
Conceptualising consumer engagement:

A review of the literature

Australian Institute of Health Policy Studies Research Project

Consumer engagement in Australian health policy: Investigating current approaches and developing new models for more effective consumer participation

Working Paper 1 (Revised)

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For the Australian Institute of Health Policy Studies

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Conceptualising consumer engagement: A review of the literature

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Preface

This literature review is the first in a series of working papers to be produced as part of a research project examining consumer engagement in Australian health policy. The project is being conducted by the Australian Institute of Health Policy Studies (AIHPS). The project's title is *Consumer engagement in Australian health policy: Investigating current approaches and developing new models for more effective consumer participation*.

This review is designed to provide an overview of the literature relevant to the practice of consumer engagement in health policy development. The review examines both theoretical and professional literature, and includes some brief examples of consumer engagement practice.

The project is funded through AIHPS's core funding from state health, non-government, and academic partners, and through a competitive research grant received from Merck, Sharpe and Dohme. The research is being conducted by Professor Brian Oldenburg, Dr Judy Gregory, and Rebecca Watson, and is guided by a Steering Committee.

The objectives and design of the project are summarised in Appendix 3 of this literature review. Put simply, the project aims to:

- Review the current practice of consumer engagement in Australian health policy development
- Explore the reasons behind current practice
- Consider some alternative ways of working.

The project involves an exploration of consumer engagement practice in both health policy development and in other fields, including examples from both Australia and overseas.

The Australian Institute of Health Policy Studies is an independent national institute devoted to studying the ways that health policy can improve the health of all Australians. It aims to improve the national capacity for health policy-relevant research and facilitate the community's role in influencing national health priorities. For further information about AIHPS, visit www.aihps.org.

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Summary

Consumer engagement is the process of involving consumers in the planning and development of policies and services. It has long been an established practice in fields such as urban planning and development, and is now widely used as part of government policy making activities. Within the health sector, consumer engagement has traditionally focused on service delivery, health care, and research. However, its use in the policy making context is growing rapidly, and commitments to consumer engagement as part of policy development are evident throughout Australia and overseas.

This review explores the current practice of consumer engagement, with a particular focus on health policy in Australia. The review is designed to provide both an introduction to the topic and an underpinning for further research. The review describes the current status of consumer engagement in Australia and includes examples of engagement practice from Australia and overseas.

Although the importance of consumer engagement in the policy making context is increasing, there is little evidence from the literature of its success. There are few examples of careful evaluation of engagement activities, and little is known about how (or if) consumer engagement influences policy outcomes. In addition, the literature shows some confusion about how to transform the theories of engagement into successful practice, disagreement over what constitutes ‘true’ engagement, and significant barriers that frequently operate against successful engagement.

A series of key themes emerge from the literature as important influencers of engagement activities:

- The type of consumer engagement activity (often described through a ladder or continuum model)
- The purpose of consumer engagement
- Who initiates the engagement
- Who gets engaged
- At what stage engagement occurs
- What types of decisions consumers can contribute to
- Whether consumers want to be engaged
- Choices about engagement techniques.

Introduction

This review is part of a research project examining consumer engagement in Australian health policy being conducted by the Australian Institute of Health Policy Studies (AIHPS) with funding from Merck, Sharpe and Dohme's International Grants Committee. The review focuses on consumer engagement in health policy in Australia. It explores the current practice of consumer engagement, reviewing both the theoretical and professional (grey) literature.

This review focuses broadly on consumer engagement. It is designed to provide both an introduction to the topic and an underpinning for the research phase of the AIHPS study. Subsequent working papers for the AIHPS study will present a theoretical framework for the research, the research methods, and findings from interviews and case studies.

The literature on consumer engagement is extensive. However, little of it directly relates to consumer engagement in health policy, particularly within an Australian context. Within the health field, the consumer engagement literature primarily focuses on service delivery (such as hospitals and specific health programs), health care (such as engagement between consumers and practitioners), and research. Consumer engagement is recognised as an emerging area in the health field, and the relevant literature is modest (CFC, 2000; Moore, 2003). A recent review by Scutchfield, Hall, and Ireson (2006) suggests that there is extensive literature discussing the importance of consumer engagement, but little literature actually showing it happening.

There is also extensive literature exploring consumer engagement in other disciplines, including urban development, planning, environmental management, and natural resource management. However, the tendency has been for each discipline to evolve its literature in isolation, with little cross-referencing (Woolcock & Brown, n.d.). This has allowed different theories and terminologies to emerge, and the extent of the literature makes it difficult for researchers to cross disciplinary boundaries.

This review provides a brief survey of consumer engagement, focusing primarily on health policy and related health issues. Literature from other disciplines is included where relevant, particularly professional literature addressing the Australian context. The literature was surveyed through advice from the project's steering committee, drilling through the references listed in recommended works, and traditional database searches. The literature review is presented as a series of themes that are important influencers of consumer engagement practice.

What is consumer engagement?

Consumer engagement is the process of involving consumers in the planning and development of policies and services. In the health policy context relevant to this study, consumer engagement is about involving consumers in developing and implementing the policies that will affect them as health consumers.

What is a consumer?

In the context of this study, a consumer is someone who makes either direct or indirect use of health services – that is, a current or potential user of the health system. This includes patients and potential patients, long-term users of services, carers and parents, and the targets of health promotion programs (this definition draws on CHF/NHMRC, 2001, CFC, 2000; DHS, 2005b; Horey & Hill, 2005; NHMRC, 2004; Oliver et al, 2004).

The term ‘consumer’ is preferred to ‘patient’ because ‘consumer’ conveys the idea that individuals make rational decisions based on the information available to them, while ‘patient’ tends to reinforce a hierarchical relationship where participation is neither valued nor encouraged (DHS, 2005b). In addition, ‘consumer’ encompasses the broader group of carers and parents, and the targets of health promotion programs, not traditionally considered under the definition of ‘patient’.

Consumers are both individuals who access the health system and groups who organise around the health system (such as health consumers’ organisations). Both individual consumers and health consumers’ organisations are relevant consumers for this study.

What is engagement?

Engagement is the term adopted in this study to encompass activities that involve consumers as participants in contributing to policy development and implementation. The terms used in the literature vary, and include ‘citizen engagement’, ‘public participation’, and ‘community consultation’.

Some authors describe different types of engagement activities through different terms. For example, Aslin and Brown (2002) use the terms consultation, participation, and engagement in the following way:

- ▀ Consultation involves seeking advice from someone else. It does not imply that anything will be done with the advice that is received.

- Participation means the act of participating, in whatever form. This can include writing letters, attending events, or using other forms of communication. Aslin and Brown see participation as being very similar to involvement.
- Engagement goes further than participation. It conveys the idea that someone is occupied, focused, and committed to an issue.

Aslin and Brown see a continuum between being consulted and becoming engaged, where people feel increasing commitment to and ownership of the outcomes, and people increasingly recognise that their interests are involved in the outcomes.

Throughout this study, the term ‘engagement’ is used in a broad way to cover the range of activities that are used by governments, organisations, and individuals to generate consumer involvement in health policy. Engagement activities vary in the extent to which they achieve active involvement by consumers – ranging from information provision or consultation activities, through to active participation or consumer control.

What is health policy?

Health policy is the approach taken to managing and planning the health system. It includes the laws, rules, financial decisions, and administrative decisions made by governments and other relevant organisations to influence the provision of health services (Nilsen et al, 2006).

The status of consumer engagement in Australia

Consumer engagement is an established practice in the Australian policy making environment. Within the health sector, engagement is a fundamental part of government policy development and a statutory obligation for organisations such as the National Health and Medical Research Council (NHMRC) and the Australian Health Ethics Committee (AHEC) (Horey & Hill, 2005). Funding organisations such as the NHMRC require grant applicants to detail the process of consumer engagement planned for funded programs, and expect project reports to include a discussion of how consumer engagement was achieved (NHMRC, 2004).

Consumer engagement is entrenched in government policies for health throughout Australia:

- In Western Australia, consumer engagement is coordinated through the Office of Citizens and Civics, which aims to give a voice within government to consumers. Community engagement goals are included in the performance agreements of Departmental CEOs, and consumer engagement is a required element of health policy development (Gillgren, 2005; Health Reform Committee, 2004).
- In the Northern Territory, a requirement for consumer engagement is written into health policy (DHCS, n.d.).
- In the ACT, a collaborative approach is entrenched within government policy, and ACT Health commits to focusing on community needs. ACT Health has established a Consumer Feedback Project and a number of consultative bodies (ACT Health, 2002).
- In New South Wales, community engagement is recognised as one of six attributes of the health system's strategic direction. Community engagement is included as an integral component of policy development and health service planning, and NSW Health articulates a commitment to inform the community and work collaboratively with community groups (NSW Health, 2000).
- In South Australia, the health reform agenda is underpinned by the need to strengthen community participation mechanisms (DHS, 2003). The health system's principles include a focus on community participation, accountability, and shared responsibility.
- In Queensland, engagement is guided by the government's Community Engagement Improvement Strategy, and coordinated by the Department of Communities. Queensland Health has articulated consumer engagement as a central strategy for health reform, and is proposing to establish a Consumer Health Council in early 2007 (Dept of Communities, 2005; Qld Health, 2006).
- In Tasmania, the Department of Health and Human Services' Corporate Plan (DHHS, 2005) commits to providing more opportunities for community members

A history of community participation in South Australia

During the early 1990s, consumers in South Australia were consulted about funding for health care through a series of meetings called Health Dollar Seminars. People were asked to make choices about health funding, but the oppositional choices resulted in a competition for funds that many participants did not feel comfortable about. The consultation process was redefined and the new Health Issues Seminars used a 'vector sum of values' approach to start a discussion about what people wanted to see in the health system. The consultative approach allowed constructive relationships to emerge between consumers and providers. (Alexander & Hicks, 1998)

to engage in decisions about the provision of health and human services, and ensuring that the Department is responsive to users' needs.

- In Victoria, there is a strong focus on ensuring consumer engagement in the health system. A participation policy for the health system, *Doing It With Us Not For Us*, was released in 2006 (DHS, 2006). This followed the publication of a *Consultation Paper* about participation and *Participation Indicators* in 2005.

- At a Federal level, the Department of Health and Ageing's Corporate Plan (DoHA, 2006) does not include a direct commitment to consumer engagement, though engagement is mentioned in two areas: partnership with consumers is mentioned as a way of achieving the Department's vision, and open and constructive consultation with community groups is mentioned as a Departmental value. The Australian Commission for Safety and Quality in Health Care (established in January 2006 to replace the Australian Council for Safety and Quality in Health Care) includes amongst its priorities a transparent consultation process and formal links with stakeholders (including consumers) through a Stakeholder Reference Group (Review Team, 2005).

Calls for consumer engagement in Australian healthcare reform

Both the Australian Consumers Association (now called Choice) (Korczak, 2005) and the Australian Health Care Reform Alliance (AHCRA, 2005) have called on the federal government to engage the Australian public on healthcare reform. They argue that a meaningful national dialogue is needed to create a sustainable health system, with a national vision and framework for health that could inform all Australian governments. They call for an engagement process that is independently managed, non-partisan, legitimate, and transparent, with processes that are deliberative and meaningful. AHCRA argues that the process should use a combination of engagement techniques, possibly including citizens' deliberative councils or citizens' assemblies, citizens' juries, round tables, ChoiceWork dialogue, and televoting. New Matilda (2006) also calls for significant healthcare reform, arguing that health programs need to be organised around the needs of users with significant public consultation being used to develop the detailed design for a new system.

There are many examples of Australian policy documents that call for consumer engagement, and only a brief overview has been included here. However, reporting on the outcomes of consumer engagement is more difficult to access, and there is little evidence that consumer engagement activities are evaluated – either in terms of the success of the process, or its influence on policy development. There are some examples of descriptive evaluations and case studies of best practice (for example, the governments in Queensland

and Western Australia include case studies on their websites – www.citizenscape.wa.gov.au and www.getinvolved.qld.gov.au), but there is little evidence of the impact of consumer engagement on the policy development process. Gillgren (2006) suggests that consumer engagement is part of a transformational change in the way that government does business; governments are moving from a managerial approach to a much more collaborative approach. Evidence of the influence of consumer engagement may emerge as its practice becomes more entrenched.

While there is a growing focus on consumer engagement at the state level in Australia, at the federal level there is some suggestion that consumer engagement may be going off the agenda. For example:

- The National Resource Centre for Consumer Participation in Health (NRCCPH), a federally funded initiative which encouraged consumer engagement and included a publications clearinghouse, was de-funded in June 2004 and closed.
- The Consumers Focus Collaboration, which was established in 1997 to work on consumer issues in acute health care, was de-funded and closed in 2001.
- Proposed changes to the Food Act will remove the requirement for public consultation relating to applications to make health claims about foods; instead, decisions will be made by an expert advisory committee that will work in secret (Davies, 2006).

Consumer engagement is an important element of health policy on an international scale.

- In the UK, consumer engagement has been formalised into the policy making process through the *Modernising Government White Paper* and the accompanying document *Professional Policy Making for the Twenty-First Century* (Bullock, Mountford, & Stanley, 2001; Cabinet Office, 1999). Policy makers are expected to consider how the policy will be communicated to the public, involve key stakeholders in policy development, consider the needs of people affected by policy, consult with those on the receiving end of policy, include mechanisms to allow service deliverers and consumers to provide feedback to policy makers, and share information about the lessons learned from consumer engagement. Extensive research into consumer engagement is being conducted in the UK (e.g., Oliver et al, 2004 and other work conducted by the Cochrane Collaboration; Rowe & Shepherd, 2002; work conducted by the Picker Institute). Within the health context, NICE (the National Institute for Clinical Excellence), which is an independent organisation responsible for providing national guidance about health, has a strong commitment to patient and community involvement and conducts frequent community consultations

(NICE, 2006). In addition, the Department of Health funds INVOLVE, a national advisory group that promotes and supports active involvement in the National Health Service, public health, and social health research (INVOLVE, 2006).

- Several OECD countries have formalised approaches to consumer engagement, as outlined in the OECD report *Citizens as Partners* (Caddy, 2001). For example, both Canada and Denmark have used consumer engagement to develop health policy, while case studies from Belgium, the Czech Republic, the USA, Hungary, France, and Korea discuss consumer engagement in policy making and implementation in other fields. The OECD report notes that evaluation of consumer engagement programs is rare, and the report includes only one case study – describing consensus conferences on genetically modified food in Norway – where an attempt is made to evaluate the engagement process.
- In Canada, consumer engagement is a recognised element of the health system. Engagement programs are intended to inform Canadians about health issues and engage them in federal health decisions. Consumer engagement is used to ensure that the concerns of the public are taken into account in the formulation and implementation of government policies (Health Canada, 2000).
- In New Zealand, the Office for the Community and Voluntary sector offers advice on how to engage with the community and provides case studies (OCV, 2006).
- In the USA, there are many examples of consumer engagement, with investment from both government and

Consulting on health policy in Canada

In 1994, through The National Forum on Health, the Canadian government committed to examining the health system, with a mandate to involve citizens in the process. Consumer engagement occurred in two phases – the scoping of concerns and issues, and ground testing of proposed directions before they became recommendations. The Forum used a discussion group approach, with participants being asked to devote 9 hours to the process. The first phase of engagement involved 71 discussion groups and involved 1300 individuals. In addition, more than 1000 written comments were received from individuals who read the widely distributed consultation document. The second phase of engagement involved a telephone survey and two regional conferences with initial participants. The Forum presented its recommendations in February 1997. Ham argues that a deliberative engagement process, when well structured, professionally facilitated, and well supported with materials, works to create a dialogue with both consumers and stakeholders. It encourages reflection and learning, promotes a common ground and collaboration, and allows new ideas to emerge. (Ham, 2001)

private foundations (Lasker & Weiss, 2003). The best known of these is the 1994 Oregon Health Plan, a health reform policy that involved the rationing of health care. The rationing process included an extensive consultation exercise to rank order medical treatments and ration health spending (Leichter, 1999).

- Several local councils are represented in the International Local Government Community Consultation Network which has published short case studies of engagement practices used by member councils (ILGCCN, 2005).

Arguments in favour of consumer engagement

Consumer engagement in health policy involves including the wider population in making decisions about the allocation of public resources. Instead of bureaucrats and elected representatives taking sole responsibility for decision making, through consumer engagement they work to actively involve consumers in making decisions about issues that will affect them. Bishop and Davis (2002) argue that consumer engagement in policy making is increasing because citizens are demanding a direct say in policy, not one that is filtered through elected representatives or peak lobby groups.

The move towards increased consumer engagement in health reflects the epidemiological shift from infectious disease to chronic disease and the need for a cooperative way of listening to the public about health improvement (Scutchfield, Hall, & Ireson, 2006). The increased interest in consumer engagement is also linked to the recognition that many of the health problems faced by the community are complex, and go beyond the capacity or jurisdiction of any single organisation to change or control (Lasker & Weiss, 2003).

Ethics and democracy

Consumer engagement is commonly seen as an ethical and democratic right – a process by which people can be involved in joint decisions about community health and the spending of taxpayers' funds (AHCRA, 2005; CFC, 2001; CFC, 2000; NHMRC, 2006; Qld Health, 2002; Scutchfield, Hall, & Ireson, 2006). Consumer engagement adds legitimacy to democratic decision making by encouraging participative democracy, public accountability, transparency, and creating a more informed and engaged public (Bowling, 1996; Health Canada, 2000; Horey & Hill, 2005; Nilsen et al, 2004). It is also a technique that encourages policy makers to recognise for diversity and community-based knowledge and experiences (Hicks & Harford, n.d.).

Improved outcomes

Consumer engagement is thought to improve both policy outcomes and health outcomes.

- At the policy level, consumer engagement helps to ensure that policies are informed, relevant, appropriate, and targeted (CHF/NHMRC, 2001; Qld Health, 2002; Review Team, 2005). The Consumer Focus Collaboration (CFC, 2001) argues that active involvement by consumers in the development, implementation, and evaluation of health strategies and programs is integral to their success. Consumer engagement can provide policy makers with a users' perspective that can not be easily obtained in any other way, and can allow consumers to put issues on to the public agenda (CHF/NHMRC, 2001).
- At the health outcomes level, consumer engagement is thought to improve the health of communities – partly by ensuring that services are delivered effectively and efficiently and are closely targeted to people's needs, and partly by improving health through the process of engagement (CFC, 2000, 2001; Health Canada, 2000; Horey & Hill 2005; Nilsen et al, 2004; Qld Health, 2002).

Improved relationships

Consumer engagement can improve the relationship between service providers and consumers by making services more responsive to consumers' needs, forming partnerships to develop solutions, and encouraging consideration and debate (CFC, 2000; Qld Health, 2002). The Department of Human Services in Victoria (DHS, 2005b) describes the relationship as being two-way: consumer engagement allows the health service to be part of the community, and allows the community to identify its health needs and work with the Department to meet those needs.

Serves political purposes

Consumer engagement can serve a variety of political purposes. It can:

- Increase the legitimacy and credibility of decisions (OECD in Cabinet Office 1999; Rowe & Shepherd 2002)
- Help policy makers learn about users' views and provide insights that might be otherwise difficult to obtain (OECD, in Cabinet Office 1999; Rowe & Shepherd, 2002)
- Increase public confidence in the policy process (Health Canada, 2000)
- Reduce political risk (Horey & Hill, 2005)

- Improve support from stakeholders (Health Canada, 2000)
- Increase the likelihood of project success and acceptance (Blamey, James, Smith, & Niemeyer, 2000)
- Allow governments to share the blame and the pain of rationing decisions (Pivik, Rode, & Ward, 2004).

Questions about the effectiveness of consumer engagement

Consumer engagement is not a new phenomenon. But its importance has increased in recent years as governments make efforts to develop policies that have consumer backing, and as consumers demand the right to participate in decision making. Church et al (2002) suggest that there are two ways of viewing consumer engagement:

- Governments are interested in engagement because consumers want to be engaged and because the process leads to better decision making (though they note that there is no clear evidence to support either of these assumptions)
- Governments use engagement as a way of co-opting consumers into the larger political agenda of downsizing; engagement can be seen as a way of legitimating potentially unpopular policy changes by involving consumers, even if that process is carefully contrived.

The difficulties of consumer engagement are recognised in the literature. Although the ideal of consumer engagement is widely supported, there are significant challenges in transforming the concepts into practice, and policy makers struggle to develop successful approaches (Abelson, Forest et al, 2003; Anderson, Shepherd, & Salisbury 2006; Rowe & Shepherd 2002). In 1999, the then Chair of Consumers' Health Forum, Hilda Bastian, argued that true consumer engagement in health was still in its infancy in most countries, including Australia (Richards, 1999). Following a review of consumer engagement practices in Western Australia, Gillgren (2005) concluded that the quality of much consumer engagement is dubious, with problems relating to the capacity of departments to undertake engagement, the stage in the policy-development process at which engagement is initiated, and the consistency of consumer engagement activities. Nathan (2004) expresses concern that the mandated requirement for consumer engagement may result in tokenistic processes that increase health inequities as policy makers race to tick the engagement box.

Nilsen et al (2006) argue that there is little evidence of the effects of consumer engagement in healthcare decisions at the population level. While the importance of engagement is widely recognised, little research has been done to find the best ways of involving consumers in healthcare decisions. Nilsen et al reviewed a series of studies about consumer engagement practice, and suggest that few conclusions can be drawn about the benefits or adverse effects of consumer engagement in health. They suggest that the effects of engaging consumers remain largely unevaluated.

Lasker and Weiss (2003) note that the experience of consumer engagement in the USA over the last 40 years has generated more frustration than results. Although foundations and government agencies have invested hundreds of millions of dollars in community partnerships and engagement initiatives, achieving results has been difficult. Consumer engagement can:

- Be unpopular with health professionals who question the competence of lay people (O’Keefe & Hogg, 1999)
- Be valued when the opinions of consumers are similar to those of other stakeholders, but be less popular and have less impact when decisions are difficult or the consumer agenda differs from those of policy makers and other stakeholders (Nathan, 2004)
- Give rise to expectations and suggestions that politicians, managers, and professionals consider to be unrealistic (O’Keefe & Hogg, 1999; OECD in Cabinet Office, 1999)
- Create delay and administrative overload (identifying and informing, seeking views, and building the results into analysis are time-consuming and potentially costly) (OECD in Cabinet Office, 1999)

Consumer influence in Australia

The Consumer Focus Collaboration (CFC, 2001) describes two important examples of successful consumer influence and engagement in Australia:

- ◆ The National Mental Health Strategy: consumer-led reform was a keystone of the new strategy in the late 1990s. Consumers and carers participated in the design and delivery of mental health services, and are involved in an ongoing way in planning. Advisory groups at the national and state level have increased opportunities for consumer and carer input.
- ◆ HIV/AIDS control: partnership approaches to policy development have been identified as critical to Australia’s success in minimising the impact of HIV/AIDS. Partnerships emerged between governments, community-based organisations, affected health communities, health professionals, and researchers, all working together to develop appropriate policies.

- Be chaotic, unpredictable, and messy – it is a process rather than an end-state, and this can be frustrating for planners and managers who prefer projects to fit within definable boundaries (Baker & Collier, 2003; Woolcock & Brown, n.d.)
- Produce unrepresentative views (through domination by well-organised lobby groups) and provide a focus for the mobilisation of resistance (OECD in Cabinet Office, 1999)
- Be susceptible to becoming a tool that reinforces the vested interests of those in power, rather than one that leads to power sharing (Nathan, 2004)
- Be a device for encouraging public enthusiasm for and promoting acceptance of a predefined solution (Durey & Lockhart, 2004).

Lasker and Weiss (2003) note that terminology has been a major source of frustration for those attempting to implement consumer engagement. Terms such as ‘community engagement’, ‘partnership’, and ‘collaboration’ mean different things to different people. This leads to widely varying expectations and frustrations about inadequate opportunities for engagement.

Types of consumer engagement

Consumer engagement is poorly defined, with disagreements about whether an activity offers ‘true’ engagement or mere tokenism. Bishop and Davis (2002) note that early work in the field worked from an ‘unstated but powerful attachment to direct democracy’, and dismissed as tokenism many activities that policy makers regularly use and believe offer valid forms of engagement. Bishop and Davis consider what is required for ‘true’ engagement: for example, when government seeks consumers’ views but makes an unpalatable decision, has engagement occurred, or does meaningful engagement require a community veto over policy choices?

Consumer engagement is often represented as a ladder or hierarchy, ranging from low levels of engagement that offer little opportunity for consumer input, through to high levels that offer elements of consumer control or partnership.

For many authors, these ladder representations allow for a distinction between true consumer engagement and lesser activities. Baker and Collier (2003) argue that true engagement only occurs when consumers are actively and effectively involved in making

decisions about issues that will affect their lives. For Bastian (1996, in CHF/NHMRC, 2001), true engagement implies the sharing of decision making power; it is an active process where participants have at least the potential for significant influence. The distinction is often articulated as the difference between consultation (a means of getting and giving information) and participation (having a say in what happens) (Draper, 1997; NHMRC, 2004; NIF, 2006). The NHMRC (2006) recognises that consultation is useful but limited, and argues that broader roles for consumers and communities need to be accepted and fostered. They call for leadership to promote the uptake of systematic and sustainable models of engagement. But Caddy (2001) argues that consultation and the provision of information should not be dismissed: they are often the key techniques used to involve consumers in policy making. To dismiss consultation as tokenism may ignore the realities of government policy making; governments often need to make final policy decisions by balancing the conflicting interests of different consumers and stakeholder groups, and to expect a decision making role for consumers may not always be realistic.

The ladder models of engagement mostly stem from the work of Arnstein (1969/2003). Arnstein's ladder has eight rungs, with each rung corresponding to the extent of citizens' involvement in determining the end product. For Arnstein, engagement is ultimately about citizen power. At the highest levels on the ladder, consumers have an opportunity to affect outcomes and control processes. The middle levels of the ladder (informing, consulting and placating) can be legitimate steps towards full participation, but are not techniques for full participation in their own right. Arnstein's biggest concern with the middle levels of the ladder is that they offer ways of inviting consumers' opinions with no assurance that those concerns and ideas will be taken into account. When restricted at the middle levels, Arnstein believes that consumer engagement becomes a token or window-dressing ritual. For Arnstein, meaningful engagement only occurs when direct democracy comes into play, and power is transferred to citizens (Bishop & Davis, 2002).

Arnstein's ladder is widely quoted in the consumer engagement literature, and Oliver et al (2004) note that it is one of the few examples when broader theoretical literature has been adapted into professional reports. (They note that, in most other cases, consumer engagement initiatives tend to happen in isolation, with little experience or expertise to guide them, and with few links to the relevant literature.) Arnstein's ladder of participation is included in Appendix 1.

Although Arnstein's ladder is often used as a starting point for discussions about engagement, it may not be the most helpful way of representing consumer engagement in policy making. Bishop and Davis (2002) note that Arnstein's ladder offers both a classification and value-judgement, which risks making direct democracy the only test for

true engagement. They note that many forms of official consumer engagement would fail to meet such a stringent test, and they question whether it is appropriate to judge all consumer engagement from this perspective.

Anderson, Shepherd, and Salisbury (2006) note that ladders suggest an aspirational level of engagement, while policy makers are often vague about the meaning of the level of engagement that they aspire to. This can create a conflict between the stated intentions of engagement and its actual outcomes, and create frustration with engagement practice.

Ladder descriptions of engagement can fail to acknowledge the trade-offs that need to be made when organisations choose between different consumer engagement activities. For example, approaches placed higher on the engagement ladder – such as partnership approaches or joint management – may allow for extensive involvement by consumers, but the trade-offs are that only a very small number of consumers can be involved, the process can be time consuming, and it is likely to be costly. Approaches from the lower levels – such as advising or gathering information – allow for large numbers of consumers to contribute, but with less active involvement. Oliver et al (2004) note that, when only small numbers of consumers are involved, there can be concerns that the engagement is tokenistic, even when the small numbers allow for great depth of involvement.

Recent models move away from ladders, to describe consumer engagement as a continuum of management techniques (Bishop & Davis, 2002). Like Arnstein's ladder, these models offer a spectrum from minimal engagement through to community control. But these models offer a set of choices for policy makers, rather than presenting a ladder as steps towards an ideal goal of full engagement. For example, Shand and Arnberg (1996, in Bishop & Davis, 2002) identify five points on their continuum, each with different objectives: information, consultation, partnership, delegation, and control. Examples of the continuum approaches are included in Appendix 1 – including the five-level continuum developed by the International Association of Public Participation (IAP2), the three-level continuum used by Consumers in NHS Research, and the seven-level continuum commonly used within the Australian context.

Thomas (1990) borrows from Vroom and Yetton's (1973, in Thomas 1990) theory of group decision making to propose five different approaches to public management decision making: autonomous managerial decision, modified autonomous managerial decision, segmented public consultation, unitary public consultation, and public decision. Thomas argues that a series of questions should be used to determine the relative needs for quality and acceptability in a decision and provides a decision flow chart for choosing the

appropriate level of decision making and consumer engagement based on the answers to these questions.

In a report describing consumer engagement in OECD Member countries, Caddy (2001) describes three levels of consumer engagement in policy making:

- **Information** – a one-way relationship where policy makers make information available to citizens and is a basic precondition for engagement. This covers both active measures by government to disseminate information to citizens, and access to information upon demand by citizens.
- **Consultation** – a two-way relationship in which citizens provide feedback to policy makers. This is based on prior definition of the issue by government. Citizens are invited to contribute their views and opinions.
- **Participation** – citizens actively engage in defining the process and content of policy making. This acknowledges equal standing for citizens in setting the agenda, proposing policy options, and shaping the policy dialogue.

One of the most clearly articulated models of consumer engagement in the health policy field was developed in Canada. Health Canada (2000) identifies a five-level continuum of engagement, and includes a discussion of when each level is most useful. This model clearly illustrates the way that engagement types can offer different choices to policy makers. The Health Canada model is illustrated in Figure 1, on the following page.

Consumer engagement as discontinuous interaction

Bishop and Davis (2002) propose an alternative way of describing consumer engagement in public policy, which does not rely on a ladder or continuum. They describe consumer engagement as a discontinuous interaction, with no single methodology and no shared theoretical base. They argue that engagement is shaped by the policy problem at hand, the techniques and resources available, and a political judgement about the need for engagement. They propose a five-way characterisation of consumer engagement – consultation, partnership, standing, consumer choice, and control – and note that consultation remains the dominant face of consumer engagement in policy making. Bishop and Davis's model of consumer engagement is included in Appendix 1 – the model describes the objective, key techniques, and limitations of each participation type.

Level	Purpose	When useful
1. Low level of public involvement and influence	Inform or educate	When factual information is needed to describe a policy/program/process When a decision has already been made When there's no opportunity to influence the outcome If the issue is simple In a crisis
2.	Gather information	When the purpose is to listen When policy is being shaped When there is no firm commitment to do anything
3. Mid level of public involvement and influence	Discuss	When a two-way information exchange is needed When people have an interest in an issue and are likely to be affected by the outcome When there's an opportunity to influence the outcome. When input may shape the policy
4.	Engage	When the Department needs citizens to talk to each other about complex issues When there's a capacity to shape policies When there's an opportunity for shared agenda-setting and open timeframes When options generated together will be respected
5. High level of public involvement and influence	Partner	When the Department wants to empower citizens and groups to manage the process When groups and citizens have accepted the challenge of developing solutions themselves When the Department is ready to be an enabler When there is agreement to implement the solutions

Figure 1: Continuum of engagement developed by Health Canada (2000)

The purpose of consumer engagement

Consumer engagement programs can be developed by organisations to fulfil a variety of purposes, ranging from providing information and encouraging acceptance of proposals, through to the joint development of new ideas. The levels of consumer engagement outlined by Health Canada (2000) clearly illustrate the way that different engagement

techniques will achieve different outcomes. Health Canada encourages policy makers to choose a level of engagement to suit their purpose. This means that organisations make decisions about the level at which they want consumers to participate before they begin any consumer engagement activity.

Boyes et al (2001, in Elrick, Boyes & McCormick, 2002) identify five possible purposes of consumer engagement:

- To inform the public of decisions that have been made
- To ask for views on decisions that are to be made
- To involve the public in discussions about issues that need to be considered in the decision making process
- To involve the public directly in making decisions
- To influence decision making from outside the policy process.

Theoretical underpinnings influence the purpose of community engagement

Draper and Hill (1995) suggest that there are four different approaches to consumer engagement. These approaches, which are summarised in Figure 2 on the following page, operate from different theoretical underpinnings and offer different outcomes for consumers. For example, the scientific approaches and market solutions tend to view consumer engagement as an information gathering exercise, allowing policy makers to learn about consumers' views and then make decisions. In contrast, the approach of democratic participation will involve consumers in planning and making decisions.

Rowe and Shepherd (2002) argue that descriptions of consumer engagement in the literature are typically underpinned by one of two competing political ideologies: the consumerist model or the democratic model. The ideology through which engagement is developed will influence both the purpose of the engagement and the way it is conducted.

- The consumerist model is service-led. Consumer engagement is seen as an instrument for eliciting consumers' preferences to help ensure that services more accurately reflect their needs. The model emphasises consumers' rights to information, access, choice, and redress. Working from the consumerist model, consumer engagement will be conducted as an organisation-initiated activity designed to produce higher-quality and more closely targeted outcomes.
- The democratic model is citizen-led. Consumer engagement is seen as a force for democratic renewal, bringing decision making closer to the people and allowing

people to challenge ideas, participate in planning, and force those in power to justify their activities. Working from the democratic model, consumer engagement can be initiated by either organisations or citizens, and is seen as part of the democratic decision making process (Rowe & Shepherd, 2002).

Thomson (2003) argues that consumer engagement should fit under a model of deliberative democracy, where decisions are at least partially shaped by citizens. Under this model, consumers can be involved in choosing the topics for discussion and deciding what issues will be on the agenda. However, Thomson notes that an alternative model is often the reality, where consumer engagement is pre-framed by government questions and interests and true participation is limited; under this approach, the purpose of consumer engagement is to encourage input relating to existing proposals and plans.

	Scientific approaches	Market solutions	Legal approaches	Democratic participation
Rely on:	Objective measurement and statistics	Market information for more responsive services	Defined rights, access to judicial and semi-judicial institutions	Ways to participate individually and collectively in health decisions
Consumers are:	Subjects of research	Informed choosers	Citizens with rights	Equal partners and citizens
Strategies:	Standards Outcomes Guidelines Variations Classification patient surveys	Information on providers Marketing Statement of expectations Consumer surveys	Health charters Right to complain Legal redress Legislation Transparent decision making Advocacy	Consultation Involvement in decisions Hand held records Representation Accountability to consumers

Figure 2: Four approaches to consumer engagement (Draper & Hill, 1995)

Consumer engagement in practice

In practice, consumer engagement is often interpreted through current government policy in a way that combines the competing models outlined above. Rowe and Shepherd (2002), in a review of engagement practice in the UK's National Health Service, found a combination approach being articulated through the New Public Management paradigm. Health bureaucrats seem to design consumer engagement to ensure that services are more responsive to consumers' needs and preferences and that public resources are used more efficiently and effectively. This places the emphasis of engagement on service obligations to ensure that public funds are well used, aligning it most closely with the consumerist model outlined by Rowe and Shepherd. This is a pragmatic approach to engagement that is missing from the alternatives proposed by Draper and Hill (1995). (A pragmatic approach is different from the 'market solutions' approach because consumer choice often does not realistically apply to health policy.)

The approach used in the UK means that power is retained by service providers. From this perspective, consumer engagement becomes a management technique – a way of increasing organisational learning and contributing to strategic and operational concerns (Rowe & Shepherd, 2002). When seen as a management technique, consumer engagement can influence decisions, but that influence will be mediated by other stakeholders and does not include a decision making capacity. Rowe and Shepherd argue that one of the ongoing confusions about consumer engagement in the UK is that the rhetoric about its purpose (of partnership and joint decision making) does not match the practice, and this creates uncertainty and fear amongst decision makers. Rowe and Shepherd propose that, if national guidance about consumer engagement acknowledged it as a management tool,

Engaging marginalised groups through community development approaches

A community development approach can encourage people in marginalised groups to become involved in consumer engagement activities. A project in the UK used community development techniques – including personal contact with a development worker over a long period, and the establishment of an independent organisation to provide an infrastructure for engagement – to involve housebound people in health planning. Although the process was labour intensive and time consuming, it provided important information for the planning and monitoring of health services. It also provided a technique for empowering people to develop the skills, knowledge, and confidence required to contribute to the planning process (O'Keefe & Hogg, 1999). The community development approach was common in the 1970s, but has been overshadowed more recently by corporatist and partnership approaches (NRC, 2002).

then decision makers may be able to develop the relationships required to make engagement more effective.

Consumer engagement can be designed to meet a variety of practical purposes for organisations. In addition to the purposes outlined by Health Canada (see page 16), consumer engagement can:

- Fulfil statutory requirements (Thomson, 2003)
- Encourage acceptance for organisational decisions (O'Keefe & Hogg, 1999)
- Minimise dissent by flushing out challenges to emerging policies (Cabinet Office, 1999)
- Advise decision makers without devolving decision making power (Cabinet Office, 1999; Planning NSW, 2003; Rowe & Shepherd, 2002).

Engagement realities may not match initial intentions

Durey and Lockhart (2004) illustrate the difficulties of translating a commitment to consumer engagement into practical outcomes with a discussion of the role of engagement in establishing a Multi Purpose Service (MPS) Program in Western Australia. Although a commitment to engagement with the local community should underpin the development of an MPS, Durey and Lockhart found that conflicts of interest, a lack of representation, and misunderstandings about the meaning of consumer engagement were evident throughout the process. In the case they reviewed, the line between consultation and persuasion was blurred, and people felt that they were left with little choice about the outcomes. The consultative committee felt that the community was uncooperative, while the community felt that the committee was nothing more than a departmental mouthpiece. The consultative committee was caught between the department and the community, and between the department and health service providers.

An organisation may choose to use different types of consumer engagement for different policy problems. Health Canada (2000) argues that people do not want to be engaged extensively over every issue. Instead, they want to be engaged appropriately. Higher level and more extensive engagement is likely to be appropriate when the policy under discussion has wide impact and/or involves potential conflicts and difficult choices (Cabinet Office, 1999; Health Canada, 2000; Qld Health, 2002).

Who initiates the engagement?

Consumer engagement is typically conceived as an activity designed and initiated by organisations as a way of contributing to organisational decision making. But consumer engagement can be initiated by either organisations or consumers, and that distinction may have an important influence on how the engagement is conducted.

A distinction between organisation-initiated and consumer-initiated engagement noted by a number of authors is that the programs will be framed and defined in different ways (Draper, 1997; Gillgren, 2005; Kashefi & Mort, 2004; Lasker & Weiss, 2003).

- Organisation-initiated engagement will generally use the language of the organisation, with organisational categories and definitions. In most cases, it is carried out in the interests of the organisation, with the issue under discussion being defined by the organisation and of relevance to the organisation. Consumers are expected to contribute in a way that fits with bureaucratic and jurisdictional boundaries. Consumers may wonder why the questions asked are narrowly focused, fail to appreciate related issues, and ignore the complexity of consumers' concerns. Gillgren (2005) gives an example of community consultation about a road project in Western Australia: community members wondered why the consultation focused only on the road when their issues of concern were much broader (such as safety for the whole area).
- Consumer-initiated engagement can reflect consumers' ways of categorising the world, drawing on both the language and definitions of consumers. This approach can ensure that the breadth of consumers' concerns are addressed, but can be difficult to slot into bureaucratic responsibilities.

O'Keefe and Hogg (1999) argue that the issue of framing can be addressed by ensuring that all consumer engagement starts from a consumers' perspective. They suggest that the individuals involved in initiating engagement should create the infrastructure for their involvement and define their concerns and priorities. When engagement is initiated by an organisation, this consumers' perspective would help to minimise problems with definitions, language, and framing.

Organisation-initiated engagement also varies according who is involved in conducting it.

- Engagement can be conducted by individuals working within the decision making organisation or by an external consultancy. Lamb, Berntsen and Kueppers (2004) note that consumer engagement activities are supported by a substantial service

industry with specialists being brought in to conduct engagement activities. These specialists may work for public relations/communication consultancies, within engineering, architectural, or planning companies, or for project developers. Kashefi and Mort (2004) are highly critical of the work conducted by this 'consultation industry'.

- Within an organisation, engagement can be conducted at senior levels by individuals actively involved in policy development, or left to junior officers. Gillgren (2005) argues that engagement is frequently left to junior officers who have difficulty in focusing on strategic outcomes and informing higher decision making levels.

Who gets engaged?

In an ideal world, consumer engagement would involve everyone. Of course, the reality is that many people do not want to be engaged, and the extent of most populations precludes full participation in a deliberative process. Instead, a small group of 'representative participants' is needed for a consumer engagement program (Abelson, Forest et al, 2003).

Decisions about who to best involve in a consumer engagement program should be based on the questions being considered and who has a direct interest in them. For example, if the discussion relates to what services should be provided, then the whole community's views are relevant. But when the discussion relates to implementation, then the views of potential users are of most interest (Hicks & Harford, n.d.; Ryan et al, 2001).

Newcastle City Council addresses the issue of who gets engaged by defining three different types of stakeholders (Manion, 2000):

- Actively interested stakeholders (people who have a strong and active interest and want to be engaged at a high level)
- Moderately interested stakeholders (people who have some interest and are likely to want information and some opportunities for engagement)
- Uninterested stakeholders (people who don't know or don't care about the issue).

Manion notes that people may move between these three groups as a project progresses. For example, uninterested stakeholders may become more engaged as the project progresses and information is released, while actively interested stakeholders may become less interested if their concerns are adequately addressed. Organisations may need to

communicate differently with these different stakeholders, and communicate with them at different stages of policy development.

The National Resource Centre for Consumer Participation in Health (NRCCPH, 2002) proposes a continuum of who can be involved in consumer engagement – from the individual at one end, to the whole community at the other. The continuum recognises that health consumers can join together in six different types of groups to participate and influence policy (the continuum also recognises that these groups rarely reflect the health sectors defined by governments):

- Groups with local geographic interests
- Groups of people with the same health condition or experience
- Groups with a shared experience about harm from a product or service
- Groups that protest particular practices
- Groups with a shared identity
- Generic groups or coalitions that form to advocate on behalf of the whole population (Bastian, 1998, in NRCCPH, 2002).

Three types of health consumers' groups seem to be most important in the health policy context:

- Groups with a social or population focus (such as ageing or children)
- Groups with a single disease or condition focus (such as mental health)
- Peak consumers' groups which are a coalition or alliance of other community and consumers' groups (Horey & Hill, 2005; Jones, Baggott, & Allsop, 2004).

Engaging consumers in the Danish health care sector

Denmark uses a range of practices to promote consumer engagement, including consensus conferences, user surveys, user boards, patients' choice feedback, open hours with ministers and parliamentary committees, mailings, written comments, and public hearings. One Danish county, Aarhus County, developed its four year health plan (1998-2001) through active consultation with consumers including a mailing to all citizens and six regional public meetings. Approximately 600 people attended the meetings, and 250 written comments were received. Blume suggests that it is sobering to realise that even with an extensive effort to consult with consumers, most do not become actively involved. However, he suggests that this lack of active participation is not necessarily a problem, if consumers perceive that they have adequate opportunities to participate if they wish to do so. (Blume, 2001)

The decision about whether to engage with consumers at an individual level or through organised consumers' groups is an important one. As Oliver et al (2004) note, members of organised groups are not typical of the general public: they have expressed an active interest in an issue, and are likely to have access to a broad range of views from within their organisation. They are also likely to be more knowledgeable than the general public, and to have formed opinions. In addition, members of organised groups will often be accountable to the wider group for the contributions that they make, and they can consult with the

organisations' members as part of their involvement (CHF/NHMRC, 2001). This means that members of health consumers' groups can often provide detailed, thoughtful, and useful input to projects, but it is possible that their views do not represent those of the less actively involved public.

Horey and Hill (2005) note that, as a sector, health consumers' groups tend to be under-funded, duplicative, have insufficient access to training, include an uneasy mix of voluntary and paid staff, offer little career structure for staff, and are multi-functional (i.e., they offer services for members but also engage in lobbying, researching, and fundraising). Another marker of the sector is the proliferation of small groups – with overlapping interests, small staffing, and little infrastructure. This proliferation can make it difficult to engage with policy making at the national level (Horey & Hill).

Engaging with consumers through established health consumers' groups allows organisations to tap into existing networks as part of the engagement process. This can bring great advantages in terms of time, cost, and clear articulation of issues, but it also brings some risks. Hicks and Harford (n.d.) suggest that consulting only with established groups risks limiting the scope of engagement to groups and interests that already have a voice, and risks not conveying the true spread of opinion. Scutchfield, Ireson, and Hall

Health consumers' groups influence policy

There is some evidence that health consumers' groups are becoming increasingly influential in policy making. A study of 123 health consumers' groups in the UK found that 'influencing national policy' was named as an important activity by all groups, with 75 per cent having been in contact with government about policy issues in the previous three years even though the main purpose of most groups was to provide services to consumers. Peak consumers' groups are most likely to have contact with government about policy issues. Consumers' groups can bring the experiences of consumers into the policy process and articulate a point of view that other stakeholders may not be aware of. The structure of most health consumers' groups allows them to claim to be the legitimate representatives of consumers. (Jones, Baggott, & Allsop, 2004)

(2004) argue that allowing groups to represent the consumer voice can perpetuate the tendency for elites (i.e., those who are already involved and have some power) to discuss the problem and solutions, instead of involving a range of individual citizens. Health Canada (2000) makes it clear that consumer engagement should involve consumers at an individual level in addition to those represented by consumers' groups.

A further potential problem of engaging with health consumers' groups is the possibility of conflicts of interest. Consumers' groups may receive funding from pharmaceutical or other organisations which may influence their approach to consumer engagement on an issue. Herxheimer (2003) argues that conflicts of interest can be a problem if consumers' groups do not disclose their funding sources.

At what stage does engagement occur?

Consumer engagement can be used at different stages of a project, and this can influence both its potential impact and value. Engagement conducted in the early stages of project definition is more likely to significantly influence policy development than engagement conducted when the available options have already been determined.

Although many authors note that engagement should be considered from the initial planning stages and implemented early in the policy development process (e.g., Oliver et al, 2004; Qld Health, 2002), the reality is often quite different. It is still possible for initiatives to reach an advanced stage of development without consumer input (NRCCPH, 2002). Nolan (2004) notes that community engagement tends to follow the naming of the problem, rather than preceding it. This confines the process of engagement to a boundary defined by the organisation and can restrict its capacity to generate solutions. In a review of consumer

Public consultation by the NHMRC

In Australia, the National Health and Medical Research Council is required to conduct public consultation before it makes regulatory recommendations or issues guidelines. The NHMRC's typical practice is to have an expert working party develop a document for consultation, then publish formal notices of consultation in the Government Gazette, on the NHMRC website, and in national daily newspapers. Working party members receive copies of all submissions, and revise the documents taking the submissions into account. This practice illustrates the way that engagement can be left until late in a project – when it becomes a process of refinement rather than a contributor to policy development. (Thomson, 2003)

engagement practices in WA, the Office of Citizens and Civics found that engagement was often pushed to the end of the policy development cycle and left to junior officers (Gillgren, 2005). As Gillgren notes, when this happens it is difficult for engagement to focus on strategic outcomes or inform higher decision making levels.

Bullock, Mountford, and Stanley (2001) suggest that, in the UK, the government's promotion of consumer engagement is leading to increasingly innovative approaches, and that policy makers are bringing forward the engagement phase so that it occurs as an integral part of policy formulation and development. They note that this is a big shift from the traditional approach where consumer engagement is left until a fully worked-up policy has been developed for consultation with external stakeholders. Bullock, Mountford, and Stanley discuss a case study from the Department of Work and Pensions, where volunteers were involved in trialling a new system, and suggest that conducting earlier consultation may be slower than the traditional approach, but the resulting policy will be well-tested and have high commitment from interest groups.

Discussions about the stage at which consumer engagement is conducted can suggest that policy development is a linear process into which engagement can be slotted. Instead, policy development tends to be complex, uncertain, and non-linear, and planning for consumer engagement can be difficult. Church et al (2002) note that, for governments, managing the complexity of policy development to achieve political objectives within short timeframes tends to be an over-riding priority that reduces the importance of consumer engagement.

In addition, policy development is frequently conducted within a reactive, crisis-style framework that makes a deliberative process of consumer engagement difficult to achieve. Scutchfield, Hall, and Ireson (2006) found that, while most government health officials agree with the philosophy of consumer engagement, many have reservations about how it can work in practice. When policy development happens as a reaction to outside or political influences, finding the time and resources for a useful consumer engagement program can be difficult.

Ideally, consumer engagement should be planned for in the initial stages of policy formulation – before the issues are fully defined and the parameters for the project are set. Consumer engagement is best seen as an iterative process that continues right throughout policy development, with engagement from one phase informing what comes next (Draper, 1997). This ongoing engagement may be more resource-intensive, but it delivers information which can not be obtained through a snapshot approach of a one-off consultation (O'Keefe & Hogg, 1999).

What types of decisions can consumers contribute to?

In Australia, consumer engagement in health has traditionally focused on two issues – non-medical aspects of health services, and choice of treatments for individual patients. Decisions at other levels tended to be made by bureaucrats and service providers (Hicks & Harford, n.d.; Mullen, 1999). However, the growing requirement for consumer engagement during policy development is widening the range of issues on which consumers' views are being considered.

An implicit assumption in engagement practice about health policy is that consumers have preferences that they can articulate. While the members of health consumers' groups are likely to have well-informed preferences, it is possible that the wider group of consumers does not. Ryan et al (2001) suggest that many people construct their preferences as they go along, and that the techniques used for consumer engagement will influence the views uncovered. For example, Ryan et al suggest that techniques which encourage deliberation, such as focus groups and citizens' juries, will help people to refine and reflect on their ideas, and may produce more valid outcomes than snapshot studies based on closed-question interviews.

It is also possible that consumers need significant levels of knowledge to contribute meaningfully at the health policy level, particularly when asked to contribute in an ongoing way. Hicks and

Citizens juries in Western Australia

Citizens juries were used by the Medical Council of Western Australia in 2000 and 2001 to consider priority setting in the health system. The guiding principles for the citizens' juries included random selection of lay participants, a community focus (participants were asked to make decisions for the community not for individuals), balance (witnesses were asked to be balanced in their presentations), and deliberation (participants were given time for discussion and decision making). The first citizens' jury, held in March 2000 recommended greater priority setting in health, equity based on equal access for equal need, positive discrimination for disadvantaged people, more spending on prevention and public health ahead of disease treatment, more spending on rural and remote health ahead of urban health, and more of a focus on community based health services. The second jury, in February 2001, focused on equity and asked participants to make decisions about resource allocation. Mooney and Blackwell argue that citizens' juries can give meaningful advice on broad issues underlying resource allocation, and are a technique capable of effectively dealing with big issues. (Mooney & Blackwell, 2004)

Harford (n.d.) note that it can be difficult for consumers to maintain comprehensive and up-to-date knowledge, and that the time and effort required can be beyond what is reasonable to ask of consumer participants. They suggest that ‘participant fatigue’ can be the result, with the possible implication that consumers will withdraw from the process (Hicks and Harford are referring to intensive engagement techniques such as consumer representation on planning committees, not to one-off techniques such as interviews or community meetings).

In an era of limited government budgets for health, rapidly developing technologies, and growing consumer need, the potential of consumers to contribute to decisions about resource allocation is important. Bowling (1996) describes a national survey in the UK exploring the views of adults about health service priorities and rationing by asking participants to rank 12 services. Bowling argues that measuring baseline public opinions and values is an important first step in opening debate about health care rationing. If those views seem to conflict with medical evidence, then public information and education are even more essential.

While policy makers may expect consumers to be community-minded when discussing resource allocation, Murphy (2005) questions whether this really happens. She notes that consumers tend to prioritise high-tech services which can overlook the needs of some community members, and that consumers can be unwilling to allocate resources in a way that disadvantages low-income people. Murphy argues that consumers may not move beyond self-interest to address the needs of vulnerable people when they are participating in community engagement programs. Ryan et al (2001) cite research that suggests consumers support an individual responsibility model for health policy, without consideration of the groups that this may exclude.

Making governments available through open hours

In Iceland, all government ministers hold open consultation once a week, providing individual citizens with an opportunity to influence public policies. In Denmark, many ministers and parliamentary committees schedule open meetings each week. At least one Minister frequently goes on tour to conduct consultations. (Caddy, 2001)

As consumers are engaged in discussions about health policy and resource allocation, they tend to become aware of the complexities of the system and the challenges faced by decision makers. It is possible that these consumers will lose their lay perspective, and become more closely aligned with other stakeholders and policy makers. Abelson, Forest et al (2003) suggest that consumer engagement needs to be planned to balance the development of an informed and engaged group who can effectively contribute to policy development, without becoming co-opted by the process.

Do consumers want to be engaged?

According to Gillgren (2005), one of the reasons behind the current focus on consumer engagement is that consumers are demanding to be involved. She argues that consumers have diminished confidence in the ability of governments and institutions to deliver the society that people want, and a diminished sense of community. One way that consumers are seeking to address these issues is by being engaged in policy development and decision making. Health Canada (2000) also argues that there is widespread public demand for greater involvement in decision making and better access to information; 93 per cent of Canadians say that the government should place higher priority on engaging the public about health care decisions. Bowling's (1996) survey of consumers in the UK found that 88 per cent of people believe consumers should be involved in planning health services.

Ryan et al (2001) conducted a series of telephone interviews exploring whether public views should be considered in setting health care priorities. Most respondents stated that the community has a role to play in decision making, and that consumers' views are important. However, when asked to rate the public's views against five other criteria for setting priorities (potential health gain, evidence of clinical effectiveness, budgetary impact, equity of access and health status inequalities, and quality of service), respondents ranked the public's views as the least important. This suggests that, while people want to be engaged, they may not feel that their views should dominate. This is supported by two other studies cited by Ryan et al: a survey by the British Medical Association and The King's Fund found that only 22 per cent of the general public felt they should be involved in making prioritisation decisions about health services; a citizen's jury reported by Coote and Lenaghan concluded that the consumers should be involved in decision making, but only in conjunction with other experts.

Litva et al (2002) used focus groups and interviews to explore the public's preferences for being involved in health rationing decisions. They found a strong desire for public involvement at the system and program levels, but less willingness for public involvement at the individual level. Their participants generally favoured an approach that included consultation and a guarantee that their contribution would be heard and considered, with some follow-up process where the final decision was explained. Participants expressed little desire to share responsibility for decision making, but argued that their involvement might improve the final decision and its acceptability. Litva et al note that the participants in this study argued for a level of engagement that is located in a gap between Arnstein's (1969/2003) levels of consultation and partnership (see page 13 for a discussion of

Arnstein's ladder), and suggest that the models need to include a form of engagement best characterised as 'accountable consultation'.

O'Keefe and Hogg (1999) suggest that key determinants of whether people want to be involved in engagement programs are whether they consider it worthwhile and have the time and resources needed. This can be influenced by whether they

think their views will be listened to, they can influence the outcome, and they are confident about their expertise and ability to contribute. It is also possible that consumers will be concerned that criticising existing services will lead to those services being withdrawn.

Moore (2003) notes that consumers only want to be involved if they feel they are being listened to. She discusses two case studies where consumers lost interest during the process: in one case, consumers lost interest in consumer forums and public workshops because they felt they had participated in many similar events but rarely received any feedback; in another case, community members reported they were tired of being asked to contribute because their suggestions never seemed to be acted upon. In addition, previous experiences with poorly designed programs can discourage future involvement.

Permanent Citizens' Forums to promote participation

In Norway, the Youth Forum for Democracy promotes the participation of young people in politics and provides advice for government authorities. It includes 16 members who represent youth organisations. (Caddy, 2001)

Citizens' panels

The UK's People's Panel involved 5,000 randomly selected people who were consulted on a variety of issues through surveys and interviews. The panel was designed as a research tool to provide a consistent way for examining the public's views on issues. The People's Panel was recruited in 1998, and was the first example of a national, government-sponsored panel. It was discontinued as a central initiative in January 2002 to allow for more targeted consultation to be undertaken by government departments, agencies, and local governments (Caddy, 2001; Cunningham, 1999; People's Panel web archive).

In Australia, Ku-ring-gai Council has established a Resident Feedback Register, based on the People's Panel concept. The register includes 200 people, randomly selected from the community, who are invited to join the register for up to two years. Participants don't meet each other unless they are recruited to form a citizens' jury or focus group. When they are invited to comment on an issue, they are provided with information a week in advance, to give them time to get to know the topic and talk to friends and family. (IAP2, n.d.b)

Engagement techniques

Engagement techniques vary widely and deliver different results. There is no best technique for engaging consumers, and no single set of ideal methods that policy makers can draw upon. Indeed, because consumer engagement occurs within a local context, prescription about techniques would not be appropriate (Cabinet Office, 1999). Instead,

engagement techniques need to be chosen for each project – to suit the issue being considered, the goals of the program, the policy or service being developed, and the consumers being engaged (Draper, 1997; Ryan et al, 2001). Decisions about the best techniques for engaging with consumers may be best made in direct discussion with the consumers themselves (Oliver et al, 2004).

Describing engagement techniques

The International Association of Public Participation website includes a toolbox that provides an overview of several engagement techniques (www.iap2.org.au). An extensive description of techniques is also included in the Citizen Science Toolbox – an online tool for community involvement in science produced by the Coastal CRC (www.coastal.crc.org.au/toolbox/index.asp).

The consumer engagement literature includes extensive discussions about techniques, offering advice about when to choose a particular technique, how it should be implemented, and its advantages and difficulties. These discussions are not reproduced here; examples of toolkit-style discussions of engagement techniques are included in Appendix 2. Figure 3, on the following page, uses Health Canada's (2000) continuum to provide examples of suitable techniques for different engagement types.

The techniques chosen for a consumer engagement program are important – different techniques allow consumers to participate in different ways, and can influence the outcome. There is some evidence that consumer engagement is most successful if a variety of techniques are used to engage consumers about a single issue. Oliver et al (2004) suggest that using a range of techniques gives greater confidence in the validity of the consumer views uncovered. NHMRC (2006) proposes that inclusive and effective engagement requires multiple approaches, with strong links between the different approaches and particular attention to including minority and vulnerable groups. AHCRA (2005) notes that using multiple techniques helps to reduce the bias inherent within each technique. In addition, using a variety of techniques, sometimes in parallel, can mean that different members of the community can be engaged in different ways – large numbers of people may be engaged in a way that is predominantly passive by providing information, while a

Engagement type and purpose	Example techniques
Inform or educate	<ul style="list-style-type: none"> Calls for briefs/requests for proposals Community mapping Fact sheets/backgrounders Focus groups Telephone hotlines Media events Open days
Gather information	<ul style="list-style-type: none"> Meetings with stakeholders Community or public meetings Parliamentary committees People's panels Polling Public hearings and seminars Questionnaires and surveys
Discuss	<ul style="list-style-type: none"> Advisory committees, boards, or councils Conferences Nominal group processes Workshops Online discussion groups Televoting
Engage	<ul style="list-style-type: none"> Charettes Constituent assemblies Delphi process Round tables Retreats Open hours Citizens' panels
Partner	<ul style="list-style-type: none"> Citizens' juries Citizens' forums Consensus conferences Deliberative polling Study circles Think tanks

Figure 3: Techniques suitable for different types of engagement (adapted from Health Canada, 2000)

small number of consumers may become actively involved (Anderson, Shepherd, & Salisbury, 2006).

Abelson, Forest et al (2003) note that while there is extensive discussion in the literature of engagement techniques, there is no rigorous comparison available: in their literature review they found no studies examining consumer engagement techniques within the same decision making process or considering the relative costs of techniques against their effectiveness.

Quantitative surveys provide insights for health policy

In the USA, a telephone survey of over 1,000 adults was used to explore people's opinions on how to improve healthcare and explore health policy priorities. The survey showed strong public support for efforts to improve the coordination of care and access to information. Three-quarters of respondents said that the US health system needs fundamental change. Expanding insurance and controlling costs should be the top priority for federal action. (Schoen et al, 2006)

Consumer representatives

Consumer representatives are discussed separately here because of their widespread use and significant impact. Involving one or more consumer representative/s on a committee or steering group is a major technique for consumer engagement in Australia. As a consumer representative, an individual is brought into a committee specifically to represent consumers' perspectives and takes part in decision

making on behalf of consumers (CHF/NHMRC, 2001; DHS, 2005b; Nathan, 2004). In most cases, the consumer representative is nominated by an organisation of consumers and is directly accountable to that organisation. For example, the Consumers' Health Forum in Australia provides consumer representatives for over 200 different committees, and consumer representatives are also provided by Choice (formerly the Australian Consumers Association) and the Health Issues Centre.

Horey and Hill (2005) note that including a consumer representative on committees has become the shared consensus of what participation means in Australia; instead of being seen as one engagement technique, a consumer representative has become the dominant model of engagement. Pivik, Rode, and Ward (2004) suggest that a consumer representative is often the most feasible technique for consumer engagement. However, Horey and Hill argue that this approach is limited, and the ongoing reliance on consumer representatives means that other possible structures are rarely explored. Nathan (2004) suggest that the dominance of the consumer representative model makes it difficult for policy makers to hear the views of disadvantaged groups. In addition, the role of the representative may be unclear: are they supposed to bring a lay person view, or represent

the wider community? And if they represent the wider community, do they have the resources and time required to consult with that community? (Nathan, 2004)

Because consumer representatives have links to formal consumers' groups, they bring a number of advantages to a committee:

- They have a structure for consulting with their peers and drawing on a range of consumers' perspectives (Oliver et al, 2004)
- They have a broad understanding of consumers' interests, and are unlikely to rely only on their individual experiences (CCAAC, 2005)
- They are accountable to their consumers' group – this helps them to remain in tune with consumers' issues and not become co-opted or enculturated by the committee they have joined (Moore, 2003).

Hybrid techniques for health reform in the UK

In the UK, a hybrid technique has been used to give consumers an opportunity to discuss health reform. Consumers were invited to mass meetings to discuss the future of the National Health Service, but the meetings operated as quasi-small group techniques by splitting consumers into small groups for discussions. The meetings were hailed by the government as a way forward in helping to form health policy. Up to 1,000 consumers attended each of five large consultation events, with consumers being paid to attend. (BBC News, 2005)

Principles for appointing consumer representatives

The Commonwealth Consumer Affairs Advisory Council has developed a set of six principles for the appointment of consumer representatives in Australia (CCAAC, 2005):

1. Appointments must be made on merit
2. Consumers should be independent and free of conflicts of interest
3. Consumer organisations should be involved in appointments
4. An appropriate range of candidates should be sought
5. The appointment process should be consistent with good corporate governance
6. The appointment process must be transparent, accountable, and cost effective.

However, their links to formal groups also mean that they can not fully represent the broader group of consumers who do not have such active involvement. Hicks and Harford (n.d.) describe consumer representatives as a restricted form of selected representation – they bring benefits from their links to existing groups, but relying only on consumer representatives risks limiting the scope of an engagement program to groups that already have a voice.

Deliberative techniques

Deliberative techniques are characterised by a process of reasoning, where consumers are given an opportunity to reflect, discuss, question, and think.

Deliberative techniques can include focus groups, citizens' juries, planning cells, deliberative polling, consensus conferences, and citizens' panels (Abelson, Forest et al, 2003; Murphy, 2005).

One value of deliberative techniques is that participants are exposed to a range of perspectives (Hicks & Harford, n.d.). Research shows that people involved in deliberative

techniques often change their attitudes as they listen and have time to reflect (Rogers & Robinson, n.d.). In some cases, participants may be given information in advance, and return to the discussion on numerous occasions.

E-engagement techniques

New technologies have increased the techniques available for consumer engagement, with online environments creating opportunities for e-engagement through web-based chat rooms, discussion groups, online polling, online panels, bulletin boards, and websites offering information. Online techniques offer some important advantages: they are not restricted by geography, can be available at all hours, offer navigation and searching, provide simple methods for consumer feedback, are often low cost, and can be easily updated. However, online techniques are still in their infancy, and it is important that they are integrated with other, offline, activities. Online techniques can not replace traditional techniques, particularly those that work in a face-to-face environment. (Caddy, 2001, Lamb, Bernsten, & Kueppers, 2004; OCC, 2005)

Consensus conferences used to advise government

In Denmark, consensus conferences have been used to advise parliament on issues such as fertility treatment, human genome research, gene therapy, and risk assessment thresholds. Sixteen randomly selected non-experts meet for four days to listen to experts' and officials' views, deliberate on an issue, and present their views (they present a consensus but not necessarily a single position, as in a citizens' jury) (Caddy, 2001).

Abelson, Forest et al (2003) note that deliberative techniques are well suited to the health field because they can meet the broader objectives of stimulating debate, improving public understanding of complex issues, and encouraging consensus about health service priorities. However, a weakness of deliberative techniques is that only a small number of people can meaningfully deliberate at any one time (Abelson, Forest et al; Institute of

Development Studies, n.d.). In addition, deliberative techniques tend to be expensive and difficult to organise, and this tends to justify their use only for substantive issues where there are clearly articulated options and readily available information (Abelson, Forest et al).

Deliberative techniques such as citizens' juries clearly offer meaningful involvement for participants, and provide a method for building awareness and expertise amongst the individuals involved. Blamey et al (2000) argue that citizens' juries have great strength as a deliberative technique because of their focus on reason, argument, and deliberation. Jurors' decisions can have great impact, and a small number of jurors share responsibility for their decisions; this means that individual jurors are usually strongly motivated to make well-informed decisions. Blamey et al suggest that jurors are imbued with a concentrated and representative notion of responsibility.

Planning for Real

Planning for Real is a technique created by the Neighbourhood Initiatives Foundation to consult with the public at all levels through existing networks. The technique looks at what level of engagement to seek, who to consult with, and what sort of support is needed. The technique is commonly used to plan local environments and new developments. A large scale model is used to help with planning, and consumers use cards to indicate what things they want to see in their community. During a planning meeting, participants group ideas into 'now', 'soon', or 'later' to develop a full-scale action plan for the community. Planning for Real is proposed as a technique for ensuring buy-in by both policy makers and consumers – the repeated engagement helps to ensure that policy makers feel comfortable with the outcomes. However, its application to the health sector has received little discussion. (NIF, 2006; Ryan et al, 2001)

There is some suggestion that deliberative techniques make a difference to participants' views, with participants being more amenable to change when more deliberation is introduced (Abelson, Eyles et al, 2003). Deliberation also offers the potential for views to become more entrenched, as participants develop arguments to underpin their opinions.

But questions remain about the extent to which techniques like citizens' juries can influence the policy process. Mooney and Blackwell (2004) argue that citizens' juries can provide meaningful advice to governments, based on their review of experiences in Western Australia. This is supported by Blamey et al (2000) and Niemeyer and Blamey (2003), based on their experiences of organising citizens' juries relating to environmental management in Far North Queensland. The Institute of Development Studies (n.d.) suggests that citizens' juries can lead to shifts in public policy. But Morkrid (2001) argues that it is difficult to assess the impact of deliberative techniques on policy making. Blamey, McCarthy, and Smith (2000) point out that citizens' juries will not necessarily produce better decisions than other forms of consumer engagement, and they note that deliberative processes need to be planned and structured in a way that reduces unwanted group dynamics and ensures that the jury's processes can proceed in a constructive way. In their

paper, Blamey, McCarthy, and Smith (2000) include a series of recommendations about the structure and conduct of successful citizens' juries.

Citizens' juries used to plan environmental management

In 2003, a citizens' jury was held in Far North Queensland to consider the future use of the Bloomfield Track and also analyse the impact of deliberation on the policy preferences of jurors. After the four day jury process, deliberators unanimously agreed that the track should not be upgraded, but were divided on how it should be used. The jury's facilitators argue that the jurors' inability to reach consensus is not an issue: the value of the jury process is that it provides a way forward for devising policies and led to agreement at the meta level of relevant arguments, preferences, and values. They suggest that citizens' juries can provide valuable decision inputs, but should not replace established democratic decision making processes. They also note that deliberation did lead to a change in jurors' preferences, with a considerable convergence towards consensus during the jury's discussions. (Niemeyer and Blamey, 2003)

In 2005, a citizens' jury was conducted in Perth to explore water management issues. The jury was organised in conjunction with the Innovations in Community Engagement Conference; conference participants were introduced to the jury process and jurors were asked to consider what methods of community engagement would be most useful in Western Australia. The jurors presented their findings to a plenary session of the conference which was attended by two government ministers. In addition to making recommendations about water management, the jury recommended that community engagement is an effective vehicle for decision making on public policy. They proposed that the methods should be used and expanded in Western Australia, integrated into the workings of government, and monitored by an independent body. They proposed two methods as being most useful: one approach combining the deliberative poll and citizens' jury methods, and another approaching using a citizens' assembly. (DPI/Jefferson Center, 2005)

In 1999, a citizens' jury was held in Canberra to discuss national park management and consider the usefulness of the citizens' jury technique. The facilitators adopted a careful planning process, including a series of focus groups to develop and test the scenarios used in the jury. Jurors considered two charges: their preferred option for national park management and the introduction of a park levy from income tax. Jurors reached consensus on a proposed park management approach and agreed that a park levy should be introduced, but were unable to agree on the extent of the proposed levy. The facilitators describe citizens' juries as a useful technique for developing, articulating, and transmitting to policy makers an informed, deliberated public view on matters of public policy. They argue that citizens' juries provide for consensual outcomes, rather than the antagonistic responses that are often a feature of other methods for public participation in environmental issues (James & Blamey, 2000).

For the Institute of Development Studies, one of the key advantages of deliberative techniques is that they provide a mechanism for presenting consumers' views as legitimate and, therefore, more difficult for government to ignore; legitimacy of consumers' views is underpinned by methods of random selection, access to 'the facts', and opportunities for argument and discussion. Another important advantage of deliberative techniques is that media interest in the process can lead to increased public awareness and further calls for consumer involvement (Institute of Development Studies, n.d.; Morkrid, 2001).

Despite the great potential that deliberative techniques offer for meaningful involvement, it is possible for decision makers to undermine the legitimacy of consumer input. This can happen if decision makers retain tight control over consumers' discussions (by controlling the parameters of the discussion or the timeframe), or if decision makers control the information available to consumers (by writing the background materials or controlling the 'expert witnesses' chosen to give advice). In addition, the outcomes of deliberative techniques are rarely binding (Abelson, Forest et al, 2003).

ChoiceWork dialogue involves consumers in health policy in Canada

The Romanow Commission on the Future of Health Care in Canada used ChoiceWork dialogue to engage consumers in discussions about health reform. Twelve one-day dialogue sessions were held across Canada, each with about 40 participants. Participants were asked to consider four scenarios for reform of health services and create their own vision of the health system they would like to see in 10 years' time. They were also asked to consider the practical choices and trade-offs necessary to achieve that vision.

The outcomes, which were fairly consistent across the 12 dialogues, were then confirmed through a follow-up telephone survey of 1600 Canadians. The cost of the dialogues was significant (\$C1.3 million), but they had an important influence on the Commission's report, released in November 2002, and on the following public debate. Maxwell, Rosell, and Forest argue that the abilities and desire of the general public to engage in policy making in this way should not be underestimated. They suggest that the dialogue heightened political interest in this type of deliberative engagement, with decision makers recognising that the methods can reveal the 'true' voice of the public. (Maxwell, Rosell, & Forest, 2003)

Consensus conferences in Norway

The first consensus conference in Norway was held in October 1996 to examine GM food. The panel included 16 laypeople. Following 2 weekend seminars for training and preparation, the panel met for 4 days, heard addresses from 15 experts, and gave a consensus report on the topic. The conference was evaluated positively, but evaluation focused on the process, not outcomes. Although the conference provided advice to government, Morkrid notes that it is difficult to assess the impact that the conference had on decision making. Perhaps the biggest benefit of the conference was to raise public awareness – both about the issue and about the government's commitment to consult with the public. Since 1996, a series of consensus conference have been held in Norway, particularly in the areas of science, health, and medicine. The Ministry of Health and Social Affairs uses consensus conferences as a permanent engagement instrument. (Morkrid, 2001)

Using deliberative forums to influence health policy in the USA

A rural community in Kentucky used deliberative forums to explore community concerns about health issues and health decision making. The community/academic partnership initially used focus groups to identify topics of interest. This was followed by a questionnaire to collect more information, and a survey of health care providers. A Community Health Profile was developed and shared through a Town Hall Meeting. Two major themes emerged from the data, health behaviour and access/cost/quality issues. Over the next 11 months, the partnership held 52 public forums and engaged with more than 575 citizens. The themes emerging from the public forums were summarised in a consumer-friendly booklet – *All is Not Well: Citizens Speak Out About Health Care in Daviess County*. The forums led to several public actions, including the formation of a new interest group – Citizens' Health Care Advocates. (Scutchfield, Ireson, & Hall, 2004)

Using a citizens' jury to develop citizen-owned views on GM foods

In the UK in 1997, the Citizen Foresight Project used a citizens' jury to explore people's views about GM foods and develop recommendations for government. The project was developed by Dr Tom Wakeford from the University of East London, in collaboration with the NGO Genetics Forum. The project was a citizen-initiated and led initiative that sought to involve a representative group of citizens in order to influence government policy. The aim was to provide a legitimate citizens' view in a way that had not been achieved through government efforts. The jury included 12 randomly selected individuals, who made use of 6 expert witnesses and developed recommendations for government – including the key recommendation of a more cautious approach to GM foods. The jury's conclusions may have contributed to the government's public consultation on biosciences and to subsequent shifts in government policy. Since the Citizens' Foresight Project, several citizens' juries have been held in the UK. (Institute of Development Studies, n.d.)

Barriers to engagement

Several authors discuss barriers which can make effective consumer engagement difficult to achieve. These barriers can be divided into three groups: resources, consumer issues, and organisational issues. One barrier which overrides all three groups is the potential of engagement to paralyse the decision making process. Consumer engagement can slow policy making and make contentious issues difficult to resolve. Paralysis can occur when engagement is repeatedly conducted in an attempt to reach consensus (Manion, 2000).

Resources

The most frequently discussed barriers to effective consumer engagement are time and cost (Bullock, Mountford, & Stanley, 2001; Horey & Hill, 2005; Oliver et al, 2004; Qld Health, 2002; Rowe & Shepherd, 2002). It appears that consumer engagement is often expected to be completed within limited and unrealistic timeframes that restrict its effectiveness. When the timeframe for engagement is driven by the pressures of politics or a pre-determined organisational planning cycle, it can be difficult to fully engage consumers – particularly if the program aims to involve consumers in developing and implementing policy decisions. It seems that techniques involving deliberation and contribution to decisions require more time and money than information gathering or one-off consultation (Bullock, Mountford, & Stanley, 2001). But even information and consultation techniques suffer through time and cost constraints: for example, poor advertising of public meetings and inadequate timeframes for responding to requests for written submissions can severely limit the potential for these techniques to adequately explore consumers' views (Horey & Hill).

Adequate resources are needed to promote engagement programs and ensure that consumers are given an opportunity to contribute. Finney (1999, in Thomson, 2003) argues that, without adequate promotion, engagement programs can become closed exercises designed to legitimise the policies developed by bureaucrats. Consumers need to hear about the opportunity for engagement and be given adequate notice if they are to be involved.

Consumer issues

The reality for most consumers is that they can not participate on an equal footing with funders, bureaucrats, and health professionals. Consumers are set apart by their lay

knowledge and lack of organisational resources, and often by their unfamiliarity with the policy process. In addition, consumers involved on committees as consumer representatives often face a situation where everyone else is a member of the committee as part of their paid employment and, even though consumer representatives are often paid for their time, their situation is different. Consumers are frequently faced with an imbalance of resources that can be manifest through disproportionate access to information, unequal access to resources, unequal interests, and differing stakes in the outcome (Church et al, 2002).

In many situations, there is a tension between the knowledge of experts and the knowledge of lay people (Horey & Hill, 2005) which can make it difficult for consumers to feel that their views are taken seriously. Oliver et al (2004) note that scientific evidence often seems to be given more weight than consumer views, and it is easy for consumers to feel that their input is not valued. There may also be a tendency for consumers to defer to medical knowledge (Anderson, Shepherd, & Salisbury, 2006; DHS, 2005b). The lay voice in expert committees tends to be restricted to one person, who can be easily intimidated by health professionals and feel like a lone voice for consumers. Bastian (in Richards, 1999) argues that health professionals often use language that reflects an entrenched medical culture and is derogatory to consumers, while doctors retain views that they are the right people to speak and act for their patients.

To be able to participate effectively at the policy level, consumers need to develop a sound understanding of the health system and the issues it faces, and they need to be able to talk about those issues. This can require extensive time in preparation, and significant support and training for their participation (DHS, 2005b; EPA, 2001; Horey & Hill, 2005; Rowe & Shepherd, 2002). If consumers are unfamiliar with the issues under discussion, the language used, the processes of meetings and policy development, or the people they are asked to work with, they can face significant challenges (DHS, 2005b; Horey & Hill, 2005; Oliver et al, 2004; Pivik, Rode, & Ward, 2004). Anderson, Shepherd, and Salisbury (2006) report that meeting processes can be both tedious and daunting for consumers, who need to survive an initially difficult period before they become familiar enough with the jargon and the processes to be able to contribute.

Consumers' expectations can also create a barrier to their engagement. If consumers have had previously poor experiences with consumer engagement, then their expectations of similarly disappointing experiences can prevent their full participation. Gillgren (2006) argues that consumer cynicism is a major barrier to their participation. Consumers may feel that they are unable to significantly influence issues and that their involvement is therefore not worthwhile (EPA, 2001). Alternatively, consumers who have high expectations may be

disappointed by the reality they face and withdraw from the process. Pivik, Rode, and Ward (2004) note that differing definitions of engagement, incongruence between the stated purpose of engagement and its practice, and tokenism have all impeded consumer engagement efforts.

Consumers can also face barriers to engagement from their own personal circumstances. Their own health issues, their need to earn an income in paid employment, their roles as carers, or a lack of resources (including financial resources, or skills and knowledge) can all make active engagement difficult (DHS, 2005b; Scutchfield, Hall, & Ireson, 2006).

Organisational issues

Barriers to consumer engagement also operate at the organisational level. Organisations may be unfamiliar with engagement practices, unfamiliar with working with consumers, and have negative attitudes towards consumers' input. In addition, organisations may not have a clear idea of how to engage consumers actively and purposefully in policy development (Oliver et al, 2004). Bramson (in Henton et al, 2001) identifies organisational barriers as involving a deficit in either will or skill: many managers lack the will to engage consumers because they feel it imposes enormous burdens without any benefit; at the same time, many have not developed the skills in facilitation, group processes, and conflict resolution that are essential for consumer engagement.

A major issue is the support for consumer engagement within the organisation. Consumer engagement requires both time and money, and to succeed it needs an organisational champion. If senior managers do not support and value consumer engagement, its practice will be undermined; it will also face difficulties if it lacks support from policy makers or committees expected to include representatives (DHS, 2005b; Draper, 1997; Hicks & Harford, n.d.; Oliver et al, 2004; Rowe & Shepherd, 2002).

A lack of organisational skills is seen as a significant barrier to consumer engagement (DHS, 2005b; Rowe & Shepherd, 2002). Organisations need training in how to plan for and conduct consumer engagement, how to talk with consumers in appropriate ways, how to incorporate consumers' views into the planning process, and how to evaluate engagement activities. Consumer engagement programs are frequently designed in isolation – designed by people with no particular expertise in engagement, in isolation from consumers, and without the benefit of knowledge from other engagement programs (DHS, 2005b). Some organisations are attempting to address these barriers through training for

staff, setting up databases of engagement experiences, and requiring managers to report on consumer engagement as part of their work (Gillgren, 2005).

Organisational structures can also become barriers to consumer engagement – organisational structures rarely mirror the ways that consumers structure issues. Church et al (2002) note that consumers are likely to mobilise around single issues, which can be difficult to fit within government structures. In addition, changes of staff throughout a project can create difficulties – caused either through staff turnover or by shifting responsibilities as the project progresses) (Anderson, Shepherd, & Salisbury, 2006).

Power relationships are an ongoing issue for consumer engagement practice. The organisers of engagement programs need to be aware that consumers may disagree with them and may reject the advocated policy (Korczyk, 2006). A commitment to conduct meaningful consumer engagement requires a commitment to engage with the results that it generates. Ultimately, organisations retain the power to work with or reject the input that consumers give. They also retain the power to control the form and extent of consumer engagement programs (Anderson, Shepherd, & Salisbury, 2006).

Power relationships can also be an issue at the committee level. In one example reported by Church et al (2002), bringing consumer representatives onto a committee changed the decision making practice. The board elites moved the locus of decision making out of the boardroom and onto the golf course, bringing issues to the board at a much later stage and thereby undermining the participation of consumers.

Kashefi and Mort (2004) argue that the increasing bureaucratic preoccupation with consumer engagement has created a ‘consultation industry’ that has become a significant barrier to meaningful engagement. They propose that the consultation industry uses pre-defined models and techniques to generate the public’s view as a standardised output. Consumer engagement is designed to serve policy requirements, with little interest in meaningfully engaging consumers in decision making.

More and more consultations are carried out without much consideration (or resources) for what is to be done after the initial process is over. ... [The consultation industry] has a plethora of fixed models of consultation that are formulaic and can be learned, packaged and replicated without being contextualized or situated. The guaranteed output of this process is *the public view* in an unproblematic format, easily digestible by the policy process. ... The public view has been commodified – turned into a negotiated product that can be bought and sold on the market and like any other product, it can even be customized to suit. (Kashefi & Mort, 2004, p. 11)

Facilitators of engagement

The facilitators of engagement identified in the literature tend to answer many of the barriers outlined in the previous section. Facilitators for engagement include:

- An organisational champion, who works at a high level and can influence others in the organisation (DHS, 2005b; Draper, 1997; Moore, 2003; NHMRC, 2004)
- Adequate time and resources (DHS, 2005b; Draper, 1997; NHMRC, 2006; Qld Health, 2002)
- An appropriate infrastructure to provide a framework to support people as they come together; the infrastructure may be a facilitator, funding, a plan, an event, or a history that brings people together (Smyllie, in Woolcock & Brown, n.d.)
- Good communication practice (well-prepared information available in advance, appropriate language, an investment in developing good working relationships, and clear processes for engagement practice and meeting structures (Church et al, 2002; DHS, 2005b; EPA, 2001; Oliver et al, 2004; Qld Health, 2002)
- Good training and support for both consumers and staff (DHS, 2005b; EPA, 2001; Moore, 2003; NHMRC, 2006; Oliver et al, 2004; Qld Health, 2002)
- Previous successes (engagement is self-perpetuating – successes strengthen partnerships and increase confidence) (Draper, 1997; Moore, 2003)
- Accountability and trust – including a clear articulation of how consumers' views will be used, good feedback about what consumers have said, and details about how final decisions will be made (EPA, 2001; Health Canada, 2000; Hicks & Harford, n.d.)
- Community workers to support the engagement program who are independent of planners and policy makers (Anderson, Shepherd, & Salisbury, 2006; O'Keefe & Hogg, 1999).

Training in consumer engagement

In Victoria, the Primary Care Partnership Strategy was launched in 2000. All 32 Primary Care Partnerships developed a Community Health Plan outlining how services would work together to improve the health and wellbeing of their community. Consumer engagement was an important element of the Strategy, and a Consumer and Carer Advisory Subcommittee was formed. Training in consumer engagement was identified as a major need – both for consumers and service providers. Training for consumers focused on health advocacy, community leadership, and action research. Training for providers focused on consumer engagement frameworks and techniques, planning, and evaluation. (Cordwell, 2005)

Evaluating engagement

Evaluation should be an important part of consumer engagement activities. It can allow organisations to reflect on the processes used, the lessons learned, and how engagement contributed to the final decision. In addition, good evaluation can help to ensure that consumer engagement is taken seriously by policy makers (Lasker & Weiss, 2003). Oliver et al (2004) suggest that each exercise in consumer engagement should be evaluated, but they note that this is not often done. It seems that many organisations do not understand how to evaluate its effectiveness (Baker & Collier, 2003).

Caddy (2001) notes that no OECD Member countries conduct systematic evaluation of their performance in consumer engagement. She argues that there is a striking imbalance between the resources put into engagement and the resources devoted to evaluation. In a survey of consumer engagement in policy making used by OECD Member countries, Caddy identifies very few examples of systematic evaluation (evaluations she discusses include an independent review of the citizens' jury process used in the 1998 review of the health system in France, and a review of consensus conferences examining GM food in Norway). Caddy argues that evaluations are needed to explore what works and what does not, to look at possible side effects and unexpected consequences of engagement, and to provide a solid basis for making future choices.

When evaluations are completed, they tend to be descriptive, explaining what was done and some lessons learned. Very few evaluations focus at the outcome level and consider how consumer engagement influenced decisions (Abelson, Forest et al, 2003; DHS, 2005b, Rowe & Frewer, 2000). There are no standard benchmarks for evaluation, and it is difficult to evaluate the impact of engagement in achieving final goals (Lasker & Weiss, 2003). Church et al (2002) argue that there is no empirical evidence to suggest that the current engagement practices adopted by government are effective.

LeGates and Stout (2003) note that it is easy to report on the engagement process, by recording how many people attend meetings, how much information is distributed, and how many people respond to a questionnaire. But this method of evaluation is flawed. It shows that organisations have gone through the motions of engagement, but says nothing about how consumers contributed to decision making or whether consumers were engaged as partners in the process. LeGates and Stout warn that process evaluations can mask a 'phoney' form of engagement, where consumers think they are contributing to decision making, but in reality they are being educated or persuaded to accept a predetermined course of action.

Abelson, Forest et al (2003) argue that the lack of rigorous evaluations is a concern for anyone looking to draw generalisable lessons about consumer engagement. They suggest that more work is needed to determine the meaning of effectiveness in the context of consumer engagement; without an understanding of what effective engagement means, it is not possible to establish clear criteria for evaluation. The meaning of effective engagement should be considered from both the organisational perspective and the consumer perspective – evaluations need to consider both whether the process was successful for the organisation’s purposes and whether consumers feel that their contribution was effective.

The outcomes of consumer engagement are difficult to measure and report. Demonstrating that broad engagement actually strengthens decisions or improves community health is difficult (Lasker & Weiss, 2003). Community engagement programs are often focused around discrete programs or decisions, and Lasker and Weiss suggest that this can mean that engagement is too short term or too thinly resourced to reach a level at which its impacts can be fairly evaluated. In addition, consumer engagement is rarely amenable to the ‘gold standard’ of evaluation – the randomised, controlled trial (Lasker & Weiss).

Abelson, Forest et al (2003) argue that the most comprehensive attempt to evaluate deliberative techniques is based on two meta-principles: fairness (equal distribution of opportunities) and competence (appropriate procedures, appropriate knowledge and understanding). They outline four components for evaluating deliberative engagement processes in the health sector. They argue that evaluations should consider:

- Representation (access of consumers to the consultation process; the legitimacy of any selection process)
- The structure of the processes or procedures (whether they are legitimate, reasonable, responsive, and fair)
- The information used in the process (what information is given and how it is presented)
- The outcomes and decisions arising from the process (how consumer input was incorporated into decisions, the degree to which the decision making authority responded to the public’s input, the satisfaction of participants).

Abelson, Forest et al note that these four components highlight the potentially competing goals for consumer engagement processes, and the trade-offs that must be made (for example, processes that emphasise fairness and meaningful involvement will often be exclusive and involve only a small group of consumers).

Rowe and Frewer (2000) propose two different groups of criteria for evaluating engagement:

- Acceptance criteria – which concern the features of a method that make it acceptable to the wider public, and include the criteria of representativeness, independence, early involvement, influence on policy, and transparency
- Process criteria – which concern features of the process that ensure it takes place in an effective manner, and include the criteria of resource accessibility, task definition, structured decision making, and cost-effectiveness.

Rowe and Frewer compare a variety of engagement techniques using their criteria, and conclude that methods such as referenda, public opinion surveys, and focus groups score well on acceptance criteria but are low on process criteria, while approaches such as citizens' juries, consensus conferences, and citizens' advisory committees score reasonably well in both areas. They note the difficulties involved in evaluating consumer engagement through controlled experimental studies because of the number of variables involved and the contextual or environmental factors that will interact with method type.

The USA's Environmental Protection Agency (EPA, 2001) argues that standard evaluation criteria and performance measures are needed to show the effectiveness of consumer engagement. The EPA proposes that evaluation criteria could be based on:

- Stakeholder/public perceptions regarding their ability to participate (expectations met, level of effort required to participate, goals and processes clearly explained, goals met, fair process, competent process)
- Factors contributing to the success/shortcomings of the engagement effort (and how could it have been designed differently)
- Resources involved in the engagement effort (and can the level of resources be associated with positive results).

Performance measures could be based on:

- How many stakeholders/consumers participated
- Whether all significant stakeholder groups were represented
- Whether the effort resulted in a product or agreement that furthered progress towards achieving positive outcomes.

Principles for consumer engagement

The Consumer Focus Collaboration provides eight key principles for consumer engagement (adapted from Lapis & Verity, 2000, in CFC, 2000):

1. Participation means partnership, means accepting uncertainty.
2. Deciding for effective participation means deciding for organisational change.
3. Align your consumer involvement plans with organisational capacity. Involve staff in building that capacity.
4. Consumer participation must be supported from the top.
5. Consumer participation must be supported from the top down, but it is built from the bottom up.
6. It's all about relationships, so use and build people skills.
7. Consumer participation needs partnerships, partnerships need dialogue, dialogue needs trust. So build trust.
8. Multiple strategies work better.

Conclusion

Consumer engagement is an established practice in the Australian policy making environment, and is now widely used for policy making in the health sector. All Australian governments include commitments to consumer engagement as part of their corporate plans. While there is extensive literature discussing the importance of consumer engagement within health policy, there are limited examples of engagement practice. The examples that are available tend to be descriptive, and there is very limited evidence of evaluation of consumer engagement in health policy – either in terms of evaluation of the engagement process or of its influence on policy making.

Consumer engagement can serve a variety of purposes for policy makers, but the most common arguments in its favour are that it offers increased opportunities for consumers to contribute to policy decisions and helps to ensure that policies are closely targeted to consumers' needs. Consumer engagement activities have increased as governments make efforts to develop policies that have consumer backing and consumers demand the right to participate in decision making. However, the ideals of consumer engagement are not

always easy to translate into practice, and the literature shows evidence that policy makers struggle to develop successful approaches.

Consumer engagement activities require a series of trade-offs and decisions, and this review has categorised some of those trade-offs through key themes emerging from the literature. They include decisions about:

- The type of consumer engagement activity (often described through a ladder or continuum model)
- The purpose of consumer engagement
- Who initiates the engagement
- Who gets engaged
- At what stage engagement occurs
- What types of decisions consumers can contribute to
- Whether consumers want to be engaged
- Choices about engagement techniques.

The barriers to and facilitators of engagement that operate within each organisational context are also important influencers of consumer engagement activity.

This review is the first part of a larger research project about consumer engagement in Australian health policy being conducted by the Australian Institute of Health Policy Studies. The next stage of this project will involve the development of a framework for describing consumer engagement practice. This will be followed by a series of interviews and case studies examining consumer engagement within health policy and other fields.

If you would like further information about the research project, or wish to make comments on this review, please contact the author or the Australian Institute of Health Policy Studies.

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Appendix 1:

Models of engagement types

Level on the ladder	Description	Type of participation
8.	Citizen control	Citizen power
7.	Delegated power	Citizen power
6.	Partnership (consumers can negotiate with power holders and engage in trade-offs)	Citizen power
5.	Placation (some level of consumer influence – government may give in to some demands, or may include representatives in decision making)	Tokenism
4.	Consultation (those without power can hear and be heard, but lack the power to ensure their views are heeded)	Tokenism
3.	Informing	Tokenism
2.	Therapy (power holders can 'educate' or 'cure')	Non-participation
1.	Manipulation	Non-participation

Figure A1: Arnstein's (1969/2003) ladder of participation

Participation level	Public participation goal	Promise to the public
Inform	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	We will keep you informed
Consult	To obtain public feedback on analyses, alternatives and/or decisions	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision
Involve	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision
Collaborate	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible
Empower	To place final decision making in the hands of the public	We will implement what you decide

Figure A2: Public Participation Spectrum developed by the International Association for Public Participation (IAP2, n.d.a)

Degree of engagement	Advantages	Disadvantages
<p>Consultation</p> <p>Consumers are asked for their views, which are used to inform decision making. Consumers' views not necessarily adopted, though there is a commitment to use them to inform decisions.</p>	<p>Views obtained quickly and without commitment to acting on them.</p> <p>A 'safe' way of working with consumers.</p>	<p>Frustrating for consumers that there is no commitment to acting on their views.</p> <p>Some consumer organisations decline engagement at this level.</p>
<p>Collaboration</p> <p>Active, on-going partnership with consumers.</p>	<p>Increased likelihood that the research will be relevant to consumer participants.</p> <p>Consumers more likely to feel ownership of the research.</p>	<p>Additional time and cost.</p> <p>Possible alienation during the process.</p>
<p>Consumer control</p> <p>Consumers design, undertake, and disseminate the results of research. Professional researchers are involved at the invitation of consumers.</p>	<p>Research is likely to address questions not otherwise considered.</p> <p>Development of research skills amongst consumers.</p>	<p>Some researchers find this level of consumer ownership unacceptable.</p>

Figure A3: Levels of consumer engagement in health research, developed by Consumers in NHS Research (discussed in Oliver et al, 2004)

Degree of engagement	Participants' action	Illustrative mode
	None	Community not involved.
Low	Receive information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
	Are consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so administrative compliance can be expected.
	Advise	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Plan jointly	Organisation presents tentative plan subject to change and open to change from those affected. Expects to change plan at least slightly and perhaps more subsequently.
	Have delegated	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions, which can be embodied in a plan it can accept.
High	Have control	Organisation asks community to identify the problem and to make all the key decisions on goals and means. Willing to help community at each step to accomplish goals.

Figure A4: Continuum of engagement used widely in Australia (Developed by Brager and Specht, and used by the Consumer Focus Collaboration (CFC, 2000), the National Resource Centre for Consumer Participation in Health (NRCCPH, 2002), and Draper (1997))

Participation type	Objective	Key techniques	Limitations
Consultation	To gauge community reaction to a proposal and invite feedback (Consultation is only participation when information gathered can influence subsequent policy choices)	Key contacts Surveys Interest group meetings Public meetings Discussion papers Public hearings	Delay between consultation and outcomes Communities feel betrayed if they don't like the decision Expensive and time consuming for complex decisions
Partnership	Involving citizens and interest groups in aspects of government decision making	Advisory boards Citizens' advisory committees Policy community forum Public inquiries	Issue of who can speak for a community Bias toward established interest groups Legitimacy issues with those excluded from the process
Standing	Allowing third parties to become involved in the review process	Review courts and tribunals Open and third party standing Statutory processes for social and environmental impact assessment	Only relevant for those issues which come to court Expensive and time consuming Bias toward well funded interests Legal approach may be inappropriate for some issues
Consumer choice	Allowing customer preferences to shape a service through choices of products and providers	Surveys, focus groups Purchaser/provider splits Competition between suppliers Vouchers Case management	Relevant only for service delivery issues
Control	To hand control of an issue to the electorate	Referendum Community parliaments Electronic voting	Costly, time consuming, and often divisive Are issue votes the best way to encourage deliberation?

Figure A5: Participation types described by Bishop and Davis (2002)

Appendix 2: Toolkit discussions of techniques

Examples of toolkit-style discussions of engagement techniques include:

- Aslin and Brown (2002) – who discuss engagement for the Murray-Darling Basin, and rate techniques according to their purpose, their likelihood of achieving engagement, their difficulty to use, and the potential numbers of people involved
- Consumer Focus Collaboration (CFC, 2000) – which provides 43 strategies and techniques for conducting engagement in the health sector, divided into five groups
- Health Canada (2000) – which provides a detailed discussion of engagement techniques, grouped under their five levels of engagement (a similar discussion is included in OCC, 2003 and Qld Health, 2002)
- Johnson and Cameron (2005) – who give a comprehensive guide for planning public involvement, but no discussion of techniques
- Manion (2000) – who discusses an engagement policy for Newcastle City Council and rates techniques according to the numbers of people engaged and the level of audience interest
- Gramberger (2001) – who has developed a practitioners' guide to using information, consultation, and public participation in policy making for OECD Member countries
- Planning NSW (2003) – which provides advice on how to engage the community in planning decisions, covering engagement techniques in some detail, and including several case studies
- Queensland's Department of Communities – which has produced a series of guides about community engagement including *Engaging Queenslanders: Get Involved* (2003), *Engaging Queenslanders: An Introduction to Community Engagement* (2005), *Engaging Queenslanders: A Guide to Community Engagement Showcasing Events* (2004), *Engaging Queenslanders: Community Engagement in the Business of Government* (2005), and *Engaging Queenslanders: Evaluating Community Engagement* (2004)
- *Working Together: Involving Community and Stakeholders in Decision-Making*, produced by Western Australia's Office of Citizens and Civics (OCC, 2006) – which describes steps in planning consumer engagement, with a specific focus on planning and evaluation. Other publications in this series include *The Resource Guide* (OCC, 2002) and *Consulting Citizens: Planning for Success* (OCC, 2003).

Appendix 3: About the project

Project title

Consumer engagement in Australian health policy: Investigating current approaches and developing new models for more effective consumer participation

Project objectives

Develop strategies for more effectively engaging consumers in health policy development by:

- Identifying and assessing current approaches and methods for engaging consumers used by Australian government, non-government and private health industry organisations, in terms of effective consumer participation
- Comparing these approaches with those used in other sectors in Australia such as urban development, environmental management, housing, and traffic planning
- Identifying, assessing, and defining the distinctive characteristics of approaches being used in similar overseas systems
- Developing and refining new models for consumer engagement in Australian health policy development.

Project design

- Identify current approaches and methods for consumer engagement in health policy and in other fields – through a literature review and interviews
- Compare the approaches for consumer engagement used in various sectors – through a literature review and interviews
- Identify, assess, and define the distinctive characteristics of consumer engagement approaches – through case studies
- Develop and refine new models for consumer engagement in Australian health policy development – through analysis and workshops

Project steering committee

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