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Victory for volunteerism? Scottish health board elections and participation in the welfare state

Scott L. Greer [a], Ellen A. Stewart [b,*,1], Iain Wilson [b,1], Peter D. Donnelly [b]

[a] University of Michigan, USA
[b] University of St Andrews, UK

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ABSTRACT

This paper presents findings from a multimethod study of pilot elections held to choose members of health boards in the National Health Service in Scotland. We begin by proposing that much current public involvement practice is dominated by a volunteerist model, in which members of the public with time and skills to offer play essentially supportive and non-challenging roles within health care organizations. This model contrasts sharply with the adversarial, political model of electoral democracy. Nonetheless, drawing on a postal survey of voters, non-participant observation of Boards, and semi-structured interviews with candidates, elected Board members and other stakeholders, we demonstrate that the introduction of elections did not overcome the volunteerist slant of current public involvement with health care organizations. Far from offering a 'quick fix' for policymakers seeking to ensure accountability of health care organizations, elections may produce remarkably similar outcomes to existing mechanisms of public involvement.

1. Introduction: the volunteerist model of participation in social services and the electoral alternative

Establishing and evaluating public involvement in health care has long been a challenge for policy and practice. On one hand, public participation in decisions that spend public money and affect public services, employment, and health is desirable on democratic grounds and for its contribution to responsive, accountable, and appropriate health services (Tenbensel, 2010). On the other hand, defining, creating and evaluating effective democratic accountability and public involvement have been a stumbling block in many different health systems (Conklin et al., 2010; Klein and New, 1998; Martin, 2008).

One of the recurrent problems described in studies of public involvement is that the people who voluntarily participate in making and implementing health policy have distinctive characteristics. They are generally better educated, older, wealthier, and often whiter than the overall population (Church et al., 2002; Flinders et al., 2011; House of Commons – Health Committee, 1997). There are multiple dimensions of representation (Urbinati and Warren, 2008) that are negotiated in public involvement practice (Martin, 2008). Nonetheless, there is a clear tension between volunteers' self-selectedness and thinking of them as representatives. The distorting effects of self-selection are widely acknowledged as a key challenge for new 'participatory' modes of public engagement (Warren, 2009; Cain et al., 2003). These self-selected participants also frequently understand their role in ways that frustrate advocates of greater democracy (Litva et al., 2002; Tritter and McCallum, 2006): rather than representatives of the full range of community needs and views, ready to challenge the decisions of the established organizations, it is common to find that those willing to engage more closely resemble meliorist volunteers. By meliorist volunteers we mean participants who seek simply to support organizations to do their jobs better. This may, in keeping with the wide range of roles fulfilled by volunteers in health systems (Naylor et al., 2013; South et al., 2013) and in line with the preferences of people who prefer to avoid overt politics (Eliasoph, 2011) make it easier to run an organization, but it will rarely offer the kinds of scrutiny and challenge envisaged by advocates of democratic health care.

In response to discontent with existing practices of public involvement, and perhaps a sense that decision-making in general could be more effective, a variety of governments in New Zealand,

* Corresponding author. Centre for Population Health Sciences, University of Edinburgh Medical School, Teviot Place, Edinburgh EH8 9AG, UK.
E-mail address: e.stewart@ed.ac.uk (E.A. Stewart).
[1] Present address: University of Edinburgh, UK.

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Scotland, England and Canada have experimented with direct elections to health boards that provide or purchase a large part of their health care (Gauld, 2010). This entails the introduction of the key tool of representative models of democracy – elections – into a field conventionally dominated by participatory or deliberative democratic modes of engagement. While diverse, and rooted in different historical experiences and structures, these experiments tend to test a hypothesis that elections will increase accountability and diversity of boards, shifting them away from a class-, age- and ethnically- biased composition with a volunteerist ethos toward one that better reflects community demographics or preferences.

This article examines the extent to which the intervention – direct elections to health boards – overcomes the strong tendency of public involvement to fall into what we characterize as a volunteerist model with both demographic and behavioral characteristics. We first sketch out the volunteerist model of public involvement, and why elections might introduce people, ideas, and motivations outside that model. We then discuss a multimethod inquiry into direct elections in two Scottish health boards designed to investigate how far elections displace the volunteerist model by changing the membership or the behavior of boards.

1.1. The volunteeristic model of public involvement

Existing literature on public involvement in health emphasizes problems of conceptualization and definition (Wait and Nolte, 2006; Contandriopoulos, 2004). This is an area replete with practical accounts but unusually dominated by a small number of theoretical models which categorize public involvement by the degree of 'empowerment' it offers (Stewart, 2013). The most notable instance of this is Arnstein's (1969) ladder of participation which plots participation along a continuum from the bottom rungs of therapy and manipulation to the author's goal of citizen control of services. This basic conceptual structure – ranking instances of public involvement by the degree to which they offer empowerment – has been the basis for a range of models of public involvement in health (Tritter and McCallum, 2006; Charles and Di Maio, 1993; Feingold, 1977; Thompson, 2007). Despite the tendency to disaggregate involvement into multiple options, many of these conceptual frameworks demonstrate a disjuncture between change-oriented activities drawing on a democratic understanding of involvement, and a less challenging consumeristic perspective from which effective public involvement may look very similar to thorough market research.

In this paper, based on extensive data collection from our case study, we explore the implications of a specific reform in the Scottish NHS. We contrast volunteerism with political activism. These are two recognizable, but rarely articulated, ideal types (in the Weberian sense) of public involvement. There are tensions between them, which come across more strongly when we think of them as contrasting conceptions of how public services like healthcare should be governed, rather than points on a continuum. These tensions were starkly illustrated by our case study, in which elections to health boards forced real decision-makers to address these tensions in very practical ways.

We propose that much public involvement in health services – including strategic public roles such as Board membership – is normally volunteerist rather than activist. In a literature that often starts from the assumed benefits of any participation (Putnam, 2000), the distinction is not consistently articulated (Harre, 2007). The substantial sociological literature on volunteering – that is "any activity in which time is given freely to benefit another person, group, or organization" (Wilson, 2000, p. 215) – preoccupies itself with the predictors and consequences of volunteering activity (Wilson, 2000, 2012). Volunteering is argued to yield a range of benefits for the individuals and the societies in which they volunteer (Verba et al., 1995; Oman et al., 1999; Harlow and Cantor, 1996; Casiday, 2008). In tune with these positive findings, creating opportunities for members of the public to volunteer within health care organizations is increasingly seen as a progressive step, associated with improved information-sharing and outcomes (Naylor et al., 2013; South et al., 2013).

More relevant to our thesis is the vexed issue of the relationship between volunteering and activist (or at least change-oriented) pursuits. Simply put, are public involvement roles a cog in an organizational machine, or do they transform the organizational machine from the inside? Wilson argues that the categories of volunteerism and activism are mere social constructions, between which individuals will shift as circumstances change and that accordingly "there is no good sociological reason to study them separately" (Wilson, 2000, p. 217). However, other authors have fruitfully done so: Markham and Bonjean (1995) distinguish 'establishment-oriented' and 'confrontational' tactics of volunteers in a women's organization; Caputo (1997) investigates the extent to which female volunteers sought to 'change social conditions'; Eliasoph (2011) explores the complex interplay of 'empowerment' and bureaucratic routine in civic associations. We propose that pursuing the distinction between activism and volunteerism in accounts of public involvement in health can be analytically valuable. In health boards, for example, members of the public serve as directors alongside senior executives. Whether they automatically approach those directors as collaborators, or foresee situations in which their interests could conflict with those of the wider public, may have profound implications in practice.

A 'volunteerist' model of public involvement emphasizes collaboration and service over challenge and opposition. The core concept of the volunteerist model is that members of the public who choose to engage with health policy and planning, for little or no remuneration, are engaged for a distinct set of reasons. Volunteers are often semi-retired or retired professionals, frequently from the public services, who seek to continue their contribution to the public good, and use their managerial or technical skills by participating in health services decision-making. This set of descriptives more or less predicts that they will be disproportionately higher-income, more highly educated, and older. They will tend to have professional backgrounds, frequently in public services, which they have been socialized to believe provide the skills to ameliorate social problems (Wilson, 2000: 219–23). Because their interest is meliorism, perhaps inspired by gratitude or a sense of obligation, rather than a specific issue, they will not usually have special reliance on health services due to current poor health, disability, or caring responsibilities. Activists, or aspiring professional politicians, would presumably have somewhat different demographics.

Beyond their demographics, a volunteerist model suggests participants will have a coherent ideology with the following characteristics:

- a community orientation, focused on the community as a whole without highlighting specific interest groups (and possibly actively hostile to perceived special interests);
- the ability to accept an institutionally bounded definition of community, serving the community assigned to the relevant public institution;
- a resistance to party politics, and to the instrumentalization of local decision-making by those interested in political careers; their politics are by avocation rather than vocation, in Weber's terms.
- a desire to contribute to the welfare of an organization, accepting its basic ongoing activities and values;