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An exploration of the longer-term impacts of community participation in rural health services design

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ABSTRACT

This article explores what happened, over the longer term, after a community participation exercise to design future rural service delivery models, and considers perceptions of why more follow-up actions did or did not happen. The study, which took place in 2014, revisits three Scottish communities that engaged in a community participation research method (2008–2010) intended to design rural health services. Interviews were conducted with 22 citizens, healthcare practitioners, managers and policymakers all of whom were involved in, or knew about, the original project. Only one direct sustained service change was found – introduction of a volunteer first responder scheme in one community. Sustained changes in knowledge were found. The Health Authority that part-funded development of the community participation method, through the original project, had not adopted the new method. Community members tended to attribute lack of further impact to low participation and methods insufficiently attuned to the social nuances of very small rural communities. Managers tended to blame insufficient embedding in the healthcare system and issues around power over service change and budgets. In the absence of convincing formal community governance mechanisms for health issues, rural health practitioners tended to act as conduits between citizens and the Health Authority. The study provides new knowledge about what happens after community participation and highlights a need for more exploration.

1. Introduction

The study reported here is a 2014 reflective exploration of what happened, over the longer term, following a 2008–2010 community participation study based in Scottish remote communities. The original study aimed to design a community-engaged process to derive contextually appropriate primary health service delivery models. This paper considers perceptions of why follow-up actions did or did not happen after the 2008–2010 community participation study. There is little research that follows up on community participation initiatives and this article addresses this gap.

The study revisits the small remote community settings of the 2008–2010 Scottish Remote Service Futures (RSF) community participation project (Farmer and Nimegeer, 2014; Nimegeer et al., 2014). RSF used action research (Carr and Kemmis, 1986) to develop a contextually appropriate community participation method based on deliberative decision-making (Kahane et al., 2013). The focus was on the deployment by health service managers to engage local stakeholders in evidence-informed decision-making. In developing the method, new ideas were introduced about ways of providing services in community settings and we assessed that these might be implemented, even though the RSF project brief contained no formal onus on any stakeholder to make service change.

In the 2014 reflective study reported here, we conducted 22 interviews to investigate the extent to which stakeholders remembered participating in the original RSF project, what they remembered, what had changed, and perceptions of what affected whether change occurred.

2. Literature review

Community participation is commended in international health services policy (Committee on the Future of Rural Health Care

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(2005); Commonwealth of Australia, (2012); Kulig and Williams, 2012; Scottish Government, 2011; Scottish Government, 2013; Wagstaff et al., 2009; World Health Organisation, 2010). Within the literature there is increasing interest in community participation, with authors highlighting examples of, methods, approaches and intentions (for example, Attree et al., 2011; Draper et al., 2010; Freeman et al., 2014; MacLeod et al., 2012; Milton et al., 2011; Summerville et al., 2008). In the Scottish context broadly, Moore and McKee (2014) propose that the Scottish Government's policy innovations, including community empowerment legislation (Scottish Parliament, 2014), envision partnerships between state and citizens.

In health, the rise of community participation can be traced to the 1978 Alma Ata declaration (Draper et al., 2010) where it was promoted as a health improvement process. Recently, it has been given an overtly political overlay, deployed as part of actions to engage civic society in public services (Summerville et al., 2008). In this regard, community participation is to enhance democratic engagement, involve or 'responsibilise' (defined by Peeters, 2014, p.2 as the state 'enabling, enticing or nudging citizens to 'take responsibility' for their lives and their communities') citizens in producing services and economic opportunities, and to engage community members in shaping individual and collective destiny (Moore and McKee, 2014). Applying Foucault's (2007, p. 108) depiction of 'governmentality' (guidance provided by the state about conduct in society), we propose that community participation can be understood as a neoliberal governmentality. It simultaneously appeals – in appearing to give choice, agency and 'a say' – while constraining individual's locus and means of operation, and proposing they should help themselves – or fail (Peeters, 2014).

Involving rural residents in designing locally appropriate services has been promoted as particularly appealing (OECD, 2006). Rural service sustainability is threatened by changing demographics, few economies of scale and limited practitioner career development opportunities (NHS Highland, 2014; OECD, 2006). Rural citizens are stereotypically portrayed as predisposed to collective working, because of small populations, high levels of relational ties and determination to sustain their community (Munoz, 2013). A contrasting view is that rural communities are heterogeneous and dynamic (Cloke, 1997) , for example in current times, contending with in-migration from culturally diverse and socially disadvantaged populations. Those that regularly, formally, participate in rural civic life, tend to have high social, cultural and economic capital (Munoz et al., 2014), but their influence can exclude others, reinforcing socio-economic division (Shubin, 2010).

Rifkin (2014) conceptualises community participation as a social process leading to public health improvements through engaging people in a learning and capacity-building exchange. She cites health commentators that regard community participation as an intervention with outcomes, for example disease control. However, policy often appears to exhort managers to do community participation, neglecting why, suggesting that it is a process rather than an outcome-oriented intervention.

2.1. The lack of evaluation of community participation

Researchers argue that community participation effects are difficult to robustly and consistently measure (Rifkin, 2014). Attree et al. (2011) gathered evidence about individual health outcomes from types of community participation, and found evidence of health improvements, therapeutic value, gains in self-confidence and self-esteem. Considering communities, Milton et al.'s review (2011) found studies observing improved information flow, social capital, partnership working and regeneration capacity. There is, however, a dearth of studies exploring longer-term outcomes, which this article addresses.

Reasons for the relative success or failure of community participation, however defined, are documented elsewhere. For example, Kenny et al. (2014) highlighted (lack of) citizen participation, power dissonance and governance, as problematical. Kenny et al. 2013 reviewed studies of community participation in rural healthcare activities and found limited involvement that conferred power on citizens, with most studies merely noting consultation. Studies that involved citizens as partners, reported raised health system awareness, improved self-efficacy, learning new skills, implementation of new policy and employment opportunities. Again, little evidence of longer-term impacts of community participation in rural healthcare was found.

2.2. The Remote Service Futures study

The 2008–2010 RSF study primarily aimed to develop a customised community participation method for designing primary healthcare service models for small, remote Scottish communities. These tend to be traditionally dependent on 'single-handed' resident practitioners. A Health Authority (a state authority to commission and provide services) provided partial funding because it wanted a low-cost, easily implemented community participation method. Health Authority managers wanted to involve stakeholders in decision-making using evidence about health status, practitioner scope-of-practice and service ideas aligned with new Scottish rural healthcare guidelines (Scottish Government, 2008).

The RSF method was developed using deliberative decision-making and action research in four communities (Snape and Spencer, 2004, p. 9–10). Deliberative decision-making, involves participants engaging with data and research evidence in a formal decision-making process (Dryzek, 2000). It is intended to offer a 'new political space' for uniting diverse stakeholder perspectives because it offers opportunities for exposure to new knowledge, particularly political knowledge (Cornwall, 2002; Cornwall and Coelho, 2006, p.8). It is viewed as inherently conservative because it involves public forums where citizens are invited, generally by authorities or government, for discussion with local officials (Williamson and Fung, 2004). Used in deliberative decision-making mode, we argue that community participation can be an intervention that produces outcomes, including stakeholder decisions about new service designs and increases in health system knowledge.

In the RSF process, a framework was derived comprising a consistent set of discussion topics and using various engagement techniques, including public workshops, drop-ins and individual interviews. Change of services following the RSF process was not stipulated. However, informal discussions by stakeholders, indicated that ideas might be raised that could progress to implementation. Ultimately, novel service designs were produced for/by participants in two of the four communities, with new knowledge of health system issues reported by stakeholders (Farmer and Nimegeer, 2014). These outcomes encouraged our thinking that some service change might have occurred following the completion of the RSF project in 2010.

In 2014, we revisited RSF settings, interviewing citizens, healthcare practitioners and managers to establish the extent to which service changes had happened after RSF. Also, given Health Authority funding for the RSF project, we wanted to investigate the extent to which the new community participation process had been adopted. The study reported here addresses the gap in evidence about what happens after community participation projects are completed, and what might impact on change or lack of change (Kenny et al., 2014).