ASSERTIVE CITIZENS

New Relationships in the Public Services

Simon Griffiths, Beth Foley
and Jessica Prendergrast

Supported by

PRICEWATERHOUSECOOPERS

FIRST PUBLISHED BY
The Social Market Foundation, February 2009
ISBN: 1-904899-64-1

11 Tufton Street, London SW1P 3QB

THE SOCIAL MARKET FOUNDATION

The Foundation's main activity is to commission and publish original papers by independent academic and other experts on key topics in the economic and social fields, with a view to stimulating public discussion on the performance of markets and the social framework within which they operate.

The Foundation is a registered charity and a company limited by guarantee. It is independent of any political party or group and is financed by the sale of publications and by voluntary donations from individuals, organisations and companies. The views expressed in publications are those of the authors and do not represent a corporate opinion of the Foundation.

DESIGN AND PRODUCTION
SoapBox

PRINTED BY
Repropoint

CONTENTS

DETAILED TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The authors would particularly like to thank the Steering Group for their comments and support. The Group consisted of:

- Professor Carol Black (Health and Work)
- Harry Cayton (Council for Healthcare Regulatory Excellence)
- John Dunford (Association of School and College Leaders)
- John Lakin (PricewaterhouseCoopers LLP)
- Karen Reay (Unite-Amicus)
- Baroness Pauline Perry (Conservatives' Public Service Improvement Group)
- Dr Rajiv Prabhakar (LSHTM)
- David Walker (formally of Public Magazine)
- Martin Ward (Association of School and College Leaders)
- Dr Tim Wilson (PricewaterhouseCoopers LLP)
- Dr Stuart White (University of Oxford)
- Tony Wright, MP (Labour)

We would also like to thank the teachers, parents, students, doctors, nurses and patients who took part in our in-depth interviews and our focus groups. Finally, we are grateful to Nick Jones of PricewaterhouseCoopers' (PwC's) Public Sector Research Centre, and to PwC in general, for their support for this project. While we have tried to do justice to the wide variety of comments which we received in the drafting of this report, errors and omissions remain the sole responsibility of the authors, as do the viewpoints expressed here.

ABOUT THE AUTHORS

SIMON GRIFFITHS

Simon is Senior Research Fellow at the Social Market Foundation, where he focuses on public service reform. He is also a Lecturer in Politics at Goldsmiths, University of London. Simon previously worked for the sociologist, Anthony Giddens, and as a parliamentary researcher. He has a PhD in Political Thought from the London School of Economics, and a degree in Politics, Philosophy and Economics from Wadham College, Oxford. Simon has published widely on the history of political thought (particularly the engagement of the left with the market after 1989); on ideology and political parties; and on the reform of the public services. He is co-editor of *British Party Politics and Ideology After New Labour* (Palgrave MacMillan, 2009) and regularly contributes to the media.

BETH FOLEY

Beth joined the SMF in July 2007. She has worked on a variety of projects, including *Creatures of Habit?*, an analysis of the potential impact of theories of behavioural economics for public policymaking and *Shifting Responsibilities, Sharing Costs*, focusing on the mental health challenge for welfare reform. She graduated from University College London with a BA in European Social and Political Studies. Beth also studied at the Humboldt University in Berlin as part of the Erasmus Exchange Programme. Prior to joining the SMF, Beth was an intern at the Westminster Forum Projects in London and the Global Youth Action Network in New York City.

JESSICA PRENDERGRAST

Jess joined the SMF in November 2007 as a Senior Research Fellow, having worked previously as a social researcher in both the Department for Communities and Local Government and the Home Office, and before that in academia. She has a Master's from University

College London (SSEES) and a BA in Politics, Philosophy and Economics from Keble College, Oxford. She has a special interest in empowerment, local government and housing.

EXECUTIVE SUMMARY

In this report we document the *rise of the "assertive citizen"*. Improved access to information, increasing prosperity and greater social freedoms have produced citizens who are more assertive of their rights and less deferential to traditional forms of authority than before. The rising expectations of British citizens have created profound challenges for the public services, particularly health and education. This report focuses on primary care and education and on the English experience. However, these issues have wider applicability – both geographically and for other public services, particularly social care.

We begin by looking at the theoretical and academic case for a shift towards a more assertive citizenship. The literature shows a significant change in the public's attitudes in recent years. In the world's richest countries, citizens are becoming increasingly individualistic and assertive in their outlook. As part of this, they are *less deferential* towards traditional sources of authority and are more likely to challenge authority than in previous generations. This is, by and large, a good thing, although some forms of assertiveness – often associated with aggressive individualism – are more problematic.

One of the most significant factors in reshaping modern society and in challenging old top-down relationships continues to be the rise and spread of *new information and communication technology*. The most obvious example of this is Internet access. By 2008, 65% of UK households were online. Public service users are now able to meet providers armed with information that was previously the preserve of the expert. They also have far greater choice of service provision and variety of providers, both in the public and the private sphere.

We examined the challenges that assertive citizenship creates for the public services through a varied *methodology*. We reviewed academic, government and "grey" literature. We also carried out

primary research with focus groups: first, with providers and users of the health service – all of whom had recent experience of using the NHS; and, second, with teachers, students and parents of school children. Those focus groups were followed up by more in-depth interviews with practitioners and experts in health and education.

CHOICE AND ENTITLEMENTS

Public services are moving away from a one-size-fits-all approach. As our wants and needs have become more complex – as we have moved towards goals of self-expression and actualisation and become increasingly assertive – the public services have had to adapt to this. The choice-based reforms, which began in the 1980s but continued under New Labour, prompted a shift in the way service users were perceived: from passive recipients to active consumers of services.

However, the demand for services that really reflect users' desires is not straightforward. Polls have found that users welcome personal choice, and the subsequent injection of flexibility and responsiveness that come into the system. However, many also view the inequitable outcomes these reforms sometimes entail as unacceptable. In particular, the idea of "postcode lotteries" – the discrepancies between service scope and quality in different areas, which often result from increasing diversification within services – is widely rejected (although there is nothing inherently inequitable in the idea of local communities deciding to use resources in different ways). These trends reflect the often contradictory duality in the demands of public service users; while they are strongly in favour of locally based, personalised public services, they remain committed to the idea that collectively financed services should distribute benefits equally and produce equitable outcomes across wider society. The challenge for government is to set an appropriate framework for service provision, capable of striking an effective balance between these sometimes competing demands.

Moves so far have been partial and have not always been designed with enough care to protect equity or enough focus on putting (all) users at the centre of public services. In this work we have suggested two ways in which entitlements can be improved to meet an increasingly assertive citizenry. The first is by refining choice reforms to *ensure that choice does not focus simply on the provision of information*; institutional comparisons are useful in some regard, but the information they provide rarely gives a full picture and the presentation of information is often inaccessible. Therefore, *the need for personalised advice*, drawing both on professional knowledge and external sources, is advocated. This will necessarily involve costs, and will therefore need to be targeted, in particular at parents who may struggle to negotiate complex admissions processes in education, and at patients managing long-term, rather than acute, conditions in healthcare.

The second way in which entitlements can be improved looks at previous attempts to create a universal system of written guarantees. These are frequently seen as unresponsive and overly bureaucratic. We therefore look at the scope for a move towards a much more personalised system. In education, this could involve drawing up agreements with the involvement of pupils, parents, teachers and assistants. In healthcare, personalised care plans for the increasing numbers of patients managing long-term conditions will also be beneficial and are already part of the Darzi Review, published in 2008.[1] *Personalised plans* in health and education can be time-consuming for professionals, but, if focused on the users who need them most, could be highly effective.

Across the public services there is room for *a much clearer charter of rights to guarantee fairness* in an increasingly diverse field of provision. This is already soon to be the case in the health service with

1 Lord Darzi of Denham, *High Quality Care For All: NHS Next Stage Review* (June 2008): www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825.

the introduction of the NHS Constitution, but there is room for such a scheme to be rolled out in education as well. This recommendation is, however, made with the proviso that there is deep citizen and professional involvement in the creation of these new charters, to prevent it from becoming a meaningless decree from above, rather than a body of rights that all feel protected by.

CO-PRODUCTION

If users are more assertive of their rights, it seems – at least on the face of it – that sharing the responsibility for shaping service provision between users and providers is a good idea. The assertive citizen can satisfy values of self-expression and full involvement through greater participation in the production of public services. In chapter 3, therefore, we examine the co-production of public services.

We discuss one common account of public service provision, which draws on two frameworks: the "dominant model" and the "co-production" model. Although initially helpful, we argue that this sharp conceptual division is misleading. Users are almost always actively involved in the production of public services: for example, pupils work with teachers and parents in the production of their own education. Thus co-production is seen as a continuum. There are times when greater user involvement will work well, and times when it will not. The difficulty is knowing where and for whom greater co-production will be effective and where it is desired.

We argue that there is considerable scope for better use of co-production in the public services. However, there is also the danger that "deep" co-production is presented as a panacea for all services – a proposition that our own research showed was a considerable distance from users' actual day-to-day experience. We also note that co-production is not a "cheap" option for the provision of public services, as it is sometimes claimed to be, and that resources are required in order for it to work effectively.

Several changes need to be made to take advantage of the benefits of co-production. We need to *examine more closely the instances in which co-production is an appropriate model.* Government also has a role to *facilitate forums in which co-production can take place*. One recommendation is for successful schemes – such as the Expert Patients Programme and others that have had demonstrable achievements – to be rolled out and encouraged nationally. We also welcome innovative approaches to encourage co-production. One of the most recent examples was the call for a *Co-production Fund* to be made available for applications in each area of the public services. Finally, there must be the recognition that co-production shifts power and responsibility towards the citizen. This should be welcomed, but *with this shift to co-production comes a shift in risk.* As the risks – both positive and negative – move towards the user, government needs to be there with a safety net in case of failure and to protect through regulation to ensure that co-production is carried out in partnership with safe, law-abiding organisations. Finally, there are *other methods of incorporating citizen views*, such as insight surveys, and these should also be included as part of the mix.

THE PROFESSIONS

The final substantive chapter in this report examines the role of the professional and professional groups and how they respond to different types of assertive citizen. The answer to this question depends to a large extent on the view one takes of the professions. The traditional view of the public service professionals as straightforwardly altruistic has been increasingly rejected in recent decades. A strong strand in academic work is far more cynical. Sceptics argue that the creation of professional bodies is a strategy by particular occupations to manipulate the labour market for their own ends. According to this view, professionals through their organisations can be seen as effectively having a veto on reform.

This argument, though, tends to be overly pessimistic about the role of the professional. Recently, there have been more subtle attempts to renegotiate the relationship between public service providers and users. We take this more subtle view and, following other writers in this field, we argue that public service professionals are neither "knights" nor "knaves".

It is this latter view of professionals and their organisations that informs this research. There has been a growing recognition that the government's relationships with the public service professions need to be re-examined. In particular, this may be achieved through greater autonomy for the professions within a new accountability framework based on high-level targets and outcome measures, rather than the more detailed targets regime.

The shift in power and responsibility that comes with co-production raises extensive challenges for the professions. In this report we concentrated on two groups – GPs and teachers – although the issues are much wider than this and include all areas of health, education and social care. Our work implies that *assertive citizens need strong, but flexible, professional groups to meet their expectations.* The evidence around public trust and respect largely suggests that professional groups require *more autonomy and less interference.* Assertive citizens need to be partnered by independent, authoritative professionals who are not regarded as pawns to government agendas. Most professional organisations will gain if they are allowed to operate at a distance from government. There is, however, scope for *strong public interest declarations* as part of the teaching and medical councils' *modus vivendi.* And there is often an unhelpful "mission creep" between the union responsibilities of professional organisations (which largely focus on pay and working conditions) and their professional role (which focuses on improving the quality of the service which professionals provide through setting standards for entry, providing a forum for best practice, and so on).

Assertive citizens also provide a strong challenge to the role that professionals see themselves as having. We call for *professionals to see themselves as Sherpas*, increasingly looking to provide options and guidance, rather than definitive answers. This also means *a focus on soft skills*, whereby professionals are offered greater help than before in negotiating with services users. It also creates new challenges for users, who must learn – and, as youngsters, could be taught – how to get the most from this relationship through a *focus on their interaction with public servants as part of school Citizenship classes.*

CHAPTER 1: NEW RELATIONSHIPS IN THE PUBLIC SERVICES

Citizens demand more from their public services than ever before. They are more assertive of their rights, expect a better service, and defer less to established sources of advice such as expert opinion. This creates profound challenges for the structure of public services, and for the relationship between the users and the providers of those services. This research examines how the public services and those who work in them must adapt to fit these changing expectations. It examines two public services in England as case studies for these changes: the health service and the education system – in particular, primary care and secondary education. However, the social changes it documents and many of its findings have wider applicability.

The anecdote that partly inspired this research – and which has been repeated in many of our expert and practitioner interviews – tells of a patient who visits her doctor. She arrives carrying a sheaf of printouts from the Internet on her symptoms and has a clear idea both of what is troubling her and how she should be treated. Depending on which doctor tells the story, the drugs she requests are either inappropriate or not available on the NHS. Either way, the patient presents the GP – and other healthcare workers – with a challenge to their expert opinion that was rarely possible in the past. And it is not just in medical settings that these new challenges are occurring; they are also evident in education, social care and elsewhere. Furthermore, they are not just the result of new information technologies; rather they reflect a wider societal change.

This introductory chapter sets out this changing context for the policy debate. It examines the claim that citizens are more "assertive" than before (a claim which is based upon contemporary debate in the social sciences and on international surveys of changing values). We then examine how this changes relationships in the public services,

and set out the research questions which dominate this report. Finally, we discuss the method we followed in order to examines these issues.

THE RISE OF THE ASSERTIVE CITIZEN

The academic literature shows a significant shift in the public's attitudes in recent years. In the world's richest nations, citizens are becoming increasingly individualistic and assertive in their outlook, and are more likely to challenge authority than in previous generations.[2] Below, we look at the evidence for this and some of the main explanations for it.

Changing values and the rise of a new individualism

There has been a significant shift in public values over the past 25 years. The best evidence comes from the *World Values Survey*, led by the political scientist Ronald Inglehart. This is an ongoing academic project, which has been carried out over the past two and half decades, to assess the changing state of various values in different cultures. It was initially focused on Europe, and now covers much of the globe. The survey provides important information for social scientists, largely around the scale of social, moral, religious and political constraints or choices open to citizens.

The survey found that Britain, along with most other nations, is becoming more individualistic and placing less emphasis on the importance of community and authority. Beginning in the 1920s, the survey shows a significant shift in most of the world (Africa is the major exception) away from values that represent conformity of various kinds and towards values of individual self-expression (a move which Inglehart characterises as being towards "post-material" values). In the UK, for example, the *World Values Survey* finds that when people are

2 Open University, "Creating citizen-consumers: changing relationships and identifications": www.open.ac.uk/socialsciences/creating-citizen-consumers/summary.php.

asked what qualities should be encouraged in bringing-up children, they are increasingly focusing on individualistic, effort-driven virtues.[3] The survey also found that British people put significantly more emphasis on the individualistic dimension if they are younger, have higher levels of income and are better educated.

In recent years, individualism and individualisation have been lent a conceptual structure by sociologists such as Anthony Giddens, Ulrich Beck and Elisabeth Beck-Gernsheim. Beck suggests that we are entering a new phase of modernity, characterised by the global growth of modern institutions as well as the breakdown of tradition and custom in daily life. Coupled with these movements is the rise of what Beck calls "individualisation", the extension of areas of life in which individuals are expected to make their own decisions. These are the kind of post-material values identified by Inglehart and his colleagues on the *World Values Survey*. As Beck and Beck-Gernsheim put it: "Individualisation means the disintegration of previously existing social forms – for example, the increasing fragility of such categories as class and social status, gender roles, family, neighbourhood etc."[4]

There are four aspects of this shift which should be highlighted. The first is that the "new individualism" is not the same as the "free market individualism" associated with neo-liberalism. Free market individualism is, in part, a moral argument for individuals to take responsibility for themselves, rather than relying on the state.[5] As Beck stresses, the new individualism is "*not* Thatcherism, not market individualism, not atomisation".[6] Rather, he explains, individualisation is, in part, an effect of certain pressures in modern society. Such pressures

3 Found in an analysis of the *World Values Survey*. World Values Survey: http://www.worldvaluessurvey.org/.

4 U. Beck and E. Beck-Gernsheim, *Individualization: institutionalized individualism and its social and political consequences* (London: Sage, 2001), 2.

5 A. Giddens, *The Third Way* (Cambridge: Polity, 1998), 34–7. See also J. Lawler, "Individualization and public sector leadership", *Public Administration* 86/1 (2008): 26–7.

6 Beck quoted in Giddens, *The Third Way*, 36.

include increases in educational opportunities and in social mobility, both of which enable individuals to be more autonomous and less tied to class membership and status groups than they were in the past. Although social class remains a stubborn indicator of life choices, its shape and structure has changed, particularly with the decline of manufacturing. Equally, geographical mobility has meant that neighbourhoods are less socially organised, and people are less likely to rely on relating to others primarily in terms of class culture.

The second aspect is the fact that an increase in assertiveness is by no means a universal phenomenon. While it is true that British citizens are, on the whole, more willing to make demands and engage in the delivery of public services, this is far more pronounced amongst the better-educated, wealthier middle class. Several reports on inequity in the provision of NHS services found that, although GP visits were generally distributed according to need, patients from more advantaged socio-economic groups were much more likely to have access to specialist, in- or outpatient treatment.[7] In recognition of this problem, a 2003 *StudentBMJ* editorial argued that assertive, articulate patients who swallow up doctors' time with their lists of questions are increasing health inequalities by leaving needier patients waiting.[8] These groups are most often from wealthier backgrounds. This suggests that, while primary care is accessible to all, once in contact with GPs, patients from higher socio-economic groups were better able to access higher-quality, more expensive service options. There are numerous reasons why this might be the case. Middle-class patients tend to be more articulate and confident when dealing with medical professionals. They are more likely to have higher literacy and numeracy skills, and are therefore better equipped to describe their symptoms and gain clarity on the diagnosis. Second, evidence shows that health professionals tend to be more comfortable dealing with patients from higher socio-economic groups.

7 Dixon et al., "Is the NHS Inequitable? A review of the evidence", *LSE Health and Social Care Discussion* Paper No 11 (2003), 10–11.

8 Hilda Bastian, "Just how demanding can we be before we blow it?", *StudentBMJ*, 11 July 2003.

Middle-class patients are also more likely to have friends or family working in health services, making interactions more familiar to them.[9]

Increased assertiveness and user engagement are associated with securing better outcomes, but equity is a key principle in public service provision. It will therefore be necessary to account for the barriers which prevent users from lower socio-economic groups from gaining access to the highest-quality levels of service delivery. Responding to the changing and diverse needs of different users will create huge challenges for the people who provide our public services.

The third point worth noting about the rise in new individualism is a normative one. This report largely embraces new individualism as a move away from deference to old orders. However, not all forms of individual assertiveness are desirable. People express assertive individualism when they do things like disable speed cameras. Parents who refuse to allow their children to be given the MMR jab are expressing an assertive individualism – one that puts both the health of their children and others' at greater risk. The policy challenge is not simply to accommodate assertive individualism, but to temper its negative consequences – to ensure that citizen assertiveness is socially responsible and well informed, and not just a reflection of a civic irresponsibility.

Finally, new individualism and the rise in assertive citizenship are not equivalent to a rise in consumerism. Consumer choices pursued in (quasi-) markets are, increasingly, a feature of public services (a point we discuss further in chapter 2). Yet, as the description above shows, this is not the same as new individualism, which is more appropriately seen as a social and institutional shift towards the individual. Assertive citizens are consumers, but they are also engaged in wider society in other ways too, often in ways that create new forms of solidarity, or

9 Dixon et al., "Is the NHS Inequitable?", 25.

involve the use of voice in collective, democratic mechanisms of deliberation.[10]

The escape of expert information and the decline of deference

There are many reasons for the shift towards a more individualist, more assertive citizenship. One of the most significant factors in reshaping modern society and in challenging old hierarchical relationships continues to be the rise and spread of new information technologies. As a society, we are not at the mercy of these changes, but we have actively assisted in disseminating and spreading them; governments, entrepreneurs, businesses, groups and individuals have all pushed the development of new technology forward, and these technologies have changed the society in which we operate too. Service users are now able to meet service providers armed with information that was previously the preserve of the expert – they no longer have to defer exclusively to one expert's opinion. Nowhere is this truer than in the field of health, with the spread of information about medicines, illnesses and ailments on the Internet, but it applies across the professions and wider public services. As the General Teaching Council for England has recently noted: "It is possible to chart the 'death of deference' to the professions, through … changes such as the contention of professional knowledge as clients inform themselves through the Internet, and are supported by pressure groups and voluntary organisations representing their interests."[11]

A survey of Norwegian doctors on their experiences of dealing with patients who had been using the Internet sums up this decline of deference well: it is subtitled "From "thank you" to "why"?"[12] The survey found that three out of four Norwegian doctors had experienced patients bringing information downloaded from the Internet into the consultation setting. Most of the doctors found this natural and

10 Catherine Needham, *Citizen-consumers: New Labour's Marketplace Democracy* (London: Catalyst, 2003).

11 General Teaching Council For England, "Teaching and learning: the role of other adults", (2002): www.gtce.org.uk/shared/contentlibs/93802/93125/trust.pdf.

unobtrusive; a few felt it influenced the doctor–patient relationship in a negative way; one out of every four doctors found meeting "the informed patient" a positive challenge. The availability of new sources of information undermines the monopoly of information that used to be enjoyed by experts, and hence lessens the deference that service users once had towards them. This research area raises several questions, which we return to throughout the report:

- What happens when the opinions of service users differ from those of experts?
- Is this challenge to expert opinion one that is actually encountered by service providers or a largely hypothetical one?
- What information sources are currently trusted by service users?
- What can policymakers do to ensure that high-quality information is available to all service users?
- Could information overload be a problem for users of the health and education systems?

The theoretical and empirical evidence suggests a move towards a more individualistic form of citizenship, one that is better informed and more expressive than ever before. A major project carried out by the Open University concurred, noting: "We found that people were becoming more assertive in their relationships with public services: less deferential, more willing to express their needs and to challenge providers."[13] However, they summed these changes up under the heading of "citizen-consumers". This reduces wider social change to a rise in consumerism.

This rise in consumerism has placed a great strain on public goods and services. The sociologist Peter Taylor-Gooby and his colleagues

12 P. Hjortdahl, M. Nylenna and O.G. Aasland, "Internet and the physician–patient relationship – from "thank you" to "why?" [original article in Norwegian], *Tidsskr Nor Laegeforen* 119/29 (30 November 1999).

13 Open University, "Creating citizen-consumers": www.open.ac.uk/socialsciences/creating-citizen-consumers/main-findings.php.

argue that these "increasingly well informed and challenging" individuals could be described as "querulous citizens".[14] Many would subsequently argue that the growth of the consumerist society has produced citizens who are increasingly self-centred and less willing to consider the communal dimensions and public consequences of their demands. One example of this might be the refusal of many parents to allow their children to receive the MMR vaccination, despite the fact that this could put the health of other children at risk. These kinds of challenge, which are an important outcome of a more assertive citizenry, will form one focus of this report.

However, while, on the one hand, assertive citizens will pose challenges for both government and professionals, on the other they also hold the potential to make major improvements to public service outcomes. There is much evidence to suggest that service users who are able to discuss and negotiate the kind of benefits they wish to receive from public services will also become far more engaged in realising the outcomes; parents taking an active interest in their children's education is closely linked to higher pupil attainment, and patients who are informed and willing to take a role in securing their own good health tend to recover more quickly and stay healthy for longer. More assertive service users need not simply be viewed as a challenge to be overcome, and this report will examine the means by which the great potential that lies behind less deferential service users could be harnessed.

RESEARCH QUESTIONS

The rise of the assertive citizen therefore creates both new challenges and new opportunities for the public services. In the chapters that follow, we focus on three areas where this is the case: citizen entitlement, co-production, and the role of the professionals. Below, we set out some of the key questions that we set out to answer in each of those areas.

14 P. Taylor-Gooby, C. Hastie and C. Bromley, "Querulous citizens: welfare knowledge and the limits to welfare reform", *Social Policy and Administration* 37/1 (February 2003), 20.

Entitlement to public services

An important set of questions over the relationship between service providers and a less deferential public arises in relation to public services and entitlement. Traditionally, public control over public services came exclusively through the exercise of voice, primarily through the ballot box.[15] Choice reforms made in the public services over the past decade have empowered service users by specifying certain entitlements to services and by providing people with the right to exit from one expert's opinion where previously they had no alternative.

Some commentators have suggested a radical extension of entitlement to public services. Tony Wright, Chair of the Public Administration Select Committee, has argued that we need a shift from targets to rights in public services.[16] Writing with Pauline Ngan, Wright argued that the arrival of a less deferential and more assertive service user could lead to a new written Public Service Guarantee.

An increase in entitlement by definition changes the relationship between service users and providers. This research will investigate the following questions:

- How has the creation of the right of public service users to choose rebalanced the power relationship between user and provider?
- In which areas should policymakers consider the broadening of entitlement?
- How will this affect the public service workforce, and what training will be necessary to prepare them accordingly?

15 Terms that derive from A.O. Hirschman, *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States* (Cambridge, MA: Harvard University Press, 1970).

16 T. Wright and P. Ngan, *A New Social Contract: From Targets to Rights in Public Services* (The Fabian Society, 2004).

- What could the unintended consequences of this kind of approach be? How can demands for choice be reconciled with the demands for equal access to public goods and services?
- How far have written guarantees of users' rights contributed to improvements in outcomes?
- How can written guarantees of rights be improved in future, particularly in the light of users' rising expectations of public services?

Co-production

In a less deferential age, in which citizens are more assertive, service users and providers must increasingly negotiate the responsibility for outcomes which they both desire. This means that the power relationship between a service user and a provider is negotiated rather than taken as given. Under this view, service users and providers share responsibility for outcomes – a concept known in the contemporary jargon as "co-production". An example of the negotiated relationship between service user and provider, in order to co-produce an outcome, is the NHS's Expert Patient Programme for people with long-term illnesses. In this case, the doctor cedes far greater power to patients over how best to manage their condition. A second example might be home-school agreements, documents which outline the respective areas of responsibility covered by parents and schools. Here, responsibility for the "production" of children's education (in the widest sense) is shared. If users and providers accept shared responsibility to create the best outcomes, then, in many cases, those outcomes are likely to improve.

Co-production provides one way of creating more user-centred public services, but it raises several questions:

- How can systems be developed that encourage users to take more control in the production of beneficial outcomes?

- In which service areas is it most appropriate or inappropriate to roll out co-production approaches?
- What are the limits and extent of co-production?
- How does co-production challenge the traditional roles of the professions?

The role of the professional

The motivations and role of professionals in public service delivery have been the subject of some dispute over the past few decades. While the traditional view of professionals in the post-war development of the welfare state generally saw them as benevolent public servants, this has been increasingly rejected in recent decades.[17] A strong strand in academic work, for example, is far more cynical. Sceptics such as Parry and Parry argue that professionalism – understood in this context as the formation of professional organisations and status – is a strategy by which particular occupations manipulate the labour market for their own ends.[18] According to this view, the professions can be seen as effectively having a veto on reform; policymakers are tied into the pursuit of producer, rather than consumer, interests.

Yet neither the view of professional altruism nor the fear of professional dominance and manipulation of the labour market provides a particularly accurate, nuanced reflection of the reality of the role of professionals. Recently, there have been more subtle attempts to address the relationship between public service providers and users. The former public policy adviser to the Prime Minister, Professor Julian Le Grand, for example, argues that professionals are neither "knights" nor "knaves", giving a more balanced view instead.[19]

17 B. Barber, "Some problems in the sociology of the professions", *Daedalus* 92/4 (1963).

18 N. Parry and J. Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London: Croom Helm, 1976).

19 J. Le Grand, *Motivation, Agency, and Public Policy. Of Knights and Knaves, Pawns and Queens* (Oxford: OUP, 2003).

It is this latter view of the professions that informs our research on how they respond to a more assertive citizenry. There has also been a growing recognition that the government's relationships with the public service professions need to be re-examined. In particular, this may be achieved through greater autonomy for the professions within a new accountability framework based on high-level targets and outcome measures, rather than the more detailed targets regime.

This research will focus on several questions about the role of the professions in a less deferential age:

- How does the fact that professionals are often, particularly in the case of GPs, gatekeepers of resources affect the power relationship between user and provider? Is this gatekeeping role sustainable or desirable?
- Would greater autonomy and better self-regulation win the trust of a more individualistic, less deferential and better-informed public – a public which, it seems, bases its sense of trust on results rather than on traditional status?
- How can government foster more collaborative relationships between policymakers, professionals and service users?

METHODOLOGY

Our research was carried out using a variety of methods, starting with a literature review and empirical research from focus groups and public service professionals. This initial desk-based research was followed by empirical research gathered from service users and providers through focus groups, administered by PricewaterhouseCoopers' International Survey Unit. Two focus groups were conducted: one for education and one for health, which included both users and professionals from these fields. The education group consisted of four parents, three 16-17 year-old pupils and three teachers. It was held in London. The health group

was made up of six patients who had used the health service recently, two GPs and two practice nurses. It was held in Sutton Coldfield, near Birmingham.

The groups were asked questions concerning the use of technology, ideas of entitlement, the role of the professional and co-production. In both instances, the professionals did not join the focus group until halfway through the discussions. This provided the opportunity to explore openly the professional/ user relationship from the user's perspective, without the professionals in the room. Other exercises carried out in these focus groups included word association exercises where participants' views on a variety of professions – doctors, politicians, solicitors and teachers – were explored. They were also asked about their levels of trust and respect for these four professions.

Finally, experts and service practitioners working in the health and education systems were engaged in open-ended interviews which explored the decline in deference of users, and how this has changed the relationship between the two sides. These sessions were attended by a primary school headteacher, several teachers working in secondary schools, and GPs.

To ensure quality, the research was put through several stages of peer review, both internally in the SMF and externally via a Project Steering Group. Findings from the previous stages of research were presented to this group of experts selected from politics, trade unions, academia and the private sector. It was a forum for the research to be discussed and any recommendation and revisions to be made. We would like to thank all members of the Project Steering Group, focus groups, expert interviewees, and PricewaterhouseCoopers International Survey Unit for their involvement.

CHAPTER 2: ENTITLEMENTS TO PUBLIC SERVICES

Almost eight in ten (79%) of the British public agree with the statement: "Britain's public services need to start treating users and the public in the same way as the private sector does."[20] One of the main challenges for government is to set out appropriate legal entitlements for all public service users that reflect this desire for higher-quality, more responsive services. This move to address "user entitlements" is a relatively recent development; as Wright and Ngan argue: "Britain's public services could benefit from shifting the focus of service delivery … from targets to entitlements."[21] Yet establishing what the term "entitlements" should encompass has been the subject of ongoing debate. At present, numerous tensions remain unresolved.

More assertive citizens have increasingly become "consumers" of public services, but their demands are not straightforward. Polls have found that users "want services to be flexible and responsive and like the idea of personally being able to choose a school, hospital consultant or GP but see 'postcode lotteries' as unacceptable (these have become a very powerful negative image in any discussions about choice)".[22] These two key demands – for greater choice on the one hand and for standardised outcomes and benefits on the other – reflect the often contradictory duality in the expectations of public service users. Most are strongly in favour of locally based, personalised public services, but they also remain committed to the idea that collectively financed services should be seen to distribute benefits equally.

Yet concepts of choice and equity in debates on public service provision are often confused. The oft-cited idea of postcode lotteries

20 B. Marshall et al, *Blair's Britain: The Social and Cultural Legacy*: www.ipsos-mori.com/_assets/reports/blairs-britain-social-cultural-legacy.pdf.

21 Wright and Ngan, *A New Social Contract*.

22 Marshall et al., *Blair's Britain*.

is an interesting one in this context. It is often used to refer to inequitable service outcomes – such as discrepancies in waiting times between different Primary Care Trusts (PCTs) – but may also refer simply to non-uniform outcomes, reflecting, for example, the different spending priorities between Trusts. When local authorities or PCTs are permitted to prioritise services as they see fit, it may mean that certain services or treatments are given precedence in some areas but not in others. It is, however, important to note that the ability of local services to respond to the varying needs of communities can be an important one, particularly in the context of resource constraints and the need to prioritise services selectively. Yet this may also mean that certain individuals could be denied services that are available elsewhere. This distinction involves a separation of collective equality in outcomes – where local decisions on funding allocations must benefit some groups over others, but all localities receive uniform funds – and equality for individuals. Public debate surrounding postcode lotteries would benefit from a more informed discussion, with more clarity on this distinction. As Daniels and Sabin highlight, decisions on resource allocations have invariably been deliberated on and have been taken for appropriate reasons, but such justifications are rarely presented to service users: "Reason giving is not standard practice and public accountability – and trust – suffers."[23]

The confusion surrounding the ideas of choice and equity – particularly in the context of individual and collective rights – actually forms part of the wider debate about the principles which should underlie public service provision. The fact remains that there are fundamental differences between the delivery of public and of private services – differences that make the scope and role of users' rights much harder to define. The realm of private transactions involves a relatively straightforward conception of the rights of individual parties

23 N. Daniels and J. Sabin, "Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers", *Philosophy and Public Affairs*, 26 (1997), 350.

involved in any one transaction. Public services, though, seek to combine the promotion of individual rights with the more complex notion of collective rights. Individuals are expected to contribute to a system in which the least well-off are heavily subsidised by the more prosperous. In turn, professionals in the public sector are not expected to be motivated solely by their private interests, but also by a "service ethic" and a duty of care. While there have been recent moves towards drawing direct parallels between public service users and consumers in the private sector, the evidence of opinion polls and the overwhelming support for institutions like the NHS suggest that certain distinctions remain. By and large, people do recognise the differing goals and standards of the public sector, and do not judge the quality of public services solely according to the particular benefits offered to them as individuals.

Nevertheless, today's public service users increasingly expect standards of provision that reflect the choice and accountability associated with the private market, even while they remain concerned about fairness of outcomes. The response has been a public service arena which, in many respects, is increasingly organised along the lines of markets, and the extent of the role for public services in the promotion of more "collective" notions of social cohesion and equality is increasingly the subject of dispute. The challenge for government is to attempt to meet these sometimes conflicting demands by ensuring that public service provision adopts a model that can balance choice, flexibility and responsiveness with demands for equity.

One interpretation of the New Labour project sees it as an attempt to strike a balance, by linking the emphasis on user choice, diversity and marketisation, prominent under Thatcher, to Labour's traditional focus on promoting equality. As a result, service users were to be offered the opportunities for choice that they had come to expect in a market economy, while providers would be increasingly subject to

uniform standards in order to ensure equal distribution of benefits. The focus on top-down targets and universal "written guarantees" of users' rights was justified on the grounds that this would put an end to postcode lotteries by means of centralised standards and clearer lines of accountability, guaranteeing equity of provision for all service users.

But this move to ensure that policy decisions remained in the hands of central government, leaving local agencies as merely vehicles of service delivery, has come in for criticism.[24] Centralised control can blur lines of accountability. It can also restrict users' ability to contribute to the formation and direction of policy. As a result, public services rarely incorporated the flexibility required to tailor services to reflect users' preferences. This, many professionals argued, led to a paradoxical situation in which the public gained the right to choose between providers and types of service, while providers themselves were rarely offered the flexibility to tailor their services to users' demands.

In recent years, however, the need to promote and incorporate local innovation in public service delivery has been increasingly acknowledged by government. In a recent Cabinet Office report, Gordon Brown calls on government to "embrace a new culture that celebrates local innovation and ends once and for all the view that the man or woman in Whitehall always knows best".[25] While targets and standards will still have a certain role to play in ensuring service quality, the challenge now will be to find a better balance between choice and equity: a combination of targets and written guarantees of rights to set minimum standards and maintain a degree of equity, and tailored, locally administered services better able to discern and reflect the priorities and concerns of their users.

This chapter will examine the types of entitlements that could satisfy the desire of service users for choice and equity. On one side of

24 S. Lee and R. Woodward, "Implementing the third way: the delivery of public services under the Blair government", *Public Money & Management* 22/4 (October 2002): 49–56.

25 Cabinet Office, *Excellence and Fairness: Achieving World-Class Public Services*, (London: HMSO, 2008), 7

this balance is the growing focus on user choice – a continuation of trends which began in the 1980s to produce services that were more responsive to the needs of users. On the other side is the demand for equity and accountability. Recently, there has been an attempt to provide some degree of transparency through written guarantees of rights for public service users and this concept will be examined in the second part of this chapter.

CHOICE

The choice reforms in public services over the past decade have been viewed as the key to promoting and extending users' rights and responding to the rising expectations of the public. In a report to House of Commons Public Administration Select Committee, the Cabinet Office recently concluded: "User choice is an effective instrument for promoting quality, responsiveness, efficiency and equity in public services."[26] It is a concept which, its proponents claim, should be offered both as an expression of the rights of citizens as free agents and as a means to improve public service outcomes. Under the Conservative administrations of the 1980s and '90s, it was frequently argued that this introduction of competitive mechanisms traditionally associated with the market would drive competition between providers and that this could bring numerous benefits for service users.

First, choice of provider should allow users to hold public services to account in the same way that consumers hold producers to account in competitive markets. If users are dissatisfied, they can choose to exit the relationship with the provider and take their business elsewhere. Providers are thereby given a clear incentive to provide better-quality, more responsive services that will match up to citizens' expectations and preferences. Second, with standards of living rising rapidly and citizens accustomed to an ever-greater degree of choice and flexibility

26 Cabinet Office, The Case for User Choice in Public Services, 2007: http://archive.cabinetoffice.gov.uk/opsr/documents/pdf/the_case_for_choice_exec_sum.pdf.

within the private sector, service users increasingly expect a similar shift in public service provision. This is reflected in recent opinion polls, which have revealed widespread public support for some degree of choice within public services.[27]

However, the choice reforms introduced during the 1980s and built on over the past two decades have come in for criticism. In recent years, a backlash against the choice agenda has come from those who feel that provision of choice will be an expensive and wasteful use of limited public resources and that extensive reforms and new, "competitive" pressures will serve further to alienate professionals. It has also been suggested that the extension of user choice will produce greater inequity in outcomes. It could create a "two-tier" system in which the wealthier and better-informed middle classes are able to monopolise the best services, and the least well-off – who often rely most heavily on public services – are consigned to sub-standard provision. At present, many are also suspicious that the introduction of choice will serve as a substitute for, rather than initiator of, what the public really wants: universally good-quality public services. This preference was reflected in focus groups conducted by the Social Market Foundation as part of this research. While there was general support for the principle of choice amongst users of the health service, that support was noticeably less evident amongst patients who had already been receiving what they saw as a good service.

Finally, the provision of choice – if applied incorrectly – can potentially produce perverse consequences. The possibility of "choice overload" may have disabling, rather than enabling, effects. In the US, studies on the uptake of a particular type of retirement plan using data from 800,000 employees found that "other things equal, every

27 Ipsos MORI: www.ipsos-mori.com/content/polls-03/public-services-and-choice-poll.ashx. Overall, 72% of respondents felt they should have "a great deal" or "a fair amount" of choice over schools for their children, rising to 89% who believed there should be a degree of choice over hospitals.

ten funds added was associated with a 1.5% to 2% drop in participation rate".[28] An overly complex array of options can lead to confusion and inertia. It is therefore vital that users are offered choice which is both meaningful and clearly presented, along with appropriate information. The dissemination of information appears to be an area that is currently lacking; while respondents in our focus groups were generally satisfied with their current GP, many also believed that they were rarely offered a genuine choice of services. This supports wider surveys which point to a lack of knowledge about choice in the NHS.[29]

Yet there remains support for choice amongst the population at large, and there is evidence to suggest that choice reforms, when applied properly, can go some way towards creating patient-centred services.[30] This can be particularly beneficial for those most dependent on public services. The public also appears to be aware of these potential benefits and keen that choice is available to vulnerable groups managing ongoing problems. The Audit Commission found that, when asked in which areas the ability to choose was "absolutely essential", the public rated choice of school for children with special needs and choice in support for elderly people living at home as by far the most important.[31]

With a general consensus that choice is here to stay for public service users, we need to ensure that any further extension can effectively harness the new engagement on the part of users to promote better service outcomes. Achieving this goal will require several steps to be taken.

---

28 S. Iyengar, W. Jiang and G. Huberman, "How much choice is too much? Contributions to 401(k) retirement plans", *Pension Research Council Working Paper 2003-10* (2003).

29 BBC, "Many 'unaware' of new NHS choice", 2 January 2006: http://news.bbc.co.uk/1/hi/health/4574342.stm.

30 King's Fund, Patient choice (London: King's Fund, 2008), 4 and 5. Results of the London Patient Choice Pilots indicated that waiting times did decline, and that the introduction of choice had not been associated with inequity when patients were offered both choice advisers and free travel to reach treatment centres.

31 Audit Commission, *Choice in Public Services*, (London: HMSO, 2004), 5.

First, we must be clear about the types of choice that service users want. Much of the confusion surrounding the potential outcomes of choice reforms stems from the fact that many of the arguments – both against and in favour – make reference to choice as a virtually uniform concept. It is important to note that the meaning of "choice" when applied to public service provision can take on many different dimensions. While much government rhetoric is focused on choices taken by users as individuals, choice can also apply on a collective level in response to the differing needs of communities. Both collective and individual actors can also take decisions at various different levels: from the broad scope of local government decisions on spending priorities, or individuals' choices between providers, to smaller-scale, more focused choices, which could include personalised home-school agreements, or the incorporation of individual preferences into programmes of medical treatment.

When assessing the merits of choice, it is these discrepancies which must be taken into account. As the National Audit Office put it:

> [It is vital] to be clear on the relative value of the particular type of choice available to the public and users, its cost and whether we are prepared to pay for it… Our poll also clearly demonstrated that there was no enthusiasm for paying more for choice through higher taxes. More is being invested in public services, so the issue is how can greater choice be introduced in a way which gives good value for money and, arguably, better value for money than other improvement mechanisms.[32]

The fact that the provision of choice cannot be all-encompassing has rarely been openly acknowledged by politicians. Their rhetoric has tended to emphasise the continual extension of choice and the benefits it offers. However, these types of commitment may in fact have fuelled public cynicism surrounding the choice agenda. Many

32 Ibid., 2.

respondents in our focus groups, for example, felt that the choice of services they were offered was rarely genuine; of respondents to a recent poll, 45% claimed that they had little or no choice over the schools to which they sent their children.[33] The best schools and local GPs are often heavily oversubscribed and constraints on public spending mean that choice will necessarily be limited.

A clearer conception of both the limits of choice and the areas in which it will be most beneficial could form the basis of a more informed, engaged public debate on the issue. For example, provision of choice will necessitate excess capacity in the system; proponents argue that such excess is offset by the improvements in productivity fostered by choice, but unused public service capacity funded by taxpayers' money has always proved politically unpopular. With much of the current debate limited to whether choice in itself is positive or negative, public scepticism could be tackled and the choice agenda improved if the discussion was widened to include the trade-offs or spending increases that extending choice might involve.

Second, where choice is offered, people need to be able to play a meaningful role in taking decisions. Doing so requires that information is available and accessible. Evidence suggests this has not been entirely successful to date; a survey of those most likely to be in contact with the health service (adults over the age of 40) found that awareness of the patient choice agenda was very low: only 4% said they knew "a great deal" about patient choice, while two in five (41%) said they knew absolutely nothing about choice in healthcare and 39% knew "just a little" about it.[34]

Provision of information will therefore be central to the promotion of the choice agenda and is an area the government has been

33 Ipsos MORI, "Public services and choice poll", July 2003: www.ipsos-mori.com/content/polls-03/public-services-and-choice-poll.ashx.

34 Ipsos MORI, "Choice? What choice?' say patients", January 2006: www.ipsos-mori.com/content/choice-what-choice-say-patients.ashx.

focusing on, moving into online communication via NHS Direct. However, evidence suggests that the provision of information alone is rarely sufficient. When taking complex decisions, most people wish to benefit from personal interaction and advice – in the case of public services, it is professionals who generally act as intermediaries and offer guidance. In the same survey cited above, 76% of those questioned wanted to access information about choice from their GP.[35] Similarly, in the case of parents' roles in education, studies have found that 40% would find parenting information from schools and playgroups useful (second only to advice from family and friends), compared to just 10% who believed they would benefit from information provided by government departments.[36]

There is therefore a real need to ensure that trusting, personal relationships are established between service users and professionals. Evidence from our focus groups suggested that levels of trust in the professions remains high and that people place a great deal of value on the relationships they have with familiar family doctors or on opportunities to interact with their children's teachers. Yet fostering these relationships will require local services which can provide a degree of continuity and face-to-face contact, and professionals who have the time and motivation to establish trusting relationships with service users. Here, the top-down nature of much public service reform and the feeling amongst many professionals that they are excluded from the debate will need to be addressed. As David Marquand argues, public services – and the public domain more generally – form the "domain of trust" which all market economies must rely on to function: "The relationships of the public domain are necessarily long-term. The loyalties which are fundamental to it could not take root in, and would not survive, a regime of Exit. It follows that, in the public domain, accountability can come only through Voice – in other words through argument, discussion, debate and democratic

35 Ibid.

36 Marshall et al., *Blair's Britain.*

engagement."[37] Relationships between service users and professionals provide the key forum through which negotiations can take place, priorities can be established and decisions reached. It is these relationships which public service reform must seek to strengthen, rather than undermine.

A focus on the information available and its accessibility, plus the quality of relationships between service users and professionals, will therefore be vital to ensuring the success of choice in public service provision. In the following section, we will look at the way the public's demand for choice in public services has impacted on policy development, first in the area of education and, second, in the area of health.

Choice in education

Developments in educational policy have been marked by two – seemingly contradictory – trends: provision of choice and promotion of "equity" via top-down targets. In response to the increasingly diverse demands of service users, parental choice has been a major theme of policy development. Yet this has been accompanied by a rapid increase in central government control over the learning process. This is partly a reflection of demands on the part of the public for both choice and equity in public service provision. Yet the expansion of central control has – some argue – restricted the ability of local authorities and teachers to play a role in shaping educational priorities that can respond effectively to the needs and preferences of pupils and their families. The introduction of the National Curriculum and league tables has provided a backdrop of increasingly uniform standards and targets, limiting the scope for diversity and flexibility within the choice agenda.

The first major expansion of parental choice in education took place under the Thatcher administration. The 1988 Education Reform Act

37 D. Marquand, *Decline of the Public: The Hollowing-out of Citizenship* (Cambridge: Polity, 2004), 61.

introduced a range of reforms ostensibly designed to reshape the system around parental preferences. Parents were allowed to specify their preferred choice of schools, and league tables were introduced to allow comparison of examination results between schools. To provide parents with a variety of different types of institution to choose from, many state schools were given the opportunity to "opt out" of their LEA and become grant-maintained schools, responsible for their own admissions policies. This, some have argued, meant that the extension of choice for parents had been introduced at the expense of local accountability, with the role of local authorities now greatly reduced.[38]

In an attempt to accommodate users' demands for both choice and equity within services, these kinds of strategy have continued under New Labour administrations. In particular, Labour has continued to promote diversity within the state sector. Comprehensive schools have been encouraged to adopt various "specialisms". In addition, the 2000 Learning and Skills Act paved the way for new types of comprehensive school. City Academies (now Academies) were intended to boost academic attainment in areas associated with low achievement and failing comprehensives. The schools are maintained in part by independent sponsors who, in return for financial contributions, are able to appoint the majority of governors and have a strong influence over the school's ethos, curriculum and chosen specialist subject.

In response to the numerous complaints prompted by increasingly complex and varied admissions arrangements in different types of school, Labour's 1997 election manifesto also promised a more open and fair system of admissions, and the 1998 Schools Standards and Framework Act introduced the office of Schools Adjudicator to better resolve admissions disputes. The School Admissions Code, introduced in 2007, also aims to make admissions arrangements more transparent, and to clamp down on schools that are considered to be abusing the system.

38 G. Whitty, "Twenty years of progress?", *Educational Management Administration & Leadership* 36/2 (2008), 166.

In recent years, however, there has been concern that – despite these efforts – policies of school differentiation could be fuelling a culture of educational segregation. Research conducted by the Sutton Trust found that comprehensive schools that act as their own admissions authorities admit a smaller percentage of pupils eligible for free school meals (FSM) – both in absolute terms and in relation to their local areas – than those schools under local authority control; these schools were unrepresentative of their local areas with, on average, 5.8% of FSM pupils, compared to an average of 13.7% in their postcode sectors.[39] Similarly, research by the Centre for Economic Performance found that extending school choice had a dramatic effect on segregation by ability: the average school in areas where pupils have no feasible alternatives has a diversity reading of around 0.41 according to the Gini index, in comparison to just 0.25 for schools in areas with extensive school choice.[40]

This suggests that pupils and parents from disadvantaged backgrounds may not be benefiting from the choice agenda, and may frequently miss out on places in the best-performing comprehensive schools. There remains a danger that choice in education, if it is not administered with these potential problems in mind, can fuel, rather than counter, social segregation. This can have severely detrimental affects on pupils from economically disadvantaged backgrounds, who remain concentrated in low-performing schools creating a "spiral of underachievement".[41]

While it is clear that some form of choice in education is here to stay, the role of schools in promoting social mobility must not be sidelined. The challenge now is to make choice work in favour of the least advantaged pupils and their families, who are generally the most supportive of choice but face numerous obstacles to exercising their own judgement.

39 The Sutton Trust, *The Social Composition of Top Comprehensive Schools* (London: The Sutton Trust, 2006), 2.

40 S. Gibbons et al "The educational impact of parental choice and school competition", *CentrePiece* (Winter 2005–6), 9.

41 Ibid. 8

Ensuring that this happens requires taking a closer look at the means by which effective choices are taken. When school choice was extended in the 1980s, it was accompanied by the introduction of league tables. These are supposed to provide parents with an independent, freely accessible means of monitoring school performance and comparing schools in an area. However, there remain significant drawbacks to comparing schools on these terms alone. A study on the statistical issues behind the definition of quality employed by school league tables found that league table results "are influenced more by factors extrinsic to the institutions than by those for which institutions might be held to be accountable".[42] Furthermore, more recent research by the University of Bristol looking at the performance of 274 schools found that fewer than 5% can be separated from the average with any statistical significance.[43]

> "If you're going to have choice, you must have quality information and the only information available is from performance tables – this is not quality information. … I don't think the amount of data and the quality of data available is sufficient for parents to make a judgment." (Secondary school teacher)

The information that might reveal most about the character and effectiveness of schools is often ill-suited to a league table format. This might relate to the ethos and atmosphere of the school, the quality of teaching and facilities, or institutional decision-making processes. In many cases, it is the sort of information that the most "engaged" parents are able to gather, largely through conversations with family and friends, visits to schools, or discussions with their children's teachers. The challenge now will be to reach those parents who are not currently accessing these sources of advice, and who are subsequently far less informed in their decision-making.

42 H. Goldstein, "League tables and their limitations: statistical issues in comparisons of institutional performance", http://www.cmm.bristol.ac.uk/team/HG_Personal/limitations-of-league-tables.pdf, 24.

43 BBC News, "League tables 'do not aid choice'", 2 June 2008: http://news.bbc.co.uk/1/hi/education/7431883.stm.

The government has recently begun to acknowledge this problem. The 2005 White Paper, *Higher Standards, Better Schools for All*, announced that, by 2008, those parents who are the least well equipped to make effective choices would receive assistance in choosing the right school for their child from a national network of dedicated "choice advisers" – £12 million was earmarked for this scheme. In addition, the government also announced the introduction of legislation which would entitle FSM pupils to free transport to any of the three suitable secondary schools closest to their home, where these schools are between two and six miles away.[44]

However, recent evidence on the impact of choice advisers has not been particularly promising. A study of the role of the new choice advisers in six local councils found that their time was dominated by "self-referrals" – enquiries from engaged parents actively seeking out information, rather than from those in target groups, who were more likely to be less engaged in their children's education.[45] These problems are most likely due to the fact that choice advisers are external sources of advice, lacking an established relationship with parents. Perhaps tellingly, the study cited above also found that "advisory services which had links with local services and community organisations tended to reach parents from different groups".[46]

> "Choice advisers, or any external personnel, need to be prepared to take time to get to know the school. An important element of this is the continuity of the relationship over a period of time." (Primary school head)

Again, this highlights the importance of personal relationships, rather than simply accessible information, when it comes to making informed choices. Choice advisers must place emphasis on the

44 DfES, *Higher Standards, Better Schools for All* (London: HMSO, 2005), 45.

45 BBC News, "Tough job for choice advisers" 4 July 2008: http://news.bbc.co.uk/1/hi/education/7489560.stm.

46 Ibid.

importance of their relationships not only with individual parents, but with pupils, teachers and the wider local community. Strategies which foster this kind of collaboration – such as the process of drawing up personalised home-school agreements (discussed in more detail later in this chapter) – could provide a forum in which all parties – teachers, parents, pupils and external advisers – could negotiate options and preferences. The danger when advice on choice is delegated to external parties is that the crucial role played by teachers' knowledge and experience is neglected. Teachers benefit from the fact that they have an already established relationship with both pupil and parent; they have a sense of their needs and preferences as well as knowledge of the local area. Teachers currently dispense advice on school choices informally or via parents' evenings. Choice advisers must be prepared to draw on this knowledge and experience of teachers to ensure that their own advice is appropriately targeted.

While these strategies will allow a far greater proportion of pupils and their parents to make effective use of school choices, we must also ensure that increasing diversification in the state sector does not create a system in which choice is effectively limited for certain families. The current situation sees the best schools being permitted to set their own admissions policies, which may be used to select the most academically able. To guarantee that choice is extended as widely as possible and works to promote equitable outcomes, it will be necessary to foster a fairer system of admissions arrangements.

To ensure that having a choice of schools is made as free and fair as possible, a standardised, local system of admissions should be put in place. This may well move back under the control of local authorities, or work through an independent body. Schools should retain some freedom over the institutional character and ethos they wish to promote, but pupils must not be precluded from attending on this basis. There is also a case for increasing the remit of the Schools Adjudicator. At present, this office is essentially reactive rather than

proactive; because it relies on complaints brought to its attention, the Adjudicator cannot carry out its own investigations in cases where it believes standards are being breached. This will be particularly important given that LEAs may have vested interests in allowing selective admission policies to continue, since schools with these policies usually perform well, boosting the LEA's performance in league tables.[47] Fairer, better enforced standards and clear avenues for redress will be needed to ensure that pupils and their families take choices on schools, rather than the other way around.

Choice in healthcare

As in education, the choice agenda in the health arena has been embraced by all of the main political parties in recent years. Again, the spur to many of the reforms made was, in part, the drive by the Thatcher administration to introduce market mechanisms into public service provision. The origin of many of the NHS reforms was contained in the 1983 Griffiths Report. This detailed inquiry into management structures within the NHS concluded that many of the organisation's problems stemmed from a lack of effective management practices. Rudolf Klein later argued that the report "marked a shift from producer to consumer values. Its invocation of consumer values was to determine much of the healthcare policy agenda for the next decades."[48]

The New Labour government sought to take forward a more "patient-centred" approach to the provision of health services. Choice was considered a key means of achieving this. *The NHS Plan*, published in 2000, set out Labour's vision for the health service and included "greater patient choice" as one of the seven key changes for patients.[49]

47 Anne West and Dabney Ingram, "Making school admissions fairer? 'Quasi-regulation' under New Labour" (London: LSE, 2001).

48 R. Klein, *The New Politics of the NHS: From Creation to Reinvention*, 5th edn (Oxford: Radcliffe Publishing, 2006), 121.

49 NHS, The NHS Plan a plan for investment, a plan for reform (2000), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002960, 88.

A key element was choice in secondary care. In 2004 it was announced that patients referred to hospital by their GP for non-emergency care would be given a choice of four or five hospitals, including at least one in the independent sector, by the end of 2005. Since April 2008, patients needing elective surgery have been entitled to choose to be treated at any hospital (public or private) that meets NHS standards and price.

A key element in the success of choice reforms will be the relative degree of patient engagement in reaching decisions. Engagement is created both through the availability and accessibility of information, and through patients' attitudes towards the health service. As the main point of personal contact, the role of primary care practitioners in fostering engagement is vital. GPs act as the main intermediary in patients" negotiations with the health service, explaining often complex information and weighing up various options. Engaging patients through primary care practitioners will also become increasingly important in future as the major public health challenges are centred on the management of long-term conditions and prevention of disease through the promotion of healthier lifestyles. Therefore, strengthening the role of primary care services should be a central element of future NHS development.

The quality of relationships between patients and primary care practitioners is a second key element in ensuring that health service users can engage in decisions about their care. In this respect, the role played by GPs as providers of healthcare services is one which does not easily fit into the market model of many choice reforms. In a YouGov poll, when asked about the relative importance of services provided by GPs, 41% of patients believed that the right to see the same doctor each time was most important to them. In comparison, 29% placed most value on being able to access a wide range of services within a primary care setting, while just 5% responded that the right to choose between hospitals if referred by a GP was most

important.[50] Patients are now demanding continuity of care and the right to establish a personal relationship with their local doctor, rather than the ability to "chop and change" between providers through market mechanisms. This development was also reflected in SMF focus groups; many were in favour of choice of primary care providers but this was largely due to the fact that they placed most value on a continuous relationship with one GP and resented being forced to change doctors if they moved house, for example.

The creation of trusting relationships between GPs and patients has also been shown to have beneficial effects on health outcomes. Users of healthcare services, more than any other public services, are in a vulnerable position: they are unwell and reliant on expert advice. A study of patient samples in the UK and the US found that, in both countries, the length of time that patients had been seeing the same doctor and their ability to see this doctor whenever they went for treatment were very closely correlated to their overall trust in their doctor and their willingness to keep appointments.[51]

Trust in GPs is already very high amongst the UK population.[52] Yet ensuring that relationships between GPs and their patients are strong and effective will also require engagement on the part of doctors themselves. Many in the medical profession remain disillusioned about continual reforms and targets. As is argued in later chapters, this professional disengagement needs to be tackled; in many cases, this will involve more flexibility and less central government control to increase their autonomy.

The idea of choice within the NHS per se generally receives even stronger support than proposals for extending choice in education –

50 YouGov / Daily Telegraph Survey on GPs, August 2005, www.yougov.com/archives/pdf/OMI050101083_1.pdf.

51 "Continuity of care and trust in one's physician": http://64.233.17 See Dawson et al., "Evaluation of the London Patient Choice Project: System-wide impacts": www.york.ac.uk/inst/che/pdf/london.pdf.

52 Royal College of Physicians, *Trust in Professions*, http://www.ipsos-mori.com/_assets/polls/2007/pdf/trust-in-professions-2007.pdf, (2007), 7.

since quality of healthcare is not influenced by the "peer effects" seen in education. In addition, the London Patient Choice Pilots (LPCPs) have had a generally positive impact both on reducing waiting times and, importantly, on improving equity.[53] However, when assessing the results of these pilots, it is important to understand the costs that come with ensuring that choice works effectively. The LPCPs incorporated financial incentives to encourage Trusts to treat external as well as local patients, and offered choice advisers and free transport to all patients exercising choice. It has also been estimated that the successful introduction of choice requires excess capacity of around 15%.[54]

The need for appropriate funding for choice reforms requires a more targeted approach to its introduction. While patients do value choice where it is administered well, widening its scope involves either an increase in public spending or compromises on the quality of the choices and decision-making processes on offer. We now need to take a broader view, and encourage patients, professionals and government to examine the potential trade-offs and decide on areas in which choice is most valuable. Those requiring basic or emergency treatment for acute conditions, for example, will benefit far less from choice than those managing long-term conditions. Spending on the provision of choice within the NHS should therefore be focused on areas in which it can be administered effectively and will have the most positive impact on health outcomes.

WRITTEN GUARANTEES FOR CLARIFYING RIGHTS

While choice has been one element in creating public service entitlements which meet the demands of increasingly assertive citizens, the clarification of rights and responsibilities more generally has been another concern for government. The idea of common rights

53 See Dawson et al., "Evaluation of the London Patient Choice Project: System-wide impacts": www.york.ac.uk/inst/che/pdf/london.pdf.

54 Ibid., 127

for all service users has been viewed as the key to ensuring that public services continue to be a vehicle for fairness and equity. With rights to choose and engage being extended in recent years, there has been increasing demand for clear, accessible explanations of these rights to raise awareness and improve accountability and transparency.

A solution that has been pioneered over the past few decades is the idea of universal written guarantees, applicable to all users of public services. This concept was introduced in the 1980s and has more recently gained support from across the political spectrum.[55] Under the Conservative administration in the 1980s and early '90s, these guarantees stemmed from the implementation of the 1991 Citizen's Charter, within which individual service charters were created, notably the Patient's Charter and the Parent's Charter. The then Prime Minister, John Major, explained the intention of the Citizen's Charter as follows:

> It will work for quality across the whole range of public services. It will give support to those who use services in seeking better standards. People who depend on public services – patients, passengers, parents, pupils, benefit claimants – all must know where they stand and what service they have a right to expect.[56]

The idea of the Charter was to form a contract between service users and service providers, by equal measure informing citizens of their entitlements to public services and clarifying to providers the level of service they were expected to provide. The commitments covered standards of care, transparency, freedom of information, choice, non-discrimination and accessibility. By explicitly stating these commitments, service providers were encouraged to improve responsiveness to users.

55 Wright and Ngan, *A New Social Contract*.

56 Speech by Rt. Hon. John Major, MP, to Conservative Central Council annual meeting, 23 March 1991, cited at http://www.publications.parliament.uk/pa/cm200708/cmselect/cmpubadm/411/41105.htm.

But as users' rights were extended, the Charter format for written guarantees was altered. The Labour administration sought to make the model more reciprocal. Ideas such as home-school agreements and proposals for patients' contracts within the NHS are both based on a combination of users' rights and responsibilities. As service users' demands for freedom to choose increase, so too will the debates about the extent of the responsibilities they should take on in conjunction with these rights (this idea is discussed in more detail in chapter 3.)

Guarantees of rights are a potentially powerful tool to ensure that service users are placed at the heart of public service provision. Indeed, a recent House of Commons report (July 2008) suggested that the impact of the Citizen's Charter has been underestimated.[57] The Public Service Committee Report (1996–7) argued that the Charter has played a key role in the changes to public services: "The Charter, it is plain, has to a great extent swept away the public's deference towards the providers of public services, and their readiness to accept poor services, and has taught providers to welcome the views of users as a positive assistance to good management."[58]

The challenge in future, as service users become increasingly assertive about their rights, will be to develop this model in a way which engages them in decisions and sets out their rights and responsibilities in an accessible and meaningful format. In particular, this will require a move away from the centrally dictated, top-down models we have seen up to now, and a move towards much more personalised agreements, tailored to the needs of individual citizens and professionals. The following section discusses the historical development of written guarantees for public service users and then outlines recommendations on their future development.

57 House of Commons Report, *Public Administration* (12th report), 15 July 2008.

58 Public Service Committee, Third Report of Session, 1996–7, *The Citizen's Charter*, HC 78-I, paragraph 92.

Written guarantees in education

During the post-war years, the prevailing view was of schools as the key providers of education, with the parental role limited to ensuring their child's attendance. However, throughout the 1970s and '80s, the idea of greater parent participation in schools took hold. The 1980 Education Act gave parents the ability to express a school preference, as well as to have access to school and curriculum information. Parental rights to information gradually increased with further Education Acts.[59] The Citizen's Charter (1991) proposed a number of rights for parents regarding their children's education. These included the right to regular reports on the child's progress, independent inspections of schools, access to prospectuses from any school, an annual report from school governors and performance tables for local schools. The Parent's Charter was formed of these rights. The Charter for Further Education was released in 1993, explaining what information parents and students have the right to receive about all colleges and school sixthforms.[60]

In more recent developments, under the Labour government, the emphasis has shifted towards establishing agreements between parents, schools and pupils, outlining not only rights, but also responsibilities. The most recent piece of legislation relating to written guarantees introduced the concept of home-school agreements.[61] Since September 1999, all state schools have been expected to provide a written agreement that is sent out to all parents and carers.[62] The 1998 Schools Standards and Framework Act defines a home-school agreement as a statement specifying the school's aims and values, the school's responsibilities (principally, the education of its pupils),

59 Education Acts of 1981 and 1986, and the Education Reform Act 1988.

60 *Department for Children, Schools and Families,* "The Parent's Charter and the Charter for Further Education": www.dcsf.gov.uk/performancetables/archives/schools_96/sec8.shtml.

61 The School Standards and Framework Act 1998.

62 See, for example, Hertfordshire County Council, "Home-School Agreement": www.hertsdirect.org/scholearn/atschool/homeschoolagreements.

parental responsibilities, and the school's expectations of its pupils (relating to conduct).[63] Alongside this is a parental declaration, which is a document to be signed by parents agreeing that they take note of the school's aims and expectations, and that they accept certain responsibilities as parents.

Home-school agreements do not have legal status; parents are not obliged to sign the declaration and are not bound by the contract.[64] Instead, the agreements represent a willingness to take responsibility for a child's education on the side of both the parent and the school through a partnership.[65] Although the content of each agreement is set out by schools themselves, the government has produced a set of guidelines proposing appropriate aspects that should be covered. These include the standard of education, the ethos of the school, regular and punctual attendance, discipline and behaviour, homework, and information that the school and parents expect to receive from each other.[66]

The Department for Children, Schools and Families argues that home-school agreements can raise standards and contribute to school effectiveness by providing the framework in which partnerships between schools and parents can be formed. At their best, such agreements should result in improved home-school communication, parents and teachers working together on important issues, parents giving better support to their children at home, and the identification of any issues that need to be addressed by the school.[67] In addition, the Department argues: "The clarification of roles and responsibilities in a home-school agreement, supported by effective home-school policy

63 The Schools Standards and Framework Act 1998, ch. 31 secs. 110 and 111.

64 Ibid. ch. 31, sec. 111, para. 5.

65 *Durham County Council*, "Home School Agreements" (26 November 2007): www.durham.gov.uk/durhamcc/usp.nsf/pws/Parent+partnership+-+Home+School+Agreements.

66 *Department for Children, Schools and Families*, "Home School Agreement: The Scretary of State's Guidance": www.standards.dfes.gov.uk/parentalinvolvement/hsa/hsa_guidance/.

67 Ibid.

and practice, should generate high expectations, parental encouragement and support, and strong home-school links."[68]

However, while it is broadly agreed that improved relationships between parents and schools are likely to result in higher educational achievement amongst pupils, there has been debate as to whether home-school agreements are the best means to achieve this. Notably, there has been controversy over the correct kind of relationship to foster between parents and schools and the balance of rights and responsibilities.[69] It has been suggested that standardised home-school agreements treat parents and pupils as homogenous groups.[70] However, the fact remains that, while parental engagement and assertiveness has generally increased over the years, there are still marked differences amongst parents in their willingness and ability to participate in their children's education. There is also the question of whether home-school agreements should be made into enforceable contracts. Some critics argue that, as they stand, they have limited use, whereas others are strongly opposed to any form of compulsion.

The idea of home-school agreements also met with scepticism from our focus groups. A number of parents were unaware of their existence, despite presumably having signed one, and those who did recognise the term were unconvinced that the agreements contributed anything constructive. While teachers did feel that agreements gave them some extra authority, they believed that the documents were basically used as a disciplinary tool rather than as a genuine attempt to engage pupils and parents in educational outcomes.

> "It can often be a tail-chasing exercise just to get parents to sign home-school agreements. There is a danger that they become just another piece of paper. We need to create something that has value for parents." (Primary school head)

68 Ibid.

69 S. Hood, "Home-School Agreements: a true partnership?", School Leadership and Management, 19/4 (1999).

70 Ibid.

One solution is to introduce more personalised versions of the currently fairly uniform model for home-school agreements. The idea of individual agreements between parents, teachers and pupils themselves is one example of good practice which could be better disseminated. Under this scheme, teacher, parent and pupil meet to draw up an individual learning plan. This document would include a small number of short-term targets, longer-term aspirations and the responsibilities of both the school and the family in achieving these goals. Some such schemes already exist in the UK: children in care have Personal Education Plans; students with special educational needs have Individual Education Plans. In both, short- and long-term targets, as well as educational requirements, are negotiated by all parties. While this kind of system would require additional resources and time commitments from teachers, the benefits of administering the scheme properly could outweigh these costs. Studies have shown that students have already benefited from these schemes, especially in schools which approached the drawing up of education plans as an intrinsically valuable process. Rolling out such schemes could improve educational outcomes, boost parental engagement and improve conditions for teachers.

First, personalised home-school agreements improve a child's educational experience both in school and at home. For parents to support their children, they need information – for example, about how their children are performing and what they are studying. Through their involvement in designing agreements, parents would be aware of their children's targets and their role in reaching them. Personalised agreements would also give teachers important information. In these exchanges, teachers could better understand each pupil's domestic context and individual aspirations. As a result, they could offer better support and encouragement. Finally, these exchanges would build stronger relationships between schools and families – the foundation for a continued relationship. By improving co-production, personalised home-school agreements could give all children a better education.

Second, home-school agreements, if administered correctly, can produce more equitable outcomes. There are a number of reasons why parents from poorer backgrounds often have weaker relationships with teachers. One barrier is a lack of assertiveness, or academic aspiration, which prevents some parents from approaching teachers. Another comes from those parents who are disengaged from education – in our focus group, teachers commented on parents who thought education was the school's responsibility, not their own. A third barrier arises when parents have negative perceptions of teachers either as a result of cultural differences or because of bad impressions from their own schooling. As a result, pupils from poorer backgrounds frequently lose out to those with more assertive, middle-class parents.

Personalised home-school agreements can remedy this inequality by providing an opportunity for parents from all backgrounds to interact with their children's teachers. In these exchanges, parents could move beyond their negative views of teachers, could learn to share their children's aspirations, and therefore would engage in the learning process. Teachers interviewed also highlighted the need for schools – particularly school leaders – to take the initiative in fostering parental engagement; this was considered to be particularly important in the early years of schooling when parents were most likely to be in contact with schools. Possible strategies could involve parents' workshops, open days and shared activities for parents and their children. It will also be crucial to target these strategies to reach parents who appear to be disengaged with their children's education, or whose children are struggling; already some schools write to these parents directly offering them a free choice of times to come and speak to their child's teacher, rather than the more formalised process of parents" evenings.

Third, personalised agreements should improve conditions for teachers. This would take time. But, in contrast with existing paperwork, personalised home-school agreements should be enjoyable exchanges and a central part of professional development.

To support this goal, teachers will need additional training – to deal with pushy parents, on the one hand, and disengaged parents, on the other. The result will be more positive perceptions of the teaching profession – an issue that teachers complained about in our focus groups. If they are given more freedom to put together agreements themselves, tailored to the needs and abilities of individual pupils and parents, teachers should find that the process of drawing up home-school agreements could become a far more positive and effective activity. (The professional status of teachers is discussed in chapter 4.)

The main worry over the introduction of personalised agreements concerns the extra time they would take to administer. Teachers already spend too much of their time on paperwork. One suggestion is that agreements are initially introduced for pupils in primary schools (where teachers have fewer pupils). The agreements could also be targeted at those who would benefit from them the most – especially those who are struggling or have behavioural difficulties. (They are already used for pupils with special educational needs.) Teachers also need to be granted extra time properly to administer this scheme, and be compensated with the removal of less effective forms of feedback.

Written guarantees in healthcare

Alongside the introduction of the Citizen's Charter in 1991 came the Patient's Charter, a universal written guarantee of patients' rights that was familiar to most members of our focus group on healthcare. The Charter, which was revised in 1995 and 1997, laid out a wide-ranging set of patient rights and expectations, including information concerning waiting times, changing GPs, hospital standards and who is entitled to subsidised dental treatment.

However, the introduction of the Charter also sparked controversy, particularly regarding the imprecision of promises made to users. A recent report suggested that the Patients' Charter was viewed as

having very limited power in practice and little meaning to most patients. In 1999, Farrell undertook a study that explored NHS staff and patients' views on the Charter and found that there was a lack of knowledge of its contents amongst patients. While NHS staff were more knowledgeable about it, they were also more critical of the Charter and of the impact it had had on their working conditions. Additionally, both patients and staff felt that any new charter should take into account their views, in order to be more relevant.[71]

Members of the SMF's focus group on healthcare were familiar with the Patient's Charter, but they shared much of this scepticism. Both patients and professionals were doubtful that the Charter could offer anything of substance, and felt it simply created more bureaucracy within the system. Patients also felt that this kind of policy tool could result in undue pressure being placed on NHS staff who were already overstretched, and pointed out that difficulties in meeting targets often forced medical staff to circumvent them; for example, although waiting times in A&E departments are limited to 20 minutes, patients are only permitted an initial assessment by a nurse within this time, not necessarily a consultation with a doctor. Perhaps unsurprisingly, both GPs and nurses were also quite sceptical about proposals for further charters or – the latest innovation in this area – a constitution.

> "We need to look again at the Patients' Charter. A lot of things it covers are sometimes better dealt with internally. The problem with the Charter is that nobody feels any sense of ownership – this is something that has been externally imposed. When we look at proposals for an NHS constitution we need to make sure this is done differently." (GP)

Proposals for an NHS constitution have formed the latest development in moves to clarify patients' rights. In January 2008 the

71 C. Farrell, "The Patients' Charter: A tool for quality improvement?", *International Journal of Health Care Quality Assurance* 12/4 (1999), 129–35.

Prime Minister, Gordon Brown, indicated that he was considering plans for the new constitution as part of Lord Darzi's review of the NHS. The King's Fund argue that this could be beneficial, and an improvement on the Patient's Charter, but only if drafted correctly. They argue that a constitution that simply restates existing targets, without any enforceable rights for patients, might lack credibility, but it could at least set out lines of accountability and thus help clarify the NHS's role and how it is governed.[72]

The draft constitution was published on 1 July 2008 and laid out patients' rights and NHS pledges. The draft placed a large focus on the parallel responsibilities that citizens have as users of the NHS, though these are not legally binding. The written guarantees include the right to receive almost all NHS services free of charge, to seek treatment elsewhere in Europe if you have the right to treatment but face undue delay in receiving it, and to drugs and treatments that have been recommended for use in the NHS. Pledges include making transparent and clear decisions for patients, providing a clean and safe environment, and continuous improvement in the quality of services received.[73]

Lord Darzi has been lobbied hard by the unions to enshrine the constitution in law, thus making its commitments legally binding to all providers of healthcare. However, the Department of Health has been resistant because of the fear of exposure to lawsuits. This has led to the document being concentrated on basic minimum standards.[74] As the House of Commons report points out: "Public Service Guarantees that are based on minimum standards of service provision would apply universally. The Guarantees would, therefore, serve as the basis for all service users to claim their right to an agreed

72 King's Fund, "An NHS Constitution could be beneficial, but only if drafted correctly, says King's Fund", 17 January 2008: www.kingsfund.org.uk/media/an_nhs.html.

73 *The National Health Service Constitution: a draft for consultation*, July 2008: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085814.

74 A. Porter and R. Smith "NHS Constitution to guarantee minimum standards of care", *Daily Telegraph*, 25 June 2008.

minimum level of service."[75] There are some fears however, that the minimum standards could set the bar too low, thus shifting the focus from the high quality in service provision that users increasingly demand.

While disputes over the format of universal charters of users' rights will continue, a potentially more powerful and binding document could come through the personalised and meaningful application of these rights – as with the home-school agreements discussed above. Those who most rely on the health service – particularly those managing long-term conditions – stand to benefit most from choice and tailored services. The government has to some extent acknowledged this, and has committed to ensuring that by 2010 all people (of all ages) with a long-term condition, including those with mental health problems, are offered their own personalised care plan. This involves individuals working with carers and with professionals such as GPs, nurses and social care teams to agree what their goals are, which services they choose to receive and how and where they want to access them.[76]

> "More personalised agreements work well in cases where patients have drug and alcohol problems. In these cases, agreements of this kind provide a good way of bringing together all the teams – such as social workers, doctors, sometimes probation officers – working on the case. In my experience this has transformed care in our practice." (GP)

The entitlements enjoyed by users of public services have expanded over the past few decades. Yet, these changes will also raise numerous questions that will have to be addressed in future. The first relates to the impact of these new rights on the conception

75 House of Commons Report, 15 July 2008, *Public Administration* (12th report), para. 48

76 NHS Next Stage Review:
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825.

of responsibilities: if citizens gain more choice and control over their interactions with public services, does it follow that they should also gain more responsibility for public service outcomes? Second, the extension of users' rights, their access to information and the focus on accountability will radically alter their relationship with professionals. As was discussed earlier in this chapter, extending users' freedom to choose and guarantees of rights may not be sufficient to ensure that public services meet their dual goals of choice and equity; the quality of relationships and cooperation between professionals and the public has an equally powerful impact on service outcomes. Attempts to address these two areas have given rise to the concept of co-production, which will be addressed in the next chapter.

CONCLUSIONS

1 Establishing *public service entitlements* that both meet the expectations of more assertive citizens and secure the best possible outcomes will require a balance to be struck between demands for freedom of choice and flexibility within services and the need for equal distribution of public goods. Many debates which currently surround public service provision would benefit from a more informed basis for discussion, with clarity on the distinction between these dual goals and the compromises that might be needed to achieve them.

As such, there needs to be a *national debate about choice, diversity and equity*. The quality of many of these debates would be improved if there was more clarity about the types of choice that service users feel would be beneficial. With much current discussion limited to whether choice is in itself positive or negative, public scepticism could be tackled and the choice agenda improved if the public were encouraged to discuss the trade-offs or spending increases that extending choice might involve.

2 We also need to make sure that, where choice is offered, people are able to play a meaningful role in taking decisions. Doing so requires that information is available and accessible. However, evidence suggests that, in taking decisions where the available information is complex and outcomes are important, *provision of information alone will not be sufficient*. When taking complex decisions, most people wish to benefit from personal interaction and advice from experts – in the case of public services, it is professionals who generally act as intermediaries and offer guidance. There is therefore a real need to *ensure that trusting, personal relationships are established between service users and professionals*. It is these relationships which public service reform must seek to strengthen, rather than undermine. (Establishing greater trust between users and professionals is discussed in more detail in chapter 4.)

3 Recent application of the choice agenda within education has suggested that pupils and parents from disadvantaged backgrounds may not be benefiting as much from choice reforms as are their middle-class contemporaries. The government has acknowledged that we need to ensure that choice works in favour of the least advantaged pupils. The introduction of choice advisers to offer personal help to parents and pupils may help in this respect, but only if certain conditions are fulfilled. As discussed above, *choice advisers must place emphasis on the importance of their relationships, not only with individual parents, but with pupils, teachers and the wider local community too.*

4 A danger when advice on choice is delegated to external parties is that the crucial role played by teachers' knowledge and experience is neglected. Teachers benefit from the fact that they have an already established relationship with both pupil and parent, have a sense of their needs and preferences and knowledge of the local area. Teachers currently dispense advice on school choices

informally or via parents' evenings. Choice advisers must be prepared to draw on this knowledge and experience of teachers to ensure that their advice is appropriately targeted. Strategies which foster this kind of collaboration – such as the process of drawing up *personalised home-school agreements* for some pupils – could provide a forum in which all parties could negotiate options and preferences.

5 To ensure that choice of schools is made as free and fair as possible, *local systems of admissions should be put in place.* This may well move back under the control of local authorities, or of an independent body. Schools should retain some freedom over the institutional character and ethos they wish to promote, but pupils must not be precluded from attending on this basis. There is also a case for increasing the remit of the Schools Adjudicator. At present, this office is essentially reactive rather than proactive; because it relies on complaints brought to its attention, the Adjudicator cannot carry out its own investigations in cases where it believes standards are being breached.

6 In healthcare, initial results from schemes such as the London Patient Choice Pilots have been positive. However, when assessing the results of these pilots, we need to be clear about how much money will be needed to ensure that choice works effectively. The need for appropriate funding will require *a more targeted approach for choice reforms*. While patients do value choice where it is administered well, widening its extent will involve either an increase in public spending or compromises on the quality of choices and decision-making processes on offer. We now need to take a broader view, and encourage patients, professionals and government to examine the potential trade-offs and decide on areas in which choice is most valuable. With low public awareness of choice, it will also be vital to ensure that GPs and other primary care practitioners have the time and the expertise to explain options to patients.

7 *Extending written guarantees of users' rights would be an important step in defining the scope of equity and accountability in public services.* Existing plans to extend these, such as the current proposals for an NHS constitution, would need to take criticisms of current models into account. A constitution that lacks enforceable rights for patients would lack credibility. It would also need to set out clear lines of accountability to clarify the role and governance of the NHS.

8 A common criticism of current written guarantees of users' rights has been that they are overly bureaucratic, top-down and inflexible. We recommend introducing a much more personalised element, involving drawing up agreements rather than dictating rights. Coming together to negotiate options and priorities improves the *collaborative relationships between parents, teachers and pupils or patients and their doctors*, which, in turn, have a beneficial effect on outcomes. A more personalised and meaningful application of rights would allow those who most rely on public services to benefit better from the choice and tailored services now available.

CHAPTER 3: CO-PRODUCING SERVICES

Co-production – in this case, the shared production of public services – is a much debated concept in academia and think-tanks. It has a relatively long history, but, as a term used in public policy debates, it has made a real impact only in the last few years. It is closely linked with a shift in the debate, which has recently moved away from a focus on meeting pressing goals through greater investment and target-setting, and towards achieving better outcomes with the money available. As such, co-production shifts power and responsibility towards groups and citizens. For it to succeed, co-production needs an active citizenship prepared to engage with and influence the public services.

Definitions of co-production vary. A generation ago, G.P. Whitaker explained co-production by referring to the fact that "[m]any public services require for their execution the active involvement of the general public and, especially, those who are to be the direct beneficiaries of service".[77] Another academic, E.B. Sharp, agreed, arguing that it is a concept based upon "the recognition that public services are the joint products of the activities of both citizens and government officials".[78] More recently, the Public Administration Select Committee has described co-production as "the notion that service users work *with* service practitioners and professionals to 'co-produce' desired outcomes such as good health or safe communities".[79]

This chapter examines co-production as a concept and a practice by examining both the literature – academic and governmental – and our own primary research talking to doctors, teachers and service users. Throughout this chapter there are examples of co-production in practice,

77 G.P. Whitaker, "Co-production: citizen participation in service delivery," *Public Administration Review*, 40 (May–June 1980), 242.

78 E. Sharp, "Toward a new understanding of urban services and citizen participation: the co-production concept," *Midwest Review of Public Administration* 14 (June 1980),110.

79 House of Commons Public Administration Select Committee, *User Involvement in Public Services* (London: HMSO, 2007), 9.

which give a clearer idea of what could otherwise be an overly conceptual debate. The first part of the chapter examines the history of the term and sets out some of the key debates in this area. The second section sets out the moral arguments for greater co-production, in terms both of constituting a full life for citizens as members of society and of driving up the efficacy of services. The final section focuses on actual examples of co-production, both for existing schemes and in terms of responses to developing the idea from our own primary research. What becomes clear is that, although co-production is a laudable idea, it is – in many, but not all cases – so far from the actual experience of service users as to be largely irrelevant. The chapter closes by setting out where co-production has been successful, and where smaller steps need to be taken to shape service around assertive users. On the way, the term is expanded upon through the uses of text-boxes that introduce co-production in practice.

CO-PRODUCTION IN PRACTICE 1: TEACHERS, PARENTS AND PUPILS WORKING TOGETHER

The Public Affairs Select Committee highlighted "personalised learning" – that is, "high-quality teaching that is responsive to the different ways students achieve their best"[80] – such that schools and teachers tailor their teaching techniques and methods to the varying learning styles, needs and aptitudes of their students so that each pupil can achieve their potential. Teachers and students work together to agree their goals and how to achieve them. There is an emphasis on a "strong partnership beyond the school"[81] whereby parents and guardians are encouraged to take part in students' studies. A range of resources have been utilised to bring about the reality of "personalised learning". An example of this is the idea of "extended schools"[82] which provide services and activities,

80 Department for Education and Skills, A National Conversation About Personalised Learning (London: HMSO, 2004), 6.

81 Ibid., 14.

82 Ibid., 17.

sometimes beyond the remit of the school day. For example, at the Jo Richardson Community School in the London Borough of Barking and Dagenham, there are facilities that benefit both the pupils and the wider community. These are contained in a school building that holds a conference centre, library, sports, ICT and performing arts facilities, to which the community has access. After-school and extra-curricular activities are held here and have excellent attendance. *Home-school partnerships* are encouraged as part of personalised learning, encouraging parents to become more involved in their children's learning, through programmes focusing on family literacy and numeracy.[83]

Regular assessment and feedback are central to this method of education, with schools regularly assessing each student's performance and adjusting the curriculum appropriately. At Jo Richardson, "student performance review days" (SPRDs) are held twice a year, with 98% of parents attending.[84] Students are encouraged to make their views heard, with a strong student council and questionnaires for students at both departmental and school-wide levels. There is also an increasing focus on the broadening of the curriculum to find options that will suit each student. This is matched by a range of teaching techniques, including small group tuition that can benefit all students, ranging from the gifted and talented to those with Special Educational Needs. The government committed £335 million from the Dedicated Schools Grant (DSG) to secondary schools to deliver personalised learning for 11–14-year-olds. Primary schools were earmarked £230 million for their own personalised learning strategy.[85] David Miliband remarked on personal learning: "It can only be developed school by school. It cannot be imposed from above."[86]

83 Department for Education and Skills: www.standards.dfes.gov.uk/personalisedlearning/five/beyondclassroom/.

84 Department for Education and Skills: www.standards.dfes.gov.uk/personalisedlearning/casestudies/.

85 Department for Education and Skills: www.standards.dfes.gov.uk/personalisedlearning/faq/#20.

86 "Personalised learning: building a new relationship with schools": Speech by David Miliband, Minister of State for School Standards North of England Education Conference, Belfast, 8 January 2004.

THE RE-EMERGENCE OF "CO-PRODUCTION"

The debates surrounding co-production have deep roots. The assumption in favour of active citizenship, which the debate contains, can be found in the social liberalism (or liberal socialism) of J.S. Mill and, later, L.T. Hobhouse, which stressed the role and responsibilities of the active, engaged individual in society.[87] This strand of social liberalism rejected the statist, top-down approach of Fabian socialists, such as George Bernard Shaw and Beatrice and Sidney Webb. It was this Fabian strand that was prevalent in the Labour Party for much of the middle part of the twentieth century; it led Douglas Jay – the post-war Labour Minister – to state that "the gentleman in Whitehall really does know better what is good for people than the people know themselves".[88] This attitude is a long way from capturing the expertise of citizens and groups that are integral to the co-production approach. It was assumptions such as Jay's that Hobhouse reacted against, arguing that, in it, the expert "sometimes looks strangely like the powers that be".[89] The Fabians, he would have argued, simply wanted to replace the capitalist with the manager and the preacher with the schoolteacher – nothing changed in the overall power relationships. Individuals were not seen as important or active authors in shaping the services that they used. The rise of an increasingly assertive and expressive citizenship makes the need to put the user in control even more urgent.

The term "co-production" in public policy was coined more recently, although its use is almost a generation old. It was first discussed in a sustained manner in the 1970s by the American political scientist Elinor Ostrom, who studied the role of community involvement in the prevention of crime. Looking at patterns of crime

87 See, for example, J.S. Mill, *Autobiography* (London 1873), 230–4.

88 D. Jay, *The Socialist Case* (London: Faber and Faber, 1937), ch. 30.

89 L.T. Hobhouse, Democracy and Reaction (1972; originally 1905), 230; also cited in R. Barker, *Political Ideas in Modern Britain* (London: Routledge, 1997) 28.

in Chicago, Ostrom found that when police stopped walking the beat and lost connection with local community members, neighbourhood crime rose.[90] Ostrom studied situations in which citizens had played an active, physical role in the production of public goods and services of consequence to them: the construction of low-cost sewage systems in the favelas of Brazil, schools in Nigeria, neighbourhood alert patrols in ghettos, and recycling in Brazil. In these cases, she found that involvement by the recipients of services led to improved public goods at reduced public expense.[91] Drawing on these ideas, think-tanks and research organisations have, since the 1980s, used "co-production" to describe the reciprocal relationship between professionals and individuals that is necessary to effect positive change.[92]

All contributors to this debate have stressed the role of active citizens in co-production. Brudney and England argue that co-production requires "a more participative citizenry".[93] Sharp agrees that the model demands a willingness of authorities to work with citizens in order to develop their capacities as potential co-producers of services.[94] The necessity of active citizenship to get the best from public services was also stressed by Ed Miliband, MP, when, as Cabinet Office Minister, he argued: "Public services must respond to and mobilise the expertise, ideas, time, and willpower of people using them. What I call the 'letterbox model' – where the service was just delivered to the user – doesn't see us as participants who can shape our own lives."[95]

90 E. Ostrom, *Community Organisation and the Provision of Police Services* (Beverly Hills, CA: Sage Publications, 1973).

91 Timebanks, "History of co-production: co-production: the emerging imperative": www.timebanks.org/co-production-history.htm.

92 See for example, recently, A. Coote, *Claiming the Health Dividend* (London: King's Fund, 2002).

93 J.L. Brudney and R.E. England, "Towards a definition of the co-production concept", *Public Administration Review* 43/1 (1983), 62.

94 Sharp, "Toward a new understanding of urban services and citizen participation", 113.

95 Ed Miliband, Speech to 5th annual Guardian public services summit, 7 February 2008, in House of Commons Public Administration Select Committee, *User Involvement in Public Services* (London: HMSO, 2007), 9.

Co-production as an everyday occurrence

Several authors distinguish between "co-production" and "dominant models" of service provision, which is (at least initially) helpful in clarifying what is meant by the term. Brudney and England argue that in the "dominant model" there are two distinct spheres – one representing producers, and another representing the clients – that is, citizens who consume the goods and services on offer. Citizens, clients or consumers may respond to the adequacy of service by making new demands; they may support or reject service patterns; and they may comment through advisory boards, citizen participation, complaints, etc.[96] This description of the "dominant model" of service provision is echoed in the work of Boyle et al., who note that, "in many ways, our welfare systems and philanthropic bodies are geared in the opposite direction – that people are defined primarily by what they lack and the administrative systems tend to expect them to be very grateful, but passive, when that is provided. To get more help they primarily have to display more problems."[97]

For Brudney and England, however, this "dominant mode" differs from co-production, because under co-production the two spheres are not distinct entities, but overlap. The co-production model is based on the premise that there is an active, participative populace. Furthermore, in the co-production model, feedback is internal to the service delivery process and part of the consumer sphere overlaps the regular producer sphere, resulting in co-production.[98] Charles Leadbeater puts the point in a similar fashion when he argues that under co-production we move from "a model in which the centre controls, initiates, plans, instructs and serves, to one in which the centre governs through promoting collaborative, critical and honest self-evaluation and

96 Brudney and England, "Towards a definition of the co-production concept", 60.

97 D. Boyle, S. Clark and S. Burns, *Hidden Work: Co-production by People Outside Paid Employment* (Joseph Rowntree Foundation, 2006), 13.

98 Brudney and England, "Towards a definition of the co-production concept", 60.

self-improvement".[99] Similarly, the New Economics Foundation, for example, recently noted: "Co-production – or labour from the consumer – is the *missing* factor that is needed in every sphere of social endeavour."[100]

However, a sharp conceptual divide between "dominant" and "co-production" models is misleading. As public services do not exist without citizens" involvement, co-production is already a part of all public services.[101] G.P. Whitaker, for example, argued that citizens have always exerted important influences on policy through their participation in the execution of public programmes, particularly "where the change in the client's behaviour is the 'product' which is supposed to be delivered".[102] (In this, Whitaker was ahead of his time in framing debates about co-production in the context of the now fashionable approach of behavioural change.[103]) Davis and Ostrom agree: "Educational services cannot be produced by a school alone. The production of education requires the active participation of students and their parents in production."[104] Brooks lends his support, arguing: "Public service reform should always recognise that outcomes are co-produced by the interaction of governance, services and citizens, and should focus on getting the relationships right between these three groups."[105] Boyle et al. put the point more forcefully: "[E]lements of co-production – a reciprocal relationship between people, professionals and each other – is actually the natural state of affairs."[106]

---

99 C. Leadbeater, *Personalisation Through Participation* (London: Demos, 2004), 90.

100 NEF, "New Economics Foundation's response to the Public Administration Select Committee's Issues and Questions Paper": www.londontimebank.org.uk/Co-production%20-%20nef.pdf.

101 "Involvement in" and "production of" a service are not the same, but (on an individual level, for example) there is a strong correlation between the amount of involvement that a citizen has in a service and the production of outcomes. It is a matter of debate how strong the relationship between involvement and the quality of a service is in each case.

102 Whitaker, "Co-production", 240.

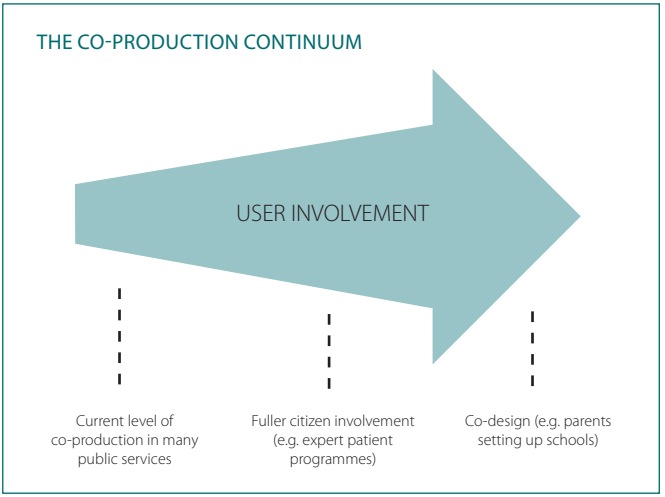
103 J. Prendergrast et al., *Creatures of Habit? The Art of Behavioural Change* (London: SMF, 2008); R. Thaler and C. Sunstein, *Nudge: Improving Decisions About Wealth, Health and Happiness* (London: Caravan, 2008).

104 G. Davis and E. Ostrom, "A public economy approach to education: choice and co-production", *International Political Science Review* 12/4 (1991), 324.

105 R. Brooks, *Public Services at the Crossroads* (London: IPPR, 2007), 6.

106 Boyle et al, *Hidden Work*, 14.

The answer here, as demonstrated in our own primary research, is that the extent of citizen production in public services varies hugely from minimal involvement, such as in the education process for example, to actively shaping the structure and even the design of children's education. Co-production is a continuum, not an absolute, and its extent varies in different parts of the public services.



What is also important here is that all of the above accounts avoid reducing the role of the citizen to that of a consumer. Leadbeater is particularly clear that co-production should be should be distinguished from the conception of the service user as a "consumer". He argues:

> Treating users as atomised consumers ignores the wider social influences on the choices they make and the wider consequences of their choices, for example, over which school to choose for their children. Treating people as citizens, who can reshape services through formal political debate, is worthy but abstract. Only policy wonks think people will be excited by attending more meetings. Users want direct attention to their needs.[107]

107 Leadbeater, *Personalisation Through Participation*, 32.

Boyle et al. also note that a consumer approach differs from co-production because a consumer approach "uses a narrow understanding of human psychology", "does not create well-being" and "impoverishes the relationship between public and service providers".[108]

An idea whose time has come?

With co-production accepted as a concept that explains an established practice rather than necessarily a "new idea", there are disagreements about whether the historical trends lead to greater co-production in the future, or whether co-production needs to be introduced to counter forces that are increasingly moving against the practice. There are several reasons why co-production, as an approach, is an idea whose time has come.

First, co-production is attractive to government, because it offers the promise of better outcomes for citizens, without necessarily costing the exchequer more money. Parks et al. argue that there will be an "increased attention to and reliance upon co-productive arrangements in public service delivery" because of "[b]udget constraints". However, recent literature has shown that this assumption is probably incorrect and that co-production is not a "cheap option". A survey of co-production in Cincinnati, Ohio, found that "[s]ervice costs actually appear to have increased rather than decreased [with co-production]"[109] However, the author notes, "[s]ervice effectiveness … has increased significantly as services have become better attuned to varying neighbourhood needs".[110]

Second, and crucially, co-production is a response to those citizens who are more assertive – as discussed in the introductory chapter – and who have "a rising consumer awareness of the importance of their

108 Boyle et al. *Hidden Work*, 46.

109 J.C. Thomas, "Neighborhood co-production and municipal productivity", *Public Productivity Review* 10/4 (1987), 95.

110 Ibid., 95 and 103.

own efforts".[111] This last point is echoed by Brooks, who noted: "Service users are now less accepting of expertise than they were and want more of a say over both what services they receive and how they access them. They are also less accepting of political authority, and want more of a say in collective decisions."[112]

Third, and related to this, there is an acknowledgement from professional groups and government of the limits of their power. Brooks noted that cooperation from citizens has always been necessary – for example, parents must send children to school, victims must normally report crimes if they want the police to investigate them. However, he suggested that, arguably, in the past, producers of public services have not understood the importance of co-production. They neglect the importance of working with families to maximise educational outcomes of children, for example, with the focus being placed on "delivery" rather than co-production.[113]

Fourth, and within the context set out above, co-production provides a way of uniting professionals and citizens. Again, Boyle et al. note that the need for co-production has been increased because "relationships between community members and "helping professionals" have become more detached and distanced". He also suggested that the natural state of affairs of co-production "has been undermined in recent generations by over-professionalism and dependency".[114] Leadbeater broadens the point to include the relationship between citizens and bureaucracies in general, arguing: "We feel detached from large organisations – both public and private – that serve us in increasingly impersonal ways."[115]

111 R.B. Parks et al., "Consumers as co-producers of public services: some economic and institutional considerations" *Policy Studies Journal* 9/7 (1981 and 1999), 1009.

112 Brooks, *Public Services at the Crossroads*, 52.

113 Ibid., 32.

114 Boyle et al, *Hidden Work*, 13–14.

115 Leadbeater, *Personalisation Through Participation*, 80.

There is also an important debate about the level – or levels – at which co-production is carried out: notably whether production is individual, group or collective. Brudney and England also identify three tiers of mechanisms based on the effect on the thing co-produced. These tiers are ordered according to their importance (first most important, last least important).

First, individual co-production includes "captured" co-production, i.e. when a citizen has little choice but to participate in the service (e.g. attend school),[116] but Brudney and England argue that the critical mixing of productive efforts of regular and consumer producers is relatively small.[117] These would only include active voluntary behaviour such as picking up litter and so on. Again, Brudney and England argue that "without organisation and coordination, the aggregate benefits to the city [in the case of their research] are minimal" and that "it is difficult to distinguish them from the notion of civic duty".[118] Second, group co-production involves voluntary, active participation and may require formal coordination between service agents and citizen groups (e.g. Neighbourhood Watch).[119] The Joseph Rowntree Foundation has undertaken an extensive survey of these kinds of co-productive activities, interviewing many relevant groups about their experiences.[120] Last, collective co-production activities result in collective goods ("goods and services jointly used by groups of persons under conditions where individuals cannot reasonably be excluded from enjoyment of the good on the basis of their failure to contribute towards its production"[121]) whose benefits may be enjoyed by the entire community.[122] Collective co-production mechanisms are

116 Sharp, "Toward a new understanding of urban services and citizen participation".

117 Brudney and England, "Towards a definition of the co-production concept", 63.

118 Ibid.

119 Ibid.

120 Boyle et al., *Hidden Work*.

121 R.C. Rich, "Interaction of the voluntary and government sectors: toward an understanding of the co-production of municipal services", *Administration and Society*, 13 (1981), 66.

122 Brudney and England, "Towards a definition of the co-production concept", 63.

considered the most important 'simply because they are likely to have a greater impact on who receives the benefits derived from co-productive activities."[123]

CO-PRODUCTION IN PRACTICE 2: TENANT-LED MANAGEMENT IN HOUSING

A second example of co-production is tenant-led management in housing, such that council tenants in England have, since 1994, had the right to manage their own housing.[124]

Arm's-Length Management Organisations (ALMOs) are an example of a tenant-managed organisation (TMO). Although the local authority owns the property, the TMO is in charge of managing services such as rent collection and maintenance work. An ALMO is a company wholly owned by the local authority with a board of directors made up of tenants (at least one third), local authority nominees and independent members. It is designed to make sure that the services it provides meet the needs of tenants and the wider community. More than one million homes in the UK are now managed by ALMOs, accounting for over half of all council houses.

The original target of ALMOs was to bring local authority-owned houses up to the Decent Homes Standard, as well as to increase tenant participation. By the end of 2006 a great majority of these organisations had succeeded in bringing all their homes up to this standard. Now they are being given more responsibility to help the wider community in supporting the creation of local jobs and development of enterprise.[125]

123 Ibid.

124 House of Commons Public Administration Select Committee, *User Involvement in Public Services* (London: HMSO, 2007), 10.

125 Department for Communities and Local Government, *Review of Arm's-Length Housing Management Organisations* (London: HMSO, 2006), 1.

There are proposals for local authorities to give ALMOs the initiative to tackle anti-social behaviour by contracting out ASBOs within the community they service. The idea is to empower citizens to deal with the problems they face in their own community.

CityWest Homes was one of the first ALMOs to be set up (in April 2002) and manages 22,000 homes on behalf of Westminster City Council. It comprises 14 TMOs and three providers (housing management contractors). At CityWest, two teams concerned with community development and resident involvement ensure that residents' views are heard and the community is enriched.[126] Increased tenant involvement, coupled with work being completed on budget and schedule, has led to a greater level of satisfaction in services provided.[127] CityWest was rewarded with a three star (excellent) rating by the Audit Commission in 2006.

THE CASE FOR CO-PRODUCTION AND SOME CONCERNS

In this section we look at the normative and evaluative elements in discussions about co-production and at some of the concerns that have been raised in the literature about the approach.

Most of the background literature in this area has been in favour of the approach, although broadly speaking two different arguments have been put forward. First, co-production improves the relationship between citizen and state in several ways. Leadbeater notably argues that using a public service is not just a consumer experience. Each engagement with a public service should deepen a sense of civic attachment and underpin a sense of citizenship: why it matters to be part of a democratic society.[128] Similarly, the Public Administration

126 City West Housing, www.cwh.org.uk

127 Audit Commission *Learning from the First Housing ALMOs* (London: HMSO, 2003), 20.

128 Leadbeater, *Personalisation Through Participation*, 53–4.

Select Committee argued that participation in decisions surrounding the design and delivery of public services is a "good" in itself, empowering citizens and connecting them to the public realm, allowing them to identify with services and see them more as "theirs", bringing society together and strengthening civic ties.[129] As Leadbeater concludes: "Users should not be utterly dependent upon the judgement of professionals; they should be able to question, challenge and deliberate with them. Nor are users merely consumers, choosing between different packages offered to them; they should be more intimately involved in shaping and even co-producing the service they want."[130] Co-production, so the argument goes, is good for us both as individuals and as a society.

Second, co-production improves the quality of the particular public service. The Select Committee's report notes that formal evaluations of users' experiences with public services show an improvement when users themselves are involved in the process. Examples include the improvement work in social housing under tenant-led management, where often performances rate higher than traditional local authority management. Similarly, DfES research showed improved pupil attainment where personalised learning programmes were used.[131] Generally, the Select Committee's findings showed that personalised services benefited both users and providers, giving better outcomes overall and higher associated satisfaction. However, they cautioned against applying these findings too widely, as initial reports come mainly from small pilot schemes where users are enthusiastic and well informed – generally an exceptional case which could prevent extrapolating these results out to wider areas of assessment.

Despite strong arguments for increased co-production, several concerns have been raised. First, there is a concern that co-

129 House of Commons Public Administration Select Committee, *User Involvement in Public Services*, 12.

130 Leadbeater, *Personalisation Through Participation*, p. 60.

131 Department for Education and Skills, *Assessment for Learning: 8 Schools Project Report* (London: HMSO, 2007), 29-40.

production and other user-centred approaches in public services undermine representative democracy – an argument which refers back to wider debates about the place that direct democracy should have in society given our traditional method of representative government. There is an understandable view that user-influenced services will veer policy away from that designed by elected representatives, who have a popular mandate to write and who enact policy.[132] However, the Committee takes the view that, unless taken to extremes, citizen involvement in public services should not undermine our democratic structures. David Bell, Permanent Secretary at the then DfES, is quoted:

> I do not see any necessary contradiction. Clearly you have got a democratically elected authority that will have responsibility, amongst other things, for deciding the structure of the youth service but, it seems to me, alongside that you can quite legitimately say, in coming to your decisions about the services for youth, you have to take account of what young people say. … I do not think we can just rely on the legitimacy of the democratic process if we assume by that that citizens have no engagement between elections.[133]

Second, co-production still requires certain resources – financial and cultural. Sophia Parker, for example, emphasises that "participating, collaborating, even making decisions as an individual, requires time, confidence and knowledge and these resources are not evenly distributed throughout the population."[134] Similarly, Thomas adds that "neighbourhood co-production is limited by being confined to areas where minimal expertise is required".[135] As Thomas

132 House of Commons Public Administration Select Committee: *User Involvement in Public Services*, 12.

133 Ibid.

134 S. Parker, "The Co-production Paradox", in S. Parker and N. Gallagher, eds, *The Collaborative State: How Working Together Can Transform Public Services* (London: Demos, 2007), 181.

135 Thomas, "Neighborhood co-production and municipal productivity", 101.

concludes, this limitation does not prevent "more advanced co-production", but it may explain the resulting "variable service quality".[136] Rich agrees: the degree of participation in group co-productions may vary according to needs, human resources (time and expertise) and demographic characteristics of residents.[137] Rosentraub and Sharp suggest that this dependence upon the demographics and resources of the local population will affect the quality of the services received.[138] Leadbeater notes that this might further exacerbate current inequalities: "The more that health and education outcomes depend on individual and private initiative, even within a public framework, the more those already well off are likely to benefit."[139]

Third, sceptics argue, people are reluctant to get involved in the governing of public services.[140] McHugh shows that a very small minority of people actually attempt to use existing methods of voice, and also demonstrates current trends of political apathy.[141] In addition, the point that the more affluent are generally better at making themselves heard leads to concerns over the widening of the "participation gap", which may "further entrench already existing inequalities" unless provisions are made to make sure the disadvantaged are heard.[142] As Oscar Wilde is once said to have noted, the problem with socialism is that it cuts into one's evening so. The same is true of the demand placed upon citizens who are fully engaged in co-production. Certainly, our own experience in conducting interviews in this area bore this concern out.

136 Ibid.

137 Rich, "Interaction of the voluntary and government sectors".

138 M.S. Rosentraub, and E. Sharp, "Consumers as producers of social services: co-production and the level of social services", *Southern Review of Public Administration* 4 (1981), 517.

139 Leadbeater, *Personalisation Through Participation*, 75.

140 Brooks, Public Services at the Crossroads, 54.

141 D. McHugh, "Wanting to be heard but not wanting to act? Addressing public disengagement", *Parliamentary Affairs*, 59/3 (2006)

142 Brooks, *Public Services at the Crossroads*, 54.

CO-PRODUCTION IN PRACTICE 3: THE EXPERT PATIENTS PROGRAMME

Expert patients are described as those living with a long-term chronic condition (such as arthritis, epilepsy, chronic depression and deafness), who take more control over their health through the understanding and management of their conditions. The Expert Patients Programme (EPP) has been designed to help chronic sufferers take control of their lives.[143]

The concept of self-management has a long history. In 1974 Kate Lorig undertook a study of people with arthritis, and discovered that many of them had developed multiple personal skills as a way of coping with the disease. This discovery led to the development of the Arthritis Self-Management Course (ASMC), which has since been used as the basis for many other specific and generic chronic disease self-management courses around the world.[144] In July 1999, the action plan *Saving Lives: Our Healthier Nation*[145] first announced the creation of EPPs as part of the NHS. The Experts Patients Task Force was set up in late 1999, with the aim of designing a nationwide EPP, taking guidance from patients, clinical organisations and representatives from non-governmental organisations. Their report was published in September 2001.[146] The first EPPs were piloted between 2002 and 2004, and, following their success, in 2004 the NHS made a commitment to roll out the programme nationally. In recent years, the programme has been expanded, with *Stepping*

143 Patient UK, "Expert Patients": www.patient.co.uk/showdoc/40024857.

144 Department of Health, "The Expert Patients Programme": www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/ProgressOnPolicy/ProgressBrowsableDocument/DH_4102757.

145 Department of Health White Paper, *Saving Lives: Our Healthier Nation* (London, HMSO, 1999).

146 Department of Health, "The expert patient: a new approach to chronic disease management for the 21st century" (London: HMSO, 2001).

Stones to Success (2005), an implementation, training and support framework to help people run lay-led programmes.[147] The 2006 White Paper set a new direction for community services, and established community interest companies to help market and deliver the EPP. While the EPP has been centrally managed since 2002 and implemented by Primary Care Trusts, the management is set to become increasingly localised.[148]

The programme focuses on five core self-management skills: problem-solving, decision-making, resource utilisation, developing effective partnerships with healthcare providers and taking action.[149] The hope is that expert patients will feel more confident and in control of their lives, and that they will aim to manage their own condition in parallel with healthcare professionals. The courses run for two and a half hours per week for six weeks, and programmes are currently available for chronic sufferers, the parents of chronic sufferers, and carers. Internal evaluation data from EPP participants indicated that the programme does provide large numbers of people with the confidence and skills to manage their condition more easily.[150] Research was from around 1,000 EPP participants; 45% of participants felt more confident that they would not let common symptoms interfere with their lives; 38% felt that such symptoms were less severe four to six months after completing the course. Over 94% felt satisfied with the course.

147 Expert Patients Programme Community Interest Company, Stepping Stones to Success: http://www.expertpatients.co.uk/public/default.aspx?load=ArticleViewer&ArticleId=445.

148 Expert Patients Programme Community Interest Company: http://www.expertpatients.co.uk/public/default.aspx

149 Ibid.

150 Ibid. Research was from around 1,000 EPP participants; 45% of participants felt more confident that they would not let common symptoms interfere with their lives; 38% felt that such symptoms were less severe four to six months after completing the course. Over 94% felt satisfied with the course.

CO-PRODUCTION: SMALL STEPS AT FIRST, LEAPS WHERE APPROPRIATE

This section sets out discussions on co-production held with focus groups, experts and practising professionals. In the health focus group, there was a general consensus that patients should take some degree of responsibility for their own health. For example, the duty to turn up on time to appointments, with potential penalties for failing to do so, was one agreed responsibility of the patient.

Both patients and professionals also felt that defining the limits of responsibilities would prove problematic in other situations. Issues such as the affordability of eating healthily and difficulties in overcoming addictions were raised as cases in which the bounds of the patient's responsibility for poor health outcomes could be disputed. Professionals felt that they did have a certain duty of care in all circumstances, regardless of the patient's behaviour. There was no support for harsh conditionality.

As with discussions on the idea of shared responsibilities in healthcare, teachers, parents and pupils felt they all shared some part of the responsibility for a child's educational outcomes. Again though, the exact extent of these responsibilities is not clear. There was little support, for example, for the idea that parents might play a role in designing their child's curriculum, and most felt that professional expertise was needed in these kinds of roles. However, teachers did suggest that they found consulting and involving parents could be very beneficial, not simply for the individual child but often for the whole class. One example was the involvement of parents in providing career advice. It was generally felt that parental responsibility diminishes over time, as children themselves take the initiative. When asked to provide a drawing representing relationships between teaching professionals and school users, many of the group used their pictures to emphasise the need for communication between all parties to support a child's education.

Many of the teachers felt that increased parental engagement would benefit educational outcomes. However, parents responded that they too are under increased time pressures. The rise in the amount of homework and coursework did require more parental involvement, but many reported struggling to find this time, particularly with the growing numbers of households in which both parents work full time. There were also mixed views on the responsiveness of schools to parents' feedback; although some parents reported that teachers did listen but didn't always act on concerns, teachers felt that they received little or no training on how to negotiate with parents.

Teachers did report that they do use certain methods to encourage more involvement from parents who appear disengaged from their child's education. These include personal telephone calls, letters or emails to set up discussions, and attempts to relay positive feedback if the pupil has improved. One of the problems identified was that the parents least likely to engage with schools are those whose children are underperforming and for whom parents' evenings could be demoralising.

We must, however, also take into account the reform fatigue and disillusionment generated by widespread programmes of this kind within the professions. In the past 10 years, public services have already been moving towards more user-centred practices and these shifts should be encouraged and strengthened. Further policy developments must therefore endeavour to build on existing practices, rather than introduce wholesale change. To achieve this, we need to build up a detailed picture of the ways in which public service users and professionals in each area currently operate. Consumer insight research would allow policymakers, schools and PCTs to find out how both users and professionals are accessing information, communicating with others and coping with time and resource constraints. This would encourage targeted strategies and solutions

that would be geared to people's existing habits and practices – and would therefore have a far greater chance of success.

CONCLUSIONS

1 We agree with the Public Administration Select Committee that the government must *first decide in which areas it is appropriate to have increased user participation* in the production of public services. For example, the Mental Health Service users that the Committee consulted expressed a desire for improved quality of services rather than the wish to have any input or control over them. In addition, the possibility was raised that in some cases people do not actually want the opportunity to decide on their treatment plan, and may in fact find it onerous to have to do so. Similarly, our own primary research demonstrated that there was little demand for some of the more radical aspects of co-production (or co-design), such as parental creation of new schools.[151]

2 *Proponents of co-production must also recognise that it involves a shift in risk* and that government must be there if co-production attempts fail. Concerns over risk are focused around the fact that by participating in the design of services, users will take on some of the responsibility for things going wrong. Users must thus have an understanding of the risks that they are incurring. The Public Accounts Select Committee suggests a possible need for regulatory safeguards against people taking on "unreasonable" risk.[152] Cost concerns are hard to quantify, especially given the variation in time periods over which effects will occur, but a clear message from the Committee's research was that personalisation of services, such as with individual budgets, should not be used as an excuse to cut or shift costs covertly. Our work supports these concerns.

151 House of Commons Public Administration Select Committee, *User Involvement in Public Services*, 16.

152 Ibid., 17.

3 There is scope for the *roll out of schemes such as the EPP*, which captures the expertise held by knowledgeable service users. Schemes such as the EPP connect users and policy should focus on how to encourage these connections. Expert patients still need assistance from the state in *facilitating a physical or virtual forum* where patients can meet, and providing access to those forums. However, it is important to acknowledge that, although such schemes have proved to be an important development, practitioner interviews suggest they only encompass a small number of patients.

4 We must also take advantage of methods of incorporating the insights of citizens that do not place the unrealistic demands on their time that some forms of co-production do. Developments in technology, such as ministerial blogs, online consultations and web forums, have increased the capacity for consultation, as have public opinion surveys, standing citizen panels, focus groups, citizen juries, youth councils, participatory budgeting, participatory appraisal, local partnership boards and e-democracy invitations. There has been a growth in user groups or forums, including police beat meetings, Parent Teacher Associations, tenants organisations, and patient and "expert patient" groups of many kinds, as well as much wider use made of opinion surveys.[153] Additionally, these forms of engagement in relation to public services seem better able to engage those from disadvantaged social groups, such as working-class groups, ethnic minorities, women and youth.[154]

There is a feeling amongst many professionals and users that the most radical aims of "co-productionists" are still a long way off – the proposal to give parents power to set up schools, for example, will only affect a very small number of people (though

153 ODPM, *Public Participation in Local Government: A Survey of Local Authorities* (London: HMSO, 2002); V. Lowndes, L. Pratchett and G. Stoker, "Trends in public participation: Part 1 – local government perspectives", Public Administration 79/1 (2001); M. Taylor, *Public Policy in the Community* (Basingstoke: Palgrave Macmillan, 2003).

154 Brooks, *Public Services at the Crossroads*, 55–6.

co-production might work well in specific areas, such as the EPP discussed above). More useful will be a much greater use of customer insight research, which seeks the views of the users of public services in their design through deliberative gatherings and asks them how they actually use and want to use public services.

5 We also support other innovative measures to boost co-production, notably the call for a *co-production fund* for public service institutions, which will match their investment in innovative asset-based experiments (such as the use of Individual Budgets).[155] Co-production creates the possibility of better outcomes and better satisfaction from users. This is something worth paying for, and could yield cheaper services in the long run as money is not wasted on inappropriate services. Because of the enormous benefit of co-production when it goes right, money should be made available in all the main public service departments to provide funding for groups that want to attempt greater co-production of services themselves upon successful bidding.

155 Boyle, et al., *Hidden Work*, 65.

CHAPTER 4: THE CHANGING ROLE OF THE PROFESSIONAL

Co-production approaches, such as those discussed above, raise considerable challenges for professionals. Doctors and teachers will have to redefine their roles, shifting from being "experts", "providers" and "fixers", to "clients", "communities" and "catalysers",[156] as providers and users begin to work together to decide on effect outcomes. This requires a great "cultural shift"[157] in attitude from public service professionals; as some of their autonomy is removed, they will have to learn to develop the habit of consulting the user in advance of making decisions that will affect them. Such a shift towards more assertive, questioning citizens marks a real challenge to professional groups.

TEACHERS AND DOCTORS: KNIGHTS OR KNAVES?

In his discussion on the role of agency and motivation in public policymaking, Le Grand sets up the now well-known "knights or knaves" analogy.[158] He posits that these two visions on the role and attitudes of professionals have been central to theories of the welfare state and have had a major impact on policy proposals for the delivery of public services.

The view of professionals as primarily self-serving "knaves" has been evident across the political spectrum. From Hume's argument that states should be set up on the assumption that all citizens would act in their own, private interests to Weber's ideas on the monopolising tendencies of professional groups, this is also a theory with a long history. Those subscribing to this view regard the professions as occupational groups that have obtained sufficient power to control both the labour market and policymaking in their own interests. Their

156 House of Commons Public Administration Select Committee, *User Involvement in Public Services* (London: HMSO, 2008), 19.

157 Ibid., 20.

158 Le Grand, *Motivation, Agency, and Public Policy.*

power is gained through a number of channels, which include placing restrictions on those entering the profession, a code of conduct designed to limit behaviour to that which is "in the collective interest of the profession"[159] and claims (often backed up by law) to a monopoly in providing a particular service.[160] Professionalism is thus regarded as "a strategy for controlling an occupation in which colleagues set up a system of self government".[161]

On the other hand, there remains an influential school of thought which takes the opposite view. The theories of Durkheim and Tawney regard the occupational groups of the professions as being underpinned by a moral code capable of subjecting individualism to the needs of the community.[162] Professionals are selected on the basis of both their capacity to fill this role and the benefits they would offer to society in doing so. For example, medical professionals are generally among the most academically able in society, because of the degree of expertise required. But in order to maintain their status and achieve societal acceptability, they will usually need to exhibit not only professional expertise, but also other qualities such as universalism (providing a high standard of care without favour or prejudice), affective neutrality (separating personal and professional judgement and opinion) and adherence to ethical standards such as confidentiality and truthfulness. These qualities, it is believed, lead to a high standard of trust amongst users of the public services, and help to create a specialisation of skill and knowledge amongst professionals that promotes the smooth and effective functioning of the social system.[163]

159 Ibid.

160 Other Weberians include Macdonald, Turner, Friedson and Jamous and Peloille.

161 Parry and Parry, *The Rise of the Medical Profession.*

162 Durkheim (1992) and Tawney (1921), cited in J. Evetts "The Sociological Analysis of Professionalism", *International Sociology (2003), 399.*

163 Talcott Parsons, *The Social System* (New York: Macmillan Publishing, 1951). Others adhering to this view of professionalism include Bernard Barber, Millerson and Durkheim.

While these two visions form a useful basis in the discussion of theories of the welfare state, the reality is, of course, that most professionals are in fact located somewhere between these two poles. A study of the motives of dentists when they decide whether to treat patients privately or on the NHS found – as expected – that their decision-making processes incorporated elements from both theories. Treating patients privately allowed them to charge higher fees and gain independence. Yet most dentists also argued that this also allowed them to provide higher-quality care to patients.[164] Although this conclusion is hardly unexpected, it is the balance of motivating factors which is important here and, in particular, policymakers' perceptions of them. For, as we shall see, public and political attitudes exert a powerful influence on professionals, both in their personal perceptions of their role and in the way they choose to act.

THE PROFESSIONS POST-WAR

What is clear when looking at the development of the welfare state after the Second World War is the profound impact of policymakers' perceptions of both the relative status and competence of professionals and the needs of service users. In general terms, the welfare state that appeared in the late 1940s rested on the assumption that the state – professionals included – was a powerful, collective force for the public good. This led to a high degree of autonomy and social status for professionals; medical professionals, for example, managed to ensure that the new National Health Service did not diminish their former status, with GPs retaining independence as small businesspeople and consultants holding power in hospitals.[165] However, this vision of welfare provision through professional authority and benevolence also relied on a view of service users as essentially passive. This was a welfare state that was designed for, rather than by, the people, relying solely on professionals' assessments of society's needs.

164 Taylor-Gooby et al. (2000), cited in Le Grand *Motivation, Agency, and Public Policy*, 33.

165 W. Anderson and S. Gillam, "The elusive NHS consumer: 1948 to the NHS Plan", *Economic Affairs* (2001), 14.

The intervening decades have seen a radical reassessment of this perception of passive, deferential users. Rising levels of education, plus increased expectations through rising prosperity, have produced a more discerning and assertive type of service user. Against new consumerist, market and choice-orientated standards, the public services of old and the professionals who represented them began to look unresponsive, inefficient and dominated by an unhealthy paternalism. Successive governments have now had to respond to voters' increasing demands for more power and influence in the public service delivery process. As discussed in chapter 2, their response has centred on two – occasionally conflicting – strategies. The first has been to allow service users greater freedom and autonomy through the introduction of choice and market mechanisms into public service delivery systems. The second has been an attempt to raise standards of service delivery through centrally imposed targets and charters of users' rights. While this new narrative of citizen empowerment and increased personalisation has created more responsive and user-centred public services, a by-product of these two trends has been – in many cases – the weakening of the position of professionals themselves. With the influence they traditionally exerted being transferred both to central government and to service users, professionals have experienced diminished status and autonomy.

As mentioned previously, suspicion of professional influence and autonomy is an issue which tends to transcend traditional left–right distinctions. Both Labour and Conservative administrations have tended to place restrictions on professional autonomy through their public service reform agendas. The creation of the modern welfare state under the post-war Labour administration meant that pay and conditions for service providers were determined outside the professional organisations for the first time.[166] Since then, state control over the professions has continued to expand. This became particularly evident from the late 1970s onwards, as the Thatcher administration

166 G. Esland, *The Politics of Work and Occupations* (Buckingham: Open University Press, 1980).

embarked on the doctrine of "New Public Management". This strategy directly combined the two trends discussed above. On the one hand, it was firmly rooted in public choice theory, with the creation of quasi-markets to stimulate competition and improve cost-effectiveness. On the other, there were moves to disaggregate policy formation from policy execution – with policy direction under the sole control of central government – accompanied by much tighter performance controls.[167] Since 1997, the Labour governments has, by and large, continued to conduct public service reform on this basis. While the focus has shifted towards "modernising government" through public-private partnerships, the central tenet of the philosophy has been the view that "it does not matter who produces the services, provided they are of an appropriate standard".[168]

Numerous commentators have argued that the reduction in professional autonomy that has resulted from these reforms has led to a deskilling of white-collar workers.[169] At the same time, the increasing specialisation of roles and external regulation have led to a loss of power and influence for professionals, coupled with increasing competition for professional jobs. Within the medical profession, for example, it has been suggested that other healthcare occupations have come to challenge the dominance of doctors; nurses have defined a semi-autonomous role for themselves by delegating less skilled tasks to those outside the nursing profession and creating new specialisations (e.g. primary nursing).[170] Governments' moves towards extending user choice and promoting competition have also added to the pressures on professionals.

167 See S. Tolofari "New public management and education", *Policy Futures in Education* 3/1 (2005).

168 J. Broadbent and R. Laughlin, *New Public Management: Current Trends and Future Prospects* (London: Routledge, 2002), 96.

169 See John B. McKinlay and Joan Arches, "Towards the Proletarianization of Physicians", *International Journal of Health Services* 15/2 (1985); and Harry Braverman, *Labor and Monopoly Capital: The Degradation of Work in the Twentieth Century* (New York: Monthly Review Press, 1998; first published 1974).

170 M. Carpenter, "The subordination of nurses in health care: towards a social divisions approach", in E. Riska and K. Wegar, eds, *Gender, Work and Medicine: Women and the Medical Division of Labour* (London: Sage, 1993).

The focus of public service reform has therefore taken a decisive shift away from the power and high status traditionally bestowed on professionals. This is largely down to a changing social context; both professionals and governments now have to contend with the rising demands of a highly educated society for openness and greater choice.[171] As a result, users are increasingly regarded as partners in, rather than recipients of, service provision – pointing ultimately to the co-production of outcomes. This new approach is changing the way in which authority is exercised, and sees an increasing acceptance and emphasis placed on the value of user or lay expertise, rather than on deference to expert opinion and knowledge: "Only when citizens are treated as equal partners do they bring their knowledge, time and energy to address challenges such as preventing ill-health."[172] As expertise is increasingly regarded as being constructed as much from self-awareness, achievement and lived experience as from professional or educational background, so there are inevitable implications for the professional–user relationship. These implications will be the focus of this chapter – in particular, their impact on the perceptions of the medical and teaching professionals, and how the changing government–professional relationship affects perceptions of status, respect and trust.

PROFESSIONALS TODAY

This perception of professionals as knights or knaves, altruistic or self-serving, clearly informs the policy focus of public service reforms. However, these reforms, in turn, have an impact on the relationships between professionals and service users that form the basis of public service delivery. As discussed in chapter 2, it is in fact these relationships which are central to the quality of service outcomes, particularly when the public are encouraged to engage in service

171 M. Haug, "Deprofessionalization: an alternative hypothesis for the future", in P Halmos, ed., *Professionalisation and Social Change* (Keele: University of Keele, 1973).

172 Cabinet Office, *Excellence and Fairness.*

delivery to a far greater extent. It is therefore important to gain an accurate picture of the perceptions and status of professionals today, both in the eyes of service users and of professionals themselves. We therefore conducted several focus groups with service users and numerous interviews with professionals to discover more about these perceptions. Below, two key roles played by professionals in the context these findings are discussed. The first is the role of professionals as the gatekeepers of power and resources – generally associated with the view of professionals as "knaves". The second is the role of professionals as the trusted, personal face of public service delivery – a more noble, "knight-like" vision of professional activity. The final section sets out conclusions on the types of policy responses which would promote a form of professionalism which best serves the public interest.

PROFESSIONALS AS GATEKEEPERS

A key part of the role of professionals, particularly in the case of GPs, has traditionally been to act as gatekeepers to resources and services, and information. The traditional informational and expertise asymmetry between professionals and users in their given fields has tended to be reflected in unequal power relations between the two groups. Yet this is a model which is increasingly challenged. The advent of a more assertive and, most importantly, better-informed type of service user has forced a re-evaluation of the gatekeeping model and efforts to adapt it to accommodate a more active and engaged citizenry.

Gatekeeping and new technologies

One major social shift which has begun to challenge the professional's role as gatekeeper has been the advent of new technologies. New sources of information, and the increasingly easy access to them, are having a significant impact on the extent to which professionals remain gatekeepers of knowledge, which is, in turn, having profound

impacts on user–professional relationships and changes in their roles. This is particularly true in relation to the doctor–patient relationship.

Patients and doctors both reported the extent to which users are able and willing to use new sources of information, particularly the Internet, to access health information. Patients report doing so for a number of reasons: to find out more about their condition after having visited their GP; as a speedy and easy source of information when health concerns arise; and in order to assess whether or not they should consult their GP at all. In addition to the Internet, many report seeking the advice of friends and family. Both sources have implications for the GP's role as gatekeeper.

In the main, medical professionals welcome the widespread use of the Internet by patients and considered the fact that patients were now more knowledgeable to be a positive development. It helps patients to understand their conditions and enables them to feel confident in asking questions, coming in to the surgery, and starting conversations with their doctor. Indeed, some doctors choose actively to refer patients to trusted websites, encouraging them to access information in their own time.

> "There is a huge amount of information available to GPs which is very good, there are huge amounts of resources which are now available, especially for GPs like me who had to practise in the pre-electronic age. Actually I am very impressed with NHS Direct. For the general public, the quality of information available if used correctly really encourages them to make a diagnosis themselves. If you do have the Internet and have an illness there is excellent information and it directs people to it giving them choices. (Doctor)

This picture fits with the academic literature. As George Lundeber has argued: "For those physicians who are comfortable with the

Internet and with patients declaring their autonomy, and for patients who have happened to come upon sites that have trustworthy information, the patient-physician relationship is enhanced and improved, and everybody benefits."[173] Similarly, Murray et al. found that "[o]f the 254 patients they surveyed who had obtained information from the Internet and taken it to their physicians only 4% said that their patient–physician relationship had subsequently worsened, compared with 30% stating that it had been improved".[174] The focus groups supported this academic literature, agreeing that the Internet complemented traditional GP visits.

Despite the positive implications of the wider availability of information, both patients and doctors also raised concerns about the reliability and quality of the knowledge supplied, in particular on the Internet and in the media. They also agreed about the dangers of using the Internet for information about health, raising concerns related to unreliability, confusion in the face of contradictory information from competing sources, and the potential for extreme examples to frighten or cause anxiety in advance of an appointment.

> "The problem is quality, some of the written information in the cheaper newspapers is awful – much of it is very badly written and poorly sourced. You have to watch where it has come from." (Doctor)

Again, this echoes the academic literature. In a US survey of medical information on the web, McClung et al. found that, of 300 hits for a search on childhood diarrhoea, only 60 were genuine documents from relevant and credible sources, of which only 12 conformed to American Academy of Paediatricians recommendations.[175] Despite the

173 George Lundeber, "What is the impact of the Internet on the physician–patient relationship?" *Journal of Medical Crossfire* 2/7 (2000).

174 E. Murray et al., "The impact of health information on the Internet on the physician–patient relationship", *Journal of Medical Internet Research* 5 (2003).

175 H. Juhling McClung, R.D. Murray, and L.A. Heitlinger, "The Internet as a source for current patient information", *Paediatrics* 101/6 (1998).

fact that most of our focus group users stated that they preferred to use trusted sites such as NHS Direct, doctors reported having often to respond to less reliable and inaccurate sources of information.

When questioned on other possible downsides of wider access to medical information, professionals tended to cite examples of patients requesting drugs not yet available on the NHS which they had read about online or heard referred to in the media. Thus, there does seem to be evidence of expectations being driven up as a result of users' increased awareness of treatments via the Internet. Despite this, however, respondents in our focus groups still considered GPs to be the most reliable source of information. This again reflects the academic literature, that the majority of people still regard their doctor as their primary and most trusted information provider.[176] This may be due to the level of trust which is still afforded to GPs and the medical profession in general, and suggests that, while external information may supplement GP advice, patients tend rarely to seek actually to override their doctor's conclusions.[177]

However, the increase in access to information has nonetheless come to challenge the traditional "doctor knows everything" or "knows best" viewpoint. This is manifested particularly in the increasing willingness, reported by both patients and doctors, of patients, not necessarily to override, but certainly to challenge, GPs' decisions. Examples were cited of patients asking for, or expecting, treatments they had read about on the Internet or in the media – with particular references to the wider public debate about the availability of new drugs or treatments.

Increasing access to information sources was less of an issue in the context of teacher–parent relationships, but an interesting example arose in the context of teacher–pupil relations. Here, the introduction

176 A. Coulter and H. Magee, *The European Patient of the Future* (Maidenhead and Philadelphia: Open University Press, 2003).

177 Royal College of Physicians, *Trust in Professions*, http://www.ipsos-mori.com/_assets/polls/2007/pdf/trust-in-professions- 2007.

of new technologies – the Internet, email, interactive whiteboards, laptops, voting technology, online exams and so on – into schools and lessons served to highlight the fallibility of teachers to pupils. Pupils mentioned that some teachers had found it difficult to adapt to the introduction of new technology in the classroom. This suggests a reverse of the normal pedagogical route – children now often teach parents and teachers how to use new technologies.

In relation to information and technology, the changing relationships reflect generational differences, with younger users seen as being less favourable about their providers than older users. This may reflect different patterns of communication between the generations and the fact that some groups are more willing and/or able to access these sources than others.[178] Younger generations, for example, are more familiar with newer technologies and have a greater willingness to access them. This can be regarded as reflecting a "cultural change", with users no longer willing to be "passive recipients" in relation to the medical professional, for example,[179] and is also reflected in the positive association of age with patient trust in doctors.[180]

Reflecting this generational shift, interviews in the health focus group revealed that older patients were considered less demanding than younger generations, who were characterised by one doctor as "wanting everything". All this points to a changing role for GPs in a context where they cannot or do not wish any longer to operate as the effective gatekeeper of information. The importance of being able to balance and negotiate choices and treatments in such a context is enhanced as GPs find themselves facing more assertive and demanding patients, armed with potentially unrealistic

178 Coulter and Magee, *The European Patient of the Future*, 208.

179 Ibid., 225.

180 C. Tarrant, T. Stokes and R. Baker, "Factors associated with patients' trust in their general practitioner: a cross-sectional survey", *British Journal of General Practice* (2003).

expectations. The newer models of user involvement which are explored in this research, such as co-production, personalisation or "customisation" of services, together with the empowerment of users, provide one way forward. These concepts serve to alter the professional–user relationship and break down the traditional gatekeeping role.

From gatekeepers to Sherpas

Sceptics argue that the gatekeeping role makes the power relationship between professionals and users unequal, and that this has been utilised to restrict expertise in the interests of the profession rather than necessarily the public. In this view, a professional group achieves prestige by maintaining an asymmetry between the information available to insiders and to outsiders. The prestige of groups such as doctors, therefore, stems from their degree of control over the flow of information ("social distance").[181] The extent of this asymmetry is referred to as the "technicality ratio", and doctors (especially surgeons) maintain a high degree of technicality, which in turn maintains their level of prestige. Consequently, their knowledge upholds the high status of their profession and sustains the unequal power relationship which may be to the detriment of the patient or user.

Blackman provides an illustration of the power of gatekeepers of resources in social care in England, which has high levels of centralised public spending coupled with significant local gatekeeping.[182] Responding to the hypothetical case of a 75-year-old widow, recently discharged from hospital and with severe osteoarthritis, just under 50% of gatekeepers would offer no home care, around 40% would offer

181 H. Jamous and B. Peloille, "Changes in French university hospital system", in J.A. Jackson, ed., *Professions and Professionalization* (Cambridge: Cambridge University Press, 1970).

182 T. Blackman, "Defining responsibility for care: approaches to the care of older people in six European countries", *International Journal of Social Welfare* (2000).

four hours per week and just under 20% would have offered 4 hours or more. From such a case, it has been argued that assigning the gatekeeping of social services to local authorities has produced a system that undermines the rights of frail and disabled people.[183] Indeed, the managerial and bureaucratic practices of local authorities systematically deny care to people who need it, either because they were not assessed or because they were assessed only for services they did not need.

The nature of professionalism and its reliance on the training and expertise of the provider does make the gatekeeping role an inevitable one. However, recent efforts to improve delivery of services have sought to move away from such managerial or bureaucratic models of care and enable users to be more actively involved in the allocation of financial resources. In the UK, the introduction (most prominently in social care) of a more personalised approach and the use of personal budgets are likely to have profound implications for both the professional–user relationship and the very nature of the gatekeeping role, leading to an enhancement of "user independence and control".[184] Here, the user is put in control of financial resources and, with necessary support, can allocate the best resources for themselves within these means.

There was also some evidence from our focus groups that GPs were increasingly recognising the value of lay expertise and knowledge in healthcare provision: when asked graphically to depict their relationship with patients, medical professionals stressed the importance of taking time to listen to patients' concerns and experience, and the sense that the relationship should be one of partnership. Similar views were reported by parents in their conceptions of the kind of relationship between themselves and

183 K. Rummery and C. Glendinning, "Negotiating needs, access and gatekeeping: developments in health and community care policies in the UK and the rights of disabled and older citizens", *Critical Social policy* 19/3 (1999).

184 Cabinet Office, *Excellence and Fairness.*

teachers – that they were working together in partnership to help the child develop, and that this relied upon two-way communications (see figure below).

PICTURE FROM MEMBER OF FOCUS GROUP

Shaking hands represents a partnership between patient and doctor

To a significant extent, of course, physicians' role as gatekeeper has always involved this balancing task. GPs have been placed in the unique position of deciding what services a patient should receive by assessing and weighing up three incompatible rationalities: patient preference, cost-benefit analysis and need of other patients as a whole.[185] This is a core and positive part of the gatekeeping role. Indeed, patients, specialists and public accountants will each lack the required knowledge to perform this role as the best-qualified group to make a decision for the user.

In a special edition of the *British Medical Journal* this new role was described as resembling that of a Sherpa – it is the job of professionals to provide trusted advice for patients as they make decisions.[186] As well as the increasingly critical role played by doctors in providing a balanced viewpoint, as opposed to the biased

185 D. Willems, "Balancing rationalities: gatekeeping in health care", *Journal of Medical Ethics* (2001).

186 "Doctors as Sherpas: BMJ round table debate", *The BMJ Patient Issue* (14 June 2003): www.bmj.com/content/vol326/issue7402/.

viewpoint perceived to be often found in Internet sources, GPs also faced a delicate balancing role in guiding patients towards an outcome that would best meet their health needs but without seeming obstructive. Similarly, in a context where the GP may no longer be gatekeeper to information about options, but remains gatekeeper to resources, services and treatments, this balancing role is joined by a new role in not only weighing up the various options but in effectively communicating this to the patient and negotiating an outcome acceptable to all.

> "Then people want to know why they are not getting [the drugs they want] or why I am not prescribing them if they are cheap. … Then we were under pressure to prescribe something. If we have got someone who absolutely insists that [one drug] is absolutely necessary compared to [another] and they want to argue the point out, you have to get quite good at saying no." (Doctor)

Interestingly, expert interviews suggested that informal or personal sources of information presented a greater problem in successfully negotiating this new balancing role – users may be more willing to accept the unreliability of Internet-sourced information, but advice gained from a friend's personal experience or another trusted source is harder for doctors to "contradict" or work around. Both these contexts suggest a new or enhanced responsibility for professionals. Their role becomes one of not just giving their opinion but of providing users with information that helps explain why they have that opinion so the user feels involved in the decision-making process. In this way, professionals must acknowledge that if they are going to recommend something that the user has a different view about, they have a responsibility to explain their decision and engage with the user about their suggestions. On the other hand, the idea of a partnership approach also suggests that the provision of more information to patients, whether it be through government or professional-endorsed

sources, points to a parallel need to equip patients and users with the tools to negotiate the information now available to them: teaching them how to deal with that knowledge which was previously the domain of the professional. This relates closely to the discussion around advice and guidance required for users in negotiating choices which is discussed in chapter 2.

For teachers too, focus groups highlighted the lack of training that they are given in how to play this kind negotiating role – of how to handle difficult conversations with parents or how to negotiate ways forward with them. In this context it was suggested that parental attitudes towards teachers played a crucial role – which, to a degree, enhances access to information (about performance of schools perhaps more than methods of teaching) and encourages what could perhaps be considered "pushy" behaviour – and that teachers need to be better equipped to handle this.

The role of the professional has shifted from one of allocation and control of services towards one more concerned with advice, guidance and monitoring of services and treatments. But such shifts will rely on professionals' ability to communicate with service users and the quality and continuity of professional–user relationships. It is the quality of these relationships in the context of both public perceptions and relationships with government that is addressed in the next section.

STATUS, TRUST AND GOVERNMENT RELATIONS

Traditionally, the professions have tended to enjoy a high social status, arising primarily from the public interest value attached to their work, and the specialised, technical or skilled expertise and knowledge required to fulfil the role. To assess the extent to which these perceptions are still held, our focus groups were asked how they perceived the teaching and the medical professions, and how they felt

perceptions had shifted over time. The groups revealed that, in general, the levels of respect afforded to both doctors and teachers were quite high, particularly in comparison to other professions such as solicitors or politicians. Interestingly, however, it emerged that the parents and pupils who participated in the education focus group held teachers in much higher regard than those who participated in the health focus group and who were also asked their views of the teaching profession. Those in the education focus group associated the teaching profession with words such as "inspiring", "knowledgeable" and "respected", while those in the health focus group used less positive words, such as "useless", "difficult" and 'stressful".

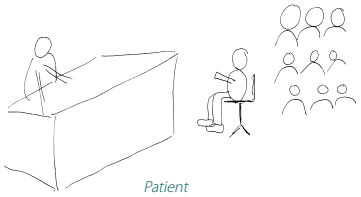
Doctors, by contrast, were held in high esteem by both groups of users, who, in word association exercises, used terms such as "clever", "respected", "gravitas", "trustworthy" and "hardworking". These kinds of perceptions are in line with larger national surveys which place doctors as one of the most trusted groups. A recent Ipsos MORI report, which considered levels of public trust in relation to various professions between 1983 and 2007, found that trust in doctors remained relatively constant over this period.[187] Significantly, this seems not to have been affected by the arrival of alternative sources of information in health, which appears to run contrary to the work referred to earlier by Jamous and Peloille, which argued that the prestige of professional groups, such as doctors, stems from their control of the flow of information.[188] In fact, as we have seen, doctors talked about new technologies as leading to a new partnership approach between users and expert, but argued that this need not undermine the respect that users held for them. On the other hand, the inequality of the power relationship between doctors and patients in particular seems to have been illustrated in the graphical

187 M. Corrado and M. Chandan, "Trust in professions 2007: Public awareness of physicians and trust in professionals", Ipsos MORI: www.ipsos-mori.com/content/polls-07/trust-in-professions-2007.ashx. According to the poll, doctors were the profession most trusted to tell the truth (with 90% trusting them to tell the truth) followed closely by teachers (86%).

188 Jamous and Pelloile "Changes in the French university hospital system".

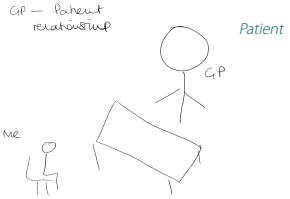
depictions produced by focus group participants. As both the images below reveal, doctors are still regarded as being "important" – a dominant figure behind a large desk – compared to the patient, concerned "not to waste his time" (see the figures below, drawn by members of the public at our focus groups).

PICTURES FROM MEMBERS OF FOCUS GROUP



The doctor behind a big desk (important)

I am one of the many patients waiting to see him - important not to waste his time.



I feel that I shouldn't be wasting too much of his time

While the general level of respect and trust afforded to teachers was quite high – at least by parents and pupils – teachers themselves expressed that they felt they were no longer held in such high regard, either by society in general or by parents and pupils, as in the past. Subsequently, many felt less proud of their profession today than they had been previously. This was reflected in the attitude, apparent within both focus groups, that teaching was now easier to get into ("anybody can teach"). Traditionally, status or prestige have been related to "professional expertise" – well-respected professions tend to be those that involve obtaining degrees and professional qualifications, without which entry to the profession is impossible. As Mike Baker put it, "status is partly about pay and working conditions but it is also about autonomy".[189] Teachers continue to be far more subject to government

control than doctors, whose higher status may be in part down to their ability to acquire and protect a degree of autonomy which has eluded the teaching profession.

It is also true that perceptions about the value of qualifications required to be a teacher have deteriorated in the public mind and this has had a negative impact on the sense of respect afforded to the teaching profession. Acknowledging this, a 2001 Department of Education report argued that "[p]rofessions also need effective regulation … best done by a strong professional body" and that "[w]e must be clear that anyone teaching at the school either must have QTS [Qualified Teacher Status] or be operating within a framework set by someone with QTS".[190] On the other hand, the report also stresses the importance of demonstrable success in fostering relationships of trust between teachers, pupils and parents, and notes the value of non-qualification-based factors, such as evidence-based teaching and partnerships between schools and communities.

Conversely, most focus group participants and interviewees agreed that teaching had become more difficult, and that it now involved numerous extra responsibilities and time pressures. Focus group recipients acknowledged that teachers face a heavy workload and that this impacts on their ability to communicate proactively with parents as much as they may like. Equally, it was recognised that societal changes, such as the increase in families with two parents going out to work, has had an impact on the amount of time that parents are able to be involved with, or communicate with, education professionals. It was suggested that, to a degree, teachers appear to be having to take on some of the parental responsibilities of old, and that the boundaries between parental and teacher roles are becoming blurred. The resultant increase in the amount of pastoral care expected

189 M. Baker, "Social services status boost was same for teachers" *The Guardian* (12 December 2008).

190 Department of Education, *Professionalism and Trust: The Future of Teachers and Teaching* (London: HMSO, 2001).

from teachers means that several compared themselves to social workers, and felt they had to wear many different hats, alongside their traditional educational role.

Related concerns about accessibility also emerged in respect of GPs, particularly around patients being able to make appointments. As with teachers, however, respondents did not necessarily blame GPs for these problems, but rather attributed them to a general lack of resources and a perceived increase in the numbers of patients per doctor. In general, respondents were very sympathetic to the pressures placed on professionals. They tended to place a great deal of emphasis on their ability to forge personal relationships with their local doctors and teachers. This preference tends to be reflected in national opinion polls; Ipsos MORI found that 76% of patients preferred to receive information about their healthcare options through their GP.[191]

Even the most assertive service users continue to place value on their right to a personal relationship with professionals. As discussed in chapter 2, the public choice agenda, coupled with the ease of access to information, has provided users with a greater say in decision-making. However, there is little evidence to suggest that service users feel that this has diminished the need for expert advice. Rather, they welcome a more equal partnership with professionals and professional recognition of their role in improving service outcomes. The relationship between service users and professional providers is not a straightforward parallel with the relationships between purchasers and providers in a market context. Within a market system, purchasers gain autonomy when the power of providers is restricted. Yet this is not the case in the context of public services. The rise of more assertive service users will not simply require a reduction in professionals' status and influence, but a role for professionals that builds on and promotes their contribution to the public good. The way in which such a role might be encouraged is discussed below.

191 Ibid.

Professionalism in the public interest

Central to perceptions of professional status, respect and trust afforded by the public is the perceived relationship between the government and the professional group and, significantly, the degree of independence that a group has from government or political interference. Indeed, in the US where the doctor's gatekeeping role is used to reduce costs (unlike in the UK where it is more about access to specialists), evidence suggests that this has led to a reduction in patient–physician trust.[192] There is a sense that trust in public service professionals is undermined where they are viewed by the user as an extension of government. In this context, a decline in deference may reflect user concerns that professionals are forsaking their objective judgement and, instead, are being influenced by government agendas. For example, the questioning of the safety of the MMR vaccine, and the significant decrease in the take-up of the vaccine, despite government and professional reassurance that it was safe, suggests that doctors are no longer necessarily the trusted gatekeepers of information concerning health. Users proved to be distrustful of the "establishment" message, particularly when this was coupled with the knowledge that GPs who carried out a high percentage of child immunisation would receive financial incentives.[193] Concerns about whether GPs were acting in the public or their own interest in this context led the authors of one study to argue that the "benefits and conflicts [faced by GPs] need to be acknowledged clearly and openly".[194]

Professionals too have raised concerns about the impact of a government agenda on their role and on public perceptions. In our interviews, for example, health professionals raised concerns that the

192 A.C. Kao et al., "The relationship between method of physician payment and patient trust", *JAMA* 280/19 (1998).

193 S. Hilton, M. Petticrew and K. Hunt, "Parents' champions vs. vested interests: Who do parents' believe about MMR? A qualitative study", *BMC Public Health* 7/42 (2007).

194 Ibid.

pronouncements of the government and the Department of Health were raising expectations of users to unrealistic levels, but subsequently not equipping doctors with the resources to be able to meet these expectations, and that there was a danger this would have a negative impact on the professional–user relationship. Conversely, in relation to teachers, concerns were raised by parents about teachers being unwilling to criticise pupil performance or behaviour – parents felt that school reports and teacher feedback was too positive, with teachers reluctant to highlight low attainment.

More broadly, the development and advocacy of a conception of service users as customers – or, more recently, as citizen-consumers – has created new challenges for both teachers and health service professionals. A number of interviewees commented on the move towards a conception of both health and education as service industries, which focuses the minds of users on the quality of care and the user–service provider relationship. Such a conception suggests strongly to the user that trust has to be earned by the professional and seems to highlight the focus on individual requirements, perhaps at the expense of the more nuanced role that professionals have to play in balancing the competing needs and priorities of many users, alongside upward accountability.

> "An odd role is beginning to emerge because patients are beginning to think of themselves as consumers. We as GPs have to facilitate this role but we also have the government directive, so these two roles can conflict." (Doctor)

The impact of government influence on professionals feeds into the considerable debate about the level of autonomy given to professionals – particularly doctors, nurses and teachers – and the extent to which this is compatible with the empowerment of users.[195]

195 The best known recent account of this is Le Grand's, *Motivation, Agency and Public Policy.*

Most recently, the dominant government conception of the role of professionals has been set out in a Cabinet Office report which emphasises a three-pronged approach based on "empowering citizens", the "fostering of a new professionalism" and "strategic leadership" from the centre.[196] The conception elucidated in this report seems to reinforce a service-based consumer-driven vision, which is somewhat sceptical of traditional professional motives. While there is an emphasis on the autonomy of public service professionals in spearheading the necessary changes to create better services, the "new professionalism" is also characterised as a "shared commitment" which requires "constant dialogue" between government and professionals. It emphasises the need to redefine the relationship between professionals and citizens, and to make professionals accountable as much to user as to managers. It argues that greater transparency and openness in the delivery of public services is needed by professionals: "Raising standards to the best in the world demands a new openness often driven by the professionals themselves."[197]

In relation to teachers, however, it may conversely be that more autonomy, rather than less, is central to ensuring a sound user–professional relationship grounded in trust. Indeed, the Department of Education report noted that "Governments over the last 30 years have not always rushed to express their confidence in teachers", which may have played a role in undermining the status afforded them by the public. The report acknowledged that "it is important to show trust in professionals to get on with the job. That does not mean leaving professionals to go their own way without scrutiny. … [W]hat it does mean is that we will increasingly want to see professionals at the core, to join us in shaping the patterns for the schools of the future."[198] Indeed, the "six characteristics to be present in a modern profession"

196 Cabinet Office, *Excellence and Fairness.*

197 Ibid.

198 Department of Education, *Professionalism and Trust.*

that were highlighted in the report[199] seemed to imply that enhancing the trust and authority of teachers would require awarding them a high degree of professional autonomy, albeit combined with the necessary regulation to ensure best results. This kind of renewed emphasis on the potential benefits of more autonomous professional roles is reflected in initiatives to decrease government control over the most successful institutions – for example, autonomy in curriculum-setting in city academies, fewer inspection requirements for schools that are high performing and increased managerial and financial freedoms for NHS Foundation Trusts.

These debates about the appropriate degree of autonomy ultimately reflect the key themes of the "knights or knaves" dispute discussed earlier in this chapter. With autonomy come control and power, enabling professionals to act on their best judgement of the public interest without political interference, but also allowing them to serve their own self-interests at the expense of the public or user interest. It is concerns about such power that have led to calls for greater regulation and/or a move away from the self-regulation that formerly characterised the professions.

There are also questions about the appropriate balance between autonomy and regulation, echoing concerns about the capture of professional self-regulating bodies in the self-interest of the profession rather than the public. As one interviewee put it: "I'm not a great fan of our self-regulation to date. It is opaque and it has lost the point in that as a professional body we're not there to maintain a cartel, we're there to serve the public." Questions were also raised about the interactions between the roles of various professional bodies, particularly in relation to the medical profession. Specifically, there is some concern regarding the appropriate separation of

199 The six characteristics highlighted were: 1. High standards at key levels of the profession; 2. A body of knowledge about what works best and why; 3. Efficient organisation and management of complementary staff; 4. Effective use of leading edge technology; 5. Incentives and rewards for excellence; and 6. A relentless focus in what is best for those who use the service.

quality assurance, regulatory activity and union activity amongst various bodies, the impact this has on the public interest, and public perceptions of the extent to which professional bodies are able to uphold this.

> "I think there has also been a confusion between union activity versus quality and regulatory activity so if you take the case of GPs who deals with quality, who deals with union issues and who deals with regulatory issues. That should be straightforward, regulatory – GMC, union issues – BMA, quality – RCGP. If you look at what these organisations do it is not as clear as all that."
> (Interviewee)

Yet, it should be noted that although this was not a concern raised by users in either of our focus groups, it does suggest that any moves towards granting greater autonomy to public service professionals – for example, the teaching profession – would need to be accompanied by clarity about self-regulatory functions and transparency about activities in order to ensure both that the public interest is best served, and that it is seen to be so.

What is clear from this evidence is that public service outcomes cannot be improved by promoting the engagement of service users alone. The quality of public services is intrinsically linked to the nature of professionalism, the way in which professionals perceive their role and the impact of their relationships with both government and service users on these perceptions. The escape of expert information through the improved accessibility afforded by new technologies has encouraged professionals to move away from paternalism towards co-production of outcomes. This will be an important step in making professionals more accountable to those who rely on their services. However, to ensure that professionals are able to respond to the varying needs of service users, they will also need more autonomy and a greater say in central government policymaking. Trust is not only an

important concept for the user–professional relationship; it is also relevant in government's stance towards professionals. A diminished role for professionals tends to rest on the perception of doctors and teachers as self-interested "knaves". If we are to foster professionalism in the public interest, government must seek to highlight and promote professionals' contribution to the public good through an emphasis on shared values and a service ethic. The concluding section sets out recommendations which could facilitate this type of role for professionals.

CONCLUSIONS

1 The evidence around public trust and respect largely suggests that *more autonomy and less interference needs to be given to professional groups*. Assertive citizens need to be partnered by independent, authoritative professionals. Doctors, largely, have been able to maintain this, in no small part due to their strong professional bodies and retention of self-regulation. We argue that the user–professional relationship between parents/pupils and teachers would benefit from more of this kind of representation and independent strength. This could mean an enhanced role for the General Teaching Council (GTC), which has recently acknowledged that "there is plentiful evidence of teachers' appetite for engaging with other teachers in processes to understand and further develop the nature of professional identity and its application in practice. This is particularly important when we consider that professional norms and ethics provide a counter-balancing force to market forces in the education system. The moral purpose of these professional values counteracts any tendency to focus exclusively on institutional interest. It encourages the wider collegiality between teachers that serves the interests of learners."[200]

200 General Teaching Council for England, *Professionalism, Teaching and the GTC, Now and 2012 – Issues and Implications:* www.gtce.org.uk/shared/contentlibs/gtc/council_mtg_pdfs/246693/professionalism_020708.

2 There is a need for explicit acknowledgement that the rise of the assertive citizen requires a new and more nuanced understanding of user–professional communications, recognising the balancing act or negotiating role that professionals often have to play, and, increasingly, their role in justifying to users decisions or requirements that are actually outside their control – e.g. around which drugs are available. This means *a focus on soft skills* for professionals, whose role it is to guide service users.

3 Increasing expectations from parents means that teachers need to be better equipped to deal with possible confrontation. In Wales, Teacher Support Cymru (TSC) – part of the Teacher Support Network[201] – has taken the initiative by providing *optional courses to teachers in conflict management and mediation*. After some reported cases of disagreements between teachers and parents, it was thought that teachers needed to refine their communication skills when dealing with parents. TSC said it is running its new course so "teachers in Wales will have the opportunity to learn more about dealing with that difficult parent and with a range of other issues".[202] Here there is a renewed emphasis on making sure that feedback to parents is communicated in an appropriate way. Because of the changing relationship between the service user and the professional, training of this type for teachers may become essential. This strategy could have an important role to play in improving relationships and preventing unnecessary frustration.

4 Government needs to recognise that professionals are no longer the gatekeepers of knowledge, and should see them more as Sherpas, guiding individuals. Professionals spend many years acquiring the knowledge to understand how to weigh up and

201 Teacher Support Network is a group of independent charities and a social enterprise that provide practical and emotional support to staff in the education sector and their families: www.teachersupport.info

202 Abbie Wightwick, "Teachers learn how to deal with aggressive parents", *Western Mail,* 14 February 2008: www.walesonline.co.uk/news/wales-news/2008/02/14/teachers-learn-how-to-deal-with-aggressive-parents-91466-20473357/.

balance the information that is available. Users also need to be given a short-hand way to start to think about the information they have – otherwise it just wastes time and causes tensions in the user–professional relationship. Users' methods of employing services – particularly the NHS – need to be guided by advice and training from an early age to ensure that they get the best from the system

5 The statutory requirement for citizenship to be taught in schools at Key Stage 3 and 4 could provide an opportunity to educate young people about their rights and responsibilities when dealing with public service professionals. The citizenship curriculum at Key Stage 3 states one of the key components as "the needs of the local community and how these are met through public services and the voluntary sector". This could be extended as an opportunity to inform users of their responsibilities when using public services. Role play is commonly used in citizenship classes and this activity could be utilised to teach students how to approach service professionals such as GPs. In addition, better advertising is needed on the resources that are available, especially regarding services such as NHS Direct. Particularly in the case of healthcare, it is important that users are educated about what to expect from a service in order to avoid dissatisfaction or wasting resources.

CHAPTER 5: CONCLUSIONS

As citizens, we look at the world differently from how our parents and grandparents did. We are less constrained by class and tradition, although the former continues to play a powerful role in determining our life chances. We defer less to expert opinion and are more individualistic and assertive in our outlook, both in our use of the public services and in our private consumption. There are many drivers of these changes – including globalisation, demographic change, emancipatory ideologies and technological change. All of these are shaped by our collective actions, but which we, individually, are able to do little about.

CHOICE AND ENTITLEMENTS

This report has set out many of the challenges that the rise of assertive citizenship produces for creating efficient and equitable public services. Public services are increasingly moving away from a "one-size-fits-all" approach. As these services developed, largely in two phases during the course of the twentieth century, they proved to be good at meeting basic needs, but poor at promoting equity.

As our wants and needs have become more complex – as we have moved towards goals of self-expression, actualisation and become increasingly assertive – the public services need to move to adapt. To some degree, this was the case with the introduction of choice-based reforms, particularly under New Labour since 1997. However, these moves have been partial and have not always been designed with enough care to protect equity or enough focus on putting (all) users at the centre of public services. This study has suggested two ways in which entitlements can be improved to meet an increasingly assertive citizenry.

First, in education there is scope for a move towards a much more personalised system of feedback for pupils and students through the

rolling out of school agreements between teachers, parents and students that are geared to the individual case. Second, across the public services there is room for a much clearer set or charter of rights to guarantee fairness in an increasingly diverse field of provision. This is already soon to be the case in the NHS with the introduction of the NHS Constitution, but there is room for this to be rolled out in education as well. This recommendation is, however, made with the proviso that there is deep citizen and professional involvement in the creation of the Constitution, otherwise it becomes a meaningless decree from above, rather than a body of rights that all feel protected by.

CO-PRODUCTION

The assertive citizen can also satisfy values of self-expression and full involvement though greater participation in the production of public services. There is considerable scope for better use of co-production in the public services. However, there is also the danger that "deep" co-production is presented as a panacea for all services – a proposition that this research has shown to be a considerable distance from user's actual day-to-day experience. First, a crucial task of government in this area is to work out the extent to which co-production approaches are appropriate in different fields. The Public Accounts Select Committee, for example, reported little desire for greater co-production in some areas of mental health care, while, by contrast, many people have benefited enormously from the "deep" co-production approach of the Expert Patients' Programme, with its considerable demands for involvement.

A second recommendation in this area is for successful schemes – such as the Expert Patients' Programme and others that have had demonstrable achievements – to be rolled out and encouraged nationally.

Third, in this we welcome innovative approaches to encourage co-production. One of the most recent examples was the call for a

"co-production fund" to be made available for applications in each area of the public services to encourage co-production and the benefits that it can bring.

Finally, there must be the recognition that co-production shifts power and responsibility towards the citizen. This should be welcomed, but with this shift comes a shift in risk. As the risks move towards the user and co-producer of a service, government needs to ensure that safety nets exist. This will largely take the form of appropriate regulation to guarantee that co-production is carried out in partnership with safe, law-abiding organisations.

THE PROFESSIONS

The shift in power and responsibility that comes with co-production raises extensive challenges for the professions. This report has concentrated on two groups – GPs and teachers – although the issues are much wider than this and include all areas of health, education and social care. This work implies that assertive citizens need strong, but flexible, professional groups to meet their expectations. The evidence around public trust and respect largely suggests more autonomy, and less interference needs to be given to professional groups. Assertive citizens need to be partnered by independent, authoritative professionals. Most professional organisations will gain if they are allowed to operative at a distance from government. There is, however, scope for strong public interest declarations as part of the teaching and medical councils' *modus vivendi*. And there is often an unhelpful "mission creep" between the union and the professional responsibilities of professional organisations.

The rise of the assertive citizen marks deep challenges for the way in which the public services are run – particularly in ensuring that the most assertive or articulate do not get the lion's share of resources.

However, for the most part this shift makes possible more efficient, dynamic and tailored services which are actively shaped around the user, empowering her in the construction of her daily life. It is these challenges that this report has sought to address.