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## Community governance in primary health care: towards an international Ideal Type

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### SUMMARY

Against a global background of increased resource management responsibilities for primary health care agencies, general medical practices, in particular, are increasingly being required to demonstrate the legitimacy of their decision making in market oriented environments. In this context a scoping review explores the potential utility for health managers in primary health care of community governance as a policy concept.

The review of recent research suggests that applied learning from international health systems with enhanced approaches to public and patient involvement may contribute to meeting this requirement. Such approaches often characterise local health systems in Latin America and North West Europe where innovative models are beginning to respond effectively to the growing demands on general practice. The study design draws on documentary and secondary data analyses to identify common components of community governance from the countries in these regions, supplemented by other relevant international studies and sources where appropriate. Within a comprehensive framework of collaborative governance the components are aggregated in an Ideal Type format to provide a point of reference for possible adaptation and transferable learning across market oriented health systems. Each component is illustrated with international exemplars from recent organisational practices in primary health care. The application of community governance is considered for the particular contexts of GP led Clinical Commissioning Groups in England and Primary Health Networks in Australia.

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Some components of the Ideal Type possess potentially powerful negative as well as positive motivational effects, with PPI at practice levels sometimes hindering the development of effective local governance. This highlights the importance of careful and competent management of the growing resources attributed to primary health care agencies, which possess an increasingly diverse range of non-governmental status. Future policy and research priorities are outlined.

**KEY WORDS:** primary health care, general practice, community, collaborative governance, international, non-governmental organisation

## CONTEXT

Primary health care is the first point of contact for actual and prospective patients. While continuing to provide first point of contact interventions primary health care now also includes community health responsibilities for prevention and promotion. In most Western democracies with market oriented health systems general medical practices continue to be the principal organisational unit of service delivery (Starfield, 2009). As a result general practices are located at a number of significant interfaces with other frontline services, across both the public and private sectors. This location makes them of particular interest to policymakers because of the information and influence these influential cross boundary relationships may contain.

Within this overarching context extensive policy changes in the management and administration of primary health care have recently been effected, especially by the central governments of more economically developed countries. The international trend has been towards larger configurations of practices with substantially enlarged resource management responsibilities.

In England, for example, the GP-led Clinical Commissioning Groups (CCGs) established by 2012 legislation (Secretary of State, 2012) are now, three years later, being augmented by new 'Vanguard' federations, each of around forty general practices, as an organisational framework for integrating community health and social care services (NHS England *et al.*, 2014). The annual budgets of the GP-led CCGs themselves together total over £70 billion. Through these, executive general practitioners directly control the majority of National Health Service contracts for acute and long term hospital care, in what was seen by central policy makers as major shift towards 'liberating' resources in more locally responsive and equitable ways (Lansley, 2010). Simultaneously across Australia general medical practices are being brought together in 30 regional Primary Health Networks (PHNs). These represent a progression from General Practice Divisions and Medicare Locals, each of which operated to improve access to care; to enhance service integration; and to increasingly align care with population needs. The management of PHNs has been the subject of external tendering. Their

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mandate is to draw on all available resources - most general practices operate through co-payment arrangements - to extend the effectiveness and efficiency of services for Australian communities, focusing especially on those with poor health outcomes in remote areas or those with high immigrant or indigenous demographic profiles.

In England and Australia, as in other locations where primary health care agencies are assuming increased decision making powers, the scale of new resource management responsibilities raises issues of legitimacy. These issues are both operational, in terms of being understood to offer a credible skills mix capacity (Naccarella *et al.*, 2011), and ethical in terms of a perceived justification for the rights and range of medical decision making. The main concerns arise where there are significant resource constraints and competing (or even conflicting) priorities. Where service delivery issues are regarded as especially sensitive, as in palliative and urgent care provision, they have both profound ethical connotations, as well as direct GP involvement in the principal caring role. Several independent commentators have questioned the role and rights of primary health care agencies in relation to their increased resource management responsibilities (e.g.s Addicott and Ham, 2014; Smith *et al.*, 2011), and pointed to such countries as Sweden and Italy, where delegated local decision making powers for GPs in community health centres are backed up by the ballot box, corporate investments and voluntary subscriptions (Callthorp and Nordstrom, 2013; Shaw and Meads, 2012). In contexts where primary health care is being undertaken through managed care enterprises it seems clear that a robust, visible and defensible expression of what can broadly be termed 'community governance' is important in ensuring effective accountabilities. Future public and professional credibility may well both depend on this.

## THEORETICAL UNDERPINNINGS

Community governance itself is a malleable policy concept. Our literature review revealed multiple uses (if not clear definitions), with the meaning of the 'community' element changing as approaches to public participation and decentralisation witness novel and dynamic developments in the roles of social enterprises, local councils, charities and other nominated, elected and representative agencies. These changes can be understood as applications of 'governance'. As a concept, by itself, however, 'governance' does have a rather more fixed meaning signifying the 'roles, laws and administrative processes for collective decision making', which together 'constrain, prescribe and enable the provision of publicly supported goods and services' (Rhodes, 1997; Lynn *et al.*, 2001, Rhodes, 2007).

Against this conceptual background we found it helpful to view organisational developments, arising from the policy changes outlined above, through the lens of two key social theories - Agency and Enactment. Both are prominent in contemporary studies of primary health care, because they capture and make sense of its increasingly complex relationships and their various nuances. The first theory derives from economic research on institutional controls

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created by elites to retain capital ownership (e.g.s. Mihret, 2014; Mustapha, 2014). In primary health care the theory focuses on changes in GPs' own understanding of themselves as they are increasingly perceived to function like accredited agents of government performance management and policy requirements (Doran and Roland, 2010; Peckham 2014; Sheaff, 2013). As a counter-balance to this potent 'principal agent' the further agency of community is now of particular interest and relevance. Historically GPs have been regarded as the principal agent (and advocate) of the individual, but growth in state level mandates has affected this view, with community agency adding a further possible accountability and/or resource for general practices.

The notion of Enactment is also associated with notions of social interaction, such as Relational Complexity and Proximity (Sweeney and Griffiths, 2002; Schluter and Lees, 1993). Its relevance now for primary health care in market oriented systems is to explain the importance of stakeholder selection and participatory profiles; aligning itself with recent research on diverse network governance models (Wye et al, 2015, Lewis, 2011). From this standpoint, successful policy conversions in primary care are those which appear to align well with those networks that influence effectively decision makers and achieve personal as well as corporate commitments. Enactment theory itself focuses mostly on the intermediate translation and interpretation roles of general practices, in relation to enacting both the substance and spirit of strategies, through their local, clinical and other formal and informal networks. General practices, (and especially practice managers), as the *animateurs* for policy implementation, are thereby seen to be in a position to access and utilise both lateral and vertical relationships in the health system unlike any other clinical unit (Checkland et al, 2011).

Taken together these two social theories offer a point of entry to the subject of community governance in primary health care by providing an understanding of how this service sector requires alternative accountability structures and processes to those emanating from past corporate, comparative and clinical governance models. These have usually been hierarchic and largely static in structural terms, whereas modern primary health care is fundamentally relational, changing and complex, with a growing range of stakeholders in its managed care enterprises. As a result the tailoring of governance to different community contexts through dynamic processes is becoming an organisational prerequisite.

Finally, in relation to its intellectual foundations, the notion of community governance in primary health care is rooted in the initiatives over five decades of the World Health Organisation and its six regional bodies. As a policy concept it brings together the three 'Pillars' of primary health care set out most notably by the World Health Assembly meeting at Alma Ata (International Conference, 1978; MacDonald, 1992 ): equity, participation and (cross-sectoral) collaboration. This 1978 Declaration was powerfully updated and reinforced by the "Now more than ever' policy which marked the arrival of the present WHO Director General (WHO Assembly, 2007). It led directly to the WHO Consultation on the role of

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alternative agencies in health care which can, in the future, 'express the power of ordinary people, as opposed to the coercive and regulatory powers of governments and the economic power of the market.' (Chan, 2012). In this global policy initiative the explicit aim of the WHO is to enhance engagement which 'strengthens governance'. The present research pursues this goal.

## REMIT

Within an overall aim of exploring the practical significance of the policy concept of community governance in primary health care the specific objectives of this scoping study were threefold, as follows:

- 1) to identify elements and dimensions of community governance in primary health care which may enable general practices to undertake their changing roles in resource management more effectively
- 2) to locate and aggregate local exemplars of these components as an international model for the community governance of primary health care
- 3) to begin to identify alternative GP based non-governmental organisations with the capacity to develop collaborative governance arrangements.

The research was undertaken from a health management perspective, with policy makers and planners identified as the main target recipients for project findings.

## DESIGN AND METHODS

The origins of the study were ideas derived from work on local engagement, mostly in the Americas (Meads et al, 2007). It was designed as follow-on research from two extended programme of studies on organisational and service developments in primary health care globally (Meads, 2007; Russell, 2010). These highlighted local exemplars of primary health care and, in particular, the transferable learning available from particular international developments in Participation and Decentralisation. Accordingly, it has an international framework for data capture as follows:

- 1)** a structured background literature review of relevant international policy statements and research since the watershed WHO annual report on primary health care in 2007
- 2)** a secondary data analysis of a decade's fieldwork in the two global sub- regions of South and Central America and North West Europe, which already possess advanced models of community governance in primary care

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- 3) feedback from two international practice settings where alternative approaches to increased resource management through general practices are operational.

This framework shaped the five stages of the research, which are summarised in Table 1 below.

- INSERT Table 1 here

The initial literature review was informed by PRISMA disciplines (Liberati *et al*, 2009), employing an iterative cascade approach to the source bibliographies identified through the use of an initial keyword search. This employed the core terms of General Practice, Primary Care, Governance and Community to identify relevant titles and then investigate Abstracts in the IRIS (WHO), SCOPUS, LILACS, EMBASE, NIHR and BIOMED search engines and databases. The keywords were used singly and in combination with appropriate variations in response to the project's developing knowledge base (e.g. through such terms as 'primary health care' and 'collaborative governance'). The searches led to the inclusion of 45 research articles in the review. This also incorporated grey literature sources (e.g. WHO Regional Office and Annual Assembly papers), and these provided the basis for the second stage analysis of alternative governance models.

In the third stage a preliminary 'Ideal Type' was developed from the initial review and analysis. Its component features were then applied in a secondary data analysis of 34 interview based case studies to help identify if there were any global sub-regions where the model was most apparent. Ten general practice settings with demonstrable good practice in the functions of community governance were then identified and examined in detail at stage four, again drawing on the interview data.

In each case the interviews were with the primary care professional(s) with the lead resource management roles; in most cases these were senior GPs. The data was collected over a ten year period on either side of the WHO 2007 Annual Assembly report 'Primary Health Care: now more than ever'. These practice settings may be understood to constitute a purposive if provisional sample for community governance in primary care. They were chosen after being nominated by both the national policy makers with the principal responsibilities for primary health care development and externally selected academic subject experts in each host country, as frontrunners for central policies on Public Participation and Decentralisation (of integrated health and social care). The identified settings were clustered geographically in South and Central America, and North West Europe.

Finally at the fifth stage, we undertook an initial validation exercise at meetings in Victoria, Australia and Hampshire, England with representatives of four local primary health care settings in each location. The GPs possessed equivalent resource management roles and responsibilities (e.g. for training and prescribing budgets). In response to the initial feedback

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obtained a basic numerical scoring (scale up to 10) was employed by the researchers to rate the defined components of community governance, with nil and negative sums permitted.

The project was sequential and undertaken over a six month period beginning in November 2014. The sequential approach ensured that the findings of the literature review were formative in relation to the case study site selection; that exemplars of the identified components of community governance in primary care were present and consistent in at least two global sub-regions; and that their relevance to primary health care enterprises and managers in market oriented systems could be asserted through initial responses from relevant general practice based respondents.

## LITERATURE REVIEW AND ANALYTICAL FRAMEWORK

The literature review first provided community agency and policy enactment as the underpinning theories on which to frame the analysis. In addition, a third theoretical source was identified to support the validation of the data capture in this study, to reflect the need for an 'enabling cultural fit'. This concept was derived from a series of Canadian studies of GP based community health centres (Abelson, 2001). Its selection here was based on its particular utility in identifying organisational factors which promote enduring change. For community governance in primary care based health systems the 'enabling' factors can be understood as those that 'create and control decision space' in which decision making is perceived to possess the intrinsic 'capacity for both sharing and repetition' (Luhmann, 2013).

Accordingly, for general practices the factors (and exemplars) identified in our data are those which are influential in ensuring cultural compliance within communities and enable the organisational units of primary health care to be benevolent forces for cultural construction through the ways in which they enact policy. With such inherent qualities as civic trust, common curricula and collaborative advantage, these units promote a lasting commitment to innovations and homeostasis in health care systems. Delineated by the Canadian research team in a series of provincial studies they are distinct from those 'precipitating' (e.g. media reported and defined crises) and 'predisposing' factors (e.g. regulatory guidance). These tend to be vehicles for more superficial short term and structural changes respectively. They are obviously not well suited to a GP based service sector which is founded on principles of comprehensive, longitudinal and lifelong care.

It was readily apparent in the literature review that the term 'governance' has been the object of multiple definitions. This has been especially evident in health care because of the increased attention afforded both globally, as well as in the UK, to the issues arising from shortfalls in 'clinical', 'comparative' and 'corporate governance' (Santiso, 2015; Chambers *et al*, 2012). Against this background it was helpful in relation specifically to primary health care to recognise that governance is regarded as one element in the basic Stewardship

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function of general practices, as, for example, set out by the European WHO region (WHO Europe, 2010); and secondly to recognise that a raised profile for primary health care derives from its novel capacity for modes of shared governance which can achieve consensus decision making in professional forums that integrate public and private stakeholders (Donahue, 2004). These recognitions led to the siting of primary health care, and the subsequent identification of its community governance features, firmly within the frameworks of 'collaborative governance'.

Accordingly the novel resource management roles of GPs chime with a recent review of 137 sites highlighting the significance of leadership which enables inclusive, fair and transparent participation, especially for weaker non-statutory agencies, as critical for the effective practice of collaborative governance (Ansell and Gash, 2008). It is in this vein, that the WHO has urged European Governments 'to strengthen governance at the policy, planning, purchasing and provision' levels with (health) strategies that are 'more informed-based, inter-sectoral and participatory' (WHO Europe, 2001). The WHO Western Pacific Region has similarly exhorted its members, in its ongoing Regional Strategy for Primary Health Care, to offer 'transparent and accountable leadership' which 'builds coalitions outside the (public) health sector' (WHO Western Pacific, 2010).

From the above references it is apparent that, as a form of governance, the 'collaborative' model is more relational than its conventional counterparts of corporate and clinical governance. For our analytical purposes its accountability structures and processes could be understood as embracing roles and responsibilities which are not simply 'to' and 'for', but also 'with' and 'by'. Recent research into contemporary health systems developments reinforces this understanding by pointing to the importance for collaborative governance of those, including explicitly general medical practitioners, who can function as 'boundary spanners' at organisational interfaces (Sorensen and Waldorff, 2014; Atun, 2004). These effective intermediaries align themselves with social trends that are moving away from deference and hierarchy 'towards mutual respect and shared responsibility and cooperation'. Other studies of collaborative governance describe how communication and human resources networks are replacing administrative units in organisational mapping exercises (Volgger *et al*, 2014); and place stress on the personal qualities of directness, discretion, fidelity and reciprocity (Ansell and Gash, 2008; Ashcroft and Meads, 2006). For community governance specifically as a form of collaboration the last appear to be particularly significant, given the repeated emphasis on 'contingent context' in recent international studies.

Because of the local variations which are an intrinsic characteristic of 'contingent context' what constitutes 'good' collaborative governance is inevitably very varied in practice, and defined accordingly in necessarily broad terms. A recent literature review informed and supported by WHO policy and performance requirements therefore suggested five overall categories or functions for measuring the outcomes of new collaborative governance approaches in health care (Barbazza and Tello, 2014). These are collaborations on

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understanding and interpreting health issues; initiating and responding to feedback; continuous communication regarding community concerns; joint decision making; and shared operational controls of health service delivery. In turn these are titled by Barbazza and Tello (2014) as follows: Information Sharing, Consultation, Involvement, Partnership and Empowerment. Together (in Figure 1), as an integrated set of core criteria, they offered this scoping review an appropriately authoritative and comprehensive global health policy framework for the international analysis of developments in respect of community governance in primary health care.

- INSERT Figure 1 here

Finally, in the literature review the components of community governance itself were identified and then reduced to ten in number, by first recognising and locating them as elements or dimensions of collaborative governance models which have been shown to operate successfully across a range of service sectors (Ansell and Gash, 2008, Lynn et al, 2001), and then viewing them through the prism of utility for the practice of managing health service delivery in primary health care settings. Their inclusion lastly was confirmed by a test of compliance with the sets of empirical measures for 'good' collaborative governance specifically in modern health systems outlined by Barbazza and Tello (2014), and informed by ten WHO principles for Stewardship in primary health care (Siddiqui et al, 2009). In addition to the relational values of participation, inclusivity, shared vision and intelligence, and responsiveness, these also reiterate the standard governance requirements of probity in relation to ethics, the rule of law, transparency, accountability and efficiency and effectiveness.

## APPLICATIONS

Our first application of this analytical framework was to identify where the five functions in Figure 1 were most prevalent at a multi-national level. Unsurprisingly, the elected local municipal and provincial councils of Norway, Sweden, Denmark, Belgium, the Netherlands and Finland, with their accountability for combined health and social care services ticked each box. So too did many of the states of Latin America: Costa Rica, Bolivia, Brazil, Chile, Venezuela, Nicaragua, Peru, Colombia and Ecuador. Here the community development agency model of primary health care prevails (Meads, 2007), and governance is often through popular representation and selection as opposed to the formal ballot box of elected local democratic authorities. Accordingly, Latin American nominated senior citizens and *missiones* are the equivalents of their Scandinavian elected Councillor counterparts four thousand miles away. Both these global sub-regions have very different approaches to health care governance to those where patients are termed 'users' and 'consumers' of services in, for example, Asian commercial franchise based or North American market oriented systems (Meads, 2006).

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The second application of the analytical framework was at the local level, within six of the countries in each of the sub regions where we had previously undertaken case studies of exemplar primary care agencies. The secondary analysis of the fieldwork data produced an extended menu of items in respect of collaborative practices, from which the shortlist of ten features of community governance were then identified and refined using the frameworks described above. Accordingly, the identification process was undertaken on the basis of recognising those specific functions of collaborative governance in community based primary care organisations which were a match with its overarching fivefold categories and supporting WHO principles, as listed above; and which recurred across both global sub-regions. In addition, for each of the shortlisted community governance features two actual exemplars were highlighted, as a consequence of which an aggregate but still outline 'Ideal Type' emerged which appeared to possess both the *prima facie* conceptual coherence and the supporting empirical validity required to confront successfully the 'countervailing powers' of differing community health contexts globally (Light, 1997).

- INSERT Figure 2 here

The final shortlist of core elements and dimensions of community governance in primary health care, is summarised in Figure 2 above. These ten component features are evenly divided between the five categories for good collaborative governance in health systems, with reference to two primary care organisational practices in Table 2 below. In each case these are drawn from Latin America and North West Europe. In line with the sequence provided by Barbazza and Tello (2014) the Ideal Type features of community governance in primary health care are: integrated soft intelligence and scientific data systems; social enterprise status which has cultural fit; secure confidentiality of private matters; multi-faceted public trust; access to philanthropic sources of income and investment; visible and defensible public service decision making processes; public participation in practice priority setting which covers critical clinical care resources and management; appropriate non-governmental organisational status; full or partial stakeholding community proprietorship; and the incorporation of community or communities in the agency paradigm of therapeutic general practice and its service delivery interventions.

- INSERT Table 2 here

The heading of Information Sharing covers the two components of integrated soft intelligence and scientific data systems, and cultural fit for sustainable enterprise. The first of these brings together with equal value informal information sources at neighbourhood and nuclear or extended family levels, with the modern evidence based health care mechanisms that underpin probability diagnoses and most clinical protocols in general medical practice. The collaboration of over 400 councils in the national *THL* applied health and welfare research centre in Helsinki is one exemplar of this contribution to effective community governance. Local GPs and elected members in Finnish towns such as Tampere have an equal stake in

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determining community health research priorities; while over in Costa Rica the counterpart is a cross-country Healthy Cantons movement. Here, in such regional centres as the Grecia municipality, prizes are won for local community health improvements that correspond to both the San Jose University's telemedicine based clinical education and the local general practice volunteers' household health need assessment priorities.

Cultural fit to ensure the sustainability of the social enterprise agency is universally an organisational prerequisite for effective primary health care. In Bolivia, for example, it means evenly balancing traditional treatments with Western Medicine in both individual case management and collective mediations. As a result, in the new city of El Alto the local tripartite *DILOS* meetings to resolve resourcing disputes have equal tripartite membership from the local community's civil society custodians and health professionals, along with a nominee from the central Health Ministry. Across the Atlantic in Oslo, the arrival of a mixed economy of providers in primary health care, with revolving doors between public and private sector providers, is only acceptable at the combined GP based Frogner Health Centre and private *Aleris* Polyclinic because it is taking place at the traditional premises of the Red Cross with the mandated approval of the elected municipal authorities. This re-use of a previous charitable hospital represents a sustainable cultural fit, given the historical significance of the building as a bastion of community welfare.

Secure confidentiality of private matters and multi-faceted public trust are the foundations of the effective Consultation which ensures that feedback properly informs decision making in the community interest. The notion of public trust as a modern multi-dimensional phenomenon, in which clinical expertise and personal loyalty are only two of several prerequisites, has been promoted most vigorously in the Low Countries of Netherlands and Belgium (Straten *et al.*, 2002), where publicly funded social care is mostly provided through independent sector agencies. For community governance in primary health care the Nieuwegein Primary Care Centre in the Netherlands is an exemplar, with public trust by the community emanating from its incorporation in local communications and quality assurance forums. Here the GPs have sought to develop a strategic vision of care management which deliberately owes as much to grassroots electives in the likes Nepal and Zambia as it does to elite sources for evidence-based medicine. For the secure confidentiality of private matters there is no need to look further than the two *MaxSalud* Clinics of Peruvian general medical practice in Chiclayo. Here the awareness and treatment of domestic violence as a major social and health issue for the local community is utterly dependent on the presence of armed guards at the entrance to the clinic premises.

Involvement as a core component of collaborative governance requires a proactive stance regarding the concerns of the community and the way these are transmitted. It is involvement which is aligned with social action at the general practice level so that access to, and use of charitable sources are legitimised and subject to a social policy position for primary health care priorities which is visible and defensible. In South America this involvement often

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means a close relationship with the Roman Catholic Church and its associates. In Santiago, for example, the *Universidad Catolica* is a key main supporter of the GP based San Joaquin Clinic. This works with the University's own pioneering medical school to provide extended primary health care services to a disadvantaged inner city population, justifying its inclusion of free nutritional supplements and prescriptions through its published social triage and service evaluation findings. Here the South Metropolitan elected zonal mayor uses local tax revenues to top up the communities' charitable contributions to these services. In Scandinavia at Uppsala in Sweden the equivalent for the likes of the local authority's problem based learning, and quintessentially interprofessional primary health care teams, are the national charity tax contributions for which named GP-led agencies can be the recipients. Here the decisions on which are the priorities for community health care services are decided at the ballot box in local council elections, including on the extent to which GPs and their organisations assume secondary care commissioning responsibilities.

In terms of the fivefold framework for good health governance, joint decisions on organisational status and service priorities, through collaboration by primary health care agencies with the community, were regarded by our GP respondents in the UK and Australia as the hardest feature of a collaboration based governance approach. For community governance this third component of community governance now requires decisions on appropriate non-governmental form, ranging from a BINGO (Business Interested Non-Governmental Organisation) to a GONGO (Government Operated Non-Governmental Organisation). The 10000 newly built and centrally funded general practice cooperatives of Venezuela are a classic exemplar of GONGOs, for instance, where their establishment and the mass introduction of Cuban GPs, as a directed initiative of the Chavez Government in Caracas, matched exactly the transforming, benevolent but autocratic political environment and the socio-demographic needs. Here priority setting for general practice was by direction and in the direction of the economically poor through the mandate of the plebiscite. In North West Europe partnership processes for priority setting are more complex. At the world leading exemplar Kangasala Health Centre in central Finland, accordingly, the use of GP and primary care professional time is decided jointly with local advocates for Wellbeing and the Environment, as well as elected councillors on the management board, because of the practice's approved holistic approach to community care. This embraces such as occupational health and animal welfare alongside general medical services. One outcome is the joint decision for a locally approved three day limit on occupancy in the Centre's GP managed beds (Meads, 2006).

The final component of collaborative governance is the Empowerment which comes to communities with the sharing of operational control. This sharing in primary health care

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constitutes a substantive exchange. It also symbolises the relationships of good community governance. For general practices there is the novel scope to use community as both a therapeutic agency and resource, and as a target of intervention. For the community there is the means of co-ownership in primary care. Across not only our two selected global sub-regions, but also in other continents, exemplars abound as this dimension of community governance has now become a powerful international force. In China, South Sudan and parts of Canada, mission societies sponsor GP based primary health care services in deprived areas. In Thailand, Crete and some Italian provinces general practices draw on the spiritual healing powers of their communities' main stream Buddhist and Christian faiths as therapeutic aids. From Latin America the local commissioning cooperatives of Colombia, the CLAS (*Comunidades Locales de Administracion de Salud*) managed general practices of Peru, and the Civil Society owned community centres - combining education, day care, job training and primary medical care – of Brazil are the illustrations *par excellence*. In all of these it is the primary health care of older people which is the most obvious beneficiary. In the hinterland of Lima the volunteer carers and sessional counsellors attached to general practices offer a range of informal service options for older people, while across in the European WHO region, at the port of Rotterdam, it is executive committees of seniors themselves which undertake the management roles in respect of commissioning the plethora of non-statutory agencies supplying different forms of day, respite and residential care. In both cases, in very different contexts, one outcome for GPs is more focused and community-directed prescribing formularies. Another is the adoption by insurers of a social model of public health which incentivises promotional and preventive interventions.

Table 3 above supplies a summary of the local exemplars cited here for each of ten components of community governance in primary care and the closing References may help signpost those seeking further information. Taken together, these component features can be considered in global policy terms as the beginning of an 'Ideal Type' model for collective organisational developments in contemporary and future general practice. In an 'Ideal Type' there is not only a perfect fit between constituent conceptual features, there is also the pragmatic virtue of each component actually being potentially adaptable from an existing location. In addition, although nowhere is there any complete or nearly complete version, as a full set, the various elements and dimensions can properly be considered as comprehensive and necessary in organisational development terms.

## LESSONS

The most obvious overall lesson from the findings above is that community governance in primary health care applies not at its frontline service delivery first tier but at its intermediate levels of service planning and strategic development. Indeed, our more detailed inquiry into exemplar site data suggested that the formulation of community governance in some settings may actually be hindered by an excessive focus on Public and Patient Involvement (PPI) at the individual practice level. Our data suggests that the latter is often felt to be unsatisfactory,

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being handicapped by skewed or inadequate popular representation, small business interests and parochial perspectives. This paradoxical finding – given that Public Participation alongside Decentralisation was one of our starting points for this exploration of community governance – suggests a significant topic from this scoping review for future research.

From our research sites typical obstructions to evidence based medicine, cited by local GPs in the validation meetings as arising from PPI sessions at practice level included, for example, a focus on such as multiple myotherapies in a hybrid Australian medical centre, or dispensing dividends in an English rural surgery. For market oriented health systems there is an important lesson in terms of locating, and promoting, local forms of community oriented collaborative governance principally at the intermediate tier of health systems.

A second less immediately apparent source of possible transferable learning, from the follow up feedback with GP representatives in Victoria and Hampshire, is that each of the above components of community governance has not just a different value or weighting, but also a negative as well as a positive motivational quality. For such factors as confidentiality of private matters and defensible public service decision making processes - whether through omission, neglect or malpractice - the negative values were seen as potentially being so high that, notwithstanding the presence of several positive components, the implementation of community governance may become untenable, especially if the thorny issue of particular non-governmental organisational status is not resolved satisfactorily. For the national institutes of health research in the UK and Australia this assessment also merits further research into its significance.

Thirdly it became clear that community governance has differing public policy connotations in different parts of the world; and that this finding justifies further investigation in its own right.

Although indebted to the World Health Organisation for its place in health care policy dialogues, we learnt that the notion of community governance has had subtly different emphases in the political narratives of each of the Organisation's six regions. This is nicely illustrated by the recent policy documents of WHO regional offices. For example, in the WHO European Region community governance is mostly associated with national governments' regulatory requirements to address and minimise risk in a burgeoning Third Sector. As in the UK governance is often enforced via the outsourcing contractual terms of municipal authorities and local councils. Specifically for frontline health care services this can mean governance is simply regarded as an executive monitoring function which covers consumer protection, product quality regulation, performance assessment and priority setting (Hart *et al.*, 2010).

By contrast, and equally predictably, for South America the PAHO guidance favouring more decentralisation to community control has been prolific and far reaching – even into recommendations for basic medical curricula – and open to community consultation, of

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course. The aim for extended community governance is nothing less than the 'renewal of Primary Health Care in the Americas' (PAHO, 2008).

In the African region the concept of community governance has tended to be reduced in practice to the means of controlling the perceived predatory activities of commercial pharmaceutical companies, and the cost, direction and delivery of drugs supplies for general practices. Linked to this has been a multinational drive led by the African Medical Research Foundation to enhance the use of sound research evidence to protect vulnerable communities through secure governance procedures. This initiative was launched in the aftermath again of the WHO global assembly's 'Now more than ever' report through the 2008 WHO regional conference in Algiers, and backed up by international donor support for the Millennium Development Goals.

In the East Mediterranean region governance is central to the creation of nationwide health systems, often for the first time. Here community governance and Development go hand-in-hand in concept and practice. Community governance signifies the need to ensure modern communication technologies, research, and information are harnessed by both communities and emerging family doctors. There is a multi-national agreement to work together across 17 states 'to analyse and prioritise their development needs' through governance which 'ensures health equity and quality of life' (WHO East Mediterranean, 2012,).

Finally, across the Western Pacific and South East Asia, for general medical practices the position is more *ad hoc*, with an absence of strategic intent. WHO regional documentation is characterised by references only to one off 'community actions' usually linked to 'Healthy Ageing' (WHO 2008); and where concerted plans do exist, as in Thailand and Malaysia, income from medical tourism is a key determinant (Volgger et al. 2014). In comparative international terms this is the area of the world where integrated primary health care is weakest, lacking consistent frameworks for general practice which often has to rely on the likes of private hospitals and insurers for its outreach franchises (Wright and Martin, 2015 Meads, 2006b).

This outline summary of differential international policy clearly links to the notion of 'contingent context' and the global review of community governance in primary care links to a fourth and final lesson: all the relevant WHO policy developments are predicated on the basis of general practice within non-governmental organisations (NGOs). In the absence of a standard definition covering such as self help cooperatives, mutuals, community interest companies and charities, the common characteristics across this wide range of forms are the scope to harness more local capacity and sustain risk. None of the NGOs is based on either exclusive or majority public employee status or not-for-profit private sector status. All anticipate a diversity of agencies. This reflects developments in recent community development theory which come together in their consensus view that this diversity is essential to a healthy civil society.

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Again this points to a future research agenda as primary health care internationally is at the heart of this transition, and recognised as such by the WHO Director General in 2008 at the World Health Assembly. Dr Chan, in her address then, and subsequently (Chan, 2012), has sought to define not just the alternative models of legitimate primary care agency in the Third Sector – from Public Interest (PINGO) cross Technical Assistance (TANGO) to Business Oriented (BONGO) non-governmental organisations – but also to emphasise that each can belong legitimately and effectively in different cultures and settings. Our review's findings support this position and Table 3 supplies a simple illustrative introduction to the international range of non-governmental organisations today in primary care.

- INSERT Table 3 here

In each of our local exemplar sites a form of community governance applies. In every one the GPs have the lead clinical and managerial responsibility. All deliberately use the term 'Primary Health Care'. And for every location governance has moved on from simple elected or nominated forms to embrace wider popular representation and engagement. Overall the picture is that of community governance seeking to include and integrate diverse forms of NGO based primary health care in support of wider developments in participatory democracy.

## DISCUSSION

The question of whether the concept of community governance has a practical value for primary health care in market oriented health systems has acquired a greater sense of urgency as general medical practices have become increasingly absorbed into larger managed care enterprises, including commercial polyclinics. For the authors of the scoping review represented by this article it is a question which is now ten years old. In 2005, in this journal, we understood community governance to be largely (but not exclusively) a particular feature of emerging policies for primary health care across the global region covered by the Pan American Health Organisation (Meads *et al* 2005). Now we recognise it as a global trend and international imperative.

Inevitably, community governance has assumed very different forms across the various continents and sub-regions, but in each setting novel accountability structures are being designed to determine the equitable sharing of power with local collectives in priority decision making processes. Previously, health management research was focussed on the engagement of local people with unmet health care needs in the universal provision of GP based frontline services. As a result, not surprisingly, community governance was usually understood as the property of less well developed nation states and their poorer areas; and one which could as easily slide into patterns of increased central regulation and resource dependency as it might engender local health gains (Zakus, 1998; Meads 2006c; Peters and Youssef, 2014).

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The need now to examine the potential benefits elsewhere has increased as countries, such as the United Kingdom and Australia, have moved rapidly to implement policies which are designed to promote the substantial expansion of resource and performance management responsibilities in general practice. With these changes serious questions have arisen regarding the legitimacy of decision making by general medical practitioners (Greaves *et al.*, 2012), who can no longer identify themselves simply as members of a clinical profession of personal physicians. In the UK the succession of GP fundholders, NHS primary care groups and trusts, practice based commissioners and GP consortia, through to the post-2012 incarnation of GP-led clinical commissioning groups, has securely established general practices as the contract holding purchasers of most hospital services with direct financial responsibility for the performance of secondary care.

In Australia the 2003 GP Divisions have been followed by Medicare Locals, mergers and now, in 2015, the streamlined and regional Primary Health Networks. These are charged nationally by the federal government with the development and delivery of individual programmes of provision for previously unmet exceptional health service needs in terms of urgent and remote care, chronic disease management and indigenous peoples. And similar developments are happening in other countries. In Italy, for example, across such regions as Bologna and Empoli, the GP role development has been less clear-cut in terms of being 'lead' purchaser or provider, but more profound as the facilitating 'boundary spanner' for operational linkages between personnel from the charitable, church and clinical sectors, which seek to maximise, harness and shape resources in support of patient care away from the old wards and into the community (Shaw and Meads 2012,). In Ireland, the parallel shift is towards mixed public-private combinations of general medical practices as sites for combined community care services, while in Macedonia these are now termed 'Health Homes' with triple registration arrangements for subscribing patients (Meads, 2009). All have required explicit community endorsement, more stakeholders and enhanced local community accountabilities.

In this international environment, across very different organisational models, a consistent challenge is the survival and sustaining of relational general practice. Its patterns and processes of relationships are becoming more complex and numerous. No longer just oriented to the individual person or family, with independent status no longer guaranteeing an arms length protection, general medical practice everywhere cannot rely just on its past personal and professional affiliations. Our GP representatives were agreed that it has to acquire other means of survival and renewal. In the market oriented health systems of Western democracies the more likely future sponsors are often those from the commercial sector, leading in the USA to the term 'consumer majority' being coined for its version of community governance in the new GP based 'federally qualified health centres (Hearld and Alexander 2014; Wright 2012)'. In Victoria, Australia during the present project the tendering exercise for the management of new Primary Health Networks was being underpinned by GP shaped consultation events with the local Tamil, Afghan and Vietnamese populations in the summer

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of 2014- 2015, as the existing Medicare team sought to demonstrate it could harness the benefits of a community governance approach for collaborative advantage (South Eastern Melbourne Medicare Local, 2015).

In academic terms this changing global environment may helpfully be interpreted through the theories of agency and enactment. In the different settings increasingly shaped by market transactions, multiple stakeholder interests and network connections, together these theories have helped to illustrate critical intermediary roles occupied by GPs as contemporary agents of mixed communities; often with support from practice nurses and practice managers. When fulfilled these roles effectively embrace substitution and alternative skill mix (for such as wound care and chronic illnesses); and mediate emergent tensions intrinsic in the relational processes required to convert central policy and performance targets into local actions.

Over the past decade, since our fieldwork, the terminology of Collaborative Governance has been developed alongside the more familiar language of clinical, comparative and corporate governance. While all four have common characteristics in respect of transparency, probity and fidelity; this review confirms that community governance belongs unequivocally to the models of accountability counted as Collaborative Governance. For primary health care agencies, and resource managing GPs in Australia, the UK and elsewhere, its practical value as a concept lies with its emphasis being as much on the lateral relationships of accountability ('with' and 'by'), as with those vertical protocols that exclusively address accountability 'to' and 'for'. In definitional terms it is in essence an expression of 'consensus decision making in forums which bring together public and private stakeholders' (Ansell and Gash, 2008), and 'where collective decision making constrains, prescribes and enables the provision of publicly supported goods and services' which are both directly and indirectly supplied (Lynn *et al.*, 2001).

As a result, in its community agency, the developing institutional designs of community governance in primary health care internationally lay a singular emphasis on multi-faceted trust, reciprocity and inclusive participation, and are, above all else, contingent on community context. There cannot be a single or absolute way of doing things, except that the primary health care organisation can never be based exclusively on a profession. In many Western countries this of itself represents a radical departure from what was once the established practice.

## CONCLUSIONS

In line with its project remit this study was able to identify a series of elements and dimensions of community governance in primary health care. Through the siting of

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community governance within empirically robust frameworks for collaborative governance, endorsed by WHO agencies, it was possible to combine these features as components in an Ideal Type model. This may be of particular value to planners and professionals charged internationally with taking forward policies for decentralisation and participation through increased resource management by primary health care organisations, and general medical practices in particular. For the latter the further shift to different forms of non-governmental status, contingent on context, would appear to be a prerequisite for effective community governance in primary health care, but it is also apparent that this carries with it several risks in relation to public trust, business viability and professional relationships. Understanding and addressing these represent significant challenges for future policy and practice.

The research has scoped transferable learning from international policy and practice developments for managed care agencies in relation to community governance in primary health care. The different defined components have different attractions in different contexts, and in all local environments some of these may be of sufficient negative attraction to prevent implementation by general practices. Careful and competent primary care management and organisational research are therefore essential.

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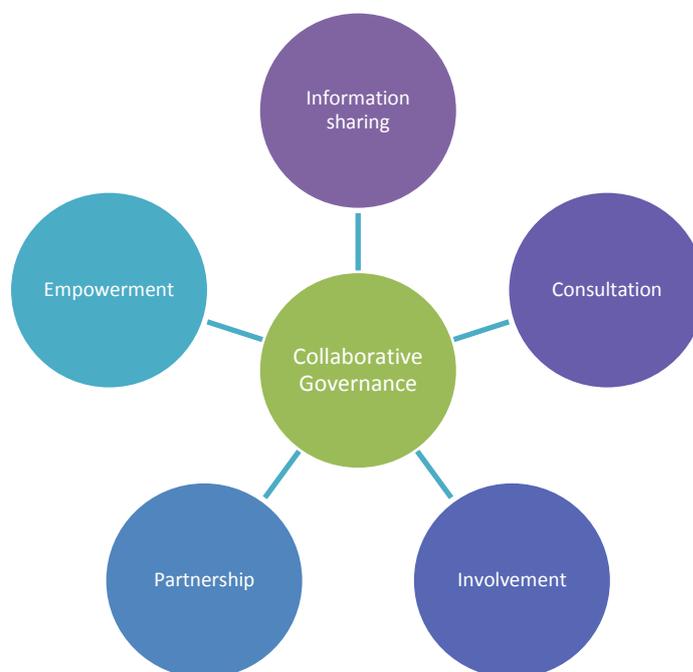
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**Figure 1: Categories for good collaborative governance**



**Figure 2: Component features of community governance in primary care – an Ideal Type**

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**Table 1: Process for review**

|                |  |
|----------------|--|
| Starting Point | Emerging theoretical model of 'Ideal Type' based on pre-conditions for good practice in public participation & decentralisation (from previous scholarship e.g. Meads 2006, Meads et al., 2007)                                |
| Step One       | Structured background literature review of relevant international policy statements and research<br><br>(Inductive and deductive approach - looking for pre-identified theoretical concepts and allowing for emergent factors) |
| Step Two       | Identification of importance of collaborative governance from WHO documentation, policy administration and policy studies  |
| Step Three     | Revision and development of 'Ideal Type' model of component features of community governance in primary care (Fig 2), based on literature review   |
| Step Four      | Secondary analysis of extant case study data (34 international case studies) to identify exemplars of Ideal Type components and most relevant global sub regions   |
| Step Five      | Validation and feedback sought from two international practice settings (GP representatives in UK and Australia)   |

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**Table 2: Categories for good collaborative governance with component 'Ideal Type' features**

|                     | <u>'Ideal Type'</u>  |   | <u>Countries</u> |
|---------------------|--|---|------------------|
|                     | <b>Component feature</b>   | <b>Good practice Example</b>  |                  |
| Information Sharing | Integrated soft intelligence and scientific data systems   | Neighbourhood needs assessments in Healthy Cantons movement, Grecia   | Costa Rica       |
|                     | Cultural fit for sustainable enterprise  | Combined modern and traditional symbols of solidarity in Frogner Centre, Oslo   | Norway           |
| Consultation        | Secure confidentiality of private matters  | Protected safeguarding of <i>MaxSalud</i> Clinics in Chiclayo   | Peru             |
|                     | Multi-faceted public trust   | Clinical evidence and patient experience quality measures of Nieuwegein General Practice  | Netherlands      |
| Involvement         | Access to philanthropic sources of income and investment   | Local faith based and municipal top up funding for San Joaquin Clinic, Santiago   | Chile            |
|                     | Visible and defensible public service decision making processes  | Multi-disciplinary problem based learning approach to long term planning in Upsalla,  | Sweden           |
| Partnership         | Public participation in practice priority setting which covers critical clinical care resources and management                       | Shared local councillor and GP board membership of Kangasala Health Centre near Tampere for public/ occupational and curative health issues | Finland          |
|                     | Appropriate non-governmental organisational status   | Centrally funded general practice and combined nutritional food and pharmacy cooperatives, Caracas  | Venezuela        |
| Empowerment         | Full or partial stakeholding community proprietorship  | Integrated Civil Society owned and led primary and day care services, Londrina  | Brazil           |
|                     | Incorporation of community/communities in the agency paradigm of therapeutic general practice and its service delivery interventions | Co-insurance based GP led health cooperatives sharing costs and risks, Medellin   | Colombia         |

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**Table 3: Non-governmental organisations in primary health care**

| <b>Acronym</b> | <b>Organisation</b>     | <b>Example</b>                            |
|----------------|-------------------------|---|
| CONGO          | Community organised NGO | Peruvian Comites Locales aux Salud        |
| PINGO          | Public interest NGO     | Belgian charitable research practices     |
| BINGO          | Business interest NGO   | Thai Contracting Units for Primary Care   |
| TANGO          | Technical advice NGO    | South African District Training Practices |
| GONGO          | Government operated NGO | Singapore Singhealth Clinics              |