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A mutual NHS? The emergence of distinctive public involvement policy in a devolved Scotland

Keywords:

Health policy; devolution; public involvement

Abstract:

Academic research on health policy divergence across the UK since devolution has characterised Scotland's approach as 'professionalistic' or 'collaborative'. This article argues that more nuanced studies of particular policy areas are needed, and offers an exploration of the Scottish approach to public involvement as an example. An analysis of policy documents since devolution reveals the shifting significance of public involvement, and the introduction of new instruments for its accomplishment. The Scottish National Party's vision of 'a mutual NHS' is presented as a complex, even contradictory, project, which warrants further empirical attention both within and beyond the context of four-system comparisons.

Introduction

Health-care policy is the archetypal example of post-devolution distinctiveness in the UK. Unlike education (Arnott & Ozga, 2010; McPherson & Raab, 1988) and criminal justice (McAra, 2008), health policy in Scotland was broadly consistent with that in England until devolution. At devolution, health was one of the areas fully devolved to the Scottish Parliament. Rather than a traditional federal system, what has emerged is a system where Edinburgh has a high degree of autonomy in policy-making (Keating, 2010), with formal contact between Edinburgh and Whitehall conducted on the basis of Joint Ministerial Committees (Greer & Trench, 2010). Contrasting this with the system of parallel Ministries at federal and state level in Germany, the US and Canada, Keating remarks that for much UK policy "there is now no 'centre' at all" (Keating, 2002, p. 5). Factors constraining divergence

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include the continued financial dependence of Scotland on Westminster via block grant funding (Parry, 2002) and the continued UK control of issues such as the remuneration of health service employees and professional regulation (Greer & Trench, 2010). Nonetheless the structures of the NHS in Scotland and England now look remarkably different. The English NHS currently faces the extension of competition and another redrawing of the purchaser-provider split (Limb, 2011), while north of the border a re-elected Scottish National Party administration defends the system of unified territorial Boards (in place since 2005) and the rejection of private provision of health services. Thus, while the NHSs in Scotland and England both remain tax-funded, state-governed health systems, there are far fewer structural similarities than at any point since 1948.

The study of devolved Scottish health policy is still in its infancy, but this article argues that its birth into the midst of a heavily politicised debate about devolution has complicated its development. In light of a decade of post-devolution policy, and three administrations on, there is scope for nuanced and empirically-grounded analyses of specific policy areas to complement broad comparisons of sectoral policy trajectories. Accordingly, this article explores the shifting understandings of public involvement within Scottish health policy documents (2000-2007). By 'public involvement' I refer to "the involvement of members of the public in strategic decisions about health services and policy at local or national level" (Florin & Dixon, 2004, p. 159). This signifies a collective dimension distinct from, but closely linked with individual level questions of patient-centredness and user involvement (Forster & Gabe, 2008). The linkages and elisions between these issues is a one focus of this article. Public involvement is a particularly pertinent field of policy in the Scottish context. In rejecting the choice and competition model influential in England since 2002 (Department of Health, 2002), Scottish health policy has been described as "professionalistic" (Greer, 2004) or in the BMA's more flattering characterisation, focused on "collaboration and integration" (BMA Health Policy and Economics Research Unit, 2010). The unified territorial Board structure minimises opportunities for dissatisfied patients to exit, except to move between primary care practices, and this has pushed public involvement high on the policy agenda. The most attention-grabbing example was the introduction of legislation for the direct election of non-executive members on Health Boards, amended by Parliament to create pilot

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elections in two Health Boards (see Greer, Donnelly, Wilson, & Stewart, 2011).

I begin by reviewing analyses of Scottish health policy since devolution, arguing that middle range accounts of specific strands of health policy have been neglected in favour of meta-narratives and micro-level 'flagship' decisions. I then introduce public involvement as one such strand which, although associated with a limited range of policies in the last decade, can potentially be effected by a broader range of policy tools (Hunter & Harrison, 1997). I then explain the process and results of tracing public involvement through Scottish health White Papers since devolution, asking whether we can discern a shift in emphasis in the policy instruments proposed to effect involvement. Finally, I consider the implementation of the Scottish National Party's proposals for public involvement, before reflecting on the implications of these findings for the study of public involvement in health.

Analyses of Scottish health policy

Studies of Scottish health policy since devolution have been preoccupied with the question of divergence from previous UK policies. This is not particular to health policy. Education policy in Scotland has always been not merely different from that in England, but self-consciously so. McPherson and Raab discuss the extent to which the "assumptive worlds" (Vickers, 1965) of the Scottish education policy community have been ordered by myths about the traditions of Scottish social democracy; "a theory supported by data it had helped to create" (McPherson & Raab, 1988, p. 499). The health policy community in Scotland can be seen as similarly beguiled by Scottish distinctiveness and this preoccupation is not confined to the world of academia. In interviews with public health stakeholders and practitioners, Harrington et al. found explicit rejection of England's marketised approach and approval of a perceived Scottish ethos of collaboration: "This emphasis on differences in the 'ethos' between countries recurred frequently in the Scottish interviews" (Harrington et al., 2009, p. e27).

Greer's (2004) four-nation study can be seen as the founding text of the study of post-

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devolution Scottish health policy. He proposes an attractively straightforward characterisation of the 'trajectories' of health policy in the four nations since devolution and considers the devolution settlement as a "divergence creation machine". For Greer, Scotland's health policy "bets on professionals as the state's allies in providing effective, efficient, legitimate health care and health care rationing. The logic, if not the forms, are close to the 1974 NHS – and the criticisms are the same as well" (Greer, 2004, p. 63). Explicitly comparative studies such as this (and that offered by the British Medical Association (2010)) set the tone for the narratives offered by textbook accounts of post-devolution Scotland. Keating (2010, pp. 209-215) and Tannahill (2005) offer overviews of Scottish health policy imbued with concern for its post-devolution distinctiveness. They describe a selection of 'headline' shifts (for example, the smoking ban) which demonstrate "the Scottish Executive's ability to take a different legislative stance to that south of the border" (Tannahill, 2005, p. 209). The analytical selection of these 'headlines' is rarely problematised. It is unclear whether their significance is primarily political, or is based on some academic standard of policy significance. Birrell (2009, p. 35) identifies flagship policies as either possessing an assessed level of innovation or as self-identified as such by governments. McGarvey and Cairney use the term in a more exclusively political sense to refer to "legislation ... which is perhaps not only high profile but also a symbol of intent" (McGarvey & Cairney, 2008, p. 205).

This "current consensus" (Smith et al., 2009, p. 218) on a distinctive Scottish approach to health policy has met some opposition (Mooney & Poole, 2004; Mooney & Scott, 2005). Prior, Hughes and Peckham's (2012) incisive analysis cites Freud's "narcissism of minor differences" (Freud, 1961, p. 78), and highlights the commonalities in health policy across the four nations. However, the concern of this article is not to contribute to an assessment of Scottish difference from English, Welsh or Northern Irish policy, but to offer a detailed study of the development of one area of policy in Scotland since the moment of devolution. It is my contention that debates around post-devolution policy divergence have created a somewhat polarised picture of policy. This identifies grand characterisations of the entire health system ('professionalistic' 'collaborative') and particular decisions (free prescriptions, Health Board elections), while neglecting the middle order accounts of policy which link them. Policy itself can be understood as a middle range concept: "something 'bigger' than

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particular decisions, but 'smaller' than general social movements" (Hecló, 1972, p. 84).

Hudson and Lowe (2009, pp. 8-11) argue that "meso-level" policy analysis is often neglected in favour of macro-accounts (which emphasise convergence between cases) and micro-level accounts (which emphasise divergence). This article aims to offer an account of policy at this middle range by focusing on the example of public involvement within Scottish health policy.

Public involvement as a sub-field of health policy

As understandings of the determinants of health have shifted, health policy has become a remarkably broad category (Hann, 2007). The whole-system analyses of health policy in the devolved countries of the UK have been criticised for extrapolating from one area of the field to others (Smith, et al., 2009). Accordingly, analysing sub-fields of health policy – in this case policy on public involvement in the governance of health services – offers one route to a more nuanced picture of Scotland's health policy since devolution. I understand 'public involvement' as a sub-field of health policy, rather than a whole-system characterisation such as 'collaboration', in that it denotes a specific set of relations and decisions, rather than an ethos or aspiration. While public involvement clearly has normative content, it is also a functional domain within health policy-making. While NHS accountability to the public has been a recurring theme in health policy debates since at least the creation of Community Health Councils in the 1970s (Klein & Lewis, 1976), from the late 1990s these issues were channelled into, and answered via, a distinctive agenda known as Patient and Public Involvement (PPI) (Department of Health, 1999). In post-devolution Scottish health policy this agenda is generally known as Patient Focus, Public Involvement (PFPI) (Scottish Executive, 2001). Accordingly I will use public involvement (lower-case) when referring to the academic term, and either PPI or PFPI when referring to how public involvement has been operationalised as a policy agenda in England and Wales, or in Scotland.

Definitions of public involvement are plentiful but vague. Defining PPI, Tritter offers "ways in which patients can draw on their experience and members of the public can apply their priorities to the evaluation, development, organisation and delivery of health services"

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(Tritter, 2009, p. 276). The breadth of this attempted definition hints at the risk of conceptual stretching (Sartori, 1970) in this area. Uncertainty about whether public involvement should be considered as distinct from, or as part of, questions of patient-centred care exacerbate this risk. Some authors consider patient choice of provider as a strategy of public involvement (Harrison, Dowswell, & Milewa, 2002), while for others, working within Hirschman's (1970) framework of exit and voice, it is an alternative (Greener, 2008). Anton, McKee, Harrison and Farrar (2007, p. 470) conclude: "Despite, or perhaps because of the current prominence of policies promoting public involvement, a number of tensions and ambiguities relating to this policy have not been well explored". These tensions include basic uncertainty about the purposes of involvement (Bochel, Bochel, Somerville, & Worley, 2008), and the presentation of involvement as a technical or managerial exercise, rather than potentially political redistribution of power.

Thanks, in part, to this prominence, we have good empirical research on how local administrators and professionals implemented public involvement policy in England under New Labour (for a summary see Farrell, 2004). However the literature lacks systematic analysis of the policy instruments of public involvement; how policy-makers have sought to effect involvement across the NHS. Related to the point above regarding unresolved tensions within this policy area, Rudolf Klein describes policy-making for patient and public involvement in England under New Labour as "a stutteringly inconsistent process" (Klein, 2010, p. 234) and "a layer-cake of initiatives, with no necessary logical link between the component parts" (Klein, 2004, p. 207). In an early overview of the policy options, Hunter and Harrison (1997, pp. 138-150) set out eight options including: elected local authority members on health boards; fully elected health boards; elected board chairs; health services coming under local authority control; a national set of health care rights; patient choice of provider; strengthened local structures of involvement and oversight (such as Community Health Councils); and improved complaints procedures. This list can be understood as the 'tool-box' from which policy makers have chosen their tools.

Existing analyses of public involvement policies (as opposed to studies of their

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implementation) include Hughes, Mullen and Vincent-Jones's (2009) exposition of divergence in public involvement policies in England and Wales since devolution, in which they trace the influence of regulatory policies to the utilities sector and local government respectively. Forster and Gabe (2008) offer an analysis of English patient and public involvement policy under New Labour. They distinguish three phases of reform: a consumerist discourse consistent with the outgoing Conservative Government (1997-2000); a collectivist approach to public involvement (2000-2003); an emphasis on individual patient choice with a concomitant loss of interest in collective mechanisms of involvement (2003-2006). As becomes apparent from this summary, their key dimension of analysis is between 'individual' and 'collective involvement'. In this article, I will use this distinction to explore policy proposals for public involvement in Scotland since devolution. Public involvement is understood, not simply as something that happens at the local level, but as a product of central Government policies (Hughes, et al., 2009).

Methods

This article draws on a qualitative analysis of Scottish health policy documents published between 2000 and 2007. Analysis of policy documents has been somewhat neglected in studies of policy divergence in the UK post-devolution, which have tended to rely predominantly on interviews with national level policy-makers and stakeholders (Greer, 2004) or on legislative output (Keating, Stevenson, Cairney, & MacLean, 2003). Policy documents can offer another useful perspective. Specifically, if we assume that Scottish distinctiveness is embedded into the "assumptive worlds" (Vickers, 1965) of policy-makers, it is incumbent on researchers to go beyond interview self-reports of a national policy 'ethos'. The particular value of this approach is in supporting analysis more detailed than macro accounts and yet more contextualised than 'flagship' decisions. Smith et al., drawing on the work of Freeman (2006), argue that policy documents "frame the nature of public policy problems, shape the boundaries of possible responses and act as points of reference for a wide variety of actors to justify subsequent positions" (Smith, et al., 2009, p. 219).

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In this article I analyse four health White Papers published between 2000 and 2007. White Papers are documents produced by the Government to set out details of future policy. As an opportunity for the Government to gauge opinion before presenting a Bill to Parliament, they are not binding, but are distinguishable from Green Papers which are more explicitly consultative (UK Parliament, 2011). This period includes the first three terms of the new (or reconvened) Scottish Parliament, and three Governments: two Labour/Liberal Democrat coalitions (1999-2003, 2003-2007), and the minority Scottish National Party (SNP) administration (2007-2011). Within this period the Scottish NHS developed from a structure of Trusts and Health Authorities to the current unified territorial Board system, with Community Health Partnerships as smaller units charged with the bulk of public involvement activity. My selection of documents includes the major White Papers in order to analyse the content relevant to public involvement.

- *Our National Health – a plan for action, a plan for change* (Scottish Executive, 2000) can be understood as a hastily 'kilted' version of the Westminster Government's *NHS Plan*.
- *Partnership for Care* (Scottish Executive, 2003) was seen, by contrast, to make a significant break with UK Government policy in dissolving Trusts.
- *Delivering for Health* (Scottish Executive, 2005). The Government response to *Building a Health Service Fit for the Future* (National Framework Advisory Group, 2005), this document focuses on issues of service redesign and the continued viability of rural hospitals.
- The SNP administration's key White Paper is *Better Health, Better Care* (The Scottish Government, 2007).

While other, more specifically public involvement-relevant publications exist (Scottish Executive, 2001, 2004; Scottish Health Council, 2010), the relative emphasis on public involvement within the broader health policy agenda – competing with topics such as clinical priorities, health inequalities, efficiency targets and service design – is instructive.

I undertook a qualitative content analysis of each document, using NVivo for the purposes of coding. I started from a position of relative familiarity with the documents and the context in

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which they were produced, and from the assumption that descriptors (e.g. public involvement, Patient Focus Public Involvement) do not have fixed meaning across the documents. The analysis proceeded from both bottom-up and top-down directions. First, each of the documents was uploaded into NVivo and coded, with categories created while working through the documents (e.g. 'involvement structures' 'service redesign' 'patient information'). I then worked back through the documents, checking, merging and grouping codes. This approach highlighted recurring themes and areas of disagreement between the documents, which were then used to inform the following questions to 'ask' of each document:

- What priority is given to public involvement in the document?
- (How) are key terms defined?
- What key proposals are associated with public involvement in the document?
- Are these proposals concerned with individual (patient) or collective (public) involvement?

Redefining public involvement in policy documents

Identifying the proposals for action associated with public involvement helps to move beyond the appeal of "warmly persuasive word[s]" (Williams, 1976, p. 76). While the symbolic power of rhetoric can be understood as one type of policy instrument (Schneider & Ingram, 1990), my concern here was with proposals for action. These are presented in table 1, separated into proposals which relate to individual (patient) involvement and to collective (public) involvement. While not always a straightforward judgement – as will be discussed below – this is primarily a distinction between policy proposals which seek to directly improve patient experience at the individual level, and those which seek to strengthen the public's collective role as a stakeholder (Forster & Gabe, 2008).

Document	Individual measures	Collective measures
Our National Health 2000	•Overhaul complaints	•Work with others to

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	<p>system</p> <ul style="list-style-type: none"> •Staff training for patient-centred care •Telephone and online feedback •Project to assess and improve patient information •Partners in Charge: projects for patient-centred service change •Advocacy services 	<p>develop proposals for new public involvement structures (modernising Local Health Councils)</p> <ul style="list-style-type: none"> •Strengthen the voice of local government on Boards •Recruitment campaign to increase diversity of decision-makers on Boards •Boards to produce annual account of public involvement and impact •Review guidance on formal consultations •Guidance and training on public involvement for staff •Make waiting times data more accessible •Boards to produce communications plans
Partnership For Care 2003	<ul style="list-style-type: none"> •New Statement of Entitlements and Responsibilities for patients •Staff training for patient focus •Patient Information Initiative 	<ul style="list-style-type: none"> •Each Community Health Partnership to have a Public Partnership Forum •Creation of Scottish Health Council
Delivering for Health 2005	<ul style="list-style-type: none"> •Bill of Rights for patients 	<ul style="list-style-type: none"> •Scottish Health Council to hold Boards to account annually for their public involvement activity
Better Health Better Care 2007	<ul style="list-style-type: none"> •Creation of national Patient Experience programme •Patient experience to be incorporated into targets •Patients' Rights Bill including a Charter of Mutual Rights •Annual ownership report to be distributed to every 	<ul style="list-style-type: none"> •Review of scrutiny of major service changes •Introduction of elections for members of Health Boards •Strengthen Public Partnership Forums (including to engage with vulnerable and seldom heard)

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	household	<ul style="list-style-type: none"> •Create a Participation Standard •Incorporate Participation Standard into performance measurement
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Table 1: individual and collective involvement proposals within Scottish health White Papers 2000-2007

Our National Health contains six proposals which relate to individual involvement. These include processes for patient complaints and feedback, patient information, patient advocacy and several proposals around patient-centred services. These policy tools are characteristic of a New Labour approach to Patient and Public Involvement, focusing on increasing organisational capacity to improve individual experiences through staff training and new avenues of communication. The document also contains seven proposals which can be understood as promoting collective involvement. Two of these (guidance and training for staff responsible for public involvement; reviewing the guidance on formal consultations) bear a close resemblance to the capacity-building tools of individual involvement. Another, the announcement of a review of the Local Health Councils), replicates decisions being made in England at the same time about the future of Community Health Councils (Department of Health, 2000). The call for local government to have a stronger voice on Health Boards resembles later proposals in England to enable local authority Overview and Scrutiny Committees to have oversight of local NHS services (Department of Health, 2000). However, there are also proposals specific to the emerging Scottish model of unified territorial Boards. A proposal is included for a recruitment campaign to improve the diversity of Board members, hinting at the more public role which is to come. Newly formed Boards are to be supported to develop communications plans to “rebuild the NHS in Scotland and reconnect it with patients and communities” (Scottish Executive, 2000, p. 32). Similarly, in this context familiar managerial proposals to make waiting times data more visible and accessible look quite different. Without the possibility of exit, this becomes a facilitating mechanism for collective, not individual involvement: to “enable the public to see how their local NHS is performing” (Scottish Executive, 2000, p. 48).

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Published three years later, *Partnership for Care* demonstrates far less emphasis on either individual or collective mechanisms of involvement. The overhaul of the complaints system and new mechanisms of online and telephone feedback, both announced in *Our National Health*, are mentioned as ongoing. A new Patient Information Initiative is announced. The shift in language from patient-centred care to patient focus (as captured in the new construct Patient Focus Public Involvement (Scottish Executive, 2001)) requires a restatement of the training and capacity-building needs for staff to advance this agenda. A genuinely novel addition (although one familiar from the modern history of the UK NHS (Klein, 2010, p. 168)) is a Statement of Entitlements and Responsibilities, linking strongly to the customer-focus of 1990s Conservative and early New Labour health policy. This document proposes the transition from Local Health-Care Cooperatives to Community Health Partnerships, and the creation of Public Partnership Forums is tagged on as one sentence: "This review [of LHCCs] should ensure that Community Health Partnerships maintain an effective dialogue with their local communities, which we envisage will be achieved through the development of a local Public Partnership Forum for each Community Health Partnership" (Scottish Executive, 2003, p. 35). The impression that PPFs are something of an afterthought is strengthened when, elsewhere in the document, Boards are to produce plans for public involvement which should merely "take account of the local Public Partnership Forums which we envisage for each Community Health Partnership" (Scottish Executive, 2003). Collective involvement is also to be furthered by the creation of the Scottish Health Council within the existing organisation of NHS Quality Improvement Scotland. As with the continuing commitment to skills training and capacity building, this suggests that the enhancement of public involvement is primarily a technical organisational exercise, in which few conflicts of interest exist between organisations, staff and local communities.

Delivering for Health was published in 2005, and, even more than the other documents, needs to be understood within the context of the time. Scotland's geography – including 20% of the population in areas described as 'remote and rural' in NHS terminology (Remote and Rural Steering Group, 2007) – renders the centralisation of services into regional centres an enduring issue. Professor David Kerr chaired a substantial review of the NHS in Scotland,

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including extensive consultative activity, which reported in 2005. This report restated the case for "a more truly Scottish model of care ... a collective approach in which we generate strength from integration ... Patient choice is important, but the people of Scotland sent us a strong message that certainty carries greater weight" (National Framework Advisory Group, 2005, p. 2). Recommendations included the concentration of specialised and complex care on fewer sites where clinically appropriate. Delivering for Health, the Scottish Executive's response, embraces this review and presents its resulting action plan. With a clear direction forward, collective public involvement is minimally included, with only one proposal, clarifying the Scottish Health Council's role in holding Boards to account for their public involvement activities. Patient focus is widely discussed, but the only significant proposal is the latest manifestation of a Bill of Rights for patients, progressed on from the Statement of Entitlements and Responsibilities suggested two years earlier. These proposals are presented as a response to extensive consultation with the public, and it is perhaps because of this (as well as the need for new arrangements to 'bed down') that less attention is given to the day-to-day operation of involvement at either individual or collective level. At times public involvement is presented as a troublesome step in the process of reform: "Our collective aim should be to implement the proposals in this plan by engaging with, and winning the support of the people we serve" (Scottish Executive, 2005, p. 54).

When the Scottish National Party took power as a minority Government in May 2007 they quickly established both the NHS generally, and public involvement specifically, as priorities. In June 2007, Health Secretary Nicola Sturgeon reversed the decision to close two Accident and Emergency departments and announced a presumption against centralisation of health services, arguing that "The two Boards did not in my view give sufficient weight to the concerns expressed by local people" (BBC News Online, 2007). *Better Health Better Care*, published in December 2007, uses the rhetoric of mutuality to underline a new vision for the Scottish NHS. It contains four proposals which I consider relevant to the individual level of involvement, and seven at the collective level. Individual level proposals include the by now familiar inclusion of a patients' charter, but this time to be enshrined in law and with the addition of a reference to mutuality: a Charter of Mutual Rights. A concern with patient focus

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manifests itself in proposals for the creation of a national Patient Experience programme, and the inclusion of patient experience data in performance management. The assertion of the public's 'co-ownership' of the NHS complicates ostensibly individualistic proposals such as an annual Ownership Report for every household in Scotland. While the name and some of the proposed content – details on how to get involved with influencing services locally – seem to sit at the collective level, more conventional information on patient rights and responsibilities, accessing services and complaining about treatment are more akin to the individual level aims of informing and educating patients. At the collective level, the direct election of non-executive members of Health Boards is certainly the most eye-catching of the proposals. However, this aside, collective proposals are modest and consistent with existing policy. The role of Public Partnership Forums is confirmed, with a proposal to strengthen them. In a progression of the annual review of public involvement activity, the Scottish Health Council is asked to produce a unified 'Participation Standard' to be integrated into the performance measurement for Boards. Finally, in the wake of the controversy over Accident and Emergency closures, a review of the procedures for scrutiny of major service changes is announced.

Overall, the emphasis given to issues of public involvement varies across the four documents, with no clear chronological trend. *Our National Health* devotes one of nine chapters to 'involving people', and *Better Health, Better Care* shows an even greater focus, with 'Towards a mutual NHS' as one of three chapters. By contrast, *Partnership for Care* contains one chapter called 'Listening to patients' and then a sub-section 'Public involvement' within a different chapter concerned primarily with service change. This separation presents public involvement as a distinct activity, mostly relevant in the case of contentious service changes. The contents page for *Delivering for Health* mentions neither public involvement nor patient focus. Particularly in the case of collective mechanisms of involvement *Our National Health*, the earliest document, and *Better Health, Better Care*, the latest document, display considerably more attention than the intervening two papers, despite coming from different political parties. Accordingly, there appear to be peaks in interest in public involvement in the first White Paper after devolution and the first White Paper of the new SNP administration, with something of a lull in the intervening years. This gap is interesting, as debates on health

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policy in this period were preoccupied with controversy over hospital closures and the future configuration of services. That public involvement was not seen as integral to these debates suggests that it was seen as a realm of activity removed from high-level decision-making. Despite the stronger emphasis on public involvement in *Our National Health* (indicating that enthusiasm for the issue crosses party boundaries) I argue that a distinctive understanding of public involvement emerges most clearly in the SNP's *Better Health Better Care*.

Discussion

As highlighted above, this is an analysis of proposal, not action. Some proposals are never implemented, and at other times legislation passes without prior inclusion in White Papers. One example of this is the statutory duty for Boards to involve the public, contained in the National Health Service Reform (Scotland) Act 2003 but not included in *Partnership for Care*. As a minority Government until May 2011, SNP proposals have been particularly subject to delays and change. In their first term they struggled to move forward with much of their agenda, and relatively few of these proposals have come to fruition. Others have been subject to significant delays and/or amendments. The commitment to directly elected Health Boards was reduced to a pilot scheme in the face of opposition. The Charter of Mutual Rights has become a Charter of Patient Rights and Responsibilities, contained within a Patients' Rights Bill passed in February 2011. The Ownership Report has, like several Patients' Charters in the past (Forster & Gabe, 2008), become essentially a guide to accessing services. While a new 'Participation Standard' has been developed (Scottish Health Council, 2010) it is yet to be integrated into the national system of performance management. Proposals to strengthen Public Partnership Forums have not materialised. While they remain in place their role has shifted subtly from being "the main way" (Scottish Executive, 2004, p. 4) the NHS involves the public to being one of "many different ways" of "listening and responding" (Scottish Health Council, 2010, p. 16). At least from a structural perspective, on-the-ground public involvement does not appear transformed, particularly in Boards which are not piloting elections. However *Better Health Better Care* remains interesting. Rather than an assessment of success in translating a vision into reality, this article asks to what extent an

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alternative vision of public involvement has emerged.

While staying firmly within Hunter and Harrison's (1997) tool-box of public involvement policies, the distinctiveness of *Better Health Better Care* lies in its shift from interest in collective mechanisms of advice (such as Public Partnership Forums) to those of control (such as directly elected Board members). Despite the pervasive and eye-catching rhetoric of mutuality, *Better Health Better Care* turns instead to more traditional tools of control of health organisations. The introduction of direct elections to Health Boards is the most self-evidently oppositional tactic, but the proposal to incorporate assessments of public involvement into performance management systems is similarly aggressive. In a sense, the ungainly, peculiarly Scottish descriptor 'Patient Focus Public Involvement' only really begins to have meaning in 2007, as the day-to-day business of engaging with current patients is firmly separated from the questions of collective control which preoccupy *Better Health, Better Care*. I do not claim in this evolution a 'better' or 'worse' (or 'weaker' or 'stronger') conception of public involvement. As others have pointed out (Tritter & McCallum, 2006), academic literature focuses near exclusively on evaluating public involvement along linear hierarchies based with varying fidelity on Arnstein's 'ladder of participation' (Arnstein, 1969). Turning away from this approach, I would argue that the SNP's interpretation of public involvement locates proposals primarily at the level of organisational governance, while a New Labour interpretation offers an advisory function which is integrated more extensively with the (privatised) patient realm than the (public, even political) realm of the citizen.

While a shift in emphasis and rhetoric is evident, these are not path-breaking reforms. The recurring spectre of a charter of patient rights is familiar. Terminology stays consistent and structures of involvement for members of the public to oversee organisations are left broadly unchanged, with Public Partnership Forums and Scottish Health Council subject to reviews but left intact (FMR Research, 2008; Scottish Councils Foundation & McCormick-McDowell, 2008; Scottish Health Council, 2009). The invocation of mutuality, often used as shorthand for the whole SNP health policy agenda, is something of a rhetorical red herring. Mutuality in the public sector and in health care has a long pedigree (Birchall, 2001; Gorsky,

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Mohan, & Willis, 2005) but is more often associated with non-universal, exclusive organisations. As Birchall argues, mutualism "has sometimes been used as a vague call to involve citizens more closely in decision made over public services. However properly used it refers to a membership-based organisation, in which the users of services are in control of provision" (Birchall, 2008, p. 5). The compatibility of a genuinely mutual organisation with the Scottish policy commitment to universality is questionable. In experimenting with membership models for the elections for Boards of Governors, English Foundation Trusts found that opt-out (i.e. universal) membership was an expensive exercise which yielded dramatically low election turnout (Day & Klein, 2005). The SNP's proposals are overtly inclusive; indeed, they seek to bring all the 'people of Scotland' into a closer relationship with the NHS. Despite the strong rhetoric of mutuality, many of the policy tools for public involvement proposed in *Better Health, Better Care* actually draw on a far more traditional hierarchical approach.

While distinguishing the individual from the collective dimensions of involvement is a useful starting point, this analysis demonstrates the limits of the approach. Instead of a switch in Scottish health policy from instruments of individual involvement to those of collective involvement, there are nuanced differences in approach and emphasis. There are behavioural assumptions at play in the selection of policy tools. Schneider and Ingram (1990) suggest that capacity-building tools (for example the provision of training, support and information to both staff and patients) assume that the policy goals are shared and welcome, and that obstacles are of ability, not willingness. By contrast, *Better Health Better Care* primarily relies upon authority tools (mandating of elections), incentive tools (incorporation of patient experience and public involvement measures into performance management), and symbolic tools (the rhetoric of mutuality and co-ownership), suggesting that their diagnosis of problems is of organisational intransigence, not inability. This is in keeping with some of the more inflammatory statements of Scottish National Party Health Secretary Nicola Sturgeon: "Elected health boards ... are the best way of ensuring that boards will no longer be able to ride roughshod over community opinion, as has happened in the past" (The Scottish Government, 2009, p. 1). Context is also crucial. The distinctiveness of the current Scottish

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approach is in part due to the structural consequences of other reforms. In a unified territorial system – where planning and not commissioning is the primary task – there is far more scope to have input from a collective manifestation of the local population. It is no coincidence that electing members of health authorities was a recurring proposal in health policy debates up until the late 1990s (Hunter & Harrison, 1997; Klein & Lewis, 1976; Klein & New, 1998): Scotland's traditional NHS structure lends itself to traditional policy tools. In this context, the dividing line between individual and collective involvement is blurred. As with the publication of waiting times data, Better Together, the programme for the collection of data on patient experience appears intrinsically individual. However it is widely publicised in order to aid the public in holding local services to account. This, then, is a tool of individual involvement put to collective purposes.

Conclusion

Public involvement in health care has been promoted by international organisations (Council of Europe, 2000; World Health Organization, 1998) as a priority for health-care systems in the 21st century. However, as Hughes, Mullen and Vincent-Jones (2009) comment with regards to the English and Welsh cases, even within the UK there are significant differences in approach. It is broadly acknowledged that this area of policy encompasses a multitude of goals, some of which may be in direct conflict with each other. These include better governance, enhanced democracy, the development of social capital, the education of individuals, and the improvement of services (Bochel, et al., 2008). In this context, the consistency in terminology of public involvement across the four nations of the UK might mask very different intentions. These policies also look remarkably different in context, as the structures of health systems across the UK continue to diverge. For example, given that NHS organisations in England are now required to compete with each other and with other providers, the role of public involvement (if the terminology does not fall entirely out of usage (NHS Evidence, 2010)) is far more complicated.

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Instead of assessing public involvement policies by the degree of empowerment they offer, this article simply seeks to explore the different policy instruments which have been proposed as part of the public involvement agenda. What is evident is that public involvement can potentially lend itself to a wide range of policy tools. Careful attention to policy documents reveals a significant evolution in approach since devolution in Scotland. Where the early introduction of the construct 'Patient Focus Public Involvement' can be seen as a path-breaking commitment to a more collective approach, the proposals associated were far more consistent with the prior model of involvement. Thus while the broader organisational structures of the Scottish NHS began to diverge significantly from the pre-devolution model (and from those elsewhere in the UK) from 2003, the overall approach to the public's role in the management of services was reasonably consistent until the introduction of the SNP's *Better Health, Better Care* in 2007. Beneath ostensibly consistent terminology and, to a lesser extent, structures, this document reignites debates about the accountability of NHS services to local communities which have been largely dormant since New Labour placed a more privatised interpretation of public involvement at the heart of their vision for the NHS. However, existing evidence emphasises a high degree of uncertainty as to the meaning and purposes of public involvement among NHS staff and stakeholders (Anton, et al., 2007; Forbat, Hubbard, & Kearney, 2009). It is necessary to understand better how the somewhat amorphous proposals for a 'mutual NHS' are put into practice by front-line staff, and crucially, how new opportunities to play a more active role in the management of health services are received by the public.

Glossary

CHC: Community Health Councils: the local structure of public involvement in England 1974-2003.

LHC: Local Health Councils: the local structure of public involvement in Scotland 1975-2004.

PPF: Public Partnership Forums: the local structure of public involvement in Scotland 2004-present.

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PPI: Patient and Public Involvement, name of this policy agenda at Westminster from 1999 onwards.

PFPI: the term most often used in Scottish policy for this agenda, first used in 2001.

SNP: The Scottish National Party: in power at the Scottish Parliament as a minority Government 2007-2011 and re-elected with a majority in May 2011.

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