

# **The Politics of Consultations: A Case Study of the Commission on the Future of Health Care in Canada**

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## **Abstract**

*The scope of public and stakeholder involvement in the various consultation activities of the Commission on the Future of Health Care in Canada was unprecedented. The primary objective for these activities was to gather compelling, objective evidence to inform the Commission's final recommendations. However, the difficult political context within which the Commission operated also made it imperative that the Commission select a particular mix of consultation instruments and approaches to help prepare the terrain for its recommendations being adopted. To that end, a "political lens" was applied to every decision made in relation to: the selection of consultation instruments; the choice of participants; the information or public education effort that preceded or framed different activities; the transparency and inclusiveness of deliberations; and, the release of findings. Accordingly, the Commission's consultations, communications, research and inter-governmental relations functions were seamlessly integrated.*

## **I. Setting the Context**

Since its introduction in the 1960's, Medicare, Canada's publicly-funded, single-tier, universal system of health care, has come to be regarded by many Canadians as an expression of national identity and solidarity. The reasons why a social program has achieved such iconic status in Canada are numerous and complex. Suffice it to say that until the late-1990s, public confidence in, and support for, Medicare proved remarkably durable.

At the beginning of the 1990s, however, in response to growing budgetary deficits, both the federal government (which transfers funds to the provinces to share in the cost of delivering Medicare) and provincial governments (which deliver health care services) began to reduce the rate of growth of health care spending. By the mid-1990s, the effects of these cutbacks began to manifest themselves across the system in the form of growing wait-times for medical treatment, overcrowded hospitals, increasingly antiquated infrastructure and shortages of health professionals- especially in rural areas.

While public support for the Medicare remained high, confidence in its long-term viability began to gradually erode. A sense of crisis soon gripped the system, accelerated in part by relentlessly pessimistic pronouncements by Canada's health and finance ministers in regard to the system's affordability. By the time the Commission was appointed in 2001, no fewer than 7 provincial governments had completed, or had underway, major reviews of their provincial health care systems, almost all of which included engaging citizens and expert stakeholders in deliberations. In addition, at the national level, a Senate Committee had also convened public hearings across the country and had produced the first 2 of what would become 4 comprehensive reports on ways to revitalize Medicare.

Yet despite this unprecedented level of consultation, review and reflection on how to improve Medicare and place it on a more sustainable footing, Canadians continued to express grave doubts about its future. By 2001, Canadians had ranked improving Medicare as their number one public policy priority for eight consecutive years. Moreover, a national public opinion poll released on the eve of the Commission being established made it clear that for most Canadians, the consultation efforts that had been undertaken were insufficient:

- 49% of Canadians wanted more debate about how to adapt and improve the health care system
- 61% said more information should be provided on options to improve the health care system
- 64% wanted more opportunity for the public to participate in the health care debate

Notwithstanding these lingering public doubts and concerns, many provincial Premiers were anxious to apply the recommendations flowing from the respective health system review processes they had completed. As well, many were openly hostile to the notion of the federal government initiating a top-down review of Medicare. This was in part because under the Canadian constitution, provinces have jurisdiction for health care delivery, and in part because they felt many of the system's problems were the result of the federal government having unilaterally, and without consultation, reduced its share of health care funding.

An unrelenting barrage of media reports about a health care system in “crisis”; dire warnings from an array of political leaders that Medicare was unsustainable; frustration among ordinary Canadians that their concerns had either not been sought, or had simply been ignored; growing concern about the potential demise of Canada's most cherished social program and a source of national identity and pride; fractious and unproductive discourse between the federal government and the provinces... This was the backdrop against which the Government of Canada appointed a one-person Commission, headed by former Saskatchewan Premier Roy Romanow, with an 18-month mandate to engage Canadian in a national dialogue on the future of their health care system and recommend ways to improve public health care and make it more sustainable.

## **II. A Focus on Process Integrity**

Recognizing the sensitive and potentially volatile environment in which it was to operate, one of the earliest decisions made by the Commission was to articulate a set of six *Guiding Principles* to frame its activities. These principles, designed to mollify skeptics about how the Commission would discharge its mandate, included:

- **Objective:** the Commission would not begin its activities with any pre-conceived notion as to the eventual direction of its recommendations.
- **Open & Transparent:** the Commission would post on its website any submissions it received, transcripts of all public meetings or activities it sponsored, the research it

commissioned, generated or considered in its deliberations (as it became available and in advance of the release of the Commission's final report) and any advice or documentation it received from governments.

- **Comprehensive:** the Commission would ensure breadth of perspective characterized its research, consultation and fact-finding efforts.
- **Evidence-based:** the Commission's recommendations would be based on evidence, not anecdote, and the evidence-base for any recommendations made would be clearly explained.
- **Inclusive:** the Commission's research and consultation efforts would be designed to ensure appropriate, relevant and balanced participation by experts and stakeholders representing a range of perspectives as well as ordinary Canadians.
- **Respectful:** the Commission would acknowledge and treat all of the inputs it received seriously, and would take account of existing work or research if and when appropriate (for example, the final reports flowing from the health system reviews commissioned by the provinces).

The *Guiding Principles* proved invaluable in helping to establish the Commission as a credible, objective and worthy interlocutor with key stakeholders, the public and both levels of government. More to the point, the consultation strategy developed and implemented by the Commission was specifically developed based on these 6 principles.

**Lesson 1: Articulating a coherent and compelling set of Guiding Principles at the outset of a consultative process, clearly elaborating how these will be made operational, and then abiding by them, can help establish the critical pre-condition for effective consultations: credibility and integrity.**

### **III. Managing Inter-governmental and Stakeholder Relations**

#### *Intergovernmental Relations*

One of the key challenges for the Commission was to attenuate provincial concerns over the sensitive issue of "jurisdiction"- the notion that a Commission appointed by the national government would intervene in health care delivery- a field of provincial jurisdiction. It was also imperative for the Commission- for its fact-finding and consultations efforts to be seen as credible- to secure the active participation of provincial governments in its planning efforts.

To that end, the Commissioner initiated a protocol contact with each Premier during which he outlined the Commission's Guiding Principles, committed to acknowledge and respect provincial jurisdiction, and asked the province designate a single point-of-contact (liaison person) with whom Commission staff could work to avoid "surprises or misunderstandings".

The designation of a liaison person in each province with whom the Commission's Inter-Governmental Affairs Director could work contributed to the success of the Commission's consultation efforts in a variety of ways.

For example, prior to the Commission issuing a new release or advisory, or posting a new publication or report, the provincial liaisons' were provided with advance copies of materials to enable them to brief their Minister's on potential questions that might arise pursuant to this. Similarly, prior to making any major policy announcements that could impact on the Commission's research or deliberations, liaisons would advise the Inter-Governmental Affairs Director accordingly. This helped minimize the risk of miscommunication that could potentially erode the Commission's credibility or alienate the province.

This arrangement also provided opportunities for the Commission to obtain useful insights or advice on potential participants in Commission consultation or engagement activities. This not only improved the caliber of participants, it helped overcome some of the early suspicions that initially characterized the relationship between the Commission and the provinces.

**Lesson 2: Establishing clear “rules-of-engagement” and designating individuals to be accountable for ensuring appropriate collaboration can strengthen the credibility and quality of consultative efforts.**

### Stakeholder Relations

Managing the diverse needs and expectations of health system stakeholders- from health professional associations, to disease support groups, to health system administrators, to patients and consumers advocates, to pharmaceutical companies, to home care providers, to public health professionals- was a daunting challenge. Indeed, the Canadian Guide to Associations listed over 4,000 separate groups, organizations and associations active in the health care sector.

A number of tactics were used to engage stakeholders in Commission deliberations and consultation activities. In the first instance, the Commission established a stakeholder liaison function, reporting to both the research and communication/consultation directors. Stakeholder organizations were then divided into three categories:

**Category I:** Constituted 20 pan-Canadian organizations whose members played a front-line role in managing or delivering health care services and national advocacy groups with longstanding interest in healthcare renewal

**Category II:** Constituted an additional 50 national organizations active in one or another aspect of health system renewal.

**Category III:** Constituted all other health system stakeholder organizations.

Early in the Commission's mandate, the Commissioner convened a meeting with all Category I stakeholders to:

- seek their advice on potential priorities and directions for the Commission as well as on which groups or organizations that should serve as Category II stakeholders;
- discuss how they and other stakeholder groups should be engaged in Commission activities on an ongoing basis;
- manage expectations as to what a 1-person Commission could realistically achieve in 18 months;
- obtain a commitment from them that, as national organizations, they would take the lead in reaching and representing a consensus position among their various provincial or regional branches or divisions, and that they would have lead responsibility for communicating information about the Commission to their members by posting the Commission’s monthly e-newsletter on their websites as well as a direct link to the Commission’s consultation portal.

This latter commitment proved enormously helpful to the Commission in advancing both its public information and consultation agendas. First, it effectively transferred responsibility for reaching consensus on certain key issues from the Commission to national stakeholder groups-ensuring more coherent, authoritative and robust interventions. Second, it leveraged the Commission’s “reach” and visibility by providing a means for information on the Commission to flow directly to literally hundreds of thousands of health system stakeholders and professionals. Third, it formalized the process through which stakeholder groups could share and exchange information with the Commission. Regular contact was maintained with Category I stakeholders for the duration of the Commission’s mandate.

Following this initial meeting, Category I and II stakeholders were contacted by mail and invited to participate in a more formal “priority setting” exercise. As discussed later in this paper, this priority setting exercise was an important part of the Commission’s public education efforts in advance of formal consultations.

**Lesson 3: Early and constructive engagement with stakeholder groups, especially those that empower them to contribute directly in consultation activities, can yield enormous benefits in terms of both overall visibility and the level and quality of participation.**

#### **IV. Fact-Finding and Research**

The Guiding Principles adopted by the Commission (i.e. ensuring breadth of perspective and balance), as well as the imperative for a sustained public education effort prior to consultations to ensure informed input, both played an important role in shaping the Commission’s research agenda. Indeed, one of the unique management approaches adopted by the Commission was to have the Research Director and Communication/Consultation Director work closely together in shaping each other’s respective work plans.

The Commission's research and fact-finding initiatives comprised the following activities:

- **6 Expert Round Table Meetings-** 3 in Canada (all of which were televised nationally on the Canadian Public Affairs Channel) as part of the Commission's public awareness/education efforts), and 3 overseas, managed and delivered by independent international think-tanks.
- **National Conference on Aboriginal Health-** bringing together 150 aboriginal health leaders, organized for the Commission by the National Aboriginal Health Organization and broadcast live nationally by both the Canadian Public Affairs Channel and the Aboriginal Affairs Channel, along with a toll-free call-in number to enable aboriginal Canadian in remote regions to participate.
- **24 Site Visits:** over the course of the Panel's mandate, the Commissioner conducted site visits in 24 locations, including hospitals, rural clinics, specialty facilities and training centres, while meeting informally with health professionals and patient rights advocates and working with media to raise the profile of various health issues.
- **640 formal submissions:** prior to convening public hearings, the Commission issued a public call for submissions from individuals or groups with issues or concerns they wanted the Commission to address. A template for these submissions was provided, and all submissions received were posted on the Commission website for public review. These submissions also helped define the consultation priorities.
- **3 major research consortium reports:** following a call for tenders from organizations to form research consortia and submit proposals in emerging areas of health policy where research was lacking, 3 major research projects were selected for funding by an expert panel established by the Commission. All three research reports were posted on the Commission web-site for comment as they became available.
- **42 discussion papers:** were commissioned- again following a call for proposals and a review of them by an expert panel. In several instances, as part of its commitment to ensure "breadth of perspective" and "balance", up to three separate papers were produced on the same subject- each from a different ideological perspective. All discussion papers were posted on the Commission web-site as they became available and all inter-governmental liaisons and Category I and II stakeholders were advised of the availability of these materials.

In short, the Commission's fact-finding and research program was specifically designed with the goal of ensuring a high degree of visibility for outputs that could help inform the public consultations process, as well as directly engaging key stakeholders in the process.

**Lesson 4: Consideration should be given to how research and fact-finding efforts can be designed to contribute to the success of down-stream public consultation activities.**

## V. Consultation and Engagement Activities

The design of the Commission's consultation agenda was based on seven critical assumptions.

- **First**, before addressing specific issues or problems afflicting the health care system, it was essential to first understand Canadians' expectations as to the core values on which the system should operate. To put it more bluntly, the Commission sought to understand what it was Canadians wanted and expected from their health care system, and what they were prepared to do or sacrifice to see that type of system established. Accordingly, as will be discussed shortly, the initial focus of the Commission's consultations was on "values".
- **Second**, if the consultations focused simply on "values", and not on tough-minded solutions to the difficult challenges confronting the health care system, the Commission's final report would be dismissed as irrelevant. Accordingly, an "issue-specific" focus for the consultations was also required.
- **Third**, to make the process as relevant to ordinary citizens as it was to experts, a variety of consultation tools and approaches, both formal and informal, would need to be deployed.
- **Fourth**, a highly visible, overarching public education program, as well as consultation-specific information sessions, would be required. In the Commission's view, both elements were necessary to respond to the concerns Canadians had expressed that they lacked both the information and opportunity to contribute in an informed way to shaping the future of health care.
- **Fifth**, the Commission needed to enlist the resources and capacities of Category I and II stakeholders, as well as other health system stakeholders, to leverage the reach and visibility of the consultations.
- **Sixth**, to the extent possible, the Commission needed to directly involve the expert stakeholder community in synthesizing and interpreting consultation inputs and results. Indeed, the consultation process was specifically designed with this purpose in mind- it was essential that accountability for correctly interpreting consultation inputs be shared, rather than the exclusive responsibility of the Commissioner.
- **Seventh**, because of the short-time frame within which the Commission was required to submit its final report, consultation inputs would need to be synthesized on an ongoing basis with a view to identifying areas of consensus and disagreement. Accordingly, the design of the consultation program provided for ongoing synthesis and interpretation of consultation inputs by experts and stakeholders, as well as by Commission staff.

Each of the three phases of the consultation process – Public Education, Public Consultation & Engagement and Deliberation & Synthesis – took careful account of these assumptions.

## Phase I: Public Education

The public education and awareness efforts undertaken by the Commission were extensive. While certain elements were delivered directly by the Commission itself, most were the result of creative partnerships with Category I and II stakeholders and between the Commission and media outlets. The public education effort included:

- **Publication of an Interim Report.** The formal launch of the Commission’s consultation efforts began with the publication in February 2002 of the Commission’s Interim Report. The Interim Report summarized the Commission’s research and fact-finding efforts to date and laid out what it described as a “framework for a national dialogue on health care”. This framework identified key issues and concerns that would be addressed during the consultation phase, provided relevant background information, and invited Canadians to participate in the review process. The Interim Report was posted on the Commission’s web-site, and most Category I and II stakeholders included direct links to it on their websites.
- **Televised Discussion Forums.** Concurrent with the release of the Interim Report, the Canadian Public Affairs Channel (CPAC) began broadcasting a 7-part series on renewing Canada’s health care system. The topics selected were those that public opinion research indicated were the highest priority concerns of Canadians. Each of these 2-hour broadcasts used an identical format co-designed by the CPAC and the Commission. The first hour of the broadcast began with a five-minute video presentation highlighting a specific issue in health care. This was followed by a moderated discussion, featuring three health care experts, each representing a different ideological perspective on the issue. During the second hour, viewers could call or e-mail in questions to the three guests. The Commission provided technical expertise to the program producer and covered the travel expenses of the experts.
- **Release of Issue/Survey Papers (followed by Dialogue Sessions).** The Commission engaged the Canadian Health Services Research Foundation, an independent think-tank, to develop 9 separate Issue/Survey papers. Each 10 page paper covered a different health care topic and was divided into 5 sections:
  - Section 1 described the purpose of the Discussion Paper and how it would be used to inform the Commission’s deliberations.
  - Section 2 provided an overview of the issue in question and its importance to the future of health care in Canada.
  - Section 3 described three possible courses of action for policy-makers in relation to the issue as well as summary of the most compelling arguments for and against each option.
  - Section 4 included a list of survey questions based on the options that could be detached from the survey and mailed or faxed to the Commission.

- Section 5 profiled the editorial team that had been assembled to review and validate the contents of the Issue/Survey Papers (i.e. advocates for and against each option). It also noted that readers had the option of completing the Issue/Survey paper on-line or making a joint submission on behalf of a group or association.

(These Issue/Survey Papers also served as the basis of a series of on-campus dialogue sessions co-hosted by the Commission and 12 different universities. Using a format similar to that of the Televised Discussion Forums, students from various faculties (e.g. Medicine, Nursing, Public Administration; Political Science; Law), as well as the public, were invited to witness these discussions, ask questions of panelists, and then complete the survey questions based on what they had read and heard. Many universities partnered with local community cable television stations to broadcast the debates.) Some 14,000 completed surveys were received by the Commission.

- **Web Postings.** As might be expected, the Commission's interactive website served as a focal point for public information and awareness efforts. In addition to providing links to relevant federal, provincial and international websites, the website featured a detailed bibliography of background and research materials by subject area. It also provided access to every speech or presentation delivered by the Commissioner; all submissions that had received; research papers, consortium reports and background materials that had been commissioned; summary minutes of all presentations made to the Commission during consultations; and, the result of completed survey instruments as they came in. Those visiting the site also had the option to register to receive a monthly Commission newsletter and e-updates advising them when new information had been posted on the website.
- **Speeches, Presentations & Media Relations.** Over the term of the Commission's 18 month mandate, the Commissioner delivered 45 speeches or presentations in 24 cities to a wide array of groups and organizations. These activities typically were followed by media availability sessions. In addition, the Commissioner authored two editorials that appeared in Canada's national newspapers.

**Lesson 5: The level of effort expended on public awareness must take account of the needs and capacities of target audiences. There are an endless variety of ways to leverage public outreach efforts where sensitive issues are involved. Many of the outreach opportunities referenced above were the result of the stakeholder engagement efforts.**

## **Phase II: Consultation and Engagement**

As noted previously, the Commission's consultations proceeded down two separate tracks, one focused on values, the other on issues.

### *Citizen Dialogues (Values)*

One of the challenges confronting the Commission was how to make sense of the seemingly contradictory results flowing from public opinion surveys that purported to reflect the “definitive” views of Canadians. To resolve this issue, the Commission partnered with ViewPoint Learning and the Canadian Policy Research Networks to develop a unique deliberative dialogue process designed to plumb Canadian values in relation to their health care system.

The process involved several steps. First, an analysis of over 15 years worth of public opinion research was completed to better understand how the views of Canadians vis-à-vis their health care system had evolved over time. Based on this analysis, it was determined that most Canadians would subscribe to at least one of the following scenarios:

1. Canada’s health care system needs more resources and the best, fairest and most equitable way to obtain them is through more public investment via Canada’s progressive tax system.
2. Canada’s health care system needs more resources, but taxes are already too high, so the government should consider a system of user-fees and co-payments that will not only raise money but make people more accountable for how they use the system
3. Canada’s health care system needs more resources, but taxes are too high. And so the government should allow a parallel private system to emerge that lets those who can afford it bypass the public system altogether. This will relieve pressure on the public system and encourage healthy competition.
4. Canada’s health care system needs to undergo fundamental reform to make it more efficient, effective, responsive and affordable.

A workbook describing these 4 scenarios, and the arguments for and against each, was then developed and used to inform a series of 12 Deliberative Dialogue sessions in different regions of the country. Each session comprised a representative cross-section of some 40 Canadians (480 participants in total) who met over 2 days to learn more about the health care system and to discuss and debate the merit of these competing scenarios. The objective for these sessions was to oblige participants to choose between competing “value choices”. For example, did their belief in their right as a consumer to use their hard-earned money as they deemed fit, supersede their belief in equity (that need, rather than ability to pay, should determine access to care).

Participants were surveyed prior to each session to ascertain their views on the respective scenarios. They were also surveyed following the session to assess if their views had changed or been reinforced and if so, why? In the event a consensus emerged across the country for a particular scenario (or modified scenario), a national public opinion survey was to be conducted to validate the findings. This in fact did occur, and it enabled the Commissioner to speak authoritatively about the values that Canadians wanted to see expressed in the programs and policies that define Medicare.

(The workbook developed for the Deliberative Dialogue sessions was subsequently converted into an on-line survey instrument. Some 14,000 Canadians took the time to complete the survey; the results of the on-line survey mirrored those from the facilitated Deliberative Dialogue sessions.)

**Lesson 6: Understanding first what values citizens want to see reflected in particular policies and programs that are under review can provide a more appropriate starting-point than simply focusing on prescriptive solutions.**

*Public Consultations (a focus on issues)*

In addition to the 12 closed Deliberative Dialogue sessions (and the on-line survey), the Commission also convened 21 days of televised, open public hearings across the country. These public hearings were carefully organized to ensure balance, breadth of perspective and equal participation by experts and ordinary Canadians. To support this, a template was developed for internal use, outlining what, in the Commission's view, constituted the representative cross section of interests it needed to hear from in each region for its hearings to be perceived as credible and objective. Where certain groups did not voluntarily come forward to appear before the Commission, they were contacted directly by the Commission and encouraged to do so to ensure balance. Hearing from similar categories of stakeholders in different sessions also allowed the Commission to compare results across regions.

Notices were then placed in newspapers across Canada inviting those wishing to appear before the Commission to submit a one-page abstract summarizing the points they wished to make. This enabled the Commission to ensure a wide range of issues would be considered at each session (i.e. there was little point hearing from, say, 10 presenters each making the same point). Only after a representative cross-section of presenters for the sessions had been confirmed did the Commission consider other potential presenters.

Provincial officials were asked to review and comment on proposed participant lists. Those whose requests to appear had been declined were invited to submit their presentations in writing using a framework developed by the Commission. They also received a commitment that their submissions would be posted on the Commission website. Roughly 30 presentations were received at each session, which began at 8:00 AM and was completed by 6:00 PM.

**Lesson 7: Care must be taken in scheduling potential presenters to ensure breadth or perspective, balance and fairness.**

**Lesson 8: Those not selected to present must also be given the opportunity to have their contribution to public discourse formally acknowledged by having their presentations posted.**

Each session began with the relevant provincial health minister (or Deputy Minister) providing an overview of the health care situation in their respective province. In every instance, opposition politicians were offered the opportunity to present a counter perspective. The balance of the day was devoted to presentation by experts, organizations and individuals. Each

presentation made by an expert or by an organization was followed by a presentation by an ordinary Canadian. These latter presentations typically focused on why Medicare should or should not be supported, or heartfelt descriptions of how the health system had either saved or failed them. The goal here was as much to remind the experts and organizations of how ordinary Canadians felt about the issues and their performance, as it was to allow Canadians to “see their issues” reflected in the Commission’s deliberations. At the end of the day, a limited number of those in the hall who had listened to the day’s presentations were invited to comment on what they had heard over the course of the day. Within 48 hours, a summary of each presentation made to the Commissioner was posted on the Commission’s web site for public review or comment.

**Lesson 9: A high-level initial “framing” presentation by senior public officials can provide important perspective and to the proceedings and contribute to their credibility.**

It should also be noted that prior to and following each day of hearings, the Commissioner made himself available for open-line radio call-in programs. This enabled those unable to travel to the public hearings- either because of their health or because of cost- to have the opportunity to express their views directly to the Commissioner.

**Lesson 10: Consultative processes on complex issues can be designed to be relevant for both experts and the public. The definition of what constitutes “consultations” should be flexible and include both formal and informal elements.**

Day 2 “Synthesis” Sessions

In nine of the 21 communities in which formal public hearings were held, closed expert stakeholder sessions were organized the following day. The purpose of these Day 2 sessions was to bring together a smaller group of some 15-20 local/regional health experts, advocates and decisions-makers to assist the Commission in interpreting the results of the previous day’s hearings. The Commission also wanted accountability for the analysis of the day’s proceedings to be shared in order to underscore its commitment to objectivity. Accordingly, provincial health officials were consulted on the selection of participants and in every province, a senior provincial Health Ministry official participated in the discussion. Summary minutes of the deliberations- without attribution to specific individuals- were posted on the Commission website within 24 hours.

The typical Day 2 session comprised four elements. First, the results of the local *Citizen Dialogue* sessions were presented to provide a high level overview of what citizens wanted and expected from their health care system (i.e. a values lens). Second, the presentation made at the *Public Consultations* previously by the Health Minister as to the challenges and opportunities for health system reform were summarized (i.e. a “public policy lens”). Third, highlights of the previous day’s presentations were provided (an “issues lens”). Last, participants were then asked to help “interpret” the significance of these various inputs- particularly where contradictory information or perspectives had been presented. Results from these sessions were presented in

the form of a grid that noted areas of consensus and disagreement (and the alternative policy choices flowing from these disagreements).

(The decision to keep these meetings closed and to post non-attributable summary minutes was based on the Commission's experience with larger, open-meetings. During open meetings, advocates often felt obliged to speak solely to their agendas rather than to seek common ground. Indeed, when television cameras were present, they typically spoke "at each other" rather than "to each other". Because the Commission had successfully established a high standard for "process integrity" in terms of access and transparency, these "closed session" did not generate the expected criticism from the media or stakeholders. In post-Day 2 evaluations, many participants indicated they appreciated the opportunity to engage in free-wheeling, open discussion and debate with those holding opposing views. They indicated the sessions enriched their understanding of the complex issues that were at stake. Anecdotally, a number of participants said they intended to have follow-up meetings with others they met during these sessions. This by-product of the consultations- bringing together people who would not otherwise have an opportunity to engage in joint problem-solving- may produce long-term benefits for the health system.)

**Lesson 11: Engagement processes that enable participants with differing perspectives to work together to solve problems can produce long-term benefits that extend beyond the specific consultation process itself.**

**Lesson 12: If properly designed, "closed" sessions involving experts can strengthen deliberative processes and can be made "transparent".**

#### Regional "Synthesis" Sessions\*

Within a month of completion of the *Public Consultations* and the *Day 2 Synthesis Session*, a series of 4 Regional Synthesis Sessions were convened. The objective was to now try and interpret on a regional basis, the results of the various individual Day 2 sessions to identify broad areas of consensus or disagreement. For example, was there a distinct Atlantic Canadian perspective, or a Western Canadian perspective on certain issues? The format for these 4 Regional Synthesis Sessions was essentially similar to that used for the *Day 2 Sessions* (i.e. closed meetings with summary minutes posted, and participants chosen in consultation with provincial government officials).

Each regional session comprised a mix of about 20 experts, advocates and decision-makers. Of these, 12 were participants drawn from the *Day 2 Synthesis Sessions* in order to ensure a degree of continuity.

**Lesson 13: Ongoing synthesis of inputs can provide for increasingly rich deliberations.**

**Lesson 14: Engaging expert stakeholders directly in interpreting inputs can produce more robust outputs that are perceived by opinion-leaders and the public as credible and legitimate.**

### Other Inputs

In addition to these various formal, structured consultation tools, the commission also received inputs from the public via correspondence and its toll-free number.

## **VI. Developing a Final Report**

Making sense of the wide range of inputs the Commission received through its consultation processes and via its research activities was an ongoing challenge. As noted in Section III and Section IV, early in the Commission's mandate, the views of the expert stakeholder community were solicited as to the priority issues the Commission needed to address in its final report. In addition to bilateral contacts and the convening of a televised multi-stakeholder round-table meeting that focused on setting the Commission's research and consultation agenda, expert stakeholders were also invited to make written submissions to the Commission- all of which were posted on the Commission's website.

Based on these inputs, Commission staff developed an initial table of contents for the final report and tracked the inputs the Commission had obtained through its consultation processes (i.e. "what we heard") and its research program (i.e. "what we learned"). Using the results of the deliberative dialogue process to provide a "values" frame (i.e. "these are the values Canadians said they wanted to see reflected in the policies and programs that define Medicare"), Commission staff then developed more detailed outlines for each chapter. These more detailed outlines included 2-3 alternative courses of action, plus whatever available evidence there was for and against them. The Commissioner was then asked to identify his preferred option, and a draft chapter was developed for his consideration. Needless to say, the Commissioner reserved the right to change his mind- particularly in light of the need to ensure consistency and coherence in the final report's recommendations. In addition, to underscore that the Commission had taken account of the inputs it received, extensive footnotes were provided to support recommendations, and the final report made extensive use of "text boxes" that used extracts from written submissions, or direct quotes from those who appeared before the Commission.

As noted previously, all of the inputs the Commission received were posted on the website for public review- whether or not they supported the final report's recommendations. In effect, having carefully cultivated a high level of public credibility and profile for its activities, the Commission was banking on its reputation for "process integrity" to ensure its final recommendations would be treated as serious, evidence-informed and worthy of implementation.

## **VII. Conclusions**

Despite the deployment of a wide variety of consultation instruments, the total cost for the Commission's extensive consultative program was under \$6 million dollars. And other than the placement of a single newspaper advertisement inviting submissions, the Commission did not

have an advertising or marketing budget. Indeed, the single biggest consultation expense was for the Citizen Dialogue sessions, and this was largely for the cost of transporting participants to the sessions and paying their accommodation expenses. Instead, most of the activities were regionally-based and partner-delivered.

There are a number of lessons-learned from the Commission's consultations process and these have been highlighted in this report. Suffice it to say, the politically charged environment within which the Commission operated made "process integrity" critical and had a significant impact on the design and "reach" of the consultative processes. The level of participation by ordinary Canadians and by experts in the Commission's various consultative processes, and the high and sustained visibility the Commission achieved, were unprecedented. This in turn made it impossible for the Commission's final recommendations to be ignored. Accordingly, the Commission's final report shaped Canada's health reform agenda over the immediate and medium term.

## Highlights of Lessons Learned

**Lesson 1:** Articulating a coherent and compelling set of Guiding Principles at the outset of a consultative process, clearly elaborating how these will be made operational, and then abiding by them, can help establish the critical pre-condition for effective consultations: credibility and integrity.

**Lesson 2:** Establishing clear “rules-of-engagement” and designating individuals to be accountable for ensuring appropriate collaboration can strengthen the credibility and quality of consultative efforts.

**Lesson 3:** Early and constructive engagement with stakeholder groups, especially those that empower them to contribute directly in consultation activities, can yield enormous benefits in terms of both overall visibility and the level and quality of participation.

**Lesson 4:** Consideration should be given to how research and fact-finding efforts can be designed to contribute to the success of down-stream public consultation activities.

**Lesson 5:** The level of effort expended on public awareness must take account of the needs and capacities of target audiences. There are an endless variety of ways to leverage public outreach efforts where sensitive issues are involved. Many of the outreach opportunities referenced above were the result of the stakeholder engagement efforts.

**Lesson 6:** Understanding first what values citizens want to see reflected in particular policies and programs that are under review can provide a more appropriate starting-point than simply focusing on prescriptive solutions.

**Lesson 7:** Care must be taken in scheduling potential presenters to ensure breadth or perspective, balance and fairness.

**Lesson 8:** Those not selected to present must also be given the opportunity to have their contribution to public discourse formally acknowledged by having their presentations posted.

**Lesson 9:** A high-level initial “framing” presentation by senior public officials can provide important perspective and to the proceedings and contribute to their credibility.

**Lesson 10:** Consultative processes on complex issues can be designed to be relevant for both experts and the public. The definition of what constitutes “consultations” should be flexible and include both formal and informal elements.

**Lesson 11:** Engagement processes that enable participants with differing perspectives to work together to solve problems can produce long-term benefits that extend beyond the specific consultation process itself.

**Lesson 12:** If properly designed, “closed” sessions involving experts can strengthen deliberative processes and can be made “transparent”.

**Lesson 13:** Ongoing synthesis of inputs can provide for increasingly rich deliberations.

**Lesson 14:** Engaging expert stakeholders directly in interpreting inputs can produce more robust outputs that are perceived by opinion-leaders and the public as credible and legitimate.