WHY DELIBERATE?
THE ENCOUNTER BETWEEN DELIBERATION AND NEW PUBLIC MANAGERS

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Introduction

Along with local government (Lowndes, Pratchett, and Stoker 2001), Britain's
National Health Service (NHS) has been leading a dramatic period of state-supported
experimentation with processes that involve citizens directly in public decision
making. Public input generally is supposed to lead to greater effectiveness (NHS
Management Executive 1992, 1), and is supposed to be good in its own right, giving
citizens a direct voice in matters that concern the fair distribution of vital resources
like health care (Coote 1997; Lenaghan 1999, 47).

Among the processes tried over the last decade are so-called "deliberative"
techniques. Unlike more research-based models of citizen engagement that seek to
elicit people's preferences "as they are", these models systematically inform their
participants about the issue at hand. Policy questions are put to a group of citizens
who are given information, listen to arguments, debate the issues and come to
recommendations — as a result they tend to be expensive in time and effort, but
rewarding in the sense that a considered opinion emerges rather than a knee-jerk
reaction. The claimed benefit is an improved democracy, both by developing more
active, engaged citizens; and by making better decisions through broader, higher
quality inputs (Stewart, Kendall, and Coote 1994, iii). Estimates to date are that more
than 200 of one such technique, citizens' juries, have now been run in the UK, at least
half on health topics, while NHS managers have experimented with numerous other
consultative processes embodying deliberative principles to one degree or another.

However, it was not inevitable that deliberative processes would be taken up in the
way they have been. We know from policy studies over the last two decades that

political practices constitute solutions to problems, problems which are rhetorically constructed (Fischer and Forester 1993, 6; Kingdon 1984, 115). Particular solutions are successful only to the degree that they are — or can be made to be — consonant with dominant discourses, consonant with the particular values and understandings of the world that are embodied in those discourses (Hajer 1993, 46; Schon and Rein 1994). Furthermore, we know that institutions have a powerful impact on political ideas (Norris 1997; Peters 1999), so it is not at all likely that deliberative techniques have been imported "pure" into an environment which has features quite antithetical to deliberative democratic ideals.

There is a small literature on the use of deliberative techniques in health, but that literature has been dominated by comparison or advocacy — how a given practice embodies deliberative democratic principles — and relatively limited instrumental criticism of particular techniques: see, for example, Barnes (1999), Bowie, Richardson and Sykes (1995), Dolan, Cookson and Ferguson (1999), Lenaghan, New and Mitchell (1996); Lenaghan (1999), Mullen (2000). In addition there are historical analyses of the rise of citizen participation initiatives more generally (Klein 2000), and a small number that discuss the links between public management imperatives and citizen involvement initiatives: Harrison and Mort (1998); Milewa, Valentine and Calnan (1998); Rowe and Shepherd (2002), and Shackley and Ryan (1994), for example.

In this paper, I offer an explanation for the interest in particularly deliberative processes in the NHS both by comparing deliberative principles with imperatives in public management discourse, and by examining the motivations behind three cases: two citizens' juries (Crosby 1998; Dienel and Renn 1995); and the development of *The NHS Plan*, a white paper released in July 2000 (Secretary of State for Health 2000b). My research is partly based on the qualitative analysis of secondary documents, partly on the analysis of 26 interviews conducted between May and July 2001 with health policy actors involved either directly in the cases or in patient and public involvement initiatives more generally. The interviewees broke down into groups as shown in Table 1:

Table 1: Interviewees by role

	NHS manager	Politician	Event manager	Interest Group	Witness	Media	Other observer
Belfast CJ	II		II	I	I		II
Leicester CJ	II	II	I	I	I	I	
NHS Plan	III	I	I	II	n/a		III

The interviews were unstructured to minimise the degree to which my own language, categories and pre-conceptions determined responses (Jorgenson 1991, 211). Interviewees' own terms were used to construct the codes used in subsequent analysis (Coffey and Atkinson 1996). This approach is particularly useful in answering "why"-type questions: it allows the researcher to peer beneath the labels applied to political practices and identify mismatches between those labels and the actual behaviour of political actors. Its limitation, of course, is that it does not allow generalisation beyond what Yin (1984) calls "analytic" generalisation, so this is cannot be taken as a comprehensive evaluation of the British government's programme. Nevertheless, it is useful in identifying patterns of discourse that pervade a policy community, so it is more than likely that their influence extends beyond the cases mentioned here.

I start by defining deliberative democracy before setting out some of the features of the ever-evolving public management discourse in Britain, highlighting the links between them. I then go into more depth in the three cases to identify the main reasons why deliberation was used. I conclude by highlighting the gaps between the ideal and the real, showing what has been gained and what has been lost in the encounter between deliberative democracy and new public managers.

Deliberative democracy

Just as democracy is a contested concept, so deliberative democracy means many things to different theorists, so it is worth spending a moment specifying what I see as

the common elements of deliberative democracy to give some reference point for the discussion that follows.

In its normative version, deliberative democracy is based on two principles: it insists on *reasoning* between people as the guiding political procedure, rather than bargaining between competing interests; and the essential political act — the giving, weighing, acceptance or rejection of reasons — is a *public* act, as opposed to the purely private act of voting. Thus democracy is conceived of less as a market for the exchange of private preferences, more as a forum for the creation of public agreements (Elster 1997), a forum in which, ideally, "no force except that of the better argument is exercised" (Habermas 1975, 108). To ensure that public reason and not private power dominates public discussion, deliberative democracy requires equality between participants, as do other versions of democracy (Beetham 1994, 28; Dahl 1989, 1). This means that the franchise should be inclusive, that agreements be decisive, that participants agree to reciprocity in their discussions (Gutmann and Thompson 1996), giving each other equal speaking time, and equality of enforcement power. Under such conditions, people's arguments for and against certain views must be made in public if they are to persuade others, and so can be examined and challenged by those others. Preferences which may be more or less vague, unreflective, ill-informed and private, are transformed into more firm, reflective, informed and other-regarding ones through the deliberative encounter (Cohen 1989). Thus, deliberative democracy is a highly rationalist ideal of democracy, a reaction to the apparent irrationality of processes based on bargaining and strategy.

In its real-world approximations, deliberative democracy comes in two versions, what Hendriks (2002) has called the "micro" and the "macro". The micro version concerns small, self-contained forums like citizens' juries (Crosby 1998; Dienel and Renn 1995), deliberative polls (Fishkin 1997), consensus conferences (Joss and Durant 1995), even deliberation within parliaments (Bessette 1980; Uhr 1998) and supreme courts (Rawls 1997), all of which have been said to embody deliberative democratic principles, some with more justification than others. The macro version concerns the wider public sphere (Habermas 1996), the ebb and flow of public debate carried on in the media, in private conversations, in formal and informal settings (Mansbridge 1999), from pubs to parliaments and back again. It is the competent, reflective control

of such debate by its participants, combined with governmental responsiveness to its ever-evolving outcomes, that Dryzek calls "discursive democracy". He reserves the "deliberative" term for those micro-level practices which are simply a "bolt-on" to liberal institutions rather than a fundamentally different conception of democracy (Dryzek 2000).

It should be emphasised that there can be a greater or lesser degree of "fit" between the micro-level techniques and deliberative democratic ideals. Particularly relevant for this discussion is the point that micro techniques are "public" in only a limited sense. The arguments that get made and are found persuasive *within* a given forum do not get transmitted easily *outside* that forum, leaving non-participants' preferences relatively untouched by the deliberative process (Parkinson 2003b), while from a franchise point of view the numbers involved are very limited. That is, they may be deliberative, but not terribly democratic. This will turn out to be important when I come to assess the purposes to which deliberative processes have been put later on.

The origins of deliberative initiatives

The first answer to "why deliberation?" is an historical one. The drive to greater public involvement in the NHS extends back at least 30 years, during which time policy actors have worked with at least four distinct sets of tools: a corporatist approach, business models, market tools, and more recently deliberative methods. In this section I briefly sketch that history, drawing out the key features of the evolving policy discourse that persist today.

From the founding of the National Health Service in 1948 until 1974, the only real means of channelling public input into the NHS was via general practitioners (GPs), but that in itself was very limited, given the awe in which medical professionals were held. Health was professionalised to the extent that doctors mystified and controlled access to medical knowledge, so that people had nothing to contribute but their ailments (Harrison and Pollitt 1994; Moran 1999, 32, 67). While the governing boards of NHS institutions had some lay members, they "represented the elite of

available voluntary effort" rather than having any demographic commonality with the public at large (Hunter and Harrison 1997, 127, citing Charles Webster).

The first major change to this limited role was the creation of the Community Health Councils (CHCs) in 1974. Governed by a board made up of nominees of the relevant local authority, local voluntary associations and the Secretary of State for Health, the 186 CHCs were to act as watchdogs over the Health Authorities. However, the CHCs were created "almost by accident" (Klein and Lewis 1976, 1). Phillips (1980) suggests they were simply created in the image of the now-defunct nationalised industry watchdogs which, even then, were regarded as ineffective by most observers, although the CHCs did attract some supporters (Hallas 1976). Interviewees suggested that few people were aware of their existence; that they were extremely variable in their effectiveness; and that they tended to draw their staff and boards from a very limited pool. This meant that, like the NHS boards and other quangos (Barker 1982), the CHCs were unrepresentative of the wider population either in a descriptive or principal-agent sense. At the time of writing, the CHCs were to be abolished on 1 December 2003; their scrutiny functions are being handed over to local government, while their advocacy and complaint handling functions are being redistributed to a variety of new local bodies.

The next major transformation of public involvement in health was driven by the market and managerialist reforms of the 1980s and early 1990s. The key features of these reforms are well known (Gamble 1994), but essentially they were based on two major beliefs: a view of people as self-interested, individual consumers of goods and services rather than citizens working together for collective goals; and, related to that, a belief that actors in public agencies and interest groups would divert public resources for private gain rather than consumer benefit, unless suitably restrained. The preferred mechanism of restraint was the market: subject public services to competition and this will empower consumers who will flock to the best supplier, forcing out the inefficient and ineffective (Pollitt 1993, 5). Market forces were introduced to the NHS most dramatically in 1990 when an "internal market" was created such that health service providers were forced to compete with each other and private sector providers for contracts to provide services commissioned by the health

authorities. This created what was strictly a quasi-market, "involving choice by the purchasing agency rather than by the patient" (Harrison and Mort 1998, 62).

In order for an organisation to become a good supplier, however, it needs to know what consumers demand, and whether contracted targets have been met or not (Lane 1987). Thus, health agencies in the centre and periphery invested heavily in developing new needs assessment and measurement tools, drawing heavily on "total quality management" ideas taken from business settings (Besterfield et al. 1995; DHSS 1983), greatly increasing their management staff to handle the load of that and other changes. They conducted customer satisfaction surveys, designed standards and performance criteria, ranked providers according to how they met those criteria and published those rankings. This trend was strengthened by a fundamental feature of health services around the world: the fact that demand for health interventions, and medicine's technical ability to meet that demand, greatly outstrip resources available (Moran 1999). This has led to a global concern with health care rationing, also known as prioritisation. The failure of early attempts at priority setting to take full account of public values has led to greater interest in methods, including deliberative methods, of eliciting public values and making difficult trade-offs (Coulter and Ham 2000; Klein, Day, and Redmayne 1996; New 1997).

By the 1990s the focus was not purely on "consumers": the key 1992 document on involvement matters, *Local Voices*, recognised that citizens more generally had a legitimate interest in the way their health services operated, regardless of whether they were actual "users" of those services. However, in practice the bureaucracy still concentrated on health service user involvement, not public involvement. The purpose of this involvement was very much focused on *research* rather than *decision-making* (NHS Management Executive 1992, 5, 9). It was to research opinions, not to enhance collective decision-making; to control the efficiency and quality of services delivered to those users, not to question whether certain services should be delivered at all, or what proportion of state funds should go to health versus other portfolios (Pollitt 1993, 183-4). This is because, at root, public involvement initiatives were extensions of tools by which central government controlled local agencies, not tools for local people to control central government.

Since 1997, the Blair government's "modernisation agenda" has added some new doctrines to public management discourse, but left others in place. In public rhetoric at least, the preference for market discipline was replaced by a preference for direct public involvement both of "users" and "citizens". The internal market was abolished in name, to be replaced by initiatives that aimed to devolve power and work in "partnership" with local communities, although GPs still effectively act as purchasers choosing among competing providers, just not on the basis of price. The modernisation agenda is also, however, driven by a demand for uniform quality across the nation, enforced using performance measurement tools even more sophisticated than those developed in the 1980s. Thus there is a tension, always a feature of the NHS, between forces of central control and local empowerment (Driver and Martell 2000, 157; Klein 2000, 96, 208).

Given that history, there are some clear parallels between deliberative democratic ideals and key elements of current NHS management discourse. Most generally, they share an antipathy towards interest-based politics (Fischer 1990, 21; Stone 1988, 4). Public managers are focused on preventing the irrationality that is said to result from strategic games between conflicting interests; deliberative democracy promises a rationalised public in which people are forced to put aside sectional interest and consider the common good. Deliberation and the modernisation agenda have mutual, in-principle concerns with broadening decision making, although the official discourse tends to use the language of "local communities" rather than citizens more generally. This, as will be seen, has an impact on the scope of decisions being taken in these supposedly more democratic ways. More specifically, deliberation has the potential to help with priority setting. Public managers want better tools for understanding people's needs and values, both so they can provide services that are actually useful, and to help them make hard choices about which services to fund for which people (Mullen 2000). Deliberative processes allow people themselves to confront such choices directly rather than leaving the managers to guess.

Particular motivations

There are many instances in which deliberative principles have been applied to practical policy questions. In this section, I outline two such processes, and consider the particular motivations in each of my cases for choosing to run "deliberation" rather than the more general points of contact noted above.

One process that is said to fit the deliberative democratic ideal well is the citizens' jury (Hendriks 2002; Lenaghan, New, and Mitchell 1996; Smith and Wales 2000). Developed independently in the 1970s in the United States and Germany (where, taking a slightly different form, they are known as planning cells), the citizens' jury is designed to address policy problems. Evidence from "witnesses" from various sides of the issue is presented to a jury of lay people who deliberate and make recommendations based on the evidence, although the analogy with the legal jury should not be taken too far: there are no lawyers or judge, but a facilitator who directs proceedings; and juries can make many recommendations, not just binary choices. Nor is the jury selection strictly random: it is usually a quota sample of anywhere between 12 and 24 (16 seems to be common), with the quotas determined by age, gender, ethnicity and whatever other demographic variables might be important on a given issue. More than 200 citizens' juries have been run in the UK (although there is no definitive list), most commissioned by health and local authorities, facilitated by professional facilitators, and overseen by steering groups made up of the commissioning body and key stakeholders including, sometimes, a media representative. Citizens' juries were introduced to the UK health policy community in 1996 when the Institute of Public Policy Research (IPPR) and the King's Fund ran six pilots with five health authorities in England (McIver 1997). This followed a trial earlier in 1996 with five local authorities, sponsored by the Local Government Management Board and managed by the IPPR and the Institute of Local Government Research at the University of Birmingham (Hall and Stewart 1996).

The Belfast citizens' jury

The first case is a citizens' jury run by the IPPR in Belfast in 1998, jointly commissioned by the Eastern Health & Social Services Board (EHSSB), roughly the Northern Irish equivalent of an English health authority, and the Eastern Health & Social Services Council (EHSSC), the local equivalent of a CHC. Its focus was to help develop a response to a white paper entitled *The New NHS: Modern, Dependable* (Secretary of State for Health 1997) which set out the government's "modernisation" agenda for the NHS. Rather than go through the whole document, the organisers asked, "What are the advantages and disadvantages of a move to primary care groups, how can our concerns be met?" (IPPR 1998). In addition, they asked two very broad questions about values surround health and social services, and opinions on public involvement in health decision making, questions that elicited fairly broad responses (see Barnes 1999 for a detailed evaluation).

When one asks "why deliberate", the reason for the vague questions becomes a little more clear. This is because the substantive issues never seem to have been the main reason for deliberating in the first place. One interviewee at the EHSSB explained it this way:

> It was to see if there were other ways other than we had been using to talk to people. What were the pros and cons of a citizens' jury approach? And particularly because this was a policy which was going to restructure the whole of the health and social care, we were trying to get a way of looking at the citizen without representative groups representing the citizen. You know, what could you do with 'the citizen' rather than some proxy for citizen about policy areas in the health field? …We were wanting to see to what extent people taken off the street would have knowledge, interest, structured information, how one would have to present, how one would have to deal with presenting technical material to people who were not experienced in the field … It was a case of trying to find ways of talking to people about what their values were about these things in a situation where we weren't coming to threaten, so that we could develop the agenda along with them.

The suspicion of interest groups and the desire to elicit public values, discussed in the previous section, are evident in this explanation. Also of interest is the experimental,

research attitude. The jury took place just a few months after the signing of the Good Friday Agreement that re-established home rule for Northern Ireland, along with a comprehensive array of measures for consulting all of the province's "communities" on every major piece of policy administered by every one of the province's government agencies. In such an environment, there was intense public, media and bureaucratic interest in processes that were supposed to make such cross-community consultation possible without degenerating into confrontation. The jury was an experiment with a process that made just such a promise.

Why is the research orientation problematic? Firstly, it presents motivational difficulties. Because the aim is to gather information for use by other decision-makers, not hand over decision-making power, the participants can feel that they can only influence the relatively small task they have been given, not the wider problems facing the health service. This undermines the legitimacy of the process in their eyes. This was a view expressed to me by all three of the process facilitators I spoke to, although from reports this was not a particular problem for the Belfast jurors. Secondly, and perhaps more seriously, it undermines the democratic character of the process by reducing the participants to the status of objects rather than subjects (Schratz and Walker 1995), means to someone else's exercise of autonomy rather than an expression of their own. In such cases, citizens are making recommendations within boundaries that are quite narrow, boundaries that are determined at levels of power to which they do not have access. In practice, there may be good reasons for this to do with cross-cutting lines of accountability. Another EHSSB interviewee said that because the jury was not formally accountable to anyone else, they might "leave us to carry the can for a decision they made". This highlights one of the problems faced when implementing a process based on one account of legitimacy — that is, the direct involvement of the people affected — in a political system based on quite another, namely the delegation of power to public officials held accountable by elections or contracts.

A further reason emerging from the EHSSB's explanation is using a deliberative process to test arguments. This came up in another interview:

…you could say, use the jury as a testing ground. In order to satisfy the demands of the jury {the commissioners} have to think through their argument and present it to the jurors, get witnesses to present the different sides, plus the professionals involved, plus the managers, and the lay people, and the other stakeholders, having all those people involved on a particular question then gives it a thorough going over. You're then a lot clearer at the end of the process, and you're more aware of the legitimacy of the arguments. You then put that out to the population using public relations. But, instead of just presenting the minimum as you have in the past and waiting for responses, you will have a lot more information about why you came to that decision and then wait for response that way.

From a macro-deliberative perspective, this may be a useful function. It follows the public logic of the deliberative project, the idea that only those arguments that can be made and found persuasive in public should have any force. However, a citizens' jury is a somewhat expensive method of testing such arguments: at around £25,000 per jury one would imagine that only relatively high stakes arguments would be tested in such a way, rather than the myriad of lower stakes yet still publicly important decisions that public organisations make every year. One would need extra reasons beyond just argument-testing to justify the expense.

The Leicester citizens' jury

Because the question was so broad, the Belfast jury was not typical of the juries run on health topics in the UK. Perhaps more typical was the jury commissioned by the Leicestershire Health Authority to resolve a bitter public controversy. The issue was a health authority proposal to reconfigure services at Leicester's three main hospitals, the Leicester Royal Infirmary (LRI), Leicester General, and Glenfield. The authority felt that "planned care" services were suffering because acute care was taking up too many resources. Following four years of consultation and planning with hospital-based specialists and other medical interests, they proposed concentrating acute services at the LRI and the General and devoting Glenfield to planned care services. This would have involved moving existing acute services from Glenfield, but when the announcement was made in late 1999, a storm of protest erupted: the authority's planning approach had not taken into account the large investment people had in

Glenfield hospital. This was for several reasons, but the key was the fact that a heart unit and breast care services had recently been set up at Glenfield largely thanks to major public appeals for donations rather than direct government spending.

In response, a petition was organised by the heart and breast unit fundraisers that gathered at least 150,000 signatures; the media was mobilised; members of parliament and local councillors weighed in. In the face of the storm, the health authority tried to find some means of resolving the situation. The means chosen, thanks to prompting from local MP Patricia Hewitt, another former member of the IPPR, was a citizens' jury that met in March 2000. The jury accepted the case for a planned care site, but recommended that it be the General, not Glenfield, to the delight of the protestors. The recommendations were accepted, and a Private Finance and Investment (PFI) application was approved by the Department to allow capital work to begin. However, the 2002 NHS restructuring has seen the Leicestershire Health Authority merge with several others, which has slowed implementation of the plan.

Once again the Leicester case highlights the usefulness of a deliberative process in rationalising a debate that has become the polarised battle between competing interests. One of the health authority managers in charge of the process said this:

> You could look at it as being a way out for us in a particular messy situation….We almost got the point where there was an impasse…. It was the single biggest factor that freed up the next steps in the service review. I don't think, if we hadn't done that jury, we would not have got through. Well, we could have got through, we'd have got through, but with losing huge public confidence because it may have been in the end that we would have bowed to particular stakeholders, in other words those clinicians who shout the most.

One of the reasons the jury process allows this is because it confines activists to secondary roles, sitting on the steering groups that oversee the process and/or as witnesses. Those with expertise in a policy field do not get the chance to deliberate as such; they only get to offer their arguments to an audience of lay people who then go away and do the deliberating behind closed doors. This separation of lay participants and activists is seen to be crucial in cutting through polarised debate and reaching

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rational outcomes, but it can be frustrating for some of the expert participants in deliberative moments. One of the organisers of the Belfast jury felt this particularly keenly:

> You are a witness, you make a statement, to some extent you get cross-examined a bit, but you don't get an opinion as it were from the jury…. And therefore I found it a bit frustrating… They're doing the deliberation and they're doing among themselves and that is fine, but it's not the most normal human interaction because I would normally have an opportunity to say, "But I didn't actually mean that", or, "Where are you coming from on that?". In the normal course of events I would expect to transact with you for a bit longer until we came to some understanding, or I said, "Well, you can think that if you like and I think this".

A further issue is that such a role separation is based on a dichotomy between "ordinary people" and the knowledgeable that may not have much content on closer examination. Hogg and Williamson (2001, 3) remark that a "lay" person is defined negatively, "by what they are not and what they do not have", especially specialist training or personal experience by which they would "acquire new norms, assumptions, values and ways of behaving." They go on to say that,

> …the definition can seem to imply that as lay people become more knowledgeable and develop more understanding of the professions, health services and clinical issues, they lose their amateur status and, thus, their value. Like the wise fool of mythology lay people's innocence and naiveté are considered useful by professionals, managers and health service commentators. Knowledgeable individuals are considered unrepresentative of other lay people. In particular, activist members of voluntary lay groups are liable to be regarded as unrepresentative (atypical) and, therefore, unable to represent (voice) the views of their peers.
>
> Hogg and Williamson (2001, 4)

Given such a view of activists and lay people, it is hardly surprising that a particular kind of process based on random selection of lay citizens has received bureaucratic attention. However, from a deliberative democratic point of view, this is surely problematic. Deliberative democracy has been advanced as a model in which people who disagree can debate *with each other* — it is explicitly thus for Gutmann and

Thompson (1996, 346) and implicitly thus for Bohman and Rehg (1997, ix), Cohen (1989, 146), Elster (1998, 1) and Habermas (1996). Nowhere in deliberative theory is it put forward as a model in which political actors can present their case to *third parties* who then adjudicate. This reflects the public management discourse view that interest groups have hidden agendas, narrow interests and goals that they will pursue by acting strategically, acts that undermine the rationality of the deliberative process. The public managers involved in these processes were therefore attracted to a process that assigns those with such problems to a subsidiary role.

The great disadvantage of this strategy is that the active do not necessarily have *their* preferences transformed by such processes because they do not get to test them against the counter-arguments of their opponents. This is a pity not just for the activists themselves, but for the prospects of rationalising public deliberation at the macro level. There are good normative grounds for positively valuing the contribution interest groups make, particularly their deliberative facilitation role (see Christiano 1996; Mansbridge 1992). Given the need to "devote time, resources and energy to acquire knowledge" (Christiano 1996, 257), and given interest groups' ability to marshal such resources, groups have an important role providing the entire deliberative system with information that would not otherwise be available, facilitating debate between other interest groups, between citizens, and within the state. Placing those people in quarantine by assigning them a subsidiary role may be to the benefit of a particular micro-deliberative moment, but may be to the detriment of macro-deliberation.

The NHS Plan

The final set of issues is raised by my last case, the development of *The NHS Plan* (Secretary of State for Health 2000b). It is interesting for two reasons: its emphasis on putting public and patient involvement at the heart of the NHS, drawing specifically on deliberative principles in the design of the institutions it recommended; and the use of deliberative principles to create the plan in the first place. As I noted in the introduction, this paper is not a comprehensive evaluation of the government's programme, and I will be focusing on the plan's creation process rather than the institutions it recommended.

Following public policy models of how policy ideas gain currency in government, the emphasis on deliberation seems to be due to the presence of policy entrepreneurs advancing deliberative ideas at key points in central government (Hajer 1993, 46; Kingdon 1984, 189-93). According to several interviewees, the most important players seem to have been in the Department of Health's Strategy Unit that advised the then-Secretary of State, Alan Milburn, one of whom had been involved in the very first citizens' jury pilots in 1996. But the ideas fell on fertile ground: they fit well with the government's rhetoric of devolving power to communities, and were taken up with enthusiasm by Milburn.

The process had four main elements. The first was a series of age-based focus groups with patients to identify health needs for the next ten years. The second was two day-long public meetings with about 200 participants each, who were given presentations on the key policy problems facing the health service and asked to prioritise those problems. The third element was not obviously deliberative in itself, but had the broadest reach. In a highly publicised release, a postcard was sent to hospitals, GP surgeries, supermarkets and other retail outlets that asked, "What are the top three things which you think would make the NHS better for you and your family?", with space inviting further comment "on any aspect of NHS care" (Secretary of State for Health 2000a). The department received 151,999 replies from the public and 48,961 from staff, which is a low response rate given the salience of the issue in Britain at the time, despite assertions to the contrary from the department (DoH 2000). The responses were sorted into broad categories by department staff, with the public overwhelmingly wanting shorter waiting times and staff wanting improved facilities. All three of the public elements were then used as inputs into the fourth, a series of working groups made up of stakeholders from the various medical and nursing colleges, branches of the NHS, and patient advocacy groups. These groups worked on the detail of the plan and, as Modernisation Action Teams, continued to work on implementation issues well after the plan's launch.

Thus the process as a whole was deliberation in the macro sense, made up of a number of different micro processes. Of the four elements, three had clearly deliberative features in their own right. While the postcard was not deliberative in the

micro sense, it nonetheless fulfilled a useful macro-deliberative function, informing a much wider audience that the detailed deliberation was going on and giving them at least some input into that process.

It is in the case of the *NHS Plan* that we can see the final major motivation for deliberating: it is a technology of legitimisation (Harrison and Mort 1998). Take the postcard technique: its primary aim was not to get information from a sample of British households, although department staff expressed surprise at how useful they actually turned out to be in that regard. That job was done better by the focus groups and public meetings. The primary purpose of the postcards was to show the British people that something was being done, to make the whole process more "public" in a way that could not be achieved by micro-deliberative processes alone. So, even though the million households that received the cards were just a fraction of the 21 million households in England, Scotland and Wales, the publicity surrounding the cards ensured that the message "we're listening" was transmitted loud and clear. At the same time, it provided the Strategy Unit with a "user card" (Mort, Harrison, and Wistow 1996) it could play to discipline the stakeholder groups if that proved necessary.

The stakeholder groups were both better informed and more substantive, but legitimisation imperatives are also a feature here. They were what the department called an exercise in "big tent politics", bringing all the competing voices into one forum to thrash out a response together. While this was unsaid, it also had the benefit of making sure that potential critics were "inside the tent", binding people to the process and to the outcomes by involving them, by making them feel part of something unusual, something significant, something with power and the attention of the Secretary.

There was some criticism of the process. One interviewee described it as,

> …very crude as a process, I think. Very quick and dirty, there was no feedback mechanism necessarily. The man in the street, I don't think they really care, but if you were to take your more informed lay membership, people who feel they have a stake in the NHS, I don't know that it altogether satisfies their need to feel involved and listened to.

But even then it had the desired effect: one of the remarkable things I noted during my interviews was that there was almost no criticism of the aims or ideals of *The NHS Plan*. People in the health service were busy trying to figure out exactly how they were going to implement the changes; and while they felt some discomfort about the process and some of its elements, they were not spending their time criticising the vision. It was agreed to be a good thing.

However, the vast majority of deliberative processes in health have been run not by central government agencies but by health authorities which, along with other quangos, have been repeatedly criticised for their lack of accountability either directly to the people or, in many cases, to elected representatives (Barker 1982, 7). Harrison and Mort (1998, 67) suggest that it is this unauthorised, unaccountable status that has led health authorities to use citizens' juries and other tools to increase the degree to which they can claim responsiveness to the public.

The Leicester case is a clear example of this. The original decision to devote Glenfield Hospital to planned care services lacked legitimacy with the people subject to it both on substantive and procedural grounds: it did not accord with their views on Glenfield and was reached using a process that excluded their voices. Both were addressed by running the citizens' jury. However, I came across speculation that the jury was also used for legitimisation purposes aimed at the Department of Health, although only as a pleasant, unintended consequence, not as a result of intentional planning. According to one of the journalists who covered the event, the jury's decision allowed the health authority to put in a stronger, and eventually successful, bid for PFI funding than a Glenfield-based proposal would have allowed. Upgrading the old and somewhat dilapidated General was a stronger proposition. The journalist wondered whether it was not just the outcome, however, that made the bid stronger, but the process as well, since it allowed the health authority to go to the Department of Health and say, "This is the will of people, and we know that because we've used a good process, a process you recommend."

The remark "we've used a good process" suggests another possible angle on the legitimisation imperative: that battles over public policy and political influence are in

part a matter of whether or not one used a good decision technology or not. This seems to have been the case in the Leicester example, in which the battle to have a decisive voice was at least in part a battle between different methods of getting at public opinion: the initial stake-holder consultations, the variously-appointed spokespeople for different interests in the debate, the petition, the CHC, and the citizens' jury itself, claims that have various strengths and weaknesses (Parkinson 2003a). The important point is that all the other technologies were trumped by the citizens' jury for which more legitimisation claims could be made: the rigour of its design, high-level political support from one of the Health Ministers, local MPs and councillors, the fact that it used ordinary citizens who became informed about the issues, and the attempt to include all sides of the argument. While I have no direct evidence that this is true, the fact that such a technology contest occurred in this case suggests it may be possible that public officials, when presented with competing claims in a policy argument, take more seriously those whose argument is based on a more sophisticated technology than a lesser one. This is a question that needs to be taken up in future research.

Conclusion

What, then, has been discovered about why deliberative techniques have been taken up in the NHS? I have identified three general reasons by comparing deliberative democratic principles with key elements of management discourse in the NHS; two more general reasons emerging from the case studies; and three case-specific reasons.

The five general reasons are deliberative processes' rationalising promise; their concern with involving ordinary citizens directly in local decision making; their potential usefulness in making difficult rationing decisions; the presence of deliberation advocates at key points in the policy community; and their legitimisation benefits. The three case-specific reasons are their usefulness in researching ordinary citizens' capacity to grapple with public policy problems; to test out arguments at the micro level before they are made at the macro level; and to cut through a polarised public debate.

The analysis has, however, revealed two important gaps between the normative version of deliberative democracy and the way it has been used by public managers in the NHS. Firstly, the collision between the deliberative concern for rationality and the public management construction of that concern has meant that there is a preference for separating "ordinary people" from the knowledgeable in deliberative processes. The ideal of the active, engaged citizen — one of the primary motivations for introducing deliberative processes in the first place — has vanished, to be replaced by the ideal of the "wise fool", as Hogg and Williamson (2001) put it. This means that, while the rationality of a given micro-deliberative moment may be enhanced in cases where the active have backed themselves into corners, the opportunity to rationalise the macro-deliberative environment is diminished. This is simply because the active, who perform a vital facilitation role in that environment, do not have *their* preferences transformed by the citizens' jury or other such micro-deliberative processes.

The second gap is that the democratic elements of deliberative democracy have been diminished. While one case featured the use of deliberative principles in a central agency, the vast majority of cases — and all the rigorously deliberative ones — have been used by local agencies on questions of fairly limited scope. Thus people find themselves deliberating about topics that are constrained by larger forces over which they have no control. Furthermore, the random selection of participants means there are no formal representative bonds between them and non-participants, meaning that the vast majority of those affected by a deliberative moment have no way of holding participants accountable, except very indirectly. Given that limited accountability, micro deliberations are restricted to delivering recommendations, not decisions, and so show little of the popular control necessary to make an event democratic (Beetham 1994; Dryzek 1996) even for their small number of lay participants, let alone those citizens on the sidelines.

Given these observations, it is doubtful whether one could successfully claim that deliberative democracy is being implemented in UK health policy: some partially deliberative *techniques*, yes; but not deliberative *democracy*.

Acknowledgements

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