

Challenging Remote Community Deficit Perspectives: An Australian Insight into the Role of These Communities in the Design of Their Health Services and the Development of Their Health Workforce

Debra Jones
The University of Sydney, Australia

Lindy McAllister
The University of Sydney, Australia

David Lyle
The University of Sydney, Australia

Abstract

This article reports on findings from a qualitative study that explored the formation of a community-campus partnership, development and delivery of an allied health practice-based service-learning program, and impacts of partnership and program participation for community and campus participants. The partnership sought to address a protracted lack of access to allied health services for children residing in remote Australia. The program aligned occupational therapy and speech pathology student placements to the provision of allied health services to these children. Community participants – school principals and senior managers from local facilitating agencies, and campus participants – allied health students and academics were allocated to focus groups, school principals ($n = 7$) and allied health students ($n = 10$), and individual semi-structured interviews, senior managers ($n = 2$) and academics ($n = 2$). A constant comparative analysis method was used to analyse data. This article describes community perspectives of partnership initiation, catalysts for participation, and participation impacts. The role of community partners in initiating the partnership was described and conditions associated with remote contexts and health sector failures were identified catalysts. Service and learning adaptation, partnership commitment and service consistency, service acceptability and accessibility, and community investment in remote health workforce development were identified impacts. This article addresses significant gaps in the national and international practice-based service-learning literature, specifically from community and remote perspectives. Study limitations are discussed and implications for how community-campus partnerships are formed and service-learning programs are sustained in remote contexts are explored.

Keywords: allied health; community-campus partnerships; practice-based service-learning; qualitative; remote Australia

**Corresponding Author:* Debra Jones, Broken Hill University Department of Rural Health, PO Box 457
Broken Hill NSW 2880 Australia *Email:* debrajones1@health.nsw.gov.au

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Introduction

Globally, remote communities confront challenges in accessing health services and workforce sustainability (Strasser 2003, World Health Organization (WHO) 2011). Whilst acknowledging this global significance, this qualitative article focuses on the health inequities confronting children residing in remote New South Wales (NSW), Australia. These children are geographically isolated, can be exposed to socio-economic disadvantages that restrict access to health services, and experience poorer educational outcomes due to limited pre-school engagement and primary school attendance, acknowledged precursors that contribute to developmental vulnerability and delay (Australian Institute of Health and Welfare (AIHW) 2009, Council of Australian Governments (COAG) 2009, Standing Council on Health (SCoH) 2013). These children are also less likely to have access to allied health services to prevent, identify or address these delays due to protracted health workforce shortages across allied health disciplines (Health Workforce Australia (HWA) 2013, Jones *et al.* 2015, Spiers and Harris 2015). A failure to intervene early can have detrimental impacts on the later life outcomes of these children. The AIHW (2009: 51) stated that “[c]hildren who enter school not yet ready for school-based learning have lower levels of academic achievement, and are at an increased risk of teenage parenthood, mental health problems, committing criminal activity and poorer employment outcomes”, as reflected in this region.

Internationally, school-based health services can be provided through agreements between health and school authorities (Boyle *et al.* 2007), with this approach reflected in some Australian states (Queensland Government (Department of Education and Training) 2009, Victoria State Government (Education and Training) 2013). However, there is limited policy and practice within NSW that reflects similar approaches to health care delivery. Significant investments are made in the early years of development, 0-5 years, yet, children residing in remote NSW can enter into school education experiencing developmental delays (NSW Department of Education (NSW DEC) 2013). The protracted nature of remote allied health workforce shortages, service inequities, unaddressed childhood delays, and limited evidence for effective solutions to address these challenges continues. Alternative approaches to health service design and workforce development are required. This necessitates strategies that ensure community perspectives and experiences inform the identification of health needs, implementation of localised solutions, and the provision of educational opportunities that support the development of responsive health professionals. This pragmatic qualitative study has sought to explore the experiences of one remote Australian region in the development of a localised solution to address protracted allied health service inequities through the formation of a community-campus partnership and development of an associated service-learning program.

Community-campus partnerships and service-learning

Community-campus partnerships and practice-based service-learning strategies have been implemented internationally to address health inequities experienced by such underserved populations (Fitzakerley and Westra 2008, Jacoby 2003, Sessa, Grabowski, and Shashidar 2013). Community benefits associated with partnership participation include enhanced access to academic expertise, human, and social capital located within universities (Jacoby 2003). Hallmarks of effective partnerships include a focus on community assets, the development of cross-cutting strategies, mitigation of practices that privilege institutional partners, and sustainable engagement (Leiderman *et al.* 2003). However, Cruz and Giles (2000) identified political, institutional, structural, professional and power barriers in the identification of community informed benefits. Furthermore, Glover and Silka (2013) raised concerns about a lack of exploration into who initiates these partnerships, for what purposes partnerships are created, a potential lack of community choice in participation, inequitable distribution of power between partners, and academically driven partnership objectives. Additional research has been called for to explore community perspectives and experiences of partnership initiation and participation (Butin 2010, Cruz and Giles 2000, Glover and Silka 2013).

Community-campus partnerships underpin the development of service-learning strategies (Sandy and Holland 2006). A service-learning approach to experiential learning links theoretical knowledge acquired within curricula to knowledge application in 'real world' settings (Cashman and Seifer 2008). Service-learning goals go beyond addressing the needs of individual students by focusing on civic engagement as a conduit to learning attainment. This engagement enables students to participate in learning that can include ill-defined problems that occur within communities. Service-learning is intrinsically linked to community engagement and contribution to student learning, reciprocity and mutual benefit (Janke 2008). However, there is little evidence that service learning provides substantive and long-term solutions to communities (Butin 2010, Cruz and Giles 2000, Glover and Silka 2013).

Community-campus partnerships and service-learning are emerging strategies across Australian health and higher education sectors (Jones *et al.* 2015, Mason 2013, Hammersley 2013) and there is limited research that describes who initiates these partnerships, how service-learning programs are sustained, and the impacts of partnership and program participation, specifically from remote community perspectives. This article explores the initiation of a remote Australian community-campus partnership, catalysts that contributed to partnership participation and service-learning program development, and participation impacts from the perspectives of community partners. The partnership sought to address the protracted lack of access to allied health services for children residing in far west NSW, and the program aligned allied health students' (occupational therapy (OT) and speech pathology (SP)), placement experiences with the provision of services to address these unmet needs. This article responds to the lack of evidence informed by community perspectives on who initiated the partnership, impacts of participation, service-learning program sustainability and contribution to substantive solutions, addressing significant knowledge gaps and contributing new insights to international and emerging Australian community-campus partnership and service-learning literature.

The remote Australian context

The community-campus partnership and service-learning program described in this article were established in 2009 and were informed by existing community-campus partnership and service-learning evidence (Bringle and Hatcher 2009, Jacoby 2003, Jones, McAllister, and Lyle In Press, Leiderman *et al.* 2003). This evidence was then adapted to ensure service responsiveness to community contexts and the learning requirements of Australian allied health students. Glover and Silka (2013: 40) identify the importance of "attending to the specificity of place in crafting sustainable partnerships". In our case, this involved a number of onsite meetings between community partners and an external university partner. The partnership is governed by health – a local health district of the NSW Ministry of Health, far west NSW school education – NSW Department of Education, a University Department of Rural Health (the Broken Hill UDRH), and an external university faculty, the University of Sydney Faculty of Health Sciences. Partners collaboratively developed an allied health service-learning program. The program aligned senior OT and SP students' learning to the provision of allied health services to school-aged children. Services are now provided across three regional communities and twelve school campuses. Six SP and four OT students undertake an inter-professional service-learning (Clark *et al.* 2015) placement for periods of six to eight weeks across the four school terms. This created a student 'team continuum' (Jones, McAllister, and Lyle 2015a) to enhance service continuity. Approximately 150 regional children accessed these services annually.

Ethics approval

Low risk ethics approval was granted through The University of Sydney Human Research Ethics Committee (approval number 2014/178), NSW Department of Education and Communities (NSW DEC) (SERAP approval number 2014117), Catholic Education Office, and La Trobe University (written approvals).

Research goals and questions

This study had two primary goals: 1) to document and describe the formation of the community-campus partnership, the development and adaptation of the service-learning program from the perspectives of community and campus participants, and 2) to develop a greater understanding of the impacts of participation in the partnership and program for community and campus participants. As this study was concerned with comparing community and campus perspectives a set of generic questions were asked of all participants:

- What influenced your participation in the partnership/program?
- What do you think the partnership/program hopes to achieve?
- What impact did your participation in the partnership/program have on you?
- How would you describe the partnership/program to your peers?

Methodology

This pragmatic qualitative study ([Sandelowski 2000](#), [Smith, Bekker, and Cheater 2011](#)) did not seek to view the world in terms of absolutes and was not committed to one philosophy or understanding. The methods drawn on were those considered best suited to obtaining, analysing and interpreting the data ([Morgan 2014](#)). This study was intentionally designed to explore and gain a deeper level of understanding of community and campus participants' experiences and relationships.

Participants

Potential community participants:

- School principals ($n = 12$), representing all school campuses engaged in the program;
- Senior managers from local facilitating agencies, school education and the UDRH ($n = 2$).

Potential campus participants:

- Allied health students ($n = 10$) undertaking their placement in the program in one school term in 2014;
- Allied health academics ($n = 2$), one with direct student supervision responsibility and one with a strategic program role at the external university.

Seven school principals, both senior managers, all allied health students, and both academics consented to participate in the study.

Data collection and analysis

Focus groups (FGs) were used with school principals and allied health students, and individual semi-structured interviews with senior managers and allied health academics. Both methods were used to support the pragmatic responsiveness of the study – enabling participants allocated to focus groups to participate in individual interviews to avoid their experiences being lost to the study, as was the case with one school principal; the parallel use of data to enable data comparison – an approach to data triangulation that has the potential to provide deep insight into shared patterns and differences of experiences ([Loiselle *et al.* 2007](#)); and our desire for data completeness. [Lambert and Loiselle \(2008: 230\)](#) stated that:

When seeking data completeness, it is assumed that each method reveals different parts of the phenomenon of interest (complimentary views) and contributes to a

more comprehensive understanding (expanding the breadth and/or depth of the findings).

FGs and individual interviews were digitally recorded and transcribed manually ([Lincoln and Guba 1985](#)). Participants were de-identified by school, community, position and discipline. Individual interview participants were informed of challenges in guaranteeing their confidentiality, and were provided with transcript copies to determine if there was a need to modify their own words ([Carlson 2010](#)); no modifications were requested.

Data was analysed using a constant comparative analysis method ([Boeije 2002](#), [Fram 2013](#)). Four stages of analysis were conducted: (1) comparison within single transcripts, (2) comparison within group transcripts (principal, senior manager, allied health student and academic groups), (3) comparison within community and campus group transcripts (principals and senior managers; allied health students and academics), and (4) comparison across community and campus transcripts. Three researchers independently reviewed a selection of campus transcripts, coded and categorised data, and identified emerging themes. All of the researchers reviewed and re-analysed results in order to refine descriptions of themes ([Creswell 2007](#)). The remaining transcripts were then analysed by Debra Jones (author).

Results and discussion

This article presents the community findings associated with partnership initiation, catalysts for participation, and participation impacts, identified through Stage 3 of data analyses. Other findings, such as campus and student impacts of participation have been presented elsewhere ([Jones, McAllister, and Lyle 2015a](#), [Jones, McAllister, and Lyle 2015b](#), [Jones, McAllister, and Lyle In Press](#)).

Initiating the partnership

The University Manager (UDRH), a self-identified intergenerational community member, provided insight into the circumstances that contributed to partnership initiation:

We were going into our high schools providing tutorial support. The principals informed us that high school may not be the best place to start, that we needed to step back and look at how we could address the needs of younger children who couldn't access allied health services. The principals highlighted developmental issues as the main cause for children disengaging from education.

A long-term principal described their perspective of partnership formation and initial program discussions:

We had a long-term frustration across the schools around the inability of health sectors to provide services for children with delays. This partnership was pretty much let's try it and see what happens. We didn't know particularly where it would end but we made a start. (FG1: Principal 1)

Another long-term principal described their perception of who initiated the partnership:

I'd describe the partnership as something that came about from a locally identified need. As a group of principals we saw that there was a need and we all came up with a model that might work for us. (P:1)

The School Manager provided their insight into partnership initiation:

It evolved from conversations between the principals and the UDRH. The potential partnership was discussed at a meeting and everyone was unanimous about

participating, what other choice did we have? But it turned out to be a real local-solutions approach.

The question of who initiates community-campus partnerships is one of importance but rarely identified in the literature. [Glover and Silka \(2013: 39\)](#) stated that a “[f]ailure to devote attention to the question of who starts the partnership ignores important relational dynamics that may actually undermine the stated goals of mutuality, equality and reciprocity.” Much of the community-campus partnership literature is focused on university engagement with underserved communities, and the question of who initiates the partnership is of importance – specifically when this literature is heavily critiqued for biasing the needs of institutional partners over those of communities ([Butin 2010](#), [Cruz, and Giles 2000](#)). [Bingle Games, and Malloy \(1999: 9\)](#) stated that these partnerships can be high risk endeavors where communities can be viewed as “[p]ockets of needs, laboratories for experimentation, or passive recipients of expertise.” Furthermore, remote Australian communities can be viewed from an existing deficit perspective. [Bourke et al. \(2010: 205\)](#) stated “[t]hat despite the very best of intentions, the persistence of identifying (remote community) problems contributes to outsiders understanding rural and remote health as inherently problematic. Undoubtedly, the prevailing deficit approach has been used successfully by many stakeholders in their political quest to gain more resources.” The findings from this study answer the ‘who’ question posed by [Glover and Silka \(2013\)](#) and challenge deficit perspectives of remote communities with community partners describing their leading role in partnership initiation and solutions identification.

Catalysts for community participation

The remote context

Features associated with remote contexts were identified as influencing community participation. The impact of geographical isolation, lower socio-economic status, protracted allied health workforce shortages, and resultant service inaccessibility were described:

My friends had to travel three hours to get to allied health services. Whilst they had the financial and transport means to do that a lot of families in this community don't. The children who are in most need of these services can't afford to access services. (FG1: Principal 3)

For a lot of parents in this community they didn't have an understanding of what allied health professionals could actually offer. Community knowledge of what they could contribute to support children was something they had no concept of. These professionals weren't visible or accessible in our community. (FG2: Principal 2)

The University Manager provided insight into their direct experience of allied health service inequity:

I was a parent that had to travel to get any sort of allied health support. My child desperately needed a program like this and I lived that lack of access to services for years and years. We lived this ourselves as children, allied health services weren't available to us when we were growing up.

The Australian [SCoH \(2012: 19\)](#) stated that “[t]he combined impact of fewer resources, poorer access to services, limited availability of key health professionals, poorer health status, lower socioeconomic status, distance and travel mean that rural and remote communities and the health challenges they face are significantly different from those confronted by metropolitan Australians.” We propose that these features can also contribute to ethical dilemmas. An increasing emphasis is being placed on enhancing community health literacy as a means of reducing health disparities and increasing service equity. The Australian National Statement on Health Literacy ([Australian Commission on Safety and Quality in Health Care \(ACQSHC\) 2014: 67](#)) proposes that local health sectors should “[p]rovide education programs for consumers

aimed at developing health knowledge and skills', to enhance the, 'motivation and capacity of a person to access, understand and apply information to make effective decisions about health and health care." Whilst seeking to improve community health literacy limited attention is paid to the implications of enhancing community knowledge of health services in the continuing absence of the health professionals required to address remote health needs. These potential ethical dilemmas need to be taken into consideration, necessitating remote representation in policy and practice development.

Health sector failures

Perceptions of health sector failures to respond to community identified needs, appear to have been a significant catalyst for partnership participation:

We have a number of different health services in this community, many different services to be honest. But there was just a glaring gap with allied health services. While schools were identifying developmental issues with children and making referrals the services were just not following these up. (FG1: Principal 3)

Community members are loathing going on a waiting list. It's another barrier to them seeking support. Children get referred to services and the momentum gets lost because of the waiting times. Appointments get missed and the child ultimately suffers. It's not that the parents don't want to take up services but the delays, transport, and socio-economic status make it more problematic. (FG2: Principal 2)

The *Australian Charter of Healthcare Rights* (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2008) stated that access to healthcare is a fundamental right for every Australian. However, children residing in remote communities are at greater risk of experiencing developmental delays (NSW DEC 2013) and are less likely to have access to allied health services to address these delays (HWA 2013, NSW DEC 2013, Spiers and Harris 2015). Gilson *et al.* (2007: viii) stated that "[t]here are examples of health systems that: fail to apply their expertise to address the social determinants of health; institutionalize health care arrangements that create financial and geographic barriers to access for disadvantaged groups." Bryson, Crosby, and Stone (2006) identify health sector failures as catalysts in partnership formation. Although not an acknowledged catalyst for partnership formation (Bryson, Crosby, and Stone 2006), we propose that direct and indirect experiences of service inequities can act to influence the formation of remote health partnerships. Furthermore, Bryson, Crosby, and Stone (2006: 46) stated that "[w]e can live with the problem, engage in symbolic action that does little to address the problem, or mobilize collective action to fashion a cross-sector solution", in this instance the development of an allied health service-learning program.

Community impacts of participation

Adaptation of service and learning components

Processes employed to support program adaptation and continuous improvement were described:

We're always having discussions about how we can make the program better. It's not just 'here a program is' and leave it alone. It's a constant evaluation. (FG1: Principal 4)

The academics have been around a while now and we've got that constant feedback. We're doing things now that we weren't in the beginning. Because of that feedback there is a smooth transition between student cohorts and how they are prepared for program participation. The lessons learnt from the previous cohorts quickly impacts on the next cohort. (FG1: Principal 3)

A principal compared this aspect of adaptation with other service approaches:

Other agencies come in, deliver what they want and it meets their needs. Why would you want to work with them? We have adapted and expanded on this model to best meet the needs of our children and the results speak for themselves.
(Principal: 1)

Despite principal-receptiveness to adaptation, the School Manager voiced concerns with a lack of program uniformity across school campuses:

We've been delivering the program for a while now. We should have fine-tuned it to a point where every school is working consistently.

The engagement of communities in knowledge production to inform service-learning activities is an important feature of sustainable community-campus partnerships and service-learning initiatives (Petri 2015, Sandy and Holland 2006). However, this co-production is dependent on health and university sector receptiveness to community input (Kernick 2004). In achieving knowledge co-production, there is a need to transition relationships between health, universities and communities from ones that are transactional “designed to complete a task with no greater plan or promise” to transformational relationships, those that are receptive to “[d]eeper and more sustained commitments” (Enos and Morton 2003: 24). Dunstan *et al.* (2009: 42) informed us that community-led adaptation can, “[p]rofoundly disturb many fundamental constructs that have long informed professional identity, defined and differentiated expert knowledge from lay knowledge and shaped the roles and rules that typically govern the ways in which health professionals and health consumers interact.” Whilst we acknowledge a desire for standardisation, study findings suggest that service acceptability and sustainability was enhanced by program adaptation that was informed by community experiences and feedback.

Partnership commitment and service consistency

The importance of community commitment to the partnership was evidenced when there was a failure by the university to meet their commitments in the early stages of program implementation:

After the first student cohort, the university was unable to provide us with a second cohort of students. We were devastated about making promises that we couldn't keep. We learnt a lot from that experience, from working through this with the principals and university. I think this experience contributed to the success of the program. (University Manager)

Programs are sustainable as long as there is that shared commitment. You're going to hit some hurdles along the way and you've got to work through them. Our principals definitely wanted this program to succeed and they weren't going to throw the towel in because we hit some hurdles. (School Manager)

A principal compared their experiences of other health relationships and service inconsistency, with the program:

Other health services and staff are always changing. This service is extremely consistent and we've always needed that consistency, that opportunity to build those relationships. (FG1: Principal 3)

The School Manager expressed their concerns about future relationship consistency and implications for program sustainability:

My greatest fear is that we have key drivers who champion the program. I worry that if these drivers leave that the program would become vulnerable. We have to identify our future leaders and build their capacity to ensure this program is secure.

Transitioning the theory of partnerships to the practical application of partnering can be challenging. Health and higher education sectors need to consider their capacity to commit to long-term service consistency and partnerships prior to implementing services and engagement strategies. [Enos and Morton \(2003\)](#) stated that, for partnerships to be successful, partners need to remain in relationships despite obstacles and challenges that inevitably arise. However, remote locations can experience high levels of relationship and service inconsistencies influenced by political, policy and funding decisions and high turnover of professional staff. Previous experiences of relationship and service inconsistencies may have significantly contributed to a community focus on the importance of these features. Community-campus partnership and service-learning literature describes the need to invest in sustainable relationships ([Sandy and Holland 2006](#)), yet less emphasis is placed on the importance of service consistency, a characteristic that may be of significance in sustaining partnerships and programs in remote contexts.

Service acceptability and accessibility

School principals reflected on their perception of service accessibility and program acceptability:

Our parental consent rate for the program is 100%. Parents know about this program. Parents who have been reluctant to go out of town for allied health services are on board with what the school is trying to achieve. They are more inclined to take our phone calls because they know we are supporting their children. (FG1: Principal 3)

The acceptability of service location, school campuses, and location impact on enhanced service accessibility were described:

Even if allied health services from the other agencies were to come to this community I don't think some of our parents would access those services if they were based at the health service. This program takes that burden off parents. It's embedded into everything that we do in our school. Because of the way the program operates the students are in our classroom environment and all of the children get the benefit of this program. (FG1: Principal 2)

The University Manager described the importance of local leadership in ensuring program acceptability:

It's not about external agencies being the guiding light. This initiative was grown locally; local people have ownership of it, are connected and invested in ensuring it succeeds. The power and knowledge exists within the community. External agencies that have the most success are ones that sit alongside rather than on top of communities. (University Manager)

The [Australian National Health and Hospital Reform Commission \(NHHRC\) \(2009:122\)](#) identified that "consumers should not only be the focus of the health system, they should be at the centre of decision-making in health." [Health Workforce Australia \(HWA\) \(2013\)](#) stated that a commensurate effort in remote health workforce development and reform was required. A failure to reform has the potential to result in a worsening divide in access to health services; a failure to impact on the quality of life of remote Australians; consumer avoidance or rejection of care; and higher cost burdens to health care systems, individuals and communities. Findings from this study provide important insights into the capacity of remote communities to contribute to the design of acceptable health services and workforce development strategies that can enhance service accessibility and sustainability.

Community investment in health workforce development

Participants described their role in supporting the development and educational outcomes of participating allied health students. The potential impact of this investment on remote practice post-graduation was identified:

Hopefully some of these students will come back as permanent health staff because they've had such a positive learning experience with us. They're made to feel like a part of the school community. I would hope that some of them will say, 'That's actually a really good option for me when I graduate'. That would be wonderful for our community. (FG1: Principal 3)

Even though the students may not be from this community, if we can get these students interested in coming to rural communities to practice then school education are doing our bit. (School Manager)

The University Manager discussed how the program was designed to better align to community expectations:

The program has been designed with community, for community, and to support students in immersing themselves into the community. It helps them understand what it's like to live and work in a rural location, to show that rural practice is not isolating, that you can have a thriving professional career here.

The provision of remote practice experiences is a key strategy in addressing health workforce shortages. However, [Spiers and Harris \(2015\)](#) described barriers to the provision of these experiences for allied health students, including an undersupply of allied health placements, lack of adequate supervision, student isolation from peers and learning resources, and lack of placement coordination. Prior to the establishment of this partnership and program, no pediatric SP student placements had occurred in the region in the preceding 15 years with minimal OT student placements. Following the inception of the program, 70 OT and 170 SP students have now been provided with a remote practice experience. Study findings suggest that student learning outcomes may be equivalent to, if not greater than, those achieved in metropolitan and traditional hospital settings ([Jones, McAllister, and Lyle 2015a](#), [Jones, McAllister, and Lyle 2015b](#), [Jones, McAllister, and Lyle In Press](#)). Community partners have played a critical role in expanding placement capacity, providing onsite education and supervision, and the coordination of student placements through the UDRH. We acknowledge that not all remote locations have access to the academic, educational and infrastructure resources associated with UDRH, and this may have direct implications for the transferability of these partnerships and programs. However, UDRH footprints are expanding and this may provide greater opportunities for other remote communities to engage in health service design and workforce development.

The findings from this study highlight the capacity of remote communities to inform how their health services are designed and a potential future remote health workforce developed. These findings challenge 'deficit' perspectives that can influence the development of remote health policies and practices and marginalise community perspectives and experiences. Health and higher education sectors need to have a greater level of responsiveness to locally developed and led health innovations, and student education that may challenge traditional supervision and training models. These findings have international and national significance for other remote communities that may be seeking alternative approaches to their engagement in their health care agendas.

Limitations

Exploring the service impact for children and their families was beyond the scope of this study and additional research is required. Impact of participation on allied health student preference

for remote practice post-graduation was beyond the scope of this study. As this study explores the experiences of one remote Australian region, findings should be generalized with caution. However, the partnership and program described in this study have been adapted for implementation in other remote contexts, and evaluations of these affiliated programs are currently being conducted.

Conclusion

Through the effective engagement of communities in the design of their health services and the development of their health workforce, collective needs can be addressed. The findings presented in this article provide valuable insights into the capacity of remote Australian communities to initiate health partnerships that seek to address their protracted health inequities and health workforce shortages. The 'litmus test' for health and higher education sectors may be whether they have the capacity to respond to remote community voices, and the ability to commit to long-term and sustainable services and relationships that address community-identified needs and expectations. These findings address significant knowledge gaps in the international and national community-campus partnership and service-learning literature. We propose that community perspectives on partnership initiation and ongoing engagement contributed to substantive and long term solutions being afforded to children residing in this remote region. Based on study findings, remote communities can lead health partnerships and support the development of programs that may provide viable and sustainable alternatives to addressing their health inequities and workforce shortages.

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