



Australian Health Care Reform Alliance

SUBMISSION TO:

**THE AUSTRALIAN COMMISSION ON SAFETY AND
QUALITY IN HEALTHCARE**

RE:

**DEVELOPMENT OF A CONSUMER ENGAGEMENT
STRATEGY FOR THE COMMISSION**

Chair and Spokesperson:

Fiona Armstrong
fiona@anf.org.au
03 9602 8500
0438900005

Mailing Address:

AHCRA
c/o- ANF Federal Office
Level 1
365 Queen St
Melbourne VIC 3000

AUGUST 2008



INTRODUCTION

The Australian Health Care Reform Alliance (AHCRA) welcomes the opportunity to have input into the development of a Consumer Engagement Strategy for the Australian Commission on Safety and Quality in Health Care (Commission).

AHCRA strongly supports an emphasis on safety and quality as an underlying principle of the health system. This should, as indicated, include clinical governance as well as open disclosure. It should also include appropriate resourcing (including human resources), appropriate services (care provided by the most appropriate health professional), appropriate care (the extent to which the care is clinically appropriate/evidence based/likely to be effective), and a strong consumer voice in quality processes (to ensure 'quality' is viewed holistically). The principle of safety and quality also extends to the corporate governance of entities and organisations that deliver health care services. There must be appropriate representation from consumers, and wider community organisations on boards of management. This will ensure transparency and accountability, but more importantly, will truly reflect the person-centred approach of a reformed health system.

AHCRA is committed to the principles of consumer and community engagement and views consumer and community engagement as a key strategy for encouraging positive health outcomes and for ensuring a sustainable health system for the future.

AHCRA commends the Commission for undertaking this exercise and acknowledging the important role that consumers and communities have in the health care system and for undertaking work to develop a strategic approach for their future involvement.

AHCRA supports the principles outlined in its intended approach to consumer engagement as outlined on page three of the discussion paper, and its acknowledgement of the resources for consumer engagement developed by the National Resource Centre for Consumer Participation in Health.

The response that AHCRA has prepared focuses on the need to consult and engage with the Australian community and the need to build processes to enhance health literacy and capacity building tools and programs that can be run practically at the local level. This should become part of the Commission's practical approach, not just to consultation, but to implementing a consumer engagement strategy that can actually help the Commission achieve its overall goal to improve quality and safety in the health system.

AUSTRALIAN HEALTH CARE REFORM ALLIANCE

The Australian Health Care Reform Alliance (AHCRA) is a not for profit alliance whose aim is ultimately the development of an equitable and just national health system that assists individuals to be healthy and delivers compassionate



and high quality health care to all Australians (Australian Health Care Reform Alliance, 2007). Its objectives are:

- To be a strong united voice for reform of the health system in accordance with AHCRA's Principles
- To monitor, analyse and influence reform of national health policy, budget and resource allocation processes
- To facilitate opportunities for exchange of ideas, communication and cooperation among member organizations
- To appropriately and effectively utilise and mobilise the political and public arena to further AHCRA's aim and principles for reform

The Alliance has developed a set of key principles which inform its work and these have been endorsed by its membership. The principles focus on: access, primary health care, community engagement, equitable outcomes, workforce and efficiency.

AHCRA'S VISION

It is the view of AHCRA that the national health system should be based on a common vision. AHCRA's vision, developed as a consensus view of all alliance members, is:

"A health system that assists individuals to be healthy and delivers compassionate and quality health care to all."

UNDERLYING PRINCIPLES

AHCRA believes several principles articulated by the National Health and Hospitals Reform Commission are salient to the Australian Commission on Safety and Quality in Healthcare's consultation on consumer engagement: *community engagement, public voice, transparency and accountability and partnerships*. AHCRA would like to see the Commission adopt similar key principles for consumer engagement.

AHCRA's comments on these principles in its submission to the NHHRC were:

1. Community engagement:

AHCRA supports this principle as it reflects the importance of the engagement of consumers beyond having a voice in relation to their own health care to the true engagement of the community in the planning, development and delivery of health services.



The legitimacy and sustainability of any major policy decision depends on how well it reflects the underlying values and views of the community.¹ Community engagement requires the opportunity for the community as well as providers and managers within the health sector to assess evidence and develop and implement plans to improve health and health care.

2. Public voice:

AHCRA supports this principle and is a strong advocate of community engagement and consumer participation in health care. However, it suggests that this principle be revised and reframed as a principle on *consumer and community engagement* to reflect the engagement of consumers beyond having a voice at many levels of health services and systems to the true engagement of the community in the planning, development and delivery of health services.

3. Transparency and accountability:

AHCRA supports this principle as there is strong evidence that there is insufficient transparency and accountability in the current system. Sound governance demands that information regarding the use of public funds collected through taxation for expenditure on health services must be clearly available to the public so they can make decisions regarding the efficacy or otherwise of the utilisation of these funds. As indicated, accountability obligations extend to health services and health professionals, and across public and private sectors, and local, state and national levels

4. Partnerships:

AHCRA acknowledges the importance of empowering consumers to establish productive relationships in the development of health policy and the delivery of health care, and for health care providers to work in partnership with consumers.

The health system has a particularly important role in helping people of all ages become more self-reliant and better able to manage their own health care needs. Health professionals have a responsibility to communicate clearly, to help people understand the choices available to them, and to empower people to take an active role in treatment in a relationship of mutual respect. Our health system should also be characterised by partnership between the government, non-government and private sectors.

Partnership also requires recognition that for shared responsibility to be a reasonable expectation there needs to be acknowledgment of the support some people may require to fulfill their responsibilities in relation to their own health. It also refers to the need for effective relationships between health providers, agencies, and governments.

¹ Maxwell, J., Rosell, S., and Forest, P-G. Giving citizens a voice in health care policy in Canada, *British Medical Journal*, 326, pp. 1031-1033.



RESPONSE TO COMMISSION'S DISCUSSION PAPER

AHCRA notes that the Commission has set out some specific questions about its approach to consumer engagement, and that this submission does not deal just with these.

In relation to who should be targeted for engagement, the Commission has listed the following groups:

- *Individual patients, and carers of patients who have received or are receiving care*
- *Consumers who have a specific interest in health, but who may not be receiving care*
- *Organisations that represent groups of consumers (that are often comprised of consumers and may operate as “gateways” to consumers)*
- *Members of the public, or citizens*

AHCRA believes that all of these groups should be catered for in the Commission's consumer engagement strategy.

Furthermore, the following options were listed as mechanisms to be employed for ensuring effective consumer engagement:

- Appointment of a consumer engagement expert to the Commission staff
- Establishment of a consumer/citizen advisory committee to provide advice
- Continuing to include consumer representatives on specific-purpose working groups established by the Commission
- Establishment of a panel of consumer experts that can be drawn on by the Commission
- Partnerships with consumer organisations
- Public consultation processes that enable consumer and citizen participation

These all seem worthy processes and AHCRA doesn't see the need to rank them as they will all be useful approaches under differing circumstances.

Finally, we acknowledge as appropriate the main activities undertaken as part of the engagement strategy development which have included:



- ongoing liaison with an Advisory Group established to provide expert consumer input to the development of the Strategy
- consultation with key stakeholders, including consumer organisations
- a public invitation to make submissions about the development of the Strategy
- a review of relevant literature to identify possible models of consumer engagement
- preparation of documentation for the Strategy.

DESIGNING A SAFE AND HIGH QUALITY AUSTRALIAN HEALTH SYSTEM

In light of its vision and its commitment to the various principles which underpin it, AHCRA recommends that the Commission develop a strategy to undertake a process of citizen and consumer engagement. Specifically, the Commission should:

- a) Inquire into and discuss with the Australian people in a deliberative process the future of Australia's health care system and the key principles of a safe and high quality health care system.
- b) Develop priorities in safety and quality in health and health care for the Australian population over the next 30 years through consultation with the Australian people. The views of ordinary Australians should have a strong influence on the Commission's strategic planning and priority setting.
- c) Outline reform strategies to support and build the capacity of consumers and communities to be involved in their own health care and in the development, planning and implementation of health services, including the development of a national, comprehensive and coordinated capacity building program for health consumers.
- d) Consider and make recommendations regarding strategies to enhance understanding within the Australian community about the inflationary pressures in the health sector and the need for individuals to manage their own health risks.
- e) Develop a national plan for improving health literacy and building health consumer capacity.

In undertaking the above, the Commission should consult widely with the Australian people by undertaking a national citizen engagement exercise, as well as consulting with peak industry, professional, industrial, representative and community organisations, and relevant government agencies and public authorities. All reports should be made public.

In addition to consultation and engagement, a consumer representative should be appointed to the boards of the various commissions (Safety and Quality, Hospital and



Health etc). Consumer representation on boards of governance would facilitate ongoing discussions and provide a useful conduit and point of reference for the Commissions' future work as well as being consistent with current best governance principles.

The Commission should take into account existing Australian research and international evidence of demonstrated success in delivering recommendations. Ultimately the Commission should make recommendations to government on implementing these measures and advise on processes to enlist support from all Australian governments and other agencies in addressing the recommendations.

CONSUMERS AND FUTURE HEALTH CARE

Health care services must be focussed on the **needs of patients, families and carers**, they must support them in avoiding illness and seeking health care and they must be safe and of a high quality.

Health care systems must be built on a partnership between the Australian community and consumers, and health care policy must be grounded in and measured against community values. The community, especially consumers, their families and carers, must play an integral part in the development, planning and implementation of our health services. Changes to the health care system must be derived from the Australian community to ensure that they are informed and ready to embrace change.

The health system should therefore be based on the community's overall values and priorities, not unwillingly and in piecemeal fashion by the health workforce.

NEED FOR A DIALOGUE WITH CONSUMERS

As Australia is presently encountering an opportunity to review and reform its health care system, there needs to be a meaningful (and we use that term carefully) national dialogue with citizens and consumers. Such a national process could create a common set of values, principles and priorities for the health system of the future. It could also examine consumers' perceptions of safety and quality. A national dialogue could create the first national vision and framework for health care that all governments in Australia could use as the basis of the system.

RATIONALES FOR CONSULTING WITH CONSUMERS

AHCRA believes there are several simple reasons why the Commission should consult Australian citizens and consumers and these include:



1. First, as noted above, we have reached a key turning point in health policy requiring some high impact decisions. Citizens / consumers have a right to have a say at such a moment: “it is their health and their money”.
2. Second, we believe that some informed and deliberative advice from citizens and consumers, especially about the underlying principles, values and priorities for the future system, will be of great value to health ministers in making sense of the more technical and sometimes vested advice they receive from the variety of organised providers and interest groups.
3. Third, there are significant broader benefits such as increasing public awareness about the difficult choices ahead in the health system, building some consensus and greater community trust and possibly some economic benefits through allocative efficiency.

The features of such a strategy should include:

- Non-partisan and legitimate
- Transparent, and run by an independent organisation.
- Information-rich for participants
- Deliberative, i.e. people will get the chance to listen, question and discuss before giving their final views.
- Meaningful, i.e. linked to genuine policy processes.
- Using a variety of methods and triangulating findings
- Resourced and well facilitated
- Respectful of participants’ contributions and non burdensome.

The process would be strategically aimed at involving:

- Random samples of citizens drawn from the general population (enough to be significant but probably less than 1000)
- High users of care who have considerable experience of how the system does and should meet their needs (e.g. chronically ill)
- Traditionally hard to reach groups, including those with special vulnerabilities (i.e. the homeless, people with disabilities) who have special prevention and care needs.

Methods used might include a combination of citizen’s juries, deliberative councils, televoting, and round-tables. Results from these various techniques would be combined to find common perspectives and values.

STRENGTHENING EXISTING WORK



In 2007, AHCRA undertook a consultation with 180 consumers from across Australia, albeit it in a modest way, but with the hope that others, especially governments, would take up and enlarge upon this approach. The findings from this consultation suggest that consumers want to contribute to decisions about health care priority settings. A summary of the findings are presented here.

First, the findings confirmed those of previous consultations regarding majority (although not unanimous) recognition of:

- The importance of access and equity as crucial principles of Australian health care.
- The significant access issues facing rural consumers.
- Support for a stronger focus on prevention.

Second, it produced a rudimentary set of **consumer-developed criteria** against which the current system, proposed changes/reforms, and future systems can be judged. The criteria that enjoyed **by far** the highest support among participants reflect the above comments and were as follows.

The health system/services should be:

- **Affordable** - and not dependent on ability to pay.
- **Accessible in geographic terms** (especially for rural Australians) including access to specialists.
- **Accessible in cultural and social ways** (e.g., via language services, cultural sensitivity, accessibility to most disadvantaged) but also show respect more broadly for all users.
- **Equitable** – for all Australians “*Equitable, fair system for all Australians, city or country, regardless of race*”.

Other criteria with reasonable support were that the system should also ensure:

- Continuity of care and assistance to navigate the system
- A stronger focus on prevention than currently exists
- Provision of quality care
- Higher level of integration of services, and holistic approach
- Consumer involvement in decision-making.

The findings support AHCRA’s position that there should be a national consultation to underpin a new national health policy around which an Australian health care system could be designed.

FACILITATING CITIZEN / CONSUMER ENGAGEMENT THROUGH HEALTH LITERACY AND CAPACITY BUILDING

This final section of AHCRA’s submission to the Commission builds on the case for strong consumer participation at all levels of the health system, expressed earlier in



the document, and argues for a much more substantial investment in health literacy in the population as a means of ensuring their ability to contribute to maintenance of safety and quality within the health system.

Such investment in health literacy will not only empower consumers in their own care and self-management, but also enable them to more effectively participate in health sector quality improvement activities. As such it represents an investment in population and system health.

“The legitimacy and sustainability of any major policy decision increasingly depends on how well it reflects the underlying values of the public”.²

This is certainly true of health care policy, and underscores the importance in health policy and health service delivery of the involvement of an informed public in policy development and informed individuals in the delivery and quality improvement of health services. But people can only engage with what they understand, and health literacy (or lack thereof) is seriously compromising the ability of many people to fully participate in their own health care.

Definitions of health literacy

Health literacy has been defined as the wide range of skills and competencies that people develop in order to seek out; comprehend; evaluate; and use health information and concepts in order to make informed choices, reduce health risks and increase quality of life.³

The Australian Bureau of Statistics 2006 Adult Literacy and Life Skills Survey (ALLS) defined health literacy as ‘knowledge and skills required to understand and use information relating to health issues such as drug and alcohol, disease prevention, first aid, emergencies and staying healthy’. The findings of the ALLS Survey showed 60% of Australians have limited health literacy (scoring 1-2 on a five point scale). Level 3 is regarded as the “minimum required for individuals to meet complex demands of everyday life and work in the emerging knowledge based economy. The survey also concluded that health literacy decreased with age and 80% of over 65-74 year olds had limited health literacy.

Rationales for investing in health literacy

Low health literacy threatens not only the health and well-being of Australians but also the health and well-being of the entire health system. Such an inference can be reasonably drawn from studies conducted in America, which show poor health

² Maxwell, J et al. Giving citizens a voice in health care policy in Canada, British Medical Journal, Volume 326, 10 May 2003.

³ Institute of Medicine



literacy costs the health care industry in that country some \$100 billion a year in overused, misdirected or misunderstood health care services.⁴

Studies show “health literacy” is a strong predictor of health status and fundamental to quality health care. Low health literacy can lead to negative effects on a person’s health and well being, including poor self-care and lifestyle decisions, misuse of health services, less interest in accessing preventive care, and overall, increased costs.

Improving health literacy helps individuals to have greater capacity to obtain and process basic health information, understand their health problems as well as the services needed, and to make appropriate decisions about health and healthy life style choices.

Costs to both patients and the health system from poor health literacy will continue to grow unless there is a concerted effort to improve it. Patients are being asked to assume more responsibility for self-care; costs are increasing and consultation times are decreasing. Emerging issues such as quality and safety, chronic disease, illness prevention are now important aspects of an increasingly complex health system that are all relevant to the need for improved literacy and health consumer capacity building.

Consumers must be able to locate health information, evaluate information for credibility and quality, and analyse risks and benefits. Consumers must be able to express health concerns clearly and quickly in the context of the financial and time constraints on consultations. They must be able to ask the right questions and understand complex medication and health instructions. Often their ability or inability to navigate the health system may reflect systemic complexity as well as individual skill levels. Even highly educated individuals may find the systems too complicated to understand, especially when people are made more vulnerable by poor health.

Building capacity for empowered and activated patients

Facilitating true citizen engagement in health care however requires going beyond health literacy to build capacity for empowered and activated patients as well. Building health consumer capacity promotes “patient activation”, self efficacy and self confidence in the health system. Capacity building promotes the belief and understanding that it is one’s job to take charge of one’s health and that one’s own actions play an important role in one’s own health outcomes. Capacity building increases feelings of empowerment and personal control surrounding the contingencies of health management regimes and motivates patients to acquire and maintain healthy behaviours.

Some examples where capacity building and high health literacy are essential are:

⁴ Vernon J. Low health literacy: an economic drain on the US healthcare system. Presented at National Press Club; October 10, 2007; Washington DC.



- Chronic disease self management – prevention and early management in such conditions as asthma, diabetes, arthritis, hypertension;
- Maintaining and improving health through appropriate food and fitness;
- Children with chronic or special health care needs;
- Immunisation – adults and children;
- End of life decisions and/or organ donation;
- Depression and mental illness – screening and treatment;
- Wound care;
- Pain control;
- Medication management – preventing errors;
- Heart disease – prevention, optimizing functional capacity;
- Stroke – early intervention and rehabilitation;
- Quality and safety – patient surveillance and prevention of adverse outcomes in care;
- Cancer – decision making in choosing and following treatment options, and
- Navigating a complex system comprising public and private services.

Improving health literacy requires definition of the scope and costs of poor health literacy. This requires identifying populations with the lowest capacity/lowest health literacy and targeting them particularly. For example vulnerable groups can include the elderly, people who speak languages other than English, immigrants, early school leavers, prisoners, paediatric patients etc.

A wholly top down approach must be carefully avoided. A grass roots approach is also needed with support and resources for solving health literacy problems and capacity building, being directed towards local advocacy, self-help and other groups which can also support the role of family, carers and peers.

Most importantly, citizen engagement as described by the Australian Health Care Reform Alliance must underpin the development of the policies, resources and infrastructure for capacity building activities, implementation and evaluation of this national priority.

AHCRA suggests there are four key areas requiring action to improve health literacy and capacity building and these include:

- Make medication and health information easier to understand using plain speak language techniques;
- Change or re-organise systems within the health care system itself to mitigate the effects of low literacy;
- Initiate intervention programs that attempt to directly improve patient literacy. Importantly, this would include not only provider/primary care interactions but



programs that target and empower the community and individuals. For example programs might be conducted by health educators where patients could get “*expert best practice support*” with problem solving skills in the self-management of their health concerns, including self-efficacy skills needed in changing behaviour to reach new goals; and other skills that empower patients to more effectively partner with their health care team.

- Develop systems that facilitate informed decision-making by consumers, e.g. through consumer-friendly Information and widespread use of decision aids and programs such as Respecting Patient Choices.

Consumer interaction with healthcare culture

AHCRA believes there is also a critical need for researching and setting standards for consumer interaction with the culture of health care (including that of the health professions and health care institutions). This is another area in which the engagement of consumers will be very important. The appropriateness of current models in healthcare (and associated culture) needs to be explored. The role of culture in health service facilities and throughout the health system also has the potential to significantly affect the quality and safety of care and thus patient outcomes. This culture and its effect on patients must be better understood. The Commission should identify ways in which this culture can be accurately measured in health facilities across the system.

Finally, AHCRA would draw the Commission’s attention to the role of the Health Complaints Commissions in each state/territory in supporting consumer engagement and monitoring health literacy development, as well as contributing to safety and quality improvements. AHCRA believes that there need to more innovative ways of ensuring that the management of complaints leads to major gains in quality and safety and improvements in the culture of health care. This currently is not happening in a systematic way across Australia.

For example, comparison of the annual reports of the various state complaints commissions and the types of complaints they receive, reveals there has been little change in the management or types of complaints over the last 15 years. While issues of misdiagnosis and miscommunication make up the largest categories of complaint issues, few are formally investigated, or end in discipline. Unaddressed, these issues have the potential to have a devastating effect on quality and safety of care. It is vital that the system of health care complaints can demonstrate responsiveness, accountability and contribute to improvements in the overall quality and safety of the health system.

To address this, it will need the national approach and leadership that the Australian Commission on Safety and Quality in Health Care can offer. This is also a major area that will require significant community engagement to ensure recommendations are relevant.



Summary

The Australian Health Care Reform Alliance has identified a number of key areas where the Commission could undertake work in as part of its Consumer Engagement Strategy. The recommendations aim to ensure consumers are supported and empowered to make decisions as well as being given the opportunity to voice their views on safety and quality and health care more generally. We have attached a list of the organisations which comprise the Alliance, and a summary of explanations of some of the techniques we have recommended for consideration throughout this submission.



ATTACHMENT A

AHCRA Members:

Allied Health Professionals Australia (AHPA)
Audiology Australia (AA)
Australian College of Midwives
Australian Council of Social Service (ACOSS)
Australian Health Promotion Association
Australian Healthcare Association (AHA)
Australian Nursing Federation (ANF)
Australian Physiotherapy Association (APA)
Australian Rural Health Education Network
Australian Salaried Medical Officers Federation
Australians for Native Title and Reconciliation (ANTaR)
Australian Women's Health Network
Catholic Health Australia
Centre for Clinical Governance Research in Health NSW
Centre for Health Services Research
Chiropractors' Association of Australia
CHOICE
Chronic Illness Alliance
Continence Foundation of Australia
Country Women's Association of Australia (CWAA)
The Council of Remote Area Nurses of Australia (CRANA)
Doctors Reform Society (DRS)
Frontier Services of the Uniting Church
Health Care Consumers' Association of the ACT
Health Consumers Council WA
Health Consumers Network (HCN)
Health Issues Centre (HIC)
Health Reform South Australia (HRSA)
Maternity Coalition Inc
National Aboriginal Community Controlled Health Organisation (NACCHO)
National Council on Intellectual Disability (NCID)
National Public Hospitals Clinicians' Taskforce
National Rural Health Alliance (NRHA)
NSW Nurses' Association (NSWNA)
OT AUSTRALIA (The Australian Association of Occupational Therapists)
Public Health Association of Australia (PHAA)
Public Hospitals, Health and Medicare Alliance of Queensland (PHHAMAQ)
Redcliffe-Bribie-Caboolture Division of General Practice (RBCDGP)
Royal Australasian College of Physicians (RACP)
Royal Australian College of General Practitioners (RACGP)
Rural Doctors Association of Australia
South Australian Salaried Medical Officers Association (SASMOA)
Services for Australian Rural and Remote Allied Health Inc (SARRAH)
Tasmanian Medicare Action Group (TasMAG)
Victorian Medicare Action Group (VMAG)
Victorian Public Health Research and Education Council
Western Sydney Health and Effective Healthcare Australia

ATTACHMENT B-

SUMMARY OF PUBLIC PARTICIPATION TECHNIQUES

Public Hearings: Perhaps the most widespread method of engaging the public, scores relatively low on both acceptance and process criteria. Public hearings often seem designed to contain and control public participation by allowing only limited choices on narrow, short-term questions at a late stage of the policy process. Therefore they also score low on early involvement criteria.

Public Opinion Surveys and Focus Groups: Both do reasonably well on acceptance criteria but not on process criteria. Although these methods might gain a fair amount of credibility with the public, the quality of the decisions may not be high, and would therefore be of concern to a sponsor. Because opinion surveys and focus groups may serve as the basis for subsequent policy formation, they may be implemented at a fairly early stage of any decision-making process and hence score high on the criterion of early involvement. These approaches take little time and fewer resources than many other procedures and are ranked high on the criterion of cost-effectiveness.

On the negative side participants in public opinion surveys and focus groups have no structured access to resources to enable them to make good decisions, and as such their output may reflect biases and misunderstandings that have no opportunity for resolution. That is they score low on the criteria of resource accessibility and structured decision-making.

Both score low on the criterion of influence and transparency since they tend to be conducted behind closed doors. Their advantage lies in clarifying bases of agreement and disagreement and identifying values that underlie opinions, rather than setting a clear direction for policy makers. As such they may be regarded as exploratory methods for complementing other procedures.

Citizens' Jury and Consensus Conference: Score reasonably well on both on both acceptance and process criteria, such as the early involvement and task identification. Extensive efforts are made in these approaches to provide participants with the appropriate resources to make good decisions, and hence score well on the resource accessibility criterion. Citizens' Juries and Consensus Conferences rate similarly on the cost-effectiveness criteria. The criterion of influence will be determined greatly by the prevailing political climate and linkage to policy makers. These approaches attempt to gain representative public samples, but only score moderately on this criterion, largely as a consequence of the small sample size they employ.

The group-based mechanism underlying these approaches is a potential source of difficulty, in that group behavior has often been shown to be sub-optimal (e.g. dominant participants). The quality of any decision reached might be a result of group dynamics and social influence, more than the public participation approach itself. However these two techniques rate more highly than other approaches on the criterion of structured decision-making because the influence of a facilitator and the definition of rules and guidelines provided might help to overcome some of these difficulties. Providing support for both decision-making and group behavior is an important component of a wider concern for creating an appropriate environment to enable citizens to contribute effectively to complex and important policy issues.

Televote: Individual deliberation therefore decisions are more likely to be based on self-interest, modified through discussion with others which is encouraged. Aggregation of competing views, rather than finding common ground to move forward or reach consensus on an issue/s. Quantitative size is statistically significant.

Deliberative Poll: Do not seek to achieve common ground or consensus, but the determination of informed individual public opinion on a topic. Expensive, due in part to the large numbers of individuals involved, and accommodating them all together over at least two days.

Focus Groups: In one study cited below focus groups were used to investigate the “Effect of discussion and deliberation on the public’s views of priority setting in health care: focus group study”. Sixty randomly chosen patients (10 groups) were invited to attend two focus group meetings, a fortnight apart. This allowed comparisons to be made between people’s initial views at the start of the first meeting and their considered views at the end of the second meeting, when they had an opportunity to discuss and deliberate. The conclusions of the study stated “the public’s views about setting priorities in health care are systematically different when they have been given the opportunity to discuss the issues. If the considered opinions of the general public are required, surveys that do not allow respondents time or opportunity for reflection may be of doubtful value”. (Paul Dolan, Richard Cookson and Brian Ferguson. *BMJ* 1999;318;916-919).

Focus groups generally rate low on representativeness, citizen participation, and community focus but this can be overcome with modifications as seen from the above study. Generally cost-effective and early involvement is potentially high.

Computer-assisted participation: Need access to the necessary technology. Not so good for complex, value-laden issues. Requires an on-line moderator to keep participants on track.

Other Options: Search Conferences and Charettes were not included in this assessment because they both target stakeholders. Additionally Charettes have an emphasis on specialist participation. Search

conferences do not use experts, rely on the expertise and knowledge of the group, and tend to address a wide range of issues.

Conclusion: The relative usefulness of public participation techniques is difficult to ascertain because systematic comparisons are rare. There is an absence of any optimal benchmark against which they might be compared and measured. The preliminary assessments presented above are based primarily on opinion should not be over-interpreted. At this time the most appropriate techniques for public participation are likely to be hybrids of the more traditional methods. One potentially effective approach to participation may be to complement one mechanism with another, which has been tried on a limited basis.

(Source: The primary and substantial source of the above commentary sourced from: Gene Rowe; Lynn j. Frewer. Science, Technology, and Human Values, Vol.25, No1 (Winter, 2000). 3-29.)