order to provide a service to their community.

“Country people see community participation as their duty. The future of general practice in rural areas these days is going to depend more on community participation just from the point of view of supporting their local GP. In a small community there is the potential to do something about the problems. There is a core of people here who keep everything going. People do help each other out in a crisis.” (General practitioner)

Community people constructed their participation as an expression of their commitment and their sense of belonging to a community of place. It fitted with the community-wide narratives about the community, it emerged naturally, and in this sense it was intrinsic to that community.

“We are all co-dependent, all the small towns work in together. Everyone has a different interest, not different agendas, because they are all community members and working on behalf of the community. There is still a strong sense of community; it is an area that has always looked after itself.” (Hospital board member)

#### *A desire to develop place*

In a community of place, there is likely to be intimate relationships between the reasons for participation and the place. In many instances it is the desire to develop place, to make it more socially and economically viable, which underpins community participation. The following example, from the study of community participation in organising rural general medical practice, demonstrates this point well.

“If the hospital closes it means that a great number of people around the area wouldn’t have work, as the hospital is the biggest employer in the district. It means that for elective surgery we would be looking at going to [capital city]. All these compounding things then, people haven’t got jobs and the family moves away, schools close down. Shops and other town services decline because the population wouldn’t sustain them. There is a massive community impact if you didn’t have that facility. That was mainly why I started to get involved.” (Health services ex-chairperson)

Another example shows the multi-level motivations for community participation in organising outreach medical services to an agricultural district of approximately 3000 people.

“The general practice is important, just grist to the mill. Every little thing you lose in a town is important. Survival is about confidence and feeling more than economics sometimes. If a doctor comes here then that is something positive; if that goes everybody gets all depressed and thinks it will be the school next. Actually it is not all that different for me to drive to [town name] to go to the doctor but you feel good about going to the doctor in your local town [an outreach clinic]. For some people it is really an important thing, as they can’t drive. It is a feeling about ourselves — our town has a doctor one day a week; this feels better than having nothing.” (Council CEO)

The continuation of this medical outreach clinic was seen as an important indicator of confidence in the community, even though the participant above mentioned that medical services could be obtained elsewhere. The service though was seriously threatened. It was financially non-viable, few people attended, and the building that housed the consulting room was run down. There was a view that people went to the clinic as a social event rather than to access medical services. Regardless of these complexities, high levels of community participation resulted in improved practice infrastructure. Community members convinced the general practitioners of the importance of providing services in this location and this resulted in the survival of the general practice services.

*The value of the processes — a way of expressing of community*

The example above also demonstrates another point. Community participation may become a social event. If community members experience community participation as the means by which they express and maintain a sense of community or ‘communion’ (Wilkinson 1998, p. 97), as a cognitive and emotional response to community, then is it likely that they will value the opportunity to contribute as well as the accomplishment of a task. The following example reveals why a participant put time into being a health services board member.

“I enjoy the challenge, I have given away a lot of things [coaching football] and I needed another direction. I was approached to join the board and I thought it over. I knew it was a big commitment with the day and night meetings. This is for the community. Now I am enjoying the challenge. I feel good about it too because I am helping out the community. That is the main reason for joining.” (Health services board member)

Feeling needed, demonstrating a ‘community spirit’, and helping keep the health services in a community of place functional, may be motivations that are intertwined. One or other may be

uppermost at various points in the processes, but multi-layered reasons for community participation in a community of place may exist and should be explored.

*Community values and attitudes and community participation*

In participating on health advisory structures in a community of place, participants may understand themselves as delegated to represent their community, its views and values (Abelson 2001; Mooney and Blackwell 2004). This means that information about the interests of different groups of health service consumers may be provided in the context of community values and attitudes. Representing community values may be very important. Each of the three communities studied in the investigation of community participation had an explicit narrative that supported community participation in health services development. In one community this narrative was dominant — it was working together to have 'the best of everything'.

"We are in a unique position as one of the smallest communities with a hospital in Australia. This has been through good management to be able to keep this service and this tradition is passed on. There is a pride in our services and our ability to sustain this for the community. It could almost be seen as vanity I guess. This community has always prided itself on having the best of everything." (Health services board member)

In another community the narrative of 'having the community spirit' was held by older women and was the reason for their participation. They were anxious that younger women may not carry on this tradition; the 'community spirit' hadn't hit them yet.

"There have been a lot of contributions to the hospital, I have been in it a few years now, I think they have given \$86,000 to the hospital that can be used to purchase things, holding fetes, raffles etc. That is the trouble now; there is a huge gap between the older ones (a 90 year old still comes to meetings) and the younger ones. We are not getting the younger ones involved. Either they work and don't want to do voluntary work. The generation behind us won't do it. They are golfing or doing their own thing. The community spirit hasn't hit them yet. They just think it is going to happen when they get that age and it won't." (Hospital auxiliary member)

In the remote community, people were encouraged to join organisations such as the health services board to battle together to keep the community viable — almost a 'survival' ethic. Therefore, participating in organisations was essential to gain community approval. Joining the health services board was one way of gaining this approval and acceptance in this community.

“We have to fight for everything. You have to be involved; you have to show interest otherwise people forget about you. We need a good hospital, good health services and doctors because of our location. If you get into this community you have to contribute to be accepted. You contribute by being involved in community things that are here. If you want to be remembered and accepted, yes, then you must join in. And you are remembered when you are gone. If you come in here and do nothing, you are basically an outsider.” (Health services ex-chairperson).

### **Summary and conclusions**

The purpose of this paper was to establish how community participants understand their community and community participation in developing health services. In each of the three communities studied, community participants understood their community as a community of place and their participation in health services organisation was about collective contributions to a task that was seen as of benefit to the community. Several concepts that are related to this understanding were explored. Firstly, community participation in health services development in a rural community of place may be about development of place. That motive, usually to ensure the communities viability and sustainability, may override an interest in the use of the health services to improve health. This is not always the case, but it must be kept in mind when working with communities.

Secondly, both the achievement of a task, and the processes involved, are important in considering community participation in health services development in a community of place. Several examples were given where participation in helping organise general practice services were opportunities to express people’s commitment to community in addition to ensuring that people had access to health services. The reasons for community participation are multi-layered and it is important to understand the layers of motivations and negotiate different perspectives if communities are to be effectively engaged in health services development.

Finally, in a community of place, people’s involvement in consultative health structures may be from the perspective of representing community values in addition to providing information about health needs and priorities. Community values are often explicit in community narratives that help continue community traditions. Understanding community narratives that may support, or work against, community participation in health service development is important.

This paper introduces a concept of rural community participation that enables it to be better understood as collective social interactions directed to the achievement of a task that community members perceive will benefit the community. This understanding has theoretical

support in well-established theory about community. The understanding may have practical value in engaging with communities of place in the development of health services.

### **Acknowledgments**

The contributions of those community residents who participated in this study are gratefully acknowledged.

### **References**

Abelson J 2001, 'Understanding the role of contextual influences on local health-care decision making: case study results from Ontario, Canada', *Social Science and Medicine*, vol. 53, no. 6, pp. 777-93.

Butler C, Rissel C & Khavarpour F 1999, The context for community participation in health action in Australia, *Australian Journal of Social Issues*, vol. 34, pp. 253-65.

Cheers B & Luloff A E 2001, 'Rural community development', in eds L Bourke & S Lockie, *Rurality bites, the social and environmental transformation of rural Australia*, Pluto Press, Sydney, pp. 129-42.

Collins Y 2001, 'The more things change, the more they stay the same: health care in regional Victoria', in eds L Bourke & S Lockie, *Rurality bites: the social and environmental transformation of rural Australia*, Pluto Press, Sydney, pp. 103-17.

Department of Human Services 2003, *Better choices better health, final report of the Generational Health Review*, Government of South Australia, Adelaide.

Eyre R & Gauld R 2003, 'Community participation in a rural community health trust: the case of Lawrence, New Zealand', *Health Promotion International*, vol. 18, no. 3, pp. 189-97.

Frankish C J, Kwan B, Ratner P A, Higgins J W & Larsen C 2002, 'Challenges of citizen participation in regional health authorities', *Social Science and Medicine*, vol. 54, pp. 147-80.

Haslin H & Brown V 2004, *Towards whole of community engagement; a practical toolkit*, Murray-Darling Basin Commission, Canberra.

Hillery G A 1955, 'Definitions of community: Areas of agreement', *Rural Sociology*, vol. 20, pp. 111-23.

Kaufman H F 1959, 'Toward an interactional conception of community', *Social Forces*, vol. 38, pp. 8-17.

McMillan D & Chavis D 1986, 'Sense of community: A definition and theory', *Journal of Community Psychology*, vol. 14, pp. 6-23.

McKnight J 1997, 'Health systems and communities', in ed. M Minkler, *Community Organising and Community Building for Health*, New Rutgers University Press, Brunswick, pp. 20-5.

- Midgley J, Hall A & Hardiman M (eds) 1986, *Community participation, social development and the state*, Methuen & Co., London.
- Mooney G H & Blackwell S H 2004, 'Whose health service is it anyway? Community values in healthcare', *Medical Journal of Australia*, vol. 180, no. 2, pp. 76-8.
- Pigg K E 1999, 'Community leadership and community theory: a practical synthesis', *Journal of the Community Development Society*, vol. 30, no. 2, pp. 196-212.
- Rifkin S B 1986, 'Lessons from community participation in health programs', *Health Policy and Planning*, vol. 13, no. 3, pp. 240-9.
- Rifkin S B 1996, 'Paradigms lost: toward a new understanding of community participation in health programmes', *Acta Tropica*, vol. 61, pp. 79-92.
- Rifkin S B 2001, 'Ten best readings on community participation and health', *African Health Services*, vol. 1, no. 1, pp. 43-7.
- Taylor J 2004, Community participation in the organisation of rural general medical practice: Three case studies in South Australia, PhD Thesis, Department of Health Sciences, University of SA, Adelaide.
- Warren R L 1978, *The community in America*, Rand McNally College Publishing Company, Chicago.
- Wilkinson K P 1970, 'The community as a social field', *Social Forces*, vol. 48, pp. 311-22.
- Wilkinson K P 1991, *The rural community in America*, Greenwood Press, Westport, Connecticut.
- Wilkinson K P 1998, 'The small-town community: Its character and survival', in eds E Zuber, S Nelson & A E Luloff, *Community: a different biography*, Northeast Regional Center for Rural Development, University Park, Pennsylvania, pp. 96-103.
- Williams L & Labonte R 2003, 'Changing health determinants through community action: power, participation and policy', *IUHPE – Promotion and Education*, vol. X, no. 2, pp. 65-71.
- Yin R K 1998, 'The abridged version of case study research', in eds L Bickman & D J Rog, *Handbook of applied social research methods*, Sage Publications Inc., Thousand Oaks, California, pp. 229-59.