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Publics, Patients, Citizens, Consumers? Power and decision making in Primary Care

This article uses theoretical approaches to the discussion of power to consider the role of public and patient participation in Primary Care organisations in the UK. There is considerable evidence to suggest that, despite major national initiatives to extend participation in health services, its role in decision-making remains under-developed. The primary purpose of this article is to understand how and why this should be the case. Using findings from qualitative research that explored approaches taken by the dominant professional groups on Primary Care Groups (PCGs) to involving patients and the public, we consider how these approaches reflect the exercise of different forms and levels of power. The explanation combines Lukes' categorisation of three forms of power with Bourdieu's dynamic conceptualisation of the relations of habitus and field. It is argued that the models observed represent different opportunities for the operation of power with implications consequences for the role that participation can play.

Introduction

Successive Governments in the UK have expressed their intention to involve patients and the public more extensively in decision making about health services, although the nature and extent of intended involvement varies (DOH 2001, 2003, NHS Management Executive 1992). Despite the body of guidance from central government, there is considerable room for local discretion, particularly about the methods used. In consequence, the approach taken to involvement and its particular local manifestation varies widely (Milewa, Dowswell and Harrison, 2002). A recent review concluded that there had been little real progress in extending involvement (Farrell, 2004). One explanation for this could be that the true purpose lies in its symbolic meaning rather than

any real intended impact on relations (Hood ref). Our research suggested that this explanation was not sufficient. We identified genuine interest in the role participation could play (authors 2002). Here we want to explore the question by considering how issues of legitimacy and power manifest themselves in the action taken by the newly created Primary Care organisations to involving patients and the public. The argument of this article is that to understand participation we need to go beyond the empirical account to explore, theoretically, the relationship between the roles of stakeholders and the differing claims to knowledge and legitimacy, within which struggles for power are conducted.

Lukes formulation of power and its operation in the dynamic relations between habitus and field (Bourdieu, 1977) are employed to analyse how participation is understood and how far it shapes decision-making in health services.

Primary Care organisations provide a useful context for the study of participation because they combine novelty of organisational form with existing histories of involvement (Klein and New 1998, Barnes 1997). These organisations became operational in 2000 and were designed to solve the problems of inequity created through General Practitioner (GP) fundholding. The Primary Care Group (PCG) and subsequently, Primary Care Trusts (PCTs) brought together professionals and lay people to develop services for the locality. They signalled some degree of reorientation from medical to social models. Although dominated by GP members, boards included representatives from social services and the lay public to broaden the social perspective. The fieldwork discussed here focuses on the early experience of primary care organisations and their orientation to

involvement. The contribution this article seeks to make, however, is not primarily empirical. The relevance of the analysis is based on its usefulness beyond the specific context of organisational constitution. Since the fieldwork was completed the transition to Primary Care Trust status has brought about a changed composition of board membership, increasing the size of lay membership. We will argue however, that we can learn more through understanding the rival claims to legitimacy that members rely on than by counting the balance of interests represented. It is widely acknowledged that lay membership, of itself, does not guarantee representativeness of wider groups of patients and the public. Further, power struggles between professionals and managerial employees of the health service have been well documented. Indeed, research has shown that these groups have sought to colonise the voices of publics and patients (Mort and Harrison, 1999). Our research focuses on the level of the board because the relationship it establishes with the public is emergent from a combination of these conflicts, policy expectations and more straightforward participatory objectives. Despite continuing internal struggle boards are required to involve the population in decision-making about service planning and delivery precisely because the legitimacy of interests from outside NHS organisations has been recognised. We need to explore contested claims a to legitimacy at this level to understand how participation is being effected or made redundant.

The requirement for boards seek to involve patients and the public raises the question of how they, as initiators and users of the products of involvement, conceive of those they involve. On what basis should participants have a voice in decision-making and what role should those voices play? To explore these issues it is important to recognise that

individuals may occupy different roles in health services, those of the public, patient, consumer and citizen. Each implies different bases of legitimacy with consequences for structures for participation and their impact on decision-making processes.

Bases of legitimacy: Consumer or Citizen, Patients and Public

The notion of the consumer identifies a relationship between individuals and their services, primarily with rights of exit supported by limited rights of voice. Consumers speak with the authority of having used, or being prospective users of, services and therefore with a legitimate interest in provision on a personal basis. Apart from the right to be heard, consumers have the right to exit or to choose an alternative service. The difficulties involved in exercising these rights in relation to welfare goods, have long been recognised (Potter 1998, Titmus, 1976, Hambleton, 1988). By contrast, the role of citizen is based on the legitimacy of legal, political and social membership of the community. Here the legitimacy implies involvement as part of a collective, defining priorities in the interests of the wider community. Citizen involvement is based on democratic principles and the aim of involvement stretches beyond consumerist notions of individual satisfaction to ensure responsiveness and accountability for the use of public resources.

The two concepts suggest different answers to questions about the influence that stakeholders should have. While consumers should be listened to, those in power quite properly weigh such individualised perspectives against the good of the community as a whole. The good of the whole population, conversely, is the precise basis for legitimacy

in the citizen involvement model and, consequently, professional interests can no longer claim exclusive rights to represent that view.

Neither consumer nor citizen can automatically claim expert status within health contexts and the voices of medical professionals and managers within the NHS have generally prevailed. This has to be understood as both historical background, and as an expression of a current set of competing interests. Introducing the concept of citizenship however, implies a necessary redefinition in the relative power to be exercised by public, professionals and managers.

The divide between patients and the public is less clear in so far as these are overlapping statuses. Patients can speak with authority drawn from experience of service, the contribution of the public is more difficult to identify on this ground. The tendency therefore to align the public with citizenship and patient with consumer status is understandable. Such elision needs to be resisted in the interests of understanding legitimacy.

Evidence for these bases of legitimacy can be found in government guidance. The citizenship agenda is stressed in Cabinet office (2000) and Department of Health guidance. The latter urged PCG/Ts to work with local communities, 'to develop shared goals and aims for improving health and well-being (1998:21). The NHS plan describes, 'fundamental reforms which will bring patients and citizens into decision making at every level.... It will enhance and encourage the involvement of the citizen in redesigning the health service from the patient's point of view' (Dept of Health, 2000:95).

The roles envisaged for "patients and citizens" in these documents are ill-defined and the terms are often used as though they were interchangeable. The scope for involvement in services is generally described in more limited and technical terms than those suggested above. Yet these different bases for legitimacy have significant implications for the degree to which professionals should retain control of decision-making or yield control to patients and/or the public.

Power and forms of capital

Two (generally implicit) conceptions of power are relevant. A variable model, as proposed by Parsons (1986) suggests that increasing the power held by some does not inevitably mean wresting power from others. This approach is consistent with the view that professionals can improve participation by building capacity and developing social capital, based in existing community networks (Putnam, 1995). Alternatively, Weber (1986), sees power as a finite resource which can only be gained by one group at the expense of another, with the implication that, for participation to be effective, power must be redistributed.

The approach adopted in this article is to combine insights into power relationships offered by Lukes and Bourdieu. It situates relationships between habitus, capital and field and in articulation with Lukes' (1974, 1986) three dimensions of power to provide a means to analyse these forms in a dynamic way. It recognizes the danger of thinking of power, 'as something, rather than as a property of relations' (p164, Clegg 2002) and seeks rather to base an 'analysis of power on the study of techniques and tactics of

domination' (Foucault p237, 1986). In taking this approach we resist the view of Lukes (particularly third) form of power as subject to a 'form of supreme sovereign will (Clegg, p4, 1989) and instead interpret it in a realist frame which recognises both the shaping reality of the material world and the role of consciousness and action. Bourdieu's approach is expressly intended to achieve this understanding.- I'M NOT SURE ABOUT THIS- I WORRY WE RISK A VERY SUPERFICIAL TREATMENT OF FOUCAULT BY NODDING IN HIS DIRECTION HERE- BUT WE REALLY DON'T HAVE THE SPACE TO WORK ON IT PROPERLY- what do you think?)

Lukes' (1974) three-dimensional analysis offers valuable insights into the forms which power takes. It includes; the most obvious form of power as force or domination, exercised when there is a conflict of interests; power which relies on dominant values and beliefs in limiting the agenda to ensure that only relatively 'safe" issues' are discussed, and: power inherent in the 'bias of the system' which encompasses the culture underpinning the behaviour of groups and institutions. This third face of power can be expressed, both through collective action that is manifest in individual behaviour, and through the more impersonal, accepted social patterns.

Lukes typology of power is reflected in dynamic form in Bourdieu's formulation of habitus and field. Bourdieu (1989) introduces the notions of habitus and field of power to identify the relationship between actors and the structures they at times work within, and at times resist or struggle to change. Habitus is primarily the set of pre-conscious actions through which daily living is conducted. It permits the actor to work in routine ways in a field without always choosing their actions. Thus, we may carry out habitual actions and

work according to accepted cultural values in a way that does not entail conscious thought and evaluation. The concept is rescued form becoming overly determinist by recognising the potential for habitus to become conscious, subject to reflexive human agency. A specific habitus is developed in relation to the conditions and contingencies of the particular field and the two must, therefore, be understood in relation to each other.

Bourdieu develops an account of forms of values deployed within a field including economic, social, cultural and symbolic capital. Cultural capital includes the possession of culturally recognised attributes and competences. This is the main source of professional and managerial power as professional and academic qualifications confer strong claims to cultural capital in the health service. Symbolic capital arises from cultural and other forms of capital and expresses more intangible elements of reputation and social standing. Social capital arises from the fabric created in communities by shared experience. Understanding how the collective elements of habitus feed into the structural level is fundamental to understanding the processes through which social structures are created and reproduced. Social capital is then understood as one form of capital, interacting with other forms within a field, to provide a dynamic account of the distribution of power and resources.

Actors deploy their capital to maximise their position in an ever-changing field and the particular distribution of power is the outcome of their interplay (Bourdieu, 1993, 1999). The operation of habitus within a field is evidence of this distribution in that it points to values which are simply accepted.

The analysis of habitus is important in explaining how actors contribute to the transformation or preservation of power relations within the field. The field of medicine and health care has been strongly dominated by holders of cultural and symbolic capital. The potential for public involvement to be a vehicle for claiming some of this power is clear. In developing an account of the roles of cultural, social and symbolic capital in the NHS we will examine the scope for involvement in primary care and understand how this ground is contested.

Contesting the value of Cultural Capital in the field of health

The possession of high levels of cultural and symbolic capital by professionals in health enables them to exercise power, which is institutionalised in decision-making structures. Such capital historically endowed professionals with a strong claim to authority. Bourdieu emphasises, however, that a field is a dynamic space in which there is a continuous struggle to maximise position through the accumulation of capital. In recent years the legitimacy of patient and the public's claims to power have gained ground, based on questioning of professional knowledge and competence, most evident in cases of clinical negligence (Kennedy, 2001). That it is not an open struggle arises to some degree, from the relations of 'misrecognition', which so characterise the field of health care (Bourdieu, 1999). Through their cultural and symbolic capital, professionals represent their exercise of power as disinterested, while patients have accepted this

dominance as 'natural', confirming a habitus of trust and deference among recipients of health service care.

In this article we intend to examine the relationship between forms of knowledge and their relative legitimacy within the wider context of participation in decisions about health. The basis for examining early thinking about participation is expressed by Thomas and Thomas when they say, 'If men define situations as real, they are real in their consequences' (1928:572 quoted in Ritzer, G. 2000). To understand the potential for, and limits to, participation it is necessary to understand how those who are in a position to enlist it, in practice define it. Our primary interest was in exploring boards' early orientations toward the part that participation could play in decision-making. What roles did they think patients and the public should play? Which activities and areas of the board's responsibilities were appropriate for participation and which should be the preserve of the board alone? We further sought to learn about the mechanisms for participation that were emerging and to discover any impacts on board decision making. The research is reported in detail elsewhere (Authors, 2002). Our purpose here lies beyond the particularities of an ever-changing policy context, to consider the forces that underpin, provoke and, frequently, limit the nature and direction of policy development. In the next section therefore, we present some evidence from two issues addressed in the fieldwork as illustrative of the operation of these forces and relations. Following this we discuss the implications of the framework for analysis outlined briefly above.

Methods

The fieldwork was based in two localities in the North of England for a regionally funded study of early approaches to public and patient participation in Primary Care Groups. The sites selected were of comparable population size and demographic structure. Both had rural profiles but, while the population was widely dispersed in one, the second had a substantial concentration of its population in a single town. These areas of similarity and difference were incorporated into the study design partly to allow exploration of the participation of harder-to-reach rural populations.

Qualitative interviews were held with twenty people, including Chairs, Chief Executives, GPs, lay, social services and nursing members of boards in 2000. In both boards GPs formed the largest single group, while individual representatives form other professions within the health service and related organizations and a single lay member, constituted the remainder. Respondents are differentiated from each other by locality (A or B) and by number, to demonstrate the range of voices reported. In view of our commitment to maintain confidentiality, (more difficult to sustain internally for participants in a small local study), they are not identified by role.

The role of the PCG

One factor, which fundamentally shapes views on participation, concerns how broadly the board defines its own sphere of operation. Taking a broad definition of its own role entails involvement in social and environmental issues, which may be beyond the direct control of the board. The interviews suggested divisions of view *within* the boards on this

matter, with GP members, in particular, preferring the more restricted medical and service-based interpretation of their role. This definition, combined with the requirement to invite participation inevitably affects the operation of power:

managers professionally will face a change in the way we work and some of that means letting go, it never feels comfortable to let go some of your decisions or take those decisions more openly and it's the same for the other professions, particularly GPs. (B:2)

In both localities participation was treated as a 'good' thing but little debate had taken place about its purpose or the range of processes by which it might be secured. This allowed unexamined values to underpin agenda-setting and define the limits for involvement. Early indications from other research suggest this phenomenon was not uncommon (Florin 2000).

Participation was generally a low-level *'softer'* priority, given the policy constraints under which boards act, *'when the going gets tough and the waiting list targets aren't being met and the budget's overspent…'* participation tends, *'to drift off the edge'* (A:2)

While at a practical level this prioritisation is understandable, it is a revealing indication of which perspectives were regarded as sufficient to constitute proper decision-making. It illustrated the dominant habitus within the boards in relation to the inclusion of public voices. Nevertheless traditional forms of public accountability were an issue that the board must take seriously. Often accountability took the form of avoidance of overt

conflict in recognition that: …*We don't want our local MPs on our back, we don't want the local papers on our back.* (A:1)

Open meetings were regarded as a minimum form of involvement, but this denoted growing confidence by boards in their ability to maintain rather than share power:

... initially there was a sense of ..., you can't let them have an opportunity to ask questions, then there was the sense that if we do let them have an opportunity to ask questions we would want to know what the questions were in advance. I know over the last year it has relaxed noticeably as ..people have gained in confidence in their ability to be able to handle these questions (A:2)

This view of involvement places emphasis on minimising external interference rather than embracing the contribution the public can make to board decisions. It involves an implicit view that participation should be sought only on those issues considered appropriate by the boards. It would suggest, at best, a minimal shift in the behaviour of the boards, primarily for the purposes of self-protection. The value of involvement at the earliest stage in decision-making was beginning to be recognised but had yet to be influential in practice:

...we all realise that, we are becoming more publicly accountable…, and if we involve the public at a stage when we are making decisions about how we do things then we have gone some way towards… pre-empting that (claims of non-involvement) *problem.* (Locality A:3)

The above quotations are not used to suggest that board members are actively exclusionary, rather that dominant and accepted ways of thinking about participation can relegate it to a marginal position, as identified in Lukes' third form of power. PCG boards in the two localities were dealing with the requirement to share power. However, real barriers to power sharing were apparent in the unreflective beliefs held about what participation would contribute. At the same time there was some recognition of the public's potential to contribute to the definition of a good decision as one influenced by participation rather than formed through, '*specialist Health Service people in darkened rooms taking decisions for the population'* (B:3).

It was, further, suggested that the changing balance of board membership could resolve this issue:

…there are certain hierarchies within medicine that can cause problems with group dynamics on the board. Hopefully, these will, to some extent, dissolve …as we move to PCTs … they (medical professions) *are going to lose a lot of their power anyway. So the lay representation on the board will get much stronger.* (B: 2)

Based on our analysis of power and the currency of different forms of capital however, there is no necessary relation between a change in the numbers of people represented and their ability to exercise power.

The role of the Public

As consultation is effectively in the gift of the board, the views taken by members, based in the identity they ascribed to the public, is fundamental. When legitimacy is based in the cultural capital, held in professional knowledge, a restricted form of listening to the public view is justified:

Now whether the views of the public will have equal weight to the views of the professionals about some of these issues I think is debatable really. Partly ..because the argument can always be made …….. (that board members have) *more inside information and perhaps the public are making decisions, or putting their views forward based on insufficient information.* (Locality A:3)

Some issues were regarded as impossible for 'non-professionals' to grasp, being the proper province of professionals, albeit with support from experienced users and carers: In the view of many respondents issues of efficiency were prime and could be best decided on the basis of the authority of knowledge.

I think it is a matter of judgement as to what we take to the public and the complexity of some of the issues.... (Locality A:9)

The capital relied on was therefore essentially that encompassed by the cultural capital of professionally qualified and knowledgeable actors supported by a limited role for a public unable to comprehend complex issues.

Implicit within the approaches taken are beliefs, not only about the differential levels of cultural capital possessed by participants, which concerned the respondents quoted above, but also the symbolic capital with which they are endowed. For those who characterised

the public as individualised, ignorant or self interested, *'people are there for their own benefit'* (B:10), it is appropriate for the PCG to listen but also to retain power in its own hands in the interests of the wider populace. The contrast between a public characterised as self-interested and one characterised as a collective of citizens is clear. Each implies very different purposes and methods for participation.

The selection of which products of consultation to respond to is also firmly controlled by boards. This control of the agenda, which forms the core of Lukes' second form of power, resulted in filtering ideas and suggestions through the lens of professional interests.

...if patients come up with 23 ideas you will look at them and think 'oh that's a good idea'. So it has to... marry up with your beliefs...(A:6)

The practice of consultation has the potential therefore to be used only in a confirmatory way to support dominant views of what is appropriate.

In both boards the dominant view was that public contributions should focus on the organisational aspects of service provision:

So I think the public have got an awful lot to offer and they have got to be made aware of the realities of the situation as well - in terms of the resource constraints. ... it's not about the actual specialist service that they receive, it's more about the, I was going to say peripheral things but that's probably the wrong word.... it's the times that things are available and how the whole things come together (B:8)

The public's contribution was acknowledged for its ability to comment on service delivery. What was missing from this conception was a view of the public collectively involved in decision-making as citizens rather than consumers.

A further basis for restricting listening occurs when Boards see themselves as impartially adjudicating between interests. Here the PCG, by limiting consultation, can be the champion of the oppressed:

... we have got probably a very well informed vocal community who ...would probably readily accept the opportunity to feed in where they would like to see things going. But, the needs out there might be (in a) *more deprived community who perhaps haven't got the skills to give you, actuall,y the feedback ...* (A: 5)

Another reason for restricting the role of participation lies in the Boards' claims to be properly exercising an onerous responsibility because:

we are employed by the health service on reasonably good rates of pay ....to take difficult decisions. (B:1)

This perspective is reinforced by the fact that an unlimited demand for resources makes weighting participation difficult. *'...some of this is actually about managing expectations .... we are not going to be able to throw additional resources at everything the public comes up with.* (B:2)

These concerns suggest a somewhat residual view of the role of participation, supported by limited pressure for its development: *At the moment there is nobody really saying 'hang on a minute guys, we really need more openness'.* (A:2)

Learning Public Views- two approaches to evidence

In addition to thinking about the public's role, perhaps the most revealing evidence of power relations lies in what is taken to constitute evidence. We have identified a hierarchical approach to knowledge and the fact that powerful groups use such knowledge to support their claims to power. In according legitimacy to a public voice, a further set of processes of hierarchization and exclusion appear. This becomes more evident in the *processes* of involvement than in consideration of its products.

The boards adopted different ways of gathering information for consultation reflecting some differences of view about the purpose of consultation and participation. We suggest, in applying the analysis of power and forms of capital presented here, that they have very different potentials for the nature of participation achieved. The objectives and methods adopted in the two approaches can be summarized, on the one hand as seeking a representative snapshot of opinion (Locality A), and on the other, of seeking dialogue with a community (Locality B).

In Locality A, the public were being approached primarily through quantitative methods of gathering evidence, by the addition of questions to a local authority ratepayers panel. Consequently the definitions of issues and the range of possible solutions is determined by the board, in keeping with Lukes' second form of power. The relationship to the public was primarily formal and responsive, based in gathering questionnaire evidence. In this context the claim to the priority of cultural capital was evident. A hierarchy was

established in which panel evidence was accorded lower value than that of either patients, whose knowledge gave them some capital, or professionals whose claim to knowledge was greatest. The findings presented by Skelcher (1993) in relation to the limited nature of involvement in terms of devolution of power are echoed here:

I suspect that in fact 99% of it (participation) *is going to be user/carer involvement, quality monitoring, satisfaction and all that sort of thing.* (Locality A:3)

While it was recognised that this offered a limited form of involvement, the further measures being contemplated would centre on checking the validity and reliability of the panel view, rather than a means of extending participation:

... there may be other ways of checking this out in that in combining the panel views which are the individual members of the public with the views of groups already established, support groups and so on, ...to see whether the people who have had direct experience of these services are giving the same kinds of views as the public. (A:1)

The approach that boards adopted to information gathering reflected their understanding of who should be consulted together with how that consultation should take place. If involvement is conceived of as learning about current public opinion, the methods of consultation will privilege neutrality and representativeness. The hierarchical approach to evidence, accepted in the medical field, reinforces a belief in the superiority of this approach. Data must be gathered without influence, from a sample that is representative of the wider population. However the emphasis on neutrality and representativeness can tend to privilege methods over substance. Lukes' second form of power is evident when

the method is more important than the content of consultation responses, limiting agenda setting and excluding some issues from even initial consideration. To the extent that expert knowledge is the currency of cultural capital, the public's capital must always have less value than that of professionals. In learning the views of a representative public, PCG boards can point to the limited information upon which responses are based.

If, however, the opinion of a knowledgeable public is valued, then more deliberative forms of consultation are appropriate. The conflict between possession of knowledge and representativeness is clear (Harrison and Mort, 1998). We suggest however that these oppositions represent only one way of thinking about participation.

Achieving interaction with forms of capital, existing within communities, may require more pro-active approaches. In Locality A, radical suggestions for engaging with communities had met with a lukewarm response:

... there was one ....Board Meeting about the homeless and I suggested that we go out to where the homeless are .. and I didn't receive a very positive response. ...So I withdrew ...(A:5)

In Locality B there was some evidence of a different approach emerging, based in community development. The PCG had sought to replicate existing community structures in its own organisational structure and to interweave its policies with those in the local authority. This had not been uncontested ground. Even in the selection of community workers initial concerns had been about preserving the relations underpinning third form

of power: *the people that were acceptable to the interviewers alongside me, were people with a strong health service focus who could speak the jargon .. (B:3)*

This concern had been superseded in favour of selecting a candidate with skills in community work. While the approach would not necessarily give rise to a transfer of power, the fact that it involved interaction with the public suggests a stronger *potential* role than even board members were entirely comfortable with:

It's difficult to envisage a scenario where the public are prioritising issues ...although ..that's what community health workers ...would be doing. It's a way of finding out the issues in your patch and getting some prioritisation on that and then feeding back to PCGs ... (B:2)

Such interaction entails engagement between the cultural capital of professionals and the social capital of the community. Recognising a public voice as a citizen voice has implications in terms of allowing for the legitimacy of the collective social capital of the community. This is significant because, when dialogue occurs, the opportunities for shaping agendas and redefining issues and problems emerge. Boards can no longer exercise tight control over the subject matter or the nature of the discussion. Community social capital has conventionally been excluded from such relationships through the individualization of health care users (Lee and Ozanne, 1999). This relationship at least accords that capital legitimacy, and therefore the *potential* exists for some shift of power.

Cultural, symbolic and social forms of capital are currently endowed with different levels of legitimacy and the claim of powerful managerial and professional groups is to the greater legitimacy of their cultural capital. While some members of both boards

considered stronger notions of involvement possible, the general view was that

professionals should be the final arbiters. Board members did not see themselves as an

interest group, but rather as impartially arbitrating between interests. The dominance of

cultural capital has been substantially supported by the ability of professionals in the past

to exclude the social capital held by communities. The differences between boards

identified above does not lie, therefore, so much in a conscious evaluation of the

respective roles of boards, patients and publics as in the opportunities for involvement

that their methods presented.

Discussion

Historically the struggle for power in the field of health can be viewed through the lens of

the changing legitimacy of forms of capital. The challenge to traditional bases of

legitimacy emerged through a reorientation of values in the public services supported by

re-evaluation of forms of knowledge. In the welfare field, in the immediate post war

period, a consensual value base of trust and reciprocity left traditional, deferential

relations between users and professionals unchallenged. In the 1970s the evidence base

began to be recognised as limited, and therefore contestable (Cochrane 1972). This was

reinforced in the 1980's and 90's by the adoption of narrowly defined, self-interest

models of human motivation (Le Grand, 1997). Following the introduction of

'managerialist ' approaches, public policy formation favoured market-based forms of

provision with the consequential rise of the consumer (Barnes and Wistow 1994). The

post war consensus came under attack from left and right, and from feminist perspectives,

recognising a welfare state modelled on an undifferentiated white, male citizen (Lister

1993, Wilson 1978). More recently the emphasis on a range of stakeholder interests has

further fragmented the image of a welfare state based on equity and comprehensiveness. In this process, a deferential patient habitus has increasingly been superseded by an emphasis on choice (Barnes and Prior, 1996) and professional dominance has been challenged.

These shifts have contributed to more fundamental questioning of the social construction of knowledge and of the ability of professional agents to act as sole repositories for knowledge. When the expert no longer provides the single authoritative voice, services can only be legitimated through recognition of the wide range of interests inherent in the policy process. This implies that knowledge held by patients and the public in defining their own needs, must be accorded some status. The debate then turns on what level of status these voices merit and how real are attempts to access and hear them.

Policy makers have had a significant impact in changing these relations in the field of health care, initially through the increasing penetration of market relationships (Barnes and Prior 1996), and latterly through the rhetoric of social inclusion and citizenship. Involvement is seen both as a mechanism for creating 'active citizenship' and also of integrating the values underpinning state provision through markets which has characterised the third way (Giddens, 1998).

Returning to our early distinction between publics, patients, citizens and consumers we pointed to the lack of clarity in policy documents and, not surprisingly, found this reflected in our interviews. Yet it is clear from the discussion above that such distinctions have real meaning for claims to exercise power.

Changes in the value placed on different types of knowledge and authority, manifest themselves in the relationships between professionals and patients. In the past GPs, in particular, have possessed the necessary cultural and symbolic capital to exercise authority with patients whose habitus was based in deference. While these relations remain powerful, they exist in the context of an increasingly generalised distrust of expert knowledge and disenchantment with the notions of science and progress which characterise late modernity. This has meant that the basis of cultural and related symbolic capital held by the expert has been challenged in favour of 'multiple authorities' (Giddens, 1994).

The Relationship Between Power And Participation

Understanding relations of power is central to understanding the role that participation can play. A prime purpose which participation *can* serve is to legitimise and reinforce existing structures of power. If a single group is dominant, consultation can strengthen its use of symbolic capital, to retain power in its hands. This is evident when professionals use the products of consultation selectively to reinforce their interests, identified elsewhere as the deployment of the 'user card' (Mort and Harrison, 1999). GPs have based their authority both on medical knowledge and, through listening, their ability to stand proxy for their patients. Evidence suggests however, that the views of professionals and patients do not always coincide, (Barnes and Wistow 1994). Accounts which ascribe failure to consult effectively to poor levels of skill and training among the consulted, fail

to acknowledge that the ability to articulate a view, while important in itself, may matter less than a requirement for the powerful to take that view into account.

Placing this understanding in terms of Lukes' discussion of power and Bourdieu's framework of habitus and field suggests that the second and particularly the third dimensions of power are those which have shaped both professionals' and patients' habitus. Acceptance of professional knowledge and, therefore, its legitimacy in promoting patients' 'real' interests, depends on the second and third forms of power in the 'operation of dominant values' and the 'socially structured and culturally patterned behaviour of groups'. The questions that arise then are: how far is habitus being redefined by the shift in value accorded to different forms of capital? Does the legitimacy of the user and public voice both arise from, and contribute to, the questioning of professional power? Does participation serve to provide professionals with another claim to legitimacy or can it actually challenge the distribution of power in the field?

Consultation has been seen as empowering because of its symbolic importance (Cowen 1999), but such symbolic gains need to be sustained by a redistribution of power (Barnes, Harrison and Wistow, 1994). Consultation can be manipulative in obscuring the exercise of power, as suggested in Lukes' third form. Research demonstrates that the language of empowerment may have meanings ranging from a genuine enhancement of participation to a cloak adopted by powerful actors to obscure their continuing exercise of power (Mayo and Anastacio, 1999). An account of competing interests explains why

consultation frequently becomes, "*a 'technocratic veneer' of techniques and tools ...*

susceptible to audit and inspection" (Sanderson, 2000:338).

Empowerment implies not only developing personal capacities, but also extending the degree to which involvement can legitimate change. PCG/T boards have to consider the role that they think it is appropriate for patients and the public to play, and thus the kinds of partnership they should develop. Moreover, the relationship between nationally defined objectives and the degree of local discretion also affects the outcome of involvement. In addition to evolving notions of participation to meet current circumstances the PCG/T, as a new organisational form, has the potential to underpin a change in the values underlying primary health care services.

We suggest that in order to 'empower' it is necessary not only to improve social capital through education and training, as is implied in initiatives toward capacity building, but also to recognise actively the struggle for power inherent in the changing forms of legitimacy held by clinicians, managers and public as citizens.

The notion that people hold capital in several forms is valuable for a number of reasons. Identifying the resources actors deploy illustrates how cultural capital enables highly educated actors to interact effectively with their local agencies. It thereby highlights the importance of the relationships established between agencies and those they serve. Relationships based primarily on formal communication will tend to exclude those without high levels of cultural capital. However, while working class communities may not have resources of cultural capital to contribute effectively, they may possess other forms of capital, which could provide a basis for a dialogue with professionals. The

history of exclusion of such groups exemplifies the way in which powerful groups (in this case health professionals) have accorded legitimacy to specific forms of capital. Questioning this dominant understanding lays bare the exercise of power by professionals, which has previously been represented largely in terms of expert knowledge and competence.

Conclusion

We set out to examine why participation is so difficult to achieve. The focus of this discussion has been to identify how the uses of capital and claims to power influence approaches to involvement. The starting point was to recognise the significance of *how* participation is conceptualised because such definitions 'are real in their consequences'. In itself this is an expression of Lukes' third form of power.   Both the method and the content of involvement are relevant because each has a separate impact on the scope and meaning of participation. In addition, an alignment can be identified between the 'hierarchy of evidence' and a medical model of health, which has extended into the way that participation is enlisted.

Health is a field in which powerful professional actors are engaging with a changing habitus, resulting from a growing acknowledgement of the status of citizens as actors. This has been driven, in part, by the undermining of professional cultural capital's claims to knowledge and competence and the associated reduction in symbolic capital. At the same time the value placed on the form of knowledge and rights to speak held by patients and public, have gained some ground. In this article we have identified the tendency to

exalt or devalue the capital held by different categories of participants as a basis for claims to power.

This study has concentrated on how boards perceived changes in the legitimacy of involvement and the forms of knowledge underpinning it. This shaped the degree to which they yielded control or sought to maintain their ground, sometimes by subsuming or claiming to act as proxy for the user interest. Here we are describing not only conscious attempts to retain power and control of individual actors but a habitus, particularly among medical professionals, which has treated medical knowledge as real knowledge, and other forms of knowledge about health as subsidiary. It has traditionally laid claim to knowledge about what individuals and communities need, while emphasising individualised relationships between professionals and patients. Further, it is clear that the methods of communication used gives rise to different kinds of knowledge, which in turn reinforces the degree of credence that professionals accord to the voices of communities. Within the approaches identified, there was divergence between localities in the structures for participation employed, Locality A, seeking a snapshot while Locality B sought a dialogue. These structures necessarily have an impact on the form of knowledge gained and therefore the role participation can play in the day-to-day decisions made by boards.

The research has led us to several reflections on the processes and relations that operate in this field of participation. There was no evidence in our research of overt conflict in the sense that active groups of patients or the public were demanding control of any kind.

What was evident however, was the potential threat that involvement was regarded as posing to rational or disinterested decision-making, suggesting that boards' (implicitly) subscribe to the zero sum model of power. The adoption of a variable sum model in the policy advice and guidance on public participation sits oddly alongside the model that appears to operate in the field.

Lukes' typology identifies the manifestation of power in its three forms. The primary means of maintaining control, identified in this study, lay in defining agendas so that only what Lukes described as 'safe' questions were the subject of consultation. A further form of power that was evident consisted in limiting the impact of participation through the operation of established expectations and practices. These forms of power become increasingly opaque as one moves from overt conflict to the implicit and internalised understandings, which underpin social patterning.

Setting this typology within the dynamic context offered by Bourdieu allows an exploration of the relationships and processes through which those forms of power are effected. Examining unreflective understandings, gives us a clear picture of the relationship between habituses of professionals and patients, which has been the basis for relations that have pertained in the field. The emergence of citizenship, and the recognition of other forms of capital, present potential challenges to both. The collective responsibility of the citizen gives it a separate and quite different basis for participating from that of the consumer, and provides a further ground for challenging the existing distribution of power.

Different forms of power are exercised in maintaining control, shaping agendas and in the socially patterned action of groups and institutions and we have used Bourdieu's conception of forms of capital to explicate the process through which these faces of power are exercised. We have argued that the structures created to enlist participation are likely to impact on the exercise of the second form of power; embedding dialogue within decision-making suggests that there is greater potential to shape the agenda. Further, this embedding could, of itself and over time, have consequences for the operation of dominant values that underpin the third face of power.

The conceptual tools offered by Bourdieu encourage a dynamic understanding of processes emerging from the interplay (conflict and accommodation) of various forms of capital with the habitus of actors. Approaches to involvement have been viewed in terms of the ways that actors in the field seek to maximise their capital and therefore to achieve power in decision making. We have looked at two approaches and pointed to potential power accorded, or yielded, to the public in each approach based in unexamined values which underpin more conscious struggles for power. Some differences did emerge that are accessible through understanding participation as interaction between forms of capital.

The multi-faceted nature of the concept of participation means that the level at which it is conducted, its form and content vary, and this research has begun to explore some of the implications of those variations for the power of participants in the local field. We acknowledge that this local field sits within a wider regional and national field and that

the redistribution of capital may change power relations between these levels. In order to explore and draw conclusions about that issue however, further empirical research would be needed.

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