HEALTH PROMOTION INTERNATIONAL
Vol. 13, No. 4

Printed in Great Britain

Judge or jury: involving people in decision-making

Health promotion practitioners and researchers have long grappled with the problem of how to effect user or consumer involvement in interventions and programmes about health. Whilst subscription to the *virtues* of needs assessment and community development has had many takers and followers, the *methods* for determining need and involving communities have been less clearly defined, disparate and lacking consensus. A recently published book epitomises this diversity (Davies and Macdonald, 1998). Many of the contributing authors promote a range of ways of approaching 'people involvement' in health, but there is little evidence that these approaches are always successful or effective. Indeed, they achieve little consensus within the academic and professional community.

Needs assessment offers the practitioner a sound ethical basis for determining the scope and direction of a health promotion programme, but it is muddied by potential professional–lay conflict. Too often the need is determined by the 'Judge', that is the health professional. This judge-led approach to needs assessment is normally based on the concept of 'normative' need, and uses routinely collected morbidity and mortality data to support it. Epidemiological evidence may therefore suggest that (normative) need—that is a need according to professionals—indicates intervention *x*, whilst lay understanding and concern may indicate an (expressed) need that promotes intervention *y*. This potential, and occasionally actual, conflict may result in professional supremacy, with the consequence that people in the community feel disenchanted with the health and care services and retreat into non-co-operation and cynicism. If needs assessment is to be more obviously based on the community's needs, then it may have to be approached differently.

Other options utilised over the last two decades, have encouraged dialogue and discussion and facilitated involvement, through the use of focus groups and rapid appraisal techniques. Both these methods rely on a small non-representative sample of members of the public coming together to discuss health issues of importance to them with researchers, policy-makers and programme managers. They have distinct advantages over other forms of needs assessment in that they tend to offer very specific insights into a community as a social entity (Ong, 1993). These approaches tend to view the user of health care services and interventions as a consumer.

The consumer model of need considers the characteristics and culture of the community paramount if the intervention or programme is to address lay, non-professional needs. However, a necessary precondition for consumers before they can voice their felt or expressed needs is access to information. In this area the power—and information is power—is with the health professional, the 'Judge'. Historically, health professionals and managers of health care have been reluctant to provide too much information or the right kind of information, because health consumption provided little, if any choice. The lay consumer wasn't consulted on need because need indicates or presumes that choice exists.

With the rise of consumerism and changes to health care delivery and management, choice is now an option. Focus group and rapid appraisal techniques have now begun to address this issue and the literature on research methods, management models and consumer studies recognises this. There often remains, though, a critical missing component to these approaches, namely participation and involvement. We may need to make a distinction between needs assessment, participation and involvement in the same way as the hierarchy proposed by Arnstein (1969). That is that the assessment of need is only the beginning—the tokenism in Arnstein's model of citizen participation. Instead we need to be heading for the top of the ladder, in the model, for

citizen participation to achieve real involvement and engagement.

Whilst the use of focus groups and rapid appraisal methods use key community informants as a means of involving people, they are generally supported less than enthusiastically by whole populations and communities. Indeed, recruitment to focus groups is often problematic and lacklustre. One way round this potential problem is to develop the concept a little further and build on the experience of political science. Here, the concept and practice of 'Citizens' Juries' has given a new robustness to people involvement (Coote and Lenaghan, 1997). The idea is to involve the public in decision-making about health care provision and public health issues. Citizens' Juries involve members of the public in small groups, normally between 12 and 18, in their capacity as ordinary citizens. They are usually commissioned by an agency which may have the power to act on the conclusion and recommendations of the 'Jury'.

Participants of Citizens' Juries are recruited through a form of random and stratified sampling and so are broadly representative of their community. They are typically asked to address an important issue or question about (health) policy or planning over a period of 4 or 5 days. The meeting is facilitated by two moderators and all members of the Jury are briefed in advance or at the meeting about the particular issue in question and this is supplemented with further material and evidence from expert witnesses. Jurors will scrutinise the material, question the witnesses and discuss the issue in smaller groups over the 4 or 5 days. Their conclusions are summarised in a report produced by the moderators and sent to Jurors individually for editing and/or approval, before passing on to the commissioning agency. The Jury's conclusion may not be unanimous or binding in any way, although the commissioning agency is honour-bound to publish the results with the members of the Jury listed.

Citizens' Juries offer a new and real step forward in the challenge to involve people in needs analysis and decision-making and provide a unique combination of information provision, deliberation and independence. They help to redress what is often an imbalance between the professionals, (*the Judge)* and the lay public *(the Jury*). Most recently they have been used in the UK as a means of determining public attitudes towards, and policy implications of, genetic testing for susceptibility to common diseases (Welsh Institute for Health and Social Care, 1998). I think we can learn a great deal from these experiences in helping to plan and prioritise health promotion programmes and interventions.

More radically, and at the very top of Arnstein's ladder, we might pay some attention to Etzioni's (1993) concept of 'communitarianism' and its attempt to involve the democratic community in decision-making and policy formulation.

Communitarianism is not without its critics, principally because of its call for restricting personal freedoms in order to protect the public good—a kind of modern day utilitarianism. However, it does provide a conceptual model for community involvement at a number of different levels including the family, the school and other community institutions. This approach is not unfamiliar territory to health promoters wedded to the settings approach. Greater examination of communitarianism is needed to exploit its application to public participation in health promotion. This reflects the call in the last editorial of *Health Promotion International* (Catford, 1998) to formally recognise the value that individuals as social entrepreneurs can make to the strengthening of community ties and therefore communitarianism.

As the world becomes a more complex and potentially alienating environment, it is not surprising that politicians and academics are searching for a new order that increasingly involves people in political decision-making to address these problems. An involvement that goes beyond the democratic election process—that merely replaces one political party with another with indistinguishable manifestos—is sought. Politicians may want real involvement by the public in the political process and we in health promotion must want the same for public health improvement. If public health is to reflect the reality of people's lives and build on the needs of the public (*the Jury*), then it has to develop mechanisms that engage the public in decision-making and not leave it to the professionals (*the Judges*). The advent of Citizens' Juries and the conceptual development of communitarianism offer us a means to help let the people decide.

Gordon Macdonald
Regional Editor for Western Europe

REFERENCES

Arnstein, B. (1969) *Citizen Participation and Power.* Hamish Hamilton, London.

Catford, J. (1998) Social entrepreneurs are vital for health promotion—but they need supportive environments too. *Health Promotion International*, **13,** 95–97.

Coote, A. and Lenaghan, J. (1997) *Citizens' Juries: Theory into Practice*. Institute for Public Policy Research, London.

Davies, J. K. and Macdonald, G. (eds) (1998) *Quality, Evidence and Effectiveness in Health Promotion: Striving for Certainties*. Routledge, London.

Etzioni, A. (1993) *The Spirit of Community*. Fontana Press, London.

Ong, B. N. (1993) *The Practice of Health Services Research*. Chapman & Hall, London.

Welsh Institute of Health and Social Care, University of Glamorgan (1998) Report of the Citizens' Jury on Genetic Testing for Common Disorders.