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Moving from rational to normative ideologies of control over public involvement: A case of continued managerial dominance

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ABSTRACT

Public Involvement (PI) is a strategic priority in global healthcare settings, yet can be seen as peripheral during decision making processes. Whilst extant research acknowledges variations in how policy is translated into practice, the majority attribute it to the limiting influence of professional hierarchies on the perceived 'legitimacy' of PI. Drawing on examples of three commissioning organisations within the English NHS, we outline how the variance in policy implementation for PI can be attributed to influence from the managers rather than professionals. In doing so we explore how rational ideologies of managerial control negatively impact PI. However, we also illustrate how PI alluded to in policy can be more successfully realised when organisational managers enact normative ideologies of control. Notwithstanding this assertion, we argue managerial domination exists even in the case of normative ideologies of control, to the detriment of more radical PI in service development.

1. Introduction

Public involvement (PI) is a global priority in healthcare settings and is assumed to empower communities, improve service decisions, provide democratic accountability and contribute to higher quality services (Barnes et al., 2003; Gustafsson and Driver, 2005). Despite the benefits of PI for health and social care services (Mockford et al., 2012), much existing research suggests that, while there is strong policy support, its potential contribution is stymied by contested terminology, limitations in the underpinning evidence base, different attitudes to PI, and variable attempts at implementation (Staniszewska et al., 2011; Baggott, 2005; Contandriopoulos, 2004). Commentators note the impact of professional hierarchies on the translation of PI policy into practice in public sector organisations (Boivin et al., 2014; Litva et al., 2002; Martin, 2011; Rutter et al., 2004), but neglect the impact of managerial influences on PI (Renedo et al., 2015). This is surprising, considering recent research highlights how PI representatives attempt to increase their influence by working more closely with managers (El Enany et al., 2013), suggesting changes in managerial context may represent a means by which to enhance involvement.

In this paper, we outline three cases from healthcare commissioning organisations which reflect variation in managerial influences on PI, and highlight the positive, or negative, impacts on involvement from each case. Our analysis suggests organisational managers should refrain from attempting to implement policy recommendations by actively creating PI roles and structures for involvement, as such rational ideologies of control (Barley and Kunda, 1992) limit PI contributions. However, we also outline how normative ideologies of managerial control enhance PI when groups are encouraged to work outside of managerially framed roles, increasing their contribution and influence over service design and delivery. While PI contributions are still subject to the dominance of managerial influence, we discuss how normative approaches may enhance the potential for the collaborative nature of PI alluded to in policy. In doing so, our paper responds to calls for an exploration of PI in different health settings, particularly in relation to how managers influence PI (El Enany et al., 2013; Renedo et al., 2015).

1.1. Public involvement

In the context of healthcare, multiple policy documents emphasise the need for representative, comprehensive involvement of 'the public' (HSCA, 2014; DOH, 2010; NHS England, 2013).

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In this paper we consider examples from the English National Health Service (NHS), but the need for PI in healthcare is evident globally (Barnes, 1999; Church et al., 2002).

Despite a political focus on the need for PI, definitions of PI are vague, with little consensus over who should be involved in public decision making processes, at what level, and what form that involvement should take. While involvement in healthcare research settings has developed with a clear architecture and policy support (Staniszewska et al., 2011), development of PI in health service development has been more diverse. In health service development, a lack of consensus of terminology, and overlapping structures (Mockford et al., 2012), potentially undermine PI, limiting the ability of the public to influence, or contribute appropriately to, strategic discussions (Baggott, 2005). However, others suggest that limitations of PI, such as perceived lack of impact on organisational outcomes (Contandriopoulos, 2004), cannot be associated entirely with the coherence of policy or the structures in place to encourage PI. Indeed, Martin (2008a) argues there is no need for comprehensive policy recommendations, as guidance is coherent but allows flexibility for interpretive involvement in different settings. The ambiguity of policy allows PI to be framed in different ways, encompassing multiple definitions of the 'public' as patients, carers, service users, communities, tax payers and citizens (Martin, 2008b), opening different avenues of interpretation of the meaning of 'involvement'. In this paper we follow Martin's definition, and use the term 'public involvement' to encompass multiple definitions of participants and their contributions.

Despite the flexibility of policy, and the potential for interpretation in different settings, research situated across multiple healthcare organisational contexts criticises the way PI is operationalised as tokenistic, not central to decision making processes, and even constructed as a mechanism for manipulating the public, rather than empowering them (Baggott, 2005). Considering the problematic translation of policy into practice, many attribute limitations of PI to the influence of professional hierarchies on the involvement, or exclusion, of members of the public during decision making processes (Litva et al., 2002; Rutter et al., 2004). The influence of professionals within healthcare organisations frames institutionalised assumptions about types of 'legitimate' knowledge, undermining the perceived legitimacy of PI (Boivin et al., 2014; Learmonth et al., 2009; Martin and Finn, 2011).

Whilst the influence of professionals on PI is well documented, there is little exploration of how managerially defined contexts influence involvement in professionalised settings. Recent work has suggested that managerial involvement in PI, for example creating managerially defined structures through which involvement occurs, may enhance PI influence or credibility within healthcare organisations by reframing their role as 'experts in laity' (El Enany et al., 2013; Martin, 2008a). However, the influence of what Barley and Kunda (1992) term 'rational' ideologies of control, whereby systems are tightly structured by managers, and the consequences of constraining involvement to managerially framed positions, are unclear. On the one hand, rational ideologies of control may realise the aims of policy by providing structure and meaning to PI groups, encouraging outputs relating to institutional priorities, which could be positive for PI contributions (Martin, 2011). On the other hand, framing PI roles in managerial structures as partners, rather than independent critical voices, could risk a loss of the distinctiveness of the PI, limiting contributions to self-legitimisation strategies for managerial agendas (Boivin et al., 2014; Learmonth et al., 2009). In other words, PI representatives run the risk of being co-opted towards managerial interests during decision making processes, which counters policy aims for their involvement. To explore this issue further, we consider PI in healthcare commissioning organisations.

1.2. Public involvement in commissioning

In this paper we consider three illuminating cases from commissioning organisations (who plan and contract for healthcare provision) in England. Whilst the following explanation of organisational arrangements is specific to the English NHS, similar approaches to PI are seen globally in healthcare settings where provider, purchaser and consumer are separated (Barnes et al., 2003; Church et al., 2002).

In the English NHS, PI is reflected in policy advocating patient choice and shared decision making, from the individual level of care to the development and improvement of health services (DoH, 2010; NHS England, 2013). The importance of PI is also reflected in recent organisational reforms that have seen the introduction of Clinical Commissioning Groups (CCGs), which lead commissioning networks (DoH, 2011). CCGs have a central focus on the involvement of community physicians (General Practitioners or GPs) and service users in commissioning decisions, driving patient-focused decision-making, theoretically autonomous from top-down control.

The new commissioning arrangements, in particular the renewed focus on public and clinical involvement, distinguishes CCGs from their commissioning predecessors, which were criticised for being managerially focused, with limited, tokenistic engagement with the public (Callaghan and Wistow, 2006; Martin, 2011). This is reflected in the new legal requirements for commissioning organisations to engage with the public at multiple stages of the commissioning process (HSCA, 2014). However, reflecting other policies relating to PI, the interpretation of what PI 'is', or how the public should be integrated into commissioning decisions, is vague. Commentators suggest this ambiguity is key to the new organisations, as they theoretically have more autonomy and flexibility from top-down control, creating contexts which have the potential to develop PI according to their local needs and organisational cultures (Hudson, 2014).

Commissioning organisations offer insight into the varying managerial influences on PI, as policy will be interpreted and implemented within an organisational context influenced by local managerial structures and priorities. As such, they offer a context from which to explore the research question: What are the consequences of co-opting PI representatives into managerially defined roles?

2. Methods

The overarching study was concerned with enhancing decision making processes for commissioning organisations, specifically related to interventions to reduce avoidable admissions of older people into hospital. The three cases presented in this study are illuminating for research into PI, as senior managers in each organisation were explicit about the commitment of their organisation to implementing PI policy. Despite this, over the course of the study, distinct variations in managerial interventions shaping PI involvement were noted, leading to different outcomes for PI influence on service development at each site.

The three cases offer insight into influences on PI, as they have similar organisational and professional structures framing involvement processes. All three commissioning organisations had formalised structures for public engagement at four levels. Each community physician's surgery had a patient reference group, one representative of which attended the PI group at the commissioning organisation. In addition to the PI group, each commissioning organisation appointed at least one lay member to the governing body. Alongside internal PI structures, the 3 organisations also engaged in wider consultation with the general public in