Engaging citizens in deliberations for health policy development:  

Democratising health policy?

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**Abstract**

With deliberative mini-publics heralded for their capacity to create a more meaningful and democratic way for governments to engage with their citizens, surprisingly little qualitative research exists on citizens’ experiences of mini-publics when used in health policy development. Working to remedy this deficit, this research finds many factors which unintentionally disable citizens’ experiences of exchanging knowledge and expressing their deliberative capacities. Instances of epistemic injustice also become apparent and questions are raised over the democratic authenticity and legitimacy of mini-publics when used in such circumstances.

Conversely, the intrinsic potential for deliberative-practice to create an intersubjective space that promotes a transformative exchange of knowledge was also evident; suggesting that mini-publics represent a significant, though currently untapped, resource in public health and wellbeing. To more fully realise this potential, I propose an intentionally enabling approach so that mini-publics become a more substantively equal, empowering, egalitarian, educative and epistemically just means of health policy development.

**Keywords:** Deliberative mini-publics; Democratisation; Health policy; Deliberative capacity; Epistemic injustice; Public health and wellbeing

**Introduction**

Throughout the last couple of decades there has been an unprecedented level of global interest in deliberative mini-publics [hereafter referred to as mini-publics]. Part of the allure of mini-publics is that they provide a more meaningful and democratic way for governments to engage with their citizens. Their use in Australian health policy settings is, however, still quite novel and there is little qualitative research on the citizens’ experiences of exchanging knowledge and expressing their deliberative capacities in such circumstances. For instance, it is not known whether an exchange of knowledge even occurs, let alone, whether a just exchange occurs. This cross-disciplinary, qualitative research aims to correct this deficit in knowledge by putting citizens at the centre of an inquiry into the use of mini-publics in the vexed arena of health policy development.¹ Effectively, it shines light upon the actual opportunities that exist within these democratic innovations (Smith, 2005) for citizens to participate on an equal-footing.

¹ At risk of appearing theoretically promiscuous this research brings together insights from the fields of political theory, public health, sociology, community and health development, philosophy, and public administration.
Determining these factors is crucial if these engagement techniques are to become more than simply a promise of their democratic ideal in health policy settings (Abelson et al., 2003).

Overall, this research identifies a significant gap between the theory and practice of deliberative democracy when mini-publics are applied in health policy settings. While a similar gap has been identified when mini-publics are applied to other policy matters², this research finds the residual gap to be so great at times when mini-publics are used in a health policy setting, that deliberative-participants can experience a ‘cognitive dissonance’ between what they expected of their participation and what actually occurred (Blaug, 1999, p. x).³ By inquiring into citizens’ experiences of the process of deliberating in health policy settings it becomes apparent just how little these experiences correlate with what the literature tells us these participants ought to be experiencing in a democratically-deliberative means of engaging in decision-making with their government bodies.

Paradoxically, the findings from this research also highlight the intrinsic potential for deliberative practice to create an intersubjective space that facilitates a transformative exchange of knowledge. The transformative capacity of democratic-deliberation sits at the crux of what is hoped to be achieved by these engagement methods; for some deliberative theorists, participants’ willingness to consider preference transformation has become one of the defining features of these engagement techniques. When viewed with the understanding that it is far more likely that existing values and structures, including bodies of knowledge, are reproduced rather than transformed (Hays, 1994), it is not surprising that the desired transformative potential of deliberative methods of engagement has sparked a great deal of attention (see, for instance, Dewey, 1927: 1954; Pateman, 1970; Warren, 1992, 1993; Dryzek, 1990, 2000; Roberts, 2004).⁴

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² Though I accept Gutmann & Thompson’s (1996) claim that the divide between the theory and practice of deliberative democracy is considered narrower than in most other conceptions of democracy.

³ My application of the term, cognitive dissonance, is somewhat different to Blaug’s (1999). Blaug uses the term in relation to what he describes as the gulf between the normative belief that all those affected by decisions have ‘participated in its making’ and the inherently contradictory reality of this empirical assertion, which precludes the ‘possibility of complete participation’ (p. xi). I acknowledge the validity of Blaug’s use of the term. My use of the term, however, is borne out of my empirical data which has shown that what citizens understood would be happening when they were engaged to deliberate on health policy development was distinctly different to what they actually experienced. This cognitive dissonance was, of course, most pronounced when participants had some insight into, or had been given information about, the mini-public they would be attending. Curiously, some of my interviewees were not even aware of the proposed deliberative nature of their engagement activity until it was discussed during our post-forum interview together.

⁴ And, indeed, this claim itself runs to the heart of the fundamentally oppositional position taken by their standard liberal democratic counterparts. In contrast, standard liberal democrats’ claim to democratic authenticity is tied into processes designed to aggregate citizens’ pre-formed preferences, such as electoral processes (see Dryzek, 2000 and Warren, 1992 for greater elaboration on this distinction).
Due to the presence of so many factors that disabled the deliberations, however, only glimpses of this phenomenon were evidenced; those that were seen, however, are encouraging and suggest that mini-publics offer a powerful, though currently untapped, resource in public health. Yet if the transformative potential of these more democratic forms of engaging citizens in health policy is to be more fully understood and realised, contextual agency-structural factors warrant greater scrutiny and transparency; this explains the first of two objectives set for this paper. My second aim is to bring together relevant empirical insights with that gained from the literature to establish empirically-grounded, coherent, theoretical, and normative support for citizens, policy administrators, and deliberative theorists/researchers/practitioners in their attempts to account for and understand more fully the process and practice of mini-publics in health policy settings.

To begin, I will set the context from which this research arose. This includes information on the research approach I have taken. I next provide some details on my research findings so that when I then turn to explain the intentionally enabling approach I put forward, its reason for being will be apparent.

**Research context and approach**

The research that informs this paper developed with my PhD work, which was associated with an Australian Research Council (ARC) Linkage Project [hereafter referred to as the Citizen Engagement Project]. The Citizen Engagement Project applied and evaluated innovative deliberative methods of citizen engagement for their effectiveness as a tool in health policy development and as a means for collecting information on citizens’ views on health policy issues. The implementation of the Citizen Engagement Project coincided with a turbulent period of change for State/Territory Health Departments in Australia, with many reeling in the wake of the broad-sweeping recommendations from the 2009 National Health and Hospital Reform Commission’s (NHHRC) Report. It also entailed a period of significant political upheaval:

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5 The word constrained, instead of disabled, could also be applied here and from many perspectives they have similar connotations. I have chosen to use the word ‘disabled’, however, because it carries with it insights gained through the awareness raising and advocacy work of the disability movement which has pointed out that it is the structures within society which disable people, not the individual differences and capacities that people might live with.

6 The full title is: Citizen Engagement: Listening to citizen’s views about Australia’s health system and prevention: ARC Linkage Project No: 0989429. The Citizen Engagement Project comprised Academic institutional partners and Chief investigators from: Monash University [as the lead-organisation], the Australian National University, Curtin University, La Trobe University, University of Adelaide, University of Queensland, University of South Australia, and University of Wollongong; along with Policy institutional partners from the Health Departments of the Australian Capital Territory (ACT), Queensland (Qld) and South Australia (SA), a health consumer representative, and myself, as the PhD scholar. Together, these people formed the Citizen Engagement Steering Group which became an important element of the deliberative system for the overall project. Essentially, the Policy partners were responsible for the implementation of their chosen mini-public, and the Academic partners were primarily responsible for the development of an appropriate and efficacious evaluation framework, which would be applied within each of the participating jurisdictions when the mini-publics were implemented.
federally and within several Australian states/territories. These factors impacted heavily the Citizen Engagement Project’s jurisdictional health policy partners’ capacity to make any definitive decisions on the timing and specific policy issue that would be most appropriate to engage with their citizens in deliberations; compounding the inherently vexatious competing rationalities of the health policy process.7

Ultimately, two jurisdictional policy partners implemented their mini-public within the timeline of my PhD research, providing opportunity for me to interview 28 forum-participants following their involvement in one of the abovementioned mini-publics.8 I also conducted participant-observations on those mini-publics and document analysis, including relevant policies and media-reporting.9 10 My empirical findings were then compiled into case studies; which, have been constructed to reflect Layder’s Theory of Social Domains (1998, 2004, 2006, 2013).11 Effectively, Layder’s domain theory enables insight into the various ways that power can manifest on the exchange of knowledge and deliberative capacity for individuals, their interactions, their social settings, and the broader social contexts of the health policy jurisdictions.

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7 Indeed, working as part of the Citizen Engagement Project immersed me deeply into the realities of research related to the health policy process, and on many levels my research is testament to the challenges that researchers face when researching in the real-world. Many research plans were thwarted and timelines broken. See Kayrooz & Trevitt, 2005 for similar insights derived from other research settings.

8 The third jurisdictional policy partner did implement their mini-public but it was not conducted within a period that provided opportunity for me to conduct similar research within their health policy setting.

9 I also conducted participant-observations on five other mini-publics, unrelated to the Citizen Engagement Project. These insights have been incorporated into my research approach.

10 I have also utilised the research tool, metaphor analysis, in this research as another way to capture the highly-nuanced, deliberative-participant's experience of the exchange of knowledge. During the development of my methodological approach I was deeply mindful that, despite the ubiquity of epistemic practices I was exploring [and go on to describe], the sensitivities and typically unspoken negotiations of power can present significant empirical challenge for any attempts to draw attention to them (Sanders, 1997; Fricker, 2007). I was also aware that, because mini-publics are a relatively new policy-instrument in Australia, it was highly likely that many participating citizens may not have experienced one before. It became evident that I needed a bridging tool, such as metaphors, to provide participants with the opportunity to reconcile this, possibly, unfamiliar experience, with something familiar to them (Lakoff & Johnson, 1980, 2003; Lakoff, 1993; Schön, 1993).

11 The theory of social domains views social reality through the filter of the four domains: contextual resources – this domain is viewed as the outermost encompassing feature of social reality. This domain considers matters related to the distribution of material resources and the historical accumulation of cultural resources, such as knowledge, social mores and values; social settings – this domain mediates between subjective and objective elements of social reality and displays aggregations of reproduced social relations, positions and practice which embody systemic [structural] aspects of social life. Representing the immediate setting/environment, this social setting domain situates the case studies within the relevant policy jurisdiction; situated activity – this domain is distinguished by the arrival and departure of people in face-to-face interactions and their social [intersubjective] exchanges – in this instance, their respective deliberative fora. This domain has a formative influence on meaning-making - given that meaning is also created and influenced by contextual factors; and psychobiography – this domain reflects an individuals’ unique self-identity in the context of their life experiences and social connections. In this research, the psychobiographical domain is compiled from the participant interview narratives and represented in the form of entries titled, Metaphorically speaking and Participant portraits. It is beyond the scope of this paper to elaborate on these entries but I will add that metaphor analysis enabled me to obtain some of this data.
they were situated within. Looking through the lens of these four social domains illuminates different facets of our common social reality, as well as providing ontological depth to any analysis by explicating objective, intersubjective and subjective features. This is not to imply phenomenon can be isolated and fully-compartmentalised within any one of the four stated domains; on the contrary, these social domains were shown to be intimately interlinked and to comprise a complex and multi-dimensional whole (Layder, 1998, 2004, 2006, 2013).

**The conceptual model**

This more nuanced and holistic view of social reality thus enabled an oversight of the combined effects of power within these different domains (Layder, 2006)\(^\text{12}\); which, in turn, exposed a pattern running throughout my research: as displayed in the conceptual model of Figure 1. Essentially, the conceptual model outlines the pathway between decisions taken at critical points of tension-management, throughout the respective health policy jurisdictions examined, to their intentional and/or unintentional, enabling and/or disabling, consequences for the citizen’s experiences of exchanging knowledge and expressing their deliberative capacities.\(^\text{13}\) Viewed from the vantage-point obtained through these citizens’ experiences, I describe the power expressed within the critical points of tension-management examined, as manifestations of either structurally reproductive agency: where the recreation of existing structures, including bodies of knowledge, was apparent; or structurally transformative agency: where the opportunity for making a structural difference, including to bodies of knowledge, was enabled (Hays, 1994).\(^\text{14}\)

Of course, health policy administrators’ decisions ‘do not necessarily imply intentionality’ (Hays, 1994, p. 64) and it is important for me clarify that I am not suggesting that the health policy administrators involved in the Citizen Engagement Project purposefully undermined the deliberations at their respective mini-public. Nor does my empirical data suggest that the relevant policy administrators were intent on producing anything other than the most effective ‘forum’ that they felt capable of doing, within the contexts they were working. What these research findings do indicate, however, is that the health policy administrators involved did not

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\(^{12}\) As such, it does not simply conflate all domains into the more highly contested, dualism of agency and structure [see, for instance, Giddens, 1976:1993].

\(^{13}\) The logic of this model is derived from the iterative process of moving between my theoretically-driven deductive analysis, my data-based inductive analysis, and the combination of both forms of reasoning with the logical underpinnings of my abduction interpretations (Denzin, 1978; Patton, 2002; Layder, 1998, 2006, 2013, (personal communication, 22 July 2015); Schwartz-Shea & Yannow, 2012).

\(^{14}\) The consequential pathways, highlighted in the overview, have been traced to and from critical points of tension-management and were applicable in the context of both policy administrators’ and citizens’ decision-making processes. Citizens’ critical points of tension-management in this context, however, were found to ensue from earlier decisions made by relevant policy administrators, whose own decision-making was made within the enabling and/or disabling structural processes those policy administrators, themselves, were situated within.
prioritise the normative requirements of democratic-deliberation to guide their actions in developing and implementing their respective mini-public, especially during their critical points of tension-management.

Figure 1: Conceptual model of empirical findings and theoretical developments

I would like to clarify at this point, too, that the intent of this overview is not simply to direct attention to the decision-making outcomes from these critical points of tension-management - as important as doing that is. It is intended that this overview also encourages critical reflection on the contextual factors that contribute to relevant decision-making within these inherently opaque decision-making processes. For instance, the ‘critical’ nature of decision-making is reinforced when one considers the contexts from which these decisions were made, as well as the consequences that were to, thereby, ensue; which, in the main, demonstrated an tendency towards reproducing – rather than transforming – the more familiar, traditional ways of

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15 The pattern outlined in the conceptual model became apparent during the second phase of coding my empirical data. For instance, initial codes/findings – for example, being deliberative, timing matters, information matters – were later viewed as situated within the larger pattern of the conceptual overview. The ‘unintentional’ trajectory with ‘disabling outcomes’ for the participant’s experience of the exchange of knowledge and deliberative capacity as an expression of ‘structurally reproductive agency’ was the most dominant pattern traced. 20 codes [distributed over 57 single-line-spaced pages of data] aligned to that trajectory; the second most dominant was ‘unintentional consequences with enabling outcomes’ which demonstrated 6 codes [distributed over 14 single-line-spaced pages of data].

That second most dominant coding highlighted how expressions of structurally reproductive agency can, given other enabling factors, go on to manifest in transformation; albeit at a lower rate than expressions of structurally transformative agency would promote more intentionally.
consulting with citizens.\textsuperscript{16,17} Structures clearly matter (Layder, 1985; 1998; 2006; O’Flynn, 2010)\textsuperscript{18} and this was affirmed throughout the machinations of the case studies of this research; reinforcing how crucial it is that we bring greater transparency and understanding to the contextual factors and decision-making that can unintentionally disable democratic-deliberation and, thereby, reproduce structural factors which diminish the citizens’ experiences of exchanging knowledge and expressing their deliberative capacities.\textsuperscript{19}

As I go on to explain, exploring the contextual factors and consequences of policy administrators’ decision-making related to their mini-public is crucial if these deliberative methods are to be ‘scaled-up’ and genuinely institutionalised in health policy settings (Grönlund, Bächtiger & Setälä, 2014; Niemeyer, 2014). While the democratisation of institutions has received some attention (see for example, Roberts, 2004; Marsh, Lewis & Fawcett, 2010; Parkinson & Mansbridge, 2012; and in the health context specifically see Löfgren, de Leeuw & Leahy, 2011), the concepts highlighted in this overview raise salient points for further consideration. These points will now be considered.

\textit{Research findings}

Foremost, my findings illustrate the significant challenges facing the institutionalisation of mini-publics into health policy settings, with many factors found to have unintentional consequences which disable citizens’ experiences of exchanging knowledge and expressing their deliberative capacities in these circumstances. It also became abundantly clear that when mini-publics are used in health policy settings it is important to be mindful of how deeply political healthcare is,

\textsuperscript{16} Where, for example, policy administrators did not provide information to participants to inform their deliberations, and the lack of time they provided for the participants to effectively deliberate showed a serious misjudgement of what is required for authentic deliberation to be generated. One interviewee described the impact of not having enough time to effectively deliberate in that the forum was too ‘rushed and we didn’t have enough time to digest exactly what it was we were asked to think about’.

\textsuperscript{17} It is now widely accepted amongst deliberative scholars and practitioners that democratic decision-making requires dedicated time for participants to learn about a relevant issue through the provision of clear and comprehensive information (see, for instance, Gutmann & Thompson, 1996; Carson, 2004; Gregory, 2007, 2008a, b; Gregory et al., 2008; Pateman, 2012). And Goodin (2000) leaves us in no doubt about what he believes to be the importance of providing citizens with adequate information to effectively deliberate when he suggests that if deliberative ‘inputs’ are restricted it can result in ‘emaciated deliberation’ (pp. 89-90). The point Goodin (2000) is making here is part of his critique on the problems and subsequent strategies employed in an attempt to overcome the challenges that ‘large-scale mass society poses for deliberative democracy’ (see pp. 84-92 for greater elucidation). He goes on to explain that because our ‘cognitive capacities rely upon informational inputs’, when little information is provided for citizens to deliberate over, it can hardly be seen as genuine ‘deliberation – of seriously reflective “weighing and judging reasons” – at all’ (Goodin, 2000, p. 90).

\textsuperscript{18} See O’Flynn (2010) for a discussion on the structural enablers and barriers to policy implementation when a cross-boundary approach is pursued.

\textsuperscript{19} Indeed, some deliberative theorists claim that the bureaucratic/structural processes within Government institutions prohibit them from effectively incorporating democratically-deliberative designs into their modus-operandi. See Dryzek (2000) for a considered analysis of the arguments for and against such claims.
with the competing rationalities of the health policy process impacting heavily and unfavourably on relevant policy administrators’ decision-making, and subsequent actions, regarding their mini-public.

These competing rationalities involve a complex intermingling of many factors, including conflictive cultural, technical and political value systems, which drive the ethical, political and financial imperatives in resource allocation (Lin, 2003). The main reason why these competing rationalities are so problematic for mini-publics is that they exist in an absence of a communicative rationality; a point to which I will soon return.

Another factor found to unfavourably impact was the prevailing emphasis on a product-dominant logic within health systems, in general. I'm aware that, on the face of it, my claim that a product-dominant logic is problematic may seem counter-intuitive to those of us who recognise the importance of deliberative outputs to the legitimacy of a mini-public. The thrust of my argument, however, is not that the emphasis was given to what the overall mini-public might achieve - as the product - instead emphasis was given to policy administrators being able to tick-the-box, so to speak, to confirm that they had ‘produced’ a mini-public - regardless of how more or less democratically-legitimately that product might have been derived. And at the added expense of not valuing what might also be derived from the deliberative process, itself.

This argument links into critiques on the theory underpinning the New Public Management approach to public services, in that some key tenets of that theory have been derived from the manufacturing rather than the service sector - with the problematic nature of this traced to the inherently different production/business logic within each. For instance, in manufacturing, production and consumption of a ‘tangible’ product occur separately; whereas, production and consumption occur simultaneously for an ‘intangible’ services. A multitude of implications arise from this distorted view - not least, a fundamentally different perception of the role that citizens play in public services (Osborne, 2010; Osborne & Brown, 2011; Osborne & Stroksesch, 2013; Radnor, Osborne, Kinder & Mutton, 2013; Osborne, Radnor & Nasi, 2013; Radnor & Osborne, 2013).

My research has found that this product-dominant logic is being extended to the use of mini-publics, in the way that health policy administrators view them as a ‘product’ to be designed and produced by them; then, consumed relatively passively by citizens - who are considered as optional add-ins rather than having an essential role in the whole process. These factors are compounded by the fears (Edwards, 2001) and ontological insecurities (Laing, 1960; Schön,
1971; Giddens 1976, 1993; Turner, 1988) that policy administrators can experience in relation to the unfamiliar nature of these democratic techniques. In part, I would suggest this is because they have not yet learnt to trust in the deliberative ‘process’, itself, and, apart from two notable exceptions, the policy administrators involved did not engage with relevant theory on the practice of mini-publics. As it stands, policy administrators try to reconcile their fears and insecurities with a propensity towards ineffective communication practices – emblematic of an overarching communicative irrationality, and reflecting the asymmetry of power within the health policy process.

Seen together, these contextual features create an environment within which policy administrators’ decision-making, regarding their mini-public, converges into critical points of tension-management that have unintentional consequences, which disable citizens’ deliberative capacities as well as being detrimental to them exchanging knowledge, with troubling instances of epistemic injustice ensuing. Two types of epistemic injustices were seen: testimonial injustice, whereby the citizens were not given credibility in their capacity to convey information; and hermeneutical injustice whereby the citizens were not given credibility in their capacity to understand certain things that would be in their best interests to understand. All things considered, these citizens were not viewed as colearners in the social learning that would manifest from these mini-publics (Roberts, 2004); nor does it seem they were viewed, by certain policy administrators, as capable of, and having an equal right to, the personal developmental opportunities that might ensue (Gould, 1988, p. 1). And due to all the disabling factors, in many instances, what occurred was not much more than an aggregation of pre-formed preferences - whereby any pre-existing opinions and adaptive preferences (Elster, 1982, 1983; Sen & Williams, 1982; Nussbaum, 2011) were far more likely to be reinforced - that is, not transformed or corrected in any substantial manner.

So what does this matter when citizens deliberate on health related topics? It matters a great deal, not least, if we accept that one of the fundamental aims of a mini-public is that the process works toward enabling citizens to gain a clearer understanding of not only what they might want, but what is also in their best interests to know. And the confluence of these factors, I am arguing, casts doubt upon the validity of any claims that can be made of the democratic
authenticity and legitimacy of mini-publics when applied in health policy settings under such circumstances.\(^{20}\) All was not lost however, because despite the predominance of findings already mentioned, a paradox appeared in my data which highlighted the intrinsic potential of deliberative practice to create an intersubjective space that facilitates a transformative exchange of knowledge. This was evident in citizens experiencing such things as improved self-esteem, a greater sense of personal and community empowerment, and increased social capital and health literacy: these factors are known to contribute to people being healthier. Some of my interviewees clearly gained realisations they had otherwise not acquired. For instance, some realised how the personal can be a deeply political matter (Mills, 1959; Freire, 1970:1993; 1992; Ife, 2002; Galbally, 2004). What became clear was that when citizens have an opportunity to exchange knowledge this way they can learn from the ‘contextualized narratives’ (Young, 1997, p. 342) and embodied experiences of their deliberative-peers. In effect, this allows citizens to make sense of matters related to their health and wellbeing, and situate their ‘personal troubles’ (Mills, 1959, p. 15) within the context of their broader societal realm. Seyla Benhabib (1996) describes the deliberative process of reasoning together as enabling participants to reach ‘certain coherence’ in their views (p. 72). Indeed, this description was reflected in the comments of many interviewees who spoke metaphorically to explain their experience of deliberating as ‘filling gaps’ in what they already knew; being able to ‘connect-the-dots’, they said, enabled them to make realisations that they had, otherwise, not gained. Some referred to this as a process of ‘building’ something together; like putting a ‘jigsaw puzzle’ together.\(^{21}\) Akin to having their sociological imaginations awoken, the realisations thereby obtained provided these people with opportunity to understand the broader context of their lives (Mills, 1959).\(^{22}\)

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\(^{20}\) When referring to democratic legitimacy I concur with Estlund’s (2008) conception as ‘the moral permissibility of the state’s issuing and enforcing its commands owing to the process by which they were produced’ (p. 2, my emphasis).

\(^{21}\) This most typically manifest in circumstances where effective table-facilitation and epistemic justice was evident. In some instances, the metaphors, cited above, were used spontaneously throughout the interview-process; at other times, the metaphors my interviewees provided were in response to my explicit request for one that described their experience of deliberating at certain points during the mini-public they attended.

\(^{22}\) C Wright Mills long since recognised that individuals ‘visions and their powers’ might otherwise be constrained by the personal ‘troubles’ of their lives (Mills, 1959, p. 9); it may not be apparent to an individual that their ‘vision’ and ‘power’ is constrained, but as the empirical findings from this research suggest, there is a strong case to be made for role that mini-publics might have to play, in relation to expanding the publics’ vision and power over their health and wellbeing; tantamount to having their sociological imaginations awoken (Mills, 1959). Indeed, it is now well-established that the ‘personal troubles’ health consumers bring to their healthcare providers are grounded in social issues beyond the remit of bio-medicinal answers and examining the roots of these ‘personal troubles’ seldom receives the critical attention it deserves during a, typically, brief doctor-patient consultation. This occurs even though these ‘personal troubles’ are ‘almost always interconnected with structures in society’ even when these ‘links’
Others, too, developed a heightened sense of empathy, and spoke of the collective wisdom they were able to tap into during their discussions which gave them an empowered sense of hope that they could learn from these other people’s experiences and make changes to their own lives and behaviour in a way that would favourably impact on their own health and wellbeing. In healthcare more generally, opinion is converging on the realisation that when people are included in their healthcare decision-making they have better health outcomes (Leadbeater, 2004). And involving people in decision-making related to their healthcare is known to increase their health literacy – with increased health literacy now considered a key determinant of health. Principally, when my interviewees said that they had gained any transformative insights, they also experienced instances of epistemic justice and effective table-facilitation. Such table-facilitation, it seems, was able to mitigate some of the unintentionally disabling factors, though none were able to circumvent all of the deliberative constraints. For instance, they all faced a shortage of time and information.\textsuperscript{23, 24}

Having drawn attention to some competing factors at play in the health policy process, it is reasonable that the reader might now be wondering what chance citizens might have of making a difference in this highly contested, expert-knowledge based, arena. Indeed, apart from effective table-facilitation, what might enable citizens to experience maximum benefit from exchanging knowledge and deliberating over health related matters? For instance, what might bring about a change in health policy administrators’ communication practices? And what might encourage health policy administrators, and the governments they serve, to adopt the norms of democratic-deliberation? It is to this type of consideration I now turn.

\textsuperscript{23} Table-groups which had fewer table-group members had more time for each person to utilise for their deliberations and experienced greater depth in their discussions but a smaller number of table-group members can also work against effective deliberations; as one interviewee put it, in such circumstances there would be ‘less-cross-pollination of ideas’ put forward.

\textsuperscript{24} When the structure of a deliberative technique does not itself emphasise the normative requirements, a particularly heavy burden falls upon table-facilitators in their efforts ‘to try to ensure that those who are usually left out of public discussions learn to speak whether their perspectives are common or not, and those who usually dominate learn to hear the perspectives of others’ (Sanders, 1997, p. 15).

When we consider how it is virtually impossible to have symmetrical relations of power (Warren, 1993), we can appreciate the challenge facing table-facilitators during a mini-public: needing to maintain constant vigilance to the power-differentials present and to be prepared to employ strategies to create a more level-playing-field for their table-group members.
An intentionally enabling approach

In response to the factors found to have unintentionally disabling consequences for citizens’ experiences when mini-publics are used for health policy, this paper has presented a strong case in support of why policy administrators ought to adopt an approach that intentionally enables participating citizens to more effectively exchange knowledge and express their deliberative capacities. To bring this paper to a close, and using some of the unintentionally disabling factors found in an inversely-instructive way, I will outline five propositions designed as fundamental principles and premises for what an intentionally enabling approach might entail. It is beyond the scope of this paper to present a full exposition of these propositions, but the interlocking set of ideas running through them becomes evident as we progress through them. Importantly, these propositions are not meant to be prescriptive, not least, because an intentionally enabling approach will be, by necessity, context-bound to the social situation of any given health policy setting. Instead, these propositions are designed with the intent to create a more democratically-deliberative environment within which epistemic justice and deliberative capacity can flourish: institutionally, collectively, and individually.

Proposition 1: An expanded view of health policy administrators’ responsibilities

An explicit and expanded understanding of what health policy administrators’ responsibilities entail is required when mini-publics are applied to health policy settings. This includes a requirement that health policy administrators take active steps towards understanding and exercising their epistemic responsibilities in relation to the norms of democratic-deliberation, so that these norms are their critical guide when operationalising mini-publics.

Bearing in mind that deliberative democratic theory is a ‘normative theory that suggests ways in which we can enhance democracy and criticize institutions that do not live up to the normative standard’ (Chambers, 2003, p. 308), this proposition uses this normative standard as a centre-point in determining health policy administrators’ responsibilities, including their epistemic responsibilities (Code, 1987)\(^{25}\), when they use mini-publics for health policy. So, to explore the

\(^{25}\) Along with Lorraine Code (1987), I consider ‘knowing well’ to be as much a ‘moral as it is an epistemological matter’ (p.252). Consistent with this view is the understanding that the essential human characteristic of ‘cognitive interdependence’ carries with it concomitant ‘expectations and responsibilities’ (Code, 1987, p. 2). One generalised and readily understandable example of what an epistemic responsibility might entail is that which accompanies a motorist who, when in his or her country of origin, drives, let’s say, on the left-side of the road. When visiting another country where motorists drive on the right-side of the road, the left-side-of-the-road-driver has a responsibility to know the road-rules of the country she or he is visiting – ignorance of such rules does exonerate him or her in the event of a traffic-accident or violation (Code, 1987).

Invoking the Socratic injunction that one must know well so as to act well, Code (1987) maintains that an individual ‘who has not been scrupulous in knowing cannot be scrupulous in doing’ (p. 95). Indeed, when we consider health policy administrators’ epistemic responsibility in the context of the health policy settings examined for this research,
ways that health policy administrators’ responsibilities might thus be reconsidered, this proposition taps deeply into the culture and ethos of health systems as it brings explicit attention to the way rationalistic forms of thinking have taken control of all facets of our lives, including bureaucratic processes, throughout the last 200 years. I also draw heavily on Michael Harmon’s (1995) critique on the ills of public administration; of which he attributes to the paradoxes and pathologies associated with the notion of responsibility.26,27

The paradoxical nature of responsibility originates in the sense that it ‘embodies opposing principles and terms, namely, subjective and objective, personal and institutional, moral agency and moral answerability’; with the pathologies traced to the unreconciled and contradictory features of each (Harmon, 1995, p. 70). Compounding the pathological nature of these features is rationalism’s sole focus on instrumental objectives, which has embedded the inability to comprehend the paradoxical character of responsibility within bureaucracies. Through the prism of a multi-faceted understanding of responsibility, however, we see three core meanings of responsibility: agency, accountability, and obligation (Harmon, 1995).28 I argued earlier that greater transparency and scrutiny is required for a more comprehensive understanding of the agency-structural factors at play when mini-publics are used for health policy; particularly pertinent, is policy administrators’ decision-making at critical points of tension-management.

The view provided by this three-dimensional notion of what responsibility entails, creates an ideal vantage point to examine the unreconciled and contradictory ways that agency, accountability and obligation might impact on health policy administrators in their decision-making and, subsequent, actions (Harmon, 1995). To briefly demonstrate what this view provides, I will tether a multi-faceted and ‘forward-looking’ (Baier, 1986, p. 190)29 view of...
responsibility to some ways in which health policy administrators might more effectively demonstrate epistemic responsibility when they use mini-publics, and consider alternative ways that they might meet their responsibilities in this innovative field of work.\(^{30}\)

Given that accountability and obligation both ‘presuppose the idea of agency’ I will begin with a reframed view of that facet of responsibility (Harmon, 1995, p. 25). In seeking to avoid the buck-passing and scapegoating, identified by Harmon as pathologies of agency (1995, p. 9), health policy administrators might instead act as ‘intentional’ and ‘self-aware’ agents expressing their free will by exercising their agency in a structurally transformative way and choose from among alternative courses of action in pursuit of, for instance, becoming more informed on the theory and philosophy underpinning mini-publics (Harmon, 1995, pp.20, 25).\(^{31}\) Indeed, if health policy administrators are to be considered practitioners in the ‘sciences of democracy’ (Lasswell, 1948, p. 132) it is crucial that they exercise these epistemic responsibilities.\(^{32}\)

A lack of engagement with relevant theory is not unique to the policy administrators of this research; a similar lack of interest in theory has been identified elsewhere when policy administrators are involved in research projects which have very practical aims or a ‘policy-oriented focus’, and arise in response to a ‘social problem’ (see, for instance, Layder, 1998, p. 11). In such circumstances, a lack of interest in theory might be viewed as an ‘unintended consequence’ of the competing demands that policy administrators work within (Layder, 1998). Yet in my experience on this research project and in other settings, it is not uncommon for certain policy administrators to refer to ‘theory’ in the pejorative; something to eschew or wilfully ignore as they go about the practical details of their ‘real’ work. Clearly, theory and practice

\(^{30}\) Indeed, this more nuanced understanding of responsibility may well be vital to public officials and administrator’s capacity to work towards reform, and intelligently and creatively manage the confusion and competing tensions that are provoked by the ‘contradictory motives and forces’ that comprise organisational and political life (Harmon, 1995, pp. 3; 19).

\(^{31}\) There were two distinct examples in my fieldwork: including a health policy administrator from both policy jurisdictions examined. These two individuals clearly exercised their epistemic responsibilities and engaged with tertiary-level training on deliberative theory and practice. The predominantly structurally reproductive environments they were working within, however, clearly constrained their individual capacities to promote structurally transformative agency in relation to the mini-publics they were involved in.

\(^{32}\) As this research has demonstrated, because the some of the health policy administrators did not exercise certain epistemic responsibilities in the first instance, many deliberative norms were not adopted either. As a consequence of not familiarising themselves with deliberative norms, not only did these health policy administrators deprive themselves of the benefits of such knowledge (Code, 1987) – which would have otherwise helped to develop their own and their institutional deliberative capacities - their decision-making had the unintended consequence of denying the participating citizens the full benefits and social learning to be derived from participating in an authentic and legitimate democratically-deliberative processes.

Although in these circumstances, such behaviour can be seen as epistemically irresponsible, what these health policy administrators were exhibiting was structurally reproductive agency: whereby many of their decisions, and subsequent actions, were emblematic of, and reproduced, traditional consultation techniques.
are important, especially when it is an innovative initiative, like a mini-public, that is being introduced into an institution and the philosophical underpinnings of that initiative are not already embedded into that institution’s culture and ethos. Finding the right balance between theory and practice, it seems, is yet another competing tension for health policy administrators to manage amidst the instrumental objectives highlighted above.  

Turning to the notion of obligation, we see the explicitly moral meaning of responsibility; considered to be derived from a source external to an agent and with implications for what particular action one should, or should not, perform (Harmon, 1995, pp. 26-7). Reframing obligation enables health policy administrators to reconsider their epistemic responsibilities beyond the perspective of a ‘purely private and self-interested activity’ to one that conceives their ‘active participation’ in an overarching deliberative system within which there is a ‘mutual creation of interests and obligations’ (Harmon, 1995, p. 7). Then, when accountability is also reframed it reunites opposing views of health policy administrators as ‘makers’ who are held accountable for their actions through an ongoing and critically-reflective dialogue in a strong and effective deliberative system – that extends beyond the authoritative edicts of the bureaucratic structures they work within - with the view of health policy administrators as ‘answerers’ who are accountable to citizens by providing them with, for instance, information resources and enough time for those citizens to effectively express their deliberative capacities (Harmon, 1995, pp. 186-

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33 There are clearly concomitant institutional responsibilities here, too, from organisational management, to exercise structurally transformative agency by, for instance, demonstrating the virtue of epistemic justice towards health policy administrators (Fricker, 2007, 2013) in a way that creates the conditions for relevant policy administrators to be provided with the requisite time and training required to understand relevant theory and practice relating to mini-publics.

34 Partnering with universities/academics and deliberative practitioners well-versed in the theory and practice of mini-publics is the most obvious starting-point, though, as this research attests, such partnerships do not, necessarily, mean that health policy administrators will engage with relevant theory and adopt normative practice: there also needs to be an explicit commitment that they will do so.

There is, also, a large amount of very accessible information freely available on the Internet, regarding the theory and practice of mini-publics, for the more self-led learners. The varying degrees of comprehensiveness with which those individuals might engage with information on the Internet though means that, ideally, that sort of personal engagement with the theory would best be used as an adjunct to, not instead of, training or information sessions conducted for all the policy administrators who would be working with the mini-public.

35 When it comes to health policy administrators’ personal agency, their responsibilities requires that they exercise their agency in a structurally transformative way with, for instance, a willingness to engage with the theory on mini-publics in a way that enables them to use this new knowledge to transform their traditional ways of consulting with the public and thus intentionally enable the normative standard of a mini-public.

It is quite feasible that not all health policy administrators will want to engage with the public this way. As this research suggests also; not all health policy administrators seem to accept that citizens truly have the capacity to effectively contribute to health policy this way. Findings from ongoing research into the transformative impacts of democratic-deliberation may convince those more sceptical policy administrators that mini-publics are worthy of their attention, but at risk of undermining the democratically-deliberative nature of any given mini-public, those individuals ought not have the veto-capacity in any substantive decision-making related to a mini-public.
When health policy administrators exercise structurally transformative agency and accept their responsibilities this way, they can effectively transform questions regarding what might be considered ‘correct’ for them to be doing at such times of uncertainty ‘from the standpoint of an abstract criterion of the good or the right’ (Harmon, 1995, p. 160) – for instance, that of a risk-minimisation perspective - to an alternate line of questioning, derived from a clear and informed view of the socially-situated context they are working within; or indeed, any other circumstance filled with ambiguity and doubt (Harmon, 1995, p. 209).

It is not my claim that the paradoxical factors within responsibility can be totally eliminated. Alternatively, what I am proposing is that the pathologies associated with the unreconciled, contradictory features of responsibility can be ameliorated by critical reflection and deliberation on the way they intersect with health policy administrators’ beliefs, values, and fears when working towards the normative requirements of a mini-public. When thinking about the way that mini-publics connect to the overarching deliberative systems of any given health policy settings, we can appreciate how a more appropriate understanding of what responsibility entails would be a necessary component in the training of all health policy administrators, not just those who are immediately involved in the operationalisation of mini-publics.

It is conceivable, too, that the critically-reflective practice considered here would have the added benefit of

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36 Health policy administrators can thus work towards purposeful goals, along with exercising their responsibilities, in a way that sees responsibility as a shared and relational construct, reframing their capacity to shape, reshape, and transform themselves and their practice of citizen engagement (Harmon, 1995); whilst further, reinstating personal responsibility ‘to its rightful place in the moral discourse on government’ (Harmon, 1995, p. 5).

37 Nor does Harmon (1995) claim to be able to eliminate these paradoxes, and although Harmon’s critique on responsibility does not directly relate to situations when public administrators are working with deliberative mini-publics, he does advocate a dialogical-process for public administration to be able to manage the prevailing tension and confusion over what constitutes responsibility (Harmon, 1995).

To be clear, Harmon is advocating a dialogical process, whereas the communicative rationality I propose would not only incorporate dialogue in these instances; it also includes other ways of exchanging knowledge with citizens. For example, other means of communication and exchanging knowledge might include, providing citizens with written material on what a deliberative method of engagement entails; involving them in decisions about what type of deliberative method to utilise in addressing matters of public interest, forum agenda-setting, and the provision of relevant material, in various audio-visual formats, to develop their information-base on relevant matters.

38 Furthermore, I would argue, that not acknowledging these factors does not diminish their effects; on the contrary, allowing these paradoxes and pathologies to remain inexplicit simply creates an environment where their insidious effects can prevail more perniciously.

39 For instance, conducting professional development sessions to facilitate a ‘safe-place’ for policy administrators to articulate the tensions they confront regarding the contradictory responsibilities of working with the more democratic-nature of mini-publics.

40 I indicated earlier that health policy administrators have been at the front-line of another strongly democratising force, in the form of the health consumer movement; mutual insights on the enabling and disabling factors in that parallel democratising process, could also be harnessed to assist in the development of health policy administrators’ and citizens’ capacities when they are involved with mini-publics. Examples of what such insights might provide can be found in: West, 1984; Davis, 1998; Gregory, 2008a; Gregory, 2008b; Judson, Detsky, Press, 2013; and Boswell, Settle & Dugdale, 2014.
strengthening the overarching deliberative system of any given health system/department, as it simultaneously develops the deliberative capacities of its constitutive individuals.

Nor is this proposition oblivious to the legal obligations and lines of accountability which health policy administrators are subject to within the organisational structures they are employed. Such historical obligations and conceptions of responsibility, however, were not able to ‘anticipate the varied and subtle meanings of responsibility as they emerge’ with the innovative and more democratic-nature of mini-publics (Harmon, 1995, p. 209). Indeed, if the critical reflection and deliberation I propose here is to promote authentically democratic practice, it needs to extend to sharing substantive decision-making power with the citizens of any given community (Roberts, 2004). Hence, health policy administrators’ responsible action becomes an ‘irreducibly social activity’; an interaction which entails ‘continuous reciprocal interpretations’ of each other’s intentions through a process of critically-reflective dialogue (Harmon, 1995, pp. 160-1); a far cry from some of the opaque decision-making processes recounted in this research.

I am not naïve to the fact either that what I am proposing in terms of health policy administrators’ responsibilities involves reversing some strong trends in bureaucratic structures [and contemporary societies, more broadly]. As such, this proposition must be viewed as part of a longer-term developmental process (Ife, 2002). Yet, these are not new realisations; as Schön (1971) well recognised, at times of uncertainty and change what we ‘need is to develop institutional structures, ways of knowing, and an ethic, for the process of change itself’ (p. 11).

41 In a similar way, though in relation to practitioners more broadly, Schön (1983) earlier called for an ‘epistemology of practice’ to help bring to an explicit level a practitioner’s ‘capacity for reflection on their intuitive knowing in the midst of action’ because he believed such reflective practice can generate the ‘capacity to cope with the unique, uncertain, and conflicted situations of practice’ (p. ix).

42 Indeed, ‘public officials have a moral as well as a legal obligation to fulfil authoritative edicts and to achieve authoritative ends’ (Harmon, 1995, p. 8).

43 Indeed, Harmon sees that what is needed ‘is a reframed understanding of the vital role of authority in public institutions’ (Harmon, 1995, p. 9).

44 I am not implying that all citizens will want to or, indeed, ought to be involved into every decision made throughout the policy process; it is neither practical nor likely that all citizens would have the time or inclination to do so. In relation to this matter, Roberts (2004) proposes that citizens are to be involved in the ‘substantive decisions’ affecting a community; with substantive decisions ‘defined as those that are important and critical in community life as defined by the members of [that] community’ (p. 320). In the context of this research, a ‘substantive decision’ would involve the decision over such things as, which health topic/policy is to be deliberated over.

It is important to bear in mind, also, that ‘substantive’ decisions can have a cascading-effect on many other important factors which, then, require further decision-making. For instance, after the decision is made on which policy to engage the citizens to deliberate over, further choices need to be made - on such things as: what point in the policy process citizens will be engaged; what information will be given to inform participants’ deliberations; how long will the engagement process run for; what features of the engagement process will be evaluated; and whether the process be internally or externally evaluated. The citizens in each policy jurisdiction examined for this research, were not given any opportunity to contribute to any of those ‘substantive’ decisions.
As part of this process of change, this research has established an empirically-grounded, theoretical basis for responsibility, including epistemic responsibility, to be viewed as a ‘pivotal normative concept’ (Code, 1987, p. 26) when mini-publics are used in health policy settings. The critically-reflective practice highlighted here is also essential to the development of the communicative rationality I propose next.

**Proposition 2: Develop a communicatively rational approach**

*An explicit communicative rationality is required when health policy administrators apply mini-publics. This requires the development of an intersubjective approach to their communicative competence to facilitate an understanding of the ways that communicative irrationality can disable the democratically-deliberative nature of a mini-public. This communicative rationality is to have epistemic justice at its core, with structures in place to help correct any epistemic injustices identified.*

This proposition addresses another cumulative argument of this research: that certain health policy administrators exhibit a communicative irrationality in the way they operationalise a mini-public. Using Elster’s (1983) theorising on rationality as a counterpoint, we can specify even further that what these health policy administrators displayed was communicatively irrational in a thin sense. That is, these people did not demonstrate a logical consistency between their stated desire/aim and their actions, as they worked towards their respective mini-public. Indeed, having explored the negative-space of communicative irrationality in the citizens’ experiences of this research, a compelling case presents for an explicit commitment from health policy administrators that a communicative rationality will be used when mini-publics are applied in health policy settings.

Although communicative rationality has a long and respectable lineage – as far back as Aristotle – it has since been eroded by the instrumental rationality considered in Proposition 1. Yet, the privileging of instrumental rationality and objectivist ways of thinking is known to create problems of domination and power, and systematically distort communicative competence.⁴⁵

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⁴⁵ These concerns directly pertain to the way that the perceptions, culture, and meaning-making processes of our lives suffer at the hand of expert cultures; with concern also raised over the way expert cultures and risk-averse ways of thinking within an instrumental rationality hold the monopoly in how we experience and make sense of the world. This is evident in, for instance, how these ways of thinking dominate within science, technology and the law (see for instance, Beck, 1986: 1992, 1997; Dryzek, 1990, 2000; Habermas, 1984, 1987, 1996; White, 1998). See Dryzek (1990) for an extended critique on the claims to rationality made by political institutions. Dryzek (1990) specifies that his criticisms of rationality – instrumental rationality, in particular - point to democracy, not hierarchy, and that we must be unceasingly vigilant to the effects of instrumental rationality. He goes on to argue for the democratisation of expertise in politics, public polity, and political science (p. 218). In acknowledging that instrumental rationality will probably linger through time, Dryzek (1990) believes that it deserves to be more limited in the domains in which it currently occupies. Objectivism, on the other hand, needs to be eradicated, entirely (p. 9).
With deliberative theorists, such as Habermas and Dryzek, going as far as to claim that instrumental rationality is antidemocratic because it can effectively repress individuals (Habermas, 1984, 1987, 1996; Dryzek, 2000, 1990). Countering the predominance of instrumental rationality and communicative distortions requires a shift in emphasis; one more towards a communicative rationality. Within this context, intersubjectivity and communicative competence can emerge, with a mutual understanding between individuals created, whereby there is an expectation that their real concerns ‘will be taken seriously, if not shared’ (Dryzek, 2000, pp. 8-22)\(^{46}\); in Habermasian terms, this as a process of moral development: both individually and socially.\(^{47}, 48\)

Although a great deal of theorising has gone into the ways that such a communicative ethic and rationality might be expressed in an ideal speech situation\(^{49}\) - little consideration has been given

\(^{46}\) By promoting and facilitating intersubjective understandings, communicatively competent individuals, ‘hear and respect different voices’: with mutual recognition the crux of the matter (Dryzek 1990, p. 17; see also, Habermas, 1970b, 1984, 1987; Benhabib, 1996; Schlosberg, 1995).

\(^{47}\) In particular, see Habermas (1979: Chapters 2, 3 and 4). Although it has not been an intentional aim of this research, in many ways, it validates Habermas’ assertion that institutional/structural factors can distort and disable communicative competence (1970a, b), and while never explicitly stated by Habermas, I would suggest that he might approve of epistemic justice being added to his communicative ethics.

\(^{48}\) Habermas argued that ‘pure intersubjectivity exists only where there is complete symmetry’ (Habermas, 1970b, p. 371). Although it is possible to derive practical insights from Habermas’ work, he does acknowledge that his theory of communicative action is ‘intended to solve problems that are rather of a philosophical nature’ (1979, pp. 95-6); whilst further acknowledging that a ‘speech situation determined by pure intersubjectivity is an idealization’. Still, he defines how ‘pure dialogue-constitutive universals’ can be used to analyse the ideal speech situation, and he elaborates on what constitutes pure intersubjectivity: for instance, ‘complete symmetry in the distribution of assertion and dispute, revelation and concealment, prescription and conformity, among the partners of communication’ (Habermas, 1970b, pp. 369-72).

Habermas believes that only an ‘interlacing of perspectives makes an intersubjectively valid meaning, and thus identity of meaning, possible’ (Habermas, 1970b, pp. 369-70) and he goes on to explain the role that the ‘system of personal pronouns’ plays in the ideal speech situation (1970b, pp. 369-71).

Indeed, an interesting avenue of inquiry which has not received attention in the literature on mini-publics emerges from cultural and cross-cultural research on how the selective use of pronouns can promote collectivist thinking – as opposed to individualist thinking. These insights offer potential benefits in facilitating collectivist thinking during a mini-public, for instance, when highly divisive issues are being deliberated over. The process is known as priming and demonstrates how small interventions could promote important changes in the development of deliberative capacity; in this instance, by facilitating citizens to transition from their individual to collective perspectives. See Oyserman & Lee, 2008, and Oyserman, Sorensen, Reber & Chen, 2009 for more information on that research.


Most notably, the notion of the ideal speech situation in the public sphere - in which more symmetrical power relations might be exercised - is identified with Jurgen Habermas. This notion is proposed as an attempt to create a public discourse in which the only force present would be his much cited, forceless force of the better argument (1975, p. 108). Other deliberative democrats, too, like Gutmann and Thompson (1996), and those loosely defined as Difference democrats, like Lyn Sanders (1997) and Seyla Benhabib (1996), have contested and expanded upon Habermas’ claims in a way that brings greater inclusivity to the process of mini-publics by acknowledging and
to health policy administrators’ requisite communicative rationality or how such a rationality might promote epistemic justice. With those points in mind, and drawing on the intersubjective understandings of this research, we can alternatively conceive of what a communicative rationality, with epistemic justice at its core, might entail when health policy administrators work with mini-publics. For instance, this would include:

**Before a mini-public:** involving citizens in the substantive decisions regarding the policy matter to be deliberated on, and the development of questions/agenda items/evaluation criteria for the mini-public; allocating an appropriate timeframe for the planning of the mini-public and information-sharing with citizens, for instance, well-balanced and accessible information on the deliberative-subject matter\(^{50}\), and information about deliberative practice\(^{51}\); consideration given to the ontological security requirements of citizens and health policy administrators, including tension-management skills and resources; effective training for support-staff that encompasses awareness-raising of the disablers and enablers of deliberative capacity and epistemic injustice; creating opportunities for citizens and support-staff to be involved in pre-forum workshops/deliberative role-playing.

**During a mini-public:** consideration given to the ontological security [feeling safe] requirements of all in attendance, including the development of tension-management skills and resources; mechanisms of recourse if citizens are experiencing factors which disable them from effectively exchanging knowledge or expressing their deliberative capacities; well-balanced, accessible information; appropriate time for critical reflection and more information-sharing, if required by those citizens; explicit networking time; and appropriately trained, effective table-facilitators.\(^{52}\)

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\(^{50}\) This information can be provided in various formats, for example, in audio-visual formats with the aid of ICTs, as well as written material. Many factors will determine what might constitute ‘adequate time’ for citizens to engage with any preparatory information: for instance, the subject-matter and the citizens’ prior understanding of that subject-matter. For this reason, it is not possible, nor desirable, to be definitive about how much time this will take. As research into citizens’ experiences of deliberating on health policy develops, however, it will be possible to draw on previous examples/case studies [such as this research] to make more informed decisions on such things as what might constitute ‘adequate time’, given the socially-situated context of any given mini-public.

\(^{51}\) For example, I developed a Deliberative pamphlet during this research project which brought together empirical and theoretical insights to demonstrate what a tangible feature of a stronger and more effective communicative framework/rationality might entail; that is, in providing citizens with information so they would know what to expect from their participation in a mini-public.

\(^{52}\) Picking-up on the point regarding table-facilitators, this research shows that if those individuals do not model epistemic justice, nor have the capacity to call upon personal resources drawn from experience and awareness of the myriad ways that ‘privilege and prejudice’ can manifest during a mini-public (Sanders, 1997), then, citizens are more
After a mini-public: building in collaborative evaluation on the process and outcome of the deliberations as part of ongoing professional and citizen/community development; keeping citizens informed of progress and new ways of staying involved/connected to the policy process and decision-making.

To reiterate an abovementioned point, raising awareness of what might constitute testimonial and hermeneutical injustice, and having mechanisms/structures in place to correct any epistemic injustices identified is of utmost importance. Although specifics will vary, depending on the context and deliberative technique being utilised, this will require explicitly identified processes for citizens to pursue if they feel certain features are disabling to their capacity to effectively deliberate and exchange knowledge. It also requires that health policy administrators either conduct or commission research, involving those citizens, prior to a mini-public to determine what is it is that is in the ‘best interests’ of those citizens to know so that they can effectively deliberate in such circumstances. Creating opportunity for such a responsiveness and continual improvement when planning and implementing a mini-public is also vital, for instance, if it is more time and/or information citizens require, then, these things are acted on and not delimited by other competing rationalities, for example, policy administrators needing to accommodate predetermined and inflexible policy timelines. Providing citizens with these opportunities to effectively exchange knowledge and express their deliberative capacities can also be seen as a matter of substantive equality; as one interviewee suggested, this is required to: ‘level-the-playing-field’ and this point leads directly into my next proposition.

Proposition 3: Substantive equality as a guiding deliberative norm

That the principle of substantive equality is used to guide development of the requisite and more equitable opportunities that enable citizens to exchange knowledge and express their deliberative capacities when mini-publics are used in health policy settings.

The imperative behind this proposition came to the fore with the realisation that the principle of equality – as it is formally and objectively understood – does not support the citizen’s ability and opportunity to effectively participate in these circumstances. Indeed, if we use Dryzek’s (2009) likely to experience instantiations of epistemic injustice. I must be clear at this point: I am not advocating for table-facilitators to take ‘control’ of the discussion, as I have seen done in many fora; on the contrary, the intentionally enabling approach I propose is consistent with the norms of deliberation – in that such a role facilitates a genuine and shared sense of value and respect for each table-group member’s deliberative capacity.

53 Of course, the principle of equality underpins the basic democratic right we all have as citizens to participate in deliberations on health policy and firmly encases the normative framework of mini-publics; indeed, ‘democrats take equality for their motto’ (Aristotle, 1885: 2000, iii 9). But the principle of equality is not unique to democracy; it is also firmly entrenched in human rights law; indeed, ‘without equality, human rights have no meaning’ (Facio & Morgan, 2009, p. 3).
tripartite for democratic legitimacy as a benchmark, we can see that these citizens’ experiences of exchanging knowledge and deliberating fall well below the line. This realisation is consistent, too, with the understanding that a narrow and objectivist conception of equality tends to focus on formal equality, alone: that is on our ‘equality’ before the law (Facio & Morgan, 2009, pp. 2-7). If citizens are to participate on an equal-footing when exchanging knowledge and deliberating on health policy, however, an intersubjective understanding of equality is required: that which is found in the notion of substantive equality. Understanding the difference between what for mal and substantive equality entails, allows us to see that substantive equality focuses on equality of results (Facio & Morgan, 2009); thereby, creating equitable opportunities that provide for the diversity of deliberative capacities that citizens carry with them into these deliberative-fora. Clearly, we cannot make all people equal but, this proposition asserts, we can more equitably allow for their differences (Benhabib, 1996; Bohman, 1996; Young, 1996; Sanders, 1997; Baum, 2002: 2008).

Instantiating the principle of substantive equality would manifest in many and varied ways, depending on the individual participants, the subject-matter of their deliberations and where in the policy-cycle, itself, that citizens are engaged to deliberate. While I may not be the first to propose that policy administrators ‘intentionally seek to level the playing field among the participating social actors during the deliberations’ (see, for instance, Roberts, 2004, p. 343 [my emphasis]), it is my ambition that having shone a light on the unintentionally disabling consequences which can arise from health policy administrators’ decision-making not underpinned

54 The reader will recall that Dryzek (2009) maintains that democratic legitimacy is now seen to reside in the ‘right, ability, and opportunity of those subject to a collective decision to participate in deliberation about the content of that decision’ (p. 1381).

55 Drawing on the findings of this research, however, it is possible to suggest that the principle of substantive equality, in relation to the exchange of knowledge in these circumstances, would be evidenced by the creation of opportunities for participants to acquire, at least, a baseline-level of knowledge about the policy issues they will be deliberating over. This would require that the organisers of a mini-public compile and provide access to relevant information, before a deliberative forum, to all forum participants. Importantly, too, participants will then require plenty of time to read-over and assimilate that information, as well as having the opportunity to request any further information they might require. While not all participants may choose to, or have time to, read material compiled for them, the principle of substantive equality would mean that, at least, reasonable opportunity had been created for them to do so.

Crucially, too, the principle of substantive equality would guide policy administrators’ decision-making regarding the structure of their mini-public. For instance, citizens require sufficient time to effectively deliberate; to express their opinions and ask questions of their fellow participants, and, then, to reflect on that information.

56 To a similar aim, a pre-deliberative forum could be conducted with the proposed-participants encouraging them to attend if they would like more information on the subject matter or practice in deliberating. Again, not everyone might take the opportunity, or indeed have the time to attend. A pre-deliberative-forum would also create opportunity for relevant individuals to help transform their understanding of their own experiences into narratives/arguments that they could, later, contribute to the deliberative process.
with substantive equality in mind, will bring this notion into closer and more explicit attention when mini-publics are used in health policy settings.

Crucially, too, the principle of substantive equality ought to be used to guide policy administrators’ decision-making regarding the structure of their mini-public. For instance, citizens require sufficient time to effectively deliberate; to express their opinions and ask questions of their fellow participants, and, then, to reflect on that information. Seen in conjunction with the understanding that citizens do not require any particular qualifications to contribute to health policy deliberations, it becomes clear that the value of their participation rests upon what they have the opportunity to provide (Ife, 2002; Gregory et al., 2008; Kreindler, 2009). For these reasons, the significance of the principle of substantive equality to the democratic authenticity and legitimacy of mini-publics in such circumstances cannot be understated.

**Proposition 4: Mini-publics are a public service**

*To counter the prevailing product-dominant logic, an active reframing of the way health policy administrators approach mini-publics is required so that their approach to mini-publics is more akin to it being a public ‘service’ than a ‘product’.*

This research finds that the prevailing emphasis on a product-dominant logic when mini-publics are used for health policy tends to obscure citizens’ experiences of the deliberative process, itself. Having now rendered citizens’ experiences apparent, and working in conjunction with some of the other ways that health policy administrators might more effectively meet their responsibilities when utilising mini-publics, this proposition seeks to explicitly reframe the use of mini-publics so that it is more akin to a public ‘service’ - not a ‘product’ - and, thus, working collaboratively and transparently with the relevant members of the public to develop, implement, and evaluate that service-delivery. When applied as a public service, the role the citizen plays in the development of a mini-public is repositioned from an optional ‘add-in’ to that of an ‘essential’ and ‘inalienable’ part of the health policy process (Walker, 2002, p. 8; Osborne et al., 2013, pp. 136-47).

What also seems to have been missed by health policy administrators in their current view of mini-publics as a product is the way mini-publics might, more appropriately, be considered as an investment in, not a drain on, resources. An investment which can generate enormous goodwill

57 To be clear, these authors are referring to a service-dominant approach being taken for a particular type of citizen engagement: that of coproduction, and Walker (2002) offers examples of coproduction providing manifestations of a ‘fundamental shift in power’ that affirms the worth and dignity of citizens as it validates their ‘voice, choice and knowledge’ (Walker, 2002, p. 8). Although the literature on mini-publics and co-production is not explicitly linked, there are clearly insights to be derived from each of mutual benefit.
and trust between citizens and government decision-makers; indeed, ‘real opportunities for rebuilding trust come not from what the state does, but the way that it does it’ (Mayo & Moore, 2002, p. 3 [my emphasis]). Seen in this light, the costs associated with such an investment would be better seen as less than the higher costs of ‘policy failure in the short term as well as loss of trust, legitimacy and policy effectiveness in the long term (Organization for Economic Co-operation and Development (OECD), 2001a, p. 20). Insights drawn from the theory on service management will be important when reconsidering how health policy administrators might develop a more service-dominant approach to mini-public\(^58\); so, too, will further research and evaluation designed to build an evidence-base for any claims made of mini-publics - leading me to my final proposition.

**Proposition 5: Mini-publics warrant further research and development**

*That a structured process of longitudinal research into the use of mini-publics on matters related to health and wellbeing is established.*

With the findings from this research suggesting that mini-publics in health policy settings can provide citizens with an opportunity to experience a transformative means of exchanging knowledge, this proposition seeks to promote research into the implications arising from any such transformations. For instance, several of my interviewees commented on the potential for shared-learning at the mini-public they attended; having determined that no information was given to these citizens for them to deliberate over, the source of this shared-learning was found to be the narratives and embodied experiences of their deliberative-peers. For instance, some interviewees remarked on how some of the older forum-participants said they enjoyed sharing their experiences and information relating to health and wellbeing with younger forum-participants. Younger forum-participants, too, spoke of how valuable it was to be able to learn from the older forum-participants’ experiences. All of these people said they would have liked more time and opportunity to have explored more of that information.

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\(^58\) For instance, and from such literature, Richard Normann’s (2002) ‘moments of truth’ metaphor focuses attention on the quality of the moments of interaction between a service-user/customer and service-provider in the service-delivery process. ‘Moments of truth’ can be of magic or misery depending on the way the service user’s expectation of a service interfaces with their subjective experience of that service delivery process. The information derived from ‘moments of truth’ can thus serve as an important resource in helping the relevant organisation to better meet the interests of its service-user/customer.

From this perspective, and transposing citizens and health policy administrators into the respective roles of service-user and service-provider, the salience of the citizens’ experiences when mini-publics are used in health policy settings becomes more prominent; with, effectively, the citizens’ experiences counting as revealing ‘moments of truth’ in the determination of the democratic authenticity and legitimacy of any given mini-public. Thus, by functioning as the medium between citizens and health policy administrators, mini-publics serve as barometers in helping to assess the democratic nature of any overarching deliberative system.
While further research is required to demonstrate any lasting impact on the development of citizens’ health-promoting, decision-making capacities or, indeed, their health and wellbeing, itself, the findings from this research are encouraging glimpses into the transformative potential intrinsic to effective deliberation. For these reasons, I propose that mini-publics offer a promising avenue of future research in public health; this is consistent with the claim that reciprocal benefits can arise when citizens become involved in health policy decision-making (Organization for Economic Co-operation and Development (OECD), 2001a, b; National Health and Medical Research Council (NHMRC), 2002, 2005a, b; World Health Organization (WHO), 2007a, b; World Health Organization (WHO), 2007a, b; National Health and Hospital Reform Commission, 2009). For instance, along with an improvement in the quality, relevance and effectiveness of the health initiative itself, the act of engagement can alleviate a sense of powerlessness for those individuals and communities involved. This process of empowerment can be observed along various trajectories, including that of improved self-esteem, and increased social capital – arising from improved social networks and supports. It is believed that these developments, ultimately, can lead to people being healthier (Baum, 2002: 2008).

In addition, involving people in decision-making related to their healthcare is known to increase their health literacy (Australian Women's Health Network (AWHN), 2014), and increased health literacy is now considered a ‘key determinant of health’ (AWHN, 2014, p. 13). With the potential benefits to be derived from placing citizens at the centre of healthcare decision-making, like health policy, still ‘greatly underestimated’ and supported by the transformative insights cited above, it is reasonable to surmise that mini-publics present as opportunities worthy of further exploration in developing citizens’ healthcare knowledge and decision-making capacities (Bovaird, 2007, pp. 846-7; Leadbeater, 2004; Dunston et al., 2009). Behind this claim, too, is the premise that because the capacity to make certain healthcare decisions is unequally

59 Some attempts at health care quality improvement have been directed towards encouraging health consumers ‘to ask questions’ during their healthcare (Judson, Detsky, Press, 2013, p. 1); while others have focused on ‘interventions that can be used to help healthcare professionals adopt practices to better involve their patients in the process of making decisions about their health’ (Légaré et al, 2010, p. 1; Berwick, 2009); with shared decision-making inextricably positioned at the core of consumer-centred care (Légaré et al, 2010). Despite these realisations, healthcare professionals often do not involve health consumers in relevant decision-making (Légaré et al, 2010); with the power and communicative asymmetries inherent to the doctor-patient relationship identified as most problematic to any shared decision-making (Judson, Detsky, Press, 2013). For instance, patients have been shown to be constrained in their inability to ‘initiate discourse and to shift topics’ in clinical settings (Bohman, 1996, p. 114; see also West, 1984; and Davis, 1988).

60 On a similar note, Niemeyer (2014) considers the developmental capacity of mini-publics when used as ‘knowledge-shapers’ and ‘myth-busters’, though not in the health specific context (p. 193). Niemeyer’s (2014) consideration of mini-publics’ transformative capacity is in relation to the potential contribution that mini-publics have to make to their scaling-up within a broader deliberative system. His exploration into the situations ‘where the public will is formed discursively’ and the emancipatory effects thereof, supports my view on the potential benefits to be derived from the use of mini-publics in relation to public health and wellbeing (Niemeyer, 2011, p. 110).
distributed, so too have been health outcomes (Leadbeater, 2004, p. 77).\textsuperscript{61, 62} If we consider how, at the other end of the health literacy spectrum, low health literacy is regarded as a ‘primary risk factor’ for chronic ill-health conditions, and that low health literacy is much more common amongst the same socially disadvantaged groups who experience higher levels of chronic conditions (AWHN, 2014, p. 13), a compelling case presents for the establishment of a longitudinal evidence-base into the benefits to be derived from the use of mini-publics in relation to raising the public’s health literacy and the circumstances within which maximum benefits might be derived. Whether or not comparably favourable outcomes might be derived from citizens deliberating, and thereby developing their knowledge-base and deliberative capacity, in relation to other areas of public policy is also yet to be determined by relevant longitudinal research.

\textbf{Conclusion}

This research has demonstrated why it is important to more fully understand citizens’ experiences of exchanging knowledge and expressing their deliberative capacities when mini-publics are used in health policy settings. Most prominently, the nuanced and holistic insights obtained in this research raise questions over the democratic authenticity and legitimacy of the use of mini-publics in health policy settings, with the challenges facing the institutionalisation of mini-publics into the health policy process brought into stark relief. The responsibilities that accompany health policy administrators, in particular, their epistemic responsibilities, in these instances warrant ongoing attention because when it comes to these more democratic means of health policy development they are, evidently, still ‘muddling through’ (Lindblom, 1959; 1979). Indeed, far from stepping-up to the democratically-deliberative paradigm, health policy administrators were shown to exhibit decision-making that was more likely to reproduce the traditional ways that government bodies tend to consult with the public.

The intentionally enabling approach I have proposed takes a bold step towards reconsidering the way mini-publics are being operationalised in health policy settings. And although only glimpses

\textsuperscript{61} Leadbeater (2004) believes that people who are more likely to make certain health-promoting behaviours are those who have the information, incentives and resources to change their lives: with ‘public values and norms infiltrating private decision-making’, those who are well educated and informed are already well prepared to take advantage of change-producing choices (Leadbeater, 2004, p. 76-86).

\textsuperscript{62} Interest in the educative effects of public deliberation is not new, however. For instance, it was John Dewey’s (1927: 1954) view that the quality of democracy is evident in the way it enables the fully-formed public opinion of its citizenry: essentially, for Dewey (1927: 1954) the formation of this fully-formed public opinion is dependent upon effective communication. Recognising the edifying potential of communication practices that promote a fully-formed opinion, it was Dewey’s (1927: 1954) belief that politicians and bureaucrats have a moral responsibility to engage with their community whenever matters of public interest are being considered.
of the transformative potential of democratic-deliberation has been evidenced in this research, what has been gleaned indicates that developing opportunities for citizens to deliberate and exchange knowledge this way, offers a promising future and fertile area of research in public health and wellbeing. Thus, reframing the application of mini-publics in health policy settings with a more intentionally enabling approach to the exchange of knowledge and development of deliberative capacity can be viewed as a guide-to-action for both citizens and policy administrators; one designed to leverage this policy instrument into becoming a more substantively equal, empowering, egalitarian, educative, and epistemically just means of health policy development.

Bibliography


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