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Community engagement in general practice: a qualitative study

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ABSTRACT

BACKGROUND: Community engagement is believed to be an important component of quality primary health care. We aimed to capture specific examples of community engagement by general practices, and to understand the barriers that prevent engagement.

METHODS: We conducted 20 distinct interviews with 31 key informants from general practice and the wider community. The interviews were semi-structured around key relevant topics and were analysed thematically.

RESULTS: Key themes identified from the interview transcripts included an understanding of 'community', examples of community engagement and the perceived benefits and barriers to community-engaged general practice. We particularly explored aspects of community engagement with Māori.

CONCLUSIONS: General practices in the study do not think in terms of communities, and they do not have a systematic framework for engagement. Although local champions have generated some great initiatives, most practices seemed to lack a conceptual framework for engagement: who to engage with, how to engage with them, and how to evaluate the results of the engagement.

KEYWORD: Māori; Rural, Primary Health Care.

Introduction

In 1978, the Declaration of Alma-Ata framed the role of primary care as 'the service of the health needs of the community'.[1] The phrase 'community engagement' is not clearly defined. The definition of community engagement used by the US Centers for Disease Control and Prevention (CDC) is:

"*. . . the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.*[2]"

On a practical level, Neuwelt *et al.*[3] found in 2005 that community engagement was in its

infancy in New Zealand primary health organisations (PHOs). In 2012, Neuwelt[4] found few well-formed views on the purpose or processes of community participation among district health boards (DHBs) and PHOs, and that general practitioners (GPs) tended to view 'community' as the enrolled population of their practice and to frame community participation as a form of quality improvement. The aims of the present study were to explore whether these views had evolved in the intervening seven years, to capture specific examples of best-practice community engagement by general practices and to understand the barriers that prevent engagement.

WHAT GAP THIS FILLS:

What is already known: The concept of community engagement is not generally well understood in general practice.

What this research adds: This research identifies ways that general practices are engaging with their communities. Even in apparently engaged practices there is a lack of a conceptual framework for community engagement.

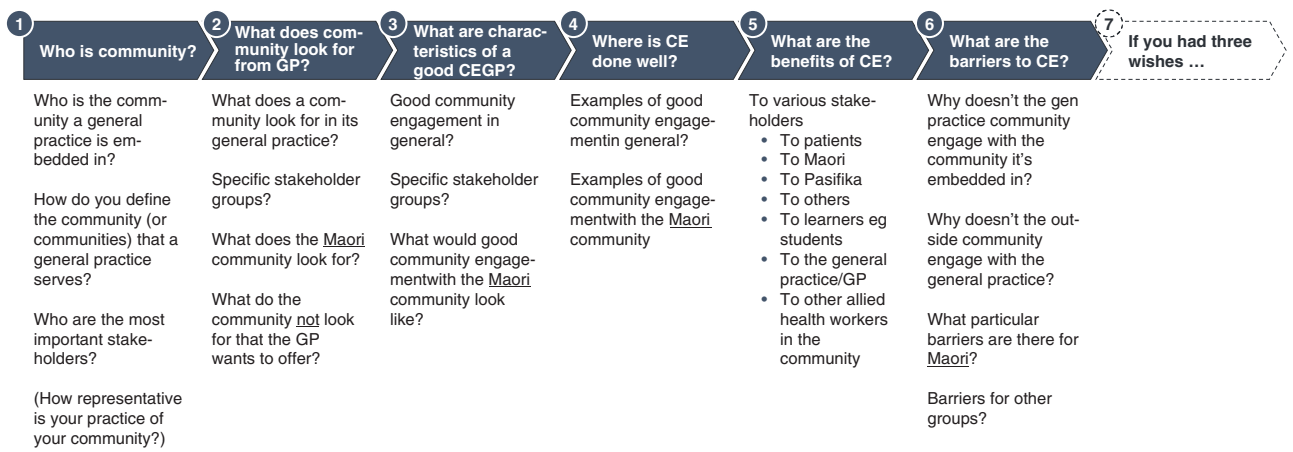
Methods

This was a qualitative study with interviews conducted under the supervision of N. Rowe, who has a background in health consultancy. Participants were identified by R. Lawrenson through his contacts with rural general practice, Waikato GP education networks, Māori providers, PHOs and DHB community advisory bodies. Purposive sampling was undertaken from this contact list and a snowball method was used to find additional interviewees. Participants were initially contacted by email, and respondents were followed up by telephone. Generally, interviews were held with individuals in their place of work. On three occasions more than one person attended the interview session. Some interviews were undertaken by telephone. The interviews were semi-structured and explored the six main themes implied by the questions shown in Figure 1. Prompts were used if the conversation strayed beyond these themes.

Questions 2, 5 and 6 (see Figure 1) were repeated with a specific focus on Māori. Participants were initially encouraged to respond to the concept of 'community' in their own way. If participants mentioned only individual patients, rather than community groups, examples of community groups were provided as prompts. Figure 1 was placed in front of participants during the interviews. Field notes were taken during interviews, with quotes captured verbatim where possible. Notes and quotes were then provided to participants by email after each interview for validation. Corrections were made where requested.

We held 20 interviews that included 31 individuals. Most interviews were face-to-face with individuals, but at three of the seven general

Figure 1. Interview themes and questions. GP, general practitioner.



practice meetings additional members of the practice attended. Five interviews were conducted by telephone. Twelve interviewees were male and 19 were female, eight were GPs and there was one rural hospital doctor. Nine interviewees were Māori and 22 were non-Māori. Participants included stakeholders from two PHOs, from both rural and urban general practices and from community groups. Interviewees were principally from the Waikato DHB with an additional input from a general practice from the Waitemata DHB.

We used thematic analysis of the field notes collected from the interviews. Key themes emerged from the transcripts and these were collated and sub-categories identified and recorded. These were then linked to the topics outlined in the interview guide. Quotes from interviewees have been included with quotation marks.

Results

Identifying communities

A general theme was that the practices identified their community as the entire population within the geographic area around the practice, enrolled or not:

> *The ethical basis of our practice is that everyone who lives here is part of our community not just those who are enrolled.*

Few participants identified subcommunities, even when prompted, other than communities defined by ethnicity or income. Thus, Māori appeared in some interviews as a distinct community (or an overlapping community). Three interviewees saw non-governmental organisations (NGOs) as part of a practice's community.

What communities look for from their general practice

No clear idea emerged as to what interviewees thought the community expected from general practice. Instead, participants cited characteristics of good general practice (eg timely, high-quality care). Asked what Māori communities wanted, most answered that Māori wanted improved health delivered in a Māori way, if possible by Māori, with high-quality relationships with their doctors:

> *Māori come to us* [a Māori provider] *because they want a Māori service: somewhere where they are greeted in a Māori way, don't have to explain who they are, and don't have to repeat their story a hundred times over.*

Māori providers also thought that Māori patients wanted resolution of existing health inequities between Māori and non-Māori.

What good community-engaged general practice could look like

Participants saw community engagement either as a way to raise practice visibility or, in a few cases, as a way of obtaining lay input to guide medical practice. One GP commented:

> *In my ideal world, community engagement would be centred on children and old persons in a PTA-type [parent–teacher association] model. . . your clinician and your management team [would] have regular governance meetings with people who represent your community.*

Examples of best practices in community engagement

Māori partnership

Many examples were found of providers partnering with the Māori community. One practice was located on a marae (meeting grounds), others had a kaumātua (elder) and in one practice staff had weekly lessons in Te Reo. One very rural practice with a high Māori population had consulted with Māori elders about how to address Māori health needs. This consultation led to the appointment of a Māori diabetes educator. The two Māori provider practices stood out in two respects. First, their premises were designed to be welcoming to Māori, recognising that general practice is often alienating; for example, Māori motifs were used in the architecture, space was provided for whānau (extended family), consultation times were longer to enable relationship building and other services were co-located on site. Second, they saw addressing social problems as a core

task and systematically addressed social determinants of health: one PHO paired kaiwhina (a Māori 'helper'[6]) with mobile nurses in outreach visits and the other Māori provider routinely incorporated the use of Whānau Ora navigators in the treatment of chronic conditions.

Community involvement

Many instances were found of outreach to specific communities. In some cases, practice staff were very active in community organisations. In others, the practices themselves ran initiatives for specific groups. Where youth are concerned, most practices in this study ran school clinics. One rural practice provided wellness offerings at the local youth festival. Another converted a building on its community gardens site to a Hang-Out Hub and hired a youth worker, offering space 'to chill', hobby platforms and a variety of therapies. An example was found of grandmothers being engaged to help with contraceptive education and where to get help for grandchildren, a wellness group for Māori and Pacific Island women and a 'Hearty Hauora' health day for gang members and their partners. In addition, initiatives were found for people on low incomes. In one community a local philanthropist sponsored vouchers to cover the GP's fee for people who would not otherwise go to the doctor. Another practice managed five acres of community gardens, with individual plots and a large communal garden (maintained by volunteers and people on periodic detention, with mulch donated by industry).

General benefits of community engagement

Community engagement was linked to increased health activity and improved outcomes that GPs value (eg screening targets). Another theme was that community engagement helped GPs focus on outcomes important to patients. Engagement was also expected to reduce workload in the long run (although not in the short term) for the practice and the health system, particularly if it addressed social determinants of health, like poor housing. Two participants expected engagement to improve the practices' competitive position:

> *There is a marketing benefit around recruitment and retention of patients.*

Benefits of community engagement for Māori

Community engagement may reduce alienation from medical providers, thus improving presentation rates, concordance and health outcomes and eventually reducing health inequity between Māori and non-Māori:

> *You could have a much better partnership relationship, rather than the paternalistic model.*

Many Māori providers expected engagement to empower Māori to take charge of their own health, reducing the disempowerment that is seen as a legacy of colonisation. Engagement was also expected to increase partnership between Māori and health providers, giving practical effect to Treaty of Waitangi principles. One participant thought that Māori patients would trust and listen to their GP more if the practice engaged with the community.

Barriers to community engagement

All participants regarded overwork as a significant barrier to engagement. Uncertainty was identified as another key barrier: participants felt that many practices found it difficult to define who the community was or know how to engage with it. Many participants thought that concern about being criticised and about creating a duty to follow through on expectations also prevented practices from soliciting external views. Several participants thought that salaried GPs in the corporate model felt less ownership of their communities, and were likely to engage less. Two participants questioned whether GPs really believed that it was their duty to engage, suspecting that many put the onus of engagement on the community. Two participants pointed out that the incentives in general practice actually work against engagement.

We also asked specifically about barriers to engaging with the Māori community. Most participants pointed out that non-Māori doctors do not always provide appropriate, or culturally safe, treatment and said that communication between

Māori patients and non-Māori doctors was often very poor.

Discussion

The key findings from this study included the limited view of what is meant by a general practice community, the different perceptions of what is thought the community wants from general practice and valuable examples of ways some practices have engaged with their community. However, a common theme was that community engagement has a cost, especially a time cost, and that this is a major barrier to wider adoption.

The strengths of this study are that we consulted widely with key general practice stakeholders in a variety of locations across the Waikato region, and spoke with leaders from the Māori community and primary care. We recognise that, because we were trying to elicit best practices, we were talking to people who were selected for their interest in community engagement. For this reason, the findings relating to barriers to community engagement may understate the case.

Our study re-confirmed previous research[4,7] that found 'community' being defined as a geographic concept. This is interesting in that there are no geographical boundaries to where patients live for enrolment in general practices. In New Zealand, the Māori community was also generally recognised, but other communities, such as the refugee or lesbian, gay, bisexual and transgender communities, were not. Most participants in this study did not distinguish between 'community engagement' and 'patient engagement': for them, the 'community' comprised only patients (or potential patients). As Woollard *et al*.[8] noted, although general practice is a community-based discipline, GPs feel most comfortable in the dyad of the doctor-patient relationship. This reflects the UK situation where there is a focus on patient participation rather than community engagement.[9] However general practice needs to think of its population in terms of communities if it is to recognise and address inequities between groups, a key component, as Buchman *et al*.[10] point out, of the social accountability required of general practices. Moreover, although GPs can be effective first responders to the acute social needs that bear upon health status (eg legal, financial or housing needs), the most effective levers for dealing with these social determinants exist at the community level.[11]

Even in the most engaged practices, community engagement appeared to be the result of an *ad hoc* response to need, usually at the behest of a committed individual. Some examples were found of innovative and popular engagement of high-needs patient groups that appear to be worth replicating. However, sustainability was an issue: succession planning seemed absent, and ongoing external funding for community engagement was the exception rather than the norm. Generally, participants believed that the onus of engagement lay on the practice, not the community. However, in the case of Māori providers, our distinction between community and practice-initiated engagement differed: Māori providers have close, multilayered links with their communities, and communication between them is frequent and bidirectional, so that the genesis of many engagement ideas was a joint product of both community and practice.

The evidence base for the benefit of community engagement is growing: it has been shown to positively affect health outcomes, including health service access, health literacy, mental health and obesity.[12–14] In the present study, participants believed that community engagement was inherently a good thing. When asked why, participants usually responded with one of two reasons. First, echoing Neuwelt's finding[3] that the purpose of engagement in the general practices she studied was quality improvement, many participants stated that community engagement would enable general practices to better deliver on their own targets, thus improving patient care from the perspective of what the practice believed was best for patients. A smaller number of participants inverted this proposition, arguing that community engagement would enable the practice to discover what really mattered to patients, improving outcomes from patients' own perspectives.

There were several perceived barriers to community engagement. Because most practices see their community only as a collection of

individual patients or potential patients, rarely identifying subcommunities, the lack of engagement with specific communities is not surprising: a community that has not been identified cannot be the object of engagement. There also seems to be a lack of concrete how-to knowledge: the most engaged practices said they had learned by trial and error what worked and what did not, and speculated that many general practices were at a loss to know how to engage. On a pragmatic level, engagement is seen as time-consuming, non-core work. Many participants said that although community engagement may well reduce the burden on the health system in the long term, in the short term it was just one more thing to do, and getting grants to fund engagement is time-consuming and difficult. Two participants pointed out that capitation funding does not encourage general practices to create more work for themselves in order to reduce workload elsewhere in the system. We believe that there could be value in examining how best to support general practice community engagement. Neuwelt produced a toolkit for PHOs,[15] and this could be revisited.

Conclusion

Overall, we found that general practices in the study do not think in terms of communities, and they do not participate systematically in community engagement. Although local champions have initiated some interesting programmes, we believe a conceptual framework for engagement is needed: who to engage with, how to engage with them and how to evaluate the results of their engagement.

Competing Interests

The authors declare no conflicts of interest.

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