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## **Towards More Meaningful, Informed, and Effective Public Consultation**

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# Towards More Meaningful, Informed, and Effective Public Consultation

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## Key Implications for Decision Makers

- Health policy decision makers are grappling with increasingly complex, contentious, and ethically controversial decisions. They want to be sure their decisions are in line with citizens' values and expectations.
- Approaches to public involvement can yield productive, long-term, trusting relationships between citizens and decision makers if they satisfy the following criteria:
  - clear communication about the purpose of the consultation and its relationship to the larger decision-making process;
  - identifiable links between the consultation and the decision outcome;
  - information presented clearly, honestly, and with integrity;
  - procedural rules that promote power and information sharing among and between participants and decision makers; and
  - processes that are viewed as legitimate by citizens and decision makers.
- Substantial organizational commitment and resources are required to successfully integrate the above criteria into public involvement processes.
- Public involvement approaches that emphasize the principles of deliberation are more effectively applied when a range of concrete decision-making options is being considered; when there are clear links between the consultation and the decision it is designed to inform; and when the time period between the consultation and the decision it is to inform is relatively short.
- Challenges to the process and outcomes of informed, effective, and meaningful public involvement within regional health authorities include:
  - provincial and local experiences with past public consultations;
  - organizational environment and receptivity to public involvement approaches; and
  - characteristics of the consultation issue and decision-making context.
- Credible, neutral, third-party facilitators, in conjunction with content experts, should be used as much as possible to build trust among participants and decision makers.
- Three key “information obstacles” must be overcome by citizens and decision makers to achieve more informed, effective, and meaningful public participation:
  - address citizen concerns about the adequacy and quality of information;
  - address decision makers' concerns about sharing information and the constraints that apply to this process; and
  - recognize public participants' experiential knowledge as an information source.

## Executive Summary

### Context

Health policy decision makers are grappling with increasingly complex, contentious, and ethically controversial decisions at a time when citizens are demanding more involvement in, and public accountability for, these decision processes. The aim of this research study was to assess and improve the effectiveness of public involvement methods as tools for 1) obtaining public views that will inform and improve healthcare decisions; and 2) communicating with the public about complex health and healthcare issues.

### Implications

Our findings provide strong evidence of decision makers' needs for new approaches to public involvement to confirm that their decisions are in line with citizens' values and expectations. These approaches must satisfy several criteria<sup>1</sup> for informed, effective, and meaningful public contributions:

- ♦ clear communication about the purpose of the consultation and its relationship to the larger decision-making process;
- ♦ identifiable links between the consultation and the decision outcome;
- ♦ information presented clearly, honestly, and with integrity;
- ♦ procedural rules that promote power and information sharing among and between participants and decision makers; and
- ♦ processes that are viewed as legitimate by citizens and decision makers.

Substantial organizational commitment and resources are required up front to successfully integrate these criteria into public involvement processes. These up-front commitments, while substantial, have the potential to yield productive, long-term, trusting relationships between citizens and decision makers.

The process, outcomes, and uptake of informed, effective, and meaningful public involvement within regional health authorities is shaped by several key influences: i) provincial and local experiences with past public consultations; ii) organizational environment and receptivity to public involvement approaches; and iii) issue characteristics and decision-making context. Some of these represent considerable challenges for organizations to overcome in order to successfully implement public involvement methods.

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<sup>1</sup> These criteria were generated from the first two phases of the research project which are not discussed in detail in this report. A discussion of these criteria can be found in Abelson, J et al. 'Will it make a difference if I show up and share?' A citizens' perspective on improving public involvement processes for health system decision-making [accepted, *Journal of Health Services Research and Policy*, 2004].

To successfully implement public involvement approaches that emphasize informed dialogue, citizens and decision makers must also overcome three key information obstacles: addressing citizen concerns about the adequacy and quality of information; addressing decision makers' concerns about sharing information and the constraints that apply to this process; and recognizing public participants' experiential knowledge as an information source.

## **Approach**

The study involved three phases, culminating in the design and testing of a new public involvement method, informed by the full research team (including decision-maker partners and researchers in each of five regional health authority/district health council study sites). The method tested in phase 3 was informed by i) case studies of public participation experiences in each of the five research sites involving interviews with regional health authority executives and focus groups with experienced public participants (phase 1); and ii) a survey of regional health authority decision makers to generalize province- and region-specific results to generate predictors of successful public consultation practices (phase 2). The public involvement method, pilot tested in phase 3, was a one-day, face-to-face, deliberative consultation meeting involving 20-25 participants selected from each community. The method's feasibility, acceptability, and impact on learning and decision-making were assessed for both citizen and decision-maker participants<sup>2</sup>.

## **Results**

The 99 citizens who participated in the project's deliberative public involvement meetings rated their experience with the method very favourably, with the exception of a small group of participants who were critical of the informational aspects of the meeting. Decision makers were both aware of and concerned about the level of time required to plan for this type of public involvement process. Participant understanding of the issues improved significantly in some sites, particularly for broader-based (such as health planning) issues, to which participants had little prior exposure. The outcome of the deliberative consultation meetings had variable impacts on organizational decision-making across each of the five study sites. Concrete, clearly-defined issues situated in short-term decision-making time frames with strong organizational commitment yielded outcomes from the deliberation that had a high degree of influence on health authority decision-making. Issues that were framed more broadly within longer-term decision time frames may have been more easily swept aside once the consultation was over, and there was less certainty about future uptake among organizational decision makers.

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<sup>2</sup> Two deliberative methods were implemented and evaluated in Quebec with help from the partner regional health authority. Martin, E. Dialogue sur le plan d'action régional de santé publique de Chaudière-Appalaches 2004-2007. Report to the jury. October 18, 2003, Sainte-Marie.

## **Further research and future practice challenges**

Our research study followed participants through the design and implementation of the public involvement exercise in each site and for three to four months following the consultation meeting. The longer-term effects of this type of process on individuals and organizations needs to be assessed to determine whether such interactions between researchers and decision makers have any lasting impact on organizations and their future public involvement activities and on individual and/or community capacity-building. Measures are needed to assess the effects of deliberative processes on groups and individuals, and to assess the effects of these types of processes on organizational learning. Further research is also needed to develop mechanisms for establishing more routine, institutionalized, and lower-cost public involvement processes.

## **Additional resources**

Abelson J, Forest P-G, Eyles J, Smith P, Martin E, Gauvin F-P. Obtaining public input for health-systems decision-making: Past Experiences and Future Prospects. *Canadian Public Administration*, 2002, 45(1) Spring: 70-97.

Forest, P-G, et al. Participation et publics dans le système de santé du Québec, dans Lemieux, Vincent, Bergeron, Pierre, Bégin, Clermont, Bélanger, Gérard (directeurs), *Le système de santé au Québec - Organisations, acteurs et enjeux*, 2nd ed., Sainte-Foy, Les Presses de l'Université Laval, August 2003, p.175-200.

Abelson J, Forest P-G, Eyles J, Smith P, Martin E, Gauvin F-P. Deliberations about Deliberation: Issues in the Design and Evaluation of Public Consultation Processes. *Social Science and Medicine*, 2003; 57:239-251.

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Abelson J and Eyles J. Public Participation and Citizen Governance in the Canadian Health System. In *Changing Healthcare in Canada: The Romanow Papers, Volume 2*. P-G Forest, T. McIntosh and G. Marchildon (eds.) University of Toronto Press, 2004, p. 279-311.

Abelson, J, Forest, P-G, Eyles, J, Casebeer, A and Mackean, G (for the Effective Public Consultation Project team). 'Will it make a difference if I show up and share?' A citizens' perspective on improving public involvement processes for health system decision-making [accepted, *Journal of Health Services Research and Policy*].

## **Context**

The objective of this research study was to find ways to make involving the public in healthcare decision-making more effective. More and more, decision makers want to obtain public views that will inform and improve healthcare decisions and communicate with the public about complex health and healthcare issues. Interest in finding more effective methods to do this is widespread in Canada, particularly at the regional health authority level, where regional decision makers routinely seek the input of local citizens and health system users in their planning, priority setting, and resource allocation decision-making processes.

Public involvement in health system governance is a means of 1) involving those directly affected by difficult choices in the organization and allocation of resources; 2) ensuring accountability to the public for these decisions; and 3) promoting the development of an active and engaged citizenry. Involving the public can be risky business, however, as the accountability and legitimacy of decisions made by governing authorities are often assessed against the nature and degree of interaction that occurs with the public. Consequently, decision makers in a variety of policy domains routinely struggle with decisions about when it is appropriate to involve the public; what the most effective means are for doing this; and how to measure their success.

Despite broad mandates for involving the public, we know little about what influences the choice of consultation method, the results obtained using different approaches, or the extent to which they have been evaluated. The scarcity of rigorous evaluation of public participation processes is of concern to those looking to draw generalizable lessons to inform the design of more effective participation processes in the future. Some of this work has begun in the fields of science, technology, and environmental policy (Rowe and Frewer, 2000; Beierle & Cayford, 2002; Petts, 2001), but very little has been done in the health field. As such, our driving research objectives

for this study were to unpack the meaning of effectiveness in the context of public participation methods, to develop guiding principles for the design and implementation of more effective public involvement methods, and to rigorously assess the implementation of new public involvement methods within regional health authorities across Canada.

## **Implications**

Our findings have implications for decision makers working in the health system who are pre-occupied with issues of how to effectively and meaningfully involve citizens in their decision-making processes, built on a solid foundation of information. Our results provide a strong base of evidence that identifies the need for new approaches to public involvement to satisfy several criteria for informed, effective, and meaningful public contributions:

- clear communication about the purpose of the consultation and its relationship to the larger decision-making process;
- identifiable links between the consultation and the decision taken;
- information presented clearly, honestly, and with integrity;
- procedural rules that promote power and information sharing among and between participants and decision makers; and
- processes that are viewed as legitimate by citizens and decision makers.

*(Abelson, Forest, Eyles et al., 2004)*

Substantial organizational commitment, learning capacity, and resources are required up front to successfully integrate these criteria into public involvement processes. These up-front commitments, while substantial, have the potential to yield productive, long-term, trusting relationships between citizens and decision makers.

The process, outcomes, and uptake of informed, effective, and meaningful public involvement within regional health authorities is shaped by several key influences: i) provincial and local experiences with past public consultations; ii) organizational environment and receptivity to new public involvement approaches; and iii) the characteristics of the issue to be discussed and the

decision-making context. Some of these may represent considerable challenges for organizations to overcome in order to successfully implement new public involvement methods.

Citizens and decision makers must also overcome substantial information obstacles to successfully implement new public involvement approaches that emphasize informed dialogue. These include the need to address citizen concerns about the adequacy and quality of information; decision-maker concerns about sharing information and the constraints that apply to this process; and the need to recognize public participants' experiential knowledge as an information source, among others.

Our results demonstrate that the principles of deliberation can be used in different types of organizations and can inform the design of many different types of public participation processes. However, the principles of deliberation are more effectively applied when a range of possible decision-making options is being considered, and when the time period between the consultation and the decision that it is designed to inform is relatively short.

Our findings also suggest that decision makers face numerous constraints that may challenge their ability to replicate the type of public participation processes that were implemented through this project. A number of tangible benefits associated with the researcher/decision-maker collaboration guided this project and the design and implementation of the public involvement processes in each site. First, researchers provided additional expertise to the partnership that offset costs that would otherwise be incurred by decision-maker organizations. Second, as respected, "neutral" third parties, they lend credibility to the public participation process and act as a buffer between decision makers and citizens. Third, they were able to reinforce important aspects of the public participation process (such as reporting back to participants) to busy

decision makers who often “need to move on” to the next pressing issue once the consultation has been held. Opportunities and funding sources to sustain these types of collaborative research models in the future should be considered.

## **Approach**

### ***Study design***

The study included three phases carried out in five regional health system research sites (in five Canadian provinces: Nova Scotia, Québec, Ontario, Saskatchewan, and Alberta). Phase 1 consisted of case studies in the five regional sites; phase 2 consisted of a two-phase nation-wide survey on current public involvement practices; and phase 3 involved testing a deliberative public participation process in five sites. Our research communities also differed with respect to population size and rural/urban characteristics (See Appendix A — Study Community Characteristics). Each phase learned from the previous one, and culminated in a comparative quasi-experimental design that tested a new public participation method (phase 3). The public participation method employed in phase 3 was informed by i) case studies of public participation experiences in each of the five research sites involving interviews with regional health authority executives and focus groups with experienced public participants (phase 1); and ii) a survey of regional health authority decision makers to generalize province- and region-specific results to generate predictors of successful public consultation practices (phase 2). Please refer to Appendix B for a summary of the project’s interim report, which highlights the findings of the first and second phases of the study. The full interim report is available from the authors. The remainder of this report describes only the third phase of this research project.

In phase 3, the same one-day, face-to-face, deliberative consultation meeting was implemented in each regional health authority site (or district health council) using a quasi-experimental design in which the following key attributes of the method were controlled:

- participant sampling and recruitment (20-25 participants selected from the community);
- length, structure, and external facilitation of the participatory method;
- provision of information in advance of the meeting; and
- meeting evaluation methods.

Each regional health authority (or district health council) identified their consultation issue (and its associated attributes) through a negotiated process with the local and national research team. Including the consultation issue, there were several contextual variables for which we were unable to control. We were aware of most of these before we entered into the field for this phase of the study. However, we did not know the type and magnitude of influence that each of these variables would exert on the public participation processes or their outcomes within each site. As such, through only a partial controlling of explanatory variables (such as the implementation of a common method) in a comparative context, our study design was uniquely positioned to explore the “real-time” influences of the following variables:

1) *Decision-making context*

- the type of decision for which the public consultation was being undertaken (such as planning, priority setting, or resource allocation)
- the stage and overall time frame of the decision-making process that the public consultation process was going to inform

2) *Socio-political context*

- the history and nature of the relationship between provincial and regional health authority decision makers and the public (such as levels of trust and respect)

- the history of the relationship between provincial and regional decision makers and the public vis à vis public participation

3) *Researcher/decision-maker partnership context*

- the history and nature of the relationship between local decision makers and research team members (such as new or on-going partnership; deference to “academic expertise;” lack of receptivity to new methods; or protectiveness toward existing approaches)

4) *Organizational context*

- the learning capacity of the organization
- decision-maker constraints (such as a limited mandate)
- level and magnitude of decision-maker commitment to the project (that is, who is committed to the project and in what way?)
- personal biographies of key organizational staff vis à vis public participation and
- evaluation

***Study population (phase 3)***

Study participants included politically and socially active local citizens identified and recruited from or through local community organizations using a stratified random sampling process.

Some modest variations in sampling approaches were observed across sites due to the nature of the consultation issue (such as the types of organizations through which participants were recruited). Organizations were chosen to achieve adequate representation across three different attributes: 1) healthcare organizations whose primary function is to deliver or manage health services; 2) health-related organizations involved in the health sector but not in direct service delivery (such as support or advocacy groups); and 3) well-being organizations involved in broader social and community-wide issues (such as parent groups or sports and recreation

organizations). Participants had to be local residents to be included. The most senior volunteer member (or equivalent) of each invited participant organization was invited to participate in the research project.

### ***Data Collection (phase 3)***

Data were collected at all five sites to evaluate the consultation process from the perspectives of the public participants, the participating decision makers, and members of the research team.

Participants who attended the consultation meeting completed questionnaires prior to the meeting (baseline), immediately following the meeting (post), and three to four months after the meeting (follow-up). Table 1 provides information about the information collected through each of the questionnaires.

***Table 1 - Participant Data Collected at T1-T3***

| <b>Baseline survey (T1)</b>  | <b>Post-meeting survey (T2)</b>  | <b>Follow-up survey (T3)</b>   |
|--|--|--|
| Participant characteristics: <ul style="list-style-type: none"> <li>• age, sex, education</li> <li>• length of residency</li> <li>• participation in community organizations experience with the issue under deliberation</li> </ul> | Participant ID linked to first survey  | Participant ID linked to previous two surveys  |
| Baseline assessments of meeting inputs: <ul style="list-style-type: none"> <li>• clarity of meeting purpose</li> <li>• clarity of background materials</li> </ul>  | Post-meeting assessments of meeting elements: <ul style="list-style-type: none"> <li>• clarity of communication</li> <li>• structure, facilitator, information</li> <li>• opportunity for adequate discussion</li> <li>• degree to which meeting met expectations</li> </ul> | Follow-up assessments of impact of deliberation: <ul style="list-style-type: none"> <li>• did decision makers report back to participants?</li> <li>• was information used by the decision maker?</li> <li>• were participant expectations about follow-up met?</li> </ul> |
| Participant understanding of deliberation issues   | Participant understanding of deliberation issues   | Participant understanding of deliberation issues   |
| Prior activity related to deliberation issues <ul style="list-style-type: none"> <li>• thinking, reading, research, talking</li> <li>• contact with public officials</li> </ul>  | Anticipated post-meeting activity related to deliberation issues <ul style="list-style-type: none"> <li>• thinking, reading, research, talking</li> <li>• contact with public officials</li> </ul>   | Long-term activity related to deliberation issues <ul style="list-style-type: none"> <li>• activity related to issues</li> <li>• interaction among participants</li> <li>• interaction among participants and decision maker</li> </ul>                                    |
| Values toward issues under deliberation  | Values toward issues under deliberation  | Values toward issues under deliberation  |

Prior to the consultation meeting, decision makers completed a brief questionnaire, which gathered their perspectives on:

- (i) the amount of planning time required for the consultation meeting;
- (ii) their expectations for the meeting;
- (iii) the potential for the deliberative method to foster a different kind of discussion and citizen input than that which is typically fostered;
- (iv) any concerns about the planning process and the meeting;
- (v) what criteria they would use to judge if the meeting was successful; and
- (vi) the least and most satisfying aspects of planning for the meeting.

All five public consultation meetings were audio taped (including all of the small-group discussions which occurred at the meetings), and comprehensive notes were taken of the proceedings. In addition, research team members in attendance observed the processes and took their own field notes.

Cost data for the planning, execution, evaluation work, facilities, and materials associated with each site's project were also collected by research and decision-maker team members.

### *Analysis*

Quantitative data were analysed using the Statistical Package for the Social Sciences software, (SPSS) version 11.5. Descriptive statistics were run for each site and for all sites combined for each of the participant questionnaires (baseline, post-meeting, and three- to four-month follow-up). Paired sample t-tests were performed on some of the data to assess before-after changes.

The qualitative data collected was analysed using constant comparison through the preparation of analytic memos based on observer notes prepared by site-specific teams, project co-principal investigators, and through in-depth discussion and interpretation of findings at full team research

meetings. Data were reviewed iteratively to identify common themes emerging both within and across sites.

## **Results (phase 3 only)**

### *The Consultation Issues*

Consultation issues were selected in each research site (in discussion with the project co-principal investigators) using the following screening criteria. They needed to be:

- “live” issues that the health authority/council was actively dealing with;
- issues for which there were multiple, viable options that the health authority/council would be prepared to consider for addressing the issue; and
- issues with adequate features around which appropriate decision options could be developed.

Consultation issues ranged both in the types and stages of decision-making processes they were to inform as well as the service/content/population areas to be addressed. Table 2 lists the key features of each consultation issue.

**Table 2 -Consultation issues**

| <b>Decision-Maker Site</b>                  | <b>Consultation objective</b>  |
|---|--|
| Calgary Health Region (AB)                  | To prioritize options for addressing two priority health and wellness issues facing young children in the South of Anderson Road Communities   |
| Heartland Health District (SK)              | To prioritize options for the configuration of primary healthcare services for Heartland Health Region’s planning process  |
| Hamilton District Health Council (ON)       | To provide input on local health planning priorities: <ul style="list-style-type: none"> <li>• local health system monitoring;</li> <li>• determinants of health; and</li> <li>• older adults</li> </ul> |
| Régie régionale de Chaudière-Appalaches(QC) | To determine a model for organizing community services for autism and pervasive developmental disorder   |
| Capital Health (NS)                         | To prioritize options for Capital Health to carry out its commitment to addressing the socio-economic determinants of health   |

### ***The Participants (phase 3)***

Ninety-nine citizens participated in the five deliberative consultation meetings. The average participant age was 46 years (with a range of 34 to 79 years), and most participants were female (84 percent). More than three-quarters of the participants (76 percent) had completed post-secondary education, with just more than half (51 percent) possessing a university degree. Participants had lived in their community for an average of 27 years and were involved in an average of 3.4 community organizations (Appendix C — Respondent characteristics table).

### ***Evaluations of the deliberative approach***

#### **Participant assessments**

Participants' evaluations of the deliberative consultation meeting elements indicate strong support for the use of this type of method across a range of decision-maker organizations and issues. Participants were extremely positive about most aspects of the deliberative consultation meeting. Almost all participants felt that the meeting format promoted discussion (98.9 percent), that it provided participants with equal opportunities to participate in discussion (95.7 percent), and that the meeting facilitator was knowledgeable about the discussion topics (97.3 percent). More than 80 percent of participants agreed that they had enough time to discuss issues in a comprehensive way (85.8 percent) and felt that information and the purpose of the meeting was clearly communicated (84.5 percent and 81.9 percent respectively). Participants also viewed this type of meeting as a useful way to bring citizens together to discuss these types of issues, although a third of the participants (from two sites) viewed this utility less favourably than the rest.

One exception to participants' widespread satisfaction came in the form of participant critiques of the adequacy of information. Compared to the exceptionally high marks given to most other

aspects of the consultation process, just more than two-thirds of participants (69.3 percent) indicated that they were satisfied with the information provided. Dissatisfaction was greatest in two sites where, in one instance, participants did not receive their background materials until two days prior to the meeting, and in another site, where some participants felt that the type of information (that is, hypothetical rather than real) posed a barrier to the deliberative process. The more general concerns about the adequacy of information reflect a more common phenomenon of participants not feeling they had enough information to make decisions.

### **Decision makers' assessments**

Decision makers were also generally positive about their experience, although they had more mixed reviews of the process. Most supported the aims of the research (to test and evaluate a new public consultation method). Just more than half (56 percent) indicated that the planning time was about what they expected; however, nearly a third of decision makers (31 percent), primarily from Ontario and Nova Scotia, raised concerns that the amount of planning time required for the consultation meeting was greater than what they had anticipated. Their views about the time required to plan for these types of consultations are reflected in the following statements:

“Planning the handout material was more time consuming than I thought but definitely a necessary process.”

“The time required to plan this type of process well is considerable, but I think I realized this up front.”

“I hate to think what it would be like if we had to do this on our own.”<sup>3</sup>

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<sup>3</sup> It is important to recall that, as participants in a research project, there were extra tasks required of decision makers and health authority/council staff to ensure the rigorous implementation of the research study and the collection of data for the purposes of comparison across sites that would not typically be associated with this type of project. So, although extra resources were available through the research funding, there were also extra activities required of participants, resulting in an increased time commitment.

Prior to the consultation meeting, decision makers were asked whether they believed that the deliberative method would foster a different kind of citizen input than what is typically produced through their consultations with the public. Across the five sites, more than two-thirds of decision makers (68.8 percent) indicated that the deliberative method would foster a different kind of discussion and citizen input. When asked why they held these views, they identified the following reasons: i) provision of background materials allowed participants to come prepared and informed; ii) the use of neutral facilitators created an environment that enabled honest exchange of ideas; and iii) the structuring of the material and presentation options provided a helpful framework to facilitate meaningful dialogue.

About a third of decision makers (31.2 percent) were less certain of the method's ability to foster a different kind of discussion and citizen input. One individual in Ontario did not see clear differences between the deliberative approach that was used in the study and other types of dialogues and priority setting methods the organization was already using.

### ***Impacts of deliberation on participant learning, organizational learning, and organizational decision-making***

#### ***Participant learning: Shaped by participant and issue characteristics***

We assessed participant learning in two ways. Immediately following the consultation meeting, participants were asked if their understanding of the deliberation issue(s) had changed based on their participation in the meeting. Across all five sites and issues under deliberation, the vast majority of participants (85 percent) indicated that their understanding of the issue under deliberation had improved, although the range varied both between sites and between issues, within sites from a low of 62 percent to a high of 95 percent. The reported change in understanding was lowest in Quebec (62 percent), where participants were likely most

knowledgeable about the issue (service provision for families of children with autism). Ontario participants reported the greatest change in understanding (95 percent) for the first deliberation issue, which was related to priority setting for local health system monitoring, an issue about which few members of the general public would have much prior knowledge.

Participants were also asked to rate their level of understanding (complete, partial, poor, or no understanding) of each issue prior to and immediately following the meeting. Table 3 presents the before-after scores for each issue in each site.

**Table 3 - Participants' Changes in Understanding of the Issues**

| Average Rating of Understanding of Consultation Issue                       | Baseline | Post-Meeting | t-test of difference |
|---|----------|--------------|----------------------|
| Local health system monitoring (ON)   | 2.07     | 1.71         | 2.110*               |
| Determinants of health planning (ON)  | 2.07     | 1.57         | 3.606***             |
| Planning for older adults (ON)  | 2.15     | 1.69         | 3.207***             |
| Service organization for autism and pervasive developmental disorder (QC)   | 2.00     | 1.92         | 0.562                |
| Nutrition and active living (AB)  | 1.60     | 1.10         | 3.000**              |
| Valuing children and families (AB)  | 1.50     | 1.10         | 2.449**              |
| Planning for primary healthcare services (SK)                               | 1.90     | 1.80         | 1.000                |
| Poverty as a determinant of health (NS)                                     | 1.58     | 1.50         | 0.561                |
| Capital Health's role in advocacy and community development (NS)            | 2.17     | 1.92         | 1.393                |
| Capital Health's role in addressing poverty as a determinant of health (NS) | 2.25     | 2.00         | 1.393                |

**Notes:** Understanding was rated as Complete understanding =1; Partial understanding =2; Poor understanding =3; No understanding at all =4

\* significant at the  $p < 0.10$  level

\*\*significant at the  $p < 0.05$  level

\*\*\* significant at the  $p < 0.01$  level

\*\*\*\* significant at the  $p < 0.001$  level

Changes in understanding of the issues were greatest in Ontario (for all three issues) and in Alberta (for both issues) as compared to Québec, Saskatchewan, and Nova Scotia. These findings suggest that the method may be particularly effective for improving participants' understanding of issues when:

- 1) the issue is newer to them and their baseline level of understanding of the issues is lower (such as in Ontario compared to Nova Scotia);
- 2) when the exchange among participants enhances the understanding of the issues (such as in Ontario and Alberta); and
- 3) when the issue under deliberation is not as emotionally charged or related to direct service provision (such as in Ontario and Alberta compared to Québec and Saskatchewan).

**Organizational decision-making: Shaped by issues, decision-making contexts, and organizational commitment**

The outcome of the deliberative consultation meetings had variable impacts on organizational decision-making across each of the five study sites. In Quebec, the “recommended decision” that resulted from the consultation was accepted and implemented by the regional health authority in relatively short order. The rapid uptake of this decision is explained by the *framing of the issue* and its *decision-making context*. The regional health authority had some modest resources to spend on community-based autism services and had come to a stalemate in discussions with community stakeholders about how to allocate the funds. The Quebec regional health authority was looking for a model to use to make a credible resource allocation decision. They had a relatively short time frame within which to make a decision and thought the public consultation approach could inform their decision. This short decision time frame is sharply contrasted with other sites' consultations, such as Nova Scotia's Capital Health, where the public consultation to assist Capital Health in shaping its role in addressing the socio-economic determinants of health

will inform decision-making over much longer time horizons, making it difficult to assess the influence of the consultation on the final decision output given the time frame of the research.

In the absence of information about the consultations' impact on a final decision outcome (with the exception of Quebec), we do know that in Ontario and Nova Scotia, reports on the outcome of the consultation were presented to their respective boards. In Alberta, a series of presentations on the process and outcomes of the public consultation meeting were given to senior health region managers and those making the decisions on the issues discussed; to health region staff interested in learning about the public involvement process and its outcomes; and to the community organizations through which public participants were recruited. The impact that these types of reports and presentations have had or will have on health authority decision-making is difficult to assess, as there are always other inputs that must be considered in a given decision-making process. In the case of Ontario, for example, the results of the consultation meeting were one of a number of inputs to council that were considered in the final process of determining its locally-driven planning priorities, and it would be difficult to delineate with any precision what emphasis was given to the output of the consultation held in conjunction with this project.

The extent to which these consultations influence organizational decision-making is also shaped by the *organization's commitment* to following through on all aspects of the consultation. Our experiences with each of the five research sites reveal distinct and, for the most part, consistent patterns of demonstrated organizational commitment. At the outset of the planning process, there was a great deal of energy and enthusiasm among participating decision makers, who found the planning process challenging and stimulating, and devoted a great deal of time and energy to the process up to and including the consultation meeting itself. While some of them felt the planning was time-consuming, there was a general feeling that it was a worthwhile endeavour. Once the

consultation was over, however, the energy and commitment to follow up dropped within some sites as decision makers moved on to the realities of new and more pressing matters within their organizations. There were one or two debriefing meetings where the results of the consultation were discussed, digested, and interpreted. In two sites, comprehensive follow-up was undertaken that included:

- reports to public participants and community organizations through which participants were recruited, summarizing the outcomes of the consultation and how the information was being used to inform planning and decision-making (Alberta);
- a day-long interagency meeting hosted by the health region, to which all of the recruiting community organizations were invited to begin strategizing collective action to address the priorities identified by the public participants (Alberta); and
- a report of the outcomes to the board and letters from the health authority to participants indicating what steps had been taken to implement the decision made by the participants (Quebec).

In Saskatchewan, Ontario, and Nova Scotia, health authority/council follow-up with participants and the board was more difficult to track. Attention to follow-up with public participants, in particular, was lacking in a couple of sites despite an explicit “accountability” mechanism built into the consultation process that required the health authority/council to communicate with participants to indicate how their input was being used by the organization. Without reminders from research team members in these sites, it is not clear whether this follow-up would have occurred. In two sites, for example, follow-up with participants was driven by the research team’s desire to keep its promise to participants to provide a summary report of the consultation meeting. In one site, the two elements were completely intertwined. The health region’s description of what it had done since the consultation meeting was contained in the body of the

cover letter that accompanied a follow-up survey for participants to complete. Many of the participants, when asked for their opinions about the adequacy of the health region's follow-up, did not respond because they did not think there had been any follow-up.

**Organizational learning: Shaped by history, individuals, and organizational commitment**

It is difficult to measure whether and how the organizations that participated in this research study learned from their experience. The compressed time frame of this study (implementing phase 3 in the final year of a three-year project) did not allow us to assess even the medium-term effects of such a process. Our close working relationships with these organizations suggest, however, that the learning capacity of the organization exerts a crucial influence on how the organization responds to new public involvement approaches, and that these learning capacities are in turn shaped by history, individuals within the organization, and the overall commitment of the organization to the process. This was evident in the two sites (Alberta and Quebec) that implemented a second consultation through the research project. In the case of Alberta, a great deal of organizational learning occurred through an initial consultation that informed the deliberative method used as part of the comparative study. In Quebec, the Régie demonstrated its learning from its first experience with a deliberative method, and this positive experience influenced its decision to plan a second consultation that employed a second type of deliberative method: a citizens' jury.

## ***The impacts on deliberation: Issue characteristics, Informational Challenges, and Researcher/Decision-Maker Partnerships***

### ***The Role of Issue Characteristics***

The range of issues selected for each site's deliberative method allowed us to consider whether some issues are more amenable to deliberation than others. Our results indicate that the more tangible and concrete the issues, the more participants would invest in this type of process. However, with this investment comes a high sensitivity to any shortcomings detected in the process. For example, participants in the Québec public involvement process were extremely committed, because it was going to inform a decision that would have a direct impact on the resources that would be allocated to community-based autism services in their region. Due to the "high stakes" nature of the issue, participants may have been critical of certain aspects of the process, such as the delay in obtaining the pre-meeting information package. These participants were also confused about the consultation objective. Some thought the purpose of the meeting was to discuss all services related to autism as opposed to discussing only community services for autism (the actual meeting objective). Similarly, participants in the Saskatchewan public involvement process were also highly engaged in the issue under deliberation: the configuration of primary health services in their region. These participants were critical of the informational aspects of the meeting, in particular the decision to use a hypothetical prototype to discuss the primary health configuration scenarios. Although these types of concerns were raised in other sites, they did not have the same level of impact on participants' assessments of the process. In the case of Alberta, participants generally found the background information packages valuable in the context of the deliberative process, perhaps due to the direct contributions made by citizens to developing this background information in a prior consultation phase. Still, it may be plausible that those who do not see themselves being directly affected by the outcome of the consultation may be less likely to critique the process. Our participant evaluation results support

this claim, as the Quebec and Saskatchewan participants, who were least satisfied with the informational aspects of their consultations, were potentially most directly and immediately affected by their deliberative consultations. This raises a challenge for decision makers who attempt to navigate this paradox of public participation.

### **Information**

There were a range of experiences with the development and use of information across sites. However, in all sites, there was some aspect of the selection, sharing, presentation, and interpretation of information by and among decision makers and citizens that produced anxiety, disappointment, and/or criticism. Decision makers in several sites were concerned at the outset with how to present information in a neutral way. For some of the organizations in our study, particularly those for whom the issue under deliberation was more emotionally charged or more directly connected to service provision, sharing information was more challenging. In one site, there was difficulty obtaining information that health authority staff could feel comfortable with and that could be produced within the time frame required to inform the consultation meeting. In another site, the decision maker did not want to give the participants all of the information, so a “prototype” region was created that would be used for the deliberation and would, in the decision makers’ view, allow participants to focus on principles for designing services rather than thinking about their own community.

Other information concerns hinged on the lack of participants’ use of “evidence” in the deliberative process. Despite the emphasis given to evidence in the deliberative method, participants in at least one site appeared to ignore or pay little attention to the evidence supporting different options, and prioritized their personal experiences with these options over the evidence provided by the health region. Participants’ prior negative experiences with the

issue of service design and location, in particular, were observed to have shaped participant reactions to the evidence presented to them. This raises two issues for consideration in the future design of these types of consultation meetings. The first is whether, in the context of a one-day consultation, participants are able to digest, interpret, and meaningfully challenge the evidence on a particular issue in the context of their values and experiences. The second is that decision makers need to recognize the experiential expertise that public participants bring to the table as an important information source (but not the only one) that should be considered along with the evidence provided by the sponsoring health region.

### **Researcher/decision-maker partnerships**

This collaborative research project between researchers and decision makers in five regional health authority/district health council sites yielded a number of tangible benefits that must be considered in assessing these public involvement experiments. First, researchers provided additional expertise to the partnership to offset costs that would have otherwise been incurred by decision-maker organizations. Second, as respected, “neutral” third parties, the researchers lent credibility to the public participation process and acted as a buffer between decision makers and citizens. This was observed in several sites where the public participants “confided” their misgivings or mistrust of the decision-maker organization based on prior experiences and were appreciative of the opportunity to contribute through a research project. Decision makers also benefited from the opportunity to bring in “academic expertise” to buffer them from criticisms of the process. Third, the researchers were able to reinforce important aspects of the public participation process (such as reporting back to participants) to busy decision makers who were already moving on to the next pressing issue once the consultation had been held.

## **Additional Resources**

This project was preceded by a project funded by the Health Evidence Application and Linkage Network (HEALNet) for which Drs. Abelson and Forest were co-principal investigators (1999-2001). Much of the early design work that informed this project was tested in Ontario and Quebec through this collaborative research project. Several papers based on this earlier work have been published or are in press.

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## **Further Research and Future Practice Challenges**

Our research study followed participants through the design and implementation of the public involvement exercise in each site and for three to four months following the consultation meeting. The longer-term effects of this type of process on individuals and organizations needs

to be assessed to determine whether such interactions between researchers and decision makers have any lasting impact on organizations and their future public involvement activities and on individual and/or community capacity-building. Measures are needed to assess the effects of deliberative processes on groups and individuals and to assess the effects of these types of processes on organizational learning. Further research is also needed to develop mechanisms for establishing more routine, institutionalized, and lower-cost public involvement processes.

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Community Characteristics

|  | Alberta  | Saskatchewan  | Ontario                          | Québec   | Nova Scotia  |
|--|--|---|----------------------------------|--|--|
| <b>RHA/DHC</b>                                       | Calgary Health Region  | Heartland Health Region   | Hamilton District Health Council | Chaudière-Appalaches   | Capital Health   |
| <b>Corresponding Municipality</b>                    | <ul style="list-style-type: none"> <li>• Calgary and surrounding area</li> <li>• South of Anderson Road is a group of growing communities in South Calgary that have a large population of families with young children</li> </ul> | <ul style="list-style-type: none"> <li>• Located in west central SK</li> <li>• includes 3 former health districts</li> <li>• the largest community is Kindersley (pop. 4890)</li> </ul> | Hamilton                         | <ul style="list-style-type: none"> <li>• region covers 137 municipalities in the south shore area from the St. Lawrence River up to the US border</li> </ul> | Halifax Regional Municipality, West Hants, & a portion of East Hants County  |
| <b>Population Served</b>                             | Calgary (pop. 1 million)<br><ul style="list-style-type: none"> <li>• SOAR (pop 150,000)</li> </ul>   | 46,127 (third smallest population of the 10 southern RHAs)  | 503,222.                         | 391,837  | Referral population of 395,000 (nearly 40% of all Nova Scotians)   |
| <b>Geographic Size (urban/rural characteristics)</b> | <ul style="list-style-type: none"> <li>• serves the rapidly growing urban areas of Airdire, Calgary and Cochrane as well as many towns and rural communities</li> </ul>  | 41,351 sq km. 67 towns and villages, 44 rural municipalities.   | 1,113 sq km                      | 15,000 sq km<br><br>Approximately two-thirds of the population live in a rural environment.  | <ul style="list-style-type: none"> <li>• stretches 160kms into mainland Nova Scotia</li> <li>• includes some of the highest-population density areas in the province, as well as rural areas, small villages and local towns.</li> </ul> |
| <b>Health Authority/ Council Budget</b>              | \$ 1 billion   | \$ 55 355 005   | \$ 960 347                       | \$498 million  | \$ 515 million   |

**Summary of Interim Report for Phases One and Two**

This report summarizes the progress made to date and preliminary results of the first two phases of the research project “Towards More Meaningful, Informed, and Effective Public Consultation: Evaluation of Regional Health Authority Approaches.” We also present a detailed proposal for the third and final phase of the research project, which involves the design, implementation, and evaluation of public participation pilots in each of our 5 research sites.

The overall objectives of the project is to improve the effectiveness of public consultation exercises as tools for communicating with the public about complex health and healthcare issues and for obtaining the public’s views to inform and improve future decisions about health and healthcare. The project specifically aims to compare and evaluate the different approaches to public participation in health issues – and the input obtained from these methods – that have been or are currently being used by health authorities across the country, and to share and test results through prospective public participation pilots.

The research study is being carried out in 5 research sites across the country and in partnership with 5 regional health authorities.

**Phase 1**

In the first phase of the study, we conducted case studies of past and current experiences with public involvement processes in two principal decision-making areas specified in the original research proposal: 1) facility closures and service/facility relocations; and 2) the reorientation of health services to meet population health goals.

Local research team members conducted in-depth interviews with past and current regional health authority decision makers in 5 research sites to detail their experiences with the selected public involvement processes. At least one focus group was held in each research site to document the experiences of active public participants.

**Summary of Phase 1 findings**

The decision makers interviewed in this phase of the study have learned a great deal from their experiences with multiple public consultation processes. Several “needs” were emphasized repeatedly which focused on the need for greater clarity of purpose and objectives of public consultation processes and the related need of greater transparency. Transparency was discussed in many ways; it was used both as a criterion for evaluating public consultation and identified as a critical element to be incorporated into the design of future public consultation processes.

Interviewees stressed that there is “no recipe” for design that can be applied universally across organizations, decision contexts or jurisdictions, but that there are clearly a set of features that need to be built into any given process. While the strengths and weaknesses of a variety of approaches were considered, the emphasis on choosing a particular method was considered much less important than giving careful consideration to the purpose of the consultation and articulating this purpose clearly to public participants.

Focus groups with public participants yielded a reasonably consistent set of themes. As highlighted by decision makers, public participants consider the need to identify and communicate a clear purpose for the consultation “essential” to ensuring legitimate and transparent processes. Public participants also view information as a crucial element to the process and describe its role in the following ways:

- information needs to be shared between decision makers and the public
- information needs to be presented clearly, honestly and with integrity
- adequate time is needed to discuss information
- as participants become more informed they have more confidence to contribute and develop a greater understanding of how decisions are made and how they can be influenced

Participants focused on the need for decision makers to think carefully about when to consult, that is, when there are clear choices and decisions on which the public can provide input; when community values need to be considered; and when there is enough time to adequately involve the public.

## **Phase 2**

In phase 2 we generalized province- and region-specific results to the broader RHA population, to determine what common experiences have been shared among provinces, what may be unique to a particular province or health authority and what predictors of “successful consultation” might be identified based on past and current experience. To do this, we conducted two separate surveys: 1) a brief screening survey of all regional health authority executives to identify the “best practices” RHAs; and 2) an in-depth survey of a smaller group of RHA decision makers ensuring an even distribution across regions and provinces.

### **Summary of phase 2 findings**

Respondents generally felt that almost everything is a potentially defining feature of “successful public involvement.” Over three-quarters of respondents rated 6 out of the 8 potentially defining features of “successful public involvement” as either “very important” or “extremely important.”

Stating clear objectives, selecting appropriate methods, creating a transparent process, and integrating public input into the final decision were felt to be very important or extremely important by almost all respondents (90%) while selecting the right participants was considered very or extremely important by over three-quarters of respondents.

RHA respondents were consistent in their desired improvements for public involvement processes and their statements of intent for future planning processes. Of those who said that they would strengthen selection of public involvement methods if they were given

additional resources (71%), this group also said they planned to work on the design of methods for involving participants over the coming year. Of those who said they would strengthen the selection and recruitment of public participants (20%), they also planned on placing more emphasis on whom they involved or on participant recruitment methods.

Factors associated with “high success” ratings include:

- a statement of clear objectives for the process
- the degree of explicitness of the goals and objectives of the process
- the selection of appropriate methods
- the integration of public input into the final decision

The degree of explicitness of the goals and objectives of the process was also found to be associated with the ability for public input to be integrated into the final decision as a feature of successful public involvement.

Who sets the goals and objectives for the process has bearing on respondents’ views of what defines successful public involvement. Where goals and objectives are determined internally (by an explicit board decision), the perceived importance of producing decisions that are acceptable to all stakeholders is less important than the perceived importance attached to educating and informing the public and communicating the results of the public involvement process.

### **Phase 3**

The purpose of this phase of the research project is to develop and evaluate new methods for involving the public in a healthcare decision-making process, informed by the results obtained in the first two phases of the research study. A single method (Method A) has been chosen that has the greatest potential for generalization across all research sites and Canadian regional health authorities. This method will be implemented in one regional health authority in each study province, by means of a controlled social experiment in which input from the public will be elicited, before being provided to the regional board.

The principles of deliberation and its emphasis on “collective problem-solving” will allow individuals with different backgrounds, interests and values to listen, understand, potentially persuade and, in the end, come to more reasoned, informed and public-spirited opinions about a range of issues. The deliberative exercise will also improve on previous consultation methods by establishing a clear purpose and objectives for the exercise as well as transparent and accountable communications and decision-making through all aspects of the process.

The exercise will involve a 1-day face-to-face, interactive meeting 20-25 with invited representatives from a broad range of community organizations including healthcare, health-related and well-being organizations. Participants will be given concrete issues to work through during the meeting and will be provided with relevant background information prior to and during the meeting.

## Respondent Characteristics

|  | Alberta<br>(n=18) | Saskatchewan<br>(n=12) | Ontario<br>(n=20) | Quebec<br>(n=23) | Nova Scotia<br>(n=26) | All Sites<br>(n=99) |
|--|-------------------|------------------------|-------------------|------------------|-----------------------|---------------------|
| Mean Age (years)                                 | 38                | 47                     | 56                | 42               | 48                    | 46                  |
| Female Gender (%)                                | 18 (100%)         | 7 (58%)                | 16 (80%)          | 18 (78%)         | 23 (92%)              | 81 (84%)            |
| <b>Education Level (%)</b>                       |                   |                        |                   |                  |                       |                     |
| Secondary of below                               | 0                 | 2 (17%)                | 3 (15%)           | 4 (17%)          | 3 (12%)               | 12 (12%)            |
| Trade/technical/vocational                       | 1 (6%)            | 5 (42%)                | 3 (15%)           | 1 (4%)           | 2 (8%)                | 12 (12%)            |
| Community college or equivalent                  | 4 (24%)           | 1 (8%)                 | 10 (50%)          | 7 (30%)          | 2 (8%)                | 24 (25%)            |
| Undergraduate Degree                             | 9 (53%)           | 2 (17%)                | 1 (5%)            | 7 (30%)          | 4 (16%)               | 23 (24%)            |
| Grad/Prof Degree                                 | 3 (18%)           | 2 (17%)                | 3 (15%)           | 4 (17%)          | 14 (56%)              | 26 (27%)            |
| Community Residency (mean years)                 | 7.7               | 34.6                   | 38.3              | 28.3             | 26                    | 26.9                |
| Community Organization Involvement (mean number) | 2.4               | 3.9                    | 4.6               | 1.7              | 4.5                   | 3.4                 |