RESEARCH PAPER

Optimizing Community Participation in Healthcare Planning, Decision Making and Delivery through Rural Health Councils

Optimiser la participation communautaire à la planification, à la prise de décision et à la prestation des soins de santé par le biais des conseils de santé ruraux

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Abstract

Background: The aim of this scoping study was to understand the optimal structure and function of rural health councils (RHCs).
Methods: The study used the scoping review methodology, informed by both Arksey and O'Malley's (2005) framework and the *Joanna Briggs Institute Reviewers' Manual* (The Joanna Briggs Institute 2015).
Findings: Evidence demonstrates that the functions of RHCs range from identifying healthcare issues and priorities to local resource management. Enabling structures included the use of skills-based merit matrices to determine membership.
Conclusion: We found evidence on how to build effective models to support patient involvement in healthcare planning and service delivery to lead to care that reflects the needs of rural communities.

Résumé

Contexte : L'objectif de cet examen de portée est de comprendre la structure et la fonction optimales des conseils de santé ruraux (CSR).

Méthode : L'étude a utilisé la méthodologie de l'examen de portée, éclairée par le cadre d'Arksey et d'O'Malley (2005) ainsi que par le *Joanna Briggs Institute Reviewers' Manual* (The Joanna Briggs Institute 2015).

Résultats : Les données montrent que les fonctions des CSR vont de l'identification des problèmes et des priorités en matière de soins de santé à la gestion des ressources locales. Les structures habilitantes comprennent l'utilisation de matrices de mérite fondées sur les compétences pour déterminer l'adhésion.

Conclusion : Nous avons trouvé des données sur la manière de créer des modèles efficaces pour soutenir la participation des patients à la planification des soins de santé et à la prestation de services afin d'offrir des soins qui reflètent les besoins des communautés rurales.

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Background

Involving patients in healthcare activities has emerged as an important priority in many healthcare systems internationally (Australian Commission on Safety and Quality in Health Care n.d.; NHS England 2017; Patient Safety Network 2019; WHO 2016). Although rooted in evidence showing improved outcomes when patients are involved in their own care (Arnetz et al. 2009; Loh et al. 2007; Rachmani et al. 2002), there is also a growing recognition of the important role that patients, families and caregivers play when they "… participate in quality improvement and healthcare redesign" (British Columbia Ministry of Health 2015: 2; Ontario Ministry of Health and Long-Term Care 2015). Underscoring this is the awareness of the need for productive relationships among researchers, healthcare professionals and policy makers. It is a short, although essential, step to recognize "community" – by either place or intent – as synonymous with patients and applicable to the larger patient-oriented frameworks driving healthcare improvement. This is particularly important where participation in health planning is understood through a rural lens, and the community-oriented, highly relational nature of rural communities is recognized.

Rural health councils (RHCs) or health boards are catchall phrases that refer to committees, boards and councils carrying out rural healthcare planning, decision making and/or delivery functions. Historically, prior to the widespread regionalization of health services in Canada, health boards existed as a mechanism for hearing and responding to local health concerns, which tend to be regionally variable. They were disbanded in most jurisdictions due to the cumbersome and expensive infrastructure needed to maintain them (Kornelsen and Grzybowski 2005) and in British Columbia (BC) prior to the advent of regional health authorities. This shift in healthcare administration from a centralized entity to new regionally responsive organizational structures, echoed in most jurisdictions across Canada and elsewhere, has paradoxically increased the centralization of decision making as it concentrates decision making in a particular region. Planning and administrative efforts are applied to areas larger than individual communities. Likewise, although the original intent was to embrace democratic participation through the involvement of community members in decision making and planning to improve the health of residents, the further regional centralization, in fact, reduced such participation (Kornelsen and Grzybowski 2005).

The principles underscoring citizen-patient-community (CPC) engagement rest in a tacit understanding that health services and policy evidence must be situated in a framework inclusive of the knowledge yielded from science-based methodologies but extended also to the recognition of individual, local and community, organizational and holistic knowledge (Brown et al. 2010). In this way, incorporating CPC voices is part of a paradigm shift away from normatively valuing scientific evidence (easily measurable) at the cost of alternate forms of knowledge (not easily measurable). CPC experience is at the core of this new paradigm, and patients are encouraged to be active participants in their own care. For this vision to actualize, however, CPC involvement must be met by a system recognition of the value of such involvement and established mechanisms and accountabilities for including the yields of patient voices in decision making. Actualizing these principles is essential to ensuring authentic CPC representation in policy development.

In this article, we review relevant literature on the structure and function of health councils through a rural lens. We believe that this literature provides value to system planning across varied rural jurisdictions.

Method

Research objective and question

This pragmatic review was undertaken to strengthen our understanding of the value of CPC participation in healthcare planning, decision making and delivery through RHCs. The topic was identified through a survey by the Centre for Rural Health Research at the University of British Columbia to understand the healthcare priorities of rural residents across BC (RER 2019). We made the strategic decision to focus on RHCs due to the historical resonance with the jurisdiction in which the scoping review was undertaken. That is, we had ongoing input from the members of a robust patient advisory committee, many of whom had awareness of and direct experience with hospital boards and health councils. The research question was as follows: What is the structure, function and impact of RHCs that include patient communities in healthcare planning, decision making and delivery activities? As no human participants were involved in this review and all materials included were available in the public domain, an ethics board approval was not necessary.

Scoping review method

This literature review used a scoping methodology, informed by both Arksey and O'Malley's (2005) methodological framework and the *Joanna Briggs Institute Reviewers' Manual* (The Joanna Briggs Institute 2015) for the conduct of scoping studies. We included publications with the following criteria: those focused on systemic and sustained mechanisms of community involvement or leadership in healthcare planning, decision making or delivery through health councils; those from high-income countries as defined by the World Bank (2018) to maximize applicability to the Canadian context; those published after 1990; and English-language publications. Due to a lack of transferability, we eliminated publications describing *ad hoc* or one-off initiatives for patient involvement in health service planning, decision making or delivery through health councils. The search terms and concepts are described in Table 1. Appendix 1 (available online at longwoods.com/content/26972) describes the search strategy.

Data extraction process

The data extraction process – or "charting the results," as it is referred to in scoping studies – is intended to produce a summary of the results of each included publication, guided by the question and the objective of the scoping study. Two reviewers (CC and contributor Zeena Yesufu) performed data extraction of the included literature using a data extraction form that was developed by the study team (Table 2). The first author (JK) reviewed the data abstraction forms and resolved any discrepancies through a review of the full text of the article and a discussion with team members.

Findings

Key findings from this review describe the evidence gathered on the *structure* and *function* of RHCs, recognizing that "one size does not fit all" and that roles and applications may be different across equally effective models. There are commonalities, however, which are discussed in the following sections.

The function of RHCs

The literature described the activities of council models from international jurisdictions where CPC participation was integral to their composition and operation (Andrews et al. 2014; Bismark and Studdert 2014; Greene 2002; Hemingway and MacLeod 2004; Hudson 1996; Hurley et al. 1994; Karash 2016; Knoble 1993; Kralewski and Moscovice 1992; Larson 1999; Longley 1999; McClean and Trigger 2017; Minister's Action Committee on Health System Reform 1994; Nelson and Gauss 2016; Pickard et al. 2002; Riley and Elder 1991; Robinson et al. 2003; Rosenthal et al. 1991; Tritter and McCallum 2006; Veronesi and Keasey 2012; Weiner and Alexander 1993; Wilson et al. 1993; Wright 2013). As members of councils, there were multiple health service activities in which CPCs might participate, including but not limited to identifying and defining healthcare issues and

TABLE 1. Search concepts

Concept	Keywords	Reasoning
Rural	Keywords: Rural* MeSH: Rural Health Rural Population Rural Health Services Hospitals, Rural	The objective of the scoping study is to understand the value of community participation in healthcare planning, decision making and delivery through RHCs, specifically. For this reason, the following keywords and subject headings were applied to limit the search to publications that describe rural and remote populations and health contexts. Note that this concept was not applied during citation searching activities.
Community participation	Keywords: Community*, Public*, Consumer*, Citizen*, Local, Patient*, User*, "Civil Society" MeSH: Community Participation Community-Institutional Relations	The "community participation" concept, together with the "governing board" concept, aimed to capture the literature that addressed community involvement in healthcare activities and relations with health service organizations.
Governing board	Keywords: "Foundation Trust*", (Health* OR Hospital* OR Govern* OR District* OR Regional) ADJ3 (Authorit* OR Council* OR Board*) MeSH: Governing Board Health Planning Organizations	This concept aimed to capture the literature that addressed RHCs. The scope of the MeSH term "governing board" captures the intent of the concept, described as "The group in which legal authority is vested for the control of health-related institutions and organizations" (Medical Dictionary Online n.d.). Note that all concept keywords were limited to the last five years in the MEDLINE database. This was due to the volume of retrieved titles in the absence of the limit and time constraints on behalf of the research team and based on the assumption that articles published more than five years ago would be indexed appropriately in the database and captured through the use of the targeted MeSH terms. The keywords were not limited in the EMBASE and CINAHL databases due to the absence of targeted subject headings for this concept in the EMBASE database, and due to the small volume of retrieved citations in the absence of this limit in the CINAHL database.

CINAHL = Cumulative Index to Nursing and Allied Health Literature; EMBASE = Excerpta Medica Database; MeSH = Medical Subject Headings; RHC = rural health council.

priorities; developing strategies to address identified priorities; implementing the identified strategies; managing resources; and monitoring and evaluation (Abelson et al. 1995; Charles and DeMaio 1993; Farmer et al. 2017; Hogg and Williamson 2001; Pickard et al. 2002; Robinson et al. 2003; Tritter and McCallum 2006).

The structure of RHCs

The organization and composition of councils described in the literature were varied, with no single structure emerging as "ideal" or "best." For instance, Weiner and Alexander (1993)

TABLE 2. Data extraction form

• Bibliographic reference (Vancouver style) • Research question(s)/objective(s) • Study rationale/context • Study design/publication type • Jurisdiction
Methods • Study population • Inclusion criteria (for participants, studies, data) • Exclusion criteria (for participants, studies, data) • Study conduct (e.g., interview protocol, survey design and distribution, outcome measurement) • Analysis (e.g., statistical)
Results • Main findings (two to three points) • What is the rationale for community or patient representation or involvement?
Structure • What is the structure of the health board or council? (i.e., how is the board organized?) What is the composition of the health board or council? • How are communities or patients represented on the health board or council? • Other relevant information.
Function • What is the function (e.g., the mandate, the activities, the responsibilities, etc.) of the health board or council? • What are important considerations with regard to the effective functioning of the health board or council? • How does the health board or council make decisions? • Describe the accountability relationship of the health board or council (i.e., who is the health board or council accountable to? Who is accountable to the health board or council?). • How are communities or patients involved in the health board or council? • Other relevant information.
Impact • What is the impact of the health board or council (as a whole), or individual board members, on health services planning, decision making or delivery? (i.e., what has been their influence? What has the board accomplished? Has the board [or individual board member] been successful/effective?) • How have communities or patients influenced the effectiveness of the health board or council? • What are the advantages to community or citizen-patient representation on the health board or council? • What are the challenges or barriers to community or citizen-patient representation on the health board or council? • Other relevant information/findings.

observed that within hospital boards, board form varied according to the organizational and environmental characteristics of the hospitals. Regarding CPC representation on councils, lay individuals comprised a portion (Andrews et al. 2014; Bismark and Studdert 2014; Hemingway and MacLeod 2004; Hudson 1996; Minister's Action Committee on Health System Reform 1994) of council members and contributed alongside health service providers and local policy makers as council members (Andrews et al. 2014). In other settings, it was believed that the inclusion of healthcare providers in the council would dilute the community voice and be an inauthentic representation of CPC interests; therefore, healthcare providers were intentionally excluded (McClean and Trigger 2017).

In addition, Godbout and Leduc (1987; cf. Hurley et al. 1994) found that having a majority of CPCs on a board was necessary for meaningful participation and empowerment.

However, Checkoway (1981; cf. Hurley et al. 1994) reported that this did not ensure that CPC voices dominated or were even heard in decision making. Hurley et al. (1994) cited Steckler and Herzog (1979), who suggested that experts can dominate the discussion, intentionally or otherwise, by framing discussions technically.

Council members might be elected or appointed and identified by volunteering themselves or by being nominated (Abelson and Eyles 2002; Bismark and Studdert 2014; Hemingway and MacLeod 2004; Hogg and Williamson 2001; Hurley et al. 1994; McClean and Trigger 2017; Minister's Action Committee on Health System Reform 1994). The literature emphasized the importance of considering the experiences, skills and knowledge, as well as the demographics of the candidates, to assure a balanced and representative council (Bismark and Studdert 2014; Guzys et al. 2017; McClean and Trigger 2017; Nelson and Gauss 2016).

To address barriers related to skills and representation in CPC involvement, McClean and Trigger (2017) described the use of knowledge- and skills-based criteria and demographic requirements within the Gold Coast Primary Health Network's Community Advisory Committee (CAC). They argued that determining the membership of the CAC was critical for the success of the committee and that this selection process ensured that membership was as representative of the local CPC as possible (McClean and Trigger 2017). However, Guzys et al. (2017) cautioned that the use of skill matrices during recruitment would likely give an edge to those with higher educational attainment, thereby increasing the influence of the "elite."

Hurley et al. (1994) described BC's Community Health Councils, whereby participants were both appointed by the minister of health and elected by the public. In this case, the authors spoke positively about the processes to determine membership, suggesting that the election and appointment assured public accountability (Hurley et al. 1994). However, Abelson and Eyles (2002) warned against the electoral process, citing the experience of health boards in the Canadian provinces of Saskatchewan and Quebec, where only candidates with ulterior interests stood for election.

The role of CPCs

Hogg and Williamson (2001) distinguished the activities of CPCs at national and local levels in the UK: at the national level, CPCs were involved in, for example, government advisory committees and professional regulatory bodies whereas at the local level, CPCs served as members of hospital boards and audit committees and were appointed as chairs and non-executive directors of health authorities, trusts and primary care groups, among other activities. In addition, Charles and DeMaio (1993) discerned three decision-making contexts: treatment, service delivery (i.e., resource allocation decisions for a defined service region) and system-level decision making (i.e., macro-level healthcare allocation and policy decisions for a jurisdiction).

Who participates?

The reviewed literature emphasized the importance of particular participant attributes for the success of CPC participation, including leadership skills (Anton et al. 2007; Hart et al. 1991; Jaklevic 2002; Larson 1999; Pirani et al. 1993); trustworthiness (Anton et al. 2007; Larson 1999); experience in and commitment to local matters (Anton et al. 2007; Ramstead 1992); knowledge of the organization, health and healthcare (Anton et al. 2007; Karash 2016) including knowledge of local health needs (Guzys et al. 2017; Wright 2013); knowledge of and experience in business (Barnett and Barnett 2001; Jaklevic 2002); expertise in finance and law (Kralewski and Moscovice 1992); expertise in strategic planning (Hart et al. 1991; Kralewski and Moscovice 1992; Pirani et al. 1993); and creativity in response to resource scarcity (Ramstead 1992).

However, with regard to the selection of CPCs with experience in business, Guzys et al. (2017) cited Keevers et al. (2012) and Maier et al. (2016) who suggested that restructuring not-for-profit boards and committees to include "business-like" and professional members might reduce advocacy in favour of service provision, disempower grassroots activists and increase the influence of the elite. Similarly, Longley (1999) refuted the importance of council members with expertise in business and finance, instead suggesting that resources to communicate to council members complicated financial issues.

Abelson et al. (1995) explored the willingness and suitability of specific community groups for decision-making responsibilities. Elected officials were most willing to take responsibility for overall decision making (85% of respondents were personally willing, and 50% believed their group was suitable), and randomly selected citizens were least willing (60% of participants were personally willing, and 17% thought their group was suitable) (Abelson et al. 1995). The individuals polled favoured a combination body – including several community groups – as the most suitable overall decision-making body with representation from experts in healthcare and social services, town hall meeting attendees (i.e., "interested citizens"), and elected officials prioritized for the combined decision-making group (Abelson et al. 1995).

Finally, Pagatpatan and Ward (2017) reported the importance of "inclusiveness" for successful CPC participation, referring to the consideration of a broad range of perspectives in public participation exercises, with a particular focus on involving marginalized and hard-to-reach publics. Tritter and McCallum (2006) echoed this sentiment, suggesting that to build a successful user involvement system, diverse individuals and groups at local, organizational and national levels must be engaged. Similarly, Dunn (2007) described the importance of diversity for hospital boards, including considerations of ethnicity, age, gender, geography and occupation.

Motivation for participation

The reviewed literature presented multiple reasons for participation by CPCs that included achieving a specific outcome for their community or organization (Farmer et al. 2017), to "have a say" or be included in decision making (Rose et al. 2014: 22), to affect service change (Farmer et al. 2017; Rose et al. 2014) or because it was "the way things were done" (Abelson et al. 1995: 407). A perception was conveyed through the literature that community members could contribute useful information (Farmer et al. 2017) and add to institutional credibility (Swapan 2016; cf. Farmer et al. 2017). Pallarito and Shinkman (1997) quoted a citizen trustee, explaining, "You do it … [because] it's part of your life" (p. 26). Included studies are summarized in Table 3, available at longwoods.com/content/26972.

Discussion

The current scoping review summarized the literature on the function and structure of RHCs, including a description of community members who participate in health planning, why they participate and what their roles and responsibilities are. We found notable similarities and differences across rural jurisdictions in the way RHCs are organized and how they function. No studies examined the efficacy of RHCs from the perspective of participating community members. To capture this literature, future studies should incorporate specific search terms that will help locate evaluation and other studies that highlight the efficacy and impact of RHCs.

The scoping review identified several themes that are reflected in the wider context of the community engagement literature. Community engagement refers to the engagement of people with lived experience in health research and program- or policy-planning processes. This engagement is guided by a set of principles (Greer et al. 2017):

- community members are experts "in the context and content of decisions that affect their daily lives" (Greer et al. 2017: 7);
- meaningful engagement of community members promotes inclusion and equity, especially among those who experience barriers and are affected by discrimination. The ability to participate equally in decision making removes power imbalances and can lead to programming that is more responsive to the needs of community members who have been historically excluded from such activities;
- processes need to be transparent, and a rationale should be provided for why decisions are made to make it less likely that the decisions are driven by personal interests or individual opinions;
- those who work with community members must be accountable and take responsibility for their actions and decisions to build trust and enhance transparency;
- "recognizing and addressing the differences in power that are entrenched at decision-making tables is paramount to the success and validity of the voices" (Greer et al. 2017: 7) of community members in community engagement work;
- through working together and sharing decision making, community and professional members build capacity by developing confidence, skills and knowledge; and

- one size does *not* fit all, and different community members might require different supports to engage (Greer et al. 2017). For example, when engaging rural community members, it is important to consider the increased time and costs of reaching people who might be geographically dispersed, be aware of issues around transportation and telephone/Internet coverage in remote areas, engagement fatigue (as requests for engagement might be fielded by a smaller number of people) and pre-existing rural–urban tensions (British Columbia Ministry of Health 2019).

It is also important that all key stakeholders understand the unique local context and community expectations, norms, customs and values. Community members should determine their desired level of engagement and be given the information, time and resources needed to engage fully. Ideally, the group should agree on the purpose and rationale for engagement early on and empower community members to co-create and co-govern processes (British Columbia Ministry of Health 2019).

Although this scoping review focused on RHCs as an established mechanism to ensure community voice in healthcare planning, we recognize that other mechanisms and frameworks for community engagement exist. For example, Boelen (2000) published a paper about the challenges and opportunities for building partnerships in health development. He noted that striking a balance and managing tensions between the values of quality, equity, relevance and cost-effectiveness are challenging; understanding the interconnectedness of these values and arriving at a consensus about how to define and enact each value among key stakeholders are important when developing and implementing health services. Boelen (2000) stressed the importance of a decentralized, community-based approach to health planning that is people-centred because understanding the "major physical, biological, social, cultural, and economic health determinants at work in a given environment is the foundation of a sound and comprehensive people-oriented health system" (Boelen 2000: 24). Factors such as housing, transportation and employment and how they affect community health need to be considered. Implementing sustainable health services that are based on community needs requires active collaboration of key stakeholders who each have different strengths, constraints, expectations and agendas. When communities, health professionals, policy makers, academic institutions and health managers share a clear vision, are cognizant of the added value of the partnership and prioritize shared values over sectoral interests, the partnership is more likely to result in health development activities that are responsive to the needs of individuals and communities (Boelen 2000).

This literature suggests a strong rationale for CPC involvement in healthcare planning, rooted in the expectation of improved decision making that incorporates the needs and preferences of end-users. This is seen most clearly in rural settings through advocacy for local services in response to perceived threats (of closure or service reduction) and also in the articulation of service gaps that may not be well understood outside the local community population. The inclusion of community members may also enhance public trust in decision making through reassurances that local perspectives are represented. This emphasis on aspirational accountability, however, may further entrench *distrust* if it is perceived as strategic or involves citizens with allegiances to business or with interests competing with the public good. This, of course, begs the question "who represents community" and whether or not representation is inclusive of those who may be excluded from political and economic processes and discourse (the "have-nots"). For many, the realities of employment, family responsibilities and, perhaps most importantly, either distrust with the current health system or lack of confidence that involvement will lead to meaningful change, make achieving diversity difficult. When adequate representation is achieved, however, health boards and councils have the potential to increase a sense of community ownership over health services, bringing with it the conditions for "self-determining, empowered communities" (Kenny et al. 2017: 1). One of the ways that this is achieved is through, as Farmer et al. (2017) noted, the expansion of the role of community members from consumers to co-producers of healthcare.

To actualize CPC voices through health councils and boards, the most salient question is this: What is the infrastructure needed? At a macro level, system prioritization of community voices is essential (having a "receptor site" for decisions made at a local level), but actualizing input also requires capacity building in the form of orientation and training to ensure that skills and expertise on quality governance exist. Training requires flexibility to respond effectively to the needs of particular groups (Bismark and Studdert 2014) and the local healthcare priorities at hand. Furthermore, capacity development needs to be a dynamic process as board or council members, along with healthcare priorities, change over time.

The discussion of compensation for the board and council members has gained traction recently and is not without contestation. Although meaningful participation necessarily requires significant time commitments that should be honoured, some feel remuneration may also negatively affect the intent of having a true "consumer" perspective (see Kidd et al. 2007: 218). When applied to a rural context, however, the heightened importance of representing local conditions and the potential for overlapping roles of patient partners with other members of the board, council or healthcare administrators counter the commercialization of public members. In fact, the role may be seen as a transparent way of participating in community improvement and one among many ways that local citizens contribute.

Several recommendations on how to optimize the integration of patients partners into RHCs emerged from the findings. First, RHCs should be seen as an important component of healthcare planning and quality improvement initiatives and a way to make health services more patient-centred. The level and quality of patient engagement should be measured from the patient perspective and integrated as a metric for assessing healthcare quality. This is the responsibility of regional health authorities. In order for patients to make decisions that benefit their communities, they must have access to local data and the ability to collaborate with key stakeholders, including health professional divisions and community agencies. Decision makers and other key stakeholders on RHCs must be skilled in hearing and integrating feedback from community members. The recruitment process for community members who want to participate in RHCs ideally includes a combination of appointed and elected positions and a diversity of skills, knowledge and personal characteristics. This is in the domain of municipal (local) hospital and community infrastructure.

The roles and responsibilities of council members and expected outcomes and influence of RHCs should be clearly described so that patient partners who participate in RHCs have realistic expectations. To ensure government accountability, government health policy makers should be responsible for RHCs and for the inclusion of the rural patient voices on RHCs.

Priority must also be given to Indigenous leadership in order for communities to consider the best possible mechanisms for Indigenous-specific RHCs. These structures may reflect local existing Indigenous governance structures, modified to meet the specific needs of communities in health planning. Local or regional Indigenous organizations (e.g., BC First Nations Health Authority), in collaboration with jurisdictional governments, should be accountable for ensuring the involvement of community voices. Other examples of structures that support Indigenous community participation in health planning include Aboriginal/Indigenous health improvement committees across eight communities in Northern BC. These committees include local representatives from Indigenous organizations and communities, the First Nations Health Authority, Northern Health and other stakeholders. The function of these committees is to collaboratively set healthcare priorities, find pragmatic solutions and develop local resources through relationship building, increasing cultural awareness and integrating Indigenous perspectives (Northern Health Indigenous Health n.d.).

Finally, it is essential to measure the efficacy of CPC participation in healthcare decision making to determine if the promises of community empowerment, improved decision making or improved health outcomes are actualized, particularly in rural settings. Indicators may include those that measure the efficiency of resource allocation (Abelson and Eyles 2002), whether or not participation leads to increased local services, and thus increased access to care (Andrews et al. 2014), and changes in levels of public commitment to the healthcare system (Abelson and Eyles 2002; Anton et al. 2007). As rural healthcare services are often central to the economy of communities, the impact of the health council's decision making on economic growth is a key marker. In most instances, however, measurement metrics will not be quantitative and static but, instead, best accomplished through process measures that are easily adaptable to changing circumstances and, importantly, co-determined by local stakeholders. Local research institutions should be tasked with working with patient groups on shared measures development.

Conclusion

When considering health councils and boards as mechanisms for increasing rural involvement in decision making, descriptions of structure and function provide a helpful starting place for planning. However, as much of this literature does not focus specifically on the health councils in rural settings, we must consider implementation through a rural lens that appreciates the differences from urban centres with regard to economies of scale and local access to resources.

While the majority of recommendations are targeted at regional health decision makers, the confluence of interaction between all levels of governance is required to successfully implement a sustainable structure for community voices in healthcare planning. Specifically, a tripartite approach – that is, collaboration between municipal, provincial/territorial and regional authorities, should be used to action the recommendations, although the specifics of the agencies involved will vary between jurisdictions.

Although the nature of the implementation of health boards or councils will vary based on local political alignment, they should leverage existing political structures as a starting point for the necessary administrative infrastructure required to support health councils. However, more nuanced decisions – such as the ratio of elected to appointed representatives, role of remuneration and nature of quality improvement processes – will be required at a local level and may vary between settings. The very process of imagining how community voice can be integrated into health planning is likely to have a cathartic effect regarding attitudes to public involvement in contemporary healthcare.

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