Rural and regional community health service boards: perceptions of community health – a Delphi study

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Abstract. Much has been written about the composition of health service boards and the importance of recruiting people with skills appropriate for effective and accountable governance of health services. Governance training aims to educate directors on their governance responsibilities; however, the way in which these responsibilities are discharged is informed by board members’ understanding of health within their communities. The aim of this study was to identify how those engaged in determining the strategic direction of local regional or rural community health services in Victoria, Australia, perceived the health and health improvement needs of their community. The Delphi technique was employed to facilitate communication between participants from different geographic locations. The findings of the study highlight the different ways that participants view the health of their community. Participants prioritised indicators of community health that do not align with standard measures used by government to plan for, fund or report on health. Devolved governance of healthcare services aims to improve local healthcare responsiveness. Yet, if not accompanied with the redistribution of resources and power, policy claimed to promote localised decision-making is simply tokenistic.

Additional keywords: governance, health policy reform, social health.

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Introduction

In developed countries, citizens are members of health service boards or part of community advisory committees (Titter and McCallum 2006). Their role is in local priority setting, to improve efficiency and effectiveness, and ensure service operations align with community need (Smith \textit{et al.} 2012; Veronesi and Keasey 2012). Traditionally, well meaning, altruistic volunteers, served on boards or committees with little understanding of governance of health issues (Bismark and Studdert 2014).

Increased service accountability (Veronesi and Keasey 2012; Considine \textit{et al.} 2014) has resulted in a greater focus on the skills, knowledge and experience of people involved in strategic directions and governance of health services (Australian Institute of Company Directors 2016). Skills matrices are commonly used when recruiting board members, to ensure the skills of the board members meet the needs of the organisation, and members of advisory committees are recruited for the skills that they bring (Considine \textit{et al.} 2014). Critics state that restructuring not-for-profit boards and committees in favour of business-like and professionalist members can lead to mission drift, reduce advocacy in preference to service provision, disempower grassroots activists, devalue qualitative evidence, and increase the influence of the elite (Keever \textit{et al.} 2012; Maier \textit{et al.} 2016).

Much of the literature on boards and advisory committees is dominated by discussion of fiduciary responsibilities (Veronesi and Keasey 2012; Considine \textit{et al.} 2014). There is a dearth of literature that explores directors or advisory committee members’ understandings of health and community health needs, yet these understandings are important in effective decision-making.

The aim of this study was to identify how those engaged in governance of regional community health services, as directors of boards or community advisory committees, perceived the health and health improvement needs of their community.

Methods

The Delphi technique (Delphi), a method of participatory research (Kezar and Maxey 2016), provides a snapshot of group opinion at a particular time, to inform practice or theory (Hasson and Keeney 2011). The technique combines collaborative effects of focus groups with the rigour of traditional surveys (McIntyre \textit{et al.} 2010). Iterative surveys are used to organise interaction between knowledgeable individuals (Fletcher and Marchildon 2014; Guzys \textit{et al.} 2015). Responses are collated then shared, facilitating a hermeneutic process of reflection on opinions of others, with areas of consensus and core differences in opinion highlighted (Guzys \textit{et al.} 2015).

Delphi is a group decision mechanism, therefore statistically significant samples are not needed (Adler and Ziglio 1996; Okoli and Pawlowski 2004). Between 7 and 18 participants have been recommended, whereas others report significantly larger
What is known about the topic?
- Health service boards have an important responsibility guiding the strategic direction of health organisations, yet how those responsible for community health service governance understand health is absent in the literature.

What does this paper add?
- This Delphi study highlights a dissonance between how community health is perceived by those responsible for community health service governance and the core principle of devolved governance.

numbers (Okoli and Pawlowski 2004; Wilkes 2015). Smaller panels are best suited to homogenous groups, whereas heterogeneous groups require larger panels (Briedenhann and Butts 2006; Skulmoski et al. 2007). Participant attrition is an acknowledged challenge in Delphi (Sobaih et al. 2012; Fletcher and Marchildon 2014), with attrition of approximately one-third of participants between rounds typical (Wentholt et al. 2009).

Regional community health services in Victoria, Australia were identified using a publicly available list on a State government website. The board chair for each service was mailed an invitation explaining the research aims and process. They were asked to share information with fellow directors and members of community advisory committees. The Chief Executive Officer of each service was emailed a reminder 6 weeks later, with a request to prompt participation of board and community advisory members.

The invitation included a survey web link and information for the participants. Geographically dispersed participation was facilitated through an online package, Qualtrics (Qualtrics LLC, Salt Lake City, UT, USA, see https://www.qualtrics.com). Consent was implied if the survey was completed. The study was approved by a university human ethics committee (FHEC14/114).

Open-ended questions generated responses in the first survey round (Skulmoski et al. 2007). Responses to: How would you know if your community is healthy; How would you know if your community has the skills and knowledge to be healthy; and What could be done to improve the skills and knowledge to be healthy in your community; were collated, generating 96 statements. These statements became the survey tool used for subsequent surveys in which participants rated levels of agreement with each statement on a 10-point Likert scale. Space provided for an additional text response was used by participants to emphasise their level of agreement with statements, rather than to provide additional textual data to confirm or challenge the themes identified. Verbatim comments were reported back to participants along with percentages of agreement for each statement, in an online summary accessed by an emailed link.

Following consideration of the summary provided, participants were invited to complete the survey again. The survey process concluded as theoretical saturation was achieved, with no change in consensus responses apparent between rounds two and three, representing stability of opinion which includes stable disagreement (Skulmoski et al. 2007; Guzys et al. 2015). Just over one-third of the participants who commenced the Delphi completed the final survey. The Delphi survey process is summarised in Table 1.

By using recursive abstraction, an iterative structured analysis process was used to interpret meaning and develop themes (Polkinghorne and Arnold 2014), with a thematic network developed (Attride-Stirling 2001). The values assigned to statements generated in the first Delphi round were summarised as percentages.

Results
In this study, 30 individuals provided responses to the first Delphi round. Demographic data from the first round is summarised in Table 2.

The level of agreement at each point on the Likert scale was represented by the percentage of participants who responded, rounded to the closest whole number. Data were clustered into three groups to facilitate analysis. Responses of 1-4 on the 10-point Likert scale were considered to indicate disagreement with the statement. Responses rated 7-10 were interpreted as agreement. Responses of 5 and 6 were interpreted as being close to neutral. A tendency to disagree was indicated by 5 and a tendency to agree was assumed when 6 was used.

None of the original 96 statements were unanimously rated 7 and above, or 4 and below. Statements rated 6 or higher were described as indicating strong agreement. This distinguished 7 of the 96 statements. Data were included where all but one participant rated statements at 6 or above. Having only one outlying opinion, this category of statements was interpreted as indicating solid agreement, contributing an additional 12 statements for consideration. The 19 statements are presented in Table 3.

The statements identified by consensus highlight which aspects of community health explored through thematic analysis

<table>
<thead>
<tr>
<th>Table 1. Summary of the Delphi survey process and data processes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delphi</strong></td>
</tr>
<tr>
<td>Round One</td>
</tr>
<tr>
<td>Round Two</td>
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<tr>
<td>Round Three</td>
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are most valued. This collective emphasis should guide health service priority setting.

Analysis of the textual data from the first round Delphi demonstrated healthy communities conceptualised by two themes: understanding health and supporting health. Understanding health as more than the absence of illness was emphasised. Local statistical data were acknowledged as contributing to how the health of the community was perceived, as was anecdotal information from within the community and observable behaviours of community members. Engaging in community life was highlighted, and infrastructure and resources were viewed as important to facilitate positive health behaviours. Recognition of the existing strengths of the community, and taking individual and collective action to benefit the wider community, were important. The thematic network developed during data analysis is presented in Fig. 1.

**Table 2.** Participant demographic data collected as part of the first Delphi survey round

<table>
<thead>
<tr>
<th>Male</th>
<th>17%</th>
<th>Female</th>
<th>83%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25–35</td>
<td>(17)</td>
<td>35–45</td>
<td>(10)</td>
</tr>
<tr>
<td>35–45</td>
<td>(33)</td>
<td>45–55</td>
<td>(37)</td>
</tr>
<tr>
<td>45–55</td>
<td>(27)</td>
<td>55–65</td>
<td>(3)</td>
</tr>
<tr>
<td>55–65</td>
<td>(37)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65&gt;</td>
<td>(3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residence (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td>Rural town</td>
<td>(27)</td>
</tr>
<tr>
<td>Rural town</td>
<td></td>
<td>Regional centre</td>
<td>(46)</td>
</tr>
<tr>
<td>Regional centre</td>
<td></td>
<td>Metropolitan city</td>
<td>(0)</td>
</tr>
<tr>
<td>Metropolitan city</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest level of education (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some secondary education</td>
<td>(0)</td>
<td>Completed secondary education</td>
<td>(7)</td>
</tr>
<tr>
<td>Completed secondary education</td>
<td>(7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade or Diploma</td>
<td>(20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree</td>
<td>(30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postgraduate Degree</td>
<td>(43)</td>
<td></td>
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</tbody>
</table>

**Table 3.** Statements recording strong and solid levels of agreement

<table>
<thead>
<tr>
<th>Strong agreement (all participants rated these statements at 6 or higher)</th>
<th>Solid agreement (all participants rated these statements at 6 or higher, with one outlier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community members are proud to be a part of their community.</td>
<td>People participate in community activities.</td>
</tr>
<tr>
<td>Public spaces are well cared for/maintained.</td>
<td>Social and community groups network well.</td>
</tr>
<tr>
<td>People are willing to assist others.</td>
<td>People smile and are optimistic.</td>
</tr>
<tr>
<td>Community members are involved in community planning.</td>
<td>Healthcare professionals maintain their professional currency.</td>
</tr>
<tr>
<td>Community lobby groups exist to influence decision-makers.</td>
<td>Local services are the preferred option of community members.</td>
</tr>
<tr>
<td>The community has visible and identifiable leaders.</td>
<td>Local political action occurs.</td>
</tr>
<tr>
<td>People can be seen being physically active.</td>
<td>People own pets.</td>
</tr>
<tr>
<td></td>
<td>Employment or unemployment rates.</td>
</tr>
<tr>
<td></td>
<td>Community projects are undertaken.</td>
</tr>
<tr>
<td></td>
<td>Health education programs are well advertised and run.</td>
</tr>
<tr>
<td></td>
<td>People can share their skills and knowledge.</td>
</tr>
<tr>
<td></td>
<td>Prompt service provision.</td>
</tr>
</tbody>
</table>

**Understanding health**

The theme *Understanding health* reflected participant understanding of health, and what they valued as important for community health.

*Health is much more than the absence of illness*

Participants identified housing security, transportation, employment and educational opportunities as influencing health, and felt that it was important that other community members recognised the significance of such issues:

If they had an understanding of the social determinants of health, and understood health as opposed to ill health [P-22].

Opportunity for employment was emphasised in the responses, specifically in reference to financial capacity. Participants associated poor health outcomes, particularly mental health and health behaviours such as substance use, with social disadvantage.

*Seeing is believing*

Observable social, emotional and physical environments of a community contributed to participant views of health. Lack of
involvement in community life was perceived as unhealthy, described as disengagement and linked to antisocial behaviours such as substance use. A healthy community was summarised in the following response:

It would be active, vibrant, connected, innovative, sustainable & full of optimism [P-13].

Quality of life, community character, volunteerism and service organisation efforts were acknowledged as contributing to health. Participants stressed the value of positive social interactions to health, giving examples such as ‘neighbours visiting each other’, ‘people acknowledging each other and engaging in conversation’, as well as ‘helping each other out’. Such behaviours contributed to less tangible indications of a healthy community:

There is a sense that people care about the town, the environment and each other [P-7].

Although emphasis primarily remained on what was visible, interpretations of the emotional status of the community were suggested in several responses; for example, ‘seeing how happy the majority of people in town are’. Physical attributes such as the environment were taken to signal social cohesion, and community pride was exhibited through ‘well cared for houses and clean streets’.

Participants commented on observable lifestyle behaviours associated with health, such as content of shopping trolleys, children’s school lunch boxes and community member obesity. Children wearing sporting uniforms or seen playing in the streets and ‘the presence of people using bikes, walking, running’ were associated with evidence of activity.

That’s what they said

The importance of conversation and communication were prominent in participant responses. Anecdotal information and formal community feedback contributed to how participants perceived the health of their communities. Informal feedback included stories relating to health, and experiences with health services from community members and health service providers. Community engagement was assessed by ‘attendance or lack of’ at public forums and community meetings.

Because the data tells me so

Several participants monitored community health through statistical data, including waiting time to access local health services and service utilisation rates. Participants referred to prevalence of disease rates, socioeconomic and demographic data, criminal activity, employment rates and medication use data. Comparison of local community statistics against data from other communities was recommended.

Supporting health

The Supporting health theme, which emphasised the creation of a physical and social environment that supports health and facilitates healthier choices, was recognised as contributing to achieving health.

There would be a lot to DO in the town, especially in the evenings, other than just going to the pub which is currently the only thing on offer in lots of small towns (example: community and cultural events, movie viewing, a youth centre with pool tables or foosball tables, or community lawn bowling) [P-19].

Joining in and taking part

Behaviours considered essential in depicting the health of a community are exemplified in the following responses:

There would also be evidence that they were healthy in terms of community connectedness [P-2].

People know how to relate to others in their community, how to help out, how to get help [P-26].

Intergenerational activities and sharing cultural experiences reflected healthy community attitudes of acceptance of difference and diversity.

Build it and they will come

Physical resources identified as facilitating healthier behaviours included footpaths, bike paths, active space in general, access to appropriate healthcare services and sources of high-quality health information. Discouraging poorer health choices was recognised as important in achieving a healthy community. Limiting the number of take away food outlets and increasing the availability of healthier food options at public venues and activities was viewed positively. Health was considered to be supported through ‘good access and use of prevention and health promotion services, such as health check-ups, screening tests’.

Making a stand and doing something

Healthy communities were perceived as those that relied on resident identification of issues and action, rather than on health professionals initiating action. Community leadership was emphasised:

If the community is able to take positive steps to being empowered to be a healthy community [P-11].

Engagement via social media with campaigns against the negative things e.g. anti-fast food outlets, anti-fracking protest [P-13].

The leaders in the community are well educated and interested in the opinions and ideas of those who don’t agree with them, and aim to work together in spite of differences [P-26].

Recognising existing strengths

Building on what is already working in the community, rather than focusing on perceived deficits, was emphasised. As one participant concluded:

I think our community is already healthy, as all these signs are present [P-5].

Discussion

Consistent with other studies, participants predominantly viewed health as a norm of everyday life, with emphasis on
maintaining the ability to function in the community, not simply to avoid illness (Idler et al. 1999; Downey and Chang 2013). Health and health behaviours influenced by social structures and social groups was emphasised in the consensus statements. Community pride, grass roots leadership and involvement in community planning and decision-making illustrated a perceived link between collective efficacy and community health. Collective efficacy describes the willingness of people to take action for the betterment of their community (Cohen et al. 2006).

Disparities between the health of rural and urban residents are generally exacerbated by higher levels of socioeconomic disadvantage, more difficult environmental conditions, occupational risks, increased transportation requirements and poorer access to health services (Kenny et al. 2013; Smith et al. 2008). An understanding of social determinants such as employment, education, income and access to transportation are apparent in the thematic analysis. The consensus statements only included employment, which may reflect dissonance between theoretical understanding of social determinants and participant experience.

Skill matrices considered beneficial to board composition are likely to preference inclusion of those with higher educational attainment, providing some justification for the claim that devolved governance increases the influence of the elite (Keever et al. 2012; Maier et al. 2016). Most participants reported tertiary level education, which is not representative of the educational attainment data reported for Victorian rural and regional communities. Diminished emphasis placed on social determinants during the consensus process might reflect the personal reality of participants.

The consensus statements reflect that social capital, and to a lesser extent, improving social determinants, are perceived as positively influencing health. Social capital has been proposed as a means to improve the capacity of communities to work together to solve collective health problems, influence political decisions and encourage health-enhancing behaviours (Eriksson et al. 2013). Empowering individuals and communities to better understand and take action to address the social determinants of health requires the development of critical health literacy (Mogford et al. 2011; Sykes et al. 2013). Those with governance responsibility require the capacity to mobilise and coordinate local resources to influence social determinants of health (Burris et al. 2007). However, political ideology, medical dominance and feeble political advocacy for health funding are recognised as hampering efforts to address health inequity and the social determinants of health (Baum et al. 2013).

Thematic analysis of the data illustrated participant cognizance of epidemiological and sociodemographic data in relation to health and health needs of their community, although these were not prioritised in the consensus process. Participant knowledge of priorities, which should inform strategic planning, are apparent in the consensus data. How this knowledge is translated to decision-making is challenging, when health funding models focus on clinical service provision. The implication drawn from consensus in this study suggest that resources to improve the health of rural communities should focus on strengthening community capital and addressing social determinants.

The purpose of this study was not to achieve generalisable findings, although the learnings from this study may be transferable to other settings. There is limited research on directors or advisory committee members’ understandings of health and community health needs. Future research should include exploration of the skills and understandings needed by community health service directors and advisory boards to ensure that strategic decisions are informed and based on local data. Although some participants in this study indicated that they used data in decision-making, research focussed on boards’ access and use of data to fulfil their governance role would be useful. Consideration should be given to the skill mix of those in community health service governance roles and whether those skills adequately address the needs of their local community. The findings from this study suggest the need for research into current primary healthcare funding models and whether boards have sufficient flexibility to prioritise responses to local health issues. Finally, research is required to determine if current models of community health service delivery are appropriate to address the social determinants of health.

We acknowledge several limitations of this study. Differentiating between board directors and community advisory committee member, through separate Delphi studies may have resulted in more nuanced data. Participant attrition delayed the process, hampered the depth of data obtained and hindered analysis. The potential for gender bias is recognised, as the demographic information demonstrates that participants were principally female.

Conclusion

Those with strategic responsibilities in health services are required to be highly skilled to fulfil their roles effectively and responsibly. Participants in this study demonstrate that they understood what makes their communities healthy; however, their ability to act on this knowledge is hampered by funding models that are heavily focussed on illness and disease. Localised decision-making requires the redistribution of resources and power to genuinely empower local community action.

Conflicts of interest

The authors declare that no conflicts of interest exist.

References


