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What should be given a priority – costly medications for relatively few people or inexpensive ones for many? The Health Parliament public consultation initiative in Israel

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Abstract

Background In the past two decades, government and civic organizations have been implementing a wide range of deliberative public consultations on health care-related policy. Drawing on these experiences, a public consultation initiative in Israel called the Health Parliament was established.

Goals To implement a public consultation initiative that will engage members of the public in the discussion of four healthcare policy questions associated with equity in health services and on priorities for determining which medications and treatments should be included in the basket of national health services.

Method One hundred thirty-two participants from the general population recruited through a random sample were provided with background materials and met over several months in six regional sites. Dilemma activities were used and consultants were available for questions and clarifications. Participants presented their recommendations in a national assembly to the Minister of Health.

Outcomes Across the regional groups the recommendations were mostly compatible, in particular regarding considering the healthcare system's monetary state, even at the expense of equity, but for each policy question minority views were also expressed. A strong emphasis in the recommendations was pragmatism.

Conclusion Participants felt the experience was worthwhile; though the actual impact of their recommendations on policy making was indirect, they were willing to participate in future consultations. However, despite enthusiasm the initiative was not continued. Issues raised are whether consultation initiatives must have a direct impact on healthcare policy decisions or can be mainly a venue to involve citizens in the deliberation of healthcare policy issues.

Introduction

Consulting the public on healthcare priorities is increasingly viewed as a necessary but contentious undertaking. In the past two decades, governments and civic organizations in various nations, including the Netherlands, Denmark, Great Britain, New Zealand, Canada, the USA and India, have been implementing a wide range of initiatives to involve the public in health care-related policy discussions.[1] The issues addressed in such initiatives range from preferences for specific healthcare services to a broad vision of the future of a national healthcare system. Underlying most deliberative initiatives is the assumption that setting priorities in healthcare inherently involves difficult value-laden choices, and therefore decisions about them should involve public discussion.[2]

A major reason health policy issues have been thrust to the forefront of many public consultation initiatives is that the attempts of local and national governments to reform healthcare services involve value-laden prioritizations, which cannot be worked through on technical grounds alone.[3] Health policy decisions need to meet health needs of diverse populations and must include a wider range of healthcare services and new medical technologies. Policy makers tend to believe it would be easier to enlist public support if the public is involved in the process.[4] Similarly, the proliferation of public consultations is also as a result of the growing recognition of the impending impact of new developments in medicine, medical technologies, biotechnology and genetics, and new advances in reproductive technologies on society and individual lives.[5] The weight of the moral problems posed by these advances and public skepticism regarding policy makers' priorities has been a strong impetus to seek ways to involve the public in the decision-making process.[6]

Consulting the public: the question of methods

Despite the logistic effort, monetary cost and ethical dilemmas involved in public consultation initiatives, there is a surge of such consultations across countries.[7] A common goal among many current public consultations on healthcare policy is to elicit participants' views through a deliberative process. The deliberative methods employed in these initiatives represent a significant departure both from 'town meetings' and traditional public opinion polling techniques – although they may contain some similar features.[8] Underlying most deliberative initiatives is the supposition that because most citizens typically do not have the opportunity to consider healthcare policy issues in depth, they are not likely to be aware of their complexity and therefore need to be provided with background information and a process that allows for discussion and exchange of views.[9] This requirement corresponds to critics' concerns regarding the willingness and competence of non-professionals to deal with complex health-related policy issues.[10] Thus, although various consultation initiatives may differ in their implementation strategy, most incorporate the following features:[11] time for careful consideration of the problem; provision of background information; opportunities to ask questions; methods that help participants consider the problem from various perspectives; and an egalitarian discussion process in which participants have adequate speaking opportunities and engage in attentive listening and dialogue.[12]

A prominent public deliberate consultation method is the 'Citizens' Juries'. In this model a group of about 20 citizens, usually recruited through a random sample, meets and is given the opportunity to question 'expert witnesses'. The group usually produces a written document that is publicized in the press and responded to by healthcare officials. This model has been used extensively in Great Britain by health authorities on rationing topics, the recommendations are usually presented to policy makers.[13] In the USA, an initiative of the Jefferson Center took place in October 1993 on the topic of reform in the American healthcare system, which did not materialize.[14] Another type of consultation method is the Consensus Conferences that draws on a model of technology assessment, originated in the 1960s in the USA and further developed by the Danish Board of Technology, an independent institution established by the Danish Parliament. Its mandate includes furthering public debate on technology issues by communicating the results of public deliberations to decision makers and the public.[15] In Canada, numerous public consultations on health issues took place; one was a large-scale governmental initiative to involve the public in broad policy issues. It included 'dialogue sessions' with about forty randomly selected participants who met for 2 days. It utilized a structured process using a workbook format that included background information and a specification of alternative policy scenarios to help participants 'work through' conflicting values and difficult choices; their views were incorporated in a summary document of the Commission of the Future of Health care in Canada, presented to decision makers in June 2002 by the commissioner that headed the process.[16]

A different type of deliberative consultation, which focuses on obtaining the views of a representative sample, was conceived by the USA researchers but implemented for the purpose of healthcare policy in Europe and Australia. It is called 'Deliberative Polling' and it combines a survey of a representative sample (usually about 300 participants). Participants are provided with background materials and are convened for a few days in one location, in which they deliberate in small groups and present questions to experts and decision makers in plenary sessions. Their individual opinions are surveyed at the outset and the conclusion of the process.[17] In contrast, in New Zealand, a series of ethics workshops were conducted to consult specifically with underserved minorities and community groups to discuss ethical and value considerations in the prioritization of health services. Participants thus engaged in ethical activities, and their views were incorporated in a report to decision makers.[18] Similarly, in Great Britain, a group of young adults were convened to discuss ethical issues associated with new reproductive technologies, but because the initiative was not commissioned by an official body its results were not aimed to influence particular policies.[5] As indicated in this review, different types of approaches are currently used to consult the public on a wide range of health policy issues.

In Israel, the healthcare system has undergone substantial changes in the past decade following a major healthcare reform, among them the development of a system of explicit rationing that calls on policy makers to make difficult choices under public scrutiny. Senior members of the healthcare system thus felt the time had come to involve 'ordinary citizens' in such dilemmas. This paper describes this process.

Background to the Israeli Health Parliament initiative

Israel's healthcare system went through substantial changes with the enactment, in 1995, of the National Health Insurance (NHI) Law,[19] under which all residents are entitled to healthcare insurance. The NHI Law defined a comprehensive and uniform basic basket of healthcare services, as part of this insurance, and set out a mechanism for updating it. Since 1998, the government has allocated almost every year a defined budget for additions to the basket. A public committee ('The Basket Committee') made up of representatives of various health system stakeholders and public interest representatives recommends a prioritized list to the Minister of Health.[20] Whereas this committee includes members who are supposed to be public representatives, it has been criticized in the news media and by advocacy organizations for its lack of diversity and for being dominated by healthcare professionals and organizations. The process of rationing within a pre-determined budget is essentially value-laden. Indeed, the national commission on healthcare reform that preceded the NHI Law had commented that healthcare allocation decisions must be based on public views and values.[21] A member of this commission (and a former Director General of the Ministry of Health) initiated in 2003 a public consultation on rationing and equity in health policy: the Health Parliament, which is the subject of this paper. This consultation was preceded by a 2-year feasibility study to explore methods for consulting with the public on rationing decisions at the Gertner Institute for Epidemiology and Health Policy Research. Drawing on this study, a workgroup at the Gertner Institute – which included senior persons from the Ministry of Health, Tel Aviv University researchers and members from the Zippori Center for Community Education – established the *Health Parliament* initiative: a new venue to elicit 'ordinary' citizens' views on pertinent healthcare policies. The recruitment and surveys were performed with the Cohen Institute for Public Opinion at Tel Aviv University.

The policy questions

A major issue was choosing and defining the questions for the consultation. This was performed by the working group; eventually, four policy questions were chosen. The first two were associated with equity and the third and fourth with issues pertaining to explicit rationing in healthcare services. The Health Parliament members were charged with deliberating these questions and formulate a summary of their views that would be presented to policy makers.

Issues of equity

The first policy question was whether people should be allowed to pay to ensure their choice of a doctor in publicly funded hospitals. The second question was whether the requirement for a co-payment for medical services and medications provided through the NHI system should be continued, and, if so, how could it be ensured that co-payments would not prevent people with limited economic means to receive necessary medical services?

Rationing criteria for medical treatments and services

Participants were asked to determine what should be considered a life-saving medical treatment, for the purpose of inclusion in the national healthcare basket of services. Whereas the Basket Committee used the value of 'life-saving' as an overriding criterion, it did not have an actual definition for it. The second question posed another rationing dilemma: should costly medical treatments that can help people with relatively rare medical conditions be given a priority (thus with a limited number of people as the immediate beneficiaries), or should priority be given to treatments or medications for relatively prevalent medical conditions that cost less (thus a relatively large number of people may benefit).

The Health Parliament's features and design

The design of the Health Parliament combined a series of regional meetings with a national assembly. The goal was to recruit people from diverse background who did not necessarily have a particular interest in healthcare issues. One of the major challenges was how to recruit members from the wide population and to ensure that members of minority populations participated. It was decided to base the recruitment on a stratified random sample of 1500 people from the adult population with an over-sampling of minorities and new-immigrant populations. People were contacted by phone, were told about the initiative, and were asked if they would be willing to participate. They were told that they were not supposed to have a particular interest or knowledge in health issues. The only exclusion criterion was that potential participants had to speak and read Hebrew. This was a contentious issue, because members of the community education centre thought that participants should be required to have an interest and should sign an official commitment. However, it was decided to rely on engaging participants' interest and commitment through the deliberation process. Forty-four per cent of those interviewed expressed a general agreement to participate, and from them a total of 130 were recruited. All Health Parliament participants met together in an opening and closing session, attended by the Minister of Health and heads of the health funds. The actual deliberations took place in six meetings held in six regional groups in community centres. Three of these meetings were devoted to questions related to equity and three to rationing. These meetings took place between February and July 2003.

During the meetings, challenges included how to devise a discussion methodology to help participants 'work through' conflicting value priorities, how to ensure that the discussion process would be egalitarian and enable each participant to express her or his self, and how to ensure that discussions on the healthcare policy issues would be performed in a competent manner.[22] To enhance the process of 'working through' value priorities, three 'value dilemma exercises' were developed (see Table 1). The time intervals between meetings (usually 2 weeks) were implemented to enable participants to have more time to think and read about the issues between sessions, and to discuss them with others. To enhance the competence of the discussion, participants were provided with written materials and presentations. The four booklets distributed to participants contained the history and structure of the healthcare system as well as background information and a description of dilemmas regarding each of the policy questions. Various stakeholders were invited to submit short position papers on the policy issues, and these were printed in a uniform format and distributed as well.

As in many deliberative public consultation initiatives, professional group facilitators were employed to moderate the discussion and to help ensure that all participants will have the opportunity to express their views. In addition, consultants from senior positions in the public healthcare system and the health research community were made available for queries throughout the meetings. These consultants would sit outside the 'circle' of participants, and would be called upon when needed. On occasion they would ask to correct inaccuracies regarding specific facts. The continuous presence of the consultants was a unique and initially controversial feature of the Health Parliament initiative. Having more than one consultant per group was meant to help ensure that the information the consultants provided would be balanced and complete. Table 1 lists the major design features and the rationale for each.

Participants' views of the process and the design features

The exclamation of one of the Health Parliament participants' – my opinion on consulting with the public? It's about time!' – epitomizes a general sentiment of many of the Health Parliament's participants. Their commitment to the public consultation initiative was evident in the strong attendance of most participants in all the six regional meetings. It should be noted that participants did not receive any monetary compensation for their participation, and that each meeting took 6–7 h of their time, including travel. Participants filled out questionnaires before, during the regional meetings, and after the final national assembly, in which they were asked to assess the materials they were provided with, the sessions and their views on the summary documents produced by their group. An overwhelming majority (86%) said they would be willing to continue to participate in the consultation initiative, this after having experienced the commitment it demands. Most (over 90% in most

Table 1 Design features of the health Parliament

Feature	Description	Rationale
Recruitment of 'ordinary citizens' by a random sampling method	A stratified random sample of the adult population and of an over-sampling method of minorities and immigrants according to geographical regions. Interviews were also conducted in Arabic and Russian.	To guarantee a fair chance of being recruited and to ensure diversity and representation of minority populations.
Regional plus national meetings	An opening and a closing national assembly. Regional meetings held in local 'parliaments' in six regional sites; conducted simultaneously.	To enhance geographical access. To provide a broader forum across the regional groups, that would be attended by senior healthcare system people.
Time intervals between sessions	Each policy issue was discussed over several sessions with an interval of usually 2 weeks between sessions.	To provide participants with time to read the materials, reflect and discuss the issues with others.
Information resources	Written background materials, stakeholder position papers, a library of articles and documents. Health policy consultants present and available during all group sessions to answer questions and clarify issues.	Guided by the principle that participants should be informed about the issues and have an opportunity for mutual learning and with resources they can consult.
A deliberative process	Group facilitation and small group discussions within each regional group.	To ensure all participants are given the opportunity to express themselves and help them articulate their views and listen to others.
Simulation activities	Simulation activities included a 'values deliberation exercise' in which participants were asked to weigh and prioritize prototype technologies and to classify their justifications. These included a 'The Ruler' activity used to prioritize medical treatments; 'the rooms' simulation that required allocating various rooms to people with different types of needs in one house.	To highlight ethical dilemmas and value considerations associated with the policy issues and 'work through' value considerations.
Summaries and recommendations	Regional groups were charged with producing a group summary of their views and recommendations regarding each policy issue, including diverging perspectives.	The summary process was guided by the principle that a consensus was not required and that diverse perspectives should be heard and included.
Documentation and evaluation	Discussions were transcribed and transcripts were made available. Participants' feedback was obtained throughout and after the consultation through questionnaires and interviews.	To document the process for the purpose of accountability and for participants' use for the summaries, and to obtain the perspective of participants.

groups) also felt confident that the document they produced demonstrated the value of involving the public in healthcare policy decisions.

The summary process was guided by the assumption that a group consensus was not required, and that minority opinion should be stated. Participants' responses to a follow-up questionnaire indicate that the final recommendations the process produced summaries that were agreed upon by most. Most (80%) said they were generally satisfied with the summary documents and believed it represented theirs' and others' views. It appears that by not compelling the groups to reach a consensus,

Table 2 Participants' comments on the process

On consulting the public
'My opinion on consulting with the public: It's about time!'
'Following our participation in the Parliament, we came to realize and appreciate the difficult ethical and moral problems the healthcare system faces, and to understand why the heads of the system thought it appropriate to bring these problems to public consultation'.
On the elicitation of views on healthcare policy issues
'Until I was in the *Health Parliament* I didn't have detailed information about the healthcare system, and the information I was exposed to here helps me express my opinion about the issues'
'I never gave importance to the issues of private pay and equity in medicine…Suddenly complex topics have been exposed to me on such weighty problems'
On learning about the health policy issues and their complexity
'When we came, we did not know where we were going, and when we started discussing the issues we saw we knew very little. But our knowledge got wider. I also liked very much the help we got from the professional advisors. They always had answers but the answers were not one-sided. They would say: 'also on this issue there is a debate, also on this there is no definite answer'. It gave me a feeling that there wasn't any feeling of superiority or distance from the advisors. They were there to follow with us the discussion. We could tell they themselves were in a quandary'.
On acquiring a wider perspective
'When my wife was ill, of course it appeared to me it would be important to give all that is possible to her: Whoever is ill should be given the treatment they need. That is from an absolute moral view. But then, you see the larger picture…and that influences you'.
'It was interesting to learn a topic that each of us usually encounters only through our own health problems and to suddenly see it open up into a wider public issue'.

participants were both open to listen to the views of others, but at the same time did not to hesitate to insist on having their own views documented.

Participants viewed very favourably the background materials and the availability of consultants. Responses to the questionnaire distributed before the first regional meeting indicate that most participants believed they had little or no knowledge of various aspects of the policy issues they were going to discuss. For example, only 15% said they had any knowledge regarding the proposed options regarding having private pay in public healthcare facilities, and only 34% said they knew about the current legal status of private payments for physicians in the public healthcare system. Assessment of self-knowledge regarding the consultation topics increased dramatically among most participants following the sessions. However, some participants also felt that they could use more information than was provided. This reflects the dilemma of how much information should be provided to participants for them feel confident in their competency to discuss the issues. The constant availability of the consultants during the regional meetings was one way to address this issue, and turned out to be a significant feature in the Health Parliament. Participants said it was important to have advisors 'on call'. Further, the consultants themselves, all senior members in the healthcare system or health policy research institutes, felt they learned a great deal from the views of the participants and about the importance of consulting the public (Table 2).

The policy recommendations

Each of the regional groups produced a summary document of its views for each of the four policy questions. The document outlined the group members' majority opinion and the justification for it, but it also specified diverging opinions. Although each regional group worked independently, their overall recommendations were surprisingly compatible for most of the policy questions. However, it should be noted that for each policy question at least one regional group differed in its majority opinion. This suggests that the process enabled both the elicitation of diverging views as well as shared conclusions within and across groups.

The policy question whether to allow patients to pay for the choice of a doctor in publicly funded hospitals generated the most diverse recommendations across groups. Two regional groups opposed this arrangement as a matter of principle, but the other four groups supported it and specified certain restrictions they believed would minimize its harm to the principle of equity in healthcare. These included a restriction that payment could be made only to choose a doctor and not to enjoy improved hospitalization conditions or other privileges in the public system. Participants also specified that the payment should be made through the hospital, with no direct monetary link between the patient and doctor. The rationale for allowing for this inequitable practice, according to the group's majority opinion, was to enable the public system to gain financially from this new arrangement. Participants explained that this would help enhance the healthcare system's limited resources and would thus benefit all citizens. The groups specified that the funds would be used only to help improve the medical service and to renew equipment of the hospital, and not for regular expenses.

In contrast, groups that opposed allowing this choice explained that 'the public health system belongs to everyone, and purchasing advantages by means of private payment should not be allowed'. Members of one group suggested that everyone should be able to have the option of a choice of a doctor in public hospitals, but that this would be restricted to after regular work hours, and with the possibly that they would entail a longer waiting period.

Across groups, the second policy question related to equity – whether to continue the practice of co-payments for medications and services – elicited less disagreement. All regional groups, except one, recommended that the co-payment system should remain. However, they also stated that certain aspects of it should be changed and that there should be some mechanism to ensure that the co-payment system should not limit vulnerable populations' access to services or medical treatments. To address this challenge, the groups made recommendations on how to expand the current system of exemptions and discounts for needy populations. Additional recommendations were to publicize information on patients' rights so that eligible individuals would be aware of their rights regarding payments. The main reasons for maintaining the co-payment system were similar to the reasons that justified allowing inequity in the choice of doctors: mainly, to help finance the healthcare system. Thus, participants across most groups felt that they had the responsibility to find ways to secure funds for the public healthcare system, even if this infringed on equity considerations. This may serve to exemplify how participants may develop a pragmatic or 'common good perspective' in public deliberation forums.[23]

When participants learned what was involved in the policy questions regarding rationing healthcare technologies and services, many were initially overwhelmed by the task, to which they referred to as 'playing God'. Not withstanding this reaction, participants proceeded to engage in deliberations regarding what should be the criteria for 'life-saving' medical treatments, and presented their recommendations in the final document. Across groups, there was nearly a consensus in the majority opinion regarding three prominent factors they thought should be considered as the criteria for 'life-saving': the potential rate of success of the treatment (in terms of numbers of lives saved); life expectancy (the average period of expected extension of life) and the quality of life following the treatment. In three of the six regional groups, there was agreement about a defined period of time which distinguishes 'saving' from 'extending' life: only technologies that extended life for over 1 year (or 6 months) would be considered 'life-saving'. As for quality of life, only one group thought it should *not* be a criterion.

The second rationing dilemma also elicited similar preferences among five of the six regional groups. The overall recommendation was to give priority to the coverage of medications or services in the medium range in terms of cost, which can benefit a relatively large number of people, but are beyond the reach of most. The minority opinion was to give preference to very costly medications for treatments that serve a small number of people. An additional recommendation related to this principle was that early detection of serious illness for populations at risk should be subsidized. Thus participants, in contrast to the Basket Committee, outlined general guidelines regarding prioritization of medical treatments or services in terms of what could be considered 'life-saving' as well as criteria related to how many people may benefit compared to the cost of the treatment.

Outcomes and prospects

Critics contend that the most contentious issue about the Health Parliament initiative is its impact on decision makers*. This concern applies to many other deliberative initiatives. According to one approach, impact should be assessed according to the extent to which participants' recommendations are incorporated in actual decisions. Others contend this criterion is problematic, both in theory and practice because public views should be taken into consideration along with other stakeholder views, and that, in general, considerations of justice and equity should prevail.[24] Another view is that the impact of public views may not necessarily have to be immediate and visible to be important. The assumption is that the deliberative process creates incremental and slow changes in the system.

In terms of the immediate impact of the Health Parliament, participants' summaries were presented to the Minister of Health, as well as to the Health Council, which acts under the NHI Law as an advisory committee on priorities of new technologies. In the final assembly, the Minister of Health addressed the Health Parliament's recommendations in detail. The views of the Health Parliament were also incorporated in documents drafted by professional Ministry of Health staff for discussions in the Basket Committee. The Basket Committee, however, was not asked for any official response. Despite a statement of official endorsement of the Health Parliament initiative by the Health Council, it did not show any interest in continuing the initiative as part of its own activities, and funds obtained privately to continue the initiative were not sufficient to ensure its continuity. In terms of general impact on the system, the professional consultants to the regional groups reported that their involvement in the Health Parliament had sensitized them to the importance of soliciting citizens' views and considerations. Also, the initiative inspired two of the largest health fund directors to implement their own public deliberative initiatives.

The Health Parliament participants themselves did not think that a condition for their participation should be an assurance that the product of their deliberation would have a direct impact on the healthcare system. They expressed both skepticism and hopes that their recommendations would be accepted, but they emphasized the importance of the process as well. Some described the initiative as 'an experiment in democracy'. After the final assembly, less than a fifth said they 'strongly believed' and between 36% and 45% said they 'moderately believed' that their recommendations regarding each of the policy issues would be taken into consideration. Yet, even when participants explicitly expressed their skepticism about the potential impact of their views on the system, they did not dismiss the deliberative initiative as having no impact. Some felt that the quality of the process and the views it generated would have an impact on decision-making, even if only indirectly. For example, the Minister of Health was scheduled to have a brief visit at one of the regional meetings and surprised his staff by insisting on remaining for a longer discussion.

A related contentious issue regarding impact concerns which aspect of the consultation initiative is of greater importance: having citizens deliberate difficult policy issues, or having them produce specific policy recommendations? Participants tended to emphasize the impact of the change that took place in the way they viewed healthcare policy issues. As one participant explained: 'When my wife was ill, of course it appeared to me it would be important to give all

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*This critique was raised in two conferences in which the *Health Parliament* was presented, by political scientists, journalists and by its own organizers.

that is possible to her: Whoever is ill should be given the treatment they need...But then [as a result of the deliberation] you see the larger picture…and that influences you'. This indicates that the deliberative process got participants to think about the policy issue beyond their individual perspective. This contradicts the contention of some critics of public deliberative forums that people will mainly base their views on personal interest.[25]

Another impact related to the deliberative process was that participants said they learned to realize the difficulties involved in making healthcare policy decisions. As stated by one of the groups in the summary document: 'Following our participation in the Parliament, we came to realize and appreciate the difficult ethical and moral problems the healthcare system faces, and to understand why the heads of the system thought it appropriate to bring these problems to public consultation'. This type of realization was viewed as important by policy makers, and can, according to scholars, enhance trust in government in a positive way.[26] However, as some critics maintain, this realization may also indicate that the deliberative process may have served to co-opt participants' views and prompt them to adopt the dominant stakeholders' perspective.[27] The fact that the summaries and recommendations of the Health Parliament included diverse views may alleviate some of the concern regarding co-optation. The fact that the recommendations of the Health Parliament lent toward 'helping the healthcare system' – even at the expense of equity considerations, is viewed as a positive outcome by some, but may raise concerns among others.[28]

Conclusions

The Health Parliament was a new precedent in the Israeli healthcare system: the first time 'ordinary citizens' had an official venue to discuss healthcare policy issues in a deliberative setting and to present their recommendations to policy makers. Its participants drafted recommendations that were surprisingly compatible across regional groups. In its design, the Health Parliament introduced a novel and controversial feature: the continuing presence of senior healthcare system officials as consultants. Regarding its design and methods, the selection of citizens through a random sample succeeded, on the whole, to recruit a group of people with diverse social backgrounds, who did not hesitate to make recommendations on issues considered by healthcare experts as involving hard choices. However, it remains a challenge on how to recruit and maintain the presence of members of minority groups, new immigrants, and people who have less flexibility in their work hours.

The Health Parliament succeeded to elicit a deliberative process. However, although participants' policy recommendations were presented to and acknowledged by the Minister of Health, and were informally cited by senior healthcare officials, it is difficult to determine its actual impact on the system. Some critics expected a more concrete official response, similarly to those who maintain that an official response is a necessary condition for a citizen consultation.[29] Perhaps one of the reasons that the recommendations did not have an immediate and tangible impact on current policy was that the policy questions regarding rationing criteria were framed in a broad manner, and the policy questions regarding equity were not on policy makers' immediate decision agenda. In addition, from the outset there was no mechanism for an official response incorporated in the process.

Despite official endorsement from the Health Council, the readiness of participants and their strong commitment to continue the process (groups of participants actually petitioned to continue), and the proven feasibility of public consultation on difficult and sensitive health policy issues, the process was not integrated in the health policy and decision-making process. Perhaps, the reason that Health Council members did not adopt the Health Parliament as one of their own activities is because they felt that their own participation as public representatives in the council is sufficient. Nevertheless, both the Ministry of Health and the health funds have expressed a strong interest to involve the public in a meaningful way in healthcare policy deliberation. As shown in other countries, public consultation can contribute to policy making not just in the area of rationing and equity. There are many pertinent issues on the current health agenda that raise controversy and ethical dilemmas, including reproductive cloning, embryo research or dilemmas in organ donations. The methodology of the Health Parliament proved to be appropriate to the Israeli context: its participants came from diverse backgrounds, were highly committed to the process, and a dialogue was created not only between them but between participants and members in the healthcare system. A remaining challenge, therefore, is to find a way to integrate such a deliberative consultation as an on-going feature in the healthcare system.

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