Challenges of citizen participation in regional health authorities

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Abstract

Citizen participation has been included as part of health reform, often in the form of lay health authorities. In Canada, these authorities are variously known as regional health boards or councils. A set of challenges is associated with citizen participation in regional health authorities. These challenges relate to: differences in opinion about whether there should be citizen participation at all; differences in perception of the levels and processes of participation; differences in opinion with respect to the roles and responsibilities of health authority members; differences in opinion about the appropriate composition of the authorities; differences in opinion about the requisite skills and attributes of health authority members; having a good support base (staff, good information, board development); understanding and operationalizing various roles of the board (governance and policy setting) versus the board staff (management and administration); difficulties in ensuring the accountability of the health authorities; and measuring the results of the work and decisions of the health authorities. Despite these challenges, regional health authorities are gaining support as both theoretically sound and pragmatically based approaches to health-system reform. This review of the above challenges suggests that each of the concerns remains a significant threat to meaningful public participation. © 2002 Elsevier Science Ltd. All rights reserved.

Keywords: Regional health authorities; Health policy; Regional health planning; Consumer participation; Health care reform; Governance; Canada

Introduction

The concept of citizen participation in health and health-system decision making has been prevalent during the last three decades around the world, and appears to be driven by a variety of factors:

- the doctrine of informed consent that individuals' preferences must be reflected in treatment choices and decisions (Boyce & Lamont, 1998);
- a public demanding greater responsiveness of health professionals and policy makers to communities (Green & Frankish, 1994);
- calls for greater accountability for allocations of economically-pressed health resources by governments, health-care providers and organizations

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(Alexander, Zuckerman, & Pointer, 1995; Morfitt, 1998);

- increased interest in "social capital" and the role of community-level factors in generating "healthy communities" (Eastis, 1998; Lomas, 1998; Veenstra & Lomas, 1999); and
- the idea that programs may be more effective if they emerge from local consensus and priorities (Zakus & Lysack, 1998).

The idea of citizen involvement in planning health programs is supported in various national and international documents (Green, 1986; Perlstadt, Jackson-Elmoore, Freddolino, & Reed, 1999). A substantial body of literature exists regarding the study of communities and community organization and development processes in health planning (Minkler, 1997; O'Neill, 1992; O'Neill, Lemieux, Groleau, Fortin, & Lamarche, 1997). Citizen involvement also has been recognized as a core element of health promotion and has long been a key tenet of community development (Florin & Wandersman, 1990; Green, 1986).

Citizen participation has been included as part of health reform, often in the form of lay health authorities (Bell, 1994; Bickerton, 1999; British Columbia Ministry of Health, 1995; Garpenby, 1996; O'Neil, 1991; Nickoloff, 1995). Church and Barker (1998) note that regionalization offers a means of better co-ordinating and integrating health-care delivery and controlling expenditures, and promises a more effective provision of services and an avenue for citizen participation in health-care decision making. Despite the alleged benefits, regionalization presents significant challenges in integrating and co-ordinating services in a manner that produces economies of scale. It requires an enhanced level of information that may be difficult to achieve; it is unlikely to involve citizens in health-care decision making; and it may actually lead to increased costs. Further, McDaniel and Chappell (1999) note the inherent contradictions and tensions in health reform as it relates to the valuing of public health care, attitudes toward cost-reductions, the vision of health care reform versus the reality, and health as a private/public good.

In Canada, health authorities are variously known as regional health boards or councils, and are either entirely or partially composed of members of the general public. For example, in British Columbia, a Royal Commission on Health Care and Costs (1991) suggested that a centralized structure for decision making and resource allocation resulted in poorly planned, poorly managed and uncoordinated health care at the local level. In response, the provincial government launched a health reform policy in 1993 called "New Directions". A core feature was the creation of Regional Health Boards and Community Health Councils. These health authorities were to govern a renewed health system characterized by "greater public participation", "health care closer to home", "effective management of the new health system", and a more holistic conceptualization of health.

Similar processes and experiences have occurred in other Canadian provinces. Casebeer and Hannah (1998), Casebeer, Scott and Hannah (2000), found a shift away from acute hospital care towards more community-based, health promoting services in a regional health authority in the province of Alberta. Variables identified as critical to the transition to regionalization were sustaining political will; pacing; resourcing; and, committing to change. Six others were described as continuous process variables included leading; communicating; informing; learning; planning; and, adjusting.

Maloff and colleagues (2000) recently proposed a framework to promote public and community participation in urban health authorities, including components of public participation and its associated purposes, values, guiding principles, and expected outcomes. Their framework highlights a variety of challenges that we believe emerge in examining the role of citizen participation in regional health authorities. These challenges relate to: the values, assumptions, and expectations underlying citizen participation in health authorities; structures and processes associated with decision making in health authorities; maintaining accountability of lay health authorities; and measuring the results of the work and decisions of health authorities. This paper discusses the challenges and their implications for health planning and health system reform.

Not everyone agrees on why there should be citizen participation

Various reasons (theoretical, practical, and political) for citizen involvement in health decision-making have been suggested in the literature. Theoretical reasons include the following notions: that health needs and health services should be more closely matched (British Columbia Ministry of Health, 1993; Charles & DeMaio, 1993; Redden 1999); that people have the right to participate in planning, implementing, and evaluating their health system (Sawyer, 1995; Schmidt & Rifkin, 1996); and that community empowerment can be fostered so that community members will have a sense of contribution and of power or place within the system (O'Neill, 1992).

Practical reasons for lay participation in health decision making include: an appreciation of untapped community resources and energy that can be mobilized; provision of a broader range of inputs to decisions or comprehensive solutions to health problems; notions

that such participation may lead to more cost-effective decisions (Creighton, 1993); and the belief that lay participation may contribute to more efficient delivery of services (Brownlea, 1987; Farrell, 2000).

Political reasons for increased citizen participation include: loss of faith in the legitimacy and superiority of professional knowledge in health-care decision making (Berman, 1997; Charles & DeMaio, 1993); a means of gaining broad-based citizen support and the efforts of volunteers (Broadhead, Duckett, & Lavender, 1989); and citizen participation in planning and delivering health programs can yield greater awareness of health problems, more appropriate use of health services, and prevention of diseases (Tewdwrjones & Thomas, 1998).

Multiple arguments against lay participation in planning and decision-making processes such as health authorities have also been suggested. These include the beliefs that: health professionals are the legitimate and superior decision makers (Scanlan, Zyzanski, Flocke, Stange, & Gravagubins, 1996); efforts to protect individual rights may compromise quality of care; community participation may involve people who have less skill or knowledge than those responsible for carrying out the decisions (Brownlea, 1987); participation may be costly and inefficient (Arnstein, 1969, 1971; Piette, 1990); and participation may involve people who are less accountable for outcomes than professional decision-makers (Brownlea, 1987).

These arguments for and against citizen participation can be usefully examined in the context of regional health authorities. The diversity of these arguments reflects a complexity in the values and goals for citizen participation (Chess, 2000). Charles and DeMaio (1993) suggest that there is a lack of clarity with respect to what are, or should be, the values and goals underlying lay participation on health authorities. Although the creation of health authorities appears to be based on a set of governmental and societal values and assumptions regarding health and the health system (Etzioni et al., 1994; Nickoloff, 1995; Scanlan et al., 1996), the values and goals for citizen participation within health authorities are not always stated explicitly. Rather than implementing citizen participation based on assumed values and goals, Stone (1992) suggests that the values, goals, and functions of lay participants in health reform could be stated more explicitly. A clearer and more specific delineation of goals and functions could aid in guiding the work of health authorities and of policy makers implementing health reform (Hunt, 1990).

Resistance to citizen participation on health authorities and in health reform can be anticipated. The involvement of lay members on regional health authorities suggests both a shift in the role of traditional government stakeholders and health professionals and an emergence of new governing bodies and forms or models of governance. The creation of lay health authorities involves a significant change from the traditional physician-dominated, biomedical illness-care system (Davidson, 1999). With a shift to greater citizen participation in health reform, the role(s) of health professionals have become less clear. Tensions emerge as health professionals feel threatened by an uncertain future and a potential reduction in their influence (Boex, Cooksey, & Inui, 1998; Lomas, Veenstra, & Woods, 1997a–c; Reinertsen, 1998; Scanlan et al., 1996). There are competing pressures between a bottom-up, community-driven process versus a more centralized, professionally-driven approach (Foley & Martin, 2000).

The term citizen participation may elicit different perceptions of the levels and processes of participation

Different levels of citizen participation have been recognized, ranging from citizens being manipulated to citizens having total control (Arnstein, 1969; Connor, 1988; Potapchuk, 1991). In addition, different processes of citizen participation have been identified, including self-help groups, coalitions, committees, forums, focus groups, and so forth. Hyman and Shingler (1999) note that citizen participation is also closely tied to a host of economic, social, and political factors.

However, the general use of terms, such as participation or involvement, especially when there is no reference as to what form they will take or how they will occur, may lead different individuals to understand "citizen participation" differently (Boon & Meilby, 2000; Willis, 1995). For example, in Vancouver, British Columbia, when regional health authorities were still being discussed and developed in 1994, there was general enthusiasm about the "new" concept of citizen participation in the province. A series of fora and working groups (composed of both professionals and the general public) were held to discuss the shape these regional health authorities would take (composition, principles, etc.). Some working groups surveyed people in their communities about health issues. The process could be described as incorporating grassroots participation and community development. However, once the regional health authority (and its community committees) was formed (1994–1995), the process became more formalized with less grassroots participation and community development. When some members of the working groups continued as members of community committees, they became frustrated because citizen participation no longer took the form they thought it should. Mere participation does not equate with feelings of satisfaction and/or influence (Boon & Meilby, 2000).

There are differences of opinion regarding appropriate roles and responsibilities for members of regional health authorities

Discussions about the roles and responsibilities of citizen participants on health authorities often focus on the capacity of citizen participants to make health-system decisions. It is recognized that health professionals normally provide scientific knowledge of what constitutes good health care and health services (McDonald & Chavasse, 1997; Morone & Marmor, 1981). Citizens are recognized as being in a better position to have knowledge about local needs and resources in relation to health, to express their opinions on what kinds of services are wanted (Richardson & Waddington, 1996), and how these services should be delivered, the form they should take, and the settings in which they should be provided (Hochbaum, 1969).

Some suggest that citizens should not be involved in broad health and clinical matters because they do not have the knowledge of health professionals (Hiller, Landenburger, & Natowicz, 1997; Hochbaum, 1969; Madan, 1987). There is also the view that lay members of regional health authorities should not be expected to become technical experts (Ellenburg, 1981; Kimmey, 1981) or perform tasks requiring specialized knowledge or advanced training (Madan, 1987). In a study of decision-making groups and their role in devolved governance of health care, Abelson and Lomas (1996) found that most randomly selected citizens indicated less interest in involvement in specific types of decisions, except for planning and setting priorities, than in overall decision making. Elected officials were the most willing, and randomly selected citizens the least willing, to take responsibility for decision making. Generally, respondents tended to assign authority to traditional decision makers such as elected officials, experts, and the provincial government, but also favored a consulting role for interested citizens. Others believe the public could be involved in professional areas of responsibility. In a study of advisory committees that included consumer representatives in the formulation and implementation of medical policy concerning newborn screening programs in the United States, Hiller et al. (1997) concluded that lay citizens can assist in the formulation of sound public and medical policies requiring an understanding of complex scientific and medical information.

Other discussions about the roles and responsibilities of citizen participants have focused on the topics or areas that will get the most community mobilization (participation). Examples include narrow and clearly defined issues with clear targets (Abelson & Lomas, 1996), and socially-related health problems (Berman, 1997; Conway, Hu, & Harrington, 1997; Milewa, 1997).

In a study of health boards across Canada, Lomas et al. (1997a–c) observed that board activity was dominated by setting priorities and assessing needs, and secondarily with ensuring the effectiveness and efficiency of services. Governance experts suggest that an effective board spends most of its time on major strategic (long term) and policy issues, on assessing outcomes, and on education for board members (Small, 1999).

Labonte (1990) cautioned that community participation is often mixed with romanticism (assuming that all community is good); bureaucratization (over-management of participation efforts in a manner that robs them of their effectiveness); and anti-professionalism (failing to recognize that professionals can play a complementary role in health authorities). There also remains a need to guard against decentralism or localism that fails to recognize that community-based efforts are limited by the reality that most economic and social policies are national and transnational in nature (Labonte, 1990). Winett (1991) concurs that not every problem is solvable at the local level and may require state/provincial or national initiatives.

There are differences of opinion on the appropriate composition of regional health authorities

Regional health authorities may be composed of different categories of members: the general public, consumers, health-care providers (physicians and nurses), health-union representatives, politicians, health planners, and so forth. Most of the regional health authorities in Canada are composed, at least in part, of members of the general public. These health authorities may also include other representatives. In British Columbia, limited numbers of physicians and health-union representatives are included as members of the regional health authorities. However, the merits of having physicians, allied health professionals or members of health unions as (voting) members of health authorities need to be discussed (Checkoway, O'Rourke, & Macrina, 1981). Health professionals and service providers may be in a conflict-of-interest when it comes to policy decisions (Reinertsen, 1998) (e.g., some decisions may relate to funding of a health service under which these professionals or providers work and get paid).

There are differences of opinion on what skills and attributes are most suited for governing on regional health authorities

There is no standard or agreed-upon set of skills and attributes that are most suited for governing on regional

health authorities. In fact, there is little in the literature on governance that focuses specifically on regional health authorities. Despite the absence of an explicit set of requisite skills and attributes, lay representatives on regional health authorities have come under fire for their qualifications (or perceived lack thereof) (Morfitt, 1998). Board self-assessments (annually) have been emphasized as an important board development activity (Dolan, 1996; Johnson, 1994; Orlikoff & Totten, 1996; Walker, 1999; Webler & Tuler, 2000; Webler, Tuler, & Krueger, 2001). Conducting board self-assessments helps boards to explore where improvements in skills or ways of working together are needed, for individual members as well as for the board as a whole. Given that boards have different mandates and are composed of different individuals, a one-size-fits-all set of skills and attributes may not be useful. Thus, annual board self-assessments appear to be a practical strategy for determining and enhancing the requisite skills and understanding needed on a governing board. In BC, the Ministry of Health requested that health authorities submit information with respect to their competence and representation to the Ministry, as part of an annual assessment (BC Ministry of Health, 1998). Such an assessment is considered critical to the appointment process, and helps to assess the composition, expertise and function of the board as a whole, as well as the participation, skills, and contribution of its individual members.

Regional health authorities have a substantial job to do and they need support such as staff, good information, and board development

In a series of four papers, Lomas et al. (1997a–c) examined several aspects of devolved authority for Canadian health care in the form of health boards. They found systematic differences between established and immature boards in regard to training, information use and activities. Consequently, lay people may be competent in helping to restructure a health system, and experts, professionals and bureaucrats may need to be "on-tap not on-top". What is emerging in Canada is a model wherein lay members of health authorities are ably assisted by a variety of professional staff, many with a health systems background. However, the board may not receive adequate or appropriate information to make informed decisions (Small, 1999).

In addition to supportive staff, board development activities are important and could include: continuous education (Dolan, 1996; Parsons, 1998); learning about different styles of decision making (Smith, 1998); learning to focus on decisions and issues that are important (Taylor, Chait, & Holland, 1996; Parsons, 1998); learning about the health system (Taylor et al.,

1996); board self-assessments (Johnson, 1994; Dolan, 1996; Walker, 1999; Orlikoff & Totten, 1996); orienting new board members to the work of the board (Parsons, 1998); board mandate and organization (Silverman, 1980); and learning about planning and evaluation (Silverman, 1980).

The governance-management divide is not always clear

Board work has often been characterized as governance work and the setting of policies, while the work of the staff, such as the CEO, has been characterized as management work (administration) and implementation of policies and decisions made by the Board. However, it has been suggested that most important matters can not be subdivided neatly into policy-related or administrative tasks (Taylor et al., 1996). For example, a board may be involved in both determining the selection criteria for a new CEO, and in conducting interviews and deciding which applicant is suitable. Board members (and their staff) may be uncertain about the different roles of governance versus management (Johnson, 1994; Small, 1999; Walker, 1999). Although the governance-management divide is not always clearly demarcated, board members and staff should come to some consensus on the elements of the two domains as they relate to their situational context, and agreement on the primary and appropriate foci for their respective roles and responsibilities.

Ensuring accountability of regional health authorities may be difficult

Accountability of regional health authorities can be viewed in two respects. First, to whom are regional health authorities accountable? Second, for what are regional health authorities accountable?

Regional health authorities may be accountable to one or more parties: the general public, politicians, government departments, and so forth. Recent research suggests that most members of Canadian health authorities are oriented to acting on behalf of the broader community (Lomas et al., 1997a–c). Lomas et al. (1997a–c) found that over 70% of respondents to a survey of members of Canadian health boards believed that they represented everyone in their locality. Lomas et al. (1997a–c) also concluded that health authorities must balance competing pressures from their provincial government, health professionals and local citizens. Appointed board members were well intentioned in representing the interests of the community, but were unlikely to overcome formidable barriers to community empowerment in health care.

The term representation has been used non-specifically throughout the literature and government documents. There appears to be different types of representation. Most references to representation are descriptive representation, which prescribes who representatives should be, not what they do (Morone & Marmor, 1981). Descriptive representation usually refers to demographic characteristics such as age, ethnicity, education, and income. However, Morone and Marmor (1981) noted that individual members of a group will not necessarily "think, feel, and reason" alike, nor represent with equal efficacy, (i.e., not be homogenous), even within a group or special interest.

An emphasis on descriptive representation may detract from an emphasis on the accountability of the representatives in the interest of their constituents. Substantive representation is related to whom representatives look after and whose interests they pursue, not what the representatives look like. There is mixed evidence in the literature about whether or not representatives actually represent whom they are supposed to represent. There is some evidence that representatives who tend to be the most vocal or that volunteer may be the least representative of the community (Sawyer, 1995). Various other studies have shown that the opinions of participants on specific health policy issues differ from those of non-participants (Beatley, Brower, & Luchy, 1994; Hutcheson, 1984). Others have found the opposite to be the case (e.g., agreement in priorities or opinions between representatives and the relevant community) (Gundry & Heberlein, 1984; Conway et al., 1997).

If lay health authority members are to be accountable to their constituents, mechanisms that ensure feedback of information from representatives to the population need to be created (Parker, 1970; Piette, 1990). Also significant is the gathering of information and feedback from the community to lay health authority members. However, there is evidence that structured community participation (groups established by health-decision makers to provide a community viewpoint to health issues and services, e.g., the regional health authorities in Canada) may lead the participants to view themselves as the community representatives (Willis, 1995), thus disconnecting them from ongoing relations with the community. Some researchers suggest that a lay health authority cannot function effectively without some link with the community (Galiher, Needleman, & Rolfe, 1971; O'Neill, 1992).

Wharf Higgins (1999) has argued that it is not necessary for regional health authorities to be representative (descriptively) of their constituency if they understand the needs and experiences of those they represent. This idea is referred to in the literature as experiential participation (Prior, Stewart, & Walsh, 1995). Yet such active representation requires an on-going relationship between the lay health authority and the citizens. Such participation constitutes a new kind of active (as opposed to passive) representation based on an experiential relationship (Prior et al., 1995). There are limits to other types of representation, such as electoral representation, because there is no guarantee that such representatives share similar constituent gender, ethnic or socioeconomic status, let alone understand their needs or experiences (Phillips, 1995). Needs are best identified and appreciated by sharing in the lives of others. Representation, based on shared experiences where needs are actively and subjectively assessed, enhances the legitimacy of representation when economy of time and problems of scale restrict participation by all.

Within any community, there are various groups that may have different health interests (Pateman, 1970; Pitkin, 1969) and segments of a population may not share the same values and priorities as the decision-making segment (Zakus & Lysack, 1998). Goodwin (1998) notes that serious discrepancies often exist between the motives, experiences and understandings of various participants in planning initiatives. There is a "tension," or what Lomas et al. (1997a–c) refer to as a pressure towards "negotiated compromise" in that lay participants must move between representing the broader community and also acting for, or protecting the interests of vulnerable groups (e.g., the poor, handicapped, persons with mental illness) in society. In the end, regional health authorities are accountable for allocating scarce resources to appropriately address health issues and disparities in their region. Their situation is similar to that noted by Terris (1999) in his comments on what he terms, the neoliberal triad of anti-health reforms: government budget cutting, deregulation, and privatization.

The results of the work and decisions of the regional health authorities may be difficult to measure

Regional health authorities have existed in Canada in many jurisdictions during a large part of the last decade. Despite the fact that these authorities have been formed and resources allocated to support their work, there is as yet little empirical evidence to indicate that they make better decisions (and thus produce better health outcomes), allocate resources more appropriately, or use resources more efficiently than did the authorities that existed before their creation. In one study, members of health boards in Canada have been reported to believe that they make good decisions, with most feeling that they make better decisions than those previously made by the provincial government (Lomas et al., 1997a–c).

Clearly, it is difficult to monitor and evaluate the work of regional health authorities and to link their efforts to

improvements in the health system, health status or quality-of-life. Assessment is further complicated by the lack of agreed-upon operational definitions for performance and output (Kovner, 1975). Green and Kreuter (1999) suggest that evaluation has two components: objects of interest and standards of acceptability. In the case of regional health authorities, it is not entirely clear what constitute these. On the other hand, to make no plan or little attempt to measure whether health authorities have made any difference is another issue. One suggested difficulty in measuring the influence of these health authorities is that they are still relatively young and their influence is yet to be seen. In five to ten years it will be interesting to see whether attempts have been made to measure their influence, or whether it will still be argued that it is too early to see their influence.

Summary

Regional health authorities are gaining support as both theoretically-sound and pragmatically-based approaches to health-system reform. However, the effectiveness of lay health authorities has yet to be broadly tested (Davidson, 1999; Frankish, Ratner, Wharf-Higgins, Kwan, & Larsen, 2000; Green, 1994). Lomas (1997) correctly notes that although regional health authorities in Canada have integrated parts of the health system (i.e., hospitals), integration of the community sector is hampered by structural constraints such as a lack of budgetary authority over physician and pharmaceutical costs.

Beyond any interest in whether an effort like the creation of lay health authorities has a positive long-term or sustainable impact, there is also a need to understand how and why such authorities succeed or fail. To do so requires an assessment of the dynamics of community structures and processes. Still several problems exist that may plague efforts towards citizen participation in health-system reform. First, there is evidence that provision of resources to enable community mobilization efforts may lead to power struggles and tensions among individuals and constituencies (Chavez, 1996). Lomas and colleagues (1997) noted tensions in participation requiring what they termed "negotiated compromise" between government expectations, providers' interests and citizen needs and preferences.

Second, despite a growing interest in citizen participation and its development into policy (mandates), various groups or stakeholders appear to interpret such participation differently. Various researchers have developed frameworks to help clarify different approaches to citizen participation, the dimensions of citizen participation, and relationships between factors and effects of participation. These models or frameworks offer a foundation for examining the complexity of citizen participation. The need remains for further clarification of the purpose(s) and scope of citizen participation.

Citizen participation on health authorities implies "responsibility" or the capability to determine one's own actions (Hancock, 1999). It also implies accountability and liability. Further, it extracts from citizens a commitment of donated time and resources that few can afford, especially among the laboring segments of the community, whose participation is most sought.

Governments may initiate policies and actions that may significantly affect citizen participation in health-system reform (Hancock, 1999). These include: promoting understanding and recognition of perspectives on health; setting health goals; providing infrastructure, and capacity (e.g., funding, defining roles, knowledge development, education and training, exemplars or centres of excellence); and setting healthful public policy, which, in turn, is driven by concerns regarding inequities in health and social conditions, problems of sustainable development and healthful environments, and development and allocation of resources. Governments may facilitate or strengthen action by regional health authorities in three ways: by improving the existing community health sector; by strengthening community control; and by strengthening the community support sectors.

The strengthening of both formal and community support networks is an important strategy. Green and Simons-Morton (1991) argued that with an active population, public and governmental agencies tend to be more responsive, elected and appointed officials tend to be more sensitive to public needs, and community organizations tend to be more co-operative in working with each other than in communities where the public waits for government and other organizations to provide all the leadership on health matters. The rhetoric of citizen participation suggests that if the public seeks more information, participates more actively in debating priorities, and watches more vigilantly the process of health-system reform, then the challenges of citizen participation in health-system decision making are more likely to be dealt with effectively. However, ambiguity remains regarding the requisite skills and attributes for serving on a regional health authority, the roles and responsibilities and composition of health authorities, the representativeness (accountability) of health authorities, and the measurement of the effectiveness of health authorities.

A review of the reasons for creating lay-based regional authorities suggests that these authorities are supported by theoretical, political, and practical reasons for citizen participation in health-system decision making. On others, it is clear that the exercise falls short. The creation of health authorities has led to greater opportunities for some local preferences to be reflected in treatment choices and decisions (Boyce & Lamont, 1998). It remains unclear whether programs that emerge

from local consensus and priorities are more effective (Zakus & Lysack, 1998).

There is also modest evidence that the creation of health authorities has focused attention on public demands for greater responsiveness of health professionals and policy makers to communities. These demands are associated with calls for greater accountability for health resources (Morfitt, 1998). At this point, it remains unclear as to whether regionalization of the health system in most jurisdictions has led to greater accountability for resources. Finally, emerging qualitative data suggest that regional authorities may offer one vehicle for increasing "social capital" generating "healthful communities" (Eastis, 1998; Lomas, 1998). Some health authorities have created programs to tap into and mobilize community resources.

Earlier, we articulated multiple arguments that exist against citizen participation in planning and decision-making processes such as health authorities. Our review of the issues and available documents and literature suggests that each of these concerns remains a significant threat to meaningful citizen participation. There is strong evidence that the system continues to operate as if health professionals are the legitimate and superior decision makers (Scanlan et al., 1996). It has been suggested that citizen participants may have less skill or knowledge than those responsible for carrying out the decisions (Brownlea, 1987). Lomas and others have clearly shown that much remains to be done in terms of training and capacity-building to support citizen participation. Third, the challenge remains that citizen participation may be costly and inefficient. There is a need for further research on the benefits of citizen participation in terms of its processes, its impacts on individuals, organizations and communities/regions and its outcomes in terms of enhanced health, well-being and quality-of-life. There remains a need to more closely examine how citizen participation is tied to accountability for decision making.

Regional health authorities putatively lead to better decisions and a more effective, efficient health system. The reality appears to be that little empirical evidence exists as to how citizen participation leads to such outcomes. Much remains to done be in developing models of citizen participation and in monitoring and evaluating its impact on the health system and the health of the population across diverse settings and circumstances. There is also a need to develop better methods for conducting research on citizen participation (Barnes, 1999).

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