Abstract

How best to involve the public in local health policy development and decision-making is an ongoing challenge for health systems. In the current literature on this topic, there is discussion of the lack of rigorous evaluations upon which to draw generalizable conclusions about what public participation methods work best and for what kinds of outcomes. We believe that for evaluation research on public participation to build generalizable claims, some consistency in theoretical framework is needed. A major objective of the research reported on here was to develop such a theoretical framework for understanding public participation in the context of regionalized health governance. The overall research design followed the grounded theory tradition, and included five case studies of public participation initiatives in an urban regional health authority in Canada, as well as a postal survey of community organizations. This particular article describes the theoretical framework developed, with an emphasis on explaining the following major components of the framework: public participation initiatives as a process; policy making processes with a health region; social context as symbolic and political institutions; policy communities; and health of the population as the ultimate outcome of public participation.

We believe that this framework is a good beginning to making more explicit the factors that may be considered when evaluating both the processes and outcomes of public participation in health policy development.

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1. Introduction

In the 1990s, participation became internationally a key part of the discourse in the health sector. Participation was central to the concept of primary health care introduced in the 1970s [1] but has moved beyond that to a broader inclusion in health policy development. Participation is also a major tenet of health promotion and is encapsulated in its 1986 Ottawa Charter definition: “Health promotion is the process of enabling people to increase control over and to improve their health” [2]. Fostering public participation was one of three strategies for health promotion encouraged in early policy documents from the Canadian government [3]. Participatory action research [4], participatory research [5]...
and participatory development [6] are just some of the activities thought to improve the chances of success in health promotion. More recently, in Canada, health sector reforms focused on acute care have taken place under the banner of increasing public input [7–10].

Other factors have also brought increased attention to participation in all parts of the health sector. Recognition that the broad determinants of health [11] and sectors other than health influence the health of populations has increased the demand for intersectoral action [12,13]. Partnerships between organizations have become a popular technique of participation and have been posed as solutions to many health problems [14–17]. Citizen juries, deliberative panels, and round tables [18] are other examples of techniques for increasing public participation.

Despite the popularity of participation, there is little consensus about what it means in practice, and the literature on participation is fraught with inconsistency [1,19–21]. The term partnerships, for instance, is used to represent many different relationships and understandings [22] such as coalitions, networks, coordinating committees, and work groups to name a few. The public participation framework of one regional health authority acknowledges a range of participation from information exchange to delegation of authority [10], based on the work of Arnstein [23] and others. Abelson et al. [9] identify that “current activity seems largely focused on efforts to design more informed, effective and legitimate public participation processes with a strong evaluation component” (p. 239).

Evaluation research requires a clear articulation of the program logic model, program theory [24], outcome line [25], or program coherence [26]. “In the absence of a clearly articulated programme theory, it may be necessary to bound the programme. . . that is, to specify which activities, services, targets, results, and parts of the environment are understood to ‘belong’ to the program in question. This at first seems simplistic; however, when one considers the complexity of social change organizations and projects, it is important to make this distinction” of what belongs to the program [27] (p. 36). In our experience in health program evaluation, often one of the most challenging activities is articulating the program components and intended outcomes [28–30], and this is true in evaluating public participation. The diversity of meanings and activities, as well as resulting differences in how or which outcomes are specified, makes integration of findings difficult across studies.

One of the areas of confusion is differentiating between public participation as an initiative or intervention encapsulating a process and a means to an end and public participation as the intended outcome or end in and of itself. The focus on processes is often on “how best” to involve citizens in the decisions that affect them [9,31]. In discussing deliberative public participation initiatives used in the health sector, Abelson et al. [9], for instance, at times imply that the outcome of interest is the decision or recommendation of the participants after their deliberation; at other times they imply that it is how this decision or recommendation is used by a health authority.1 Abelson et al. [9] also state that the ‘decisions’ or policy issues that are to be affected by participants range from identification of public values to allocation of resources to general governance of the health sector. Public values may, however, be one of the factors that go into a decision to allocate resources. In this paper we will use the term public participation initiatives to refer to the whole set of activities and processes, and public participation techniques to refer to the methods chosen to engage people. As we see participation, a number of processes (e.g., setting up the management group, choosing the participants) may be involved in any initiative and any technique.

Abelson et al. [9] note the “paucity of rigorous evaluations” (p. 249) available to those who want to draw generalizable conclusions on public participation. They call for the use of “clearly defined and agreed upon criteria” (p. 249), presumably of effectiveness. Similarly, Church et al. [32] identify the need for more research on the many ways that citizens can influence decision-making in the health sector. We argue that for evaluation research on public participation to build generalizable claims, some consistency in theoretical framework is needed. A framework that encourages clear articulation of an initiative would help describe its components, specify the public participation techniques (e.g., advisory councils, public forums, citizen juries, partnerships), the resources used, the objectives pursued, as well as the target of change or desired

1 In this paper, we will use the term health authority to refer to those who have the mandate to govern within the health sector. In Canada, governance structures vary.
outcomes, and the environment in which that target is situated. Research based on this framework would make integration of findings more possible. The research reported on here used grounded theory to develop a theoretical framework for understanding public participation in the context of regionalized health governance.

2. Research methods

Our research project studying public participation in health policy development was conducted from 2000 to 2003. The overall research design followed the grounded theory tradition and involved case studies of five public participation initiatives in the Calgary Health Region and a survey of community agencies. The case studies selected for the project vary on a number of characteristics including the population participating, how and when the initiative began, and the mandate of the initiative. Details of each case will be reported in subsequent papers.

2.1. Data collection

Case studies are stories and, as such, data collection methods are selected in order to be able to tell the story. The research questions for this project and for the case studies were primarily how and what questions, so the case studies were both exploratory and explanatory in nature [32]. The specific data collection methods used to explore the nature of the five public participation initiatives studied included: document reviews; observation; semi-structured individual interviews; and focus groups. (Table 1)

For each of the five case studies, historical and current documents were reviewed. Documents were included in this data collection based on their ability to contribute to the story being told and included: minutes of public participation initiative meetings; committee terms of reference; planning documents; and local newspaper articles. Related committee meetings were observed in three of the five case studies. Selected other activities were observed in some of the cases (e.g., community consultations). Decisions about what to observe were based on an expectation that this data would make a significant contribution to the story of a particular case.

Individual interviews with key informants were conducted for all five case studies, and focus groups were done in two of the case studies. Interview guides were developed to guide the semi-structured, ethnographic individual interviews and the focus groups. Consistent with qualitative research methods generally, and grounded theory specifically, new questions emerged as the research project progressed meaning that these interviews guides evolved with the project.

Subsequent to the case studies, an external survey of Calgary non-profit, non-governmental organizations was conducted. The purpose of this survey was to find out from the broader policy community [33] as represented by non-profit, non-governmental organizations about their experiences working with and trying to influence the Calgary Health Region’s Policy and decision-making. Out of 214 questionnaires, 144 were returned, for a response rate of 67%.

2.2. Data management and analysis

All the interviews, individual and focus group, were audio taped and transcribed with both the signed and verbal consent of the informants. The transcribed interviews, and where possible the historical documents, were imported into the QSR Nvivo software program to facilitate the data analysis [34]. Where it was not possible to import historical documents into QSR Nvivo, these documents were analyzed manually using the coding template that had been developed through the software. Following the grounded theory tradition, the data collection and analysis took place concurrently [35]. The ongoing analysis of the data was used to guide the evolution of individual interview guides, the interview guides developed for the focus groups, as well as the selection of key informants. The constant comparative method of analysis [35] was followed and involved reviewing the transcripts and historical documents, looking for the emergence of common themes over time. Quantitative data was analyzed using Stata software [36].
Table 1
Data collection methods used in the five case studies.

<table>
<thead>
<tr>
<th>Case</th>
<th>Time period covered</th>
<th>Documents reviewed</th>
<th>Observation</th>
<th>Individual interviews</th>
<th>Focus groups</th>
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<tr>
<td></td>
<td></td>
<td>- minutes of Grace Hospital Board meetings</td>
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<td>- other relevant historical documents provided by key informants</td>
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<td></td>
<td></td>
<td>- local newspaper articles</td>
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<td></td>
<td></td>
<td>- other historical documents</td>
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<tr>
<td>3. Family Liaison Council (FLC)</td>
<td>1972–2001</td>
<td>- ACH Board minutes</td>
<td>none</td>
<td>N = 9 (with 11 key informants)</td>
<td>One (with 4 current members of the Council)</td>
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<tr>
<td></td>
<td></td>
<td>- FLC minutes</td>
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<td>- other historical documents</td>
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<td></td>
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<td>- Local newspaper articles</td>
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<tr>
<td>4. Health Advisory Council (HAC)</td>
<td>1995–2002</td>
<td>- Council minutes</td>
<td>3 meetings (spring of 2001)</td>
<td>N = 11 (with 10 key informants)</td>
<td>One (with 8 current members of the Council)</td>
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<td></td>
<td></td>
<td>- Other historical documents</td>
<td></td>
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<tr>
<td>5. Diversity Initiative</td>
<td>1999–2002</td>
<td>- Regional diversity committee minutes and related documents</td>
<td>2 Diversity Steering Committee meetings</td>
<td>N = 8 (with 8 key informants)</td>
<td>None</td>
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<tr>
<td></td>
<td></td>
<td>- Community Consultations Project Team minutes</td>
<td>-5 ethno-cultural community consultations working group meetings</td>
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The Grace Women’s Health Services and the Aboriginal Health Council cases were initially analyzed as distinct case studies, that is, as stories unto themselves, and then subsequently as a piece of the bigger story of public participation in regional health policy. The preliminary findings emerging from these two case studies helped shape the preliminary analytic template used to guide the coding of data in the subsequent case studies. The within-case analytic process involved using this template to guide the coding, category and theme development. The analytic template continued to evolve based on the categories, sub-categories and properties emerging from the case studies. The findings emerging from the first four cases were used to determine the focus of the fifth case study, as well as the target populations and questions for the external survey.

The analysis was carried out by a multidisciplinary research team that included health region decision-makers and academics from a variety of disciplines (e.g., management, health promotion, health policy, public health nursing, health systems research, epidemiology, women’s studies). The team members brought different foci and experience to the table that contributed to a rich and theoretically sensitive analytic process. Half- and full-day meetings were held where both within- and between-case study analysis took place. Following the grounded theory tradition, constant comparative analysis was ongoing both within and between cases. Also, we returned to the literature once the data collection was nearing completion in order to contribute to the development of the theoretical framework. As the theoretical framework emerged, we went back to
data, collected more data and sought clarification of components.

2.3. Rigor

A qualitative study can be described as trustworthy [37] if the findings are: credible, transferable, dependable, and confirmable [38]. A variety of strategies were used to increase the trustworthiness of the research findings: triangulation of data methods and sources; member checking; peer examination of transcripts and historical documents; and reflexivity. These strategies were used in both the data collection and analysis.

3. Findings

The resulting theoretical framework of public participation in Regional Health Policy is depicted in Fig. 1. The major components of the framework are explained in the following sub-sections.

3.1. Public participation initiative process

The initiatives examined in the five case studies of the research project used a variety of public participation techniques, including long-term standing committees and one-time community consultations using focus groups and individual interviews. Public participation initiatives are often described in the literature as single events or time-limited techniques (e.g., focus groups, town hall meetings, task forces, citizen juries, etc.). Even if a public participation initiative is limited to the utilization of one technique, our data suggest that it would be best understood as a process that occurs before, during and after the particular point in time that the technique is applied. Defining a public participation initiative as a technique limits the scope of interest to that technique (e.g., how to do focus groups well) and fails to capture the complexity of using a particular technique within a given organizational and social context, including the nature of the issue that is going to be discussed. It is these latter aspects that may be most important to understand when trying to generalize from evaluation findings concerning public participation.

Further, the processes may be affected by a number of external factors that may be critical to success quite apart from how well a technique is employed.

The Diversity Initiative case study illustrated this point well. A decision was made to use focus groups to consult ethno-cultural communities about the provision of health services by the health region to diverse populations. The discussions among health region staff about whether ethno-cultural communities should be consulted and then about how to do these community consultations took place over an extended period of time and were influenced by the mandate of the Diversity Steering Committee and the historical relationships between ethno-cultural community organizations and the health region. The mandate and the historical relationships helped shape the form and questions for the focus groups.

From our data, we identified a number of themes relevant to describing the processes of public participation initiatives. These can be summarized as follows:

- the public participation technique or techniques employed (e.g., standing committee, task force, focus group, intersectoral committee, interorganizational partnership);
- which public participants are involved in a particular initiative, including how and why participants became involved and who they represent;
- profiles and credibility of an initiative;
- history and prior identities of initiatives;
- formal mandates of initiatives;
- the actual functions of the initiative (e.g., advocacy; informing management and/or the board; monitoring of the health care sector’s performance; acting as a liaison between a community and the health region; capacity building and community development); and,
- the formal and informal rules of engagement of various aspects of the initiative.

Describing each of these may be important in understanding a given public participation initiative and the resulting outcomes. For example, the actual functions of a public participation initiative may differ from what is described in the formal mandate. Unless the actual functions are identified, it can be difficult to understand how particular outcomes were achieved. In the Family Liaison Council case study, for example, we found that the terms of reference described the Council as being advisory to the health region’s board, but data showed that it also advocated for systems change.
in other sectors (e.g., education, social services) that impact the health of children.

Over time, a given public participation initiative may use a number of techniques to facilitate broader policy community involvement. Following the two-sided arrow from the Public Participation Initiative to the Policy Community below it in Fig. 1, this may be seen as a legitimate goal in and of itself, without requiring immediate linkage to a change in health policy. The Aboriginal Health Council, for example, hosted conferences with a goal of fostering broader community discussion of how to make the health care system more responsive to the unique needs of Aboriginal peoples. Each of these conferences could have been evaluated for their effectiveness, and assessed in terms of relative contribution to the goal of health sector reform, recognizing that to do so systematically would be a costly research project. Even if the number of voices asking for a particular change in the health system increased, and this could be attributed to participation in the conferences, we know that momentum for change in the health sector usually comes from several sources and that linking a decision in the health system to these conferences would probably have been impossible. Furthermore, there is a feedback loop because the processes in public participation initiatives may subsequently be influenced by the very changes in social context that are sought. More voices for changes in Aboriginal health policies may sometimes deflect attention from the Council, for instance, and sometimes give it more influence.

The history of the Family Liaison Council further illustrates the role of social context, in this instance, the impact of government economic policy. In certain years, the Council played a very active role in policy making, while in other years it was virtually inactive. After a period of quiet, the Family Liaison Council
became every active in the face of threats to close a children’s hospital in the name of cost reduction. In recent years, the Family Liaison Council supported the assertion that parents had to be included in designing a new hospital. In this theoretical framework, we have artificially pulled out the public participation initiative from a given policy community, and both from the social context, but as the bi-directional arrows indicate, these are interrelated. This inherent complexity in initiatives, along with other factors that we will discuss in subsequent sections, often makes it impossible to draw a causal link between a particular public participation technique within an initiative and a program decision in the health sector.

Another important point is the temporal nature of these processes. Examining an initiative at one point in time can give you only a partial understanding of whether and/or how decisions are influenced. In the case of the Family Liaison Council, for instance, the Council made a formal request to the Canadian Association of Pediatric Hospitals to establish a consumers’ group to be part of that association; the request was denied. In 2003, at the conference of the renamed Canadian Association of Pediatric Health Centers, a day of sessions for families was held and representatives from the Family Liaison Council took part in discussions of forming a national coalition of pediatric health center family advisory committees. Undoubtedly, many other events and factors led to these discussions in 2003; nevertheless, the fact that the Family Liaison Council continued to exist and to see recognition of families in this organization as an important outcome, allowed them to influence the decision. There were numerous other examples collected across the case studies of policy or other kinds of decisions being enacted many months, and often years, after a recommendation had come from the public group.

3.2. Policy making process within the health region

In an early version of this framework, the component in Fig. 1 entitled “Policy Making Process within the Health Region” was simply a small black box labeled “Decision-making within the regional health authority”. It was in discussing this small black box that we realized the irony of its existence; that is, many papers on public participation treat health sector decision-making as a black box into which the public inserts information and out of which comes decisions about health policy. We believe this is attributable in part to the focus on health region decisions as the outcomes of public participation processes. As we looked more closely at our data and the outcomes and successes discussed, we turned to the literature on policy development, public policy and organizational change to illuminate this black box. As Fig. 1 suggests, the policy making process within the health region is not bounded by organizational borders. Instead a political space for issues and constituencies exists where problems, solutions, and policy windows can be identified. Four types of policy outcomes are identified, and these may or may not actually result in action or implementation. Each of these parts of the policy-making process will now be discussed in more detail.

Policy-making is neither rational nor linear; rather it is a complex political process that is influenced by a multitude of factors both internal to and external to the health region. In our theoretical framework, this is shown by depicting the policy-making process taking place within a political space that is nested within a number of intersecting policy making environments. The policy making process within the health region is seen to take place within a political space (Fig. 1). The public participation literature traditionally has focused outcome assessment primarily on decision-making [23,31,32,42–44], with the focus often being on governance level policy and decision-making (i.e., decisions taken by health authority boards and senior managers). Our data supports the view that policy and decision-making is a complex process [9,45,46] and that outcomes can be conceptualized in a number of different ways. The political space, therefore, incorporates much more than the health region, although the ability to make decisions and statements will be limited to those granted authority by the organization.

Webster and Engberg-Pederson [39] conceptualize political space as being shaped by mechanisms available to the public to influence policy; by prominent discourses that create willingness to address policy issues; and by the capacity of groups to access policy processes. A public participation process may seek to change the political space within which policy is shaped, and as others have noted [8,39], the process is mutually affected by that political space. Public participation initiatives may take place in other political
environments that subsequently influence the local political space (e.g., lobbying the provincial government for health sector reform). At the local level, the data collected through this research illustrates that a public participation initiative is most often only one of many factors contributing to any particular decision or statement made by a health authority. The relationship between an initiative and a decision is usually not one of simple cause and effect; and success in creating a conducive environment for a particular policy orientation may be just as important a contribution of a public participation initiative in the long-run as providing advice in drafting a specific policy decision.

The political space faced by public participation initiatives is influenced by the characteristics of the health organizations involved. An ecological model of organizations recognizes that individuals both shape and have their behaviour shaped by the organizations in which they operate [47,48] and that these organizations are influenced by external environments. Organizational culture can be seen through practices, expressive symbols, values, and beliefs that shape what is appropriate behaviour in that organization. Organizational culture is important in how it affects the ability of managers and others to achieve their goals [49]. It can have a significant impact on the ability to introduce change into an organization, either from the bottom up or from the top down in a hierarchical bureaucracy. Informants both from inside and outside of the health region predominately discussed aspects of organizational culture that impeded the effectiveness of participation (e.g., culture of secrecy, fear of reprisal, domination of physician views). Consistent with the observations of Webster and Engberg-Pedersen [39], community organizations were also reported to have cultures that sometimes made collaborative relationships difficult (e.g., supporting competition for social status and power).

The public policy literature suggests that two processes (problem development and solution identification) interact to create an opening (a policy window) for a policy change [33,45,50]. For the purposes of our theoretical framework, problem development is referred to as the problem stream and solution generation and selection as the policy stream [45]. A public participation initiative can aim to affect one or both. Whether this then leads to a policy decision is affected by the creation or identification of a policy window. The policy stream and problem stream processes interact and also influence the public participation initiative. The Health Advisory Council, for instance, served to provide analyses of problems in health service delivery and to propose possible solutions that would be acceptable to both front-line providers and senior management. The Council originated in, but also served to reinforce, a political space where the inclusion of perspectives other than those of physicians was considered important by the health authority. One of the Council’s functions was to identify policy windows or strategic times to make certain recommendations to the health region board.

In order to affect policy, both identifying and creating policy windows in health regions are important to public participation initiatives. Our data suggest that two types of policy decisions, governance and operational, should be included when designing and assessing the impact of participation initiatives on policy. A focus on governance level policy decisions (i.e., those made by boards) will exclude many of the successes that public participation initiatives achieve in policy change, thus the need for recognition of operational policy decisions. Further, attention should be paid to governance and operational policy statements. (We distinguish policy statements from decisions by the degree and type of documentation that is involved. Governance and operational decisions were usually formally recorded and disseminated using formal administrative processes). Given the context and competing priorities of the decision-makers, a governance policy decision may or may not get made. In the case of the Grace Women’s Health Services, for example, the existence of a policy window supporting the uniqueness and importance of women’s health, supported by an active and powerful policy community, led to a governance policy decision that supported the maintenance of a women’s health center within the newly created health region, albeit in a reduced form. Competing priorities, in a context of shrinking health care resources, led to a compromise decision where the women’s health program remained but without maternity services. The partnership agreement governing the relationship between the Salvation Army and the health region was a governance policy decision captured in a formal legal document establishing reporting mechanisms. Also documented was an operational policy decision that abortion services would not be provided in
the programs operated by the Grace Women’s Health Centre.

Even if no governance level decision gets made, the public participation process can directly influence operational decisions through either the policy and/or problem streams. While it is often assumed that governance level support is essential for changes to occur, significant changes can be made at a lower level of administration where resource allocation often takes place.

The effect of a public participation initiative on governance or operational policy statements may be more difficult to capture for the evaluator than the impact on a policy decision. This is one reason why it is important to look over an extended period of time when evaluating the effectiveness of public participation. The existence of the informal, unwritten policies can be determined through interviews, analysis of minutes and in cases where they result in action, by observations of activities and behaviours over time. What emerged strongly from the case study data was that public participants most often described the accomplishments of a particular public participation initiative by the changes on the ground that they could see; that is, they judged their success through operational policy changes, many of which were a change in the way things were done rather than a change resulting from governance policies. This is not to say that important governance issues were not identified, such as the creation of the Aboriginal Health Council and room on the health region board for a representative of that Council, but the majority of successes were operational.

Finally, even though decisions are seen to have been made (governance or operational), whether or not action follows is another consideration for evaluation of public participation processes. Sometimes a decision is actually that no action will be taken, and this can happen at either the governance or operational levels. “No action” can mean that a recommendation obtained through a public participation initiative is accepted but any action is deferred or the recommendation can be rejected outright. Similarly, action can be taken at the operational level to respond to public input while the governance level response is that no action will be taken. Within this framework then it is necessary to be clear on a number of possible outcomes when assessing public participation effectiveness, and to differentiate formal from informal policies, and decisions from actions.

3.3. Social context: symbolic and political institutions

Our theoretical framework draws on Gidden’s structuration theory [51] to explain the impact of broader social factors on public participation. Social context is created by institutions and understood to be clusters of rules and resources sustained across time–space and among social systems (i.e., symbolic, regulatory, political, and economic). A major change or event in any of these social institutions or social systems can have an effect on a public participation initiative, either directly on the initiative and/or on the policy community and/or the political space it faces [52]. The regionalization of health services in Alberta, for example, had impacts on all five of our cases. The Aboriginal Health Council became a community health council under the Alberta Regional Health Authorities legislation. The Family Liaison Council ceased to have any formal reporting relationship for a period of years post-regionalization, because the children’s hospital board with which it had had a formal reporting relationship ceased to exist. The impending closure of the Grace Women’s Health Centre at the time of regionalization created the impetus for a new partnership. The Health Advisory Committee was formed shortly after regionalization as a mechanism to obtain frontline health care professional input into planning and decision-making. The Calgary Health Region Diversity Initiative developed out of a need, post-regionalization, to bring together a number of pre-regionalization organization-specific diversity initiatives under a regional umbrella.

There were other factors in the external environment that affected the public participation initiatives examined in this research project. The Aboriginal Health Council processes and structure, how it related to the health region, were influenced by the broader context. For example, the Tribal 7 Band Council was not represented on the Aboriginal Health Council because of ongoing negotiations with the federal government around self-government and responsibility for Aboriginal health. In the Family Liaison Council and Salvation Army partnership cases, Federal-Provincial funding arrangements, along with other economic factors, led to the decision to close hospitals. Members of the public were confused about whether hospital closures would have occurred regardless of regionalization. The
economic factors occurred in the same time period as the devolving of authority to the local level, but all the levels of government retained some power through the legislation and through funding mechanisms. This led to some mistrust between many members of the public and the health region, which affected the public participation initiatives we were studying.

Symbolic institutions (i.e., gender, race, art, and religion) are inherent in defining and demarking political space [40,53–55]. Feminists, for instance, were automatically assumed to be in an adversarial position with the Salvation Army–Calgary Health Region partnership because of the Salvation Army policy against abortion services. Yet the Grace Women’s Health program developed a woman-centered model of care consistent with feminist principles, had feminists on staff and ensured that individuals got counseling around abortion. A separate operational arm was responsible for abortion services provided by the health region. In the Family Liaison Council case, women dominated the membership throughout the Council’s 30-year history.

Drawing on structuration theory to understand social context highlights the issue of power. Our research findings are consistent with Clegg’s conceptualization of power being fluid and circular, and ultimately about influence [56]. Power is the ability to decide what is important, what is not important, what is a benefit or a loss, and what the goals of a public participation initiative should be. This means that one can wield power without necessarily having decision-making authority. Achieving collective power is partially dependent on having a sense of commonality, of experiencing common struggles. The public participants in our case studies rarely overtly spoke about power, particularly with respect to obtaining power or having power over others, but they did talk about influence. Public participants had a desire to have an effect on the policies being developed and decisions being made, to the extent that these affected how health and related services were being delivered to their population of interest (e.g., Aboriginal people, women, children, people from ethno-culturally diverse communities). Our data show that public participants directed actions towards the broader community rather than just the health region. They were aiming to affect public opinion, to shift how groups and/or positions were framed [57,58], and to affect the political space within which they operated. Ultimately, they were attempting through these broader actions to increase their ability to influence policy. The focus, primarily, was on collective rather than individual influence.

An important theme emerging through the five case studies was the importance that public participants placed on the profile and credibility of a public participation initiative, with respect to its ability to influence policy at some level. Another finding was that the public the level of influence changed as a result of what was happening in the social context. Parents of children with health problems or people from diverse ethno-cultural communities, for example, could have little influence at some times and then something happened in the organizational and/or social context that increased their influence. Public participants tended to look within themselves or within the initiative that they were involved with (e.g., a standing advisory committee; a task force) if their ability to influence policy seemed to be decreasing. Yet it was often the changes that were going on around them that were having the greatest impact on their ability to influence. In our theoretical framework, the overlapping of these environments indicates the interrelationship between the social and symbolic institutions (i.e., regional government and other sectors; other levels of government; non-governmental, non-profit organizations) within which the regional health policy-making process is imbedded.

3.4. Policy community

Included in the broader social context is what Howlett and Ramesh [45] refer to as policy communities. A policy community is defined here as those people who share an interest in a specific policy topic. Members of policy communities may have different types of expertise but share a common policy focus and knowledge with respect to a policy area (e.g., family-centered child health care; culturally sensitive care). In our theoretical framework, the policy community and the public participation initiative are both situated in the broader social context. As is depicted, a policy community is comprised of a number of networks and/or advocacy coalitions. Policy networks can be defined as subsets of members of a particular policy community that interact on a regular basis. Advocacy coalitions are defined as a subset of actors who share a set of beliefs and who seek to use the rules, budgets and personnel of public organizations to achieve goals. A public participation initiative can be an advocacy coalition. Some
policy communities are much larger and/or more organized than others. The data from our research project indicated that the child/youth policy community was large but not particularly well organized. In contrast, both the Aboriginal and the ethno-cultural policy communities were smaller but better organized and connected to local and provincial advocacy coalitions.

The results of the community survey component of our research project suggested that a large number of members of a policy community would not see themselves as having a health focus and having any interaction with the health region. They would be unlikely to get involved in a public participation initiative developed by the health region and/or to participate in a health region-led network or coalition. Federal and provincial funding arrangements directly affect the number of non-governmental, non-profit organizations that exist in a particular policy community [59]. In the case of the Diversity Initiative, some study participants described the lack of organization of some ethno-cultural populations (usually defined by country of birth) as a barrier to involving these populations in policy-making, with the lack of government funding a direct and major contributing factor to this lack of organization.

The concept of representativeness is connected to this description of a policy community. The public participants involved in the five case studies were often sought out to join a public participation initiative because of their involvement in a policy community. Sometimes they were explicitly asked to represent a particular network or advocacy coalition. Other times they were asked to represent an entire population (e.g., all parents; all aboriginal people; all community-based, non-traditional health care providers). Many of our study participants felt that the expectation that they speak for whole populations was unrealistic, finding that is supported by other research [18,60,61]. Unless there were available communication channels to readily connect the chosen representative with everyone they were supposed to be representing, there was tension associated with representation. Some participants tried to make a distinction between representing a population and bringing a perspective as a member of a particular population. On the Family Liaison Council, for example, parents described trying to bring a perspective as a user of health care services on behalf of their child(ren) based on their own personal experiences and those of other families that they were in contact with. They often described feeling that they could not represent all parents whose children used regional health care services. This description of representation fits what some authors call experiential participation [8]; that is, public participants feel that they can understand many of the needs and experiences of those they are trying to represent because of common shared experiences.

Several people stated that providing advice that contradicted the status quo often meant that they were accused of being uninformed or not representative of the community. If they were linked to a specific network or advocacy coalition (e.g., professional association, immigrant service organization, patient support group) they might also be accused of having a single focus or special interest and being atypical or not representative of the broader population [57]. The conceptualization of a policy community should lessen concern about control of “vested interests” [9] (p. 248) or “community ‘agitators’” [62] (p. 157) and replace it with a need to understand and/or evaluate the characteristics of the whole policy community.

While some public participants may benefit from being connected to a network and/or advocacy coalition for support [43], these cases studies have illustrated that an overly optimistic assumption is that these networks will have the capacity to support participants in health policy development. Further, the benefits of participation in a policy network (e.g., a sounding board for ideas, learning about others’ experiences with the health sector and skill development) must be balanced with the time and energy costs required. Burnout was talked about by those members of the public who had served for a long time on a public participation initiative, at least partially because their involvement in such an initiative often led to multiple invitations to get involved with other groups in the policy community.

One of the possible outcomes of a public participation initiative may be its contribution to building the capacity of a policy community. Public participation initiatives can create social elites in the policy community, which may be seen as a negative [60,63] or a positive [64] outcome. Both individual and group capacity building emerged in our data as valued outcomes of public participation initiatives. This is illustrated in Fig. 1 by the wide, two-headed arrow between “public participation initiative as a process” and
“policy community”. Affecting the policy community can thereby change the political space and the government and non-governmental sectors. This is in keeping with the understanding of a policy community and the micro–meso–macro-level interfaces between systems [65].

3.5. Health of the population

In all of the public participation initiative case studies, health was broadly defined to include more than the absence of disease; it was seen as a balance of social, physical, emotional, spiritual, and social determinants. Ultimately, health region policy development and implementation can effect the health of the population, but it is widely accepted that health services are only one determinant of a population’s health. Much of the existing literature does not focus on the health of populations as the ultimate outcome desired as a result of public participation processes. The evaluation interest expressed in the literature is often limited to whether a “better decision” was made than was possible without public participation and does not extend to whether the decision had an impact on population health. As our framework indicates, public participation can lead to a governance level decision to implement a policy, which can lead to an operational decision, and ultimately a formal or informal operational policy. However, unless there is actually some form of action there can be no direct impact on the health of the population. Failure to act means that resources have been committed to public participation with no resulting impact; in health economics terms this is an opportunity cost.

In a health promotion framework, capacity to affect the environment is a determinant of the health of populations. Improvements in the size or influence of the policy community, therefore, may be seen as a direct indicator of the health of the population and a measure of success of a public participation initiative. Public participants involved in an initiative can gain skills that they then take with them to their work in a broader policy community. These participants can use these skills to advocate for change in other sectors that affect the health of their population of interest and/or teach these skills to others within their policy community in order to increase the capacity of the entire community to do so. An evaluator should again be concerned about assessing this over time as there may also be unintended negative outcomes. Most of the members of the Aboriginal Health Council, for example, worked in community agencies that served Aboriginal people. Time that they spent sitting on the Aboriginal Health Council and or working on related projects was time that they then did not have to spend working directly with Aboriginal people as clients. Participants in several cases also talked about the non-profit sector subsidizing the public sector through their work on various public participation initiatives and putting a strain on the resources of the non-profits. An important finding of our research was that members of the public did not participate solely for gains in knowledge or other capacities; they were interested in making a difference in the health status of their population of interest. Therefore, while improved capacity may be an important intermediate outcome of interest, the linkages to health status should also be made when developing policy responses.

4. Discussion and conclusion

This study looked at public participation to change health policy. The framework and findings are consistent with Rutter’s work on healthy policy outside of the health sector [52]. His discussion of a cooperative planning group is an excellent example of one type of initiative to engage participation in policy development. Similarly, our framework is compatible to that of Milio [66]. Although our general findings are in keeping with Milio’s general conceptualization of policy as “changing the decisions of organizations about their use of resources” (p. 367), we think it is important to distinguish governance and operational policy. Our framework also expands on Milio’s description of a policy environment and policy processes.

The key implications for evaluation emphasized in this model first include the need to think of public participation as a process that unfolds over time and to distinguish techniques of public participation within this process. In order to evaluate the effectiveness of public participation initiatives, it is important that an evaluator can be clear about what a particular participation initiative includes. Second, there is a need to clarify the intended outcomes of a participation initiative, what it is trying to effect. This requires, third, that the mechanisms through which public participation are intended
to improve population health be specified so that the processes can then be monitored. Fourth, when the effects can be expected to appear needs to be considered. These four foci are not independent.

In determining what an initiative includes, various techniques to engage groups can be adopted and each of these will have its own literature and criteria for effectiveness. The evaluator may have to query, for instance, the potential of various techniques to have an impact on the policy community, the political space, the policy stream, or the problem stream of the local health sector. The public participation initiative may also seek to influence other levels of government or non-governmental organizations, and the evaluator can again ask whether there is reasonable cause to think that this will occur. Outcome evaluations should be based on an understanding of the complexity of the policy and decision-making processes, the many opportunities to influence actions, and both the short- and long-term outcomes of participation techniques and initiatives. Both organizers and participants in public participation need to remind themselves of the differences between governance and operational health policy-making, and formal versus informal policies. They need to consider the iterative nature of the policy making process and to use evaluation to inform the strategic adjustment or modification of the public participation initiative and its techniques.

Ultimately, what people in a public participation initiative care about is the health of the whole population or a sub-population. If insufficient knowledge is available from policy analysts concerning the potential benefits of health sector action, then the focus of the participation initiative may stop at building the knowledge base or policy stream. Articulating the desired outcomes of public participation in regional health policy may help decide whether or not to proceed with a particular participation initiative. If a policy decision has already been made, for instance, the model suggests that informing some part of the policy community is more appropriate than creating a public participation initiative. Health sector decision-makers should be encouraged to ask, however, whether an initiative exists and how it will be effected by or could effect the decision taken. Health sector managers and governing bodies can also ask a range of questions when assessing whether a public participation was worthwhile. However, it must be remembered that maintenance of organizations and networks of non-professionals, even those that are relatively small and loosely organized, is an important way of ensuring an infrastructure through which community members can organize to voice their perspectives when the need arises. Deciding that a specific initiative supported by the health sector has been successful and should be ended could simply recreate the need to create a forum for the participants.

In understanding the mechanisms of public participation and why an initiative or technique will be or was successful, it is necessary to assess the social context within which an initiative takes place. We stress understanding the role of symbolic institutions rather than simply describing the material or structural resources. Moving beyond simplistic notions of power and empowerment will assist in understanding the policy community and the political space. In this complex policy development and implementation process, power goes far beyond knowledge levels and acquisition. The public participants’ ability to influence decisions is not primarily about their level of information about a given health issue. Policy-making processes and structures are not equitable or transparent; nor do they often produce visible or material outcomes. It is simplistic to suggest that all public participants need is access to information in a rational decision-making framework to produce visible outcomes. Describing the broader policy community and clarifying expectations around representation will improve understanding of effectiveness of participation initiatives.

Understanding the political space within the local health authority concerning any specific health problem or issue will also aid in assessing effectiveness of public participation. The expert model of decision-making that dominates the health sector may be incompatible with successful public participation. Unless there is a belief that broad based policy communities result in better-informed decisions, that is, that the lay public has an important perspective to bring to health policy development and implementation, then focusing on the methodological debate over the most effective means of involving the public may be premature. The results of this research clearly support Tenbensel’s [67] conclusion that “methodological improvement is admirable as long as it is not accompanied by the belief that methodological sophistication can solve fundamental political problems” (p. 192).
We believe our theoretical framework is a good start at making more explicit the factors that may be consid-
ered in assessing the processes and outcomes of public participation in health policy development at the lo-
cal level. We have discussed at some length how our research findings informed the development of this the-
oretical framework. Our data did not pertain to public participation in local government or other sectors, other
levels of government, or in non-governmental organiza-
tions. However, the data did indicate that decisions at other levels directly affected the local level and the
opposite may also be true; for instance, new models of primary care being tested in one health authority [68]
is informing national policies. We believe it would be
reasonable to test the framework in these other cases; for
instance, one could ask whether a public participa-
tion initiative could be successful in creating change at
both local health sector and federal government levels.
It seems plausible that the boxes contained in the politi-
cal space of the local health sector would be duplicated
within other sectors of the local, provincial and federal
governments, and within non-governmental organiza-
tions. Our data do indicate that attention to the influ-
ences of the levels of government and organizations outside of the health sector is important in understand-
ing whether and how a public participation initiative
achieved its intended outcomes when directed at the
local health sector.

As studies that employ and test this framework accu-
mulate, we propose that they will provide the richness of
data that will ensure that comparability of findings is
increased, and that practitioners can draw implications
for their practice. The research will necessarily include
collection of data from various sources and consider-
ation of both quantitative and qualitative methodolo-
gies. It could be argued that such research must also
actively engage the stakeholders in order to provide
useful conclusions [66, 69]. A major note of optimism for the public taken from this research is that they can be
more optimistic about their influence on health policy
decisions when the focus is moved beyond governance
and when a long-range perspective is taken.

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