A (non-Deliberative) Systems Approach to Participation in Public Administration

Rikki Dean, London School of Economics

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Abstract

Public administration has become an important preoccupation for deliberative democrats, especially for deliberative systems theorists. The most prominent statements of the deliberative system all reserve a place for public administration (Dryzek, 2010; Mansbridge et al., 2012; Parkinson, 2006). This raises some questions about how well a theory originally intended to explain the political/legislative process translates to the policy/administration process. This article argues that the deliberative system inscribes a partial understanding of public administration, public participation and political legitimacy: public administration is reduced to governance networks; participation is reduced to deliberation; and political legitimacy is reduced to deliberative legitimacy. The article then proposes three alternative functions – effectiveness, autonomy and accountability – as a basis for thinking systemically about participation in complex policy systems. Practical examples from the English National Health Service (NHS) are drawn on throughout, both to illuminate the discussion and demonstrate its applicability to actual processes of policy-making. It is argued that these functions are more inclusive in their conception of public administration, participation and political legitimacy, thus embrace the inescapable plurality in preferences for political organisation in contemporary democratic societies.

Key words: public participation, public administration, deliberative system, deliberative democracy, NHS, health policy

Comments to r.j.dean@lse.ac.uk
The rise and rise of deliberative democracy has arguably made it the pre-eminent contemporary theory of democracy. We are now in the third phase of the ‘deliberative turn’ in political theory and science (Owen and Smith, 2015). The first phase was primarily concerned with the development of the normative ideal of deliberative democracy, the second phase with the empirical study of deliberative institutional innovations, such as the various forms of mini-publics. The latest, third phase has turned towards conceptualising the political system as a whole as a ‘deliberative system’. This turn towards the deliberative system has been accompanied by deliberative democrats’ growing interest in public administration, “policy and administration are moving into the front lines of the project of democratization” (Warren, 2009: 3). As such it is no surprise to see the deliberative systems approach being extended to the realm of public administration. All of the most prominent statements of the deliberative system reserve a place for policy within the system (Dryzek, 2010; Mansbridge et al., 2012; Parkinson, 2006). This shift from deliberative democracy to deliberative governance raises some questions about how well a theory originally intended to explain the political/legislative process translates to the policy/administration process. How does deliberative governance conceive of public administration?

The term ‘deliberative system’ conceals to some extent that this theory is intended to be a theory of participation just as much as it is a theory of deliberation. The term was coined by Mansbridge in an attempt to expand deliberative democracy to take account of everyday political talk, in an essay where: “The analysis calls throughout for a democratic theory that puts the citizen at the center” (1999: 212). Similarly, other statements of the deliberative system have emphasised it strengths with regard to the all-affected principle – that everyone affected by a decision should have some means to influence its determination (Dryzek, 2010; Parkinson, 2006). For Parkinson (2006) the deliberative systems approach is an effort to rescue the deliberative conception of legitimacy from the problem of scale – that is, it is close to impossible for all those affected by a decision to deliberate together. If the deliberative system is intended to be a theory of public participation in public administration, then we must pose a similar
question concerning its conception of participation. Given the deliberative emphasis, does it conceive of participation only as talk or reason-giving and neglect other forms of participation?

This article argues that the application of the deliberative systems approach to public administration results in three forms of synecdoche, since it has only a partial conception of participation, public administration and political legitimacy. The article then proposes three alternative functions – effectiveness, autonomy and accountability – as a basis for thinking systemically about participation in complex policy systems. Practical examples from the English National Health Service (NHS) are drawn on throughout, both to illuminate the discussion and demonstrate its applicability to actual processes of policy-making. It is argued that these functions are more inclusive in their conception of public administration, participation and political legitimacy, thus embrace the inescapable plurality in preferences for political organisation in contemporary democratic societies.

**Synecdoche in the deliberative system**

The deliberative system has capacious boundaries. It encompasses “all governmental and non-governmental institutions, including governance networks and the informal friendship networks that link individuals and groups discursively on matters of common concern” (Mansbridge et al., 2012: 8). The position of governance networks or public bureaucracies and the roles of public administrators in the deliberative system are not, however, clearly specified. Most of the empirical examples of deliberative innovations analysed by Parkinson (2006) are from the NHS, so we may expect a more detailed account of deliberative public administration therein. Nonetheless, whilst Parkinson’s specification of the deliberative system expends a great deal of effort on reconceptualising the representative relationship, there is no such treatment of the bureaucracy. Bureaucrats are neutral functionaries who manage, monitor and implement but play no role in decision-making (2006: 169). Given the context of the empirical work in the NHS, this is a surprising omission considering the number of appointed officials taking binding decisions on matters of common concern in this domain.
is likely much greater than the number of elected officials with a representative relationship to the public. It is guilty of common tendency amongst deliberative democrats to slip into a stylized distinction between democratic politics as the locus of will-formation and public administration as a process of neutral translation of democratic will into output (Boswell, 2016). It is no surprise that deliberative democrats have viewed politics through the lens of will-formation, given that this is the function that deliberation best serves (Warren, 2012). Still, the focus on inputs characterised by reflective will-formation and the neglect of how this will is translated into outputs is problematic for applying the deliberative systems approach to public administration, which is exactly the realm of this translation. It is especially problematic given deliberative democrats increasing propensity to view the process of will-formation as one of reaching ‘incompletely theorised agreements’, since it neglects the ways that such agreements are contested and interpreted in translation, including the ways that those with power and access can manipulate this translation process to their advantage (Boswell, 2016).

The idea of the public administrator as neutral functionary is of course compatible with the classical public administration conception of bureaucracy, but this is a conception that has been subject to extensive critique from diverse traditions of public administration scholarship, which have attempted to establish new perspectives on public encounters between citizens and bureaucrats (Bartels, 2013). New Public Management (NPM) has emphasised the importance of such interactions to enhance the power of consumers over an inefficient, over-regulated and unresponsive bureaucracy. Critical Theorists have argued that administrators should not be seen as inhumane cogs in the political machine and stress the necessity of re-founding the moral agency of public officials in their interactions with citizens. In addition, participatory governance has called for public encounters of shared decision-making in order to reverse the alienation of citizens from officials and find more effective policy solutions (Bartels, 2013).

Is there a distinct deliberative conception of the bureaucrat? Boswell’s (2016) suggestion the that the process of policy implementation should be characterised by a number of mechanisms that force those who have exercised discretionary power to account for their actions implies that there is, and it is one in which the bureaucrat is both a decision-maker and a participant in deliberations about what is to be
done and what has been done. This is a marked shift away from the ‘Whitehall public service bargain’
of classical public administration, whereby bureaucrats give-up their public profile and partisanship in
favour of loyalty to their political masters, and in exchange for permanence in office (Hood and Lodge,
2006). It is difficult to see how bureaucrats could regularly engage in public justifications surrounding
the politics of administration without embroiling themselves in the kind of political arguments that have
traditionally been viewed as the domain of politicians.

The few proponents of the deliberative systems approach that have elaborated the role of public
administration in more detail (Boswell, 2016; Dryzek, 2010) have equated public administration with
governance networks. This is again perhaps not surprising given that network governance is arguably
the most compatible mode of public administration with the deliberative systems approach. It too is
based around relationships of horizontality rather than hierarchy, and persuasion rather than coercion
(Rhodes, 2007; Sørensen and Torfing, 2005). Nonetheless, there are a number of doubters of the
supposed hollowing out of the state and public administration’s inexorable march towards governance
through decentred networks (Goldfinch and Wallis, 2010; Lodge and Gill, 2011; Marinetto, 2003). Even
Rhodes (2007), one of the originators of the shift towards thinking about administration in terms
governance networks, admits that public administration is not equivalent to governance networks. They
are only one component and administration is pursued through a mix of bureaucracies, markets and
networks. Similarly, Torfing and Triantifillou (2013) have argued that their ‘New Public Governance’
(network-oriented) co-exists alongside New Public Management (market-oriented) and Classical Public
Administration (bureaucracy-oriented), and that this co-existence will continue into the future. The
non-equivalence of public administration and governance networks poses some difficult questions that
deliberative theorists are yet to answer. Does the deliberative system encompass the entirety of public
administration, or just networks? If the former, then there is a need to elucidate the implications of the
deliberative system for markets and bureaucracies, particularly since deliberative principles do not
mesh as neatly with the logics of markets and bureaucracies, as is apparent from the dissonance
between the deliberative bureaucrat and the Whitehall public service bargain noted above. If
deliberative governance only encompasses networks, is this due to the limitations of deliberative
time, or because networks are normatively superior from the deliberative perspective, thus public
administration should replace bureaucracies and markets with networks?

The ways that public administration is conceptualised within the deliberative system filters into the
conceptualisation of public participation too. Dryzek’s (2010) focus on networks, which he claims are
easy to exit and have an ill-defined demos, leads him to reformulate the usual preoccupations of
participatory governance: popular control and political equality. Popular control becomes “participation
in deliberation about a decision on the part of all those affected by it” and political equality becomes
inclusion in deliberation in proportion to affectedness (Dryzek, 2010: 126). These reformulations are
unlikely to impress participatory democrats for whom participation in governance has always been
about sharing in decision-making through the assumption of formal powers. Whereas for Arnstein
“citizen participation is a categorical term for citizen power” (Arnstein, 1969: 216), for Dryzek citizen
participation is a categorical term for citizen deliberation. Parkinson (2006) is also sceptical of placing
decision-making powers in the hands of citizens, reserving them for elected representatives. In his
deliberative system bureaucrats act on behalf of citizens to provide a check on strategic action in the
political process. This is a direct inversion of the Weberian and Habermasian conception of the
political-administrative relationship, in which politics provides a necessary check on the totalising
power of administration. It is unclear why bureaucrats over whom citizens have no direct mechanism of
control would be better at acting on their behalf than the politicians over whom they at least wield
electoral power. Accordingly, this conception also misses the impetus that drives proponents of
participatory governance – a desire for citizens to have some direct control over administrative
decisions.

There are a number of other forms of public participation in administration that are aligned with the
logics of bureaucracies and markets and that could only loosely be described as deliberative; notably
individualised, market behaviours aimed at driving competition between service providers (Dean, 2016;
Papadopoulos, 2012; Warren, 2012). Deliberative democracy is founded in a rejection of the liberal
democratic concern with aggregation of pre-political, individual preferences (Dryzek, 2000), and it
appears deliberative governance is also sceptical of NPM and the consumer-orientation to governance
(Boswell, 2016; Parkinson, 2006). It is possible that these non-deliberative acts could be integrated into
the deliberative system in the same fashion that Mansbridge et al. (2012) integrate protest – that is,
they may violate deliberative norms yet still contribute to the system-level functions. Still, it feels
counterintuitive to assess something according to functions that it was never intended to realise ahead
of the functions that it was instituted to serve. In the case of consumer choice, for instance, the
intended functions would be individual autonomy for the consumer and an accountability sanction on
providers, neither of which feature as important functions of the deliberative system.

The way that the deliberative system interprets non-deliberative acts, only valuing them to the extent
they contribute to deliberative functions, highlights its third form of synecdoche: it is wedded to a
specifically deliberative ideal of legitimacy that takes no account of the inescapable pluralism in
conceptions of political legitimacy in modern societies. As Mansbridge et al. note, “the legitimacy of a
democracy depends in part on the quality of deliberation that informs citizens and their
representatives” (2012, p. 1, emphasis added). However, in analysing all political activity according to
deliberative ideals, the deliberative systems approach makes the deliberative conception of legitimacy
the whole rather than part of the story. The approach is thus a particular frame for analysing the
political system. It can be a useful one, but it is important to recognise that its conceptions of public
administration and public participation are not neutral. In its current specification the deliberative
system engages in three forms of synecdoche: public administration is reduced to governance
networks; participation is reduced to talk; and political legitimacy is reduced to deliberative legitimacy.

Three functions of participation in public administration

Despite the above criticisms of the deliberative systems approach, its central insight – that a single
deliberative arena does not have to realise all the functions that make a political system legitimate, that
these functions can be distributed across different arenas with each performing different labours – remains a valuable one for thinking about public participation in public administration. The remainder of this article aims to demonstrate how this insight can be harnessed without lapsing into the forms of synecdoche levelled at the deliberative systems approach. The first step is to flip the systemic question upon its head. The deliberative system encounters problems because it attempts to theorise a system from within a single model of democracy and, as Warren (2012) has argued, models-based approaches always result in functional over-expansion. Since participation, like deliberation, is a foundational concept of democratic government, it may be tempting to develop an alternative theory of a participatory governance system that assesses all public administration activity in terms of participatory functions, but this would commit the same error as the deliberative systems approach. This article thus eschews a model-based approach in favour of a problem-based approach that is more ‘ecumenical’ with regards to the functions a political system has to serve (Owen and Smith, 2015; Smith, 2009; Warren, 2012). It asks not whether a policy system is participatory in nature, but instead considers the diverse roles that participation can fulfil within a complex policy system. The systemic questions then become what functions does a policy system have to realise; followed by, how does participation serve these functions?

This section outlines three such functions, drawn from Dean’s (2016) typology of four modes of public participation in policy-making (Figure 1). Each of the four modes is associated with a different tradition in democratic and public administration theory. Participation as knowledge transfer is primarily connected to the Weberian tradition of hierarchical bureaucracy, participation as collective decision-making to participatory democracy. Participation as choice and voice is primarily linked to the liberal tradition, participation as arbitration and oversight to pluralism. These modes of participation should not be viewed as models of participatory governance. They are not different, fully self-sufficient answers to the problem of democratic policy-making. Each mode of participation is better viewed as a set of practices oriented towards responding to a particular problem of governance. Participation as knowledge transfer is oriented to solving the problem of how in highly differentiated societies all the
relevant expertise can be brought to bear on developing optimally effective policy solutions. Participation as collective decision-making is about empowering those who are affected by a decision to wield some control over it. Choice and voice is oriented towards ensuring the responsiveness of decisions and services to the wants and needs of users. Finally, arbitration and oversight is about demonstrating that where power is wielded it is done so accountably (Dean, 2016). The four modes of participation therefore each provide a particular function for participation in governance: *effectiveness* (from knowledge transfer); *autonomy* (collective decision-making); *responsiveness* (choice and voice); and *accountability* (arbitration and oversight).

Figure 1: A Typology of Four Modes of Participation

![Diagram of Four Modes of Participation](image-url)
Three of these functions – effectiveness, autonomy and accountability – will now be described in more detail (the fourth function of responsiveness is merged into effectiveness, as will become apparent in the discussion). Concepts such as effectiveness and autonomy can be construed in multiple ways, so it is important to clarify how they are being used here. Moreover, though each function is primarily associated with one mode of participation, there is not a direct one-to-one relationship between modes and functions. In clarifying the content of the three functions, it will be possible to outline the extent to which different modes of participation are attuned to serving these functions, and thus how they perform different labours within the policy system. These explications will be illuminated throughout with examples of participation in the English National Health Service (NHS). The NHS is a complex system of multi-level governance with a wide range of opportunities for participation both individualistically as a consumer of health services and collectively as a citizen. It presents an ideal case of a complex but bounded policy system in which participation is employed to serve an array of functions.

**Effectiveness**

Effectiveness in producing good outcomes is a core function any policy decision-making process. For JS Mill the merit of any set of political institutions is to be judged “by the goodness or badness of the work it performs for [the people], and by means of them” (1991: 43). Epistemic theories of democracy have similarly attempted to root the superiority of democracy in actual democracies’ propensity to produce better decisions (Anderson, 2008; Estlund, 2008a, 2008b). The epistemic function of the deliberative system is related to these ideas. For Mansbridge et al. (2012) it is partly about whether decisions are informed by facts, logic and the relevant reasons, but stops at the domain of opinion and will-formation, so is output- rather than outcome-focused. Participation in governance has tended to be favoured more for its ability to potentially improve policy outcomes (Barnes et al., 2007; Cabinet Office, 2002; Fung, 2003, 2006; Involve and National Consumer Council, 2008; Papadopoulos and
Warin, 2007; Parkinson, 2004). The role of citizens in improving policy outcomes through improving the quality of decisions, implementation and delivery has been primarily focused on the distinctive but complementary knowledge that non-professionals can contribute to the policy process. This can be because they bring specialist technical information and/or novel perspectives routed in their experience of a phenomenon, or new perspectives simply because they may be free of the blinkers of received professional wisdom (Fung, 2006). The importance of outcomes is rejected by pure proceduralists, who question the extent to which it is possible for there to exist procedure-independent standards of goodness (Peter, 2008). Nonetheless, people find it difficult to separate process quality from outcomes, so much so that their assessments of the quality of the same decision process alter substantially when associated with different quality of outcomes (Arvai and Froschauer, 2010).

The theoretical literatures’ concern with effectiveness is mirrored in practice. The facility for participation to improve health policy outcomes is at the heart of the NHS’s participation strategy, “Patient and public participation is important because it helps us to improve all aspects of health care quality” (NHS England, 2015). There are a range of opportunities for the public and patients to involve themselves in NHS decision structures in order to contribute their perspectives and expertise. At the national level, NHS England’s public voice team conducts a number of initiatives, most prominently the NHS Citizen process which combines an online platform for raising and collaboratively solving issues with a biannual, national citizens’ assembly. At regional and local level:

- NHS Trusts have patient and public voice teams that often mostly deal with complaints but also run ad hoc participation initiatives such as ‘Experts by Experience’ groups;

- local clinical commissioning groups (CCGs) have a duty to involve and consult on plans and decisions, and a number of them have set up patient participation groups (PPGs) and/or other involvement mechanisms such as citizens assemblies;

- general practitioners are now statutorily mandated to set up PPGs for their practices;
• and independent local Healthwatch networks also organise extensive patient and public participation (see Table 1 for a summary of NHS participation mechanisms).

Though local practices vary it is common for these initiatives to be framed as means for working collaboratively with professionals to improve services, namely as knowledge transfer activities. PPGs in general practice, for instance are described as “patients and practices working together... to bring about positive change to the benefit of all patients and practice staff” (Royal College of General Practitioners, 2014: 3).

It is noteworthy that only patients and carers, particularly those dealing with long-term conditions, are painted as ‘experts by experience’ throughout NHS participation literature. There is little consideration of the expertise the public more generally may bring, who are instead involved to ensure their views, needs and preferences are reflected in services provided (Department of Health, 2008; NHS England, 2013, 2015). Patients and carers are also involved as service users to provide feedback that can improve outcomes through a range of consumer insight mechanisms. One of the most prominent is the Friends and Family Test, which is administered to patients after they have received care and asks if they would recommend the care they have received, but there are also a number of additional surveys conducted by the Care Quality Commission (CQC) and avenues for patients to complain about poor care. There is frequently little distinction between the ways that public participation and consumer insight are described as improving outcomes in the NHS; both are seen primarily as ways to ensure services are responsive to the needs of those they serve (see, for instance, NHS England, 2013). As such we find knowledge transfer type activities, where the public is asked to provide its input on public priorities for the NHS, and choice and voice type activities, where service users and public are asked to provide input on what they expect for their own care, both employed in service of the idea of effectiveness as responsiveness, to public values and patient needs. In practice then, effectiveness contains two distinct ideas that are often pursued in tandem: outcome quality and outcome responsiveness.
<table>
<thead>
<tr>
<th>NHS mechanism</th>
<th>Description</th>
<th>Function(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Citizen (NHS England)</strong></td>
<td>NHS England is the national level commissioning body responsible for distributing the NHS budget.</td>
<td></td>
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<tr>
<td>a) Online Issue Raising</td>
<td>Online platform for raising and collaboratively solving issues about the English health service.</td>
<td>Effectiveness (responsiveness &amp; quality)</td>
</tr>
<tr>
<td>b) NHS Citizens’ Assembly</td>
<td>Biannual two day public assembly to discuss priorities for NHS England.</td>
<td>Autonomy (communal) Accountability (communicative)</td>
</tr>
<tr>
<td><strong>Foundation Trust</strong></td>
<td>Foundation Trusts are the main providers of secondary and tertiary healthcare services.</td>
<td></td>
</tr>
<tr>
<td>a) Expert by Experience</td>
<td>Groups of volunteer patients and carers who give a patients perspective to influence strategy and provision.</td>
<td>Effectiveness (responsiveness and quality)</td>
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<tr>
<td>Patient Groups</td>
<td></td>
<td></td>
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<tr>
<td>b) Foundation Trust</td>
<td>Elected public governors and patient governors sit on the board of the Trust and represent the perspective of these respective groups in decision-making.</td>
<td>Autonomy (plural)</td>
</tr>
<tr>
<td>Governors</td>
<td></td>
<td></td>
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<tr>
<td>c) Foundation Trust</td>
<td>Foundation Trust members vote in elections for governors, can stand for election and are consulted on development plans.</td>
<td>Autonomy (communal)</td>
</tr>
<tr>
<td>Members</td>
<td></td>
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<tr>
<td><strong>Clinical Commissioning Group</strong></td>
<td>Clinical Commissioning Groups (CCG) are responsible for distributing the NHS budget to local services.</td>
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</tr>
<tr>
<td>a) Patient Participation</td>
<td>Patient participation groups provide a patients perspective on local services to influence commissioning decisions.</td>
<td>Effectiveness (responsiveness and quality)</td>
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<tr>
<td>Groups</td>
<td></td>
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<tr>
<td>b) CCG Lay Members</td>
<td>Two representatives on the CCG board who represent the patient and public perspective in decision-making</td>
<td>Autonomy (plural)</td>
</tr>
</tbody>
</table>
and engage in patient and public engagement activities.

<table>
<thead>
<tr>
<th>General Practice Patient Participation Groups</th>
<th>General Practices are the main primary care providers.</th>
<th>Effectiveness (responsiveness and quality)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient participation groups provide a patients perspective on services to influence provision.</td>
<td>Patient participation groups provide a patients perspective on services to influence provision.</td>
<td>Effectiveness (responsiveness and quality)</td>
</tr>
</tbody>
</table>

| Friends and Family Test | A satisfaction survey administered to patients after they have received care. | Effectiveness (responsiveness) |

| Regional Citizen Senates | A group of up to 35 members of the public that work alongside clinical senates to decide upon priorities for regional healthcare strategy. | Autonomy (communal) |

| Patient Choice | The ability of the patient to choose between competing providers of healthcare services. | Autonomy (individual) |

| Care Quality Commission (CQC) | CQC is one of the main regulators of health care services. | Accountability (sanction) |
| Experts by Experience Inspectors | ‘Experts by experience’ are service users that conduct inspections alongside professional inspectors to provide the patient perspective. | Accountability (communicative) |

| Healthwatch | Network of statutory bodies performing role of local consumer champion. | Effectiveness (responsiveness and quality) |

| a) Information gathering | A range of independent engagement activities to assess local views and experiences of healthcare that are fed to providers to influence provision. | Effectiveness (responsiveness and quality) |
| b) Inspection | Monitors and reviews local healthcare services from the perspective of local people, with a number of tools to enable public inspection of services. | Accountability (communicative) |
Autonomy

Autonomy is key function of democratic organisation. Democracy's respect for autonomy is a common justification for its superiority to other forms of government, and it has been argued that some conception of autonomy is at the heart of all democratic thought from ancient Athens to our contemporary representative democracies (Held, 2006; Lakoff, 1996). Lakoff (1996) stipulates three different conceptions of autonomy that have underpinned democracy. *Communal autonomy* is the ability of a collectivity to determine the rules and structures by which it operates, which Lakoff associates with Athenian democracy but also informs participatory democracy and the civic republican tradition. *Plural autonomy* is the ability of social sub-groups to regulate their own affairs and share in power, which Lakoff links to the Roman Republic and is also realised in modern forms of corporatism. Finally there is *individual autonomy*, which concerns individual citizens’ ability to pursue their own will, and is primarily associated with liberal democracy.

It may be uncontroversial that democracy should function to promote autonomy, but the question of whether participation in public administration should do the same is more contested. For classical public administration, autonomy is realised through politics and the legislature, thus is unnecessary in administration. Nonetheless, the extent to which electoral mechanisms realise effective popular control over public services has become questionable as governance has begun to be prosecuted through markets and networks as well as bureaucracies, weakening the connection between elected politicians and the provision of public services. Sorenson and Torfing (2005), for instance, have pointed to concerns regarding the lack of democratic control over governance networks and the need for such networks to be democratically anchored. The NHS is no exception. Successive reforms have weakened the control of national and local politicians over health provision. One of the main charges against the much criticised 2012 Health and Social Care Act was that it transferred the responsibility of the Secretary of State for Health to commission local NHS services to local CCGs. Accordingly, the Secretary of State no longer has responsibility to answer for, nor power to intervene in, local commissioning decisions. The NHS is now made up of a number of relatively autonomous bodies – for
example, commissioners like NHS England and CCGs and service providers like Foundation Trusts – that make decisions about provision of health services without the traditional forms of democratic control.

The fragmentation of democratic authority in the NHS has however been accompanied by a trend towards distributing empowerments directly to citizens. These empowerments have primarily been conceived of in terms of plural autonomy. Citizens have been seen as one of a number of stakeholders that need to be represented in governance structures, and there are number of NHS organisations that include lay representatives on boards. CCGs must have two lay members, who "ensure the public voice of the local population is heard and that opportunities are available for PPE [Patient and Public Engagement]" (Gilbert, 2012: 6).

Foundation Trusts are membership organisations that combine forms plural and communal autonomy. Plural autonomy is again through representation on the board. The board of governors consists of four groups: public governors, patient governors, staff governors and appointed stakeholders. Communal autonomy is through the membership process. Trusts are tasked with creating their own public by recruiting a membership, taking steps to ensure it is broadly representative of the community they serve. Membership is open to anyone who works at the trust, has been treated by the trust or lives in the area served by the trust. Members are consulted on development plans, can stand for election as a governor and vote to elect the public, patient and staff governors.

Attempts to realise communal autonomy through processes of collective decision-making are rarer, yet there are some nascent initiatives to institutionalise forms of participatory co-governance. One example is the biannual NHS Citizens’ Assembly, a two-day public meeting with the NHS England Board to decide on key priorities; another is the regional citizens’ senates, which have been founded to complement the regional clinical senates of health care professionals. These citizen senates consist of up to 35 members of the public who, in consultation with other public and patient forums and organisations, independently determine their own priorities for strategic healthcare developments.
They then work alongside the clinical senates in strategic clinical networks to try to implement their agenda for regional health improvements.

Respect for individual autonomy has also been a key driver of changes in governance structure of the NHS, though mainly focused at the level of individual care. This has been concerned with transforming the relationship between patient and professional, so that patients are not passive recipients of the decisions of professionals but active participants in decision-making about their own care (Department of Health, 2012; Le Grand, 2003; NHS England, 2013). The most prominent approach to fulfilling the principle of individual autonomy has been the institutionalisation of patient choice. Advocates of choice have explicitly viewed it as a means for distributing individual empowerments in order that patients can demand inclusion in decisions about their health when faced with paternalistic professionals (Le Grand, 2003, 2008).

**Accountability**

The final function to be considered here is accountability. Accountability has been described as “the buzzword of modern governance” (Bovens et al., 2014: 1). Following Pitkin’s influential account, the representative relationship has commonly been conceived as one of authorisation and accountability through elections (Manin et al., 1999; Mansbridge, 2003). This has primarily been constructed in terms of a principal-agent relationship; as Warren and Castiglione neatly summarise,

> “Democratic representation involves a representative X being held accountable to constituency Y with regard to interest Z. Accountability means that X provides, or could provide, an account of his/her decisions or actions to Y with respect to Z, and that Y has a sanction over X with regard to Z” (2004: 20).

In this description accountability has two elements. There is a communicative element, namely providing an explanation or justification (which could be about decisions or actions but can also be
extended to include inputs, outcomes, or performance), as well as a process of interrogation of the principal rendering this account. Then there is an element of judgement whereby the agent assesses the account and rewards or sanctions the principle accordingly. Theories of democratic representation and accountability have moved beyond this simple principal-agent model of electoral accountability becoming more complex and diverse (Mansbridge, 2003; Warren, 2014); still, Bovens et al. (2014) argue that there is an underlying conceptual consensus in public administration and political science on these two constituent elements of public accountability.

The notion that bureaucracy could be made directly accountable to citizens is a relatively new one. Whether at the coal-face or walking the corridors of power, bureaucrats have traditionally been held accountable vertically through hierarchy and horizontally through professional self-regulation (Peters, 2014). They were only indirectly accountable to the public, through the elected politician at the head of the hierarchy (Manin et al., 1999). Nonetheless, a number of issues already documented above, such as the recognition of network governance and the discretion that bureaucrats have in interpreting legislation, as well as a perceived lack of bureaucratic responsiveness to both politicians and public, have driven attempts to institutionalise new accountability mechanisms. In the UK this has included publicly reported performance target regimes, increased performance audit and inspection, increasing competition between public service providers, and increased participatory accountability. Damgaard and Lewis (2014) have described five levels of citizen participation in public accountability, which mirror the rungs from Arnstein’s ladder. Each level progressively broadens the extent of communication with citizens, with their highest mode of “joint ownership” also including the power of citizens to sanction public servants, for example, holding power over which staff to hire and fire.

The largest experiment to provide individuals with powers of sanction over public servants in the NHS has been the introduction of choice and competition through a quasi-market in providers of health services. As Le Grand (2008) notes choice only becomes a sanction when there is competition between providers, otherwise the choice to exit does not have any consequences for the provider. Despite noting its growth across multiple policy areas and countries, Damgaard and Lewis strangely exclude
this from their framework of participatory accountability in an effort to retain the form of Arnstein’s ladder (2014: 268). Nonetheless, competition is commonly conceived of as an instrument of accountability (Peters, 2014), and, with the questionable proviso that the quasi-market functions effectively, this is quite a substantial transfer of public accountability to consumers of health services.

Participatory accountability also echoes through the terms of reference of a number of other NHS institutions. These efforts, however, have mainly revolved around citizen oversight, focused on increasing instances of direct communicative accounting of health professionals and administrators to citizens, with the opportunity for citizens to pass judgement though without the power to directly sanction. The Care Quality Commission (CQC) now advertises for ‘experts by experience’ to assist its inspections of health and social care services by providing a patient’s perspective on service performance through talking to current service-users and staff and observing service delivery.

Healthwatch draws its name from the oversight metaphor of the consumer watchdog. One of its three core functions is enabling people to hold local services to account by monitoring and reviewing provision (Local Government Association and Healthwatch, 2013). It uses a number of participatory tools to carry out these functions and understand quality of performance from local people’s perspective, including ‘enter and view’ inspections, ‘patient-led assessments of the care environment’, and 15-step challenge visits (Gilburt et al., 2015).
Figure 2: Summary diagram of relationships between functions and modes of participation
Conclusions

The objective of this article was to retain a key insight of the deliberative systems approach – that functions can be distributed across different parts of a system – while avoiding the synecdoche that results from conceptualising participation in public administration in solely deliberative terms. The three functions of effectiveness, autonomy and accountability have significant advantages in this regard. First, participation is not reduced to deliberation to influence decisions. A range of participation types are included that each target different functions (see Figure 2). This reflects the variety of ways citizens participate in the policy process, from individual consumer choices to shared decision power. These different modes of participation are compatible with the variety in modes of public administration. The conception of public administration is thus not limited to governance networks, but encompasses bureaucracies and markets. Moreover, the three functions are not rooted in a specifically deliberative conception of legitimacy. They do not reify any single, normatively contentious conception of legitimacy, but converse with multiple variants of normative political theory, as well as the many ways that participation has been justified in practice. As such, the functions engage with the important expectations that underpin people’s assessments of participatory decision-making. This grounded approach, which asks what are the problems participation is intended to solve and what are the values this problem-definition embodies, is one possibility for bridging the gap between normative political theory and empirical social science that Smith (2009) argues has stymied the development of this field of research. The openness to multiple, potentially competing, values and functions is of particular importance in contemporary democratic societies where there exists an inescapable plurality in competing principles of justice (Sen, 2010) and preferences for political decision-making (Bengtsson, 2012; Font et al., 2015). It holds out the possibility that a system which realised all of the functions could generate widespread support amongst people with heterogeneous preferences on the basis of what Sen (2010) has called ‘plural grounding’. The system could be supported for a number of different reasons without agreement on the relative merits of those reasons.
The presence within the English NHS of a vast number of participation opportunities employing a variety of modes of participation to contribute to different functions demonstrates that this is not simply an abstract theory but also has some purchase for describing how complex policy systems are actually functioning. Since it would be misleading to claim that participation in the NHS (or anywhere else) has been explicitly designed as a system, a systemic analysis can improve our understanding of how well participation is functioning in these complex policy systems, and how it might be improved. The creation of unproductive tensions through an attempt to serve multiple functions has been a consistent problem across different NHS participation mechanisms. This is apparent in Healthwatch’s efforts to combine collaborative partnership for increasing effectiveness along with the production of accountability, which is often interpreted by participants as adversarial. Local Healthwatch organisations have struggled to balance these alternative functions, instead opting to act as critic or friend (but not both) to other local health institutions (Gilburt et al., 2015: 36). This has led to quite distinct practices between different localities. ‘Friendly’ Healthwatch organisations, with the perception that other local institutions are doing their best, have focused on acting as a strategic partner providing support to improve services. ‘Critical’ Healthwatch organisations have focused on being an independent public voice that holds to account by rattling the cages of other local institutions. Both types have rejected the practices of the other as ineffective (Gilburt et al., 2015). It appears that specific Healthwatches have been characterised by functional myopia whereby the pursuit of either effectiveness or accountability has come to dominate. The systemic remedy would be to distribute these different, clashing functions. This could be achieved internally within Healthwatch, which, as aforementioned, has a number of potential participation mechanisms at its disposal. Alternatively, if this is impossible – perhaps the need for a coherent organisational identity may prevent a single Healthwatch simultaneously engaging in both collaborative and adversarial interactions with other local healthcare institutions – the functions would need to be distributed to different organisations.

Another common problem that the systems perspective helps us to diagnose is functional over-expansion. In the NHS this is evident in choice theorists’ argument that there should be a non-
negotiable, market-based rule to determine the closure of hospitals. If an insufficient number of patients choose to use a hospital so that it becomes financially unviable, then it should close and there should be no interference from the democratic process (Le Grand, 2008). This argument uses a single mechanism (choice) that is appropriate for realising individual autonomy and over-extends it to a domain that is properly the concern of communal autonomy. Whether a hospital should close clearly has implications for the community in which it is situated and there should be avenues for the community to influence this decision, as opposed to it being decided indirectly through the aggregated choices of individuals concerning a different matter, their own care. The systemic remedy here would be to sequence participatory activities so that market-failure triggers a community decision process in order to decide whether the hospital should close and, if not, to generate viable solutions for keeping it open. This sequencing enables choice and competition to do its work in serving individual autonomy and sanctioning poorly performing hospitals, whilst using a more appropriate process to realise communal autonomy on a matter of community concern.

In conclusion, this article has argued that a systemic approach to thinking about public participation in public administration has significant potential benefits, both for designing institutions that can command widespread legitimacy amongst populations with diverse preferences, and for diagnosing and remedying problems in the current practice of participation. However to realise the benefits it is necessary to go beyond the deliberative systems approach and embrace a more capacious conception of participation, public administration and legitimacy.
References


