

Turning theory and empirical research into reflective practice

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Abstract

This paper shows how cross-disciplinary, qualitative research, approached from within the critical realist paradigm, provides access to many novel insights when applied to citizens' experiences of deliberative means of Australian health policy development. Deliberative means of policy development – collectively, known as deliberative mini-publics - form part of a growing international, participatory-turn in policy development; they are heralded as more democratic and meaningful forms of citizen engagement. Yet citizens' experiences at such times, have received little attention; even less in Australia, where deliberative mini-publics are still fledgling means of policy development.

To create a fuller understanding of what 'really happens' within citizens' experiences at these times, this research has examined the relevant mechanisms and effects of the deeply intertwined and mutually influential behavioural [subjective] and systems/structural [objective] factors. This demonstrates a pattern running through the data which illuminates the various ways that power can manifest on individuals, their interactions, their social settings, and their broader social contexts.

The ontological-depth of view thus provided, enables a nuanced and holistic understanding of the combined effects of power; with the significance of communicative asymmetries and health policy administrators' decision-making processes most pronounced. These features have been traced into a conceptual model which has become an empirically grounded, theoretical framework conducive to critical reflection on the various, socially-situated, trajectories outlined. This includes the ethical and political dimensions associated with the intended and unintended consequences of health policy administrators' decision-making and communicative action when they operationalise deliberative mini-publics.

The critical edge to the realist position adopted for this research culminates in a critique on what these research findings imply for the theory and practice of deliberative mini-publics in health policy settings, and several propositions are put forward as to why health policy administrators ought to adopt an approach to these engagement techniques that intentionally enables participating citizens to more effectively exchange knowledge and express their deliberative capacities.

Introduction

Deliberative means of engaging citizens in policy development – collectively, known as deliberative mini-publics [hereafter, referred to as mini-publics] - form part of a growing international, participatory-turn in policy making. Although heralded as more democratic and meaningful forms of citizen engagement, citizens' experiences of these public fora have received little attention; even less in Australian health policy settings, where mini-publics are a fledgling means of policy development. This brief paper will explain how I sought to discover what it is that citizens actually experience when mini-publics are operationalised in Australian health policy settings - in particular, their experiences of deliberating and exchanging knowledge.

Firstly, I will set the context for this piece of research. The research approach is then detailed. To demonstrate the ontological-depth of view provided and the theory generating capacity of this research, some research findings are then displayed in the form of a conceptual model. I conclude with propositions put forward in light of these research findings, which are designed to promote a more intentionally enabling approach to the use of mini-publics in health policy settings.

Setting context

The research informing this paper was conducted and funded as part of an Australian Research Council (ARC) Linkage Project, entitled: Citizen Engagement: Listening to citizen's views about Australia's health system and prevention: Project No: 0989429. That ARC Linkage Project was a multi-university and state/territory health department collaborative project, and one of the first large-scale efforts to conduct a series of linked mini-publics for health policy in different states/territories of Australia. Working as a PhD scholar on that ARC Linkage Project, it soon became clear just how little was known of citizens' experiences of mini-publics in health policy settings and the unique opportunity which presented to explore what it is that citizens actually experience at those times. I then focused my inquiry on the citizens' experiences of deliberating and exchanging knowledge [the epistemic practices, in particular], and what accounted for those experiences. I also wanted to know what these citizens' experiences implied for the theory and practice of mini-publics in health policy settings.

So what are mini-publics and what place do they have in health policy settings?

Although there has been some international progress towards the development of innovative means of engaging citizens in healthcare decision-making, many governments - including Australian Federal and State/Territory Governments – still flounder in their attempts to

reconceptualise their traditional ways of obtaining public opinion on these important 'public goods' (World Health Organization, 2007; National Health Hospital Reform Commission, 2009). Yet, one persistent reason cited against 'the poor quality of some public services is the failure to involve the public' (Walker, 2002, p. 8); with some policy scholars and practitioners now convinced that 'taking positive action to give people a voice and allow them to be heard can improve trust as well as enhance policy development and implementation' (Althaus, Bridgman & Davis, 2007, p. 97).

In this context, mini-publics represent a promising way forward, primarily, because their democratically deliberative emphasis is on a process of public reasoning. Within this process, citizens are given opportunity to reflect, discuss, question, listen to others, and think critically with an open mind and a willingness to respectfully justify their arguments in terms that others can accept (Benhabib, 1996; Gutmann & Thompson, 1996; Cohen, 1998; Dryzek, 2000, 1990; Chambers, 2003; Parkinson, 2004, 2006; Hendriks, 2011). Viewed holistically, these procedural features mirror certain democratically deliberative standards which are now widely viewed as comprising the normative theory and principles which democratically legitimate the process and outcomes from a mini-public. Given these features, it is not surprising that mini-publics are heralded as more democratic and meaningful forms of citizen engagement; they undoubtedly represent a new paradigm of participatory governance in healthcare decision-making.

Manifestations of power

The transferability of these democratically deliberative norms and features to Australian health policy settings cannot be taken for granted, however, especially given how little has been known of citizens' experiences at such times. For instance, what genuine opportunities exist within these democratic innovations (Smith, 2005) for citizens to effectively participate, let alone, participate on an equal-footing and have their voices heard and valued? These are important considerations because health policy is notoriously political and deeply contested. Indeed, the competing rationalities of the health policy process are known to involve a complex intermingling of many factors, including conflictive cultural, technical and political value systems (Lin, 2003) which lie deeply within the policy process, and the diversity of perspectives and values that drive the ethical, political and financial imperatives in resource allocation (see, for instance, Sax, 1984; Baum, 2002, 2008; Sindall, 2003; Lin, 2003; Lin & Gibson, 2003; Bovaird, 2007; Dugdale, 2008; Dunston et al., 2009; Deebie, 2010).

Given these and other cross-disciplinary theoretical insights, a recurring theme throughout this research was that of power. Reflecting on relationships of power steered my attention towards one of the key sociological debates: that is, regarding agency and structure. Essentially, the agency-structure debate refers to attempts made to understand the extent to which human behaviour is determined by social structure (Germov, 2005). Many contending arguments have formed this sociological debate, though few contemporary social theorists contest the notion that social structures are the accumulated outcomes of the actions of many actors enacting their own intentions; such intentions are, often, uncoordinated with others (Young, 2013, pp. 59-62). Various manifestations of power form the bond between agency and structure and the confluence of actions on the part of participating agents can have intended and unintended consequences. Indeed, power is found everywhere in social life, and its many forms and permutations vary depending upon whether we are dealing with individuals, social interactions, social settings, or wider social contexts (Layder, 1985, 1998, 2013; Patton, 2002).

Research approach

Faced with the challenge of how to explain what was 'really happening' (Dowding, 2004, p. 140) within the relevant agency-structural factors sparked a foray into several, diverse epistemological territories and many different methodological approaches. Ultimately, I adopted a critical realist perspective as the 'best-fit' for me and this piece of research. Staking-out a realist epistemological approach does not, necessarily, mean that I adhere to the positivist notion that 'the facts' lie waiting to be revealed as a purely, objectively-understood, universal truth-for-all time. Instead, a realist perspective soon appeared as most consistent with my view that social life is composed of both subjective and objective elements, which can be unpredictable and are 'constituted by the actions of meaning-conferring humans' (Layder, 1998, p. 139; Patton, 2002). Of particular value to my inquiry into the exchange of knowledge [especially, the epistemic practices (Fricker, 2007) that occur] is the way that a realist approach goes beyond the sensory limitations inherent to the human experience, in its attempts to understand the objective nature of the social relations inherent to the social systems of our lives (Layder, 2006).

The broad-church of approaches to realism vary (see, for instance, Bhaskar, 1975; Layder, 1990, 1993; Miles & Huberman, 1994; Dowding, 2004); not least because adhering to a realist position does not entail any particular ontological or epistemological commitments (Dowding, 2004, p. 140). Working within the critical realist paradigm does, however, mean that a researcher aims to apply social research methodologies and strategies designed to increase knowledge, to understand and trace the mechanisms and effects of the deeply intertwined behavioural

[subjective] and systems/structural [objective] factors. This includes examining the way that these factors mutually influence each other, and involves a process of drawing upon different types of theory and evidence in a way that seeks to determine the validity of certain propositions or claims (Layder, 1993, 1998, 2006; Patton, 2002; Dowding, 2004). Through this process ‘definitive accounts of actions, practices or institutions are possible’, yet inherent to such a claim is an important caveat: such definitive accounts can later be challenged in light of new theoretical or empirical evidence which can ‘overturn accepted beliefs’ (Dowding, 2004, p. 142).

Adaptive theory and the Theory of social domains

So, to capture and convey the richly, in-depth insight into the citizens’ experiences I was aiming to achieve, four kinds of data collection methods were applied in a qualitative way (Carspecken, 1996; Denzin & Lincoln, 2000; Patton, 2002): interviewing [28 in-depth, semi-structured interviews conducted with people following their participation in one of the mini-publics under examination]; metaphor analysis; participant-observations; and document analysis. I also chose two closely-linked theories as the analytic framework for my critical realist approach: Adaptive theory and the Theory of social domains – each theorised and empirically validated by Derek Layder (see, for instance, 1998, 2006, 2013).

Adaptive Theory originated in Layder’s concern about the gap between general social theory and research and entails a process of a ‘two-way borrowing - from general theory to empirical research and from empirical research to general theory’ (Layder, 1998, 15); effectively, comprising deductive, inductive and abductive forms of logic (Layder, 2015 [personal communication, 22 July]). So, although this piece of research sits firmly in extant theory and my deductive perceptions of it, for any new theory to emerge, I also stayed open to the unexpected and inductively, emergent findings (Layder, 1998; Patton, 2002; George & Bennett, 2005). This was not a linear process but an iterative one of moving back-and-forth with each phase informing and refining the logical underpinnings of my abductive interpretations with the ultimate aim of generating theory that contributes to relevant practice and existing bodies of knowledge (Denzin, 1978; Patton, 2002; Layder, 1998, 2006, 2013, 2015 [personal communication, 22 July]; Schwartz-Shea & Yanow, 2012).

Consistent with an adaptive theory approach, initial insights derived from the literature, and my experiences and observations of mini-publics [unrelated to the ARC Linkage Project] were used as ‘orienting concepts’ to focus my interview-schedule (Layder, 1998, 2013). For instance, the processes of exchanging knowledge [the epistemic practices] that occur when mini-publics are

used in health policy settings became a key, orienting concept, and I used a variety of approaches in my line of questioning to tap into my interviewees' thoughts, opinions and feelings on this matter. With the consent of my research participants, I recorded their interviews. These conversations were then transcribed and entered into the qualitative-analysis program, NVivo, from within which I coded my data.

The first-stage of analysis was done through the lens of the orienting concepts with which I had used to focus my interview-questions. During this deductive phase, I developed coding in relation to how my interviewees' responses related to my research questions and any other pre-existing theoretical constructs I was working with at the time (Richards, 2005). This phase of analysis captured, for instance, the 'epistemic practices'; the 'information provided' to the citizens; and the metaphorical responses I had requested from each interviewee to describe certain experiences at their respective mini-public. This coding process also helped to gather all relevant material together, of which I was able to readily retrieve through searches enabled by the NVivo software, allowing me to easily develop more nuanced coding as my analysis progressed beyond the initial broad categories (Richards, 2005).

With the deductive findings clearly defined, it became easier to identify and differentiate the emergent [inductive] themes as I worked through my data again. For instance, emerging themes indicated 'participation frustrations', 'opportunity lost'; 'feeling safe' was important to many; and the 'emotional nature of health deliberations' was identified. This phase of analysis involved reading through the coding and listening to the recorded-interviews, repeatedly - this process remained a constant feature throughout my analysis and subsequent writing-up of my research to help ensure that my interpretations stayed true to my data.

With all data analysed this way and with a view to theory development, I then worked through the data to differentiate behavioural from systemic concepts. From an adaptive theory perspective, behavioural concepts refer to certain features of human behaviour and social interaction; whereas systemic concepts are used to denote the key research problem derived from social settings and the broader contextual factors/resources: together, capturing and conveying the dialectical agency-structure relationship (Layder, 1998, 2013). These concepts effectively became another way for me to bring order to the large amount of research data I had accumulated; with the point being that it would also help to identify the agency-structural factors within.

As such, systemic and behavioural concepts complement, and were closely intertwined within, each other. One example of how this process unfolded is with what began as a code labelled, 'deliberative constraints'. These constraints had been identified in the citizens' experiences at various points in relation to the respective mini-publics. Many factors were isolated; some lying at the behavioural level: for instance, one interviewee noted the lack of time to 'really flesh things out' and another recognised how the lack of time and material to inform the deliberations made it feel like they were being expected to 'deliberate on the run' – 'like speed-dating'. While individual differences in 'deliberative capacity' were identified by one interviewee as making this 'deliberation on the run' process seem easier for some citizens than others, systemic concepts/factors were also seen as deeply implicated. For instance, the way that the forum-questions were worded and the lack of time provided for effective deliberation soon became dominant systemic concepts/themes as it was evident that these factors were the direct result of the structure these citizens were required to deliberate within which, itself, was a direct result of the health policy administrators' decision-making in their social setting domain [this domain is described below].

Although the agency/structural factors had become apparent working with behavioural and systemic concepts, I could not yet see a definitive pattern in my data which would prove resilient and consistent enough to lead to theory development. The process of analysis thus continued as I looked for 'bridging concepts' to help me find such a pattern in my data (Layder, 1998, 2013). In adaptive theory bridging concepts depict 'a fairly balanced, synthetic... connection between behavioural and systemic phenomena' and represent the 'combined effects of the objective world of "systemic" phenomena and the subjective and intersubjective world of "behavioural" phenomena'. In this sense, the validity of a bridging concept is inherent to its capacity to reference the duality of the concept (Layder, 1998, p. 92-3; Layder, 2013, p. 124).

There are three broad types of phenomena which bridging concepts represent or upon which may focus our attention as researchers: firstly, the agency/structure linkages as mentioned above; secondly, bridging concepts may portray the 'fact that certain kinds of social actor or personnel occupy strategic positions of control in social life' and that those individuals 'holding positions of authority or influence' in organisations and other social settings tend to be involved in relevant agency/structure situations. The decision-making power held by certain health policy administrators represents the most pertinent example of this bridging phenomenon in relation to

this research. In addition, the cross-disciplinary approach I had pursued enabled me to strengthen the conceptual bridges I was building by adding highly-nuanced, theoretical insight into the decision-making power on display. For instance, Edwards' (2001) identification of the fears that policy administrators can experience when they utilise the more democratic forms of engagement connected strongly to the notion of ontological insecurity (Laing, 1960; Schön, 1971; Giddens, 1976, 1993; Turner, 1988). With the aid of Hays' (1994) conceptualisation of the agency-structure conundrum, I was then able to link the ontological insecurity connections that were becoming evident more firmly by demonstrating how health policy administrators' decision-making, at what can be seen as critical points of tension management, can be viewed as expressions of either structurally transformative or structurally reproductive agency.

The third way a bridging concept can be used is to characterise the 'nature of social relations that are significantly influenced by systemic features but which also express the nature of people's involvements and their motivations' (Layder, 1998, p. 92). Examples of this type of bridging concept appeared in the form of the notion of intentionality and the intended and unintended consequences of health policy administrators' decision-making and communicative actions. Several of my interviewees spoke of the 'intention' with which they perceived the health policy administrators to have approached their proposed mini-public, but it was not until I considered the notion of intentionality in tandem with what I had been reading in the literature – in particular, Wade's (2004) *Intentional Values Based Dialogue* – that the potential for these concepts to be applied as bridging concepts, and to facilitate the theory generating capacity of my research became apparent. For instance, by comparing and contrasting what the relevant health policy administrators in both the ACT and SA jurisdictions said they would be doing with what they did do, and how the citizens experienced those actions, I was able to interpret the ensuing consequences as either intentional or unintentional with disabling or enabling outcomes. The next and final phase in this process was comprised of tracing the various bridges thus displayed into a conceptual model. I then used that model as a template to reconfigure my earlier coded data within the trajectories defined [see Figure 1]. This process was analogous to a theory-testing and further theory-building phase.

To complement insights derived through the process of working as an adaptive theorist, Layder's Theory of social domains was incorporated as a heuristic to guide my research analysis and in the composition of the qualitative case studies used to portray my empirical findings. Viewing social reality through the lens of these four social domains illuminated different facets of the common

social reality I was exploring and provided ontological depth to my analysis by explicating objective, intersubjective and subjective features. As such, the Theory of social domains views social reality through the filter of four domains:

- contextual resources: this domain is viewed as the outermost encompassing feature of social reality. This domain considers matters related to the distribution of material resources and the historical accumulation of cultural resources, such as knowledge, social mores and values;
- social settings: this domain mediates between subjective and objective elements of social reality and displays aggregations of reproduced social relations, positions and practice which embody systemic [structural] aspects of social life. In this research, the social setting domain represents the respective, policy jurisdictions;
- situated activity: this domain is distinguished by the arrival and departure of people in face-to-face interactions and their social [intersubjective] exchanges. This domain has a formative influence on meaning-making - given that meaning is also created and influenced by contextual factors and psychobiography. In this research, this social domain marks the arrival and departure of the citizens from their respective mini-public;
- psychobiography: this domain reflects an individual's unique self-identity in the context of their life experiences and social connections. It also identifies an individual's passage through time and space in the social world demonstrating how they have responded to the tensions of the dialectic of separateness and relatedness of all social life (Layder, 2006, pp. 272 -301). In this research, the psychobiographical domain is portrayed through the participant narratives, as well as the boxed-entries titled, Participant portraits [similar to small vignettes] compiled from information provided by each interviewee (Layder, 1998, 2006, 2013).

This brief overview is not intended to imply that phenomena can be isolated and fully-compartmentalised within any one of the four stated domains; on the contrary, these social domains were shown to be intimately interlinked and to comprise a complex and multi-dimensional whole. With the nuanced and holistic view of social reality thus obtained, revealing the combined effects of the different manifestations of power expressed within the various social domains, enabling the conceptual overview of findings, given in Figure 1, to be defined (Layder, 2006).

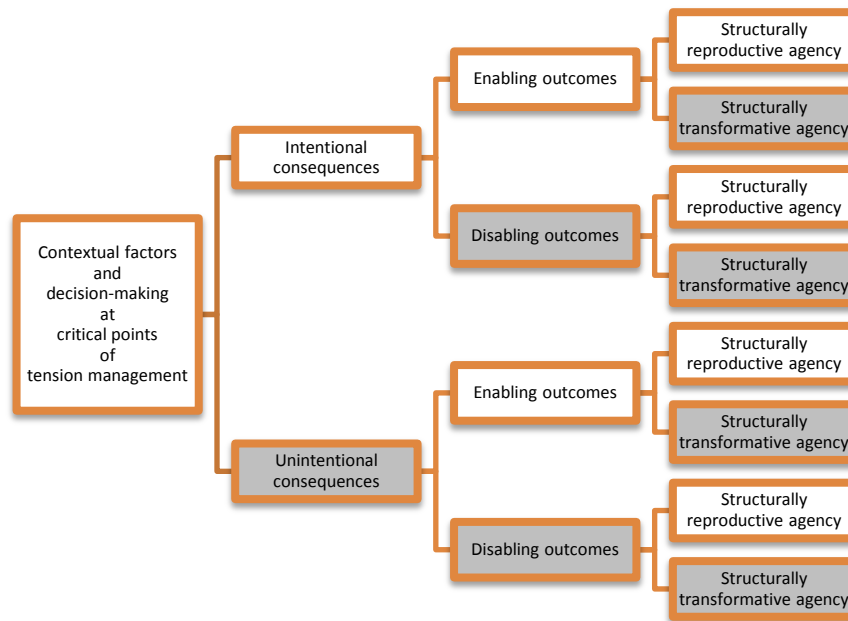


Figure 1: Conceptual model of the various trajectories found throughout the research findings

A conceptual model of research findings

This conceptual model outlines the various trajectories found throughout the research findings. Specifically, it focuses attention on the pathway between contextual factors and decisions taken by certain health policy administrators at critical points of tension management, and the intentional and/or unintentional, enabling and/or disabling consequences for citizens' experiences of deliberating and exchanging knowledge when mini-publics are applied to health policy settings. Viewed from the vantage-point obtained by these citizens' experiences, I describe to the decision-making power expressed within the critical points of tension management examined, as manifestations of either structurally reproductive agency: where the recreation of existing structures, including bodies of knowledge, was apparent and the status quo far more likely to be maintained; or structurally transformative agency: where the opportunity for making a structural difference, including to bodies of knowledge, was enabled. As it transpired, the predominant path taken by the health policy administrators examined in this research was that of the 'unintentional' trajectory with 'disabling outcomes' for the citizens' experiences of exchanging knowledge and expressing their deliberative capacities, as expressions of 'structurally reproductive agency'. With the confluence of these and other research findings, casting doubt upon the validity of any claims that can be made of the democratic authenticity and legitimacy of mini-publics when applied in health policy settings under such circumstances.

Investigating what ‘really happens’ regarding any particular phenomenon does not simply need to be about explanation, however; ‘it can aid meritorious conduct too’ (Dowding, 2004, p. 141). Indeed, the purpose of the conceptual overview provided in Figure 1 is not simply to direct attention to the decision-making outcomes from critical points of tension management - as important as doing that is. It is also designed to encourage critical reflection on the contextual factors that contribute to relevant decision-making within these inherently opaque decision-making processes, as well as the ethical and political dimensions associated with the intended and unintended consequences of certain decision-making when mini-publics are applied in health policy setting.

Concluding comments

With these points in mind, and by way of concluding this brief paper, I will exemplify how the critical edge to my realist position encouraged me to transform certain unintentionally disabling factors found – essentially, using them in an inversely-instructive way - to formulate five propositions. Space precludes an elaboration of these propositions but I will point out that they are designed to promote an intentionally enabling approach to the use of mini-publics in health policy settings by creating a more democratically deliberative environment whereby epistemic justice (Fricker, 2007) and deliberative capacity can flourish: institutionally, collectively, and individually.

Proposition One: Expanding the view of health policy administrators’ responsibilities

An explicit and expanded understanding of what health policy administrators’ responsibilities entail is required when mini-publics are applied to health policy settings. This includes a requirement that health policy administrators take active steps towards understanding and exercising their epistemic responsibilities in relation to the norms of democratic deliberation, so that these norms become their critical guide when operationalising mini-publics.

Proposition Two: Develop a communicatively rational approach

An explicit communicative rationality is required when health policy administrators apply mini-publics. This requires the development of an intersubjective approach to their communicative competence to facilitate an understanding of the ways that communicative irrationality can disable the democratically deliberative nature of a mini-public. This communicative rationality is to have epistemic justice at its core, with structures in place to help correct any epistemic injustices (Fricker, 2007) identified.

Proposition Three: Substantive equality to be used as a guiding deliberative norm

That the principle of substantive equality is used to guide development of the requisite and more equitable opportunities that enable citizens to exchange knowledge and deliberate when mini-publics are used in health policy settings.

Proposition Four: Mini-publics are a public service

To counter the prevailing product-dominant logic (see, for instance, Osborne, 2010; Osborne & Brown, 2011; Osborne, Radnor & Nasi, 2013; Osborne & Strokosch, 2013) an active reframing of the way health policy administrators approach mini-publics is required so that their approach to mini-publics is more akin to it being a public ‘service’ than a ‘product’.

Proposition Five: Mini-publics warrant further research and development

That a structured process of longitudinal research into the use of mini-publics on matters related to health and wellbeing is established.

References

- Althaus, C., Bridgman, P. & Davis, G. 2007. *The Australian policy handbook*. 4th Edn. Crows Nest, Sydney. Allen & Unwin.
- Baum, F. 2002. *The new public health*. 2nd Edn. South Melbourne. Oxford University Press.
- Baum, F. 2008. *The new public health*. 3rd Edn. South Melbourne. Oxford University Press.
- Benhabib, S. (ed.) 1996. *Democracy and difference: Contesting the boundaries of the political*. Princeton, New Jersey. Princeton University Press.
- Bhaskar, R. A. 1975. *A realist theory of science*. Leeds, United Kingdom. Leeds Books.
- Bovaird, T. 2007. Beyond engagement and participation: User and community coproduction of public services. In *Public Administration Review*. 67: 5: 846-860.
- Carspecken, P. F. 1996. *Critical ethnography in educational research: A theoretical and practical guide*. New York. Routledge.
- Chambers, S. 2003. Deliberative democratic theory. In *Annual Review of Political Science*. 6: 1: 307-326.
- Cohen, J. 1998. Democracy and liberty. In Elster, J. (ed.) *Deliberative democracy*. Cambridge, United Kingdom. Cambridge University Press.
- Deeble, J. Year. Reflections on health reform debate. In *At the Health Care Reform and Policy Implementation: Cranford Policy Forum*. 6 July 2010. Australian National University.
- Denzin, N. K. 1978. *The research act: A theoretical introduction to sociological methods*. 2nd Edn. New York. McGraw-Hill.
- Denzin, N. K. & Lincoln, Y. S. (eds.) 2000. *The handbook of qualitative research*. 2nd Edn. Thousand Oaks, California. Sage.
- Dowding, K. 2004. Interpretation, truth and investigation: Comments on Bevir and Rhodes. In *The British Journal of Politics & International Relations*. 6: 129-164.
- Dryzek, J. S. 1990. *Discursive democracy: Politics, policy, and political science*. New York. Cambridge University Press.
- Dryzek, J. S. 2000. *Deliberative democracy and beyond: Liberals, critics, contestations*. Oxford. Oxford University Press.
- Dugdale, P. 2008. *Doing health policy in Australia*. Crows Nest, Sydney. Allen & Unwin.
- Dunston, R., Lee, A., Boud, D., Brodie, P. & Chiarella, M. 2009. Co-production and health system reform - from re-imagining to re-making. In *Australian Journal of Public Administration*. 68: 1: 39-52.

- Edwards, M. 2001. Participatory governance into the future: Roles of the government and community sectors. In *Australian Journal of Public Administration*. 60: 3: 78-88.
- Fricker, M. 2007. *Epistemic injustice: Power and the ethics of knowing*. New York. Oxford University Press.
- George, A. L. & Bennett, A. 2005. *Case studies and theory development in the social sciences*. Cambridge, Massachusetts. Belfer Center for Science and International Affairs, Harvard University.
- Germov, J. (ed.) 2005. *Second opinion: An introduction to health sociology*. 3rd Edn. Melbourne. Oxford University Press.
- Giddens, A. 1976. *New rules of sociological method*. London. Hutchinson.
- Giddens, A. 1993. *New rules of sociological method*. 2nd Edn. Stanford, California. Stanford University Press.
- Gutmann, A. & Thompson, D. 1996. *Democracy and disagreement*. Cambridge, MA. The Belknap Press.
- Hays, S. 1994. Structure and Agency and the Sticky Problem of Culture. In *Sociological Theory*. 12: 1: 57-72.
- Hendriks, C. M. 2011. *The politics of public deliberation: Citizen engagement and interest advocacy*. New York. Palgrave Macmillan.
- Laing, R. D. 1960. *The divided self: A study of sanity and madness*. London. Tavistock Publications.
- Layder, D. 1985. Power, structure and agency. In *Journal for the Theory of Social Behaviour*. 15: 2: 131-149.
- Layder, D. 1990. *The realist image in social science*. London. Macmillan.
- Layder, D. 1993. *New strategies in social research*. Cambridge. Polity Press.
- Layder, D. 1998. *Sociological practice: Linking theory and social research*. London. Sage.
- Layder, D. 2006. *Understanding social theory*. 2nd Edn. London. Sage.
- Layder, D. 2013. *Doing excellent small-scale research*. London. Sage.
- Lin, V. 2003. Competing rationalities: Evidence-based health policy? In Lin, V. & Gibson, B. J. (eds.) *Evidence-based health policy: Problems and possibilities*. South Melbourne. Oxford University Press.
- Lin, V. & Gibson, B. J. (eds.) 2003. *Evidence-based health policy: Problems & possibilities*. Melbourne. Oxford University Press.
- Miles, M. B. & Huberman, A. M. 1994. *Qualitative data analysis: An expanded sourcebook*. 2nd Edn. Newbury Park, California. Sage.
- National Health and Hospital Reform Commission. 2009. *A healthier future for all Australians: Final report*. Canberra. Commonwealth of Australia. Available: <http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-report>.
- Osborne, S. P. 2010. Delivering Public Services: Time for a new theory? In *Public Management Review*. 12: 1: 1-10.
- Osborne, S. P. & Brown, L. 2011. Innovation, public policy and public services delivery in the UK. The word that would be king? In *Public Administration*. 89: 4: 1335-1350.
- Osborne, S. P., Radnor, Z. & Nasi, G. 2013. A new theory for Public Service management? Toward a (Public) Service-Dominant Approach. In *The American Review of Public Administration*. 43: 2: 135-158.
- Osborne, S. P. & Strokosch, K. 2013. It takes two to tango? Understanding the co-production of public services by integrating the services management and public administration perspectives. In *British Journal of Management*. 24: S31-S47.
- Parkinson, J. 2004. Why deliberate? The encounter between deliberation and new public managers. In *Public Administration*. 82: 2: 377-395.
- Parkinson, J. 2006. *Deliberating in the real world: Problems of legitimacy in deliberative democracy*. Oxford. Oxford University Press.
- Patton, M. Q. 2002. *Qualitative research and evaluation methods*. 3rd Edn. California. Sage Publications.

- Richards, L. 2005. *Handling qualitative data: A practical guide*. London. Sage.
- Sax, S. 1984. *A strife of interests: Politics and policies in Australian health services*. Sydney. Allen & Unwin.
- Schön, D. A. 1971. *Beyond the stable state*. Toronto. Norton Library.
- Schwartz-Shea, P. & Yanow, D. 2012. *Interpretive research design: Concepts and processes*. New York. Routledge.
- Sindall, C. 2003. Health policy and normative analysis: Ethics, evidence and politics. In Lin, V. & Gibson, B. J. (eds.) *Evidence-based health policy: Problems and possibilities*. South Melbourne. Oxford University Press.
- Smith, G. 2005. *Power beyond the ballot: 57 democratic innovations from around the world*. London. The Power Inquiry.
- Turner, J. H. 1988. *A theory of social interaction*. Stanford, California. Stanford University Press.
- Wade, S. O. 2004. Using intentional, values-based dialogue to engage complex public policy conflicts. In *Conflict Resolution Quarterly*. 21: 3: 361-379.
- Walker, P. 2002. Co-production. In Mayo, E. & Moore, H. (eds.) *Building the mutual state: Findings from the virtual thinktank*. London. New Economics Foundation and Mutuo.
- World Health Organization (WHO). 2007. *People at the centre of health care: Harmonizing mind and body, people and systems*. WHO. Available:
<http://www.wpro.who.int/NR/rdonlyres/80F000DD-F2B7-4027-B676-EC3840AF5A16/0/PEOPLEATTHECENTREOFHEALTHCAREBook.pdf>.
- Young, I. M. 2013. *Responsibility for justice*. New York. Oxford University Press.