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**The Democratic Potential of Public Participation:
Healthcare Governance in England**

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Abstract

Public participation is commonly advocated as part of the solution to the problem of democratic deficit in the development and implementation of policy. This article considers the democratic function of different arrangements for public participation with reference to alternative rationales for democratic engagement. We review the limitations of aggregative and representative notions, before exploring the senses in which a deliberative approach based on justification to the public can increase confidence in the democratic legitimacy of decisions. This theoretical understanding is used to evaluate the democratic potential of the recently reformed framework for Patient and Public Involvement (PPI) in healthcare governance in England.

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The democratic potential of public participation: healthcare governance in England

Public participation is commonly advocated as part of the solution to the problem of democratic deficit in the development and implementation of policy. This article considers the democratic function of different arrangements for public participation with reference to alternative rationales for democratic engagement. We review the limitations of aggregative and representative notions, before exploring the senses in which a deliberative approach based on justification to the public can increase confidence in the democratic legitimacy of decisions. This theoretical understanding is used to evaluate the democratic potential of the recently reformed framework for Patient and Public Involvement (PPI) in healthcare governance in England.

Introduction

Public participation is increasingly regarded as playing an important, and perhaps even a necessary, role in the democratic development and implementation of policy in western societies. The Council of Europe has stated that ‘[t]he right of citizens and patients to participate in the decision making process ... must be viewed as a fundamental and integral part of any democratic society’ (Council of Europe 2000). A democratic function is also recognised in trans-national governance instruments, for example the UNECE Aarhus Convention on Access to Information, Public Participation in Decision-making and Access to Justice in Environmental Matters (UNECE 2008). Public participation is frequently advocated in contemporary debate as a remedy for weaknesses in traditional representative structures, which suffer from ‘low electoral turnout, a focus on service provision rather than local voice, [and] poor representation’ (Harrison and Mort 1998, p. 61). Again, while most people can exercise some control over policy through elections, voting usually amounts to deciding between limited sets of choices, with little depth of involvement (Mullen 2008, pp. 398-402). A related argument is that public participation is necessary in

order to enhance democracy by redressing power imbalances and increasing the influence of citizens and the public relative to that of bureaucrats and professionals (Arnstein 1969).

If we accept the democratic case for public participation, the question becomes whether or how this role may legitimately be fulfilled. We address this question by distinguishing alternative democratic rationales for public participation, showing how this account can be used to evaluate regulatory arrangements for participation with reference to the example of recent developments in the system of Patient and Public Involvement (PPI) in healthcare governance in England. Rather than simply applying theoretical ideas in the evaluation of practical arrangements for participation, we suggest that consideration of such arrangements can allow insight into, and clarification of theoretical aspects of democracy (in this we follow an approach used by Bohman 1998, p. 400). Healthcare governance provides an illuminating focus for discussion and a promising subject matter for testing ideas and systems of democratic decision making, not only because it affects people's fundamental interests, but also because decisions on access to, and provision of, healthcare services are particularly contentious and open to debate and disagreement. The suitability of this case study of the democratic potential of public participation is enhanced by the history of government initiatives on citizen and service user involvement in this field over the last forty years.

In the first part of the article, we assess approaches to participation that might claim democratic legitimacy through aggregative and representative procedures which give people a say in decisions which will affect them. While acknowledging that these approaches might supply an element of democratic legitimacy, we emphasise fundamental limitations of lack of depth of public involvement associated with each approach. We then show how such limitations may be avoided through the development of a conception of public participation based on deliberative democracy. However, we contend that while the deliberative conception might contribute to increased confidence in democratic legitimacy of decisions, this approach also suffers from inherent limitations in the extent to which it may be said to provide full or complete legitimacy. In the later sections of the article, we show how this theoretical analysis may be applied in the provisional evaluation of the recently reformed system of PPI in healthcare governance in England. We suggest that the clarification of

reasons why public participation is important in these theoretical terms is a crucial preliminary step towards empirical research investigating the effectiveness of policies encouraging increased citizen involvement in fields such as healthcare (cf. Barnes et al, 2007).

Before continuing we should note that since our discussion is specifically concerned with the democratic aspect of decision-making processes we ignore for present purposes other possible rationales for public participation, for example its role as a means of increasing public trust in official decision-making affecting public services (cf. Milewa 2004, p. 243), and its function in monitoring the provision of healthcare services (see HCHC 2007; Vincent-Jones et al, 2009). The analysis presented here is part of a broader research project focusing on the communicative, democratic and cognitive conditions that arguably need to be satisfied in order for reflexive governance effectively to operate through social learning on the part of key actors and stakeholders in public service networks (Vincent-Jones and Mullen 2010).

Democratic legitimacy based on participation for all

Public participation might perform a democratic function by providing members of the public with a voice, or the ability to express an opinion, which then carries weight in determining policy and implementation. If public participation is to claim democratic legitimacy on this basis then we need to decide who is entitled to have a voice – that is who is the relevant public or constituency. People have interests in public services as users, taxpayers and citizens, and while memberships of these groups overlap, they are not identical (Tritter and McCallum 2006, p. 160; Callaghan and Wistow 2006, p. 584). Once the relevant constituency has been identified, we need also to consider the capacity in which individuals should be involved (Mullen 2008, p. 399). Democratic legitimacy in this sense is arguably dependent on every person within the constituency (or at least every member satisfying certain criteria, for example adulthood) having the opportunity to express an opinion (see Harris 1998, p.87).

A further problem then concerns processes or mechanisms of participation. One solution could lie in the adoption of an aggregative approach (see Chambers

2003, p. 308), for example using large scale surveys giving each member of the constituency the opportunity to have a direct say on particular issues. Unsurprisingly the appeal of this method is likely to be limited to relatively simple issues where straightforward choices may be made between limited numbers of fixed options, and even then this model would require an explanation of how responses should be aggregated in order to reach a decision. In more complex cases there may be concerns about the limited opportunity for participants to give voice to nuanced ideas, choices, or arguments (cf. Mullen 2008, pp. 401-402). Moreover, unless participants have a say in deciding what choices should be offered, or who should set these choices, then we might question the extent to which the results of surveys could be considered to have resulted from the opinions of the constituency.

Elections might appear to avoid the limitations of surveys, while retaining democratic legitimacy by providing each member of the relevant constituency with the opportunity to express an opinion. Members of the constituency could each have a vote for (and could stand as) representatives to form a group which would engage in the definition and discussion of issues, problems and solutions. But while this approach would facilitate debate among representatives chosen by the constituency, problems of inclusiveness and depth of involvement remain. One concern is the tendency for varying levels of participation by different groups in formal electoral processes (Tritter and McCallum 2006, p. 160). A further difficulty is raised by Dryzek, who argues that if the rationale for representation by an elected group stems from the democratic value placed on enabling depth of involvement in deciding issues, then we should be concerned if the process of choosing the system for electing the group is not marked by similar depth of involvement by members of the relevant constituency. However, if each person is to have a say in settling the system for election, then it is difficult to see how there can be depth to their involvement. In other words limited involvement in choosing the electoral system means that 'the problem of scale reappears, only this time in a slightly different location' (Dryzek 2001, p. 653).

Deliberative democracy: legitimacy based on justification to the public

Given the persistent tension between inclusiveness and depth of involvement (Tritter and McCallum 2006, p. 162), we may consider whether democratic legitimacy can be reframed in a way that does not require opportunity for participation by every member of a constituency (cf. Dryzek 2001, p. 657). Accordingly, this section suggests an alternative conception of democratic legitimacy based on public participation leading to decisions that can be justified to the public. Although we argue that ultimately it is impossible to claim full democratic legitimacy for decisions arrived at through public participation in whatever form, we nevertheless suggest that a deliberative approach may contribute to increased confidence in the legitimacy of decisions and decision-making processes.

Justification to all affected

While commenting that there are various conceptions of deliberative democracy, Chambers suggests a common theme in the ideal of legitimacy as involving ‘justification to all affected’ (Chambers 2003, p. 309; see also Bohman 1998, p. 402). Cohen maintains that ‘outcomes are democratically legitimate if and only if they could be the object of a free and reasoned agreement among equals’ (Cohen 2006, p162). Following these ideas, democratic legitimacy might be claimed where participation leads to reasoned decisions that are justifiable to the public in the relevant constituency. This conception focuses attention on whether there are methods of public participation, and participatory fora or structures, that have the potential to facilitate decisions that have the quality of justifiability.

In order for legitimacy to be grounded in this way, participants must have, or be able to acquire, relevant knowledge or understanding, and have or be able to develop the capacity to articulate views on policy issues. In the case of healthcare policy and implementation, practical arrangements would need to be made to provide the participants with access to sufficient information and knowledge to facilitate their engagement in debate on quite technical matters (cf. Wakeford 2002), for example relating to a population’s needs and preferences, finance, measurement of health gain, knowledge of transport systems, and accessibility. Deliberation would then involve participants using their understanding of these technical issues to question or test

existing and proposed policy. The deliberations might be expected to result in at least some decisions which could be explained and justified to the wider public (cf. Chisholm et. al. 2007, p. 16). However, one problem here is that technical issues (for instance concerning the organisation and management of public services, or the implementation of regulation) frequently cannot be separated from social and ethical considerations of value, including matters of how values should be interpreted in decision-making (see Mullen 2008, pp. 397-398; see also Dryzek 2001, p. 658)). Consider, for example, the question of whether a general practice surgery should be relocated or merged with the potential for improved quality of specialist services, but at the cost of reduced accessibility for a small section of a community (see Weale 2006, p.38). While technical issues are relevant (such as costs or the degree of accessibility associated each option), this question also raises matters of value such as the value that should be given to preserving life, or the priority that should be accorded the protection of minority interests weighed against the benefits to a majority. Where ethical and social considerations are at stake, then it may be thought difficult for participants to agree on decisions, and more problematic to justify those decisions to the public.

This difficulty need not necessarily prevent participants from reaching agreement on decisions which are supported by reasoned arguments. In particular, we might expect that processes of deliberation would enable participants to address and resolve concerns or criticisms about each other's arguments and judgments. We may further suggest that if participants reach agreement on reasoned decisions then there is some basis for holding that the public may also accept those decisions. Heyse describes a case for claiming that we might expect such agreement among participants and acceptance by the wider constituency:

'If I believe myself to have good arguments for a particular judgment (for instance concerning the moral justification of a certain conception of justice) these arguments must be good enough for others. Consequently, I must believe that either those others will (ultimately) come to agree with my judgment or their judgment is flawed (i.e. misinformed, prejudiced, incompetent, etc.).' (2006, p. 270)

So, according to this argument, if deliberation produces ideas that are based on reasoned arguments, then they should be justifiable both to participants and the wider public.

However there are at least two sources of a counter case that can be made against the expectation that a reasoned argument will be justifiable in this way. First, it is possible that the public might reject reasoned decisions resulting from participants' deliberations, and moreover that they might have reasons to support their rejection. If this occurred, then it could be claimed that the participants' decisions were not justified to the public. People may have reasons for disputing even considered arguments, if those arguments have failed to examine alternative social and ethical assumptions and positions (cf. Dryzek's discussion of 'competing discourses' 2001, pp. 657-663). Participants in deliberations may have shared ethical assumptions, or be simply unaware of some ethical positions (Mullen 2008, p. 405). In either case, this can lead to decisions made without consideration of potential alternatives, and it is these alternatives which could justify objections to the participants' decisions. It may be that the risk of failing to consider alternative ethical positions is increased if the participants are drawn from narrow sections of society (cf. Levit 2003, p. 23), and conversely this risk might be mitigated if steps are taken to ensure that the participants reflect characteristics (in terms of gender, age, ethnicity, health status, income etc.) of the relevant constituency.

A further factor which can influence the risk of relevant alternative positions remaining unconsidered stems from the way in which people can develop ethical understanding and concerns for health and social care based on their experience as service users. Martin (2008) suggests that at least some members of the public develop opinions which are informed by their individual experiences coupled with an understanding of both technical aspects of health and social care, and of social and ethical arguments. In other words, people can use a reflexive approach in developing opinions involving analysis of their individual experiences according to ethical and social notions (*ibid*, pp. 38-42). Martin's account emphasises the need for constant awareness of the possibility of development of new opinions and concerns in human service fields such as healthcare in order to minimise risks of failing to consider relevant alternative positions. Yet even if steps are taken to consider the various ethical and social assumptions held within the constituency, arguments may still be

missed. In response to a similar concern, Dryzek suggests that legitimacy can still be assumed if there are opportunities for participation by members of the constituency who hold alternative positions (2001, p. 662). However, even if we allow that people who develop new opinions will be keen to make them heard (Martin 2008 pp. 40-41), it does not necessarily follow that if people do not engage in a debate they have no reasons to reject the outcome of that debate. This difficulty of knowing whether account has been given to relevant ethical assumptions is one reason for caution in claiming that decisions resulting from deliberation can ever be fully or completely legitimate.

Secondly, as Dryzek has noted, deliberation may not end in consensus (2001, p. 661). A particular difficulty is that judgments which are the result of a process of reasoned argument that has considered relevant alternative ethical positions might still be countered by other reasoned arguments. To see this, consider again the debate on whether a surgery should be relocated or merged. Let us assume participants in the discussion begin from differing positions, but can nevertheless be understood as engaging in a communicative action in which they attempt to resolve one another's criticisms and to reach agreement (cf. Habermas 1998, p. 232). Further let us assume they have a shared conception of what constitutes a reasoned argument (for instance, on how to verify technical details, or on whether a particular step in the argument is rational one), and agree on matters of what constitutes relevant considerations (for instance, accepting that accessibility is important). Despite all of this, discussion can still end in basic disagreement on the relative priorities that should be given to ethical considerations (cf. Dworkin 1996, p. 113; Mullen 2008, p. 405). Dryzek argues that despite such disagreement it might nevertheless be possible to reach 'workable agreements' which are broadly compatible with each of the conflicting arguments (2001, p. 661). While this may be possible in some circumstances, in other cases conflicting arguments seem to require different and incompatible actions – for example disagreement on whether accessibility to services for each person in a population should take priority over increased quality which brings improved health to some. This possibility of conflicting positions each supported by reasoned arguments reinforces the suggestion of the need for caution in claiming legitimacy in this deliberative sense. The decisions *might* be justifiable to the relevant constituency, assuming that all accept they are grounded in reasoned argument. However, the

possibility remains that there would be other, conflicting decisions which are also based on arguments which all agree to be sound, and which might also be justifiable. Where two conflicting positions could both be supported by reasoned arguments, then it is plausible to allow that people may prefer either position and thus deny that the other position is justified.

Increased confidence in democratic legitimacy

Despite the obstacles to claiming full legitimacy on the basis of justification to the public, deliberative participation may still contribute to increased confidence in the democratic legitimacy of decisions. Such confidence is likely to require the maximising of opportunities for testing whether ideas of decision-makers can or cannot be justified to the public, and to depend at least in part on how effectively participants can develop ideas and challenges which take account of the range of positions held by members of the relevant constituency (cf. Dryzek 2001).

Any disagreement between participants and decision-makers could prompt discussion in which decision-makers would give reasons for rejecting the participants' judgments: for instance arguing that ideas failed to properly take account of technical aspects, or that they were inconsistent, or possibly that there was a valid alternative position. This may lead to further questions from participants (possibly after further deliberation), to which further responses should in turn be provided. If, ultimately, decision-makers could not provide a reasoned response to such challenges, then there would be a case for them adopting participants' judgments. If decision-makers failed to accept the participants' judgments but could not provide a reasoned counter-argument, then we would have grounds to doubt that the decision-makers' ideas could even potentially have democratic legitimacy as the 'object of a free and reasoned agreement among equals' (Cohen 2006, p.162). So while we may not be able to claim that the reasoned decisions of participants *would* be justifiable to the whole of the relevant constituency, we can maintain that a decision *would not* be justifiable to the constituency if participants have rejected it on the ground that it is not supported by reasoned arguments.

The extent of public confidence in democratic legitimacy will depend ultimately on how the results of debate and decisions reached by participants are

treated by final decision-makers, such as policy makers or commissioners of services. Arguably there is little point in extensive deliberation resulting in proposals – however well justified and supported by relevant arguments – which do not receive a response from such decision-makers also based on relevant arguments and considerations. As Milewa has noted, ‘[t]he role of consultative and deliberative mechanisms in deflecting challenges to managerial and political power has been a recurrent feature of studies in “lay” involvement’ (2004, p. 249).

Evaluating participatory arrangements

The foregoing discussion has provided an account of how public participation in decision-making might be used in differing ways to strengthen democratic society. That is, surveys concerning straightforward choices might provide an element of democratic legitimacy by giving each member of the relevant constituency a say on specific issues of policy and implementation. Elections might supply each member with a limited voice, and allow for more detailed discussion through the role played by elected representatives. Finally, a conception of deliberative participation may enable increased confidence in the legitimacy of decisions by testing whether reasoned arguments can be given against challenges to those decisions.

We now use this account to evaluate the democratic potential of arrangements for participation in decision-making on policy and implementation with specific reference to the system of PPI in England. Institutional arrangements for participation were radically reformed by the Local Government and Public Involvement in Health Act 2007, which replaced Patient and Public Involvement Forums (Forums) with Local Involvement Networks (LINKs). Forums had been in existence only since the beginning in 2003, having themselves replaced Community Health Councils (CHCs) established in 1974 (HCHC 2007, paras 35, 42). In this section we demonstrate how the substantial differences in the remit and the membership of these three institutional structures may be analysed according to the different senses in which they may legitimately be regarded as fulfilling a democratic function. While the creation of LINKs is the most visible of the recent changes in the PPI regime, the 2007 Act also contained significant amendments to the duty on NHS bodies to engage in consultation. Together these reforms provide excellent material for comparative

evaluation of the potential contribution of public participation to democratic decision-making. We begin by outlining how the successive structures for participation might contribute to legitimate decision-making, before describing the changes to the duty on the part of NHS bodies to consult the public. Finally we evaluate the democratic potential of the current system of PPI relative to previous arrangements, using the theoretical analysis developed above.

Local involvement networks and their predecessors

LINKs are required to involve patients and the public in decisions concerning the provision of health and social care across an entire local authority area. This broad remit differs significantly from the more limited role of Forums, which had sought to represent patient and public interests in services provided by a single NHS Trust (HCHC 2007, pp. 18). By contrast CHCs had not been attached to individual NHS Trusts but instead represented the public's interests in 'local health services' (HCHC 2007, pp. 18). LINKs will obtain views from citizens and service users about health and social care needs and experiences, and convey those views to organisations responsible for commissioning, providing, and managing local health and social care services. In addition, LINKs will make 'reports and recommendations about how local care services could or ought to be improved' (2007 Act, s221(c)), and ... 'consider how to address areas of concern' (such as health inequalities – see DoH 2007b, p. 34). This suggests that LINKs will play a proactive role in shaping agendas, beyond gathering and conveying of information about needs and preferences. In making reports and recommendations, LINKs will have to consider how different needs should be met in the light of competing policies and underlying values (such as respect for autonomy, or reduction of inequalities). While Forums and CHCs also had the option of making considered recommendations, the significant difference here is in the range of public service issues covered by the organisations. The wide terms of reference enjoyed by LINKs compared with their predecessors will enable them to make reports and recommendations concerning multiple services. This will avoid difficulties that had confronted Forums in addressing problems within one service which were related to deficiencies in other services outside their remit (see HCHC 2007, p. 21).

Members of Forums were appointed by a non-departmental public body – the Commission for Patient and Public Involvement in Health (CPPIH) – which had a formal role in speaking on their behalf (HCHC 2007, paras. 42-3). Forums, which each comprised around eight appointed members, had been criticised for failing to reflect the range of backgrounds of members of the community they represented (HCHC 2007, pp. 28-33). Prior to their abolition and replacement by Forums, CHCs had between fifteen and twenty-five members, half of whom were appointed by local authorities, one-third elected by the voluntary sector and the remainder by NHS regions (Hogg 2007, p. 132). Like Forums, they were criticised for their ‘inability to reflect the diversity of local communities’ (Tritter and McCallum 2006, p. 158). Again in contrast with Forums and CHCs, each LINK is free to decide its governance structure and membership, which may include both voluntary organisations and individuals (DoH 2006a, pp.14-6; DoH 2007b). LINKs remain formally independent of both the NHS and local authorities, their work being supported by a ‘host’ organisation under contract with the local authority (2007 Act, s222; DoH 2007b, pp. 7-11). LINKs have the freedom to engage a greater number and broader range of participants than either Forums or CHCs (DoH 2007b). The Department of Health maintains that ‘every LINK should be established in a way that is inclusive and enables involvement from all sections of the local community, especially those who are difficult to involve or seldom heard’ (2007b, p. 4).

In determining their governance structure (Statutory Instrument 2008, Number 528, Part 2), LINKs may adopt a steering group or a network model, or a combination of the two (HCHC 2007, paras 115-126). In the steering group model, the detailed discussion of issues will primarily fall to a limited number of people. This need not preclude roles for other participants in raising issues and contributing to discussion, and indeed Department of Health guidance states that ‘[t]he governing group should not itself act as a consultative body or speak on behalf of the LINK without the wider participants’ involvement and consent’ (DoH 2007a, p.19). While the adoption of a network model presents the opportunity for more people to directly engage in discussions, it would also make internal decision-making more complicated, and may lead to concerns about inclusivity (for instance, if de facto decision-making tends to rest with a few participants). The role of participants in internal decision-making may also be influenced by the relationship between the LINK, the local authority and the

‘host’ contracted to support the LINK. While the host should facilitate rather than direct the work of the LINK (see DoH 2007a), the contractual relationship with the local authority (itself a provider of social care services) is a potential threat to the autonomy of the LINK in making its decisions independently.

In addition to the question of how LINKs will produce recommendations, there are also questions concerning the impact those recommendations will have on decisions made by policy makers or commissioners of services. LINKs are entitled to receive a response from the ‘relevant services-provider’ (that is, an NHS Trust or local authority) explaining what action it will, or will not, take in light of a report or recommendation made by the LINK (Statutory Instrument 2008, No. 528, regulation 5). Accounts of how services-providers have responded will be given in each LINK’s annual report to the Secretary of State (DoH 2008a, s8). Therefore while the LINK cannot insist that a recommendation is acted upon, there exists a mechanism which should ensure that it is at least considered by services-providers. Further, LINKs have not regained the power that CHCs had ‘to veto proposals involving service re-design, such as ward closures, and to refer matters directly to the Secretary of State’ (HCHC 2007, p. 18). Like the representative structures before them, LINKs have a power to refer matters regarding services to local authority Oversight and Scrutiny Committees (OSCs) (*ibid*, p. 21). Although this power arguably provides a further incentive for decision makers to take seriously recommendations made by the organisation, OSCs have a discretion whether to take on any case that has been referred to them, and even where they do take on an issue, their recommendations are not binding.

Limiting the scope of the duty to consult

While LINKs have broader terms of reference than their predecessors, the new ‘duty to consult’ under the 2007 Act restricts the range of matters on which NHS bodies are required to consult. The original ‘Section 11’ duty, as embodied in the Health and Social Care Act 2001, had required NHS bodies to involve and consult ‘persons to whom ... services are being or might be provided’ in the ‘planning of the provision’ of services, in decision-making affecting their operation, and in ‘the development and consideration of proposals for changes’ in the manner of their provision (s 11 of the 2001 Act, which became s 242 of the NHS Act 2006). Early guidance on the scope of

the duty made explicit the government's intention at this time not to present patients and the public with fixed choices determined in advance, but rather to:

'open discussion with patients, the public, and with staff ... right at the beginning – before minds have been made up about how services could or should change.' (DoH 2003, p.7)

The revised duty under the Act retains the requirement for involvement: (a) on 'the planning of the provision' of services; (b) on 'changes in the way those services are provided'; and (c) on 'decisions...affecting the operation of those services'. However this is now subject to the condition that parts (b) and (c) only apply if proposals would affect 'the manner in which the services are delivered to users of those services...at the point when they are received by users,' or 'the range of health services available to those users' (s233 of the 2007 Act).

Compared with the original Section 11, therefore, there is no duty to consult on changes in the way in which services are delivered (for instance through independent providers), unless it can successfully be argued that such changes ultimately affect the services that people receive (DoH 2008b, p.22). The government's shift of position since the earlier guidance is evident from the statement that subjects for consultation should typically include issues such as 'a change in opening hours, or a change of site, rather than managerial changes that do not affect service provision' (Cm 7128 2007, p. 22).

However, the reduced scope for consultation under the 2007 Act may be of little practical consequence, given the government's persistent failure to observe the terms of the original Section 11 duty. According to the House of Commons Health Committee, the government had taken every opportunity to point to 'circumstances in which formal Section 11 consultations should not take place either because they would be a waste of money or because they would compromise safety' (HCHC 2007, para 257). In similar spirit, the Department of Health issued advice to Health Authorities and Primary Care Trusts that the duty did not apply in relation to the establishment of Independent Sector Treatment Centres (see HCHC 2007, para 251). The Court of Appeal held that while the duty did indeed apply in these circumstances, it could be discharged by mere provision of information (see Fudge, R (on the

application of) v South West SHA 2007, para 64). More embarrassing for the government was the successful challenge to the decision by North Eastern Derbyshire Primary Care Trust not to consult over a decision to award a contract for general practitioner services to a private company. The judge rejected the argument by the PCT and Secretary of State that the decision to award the contract was ‘merely the re-provision of services’ (Smith v North Eastern Derbyshire PCT 2006, para 15; Smith v North Eastern Derbyshire Primary Care Trust [2006] EWCA Civ 1291 (23 August 2006), para 6). The likely effect of the revised duty will be to remove in future the inconvenience to the government associated with such litigation.

Although the 2007 Act formalises limitations in the scope of matters of consultation, it should be noted that there is a different respect in which the Act extends the duty to consult, by creating a duty for Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) to report on consultations in relation to commissioning decisions (s233 of the 2007 Act). According to the guidance on this duty, the reports should:

‘set out...an explanation of how the views of the people who were consulted were taken into account when the decision was made; how feedback influenced the decision taken – whether anything was commissioned differently as a result of the feedback received; and the main issues considered on which it was not possible to act, and the reasons why’ (DoH 2009, pp. 12 and 23)

Democratic potential of PPI

If the democratic potential of the system of PPI is assessed according to the extent to which people in the relevant constituency are able to have a say in decision-making, then it may seem that the English reforms weaken what was already a restricted role for participation. Neither the reformed arrangements nor their predecessors are much concerned with processes that would enable democratic legitimacy to be grounded in the provision of voice to every member of the constituency. LINKs might undertake surveys which could claim some legitimacy in this sense, but only if the choices offered were straightforward and if each member of the relevant constituency had the opportunity to respond. As regards the provision of each member or their

representatives with a voice through elections, there is a significant difference between CHCs and their successors. CHCs could make some, albeit indirect, claim to electoral legitimacy by virtue of the appointment of a proportion of their membership by local government which is itself elected (Baggott 2005, p. 535; Hogg 2007, p. 132). Neither Forums nor LINKs involve elected members even in this sense (elections do appear in another area of healthcare – in hospital Foundation Trusts whose Boards of Governors are elected – see Baggott 2005, p. 543, and HCHC 2007, p. 24). LINKs, Forums and CHCs can claim only indirect electoral justification in referring matters to OSCs who are themselves made up of elected local councillors (see DoH 2006b, paras. 5.3-5.4). However, despite such weaknesses, we have suggested that we should not be too concerned that the PPI system lacks prospects for legitimacy based on providing a voice for each person, since any form of participation which can claim legitimacy in this sense will also be one which allows only limited depth of participation.

If the democratic potential of PPI is assessed according to how far arrangements for participation may increase confidence in the legitimacy of decisions, the recent reforms offer more mixed prospects. Prior to the 2007 Act, the Section 11 consultation duty provided scope for enhancing debate and deliberation on a range of issues concerning local policy, planning and implementation. The possibility that relevant ideas and challenges by members of the public might inform and influence decision-making was acknowledged in official guidance, which specifically encouraged discussion with patients and public before choices had been framed (DoH 2003, p.7). While there is evidence that this guidance was followed in at least some cases (see HCHC 2007, paras 243-50), there were also moves to restrict the range of issues subject to the duty, which would have limited any deliberative value in these arrangements. As we have seen, the revised duty under the 2007 Act reduces further the potential for deliberation. The effect of the reform is arguably to limit the role of patients and public to that of consumers (cf. Tritter and McCallum 2006, p. 161), rather than citizens contributing to a broader debate on wider issues such as the degree of private sector involvement in healthcare provision. Nevertheless, there is also a sense in which the reformed consultation duty may enhance prospects for deliberation, albeit on narrower range of issues. As we have noted, if deliberative participation is to increase confidence in democratic legitimacy then decision-makers

need to engage in reasoned consideration of the results of public deliberation. The requirement for SHAs and PCTs to explain how they have taken account of consultations on commissioning decisions has the potential to act as a check on whether decision makers are presenting reasoned responses to the public's ideas and opinions.

By contrast with the move to restrict the scope of the consultation duty, the reform of representative structures may be regarded as increasing the potential for deliberation through the wider terms of reference enjoyed by LINKs compared with Forums in considering matters covering both health and social care. However, the realisation of such potential will depend on a variety of factors. In order to develop recommendations and reports raising reasoned questions, proposals and challenges, LINKs will need effectively to engage people in the relevant constituency, and provide the means for advancing and debating ideas. A key question here is the extent to which LINKs exploit their remit to consider broad issues of policy, planning and implementation. The deliberative potential of LINKs may depend also on their success in involving a greater number of people, and people from more diverse backgrounds than was the case with CHCs and Forums. The aim should be to maximise the input of reasoned questions, ideas, and challenges within the deliberation by drawing upon the widest possible range of experience, knowledge and understanding (see Mullen 2008, p. 407). The host organisation contracted to support a LINK could also have an impact on the LINK's deliberative capacity through its role in assisting with setting up and managing forums for debate, and possibly shaping subjects of debate. The potential influence of the host organisation in this respect might be compared to the role of the CPPIH in appointing Forum members and speaking for Forums.

A further question is whether the LINK chooses a governance structure limiting debate within smaller governing groups or allowing a broad range of participants. The risk with the former approach is that the members of the governing group may not between them possess the range of relevant ideas and challenges that could be brought into play by a larger grouping of participants. The latter model appears to offer greater opportunity for including people with a range of ideas, but carries the risk that debating fora may become over-complicated, or dominated by a minority of participants. As with the duty to report on commissioning consultations, the duty to consider and respond to LINKs' reports and recommendations may help to

ensure that services-providers take account of relevant ideas and challenges. Similarly, the obligation on OSCs to ‘take into account any relevant information provided by a local involvement network’ (2007 Act, s226), where it decides to take up a matter referred by a LINK, may create incentives for debate and deliberation on issues of concern to service users and citizens. Ultimately, although the formal framework for LINKs offers significant potential for improving the quality of deliberation, the realisation of this potential depends in practice on the ways in LINKs conduct their work, and on how decision-makers respond to their arguments.

Conclusion

In subjecting to critical scrutiny the assumed democratic role of public participation in modern societies, we have argued in this article that citizen engagement in whatever form can only ever make a limited contribution to democratic decision making. On the one hand, public participation which claims legitimacy by including every member of a relevant constituency has an appeal which is reduced by limitations in the depth of participation which is possible. On the other hand, we need also to be cautious about claiming legitimacy for participation based on conceptions of deliberative democracy, since we can never be satisfied that decisions are capable of being fully or completely justified to the public in the relevant constituency. Nevertheless, to the extent that it may help rule out decisions that would not be justifiable to the public, we have suggested that the deliberative approach holds the possibility of increasing democratic confidence in decisions. In this sense we can conclude that deliberation may contribute to democratic decision-making.

We have suggested that the clarification of alternative democratic rationales for public participation is a necessary preliminary to empirical research investigating the effectiveness of policies such as PPI. In other words, the ultimate evaluation of the democratic potential of practical arrangements for public participation cannot properly be accomplished other than on the basis of in-depth consideration of the underlying purpose or purposes of policies supporting the involvement of citizens and service users in decision making. The analysis of the reformed PPI framework in England has shown how arrangements for public participation with only weak provision for

citizens to have a say in determining decisions may nevertheless have democratic potential. In particular we have suggested that the current PPI system holds some promise for deliberation which could increase confidence in the legitimacy of decisions. However, the realisation of this potential is contingent on several aspects of the practice of participation. The success of the new regime will depend on the effective engagement of a broad range of participants in deliberative processes, and on the contribution of ideas and challenges by members of the public. How far the deliberative approach can enhance confidence in the democratic legitimacy of decisions will depend also on the willingness of key actors in healthcare networks to respond appropriately to those ideas and challenges in their decisions on policy and implementation. We argue elsewhere (Vincent-Jones and Mullen 2010) that the cognitive processes involved in effective justification to the public serve not only to increase confidence in legitimacy, but also as an essential condition for an alternative approach to the evaluation of public participation, which conceives of the advancement of the public interest in democratic societies in terms of the notion of reflexive governance as social learning.

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