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**Embedding Economic Relationships through Social Learning?
The Limits of Patient and Public Involvement in
Healthcare Governance in England**

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Embedding Economic Relationships through Social Learning? The Limits of Patient and Public Involvement in Healthcare Governance in England

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Abstract

The healthcare modernisation agenda pursued by Conservative and New Labour governments in England since the 1980s has both economic and democratic dimensions. As competition intensifies and the role of private and not-for-profit service providers increases, economic regulation is becoming more important. At the same time, other pressures at national and supra-national levels are reinforcing the trend towards more democratic and participatory forms of governance. This paper analyses the limits of the recently reformed framework of Patient and Public Involvement (PPI) in embedding economic relationships in social relations in the English healthcare context. It argues that this goal can be achieved only on the basis of a better understanding of the relationship between economic and democratic strategies for NHS modernisation, requiring that policy makers and professionals pay specific attention to the social learning dimension of governance in this and other human service sectors.

Introduction

This paper offers a critical evaluation of the strategy for NHS modernisation in England, focusing on the relationship between economic reforms designed to increase market incentives and competition, and the development of the system of Patient and Public Involvement (PPI) aimed at improving citizen participation and democratic accountability. The economic and democratic elements in the current reform agenda co-exist in a state of mutual tension. On the one hand, competition is intensifying and the governance of healthcare is approximating increasingly to the regulatory model found in the public utilities sectors. On the other hand, pressures at national and supra-national levels are reinforcing the general trend in the UK as in other western societies towards more democratic and participatory forms of governance.¹ Against this background, the

¹ Council of Europe, 'The Development of Structures for Citizen and Patient Participation in the Decision making Process Affecting Healthcare' (Council of Europe, 2000).

paper explores the links between notions of embeddedness and the contemporary continental legal-philosophical theory of ‘reflexive governance as social learning’ associated with the FP6 project ‘Reflexive Governance in the Public Interest’ (REFGOV).² Drawing on these theoretical perspectives, the paper suggests that the effective embedding of economic relations in social relationships requires that both policy makers and professionals pay attention to the *social learning* dimension of governance, as distinct from the more familiar preoccupation with issues of efficiency, legitimacy and accountability.

The first part of the paper provides a historical overview of the development of the NHS. Here we show how the modernisation strategy embraced by Conservative and Labour governments in recent years, combining neo-institutional economic and democratic/deliberative approaches to governance, has developed in reaction to perceived deficiencies in the form of bureaucratic organisation of the NHS after 1945. In the second section, we show how the REFGOV perspective may contribute to a Polanyian analysis of embeddedness in this field,³ focusing on the weaknesses of the current system of PPI and on the deliberative and experimentalist conditions that need to be established in order to support reflexive decision making and problem solving in healthcare networks. The final section explores the relationship between social learning and regulation, showing how the role of regulatory agencies in England might be interpreted as including responsibility for the development of conditions of more reflexive governance of healthcare.

A. NHS modernisation

The NHS was founded in 1948 based on the principle that services should be provided free at the point of use and funded from general taxation. The role of the state was significantly extended beyond securing the formal institutional framework and enforcement machinery for guaranteeing market exchange, as envisioned in neo-classical economic theory. Hospitals that had previously been run by local councils or voluntary bodies were nationalised and reorganised on a regional basis, under the ultimate control of the Secretary of State in a system of centralised planning. This shift from market to bureaucratic organisation was followed by a counter-movement. The era of neo-liberal marketisation and privatisation beginning in the 1970s marked a radical break with the post-1945 welfare state settlement. A first strand of NHS reform in this period was concerned with combating economic inefficiencies associated with large-scale vertical integration. However, a second and simultaneous reform trajectory

² See the REFGOV project website, at <http://refgov.cpd.ucl.ac.be/> (accessed 7 April 2010). See also: O. De Schutter and J. Lenoble (eds.), *Reflexive Governance* (Oxford: Hart Publishing 2010); J. Lenoble and M. Maesschalck, *Democracy, Law and Governance* (London: Ashgate, 2010).

³ K. Polanyi, *The Great Transformation* (New York: Holt, Rinehart, 1944).

addressed the limitations of traditional democratic structures and processes in securing adequate accountability for the management of services in fields of large-scale welfare state provision such as healthcare.

The modernisation of the NHS in England has led to increasing complexity in the nature and composition of healthcare networks (see Figure 1).⁴ New classes of actor have been created or refashioned from pre-existing entities. Service providers that have historically been excluded from participation in the NHS have been encouraged to compete for NHS business. Patient and public interests have been recognised and views represented by a succession of very different structures. New regulatory agencies have been established or adapted to oversee the operation of the developing quasi-market. Commissioners and providers of services have been made subject to various legal duties to involve patients and the public, and to respond to reports and recommendations made by regulators. The modern NHS may thus be considered a product of ‘economising’ and ‘socialising’ influences that have developed contemporaneously in reaction against the multiple limitations of bureaucratic organisation.⁵ These influences may be examined in turn.

1. Economising influences – quasi-markets and competition

Following an early experiment with competition in the NHS ‘internal market’ in the 1990s, the New Labour government elected in 1997 embraced with enthusiasm (after some early hesitation) the Conservative economic reform agenda based on increasing competition and market incentives. By 2003 a package of inter-related measures was introduced with the aim of encouraging the development of a quasi-market for healthcare services. While Primary Care Trusts (PCTs) retained the principal commissioning function, the main focus was on increasing supply-side competition. The key elements of economic reform in this period were as follows:

First, NHS foundation trusts began to be established in 2004 as semi-independent corporate entities, able to compete with one-another and other providers in the private and voluntary sectors. By April 2010 there were one hundred and twenty-nine foundation hospital trusts in operation across England.⁶ These hospitals are not bound by the hierarchical constraints that continue to apply to ordinary NHS trusts. They enjoy increased powers to borrow for capital developments, set up subsidiary companies, and retain the proceeds of asset sales. They are free to sell services to NHS

⁴ Since devolution there has been significant policy divergence in the organisation of healthcare within the UK. On the contrasting reform paths in the English and Welsh NHS, see D. Hughes and P. Vincent-Jones, ‘Schisms in the Church: NHS Systems and Institutional Divergence in England and Wales’ (2008) 49 *Journal of Health and Social Behaviour* 400.

⁵ On the concept of ‘economising’ from a Polanyian perspective, see M. Gangiani, ‘The Forgotten Institution’ (2001) 13 *International Review of Sociology* 327-341, p. 330.

⁶ http://www.dh.gov.uk/en/Healthcare/Secondarycare/NHSfoundationtrust/DH_072544 (accessed 3 April 2010).

purchasers on the basis of legally binding contracts, rather than the non-litigable contracts previously used for transactions between NHS bodies, and are accountable to a new regulatory agency ('Monitor') rather than the NHS line-of-command.

Second, the role of the private sector in NHS provision was expanded through introduction of a new category of independent sector treatment centres (ISTCs), dedicated largely to NHS work. The first wave of ISTCs was commissioned by the DoH in late 2002. By late 2007, 24 first-wave ISTCs were operating, owned by a range of home and overseas enterprises. Contracts have recently been let for a second wave of about 20 additional ISTCs, and this is being supplemented by the creation of an 'extended choice network' of independent providers, supplying NHS treatments on an *ad hoc* basis. ISTCs were set to undertake half a million procedures per year by the end of 2008. Most first-wave ISTC contracts were for five years and are coming to an end between 2011 and 2013. In the current economic climate it remains uncertain whether contracts guaranteeing payment on a preferential 'tariff-plus' basis will be renewed, or if ISTCs will be expected to compete on an equal footing with other providers of hospital services.

Third, a new system of standard tariffs was introduced to remunerate public and private sector providers, known as 'payment-by-results' (PbR).⁷ Providers are reimbursed according to fixed tariffs for procedures based on health resource groups, a simpler costing system with fewer categories than US diagnosis-related groups. This ends negotiation over price, and shifts the emphasis to competition based on quality or access times. However, it also helps build a supplier market for NHS work, because any accredited provider offering care at national tariffs can tender for NHS activity. Foundation trusts began using PbR in 2004 and, from 2005 all NHS trusts utilised it for elective care, representing about 30% of activity. By 2008/09 PbR applied to approximately 90% of English inpatient, day-case and outpatient work.⁸

Fourth, under the 'Choose and Book' system introduced in 2006, NHS patients awaiting referral to hospital could select from four or more locations. Since then the scope of choice has been increased to the point that, in addition to local options, patients may select from a "national menu" of NHS Foundation trusts and ISTCs. The incoming Brown Government announced its intention to widen this to a 'free choice' system, in which patients referred for most kinds of planned treatments can select any foundation trust hospital, ISTC, or independent hospital in the 'extended choice network'. The rules permit both public and private hospitals to market and advertise their services. Choice supports the growth of the NHS market, both because of the possibility that

⁷ Allen, P., 'Payment by Results in the English NHS: The Continuing Challenges' (2009) *Public Money and Management*, 161-166.

⁸ http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_900 (accessed 3 April 2010).

many prospective patients will select the independent sector options, and because real choice will require over-supply and an expansion of provider capacity.

Finally, building on previously established quasi-market foundations, service commissioners (Local Authorities, Primary Care Trusts, and some Strategic Health Authorities) may enter legally enforceable contracts for the provision of health and social care services with corporatized NHS Foundation Trusts, ISTCs and other private sector and third sector organisations such as NGOs.⁹ In the negotiation and conduct of contracts, commissioners and providers are expected to have regard to the Principles and Rules for Cooperation and Competition (PRCC),¹⁰ and other guidance on World Class Commissioning and the Standard NHS Contract.¹¹ The principles give strong support to the choice and competition agenda, making clear that vertical integration is permissible only where it does not undermine this agenda, and where it can be justified in patient and taxpayers' interests.¹²

The regulation and oversight of the new quasi-market in healthcare has been entrusted to a number of arms-length regulatory agencies. The Health and Social Care Act 2008 merged the Healthcare Commission, Commission for Social Care Inspection, and Mental Health Act Commission to create the Care Quality Commission (CQC), whose main objective is 'to protect and promote the health, safety and welfare of people who use health and social care services.'¹³ The Commission must perform its functions 'for the general purpose of encouraging – (a) the improvement of health and social care services, (b) the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and (c) the efficient and

⁹ They enter into service level agreements that are not legally enforceable with ordinary 'non-corporatized' NHS Trusts.

¹⁰ DH, 'Principles and Rules for Cooperation and Competition', 25 March 2010, Gateway reference 13791. The ten principles state: (i) Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population; (ii) Commissioning and procurement must be transparent and non-discriminatory; (iii) Payment regimes and financial intervention must be transparent and fair; (iv) Commissioners and providers must cooperate to improve services and deliver seamless and sustainable care to patients; (v) Commissioners and providers should encourage patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare; (vi) Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers' interests; (vii) Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients and taxpayers' interests; (viii) Commissioners and providers must not discriminate unduly between patients and must promote equality; (ix) Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and the reputation of the NHS; (x) Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients and taxpayers' interests, for example they will deliver significant improvements in the quality of care. <http://www.acevo.org.uk/Document.Doc?id=504> (accessed 7 April 2010).

¹¹ DH, 'Guidance on the Standard NHS Contract for Acute Hospital Services', 7 April 2008 http://www.dhcarenetworks.org.uk/library/Guidance_on_the_standard_NHS_contract.pdf (accessed 7 April 2010).

¹² *op. cit.*, n. , Principle (x).

¹³ Health and Social Care Act 2008, s 3(1).

effective use of resources in the provision of health and social care services.’¹⁴ In addition, the Co-operation and Competition Panel (CCP) began work in January 2009, charged with helping to ensure value for money for taxpayers and high quality care for patients for NHS funded services. Its regulatory remit, set out in terms of reference agreed by the Department of Health and Monitor, includes: monitoring compliance with the PRCC; investigating potential breaches of the Rules, conducting inquiries, and making of recommendations to SHAs, the DH, and Monitor (in relation to Foundation Trusts) on how such breaches should be resolved; reviewing proposed mergers, and providing advice on the wider development of co-operation, patient choice and competition within the NHS; hearing procurement dispute appeals in accordance with the Rules of Procedure and Procurement Dispute Appeal Guidelines; and hearing appeals in cases involving complaints concerning advertising or misleading information, where commissioners and/or providers are alleged to have failed to provide accurate and reliable information to enable patients to exercise choice and control over their healthcare. The Panel’s website states:

‘The CCP’s approach is grounded in the established principles of economic and competition analysis. However, in applying these principles, the CCP ensures that it takes account of the special features of the healthcare sector, such as it being free at the point of service for patients, the not for profit nature of many organisations providing healthcare services and the help many patients need to make informed choices between service providers.’¹⁵

These regulatory agencies have a key role to play in attempting to correct deficiencies in the operation of market forces. According to neo-institutional economic theory, service improvement in fields such as healthcare is dependent on overcoming various obstacles to responsiveness including monopoly power, bounded rationality, asymmetric information, externalities and agency.¹⁶ Given appropriate institutional structures and incentives, the assumption is that actors in health and social care networks will adopt solutions to governance problems that maximise efficiency and minimise transaction costs, in the context of other goals and constraints determined by

¹⁴ s 3(2). The CQC has duties and powers under the Act in respect of: (i) Registration (Ch 2) – persons carrying out ‘regulated activities’ in health or social care in England are required to register with the Commission as service providers (s 10). The registration regime includes NHS service providers for the first time. (ii) Review and investigation (Ch 3) – for each PCT and English NHS provider and local authority, the Commission must conduct periodic reviews of the provision of health/adult social services, and publish a report on its assessment (s 46). (iii) Inspection and enforcement (Ch 6) – the Commission has powers of entry onto, and inspection of, regulated premises for the purpose of carrying out its regulatory functions (ss 60-63). (iv) Requiring explanations – the Commission has powers to require prescribed persons ‘to provide an explanation of any relevant matter ... in circumstances where the Commission considers the explanation necessary or expedient for the purposes of any of its regulatory functions’ (s65(1)).

¹⁵ <http://www.ccp-panel.org.uk/about-the-ccp/index.html> (accessed 4 April 2010).

¹⁶ Department of Health, *The Future Regulation of Health and Adult Social Care in England*, (Consultation Paper, November 2006), para. 1.14.

regulation. For example, commissioners of services such as PCTs and local authorities will be motivated to improve tendering and contracting procedures. Through increasing competition and appropriate regulation, service providers will have incentives to develop ‘new models of care’ and ‘smoother pathways of care’ that are more responsive to the needs and preferences of patients and service users. Patients will contribute to the overall improvement of services through the ‘Patient’s Choice’ scheme, which together with increased supply-side competition will enhance efficiency by changing referral patterns and resource flows.

We argue below that the impossibility of achieving this ideal in practice is one of the reasons why, in the case of complex human services such as healthcare, economic rationality must be supplemented by democratic governance; and why also economic regulation must be combined with other forms of regulation as a means of helping to secure the conditions of reflexive governance as social learning.

2. *Socialising influences – democratic renewal and PPI*

The second strand of NHS modernisation has aimed to increase the involvement of patients and the public in healthcare governance. Limited citizen representation was achieved through the creation in 1974 of Community Health Councils (CHCs). By the end of the 1990s such bodies were considered as failing due to a combination of lack of consistency in working practices and an inability to reflect the diversity of local communities.¹⁷ The foundations of the modern PPI framework were laid at the turn of the century.¹⁸ From 2001 NHS bodies were required to ‘involve and consult’ patients and the public in the planning of services, in decision making affecting their operation, and in the development and consideration of proposals for changes in their provision. Legislation in 2002 provided for the abolition and replacement of CHCs by Patient and Public Involvement Forums (hereafter ‘Forums’) for each PCT and NHS Trust in England.

A further wave of PPI reform began in 2007. This phase was prompted by New Labour’s decision after three years in office to continue with the Conservatives’ policy of increasing competition and provider pluralism, reversing its earlier commitment in the immediate aftermath of the 1997 general election to a programme of NHS modernisation involving bureaucratic restructuring and performance management. The Local Government and Public Involvement in Health Act 2007 provided, first, for the abolition of Forums and their replacement by Local Involvement Networks (LINKs) from 31 March 2008. Whereas Forums had a limited role in representing patient and

¹⁷ J. Tritter and A. McCallum, ‘The Snakes and Ladders of User Involvement: Moving Beyond Arnstein’ (2006) 76 *Health Policy* 156-168, p. 158.

¹⁸ For a more detailed analysis of the legislation and policy context, see P. Vincent-Jones, D. Hughes and C. Mullen, ‘New Labour’s PPI Reforms: Patient and Public Involvement in Healthcare Governance?’ (2009) 72 *Modern Law Review* 247.

public interests in respect of health services provided by a single NHS Trust, the remit of LINKs covers both health and social care and extends across an entire local authority area. While LINKs play a broader regulatory role than the CQC or the CCP, in many respects this complements economic regulation. In addition to their powers in respect of supporting the involvement of people in the commissioning, provision, and scrutiny of local care services,¹⁹ obtaining the views of people about their needs and their experiences of local care services,²⁰ and making reports and recommendations about how local care services could or ought to be improved,²¹ LINKs have various powers: to enter NHS premises and observe and assess the nature and quality of health and social care services;²² to enter premises of independent providers for similar purposes (but only in respect of health and care services that are funded by taxpayers) through terms in their contracts with service commissioners; to require ‘services providers’ to respond to requests for information or to reports or recommendations made by the LINK;²³ and to refer matters regarding services to local authority Oversight and Scrutiny Committees (OSCs), who in turn may conduct reviews and make their own recommendations to the services-providers.²⁴

Second, the 2007 Act narrowed the scope of the ‘duty to consult’ on the part of NHS bodies, requiring only that ‘users of services’ be ‘involved (whether by being consulted or provided with information, or in other ways)’ in the planning of the provision of those services, the development of proposals for changes in the way those services are provided, and decisions to be made affecting the operation of those services.²⁵ The range of issues on which users must be involved is limited to those which would affect the user’s experience of the service, or the choice of service available. This appears to preclude wider citizen involvement in more fundamental issues of how services are provided and by whom (for example by public or

¹⁹ Local Government and Public Involvement in Health Act 2007 (hereafter ‘2007 Act’), s 221(2)(a).

²⁰ s 221 (2)(c)

²¹ s 221 (2)(d)

²² s 225

²³ s 224 (1). Regulations specify that the response must ‘provide an explanation to the referrer of any action it intends to take in respect of the report or recommendation or an explanation of why it does not intend to take any action in respect of that report or recommendation.’

²⁴ Statutory Instrument 2002, No. 3048; 2007 Act, s226; DoH 2007b, p. 17). The influence of LINKs in this sense is dependent on the OSC’s decision to take on a case that has been referred to it. OSCs were established by local councils under s 21 of the Local Government Act 2000, amended by s 7 of the Health and Social Care Act 2001 (now s 244 of the NHS Act 2006). The 2001 Act gave OSCs an extended role in reviewing health and social care services. OSCs have powers: to request information and summon people before them to explain actions; to examine the efficacy of efforts to involve patients and public; to request action to be taken; to scrutinise any subsequent report; and to recommend an independent inspection of premises. OSCs must be consulted by NHS organizations in the event of proposed major changes to health services.

²⁵ NHS Act 2006, s 242 (as amended).

independent providers).²⁶ However, the Act goes further than the previous framework in imposing duties on ‘services-providers’ to reflect upon and explain what they have done differently in response to reports and recommendations made by LINKs,²⁷ and on service commissioners similarly to show what they have done in response to consultations required to be undertaken with users of services.²⁸

These developments may be assessed according to a democratic rationale for PPI which focuses on the capacity of institutional and organizational arrangements to facilitate patient and public voice in contributing to deliberation which informs, but does not necessarily determine, decision making.²⁹ By contrast with the emphasis on ‘choice’ in the neo-institutional approach to governance, this interpretation of the function of ‘voice’ in the PPI system suggests the need to maximise dialogue and deliberation among all parties with interests or stakes in the issues that affect them. This requires the opening of channels of communication between decision makers and citizens, and the development of appropriate venues and fora for the participation of patients and the public in order that they may effectively engage in deliberative processes.

3. *Governance approaches in tension*

The foregoing analysis has traced twin trajectories of NHS modernisation with distinct theoretical bases and rationales. A consensus has emerged among the major political parties over how the public interest in healthcare should be maintained, based on the continuing commitment to a service which is free at the point of delivery and funded from general taxation. Economic reforms directed at increasing efficiency through quasi-market competition and individual choice are being combined with reforms aimed at enhancing patient and public voice in democratic processes. In tandem with these strands of healthcare reform we may identify the development respectively of distinct neo-institutional economic and democratic/deliberative approaches to governance.

Broadly following Polanyi, the ‘great transformation’ might be analysed in this context historically as having entailed the displacement of a traditional system of ‘care

²⁶ The effect of the reform is arguably to limit the role of patients and public to that of consumers rather than citizens (cf. Tritter and McCallum, op. cit., n. , p. 161)

²⁷ 2007 Act s 224 (1). ‘Services-provider’ is defined in s 224 (2) as meaning (a) a NHS trust; (b) an NHS foundation trust; (c) a PCT; (d) a local authority; or (e) a person prescribed in regulations.

²⁸ 2007 Act, s 234, inserting a new s17A (SHAs) and s24A (PCTs) into Part 2 of the NHS Act 2006.

²⁹ C. Mullen, ‘Representation or Reason: Consulting the Public on the Ethics of Health Policy’ (2008) 16 (4) *Health Care Analysis* 397-409, p. 399. An alternative democratic rationale for PPI is that the system should enhance the influence of patients and the public in matters of policy making, planning and implementation by allowing them a voice in directly determining decisions. The problem with this conception is that it leaves relatively little scope for communicative and deliberative processes that arguably are essential pre-conditions of democratic governance, and of the effective embedding of economic activity in wider society.

of health’, in which economic activity was embedded in social relations through values of reciprocity and redistribution, by a mode of organisation based on capitalist market relations and the provision of health services and treatments for monetary gain. Subsequent reforms might then be cast in terms of successive cycles of ‘re-embedding’ and ‘disembedding’, with the founding of the NHS as part of the post-1945 welfare state settlement being viewed as a high point in the attempt to reinstitute economic activity, followed from the 1970s by an epoch of disintegration through neo-liberal privatisation and debureaucratisation which continues until the present day.³⁰ However, this rather over-simplified account does not do justice to the complexity of historical development, or indeed to the subtlety of Polanyi’s own argument. Having replaced market relations by a system of large-scale vertical integration, the NHS remains a public bureaucracy in spite of a series of radical reforms representing an ‘economising’ tendency both within it, and in the organisation of healthcare more generally.³¹ Furthermore, such an account does not capture: (1) the way in which the democratic dimension in healthcare modernisation should be seen as a reaction to the limitations of bureaucratic organisation, rather than as a movement in opposition to marketisation; and (2) the co-existence of ‘economising’ and ‘socialising’ trends in the healthcare reform agenda, reflected in various hybrid institutional and organisational forms,³² both of which trends (as will be demonstrated below) are increasingly subject to regulation.

This argument implies that we are witnessing not a battle between market and alternative forms of integration,³³ but rather the struggle for an appropriate articulation of two distinct modes of instituting economic processes, supported by different regulatory systems. The two trends may be in tension, but they are not fundamentally inconsistent or contradictory. Market rationality in some form is arguably essential in order to satisfy the public interest in efficient and effective healthcare services. What is necessary for the effective embedding of economic relationships in social relations is a balance between these modes of integration in the governance of healthcare. In the remainder of this paper we show how such a balance might at least begin to be achieved.

³⁰ cf. F. Adaman, P. Devine and B. Ozkaynak, ‘Reinstituting the Economic Process: (Re)embedding the Economy in Society and Nature’ (2003) 13 *International Review of Sociology* 357-374, p. 358. The authors analyse this trajectory in terms of a successive cycles of regulation and de-regulation, suggesting that the de-regulation phase associated with neo-liberalism may now be being superseded by a new era of regulation ‘this time with a more global dimension, in order to deal with the increasingly felt social injustices and the ominous ecological threats facing society at the start of the 21st century.’

³¹ J. Wright, ‘The Regulatory State and the UK Labour Government’s Regulation of Provision in the English National Health Service’ (2009) 3 *Regulation and Governance* 334-359.

³² D. Hughes, C. Mullen and P. Vincent-Jones, ‘Choice vs. Voice? PPI Policies and the Re-positioning of the State in England and Wales’ (2009) 12 *Health Expectations* 237-250.

³³ Polanyi distinguishes three forms of economic integration – exchange, reciprocity and redistribution – which prior to the advent of market society together served to structure the interaction of human beings with their environment. Still less should the the process be seen as a struggle between deregulation and regulation, as depicted by Adaman et. al., op. cit. n. .

B. Embedding economic relationships through social learning

This section builds on the foregoing analysis by exploring the potential for instituting economic relationships in the health field with reference to the legal-philosophical theory of reflexive governance developed within REFGOV project. According to this theory, the general interest in decision making on matters of public importance is dependent on social learning processes involving specific kinds of communication, deliberation and reflection on the part of actors and stakeholders affected by the activity in question. In order for governance problems to be resolved effectively in the public interest to the greatest extent possible,³⁴ professionals, citizens and service users must have the capacities and competencies to participate in and contribute to social learning; they must communicate and interact in relational and deliberative ways; they must engage in and learn from experimentation through collaborative forms of joint inquiry; and their learning must be informed by cognitive processes entailing the adjustment and redefinition of frames, representations and collective identities.³⁵

This conception of reflexive governance as social learning is diametrically opposed to rationalist or technocratic notions of decision making. Instrumentalist problem solving models are particularly inappropriate in the health sector due to the inherent complexity of services, the extent of structural reform, and the rapid pace of NHS reorganisation. While social learning must necessarily take account of economic considerations, it must also incorporate democratic and (it will be argued below) pragmatist elements. Neither the nature of governance problems nor the interests of actors can be assumed to be fixed. Rather they are negotiated, defined and redefined through collective engagement in various communicative, deliberative and experimental practices. Social learning is characterised by a fundamental openness to the need for revision of basic assumptions underpinning the provisional goals and problem solving strategies of the organisation.³⁶

The principal focus of this theoretical approach is on social action rather than on formal legal or regulatory frameworks. While the parameters of social action are environmentally determined, the way in which governance issues are addressed depends

³⁴ For this formulation see Lenoble and Maeschalck, op. cit., n. .

³⁵ While all social learning involves cognition, the present discussion does not include cognitive processes involving frame reflection and collective identity transformation. For a detailed theoretical analysis encompassing all these dimensions, see P. Vincent Jones and C. Mullen, 'From Collaborative to Genetic Governance: The Example of Healthcare Services in England', in O. de Schutter and J. Lenoble (eds.), *Reflexive Governance* (Oxford: Hart Publishing, 2010).

³⁶ C. Argyris and D. Schön, *Organisational Learning: A Theory of Action Perspective* (Reading, Mass.: Addison Wesley, 1978).

ultimately on the specific capacities and dispositions of actors and stakeholders engaged in the performance of various functions in healthcare networks. Reflexivity as a quality of governance refers ultimately to a particular kind of orientation on the part of actors in decision making and problem solving, both individually and in relation to other actors. This is not to deny the fundamental role of the state and supra-national authorities such as the EU in constituting the institutional and organisational environment in which social action occurs. We return to this distinction between social structure and social action in the discussion of regulation, below. In the remainder of this section we examine obstacles to social learning (and therefore to the effective embedding of economic relationships in social relations) within both the neo-institutional economics and democratic/deliberative approaches to governance, before considering further dialogic and experimentalist dimensions of social learning which can only be built on firmly established democratic foundations.

1. *Social learning and the neo-institutional economics approach*

Two main limitations may be identified with the neo-institutional economic conception of governance. First, this approach remains rooted in neo-classical assumptions concerning the fixed nature of individual preferences, the ‘natural’ competencies of actors, and the nature of economic rationality. Even on narrow economic criteria, numerous barriers to efficiency remain in spite of institutional reform. An established body of empirical evidence has revealed structural problems with quasi-market organisation similar to those that occur in real markets.³⁷ Such problems, and the associated absence or ineffectiveness of appropriate incentives, pose major difficulties for a social learning model based solely or predominantly on economic calculation.

Second, this approach tends to ignore the need for decision making (in order to satisfy the general interest to the greatest extent possible) to take account of a wider range of criteria, interests and values, requiring public participation and democratic deliberation. Consider, for example, the role of PCTs and local authorities as commissioners of services in health and social care quasi-markets. Prior to tendering, contracts have to be planned and specified with regard to future contingencies and the allocation of risk. Government guidelines for public contracting generally follow the prescriptions of textbook transaction cost economics on public procurement. Contract design is supposed to be carefully matched to the circumstances. ‘Arm’s length’ contracting is suited to low-risk situations where the activity is not critical to the purchaser’s strategic objectives, there are many suppliers, and the costs of changing to another provider would be low. At the other extreme is a form of ‘partnering’, considered suited to situations in which the service is critical to the client’s strategic

³⁷ C. Propper and W. Bartlett, ‘The Impact of Competition on the Behaviour of National Health Service Trusts’, in R. Flynn and G. Williams (eds.), *Contracting for Health: Quasi-Markets and the National Health Service* (Oxford, Oxford University Press, 1997).

objectives, where requirements are changing, and where the market is evolving and relatively under-developed. Such prescriptions are reflected in the Standard NHS Contract and associated guidance. However, the complexity of contracting for human services such as health and social care poses particular difficulties. In addition to specifying the contract, the commissioning authority has to select among competing providers with very different characteristics in the public, private and voluntary sectors. While transaction cost theory is clear about the factors that ideally need to be taken into account in decision making, in practice problems of monopoly power, asymmetric information, bounded rationality, and opportunism make these processes hazardous. Just as there are limits to the capacity of economic rationality in addressing these deficiencies, so there are inherent limitations in a conception of social learning based on the neo-institutional economics approach to governance.

More fundamentally, commissioners of services cannot avoid taking account of a range of factors beyond narrow economic calculations based on efficiency. Quasi-market contracting implies a trilateral rather than a bilateral relationship, with the services being purchased on behalf of ‘third party’ consumers of healthcare services. This gives rise to a further set of governance problems, concerning the responsiveness of purchasing decisions to the needs and preferences of service recipients and citizens. Here PCTs and local authorities are engaged in a different form of social learning based on communications with patients and the public.

2. *Social learning and the democratic/deliberative approach*

The limitations of the democratic/deliberative approach to governance in embedding economic relationships in social relations are reflected in the past failure of the PPI system to encourage NHS commissioners, service providers and other key actors in healthcare networks to open up decision making processes to a wider range of stakeholder influences. A first problem here concerns the legal duty to involve patients and the public, which on past experience has resulted in ‘consultations’ that have tended to be insincere and tokenistic. Many NHS bodies have been suspected of seeking to avoid their statutory duties or interpreting narrowly the range of situations in which they are required to consult, often with the collusion of the Department of Health. The House of Commons Health Committee (HCHC) concluded its review of the original consultation duty:

‘Too often it seems to the public that decisions have been made before the consultation takes place. Too often NHS bodies have sought to avoid consultation under Section 11 about major issues. Unfortunately the Department of Health has supported those NHS organisations in trying to limit the scope of Section 11.’³⁸

³⁸ House of Commons Health Committee, *Patient and Public Involvement in the NHS*, Third Report of Session 2006-07, HC 278-1, para. 271.

As has been seen, the revised duty to ‘involve’ patients and the public in service planning and decision making under the 2007 Act is narrower than the original duty, precluding public engagement on the matter of how (and by whom) services are provided. The reduced scope for consultation might be argued to be of little consequence, given the government’s own reluctance to observe the terms of the original wider duty and its ineffectiveness in practice. However, what is important about the failure of this aspect of PPI is the attention drawn to the limits of *law* (or at least the limits of this *form* of law) in changing the *behaviour* of key actors in healthcare networks. The legal framework by itself is incapable of facilitating the conditions necessary to promote a sufficiently receptive and deliberative orientation on the part of the relevant actors.

A second problem with this approach to social learning in practice has been the ineffectiveness and lack of representativeness of democratic fora such as CHCs and Forums. The HCHC review noted various failings in the role of Forums, including excessive preoccupation with monitoring and review of services; over-reliance on volunteers; lack of diversity in the pool of participants; inadequate representation of employed people or those with other commitments such as caring responsibilities; failure to encompass the patient’s journey through a variety of health and social care services; lack of clarity in the relationship between the PPI activities of NHS and other bodies such as OSCs; confusion between the functions of service improvement and long-term service planning; and generally, the loss of public confidence in their ability to engender service improvements.³⁹

By contrast with their predecessors, LINKs might be argued to offer better prospects for increasing patient and public involvement in decision making. Each LINK is free to decide its governance structure and membership, which may include both voluntary organisations and individuals. LINKs may therefore engage a greater number and broader range of participants than either of their predecessors (Forums or CHCs). 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.’⁴⁰ LINKs will ideally 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. By representing the views of patients and the public in this way, LINKs may compensate for the reluctance or inability of commissioners and service providers to consult with the public directly. Furthermore, the power to make reports and recommendations about how local care

³⁹ House of Commons Health Committee, *Patient and Public Involvement in the NHS*, Third Report of Session 2006-07, HC 278-1.

⁴⁰ Department of Health, *A Stronger Local Voice: A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services* (July 2006), p 4.

services could or ought to be improved implies a pro-active role in conducting investigations and shaping agendas, beyond gathering and conveying information about needs and preferences. It is too soon to know how far LINKs will take advantage of the opportunities provided by their wider remit. Their potential contribution to social learning will depend on a two-fold communicative process, involving both the obtaining of views of patients and the public, and the representation of those views to relevant bodies such as commissioners and service providers. There is no guarantee that such communication will occur, or that any information conveyed to decision makers will be understood or taken into account in practice.

3. *Social learning through dialogue and defensibility*

In order for economic relationships effectively to be embedded in social relations in healthcare networks, it is necessary not only that patients and the public are enabled effectively to contribute to deliberative processes (as just considered), but also that key actors such as commissioners and providers of services are receptive and responsive to their inputs. Building on such communicative foundations, a deliberative model of democratic engagement opens up a space for social learning, drawing on the unique experiences of patients as co-producers of human services. User involvement here entails ‘constructive dialogue aimed at reshaping the relationship between patients, healthcare professionals and the public ... as a catalyst to more widespread cultural change’:

‘The key contribution users make arises from their distinct personal experience and non-medical or technical frame of reference; it is asking questions that health professionals have not considered. One aim of user involvement may be to break down boundaries, share experience, and build understanding. This suggests not a hierarchy of knowledge – relevant professional versus irrelevant lay – but rather a complementarity between forms of knowing, set within a willingness to acknowledge differences.’⁴¹

While many questions of health policy, planning and implementation raise difficult technical issues, these frequently cannot be separated from social and ethical considerations of value, including how values should be interpreted in decision making.⁴² This implies a vital role for patients and the public in contributing to the resolution of even the most complex and intractable problems. For example, the decision whether a General Practice surgery should be relocated or merged at the cost of reduced accessibility for a small section of a community must take account of matters such as finance, measurement of health gain, knowledge of transport systems, and accessibility. But these technical issues are in practice bound up with other other dimensions such as the value that should be given to preserving life, or the priority that

⁴¹ Tritter and McCallum, op. cit., n. , p. 164.

⁴² Mullen, op. cit., n. , pp. 397-8.

should be accorded the protection of minority interests weighed against the benefits to a majority.⁴³ Because technical knowledge cannot be neatly separated from social and ethical considerations, it cannot be assumed that such dilemmas are most appropriately addressed by professionals. Patients and the public may contribute to social learning by raising what would otherwise be unconsidered questions or ideas, drawing on their particular experiences, knowledge and understandings.⁴⁴

Dialogic involvement may accordingly be understood as a form of democratic engagement drawing on people's ideas and questions to test and challenge decision making on existing or proposed policy, planning or practices. In this conception, citizens and service users should be entitled to expect from decision makers a reasoned response to relevant matters raised, which may lead to further queries or questions, to which further responses should in turn be provided. Where no relevant response can be given, the decision should be reconsidered. Conversely, where responses can be provided, or where plans or practices are altered and developed in order to enable a response, then it is plausible to maintain that the decisions have some defensibility.⁴⁵ The notion of 'defensibility' avoids the simplistic assumption that the purpose of deliberation is to reach consensus.⁴⁶ The aim instead is to develop proposals and practices that are more defensible than they would otherwise be, in the sense of requiring reasoned responses to different forms of patient and public input.

While the notion of 'defensibility' here may be used to justify the decision ultimately reached as the most legitimate possible in the circumstances, it also draws attention to the cognitive processes in which key actors may engage in consequence of effective patient and public involvement, and which are essential to maximising the potential for social learning. This takes us back to the deliberative foundations of reflexive governance. As a necessary condition for social learning, dialogue presupposes mutual communication (speaking and listening) on the part of decision makers and other stakeholders. This implies that citizens have, or can acquire, relevant knowledge or understanding, and also that they have or can develop the capacity to articulate views on healthcare issues in order to contribute ideas and challenges. LINKs clearly have a potential role to play in such capacitation, as collective actors representing the views or interests of individual patients and members of the public.

⁴³ A. Weale, 'What is So Good about Citizens' Involvement in Healthcare?' in E. Andersson, J. Tritter and R. Wilson (eds), *Healthy Democracy: The Future of Involvement in Health and Social Care* (London, Involve and NHS National Centre for Involvement, 2006), p. 38.

⁴⁴ id., p. 40; G. P. Martin, 'Ordinary People Only': Knowledge, Representativeness, and the Publics of Public Participation in Healthcare' (2008) 30 (1) *Sociology of Health & Illness* 35–54; M. Levitt, 'Public Consultation in Bioethics. What's the Point of Asking the Public when they have neither Scientific nor Ethical Expertise?' (2003) 11 (4) *Health Care Analysis* 15–25, p. 23; Mullen, op.cit., n. , pp. 404-8.

⁴⁵ Mullen, op.cit., n.

⁴⁶ M. Dent, 'Patient Choice and Medicine in Health Care: Responsibilization, Governance and Proto-Professionalization' (2006) 8 *Public Management Review* 449-462, p. 457.

They have a further capacity-building role in providing fora or methods of debate which maximise the input of relevant ideas, questions and challenges within the deliberative process, drawing upon the widest possible range of experience, knowledge and understanding.⁴⁷

4. *Democratic experimentalism in social learning*

The dialogic and deliberative dimensions of social learning so far considered are necessary conditions of reflexive governance, but they are not by themselves sufficient.⁴⁸ As has already been made clear, a fundamental requirement is that decision makers remain open to the nature and definition of issues, rather than attempting to find solutions to problems that are fixed in advance. Such openness may be regarded as particularly important in light of challenges posed by the complexity of NHS reorganisation and the frenetic pace of reform. Rational-technocratic assumptions are a feature not only of narrow economic approaches to governance, but also of some democratic models that see the purpose of public engagement in terms of the aggregation of fixed individual preferences, or the provision of citizens with a voice in directly determining decisions.⁴⁹

Democratic experimentalism describes a form of social learning in which actors engage continually in pragmatic processes of joint inquiry, benchmarking and peer review in their constant search for solutions to governance problems. For Sabel, ‘learning by monitoring’ is an experimentalist practice involving the ‘creation of institutions that make discussion of what to do inextricable from discussion of what is being done’, such that ‘discrete transactions among independent actors become continual, joint, formulations of common ends in which the participants’ identities are reciprocally defining.’⁵⁰ While originally used to analyse the superior performance of Japanese production systems in private industry, this perspective is arguably applicable to English healthcare governance which is similarly characterised by a form of vertical disintegration and the breakdown of hierarchy as the instrument of collective problem solving. The actors in this context (commissioners and service providers, regulators and rule-makers, patients and citizens) may also be seen as collectively engaged in continuous discussion of joint goals in situations of uncertainty and limited understanding. Democratic experimentalism requires that groups of such actors ‘jointly specify what they believe they understand so as to expose and begin exploring the limits of that understanding. Just as in a conversation they must accept the possibility that

⁴⁷ Mullen, op. cit., n. , p. 407.

⁴⁸ See Lenoble and Maesschalck, op. cit., n. .

⁴⁹ See C. Mullen, D. Hughes, and P. Vincent-Jones, ‘The Democratic Potential of Public Participation: Healthcare Governance in England’, in draft.

⁵⁰ C. F. Sabel, ‘Learning by Monitoring; The Institutions of Economic Development’, in N. J. Smelser and R. Swedberg, R. (eds.), *The Handbook of Economic Sociology* (New York, Russell Sage Foundation, 1994), p. 138.

their views of themselves, or the world, and the interests arising from both – their identities, in short – will be changed unexpectedly by those explorations.’⁵¹ A recent strand in socio-legal contract scholarship suggests that vertical disintegration of the supply chain in many industries is being accompanied by new forms of ‘contracting for innovation’ that are distinct from the collaborative mechanisms of relational contracting (norms of reciprocity, expectations of future dealing, etc).⁵² The contractual relationships between commissioners and providers of services in health and social care networks may similarly be analysed in terms of the scope for such iterative collaboration. These various forms of cooperation and collaboration may be understood as contributing to the embedding of economic in social relations by increasing the capacity of networks of actors to experiment with the widest possible range of solutions to governance problems.

There is significant scope for experimentalist practices involving recently corporatised semi-autonomous foundation trusts and new entrants to markets for healthcare services such as ISTCs and NGOs. Due to their relative autonomy from the NHS hierarchy, such groupings may resemble the federated or networked bodies described by Sabel:

‘Once a service is being provided, initial rules are in place, or production begins, continuous monitoring detects errors and breakdown, uses these findings to trigger searches for the root causes of design or other flaws that escaped earlier examination ... Taken together routines such as benchmarking, simultaneous engineering, continuous monitoring, error detection and root cause analysis define methods for choosing provisional, initial goals and revising them in the light of more detailed, partial, proposals arising from efforts to implement them.’⁵³

By contrast with traditional hierarchical approaches to problem-solving, ‘search networks’ serve as devolved pragmatist institutions that work by finding others in similar situations and providing comparative information on methods and relative performance.⁵⁴

⁵¹ id., p. 145.

⁵² R. J. Gilson, C. F. Sabel and R. E. Scott, ‘Contracting for Innovation: Vertical Disintegration and Interfirm Collaboration’ (2009) 109 *Columbia Law Review* 431-502.

⁵³ C. F. Sabel, ‘Beyond Principal-Agent Governance: Experimentalist Organisations, Learning and Accountability’, draft discussion paper prepared for WRR meeting, Amsterdam (May 10-14, 2004), in Ewald Engelen & Monika Sie Dhian Ho (eds.), *De Staat van de Democratie. Democratie voorbij de Staat*. WRR Verkenning 3 (Amsterdam, Amsterdam University Press, 2004). p.11. ‘Put another way, the routines make it routinely possible to correct ends through the exploration of means and vice versa ... So we can think of these new institutions as pragmatist in that they systematically provoke doubt, in the characteristically pragmatist sense of an urgent suspicion that their own routines – habits gone hard, into dogma – are poor guides to current problem solving.’

⁵⁴ C. F. Sabel, ‘Globalisation, New Public Services, Local Democracy: What’s the Connection?’ in *Local Governance and the Drivers of Growth* (Paris: OECD, 2005).

Benchmarking may be defined simply as the comparison of practices, systems or organisations according to accepted standards or indicators. While international benchmarking of healthcare systems was pioneered by the OECD in the 1980s, the use of this technique at the national level began a decade later as part of the government's New Public Management drive for increasing efficiency and service quality.⁵⁵ Other forms of benchmarking have developed recently at the initiative of various groups of actors in healthcare networks. Benchmarking may be used by government as a tool for driving up standards through performance metrics and rankings, or by organisations performing similar roles or located in the same sector as a more collaborative mechanism for joint improvement and dissemination of best practice.⁵⁶ A further distinction may be drawn between 'indicator' and 'ideas' benchmarking, the former associated with league tables and 'star-ratings' while the latter focuses on organisational learning and process improvement.⁵⁷ There exists in this regard a fundamental ambivalence in New Labour policies which emphasise the value of collaboration and service improvement on the one hand, while pursuing competition and penalising poor performers on the other hand. The suspicion is that: 'as long as benchmarking metrics are employed for political purposes, the more desirable results of this tool will be difficult to achieve.'⁵⁸

In any event, benchmarking can only operate effectively as an experimentalist mode of learning if it is accompanied by internal reflection by members of the organisation on its methods and processes. There is little evidence that state-imposed benchmarking is having this effect.⁵⁹ The current scheme in the NHS, 'Essence of Care', is a supposedly new benchmarking approach launched by the Department of Health in England in 2001 to provide incentives for continuous quality improvement in areas such as privacy and dignity, nutrition and hygiene. In practice the use of this 'tool kit' is patchy, with NHS managers tending to focus their efforts on quantitative rather than qualitative aspects, and on measurability of comparative performance data.⁶⁰ There appear to be significant problems of regulatory ineffectiveness and unintended consequences, for example the encouragement of a short-term culture of box ticking, deflection of attention from aspects of health care which are more important but more difficult to measure, and perverse incentives to alter recording methods to achieve higher rankings at the expense of actual performance improvement.⁶¹ Such problems

⁵⁵ S. Waite and E. Nolte, 'Benchmarking Health Systems: Trends, Conceptual Issues and Future Perspectives' (2005) 12 *Benchmarking* 436.

⁵⁶ D. Northcott and S. Llewellyn, 'Benchmarking in UK Health: A Gap Between Policy and Practice?' (2005) 12 *Benchmarking* 419.

⁵⁷ id., p. 423.

⁵⁸ id., p. 431.

⁵⁹ Waite and Nolte, op.cit., n. .

⁶⁰ J. Ellis, 'All Inclusive Benchmarking' (2006) 14 *Journal of Nursing Management* 377.

⁶¹ Waite and Nolte, op.cit., n. , p. 444.

with this form of performance management apply across the whole field of public services regulation in England.⁶²

C. Social learning and regulation

The limits of economic regulation and of the neo-institutional approach to governance have already been indicated. This section shows how the role of regulatory agencies in England might be interpreted as extending beyond this remit to include responsibility for fostering the development of democratic conditions of social learning. The role of regulation in promoting patient and public involvement has been explicitly recognised in recent government policy. The report of the Expert Panel set up to review PPI in 2006 recommended that ‘assessment criteria are established to enable regulators to assess the performance of commissioners ... including an assessment of how local arrangements for involving service users and the public, in particular the LINKs, are supported and utilised, and how well commissioners have sought and responded to the views and needs of communities and needs within their populations.’⁶³ The government’s White Paper issued soon afterwards accepted this recommendation:

‘The regulators will seek to develop assessment criteria to measure performance against national standards ... Current core standards for the NHS include the need to seek out and take account of the views of patients, carers and others in designing, planning, delivering, and improving healthcare services. LINKs and OSCs will help commissioners be more accountable to local people.’⁶⁴

The ensuing 2008 Act provided that the Secretary of State may direct the CQC to devise indicators which will be used to assess PCTs, NHS providers and local authorities across all aspects of their performance, including in relation to PPI. Included in the ‘fifth domain’ of CQC’s current Core Standards (‘Accessible and Responsive Care’) is core standard C17, which requires that: ‘The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.’⁶⁵

It is suggested that, in devising and reviewing performance against such indicators, the CQC might have regard to the need to help create and sustain the various

⁶² P. Vincent-Jones, *The New Public Contracting: Regulation, Responsiveness, Relationality* (Oxford: Oxford University Press, 2006), pp. 160-164.

⁶³ Department of Health, *Concluding the Review of Patient and Public Involvement: Recommendations to Ministers from the Expert Panel* (May 2006), para. 11.6.

⁶⁴ Department of Health, *op. cit.*, (2006) p 20.

⁶⁵ <http://www.cqc.org.uk/guidanceforprofessionals/nhstrusts/specialreviews/2008/09/patientandpublicengagement.cfm>

The CQC is currently completing a national study of how NHS and independent sector organisations are engaging with patients and the public, with a view to developing a detailed assessment framework that can be used for future regulation.

democratic and deliberative conditions of social learning. As has been seen, reflexive governance is dependent on patients, the public and other stakeholders being enabled to contribute ideas and challenges, and on decision makers being sufficiently receptive to such inputs in a manner that allows genuine dialogue, deliberation and revision. The CQC might have a further regulatory role in encouraging and monitoring experimentalist practices on the part of healthcare bodies, for example through support for the grass roots development of benchmarking schemes within and between different sectors and functions. There is already some evidence that secondary care Trusts voluntarily exchange benchmarking information.⁶⁶ Under the auspices of the NHS Confederation, the Foundation Trust Network (FTN) has developed its own benchmarking scheme in collaboration with management consultants focusing on quality (clinical outcomes and patient experience), cost effectiveness, and operational management. Iterative codesign as a feature of democratic experimentalism implies a collaborative relationship between those responsible for policy and implementation.⁶⁷ This relational quality might be easier create and maintain between regulated bodies and the semi-independent CQC than with central government directly.

This vision may be difficult to achieve in the current economic and political climate, given competing claims on the time and resources of regulators and the priority likely to be accorded basic quality standards and pressing issues such as hygiene control, survival rates, and waiting times for hospital operations. There may be difficulties also in encouraging regulators to conceive of their role in such social learning terms. Certainly mainstream policy discourse, even in its more sophisticated variants, tends to over-simplify the task of regulation. Consider for example the Kennedy report, which advocates three stages in an effective regulatory process: (1) It is necessary to establish the views of patients, public, professionals, and other bodies in healthcare networks as to what is important in various domains. (2) The views of stakeholders should be sought as to what would promote improvement in regard to the particular matter identified as important. (3) Finally, it is necessary to decide how best to measure progress in the achievement of improvement, through the development of indicators and data on performance in relation to those indicators.⁶⁸

From the social learning perspective presented in this paper, there are various problems with this analysis. First is the assumption that the views of patients, the public and other stakeholders, as to both what is important and what would promote improvement, can easily be ascertained and made known to the regulatory agency.

⁶⁶ Northcott and Llewellyn, *op.cit.*, n. , p. 429.

⁶⁷ Sabel, *op.cit.* (2004), n. .

⁶⁸ I. Kennedy, 'Of Regulation', in *Learning from Bristol: Are We?* (London, 2006). p. 67.

Indicators and measures of improvement are necessary since the cultural changes within and between healthcare organisations that are preconditions of effective social learning can only occur gradually. 'Any new organisation, created to carry out a range of complex tasks, will need time to learn and develop ... and will need subtle measurement ... The indicators of success may take a myriad of forms and be hard to discern ... the tools have to be designed.'

These views are presumed to be fixed and there is no space for dialogue or deliberation, either with the regulator or other bodies such as commissioners and service providers. Second, it is assumed that objective indicators can be devised that are capable of measuring progress towards the substantive attainment of the improvements specified by stakeholders. The third assumption is that there is a causal link between the activity of regulators in publishing indicators and standards on the one hand, and the behaviour of regulated entities on the other hand: ‘Once it was *known* what the regulator was seeking to measure, because it was regarded as constituting good performance ... organisations would *direct their efforts so as to comply with what was called for*.’⁶⁹ In this way it is presumed that ‘the regulatory system creates a virtuous circle, listening to what promotes improvement, reflecting it in what is asked of organisations, measuring compliance, and thereby entrenching improvement.’⁷⁰

This model of the regulatory process appears responsive in the limited sense that what is measured is not imposed from above, but rather ‘owned by those within the system ... grown from the bottom up.’⁷¹ But the analysis is naïve as to the complexity of the governance issues involved in deciding what constitutes ‘improvement’, and as to the nature of the relationship between key actors and patients and the public necessary to negotiate and achieve this. As has been seen, reflexive governance is dependent on deliberation and openness to alternative possibilities in the framing of problems and the suggestion of solutions, and on other democratic and pragmatist conditions. Regulators may help facilitate such conditions, but the quality of healthcare governance in these social learning terms will depend ultimately on the attitudes and dispositions of key actors and stakeholders in healthcare networks.

Conclusions

This paper has suggested one possible means of resolving tensions that have arisen between the economic and democratic strands in the contemporary NHS modernisation agenda – an agenda that has been adopted by both Conservative and Labour governments in England over the past 30 years, and which seems unlikely to be significantly challenged in the near future whatever the outcome of the general election in 2010. We have shown how the understanding of embeddedness may be enriched by exploring the link between this notion and social learning processes incorporating economic, deliberative and cognitive dimensions in the governance of complex public services such as healthcare. The theoretical analysis has built on the Polanyian insight that the market should not be permitted to determine or dominate social relations,

⁶⁹ id., p. 63 (emphasis supplied).

⁷⁰ id.

⁷¹ id.

accepting the implicit argument that the world-wide trend towards increasing commercialisation of human service sectors such as healthcare make it necessary to reinstitute or reintegrate economic forces within social relationships in order to counter the potentially damaging effects of marketisation and privatisation.

The commercialisation of health services carries particular threats to social integration and respect for fundamental values such as equality and solidarity. The reasons why healthcare cannot be considered just another service like those in the liberalised telecommunications and utilities sectors include the particularly high and expanding value placed on health in ageing societies; the dangers of social divisiveness and inequality associated with privatisation; the problems of social exclusion accompanying increased reliance on social insurance systems; and the inefficiencies and perverse incentive structures encouraging cost escalation in health care markets.⁷² By contrast, effective health systems are likely to be ‘...both developmental and socially integrative: they generate well being, help people to continue working, redistribute resources towards the poor and needy, and are a source for social inclusion and democratic accountability.’⁷³ However, given the economic and democratic deficiencies widely acknowledged to have characterised the ‘old’ NHS, this analysis does not imply an argument in favour of any simple reversal of recent reforms or a return to vertical integration. Our conclusion here is consistent with Granovetter’s emphasis on the need to avoid ‘oversocialised’ as well as ‘undersocialised’ accounts of economic behaviour (those respectively that underemphasise and overemphasise the importance of economic rationality in social organisation), and prescriptions based on such accounts.⁷⁴ There is no reason why the developmental and socially integrative benefits of effective healthcare, referred to by Mackintosh and Kovalev, cannot be secured through competition in quasi-markets in a system where services are funded through general taxation, and free at the point of consumption and allocated according to need. Again,

⁷² M. Mackintosh and S. Kovalev, ‘Commercialisation, Inequality and Transition in Health Care: The Policy Challenges in Developing and Transitional Countries’ (2006) 18 *Journal of International Development* 387-391, p. 389.

⁷³ id., p. 387.

⁷⁴ M. Granovetter, ‘Economic Action and Social Structure: The Problem of Embeddedness’ (1985) 91 *American Journal of Sociology* 481-510. Granovetter provides a detailed critique of the ‘new institutional economics’, and in particular Williamson’s explanation of the development of different forms of market and vertical integration in terms of transaction costs, arguing that Williamson underestimates the level of order that can often be found in markets while exaggerating that which is typically found within hierarchically integrated firms (p 502). Granovetter’s analysis is clearly not directly relevant to the present discussion of the relationship between vertical integration and market organisation in NHS context. However the point to be emphasised here, drawing on this analysis, is that economic relations may be embedded just as successfully in market as in bureaucratic relations. In terms of the argument developed in this paper, market relations are a barrier neither to embeddedness nor to social learning. In fact, some of the conditions of effective social learning (for example those involving experimentation and learning by monitoring) may be easier to establish through markets and competition than within public bureaucracies.

empirical socio-legal studies have demonstrated conclusively that trust, reciprocity and cooperation are just as much a feature of market as as bureaucratic organisation.⁷⁵

We have argued that the participation of service users and citizens in decision making and problem solving is an indispensable condition of the embedding of economic in social relations in the healthcare context. In this we follow a similar argument made in the field of environmental protection and governance by Adaman and colleagues,⁷⁶ who advocate a ‘participatory planning’ approach in which ‘civil society exercises control over both the state and the economy and is thus able to mediate the relationship between the economy and nature directly.’⁷⁷ Participatory planning replaces the self-regulating market by a process of negotiation:

‘It envisages a self-governing society in which, rather than the state or the self-regulating market or some combination of the two coercing society, the diverse voluntary associations that make up civil society control both the state and the economy. Self-government may be defined as the situation in which those affected by a decision participate in making the decision, in proportion to the extent to which they are affected by it.’⁷⁸

This is said to be a form of ‘reinstating economic activity by transcending the separation of the economy from the rest of society’. Participatory planning ‘provides an institutional framework for the social relations necessary to re-embed the economy in both society and nature.’⁷⁹ However, we have gone beyond this analysis in showing how democratic engagement through effective patient and public participation in healthcare governance is essential not only as a means of instituting economic activity in social relations, but also of contributing to social learning processes that are capable of supporting decision making and problem solving in the public interest.

The foregoing analysis leads to a number of more specific conclusions and recommendations. First, policy makers and professionals should pay specific attention to the *social learning* dimension of governance in public service sectors such as healthcare. Such recognition might lead to a better understanding of the relationship between the economic and democratic strategies for healthcare modernisation, and of the need to avoid undermining the basic democratic/deliberative conditions of effective social learning. While not denying the importance of more familiar concerns with efficiency, legitimacy and accountability, the social learning perspective casts fresh

⁷⁵ S. Macaulay, ‘Non-Contractual Relations in Business’ (1963) 28 *American Sociological Review* 55-67. For theoretical support, see: I. R. Macneil, ‘Contracts: Adjustment of Long-Term Economic Relations under Classical, Neoclassical, and Relational Contract Law’ (1978) 75 *Northwestern University Law Review* 854-905; D. Campbell and D. Harris, ‘Flexibility in Long-Term Contractual Relationships: The Role of Cooperation’ (1993) 20 *Journal of Law and Society* 166; Gilson et. al., op.cit., n. .

⁷⁶ Adaman et. al., op.cit., n. .

⁷⁷ id., p. 359.

⁷⁸ id., p. 369.

⁷⁹ id., p. 370.

light on these elements of modern social democracy and suggests how they may contribute to a more sophisticated understanding of the conditions that need to be established in order to secure reflexive governance in the public interest.

Second, we have argued that regulation, appropriately conceived and implemented, may have a vital role in helping secure these basic foundations of reflexive governance. Local authority OSCs, Monitor, and the CQC might include in their conception of the purpose of regulation the need to overcome obstacles to social learning in the democratic/deliberative and experimentalist as well as neo-institutional senses. The CQC might draw on new resources for innovation and experimentation accompanying the increased involvement of independent sector bodies, including charitable organisations and NGOs, in the provision of health and social care services.⁸⁰ Of course this implies a significant challenge to the currently dominant conception of regulation.⁸¹ Indeed, the regulators themselves may be viewed as collective actors engaged in social learning, addressing the problem of how to interpret their roles and approach the tasks of monitoring, evaluation and enforcement in the evolving healthcare environment.

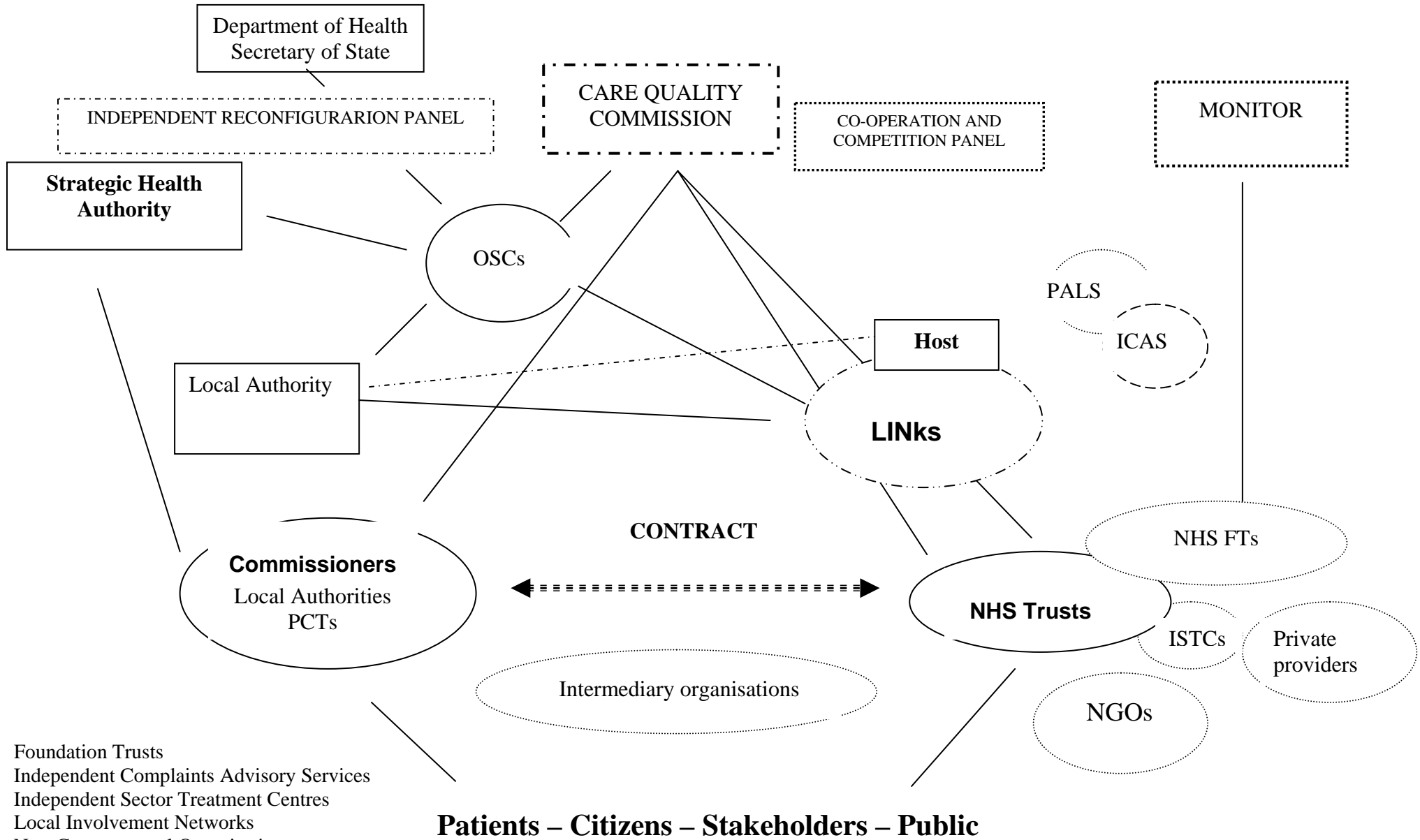
Finally, the limits of what can be achieved through regulation and other forms of government intervention must be properly acknowledged. Combined with appropriate economic and social policy initiatives on the part of government, regulation can help secure the conditions of more effective social learning, but it cannot compel the adoption of effective social learning processes or the resolution of the most complex and intractable governance problems. This leaves open the question of whether the prospects for social learning in the health context might be improved by legislative and policy reform reversing the recent changes to the system of PPI which have seen an overall weakening of the democratic element in the legal framework.⁸² If patients and the public are precluded from contributing to debate and deliberation on fundamental questions such as how services are provided and by whom, it is difficult to see how decision making processes can be regarded as either democratically legitimate or likely to satisfy the criteria of reflexive governance as social learning.

⁸⁰ Vincent-Jones and Mullen, *op.cit.*, n. .

⁸¹ A recent review completely omits human services regulation – see A. Ogus, ‘Regulation Revisited’ (2009) *Public Law* 332-346. For discussion of regulation in the health field, see R. Lewis, A. Alvarez-Rosete and N. Mays, *How to Regulate Health Care in England? An International Perspective* (London: King’s Fund, 2006).

⁸² Vincent-Jones et. al., *op.cit.*, n. .

Figure 1, *Health and Social Care Networks (England)*



- Key
- FTs Foundation Trusts
 - ICAS Independent Complaints Advisory Services
 - ISTCs Independent Sector Treatment Centres
 - LINKs Local Involvement Networks
 - NGOs Non-Governmental Organisations
 - OSCs Oversight and Scrutiny Committees
 - PALS Patient Advice and Liaison Services