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ORIGINAL ARTICLE

Deliberating with purpose: Deliberative civic engagement for health policy

Joanna Massie

McMaster University, Hamilton, Ontario

Correspondence
Joanna Massie, PhD Student, Political Science, McMaster University, Hamilton, Ontario.
Email: massij1@mcmaster.ca

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Abstract

This article seeks to understand why deliberative civic engagement is chosen as a method of engagement by policymakers, using two jurisdictions as exploratory cases: the Nova Scotia Health Authority's *Community Conversations about Collaborative Family Practice Teams* and Algoma Ontario Health Team's *Citizen Reference Panel on Integrated Care*. The purpose is to interrogate a presumption that deliberative civic engagement is choice driven by an alignment between the goals of engagement and theories of deliberation. I find that in both instances, policymakers chose deliberative civic engagement largely because of situational factors, rather than through the theoretical claims of different methods of engagement and the goals of the engagement activity. I argue that for practitioners seeking to embed deliberative processes, greater consideration should be given to the contextual factors that enable or inhibit the commissioning of such activities.

Sommaire

Cet article tente de cerner les raisons pour lesquelles l'engagement citoyen délibératif est choisi comme une méthode d'engagement par les décisionnaires; nous utilisons deux compétences comme cas exploratoires :

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Les conversations communautaires sur les équipes de médecine familiale collaborative menées par la Régie de la santé de la Nouvelle-Écosse, et *le comité de référence citoyen sur les soins intégrés* de l'équipe Santé Ontario d'Algoma. Notre but est de questionner la présomption selon laquelle l'engagement citoyen délibératif est un choix motivé par un alignement entre les objectifs de l'engagement et les théories de la délibération. Nous constatons que dans les deux cas, les décideurs ont choisi l'engagement citoyen délibératif essentiellement en raison de facteurs conjoncturels, plutôt qu'en raison des revendications théoriques relatives à différentes méthodes d'engagement et aux objectifs de l'action d'engagement. Je soutiens que les praticiens cherchant à intégrer les processus délibératifs, devraient accorder plus d'attention aux facteurs contextuels qui permettent ou entravent la mise en œuvre de telles activités.

INTRODUCTION

Deliberative civic engagement describes the process by which a group of participants learn about, consider and discuss, and weigh opinions to reach a conclusion on a particular topic, usually with the aim of informing policy. There has been increased interest in deliberative tools as a method of public engagement over the last thirty years; deliberative tools have become particularly popular since 2010, leading the Organisation for Economic Co-operation and Development (OECD) to term the current popularity as a "deliberative wave" (OECD, 2020). Although there is rich descriptive literature about methods and processes of engagement, relatively little is known about precisely why policymakers choose deliberative engagement activities—a gap which this research seeks to fill. Rather than being aligned with the goals of deliberation as articulated in deliberative democracy literature, I find that the decision to use deliberative engagement is driven by factors such as a desire to "do something different," or as a tool to manage difficult conversations. Health policy is fertile ground for deliberative methods of engagement. Health policy is often opaque, with multiple actors and interacting levels of government. Participatory engagement is beneficial to health policy, as it can act as the link between citizen and political institutions, and can improve accountability and legitimacy of the health system (Abelson & Eyles, 2002; Daniels & Sabin, 1997). However, deliberation—with its emphasis on trade-offs and public learning—has been particularly noted for its usefulness in complex systems such as health, where there are conflicting public values, high levels of controversy, a need to combine expert and real-world knowledge, and low trust in government (Abelson et al., 2003; OECD, 2020; Solomon & Abelson, 2012).

Using goals of deliberative civic engagement as a starting point, I aim to understand the conditions under which policymakers choose deliberative civic engagement. I explore the extent to which organizations choose deliberative civic engagement based on alignment of goals and methods of engagement. I then look to understand what motivates policymakers in health policy to choose specific methods. I explore these questions through a comparative case analysis, looking at the Nova Scotia Health Authority's Community Conversations about Collaborative Family Practice Teams and Algoma Ontario Health Team's Citizen Reference Panel on Integrated Care.

Both cases demonstrate deliberative practice—a period of learning, followed by group discussion, and the production of recommendations based on public interest. Both processes aimed to understand local concerns and needs. Yet the two processes approached engagement differently: while Nova Scotia Health Authority (NSHA) prioritized breadth of feedback, engaging over 600 participants in 2-h sessions across the province, Algoma Ontario Health Team (AOHT) prioritized depth, working with 33 randomly selected, demographically representative citizens for over 26 h. I develop a descriptive analysis of each process. Secondary research drew on publicly available information such as strategic plans, board minutes, event summaries, and policy reports. Semi-structured interviews were conducted with two representatives from each region.

I first examine theoretical understandings of deliberation and review existing literature on deliberative civic engagement in Canadian health policy. I expect that deliberative civic engagement was chosen as a method of engagement to achieve one or more of the following aims: to explore the issue; to resolve conflict; to foster collaborative action; or to help make policy decisions (Nabatchi, 2012). Contrary to expectations, my comparative case analysis suggests that while policymakers can clearly articulate their reasoning for choosing deliberative civic engagement, these reasons are inconsistent with the theoretical goals of deliberation articulated in the literature; further, the choice to pursue deliberative civic engagement over other methods of engagement is heavily influenced by situational factors, rather than being the result of reasoned consideration of the goals of the engagement activity and methods of achieving those goals.

DELIBERATION IN HEALTH POLICY

Deliberation

Deliberative democracy describes a democratic ideal in which "free and equal citizens, justify decisions in a process in which they give one another reasons that are mutually acceptable and generally accessible, with the aim of reaching conclusions that are binding in the present on all citizens but open to challenges in the future" (Gutmann & Thompson, 2004, 7). Early work by Habermas conceptualizes deliberation as a principle of discourse, where choices are justified if all those affected could accept it in a reasonable discourse; where all those affected is the basis of the all affected principle, and where considered public opinions, with justifications, are indicative of what would be accepted in reasonable discourse (Habermas, 1975, 2006). This forms the basis of deliberative systems: interconnected sites (both formal and informal) of deliberation in which claims are listened to and matched with reasons (Chambers, 2012; Mansbridge et al., 2012; Parkinson, 2018; Parkinson & Mansbridge, 2012).

Recent literature has pointed to the growth of deliberative civic engagement practices, such as deliberative mini publics (OECD, 2020; Owen & Smith, 2015), in large part a response to a perceived "democratic deficit" (Barrett et al., 2012; Michels, 2011; Nabatchi & Amsler, 2014). These deliberative practices may address democratic deficits and crises of legitimacy through bridging the perceived gap between citizen and politician, emphasizing transparency and accountability, and contributing to increased trust in government (Boulianne, 2019; Edelenbos & Klijn, 2006; Goodin & Dryzek, 2006). Deliberative civic engagement "requires that a diverse group of participants take part in an open and accessible process of reasoned discussion," weighing opinions to reach a decision in the public interest based on facts, values, and emotions (Nabatchi, 2012, 9; Fishkin, 2018). Decisions are made by citizens and/or representatives following a period of deliberation, in which citizens learn about a policy area and differing perspectives, consider and discuss these (and their) perspectives, and ultimately reach a conclusion that they deem to be in the public interest (Fishkin, 2009; Gutmann & Thompson, 2004; Nabatchi, 2012; OECD, 2020). Deliberative civic engagement may serve one or more of the following functions: (1) to explore an issue and generate understanding; (2) to resolve conflict, or as Goodin and Dryzek (2006) articulate, to break gridlock in high-tension or values-conflicting environments; (3) to foster collaborative action; or (4) to help make policy decisions (Nabatchi, 2012). However, while policymakers may seek to build trust through these processes, deliberative processes cannot be exclusively trust-building exercises. The institution must be responsive to the recommendations of the public to achieve increased trust (Boulianne, 2019); or as Michels and Binnema claim, deliberation must have "substantive and durable effects" to be anything more than an interesting experiment (Michels & Binnema, 2019, 766).

Deliberative civic engagement is useful for values-based decisions, which makes deliberative processes particularly pertinent in health policy planning (Solomon & Abelson, 2012). Deliberative civic engagement has been used in policy areas including palliative care (Roulston, 2018), health technology assessments (Abelson et al., 2016; Gagnon et al., 2014; Lehoux et al., 2016; Menon et al., 2008), xenotransplantation (Einsiedel, 2002), and biobanking (Secko et al., 2008 Burgess et al., 2008; O'Doherty et al., 2011, 2012). Yet little has been written about the potential of deliberative civic engagement as a tool for meaningful engagement in the health system. Those articles that do focus on system-level analysis tend to focus on specific aspects of engagement. For example, Boyko et al. (2012) identify the core features and intended effects of deliberative dialogues as a tool for knowledge translation and exchange, rather than as a tool for policy development.

Surveying the Canadian landscape

Analysis conducted by the *Public Engagement in Health Policy* team found that of 130 health engagement activities initiated by Canadian governments between 2000 and 2021, 29 (or 22 percent) were considered deliberative (Dhamanaskar et al., 2022). The definition of deliberation used for the case survey was purposefully broad: any mention in the event materials to discussion or similar activities (e.g., panel, committee). As noted in the above section, models of deliberative civic engagement are useful tools for health policy planning because of they create conditions in which participants can have values-based discussions and provide rationale, and they can also lead to increased trust. However, there are concerns that existing models of deliberative civic engagement such as mini-publics may fall short in achieving large-scale or mass participation, instead favouring a smaller group of participants for deep engagement—and in doing so, leading to shortcuts in democracy (Fishkin, 2018; Lafont, 2020). How do these trade-offs interact? Do policymakers choose deliberative civic engagement because of a (perceived or real) outcome that cannot be achieved through other methods of engagement?

There is limited literature about the reasons behind the use of deliberative civic engagement in Canadian health policy. What literature does exist contributes to the burgeoning scholarship of participation, but does not address the specific ways in which policymakers adopt deliberative civic engagement over other methods of engagement, or to what extent choices are made within the spectrum of deliberative civic engagement. Burgess (2014) puts Canada in a comparative perspective against the US and Australia, articulating the extent to which policymakers codesign policy solutions alongside citizens. Litva et al. (2002) focus on the public's preference for engagement in healthcare, finding a strong desire among citizens to be involved and consulted, but a reluctance to carry responsibility for decisions. Abelson et al. (2007) use a comparative quasi-experimental design to evaluate the effects of public participation across five regional health settings between 2001 and 2004. They find that deliberative public participation can be implemented in different contexts and their work contributes to a growing understanding of the factors that affect the success of deliberative processes. Mitton et al.'s scoping review (2009) goes some way to explicating engagement activities in a comparative context. Focusing on priority setting and resource allocation, their literature review finds that traditional approaches to engagement such as opinion polls or surveys, public meetings, or focus groups remain dominant, although there is appetite for conducting a mixed methods approach to engagement, including engaging with multiple publics. Further, they find the field of public engagement lacks guidance on how to incorporate the outcomes of these processes with other forms of evidence, going so far as to say that "there was typically no recognition that different methods might produce different impressions of the public's preferences or consideration of how discrepancies might be reconciled in setting priorities or allocating resources" (Mitton et al., 2009, 227).

Despite a comprehensive search of existing literature, there is a dearth of literature from the last decade; this is surprising considering the increased use of deliberative processes since 2010 noted by the OECD (2020). Although the literature outlined in this article offers guidance for the structure of deliberations and how to understand the role of citizens in these processes, there remains a gap in understanding how policymakers choose specific engagement activities. Solomon and Abelson (2012) suggest that deliberation is a good choice for achieving values-based decision making; Nabatchi (2012) suggests that deliberative civic engagement can help policymakers to achieve one or more of the following goals: to explore the issue; to resolve conflict; to foster collaborative action; to help make policy decisions. Both arguments suggest that policymakers consider their options for engagement and choose deliberative civic engagement because it is the method most aligned with their values. Yet we lack knowledge about the practice of deliberative civic engagement, specifically: what leads policymakers to choose deliberative civic engagement as a method of engagement; and what motivates policymakers to choose specific methods of deliberation over others?

METHOD

To understand the conditions under which deliberative civic engagement is chosen as a method of engagement, I sought two cases that demonstrate distinct deliberative processes. The starting point was the case survey developed by the Public Engagement in Health Policy team

(Dhamanaskar et al., 2022). The case selection was done in such a way as to achieve the twin goals of: (1) a representative sample; and (2) variation on the dimensions of theoretical interest (Seawright & Gerring, 2008). Initially, the research design was to explore why policymakers choose deliberative processes such as deliberative mini publics or citizens' reference panels rather than other forms of civic engagement. However, given the lack of prior research in this area, we chose a case selection that could aid with exploratory research rather than hypothesis testing, and we were interested in understanding the variety of deliberative methods. We chose a diverse method of comparison (Gerring, 2017; Seawright & Gerring, 2008). The consequence of this is that we may not achieve full representation of deliberative methods but can claim that these cases are representative in the minimal sense of capturing variation (Ibid). Once the method of case selection was chosen, we looked to cases that represented the diversity of variables (province, relationship to the policy process, participant selection method, length of process, and number of participants). While there are unique health contexts across provinces that may imply that a within-province analysis would be more illuminating, we are not focusing on the specific implementation of context-dependent policies. Instead, we are interested in how policymakers choose to engage—a trend that is happening across Canada. This approach is also consistent with prior comparative research in areas of non-health deliberation (e.g., Johnson, 2015).

Nova Scotia's *Community Conversations* was the most recent deliberative engagement activity held at the provincial level. The case survey list was also cross-referenced with cases explored in the literature described above. Algoma Ontario Health Team's *Citizen Reference Panel on Integrated Care* was known to the research team as a recent model of deliberative civic engagement which adopts a specific process, a citizens' reference panel (also known as a deliberative mini public). These cases demonstrated variation in the key areas of comparison: relationship to the policy process, participant selection process, number of participants, type of event (one-off vs. series), and type of engagement. In summary, Nova Scotia emphasized breadth, choosing a broad understanding of deliberative civic engagement in which participants took part in a 2-h event; and Algoma, where participants engaged in a deep engagement process that aligned with a structured process of deliberation, a deliberative mini-public. The cases are presented in Table 1.

TABLE 1 Cases for comparison.

	Community conversation	Citizens' reference panel
Province	Nova Scotia	Ontario
Level of government	Provincial	Regional
Commissioning agency	Nova Scotia Health Authority	Algoma Ontario Health Team
Year	2016-2018	2021
Method of engagement	Roundtable discussion	Deliberative mini public
Typical event length	2 h	4.3 h
Number of events	25	6
Type of event	One-off	Series
Citizens engaged	600+	33
Method of recruitment	Self-selection	Stratified random sample

This analysis draws on two main sources of information: (1) "grey" literature, such as policy documents, board reports, event promotion materials, and process reports; and (2) semi-structured interviews conducted with practitioners working in each case. I conducted a review of academic and grey literature relating to the origins, process, and outcomes of the engagement exercises, and final or summary process reports provided much of the procedural details. I analyzed board meeting notes and strategic plans in both Nova Scotia and Algoma for references to public engagement more broadly, and these processes specifically. Interview candidates were identified from publicity materials and reports. Between February and March 2022, I conducted four semi-structured interviews with actors involved in commissioning or hosting these engagement processes. Two interviews were conducted in each region; for Nova Scotia Health Authority these were with a Director and a Colead; in Algoma these were with an OHT lead and a patient partner. The quotations that follow come from these interviews. Participants are referred to pseudonymously.

NOVA SCOTIA HEALTH AUTHORITY: COMMUNITY CONVERSATIONS ABOUT COLLABORATIVE FAMILY PRACTICE TEAMS

Background

The Nova Scotia Health Authority (NSHA) was established in April 2015, bringing together nine district health teams under one provincial authority. Under the Health Authorities Act (2014), among other clinical and service provision responsibilities, NSHA also carries responsibility for "engaging with the communities they serve, through the community health boards." The NSHA's inaugural strategic plan was published in 2016, and central in the strategic directions was a commitment to engage "with Nova Scotians to create a healthier future" (Nova Scotia Health Authority, 2019, 46). In addition to outreach through the community health boards, NSHA sought to engage "the public and key stakeholders to collectively understand the population of Nova Scotia as it relates to health services and supports required" (Ibid). Further, NSHA established an online platform to connect citizens to conversations and consultations held across the health authority, *engage4health. ca*. While most community engagement resources in NSHA are to support the legislated community health boards, there is also a team whose primary responsibility is to build engagement capacity in the organization and supporting corporate engagement initiatives (Director, interview).[1]

In 2016, NSHA began to engage stakeholders and patients in conversation about the role of collaborative family practice teams (CFPTs) in Nova Scotia. Underlining a shift towards greater collaboration in care, CFPTs in NSHA sought to bring together a breadth of health practitioners under a single team, to "provide co-ordinated and comprehensive care that meets the health needs of individuals and their families" (Nova Scotia Health Authority, 2018a). Between 2016 and 2017, NSHA held network meetings and webinars with family doctors and staff in primary care; and hosted discussions with elected leaders at the municipal levels, First Nations Band Leaders, and members of the legislative assembly. This provided a wealth of information, including how to tailor information presented during the sessions to reflect local needs (Colead, interview).[2] In 2018, the NSHA held 25 community conversations about collaborative family practice teams across Nova Scotia. Advertising for the community conversations defined two primary goals: (1) to get reflections on family practice teams, and (2) to learn how to make these family practice teams a success at a local level. They were also an outreach exercise—to "connect with the community [and] to have them hear what [NHSA has] been planning" (Nova Scotia Health Authority, 2018b). Meetings were held in all major communities across the province, focusing on community hubs within each county.

Process

In the 2-h workshop, attendees were presented with information about team-based care. The information was presented to them in three forms: a video that explained what a CFPT was; a patient story about their experience with a CFPT; and a presentation that went into more detail about the roles in a CFPT. Participants were then asked to take part in discussion at their tables. They were given prompts, to discuss what they liked about family health teams, what concerns they had, and to share information about their community regarding access to primary care. These table discussions constituted the bulk of the meeting: 90 min of the 2 h. Participants were encouraged to note down key points during the discussion, and during the plenary session, each table reported back themes from their conversations. Although one interviewee did highlight that it was likely "on the inform/consult side of the IAP2 engagement spectrum"[3] (Director, interview), the table discussion format allowed for conversation between participants in such a way that reflects deliberative intent. Participants were presented with information, then given time to discuss and share their experience with their tablemates. Summaries of the discussions in each meeting were posted online after the event, and shared with participants via email.

Meetings were promoted through print advertisements in community newspapers; Facebook geo-targeted (county-wide) advertisements; public service announcements on local media (radio, newspaper, TV); community dissemination through elected leaders, community health boards, and community groups; and posters distributed in community locations. Over 600 participants attended these meetings. There was also an option to participate online, both to watch the learning materials and to share thoughts. The website was accessible in English, French, and Arabic, and over 160 participants contributed online. While emphasis was placed on geographic breadth, the open-door recruitment policy meant that they did not attract a diversity of participants; 70 percent of attendees were female, and almost half of participants were in the 55-70 age group (Nova Scotia Health Authority, 2018c), compared with 27 percent of the population who fall into the 55-75 age group (Province of Nova Scotia, 2021). Effort was spent engaging with First Nations communities, including inviting the participation of Elders at the meetings with elected leaders. Although the NSHA organizers considered hosting community conversations within First Nations communities, they were limited by the availability of suitable space for such meetings; subsequently, many meetings were held in close proximity to, but not directly in, First Nations communities (Colead, interview). Aside from the engagement with First Nations communities, no specific steps were taken to foster participation from typically underrepresented communities.

Goals

Underlying these conversations was the fact that these outreach activities were the first public events since the amalgamation of the health authorities: "In my opinion, I don't feel the amalgamation of health authorities was well received, especially outside of urban areas. That was a comment we heard in one of our first community conversations: 'you put a face to the organization'" (Colead, interview). The interviewee continued, "There was some reluctance about people maybe not really liking the model [CFHTs] or not understanding it. And another layer of consideration was that there was a decent amount of people in Nova Scotia who don't have a regular primary care provider, so there were concerns that we were going to get a lot of upset people showing up saying, well that's all well and good but I don't have a doctor" (Colead, interview). There were concerns that an open forum may be dominated by people expressing grievances rather than contributing to a constructive conversation. The project leads spent time considering the structure of discussion, and after seeking advice from the wider NSHA engagement team, the decision was made to host roundtable discussions instead of an open forum. It was also developed using the *Chaordic Stepping Stones* approach (Corrigan, 2016) for the engagement design, which was known to the organizing team, to structure the conversation to be constructive. "We also went through the process saying, what is it that people actually need? What is the purpose? What are our principles?" (Colead, interview). Effort was spent ensuring regional representation: meetings were held in each county, content in the presentations reflected each region, and presenters were from each region's CFPT. This effort was seen as a positive output of the approach, demonstrating "a real intention to go and share information with people and listen to what people had to say, which was meaningful in and of itself" (Director, interview).

ALGOMA ONTARIO HEALTH TEAM: REFERENCE PANEL ON INTEGRATED CARE

Background

The Algoma Ontario Health Team (AOHT) was officially established in 2020, as one of the 50 Ontario Health Teams (OHTs). The OHT model was introduced by the Ontario Ministry of Health "to provide a new way of organizing and delivering care that is more connected to patients in their local communities" (Ontario Ministry of Health and Long-Term Care, 2021). OHTs differ from Local Health Integration Networks (LHINs) in their emphasis on patient-centred codesign of services, with integration "done directly by representatives of the people served and their health service providers [...] instead of as directed by a LHIN's and/or central Ministerial bureaucracy" (Sinclair et al., 2019). AOHT's mission is to "collaborate in a model of care that is person-centred, efficient, and simplified for both individuals and providers" (Algoma Ontario Health Team, 2021a, 2). The AOHT region is comprised of around 100 000 people, spread over a large and sparsely populated region, with over 30 percent of the population living outside of the major city Sault Ste. Marie. The region is also comprised of Indigenous, Francophone, and low-income populations higher than the average rate in Ontario (Algoma Ontario Health Team, 2019).

The newly established OHT outlined a series of steps for engagement in their 2021-22 Annual Plan, to ensure that citizens were meaningfully engaged and driving priority-setting in the region. These commitments to engagement included holding a Citizens' Reference Panel, developing a patient engagement framework, and testing and launching a Caregiver ID program. Each of these pillars of engagement sought to "upstream patient and community engagement and codesign to ensure [their] work is truly reflective of the needs of [the AOHT] community" (Algoma Ontario Health Team, 2021a, 20). The Citizens' Reference Panel was articulated as an opportunity to ensure that initiatives were co-designed with system users; to hear about what matters most for Algoma residents; and to contribute recommendations for health challenges faced by Algoma residents (Algoma Citizens' Reference Panel, 2021; Algoma Ontario Health Team, 2021a). Participants were "truly representative of [the] community" (Algoma Ontario Health Team, 2021b). Regardless of whether or not these processes fulfil a gold standard definition of codesign (e.g., Moll et al., 2020), the language articulates an intent and direction to embed citizens into the policy design process.

Process

In March 2021, 7500 households in the Algoma region received an invitation to volunteer for a Citizens' Reference Panel from AOHT. They were asked to "identify guiding principles for integrated care and make recommendations about how to improve the health system in Algoma" (Algoma Citizens Reference Panel 2021, 10). The Reference Panel would meet for six online sessions over 3 weekends in May 2021—three evening sessions and three full-day sessions, for a total of 26 h. The letters went to households in the Algoma region randomly selected by Canada Post. This was complemented by outreach from local health and social services agencies, to select patients and clients.

Of those who volunteered, 36 participants were randomly selected by civic lottery to ensure that participants were representative based on established criteria. Demographic data included geographic location; age, gender, and socioeconomic status; whether they had access to a family doctor or nurse practitioner; whether they were a frequent user of health services; and whether they identified as racialized, a visible minority, Indigenous, or Francophone. Of those 36, 33 participants were able to engage in the full process. The deliberative process and civic lottery were delivered by MASS LBP, a consulting firm that specializes in long-form deliberative processes. As well as running the civic lottery, MASS LBP were responsible for developing the program and hosting and facilitating meetings.

Following a standard deliberative structure, participants primarily spent the first 2 weekends learning about the AOHT, hearing from stakeholders and experts, identifying shared values, and brainstorming issues and solutions. They spent the final weekend in small group discussions, ultimately developing a set of recommendations which were presented to the AOHT team. The final recommendations were shared with the AOHT and have subsequently been used to shape the AOHT's strategic plan: "Many of those [Citizens' Reference Panel] members may think now what,' but we are using the [final report] that we received as our compass—guiding our work as we go forward, and embedding their language in the process" (Patient partner, interview).[4]

Patient engagement was part of the AOHT's initial application to become an Ontario Health Team. The AOHT committed to establishing an advisory council, developing an AOHT patient declaration of values, and holding community engagement sessions. In part this was driven by the region's unique geography: it is large and sparsely populated, so, as one interviewee said, "the experience in 'the North' [of Ontario] is different. People have to travel even for a family doctor; if our hospital closes, there's nowhere else to go. [Because of this …] we really need to have their voices at the table" (Patient partner, interview).

Goals

The team sought to conduct engagement that incorporated a diversity of voices. Given the emphasis on codesign within the OHT structure, the team was looking to invest in a model of engagement that would be different: "The focus of OHTs isn't necessarily about getting feedback from patients, it's about codesign. So to me, if we wanted to do something more deliberative, we really had to invest in it. Something different to the regular, to seek broad engagement" (OHT lead, interview).[5] Organizers were also looking for an activity that could both refocus the OHT on the community, rather the disparate members of the OHT, and unite the OHT behind a "shared goal, and bring the different partners and organizations together" (OHT lead, interview).

One member of the team was familiar with deliberative activities and suggested that the OHT consider a citizens' reference panel as an engagement tool. It was decided that outsourcing the engagement activity would be the most effective approach, given that the team at AOHT was small: "they [MASS LBP] had the capacity to do the whole process for us, and it was tried and tested" (Patient partner, interview). Further, it was a way in which the team could allocate money in the budget that they were otherwise unable to spend: "The budget was about $80k and there was no way we were going to use all of our funding on salaries and stuff, so I sensed that it was something I could push through [...] I didn't think hiring an individual would have the same level of impact, and I don't think they would have been able to move so quickly" (OHT lead, interview). Hiring of the engagement firm MASS LBP happened through the regular procurement process. Interviewees provided additional justification of the cost: "Because the region has such wide geography, doing small engagement activities in the region with 20-25 people in one community can still cost $30k for travel" (OHT lead, interview).

DISCUSSION

In both cases, the goal was to gather input from the community about the structures of healthcare in the region. In NSHA, this goal was secondary to a goal of information-sharing; to inform and consult about changes to the structure of family health teams. In AOHT, the goal was to gather input, particularly from a broader range of the community, including those who cannot or do not normally participate in such conversations.

Goals

The four goals of deliberative civic engagement articulated by Nabatchi are: (1) to explore an issue and generate understanding; (2) to resolve conflict; (3) to foster collaborative action; or (4) to help make policy decisions (Nabatchi, 2012).

In both cases, the engagement sought to explore an issue and generate understanding. This was clearest in NSHA, which clearly articulated goals gathering reflections on family practice teams and learning how to make these family practice teams a success at a local level. However, in the case of NSHA, that was the only goal which appeared to be present. Although it is possible that the community conversation did go some way to resolving conflict, addressing tensions resulting from the amalgamation of the health regions, this was neither an articulated goal nor was it part of the process design. For AOHT, the goal was multifaceted: they sought to explore the issue and to aid with strategic planning, but further, they sought to use the activity as a method of fostering collaborative action between the discrete teams that formed the AOHT. Perhaps unsurprisingly, this motivation to create an activity that united partners was not communicated in the materials related to the citizens' reference panel: instead, language focused on the "expertise of residents" and including "voices from the community in planning for our upcoming projects" (Algoma Ontario Health Team, 2021b). Even though the goals were multifaceted, there was limited articulation of these goals as being primary motivators for holding either a deliberative mini-public or a community conversation. Instead, the primary goals were articulated as being about hearing from a diverse audience, in AOHT, and informing the community, in NSHA. While in both cases their goal was broadly about bringing people together, it is unclear that these events were trying to achieve the goal of reasoned decision-making, or to fulfil the all-affected principle. Certainly in AOHT there were claims that were justified, and this was a result of the process selected. However, it is unclear whether these goals could only have been achieved through deliberative civic engagement, or whether other forms of community engagement may have achieved similar goals.

Outcomes

The goals of NSHA were to inform citizens and hear from them about their concerns, as well as being seen to be present in the community. While anecdotally citizens reported positive feedback in seeing a "face of the organization," awareness of the policy process was not measured and there was no meaningful change in the process because of the deliberations. According to one interviewee, based on feedback about a lack of communication, a website was developed to promote CFPTs—however, promotion of its launch was stalled because of the COVID-19 pandemic (Colead, interview). Yet despite this outcome, the community conversations did little to unearth any new concerns, or issues that were unanticipated. Of course, it is possible that this could reflect a particularly empathic and well-attuned health authority that is aware of the dynamics of its population—but it could also be indicative of a process that was not designed to generate new, emergent ideas.

The deliberative civic engagement in Algoma did shape the Ontario Health Team's strategic plan. But it also provided novel insights that were unexpected to the organizers. As one interviewee said, "Most of the findings weren't a surprise, but one that really caught people off-guard was that idea of rebuilding trust in the community. That really tugged at people's heartstrings" (OHT lead, interview). Both interviewees from AOHT emphasized the extent to which outputs of the engagement shaped the strategic plan, but also continue to shape the direction of the OHT. The citizens' reference panel also unearthed a concern of residents that was unexpected: community members expressed having low levels of trust in the medical system. On top of integrating trust into the language used in the strategic plan, AOHT has subsequently seen later activities as being geared towards trust-building. For example, one interview participant highlighted how the region's mass immunization clinics, held over summer 2021, became an opportunity for people to demonstrate working together and being present in the community.

While we cannot draw the conclusion that the issue of trust was only surfaced as a result of the deliberative civic engagement, we can observe that in the process designed for deep deliberative civic engagement, a novel idea was surfaced that surprised practitioners. This is in comparison to the shallow engagement as seen in NSHA, where the emphasis was on discussion between participants, rather than to generate new ideas. A new theme raised during a citizens' panel may be more likely to be heard because of the space given to individual voices, and the size of the group. With over 600 participants and only 2 h per session, it is possible that even if new issues were raised in the Community Conversations in Nova Scotia, the signal may get lost in the noise. By understanding how different engagement processes may entrench or unearth perspectives, policymakers would benefit from understanding the extent to which they are looking for reflections on existing ideas versus unearthing novel ideas, and making decisions accordingly.

Choosing deliberation

Both authorities wanted to engage citizens, and both authorities chose a method of engagement that allowed them to achieve their goals. One interviewee clearly articulated the value of citizen engagement, stating: “When we listen to physicians speak, a lot of them truly know what the community is thinking. But hearing it from the community gives it much more weight. Hearing ‘this is what we need’ is giving a voice to them and giving them authority to guide us” (Patient partner, interview). However, these goals were not necessarily consistent with traditional goals of deliberative civic engagement as articulated in the literature. In AOHT, a combination of having resources available that needed to be used, the lack of capacity to use those resources internally, and a formative time in which novel or innovative ideas were welcome, meant that a citizens' reference panel was possible. As one interviewee said, “I know that on a regular year, I wouldn't be able to get the budget approved” (OHT lead, interview). This supports the theory that deliberative civic engagement is not yet institutionalized in political systems (OECD, 2021); and for policymakers seeking to meaningfully engage citizens, this means considering how to facilitate the conditions to allow for those innovative engagement opportunities. Similar research in non-health policy areas suggests that the motivation of policymakers is key to empowering (or disempowering) citizens, including the redistribution of power (Johnson, 2009). Furthermore, there should be a frank discussion about the value of engagement as a democratic versus a technocratic benefit to the policymaker. As one interviewee stated, “I find that the focus [...] on working with citizens is 95% *what can we get out of engagement?*, and 5% *we should do this because it's democratic*” (Director, interview).

Notably, AOHT deliberately sought to attract “unusual suspects,” or those who didn't necessarily have a primary care provider. This was demonstrated through using a civic lottery (or stratified random sample) which had a criterion of whether the volunteer had access to a family practitioner. This was a design decision and reflects a choice in AOHT's engagement strategy to use terminology about *community* (rather than patient) voices, blurring the patient/public distinction. Although a secondary outcome, this inclusion both gave the process legitimacy by being the voice of “the community,” and had a positive effect when trying to work with the social sector, reflecting a broader, nonclinical definition of community. NSHA framed their engagement as a “community conversation,” reflecting a nonclinical approach to health. However, the events were not targeted at particular subgroups and there was little consideration given to composition of participants, beyond the inclusion of Indigenous communities.

CONCLUSION

To what extent can we articulate what leads to one method of deliberative civic engagement being used over another? Is there something intrinsic in deliberative civic engagement that leads policymakers to utilize it as a method of engagement; or are we just using deliberative civic engagement as a stand-in for "doing engagement differently"? Using two cases, I sought to analyze the extent to which deliberative civic engagement was chosen based on alignment with engagement goals. The cases demonstrate deliberative practice, insofar as they incorporated a period of learning about the topic of interest, space for group discussion, and activities designed to capture issues of public interest. In both instances, the decision to use the approach was steered by a team or individual, which suggests that policymakers choose processes based on information available to them, rather than exploring all potential options and choosing a method most aligned with their goal, consistent with theories of bounded rationality. This is a particularly compelling finding for practitioners as they seek to embed deliberative processes in governmental decision-making. Practitioners would benefit from *pre-emptively* positioning themselves as a clear option for policymakers in advance of policymakers choosing to undertake engagement initiatives, as these findings suggest that the method of engagement—and subsequent commissioning process—is shaped largely by pre-existing knowledge.

Furthermore, in both cases, organizers articulated decision-making factors that were not directly related to the theoretical expectations of deliberative civic engagement: in NSHA, organizers developed a roundtable model based on the advice of their team to mitigate opportunities for disgruntled citizens, and to maximize the opportunity for a productive conversation. In AOHT, organizers wanted to "do something different," engage citizens who would not ordinarily participate, and to host an activity that could be unifying factor among the AOHT members. There was an articulation of wanting to explore policy issues or deepen the organizers' understanding of citizen perspectives. NSHA also wanted to redevelop a relationship with its citizens, which had been worn down as a result of recent regional policy changes. AOHT sought input in its guiding strategy and wanted to meaningfully engage citizens. Yet there is little to suggest that these goals could only have been achieved through deliberative civic engagement, or whether another participatory approach may have garnered similar outcomes.

The analysis here explores whether deliberative civic engagement is a tool used to realize deliberative ideals, or because such models of engagement are novel or innovative. Similar discourse may have occurred, for example, around the founding of patient and family advisory councils (PFACs). Of course, deliberation and innovation may not be mutually exclusive goals. This suggests useful direction for future research, and provides nuance to the understanding of deliberative civic engagement for practitioners and researchers. First, future research in this area should explore the extent to which the values of deliberation as articulated in the literature correlate with the goals of deliberative civic engagement as articulated by practitioners. Second, while there is a wealth of literature on models of deliberation, better articulation of the distinct values of deep deliberative civic engagement—characterized by small-group, lengthy, intensive discussions—and shallow deliberative civic engagement—characterized by open forums over a shorter time period—would enable research that is more nuanced and reflects the specific conditions under which deliberative civic engagement takes place.

ORCID

Joanna Massie http://orcid.org/0000-0002-6293-2589

ENDNOTES

[1] Interview conducted by author, 27 January 2022.

[2] Interview conducted by author, 1 March 2022.

[3] IAP2 (International Association for Public Participation) Spectrum of Public Participation: https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5×11_Print.pdf.

[4] Interview conducted by author, 22 January 2022.

[5] Interview conducted by author, 10 February 2022.

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