# Citizen deliberation in setting health-care priorities

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## Abstract

**Background** Citizen deliberation is a prominent theme in health policy literature. It is believed that citizens who deliberate may influence the setting of public health-care priorities. Currently, in some jurisdictions, citizens are members of community health boards, and thus have a forum to articulate and share values that could affect the reduction of health inequalities within their communities. However, there is little conceptual clarity on the character of citizen deliberation, or, more specifically, how citizens may articulate and share values.

**Objectives** This paper reviews the literature on citizen deliberation in setting health-care priorities; discusses potential challenges for citizens in setting health-care priorities; outlines a developing theory of citizen deliberation; describes how citizens may articulate and share values that ground their health-care priorities and outlines implications of a developing theory of citizen deliberation, its relevance to UK study findings, and to community health boards in setting health-care priorities.

**Conclusions** As members of community health boards, citizens can evaluate their subjective experiences. In reasoning about embedded values, citizens may gain insight into the kind of community they aspire to be, and, in that process, examine their intentions, including whether to serve self or other(s). Citizens who articulate and share values such as respect, generosity or equity may justify health-care priorities that create opportunities for all community members to gain mastery over their lives.

## Introduction

Citizen deliberation or reasoning about collective values[1] is a prominent theme in public policy literature,[2] as well as health policy literature.[3] Specifically, the theory of primary health-care[4] or health promotion is premised on the notion that as citizens articulate their values, they may guide policy-makers to choose health services that respond to health inequalities associated with social contexts. At the same time, there is little conceptual clarity about the character of citizen deliberation; in particular, how citizens may articulate and share values that could affect health promotion. In the United Kingdom, investigators have begun to explore citizen deliberation in the setting of public health priorities. The notions of citizen deliberation that frame the studies are limited, however. Dolan *et al.*,[5] for example, define deliberation as being exposed to the arguments of others (p. 916). Taylor,[6–8] a Canadian political philosopher, offers a theoretical context to guide citizens as they articulate and share values that could affect public health-care priorities. He asserts that all persons seek to evaluate their

  

subjective experiences and choose responses that express their values; therefore deliberation, by a person or between and among people, entails an expansion of consciousness of values, or, stated differently, self-clarification through evaluation of subjective experiences. Thus, citizens may set health-care priorities as they expand their consciousness of their values.

Several countries have established institutional structures to integrate citizens' perspectives in setting public health-care priorities, including councils.[9] In Nova Scotia (NS),[10] as in other Canadian jurisdictions, citizens serve on community health boards that have a mandate to recommend a range of community health-care services. These boards are a forum by which citizens can deliberate and set priorities that reduce health inequalities related to social contexts.

This paper will fulfil the following objectives: (i) review literature addressing the aim of citizen deliberation in setting health-care priorities; (ii) discuss potential challenges for citizens in setting health-care priorities; (iii) outline premises and aspects of Taylor's[6–8] theory of citizen deliberation; (iv) review UK research studies on citizen deliberation in setting health-care priorities; (v) using the studies as an optic, explain how Taylor's[6–8] theory of citizen deliberation can advance understanding of how citizens may articulate and share values that ground their health-care priorities; (v) outline implications of Taylor's[6–8] theory on citizen deliberation, relevant UK study findings and community health boards for the setting of health-care priorities.

## Citizen deliberation in setting health-care priorities

Reputed health analysts stress the public need to reduce health inequalities related to socio-economic conditions including low income.[11,12] Evidence indicates that the greater the disparity in income within a population, the greater the health risks for the community as a whole.[13] All community members should have the health needed to experience mastery over their lives.[14] Hence, health-care leaders advocate primary health-care as a means to reorient health-care services towards health promotion.[4,15,16] Citizen deliberation has been identified as a key means for setting health-care priorities that aim to promote individual and community health.

Recall that citizen deliberation is defined as reasoning about collective values or common good(s).[1] In the health field, theorists stress that citizens need to express their values to health policy-makers[17,18] in order to assist them in setting health goals.[19,20] Daniels *et al.*[14] contend that justice ought to be a primary value to guide contemporary health-care priorities. It could be argued that citizens who deliberate may express a multitude of values that justify their health-care priorities, and thus possibly reduce health inequalities.

Although theorists in the health field advocate citizen deliberation, citizens may need the guidance of theoretical contexts on deliberation to articulate and share values that address health inequalities. Consistent with the health promotion perspective, Lomas[21] urges citizens to ground their health-care priorities in community perspectives. Investigators report, however, that citizens have tended to prioritize high-tech, acute care services,[22,23] which can overlook the needs of some community members. In explaining this discrepancy, Lomas[21] contends that citizens' rationale for their priorities may be the satisfaction of immediate, personal needs. On the contrary, Maxwell *et al.*[24] suggest that health-care priorities are complex and citizens may need to engage in a dialogue to 'work through' (p. 1031) their priorities. They assert that citizens who conduct a dialogue on their health-care visions are willing to make 'trade-offs and choices' (p. 1082), which are based on 'values of need, fairness and efficiency' (p. 1082). However, the notion of trade-offs is inconsistent with reasoning about collective values or common good(s) and is simply the usual method of influencing public policy-making; i.e. bargaining between and among individuals and interest groups. This in fact is consistent with Lomas' conclusion that citizens' priorities are based on immediate personal or group needs.[21]

At the same time, Anand and Wailoo[25] report that some citizens are guided by multiple perspectives in setting health-care priorities, including protection of individual rights and embedded community values. They assert, for example, that citizens seek to balance the individual's right to health-care opportunities, self-responsibility for health, and benefits of medical treatments. In addition, Anand and Wailoo[25] point out that some citizens are unwilling to allocate health-care resources in a manner that disadvantages low-income community members. Although it is reasonable to assume that citizens are guided by multiple perspectives, it is unclear whether they justify their priorities in accordance with values that are shared among members of the communities to which they belong.

In order to address health inequalities, citizens will need to move beyond self-interests to respond to the needs of others who are vulnerable. Taylor's[6–8] theory raises the possibility that citizens who deliberate could transcend self-interests or bargaining to articulate values that they hold in common. Grounded in these values, citizens may go beyond the self to serve others, and thus set innovative and responsive health-care priorities.

To reiterate, citizens may need the guidance of conceptual frameworks in setting health-care priorities. Health policy analysts are now beginning to discuss the character of citizen deliberation. However, their conceptual definitions provide only a general understanding of how citizens may deliberate on health-care priorities. Abelson *et al.*[26] assert that citizens who deliberate on health-care issues must consider different points of view, debate potential options and arrive at a mutual agreement or at least one view that all participants can abide. Abelson *et al.*[26] contend that citizens can thus make reasoned and 'public-spirited' (p. 240) choices. Similarly, Bowie *et al.*[27] suggest that citizens need to talk and listen to the arguments of others in order to gain clarity on their health-care views. Dolan *et al.*[5] extend the notion of argumentation to suggest that citizens who deliberate may change their own health-care choices. Taylor,[6–8] who broadens the concept of citizen deliberation to embrace an expansion of consciousness, offers a context to understand how citizens may reason about their values, and set public-spirited health-care priorities.

## Charles Taylor's[6–8] expansion of consciousness: a theoretical context for citizen deliberation

### Four premises of Charles Taylor's[6–8] theory

More specifically, Taylor's[6–8] theory of deliberation offers a context by which citizens may articulate and share values that could ground progressive health-care priorities. Four premises will be reviewed as background to understanding Taylor's[6–8] expansion of consciousness as a theoretical context for citizen deliberation.

Taylor[6,7] emphasizes that for a conscious person, (i) some life choices are more worthwhile than others and (ii) he or she seeks to make life choices in his or her own original way. In other words, a person chooses his or her responses to subjective experiences based on what he or she perceives to be worthwhile. In making a choice, a person is oriented to 'goods, or standards of excellence and obligations',[28] known commonly as values. These values are embedded in a person's community practice, which Taylor[29] defines as culturally constituted, meaningful action that embodies notions of good, a 'more or less stable configuration of shared activity' (p. 204). Of particular significance, community practices provide a context for a person's reasoning about choices such as whether to serve self or others.[6,7]

These embedded values can remain unarticulated. A person's consciousness of the values may expand, however, as he or she interprets the meaning of subjective experiences.

Taylor[6] explains that experiences come to be understood as feelings surrounding them are examined. In turn, these feelings are understood in relation to the values that underlie them. Such examination usually occurs during a conflict. During a humiliating experience, for example, a person has a feeling of shame because his or her dignity is not respected. In evaluating the feeling, the person may choose a way to act in

order to redeem his or her respect. The value of respect lends understanding to the subjective experience, and may lead to a new way of responding.

A person can make qualitative distinctions in understanding a subjective experience guided by embedded values. Taylor[6] argues a person can make a weak or strong evaluation. The evaluations belong to different personal motivations or intents. In making a weak evaluation, a person is concerned with an outcome, which is judged to be good because it is desired or convenient. In contrast, a person making a strong evaluation is concerned with the worth of multiple intents. Strong evaluations use a language of distinctions including whether to act with courage or cowardice, generosity or meanness. The conceptual contrasts help the person to examine his or her intent and make a choice.

Individuals may hold values in common because of their community practices.[7] Taylor[7] asserts that multiple values embedded in the practices are not just in the minds of individuals, but are 'out there in the practices themselves' (p. 36). The practices thus provide 'common terms of reference' (p. 36). In evaluating their subjective experiences, guided by the community practices, citizens may expand their consciousness of what matters to them as a community. In deliberating, citizens are able to make strong evaluations about the kind of community they aspire to be, and hence share values to guide their public choices. Taylor[7] recognizes that citizens will share only some values; other values remain divisive.

In evaluating their subjective experiences, in a context of community practices, citizens may articulate and share values that ground their health-care priorities. In clarifying their motivation or intent, as a basis for their strong evaluations, citizens could ultimately set health-care priorities that support vulnerable community members gain self-mastery.

## Evaluation of subjective experiences

Citizens may not however, evaluate subjective experiences within the context of community practices, particularly during a conflict. Taylor[8] elaborates that when a conflict exists between parties, it is thought that one person is right and the other(s) is/are wrong. One person attempts to show the other(s) that his or her premises are incorrect. Offering an alternate view, Taylor[8] asserts that the conflict may arise from an error in thinking among the parties, in other words, a confusion or a lack of clarity. Taylor[8] also contends that, in interpreting the meaning of the conflict, parties recognize that they hold at least some premises or values in common.

Taylor[8] explains, furthermore that self-clarification through an expansion of consciousness about one's values entails rational transitions, which are similar to transitions in scientific development. A passage in science from one theory to another theory represents a gain in understanding. Taylor[8] proposes that a transition from X to Y may be seen as mediated by some error-reducing move by which a contradiction or confusion is clarified or an ignored but relevant factor is recognized. Y is thus accepted as a superior response because it is understood as a gain; or stated differently, through clarification, the response is evaluated as more worthwhile than another response(s).

To elaborate on the expansion of consciousness, Taylor[8] draws on the notion of 'pre-understanding' (p. 48), which he explains as an 'implicit understanding of a given domain… that gives a person the ability to make his or her way about and effect his or her purposes in that domain' (p. 48). The pre-understanding embodies values that are grounded in community practices. In examining the meaning of a conflict, a person may change a dim awareness of a value into its explicit expression. In other words, as a person interprets his or her feelings about an experience, his or her consciousness of what is worth doing expands and insight develops. A mediating element, perhaps a perception that had been ignored, shapes the transition. Hence, as a person expands his or her consciousness, he or she can overcome an error in thinking, and hence make a choice that is based on an explicit value.

Taylor[8] explains the point in the case of a petulant child who was acting arrogantly

towards his siblings because he felt cheated of his rights as the eldest son. Upon deliberating on how to treat others, the child recognized that he was not practising the value of respect, which was a part of his family life. In perceiving a mediating factor, the value of respect, he makes an error-reducing move and chooses to act in a superior way. He has made a rational transition in understanding his experience, and thus makes a strong evaluation. He acts to experience a gain, specifically, a sense of belonging to his family.

Similarly, citizens may interpret the meaning of their health experiences within the context of their community practices. In expanding their consciousness of their common terms of references or values, perhaps in response to differences in understanding community health experiences, they may evaluate their multiple motivations or intents. Subsequently, they may come to understand that they share perceptions about what they believe to be worthwhile – their values. In turn, the values that citizens explicitly articulate as their own can warrant their health-care priorities. Thus, in articulating and sharing values, citizens may choose community health-care services that reduce health inequalities related to social contexts.

### Potential limitations of Charles Taylor's[8] citizen deliberation

There is a concern in using Taylor's[6–8] theory as a context for citizens' reasoning about values, that one or some citizens may impose their values on others. Political theorists have raised the public's awareness that no one citizen or group of citizens should impose their values, or concept of the common good, on others.[30] Following from this precept, Habermas[31] outlines procedural conditions for citizen deliberation by which all citizens are recognized as equally competent to critique the worth of others' assertions. Moving beyond conditions for speaking, Kingwell[32] argues that citizens need to cultivate the virtue of civility or openness. In developing a sense of openness, citizens may reason about values rather than use power to dominate and bargain.

Taylor[28] stresses that citizen deliberation rests on a rhythm or cadence, which means that at a certain point, 'the semantic turn' (p. 314) – the speaking – is passed over to another. The purpose of the cadence is the clarification of values, in particular values that are shared. In passing the speaking from one citizen to another, the cadence may thus curb a trumping of one citizen's values by others. However, the practice of taking turns is not universal, and some citizens' efforts to deliberate will be thwarted by the power of dominant others. Research is needed to understand how citizens may deliberate in an effort to articulate and share values and at the same time respect differences in their values. For example, research is needed to understand civility as an integral aspect of contemporary citizen deliberation. In a disposition of civility, citizens may willingly engage in the semantic turn. In sharing values such as civility, citizens' power imbalances may thus be reduced.

## Investigations into UK citizen deliberation in setting health-care priorities

This section will present four UK studies investigating citizen deliberation on health-care priorities. In addition, it will use the studies as an optic to examine how Taylor's[6–8] theory of deliberation may extend understanding of how citizens may articulate and share values. The studies are presented in a sequence that frames an understanding of how citizens may articulate and share values. First, Bowling[22] draws attention to citizens' predominate concern with their own health matters, when polled. Secondly, Dicker and Armstrong,[33] on the other hand, emphasize citizens' tendency within an interview to respond to others' suffering as they interpret their subjective experiences. Thirdly, building on the Dicker and Armstrong[33] findings, Bowie *et al.*[27] conclude that study participants who met over time to listen to one another's arguments in order to clarify their individual health-care views were inclined, in the end, to share community health perspectives. Finally, to advance the discussion on a theoretical level, Dolan *et al.*[5] move beyond conceptualizing deliberation as listening

to one another's views to emphasize deliberation as generating a change in viewpoints. Taylor's[6–8] theory of deliberation offers an explanation of how that change may evolve.

## Information on the research studies: samples, purposes and methods

It might be questioned to what extent the findings reflect the deeply held views of the UK population. Bowling[22] may have generated a study bias because of the wording and ordering of the questions. For example, treatment for children with life-threatening illness was the first item on the questionnaire. Citizens' responses

| Author | Bowling[22] | Dicker and Armstrong[33] | Bowie *et al.*[27] | Dolan *et al.*[5] |
|---|---|---|---|---|
| Sample | National, stratified random, descriptive survey of 2005 adults | A purposive, qualitative study of 16 participants selected from an inner-city medical practice | A pre-/post-test descriptive focus group design, to determine whether participants agree on health issues is related | A pre-/post-test descriptive focus group design 60 randomly selected patients from two urban medical practices were assigned to 10 focus groups that attended two meetings 2 weeks apart |
| Purpose | To elicit public views on health-care priorities | To investigate whether community members share community health beliefs | To listen to one anothers' arguments. Eight groups of 12 participants met five times over 18 months. Members answered the same questionnaire at each meeting to determine differences | To determine whether participants change their health-care views after deliberation |
| Method | During an interview, each participant ranked the importance of 12 health-care services, and responded to open-ended questions to determine attitudes about health priorities | Data on health-care choices were collected through semi-structured, individual interviews | Participants discussed 'live' (p. 1155) issues of concern to the Health Authorities, plus responded to open-ended questions at each meeting such as: 'Should doctors establish more nursing clinics to advise clients on on-going health conditions'? | Participants responded to a questionnaire about health-care choices, deliberated and responded to a second questionnaire to determine a change in views |

### Study 1: Bowling[22]

Based on the findings of one interview, in which participants were asked to rank-order health-care priorities, Bowling[22] observed that 34% of participants chose treatments designed for children, while 3% gave priority to treatments that focussed on people with psychiatric illnesses, and further, that 42% of participants gave lower priority to aiding people with lifestyle health problems,[34] a finding that is supported in earlier investigations.[23,35] Bowling[22] concluded that the public may be 'prejudiced' (p. 6) against some community members.

may reflect their personal concerns. About 64% of participants were married, and they may have chosen treatment for ill children first because of concern for their own children. In expanding their consciousness of values, citizens may overcome this natural tendency to turn inward in the face of personal problems.[36]

Bowling[22] concludes that citizens need to be educated to overcome their prejudices. At the same time, they may need to deliberate on collective values, or the common good(s), as Lomas[21] urges. More specifically, in making clear their explicit values, citizens may choose services that respond to health problems

associated with health inequalities. They may need the opportunity beyond a short interview, however, to evaluate subjective experiences in order to explicitly articulate values, for example, Taylor's[28] goods and obligations, which lie implicitly in their community practices. Hence, it may be argued that health inequalities persist related in part to inadequate deliberation by citizens. Effective deliberation could have led to an understanding of a gain or gains in community health, i.e. actions that respond to health inequalities.

### Study 2: Dicker and Armstrong[33]

The Dicker and Armstrong[33] findings indicate that citizens who examine their subjective experiences may act to relieve the suffering of vulnerable individuals. In analysing participants' health-care views, Dicker and Armstrong[33] found (i) that participants shared 'common terms of reference'[7] (p. 36), specifically, the principle of equity and (ii) that participants reflected on their subjective experiences. Participants indicated that witnessing community members who had unmet needs influenced their choices; furthermore, they justified their community-perspective choices because of their respect for human dignity. Dicker and Armstrong[33] suggest further that participants' principle of equity may be rooted in their family histories. The interviews spanned 30–40 min, which is a short period for an examination of values. However, the Dicker and Armstrong[33] findings seem consistent with Taylor's[28] assertion that citizens interpret the meaning of their subjective experiences based on values (goods and obligations) embedded in their community practices.

Dicker and Armstrong[33] assume that the study participants were primarily influenced by a sense of equity. Health analysts similarly emphasize that equity or reasonableness should be a guiding principle in health policy-making;[3,14] however, over-reliance on the principle of equity may lead to a narrow vision of health-care. In deliberating, citizens may instead refer to multiple values. Taylor[7] reinforces this notion in asserting that citizens may deliberate on multiple values embedded in community practices. Within a communitarian or historical context,[37] these values would include respect,[6] generosity,[37] and compassion.[38] Within a liberal context, Kingwell[32] identifies civility or openness as a value that ought to be cultivated. Citizens who expand their consciousness of the value of respect may act to relieve health experiences associated with the humiliation of social disadvantage, particularly drug problems; others may respond because of their sense of compassion or generosity. Thus, in deliberating on multiple values, citizens may choose broad health-promotive, community-based services.

### Study 3: Bowie *et al.*[27]

Bowie *et al.*[27] lend support to the notion that, as citizens evaluate the meaning of their subjective experiences, they may articulate values that are shared. Bowie *et al.*[27] sought to develop a method of public health-care consultation that encouraged a focus on community rather than individual values. Specifically, they undertook a pre-/post-test focus group[39] study to determine if listening to one another's arguments about health-care might enhance their agreement. Members discussed 'live' (p. 1155) health issues, for example, 'should more nursing clinics be established to advise clients on on-going health conditions'? (p. 1156).

Overall, the Bowie *et al.*[27] findings indicated participants held broad community health perspectives. They observed, for example, that 98% favoured the establishment of more clinics run by nurses. However, the conclusions that can be drawn from the Bowie *et al.*'s[27] study are limited because only one set of figures related to the response frequency on selected questions are reported. It is assumed that the figures reflect the findings of the final questionnaire (the post-test). The findings of the first questionnaire (the pre-test) are not reported; therefore, a change in agreement among participants on health issues related to argumentation is difficult to assess. As well, because of the lengthy time span of the study, the findings could have been influenced by history, or events not planned as part of the

study, but which may have influenced the results.[40] Thus, it is unknown whether the findings accurately reflect change in participants' agreement because of argumentation.

The Bowie *et al.*[27] focus groups met over extended time to discuss live rather than hypothetical issues. By listening to one another's arguments about significant issues, members may have gained insight into values that they share. Thus, in articulating the kind of community they aspire to be, participants may have made qualitative distinctions, or comparisons, in their understanding of their own, each other's, or community members' health experiences. A qualitative analysis of the focus group meetings might have been reported to offer further insight into how participants made distinctions in their evaluations of health experiences.

### Study 4: Dolan *et al.*[5]

Dolan *et al.*[5] investigated whether citizens might change their health-care views as a result of deliberation. They undertook a pre-/post-test study to provide focus group members with opportunities to listen to one another's arguments about health services to determine whether they might change their views about who ought to receive services. At the first meeting, participants responded to a Likert scale questionnaire[41] based on 21 grouped client characteristics, for example, lifestyle health problems. The participants then deliberated on a number of patient scenarios, and finally responded to a final questionnaire. This questionnaire included three questions also posed in the initial questionnaire in order to recognize changes in the participants' views. Change in participants' attitudes was measured solely in reference to these repeated questions.

Dolan *et al.*[5] findings indicate that the form of deliberation undertaken by the participants did not re-orient all of the participants' views toward health-promotive, community-based health-care. In the final questionnaire, for example, only six participants indicated more favour towards people with lifestyle health problems, while nine indicated less favour. The Wilcoxon sign rank test used to compare changes in participants' responses between the initial and final questionnaire was significant at $P < 0.01$. To understand the nine participants' change of view, it is worth noting that 45 of the 60 participants (75%) were non-smokers; a portion of these participants may have become less lenient towards individuals with lifestyle health problems as the study progressed.

In relation to lifestyle health problems, the Dolan *et al.*[5] study findings do not support the claim that citizens who deliberate can articulate and share values. However, there were limitations in the study design that could have affected the outcome. Participation was voluntarily and the reasons for participation are unknown; as well, it is unknown how their views differed from participants who declined to participate, which is a potential source of bias. In addition, participants met on only two occasions, which may be a short time period for a change in viewpoint. The results of the study related to changes in views about health-care services for lifestyle problems should be accepted with caution.

However, Dolan *et al.*[5] characterize citizen deliberation as going beyond mere listening to argumentation to the premise that, through deliberation, people may change their perspectives. At the same time, they do not explain how such change may evolve. Within Taylor's[8] theoretical context, the change reflects a gain in understanding of what is valuable. Specifically, citizens may change their points of view as they make rational transitions in their evaluation of subjective experiences. In other words, perspectives evolve as citizens move beyond their pre-understanding of an experience to articulate explicit values; thus, a change in viewpoint is due to self-clarification.

## Implications for setting health-care priorities

Citizens are expected to be community-minded in advising policy-makers on health-care priorities. In evaluating their subjective experiences, citizens may understand that it is only rational to ground their priorities in a community perspective, as Lomas urges.[21] They may conclude

that the community as a whole gains when all members experience mastery over their lives. The community-mindedness is substantiated by Raphael,[13] who points out that a community is at risk when some of the members are exposed to adverse health conditions. Yet in order to articulate and share values to ground their policy-choices, citizens may need theoretical contexts, as well as appropriate forum and time.

Taylor[6–8] offers a distinct theoretical context to guide citizen deliberation through the expansion of consciousness of values. Following his direction, citizens would make strong evaluations about the kind of community they aspire to be, and, in that process, they would examine their intentions, in particular whether to serve self or other(s). Their insight about what is significant to them would evolve as they deliberate on their subjective experiences. In other words, they would know the explicit values they hold in common. Value(s) that had been embedded within their community practices, including respect, generosity or the principle of equity, may now mediate a rational transition in their conscious conclusions about whether to serve self or serve other(s). And thus, citizens may choose to address health inequalities.

At the same time, citizen deliberation is a complex matter. Dolan *et al.*'s[5] findings on the effects of discussion and deliberation on study participants' viewpoints on lifestyle health problems reveal its uncertainties. As well, it should be pointed out that Taylor's[6–8] theoretical context is not seamless. It has the inherent potential for an over-riding of some citizens' values by others citizens' values. Yet his theoretical-perspective holds promise for an articulation and sharing of values by and among citizens. In order to deliberate on deeply held and shared values, citizens may need a certain forum and time.

Membership on community health boards such as the NS model,[10] or the Bowie *et al.*[27] focus groups, may provide citizens with the forum and the time to evaluate their subjective experiences and to set innovative health-care priorities that are responsive to broad community needs. The UK research studies support the idea. Bowling[22] concludes that citizens, when polled, are prejudiced against some community members in setting health-care priorities. Dicker and Armstrong,[33] on the other hand, found that citizens were sensitive to the health experiences of vulnerable community members during one-on-one interviews. Bowie *et al.*[27] reinforce the Dicker and Armstrong[33] finding by concluding that citizens in focus groups who meet over time to deliberate – listen to one another's arguments on live health experiences – hold broad community health-care perspectives. Citizen as members of community health boards may have the opportunity for self-clarification, which may entail a change in some members' health-care views, as Dolan *et al.*[5] suggest.

In articulating their values, citizens may reorient health-care priorities in order to reduce health inequalities within their communities. More specifically, in making strong evaluations, citizens may come to perceive the need to set health-care priorities that offer all community members the opportunity to experience self-mastery in their lives. Thus, citizens who reason about their values, or common terms of reference, could become leaders in promoting community health – the common good(s).

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