

Plus ça change:
The use of deliberation by new public
managers¹

John Parkinson

Social & Political Theory, Research School of Social Sciences
Australian National University

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Plus ça change, plus c'est la même chose

The more things change, the more they stay the same

- *Alphonse Karr, Les Guêpes (The Wasps), January 1849*

I Introduction

Britain's National Health Service (NHS) has been leading a dramatic period of state-supported experimentation with "deliberative" processes which involve citizens directly in public decision making. Patient input 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 which concern the fair distribution of vital resources like health care (Coote 1997; Lenaghan 1999, 47). But we know both from institutionalism and from the "argumentative turn" in policy studies that deliberative practices cannot operate in an institutional or discursive vacuum: ideas, practices, people and policies are all shaped in significant ways by their settings (Evans, Rueschemeyer, and Skocpol 1985; Fischer and Forester 1993; Peters 1999; Weaver and Rockman 1993). Therefore, the results of the encounter between those practices, the NHS, dominant public ideas like the Third Way, and a new public management focused bureaucracy embedded in a liberal state, are unlikely to be straightforwardly democratic.

To date, however, the academic literature has not considered this to be problematic, or has focused on fairly instrumental criticisms. On the one hand, political theorists and political scientists have tended to move from an exposition of deliberative principles to exploring how those principles are embodied in micro-level practices, without giving much consideration to intervening institutions and competing public ideas.² On the other hand, and with a few notable exceptions (Barnes 1999; Harrison and Mort 1998; Milewa, Valentine, and Calnan 1999), the health policy and medical literatures have tended to focus on the use of deliberative techniques in fairly instrumental terms – whether these are good means to a given set of ends – without giving much consideration either to the democratic principles the processes are supposed to embody or to how those ends are structured by the intervening institutions and discourses.³

In this paper I make a start at filling both gaps by considering how deliberative and how democratic two of the new practices are, taking account of the broader institutional setting. I begin by sketching the key features of deliberation, democracy, and of the United Kingdom's health policy setting. I then use three criteria for democracy to examine two processes used in recent health debates. I ask who is involved and why, what they deliberate on and why, and how "authentic" those deliberations are in terms of the degree of competence and control they exhibit. The analysis reveals issues to do with the research and legitimacy motivations behind involving citizens and conflicting models of accountability, and will question whether the reforms are truly as dramatic a revolution as they are claimed to be, or whether it is a matter of the more things change, the more they stay the same.

First, a methodological note and disclaimer. While much of my research is based on analysis of a variety of secondary sources, I also undertook some primary qualitative research, conducting 30 unstructured interviews between May and July 2001 with health policy actors involved in four deliberative events: a citizens' jury in Belfast in July 1998; a deliberative poll on the NHS in Manchester, also in July 1998; another jury in Leicester in March 2001; and the development of *The NHS Plan*, a policy template for the NHS 2001-2010, which happened between January and July 2001. The interviewees broke down into groups as shown in Table 1:

Table 1: Interviewees by role⁴

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

Time pressures and the lack of published material surveying deliberative practice in Britain meant that I used snowball sampling to select my interviewees (Berg 2001, 33), which then meant that I was not able to interview people in every role in every process. I did not interview any lay participants. Interviewees themselves set the terms of the

discussions to minimise the degree to which my own language, categories and pre-conceptions structured their responses (Jorgenson 1991, 211).

This great advantage of this kind of approach is that it allows the researcher to peer beneath the labels of political practices and identify mismatches between those labels and the actual behaviour of political actors; the great disadvantage is that it does not allow me to generalise beyond those cases. In this paper I consider just three cases of what has been a broad set of initiatives, and so what I say cannot be taken as applying to all recent deliberative experiments – this is not meant to be a comprehensive evaluation of the British government's programme. However, I can be confident that certain patterns of discourse, certain dominant ideas, certain perceptions of events, were present; and that these should call into question the too-ready acceptance of the label "deliberative democracy" in other cases not examined here.

II Deliberative democracy

Just as democracy is a contested concept (Dryzek 1996, 4), so deliberative democracy seems to mean many things to different theorists. I need to spend a moment specifying what I see as the common elements of deliberative democracy to give some reference point for the discussion which follows.

Deliberative democracy is characterised by two essential 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. 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). The deliberative variant shares with other conceptions of democracy the requirement that everyone be treated as political equals, and that their agreements be decisive (Beetham 1994, 28; Dahl 1989, 1). Furthermore, the agenda should be open: people should not be restricted as to what they can deliberate on and what they cannot (Catt 1999, 16; Saward 1998, 61).⁵ It is these requirements of equality, decisiveness and unlimited scope that distinguish conceptions of deliberative democracy, in which democracy is the substantive element and "deliberative" the adjective, from conceptions of mere "deliberation" which

quietly forget about the democracy part – Dryzek (2001, 665) makes this criticism of Rawls (1997).

Equality is required not just for democratic reasons of respect for the political equality of persons, but also to ensure that reason dominates public discussion. Minimally this might just mean a reciprocity requirement, that people should treat each other with respect (Gutmann and Thompson 1996); more stringently, it might require equality of speaking rights, equal group representation, and equality of enforcement power, all monitored by a more or less powerful mediator (Dryzek 1987); maximally, it might require material equality between participants (O'Neill 2000).

Deliberation also requires inclusiveness and accountability. In some versions of deliberative theory, the inclusion condition applies to *all* those affected by a decision. Without full inclusion, important perspectives may be missed, and decisions cannot legitimately bind those whose voices have not been heard (Benhabib 1996; Cohen 1989). In such cases, accountability is achieved through the publicity condition, the Kantian notion that only those reasons that can be given publicly have any moral force (Gutmann and Thompson 1996, 95, 101). Thus, people are made accountable to each other by having to offer their reasons to each other for consideration, debate, acceptance or rejection. However, many theorists reject full inclusion as unrealistic: for most issues and debates, not all those affected can plausibly deliberate together (Goodin 2000, 82; Walzer 1999).⁶ A less demanding requirement is that all those affected must at least be represented in one of a number of ways; or be able to watch and consider debates through the news media (Christiano 1996; Fishkin 1997). In these cases, legitimacy depends partly on formal bonds of accountability created by elections and responsiveness to public opinion and partly on acts of legitimisation, the *claims* as opposed to *grounds* of legitimacy (Beetham 1991; Habermas 1975, 101-2; Schaar 1984, 126). In practice, this can lead to a conflict between the deliberative and the representative models of accountability, and of legitimacy, with elected representatives reserving decision making power to themselves on the grounds that only they are accountable to the public at large.

Finally, deliberative democracy tends to be written about as if its principles were only applicable in small self-contained forums, but this need not be so. For example, Mansbridge talks about a “deliberative system” which includes “a range of forums, a range of standards”, including formal representative structures but extending beyond them to include the informal public sphere and private talk that is recognisably political (Mansbridge 1999, 215, 227-8). It is a spectrum along which outcomes become progressively less binding, and less procedurally demanding, the closer the forum is to the informal end. Benhabib, Dryzek and Young stress that deliberation can also be

thought of as conversations carried on across time and space (Benhabib 1996; Dryzek 1990; Young 2000, 67). It is the competent, reflective control of such conversations by their participants, combined with governmental responsiveness to their ever-evolving outcomes, that Dryzek calls “discursive democracy”.

State responsiveness can be promoted by a number of mechanisms, all of which can themselves be more or less deliberative and democratic in practice. These include tools which reach out from civil society, such as direct protest, representations to government, and commissioned reports; those which reach out from the state, like commissions of inquiry, select committee hearings, consultative processes, even government-commissioned opinion research; and many other techniques which inhabit that area called “middle democracy” (Gutmann and Thompson 1996, 12) like deliberative polls, citizens’ juries, consensus conferences and so on.

All these elements of deliberative democracy are summed up in Dryzek’s broad conditions of democracy, namely franchise, scope and authenticity (Dryzek 1996, 5-6). For Dryzek, franchise “refers to the number of participants in any political setting”, but I stress that those participants should be political equals within deliberations, not just equally invited and then asked to keep quiet. Scope “concerns the domains of life under democratic control”. Authenticity is “the degree to which democratic control is substantive rather than symbolic”, which captures the decisiveness requirement; and the degree to which debate is “informed rather than ignorant, and competently engaged”, which captures the deliberative requirements of public reasoning. In section four I will use each of these elements of democracy to structure the discussion and answer the question, “How democratic is deliberation in UK health policy?”

III The health policy context

One of the problems with describing the health policy context in the UK is that it is highly complex: what counts as a “health” issue is socially constructed and framed by technical expertise; the policy community is large and complex; and the institutions vary between members of the Union and are constantly changing. In what follows, therefore, I have been extremely selective, pulling out a few key features which have a direct bearing on the kind of citizen participation practised in England.⁷

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 (Harrison and Pollitt 1994), so that people had nothing to contribute but their ailments. GPs were the gatekeepers of the whole system, responsible for referrals to hospital-based specialists. This was done to distance government from the rationing decisions that were becoming increasingly necessary: it could claim they were legitimate on the basis of medical judgement rather than political calculation. It was a Faustian bargain, however, as the government effectively handed over budgetary control to a group of people who had little interest in exercising restraint (Klein 1990; Moran 1999, 32, 67).

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 on the Health Authorities which, at the time, were responsible for health service delivery in areas whose boundaries matched those of local authorities.⁸ However, the CHCs seem to have been created “almost by accident” (Klein and Lewis 1976, 1) and with remarkably little thought – 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. Interviewees suggested that even until their demise in 2002 few people were aware of their existence. As with many other British quangos (Barker 1982), they have no formal bonds of accountability to the public; and have boards which are not descriptively representative of the wider community. As a result, CHC effectiveness, assessed in terms of representing public and patient interests with the health authorities, is seen as extremely variable by others in the health policy community.

It was under the Conservative governments of Margaret Thatcher and John Major that some form of public involvement received a boost, but under quite a different model in which groups like the CHCs and their member organisations were no longer lauded as essential to broadening participation in democracy, but damned as “vested interests” who diverted public resources for their own private ends.

The key features of neoliberal government in the UK and its administrative offshoot, the New Public Management, are fairly familiar.⁹ The key element is a view of human activity as the individual pursuit of competitive advantage; but that pursuit can be made to serve the needs of others by encouraging markets which supply people with goods and services

at high quality (Pollitt 1993, 183). Thus individual advantage and collective benefits are believed to happily coincide, so long as markets are not “captured” for private gain by strategic misrepresentation of demand, supply, the nature of needs or the goods on offer, and so on. The purpose of government, on this view, is not to supply goods and services, but to ensure that the markets for those goods and services are not distorted.

In the public policy arena, this world-view problematised what earlier models of government had considered the normal provision of services, and normal working relationships between civil servants, organised interests and elected representatives. Inspired by transaction cost economics and agency theory (Boston et al. 1996; Hood 1991), the government asked what institutional arrangements would minimise diversion of public resources by supposedly self-interested actors. Concerned about such problems – evidence for which was often more anecdotal than systematic – governments in several countries developed a remarkable range of tools of control. The preferred mechanism was the market: subject public services to competition and this will empower “consumers” who will flock to the best supplier, forcing the inefficient and ineffective to shape up or ship out (Pollitt 1993, 5). Thus “purchasers” were split from “providers”: the government purchased services for delivery to consumers, but it could choose from a range of competing suppliers, both public and privately-owned, who were then bound by contracts (another key element in the new regime) to provide specific services to particular quality and cost standards. Market forces were introduced into 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 – thus creating what was strictly a quasi-market, “involving choice by the purchasing agency rather than by the patient” (Harrison and Mort 1998, 62).

These ideas were combined with managerialism, a view with a long history that management is a neutral, “scientific”, and hence more noble function which should be kept quite separate from the messiness of politics (Dunsire 1973, 87-94; Pollitt 1993, 15), and that its methods, developed in business settings, were universally applicable. Managerialism includes the doctrine that “managers should be free to manage”, to achieve results without direct interference from their ministers. Rather than accounting for inputs into public services (from personnel to pencils), or outputs of departments (numbers of operations, brochures, etc), government agencies were asked to account for outcomes: that is, the effects they were having on people’s lives. Given specified outcomes and budgets, managers should be free to develop whatever programmes and services they felt would meet those objectives (Pollitt 1993, 2-3). These ideas were first introduced to the health sector following the publication in 1983 of a cabinet-commissioned report by Roy

Griffiths, managing director of the Sainsbury's supermarket chain, who recommended the creation of a general management function which would plan, implement and control services, leading to a dramatic increase in the number and cost of managers in the NHS.

In order to deliver a high quality product, one must also be aware of the needs and tastes of consumers (Besterfield et al. 1995). One also needs to know whether one has delivered on a contractually required target or not. This meant that customer research became crucial, the institutionalisation of which was another key Griffiths recommendation. Thus, the NHS invested heavily in developing new needs assessment tools, conducting customer satisfaction surveys, designing standards and performance criteria, ranking providers according to how they met those criteria and publishing those rankings.

By the 1990's 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 the 1997 election of the Blair Labour government, a new set of ideas which go under the "Third Way" banner have been introduced into the health policy setting. Broadly, the Third Way is about the social justice goals of social democracy, but is "flexible, innovative and forward-looking in the means to achieve them" (Blair 1998, 2). It combines this with a somewhat conservative brand of communitarianism which stresses reciprocal duties to the state in exchange for welfare, and group membership above individualism. Thus, the Third Way has both egalitarian and collectivist tendencies – adherents believe both in decentralisation of power to local communities and the encouragement of individual drive and ambition; but also in duty, cohesion and norm-reinforcing institutions like the family and the nation, with which individual ambition does not necessarily sit comfortably (Driver and Martell 2000, 157).

Therefore, despite some claims of a clear break with the past (Gray 1996), the Third Way shares some features with managerialism and with the strong government of

Thatcherism. Third Way adherents still believe in unarguable symbols (Hood and Jackson 1991) like “efficiency” and “value for money” while adding the “modernisation” one. Like managerialists, they are more concerned about outcomes than the means of achieving them; they claim to have a more pragmatic view about public versus private provision of services, but nonetheless admires “entrepreneurial zeal” (Blair 1998, 4). They are interested in devolving power and working in “partnership” with local communities, but still expect uniform quality across the nation, enforced using performance measurement tools even more sophisticated than those developed in the days of “distrust” (Klein 2000, 208).

These ideas were first applied to health in the government’s white paper entitled *The New NHS: Modern, Dependable* (Secretary of State for Health 1997). Reflecting the mix of old and new in the government’s overall approach, it became clear that some things had changed while others had not. The internal market was abolished but other competitive aspects remained. The purchaser/provider split was still largely in effect: the Department of Health in London managed policy advice and target setting, while the NHS Executive in Leeds managed service planning and delivery to meet those objectives through the various health authorities and NHS Trusts running hospitals, primary and specialist services. Further restructuring since has not altered that much: most budgetary authority is being devolved to trusts, while the 95 health authorities are being further consolidated into 28 “Strategic Health Authorities”, responsible for needs assessment and planning for an average of 1.5 million people each. However, there is still much uncertainty about precisely what constitutes “strategic planning”, or how conflicts between that and the autonomy of local trusts will be managed. Thus the tensions between forces of centralisation and forces of decentralisation, always inherent in the NHS, continue under the new regime (Klein 2000, 96).

IV Two deliberative processes

Because the next stage in the story of the development of deliberative processes in the UK is closely tied up with one of my case studies, it is time now to move to a much greater level of detail. Towards the end of section two I noted that there are three main ways in which deliberation can proceed: within civil society, within state institutions, and in the space between the two, that area called “middle democracy” by Gutmann and Thompson. My research examined all three fields of deliberation, but in this paper I restrict my

comments to middle democracy only, discussing two models of state-directed public participation: a central government consultation exercise and two citizens' juries.

The NHS Plan

The first case is the development of *The NHS Plan*, released in July 2000. While the 1997 reforms were supposed to "fix" the NHS, a sense of crisis grew steadily. This was partly of the government's own making: it made waiting lists the key measure of performance, but the length of those lists was neither entirely under its control, nor an unambiguous measure (Klein 2000, 213). When the lists continued to grow, the government was blamed. The sense of crisis was exacerbated by several well-publicised cases of medical mismanagement, the Harold Shipman murders,¹⁰ and the failure of "lean" hospitals to cope with a major outbreak of influenza in early 2000.

The government's response was *The NHS Plan* in July 2000 (Secretary of State for Health 2000). The NHS Plan is interesting for two reasons: the attempt to put public and patient involvement at the heart of the NHS, and the conscious use of deliberative principles to create it. As I noted in the introduction, this paper is not a comprehensive evaluation of the government's programme, and I will be focusing narrowly on the Plan's creation process. However, it is worth noting that the Plan proposed, and the government is implementing, a range of measures to create "a system whereby the patient voice is stitched right throughout the healthcare system",¹¹ including citizen advisory forums designed to run on deliberative lines, compulsory lay membership on trust boards and other regulatory bodies, and granting local councils new scrutiny powers over local health services.

Following Kingdon's model of how policy ideas gain currency in government (Kingdon 1984), the emphasis on deliberation seems to be due to the presence of policy entrepreneurs advancing deliberative ideas at key points in central government. The most important players in this regard seem to have been in the Department of Health's Strategy Unit which advised the new Secretary of State, Alan Milburn (who replaced Frank Dobson in early 2000).¹² Particularly important was Jo Lenaghan, a former analyst at the Institute for Public Policy (IPPR) who ran some of the UK's first citizens' juries in 1996. It was Lenaghan who largely designed and ran the consultation process that informed *The NHS Plan*. But the ideas fell on fertile ground: they fit well with Third Way rhetoric of devolving power to communities, and were taken up with enthusiasm by Milburn.

The process was what Lenaghan called an attempt at “big tent politics”, trying to include all the relevant voices in one set of deliberations. It had four elements, the first three of which had some obviously deliberative elements, the fourth less obviously so. The first was a series of gatherings and internet-enabled discussions of 120 stakeholders from the various medical and nursing colleges, branches of the NHS, and patient advocacy groups. They were given background papers and split into six working groups, including one which dealt specifically with public and patient involvement – as Modernisation Action Teams, these groups continued to work on detail and implementation well after the plan’s launch. The second was a series of age-based focus groups with patients to identify health needs for the next ten years. The third was two day-long public meetings with about 200 participants each, who were given presentations on the key policy problems facing the health service, split into groups of ten, and asked to prioritise those problems. The fourth element was not obviously deliberative in itself, but certainly met the requirement that the deliberative system as a whole be open to a variety of inputs from citizens (see pp3-4 above). In a highly publicised release, Milburn sent a postcard to hospitals, GP surgeries, supermarkets and other retail outlets which 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 2000). The Department received around 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 within the Department that this was a reasonable rate.¹³ The responses were sorted into broad categories by Department staff, with the public overwhelmingly wanting shorter waiting times and staff wanting improved facilities.

Let’s turn now to some aspects of the deliberative democratic criteria specified at the end of section two. In terms of scope and franchise, the process opened up a sector of policy making in a way that had never been done before in the UK (interview, NHS Executive, Leeds). Participation was broader than the usual bureaucracy/parliament dominated process, particularly with the postcards and the associated publicity which brought the issues to the attention of millions more. Having increased the raw number of people involved, and included a much broader range of backgrounds, however, equality between participants was not considered. For example, the postcard idea allowed 200,000 people to participate, but their input was not of equal breadth or depth compared with those invited into the stakeholder process, nor even of those involved in the focus groups or public meetings. What they lacked in depth was partially made up for in weight: the decision makers placed a lot of emphasis on the results of the cards, but not as much as on the focus groups and public meetings which involved only about 500 people.

There was little in the way of *control* in any of these exercises, because of a fundamental clash of models of accountability between deliberative techniques and the representative democratic system in which they are set. The decisive voice did not belong to participants in any of the exercises, accountable to each other in the Kantian sense noted in section two; it did not belong to the stakeholders who, through the Modernisation Action Teams, had a role in designing the detail but not the grand vision. The decisive voice belonged to the Secretary of State who, at least in theory, is held accountable both to parliament and the electorate. This is hailed as a positive good: a key criticism of deliberative processes made by adherents of representative democracy is that representatives can use deliberative and participatory techniques to dodge responsibility for taking the hard decisions by passing the buck to unelected bodies which cannot be called to account for their actions – recalling the discussion of legitimacy and accountability in section two – which makes public policy *less* responsive, not more, to the public (interviews, Eastern Health & Social Services Board, Belfast). While the criticism highlights an interesting clash of models of democracy, my feeling is that it is based on a rose-tinted view of representative government: in practice, assemblies have a mixed record in holding ministers accountable for their actions, and thus less power to hold decision makers accountable between elections than the representative model suggests (Catt 1999, 111), while other means of accountability are more restricted in scope and have low public visibility, thus lacking persuasive power with the public (Ferlie et al. 1996, 198). Deliberative democratic processes – or at least consultative ones – are necessary to promote democratic responsiveness and accountability to the public between elections. According to Department of Health, this is exactly what the *NHS Plan* consultation process achieved: it “helped Ministers to listen and other stakeholders to understand the bigger picture” (Jo Lenaghan, personal correspondence).

Turning to the authenticity criterion, it seems that the postcard technique was more symbolic than substantive. The stated aim was to get information from a much larger sample of citizens than had been possible with the focus groups and public meetings (Lenaghan, *ibid.*), but to do so, the Department traded off quality against quantity – from a statistical point of view, the sample was unlikely to be representative, and the responses themselves contained very little detail, although Lenaghan expressed surprise at how useful they actually turned out to be. On the “informed rather than ignorant” dimension, there was no attempt to supply the postcard recipients with information from competing sources other than that which is picked up through the media and through ordinary, everyday participation in political discourse; but for the vast majority of participants, that discourse exhibits none of the features of competent, reflexive control which Dryzek (1990, 14-9) suggests are necessary for communicative rationalisation. However, if seen as an exercise in legitimisation – showing the British people that something was being done –

then the postcards were a good means to that end. Even though the 150,000 responses represented 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.

The stakeholder groups were both better informed and more substantive, but only to an extent: some felt that there was no clear link between their inputs and the final product; and some felt that they weren’t being involved in decision making so much as being the objects of a research exercise themselves. This made for an interesting change from the usual power relationships, in which the technical experts make the decisions and the public simply provide input, a role reversal some were not comfortable with. Nonetheless, an important outcome of the process for stakeholders was a remarkable degree of consensus about the way forward. As deliberative theorists would expect (Benhabib 1996; Cohen 1989; Manin 1987), this consensus had legitimising effects: there was very little 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, they were not spending their time criticising the vision. The same goes for the wider public: while there may be criticism about the pace of change or the specific way things are being done, there is almost no criticism of the plan itself. It is agreed to be a good thing.

It should be emphasised that the Department never pretended that the process was perfect, although their procedural bar was also set lower than the one I have suggested. Nonetheless, even had the desire for a gold standard process been strong, other institutional imperatives would have overridden it. The sense of crisis meant that the government felt it had to act quickly, while rigorous deliberation takes time; ministerial accountability would have conflicted with any desire to give the discussions any real democratic control; and in at least the public elements of the consultation, legitimisation imperatives (getting out to as many people as possible) overrode other deliberative values (testing the quality of the views raised through deliberation between participants). In such an institutional context, it is extremely unlikely that a “pure” deliberative democratic process could have been designed by government actors, even if they had wanted to.

The citizens’ juries

By way of comparison, let’s turn now to a process that some authors have cited as a generally good example of deliberative democratic practice, namely 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),¹⁴ the citizens' jury is designed to address policy problems – evidence from “witnesses” from various sides of the issue is presented to a randomly selected jury which deliberates and makes recommendations based on the evidence.¹⁵ The jury selection is not strictly random: it is usually a quota sample of anywhere between 12 and 24 citizens (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). I gathered some information on a number of recent juries, but looked closest at one held in Belfast in July 1998 and one in Leicester in March 2000.

I chose the Belfast jury because it was triggered specifically by the Blair government's 1997 health white paper. Jointly commissioned by the Eastern Health & Social Services Board, the local equivalent of an English health authority, and the Eastern Health & Social Services Council, the local equivalent of a CHC (the Board and Council henceforth), its purpose was to help develop a response to the Northern Ireland version of the white paper. However, that purpose was only ever secondary: according to the event's facilitator, the question was too broad and unconnected to an actual decision-making moment to be considered a “good question” for a citizens' jury (interview, IPPR, London), and the recommendations have never been specifically acted on by the Northern Ireland Department of Health & Social Services. It was done this way in part because the Board was afraid that the jury's recommendations would hold a lot of public weight, yet would not take the Board's tight financial situation into account and make unrealistic recommendations for which they had no accountability (interview, Eastern Health & Social Services Board, Belfast). It also took place just a few months after the signing of the Good Friday Agreement which 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 and media interest in processes which were supposed to make such cross-community consultation possible without degenerating into name calling (at best) or violence (at worst). Thus, beyond the specific goal of developing a response to the white paper, the Board particularly commissioned the jury as an exercise in researching the capabilities of ordinary people (interview, Eastern Health & Social Services Board, Belfast).

The Leicester jury, by contrast, was perhaps more typical of the juries run in the United Kingdom. It was commissioned to resolve an increasingly bitter public controversy. The issue was a Leicestershire Health Authority proposal to reconfigure services at Leicester's three main hospitals, the Leicester Royal Infirmary (LRI), Leicester General, and Glenfield. The health 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 accident and emergency (A&E) and other acute services at the LRI and the General and devoting Glenfield to planned care services, which involved moving existing acute services from Glenfield. When the announcement was made in November 1999, however, 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 which gathered at least 150,000 signatures; the media was mobilised; members of parliament and local councillors, armed with new health authority oversight duties, 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, which 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 latest round of restructurings (see note 13) has seen the Leicestershire Health Authority merge with several others, which has slowed implementation of the plan.

Comparing the cases once more with the deliberative democratic criteria, the numbers involved in citizens' juries are low, which calls into question the degree to which they enhance franchise. One way in which this problem is made less acute is by emphasising the "representativeness" of the jury,¹⁶ but this is to confuse statistical representation with the formal bonds of accountable and authorised representation which are necessary for legitimate decision-making bodies (Parkinson forthcoming). Another way is to think of activists representing the inactive citizenry (Christiano 1996), and so the fact that these juries gave activists important roles as witnesses and/or on steering groups might lead us to conclude that the franchise, while indirect, is nonetheless broad. However, even if activist representation model were uncontroversial, the citizens' jury model is used by

bureaucrats specifically to *sideline* activists, to ensure that decision makers hear from people other than “the usual suspects” who are assumed to be the self-interested purveyors of only those facts and values which suit their strategic goals.¹⁷ Thus the active do not get to deliberate at all in citizens’ juries, but only provide information to the jurors, a situation which some find intensely frustrating (Beresford and Campbell 1994; interview, Eastern Health & Social Services Board, Belfast).

Like the *NHS Plan* consultations, both citizens’ juries seemed to allow greater scope for citizen *involvement*, but only the Leicester case allowed for much citizen *control*. Even then the control actually lay with the petitioners, not with the jury. Interviewees speculated on what would have happened had the jury supported the health authority’s original plan, and suggested that the petitioners would have won simply because the direct voice of a large number of the people, albeit a non-deliberative voice, was thought to carry more legitimacy than a small group of neutral arbiters reasoning together (Interviews, Leicestershire Health Authority, Leicestershire Community Health Council, and *Leicester Mercury*). However, if we take the systemic view of deliberative democracy noted in section two rather than expecting perfection in any one deliberative moment, then this is not really a problem: the jury was the end point of a long battle in which citizens wrested control back from the professionals and the health authority, not an isolated moment.

It is much harder to find democratic control in the Belfast case: the question was deliberately chosen to be non-threatening to the bureaucracy; and it was not commissioned by the real decision-makers but only as something which supported the Board and Councils’ own recommendations to the Department, which were themselves non-binding. In neither case, however, did citizens have much say over decisions that were clearly out of the hands of the health authorities which commissioned the juries. This was especially obvious in the Leicester jury in which jurors early on recognised that one of the reasons for the situation was a shortage of medical staff, but it was not in the power of anyone present to change it.

On the authenticity condition, evidence suggests that citizens’ juries do an excellent job at cutting through the symbolic and getting to the substance. Of particular interest is recent work by Niemeyer who concludes that the citizens’ jury process “deactivates” purely symbolic attitudes picked up from the media or other unreflective communication, clearing the decks to allow genuine deliberation of substantive issues to take place (Niemeyer 2002). But all the deliberative authenticity in the world does not matter if it is not decisive; if the real decision-making power lies further up the hierarchy; and if decision-makers at any level use deliberative processes more for researching people-as-objects rather than engaging with citizens-as-subjects (Gergen and Gergen 1991, 86).

V Conclusions

It is clear that intervening institutions and public ideas influenced the way deliberative processes have been used, such that they fall short of deliberative democratic ideals. One major influence is that a research paradigm dominates thanks to two key elements in public management thinking. The first is a managerialist concern with producing quality outcomes for citizens conceived of as consumers, which has led to the importation of business methods of researching consumer ideas and preferences. Elements of the Third Way have pulled in opposite directions here: on the one hand, the central government has been at pains to reintroduce the “citizen” back into the policy arena, something which was stressed in *The NHS Plan*; however, the emphasis on local patient responsiveness has reinforced the managerialist concern with “users”, not weakened it. For local bureaucrats in particular, it’s about “knowing your customer” so that you can produce the services they want – for example, the fact that citizens’ juries get lumped in with focus groups speaks volumes about the way in which juries are conceptualised. The second, which can conflict with the first, is an agency theory-driven concern with controlling local bureaucrats, meshed with a Third Way concern with achieving national consistency of service regardless of socio-economic status, which leads to strict performance measurement against national criteria which are at least in part derived from public and patient research. For central government, citizen involvement is, at least in part, about producing better performance measures, better quality data, better understanding of national needs, so that central government can better control local implementation.

Thus, deliberative techniques have been used by central government to cut through local disagreements or to legitimise national courses of action – as in the *NHS Plan* and Leicester cases; while local government agencies have used them to strengthen their hand in their own discussions with those higher up the food chain, as in the Belfast case. In such instances, the role of lay people as empowered citizens can be secondary to the needs of government.

Interestingly, it is the local agencies which have used more rigorous techniques, not central ones. This, I have suggested, is because of a fundamental conflict between the deliberative and representative models of accountability and legitimacy. The legitimisation imperatives can, and do, override any desire for more rigorous deliberative democratic procedures. However, deliberations conducted at the local level do not escape such problems either, particularly where participants are chosen by random selection: such processes break that legitimising chain of accountability between participants and

non-participants, which is why those who *do* have formal accountability to those citizens outside the deliberative moment retain control.

Plus ça change, plus c'est la même chose? Not quite, particularly if we take the central government's desire to move away from Thatcherite command and control seriously, but there are many commonalities. On both the grounds of the research orientation and the lack of control, I suggest that the UK might be experimenting with deliberative *techniques*, but it certainly is not implementing deliberative *democracy*, and in that respect the techniques are new ways of doing old things.

References

- Barker, Anthony. 1982. 'Governmental bodies and the networks of mutual accountability.' In *Quangos in Britain*, ed. A. Barker. London: Macmillan, pp 3-33.
- Barnes, Marian. 1999. *Building a deliberative democracy: an evaluation of two citizens' juries*. London: Institute of Public Policy Research.
- Beetham, David. 1991. *The legitimization of power*. Basingstoke: Macmillan.
- — —, ed. 1994. *Defining and measuring democracy*. London: Sage.
- Benhabib, Seyla. 1996. 'Toward a deliberative model of democratic legitimacy.' In *Democracy and difference*, ed. S. Benhabib. Princeton: Princeton University Press, pp 67-94.
- Beresford, Peter, and Jane Campbell. 1994. 'Disabled people, service users, user involvement and representation.' *Disability and Society* 9 (3):315-325.
- Berg, Bruce L. 2001. *Qualitative research methods for the social sciences*. Boston: Allyn and Bacon.
- Besterfield, Dale, Carol Besterfield-Michna, Glen Besterfield, and Mary Besterfield-Sacre. 1995. *Total quality management*. Englewood Cliffs: Prentice Hall.
- Blair, Tony. 1998. *The Third Way: new politics for the new century*, Fabian Pamphlet 588. London: Fabian Society.
- Boston, Jonathan, John Martin, June Pallot, and Pat Walsh. 1996. *Public management: the New Zealand model*. Auckland: Oxford University Press.
- Bowie, Cameron, Ann Richardson, and Wendy Sykes. 1995. 'Consulting the public about health service priorities.' *British Medical Journal* 311:1155-8.
- Brown, Ian. 1999. 'Patient participation groups in general practice in the National Health Service.' *Health Expectations* 2:169-78.
- Button, Mark, and Kevin Mattson. 1999. 'Deliberative democracy in practice: challenges and prospects for civic deliberation.' *Polity* 31 (4):609-37.
- Catt, Helena. 1999. *Democracy in practice*. London: Routledge.
- Christiano, Thomas. 1996. 'Deliberative equality and the democratic order.' In *Political Order: Nomos* 38, ed. I. Shapiro and R. Hardin. New York: New York University Press.
- Coffey, Amanda, and Paul Atkinson. 1996. *Making sense of qualitative data: complementary research strategies*. Thousand Oaks: Sage.
- Cohen, Joshua. 1989. 'Deliberation and democratic legitimacy.' In *Contemporary political philosophy: an anthology*, ed. R. E. Goodin and P. Pettit. Oxford: Blackwell, pp 143-155.
- Coote, Anna. 1997. 'Direct public and patient involvement in rationing.' In *Rationing: talk and action in health care*, ed. B. New. London: British Medical Journal, pp 158-164.
- Crosby, Ned. 1998. 'Using citizens' juries: a process for environmental decision-making.' In *Making better environmental decisions*, ed. K. Sexton, A. A. Marcus, K. W. Easter and T. D. Burkhardt. Washington DC: Island Press.
- Dahl, Robert. 1989. *Democracy and its critics*. New Haven: Yale University Press.
- DHSS. 1983. NHS Management Inquiry (The Griffiths Report). London: Department of Health and Social Security.

- Dienel, Peter, and Ortwin Renn. 1995. 'Planning cells: a gate to "fractal" mediation.' In *Fairness and competence in citizen participation*, ed. O. Renn, T. Webler and P. M. Wiedemann. Dordrecht: Kluwer.
- DoH. 2000. *The National Plan: analysis of the response to the consultation exercise carried out in May/June 2000*. London: Department of Health.
- Dolan, Paul, Richard Cookson, and Brian Ferguson. 1999. 'Effect of discussion and deliberation on the public's views of priority setting in health care: focus group study.' *British Medical Journal* 318 (7188):916.
- Driver, Stephen, and Luke Martell. 2000. 'Left, Right and the third way.' *Policy and Politics* 28 (2):147-61.
- Dryzek, John. 1987. 'Complexity and rationality in public life.' *Political Studies* 35:424-442.
- — —. 1990. *Discursive democracy*. New York: Cambridge University Press.
- — —. 1996. *Democracy in capitalist times: ideals, limits, struggles*. New York & Oxford: Oxford University Press.
- — —. 2001. 'Legitimacy and economy in deliberative democracy.' *Political Theory* 29 (5):651-69.
- Dunsire, Andrew. 1973. 'Administrative doctrine and administrative change.' *Public Administration Bulletin* 15 (December):39-56.
- Elster, Jon. 1997. 'The market and the forum: three varieties of political theory.' In *Contemporary political philosophy: an anthology*, ed. R. E. Goodin and P. Pettit. Oxford: Blackwell, pp 128-42.
- Evans, Peter B., Dietrich Rueschemeyer, and Theda Skocpol, eds. 1985. *Bringing the state back in*. Cambridge: Cambridge University Press.
- Ferlie, Ewan, Lynn Ashburner, Louise Fitzgerald, and Andrew Pettigrew. 1996. *The new public management in action*. Oxford: Oxford University Press.
- Fischer, Frank, and John Forester. 1993. *The argumentative turn in policy analysis and planning*. Durham: Duke University Press.
- Fishkin, James S. 1997. *The voice of the people: public opinion and democracy*. 2nd ed. New Haven and London: Yale University Press.
- Gamble, Andrew. 1994. *The free economy and the strong state: the politics of Thatcherism*. 2nd ed. Basingstoke: Macmillan.
- Gergen, Kenneth J, and Mary M Gergen. 1991. 'Toward reflexive methodologies.' In *Research and reflexivity*, ed. F. Steier. London: Sage, pp 76-95.
- Goodin, Robert. 2000. 'Democratic deliberation within.' *Philosophy and Public Affairs* 29 (1):81-109.
- Gray, John. 1996. *After social democracy: politics, capitalism and the common life*. London: Demos.
- Gutmann, Amy, and Dennis Thompson. 1996. *Democracy and disagreement*. Cambridge, Massachusetts: Belknap Press of Harvard University Press.
- Habermas, Jürgen. 1975. *The legitimation crisis of late capitalism*. Translated by T. McCarthy. Cambridge, MA: Beacon Press.
- Ham, Christopher. 1999. *Health policy in Britain: the politics and organisation of the National Health Service*. 4th ed. Basingstoke: Palgrave.
- Harrison, Stephen, and Maggie Mort. 1998. 'Which champions, which people? Public and user involvement in health care as a technology of legitimation.' *Social Policy and Administration* 32 (1):60-70.
- Harrison, Stephen, and Christopher Pollitt. 1994. *Controlling health professionals: the future of work and organization in the NHS*. Buckingham: Open University Press.

- Hendriks, Carolyn. 2002. 'Institutions of deliberative democratic processes and interest groups: roles, tensions and incentives.' *Australian Journal of Public Administration* 61 (1):64-75.
- Hood, Christopher. 1991. 'A public management for all seasons?' *Public Administration* 69 (Spring):3-19.
- Hood, Christopher, and Michael Jackson. 1991. *Administrative argument*. Aldershot: Dartmouth.
- Hughes, Owen E. 1998. *Public management and administration: an introduction*. 2nd ed. Basingstoke: Macmillan.
- Jorgenson, Jane. 1991. 'Co-constructing the interviewer/co-constructing 'family'.' In *Research and reflexivity*, ed. F. Steier. London: Sage.
- Kavanagh, Dennis. 1987. *Thatcherism and British politics: the end of consensus?* Oxford: Oxford University Press.
- Kerr, Peter, and David Marsh. 1999. 'Explaining Thatcherism: towards a multidimensional approach.' In *Postwar British politics in perspective*, ed. D. Marsh. Cambridge: Blackwell.
- Kingdon, John W. 1984. *Agendas, alternatives and public policies*. Boston: Little, Brown.
- Klein, Rudolf. 1990. 'The state and the profession: the politics of the double bed.' *British Medical Journal* 301 (6754):700-2.
- — —. 2000. *The new politics of the NHS*. 4th ed. Harlow: Prentice Hall.
- Klein, Rudolf, and Janet Lewis. 1976. *The politics of consumer representation: a study of community health councils*. London: Centre for Studies in Social Policy.
- Lane, Jan-Erik. 1987. *Bureaucracy and public choice*. London: Sage.
- Lenaghan, Jo. 1999. 'Involving the public in rationing decisions. The experience of citizens juries.' *Health Policy* 49 (1-2):45-61.
- Lenaghan, Jo, Bill New, and Elizabeth Mitchell. 1996. 'Setting priorities: is there a role for citizens' juries?' *British Medical Journal* 312 (7046):1591-4.
- Manin, Bernard. 1987. 'On legitimacy and political deliberation.' *Political Theory* 15 (3):338-68.
- Mansbridge, Jane. 1999. 'Everyday talk in the deliberative system.' In *Deliberative politics: essays on 'Democracy and disagreement'*, ed. S. Macedo. New York: Oxford University Press, pp 211-39.
- Milewa, Timothy, Justin Valentine, and Michael Calnan. 1998. 'Managerialism and active citizenship in Britain's reformed health service: power and community in an era of decentralisation.' *Social Science and Medicine* 47 (4):507-17.
- — —. 1999. 'Community participation and citizenship in British health care planning: narratives of power and involvement in the changing welfare state.' *Sociology of Health and Illness* 21 (4):445-65.
- Moran, Michael. 1999. *Governing the health care state: a comparative study of the United Kingdom, the United States and Germany*. Manchester: Manchester University Press.
- Mullen, Penelope. 2000. 'Public involvement in health care priority setting: are the methods appropriate and valid?' In *The global challenge of health care rationing*, ed. A. Coulter and C. Ham. Buckingham: Open University Press, pp 163-73.
- Nelson, William. 2000. 'The institutions of deliberative democracy.' *Social Philosophy and Policy* 17 (1):181-202.
- NHS Magazine. 2002. 'New health authority leaders announced.' *Primary Care, NHS Magazine*, February 2002.
- NHS Management Executive. 1992. *Local voices: the views of local people in purchasing for health*. London: Department of Health.

- Niemeyer, Simon. 2002. *Deliberation in the wilderness: the institutional formation of preferences and their discursive transformation*. PhD, Graduate Program in Political Science and International Relations, Australian National University, Canberra.
- O'Neill, Shane. 2000. 'The politics of inclusive agreements: towards a critical discourse theory of democracy.' *Political Studies* 48:503-21.
- Osborne, David, and Ted Gaebler. 1992. *Reinventing government: how the entrepreneurial spirit is transforming the public sector*. Reading: Addison-Wesley.
- Parkinson, John. forthcoming. 'Legitimacy problems in deliberative democracy.' *Political Studies* 50 (5):974-990.
- Peters, B Guy. 1999. *Institutional theory in political science*. London: Pinter.
- Phillips, David. 1980. 'The creation of consultative councils in the NHS.' *Public Administration* 58 (1):47-66.
- Pollitt, Christopher. 1993. *Managerialism and the public services*. 2nd ed. Oxford: Blackwell.
- Pollitt, Christopher, Stephen Harrison, David Hunter, and Gordon Marnoch. 1991. 'General management in the NHS: the initial impact 1983-88.' *Public Administration* 69 (Spring):61-83.
- Rawls, John. 1997. 'The idea of public reason revisited.' *University of Chicago Law Review* 94:765-807.
- Saward, Michael. 1998. *The terms of democracy*. Cambridge: Polity Press.
- Schaar, John H. 1984. 'Legitimacy in the modern state.' In *Legitimacy and the state*, ed. W. Connolly. Oxford: Blackwell, pp 104-33.
- Secretary of State for Health. 1997. *The new NHS: modern, dependable*. London: The Stationery Office.
- — —. 2000. *Have your say on a better NHS: creating a 21st century NHS (postcard)*. London: National Health Service, Department of Health.
- — —. 2000. *The NHS Plan: a plan for investment, a plan for reform*. London: Her Majesty's Stationery Office.
- Shackley, Phil, and Mandy Ryan. 1994. 'What is the role of the consumer in health care?' *Journal of Social Policy* 23 (4):517-41.
- Smith, Graham, and Corinne Wales. 2000. 'Citizens' juries and deliberative democracy.' *Political Studies* 48 (1):51-65.
- Social and Community Planning Research. 1998. *Deliberative poll: the future of the National Health Service - project instructions*. London.
- Stronks, Karien, Anne-Margreet Strijbis, Johannes Wendte, and Louise Gunning-Schepers. 1997. 'Who should decide? Qualitative analysis of panel data from public, patients, healthcare professionals, and insurers on priorities in health care.' *British Medical Journal* 314 (7100):92-6.
- Walzer, Michael. 1999. 'Deliberation, and what else?' In *Deliberative politics: essays on 'Democracy and disagreement'*, ed. S. Macedo. New York: Oxford University Press, pp 58-69.
- Weaver, R. Kent, and Bert A. Rockman. 1993. *Do institutions matter?: government capabilities in the United States and abroad*. Washington, D.C.: The Brookings Institution.
- Young, Iris Marion. 2000. *Inclusion and democracy*. Oxford: Oxford University Press.

Notes

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² Gutmann and Thompson (1996); Lenaghan (1996); Lenaghan (1999); Nelson (2000); Smith and Wales (2000); or paying relatively little regard to deliberative principles in the first place – see Button and Matson (1999)

³ See, for example: Bowie et al. (1995); Brown (1999); Dolan et al. (1999); Mullen (2000); Shackley and Ryan (1994); and Stronks et al. (1997).

⁴ Note that n=34, not 30, because some interviewees had multiple roles in the processes. “Observer” includes health policy academics conducting evaluations; the “other” process category includes academics interested in general public and patient involvement initiatives; “event manager” includes NHS staff and external consultants who facilitated the deliberations, as opposed to those on whose behalf the event was commissioned.

⁵ This “scope” requirement is controversial. Constitutionalists would argue that certain principles are necessary for the working of democracy itself and therefore should be fenced off from popular interference; others argue that such fencing is undermines democracy. For a discussion of both positions which comes to deliberative conclusions, see Gutmann and Thompson (1996, 26-39); for a discussion which denies the tension between constitutions and democracy, see Saward (1998, 53-7).

⁶ Dryzek (2001), however, offers a model of discursive democracy which attempts to overcome this problem by thinking of democracy in less individualistic terms. For discussion of Dryzek’s solution, and others, see Parkinson (forthcoming).

⁷ For more comprehensive descriptions, see Ham (1999) and Klein (2000). Only Klein covers the specifics of the key Blair reforms.

⁸ The CHC structure did not keep in step with repeated local and health authority restructurings from the early 1980s so, at the time of my research, the boundaries did no longer overlap so neatly: many health authorities had more than one CHC acting as their watchdog.

⁹ For good overviews and analysis of the Conservative reforms, see Gamble (1994), Kavanagh (1987) and Kerr and Marsh (1999). The new public management tends to attract more messiahs than septsics: for writing in the first camp, see Hughes (1998), Lane (1987) and Osborne and Gaebler (1992); for more critical discussion, see Ferlie et al (1996) and Hood (1991).

¹⁰ Harold Shipman was a Greater Manchester GP who was convicted in January 2000 of the murders of 15 patients; in July 2002 an inquiry found him responsible for 215 deaths, making him the UK’s worst mass-murderer.

¹¹ A phrase repeated, with minor variations, by three of my interviewees.

¹² The Strategy Unit and Milburn were directly credited by current or past NHS Executive members and those health policy academics closely involved with the Plan’s development and implementation.

¹³ DoH (2000, 7). Thanks to Carolyn Randall for the discussion on response rates.

¹⁴ In the US, the originator was Ned Crosby who registered the name “citizens’ jury” to protect both the intellectual property and to ensure consistency of process. The planning cell was developed by Peter Dienel, and is generally an iterative process: five or more cells running concurrently in different locations, each of which sends representatives to a final cell which puts together a final response. See Crosby (1998) and Dienel and Renn (1995).

¹⁵ Robin Clarke, Institute of Public Policy Research (IPPR), suggests that the analogy with the legal jury should not be taken too far: for example, there are no lawyers or judge, but a facilitator who directs proceedings; and juries can make many recommendations, not just binary choices.

¹⁶ Deliberative poll organisers in particular emphasise this claim – see, for example, Fishkin (1997, 163), and Social and Community Planning Research (1998, 8). In fairness, citizens' jury advocates, when emphasising representativeness, tend to do so only in the context of recommending juries for advisory purposes, not for making binding collective decisions – see Hendriks (2002)

¹⁷ A point made most strenuously by the former Undersecretary of State for Health, Gisela Stuart MP, and backed up by other interviewees in each of the locations I visited.