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Public Participation and Citizen Governance in the Canadian Health System

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CONTENTS

Highlights

The public participates in the governance of the health system in a variety of ways in pursuit of multiple and sometimes conflicting goals. Public participation may be undertaken to improve decision making and health system performance, to foster a more active, engaged and public-spirited citizenry, or both. At present, an increasingly pluralistic and fractured public does not appear by its participation to contribute to improved efficiency, increased public commitment to the health-care system, or to deepened values of solidarity and tolerance. The desire for public participation to contribute to these goals must be balanced against the value of public participation in its own right, as a basic feature of democratic society.

Participation may never contribute to a more efficient health system and may, at times, lead to the inefficient allocation of resources. Its greater potential lies in its ability, through legitimate and accountable participation, to strengthen citizen commitment to health programs and policies, and to encourage the expression of democratic values.

To enhance democratic processes, we recommend:

◆ recognizing the multiple goals of participation and their inherent tensions;
◆ recognizing a major role for interested parties in the governance of the health system;
◆ capitalizing on the public's tendency toward issue-based participation.

To enhance links between citizens and their political institutions, we recommend:

◆ establishing and enhancing roles for "health system advocates" at regional/local, provincial and national governance levels;
◆ providing accessible, identifiable opportunities for direct citizen input;
◆ cultivating civic infrastructures as "institutions" for democratic participation.

To improve the legitimacy of public participation processes, we recommend:

◆ clearly articulating the goals for public participation, its intended product, the selection of participants and its multiple approaches (*transparency*);
◆ creating an ongoing dialogue with individual and community participants throughout the decision-making process (*accountability*);
◆ using complementary approaches to respond to different issues, decision making and community contexts;
◆ pursuing deliberative processes on a selective basis where they have the greatest potential for fostering shared learning and contributing to improved decision making.

Executive Summary

Public participation in the health sector in Canada has taken many forms since the establishment of a universal, publicly administered health system. With so many distinct and overlapping roles and goals for participation in the governance of the health system, public participation can contribute in many ways to the performance of the health system and to the expression of democratic values held in Canadian society. Our discussion of these issues is guided by the following questions:

1. What *can* public participation, and democratic processes more broadly, contribute to the health system, its governance and the values held by Canadians toward and in the health system?

2. What *has* public participation in the Canadian health system contributed toward:
    a) the efficient functioning of organizations in the health sector?
    b) strengthening citizen commitment toward health programs and policies? and
    c) encouraging the expression of democratic values in Canadian society?

3. What *are* reasonable objectives for public participation in the future governance of the Canadian health system and how can more effective, legitimate processes be created to achieve these objectives?

    Public participation in the health system is primarily concerned with:

*   improving the quality of information regarding the population's needs and preferences;
*   encouraging public debate over the fundamental direction of the health system;
*   ensuring public accountability for the processes within and outcomes of the system;
*   protecting the public interest.

The pursuit and achievement of these goals are one indicator of how well a health system is performing with respect to the efficient and equitable achievement of its desired goals and outcomes. A strong democratic presence in and commitment to the governance of public institutions is also believed to contribute to the development and maintenance of a civic culture that promotes the values of solidarity and tolerance.

At present, an increasingly pluralistic and fractured public does not appear by its participation to contribute to improved efficiency, increased public commitment to the health care system, or to deepened values of solidarity and tolerance. The desire for public participation to contribute to these goals must be balanced against the value of public participation in its own right, as a basic feature of democratic society.

Participation may never contribute to a more efficient health system and may, at times, lead to the inefficient allocation of resources. Its greater potential lies in its ability, through legitimate and accountable participation, to strengthen citizen commitment to health programs and policies, and to encourage the expression of democratic values.

The experience with public participation in the governance of the Canadian health system can be summarized by the following statements:

1. citizen domination by powerful groups interested in involving the public when it suits their purpose;

2. policymakers touting citizen governance as a critical element to achieve more responsive decision making while using these structures as instruments of cost cutting and restructuring;

3. the ability for only the most educated and sophisticated and arguably the most unrepresentative and biased "publics" to participate as citizen governors;

4. an increasingly cynical public weary of pre-determined illegitimate public consultation processes, reluctant to take responsibility for decision making, seeking more accountable consultation.

We offer the following guiding principles and recommendations for improving democratic processes and citizen governance in the health system:

To enhance democratic processes, we recommend:

◆ recognizing the multiple goals of participation and their inherent tensions;

As long as there are competing objectives for public participation, there will be difficulty reaching agreement on how best to proceed. Focusing efforts on trying to achieve multiple goals simultaneously is extremely difficult and would warrant substantial resource investments. A more fruitful strategy is the articulation of distinct goals for public participation as viewed for different governance levels, individuals and communities.

◆ capitalizing on the public's tendency toward issue-based participation;

It is unreasonable to expect "disinterested" citizens to function as citizen governors. The public is most likely to get involved when they are affected by an issue. This approach to participation should be fostered along with an approach that emphasizes "accountable consultation" (i.e., assurances that input will be considered in the decision-making process).

To enhance links between citizens and their political institutions, we recommend:

◆ establishing and enhancing roles for "health system advocates" at regional/local, provincial and national governance levels;

Health system advocates should be established as "guardians" of the public health system to improve the interface between citizens and their governing institutions. These could be implemented at all governing levels and modelled after other advisory bodies such as the National Round Table on the Environment and the Economy.

◆ developing and cultivating civic infrastructures as "institutions" for democratic participation;

In an increasing number of public sector arenas, existing social and civic networks are being relied upon to build the needed capacity for participation and shared decision making. Civic organizations are important channels of public participation and are able to attract citizen involvement. Regional health authorities could be used to foster and build this civic infrastructure by supporting service user and citizen networks. Examples of these types of networks that have become important vehicles of community capacity building include the community health boards in Nova Scotia and citizen advisory committees in Saskatchewan.

To improve the legitimacy of public participation processes, we recommend:

◆ clearly articulating the goals for public participation, its intended product, the selection of participants and approaches (*transparency*);
◆ creating an ongoing dialogue with individual and community participants throughout the decision-making process (*accountability*);
◆ using complementary approaches to respond to different issue, decision making and community contexts;
◆ pursuing deliberative processes on a selective basis where they have the greatest potential for fostering shared learning and contributing to improved decision making.

Acknowledgments

I. Introduction

Public participation in the health sector in Canada has taken many forms since the establishment of a universal, publicly administered health system. Citizen users routinely act as "consultants" in service and program planning offering their advice about service needs and problems. Interested citizens act as resource allocators through membership on priority setting committees and, ultimately, as health system governors in their role as hospital, health centre or health authority board members. The public also participates as "protector of the public interest" through membership on regulatory bodies. Increasingly, the public is being asked to offer its views about the future directions of the health system, either through opinion polls or more in-depth public dialogues. Formal, explicit public participation mechanisms have been called for recently within a federal/provincial/territorial agreement to ensure the health system's accountability to the public.

With so many distinct and overlapping roles for the public, and goals for its participation in the governance of the health system, public participation can contribute in many ways to the performance of the health system and to the expression of democratic values held in Canadian society. This paper discusses these issues and is guided by the following questions:

1. What *can* public participation, and democratic processes more broadly, contribute to the health system, its governance and the values held by Canadians toward and in the health system?

2. What *has* public participation in the Canadian health system contributed toward:
   a) the efficient functioning of organizations in the health sector?
   b) strengthening citizen commitment toward health programs and policies?
   c) encouraging the expression of democratic values in Canadian society?

3. What *are* reasonable objectives for public participation in the future governance of the Canadian health system and how can more effective, legitimate processes be created to achieve these objectives?

Before addressing each of these questions, we briefly discuss a number of concepts that will be referred to throughout the paper to ensure a common understanding at the outset. First, *public participation* is a broad set of practices that includes passive forms of citizen involvement, where the public's views are sought as an input to a planning or decision-making process, and more active involvement through direct participation in decision-making processes and structures. Public participation also encompasses citizen engagement and deliberative democracy. In some sections, we refer to specific forms of public participation that are undertaken within different issue and decision-making contexts. In other sections, we simply refer to the broad range of participation activities. With respect to the "public" in public participation, there are multiple meanings of public and a need to cast widely to consider all those who have a stake in the health system, including users and potential users of care, public and patient advocates, providers and experts who are also citizens as well as taxpayers. Given the paper's orientation to democratic processes and governance, we are primarily interested in the public as actual and potential "citizen governors" with a necessary bias toward those demonstrating an interest in this role.

Discussions of *governance* also feature prominently. Like participation, meanings of governance vary among fields of study and intended audiences. In this paper, governance is viewed as the interaction between citizens, experts and elected representatives in the development and implementation of policies designed to solve social problems. Health system governance may be considered at one or more levels: 1) the macro level (i.e., central or national authority), which has responsibility for the public sector as a whole (e.g., federal or provincial governments or pan-Canadian authorities; 2) the meso level, which includes regional or functional authorities determined either geographically or by population group; and 3) the micro level of specific organizations or communities (Forest et al. 1999). Given the paper's focus on issues of public participation, we are specifically interested in the contributions of citizens, through their democratic participation and interactions with experts and elected officials, to the governance of the health system.

II. How Public Participation Can Contribute to the Health System and the Expression of Democratic Values

Public Participation and Citizen Governance Ideals

The contribution of a participatory citizenry to successful democracy has been the subject of long-standing (and seemingly never-ending) debate among democracy theorists and practitioners. These debates frequently focus on the merits of representative versus participatory democracy[1] (i.e., how directly should citizens be involved in government decision making), the desired goals for participation and the methods for achieving them. Tensions exist between views of participation as an essential element of successful democracy (and inherently desirable in its own right) and participation as a means for achieving something else, be it a specific decision outcome, a desire for more informed, accountable or legitimate decision making, or perhaps to delay or share the blame for a difficult decision. Lying somewhere between these two basic tenets is a desire for public participation to contribute to a more educated and engaged citizenry.[2] Choosing between public participation goals and the means for achieving them is shaped by broader social and economic contexts and changes, and the values held by the governing elite and publics. Over the last few decades, public confidence and trust in representative democracy and traditional political institutions has declined as interest in politics has increased. This relationship has produced a frustrated public, dissatisfied with the status quo, yet unable to find meaningful ways to participate in society (Nevitte 1996; Ekos 1996). The precise source of this dissatisfaction is thought to result from the interaction of economic, cultural and political changes that have altered citizens' views about, and desired relationships with, their political institutions (Inglehart 1995; Inglehart, Nevitte and Basanez 1996). It is also believed to explain the shift away from more traditional notions of representative democracy toward those of direct, engaged citizen participation (Graham and Phillips 1998).

Changing views about public participation are also shaped by shifts in political discourse (e.g., the relative roles of the market versus the state in service provision), structural changes linked to changes in public values systems and evolving concepts of citizenship. For example, the post-World War II period leading up to the establishment of many of Canada's significant social welfare programs was a time of collective problem solving and "pan-Canadian citizenship" (Maxwell 2001, p. 5). The poor health of army recruits, ravages of the Depression and the inadequacy of employment wages to provide basic health propelled public opinion and politicians toward the creation of new economic and social policies that would ensure access to basic government services and, in turn, provide the seeds for a national health insurance program (Taylor 1987). These collective policy goals were pursued alongside unprecedented levels of affluence and expanded educational opportunities over the next 25 years (into the 1970s), and dramatically changed social structures characterized by a strong welfare state and the collective values of universality, equity and equal opportunity.

Over time, however, these collective goals have been replaced by more individualistic goals, again, shaped by economic conditions, periods of retrenchment and the dominance of neo-conservative values, followed by the introduction of market forces into public sector management (Nevitte 1996). These individualistic goals have, in turn, inspired new public

participation ideals of increased public sector accountability and a customer service orientation espoused by new public management principles (Osborne and Gaebler 1992; Borins 1995).

The "new public participation" also hinges on a perceived need for social capital to enable citizens in communities and organizations to solve problems collaboratively (Putnam 1993). Associational relationships and civic participation are thus seen as being built on mutuality, i.e., *trust* (formed and displayed through personal and social relationships and in institutions) and *commitment* to the common good that may be manifested in commitment to community or local level affiliations or governing institutions (Giddens 1991; Veenstra and Lomas 1999). These calls for increased civic participation, capacity building and the creation of social capital are a partial response to the rise of individualism of the 1980s and view a re-created community as the cornerstone to improvements in social and economic conditions (Putnam 1993; Sandel 1996; Bellah 1985).

Participation and Governance Ideals in the Health System

To what extent do new public participation and governance ideals resonate with those in the health system? As its broad goals, public participation in the health system is primarily concerned with:

- improving the quality of information regarding the population's needs and preferences;
- encouraging public debate over the fundamental direction of the health system;
- ensuring public accountability for the processes within and outcomes of the system;
- protecting the public interest.

Taken together, the pursuit and achievement of these goals are indicators of the health system's performance with respect to desired goals. A strong democratic presence in and commitment to the governance of public institutions are also believed to contribute to the development and maintenance of a civic culture that promotes the values of solidarity and tolerance, also a potentially desirable goal for the health system. As we discuss in the following sections of the paper, public participation in its various forms may both contribute to and thwart the achievement of these desired goals.

Public Participation and Improved Information

A basic objective of public participation is to obtain information from the public about its needs and preferences to design a responsive health system. This objective was the basis for the creation of some of the earliest citizen representative health authorities (e.g., health systems agencies in the United States, community health councils in the United Kingdom and district health councils in Ontario) (Checkoway 1981; Checkoway and Doyle 1980; Klein 1976; and Tuohy and Evans 1984). Citizen users are often the most appropriate individuals to provide this information as they can articulate service needs, gaps in service availability or problems with service delivery. The public, generally speaking, feels comfortable providing this type of information and believes it is well suited to this role (Litva et al. 2002; Abelson et al. 1995). This

type of involvement can contribute to more effective governance when user views have been honestly incorporated into the decision-making process and when a range and diversity of views and types of users are involved. It also requires sensitivity to the vulnerability of service users who may be reluctant to "speak out" for fear of losing service. Embracing a customer-centred, patient rights movement in a health system historically dominated by a hierarchy of professions, therefore, requires a significant shift of mindset.

Public Participation, Public Values and the Values of the Health System

The public may be a crucial "idea source" when it comes to expressing the values that should root, and ultimately, guide the health system. Creating a transparent process for involving the public in this way can be difficult, challenged by a complicated relationship between public values, social institutions and changing political discourse. For example, it is not clear whether the post-World War II consensus on the solidarity principles that shaped the Canadian health insurance system (e.g., equity, universality and accessibility) is still held by the vast majority of Canadians or if the consistently strong support for a universal health system has been shaped by the system itself and its symbol of Canadian identity (Giacomini et al. 2001; Maxwell 2001; Health Action Lobby 1992; and National Forum on Health 1997).

Values may also be shaped by interests such as those held by professional organizations looking to protect their organizational culture, industry stakeholders and consumer and patient advocacy groups seeking to mobilize support for or opposition to various policy proposals. The policy elite also wield influence over beliefs and, in turn, support for their policy agendas. All groups use the media as the primary vehicle for interest group "claims-making" (Best 1989) and policy elite "crafted talk" (Jacobs and Shapiro 2000). The establishment of commissions, such as the Commission on the Future of Health Care in Canada, provide additional opportunities for shifting beliefs through the commissioning of ideas (Jenson 1994) and identifying the tensions underlying these values and interests, and the potential methods for resolving them. In these instances, the lines between public "pawn" and "participant" become blurred.

To illustrate this complex relationship, consider recent surveys, opinion polls and public dialogues that have focused on Canadians' eroding confidence in the health care system (Donelan et al. 1999), the "future sustainability" of the health care system and attitudes toward the expansion of insured health services or toward increased privatization (PriceWaterhouseCoopers 1997; Ekos 1999). These evaluations of system performance and deterioration are efforts to gauge public opinion, but they also have the potential to shape Canadians' values toward these issues. Furthermore, these predominantly attitudinal surveys do not reflect on how the public has reached these views.

More detailed analyses of public values toward the health system indicate that the public's values are not reflected as closely in the current system as they once were. More prevalent today are the values of self-reliance, autonomy and choice as well as those of compassion and future investment (Maxwell 2001; Mendelsohn 2002). The current values discourse is also more pluralistic than that which prevailed when Canada's social programs were being established. Now, there is a pluralism of values across population groups such as the young and old, the

affluent and the poor, across regions and governing parties (i.e., those that have embraced market-style reforms versus those that support a large role for the state). This pluralism complicates efforts to pursue unified social policy goals, to maintain a collective approach and to encourage, through participation, the expression of democratic values (Maxwell 2001; Mendelsohn 2002). Within this values discourse, questions arise about the compatibility of choice and autonomy with social insurance models (see Klein 2001). Given that collectivist values appear to be less dominant than they once were, the health care system and its principles may need reinventing to emphasize choice and autonomy within compassion and investments for all Canadians.

It is clear that the public can clearly play an important role in shaping the values expressed by the health system, but there is no single way to elicit or articulate a nation's collective values. We are often interested in ascertaining "Canadians'" values toward the health system with little recognition that Canadians' values exist in individuals and communities, that there may be conflicts between individual and community values with no straightforward way to aggregate from one level to the other (Giacomini et al. 2001). Furthermore, it is unlikely that public participation processes will be sufficient for encouraging the expression of democratic values given the current trend toward more pluralistic and individualistic values.

Public Participation and Commitment to Public Institutions

An increasingly fractured set of public values requires a highly effective set of institutions to manage conflict and find common ground to inform public policy decisions. Our earlier discussion described a citizenry disenchanted with its public institutions and the means available for public participation. Political theorists such as Rousseau and Barber argue that participation contributes to an educated and engaged citizenry potentially supporting collective problem solving and public institutions (Barber 1984). Other arguments suggest that, over time, the public moves from shallow "public opinion" to deeper more reasoned "public judgment" and becomes more willing to take responsibility for its views and more committed to the policies it supports (Yankelovich 1991). At present, the interested public appears eager to participate in meaningful ways but is neither active nor engaged, due in part to weak institutions. To what extent does this phenomenon exist in the health system and what does "public commitment to public institutions" mean in the context of the health system? At a macro level, commitment to public institutions might be considered in terms of support for a publicly funded and administered health system. Through the participatory process, citizens become more knowledgeable about the health care system, more interested in pursuing collective problem solving through public means and shared resources and, hence, develop an increased commitment to a publicly funded system. While this argument is reasonably compelling, it is not clear whether or how much public participation is necessary to achieve this kind of commitment to public institutions although it may be a useful mechanism for mitigating the erosion of this commitment.

At the meso level, public participation in a regional health authority might also promote greater commitment to public institutions. For example, the experimentation with elected health board members in Saskatchewan, Quebec and Alberta represents one method for fostering public

commitment to public institutions, in this case, the health system. We discuss the performance of such mechanisms in the next section of the paper.

The opportunity to foster increased commitment to public institutions is perhaps most likely to be realized at the micro or local governance level through civic participation such as community associations, community health centre boards, and community health councils. In the United Kingdom, citizen-driven community health councils have had a long history of providing input into local health governance structures (Klein and Lewis 1976). In Canada, community health boards were established in Nova Scotia as arms of the regional health boards in the 1990s and the newly established district health authorities, vested with the responsibility for developing community service plans. Despite these examples, regionalization of the health sector in Canada has led to the dismantling of hundreds of local health governance structures and traditional forms of civic participation (Veenstra and Lomas 1999; Lomas 1997*a*). A further challenge is the complexity of some public policy sectors such as health care, which pose a barrier to increasing the civic competence necessary for more than token citizen participation (Dahl 1992).

Public Participation for Efficiency or Efficient Public Participation?

If public participation and democratic processes are valued as critical inputs to policy decision making and, consequently, health system performance, then it is also plausible to consider how public participation contributes to the "efficient functioning" of the health system. Once again, our examination of this relationship is challenged by the different underlying goals of participation. For example, public participation is often viewed as an end in itself, a desirable goal for democracies and public policymaking and, as such, does not demonstrate obvious benefits beyond the achievement of democratic goals. In the early 1990s, public participation was seen as an instrument for achieving broader health system goals such as improved service coordination and integration (i.e., efficiency) through regionalization and devolution. Considered in this way, what aspects of efficiency does public participation have the potential to influence? In economic terms, there are three different types of efficiency to consider with respect to the provision of public goods such as health and health care:

1. Technical efficiency – for a given output, the inputs required to produce it are minimized or the maximum output is produced from a combination of inputs.

2. Cost-effectiveness – similar to technical efficiency, but the cost of the inputs is also accounted for (i.e., for a given output there will be a specific combination of inputs that will be cost-effective) – "doing things right."

3. Allocative efficiency – links supply and demand by considering the values and preferences of those consuming the outputs (i.e., produce types and amounts of output that people value most) – "doing the right things."

Applying the first two concepts of efficiency to the case of public participation might push us to look for technically efficient ways to involve the public to produce a given output. But the public participation literature rarely describes examples of technically efficient or cost-effective

participation although there is discussion of effective participation processes (Beierle and Cayford 2002; Rowe and Frewer 2000; Petts 2001; and Webler, Tuler and Krueger 2001). A commonly held view is that democratic processes, at best, slow decision making but are essential to ensure that legitimate decisions are made, and at worst, can significantly alter or derail a decision-making process if not carefully "managed" (Abelson and Lomas 1996). In short, public participation is rarely viewed as compatible with the technically efficient or cost-effective functioning of the health system.

Of greater relevance is the notion of allocative efficiency, which considers both the supply/production side of the equation as well as the demands, preferences or values that shape what is produced. The essence of this argument is that information obtained from the public about values, needs and preferences can contribute to the efficient allocation of societal resources (see Hurley, Birch and Eyles 1995). Thus public participation may potentially contribute to the effective performance of the health system by helping create a fully informed citizenry, transparency and, ultimately, accountability, and in this way contributes to the achievement of efficiency goals.

The Darker Side of Public Participation

While it is often assumed that public participation is inherently beneficial to policy decision making, some instrumental goals for public participation have the potential to thwart its well-intentioned promotional efforts. A community's desire to pursue a narrowly defined set of collective interests, for example, often mobilizes citizens to participate actively to achieve their goals. In the education sector, this has manifested itself in pressure being exerted among some groups to opt out of the public education system in pursuit of greater choice (see Stein 2001). The social cohesion fostered within these communities threatens broader collective values of solidarity and tolerance. There are perhaps fewer examples of communities "opting out" within the health sector, but there is little doubt that the intense mobilization witnessed in response to the threatened hospital closures throughout the 1990s entrenched values of intolerance and parochialism within some communities, particularly those where social cleavages previously existed (Abelson 2001).

Public participation at regional and local levels, furthermore, may weaken the attachment to larger-scale public systems and exacerbate current jurisdictional conflicts in Canada between federal-provincial and provincial-local roles in the health system. The emotional attachment that communities develop toward local institutions such as hospitals has clearly contributed to the inefficient allocation of resources. Local hospital restructuring experiences across the country are excellent examples of this local resource attachment phenomenon where communities have fought to keep multiple hospital sites open at the expense of other system goals such as expanded community care (Abelson 2001; Lepnurm and Lepnurm 2001).

An increased emphasis on direct democracy at the expense of representative democracy is another double-edged sword. Mounting concerns about governments being too far removed from citizens and about citizen representatives (i.e., elected public officials) inadequately representing citizen interests or having too many competing interests to represent have led to calls for greater

and more direct citizen involvement in democratic processes through various forms of public participation and citizen engagement. A shift from the historical tradition of rational expert-driven to greater citizen-controlled decision making does not guarantee improvements and may lead to a requirement for greater resource expenditures in the process of training and preparing citizens for their decision-making roles.

In this first section of the paper, we have considered the potential contributions of public participation to the achievement of different health system goals (e.g., efficiency, commitment to public institutions, expression of democratic values). In doing so, we underscore the conflicts that arise in pursuing different health system goals, the multiple goals of public participation itself, and the positive and detrimental influences that public participation may have on the achievement of desired health system goals.

III. The Canadian Experience with Public Participation in the Governance of the Health System?

Different Means for Different Ends

The first calls for public participation in Canada's health system date back to the 1970s when citizen representation on regional health services delivery or administrative boards was recommended by early health system reform reports (Community Health Centre Project 1972; Foulkes 1973) and implemented, in the form of district health councils, in Ontario (Tuohy and Evans 1984). Citizen participation was viewed as a means for rationalizing, integrating and coordinating health services through local structures that would, through community representation, better respond to local health needs. Outside Ontario, which has now had close to 30 years of experience with district health councils and consumer representation, experiments with regional governance structures did not occur until the 1990s. Like its 1970s predecessor, the devolution movement of the 1990s (and accompanying calls for increased public participation) was unanimously accepted by provincial policymakers in the absence of supporting evidence or well articulated plans for its widespread use. Indeed, an international review of devolution initiatives found few studies of its impact on government performance with equivocal results about its merits or weaknesses (Canadian Medical Association 1993). Other evidence questioned the ability of these newly formed structures to achieve community control in the health care sector (Marmor and Morone 1980; Bjorkman 1985).

Calls for greater community control in the health sector signaled a major departure from previous decades of expert and bureaucracy-controlled decision making and health system governance. The prevailing view had been that only professionally controlled governance was compatible with the pursuit of health system efficiency and equity goals. In the early 1990s, provincial governments called for a move away from this privileged relationship between health care bureaucracies and dominant structural interests, namely physicians and hospitals, to increased community control and the creation of new governance structures (Rasmussen 2001).

While community control through citizen governance has been more rhetoric than reality in much of Canada's public health system, we note a fundamentally different history of public participation in Quebec, where recommendations of the Castonguay-Nepveu's Commission of Enquiry on Health and Social Welfare (1967-1971) identified the importance of public and user involvement in health care decision making and positioned such involvement centrally within its reforms by legislating public participation through regional health board elections (Charles and DeMaio 1993; Forest et al. 2000).

Citizen governance has also been a feature of the primary care delivery system in Canada although it has been largely relegated to an "alternative" model to the traditional physician-governed organizations. Centres locaux de services communautaires (CLSCs) were introduced in Quebec in 1972 to provide primary medical and social services to geographically defined populations. Community health centres were introduced in Ontario in the late 1970s as community-governed, globally funded primary health care organizations designed to improve

access to health and health care for the socially disadvantaged and difficult-to-serve populations (Hutchison, Abelson and Lavis 2001; Church 1994).

While citizen governance may be a sentinel measure of democratic control of the health system, the public participates in a variety of other ways that have the potential to influence health system decision making. Public consultation exercises have been the traditional mechanism through which the public provides input to the health system. These are typically government-initiated processes conducted at various stages of a decision-making process to inform planning, priority setting or resource allocation decisions. There is a rich tradition of public consultation in Canada at all levels of government. In the health system, federal and provincial governments, regional and local health authorities (through community, district and regional health councils and boards) routinely seek the public's input, as do higher profile (and ever-present) provincial health commissions, to inform their recommendations.[3]

Public representation on regulatory bodies has long been used as a method of ensuring professional accountability to the public and protecting the public's interest. Legislation governing regulatory bodies stipulates public representation on statutory committees and the governing council, but the degree and type of public involvement on these bodies varies provincially and by health professional. The experiences with each of these public participation approaches are assessed in the following sections.

Public Participation in Regionalized, Devolved and Community Health Governance Structures: Promise and Reality

Canada's 10-year experiment with regionalization and devolution and attempts to increase democratic control over health system governance provides an excellent laboratory for judging the public participation experience. Unfortunately, there is little solid evidence to make any claims about whether and how increased democratic control has contributed to improved system performance. This situation is not unique to Canada, or the health system in particular (Zakus and Lysack 1998). What can be assessed with reasonable rigour, however, is the extent to which increased democratic control has been achieved; how public consultations have contributed to the quality of information used in decision making; and how they have contributed to the public's sense of ownership and commitment to the health system.

Elected regional health boards were established at different times in Saskatchewan and Quebec as tools seen as useful for achieving political accountability and, hence, enhanced responsiveness to local needs. By selecting board members through an electoral process, health boards would be directly accountable to their communities. The experience with these elections is that only those who had the most to lose or gain (i.e., concentrated interests) stood for election. In the health sector, these are typically those who derive their incomes from the system. The communities' diffuse and fragmented interests pose further barriers to participation (Alford 1975; Marmor and Morone 1980; and Tuohy and Evans 1984). Low voter turnout has been the norm (e.g., 10 percent in Saskatchewan's 1999 board elections) with a tendency for higher turn out in rural communities and in highly politicized communities where major cuts were being contemplated (Lomas 2001; Rasmussen 2001).

A 1997 survey of Saskatchewan board members found that 63 percent of members believed that health care reform had increased local control over health care services and 62 percent believed that the quality of health care decisions had improved under the devolved authorities (Lewis et al. 2001). When compared with the experiences found elsewhere in Canada, "there was little that could be attributed exclusively to the electoral process" (p. 346). Furthermore, the experience has demonstrated that health board elections are costly, cumbersome and produce low voter turnout and have failed to foster a more active, engaged citizenry committed to collectivist goals. In light of these experiences, their continued use should be questioned if efficient, effective participation and public commitment are desired goals.

The Quebec reforms of 1991 (Reform Centered on the Citizen) opened the door for broader citizen involvement. Created for the purposes of bringing the health system closer to the population, the establishment of Quebec's regional health and social services boards was also seen to play a role in breaking the monopoly that interest groups appeared to have over decision-making processes (Forest et al. 2000). The goal of increasing community participation through board membership has been achieved, but establishing community control and empowerment has clearly not occurred (O'Neill 1992; Godbout 1981, 1987; Eakin 1984*a*, 1984*b*; Forest et al. 2000; and Abelson et al. 2002).

The Nova Scotia regional health board experience was similar despite the same representation from consumers and providers at the community health board level and a two-thirds to one-third majority of consumer representatives at the regional health board level. Increased public representation is no guarantee for meaningful participation with an "implicit power hierarchy in health care… made up of prearranged tiers of professionals, administrators and consumers"; the lack of consumer ties to constituency support networks; and disparities in technical and administrative skills between consumers and professionals (Sullivan and Scattolon 1995).

Furthermore, early accounts of Saskatchewan health board activities indicate the absence of a public record of board meetings with few open meetings, no published agendas and no opportunities for the public to comment on plans. The only opportunities for citizens to participate came at election time (Rasmussen 2001). In British Columbia, early enthusiasm for a new "closer to home" citizen participation and an open process for designing the shape of the regional health authorities quickly gave way to frustrated participants who no longer felt they were able to influence the boards the way they had envisioned at the outset (Frankish et al. 2002). Fractured decision making and an intensely competitive relationship between politicians and professionals have provided little scope for collaborative problem solving and caused the public to withdraw from their participatory activities, suggesting that "if there is any crisis in health care, it is in the governance of the health system" (Maxwell 2001, p. 22). Thus citizen governance in the health system (and in many other public policy sectors) has remained an elusive goal for decades. Multiple conflicting goals of participation, the reluctance for those with concentrated interests to allow their futures to be determined by others, and the reluctance of the public to take responsibility for decision making have presented significant barriers. Many organizations in the health system have recognized these challenges and are seeking ways to more meaningfully involve the public in their decision-making processes while moving away

from the pursuit of goals of increased community control (Regionalization Research Centre 2000; Abelson et al. 2002).

Public Participation on Regulatory Bodies: Governing the Health Professions

Public representation on regulatory bodies has long been used as a method of ensuring accountability of health care professionals to the public but there have been few attempts to document or assess the public's experiences with this form of participation.[4] It is difficult to determine, therefore, whether or how the broader experiences of citizen governance of the health system is generalizable to that of public participation on regulatory bodies. A review of Governing Councils of Colleges of Physicians and Surgeons across Canada[5] reveals considerable variation in the governing council composition of these bodies with a range of 14 to 25 percent public membership on 7 councils, 30 percent public representation on 1 council and a 40 to 50 percent range of public representation on 2 councils. While the number of public representatives alone is no guarantee of their empowerment, a commitment to greater than 40 percent public membership by the Ontario and British Columbia colleges is an important symbol.

Consulting the Public for Health Care Decision Making

Local efforts to consult with the public during health planning and more recent priority setting and resource allocation decision-making processes have provided valuable case studies of public participation. The health services restructuring exercises that have taken hold of communities across the country over the past five to seven years are examples of intense, issue-based participation rarely seen since the health care system's establishment. Mobilization occurred in response to threats of hospital closures and provided several lessons about issue- and interest-based public participation.

First, efforts to involve the public locally have largely failed with respect to the outcome-oriented goals of participation (i.e., contributing to a decision-making process geared toward shifting resources from hospitals to communities) but have been hugely successful in mobilizing community-wide participation. Judged in these terms, public participation in local health services restructuring processes contributes little, if anything, to the achievement of efficient and equitable health system goals or outcomes and may, as discussed earlier, contribute to greater inefficiencies in resource allocation. A potential benefit of these restructuring processes may, however, be the fulfillment of participation's educative goals through the community's enhanced understanding of the complexities of health system decision making and the relative contributions of hospitals and community-based service delivery in meeting population health needs (Abelson et al. 2002).

The failure of these public participation processes (with respect to efficient resource allocation decisions) must be considered in designing future public participation processes. Characteristics of these failures include: 1) the success of the media and stakeholder groups in

framing of the issue as a decision about health care cuts and government retrenchment despite local health council attempts to re-frame the debate as one of resource reallocation; 2) the absence of legitimate deliberation (i.e, shared learning, considered public judgment) due to the abstractness of issues such as primary care reform and community-based delivery compared to highly recognizable hospital-based care; 3) lack of legitimate opportunities for public participation with provincial governments making the final decisions and controlling the public consultation agenda; 4) lack of clarity about what the public's role as consultant versus decision maker; and 5) deference to and power wielded by the local health care elite resulting in restrained attempts to offer and promote alternative solutions (Abelson 2001).

Furthermore, communities (defined geographically or by shared needs or characteristics) are not all alike and engage in different forms of participation shaped by different community characteristics such as language and religion, education and income levels and the presence of shared community values. The presence of sharp social cleavages, for example, can mobilize intense, issue-driven participation that may conflict with solidaristic principles (Abelson 2001). It is questionable, therefore, whether the public and geographic communities should be involved in local cost-cutting exercises such as decisions about which local hospitals should be closed. These are "tragic choices" that communities are not likely to make comfortably and should not, therefore, be expected to make (Calabresi and Bobbitt 1978).

Public consultation processes in the health sector have been fraught with problems that have produced angry, frustrated citizens and hindered policy development. Consultations that are presented as open-ended processes but framed very narrowly raise the ire of participants who judge the process to be a "done deal" (Deber and Williams 1995; Aronson 1993). These experiences have resulted in calls for public consultation processes to have greater clarity of purpose and clearer lines of accountability between the consultation and the final decision taken (Abelson et al. 2002).

The Public's Perspective on Public Participation

With the exception of satisfaction surveys and some limited polling data, we know little about how the public views themselves in their actual or potential roles as citizen governors, resource allocators or health system consultants. The public's apparent dissatisfaction with current political institutions and participatory opportunities hardly provides any concrete evidence on which to base future design processes. The limited evidence that exists points to the public as "reluctant rationer" of services (i.e., unwilling to take responsibility for setting priorities either among broad health service categories or specific services) (Lomas 1997*b*; Litva et al. 2002). Evidence also suggests that those citizens willing to consider this responsibility have an insatiable appetite for information about the costs and benefits of various programs and services, information that may be unavailable, costly to obtain or difficult to interpret (Abelson et al. 1995; Lomas 1997*b*; and Litva et al. 2002).

Participants cite generally positive experiences with their involvement in some consulting roles although they are becoming increasingly impatient when they perceive themselves to be a rubber stamp for decisions that are already taken (Coote and Lenaghan 1997; Litva et al. 2002).

Experiences with public involvement in deliberative exercises such as citizens' juries and panels have generated positive feedback from participants who welcome the opportunity to become more informed about their local health system but who also express concerns about the outcome of the process given the substantial time investment. Participants in these types of deliberative processes also tend to emerge from these experiences with a fuller understanding of the complexities of decision making in the health sector and, hence, renewed respect for existing decision makers (Abelson et al. 1995, 2001).

A recent study of the participation in *actual* health care priority setting decisions found that public representatives view themselves as contributing to both the process and outcomes of the decision-making process (Martin, Abelson and Singer 2002). Another study of public preferences for participation in the United Kingdom, aptly summarizes the public mood suggesting that citizens are seeking "accountable consultation" – consultation that provides them with opportunities to express their views (but not the responsibility for decision making) with a guarantee that their contributions will be heard and an explanation of the rationale for the decision ultimately made (Litva et al. 2002).

IV. The Future of Public Participation and Citizen Governance in the Health System

The signing of the Social Union Framework agreement in February 1999 has committed all provincial and territorial governments (with the exception of Quebec) to a variety of principles for treating and meeting the needs of Canadians. The framework also attempts to reflect and give expression to Canadians' fundamental values. Relevant to the health sector is the commitment to ensuring "adequate, affordable, stable and sustainable funding for social programs" (Social Union Framework 1999, p. 1). Relevant to public participation in the health system and its contribution to the efficient functioning of the health system is the agreement for governments to improve public accountability and transparency by ensuring "effective mechanisms for Canadians to participate in developing social priorities and reviewing [health system] outcomes" (Social Union Framework 1999, p. 3).

As with previous commitments to public involvement in the health sector, the commitment described in the social union framework is well intentioned but may be doomed to fail without carefully articulated goals and means. A major challenge remaining is the establishment of transparency about the framework agreement itself, its purpose and mandate. Intergovernmental agreements are extremely difficult for the public to digest. They are opaque products of complicated institutional arrangements far removed from the public's day-to-day interaction with the health system, and, therefore, at risk of generating expectations that will be left unrealized or simply dropped from the public participation agenda.

This most recent effort to institutionalize public participation into health system decision making warrants attention to the weaknesses that have plagued previous public participation efforts:

1. citizen domination by powerful groups interested in involving the public when it suits their purpose;

2. policymakers touting citizen governance as a critical element to achieve more responsive decision making while using these structures as instruments of cost cutting and restructuring;

3. the ability for only the most educated and sophisticated and arguably the most unrepresentative and biased "publics" to participate as citizen governors;

4. an increasingly cynical public weary of pre-determined illegitimate public consultation processes, reluctant to take responsibility for decision making, seeking more accountable consultation.

A more positive set of local experiences surely exists across the country but these are more difficult to identify and assess, in part because they are often regarded as "trivial" or "marginal" examples of local citizen-initiated processes, despite their success in effectively mobilizing communities, that contribute to collaborative problem solving and to a greater sense of commitment and ownership of the health system. They may not even be immediately

recognizable as examples of public participation in the health system (e.g., volunteer activities, local fundraising, resource pooling among community health agencies) but more civic-minded participation, inextricably linked to trust, commitment and collaborative problem solving. We discuss these examples in more detail in subsequent sections of the paper.

In summary, public participation in the governance of the health system, despite its potential, has contributed little to:

a)   the efficient functioning of the health system,
b)   strengthening the commitment of citizens toward health programs, or
c)   encouraging the expression of democratic values of solidarity and tolerance in Canadian society.

In the remaining sections of the paper, we focus on the development of strategies to realize public participation's potential for achieving these goals, which we believe are at least partially attainable.

Which Way Forward?
Recommendations for Enhancing Democratic Processes and
Citizen Governance of the Health System

We offer a set of guiding principles as well as selected strategic and technical recommendations designed to strengthen democratic processes toward the achievement of improved citizen governance of the health system.

Guiding Principles

1.   Recognize the multiple goals of participation and their inherent tensions

As long as there are competing objectives for public participation, there will be difficulty reaching agreement on how best to proceed. Designing equitable public participation processes, for example, may not be compatible with public participation processes that can contribute to the efficient functioning of the health system, nor with the promotion of public participation to foster greater commitment to public institutions and the expression of democratic values. The specific goals for public participation must be clearly articulated for different governance levels, different participants and for different public participation processes. The trade-offs of pursuing one goal for the achievement of another must be recognized.

2.   Acknowledge a major role for interested parties and capitalize on the public's tendency toward issue-based participation

We address several issues pertinent to an enhanced role for individual public participants in the health system. First, we believe that it is unreasonable to expect "disinterested" citizens to function as citizen governors (i.e., public members on health councils and boards) and advocate

for more flexible definitions that assume that citizen participants are interested members of their community, not simply users or consumers as they are often labelled. The broader public participation literature and the health care participation literature, more specifically, have clearly emphasized the link between interest, issues and participation among the public (Abelson 2001; Abelson et al. 1995). It may also be the case that only "interested" citizens and community members will be willing to dedicate their time to the more intensive deliberative approaches advocated by citizen engagement proponents.

The task remains then to determine what constitutes "interested," a difficult concept to sort out in the health arena. The conventional view of interested parties in the health sector has been based on the notion of individuals who derive their income from the health care system or who have a particular stake in the health care system, and for whom active participation enables them to influence decisions based on a narrow set of interests (e.g., hospital administrators seeking to block the closure of their hospital). Ideally, interests should be conceived of much more broadly to capture interest in collectivist goals such as the efficient and equitable functioning of the health system. To operationalize this concept at the community level, for example, a group of interested citizens might be brought together from a broad base of community organizations that are not directly involved in health services delivery but for whom the health system is seen as an important community resource. The selection of participants who pursue collective over individual interests is both difficult to achieve and may contradict some democratic principles (i.e., providing equal opportunities for public participation) but may, nevertheless, be an important vehicle for promoting this particular public participation goal.

Moving from the interested to the "disinterested citizen," this person is not likely to participate unless affected by an issue. When she does get involved, she wants to know why she is being asked to participate and that her participation will make a difference (i.e., that it will be considered in the decision-making process). She may prefer to provide the input without taking overall responsibility for the final decision or may be willing to share a more expanded role with experts and elected officials. In essence, this participant is seeking "accountable consultation" that she perceives to be missing from the health system currently (Litva et al. 2002; Abelson et al. 1995). The movement to replace conventional standing committees with issue-based task forces and working groups in a variety of health planning organizations is one way to begin to address this demand for more "purposeful consultation" although its effects on decision making are unknown (Abelson et al. 2002).

Strategic Recommendations

3. **Establish and enhance a role for "health system advocates" at local/regional, provincial and national governance levels**

At the citizen user level, patient charters have become a popular tool for institutionalizing patient rights and responsibilities although the relative weight given to rights versus responsibilities in these charters can differ enormously. The key is to provide citizen users with adequate means for communicating their concerns about their care through accessible, easily identifiable channels (i.e., they need to know where to go). In some instances, these processes

may also need to ensure an adequate separation between the "the complainer" and the service provider or funder, particularly when the users are vulnerable clients such as the elderly and the mentally ill. Such an approach has been adopted in the recently released Report from the Premier's Health Quality Council in New Brunswick, which has proposed a charter of rights and responsibilities (Government of New Brunswick 2002). "Health system advocates" have been proposed as a supporting mechanism of the charter to "facilitate citizen interface with the system… when issues need to be addressed, when information that is not easily accessible is needed, or when a citizen feels he/she is not receiving appropriate information or treatment" (Government of New Brunswick 2002, p. 85). Advocates would be appointed at both the regional health authority and provincial level with appropriately integrated functions to ensure clarity of roles and responsibilities.

A variant of this model could also be implemented at the national level to create, in effect, a "guardian" of the public health system. The National Round Table on the Environment and the Economy (NRTEE) is one such model. It is an independent advisory body that provides decision makers, opinion leaders and the Canadian public with advice and recommendations for promoting sustainable development. A parallel health roundtable could be created that would promote the health system goals of high quality, accessibility and efficiency.

Opportunities for citizens to directly contribute through complaints, submissions, etc. should still be available through fully transparent mechanisms such as dispute settlement procedures established under the Social Union Framework Agreement or parallel provincial mechanisms.

4. Develop and cultivate civic infrastructures as "institutions" for democratic participation

If we accept the notion that the existing governance structures in the health system have failed to foster participatory decision making and collective problem solving (and perhaps should never have been relied upon to achieve these goals), then how are the public's calls for meaningful and accountable participation to be met? In an increasing number of public sector areas, existing social and civic networks are being relied upon to build the needed capacity for participation and shared decision making. Civic organizations are considered important and attractive channels of public participation, examples of "better government by offering deliberative consultation involving extensive interests" (Lindsay 2000). Civic participation and strong associational networks can also increase the effectiveness of democratic citizenship and governance (Putnam 1993).

How might this work in the health system? "Building social capital and civic infrastructure is largely a matter of removing the constraints that often truncate that self-organizing process, and of improving the space it needs to flourish" (Rosell 1999, p. 50). One approach to removing these constraints might be to use regional health authorities to foster and build this civic infrastructure through user and citizen networks (Veenstra and Lomas 1999). Community health boards in Nova Scotia and citizen advisory committees in Saskatchewan are examples of these institutions as they appear to be the right size to foster interaction around local health issues and have not, as some might have expected, functioned as veto points for decisions that are unpalatable to communities. These structures have flourished with a committed group of local

leaders who have had public participation experiences in multiple sectors and who, on an ad-hoc basis, come together to address local problems.[6] In the case of the Nova Scotia community health boards, these groups have grown from existing community networks and are now in a better position to understand and weigh the needs, preferences and values of their constituents than could a non-local public body (see Mays 2000).

This approach is not without challenges, including its reliance on communities with shared collective interests and associational networks that cross social classes. Communities with social capital (i.e., able to engage in collaborative decision making), are typically found in more homogeneous communities where there are fewer competing political goals that divide a community. Some communities, however, may overcome their divisions more easily than others pointing, once again, to the presence of community values as distinct from individual values. This approach's strength may also be a weakness in its reliance on the same group of civic leaders to move from issue to issue and the potential this creates for volunteer fatigue, stifling innovation or consolidating power within a community elite. Efforts would need to be made to mitigate this risk.

Technical Recommendations

5. Improving the legitimacy of public participation processes

Improved legitimacy of public participation processes requires a clearer articulation of goals, intended products (i.e., why the public is being asked to participate), and selection of participants. This is necessary for *transparency*. *Accountability* for the public's involvement can be achieved by maintaining an ongoing dialogue with individual and community participants at various points in the decision-making process. But, as yet, no consensus about which approaches are most effective for these different community and decision-making contexts.

Citizen engagement and deliberative processes are widely viewed as promising solutions to a perceived "democratic deficit" and to produce more legitimate participatory processes. Calls for two-way, interactive engagement are ubiquitous throughout the public sector governance literature as mechanisms for fostering strengthened commitment to public institutions, shared values and collective problem solving (Gastil 2000). Attempts to engage citizens through deliberative processes have been experimented with only recently in the health sector, and primarily in the United Kingdom, not in Canada (McIver 1998). These processes remain vulnerable to control by powerful stakeholder interests who seek to initiate or sponsor these processes and thereby control the information that is selected, presented and ultimately influences the outcome of deliberations (Dunkerley and Glasner 1998). While the principles of deliberation such as informed dialogue leading to reasoned public judgment have the potential to contribute to both instrumental (i.e, improved decision making) and developmental (i.e., commitment to health programs and policies; expression of democratic values) goals, mechanisms are needed to reduce their vulnerability to the same problems that have plagued traditional participation practices. Greater emphasis also needs to be given to the outcomes of these processes (i.e., producing concrete input, recommendations or decisions) to ensure that they become more than a democratic luxury (Gastil 2000).

6. Pursuing efficient participation

Public participation at all costs is not sustainable in a health system preoccupied with efficiency and "value for money." Those designing public participation processes must consider both the costs and effects of these processes. Neither have been adequately addressed by the literature or decision-making organizations although participation researchers have begun to turn their attention to effective process (Rowe and Frewer 2000; Webler, Tuler and Krueger 2001; and Beierle and Cayford 2002). Deliberative methods warrant particular scrutiny given the substantial costs associated with their implementation.

With respect to allocative efficiency and public participation, consideration needs to be given to the role of an informed citizenry and how much information is required to achieve this goal. The evidence suggests that the public's demands for information to inform decision making are substantial. However, over time, as public opinion turns to more informed "public judgment," the public assumes a greater responsibility for its views, is able to consider the trade-offs associated with different positions and willing to accept the costs and the benefits of a given public policy (Yankelovich 1991). A final consideration is that some of the most democratically driven participation processes (particularly those that produce issue-based community mobilization designed to protect the status quo) will lead to the inefficient allocation of resources.

V. Conclusions

The analysis and recommendations presented in this paper emerge from the mixing of conceptual and theoretical ideas, empirical research on the experiences with public participation in the health system and some practical advice for enhancing democratic processes in the health system to contribute more effectively to the performance of the Canadian health system. Our review of the public participation experience suggests that, at present, an increasingly pluralistic and fractured public does not appear, by its participation, to increase the efficiency or the broad public commitment to the health care system, or to deepen the values of solidarity and tolerance. However, there may be ways, via regional and local processes, in which citizens, motivated by interest, can nevertheless foster commitments to the system as a whole.

More fundamentally, however, the desire for public participation to contribute to the efficient functioning of the health system must be balanced against the value of public participation in its own right and as a basic feature of democratic society. Although the contributions of public participation have not likely altered the health system's performance per se, it is conceivable that our health system might be worse off without the modest attempts to involve the citizenry that have taken place over the past 40 years. If public involvement in the health system (however defined) is considered a value in its own right, and this view appears to be largely supported, the basis upon which we judge its success or failure, and the quality of the evidence used to make this judgment needs more careful consideration. Participation may never produce greater efficiencies nor is public participation likely a necessary condition for the efficient functioning of the health system. It has the potential, however, through the adoption of some of the recommendations made here, to strengthen citizen commitment to health programs and to encourage the expression of democratic values.

As governments deal with increasingly challenging questions about how to manage and sustain a high quality, accessible and efficient health system, the public will undoubtedly be asked and encouraged to participate in these decisions. An increasingly savvy public is likely to recognize if it is being asked to share the blame for the consequences of difficult and painful decisions or to be legitimately involved in charting the future direction of the health system. Decision makers would be wise to tread carefully on this line as they determine how best to involve the public in these decisions.

Notes

1. See Pateman (1970) for a detailed discussion of this issue.

2. Aristotle, Rousseau and J. S. Mill discuss the educational and developmental benefits to the citizenry of citizen participation and its positive influence over citizens' commitment to public interests.

3. Recent examples include the Report from the Premier's Health Quality Council in New Brunswick, 2002; the Premier's Advisory Council on Health for Alberta, 2002; la Commission d'étude sur les services de santé et les services sociaux du Québec, 2001; and the Fyke Commission, 2001. Throughout the 1990s almost every provincial government established a commission or panel to propose health system reforms and some governments such as Nova Scotia and Ontario established provincial health councils as advisors to the provincial government.

4. Although we were unable to find any empirical studies of public participation experiences on regulatory bodies, there are numerous accounts of public attempts to seek justice for medical errors that have fuelled patients' rights movements internationally and the establishment of patients' charters to address concerns about the health system's lack of public accountability. One of the most comprehensive reviews of a regulatory body from the public's perspective is an analysis of the United Kingdom's General Medical Council (see Stacey 1992).

5. These data were collected from Web sites and through personal contacts with the Colleges or medical boards in each province.

6. These views reflect preliminary findings from a cross-jurisdictional public participation study led by J. Abelson and P.-G. Forest and funded by the Canadian Health Services Research Foundation.

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