

Recruiting for Engagement in Health Policy

Joanna Massie & Katherine Boothe

Introduction

We know that *who participates* in public and patient engagement processes, and *in what capacity* they participate, matters. Are participants contributing on the basis of their lived experience with the health system, or on the basis of broad “public values”? Are a diverse range of participants and perspectives given meaningful opportunities to participate? How does the process of recruiting participants for public engagement shape the outcomes of these processes, and their legitimacy?

Our team’s survey of [public engagement in health policy in Canada](#) over the last twenty years found limited evidence of recruitment efforts that are specifically designed to draw on the perspectives of marginalized or underrepresented groups (Dhamanaskar et al., 2022). Our colleagues’ research on [Black community-led engagement](#) also demonstrates crucial gaps in who is engaged in Canadian health policy (George and Abebe, 2022). These gaps and failures have implications for the legitimacy of public engagement projects. When certain individuals and groups are systematically excluded from engagement, these processes may fail on both technical and democratic grounds. That is, they don’t get the necessary information or perspectives for policymakers to make good decisions, nor do they meet democratic goals related to representation and inclusion.

Faced with these challenges, researchers and engagement professionals often turn to “better” recruitment, and the adoption of technical fixes to “reach the hard-to-reach.” Epstein (2008) calls this focus on technical improvements to the selection and retention of participants “recruitmentology”, and argues that improvements to recruitment should instead be “focused attention on issues of trust, collective memory, and power relations” (Epstein 2008, 823). Rowland and Kumangi

(2018) explore how a lack of clarity about the representative role patients are intended to play affects both the patient experience and related process outcomes. In a recent *Matters of Engagement* podcast episode, Dr. Nav Persaud warns against the propensity to equate diversity with equity when it comes to recruiting public and patient participants without addressing wider, systemic barriers to equity and diversity in the system (Persaud 2021).

There are thus important concerns about “recruitmentology” as a solution to the persistent exclusion of certain individuals, communities, and perspectives in public engagement. These problems are a key focus for our team’s research on the future of public engagement in health policy in Canada. Our goal is to facilitate more nuanced conversations about recruitment for public engagement, and prompt new research about the connections between who is engaged and how engagement meets its democratic and scientific objectives.

Recruitment methods, costs and benefits

Recruitment methods for public engagement can be categorized into a few broad approaches. Here, we briefly define these methods and consider their costs and benefits related to [representation](#) and [legitimacy](#).

Self-selection

Self-selection, where individuals learn about the engagement activity and choose to participate on their own, was the most common method of recruitment in our team’s survey. Self-selection, in theory, “promotes a kind of universal opportunity for participation that ostensibly ignores social circumstances” (Beauvais 2018). Beauvais goes on to note that “the primary benefits of self-selection include ease of implementation,” yet she and other authors have described a range of challenges, mostly focused on the fact that social circumstances *do* strongly influence who is able to self-select into an engagement opportunity. Fung (2006, 67) notes that when participants self-select, the resulting groups “are frequently quite unrepresentative of any larger public. Individuals who are wealthier and better educated tend to participate more than those who lack these advantages, as do those who have special interests or stronger views.” In the worst case scenario, self-selection uses the guise of “openness” to absolve organizers from careful consideration of the groups and individuals whose contributions are necessary to achieve the expressed goals of the process.

Stratified random sample

An alternate approach to recruitment that seeks to address issues of representation is “stratified random” selection, in which participants are randomly selected but within confines of certain demographic criteria. Individuals can choose to volunteer after receiving an initial invitation and participants are randomly selected from the pool. In this way, stratified random sampling addresses the imbalance in opportunity present in self-selection; the sample can draw a (statistical) microcosm of the public, and in doing so, can go some way to

overcoming traditional barriers to engagement such as socioeconomic status (Fishkin 2018; Smith 2009). It is also possible to sample for particular target demographics to reflect “politically salient characteristics from within the wider population” (Smith 2009). For example, the sampling process can ensure a representative population of people not affiliated with a family health practitioner (Massie forthcoming) or patients with chronic health conditions (Bentley et al 2019). Such models are most commonly used in deliberative democracy, wherein a small but statistically representative group meet to learn from each other; seek common ground; and build a shared vision (Fung 2003). One example of this is in Deliberative Mini-Publics, a subject of study in this project (Kuang and Abelson, 2022; Massie, forthcoming).

Stratified random sampling is, however, not a panacea to issues of representation: there is an element of self-selection in who chooses to volunteer, and the process itself is time-consuming and “pose[s] significant logistical dilemmas” in bringing participants together (Ryfe and Stalsburg 2012, 51). Statistical representation also does not guarantee substantive representation in discussions; without consideration given to structure and facilitation of the activity, there is a risk that the engagement can perpetuate existing power dynamics (Beauvais 2018).

Targeted recruitment and appointment

When a random sample is not possible or appropriate, targeted recruitment and appointment processes may address some of the pitfalls of self-selection. For targeted invitation, individuals receive an invitation to apply based on factors such as expertise or knowledge. For appointments, individuals are initially recruited through open advertisements and/or invitations to apply, and from the application pool, candidates are selected to engage. An appointment process implies an assessment process after individuals apply to ensure some criteria for participation are met (Dhamanaskar et al., 2022).

These methods may involve selectively recruiting from groups that are less likely to engage, or setting explicit or implicit criteria for the skills, experiences, and characteristics necessary to fulfill the participant role (Fung 2006, El Enany et al 2013). For example, the Ontario Government’s *Roadmap to wellness: a plan to build Ontario’s mental health and addictions system* sought input from health system leaders, community organizations, and other governmental actors - but also specifically sought input from “people with lived experience of mental health and addiction issues, their families and caregivers” (Government of Ontario, 2020).

There is a risk that these methods of recruitment may replicate some of the problems of self-selection if they privilege the “usual suspects”, people organizers have an existing relationship with, and/or those who have previous experience with patient engagement. They can also present distinct challenges: for example, El Enany, et al. (2013) have documented the ways only inviting or appointing people with a particular set of skills can lead to a professionalization of participants and their loss of legitimacy with the group they purport to represent. Targeted

recruitment and appointment runs the risk of trying to have the participants “fit” the process rather than the other way around.

There is also a risk that a combination of self-selection and targeted recruitment and/or appointment can informally exclude certain participants by using narrow norms of engagement. Glimmerveen, Ybema, and Nies’ (2021) study of community engagement in a long-term care organization in the Netherlands finds that critical voices were excluded from the engagement process by organizers and more supportive participants because they violated the norm of “constructive engagement.” In this case, participants who were critical of the process were characterized by organizers and other participants as “too loud,” “not saying anything substantial,” or not really looking for solutions, and thus their participation was deemed illegitimate (Glimmerveen, Ybema and Nies, 2021, Table 2).

The problem of replicating issues of self-selection may be relatively easy to see and therefore avoid, although moving beyond “the usual suspects” has costs in terms of time and resources. The problems of professionalization of participants leading to a loss of legitimacy, and an informal exclusion of critical voices are more subtle, and may require fundamental changes to the ways an engagement process is designed and implemented. It is not just a matter of “recruiting better”, it is also a matter of ensuring that the engagement process is able to accommodate and metabolize the contributions of a wider range of participants.

Conclusion: A call for comparative research and for reflexive recruitment

Public engagement in health has well-documented issues in the composition of participants. However, a shift towards what Epstein (2006) terms “recruitmentology”, or increasingly technical methods of choosing participants, are not a panacea to these issues.

For researchers in the field of public engagement, we suggest more attention to comparative research that explores the ways in which recruitment affects both the process of the engagement itself, and the outcomes that follow. Few comparative studies explore this question, which has led to a lack of both understanding and articulation of the impact that different recruitment methods have on engagement. This is an area of forthcoming research for one of us that examines two cases where practitioners chose deliberation as their method of engagement, but chose two very different approaches for recruitment: stratified random sampling and self-selection (Massie, forthcoming).

For practitioners doing public engagement, we suggest meaningfully considering what they are trying to achieve and how recruitment may shape their ability to realize these goals. We urge practitioners to be reflexive in their engagement activities: in addition to considering who they would like to participate in engagement processes, consider what barriers to participation exist. These could be logistical (costs, location, time) – but they could also be experiential (how safe, welcoming, and inclusive the space feels; whether the institution has the capacity to hear different perspectives and institute change). In some instances, the best

solution may not be a marginal adjustment to standard recruitment methods, but instead a process of public engagement that turns “recruitment” on its head by seeking out community-led engagement where affected groups determine the terms on which they contribute to the policy process, and decision-makers adapt to receive these contributions (George and Abebe, 2022).

Practitioners should not feel that they are starting from scratch with these conversations. They are complex, but there are already tools and resources to help avoid common pitfalls in recruitment and ensure more meaningful engagement (see for example the [McMaster Public and Patient Engagement Collaborative Website](#), the [Centre of Excellence on Partnership with Patients and the Public](#), or explore other resources on our [project website](#)). We hope the questions and challenges we raise here create space for novel understandings of public engagement, where groups and communities can exert agency over how, when, and why they engage with policy makers.

***Joanna Massie** is a PhD student in Political Science at McMaster University. Her research explores deliberative democracy and public opinion, and relationships between citizen and state. She is a Fellow in the Digital Society Lab at McMaster University, and was an inaugural Fellow of the Public Engagement in Health Policy project. She is also a Research Assistant with the Public Engagement in Health Policy team.*

***Dr. Katherine Boothe** is an associate professor in the Department of Political Science and a member of the Centre for Health Economics and Policy Analysis at McMaster University. She studies health and social policy in mature welfare states, with a focus on pharmaceutical policies and public engagement in health policy. Her current research focuses on the role of patients and the public in health policy decision making, and the role of ideas about evidence and legitimacy in health policy decisions. She earned her PhD in political science from the University of British Columbia.*

This essay was prepared by members of the Public Engagement in Health Policy team, which is supported by the Future of Canada Project at McMaster University. Please visit www.engagementinhealthpolicy.ca for further research outputs and resources.

References

Beauvais, E. (2018). Deliberation and Equality. In A. Bächtiger, J. S. Dryzek, J. Mansbridge, & M. Warren (Eds.), *The Oxford Handbook of Deliberative Democracy* (pp. 143–155). Oxford University Press.
<https://doi.org/10.1093/oxfordhb/9780198747369.013.32>

- Bentley, C., Peacock, S., Abelson, J., Burgess, M. M., Demers-Payette, O., Longstaff, H., Tripp, L., Lavis, J. N., & Wilson, M. G. (2019). Addressing the affordability of cancer drugs: Using deliberative public engagement to inform health policy. *Health Research Policy and Systems*, 17, 17.
<https://doi.org/10.1186/s12961-019-0411-8>
- Dhamanaskar, R., Abelson, J., Boothe, K., Massie, J., You, J., Just, D. & Kuang, G. (2022). Trends in Public Engagement in Canadian Health Policy from 2000 - 2021: Results from a Comparative Descriptive Analysis. *Public Engagement in Health Policy*.
https://static1.squarespace.com/static/5fd79baad033e06212495160/t/61e70e2826b3ea4a7c9ddc6d/1642532393787/2022_Case_Report_FINAL.pdf
- El Enany, N., Currie, G., & Lockett, A. (2013). A paradox in healthcare service development: professionalization of service users. *Social science & medicine*, 80, 24-30.
<https://www.sciencedirect.com/science/article/pii/S0277953613000166>
- Epstein, S. (2008). The Rise of 'Recruitmentology': Clinical Research, Racial Knowledge, and the Politics of Inclusion and Difference. *Social Studies of Science*, 38(5), 801-832.
<https://journals.sagepub.com/doi/abs/10.1177/0306312708091930>
- Fishkin, J. (2018). *Democracy When the People Are Thinking: Revitalizing Our Politics Through Public Deliberation*. Oxford University Press.
- Fung, A. (2003). Survey article: Recipes for public spheres: Eight institutional design choices and their consequences. *Journal of political philosophy*, 11(3), 338-367.
<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.320.6008&rep=rep1&type=pdf>
- Fung, A. (2006). Varieties of participation in complex governance. *Public administration review*.
<https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1540-6210.2006.00667.x>
- George, R. and A. Abebe. (2022). Unpacking the 'Public' in Public Engagement: In Search of Black Communities. *Public Engagement in Health Policy*.
<https://www.engagementinhealthpolicy.ca/blog/unpacking-the-public-in-public-engagement-in-search-of-black-communities>
- Glimmerveen, L., Ybema, S., & Nies, H. (2021). Who Participates in Public Participation? The Exclusionary Effects of Inclusionary Efforts. *Administration & Society*, 00953997211034137.
<https://journals.sagepub.com/doi/pdf/10.1177/00953997211034137>

- Government of Ontario. 2020. [Roadmap to wellness: a plan to build Ontario's mental health and addictions system](https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system). Queen's Printer for Ontario.
<https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system>
- Kuang, G. and Abelson J. (2002). Assessing good practice in the online public sphere: A descriptive evaluation of virtual deliberation in the COVID-19 era. *Public Engagement in Health Policy*.
https://static1.squarespace.com/static/5fd79baad033e06212495160/t/6231fdb43c488128e7c21486/1647443384621/Assessing+good+practice+in+the+online+public+sphere_FINAL.pdf
- Massie, J. (Forthcoming). Deliberation as a method of public engagement in health. *Public Engagement in Health Policy*.
- Persaud, N. (2021). [Equity, diversity, and patient engagement](https://mattersofengagement.com/equity-diversity-and-patient-engagement-with-nav-persaud/). Interview on *Matters of Engagement* podcast, November 16, hosts Jennifer Johannesen and Emily Nicholas Angl. <https://mattersofengagement.com/equity-diversity-and-patient-engagement-with-nav-persaud/>
- Rowland, P., & Kumagai, A. K. (2018). Dilemmas of representation: patient engagement in health professions education. *Academic Medicine*, 93(6), 869-873.
https://journals.lww.com/academicmedicine/FullText/2018/06000/Dilemmas_of_Representation_Patient_Engagement_in.30.aspx
- Ryfe, D. M., & Stalsburg, B. (2012). The Participation and Recruitment Challenge. In T. Nabatchi, J. Gastil, M. Leighninger, & G. M. Weiksner (Eds.), *Democracy in Motion: Evaluating the Practice and Impact of Deliberative Civic Engagement*. Oxford University Press.
<https://doi.org/10.1093/acprof:oso/9780199899265.003.0003>
- Smith, G. (2009). *Democratic Innovations: Designing Institutions for Citizen Participation*. Cambridge University Press.
<https://doi.org/10.1017/CBO9780511609848>