

Inclusion and representation in democratic deliberation: lessons from Canada's Romanow Commission

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¹ The ordering of authors reflects the fact that research leading up to this paper began as a solo effort by von Lieres. The final paper is a collaboration, representing equal contributions from Kahane and von Lieres.

Introduction

In both Northern and Southern contexts it is now widely affirmed that public deliberation “results in better policies, superior public education, increased public trust, and reduced conflict when policy moves to implementation.”² However, whereas in many Southern contexts new democratic deliberative spaces are often localized and rarely involve large-scale, society-wide deliberations, in Northern contexts there has been a recent proliferation of extensive deliberative consultations with citizens on issues of national importance.³ These large-scale, handsomely-resourced consultative exercises raise distinctive questions about citizenship and inclusion, especially when it comes to including marginalized groups in deliberative processes. Our paper explores these issues of deliberative inclusion through an examination of the role of Aboriginal people in the deliberative components of the Romanow Commission, established in April 2001 by the Canadian government to deliberate with citizens on the future of health care in Canada.

The Romanow Commission's mandate was to review Canada's health care system, engage Canadians in a national dialogue on its future, and make recommendations to enhance the system's quality and sustainability. The range of the Commission's consultations was vast: it commissioned 40 expert reports and convened nine expert panels over its one-and-a-half year mandate; it partnered with broadcasters, universities, business and advocacy groups, and the health policy community in a ‘four-phase national dialogue’; and it sponsored explicitly deliberative consultation methods, designed to “probe deeply not only Canadians’ current views, but also how those views evolve as citizens work through difficult trade-offs in dialogue with each other and try to reconcile those views with deeper values” (Report on Citizens’ Dialogue on the Future of Health Care in Canada 2002: 2). The Commission was amply resourced in these tasks: with a staff of 47, the Commission ultimately cost between fifteen and twenty million Canadian dollars.

There is a strong tendency, in deliberative democratic theory and practice, to treat citizenship as a unified category, with deliberation involving generic, individual citizens in dialogue about the common good. On this model, political deliberation demands that citizens take up a reflective stance toward their own interests and attachments, so that collective conclusions are based on the force of the better reason, emerging from unconstrained dialogue.⁴ Critics of this dominant deliberative paradigm have argued,

² DDC website

³ Cite range of models: deliberative opinion polls, Royal Commissions in Canada, America Speaks, etc., etc.

⁴ See, for example, James Fishkin, *Democracy and Deliberation: New Directions for Democratic Reform* (New Haven: Yale University Press, 1991) Jürgen Habermas, “Discourse Ethics: Notes on a Program of Philosophical Justification,” in *Moral Consciousness and Communicative Action*. Sherry Nicholsen, ed. (Cambridge, Mass.: MIT Press, 1990).

however, that the dynamics of political deliberation are heavily conditioned by relations of power: marginalized groups are less likely to participate in deliberation and their perspectives less likely to influence outcomes, even though these groups may be especially vulnerable when it comes to the policy contexts about which citizens are deliberating.⁵ From the point of view of these critics—and we number ourselves among them—the challenge is to design political deliberations in ways that make space for marginalized perspectives and empower these to influence collective decisions.

The challenge of empowering the perspectives of marginalized groups in political deliberations is acute in the Canadian context, especially when it comes to Aboriginal people. The complex legacies of colonization have left First Nations, Metis, and Inuit people in Canada at the bottom when it comes to a wide range of indicators of wellbeing, including economic status, education, housing quality, and health outcomes; these legacies also have cultivated a deep sense of alienation, disenfranchisement, and mistrust on the part of Aboriginal people toward the Canadian state. Complicating matters yet further is the fact that many Aboriginal peoples claim self-government rights, often based in centuries-old treaties; so there are conflicting views of what political units are involved in dialogues on the territory called ‘Canada’, and whether Aboriginal peoples are properly subject to the rule of the Canadian state.

The Romanow Commission engaged in complex and sometimes contradictory ways with questions of Aboriginal inclusion and Aboriginal health. On the one hand, the final report of the Commission devoted a chapter to questions of Aboriginal health, based upon careful consultation with Aboriginal people. On the other hand, the explicitly deliberative elements of the Commission’s work were with statistically representative groups of ‘unaffiliated citizens’ that, though they included Aboriginal people, did not focus on questions of Aboriginal health, or overtly build in devices to allow Aboriginal participants to overcome dynamics of marginalization.

In what follows, we first sketch the political context within which the Romanow Commission did its work, laying out the controversies that define current debates over Canadian health care, and the distinctive situation of Aboriginal peoples when it comes to questions of health. We next describe the activities of the Romanow Commission, showing how citizen deliberation fit into the work of the Commission as a whole, and how the Commission structured a separate track for consultation with Aboriginal people. We then look more closely at the design of Citizen Dialogues, and at the day-long Aboriginal Forum that was the closest the Commission came to making space for deliberative engagement with Aboriginal people.

⁵ Nancy Fraser, “Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy,” in *The Phantom Public Sphere*, Bruce Robbins, ed. (Minneapolis: University of Minnesota Press, 1993); James Tully, *Strange Multiplicity: Constitutionalism in an Age of Diversity* (Cambridge: Cambridge University Press, 1995); Williams, M. S. (1998). *Voice, Trust, and Memory: Marginalized Groups and the Failings of Liberal Representation*. Princeton, Princeton University Press; Young, I. M. (1997). *Intersecting Voices: Dilemmas of Gender, Political Philosophy, and Public Policy*. Princeton, Princeton University Press.

We suggest that the successes and shortcomings of the Romanow Commission in including Aboriginal people in deliberations are tied to three key features of deliberative design:

1. The extent to which the process is **reflexive**, in the sense of giving participants a deliberative say in defining the terms of their participation, the issues they will address, the form deliberation will take, and so on.
2. The extent to which public involvement is **recursive**, so that citizen deliberation takes place from the beginning, applying to the range of decisions made.
3. The existence of **separate spaces** in which members of marginalized groups can reflect on dynamics of power and exclusion, and negotiate questions of common agendas, strategies, identities. These separate spaces can take many forms, from parallel deliberative processes, to opportunities for caucusing within heterogeneous deliberations.

Our discussion of the Romanow process reaffirms the importance of these design choices, and shows their importance in enabling the negotiation by marginalized groups of the complex politics of recognition and representation. The paper concludes with lessons from the Romanow process for the design of deliberative spaces in other contexts.

The context for the Romanow Commission

Canada's health system

Canada's health care system is a publicly funded, single-tier system. The Canada Health Act (CHA) sets the national policy framework, centered around the principles of universal, portable, comprehensive, accessible, and publicly funded health care. Provinces have constitutional authority over the delivery of health care to Canadians (with the exception of First Nations and the military), with the federal government enforcing principles of the CHA through control over resources: as much as 50% of spending on insured services comes from federally-controlled transfers to the provinces, and provincial conformity to the CHA is a condition for receipt of these funds. There is ongoing struggle between provincial governments and the federal government over questions of jurisdiction and funding, and over the flexibility that the CHA allows to provinces for experimentation with forms of health care funding and delivery (e.g. user fees, privately available diagnostic services, paying for-profit companies to provide government-insured services). There also are Canada-wide challenges of sustainability (demographics, pharma costs), growing waitlists, shortages of health professional, access to care in rural and remote regions, fragmentation (minimal integration across jurisdictions/continuum of care), pressure for more privatization/choice versus expansion of the public system/enforcement, and the challenges of Aboriginal health.

Aboriginal marginalization and health policy

Until 1500, the territory now called Canada was the domain of diverse Aboriginal societies. Contact with explorers, traders, and settlers from Europe initiated a centuries-long period of complex cooperation based on exchange, trade, and military alliances. These cooperative relationships between sovereign peoples were formalized in treaties and in the *Royal Proclamation of 1763*. The relationship of rough equality represented by the treaty period gave way, in the 19th century, to coercive forms of colonial domination; the ‘protection’ promised to aboriginal people by the treaties and the *Royal Proclamation* transmogrified into a reserve system, together with a host of coercive policies that marked ‘Indians’ as less civilized, and responded to this with programs of coercive ‘civilization’ (a residential school system, a pass system, the outlawing of ceremonies such as the potlatch, and the relocation of Aboriginal communities). This domination was entrenched in the *British North America Act*, which established Canada as a partnership between English and French colonists, and incorporated Aboriginal people as subjects of the Canadian state. The *Indian Act* (1876, 1880, 1884) codified this domination, though also preserving the language of a special relationship between Aboriginal people and the Canadian state.⁶

A turning point in relations between Aboriginal peoples and the Canadian state came with the federal government's White Paper on Indian policy in 1969: this policy document proposed to eliminate the *Indian Act* so that Aboriginal people could assimilate fully into Canadian society, rather than having a relationship to the state different from that of other Canadians. The White Paper provoked strong political and legal resistance from Aboriginal people, who insisted on the validity of historic treaties, and on distinctive rights as indigenous peoples. Court battles and political struggles led to the recognition of some of these claims, most notably with the entrenchment, in the *Constitution Act* (1982), of “existing Aboriginal and treaty rights”. These political and legal struggles continue unabated.

The historical relationship between Aboriginal people and the Canadian state has had three broad consequences that cast shadows on any discussion of health policy in Canada. First, this history of colonization has contributed to endemic social and health problems in Aboriginal communities. Despite improvements in the general health status of Aboriginal people in the last 50 years, significant disparities with other Canadians remain.

Second, treaties and the process of colonization together established special federal responsibilities for Aboriginal health, though the nature of these ‘fiduciary’ responsibilities is contested. Although federal responsibility developed as early as the late nineteenth century for most of the twentieth century there was no systematic strategy for the development of government health services for Aboriginal peoples. Waldram notes that “it is mainly since the 1980s that the provision of health care for Aboriginal people

⁶ Cite RCAP.

has, on the one hand, grown into a multimillion-dollar service, and on the other begun to shift its focus from “who gets the service” and “who pays for it” to “who controls it”.⁷

Third, the troubled history of relationships between diverse Aboriginal peoples and the Canadian state makes democratic policymaking on Aboriginal issues extremely complex. For one thing, ‘Aboriginal’ is a loose umbrella term for a culturally, linguistically, economically, socially, and politically diverse assemblage of communities and nations, including First Nations, Inuit and Metis peoples. “In the case of the First Nations, for example, there are more than 600 communities that fall under approximately 50 culturally and linguistically distinct groups dispersed across Canada.” (Final Report, 221) For another thing, there are a diversity of political claims and ideologies among Aboriginal peoples, ranging from an insistence that treaty rights and *sui generis* aboriginal rights give full sovereignty to Aboriginal nations, which deserve a nation-to-nation relationship with the Canadian state; to more modest conceptions of self-government that would give Aboriginal communities an authority and autonomy akin to that enjoyed by municipalities in a federal system. This political diversity finds expression in a plethora of Aboriginal representative entities, from local Band Councils, to regional tribal councils, to territorial and provincial organizations, to national organizations such as the Assembly of First Nations (AFN); there also are organizations of constituencies such as urban Aboriginal people, Aboriginal nurses, and Aboriginal women. The above forms of cultural, linguistic, and political diversity yields widely varying perspectives on how the funding and delivery of health care to Aboriginal communities should be organized; even apparently shared agendas (around greater self-government, for example, and community control of health services) are interpreted differently from different Aboriginal perspectives.

The poor health status of Aboriginal people in Canada, and the complex constitutional status and political construction of Aboriginal health issues, formed an inevitable part of the backdrop to the Romanow Commission’s work on the health of Canadians. Aboriginal issues also played an ambivalent part in the citizen deliberations set up by the Commission.

Deliberation and Aboriginal voices in the Romanow Commission

Royal Commissions form part of Canada’s British parliamentary heritage: they are struck by governments to investigate issues of public concern (or, more cynically, to allow governments to defer dealing with fraught political issues). In the 1990s, the Canadian health system was without doubt a fraught political issues, with public support for the system declining in the face of perceived problems such as long waiting lists for surgical procedures, shortages of trained medical personnel, and lack of access to health services in rural and remote areas. A comparison of polls conducted in 1991, 1995, and 1999, for example, showed the percentage of Canadians rating the health service as ‘excellent’ or

⁷ Waldram et al 1995: 262

‘very good’ declining from 61% to 52% to 24%.⁸ Infusions of federal funding in the late 1990s temporarily defused public anxiety, but it was widely recognized that this would provide only a short respite. And so the Canadian government struck a commission to canvass Canada’s citizens’ views on health care and “to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment.”⁹ The Commission was to be led by Roy Romanow, the former premier of Saskatchewan.

The mandate of the Commission was quite open, requiring that there be a fact-finding stage of work followed by an interim report, and then dialogue with the Canadian public and interested stakeholders based on that report. It is important to note that nowhere in the official mandate of the Commission is there mention of Aboriginal health; indeed, in the early months of the Commission’s work, there was considerable uncertainty about whether Aboriginal health even fell within the mandate.¹⁰

In the end, the Commission engaged in a range of consultative mechanisms, which Romanow describes as follows:

We began by analyzing existing reports on medicare and by inviting submissions from interested Canadians and organizations. To clarify our understanding of key issues, we organized expert roundtable sessions and conducted site visits, both in Canada and abroad. Where we identified knowledge gaps or needed a fresh perspective, we commissioned independent experts to conduct original research. Finally, I met directly with Canada’s foremost health policy experts to hear their views, challenge them and have them challenge me. We also worked hard to engage Canadians in our consultations, because medicare ultimately belongs to them. We partnered with broadcasters, universities, business and advocacy groups, and the health policy community to raise awareness of the challenges confronting medicare. The contribution of the health research community to this effort has been invaluable. We also established formal liaison contacts with provincial governments to share information, and I spoke with the Premiers and heard from many health ministers. I also had the privilege of leading one of the most comprehensive, inclusive and successful consultative exercises our country has ever witnessed. Tens of thousands of Canadians participated, speaking

⁸ Shulman and Raza 2003: 38.

⁹ Order in Council P.C. 2001-569, Privy Council of Canada.

¹⁰ P.G. Forest, interview. According to Forest, the Research Director of the Commission, part of the uncertainty around whether Aboriginal health fell under their mandate derived from the fact that the Royal Commission on Aboriginal Peoples had delivered its own report in 1996, a report that included an extensive chapter on Aboriginal health. Forest proposed that given the uncertainty about this aspect of the mandate, his own team within the Commission would pursue issues of Aboriginal health as a parallel research track. It was months later that the decision was made to include a separate consideration of Aboriginal health in the Commission’s report; at this point the Commission partnered with the National Aboriginal Health Organization (NAHO) to design an Aboriginal Forum that would consult with Aboriginal stakeholders (although not, as it turned out, in an especially deliberative way).

passionately, eloquently and thoughtfully about how to preserve and enhance the system. We also sought advice from health experts and from Canadians in interpreting the results of our processes. (Commission on the Future of Health Care in Canada 2002: xv)

The ‘inclusive and successful’ consultation with Canadian citizens took a number of forms, including televised forums¹¹, open public hearings, and a consultation workbook.¹² It is the National Citizens’ Dialogue, however, that most stands out: here the Commission stepped beyond conventional forms of citizen input to construct an intensively deliberative form of citizen consultation, one that sought to move participants beyond their preformed understandings and interests, to positions informed by careful exchanges of perspectives and reasons. The Final Report of the Commission gives the Citizens’ Dialogue credit for clarifying Canadians’ core values around health care, in a way that defined and framed the Commission’s recommendations; the pivotal role of the Dialogue is corroborated by P.G. Forest, the Research Director for the Commission, who credits it, for example, with moving themes of accountability and efficiency into the foreground of the Commission’s work.¹³

In what follows we explore the design of the Citizens’ Dialogue, and what transpired within it; we look in particular at the very limited role that Aboriginal voices and issues played there. We go on to look at other ways in which Aboriginal voices and issues entered the work of the Commission, and the extent to which these other spaces can be characterized as deliberative.

The National Citizens’ Dialogue

The Order in Council that established the Romanow Commission specified that the work of the inquiry include ‘dialogue with the Canadian public’, and the Commission took this part of the brief quite seriously. The Commission sought ways to take citizen involvement beyond consultation—hearing the views of citizens and stakeholders—to *deliberation*: engaging citizens in a dialogue that challenged their existing understandings, confronting them with the sorts of trade-offs called for in the health policy area, and urging them to define paths to health care reform that fit with their deepest values. The Commission partnered with the Canadian Policy Research Network

¹¹ “In order to raise awareness of the challenges confronting the health care system and to encourage informed discussion during the public consultations, the Commission initiated a number of public education activities, including a nationally televised Policy Forums delivered in partnership with Canada’s Public Affairs Channel (CPAC). This nationally-televised six-part series featured health experts representing different points of view engaging in a moderated discussion of key health issues. Each program was followed by an open-line call-in that allowed interested Canadians to question the participants.” (Final Report, 272)

¹² The typical workbook participant was “older, with higher levels of education” and “women were overly represented.” (Consultation Workbook, p. ?)

¹³ Forest, interview.

(CPRN), a think-tank with extensive experience in researching and designing invited spaces for citizen dialogue.¹⁴ The CPRN in turn partnered with Viewpoint Learning, a private consulting firm specializing in structuring dialogues in both business and public policy contexts using a ‘ChoiceWork’ dialogue methodology.¹⁵ The process that emerged from this partnership was the Citizens’ Dialogue on the Future of Health Care in Canada.

The Citizens’ Dialogue was designed in explicit contrast to two models of citizen involvement used by past Royal Commissions, commissions of inquiry, and legislative committees. A first contrast was with public hearings, which make space for the voices of self-selecting citizens, but “do not create the ambience where average citizens can present their views and participate actively in the public debate.”¹⁶ A second contrast was with the National Forum on Health, a task force chaired by Prime Minister Jean Chretien between 1994 and 1997: this task force “explicitly set out to learn Canadians’ core values in relation to health care by having focus groups discuss a series of scenarios that presented discrete issues and personal situations. However, the Forum did not find a method that enabled citizens to make the trade-offs needed to come to terms with difficult reform choices.” (Ibid: 2) Indeed, in its final report the National Forum noted that “the majority of participants were ingenious at avoiding the hard choices.” (cited in *ibid*: 122, n.15) The Citizens’ Dialogue, and the ChoiceWorks methodology it used, were designed to avoid these pitfalls: “to probe deeply not only Canadians’ current views, but also how those views evolve as citizens work through difficult tradeoffs in dialogue with each other and try to reconcile those views with their deeper values.” (*ibid*: 2)

The Citizens’ Dialogue convened twelve one-day sessions across the country, each involving about forty citizens (a total of 489 participants took part). There were three sessions held in each of the four regions—Atlantic, Quebec, Ontario and the West; three of these sessions were conducted in French and the rest in English. Participants were randomly selected, although health care professionals and managers were screened out, as were those under 18, and those who could not take part in a dialogue in English or French. The cost of the dialogues is estimated at 1.3 million Canadian dollars.

The Commission developed a workbook¹⁷ for participants; in assembling this, “the challenge for the project team was condensing a vast amount of information, simplifying it so that citizens with varied literacy skills could absorb the ideas, and providing a balanced perspective on the pros and cons of the policy directions, some of which are highly controversial.” (*ibid*: 9) The workbook focused on three characteristic challenges confronted by the Canadian health care system: growing costs, public dissatisfaction with

¹⁴ <http://cprn.ca>

¹⁵ <http://www.viewpointlearning.com>

¹⁶ The *Report on the Citizens’ Dialogue on the Future of Health Care in Canada* is available online at http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/Dialogue_E.pdf

¹⁷ The workbook is reproduced as an appendix to the *Report on the Citizens’ Dialogue on the Future of Health Care in Canada*.

the quality of care, and varying levels of coverage across the country. It then laid out four scenarios for responding to these challenges, meant to serve as a starting point for discussion; the scenarios were themselves developed through extensive research and expert deliberation.

To do their job, good scenarios need to be plausible so that participants will explore them seriously and not reject them out of hand. They need to be challenging and balanced—leading to both good and bad outcomes that are made explicit in each scenario (in the pros and cons listed for each), so that participants can work through the trade-offs. They need to be internally consistent and phrased in language that is easily understood. And they need to be relevant to the lives and experiences of ordinary citizens. (ibid: 13)

The four scenarios were as follows:

More public investment in doctors, nurses, and equipment, either through tax increases or by reallocating funds from other government programs;

Shared costs and responsibilities (e.g. user fees or co-payments) to discourage overuse of the system and increase government revenue

Increase private choices for patients via a restructuring of the health care system that includes private sector providers; and,

Re-organization of service delivery (e.g. teams of doctors, nurses and other professional working together) to improve efficiency and cost-effectiveness.

The morning of each dialogue began with time to read the workbook, and with a facilitator explaining the purpose of the session and the agenda to be followed. Participants then completed a questionnaire to measure their initial judgments of the four scenarios: the results of these initial questionnaires showed that no particular change was overwhelmingly supported; favorable judgments of each scenario (scores of 5-7 on a seven-point scale) ranged from 34% (for increasing private choice) to 56% (for reorganizing service delivery). (ibid, 27-28)

The next step of the dialogue involved each participant introducing themselves and speaking briefly about an issue of concern: issues raised at this stage, in descending order of frequency, included universality and accessibility; affordability and future sustainability; inefficiency, waste and abuse; prevention and health education; expanding services covered; and privatizing services to increase individual choice.

Next, participants worked in groups of about ten to define the future for health care that they desired:

Each of the groups was self-facilitated, guided by a set of ground rules for dialogue. Groups were asked first to work through each of the scenarios and define what Canada's health care system would look like in 10 years if that scenario were followed. What would be good or bad about that future? Then the groups were asked to review the good elements they had identified for each

scenario and to select those they most wanted to see in the health care system in the future. Finally, the groups were asked to review their list of desirable elements and to add whatever elements they think are needed to complete the picture of the health care system they would like to see in 10 years. After working in small groups for about 90 minutes, they reconvened in plenary and created a composite desirable future, building upon the similarities in the reports of the different groups. (ibid: 30)

The ideal health care system defined in the morning “was remarkably consistent in the 12 dialogues held from coast to coast”: access is based on need ; coverage is universal; accountabilities are clear for all the players; individual needs are met in a more patient-centered system; wellness and prevention are emphasized; care is integrated, multi-disciplinary and convenient; and the system is efficient and affordable. (ibid)

Where morning sessions were devoted to articulating values and ideals, the afternoon sessions pushed participants to consider the choices and trade-offs that they would be willing to make in pursuit of these values and ideals.

Citizens worked in the same groups to answer the question: “How can we best move toward a desirable future for health care in Canada, what specific steps should we take?” Facilitators emphasized the importance of developing a list of steps that are mutually consistent (that do not work at cross purposes) and affordable; to be as specific as possible on the steps that should be taken and how they would be paid for. They underlined: “If we do not make the choices and trade-offs they will be made for us, and they may not be the choices we want.”

To provide further guidance, the facilitators in most of the dialogues used three wall charts to indicate the sorts of questions that participants would need to answer: the first listed different ways to “pay for what we want”; the second asked participants to be specific about what constraints they were prepared to accept on how they access health care “to reduce costs and improve efficiency” under a rostered (team-based) system; and the third asked where participants would draw the line with respect to the services for which people should be able to buy private insurance....

Citizens worked together intensively in their groups for a further 90 minutes, constructing their list of suggested steps and working through the difficult choices and trade-offs. In this process, hope faded that the system could be made sustainable simply by eliminating waste and improving the efficiency of management, and citizens began to examine more deeply what needed to be done. The groups then reported their conclusions, and the balance of the dialogue was spent defining the common ground among citizens on the steps that should be taken. (ibid: 35)

The reforms that emerged in the afternoon sessions centered on reorganizing service delivery (e.g. assigning individuals to clinics, decreasing use of emergency rooms for non-emergency treatment, limiting choices of hospitals and specialists, limiting access to second opinions); increasing public funding for the health system (rejecting a parallel private system, ambivalence about user co-payments); and building stronger

accountability and transparency into the system (on the part of providers, drug companies, administrators, and governments).

The final step of the eight hours of citizen deliberation was for participants to complete the same questionnaire that they'd filled in at the start of the day: overall, the number of undecided responses diminished, support for the status quo dropped, and support for all four scenarios increased (the scenarios were not necessarily disjunctive, and indeed the outcome of the afternoon session was a synthesis of all of the scenarios except that favoring increased privatization). Support for 'reorganize service delivery' rose from 56% to 79%; support for 'more public investment' rose from 48% to 61%; support for 'share costs and responsibilities' rose from 45% to 50%, and support for 'increase private choice' rose from 34% to 39%.¹⁸

Comparisons of participants' views as expressed in questionnaires before and after each Citizens' Dialogue show that deliberation brought about shifts in their understandings and prescriptions around health care reform. This would seem to substantiate the contrast that the space-makers drew between deliberative engagement and the sorts of perspectives elicited through more conventional forms of public consultation.

The Citizens' Dialogues proved important in the deliberations of the Romanow Commission as a whole, revealing that citizens were capable of nuanced understandings of issues in health care reform, and were willing to make tough trade-offs:

The Citizens' Dialogues proved important in the deliberations of the Romanow Commission as a whole. First, they revealed that citizens were capable of nuanced understandings of issues in health care reform, and were willing to make tough trade-offs: In this dialogue, not only were choices made but trade offs that have been considered unworkable in Canadian healthcare policy were accepted. For instance, elite groups in Canada generally believe that Canadians

Will not sign up with a primary care network

Will reject having their personal information on an electronic health record

Do not care about health education and prevention

Have no useful views on governance.

Participants in all the dialogues contradicted these preconceptions. And they were elated and empowered by experiencing the dialogue. It was remarkable how quickly participants in all the dialogues absorbed complicated information,

¹⁸ After the twelve dialogue session were completed, the Commission sponsored a national telephone survey of 1,600 Canadian: "the survey was designed to test reactions to the scenarios, the arguments pro and con each scenario, the conditions used by citizens to explain the reasons behind their choices, and the values." (Report on the Citizens' Dialogue on the Future of Health Care in Canada: 58) The 14-minute telephone survey found the same ranking of the four scenarios, but with telephone respondents showing less support for each scenario than was the case with dialogue participants.

learning from each other and the workbook, and applied this knowledge to make difficult choices. One important lesson is that the abilities (and desire) of the general public to engage in this way should not be underestimated. (Maxwell, Rosell, and Forest: 1033)

The Final Report of the Commission was influenced in two key ways by the Citizens' Dialogue. First, demands for transparency and accountability that emerged from the Dialogue were unexpected to members of the Commission—who had not perceived these as important values on the part of citizens—and came to inform their recommendations.¹⁹ Second, the Dialogue instantiated an active role for citizens in health care policymaking and governance, a role that was emphasized by the Commission's final report: "The principles of public participation and mutual responsibility were entrenched in a proposed health "covenant" between governments, providers, and the Canadian public. And the report recommended regular reruns of the dialogues." (Maxwell et. al.: 1033)

Members of the Romanow Commission, and the Commission's final report, speak with justifiable pride about the Citizens' Dialogue, which engaged large numbers of Canadians in disciplined reflection on complex questions of health care provision, and yielded considered judgments that informed policy recommendations. Yet when it comes to including the perspectives of marginalized groups—and particularly Aboriginal people—there is room to question the success of the Citizens' Dialogue. While some Aboriginal people were included in the dialogues, neither the design of these deliberations nor their amply documented outcomes include even a whisper about Aboriginal health issues. We will suggest that this absence results from a failure of the Citizens' Dialogue to engage overtly with the complex politics of representation involved in any public deliberation: with questions of who needs to be at the table and in what numbers, who is typically marginalized in political dialogues and how this takes place, how dynamics of exclusion and marginalization can be thematized and managed within the deliberation, and so on. It is our view that a serious engagement with these politics of representation would have required changes in the extent to which the Citizens' Dialogue process was **reflexive** (giving participants a deliberative say in the terms of their participation), **recursive** (so that participants have a say from the beginning to end of the process of the process), and involved **separate spaces** for caucusing and deliberation by marginalized groups.

A first set of design choices that bear on including the marginalized involve the **reflexivity** of the process. We would argue that questions of deliberative inclusion and representation are always complex and politicized, insofar as a goal of deliberation is to include the voices of social groups that are typically disadvantaged in political dialogues, given structures and histories of inter-group power. These issues of inclusion and representation deserve the close attention of space-makers before deliberation takes place, but there are both practical and normative reasons why these issues cannot be settled in advance. Practically speaking, even a diverse group of space-makers will be unable to anticipate how issues of inclusion and voice will play out in a deliberation, or the questions that will arise; space needs to exist within the deliberative space for these

¹⁹ Forest interview; Maxwell et. al. 1033.

issues to be raised and addressed. And from a normative point of view, the very justification of democratic deliberation is based on connections between political legitimacy and unconstrained dialogue;²⁰ so there is reason to worry when the terms of dialogue and the questions to be addressed are established by elites, outside of the deliberative exercise itself.

The Citizens' Dialogues were designed from the top down: the topics and conduct of the deliberation were very deliberately structured, and highly structured at that. The workbook, the sequence of the day, and the scenarios to be considered were all products of elite rather than popular deliberation. Invited spaces such as the Citizens' Dialogue will, of course, always be framed in ways that enable some forms of deliberation and discourage others, that foreground some topics and take others off the agenda. But it's important to note that there are a continuum of possibilities here, and that the Citizens' Dialogue were on the structured and pre-determined end of that continuum.

We can also note that this predetermined structure focused participants' attention on what they shared as generic, individual citizens. Indeed, it is a linchpin of the ChoiceWorks process that dialogues are most successful when participants are 'unaffiliated citizens', rather than stakeholders who self-consciously represent some particular identity or interest group in society.²¹ The language of the workbooks, and indeed of the Romanow Commission more broadly, encouraged a focus on the common values of Canadians, so that the particularity of individual citizens could be folded together into a set of shared goals. This orientation toward 'unaffiliated citizens' also plays out, we would suggest, in the selection procedure for the Citizen Dialogues, where what mattered most was getting a statistical cross-section of the population; this contrasts with selection procedures that focus on groups most affected by decisions, or groups typically marginalized in discussions of a given policy area.

Had there been a greater degree of reflexivity in the Citizens' Dialogues, participants would have been able to deliberate together about the terms of their conversation—about the proper sequence and duration of discussion, the scenarios to be discussed, the relative importance of the shared and the divergent. This reflexivity would have made the Citizens' Dialogues much less predictable, and more complex to manage; it might also, however, have made them much more meaningfully deliberative and democratic.

These issues of design—of how much is decided before the fact, and how much within deliberation itself—also connect with how **recursive** the process is. Where reflexivity refers to participants' ability to deliberatively consider the terms of their conversation, recursiveness describes the ways in which deliberation is treated as ongoing, as recurring at different levels and in different contexts. From the standpoint of each participant, the

²⁰ Habermas, *op.cit.*; see also James Bohman, *Public Deliberation: Pluralism, Complexity, and Democracy* (Cambridge: MIT Press, 1996); and Simone Chambers, *Reasonable Democracy: Jürgen Habermas and the Politics of Discourse* (Ithaca: Cornell University Press, 1996).

²¹ Conversation with Dan Yankelovich.

Citizens' Dialogues were non-recursive: each dialogue was a single, eight-hour process, with participants' organized involvement beginning and ending there. Moreover, the Citizens' Dialogue sessions took place within a six-week period in 2002, with elites both deciding on the structure of the Dialogue, and deciding how to assimilate outcomes of the Dialogue into the Commission's reports.

We can imagine much more recursive versions of citizen deliberation in connection with the Commission's work. First, the design of the Citizens' Dialogue might itself have involved consultation with and deliberation by citizens. And second, there are many ways in which deliberating citizens could have played a more ongoing role in the work of the Commission: they could, for example, have been given a voice in how their day's work was taken up by the Commission, or on the adequacy of the Commission's final report.

The Citizens' Dialogue seems to have had an important influence on the deliberations of the Commission and on the final report; it did so by being heard and interpreted by Romanow and the Commission staff. The role of the Dialogue, though, was purely consultative: the outcome of the dialogue had no formal authority in the construction of recommendations, and participants in the Dialogue had no agency in the interpretation of the sessions. This non-recursive nature would seem to speak to a particular construal of the role of citizen representatives, relative to experts and elites, in producing knowledge and recommendations around health policy. Notwithstanding the rigorous and extensive quality of citizen deliberation, it had a non-authoritative, merely consultative place within the Commission.

There is one more way, though, in which the notion of recursiveness can be taken up, given that the Romanow Commission as a whole stands in complex relationship to a much broader set of deliberative spaces: the Canadian Parliament, provincial legislatures, and debates in the media and civil society, to name some. This complex network of spaces complicates judgments about whether the Citizens' Dialogue (and the Romanow Commission as a whole) were adequately democratic, or deliberative, or inclusive: the Dialogue and the Commission are, after all, themselves only one contribution to a larger (recursive) societal dialogue. While this is true and important, however, it still seems important to form judgments of the democratic adequacy of the Citizens' Dialogue itself, and the Commission itself; for as contributions to broader deliberations, they claim certain kinds of legitimacy based on conceptions of citizenship, representativeness, and inclusion. It matters, in wider discussions, whether the Citizens' Dialogue can claim the authority of representing the Canadian public, construed in particular ways; and it matters whether the Dialogue's place in the Commission's work is able to legitimate claims that the Commission was responsive to deliberative input from citizens.

A third key dimension of deliberative design is the existence of **separate spaces** for marginalized groups. As already noted, the ChoiceWorks methodology, taken at face value, treats participants as individuals. As the "Ground Rules for Dialogue" in the workbook explains, "All dialogue participants speak for themselves, not as representatives of special interests." (Report on the Citizens' Dialogue on the Future of Health Care in Canada: 94) Given this methodology, issues of group-based marginalization and inclusion can be dealt with, at most, as issues of protocol, equal

speaking time, and imprecations to take all views seriously—e.g. “Listen with empathy to the views of others: acknowledge you have heard the other especially when you disagree.” (ibid.) This individualistic orientation in dialogue design may not take seriously enough the complex ways in which marginalization may be perpetuated in deliberative spaces, for example in privileging of certain kinds of reasons, leaving mainstream criteria of authority and credibility in place, or favoring certain tones and structures of argument.²²

The participation of Aboriginal people in the Citizens’ Dialogue substantiates some of these concerns (given demographic variations across Canada, Aboriginal people were present in all sessions, and in largest numbers in western sessions). Organizers were disappointed, overall, in the degree to which the dialogue was able to engage Aboriginal participants, who often didn’t show up to sessions once recruited, and who typically were very quiet in the dialogue sessions. Interestingly, there were two significant (if ad hoc) attempts, as the dialogue process proceeded, to intervene in these dynamics. First, organizers worked to cluster Aboriginal participants so that they would be less isolated in small group discussions, and could build confidence and voice. Second, in advance of the Winnipeg session, and given experiences of Aboriginal under-representation and silence in previous sessions, organizers sought to bring more Aboriginal people to the dialogue than dictated by the representative sampling methodology: they extended extra invitations through the Native Friendship Center for staff and clients to take part in the dialogue.²³ Neither of these ad hoc innovations had much effect, however, and there few strong Aboriginal voices emerged in the Citizens’ Dialogue.²⁴ This experience points to the difficulty of engaging and empowering members of marginalized groups within invited deliberative spaces, and to the limitations of piecemeal innovations in surmounting these difficulties; it may be that giving Aboriginal people a more influential voice in the Citizens’ Dialogue would have required changes to the basic structure of the dialogue, at which point the tension with the individualistic premises of the ChoiceWorks method would have been acute.²⁵

²² See Williams, op.cit.; and Young, I. M. (1996). "Asymmetrical Reciprocity: On Moral Respect, Wonder, and Enlarged Thought." *Constellations: An International Journal of Critical and Democratic Theory* 3(1).

²³ In response to a question about whether this ‘oversampling’ of Aboriginal people was at odds with the norm of statistical representativeness, Maxwell replied that from her point of view, general claims to have a representative sample in the dialogue as a whole were compatible with limited oversampling within particular sessions of the dialogue. (Maxwell interview) Dan Yankelovich echoed this openness to oversampling as a way of meeting goals of inclusiveness: “Random sampling is rough justice. It solves a host of practical problems.” But where you want a particular conversation to take place or a certain perspective to be heard, he continued, oversampling can be very useful. (Yankelovich conversation).

²⁴ (Maxwell interview)

²⁵ For a discussion of issues of sampling and inclusiveness in connection with James Fishkin’s ‘deliberative opinion polls’, see David Kahane, “Délibération démocratique et ontologie sociale,” *La démocratie délibérative*, Numéro spécial de *Philosophiques* 29,2.

The two ad hoc attempts to build Aboriginal voice in the Citizens' Dialogues sought to lessen the isolation of Aboriginal people during deliberation by letting them work together, and by increasing their relative numbers. Separate deliberative spaces are a more concerted way to build voice for marginalized groups, through mechanisms such as group caucusing, or separate deliberative streams. Mechanisms such as these enable members of marginalized groups to develop strategies for naming and countering dynamics of exclusion; develop confidence and capacities; reflect upon and consolidate common goals and identities; and make space for differences within the group.²⁶ Separate spaces for Aboriginal participants in the Citizens' Dialogue would have been one route to mitigating the marginalization of Aboriginal perspectives, while also taking seriously the distinctiveness of issues of Aboriginal health in a context where constitutional and jurisdictional issues are very much in question.

Creating separate spaces for Aboriginal deliberation (whether by building caucusing into a heterogeneous deliberation or by creating an entirely separate stream) would have real potential benefits, and costs. A first benefit of separate spaces for Aboriginal participants would have been to offer a space within which Aboriginal values and claims could be sorted through concertedly and deliberatively, without the ongoing need to translate and justify Aboriginal perspectives to make them intelligible to non-Aboriginal people; in such contexts, culturally specific modes of communication and self-representation can find expression and roots. Secondly, separate spaces provide room for the internal complexity of Aboriginal perspectives to be dealt with democratically and deliberatively; in more heterogeneous spaces, by contrast, Aboriginal people can feel pressure to present a common front (downplaying differences, say, between on-reserve and off-reserve Aboriginal people, or Metis, First Nation, and Inuit perspectives) in order to make their voices intelligible to others, and to exercise some minimal influence on deliberations. Third, separate spaces for Aboriginal participation may allow greater reflexiveness about how issues are framed; this is especially important in connection with cross-jurisdictional issues like health care, given the extent to which Canadian state sovereignty over Aboriginal people is itself contested. Separate deliberative spaces leave open the question of whether Aboriginal people are properly considered Canadian subjects whose views should be folded into a nationally shared understanding.

There would have been costs to creating separate deliberative spaces for Aboriginal people in the Romanow process. A first, obvious cost is that the Citizens' Dialogue, and the work of the Commission as a whole, would have had to be conducted differently, and quite possibly in more time-consuming and resource-intensive ways. Secondly, creating separate spaces itself enacts presumptions about individual and collective identities—both in treating Aboriginal people as a bounded (if internally complex) group, and by supporting narratives of separateness or incommensurability between Aboriginal and non-Aboriginal beliefs and interests.²⁷ Second, insofar as separate spaces means entirely

²⁶ See Mansbridge, J. (1993). "Using Power/Fighting Power." *Constellations* 1(1): 53-73.

²⁷ See Kahane, "What is Culture? Generalizing About Aboriginal and Newcomer Perspectives," in Kahane and Bell (eds.), *Intercultural Dispute Resolution in Aboriginal Contexts* (UBC Press, 2004).

separate deliberations (and this is only one possibility), there is no deliberative space within which the values and perspectives of Aboriginal and non-Aboriginal people can themselves be brought into deliberative contact. Without this deliberative contact, neither side can fully consider the tradeoffs and sacrifices they are demanding from the other, nor is there an opening to discovering how the values and perspectives of each side might be changed in dialogue with the other. Given the dense and inescapable interconnections between Aboriginal and non-Aboriginal communities, this kind of common dialogue seems a crucial counterpoint to deliberations that take place within separate spaces and particular communities; only this sort of common dialogue could take account of the interpenetration of policy decisions on Aboriginal health, and on the health of Canadians.

If these are the issues that arise at the abstract level in considering separate Aboriginal and non-Aboriginal dialogues within the work of the Romanow Commission, a host of other questions emerge when we notice that the Commission **did** in fact run parallel dialogues: in addition to the Citizens' Dialogue there was a day-long Aboriginal Forum that provided input into the Chapter 10 of the Final Report, "A New Approach to Aboriginal Health".

The Aboriginal Forum

On June 26, 2002, the Romanow Commission partnered with the National Aboriginal Health Organization (NAHO) to host the Aboriginal Forum in Aylmer, Quebec. The forum represented the centerpiece of the commission's engagement with Aboriginal groups. The overall aim of the Aboriginal Forum was framed as sharing "successes and to provide an opportunity for participants to share their views on the future of health care."²⁸ It was chaired by Dr. Judith Bartlett, the Chairperson of NAHO's Board of Directors.

The Aboriginal Forum represented an important turning point in the commission's deliberations with Aboriginal peoples. Prior to the Forum, special attempts had been made to ensure Aboriginal participation in a number of different consultative spaces. These included the citizens' dialogues, the consultation workbook, site visits, meetings with national organizations and national caucuses, and regional public hearings. Together the consultations highlighted important shortcomings in the commission's strategy for Aboriginal consultation. According to the director of ITK's health desk, the citizens' workbook, for example, was largely ineffective amongst Inuit people as "Inuit culture is a verbal culture and for many Inuit the written format cannot be translated into dialogue, although some regions are completely connected to high speed internet."²⁹ But it was during the public hearings that the real challenges of Aboriginal participation became evident.

²⁸ AF Report, p. 3

²⁹ (Interview with Onalee Randell, November 26).

The regional public hearings consisted of 21 days of “open” public hearings in which individual Canadians and health care stake holder and advocacy groups presented their views on the future of the Canadian health care system. In its report the commission described these consultations as follows:

To ensure breadth of perspective and balanced participation, notices were placed in newspapers across the country inviting interested individuals and groups to come forward and to submit a one-page abstract of their proposed submission. At the end of each session, the Commission opened the floor to individuals who wished to comment on the proceedings or provide additional input. Participants had the option of addressing the Commission in their official language, and in Nunavut, special arrangements were made to allow presentations in Inuktitut. The Canadian Public Affairs Channel (CPAC) broadcast all sessions in both official languages.³⁰

Many regional and national Aboriginal Organizations participated in these consultations.³¹ Despite this participation, however, it quickly became clear that issues of Aboriginal health featured minimally during these short, one-day exercises. According to Michel Amar, the Saskatchewan health minister was the only regional health minister to mention Aboriginal health in his contribution. The brevity of the hearings provided little space to explore the deeply political context of Aboriginal health, and its context-specific challenges.³² The hearings were not well attended by Aboriginal organizations and participants as many found it difficult to organize and mobilize their members in remote and rural areas, where people have little access to the logistical infrastructure necessary to attend and to host participatory spaces. Key groups such as the Labrador Inuit were not represented at all in the hearings.³³

The decision to convene a distinct consultation process for Aboriginal participants followed the 21 days of public hearings during which it soon became apparent that the “the one-size-fits-all approach”³⁴ to consultation was a weakness in the overall consultation strategy with Aboriginal groups.³⁵ In particular, it failed to address group-

³⁰ RC Report, p. 274

³¹ In Nunavut, for example, the Inuit Women’s Association of Canada, Pauktuutit, and its key land organization, Nunavut Tunngavik Incorporated, gave presentations. At the Regina public hearing the Federation of Saskatchewan Indian Nations was represented. In Winnipeg the Assembly of Manitoba Chiefs and the Southern Chiefs Organizations appeared. In Vancouver the First National Chiefs’ Health Committee attended the hearing. In Ottawa the Assembly of First Nations spoke. (more examples: was there a pattern of participation? Key organizations left out?)

³² Amar Interview, June 8, 2005

³³ Randell Interview, November 2004

³⁴ Randell interview

³⁵ Randell also pointed out forms of consultations that would have been more effective for Inuit groups: more local visits and tours by Romanow in the Arctic regions to raise the profile of the commission, more

specific forms of communication and underestimated logistical constraints. But aside from these difficulties, it soon became clear that there were also important challenges of political representation.

During the first half of the commission Aboriginal participation had been structured around individual organizations and unaffiliated citizens. However, it became apparent that the problem of Aboriginal health was not going to be addressed adequately in these generalized deliberative spaces, with their assumptions of an underlying consensus on forms of citizenship and structures of representation. What was needed was a space in which Aboriginal groups could meet separately in order to discuss not only the specific challenges of Aboriginal health, but also to construct legitimate and effective representative processes.

The decision to run a separate Aboriginal consultation was made fairly late in the Commission's life. It was driven in large part by the commission's response to weaknesses identified in the early rounds of engagement. However, there were a number of other reasons: firstly, the commission's initial mandate had not included a clear reference to Aboriginal health. Interestingly, for RCAP, too, health had not been part of its initial mandate.³⁶ In analyzing the reason for this, Lemchuck-Favel argues that "this could have been a recognition of the reality that health issues do not stand alone and permeate all facets of Aboriginal life, whether they be housing, justice, social, education, economic development or others."³⁷ Secondly, the Commission did not want cover ground already traversed by RCAP.³⁸ Thirdly, after the initial approach by the commission to design a separate consultation process, it took quite a while for NAHO to engage in its own engagement and deliberation process building up to the Aboriginal Forum.³⁹

The commission approached NAHO to ask if the process was sufficient; NAHO affirmed that a separate consultation with Aboriginal groups was needed. The commission then asked NAHO to co-host a more effective consultation process with Aboriginal groups. The commission's choice of NAHO can be understood in the context of a series of

use of 'verbal' media like the radio and opportunities for Inuit to phone in, and more community-based fora.

³⁶ RCAP devised a template for reform, a system which would recognize the existent health and social services in to a network of health and healing centers and healing lodges under Aboriginal control. The health and healing centers would assemble under one roof the resources needed to address interrelated problems dealt with by separate agencies from child protection to mental health. These centers would provide services ranging from medical care to health promotion programmes. The health and healing centers would be complemented by healing lodges which would provide acute residential treatment for persons overwhelmed by social, emotional and spiritual distress.

³⁷ Lemchuck-Favel, Laurel. (2001) "Consultations and Implementation Activities, 1998-2000", Discussion Paper prepared for NAHO, p. 1

³⁸ Amar interview, June 8, 2005

³⁹ (need more stuff on the complexities of Aboriginal consultation processes).

extensive consultations between 1998 and 2000 around establishing an Aboriginal Health Institute (which later resulted in the formation of NAHO in 2000). In 1996, the Royal Commission on Aboriginal Peoples (RCAP) identified the need for a national Aboriginal health institute. The National Forum on Health in 1997, the Speech from the Throne and formal consultations with the five national Aboriginal organizations in 1998 reaffirmed that the federal government should collaborate with Aboriginal communities, organizations and leadership to establish such an institute. In 1998 an initial consultation process was held with five national Aboriginal organisations: AFN, Inuit Tapirisat of Canada (ITC), Pauktuutit, Metis National Council (NMC) and the Native Women's Association of Canada (NWAC).⁴⁰ The Congress of Aboriginal Peoples (CAP) did not attend the initial meeting, but it was a full partner in the discussions that followed. These consultations were considered extensive, legitimate, and established NAHO as “an Aboriginal designed and controlled body.”⁴¹

The commission's partnership with NAHO entailed setting up a joint decision-making process to identify the best consultative model for securing appropriate engagement. The commission adopted a “hands-off” approach to the design of the Forum. One of the very few guidelines it gave NAHO was to “include all key Aboriginal groups equally.”⁴² The commission's space-makers initial and primary concern was around the inclusivity of the forum. As one commissioner said: “In order to say that you have heard the Aboriginal voice you have to design a process in which all voices are heard. We needed the big five to be there.”⁴³

The overall aim of the Aboriginal Forum was to provide a national space at which Aboriginal Peoples could participate in a facilitated dialogue. The forum's key aim was to generate recommendations specific to First Nations, Inuit, Métis and Urban Aboriginal populations. A one-day meeting with opportunities for introductions by Aboriginal leaders, facilitated discussions, and spaces for reporting back and reflecting on key issues, was agreed upon.

About 100 people, mostly regional health and community representatives participated in the forum.⁴⁴ Participants consisted of practitioners (health technicians, policy analysts),

⁴⁰ For a summary of the consultation process, see Lemchuck-Favel, Laurel. (2001) “Consultations and Implementation Activities, 1998-2000”, Discussion Paper prepared for NAHO

⁴¹ Lemchuck-Favel

⁴² Amar Interview, June 8, 2005

⁴³ Amar Interview, June 8, 2005

⁴⁴ The following organizations were represented: the Labrador Inuit Health Commission, the Innulitisivik Health Centre (Nunavik), the Department of Foreign Affairs and International Trade, NAHO's Inuit Centre, the Eskasoni Health Centre (First Nations community in Cape Breton Island, Nova Scotia), the Nisga'a Lisims Government, the Kahnawake Community Services (Mohawk Nation of Kahnawake), the Centre for Indigenous Sovereignty, NAHO's First Nations Centre, the Metis Nation of Ontario, the

ordinary members of organizations, and leaders. They were figured as affiliated and unaffiliated citizens, some representing the views of their organizations, and others speaking in a non-representative capacity as individual users of the Aboriginal health system. From the beginning the organizers clarified that the forum “was not a consultation”.⁴⁵ In his summary of the Metis-specific discussion, Larry Chartrand pointed out that “the comments from his group discussions contained a lot of valuable insights and ideas, but that they did not necessarily represent the views of the Metis National Council (MNC) or of the representative political bodies.”⁴⁶ The term “consultation” here seems to be linked to a series of deeper representative ideas around the notion of “speaking with one voice”. One of the commissioners interpreted these comments in the light of the difficulties of conducting effective and deeper consultations amongst Aboriginal groups: “You need lots of funding to conduct consultations in Aboriginal communities, if you want to say that people speak with one voice.”⁴⁷

The forum opened with prayers led by elders on behalf of First Nations, Inuit, Metis and Urban Aboriginal Peoples. The first half of the Forum was structured around group-specific workshops in which participants met to discuss the specific challenges faced by their specific indigenous community, First Nations, Inuit, Metis and urban Aboriginal Peoples. Participants were told to focus on “successes and challenges, suggestions and strategies for dealing with these challenges.” This was viewed by some delegates as a positive element of the design process as it allowed participants to develop group-specific challenges. Each session had a moderator and a facilitator who “sought participants’ responses to a series of questions relating to the barriers and challenges for” group-specific health care initiatives as well as recommendations for improvement.”⁴⁸

Lakeland Regional Health Authority (one of 17 health authorities in Alberta with four land-based Metis settlements in its region), the Metis Addictions Council of Saskatchewan Inc., NAHO’s Metis Centre, Aboriginal Health and Wellness, Winnipeg, Anishinabe Health Toronto, the Vancouver Native Health Centre and the Ontario Federation of Indian Friendship Centres, ICA Canada Inc., the Metis Provincial Council of British Columbia and the MNC Minister of Health, the Inuit Women’s Organization, Pauktuutit and the Manitoba Metis Federation. The following organizations were represented through video submissions: Aboriginal Health of Manitoba, Inuit Tapirisat Kanatami, Policy Analysts, Association of Iroquois and Allied Indians, the Inuvialut and Gwichin of Western Arctic, the Labrador Inuit Health Commission and the Federation of Saskatchewan Indian Nations.

⁴⁵ Judith Bartlett, AF Report, Opening Remarks, p. 3

⁴⁶ AF Report, p. 21

⁴⁷ Amar interview, June 8, 2005

⁴⁸ AF report, p. 15. The Inuit health discussion was led by panellists from the Labrador Inuit Health Commission, the Innulitisivik Health Centre and an unaffiliated member who gave an overview of overview of health in Nunavik. The First Nations health discussion was led by panellists from the Eskasoni Health Centre, the Nisga’a Lisims Government and the Kahnawake Community Services. The Metis health discussion was led by presentations from the Metis Nation of Ontario, the Lakeland Regional Health Authority and the Metis Addictions Council of Saskatchewan inc. The Urban Aboriginal Health discussion featured three panellists from the Aboriginal Health and Wellness Winnipeg, Anishinabe Health Toronto and the Vancouver Native Health Centre.

The second half of the forum featured a televised town hall style interaction where individuals could present their concerns in person, or via telephone link-ups directly to Commissioner Romanow. Each group's moderator synthesized their morning's discussion into a 15-minute presentation, which were also handed over to Romanow in the afternoon. The presentations were augmented by comments and questions from the in-house phone-in audience participating via Canada's public Affairs Channel (CPAC) live televised and video-streamed coverage of the event. Callers and the in-house audience from various areas of the country spoke to the Commissioner in one of three languages: English, French or Inuktitut through translators.

Analysis

The first benefit of the Aboriginal Forum was that it offered a space within which Aboriginal values and claims could be sorted through concertedly, without the ongoing need to translate and justify Aboriginal perspectives to make them intelligible to non-Aboriginal people. In such contexts, culturally specific modes of communication and self-representation can find expression and roots. However, here there are also obvious questions. On the one hand it seems as though a range of shared commitments among aboriginal participants could be taken for granted, and participants did not have to fight to legitimize the privileging of issues of Aboriginal health. But on the other hand, it's not clear how 'deliberative' the session was, nor did it obviously center on culturally distinctive or appropriate modes of communication. The forum took on a relatively conventional format, with highly structured and formal discussions. It is also not evident to what extent the discussions were rooted in more in-depth explorations of the complex politics surrounding Aboriginal health. While the non-deliberative nature of the form may, in a roundabout way, have respected Aboriginal autonomy, sovereignty, and allowed for a focus on needs and policies, (and not with putting deepest values and perspectives on the deliberative table) this had costs too. It did not obviously allow for the articulation of political values, treaty claims, and deeper political challenges to the overall framing of the process. Separate spaces for Aboriginal participation may potentially allow greater reflexiveness about how issues are framed; this is especially important in connection with cross-jurisdictional issues like health care, given the extent to which Canadian state sovereignty over Aboriginal people is itself contested.

The second benefit of the separate Aboriginal Forum was to provide room for the internal complexity of Aboriginal perspectives to be dealt with democratically. In more heterogeneous spaces, by contrast, Aboriginal people can feel pressure to present a common front (downplaying differences, say, between on-reserve and off-reserve Aboriginal people, or Metis, First Nation, and Inuit perspectives) in order to make their voices intelligible to others, and to exercise some minimal influence on deliberations. In the Aboriginal Forum there emerged a clear differentiation by subgroups, which was viewed as very important for many delegates. In assessing the impact of the commission's consultation process on distinct Aboriginal peoples such as the Inuit, Onalee Randell, the Director of Health of Inuit Tapiriit Kanatami, the national Inuit organization, pointed out that the commission gave the four Inuit regions a "common project" and that "it forced Inuit groups to focus on their common agenda." It also gave impetus to the call for an "Inuit-specific" approach which acknowledges Inuit as a

distinct Aboriginal group. She praised Romanow for listening to Inuit-specific demands. “Romanow actually listened. He was the first commissioner to actually mention Inuit”.⁴⁹

A major cost of the Forum was that its separate stream might have obstructed dialogue between Aboriginal and non-Aboriginal people about relationships and trade-offs, etc. Separate deliberative spaces leave open the question of whether Aboriginal people are properly considered Canadian subjects whose views should be folded into a nationally shared understanding. As the Citizens’ Forum didn’t take up issues of Aboriginal health, there was no systematic discussion of issues **beyond** Aboriginal health. It is unclear to what extent the Forum had any influence on the final report, given the fact that the forum was a once-only deal. There was no opportunity of participants to check back, give feedback on final report as they were not in ongoing dialogue with their communities, before and after the Forum. NAHO’s Richard Jock argued that one weakness in the process was that there was not enough consultation around the actual drafting of the report. This criticism was echoed by Onalee Randell.⁵⁰

On the other hand, many participants assessed the Aboriginal Forum partnership with the Romanow Commission positively. “There was a good process, no vague understandings, clear parameters, and sufficient opportunity for a dialogue between Romanow and Aboriginal leaders. Romanow was one of the few commissions who engaged in a partnership with Aboriginal groups. His commission’s reporting-back format has set the pattern for subsequent meetings between cabinet and Aboriginal groups⁵¹ According to Richard Jock, the fact that there was a “partnership” in the planning and design stage of the forum was one of the reasons why the consultation process was successful.⁵²

Conclusion//After Romanow: Institutionalizing Citizen Participation

With regard to Aboriginal health the commission’s report recommended that a new approach to Aboriginal healthcare was required – one that tackles the root causes of

⁴⁹ Randell Interview, November 26, 2004

⁵⁰ Randell said that “one of the recommendations were Inuit- specific enough. They were too general. The rural and remote communities chapter was far more relevant for Inuit. None of the recommendations have been taken up. They are too broad.” The commission’s feeling, however, was that all five Aboriginal groups had felt incorporated. It also felt that it had successfully opened up the process to public scrutiny through live broadcast of the proceedings. Amar said that “there was no negative feed-back on the report posted on the website”.

⁵¹ Interview, March 22, 2005)

⁵² Jock Interview, April 2005

health problems for Aboriginal peoples, cuts across administrative and jurisdictional boundaries, and focuses squarely on improving the health of Aboriginal peoples. Specific actions were recommended. These were to consolidate fragmented funding for Aboriginal health to take the best advantage of the total potential funds available to improve health and health care for Aboriginal peoples; to create new models to coordinate and deliver health care services and ensure that Aboriginal health care needs are addressed; to adapt health programs and services to the cultural, social, economic and political circumstances unique to different Aboriginal groups; and to give Aboriginal people a direct voice in how health care services are designed and delivered.⁵³

Taken together, both deliberation processes of the Romanow Commission, the Citizens Dialogues and the Aboriginal Forum, represented an important attempt to include a differentiated citizenry in a large-scale public participation process. However, both processes were also fairly isolated parts of a large, complex process where the ultimate interpretive authority resided with an elite (Romanow and his staff). Citizen deliberation represented only one facet of the complex process of the Romanow Commission. The Citizens' Dialogue represented an important space for deliberation, and one worth studying in detail. But it is crucial to recognize the extent to which the deliberative space of the Citizens' Dialogue was localized, surrounded by decisions and processes that were much less broad-based. The mandate of the Commission was established in the elite space of the Canadian government's Privy Council; this mandate was interpreted by Romanow and his staff, who had authority to decide how citizens would be consulted; the deliberations of citizens in the Dialogue were subject to interpretation by Romanow, and were in no way binding; and the Final Report of the Commission was Romanow's to construct. The success of the Citizens' Dialogue and the Aboriginal Forum as deliberative spaces needs to be evaluated, then, not only in terms of its internal structure and what this enabled to happen, but also in terms of its connection to a broader range of spaces that constituted the Commission's activities as a whole.

While Romanow had flaws as a participatory, deliberative process (around reflexivity, recursiveness, separate spaces, which limited Aboriginal voice and the weaving together of Aboriginal and /non-Aboriginal concerns), it was not **meant** to be deliberative all the way down. And so we really are forming judgments on a complex terrain, not only because dynamics of deliberation in heterogeneous public spheres are elusive, but because our politics are not entirely democratic, nor do space-makers want them to be; there are roles preserved for expertise, representative legislatures, entrenched interests, judicial review, etc. But insofar as what we want is democratic deliberation, issues of including the marginalized should be key. The Romanow case sheds light on a number of underlying issues raised by the incorporation of marginalized groups into mainstream deliberative processes. Key amongst these is the challenge of creating space for "affiliated" marginalized citizens and the complex processes in and through which their

⁵³ Romanow Report : 213

representative identities are established in deliberative spaces. A further challenge is the need to incorporate into the design of large-scale deliberative processes iterative spaces in which marginalized groups can periodically exit and enter in order to reach consensus with their members before entering other spaces in the overall process.

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