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Governance and public involvement in the British National Health Service: Understanding difficulties and developments☆

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Abstract

The article considers the role of public involvement in the British National Health Service 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 of governance which rest on inter-organisational 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: Participation; Public involvement; Citizenship; Governance; Primary care trust; UK

Introduction

This article examines the role the public can play in the ‘policy space’ (King & 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 National Health Service (NHS) said to be changing from its traditional monolithic, hierarchical form to a looser network structure (Milburn, 2003).[1] Burns, Hambleton, and Hoggett (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’ (p. 282). Plurality alone, however, seems

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[1] Four hundred and ninety-eight 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.

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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, & Smith, 2002, p. 26) 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, Valentine, and Calnan (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 (Callaghan & Wistow, 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 range of 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 & Stoker, 1996). In particular, they tended to overlay the direct accountability of elected representatives with self-organising networks of local organisations, mixed economies and partnership working, thereby shifting the emphasis from government to governance (Stoker, 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 (Department of Health, 1992; Griffiths, 1983; Wistow & 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, & Arthur 1997; Dougall, Russell, Rubin, & Ling, 2000; Williams, Coyle, & Healy, 1998). More generally, evidence that involvement has a meaningful place in decision-making is sparse (Farrell, 2004; Gilliatt, Fenwick, & Alford, 2000; Skelcher, 1993). 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 (Callaghan & Wistow, 2006). 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,