

Governance and Public Involvement in the British National Health Service: Understanding Difficulties and Developments

Abstract

The article considers the role of public involvement in the NHS in the context of the wider shift from government to governance. Based on a comparative case study, it identifies different outcomes, from a single policy initiative in two localities. It argues, following Jessop, that accounts which rest on inter-organizational relationships are inadequate, and that we also need to look at inter-systemic and inter-personal levels for more complete explanations. Investigating the relationships between these levels, we derive an account of governance within which to situate the role of public involvement. It is against this background that we focus on why the **methods** of involvement deserve greater attention for their substantive contribution to its quality and effectiveness.

Keywords

Community participation, public involvement, citizenship, governance, PCTs

Introduction

This article examines the role the public can play in the ‘policy space’ (King and Stoker, 1996) created by the shift from government to governance, using insights from research in two primary care groups/trusts (PCG/Ts). These organisations were inserted into an NHS said to be changing from its traditional monolithic, hierarchical form to a looser

network structure (Milburn, 2003)¹. Burns et al (1994) have argued that the more pluralistic institutional environment created by the move from hierarchies of government to networks of governance, offers better possibilities for democratic involvement than traditional representative systems. They suggest that ‘an adequate democratic project must centre itself upon recognition of the need for a plurality of power bases, modes of expression and participatory forms’ (p282). Plurality alone, however, seems likely to be insufficient to achieve the desired objectives. Research into public participation in primary care has previously identified a danger that ‘initial efforts to engage communities will become little more than token gestures’ (Alborz, Wilkin and Smith, 2002, p26) in view of the difficulties involved. As relationships of accountability change, the potential for meaningful participation remains open to question. In their review of the role of participation in health care in the 1990s, for instance, Milewa et al (1999) argued that involvement was best conceived as based on ‘active management’ and professionalisation rather than active citizenship, because the citizen lacks the knowledge required to participate fully in the complex responsibilities of health care planning. Our own empirical research (authors 2002) identified both the limited effect of exhortations to involve the public and the distinctive impact of the different *ways* in which PCTs engaged with them.

In this article we suggest that an analysis founded solely in the democratic basis of legitimacy ignores other motivations for public involvement. We draw on Jessop’s account of heterarchy and Bang’s discussion of participation to identify a a range of

¹ 498 PCGs were established during 1998, as subcommittees of Health Authorities, to cover ‘natural communities’ of 100,000 people. They had three main roles: to improve health; develop primary care; and commission secondary care. General Practitioners chaired their Boards and were numerically dominant, though nurses and social services were represented and there was also one lay member. PCGs were replaced by PCTs, freestanding bodies with their own budgets, a lay chair and a lay majority on the board.

motivations present within a stratified system. It is only by understanding their influence that we can account for the particular place that participation holds in a given locality. Based in a critical realist approach to the interaction between structure and agency we argue that it is not diversity *per se*, but how relationships are structured in diverse environments, that is more significant in shaping the local space for public involvement. The very indeterminacy of this space means that the approach chosen to channel communication between PCTs and the public can be critical in determining how far participation is real rather than token.

Governance and Primary Care

‘Reforms’ to local government and the NHS in the 1980s and 1990s impacted significantly on local democratic accountability (King and Stoker, 1996). In particular, they tended to overlay the direct accountability of elected representatives with self-organising networks of local organizations, mixed economies and partnership working, thereby shifting the emphasis from government to governance (Stoker, 1996, 2000). Public involvement within the hierarchical structure of the NHS has historically consisted of limited agendas and formal advisory roles. Such initiatives were originally aimed at securing consumer feedback and advice (Griffiths, 1983; Department of Health 1992; Wistow and Barnes, 1993).

The public involvement policy embodied in ‘Local Voices’ (Department of Health, 1992), advocated the importance of listening to local communities, but in practice, focused primarily on developing methods of consultation about satisfaction with existing services (Milewa, 2004). Yet, although a wide range of methods has been used, such exercises have yielded little information about user definitions of needs, priorities or

outcome (Avis, Bond and Arthur 1997; Williams, Coyle and Healy, 1998; Dougall et al 2000). More generally, evidence that involvement has a meaningful place in decision-making is sparse (Skelcher, 1993; Gilliat, Fenwick, Alford. 2000; Farrell 2004). As we have shown elsewhere, these limitations can be explained by the underlying structures of power, which have permeated the NHS and its decision-making processes (Authors, forthcoming). Such relations of power were, in turn, linked to the relative influences of medical or social models of health. To understand the role accorded to public involvement in primary care, it is necessary to understand the values and ideologies embedded in those structures and, consequently, in the methods adopted to advance it. Historically, scientific rationalism provided the dominant value structure in an NHS in which medical and associated clinical professions have prevailed. Harrison (2002) argues that the process of modernisation in the service was similarly founded in “scientific-bureaucratic” values, that privilege randomised controlled trials and independently observed, rather than patient experienced, measures. This approach has emerged, he suggests, in order to manage an emergent consumerism.

We suggest here that insufficient attention has been given to the impact of the shift to governance on public involvement in the NHS. Further, we argue the need to view approaches to involvement as both signalling and reproducing these changed bases of legitimacy. We explore these ideas by reflecting on the divergent findings from case studies in two localities, selected for similarity of locality profile, national policy frameworks and regional performance management structures. In particular, we seek to explain our primary finding, the emergence of two distinct approaches to involvement, each implying different trajectories for public participation in local governance structures.

The term 'governance' has been used so loosely that it has been described as, 'a "weasel" word- slippery and elusive, used to obscure not to shed light' (Bevir, Rhodes and Weller, 2003. p41). Conceiving of governance as providing 'policy space' is useful in expressing the indeterminate nature of policy direction in self-organising governance networks.

While policy may be defined centrally, it is implemented in a space determined by the interaction of national and local factors rather than through specific prescriptions for action. As a result, linearity and central direction have become inappropriate concepts for understanding policy processes. The existence of a centrally defined policy to legitimise the public voice is but one, admittedly important, element framing public involvement.

Jessop defines governance as:

'the reflexive self-organization of independent actors involved in complex relations of reciprocal interdependence, with such self-organization being based on continuing dialogue and resource-sharing to develop mutually beneficial joint projects and to manage the contradictions and dilemmas inevitably involved in such situations, (Jessop, 2003. p1).

This approach, he suggests, has the advantage, of distinguishing governance from methods of central control or market exchange. It neither assumes symmetry in power relations nor equality in the distribution of benefits. Jessop also argues that governance should be conceptualised as heterarchy rather than focusing on inter-organizational networks alone. Three forms of heterarchy are distinguished, based in: interpersonal networking; the self-organization of inter-organizational relationships and 'more programmatic or mission oriented inter-systemic steering'. These three forms are 'often

linked in tangled hierarchies' and, Jessop argues, the move toward governance is driven by increasing societal complexity in which legitimacy can only be sustained by the representation of multiple stakeholder interests.

Associated with each form of governance is a particular rationality. Heterarchical governance replaces the procedural rationality of the market and the substantive rationality of the state with reflexive rationality. In its very essence this rationality is dialogic. We will go on to argue that the nature of this dialogue in primary care, who is included or excluded, and how actors are involved, is both evidence of the basis of legitimacy and is instrumental in producing it.

Heterarchy and Primary Care

In government through hierarchy, the inter-systemic basis for legitimate involvement comprises the direct expression of professional authority and the indirect expression public voice through elected representatives and professionals. By contrast, in network governance, the *direct* voice of the public is, in principle, accorded increased legitimacy. One of the stated aims of introducing PCTs was to enable the NHS 'to re-connect' with local publics (Department of Health, 2001).

This formal objective was consistent with the view that governance can:

'be seen, in theory, as a means of promoting participatory democracy where existing institutions are restructured and new ones are created, in order to mobilise and implicate more citizens and social groups in the management of local affairs

(Maloutas and Malouta, p456 2004)

However, as these authors argue, its very flexibility leaves it open to manipulation by the better organised and more powerful, whether these be professionals, managers or, in some cases, user groups. We will suggest this vulnerability to colonization stems, in part, from contradictions existing within the heterarchical system and which, in turn, frame the space within which public involvement is possible.

The systemic level

The systemic level in Jessop's heterarchy is important in establishing the form of democratic legitimacy which underpins the whole system. While UK governance structures have been seen to be developing in the context of an advancing neo-liberal ideology and associated state practices, this process is not one-dimensional. Milewa (2004) suggests that the UK welfare state represents a compromise between the extremes of 'individual responsibility' and 'enforced altruism'. 'Enforced altruism' suggests a paternalistic state/citizen relationship, while 'individual responsibility' identifies a non-collective basis for the public's voice. In reality the system sustains strands of social democratic and neo-liberal types simultaneously (EspingAnderson, 1992) suggesting that both bases of legitimacy remain relevant. This is reflected in the co-existence of both a hierarchical model of modernisation (Harrison, 2002) and the increasingly individualised basis of organisation founded in consumer choice (6 and Peck, 2004)

The changing role of the state and its relationships with the public as citizen/consumer at this systemic level necessarily underpins expectations about the proper role of stakeholders in governance. Bang (2004) has introduced the notion of 'culture governance' to identify the divergence between the straightforward translation of neo-

liberalism into New Public Management and the repoliticisation of the ‘connections between the public institutions and everyday life’ (p171). The implication of Bang’s argument is that we need to disentangle these grounds of legitimacy that have been elided in many discussions of involvement. While the public may be described as though it were a single entity, the relationships of the state to the public as citizens and consumers need to be distinguished. Moreover, the co-existence of different frameworks of legitimacy is a source of ambiguity, at locality level, about the status of those involved. In this context, therefore, it is important to examine how accountability mechanisms are developing to accommodate the public’s twin roles of citizen and consumer.

Inter-organisational level

At the inter-organizational and inter-personal levels, Primary Care Trusts work in partnership with other health and welfare organizations, with patients and the public in the locality. As newly formed organizations, PCTs had opportunities to join existing networks of service organisations and create new sets of relationships with users and the wider public. The requirement to focus on improving the health of individuals and the public implied a departure from the traditional emphasis on direct service delivery toward understanding health status as the product of a wide range of socio-economic conditions (Department of Health, 2001, Wistow 2001). It is here that the normative connotation of governance, based in its apparent ability to overcome the fragmented responsibilities for the NHS and the underlying socio-economic causes of ill health, assumes particular significance. To operationalise a social model of health, the public and patients must be included as stakeholders in these inter-organizational networks. At this inter-organisational level, however, Bang (2004) suggests that the primary motivation to

involve the public lies in its ability to facilitate efficient service delivery rather than to extend public influence over new policy or service design.

At the inter-systemic and inter-organisational levels of health governance, therefore, two related processes are potentially occurring. First, new relationships are being established between networks of state actors promoting public engagement as a means of enhancing organisational effectiveness, as exemplified in the notion of ‘culture governance’.

Second, a changing legitimacy is accorded to the public voice, deriving from the changes inherent in modernity and widespread challenge to the authority of the expert (authors forthcoming).

Interpersonal level

While the inter-personal level is often treated as the context in which agency can most readily be detected, critical realism points to the presence of agency within structure, and of structure within agency. The relationship is expressed by Bourdieu who emphasises the ‘social at the heart of the individual’ (p89,1992)), and we have discussed its impact in the field of health elsewhere (authors forthcoming). Relationships operating at the interpersonal level are shaped by, and shape, inter-organizational relationships and together they interact with the inter-systemic level as our empirical account will seek to show.

Heterarchy, Primary Care and Public Involvement

Exploring the concept of heterarchy and how it operates in practice helps us to understand why different outcomes emerge from similar inter-organisational structures.

The creation of a set of ‘complex relations of reciprocal interdependence’ cited earlier (Jessop 2003), necessarily yields structures that emerge from historical and local factors and are, therefore, widely divergent. In addition, Rhodes (1997) has identified the continuity of some hierarchical forms so that they coexist with network forms of organization. Turning to the role of the public, this complexity is compounded by the gaps between official discourses of involvement and the realities of implementation. Although interests outside traditional organizational structures are voiced, they have frequently been colonized by managers and professionals to advance their own interests (Mort et al 1996, Mort and Harrison 1999, Milewa et al, 1998). Indeed, the existence of multiple rationales for public involvement itself suggests the absence of a clearly defined and accepted role for it. In the subsequent account, our two case studies are used to reflect on how primary care organizations engage with the public. In doing so, we recognise that both are grounded in the same inter-systemic context but suggest their interaction with inter-organizational and inter-personal levels shape different opportunities for voice in each locality. We argue that we must consider the methods employed to enlist involvement, not merely in terms of technical questions of effectiveness, but rather as signalling the nature of the local welfare system within which they are embedded. Thus, the form of involvement achieved between boards and the public is evidence of wider relations of governance including the competing claims of consumerism and citizenship and the reconciliation of marketised and social democratic models.

The research

Our empirical research was an NHS-funded exploratory study of ways boards were beginning to involve patients and the public in decision making. The reflections developed in this article did not form substantive questions in the original enquiry, whose principal aim was merely to identify early approaches to involvement. The fieldwork evidence helps to illustrate the theoretical ideas developed out of that enquiry.

The research design was multi-method, including attendance at public and at three board meetings in each locality, analysis of documents and unstructured interviews. The evidence below draws from twenty interviews, conducted with a range of board members including the Chair, Chief Executive, GP, Nursing and Lay members. For the purposes of this article, we have identified respondents by locality and number because our focus is not upon differences of approach within boards, but upon relationships between boards and communities. Further, our commitments to confidentiality, means that it is not possible, in a local study, to identify people according to role.

Two localities were selected on the basis of similarities in socio-economic profiles and geography, location within a common national policy framework and subject to the same regional performance management regime. Yet, real differences in approach were emerging in which, even at an early stage, different value systems and relationships between primary care organizations and their communities were becoming evident. We outline these differences of approach before going on to consider their origins.

Approach to Involvement: Locality 1

Locality 1 had a significant rural population but it also contained a large urban centre.

This geographic structure may have been one element shaping approaches to

consultation. Historically, new initiatives had been aimed first at the urban population while those for the rural part of the locality had followed if, and when, funds permitted. Consequently, formal participatory requirements could be satisfied by accessing the central population.

In locality 1 the PCG had developed relationships with social services, housing department and the voluntary sector, but conceived of consultation as gathering direct opinion on the services it offered. The board's focus was on the practical difficulties of accessing 'public opinion', conceptualised as being 'informed' versus being 'representative'. The approach was to identify local opinion as merely one source of advice for the board to consider in its decision making process, much in the way that Milewa et al (1999) relate in their research following 'Local Voices' (1992). While this enables information to be gathered about the local community and its views, there is no reciprocity involved in the relationship established. The approach acknowledges inter-organisational and inter-personal networks which treat the public voice as subordinate. The necessary consequence of seeking representativeness on these terms was to define the public as reactive, choosing between alternatives proposed by the board, registering wishes and beliefs for the board to take into account, but lacking any active voice in selecting the issues for consideration.

Approach to Involvement: Locality 2

Locality 2, although also rural in character, had a different internal geographic profile, giving rise to different organisational structures of governance. The population was dispersed over a distance of 40 miles but possessed no significant population centre in which to concentrate participatory processes. Existing agencies had addressed this

problem by developing networks of sub-locality organizations based in the 'natural' geographical areas. Thus the PCG joined an established network structure which shaped both its inter-organizational relationships and the interactions it established with the public.

In Locality 2, the search for 'representative public opinion' was abandoned in favour of developing *processes* of communication. This took the form of dividing the locality into three 'natural communities'. Based on the prior experience of other organizations the PCG saw these areas as internally coherent bases for consultation, through pre-existing network structures linking communities, agencies and boards. Moreover, relationships with the public were conceived as multiple, dynamic and developing. Their purpose was to achieve shared understandings within complex and changing settings rather than feedback through responses to pre-formulated questions.

The remainder of this paper aims to account for the different trajectories in public involvement that we have identified in localities sharing many structural features. We explore, therefore, how far the framework sketched above might help us understand such different outcomes. In particular, we consider how far Jessop's (2003) definition of governance as heterarchy provides insights into the structures and processes through which significantly different relationships between PCT boards and their publics could emerge. Three principal dimensions of similarity and difference were identified from our fieldwork in the two localities: their conceptualisation of the public; their selection of approaches for public engagement; and their understanding of each PCT's role as

improving health services or improving public health. As we will demonstrate, these divergences in thinking and understanding are themselves interdependent and mutually reinforcing, originating, as they do, in the extent to which scientific rationalism predominates at the systemic level of governance the NHS.

Defining the public

The requirement to involve the public has been made clear by the Department of Health but little has been specified beyond this general objective (Department of Health, 2001b). Policy guidance on the involvement of stakeholders has frequently conflated the roles of public, patient, consumer and citizen (Department of Health, 2001). Yet, clarity about the grounds upon which involvement is sought is crucial to understanding its purpose and intended consequences for decision-making. While the user may be consulted because of their specific experience of services, the public are consulted because of their status as citizens. The rhetoric of New Labour has favoured an interpretation in which stakeholder status comes from membership of the community and the belief that participation reinforces the fabric of civil society (Newman, 2001; Perri 6,2004). However, Bang (2004) argues that, at the inter-organisational level, the prime rationale for participation is improving efficiency rather than democracy.

The inter-systemic concern with democracy should, in principle, produce considerable common ground about involvement rooted in citizenship. Yet, we found major areas of uncertainty in both boards about the legitimacy of either citizenship or consumerism as the primary basis for involvement and the forms that it took. Moreover, there was

consensus that their greater levels of knowledge and expertise justified the boards retaining power over decision making:

We have to listen to everything and it doesn't mean that the public's views are any less than anybody else's but they have to fit with the bigger picturebecause that will establish what our relative priorities are. ..(2:2)

It was frequently claimed that boards had the advantage of a wider view in making the most 'rational' decisions about the use of resources, suggesting a hierarchical relationship with the public remained appropriate. This finding supports Jessop's (2003) emphasis on the unequal distribution of power within local governance systems. In both boards, professionals and managers placed emphasis on their responsibility to manage scarce resources effectively in the 'general' interest:

If we try to meet everybody's wishes as opposed to their needs ..., we are doomed to failure. (1:2)

Counterposing unrealistic 'wishes' against well judged provision for 'needs' is clearly a claim to authority based in enforced altruism. While individual responsibility for health status was recognised, it was not used to support arguments for resource allocation and planning

The difficulty in identifying 'the public' also led to questioning the value of consultation. Seen as an attempt to gain a view of the locality as a whole, the task was daunting, perhaps even impossible:

One is always aware that the people who perhaps shout loudest aren't necessarily revealing the ...basic, more general needs of everybody but may be talking about their

own needs.... But it is quite hard....., with a large population, to get everybody's view.

(1:4)

This finding points up the possibility of governance failure. There is, at least, an apparent inconsistency in trying to insert the public, a body potentially at odds with itself, into organizational forms defined by Jessop as ones of 'reciprocal interdependence' to develop 'mutually beneficial joint projects' (2003).

These concerns about the diversity of public views were common to members of both boards. Indeed, they severely inhibited their acceptance of either the citizen or consumer role as a sufficiently legitimate basis for the public to shape decisions about health and health services compared with their own expert knowledge. While this perspective might appear consistent with the notion of enforced altruism, it is not consistent with citizenship as the legitimate *basis* for decision-making. Rather, it reveals that it is the board that determines both the collective good and the knowledge base on which such decisions can legitimately rest. As will become apparent below, this knowledge base remains heavily influenced by traditional scientific rationalism.

Approaches to Public Involvement

Critical differences arose from the ways that the boards' views about the role of the public interacted with opportunities for communication and consultation within pre-existing governance structures. We distinguished between the two localities as one seeking a 'snapshot' of local opinion and the other aiming to sustain a dialogue with the community. Each approach affected the nature of governance and its products. Signs of this difference emerge in the routes to consultation taken in each locality and the

subsequent trajectories of involvement. Each route both arises from, and reinforces, different sets of relationships within the respective governance structures.

Locality 1: a snapshot

In locality 1 the board stressed the importance of informing the public of its activities and decisions:

I think a lot of the other PCGs are still holding alternate (open) board meetings. But they (the board) said 'no let's do it, let's have it once a month in public - if we are going to have a row ...then let's have it'. (1:1)

Public involvement was also defined as seeking an accurate view of opinion by including a number of questions on the quarterly 'ratepayers' panel questionnaire in order to 'get a genuine local community public view of some of the big issues (1:2). the issue of representativeness was primary and was being addressed in an attempt to capture 'genuine' public opinion.

I suspect that in fact 99% of it is going to be user/carer involvement, quality monitoring, satisfaction and all that sort of thing. .. and only the borough council is going to be able to demonstrate public participation in terms of seeking views on policy development, prioritising and what have you. (1:6)

In terms of the heterarchical framework, the board established an active relationship at the inter-organizational level, supplemented by information drawn from a more passive/responsive public voice. If the ratepayers' panel was the most accurate way of accessing public opinion, it was nonetheless considered less well informed than user groups, with inevitable consequences for its credibility:

... there is going to be a sort of hierarchy with the panel, perhaps, I wouldn't say the lowest, but probably lower than some of the experienced public member groups. And then perhaps the professionals inevitably, perhaps, having more weight. (1:6)

This approach is not straightforwardly statist. It allows for a New Public Management approach, which recognises the role of the public as consumer combined with continuing hierarchical deference to the professional. The significance of this hierarchy of *informants* is intensified by a hierarchy of *information*. The authority accorded to the 'ratepayers' panel' was based on an assumption that there was an identifiable 'body' of opinion, which was real, relatively stable and could be harvested or gathered in. Consequently, the primary problem was how to collect evidence that spoke for the whole population. While involvement might be secured through a range of methods, they sat within an evidence hierarchy headed by representativeness.

The same hierarchy emerged in considering who should join the commissioning team:

What is a typical member of the public.....if you are trying to choose either one or two members of the public to represent 150,000 people? And is there such a thing at all? (1:5)

The consequence of seeking opinion in this way is that the possibilities/agenda must be pre-defined. The relationship emerging is that of a board engaging actively with its organisational partners but assigning a passive role to the public. This reinforces a hierarchical dyadic relationship, separate from, and therefore not interacting with, the wider network of inter-organisational governance relationships .

Locality 2: a dialogue

In locality 2, the representativeness of public views and the accuracy with which they were captured were seen as less important:

You start to think, 'what sort of representative? Of what?' and that's where I ended up in my disillusionment ... "to hell with this, we are never going to get the perfect representation; let's go with what we've got and be aware of the dangers" (2:6)

Consequently, advantage was taken of formal arrangements that already existed to link communities with agencies and boards, including networks of relationships between community health workers, and the public in three localities..

..we'll have three locality managers ...and they will all have the role of getting to know their local communities and building up links with the agencies and voluntary organizations on their patch. (2:2) -

Moreover, the pre-existing relationships between organizations provided different understandings and experiences of what constituted participation. The networks included relationships between organizations and the public at both local authority and small area level, thereby encouraging an approach in which patients and the public were perceived to be overlapping categories, containing people with multiple roles and relationships with local services.

Unless you're talking to patients you miss the stickiness of situations. You totally miss the fact that a patient isn't just a patient who has had a heart attack, they've got bad backs, they've got arthritis, they've got cancer, they've got a mixture of the three – you know they've just had a bereavement themselves and it just seems to undermine the whole idea of a scientific approach to anything. (2:6)

This rejection of a notion of opinion as stable, separate and measurable is reflected in the relationship being developed between agencies, the public and patients.

.. we just have a health hat on when we look at the bit of the service we provide to them without realising the much wider range of services that they will tap into, starting with their own informal networks and carers at home.....(2:1)

While the public's multiple roles were recognised in Locality 1, there were no organizational structures to reflect this understanding and enable it to shape communications. Separate relationships existed between the board and local organizations and between the board and the public: those with the public were therefore constituted in dyadic rather than network form. In locality 2, such interrelationships bridged organizational boundaries in ways consistent with Jessop's (2003, p6) notion of 'metagovernance', defined as:

'managing the complexity, plurality and tangled hierarchies found in prevailing modes of co-ordination. It is the organization of the conditions of governance and involves the judicious mixing of market, hierarchy and networks to achieve the best possible outcomes from the viewpoint of those engaged in metagovernance'.

This influence was reflected in a discussion of the PCG's potential to become part of a wider network of communications with the public:

There is so much going on in the different areas of our patch.... we've got regeneration zones from social services, ... they've all got their own... ..processes in place to communicate with the local public... I think we need to tap in on things like that and

become part of it, so that people don't have to think too much about the boundaries of these organizations ... (2:5)

If the process of involvement is to become one of dialogue, then involvement in decision-making implies information exchange and debate from an early stage:

....by involving people very early on because it is that that builds ownership to the decisions So we tried to do that right from the early days with our strategy ...document, which was a very early view of some of the priorities in the patch, and at the bottom of every page, just about, was, "this is what we think, what do you think? (2:2)

This approach was further reflected in the creation of an organizational context that emphasised blurring traditional role boundaries:

..part of the joint finance set-up organised by the local authority is the local working groups with a multi-agency representation including the police, education, social services, health and so on. And they are tailor-made for what the Primary Care Group is trying to do which is build the bridges between all these agencies...The community development worker will support those local working groupsand the locality manager will join them as well and try and weld the whole lot together. (2:7)

The reflection of the locality-wide governance structures in these smaller area-based groups has the potential to mediate (although not necessarily to redress) the imbalance of power between board and public and to bring both interests to the table. It legitimises *experience* of the interaction of services as knowledge to be valued as compared with seeking information on isolated and direct service experience

The pursuit of involvement was consequently concerned with allowing flexibility to respond to the outcomes generated by the complex inter-relationship of all three levels of heterarchy:

And I think you need to take your opportunities. You know, if something exists, you need to be in there and building on it and influencing it whether it is organised by another agency or not and it becomes part of your, to use the trendy term, virtual organization ...2:2)

Health Service Improvement And Health Improvement

One of the core functions of the new Primary Care organisations was to support a shift in emphasis from the treatment of disease and disability: to improve the health of the public and its access to more responsive health services (Department of Health,1997, 2000). In turn, this initiative implied extending the influence of a social model of health, founded on a wider definition of what constitutes legitimate knowledge and, thereby, the role of public involvement. Our fieldwork suggested that Locality 1 focused its energies on improving health *services* and worked with partner organisations to achieve this aim (Authors, 2002). Its conception of the public's role was one that emphasised dyadic active/passive relationships consistent with the traditional patient/professional relationship. In Locality 2, the emphasis was on *health* as affected by social and environmental conditions, and the public's contribution in actively creating its own health through its voice in decision-making. This approach was positively reflected in the Board's preference for utilising pre-existing inter-organisational networks as vehicles for public involvement:

.....part of the joint finance set-up organised by the local authority is the local working groups with a multi-agency representation, including the police, education, social services, health and so on and they are tailor-made for what the Primary Care Group is trying to do which is build the bridges between all these agencies.

The significance of these networks signals their support for a social model of health, constituting a recognition that medical knowledge is but one necessary source of information:

...I think the Health Service as a whole, the whole culture of it, is moving away from the medical model to the social model and that's where you start to bring in the public views.

(2:6)

Moreover, the need to challenge the medical model was considered part of the community development role:

I don't know how you felt about (that board meeting).. but I felt it was very medical model-based and a part of a community health worker's role is to try and disrupt that to some extent and get the social model being considered ...and to keep talking about public involvement....

In locality 2, therefore, inter-organisational networks combined with associated structures for community involvement to encourage a different logic for communication with the public, which was supportive of a social/environmental model of health. By contrast, the more restricted approach to public involvement in locality 1, together with

the continuing authority accorded to professional knowledge, also restricted the focus of involvement to feedback on, and the improvement of, existing services.

It was recognised in locality 2 that, in addition to challenging professional influence, pluralistic approaches to decision making had major implications for management:

The NHS has perhaps had a very autocratic management style with rigid hierarchies and, you know, somebody at the top takes the decision, it rattles through and that's what the patient gets at the end of the day and we are trying to move a bit more towards the other extreme of participative management where you are almost managing by persuasion rather than by dictat and that requires quite different managers, really, and management styles ...it takes a lot of.. confidence to let go to some degree those decisions you would have held close to your chest and could have taken comfortably in the knowledge that nobody else was really aware that you were taking them.

It follows, therefore, that 'active management' needs to give ground to 'active citizenship' is public involvement is to be more than another tool for organisational effectiveness.

Conclusion

We began this account by noting that public involvement had been accorded renewed legitimacy in the NHS as part of a wider programme of modernisation designed to secure more responsive and effective relationships between the service and the public. PCGs and PCTs were established by the New Labour government to 'reconnect' the NHS with local publics and deliver different outcomes through greater pluralism in decision-making. We also recognised that public involvement had a record of being more token than real. At

the same time, however, these developments in the NHS were taking place in the context of a wider shift from government to governance in which hierarchical influences were apparently being diluted in more pluralistic local networks potentially providing greater opportunities for public involvement in decision-making.

The exploratory research we undertook was designed to examine how PCG/T boards understood and implemented their responsibilities for public engagement in this new environment. The two localities in which we conducted fieldwork were purposively selected to provide similarities in organisational and other contexts for the implementation of a common policy initiative. We have identified a mixed pattern of similarity and difference in the emerging outcomes from the policy space shared by the boards.

One was a form of governance which took account of networks at the organizational level but retained traditional hierarchical relationships with the public. In doing so, it limited possibilities for the emergence of issues the board had not already placed on the agenda. Moreover, its focus on establishing public ‘opinion’ was in keeping with a consumer-oriented view of the public’s role. In the second locality, network structures cut across that hierarchical relationship and encouraged involvement based on dialogue, the consequence of which was fundamental to both the content and the form of engagement. It also approximated more closely to a public role based on a collective conception of citizenship. The appearance of divergent trajectories within the same (or very similar) policy space requires us to explain the patterning of the processes and outcomes we identified. In particular, we need to consider the relevance of Jessop’s emphasis on

heterarchy. This framework is especially important in shifting the focus of analysis beyond the inter-organisational and interpersonal dimensions of explanation. Professional views and expectations, organizational structures, and the methods adopted to promote involvement, are nested within more fundamental values located at the inter-systemic level. In focusing on that level, we have drawn attention to notions of individual responsibility and enforced altruism as values that are embedded but conflicting within the system. The latter was found to be dominant in that both boards gave primacy to their own 'expert' knowledge. The value of scientific rationalism, which underpins enforced altruism, not only supported the higher value accorded to medical and managerial knowledge, it also validated 'scientific' approaches to public involvement thereby prioritising representativeness over dialogical knowledge. In the secondary role accorded to public voice, two conflicting sources of authority were evident: a consumer orientation that corresponded with 'individual responsibility' and a citizenship status based on collective agency as a further ground of legitimacy.

Our empirical evidence suggests the potential for involvement emerges from the interaction between levels of the heterarchy, providing different kinds of space. In locality 1 success was defined largely by decision making through expert knowledge, supported by public opinion. In locality 2 the social world of the public, its priorities and values assumed greater significance, with the potential to challenge the historic ascendancy of professional and management influences. Thus, the extent of policy space and scope for variations in policy outcomes was not pre-determined by the policy itself, but was contingent on the particular interaction of factors within the two localities. In this respect, our findings are consistent with the concept of 'path dependence' and the

significance of history in creating divergent configurations (Gains, John and Stoker, 2005).

From this perspective, the nature of the space opened up for public involvement does not come from the action of citizens forcing change. Rather, it arises from a combination of: the forms of legitimacy accorded to the voice of the public at the inter-systemic level; relationships that emerge from the interaction of that level with the pursuit of organisational efficiency at inter-organizational level; and the operation of both sets of influences at inter-personal level in relations between local actors. Where this is defined firmly in an active/passive dyad, the scope for the public's voice is limited by the board's definition of the relevant questions and issues for participation. By contrast, where a dialogical approach is adopted in the context of a network of stakeholders, the *space* for plurality of contributions to governance offers potential for the public to have a more fundamental agenda shaping role. The difference between approaches, therefore, is to be explained less in terms of respective enthusiasms to consult the public than about how the underlying legitimacy of public involvement, efficiency seeking, and conceptions of what constitutes consultation, penetrate the policy space.

The legitimacy accorded to the public voice is directly related to how the role of the public is embedded within the system. The multiple conceptions of the public role, which manifest themselves in confusions of status at the locality level, originate in the space created by the inter-systemic bases of legitimacy combined with inter-organisational considerations of efficiency. The contribution of the public voice, in turn,

is not only to provide information to inform the design and delivery of services, but to reinforce, or challenge, the particular manifestation of those system factors.

This article has sought to go beyond the identification of indeterminacy created by the policy space which now constitutes local governance, to consider how we might understand emergent variations. We have acknowledged the importance of the move from hierarchies to networks, as well as of the persistence of both. In this context we have suggested that the role of public participation has been treated simply as one of a plurality of power bases jostling for position. We have suggested that such an understanding must presuppose the public as ‘active citizen’ and that this is far from reflecting the reality of the public role. In order to understand the role the public might play, we have employed Jessop’s conception of heterarchy as a framework expressing the levels at which both structure and agency operate within the system. Policy space then becomes much more than a set of organisational structures and is shaped through an interaction between structure and agency at all levels of the heterarchy. To understand that interaction, however, we must also understand the embedding of values within the system and their impact on its reproduction.

References

6, P. and Peck, E. (2004) “Modernisations”: The Ten Commitments Of New Labour’s Approach To Public Management? *International Public Management Journal*, 7, (1). pp1-18

Alborz, A., Wilkin, D., & Smith, K. (2002) Are primary care groups and trusts consulting local communities? *Health and Social Care in the Community*, 10 (1), pp. 20-27.

Avis, M., Bond, M., & Arthur, A. (1997) Questioning Patient Satisfaction: an empirical investigation in two outpatient clinics. *Social Science and Medicine*, 44, pp85-92.

Bang, H. (2004) Culture governance governing self reflexive modernity *Public Administration*, 82 (1), pp 157-190.

Bevir, M., Rhodes, R. & Weller, P.(2003) Traditions Of Governance: Interpreting The Changing Role Of The Public Sector *Public Administration*, 81(1), pp41-62.

Bourdieu, P. & Wacquant, L. (1992) An Invitation to Reflexive Sociology Cambridge, Polity

Burns, D., Hambleton, R., & Hoggett, P. (1994) The Politics of Decentralisation: Revitalising Local Democracy Basingstoke. MacMillan

Cabinet Office (2000) *National strategy for neighbourhood renewal*. Social Exclusion Unit www.cabinet-office.gov.uk/seu1/publications/reports/html/nat_strat_cons/contents.htm

Authors (2002) *Public and Patient Participation in Primary Care Groups: New beginnings for Old Power Structures*. Leeds. Nuffield Institute for Health

Authors (forthcoming) *Publics, Patients, Citizens, Consumers? Power and decision making in Primary Care*. *Public Administration*

Department of Health (2000) *NHS Plan: The Government's Response To The Royal Commission On Long Term Care* London. Stationery Office.

Department of Health (2001) *Shifting the balance of power in the NHS* London : Department of Health Publications.

Department of Health (2001b) *Involving Patients And The Public In Healthcare: Discussion Document* London : Department of Health Publications.

Dougall, A., Russell, A., Rubin, G., Ling, J. (2000) *Rethinking Patient Satisfaction: Patient Experiences Of An Open Access Flexible Sigmoidoscopy Service*. *Social Science and Medicine*, 50 pp53-62.

EspingAnderson, G. (1999) *Social Foundations of Postindustrial Economies* . Oxford. Oxford University Press

Farrell, C. (2004) Patient and public involvement in health the evidence for policy implementation. Department of Health.

Gains, F., John, PC., Stoker, G. (2005) Path Dependency And The Reform Of English Local Government. *Public Administration*, 83 (1) pp24-45.

Gilliatt, S., Fenwick, J., & Alford, D. (2000) Public Services and the consumer: empowerment or control? *Social Policy and Administration*, 34(3), pp.333-349.

Hambleton, R. (1988) Consumerism, decentralisation and local democracy *Public Administration*, 66, p125-147.

Harrison, S. & Mort, M. (1998) Which champions, which people? public and user involvement as a technology of legitimation *Social Policy and Administration*, 32(1), p60-70.

Hunter, D. & Harrison, S. (1997) Democracy, accountability and consumerism in S. Iliffe and J. Munro (eds) *Healthy choices: future options for the NHS* Lawrence Wishart

Jessop, B. (1998) The Rise Of Governance And The Risks Of Failure: The Case Of Economic Development. *International Social Science Journal*, 50, 155pp29-46.

Jessop, B. (2003) Governance and Metagovernance: on Reflexivity, Requisite Variety and Requisite Irony <http://www.cddc.vt.edu/host/lnc/papers/JessopGovernance.htm>

King, D. & Stoker, G. (1996) *Rethinking Local Democracy*. London. MacMillan

Klein, R. & New, B. (1998) *Two cheers? Reflections on the health of NHS democracy*
Kings Fund

Maloutas, T. & Malouta, MP. (2004) The Glass Menagerie Of Urban Governance And Social Cohesion: Concepts And Stakes/Concepts As Stakes *IJURR*, (28(2)) pp449-65.

Milewa, T., Valentine, J., & Calnan, M. (1999) Community participation and citizenship in British health care planning: narratives of power and involvement in the changing welfare state. *Sociology of Health and Illness*. 21(4). p445-465.

Milewa, T., Valentine, J., & Calnan, M. (1998) Managerialism And Active Citizenship In Britain's Reformed Health Service; Power And Community In An Era Of Decentralisation. *Social Science and Medicine*, 47, pp507-517.

Milewa, T. (2004) *Local Participatory Democracy In Britain's Health Service: Innovation Or Fragmentation Of A Universal Citizenship?* *Social Policy and Administration* 38(3), pp 240-252.

Mort, M., Harrison, S. & Wistow G (1996), '*The User Card: Picking through the Organizational Undergrowth in Health and Social Care*', in I. Hampsher-Monk & J. Sayer (Eds). *Contemporary Political Studies 1996 Volume Two*, Political Studies Association.

Mort, M, & Harrison, S. (1999) *Healthcare users, the public and the consultation industry* in T. Ling (ed) *Reforming Healthcare By Consent: Involving Those Who Matter*. Radcliffe Medical Press.

National Health Service Management Executive (1992) *Local Voices: the Views of Local people in Commissioning for Health*. London: NHS Management Executive.

Newman, J. (2001) *Modernising Governance: New Labour, Policy and Society*. London Sage.

Peck, J. (2003) *Geography and Public Policy: Constructions of Neo-liberalism* *Progress in Human Geography*, 8(3), pp.392-405.

Rhodes, R. (1997) *Understanding Governance: Policy Networks, Governance And Accountability* OU Press

Skelcher, C. (1993) *Involvement and empowerment in local public service* *Public Money and Management* Jul-Sept p 13-20

Stoker, G. (2000) *The New Politics of British Local Governance*. Basingstoke. MacMillan.

Williams, B. Coyle, J. Healy, D. (1998) The meaning of patient satisfaction: an explanation of high reported levels. *Social Science and Medicine*, 47, pp1351-1359.

Wistow, G. & Barnes, M. (1993) User involvement and community care *Public Administration*, 71, p279-299.

Wistow, G. (1994) *Social Care in A Mixed Economy*. Buckingham. OU Press.

Wistow, G. (2001) Modernisation, the NHS Plan and healthy communities, *Journal of Medicine in Management*, 15 (5), pp334 -351.