DISCUSSION PAPER NO.33

How Can the Public Be Meaningfully Involved in Developing and Maintaining an Overall Vision for the Health System Consistent with Its Values and Principles?

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Contents

Highlights

- The democratic deficit is identified as a primary motivation for increased public involvement in healthcare policy planning and decision-making.

- Medical dominance is identified as a feature of Medicare that has contributed to the emergence of the health promotion policy paradigm.

- The central role of public involvement in health promotion is highlighted.

- Regionalization is identified as a means to institutionalize the health promotion policy paradigm and to realize its two objectives – promoting population health status and demedicalizing and de-institutionalizing healthcare services.

- Regional Health Authority board meetings are sites that approximate the rules of deliberation.

- Attention is focused on deliberative public consultation methods and their role in policy planning and implementation.

- Deliberative consultation procedures are argued to be necessary to rationally assess the justice of proposed policies from the point of view of all those affected by it.

Executive Summary

As citizens, consumers, patients and volunteers, we are both demanding and being exhorted to become more involved in healthcare decision-making and service delivery.

These expectations and opportunities raise questions such as:

- How can and should the public be involved in setting overall directions for the health care system?
- What mechanisms are most effective in ensuring the system reflects public values and principles?

In my answers to these questions, I argue that deliberative public consultation procedures have several features that recommend their expanded use for the formation of both *informed* public opinion and the political will to act upon it.

It is via the formation of informed public opinion and its conversion into actionable political will that the public, in its role as citizen, can be most meaningfully involved in developing and maintaining an overall vision for the health system consistent with its values and principles.

I also argue that Regional Health Authorities[1] (RHAs) provide an effective institutional site for linking deliberative public consultation procedures to both the policy and operational levels of decision-making.

The limited available evidence suggests that RHAs in the four Western provinces may have been most successful in involving the public in consultations, if not decision-making.

The paper begins with a brief discussion of two dimensions of the democratic deficit and the crisis of legitimacy faced by contemporary representative democracies. The first relates to a general tendency towards elitism and the marginalization of the public from political decision-making. The second relates to medical autonomy and dominance as defining features of Medicare. I explore how they are related to elitism in healthcare decision-making and form obstacles both to public participation and health system reform.

Following this, I identify the renewed interest in regionalized healthcare system governance and service delivery as a strategy, *inter alia,* to involve the public in institutionalizing the health promotion policy paradigm. Within this context, I described efforts to inform, to consult and to actively engage the public at the level of RHAs.

I do not advocate for direct democratic decision-making but rather for public involvement in achieving agreement on goals, principles and values for the healthcare system. Deliberative participation procedures provide a means for insuring that legitimate needs and interests are identified, interpreted and considered in deciding on the goals of healthcare policy and the means of achieving them.

Both democratically constituted and representative appointed RHA boards provide an important institutional means for linking deliberative public consultation procedures to decision-making processes. Linking deliberative consultation with decision-making seems ideally suited to realization of the various benefits claimed for applied discourse ethics.

Similarly, initiatives such as the National Forum on Health and the current Commission on the Future of Health Care in Canada at the national level, as well as provincial level commissions and task forces provide important but *ad hoc* opportunities to engage the public in the process of generating informed public opinion and the political will to act in important policy domains. By so doing, they provide an opportunity for us all to deliberate on the kind of society we want to live in and the best ways to bring it about.

Acknowledgements

Introduction

We live in turbulent times. New scientific knowledge, technological innovations and organizational reforms render traditional truths, occupational hierarchies and established social roles obsolete at increasingly rapid rates. The perpetual transformation of the healthcare system, for example, is accompanied by calls for greater public involvement in a variety of decision-making and service-delivery activities. In responding to these calls, the public – in the roles of patient, consumer, volunteer and citizen – is imbued with new rights and responsibilities relative to governments, service providers and others. Changes of this sort are contentious because they affect established needs and interests (Lalonde 1974; Epp 1986; Charles and DeMaio 1993; Abelson, Lomas, Eyles *et al.* 1995; Dickinson 1994, 1996, 2002; Lomas 1997; Dickinson and Torgerson 1998-99; Bolaria and Dickinson 2001; Church 2001; OECD 2001).

Among these contentious changes are calls for informed and shared clinical decision-making as a way to increase the involvement of the public as *patients* (Makoul, Arntson and Schofield 1995; Short 1996; Caress 1997; Charles, Gafni and Whelan 1997; Partridge 1997; Ubel and Lowenstein 1997; Gafni, Charles and Whelan 1998; Guadagnoli and Ward 1998; Gwyn and Elwyn 1999; O'Connor, Drake, Fiset *et al.* 1999; Robinson and Thompson 2000; Stevenson, Barry, Britten *et al.* 2000; Barry, Stevenson, Britton *et al.* 2001; Weston, 2001).

Medical savings accounts (MSAs), a recently proposed way to expand *consumer* involvement through the application of market principles to the provision and consumption of healthcare services, are seen by proponents as a way to save Medicare and by opponents as undermining its foundational principles (Litow and Muller 1998; Ramsay 1998; Deber 1999; Gratzer 1999; Stein 2001; McMahon and Zelder 2002).

Patient Charters, proponents argue, enhance system accountability by defining the rights and responsibilities of healthcare *consumers/patients* relative to those of service providers and governments. Opponents claim they simply entrench existing power relations and interests (Flood and Epps 2001; IRPP 2001; Gratzer 2002).

Efforts to forge new relationships between government and the *voluntary* sector are multidimensional. On the one hand, some focus on the relationship between enhanced public participation, increased levels of social capital and improved population health status. Others maintain increased reliance on volunteers marks an abandonment of the sick and the transfer of uncompensated responsibility for the provision of care to the community, particularly to women (Armstrong and Armstrong 1996; McDowell 1986; Bolaria 1988; Putnam 2001; Veenstra 2001; Woolcock 2001).

On the other hand, some see the negotiation of a new government-voluntary sector accord as part of a neo-corporatist redefinition of citizens' rights and responsibilities relative to democratic policy development and implementation. Others see it as contrary to the principles of liberal democracy and a process that will further marginalize the politically unorganized (Crichton, Robertson, Gordon *et al.* 1997; Hunold 2001; Wilensky 1981; Wooley 2001; Reed and Selbee 2001; Good 2001; Brock 2001).

Clearly, the public occupies a variety of roles and has numerous competing interests relative to the healthcare system. It is impossible to completely compartmentalize these social roles or to differentiate clearly the public's various, and sometimes competing, interests (Charles and DeMaio 1993; Lomas 1997). Having said that, however, in this paper I concentrate primarily on efforts to involve the public in its role as citizen. In doing so, I address the following general questions:

- How can and should the public be involved in setting overall directions for the healthcare system?
- What mechanisms are most effective in ensuring the system reflects public values and principles?

In my answers to these questions, I argue that deliberative public consultation procedures have several features that recommend their expanded use for the formation of both informed public opinion and the political will to act on it. The creation of informed public opinion and its conversion into actionable political will are the means by which the public, acting as citizens, can be most meaningfully involved in developing and maintaining an overall vision for the health system consistent with its values and principles. Regional Health Authorities (RHAs) are a promising institutional site for linking deliberative public consultation procedures to policy and operational levels of decision-making.

I begin by discussing two dimensions of the democratic deficit and the crisis of legitimacy faced by contemporary societies. The first is a tendency towards elitism in political decision-making inherent in the institutions and procedures of representative democracy. The second relates to medical dominance as a defining feature of Medicare and as a barrier to public involvement in healthcare decision-making in particular. Following this, I identify regionalization as a strategy to involve the public in deliberative consultation related to healthcare governance and service delivery, and thereby to facilitate health system reform. I conclude that the results to date are equivocal but promising.

The Uninvolved Public, Medical Dominance and the Democratic Deficit

Contemporary democracies are faced with declining political party membership, decreasing voter turnouts, widespread cynicism and lack of trust in the institutions of representative government (Dalton, Burklin and Drummond 2001). In combination, these features constitute a democratic deficit. The democratic deficit is related to a political crisis of legitimacy. Both are rooted in a belief that those who make and implement policy do not adequately represent the interests of the general public (Habermas 1976).

The democratic deficit and the associated legitimacy crisis exist at two levels. The first is in the context of the institutions and processes of representative democracy in general. The second is in the context of specific policy domains such as healthcare. In this section, I discuss both. I also discuss public participation as a means to reduce the deficit and resolve the crisis.

Paradoxically, representative democracies are characterized by a structural tendency towards elitism and the disempowerment of the general public. This occurs through, and to the extent that, the political role of citizens is limited to periodic voting. A process described as "a regulated acclamation procedure for alternately appointed elites to exercise power" (Habermas 1971, 68). To the extent that this is an accurate description, it is not surprising that the public is foregoing the opportunity to play its appointed role.

The generally agreed to corrective to the democratic deficit is more democracy. Several influential analysts, for example, advocate the introduction of direct democracy as a means to increase citizen control of policy-making and implementation (Arnstein 1969; Feingold 1977; Charles and DeMaio 1993).

Others do not make the assumption that the goal of public participation is direct democracy and citizen control (Connor 1986; OECD 2001). Connor (1986), for example, argues that the goal is conflict avoidance and, failing that, conflict resolution while leaving intact representative forms of decision-making.

Similarly, the OECD (2001) specifies three strategies for increasing public involvement: informing, consulting, and actively engaging the public in proposing policy options and participating in policy dialogue. In this model, authority to make final decisions remains with elected governments (OECD 2001, 2). From the perspective of proponents of direct democracy, the forms of public participation advocated by these models are mired in tokenism (Arnstein 1969) and may contribute to a deepening of the democratic deficit, not its reduction.

Popular support for direct democracy versus reformed representative democracy is split. The strongest support for direct democracy is among citizens at the periphery of politics – the less interested, the less informed, and adherents of extreme parties with strong populist and nativist tendencies. This feeds fears about direct democracy and the tyranny of the majority (Dalton, Burklin and Drummond 2001, 151).

It is not just the politically marginalized that support more participatory forms of democracy. According to opinion polls, most people in Western democracies favour moving toward a more participatory style of democratic government (Dalton, Burklin and Drummond 2001, 145).

This is not to say that all are in favour of direct democracy and citizen control. Abelson, Lomas Eyles *et al*. (1995) report that participants in their deliberative polling study favoured different decision-makers for different types of decisions and different decision contexts. Relative to devolved authority, for example, participants favoured an advisory role for interested citizens, with decision-making authority assigned to traditional decision-making bodies, including elected officials and experts.

This last point draws attention to the practice of delegating decision-making authority to third parties. This has been referred to as government-by-proxy (Salamon 1981; Kettl 1988; Brudney 1990; Reed and Selbee 2001). In the case of healthcare, control over decision-making and service delivery has historically been delegated to the medical profession. It has been argued, in fact, that relative to healthcare decision-making, the medical profession constitutes a "state within a state" and, in particular circumstances, a threat to democracy (Taylor 1960; Badgeley and Wolfe 1967). To the extent that this is true, health system governance is more technocratic than democratic and provides little opportunity for public participation (Freidson 1973; DeSario and Langton 1987).

This societal delegation of power to the medical profession occurred at a time when infectious diseases were the main source of morbidity and mortality. Advances in medical science during the late 19th century and early 20th century enabled the medical profession to prevent and cure many of these illnesses. It was widely believed that the continued development and application of medical science to the diagnosis and treatment of illnesses would result in continued improvement in population health status.

In this context, the central task of policy-makers was ensuring that individuals had access to physician and hospital services regardless of their ability to pay. Medicare, built on the principles of universality, comprehensiveness, portability, public financing and administration on a non-profit basis, eventually was instituted as the means to achieve that goal.

The medical profession vigorously resisted the introduction of Medicare because it was seen as a threat to professional autonomy (Coburn, Torrance and Kaufert 1983; Coburn 1998; Blishen 1991; Touhy 1999; Taylor; 1960, 1978; Badgeley and Wolfe 1967). As a result of this resistance, the profession secured several concessions from the government that entrenched medical autonomy and dominance by creating a healthcare system characterized by private practice and public payment (Naylor 1986).

The private nature of clinical practice decisions put them beyond external scrutiny and management. Combined with a fee-for-service system of payment that ties physician incomes to fee levels and volume of services provided, the system has built-in tendencies towards high levels of provider-driven demand and rising costs.

By the mid-1970s, and through the 1980s, these inflationary tendencies gave rise to a variety of cost-control initiatives (Armstrong 1997; Fuller 1998; Dickinson and Hay 1988; Weller and Manga 1983; Vayda, Evans and Mindell 1979). None of these initiatives fundamentally affected the inflationary dynamic of Medicare or the extent of medical dominance (Touhy 1999).

In recent years, however, several factors have converged to generate a renewed interest in reducing medical autonomy and dominance. These include substantial small area variations in diagnostic and therapeutic interventions that appear, in many cases, to be more related to physician idiosyncrasies than medical need (Roos and Roos 1994; Crombie, Cross and Fleming 1992; Anderson and Mooney 1990) and relatively high levels of medical error (*Health Edition* 2002c, 2).

In combination, these factors have raised doubts about whether medical practice is sufficiently grounded in medical science to warrant the profession's control over the form and content of its work (Lomas and Contandriopoulos 1994). Calls for evidence-based medicine can be seen, in part, as a response to this (Sackett, Rosenberg, Gray *et al*. 1998; Gray 1997; Dickinson 1998). Concerns that evidence-based medicine conceals a threat to professional autonomy are evident in the critical response by some clinicians (Grahame-Smith 1995).

Other factors, not directly related to the nature and organization of medical practice, are also at play to reduce medical autonomy and dominance. Demographic and epidemiologic shifts, for example, have resulted in a relative decline in infectious diseases and an increase in chronic conditions and accidents as the major sources of morbidity and mortality (Omran 1971; Lalonde 1974). For the most part, the medical profession is unable to cure these conditions and the hospital–centered healthcare system is not well designed, in terms of effectiveness or efficiency, for the long-term care and management of people with chronic conditions.

The demographic and epidemiologic shifts also contribute to a reduction in the knowledge gap between physicians and the general public. Patients and their families often have more knowledge than physicians about how best to manage chronic conditions. Increased levels of education among the population and easy and widespread access to health related information made available by new information and communications technologies are also seen to contribute to a reduction in the knowledge gap (Blishen 1991).

This shift in the knowledge/power base is associated with emergence of patient/consumer rights movements and demands for increased opportunities to participate in healthcare decision-making and service delivery. Organizational and governance reforms such as regionalization have increased opportunities in this regard, as has elucidation of the health promotion policy paradigm (Epp 1986; Blishen 1991).

Health Promotion: From Access to Healthcare to Health for All

Increased public involvement in healthcare decision-making and service delivery is at the heart of the health promotion policy paradigm. The health promotion framework emerged in the early 1970s as a result of research showing that a relatively small proportion of the population health status was attributable to clinical medicine. Factors outside the healthcare system, including human biology, the physical and social environments, and individual lifestyle choices were identified as important determinants of health. Relative to these factors, healthcare services accounted for a relatively small proportion of population health status. It follows that ever increasing expenditures on healthcare services result in diminishing returns in terms of health status (Evan and Stoddart 1994).

Thus, from this perspective, the greatest gains in population health status were to be found in encouraging behaviours the preserved and promoted health and discouraging those that didn't. It was expected that identifying and supporting health promoting behaviours would increase population health status and reduce both the need for, and unnecessary use of, expensive medical care and hospital services (Lalonde 1974; Epp 1986). Critics, however, pointed out that these ideas could be interpreted as a form of victim blaming and abandonment of the sick (Bolaria 1988; McDowell 1986).

These concerns notwithstanding, the concept became increasingly entrenched in the policy discourse. By the late 1980s and early 1990s, a series of provincial commission reports recommended a number of common reforms, including: increased emphasis on health promotion and decreased emphasis on institutional care; better coordination and integration of services; and increased public participation in policy planning and service delivery. In all provinces, except Ontario, regionalization was adopted as the means to achieve these goals (Angus 1991; Angus, Auer, Cloutier *et al*. 1995; Crichton, Robertson, Gordon *et al*. 1997; Dorland and Davis 1995; Mahtre and Deber 1992).

Regionalization: Promoting Health and Cutting Costs

Many of the reforms called for in the various reports were not new. Neither was the notion that regionalization is an effective way to achieve them. Saskatchewan, for example, experimented with regionalization as early as 1946 (Feather 1991a,b). Despite this, regionalization was never the dominant mode of system governance and service delivery. Following the introduction of Medicare, it was pronounced dead (Taylor 1978).

Its resurrection began in the mid-1970s when governments in the Northwest Territories, Quebec, Manitoba and Ontario (Vayda, Evans and Mindell 1979; Taylor 1978; Badgeley 1982) regionalized aspects of healthcare as a way to deal with rising costs. These fiscal concerns were exacerbated by the fact that Medicare was not producing the expected health outcomes.

Thus, the search was on to find a way to implement health system reforms in the face of powerful provider interests committed to the *status quo*. Efforts to establish a new balance of power took the form of a neo-corporatist strategy involving extensive public consultation exercises and the formation of new partnerships and collaborations with a wide range of stakeholders (Boudreau 1991a,b).

In Canada, interest in the neo-corporatist model was heightened as a result of a 1980 OECD conference on the growing fiscal crisis of the welfare state (Crichton, Robertson, Gordon *et al.* 1997). Wilensky (1981, 194), in a paper presented at the conference, argued that countries adopting neo-corporatist models of policy formation were more likely than the least corporatist countries, such as Britain, the United States and Canada, "to contain the bargaining power of physicians and other provider groups, and thereby move the [healthcare] system towards real health outputs". Regionalization, thus, re-emerged as a neo-corporatist strategy to involve the 'public' in a quest to actualize the health promotion policy paradigm and to break the 'Medicare Pact' (Lomas 1997d).

Cast in these terms, it is clear that the goals of the health promotion policy paradigm are not to be understood only as add-ons to the existing physician dominated and hospital-centered healthcare system. Regionalization must also be understood as a means to demedicalize and de-institutionalize healthcare. Increased public involvement is necessary (although not sufficient) to form both the public opinion and the political will necessary to bring about the new balance of political power required to implement successfully these reforms.

This relates to the previously discussed concerns about the democratic deficit. Policy-makers and reformers are concerned that if the public is not involved in, and supportive of, proposed reforms to the healthcare system, it may not be possible to make the desired changes, or at least it may not be possible to make them without unacceptable political costs. This is a concern to the extent that regionalization and health promotion are seen as threats to Medicare.

By creating new planning and management capacities between provincial and local levels of health system governance and service delivery, regionalization is intended to be a means to help establish and mobilize new stakeholders in reform efforts (Dorland and Davis 1995; Lewis 1997; Lomas, Woods and Veenstra 1997a,b,c; Lomas 1997d; Church and Barker 1998; Lewis, Kouri,

Estabrooks *et al*. 2001). It is a contradictory process, however, that involves both centralization and decentralization of authority and responsibility and, associated with this, a tension between democratic (community control) and technocratic (professional control) of decision-making (Rasmussen 2001, 256).

Relative to the centralization-decentralization of decision-making capacity, regionalization invariably resulted in the replacement of a relatively large number of local hospital and other facility boards with a smaller number of RHAs. In the early 1990s, for example, the Government of Saskatchewan replaced more than 400 local boards with 32 District Health Boards. This number subsequently was reduced to twelve. The scale of centralization was similar or greater in all jurisdictions that regionalized their healthcare systems.

Critics of regionalization argue that the elimination of local hospital boards has de-democratized healthcare decision-making by reducing the number of opportunities for public involvement. Proponents, on the other hand, argue that it has resulted in enhanced democratic participation, especially in jurisdictions, like Saskatchewan, that created partially elected boards. Most other jurisdictions, however, have appointed boards although several provinces indicated their intentions to introduce elected or partially elected RHA boards. So far, however, Alberta is the only province to have done so. Saskatchewan, on the other hand, replaced its partially elected boards with entirely appointed boards in the most recent round of reforms. This clearly de-democratizes decision-making.

Although there are contradictory tendencies, regionalization has resulted in increased efforts to increase public involvement in, and to assert lay (public) control over healthcare providers and system planning and management. These efforts have taken a number of different forms. I discuss some below under the headings Informing the Public, Consulting the Public, and Deliberative Consultation: Active Public Participation.

Informing the Public

Meaningful public involvement is the best prophylactic and therapeutic response to the democratic deficit. Meaningful public involvement presupposes an informed public. The most direct way for governments to inform members of the public is to produce and disseminate information for their use. This takes the form either of providing 'passive' access to information requested by members of the public, or 'active' measures taken by governments to disseminate it regardless of public requests (OECD 2001, 2).

Standard annual public meetings and reports, along with brochures, newsletters, pamphlets, news releases and various other print materials are common ways to disseminate information. Various electronic media are increasingly used for this purpose, including cable television, radio, and Internet sites.

Providing information to the public is an important way for all levels of government to meet accountability requirements. Certainly, RHAs attempt to engage the public through the provision of information. In Saskatchewan, for example, RHAs are required by law to provide public access to meetings and minutes and to present annual reports and health service information.

The provision of information by governments is generally thought to be a foundation stone of representative democracy. There are concerns, however, that governments may provide information in a self-serving fashion, rather than as a means to enhance informed public involvement in policy discussions. When this occurs, it heightens public suspicion and cynicism and contributes to a deepening of the democratic deficit. Thus, it is necessary to have external, arms-length scrutiny of government activities, even ones that seem to be as unproblematic as providing information to the public.

Experience also shows that it is insufficient to leave government provision of information on a voluntary basis. Governments often are reluctant to make information too freely available. The two main reasons are protection of individual's privacy and state security. In many cases, these are legitimate grounds to restrict freedom of information. In some cases, however, reluctance to make information public may be an attempt to avoid accountability.

Despite recent setbacks, the legal frameworks and mechanisms for ensuring public access to government information have expanded and improved over the last two decades. In 1980, for example, about 20% of OECD countries had freedom-of-information laws. This proportion had increased to 40% in 1990 and reached 80% by 2000 (OECD 2001, 3).

As important as it is, the provision of information is limited as a means to involve the population in public affairs. The approaches used are not interactive. Information generally flows only one-way and it may be non-responsive to the particularities of peoples' interests and concerns. They fail to provide opportunities to engage in discussion about the validity and meaning of the information provided. To address these shortfalls, increased efforts have been devoted to developing more interactive ways to consult the public.

Consulting the Public

Public consultation is another common means to involve the public in decision-making. Public consultation processes consist of two-way exchanges of information between governments and the public. Abelson, Forest, Eyles *et al.* (2001) classify consultation methods as either deliberative or non-deliberative. Non-deliberative methods involve exchanges of information but they do not involve deliberative dialogue aimed at achieving mutual understanding. Deliberative consultation procedures do include a dialogical component.

Public opinion polls are at the non-deliberative end of the consultation continuum. Public hearings and focus groups are more interactive, and various types of citizen advisory and decision-making bodies are at the most deliberative end of the consultation continuum.

Experience with non-deliberative consultation procedures shows that they are useful, but limited (Abelson, Forest, Eyles *et al.* 2001). They tend to be sporadic and reactive gripe sessions involving more or less isolated individuals (Eksterowicz and Cline 1988).

Deliberation is seen as the means to overcome these limitations (Eksterowicz and Cline 1988). Procedures such as citizen juries, citizen panels, planning cells, consensus conferences and deliberative polling are all deliberative public-consultation methods that have potential application in the health policy domain at all levels of decision-making – federal, provincial and regional (Abelson, Forest, Eyles *et al.* 2001).

An Excursus on Deliberation, Discourse Ethics and Forms of Representation

What is deliberation? Deliberation is dialogical and public. This distinguishes it from personal contemplation (also often termed deliberation) and non-deliberative consultation and information giving. Proponents argued it is the essence of public rationality and democracy and the only sure cure for the democratic deficit (Habermas 1984, 1987, 1996; Majone 1989; Dryzak 1990; Fischer and Forrester 1993). As Mathews (1995, 42) states, "Deliberation is the DNA of democracy, it both forms and informs a public."

The principal objective of deliberative procedures is to achieve mutual understanding and, ideally, agreement on the normative legitimacy (justice or fairness) of a policy among all those whose needs and interests are affected by it. Discourse ethics specify the means to do this (Dryzak 1990; Benhabib and Dallmayr 1990; Habermas 1990, 1994).

Discourse ethics take the form of normative guidelines that specify the 'who, what and how' of deliberation directed towards answering the following general question: "In a world characterized by an irreducible plurality of values, and in the absence of a universal morality, how can we resolve, or at least accommodate, value differences in a way that is acceptable to all without resort to manipulation, threat or violence?" Specific versions of this question must be answered relative to all policy and practice decisions if those policies and practices are going to be rationally justifiable and acceptable to all those who are affected by them.

Who may participate in deliberations? Anyone who is competent to speak and act, in principle, has a right to take part in discourse. In modern, mass societies, of course, it is impossible to achieve this degree of participation. It was for this reason, in part, that representative forms of democratic governance were developed and why they remain essential. The current democratic deficit, however, signals a crisis of legitimacy for existing institutions of representative democracy. Development and deployment of deliberative consultation procedures is part of the attempt to resolve this crisis without abandoning representative forms of governance to direct democracy or to non-democratic forms of authoritarian and elite (technocratic) decision-making.

Deliberative consultation procedures generally are linked to neo-corporatist forms of interest representation, although Hunold (2001) maintains they are also compatible with other forms of representation. DeSario (1987, 135) identifies four main forms: formal, ascriptive, descriptive, and substantive.

Formal political representation entails entrusting elected officials with decision-making power they exercise in the way they see fit. As we have seen, dissatisfaction with this form of representative democracy is thought by many to be the main source of the democratic deficit.

Ascriptive representation refers to a situation where some group is delegated authority to make decisions in particular policy domains. It is premised on the assumptions that those to whom this authority is delegated possess superior specialized knowledge and that they will use it

to pursue general interests, not narrow self-interests. I argued previously that doubts about the validity of these assumptions as they apply to the medical profession are contributing to a legitimacy crisis in healthcare and calls for increased public involvement.

Descriptive representation refers to the idea that participants in deliberative and decision-making processes should reflect the socio-demographic characteristics of the community as a whole. The underlying premise is that people with common characteristics share, and will promote, common interests.

Finally, substantive representation is based on the premise that public consultation and decision-making should involve members of groups espousing and working to realize particular interests. It assumes active members of interest-based groups are more motivated to become informed and to participate in policy development and implementation than those with only diffuse interests. The legitimacy of neo-corporatist forms of policy-making and implementation rests upon these assumptions.

Descriptive and substantive forms of representation have assumed the greatest significance in the context of calls for both deliberative consultation and direct democracy (DeSario 1987). Faced with a democratic deficit, governments are actively developing relationships with interest-based groups in order to extend and strengthen neo-corporatist decision-making capacity (Good 2001; Reed and Selbee 2001).

Proponents of neo-corporatism, or substantive representation, recognize that not everyone is equally motivated or mobilized to participate in various aspects of civic life. Reed and Selbee (2001) refer to the minority of Canadians who are disproportionately engaged as Canada's civic core. Based on their analysis of the 1997 *National Survey of Giving, Volunteering and Participating,* they found that 28 percent of Canadian adults account for 83 per cent of total hours volunteered, 77 percent of total charitable dollars donated and 69 per cent of civic participation. In terms of socio-demographic characteristics, the civic core is older, religious (but not Catholic), and relatively well-educated compared to the general population.

Given this, initiatives like the Federal government's effort to establish a government-voluntary sector accord (Good 2001) causes some to be concerned that it is an exercise in mobilizing bias (DeSario 1987). Reed and Selbee (2001) agree, but maintain it is mobilizing a bias towards the expansion of social capital and, therefore, it is desirable: "The civic core, although small, is clearly a pillar of enormous significance in maintaining a just and mutually caring society; we would speculate that it may also have a central role in supporting democratic governance as well".

The discourse ethics specify that everyone whose needs and interests are affected by a decision have the right to participate directly in policy deliberations. In practice, however, participation is generally mediated through various forms of representation – descriptive, substantive, ascriptive and formal political.

Representativeness, considered both as goal and process, is not achieved through any singular means. Rather, as we have seen, there are numerous forms of representation, "each by

virtue of its own peculiar nature seeing, reflecting, [and] attempting to effectuate a slightly different facet of that great conglomeration of desires and interests that make up the electorate" (Pennock 1968, 27 quoted in DeSario 1987, 135). Thus, there is not one best way to represent interests in the exercise of power.

The discourse ethics address the issue of who may be involved in deliberations. They also address the question: "What may be discussed?" In principle, every participant in a discourse has a right to express his or her needs and interests, desires and preferences, principles and values. Similarly, any other participant may challenge the validity of such assertions. The person so challenged is obliged to provide reasons and arguments in support of his or her assertions. Argumentation, motivated to achieve mutual understanding, is the essence of rational deliberation (Toulmin 1958; Habermas 1984; Dickinson 1998).

The discourse ethics also provide normative guidelines concerning how participants in deliberations are to interact? As we have seen, participants in deliberative discourse have the right to assert anything and to challenge any assertion made by others. They must not only exercise their own rights in these regards, they also have obligations to respect the rights of others to do so. Some argue that participants in deliberative discourse have obligations not only to respect others' rights to participate in deliberations, but to ensure all other participants actually exercise their rights (Chambers 1995).

These normative expectations presuppose participants will be self-interested. The discourse ethics do not begin with the unrealistic expectation that participants will adopt Rawls's "veil of ignorance", or some other artificial device, as a way to move beyond self-interest to altruism (Lomas 1997). Rather, the rights that participants in deliberations have publicly to assert anything and to challenge any assertions made by others discourages narrowly self-serving strategic communication, such as misrepresentation, deceit or manipulation, threats, coercion, and violence.

By exposing strategic communicative action, deliberation discourages it and, in the process, contributes to the achievement of rational understanding and agreement based only on the force of the better arguments. Only agreements achieved through this means are recognized as genuine and legitimate (Habermas 1990, 89). Following from the discourse ethics is the principle that valid policies are those "that meet (or could meet) with the approval of all affected in their capacity as participants in a practical discourse" (Habermas 1990, 93).

It is obvious that implementation of the norms of rational deliberation as specified in the discourse ethics is impossible. It is possible, however, to approximate more or less closely these deliberative procedures and, thereby, to approximate realization of the above-mentioned policy principle that follows from them. Various deliberative consultation processes are more or less well designed to approximate these normative procedures (Abelson, Forest, Eyles *et al*. 2001; Pickard 1998).

Proponents of deliberative procedures argue that even rough approximation of the ideal is worth pursuing. Several possible benefits of doing so are commonly identified. These include increased legitimacy of policy decisions that results from stakeholder and public involvement.

The increased legitimacy is seen to come from the fact that deliberative consultations allow consideration of a broader range of options than may have occurred otherwise. Associated with this is the capacity that deliberative procedures create for participants to clarify their value preferences and to express the intensity and relative weights of their preferred options.

More importantly, perhaps, deliberative procedures also are the basis of social learning, where social learning, among other things, is understood as the achievement of new understandings of oneself, one's needs and interests, and one's rights and responsibilities relative to others. Policy development, implementation and compliance are most effective when they are the result of mutual understanding and agreement based on processes of social learning. Effective institutional reforms, that is, organizational and procedural innovation, are predicated on social learning.

Finally, social learning that takes place through participation in deliberative procedures has a correlate in the enhancement of deliberative skills and abilities of individuals who participate. That is, practice makes perfect – or at least better, and more civically literate – individuals. Such individuals are precisely those that increase the stock of social capital, and thereby help sustain a just and mutually caring society with increased democratic capacity (Veenstra and Lomas 1999; Reed and Selbee 2001).

Deliberative consultation is the most actively participatory form of public participation. The bulk of experience with using deliberative procedures for setting health services and policy priorities has been in the United Kingdom (Abelson, Forest, Eyles *et al*. 2001). Having said that, however, it is also the case that both non-deliberative and deliberative consultation procedures have been, and are, used by various levels of government in Canada from the national to the provincial, municipal and regional levels.

Deliberative Consultation: Active Public Participation

Active public participation in policy formation and implementation is conceived of as a partnership between government and citizens (OECD 2001). Within this partnership, citizens have a right to be actively engaged in the policy-making process and governments have an obligation to enable meaningful public involvement and to take the results into account in making decisions.

There is no consensus around the types of decisions various publics want to be, or should be, involved in (Abelson, Lomas, Eyles *et al*. 1995; Lomas 1997). Nor is there a single, best way to involve the public in deliberative consultations. Various tools, procedures and institutional means, and forms of representation to enable effective deliberative consultation are being experimented with (Pickard 1998; OECD 2001).

In Canada, at the federal level of government, efforts in this regard have increased since the early 1990s through the public consultation processes of the National Forum on Health (Ham 2000) and, more recently, the Commission on the Future of Health Care in Canada (the Romanow Commission) and the Kirby Committee. At the provincial level of government,

there are numerous examples of task forces and commissions using public consultation procedures. At the regional level, various initiatives of this sort also are evident. I concentrate on these.

RHAs and Deliberative Procedures

An assessment of the decision-making needs of Saskatchewan RHAs done in the mid-1990s identified increased public involvement in health system planning and governance as a top priority (Kouri 1996). A recent national survey also indicated that developing effective public consultation procedures was the second ranked priority for RHA board members after population health research (Kouri 2002). Clearly, but not surprisingly, public consultation is a priority for RHAs.

What do we know about RHA practices in this regard? Abelson, Forest, Smith *et al.* (2001) found that regional health advisors in Ontario and decision-makers in Quebec used public consultation procedures such as issue forums, workshops, focus groups, private meetings, public hearings and surveys. They identify a trend away from large, formal, and often confrontational, public hearings as the method of choice for public consultation, towards smaller, less formal and more consultative processes such as open house meetings.

Open house meetings seem to be an increasingly popular way to consult with the public among healthcare advisors in Ontario. They are defined as an opportunity for interested members of the public "to 'drop in' to local or neighbourhood establishments to meet the decision-makers, obtain information, discuss the issue under deliberation and offer feedback" (Abelson, Forest, Smith *et al.* 2001, 16).

The August 2002 *Newsletter of the Canadian Centre for Analysis of Regionalization and Health* (CCARH) reported some of the findings of a recently completed national survey of public participation practices of RHAs (CCARH 2002, 3). The Effective Consultation Project was funded by the Canadian Health Services Research Foundation (CHSRF) and conducted by Julia Abelson, Pierre-Gerlier Forest, John Eyles and their colleagues.[2]

The RHAs that responded reported using a range of methods to involve the public. In descending order, they were focus groups (41%), public meetings (39%), small group meetings (34%), surveys (29%), open houses (10%) and public hearings (9%) (CCARH 2002, 3). Of these methods, all but surveys could have deliberative dimensions with focus groups probably being the most deliberative.

Between 70 and 80 percent of the responding RHAs involve the public to set goals and priorities, and to help design services. Around one quarter involved the public in resource allocation decisions (CCARH 2002, 3). Public involvement in these areas is consistent with the goal of ensuring that the healthcare system reflects public principles and values (Lomas 1997; Mitton and Donaldson 2002).

The survey also showed that over 90% of the responding RHAs attempted to involve citizens and the general public. About 77% reported involving both patients/health services users and other stakeholder groups, while about 64% attempted to involve broad-based community organizations. Over 40% of responding RHAs reported involving all the above-mentioned groups (Abelson, Forest, Eyles *et al*. 2002).

These data support the contention that RHAs pursue multiple public consultation strategies that employ different modes of interest representation. Consultations with patients, other health services users and stakeholder groups, and broad-based community organizations seem to fit the model of substantive representation discussed above. The widespread involvement of interest-based groups in the consultation process is also indicative of a neo-corporatist policy-making and implementation strategy. At the same time, efforts to involve citizens and the general public in consultation processes are consistent with descriptive forms of interest representation. The data give some support to the view that RHA boards recognize different forms of interest representation as legitimate and employ various consultation procedures.

Relative to strategies for securing public participation, the survey showed that the most common means was through existing RHA committees (80%). This was followed by the use of existing community networks, mailed invitations, the media, word of mouth and electronic means (CCARH 2002, 3).

These data are interesting insofar as they suggest that the primary means to secure public participation and consultation is through the regular structures and functioning of the RHAs themselves. This supports the notion that RHAs constitute sites for enhanced public participation in healthcare policy and service delivery. I return to this point below.

Which jurisdictions in Canada have been most successful in involving the public? This is a very difficult question to answer because of the diversity of organizational and decision-making structures that exist in Canada and because of the variety of consultative processes being used.

Having said that, however, if one uses the number of RHAs per province that reported using four or more public involvement procedures as an indicator of where the greatest efforts to involve the public have taken place, Western Canada clearly sets the pace. In Manitoba and British Columbia, five RHAs reported using four or more public consultation procedures. This is followed by Alberta and Saskatchewan with three each. Nova Scotia and New Brunswick each have one RHA reporting the use of four or more public participation procedures. No RHAs reported using four or more public participation procedures in any of the remaining regionalized provinces or territories (Abelson, Forest, Eyles et al. 2002).

Analysis of the instrumental use of deliberative public consultation procedures *by* RHAs needs to be supplemented by an analysis of RHAs *as* deliberation. That is to say, regionalization itself, or more precisely, establishment of RHA boards, can be understood as the creation of new public spaces where deliberation, or at least an approximation of deliberation, can, and does, occur (Finlay and Dickinson 2001).

RHAs as Deliberative Consultation

In this section, I suggest that the various regular and special meetings of RHA boards can approximate deliberative consultation methods. Such meetings, and the talk that takes place at them, are not widely recognized as deliberation. One reason for this is the tendency to see RHAs only as decision-making entities and not as sites where public consultation, deliberation and social learning take place.

Much of the talk that occurs in the context of formal RHA board meetings is not immediately related to decision-making. For that matter, much of it is not deliberative either. Based upon ongoing HEAL*Net* funded research on the nature and use of evidence by RHA board members, the greatest proportion of talk appears to be for the purpose of information exchange. In particular, it consists of management personnel providing reports on various operational aspects of the healthcare system for which the RHA board is responsible. This is consistent with the findings of Mitton and Donaldson (2002), Lomas, Veenstra and Woods (1997b) and Kouri, Dutchak and Lewis 1997).

Another proportion of RHA board talk is *directly* linked to the making of decisions. A third proportion can be understood as approximating deliberation. In this context, the discussion focuses on issues of board identity, its collective needs and interests, its rights and responsibilities relative to various stakeholders, and issues of how to develop and sustain those relationships in ways that enable the board to realize its objectives and meet its responsibilities. Talks can include reports of meetings with external interest groups that have occurred through the regular functioning of board committees or the activities of management personnel. It also involves face-to-face meetings with stakeholders.

Deliberation is not decision-making. It is, rather, a process of rational public opinion formation. Deliberation *qua* deliberation is a means to achieve mutual understanding and non-coerced agreement. Relative to democratic decision-making, its function is to create informed public opinion and a political will to act, that is, to create the collective capacity and will to make justifiable choices. Deliberation, related to forging informed public opinion and a political will to act, should be uncoupled from the immediate decision-making needs (Habermas 1984).

My argument is that RHA boards, both structurally and procedurally, constitute relatively new sites for deliberative public consultation. The structure and functioning of RHA boards is substantially equivalent to features identified as characteristic of effective public consultation procedures. On the basis of a review of relevant literature, Lomas (1997, 110) suggests that the most effective means to involve the public is through representative panels of 10 to 20 members who are provided small honoraria, who are replaced on a regular basis, and who meet regularly to set priorities via the deliberative achievement of a consensus view.

These characteristics support effective public consultation in at least four ways (Lomas 1997). First, panels that meet on an on-going basis make it worthwhile to ensure the membership is representative. He discusses two forms of representativeness. The first is what was previously identified as descriptive representativeness. That is, members can be chosen to reflect the socio-demographic characteristics of the general population in an area. Panels that are representative in

this way, according to Lomas (1997), are appropriate for consultation regarding broad service category priorities. The second form of representativeness discussed is a form of substantive representation. Here Lomas (1997) suggests a spectrum of patients to be consulted on more specific questions of service.

The second advantage of on-going panels identified by Lomas (1997, 110) is related to the fact that regular interaction among members enhances the willingness of panel members "both to take a collective rather than an individual view and to arrive at a consensus view". To the extent that this is the case, it is consistent with the expectations associated with the application of discourse ethics.

Thirdly, constituting panels on an on-going basis makes it worthwhile to make considerable investments in information acquisition and it allows for a critical interpretation of the relevance of the data for decision-making. It also enables panel members to discuss information and its relevance with various experts.

Finally, establishing panels characterized by the features and procedures described above makes the process of public consultation and input both visible and accountable. Such publicity in the process helps minimize strategic actions and self-serving behaviours on the part of stakeholders and those with vested interests.

To summarize, I suggest that the structural and procedural features of the panels described by Lomas (1997), as well as the advantages that derive from them, can all be seen as descriptive of RHAs. In addition RHAs, in some jurisdictions, have the advantage of being not only deliberative bodies but also decision-making entities.

Suggesting that the RHA boards, either elected or appointed, are sites where deliberation can occur is not to say that this potential is always realized. It is not. However, it is true that structural imperatives and organizational incentives can create an interest in achieving rational understanding and agreement among the occupants of decision-making positions. Those who are in positions of public responsibility for decision-making and who are publicly accountable to all those affected by them, as are RHA board members, will, more or less, be so motivated.

This capacity can be further enhanced by conscious efforts to ensure that RHA board deliberations approximate as closely as possible the norms identified by the discourse ethics. It can also be enhanced by the use of a range of the deliberative and non-deliberative consultation procedures currently available (Abelson, Forest, Eyles *et al.* 2001).

Despite being in positions characterized by structurally generated interests to achieve mutual understanding through deliberative means, and despite being motivated to engage in that type of public involvement, counteracting characteristics of the decision-making environment undermine realization of the goal of *informed* deliberation and decision-making.

Impediments to Informed Deliberation

Informed deliberation and decision-making require relevant information available in a timely fashion and in comprehensible and useful formats. This is a perennial problem because RHAs often don't have the capacity to collect the needed information on their own (Badgeley 1982).

The problems of availability and accessibility of relevant information are particularly germane where RHAs are legally responsible for the health status of the populations within their regions. For example, the results of a needs assessment done with RHA board members and senior management in Saskatchewan show that they were concerned about their ability to make informed decisions relative to health promotion because of inadequate information (Kouri 1996).

This is not just a Saskatchewan problem. A national survey of RHAs showed that seventy-nine per cent of all RHAs in the country identified population health research as the most important type of research needed. Community participation research was ranked as the second priority by sixty-five per cent of all RHAs (Kouri 2002, 17).

Not only do RHAs lack the necessary information to make rational policy decisions relative to health promotion, they also lack the resources and the jurisdiction to address the most important determinants of health – poverty, environment, education, justice, employment and working conditions – to name a few. As a result, health promotion efforts are restricted to the things that RHAs feel they can affect – primarily individual lifestyle choices and certain types of self help and mutual aid initiatives directed at the family and community levels (Burgess 1996).

Given this limited scope for action, RHAs tend to understand health promotion in terms of reduced use of medical, hospital and other forms of institutional care (Burgess 1996). This has at least two potentially contradictory effects. First, it often results in unpaid home-based care, usually provided by women, being substituted for professionally provided hospital and institutional care. The burdens, costs and negative consequences associated with this trend are inadequately recognized or compensated.

Second, de-emphasizing medical and hospital care may result in inadequate provision of, and access to, necessary healthcare services, or at least it may result in the perception of such inadequacies. Those who focus attention on waiting lists and waiting times generally interpret them as indicators of a crisis of availability caused either by the putative inadequacies of public administration, or by inadequate levels of government funding.

This is especially a concern where healthcare services and health promotion budgets are combined so that increased expenditures on health promotion come from resources gained through decreased expenditures on healthcare services. This is certainly the case in Saskatchewan where not only the two budgets are combined, but resources can only flow through a one-way valve – that is – resources can be moved from institutional care to community-based and home care services, but not the other way (Lewis, Kouri, Estabrooks *et al*. 2001). This undermines the legitimacy of health promotion among the general public who tend to conflate health with healthcare (Lomas and Contandriopoulos 1994).

Paradoxically, regionalization, by providing numerous sites for active public involvement in health care planning and system governance, appears to have helped mobilize public resistance to health reform, at least those dimensions of health reform thought to jeopardize access to physician and hospital services. This resistance takes the form of critiques of health promotion and regionalization.

From Health for All to Access to Healthcare:
Around the Policy Circle

Evidence of an inversion of policy priorities, from health promotion to access to healthcare, is found, among other places, in the themes being addressed by the Commission on the Future of Health Care in Canada. The public consultation exercises, for example, focused on three options for securing new resources for Medicare: (1) fundamentally reforming the nature and delivery of healthcare services so as to increase efficiencies and thereby secure additional resources without need for new money; (2) increasing the investment of public money in the system; or (3) finding new sources of new resources by allowing increased private sector participation. These general options were advanced through concrete reform proposals.

A similar emphasis is present in the three most recent provincial commission reports – Clair in Quebec, Fyke in Saskatchewan, and Mazankowski in Alberta. These topics give little indication that the health promotion policy paradigm is a priority.

The Saskatchewan government's most recent plan for health reform also highlights this point. Developed in response to the recommendations of the April 2001 Fyke Commission report, and based on its own public consultations, it states prominently, and repeatedly, that it "does not call for any hospital closures or conversions", and that communities "will be involved in decision-making if a hospital cannot be maintained due to shortages of key health professionals or other circumstances" (Saskatchewan Health 2001, 5).

It may appear from this that efforts to demedicalize and de-institutionalize health care are in abeyance and that the health promotion policy framework has been abandoned. This, I believe, would be too hasty a judgment. The above quoted statement notwithstanding, the Saskatchewan government's action plan is replete with an energetic commitment to enhanced managerialism in the form of plans to introduce performance indicators and increased system accountability.

Key elements of the Saskatchewan government's action plan included, for example, a drastic reduction in the number of RHAs from 32 to 12, government appointed CEOs for the reformed regions, the elimination of elected boards, primary health care reform initiatives, and creation of a Quality Council. All are claimed to be responses to the fact that people have told the government "they want more efficient management, and more accountability" (Saskatchewan Health 2001, 7).

Regionalization under Attack

The Saskatchewan government's action plan marks a turn towards a more technocratic management regime and away from what arguably was the most democratic of the regionalized healthcare system in Canada. In a sense, this brings it more in line with regionalization in other provinces.

The managerialism of regionalized healthcare systems across the country is seen as a threat to the autonomy of physicians and hospitals (MacKinnon 2002; Borsellino 2002; Borsellino

1997a,b; Gray 1995). It is perhaps not surprising that strong criticism of regionalization has recently come from the CEO of the Ontario Hospitals Association (OHA) and the editor of the *Medical Post*.

As we have seen Ontario is the only jurisdiction where hospital management has not been placed under the control of RHAs. Given the success of regionalization in reducing the number and use of hospital beds in those jurisdictions where it has been introduced, there surely are advocates for its introduction into Ontario. An April 8, 2002 OHA conference entitled *Regionalization: Is It the Answer for Ontario?* suggests this may be the case.

In a presentation at that conference the president and CEO of the Ontario Hospital Association (OHA) declared regionalization in the rest of the country a failure. According to him, it has failed to contain costs, it has failed to better integrate and coordinate services, and it has failed to increase community involvement (MacKinnon 2002). The main reason given for its failure is that regionalization provided no role for physicians in the reform process. The editorial in the April 30, 2002 issue of the *Medical Post* vigorously endorsed the argument that regionalization has failed and echoed the view that lack of physician involvement is the main cause of this (Borsellino 2002).

Declarations of the failure of regionalization may be as premature as was its previously reported death (Taylor 1978). None of the factors previously identified as motivating its introduction have abated. Having said that, however, regionalization has not been successful in demedicalizing healthcare, or in altering the state/profession accommodation at the heart of Medicare (Touhy 1995). Nor has it been successful in dislodging the widely held belief that the primary determinant of health is medicine (Lomas and Contandriopoulos 1994).

Regionalization has been much more successful in de-institutionalizing healthcare delivery. In particular, it has been successful in significantly reducing the number of hospitals, hospital beds, rates of utilization, duration of stay, and costs. In some senses, it has been less effective in expanding community-based and home care services and in integrating and coordinating services. Rising prescription drug expenditures, however, suggest a predominantly pharmaceutical strategy for providing community-based care.

Relative to the goal of increased public involvement – the main focus of this paper – it is hard to say whether regionalization has been successful or not. If the measure of success is the successful institutionalization of the health promotion policy paradigm, then it has failed. RHAs, just like provincial governments and the federal government, have been unsuccessful in convincing people that health promotion works. The main reason for this failure, however, is probably public resistance to the demedicalization and de-institutionalization of the health care system – a process that is widely understood as a threat to Medicare and to health.

If I am correct in this assessment, then public involvement has been successful, but successful in resisting a major health policy initiative, not in implementing it. The most difficult, and important, task facing health reformers is still changing the popular belief that providing medical care is the same as promoting health (Lomas and Contandriopoulos 1994, 282).

Conclusion

In these turbulent times nothing is more volatile than the healthcare system. Even experts in health policy and healthcare reform are hard pressed to keep abreast of changes, let alone to know what they all mean. Is it any wonder that the public is concerned, if not confused, about what's going on and what the future holds?

There is no guaranteed solution to this state of anxious uncertainty, but getting involved is strongly recommended. There are, as we have seen, contradictory imperatives and interests both pushing for, and pulling against, expanded opportunities for meaningful public involvement in healthcare decision-making. Furthermore, the balance of these forces varies from time to time and from place to place. Similarly, different procedures for public involvement result in different outcomes.

Having said that, I have argued throughout this paper that deliberative public consultation procedures have several features that strongly recommend their expanded use in policy development and implementation. This is particularly the case with regard to the formation of public opinion and political will, especially as a means to address questions of fairness.

Relative to this, meaningful public involvement in policy relevant decision-making requires the creation of organizational capacities, and the institutionalization of deliberative procedures. As we have seen, substantial progress has been made in these regards. There is also much optimism that new information and communication technologies will greatly expand the capacity and opportunities for public involvement. Much of this potential, however, has yet to be realized.

I do not advocate direct democratic decision-making, but rather public involvement in achieving agreement on goals, principles and values for the healthcare system. Deliberative participation procedures provide a means for insuring that needs and interests are interpreted and considered in deciding on the goals of healthcare policy and the means of achieving them.

Democratically constituted, or representative appointed RHA boards provide an important institutional means for linking deliberative public consultation directed to public opinion and political will formation to the decision-making process. Linking deliberative consultation with deliberative decision-making seems ideally suited to realization of the various benefits claimed for applied discourse ethics.

Similarly, initiatives such as the National Forum on Health and the current Commission on the Future of Health Care in Canada, as well as provincial commissions, provide important, albeit, *ad hoc*, opportunities to engage the public in the process of generating informed public opinion and the political will to act in important policy domains. By so doing, they provide an opportunity for us all to deliberate on the kind of society we want to live in and the kind of people we want to be.

Notes

1   Throughout this paper, I use the phrase Regional Health Authority (RHA) to refer to the sub-provincial structure of health care policy-making and service delivery. The names of these entities vary by province.

2   Julia Abelson generously gave me permission to report some of the unpublished findings from this study. My interpretation of the data may not reflect the views of the researchers or the funding agent.

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