Partnerships and Collaborative Governance in Welfare: The Citizenship Challenge

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Whilst there is ample literature on the governance and management of partnerships in welfare, particularly within mixed-economy states, much of it has focused on the governance and organisational capacity issues. This paper draws on that body of literature and evidence from health and social care partnerships, and attempts to develop the theoretical and empirical work in the area to address the issue of citizens' social rights, asking whether collaborative governance and partnerships between agencies are the solution to promoting citizens' social participation, or another state-driven method of indirectly enhancing social exclusion.

Introduction

As the governance of welfare across mixed-liberal welfare states develops to take account of the myriad of different partners involved in the delivery of welfare, so interest in both the academic and practising policy community on the nature of partnership working has increased, not just in the UK but across Europe, North America and Commonwealth states (Geddes and Benington, 2001; Considine and Lewis, 2003; Bradford, 2003; Ovretveit, 2003). This is due to the perception that the struggle to respond to rising demand for services (and the perceived failure of traditional welfare regimes to respond adequately to users' needs) is due, at least in part, to the failure of the state to work properly 'in partnership' with the private and voluntary sectors, and with welfare users. The policy community has therefore focussed on the issue of partnership working, particularly on how in practice to develop and maintain inter-organisational partnerships (Balloch and Taylor, 2001; Sullivan and Skelcher, 2002; Glendinning, Powell and Rummery, 2002). Some of this work has examined issues that go to the heart of concerns about the governance of welfare: how to ensure the accountability of services to funders, and concerns about the sustainability and responsiveness of services for vulnerable users (Powell *et al.*, 2001; Glendinning, 2002; Newman *et al.*, 2004; Papadopoulos, 2003).

However, the policy push towards partnership working is neither particularly new, nor is it limited to being part of New Labour's 'third way' agenda – how to ensure better co-ordination between services such health and social care, given their interdependence particularly in the key fields of mental health and older people's services, has long been a 'wicked' issue in social policy. Social care is means-tested for users, and is funded partially through local taxation, which means that social care workers are accountable to locally elected councils through local authorities. Primary health care, in contrast, is free at the point of delivery and funded through national taxation, and provided through a mix of General Practitioners who are independent contractors and other community health staff

who are employees of local health care trusts. These organisational differences, coupled with interprofessional problems between doctors, managers, nurses and social workers, have led to sometimes significant barriers to the co-ordination of service planning and delivery between primary health and social care. Policies such as the 1990 NHS and Community Care Act, which were meant in part to clarify responsibilities and aid joint working, have not necessarily succeeded in supporting partnership working. The failure of service co-ordination in areas such as hospital discharge for older people, duplication of assessments and services and overuse of acute and residential services have highlighted how interdependent health and social care services are, particularly in providing services for older people.

For this reason as much as any other, the policy direction in UK health and social care policy under the New Labour government has been in clear support of collaborative governance and partnership working, and this can be seen as part of a wider commitment to partnership working in the welfare state. Policy developments such as the National Framework for Older People (Department of Health, 2001) have stressed the importance of developing joint assessments of need, and joint working now forms one of the key performance indicators for both the National Health Service and local authorities. Partnership working between health and social care has moved from the margins to the mainstream and is now mandatory rather than optional (Coppel and Dyas, 2003; Boyne *et al.*, 2003; Cameron and Lart, 2003).

Further developments have meant that new professional allegiances are having to be formed. *The New NHS: Modern, dependable* (Secretary of State, 1997) and the *NHS Plan* (Secretary of State for Health, 2000) signalled the development of new Primary Care Organisations (Primary Care Groups and Trusts) which would take on the responsibility for commissioning and providing health services on a locality basis. These Primary Care Organisations have representation from local General Practitioners, nurses, lay representatives and, crucially, social services organisations. This means that primary care doctors, managers, nurses and social services workers are having to find new ways of working together to deliver the government's health and social care agenda, encompassing both the localisation of service planning and delivery, and the fostering of horizontal networks of service commissioners and providers, in keeping with New Labour's commitment to 'Third Way'-type welfare policies. In particular, due to their status as independent contractors within the British health care system, General Practitioners have little historical experience of working together collaboratively with other health care workers to commission and provide services (Harrison and Dowswell, 2002; Calnan and Gabe, 2001), let alone working collaboratively with social care professionals outside of individual projects such basing social workers in GP surgeries (Rummery and Glendinning, 2000; Lymbery, 1998).

Partnership and the governance of welfare

Contemporary welfare states in European and Commonwealth mixed economy states are undergoing theoretical and policy revisions to the way in which they provide health and social care services, particularly in the light of rising demand for services from older people (Tester, 1996; Glendinning, 1998). Within centre-left and social democratic traditions, social theorists and politicians have been debating how to achieve a 'Third Way'

(Giddens, 1998) of delivering welfare, between centralised, bureaucratic planning on the one hand and liberalised free markets on the other. The challenge facing governments is how to deal with a rising demand for services against a backdrop of increasing globalisation and changes in economic and social developments which have led to traditional patterns of service delivery being criticised as being inefficient, insufficiently responsive to user demand and being delivered in organisational 'silos' which have led to the failure of collaborative or 'joined-up' governance (Ranade and Hudson, 2003; Papadopoulos, 2003). One way of moving services away from traditional patterns has been the development of a sustained policy focus on ways of facilitating partnership working between the private and public sectors and between different areas of public sector provision, such as health and social care.

Coupled with the rise in demand for services has been a general shift in older people's services away from institutional and towards community-based services and concern about the limitations of those services, a pattern which has been evident in areas as diverse as European Union countries, Australia and Asia (Otero *et al.*, 2003; Glendinning, 1998; Teo *et al.*, 2003). These twin developments have meant that a focus on partnership working between health and social care has assumed central importance in policy developments in the European Union, Nordic, Commonwealth and North American welfare regimes (Geddes and Benington, 2001; Considine and Lewis, 2003; Bradford, 2003; Ovretveit, 2003). Partnership working, both between public and other sectors, and between different areas of the public sector, is held up as being a way of achieving improved services for users where there is a commonality of interest between the partners and a history of failing to co-ordinate services effectively by other means (Audit Commission, 1998).

Concerns have been voiced about partnership working in the context of welfare delivery. The first set of concerns, from political scientists, has centered on the perceived legitimacy problems raised by issues of democratic accountability and the responsiveness of governance arrangements (Papadopoulos, 2003; Rhodes, 2000; Pierre, 1998; Newman *et al.*, 2004). The second set of concerns, voiced mainly by policy commentators and researchers attempting to evaluate or measure the success of partnership working, centres on the definitional problems (what constitutes a 'partnership'?) and on the difficulties in evaluating how successful partnership working is compared with other governance arrangements (Glendinning, 2002; Ling, 2002; Hudson, 1999; Dowling *et al.*, 2004). The final set of concerns revolves around the efficacy of partnership working and the lack of evidence that it produces any improvements in user outcomes (Rummery, 2002; Ling, 2002; Cameron and Lart, 2003; Ranade and Hudson, 2003).

In this paper I am hoping to raise a fourth set of concerns, not unrelated to the first and third above: that is the issue of citizenship within the welfare state, and the impact the focus on partnership working, and particularly the results of partnership working in health and social care, has had on the citizenship of individuals, particularly those from vulnerable groups in society.

Citizenship and the governance of health and social care

However, both the policy impetus and the academic debate surrounding welfare partnerships has focused largely on inter-organisational concerns, thus leaving underdeveloped the issues of governance which might concern welfare users, such as

user and community participation, accountability, and user outcomes. It has also left largely underdeveloped the linked issues concerning the social rights of citizens: the effect welfare partnerships have, or might have, on the 'non-political capacities of citizens which derive from the social resources they command and to which they have access' (Barbalet, 1988: 1). Turner points out that citizenship is concerned with both the 'content of social rights and obligations' and the 'various social arrangements whereby ... benefits are distributed to different sectors of society' (Turner, 1993: 2–3). Therefore, the way in which citizens gain access to resources to meet their needs, the way in which they participate (or do not) in the governance of welfare partnerships and the way in which relations between individuals, communities and the state are affected by welfare partnerships are crucial questions, not just for the governance of welfare, but need addressing in order to understand the role of citizenship in the welfare state.

Moreover, whilst policy makers have acted largely on the assumption that supporting welfare partnerships will, *per se*, lead to improved outcomes for users and communities, this assumption is as yet unsupported by any large body of empirical work and predicated on the assumption that the failure of the welfare state to respond adequately to need is down to its failure to work in partnership. Neither of these assumptions necessarily holds up to empirical scrutiny. Whilst there is a large body of evidence that what might be termed *intermediate* improvements in outcomes (e.g. improvements in interprofessional relations, improvements in access to services for users) can be discernable in areas that have focused on improving partnership working in health and social care, it is impossible to isolate these effects from other mechanisms of improving service delivery and co-ordination (Dowling *et al.*, 2004).

Lowndes and Sullivan (2004) have argued that although partnership and participation have co-evolved in New Labour's agenda for 'democratic renewal', the evidence shows that partnerships do not, *per se*, lead to enhanced public participation. Indeed, partnership working can create methods of working that operate against citizen involvement in the planning and delivery of services: the evidence suggests that focusing on working in partnership is not a cost-neutral activity; it diverts attention and resources away from other activities. Moreover the *costs* entailed in working in partnership with another organisation can lead to 'organised tribalism' amongst professionals (Dalley, 1989), whereby different professionals become more, not less, protective of their own professional spheres of expertise. Numerous studies of health and social care reorganisation have shown that the organisational turbulence experienced by each organisation can cause them to focus on protecting their agencies' boundaries, and thus give less attention to outward concerns (Rummery, 2004; Cameron and Lart, 2003). This can mean that *both* partnership working with other agencies *and* involving service users in planning and delivering services can suffer. Lowndes and Sullivan (2004) conclude that citizen participation needs to be 'designed-in' to local partnership arrangements, not 'assumed-in', as it is likely to fall by the wayside unless it is a specific objective from the outset.

The other phenomena that mitigates against citizen involvement in partnership is that the evidence shows that what partnerships achieve largely reflect the aims and aspirations of the stakeholders: if individuals and organisations realise that in order to achieve their own core objectives they need to work with the other person or organisation, they will do so, and if they can evolve ways of working that are based on trust (rather than, for example, on contracts or directives) then this characterises working in partnership, as distinct from other ways of co-operating or co-ordinating services (Rummery, 2002). The

evidence shows that stakeholders who are involved early on in partnership projects across a range of welfare settings can be very successful in manoeuvring these projects to achieve their own goals. However, citizens and service users (or vulnerable groups who may be potential service users) are rarely involved at the outset as stakeholders, and if they are they are rarely stakeholders who have access to budgets or any other kind of powerful lever. It is therefore very difficult for service users to influence partnership projects to achieve their own aims: the vested interests and the access to budgets wielded by the more powerful agencies, and the fact that it is the agencies that set the agenda and scope of reference for partnership projects, are a powerful shield against meaningful citizen involvement.

Moreover, increasing citizen involvement in the planning and delivery of services more broadly, and specifically in the case of health and social care partnerships, has never been a particularly powerful policy driver in the push towards partnership working. A more powerful discourse of 'modernisation', 'efficiency' 'effectiveness' and 'responsiveness' in the public sector has been a recurring theme (Newman, 2001). Within health care itself, citizen involvement is notoriously weak, and any progress towards citizen-involvement in health care within the UK has been limited by the dynamics of power relations and decision-making processes within the National Health Service (Harrison and Ahmad, 2000; Cawston and Barbour, 2003). Nevertheless, some commentators have noted that other levers – particularly the new managerialist strategies of surveillance and accountability to service-users as well as funders – could offer significant scope for citizen challenges to the hegemony of managerial and medical power in health care (Milewa *et al.*, 2002).

However, citizen involvement within local government in general, and social care in particular, has a much stronger history than within health care. This reflects the fact that the bulk of social care services in the UK, in common with other countries, fall within the remit of locally elected (and therefore locally accountable) government, whereas health care still falls within the remit of the Department of Health and historically has only been accountable through bureaucratic means to central government. There are, however, moves to change this, for example by making some local health functions fall under the scrutiny of local government (Milewa *et al.*, 2002). Although both health care and social care policy in the UK since the early 1990s have focused on the introduction of new managerialism and market mechanisms in an effort to improve the effectiveness and efficiency of both the planning and delivery of public services, incentives (and punishments) for accountability to local citizens and service users have been much stronger within social than health care. For example, the 1990 NHS and Community Care compelled local authorities to show that they had involved local users in the drawing up of community care plans: no duty of comparable weight was placed on health authorities. Whilst under New Labour pressures to increase citizen involvement in the planning of health care services, including strengthening mechanisms designed to increase accountability to local health care service users, local authorities and social care have had a much longer history, and therefore much greater expertise in this area.

Where partnerships between health and social care have been successful, both organisations have often been seen to adjust their aims, priorities and values in accordance with those of the opposite organisation. Where one partner – usually social care – places a greater value on citizen involvement in service planning and delivery than the other, a successful partnership can place that agenda within the core business of both

organisations. Moreover, as organisational boundaries become permeable through the process of partnership working, the sharing of information and expertise becomes easier, which enables organisational learning to take place (Mann *et al.*, 2004), not the least in the field of citizen involvement. In other words, by working in partnership with local authorities, the NHS can both bring citizen involvement higher up their own agenda, and tap into local authorities' expertise in citizen involvement without needing to re-invent the wheel (Young, in this edition).

Health and social care partnerships: issues and challenges

Although the rhetoric and rationale of health and social care partnerships is often about improving access to and the quality of services for users, in reality other, more powerful forces have driven policy in this area. The introduction of new managerialism into the public sector, whilst in theory increasing pressure on state bureaucracies to become more responsive to citizens, is only effective if citizens can be treated as consumers, or clients. However, the power that consumers have in a marketised welfare state is relatively weak, as they are often unable to exercise the levers of choice, voice and exit that would lead to market responsiveness (Barnes, 1997). Moreover, through overstressing the significance of responsiveness of services, the state obscures the significance of citizen action and participation (Vigoda, 2002), and this is very apparent when developments in health and social care policy in the UK are reviewed. Consumerism remains a significant policy driver in both health and social care policy (Calnan and Gabe, 2001), including the most recent round of health and social care reforms, although it is questionable for several reasons outlined above how far users of services can be viewed as 'consumers' and how far they can be empowered by the use of market, or quasi-market mechanisms (LeGrand, 1991).

Leaving aside the limits of marketisation and new managerialism in empowering citizens and service users, there is also the issue that moves towards partnership between health and social care services, whilst high on policy makers and professionals' agendas, is not necessarily high on the list of priorities that citizens would like to see tackled in the planning and delivery of health and social care. Often a greater concern for citizens, whether they are service users or only potential users of health and social care services, is the availability, quality and ease of access to services – in fact, users often cannot distinguish between a 'health' and 'social' care service except when they are asked to pay services charges for one and not the other (Twigg, 2002).

Nevertheless, there are changes in the way that health and social care services are planned and delivered that should, in theory, be the result of partnership working (or at least improved co-ordination) between health and social care. These changes often (but not always) are ones which users welcome and value, including:

Improvements in access to services. Issues such as waiting lists for services, difficulties in knowing how to access information and services (including information about which agency or professional is responsible for providing which service), delays in assessments for services because of failures to share information appropriately between professionals and agencies are of prime concern to users. The evidence shows that properly planned and executed partnerships between health and social care can improve interprofessional relationships, which leads to better assessment systems and improved

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sharing of information, reducing the need for several assessments and thereby reducing delays in accessing services. However these improvements seem, so far at least, to be largely the indirect result of changes in service provision or organisation designed to meet the needs of professionals and/or agencies, rather than users: for example, many joint health and social care assessment systems were designed to reduce paperwork and demands on staff time, rather than to improve users' experiences of accessing the services. The result of this focus is that the improvements to access are incidental to other gains, and only happen if they follow on from those gains. This echoes findings across other welfare partnerships that have tried to involve citizens in the planning and deliver of services: it is very rare that citizens' priorities align with those of agencies, and thus any improvements to services for citizens only seem to happen if that is in line with what agencies are trying to achieve (Williams, 2004).

Reductions in service fragmentation and duplication. As well as being of concern to users, these are also of prime concern to policy makers: nearly all investigations of 'systems failures' in welfare services – whether it be children who are abused or murdered when they fall between the cracks of social and other welfare agencies, or older people 'blocking' hospital beds because of failures to provide adequate support in the community or residential care – have laid a large proportion of the blame on agencies and individual professionals who have failed to co-operate or share information appropriately with another agency or professional. Whilst this may be the case, there is also often substantial evidence in such 'systems failures' that the individual agencies or professionals are also failing in their duty of care to meet their core obligations to service users and citizens. This failure to meet the needs of citizens is often overlooked in favour of focusing on failure at the margins or boundaries of services and agencies – in part because it is probably easier and more 'rational' response for agencies to try to shift the blame for failure elsewhere than to admit, and therefore to have to act on, their own failings. Nevertheless, however 'rational', this is dangerous for citizens. It means that energy and resources are encouraged to be diverted from the 'core' business of agencies to the 'margins', to improving the flow of information and resources across boundaries, rather than improving the flow of information and resources to users. Nevertheless, if improvements in the flow of information and resources across agency boundaries results in reduced service fragmentation and duplication, that will translate, albeit indirectly, to improvements in services for users.

Delivery of 'integrated' services. Linked to the issues outlined above is the issue of integrated health and social care services. In theory, these should avoid the 'interface/boundary' problems outlined above, by constructing services that are jointly funded and provided, ending boundary disputes over funding and provision that can cause delays for users. However, if we examine one example of such services some of the problems for citizens and users become clear. The development of so-called 'intermediate care' services – services designed to meet the needs of users, particularly older service users who are do not need to be in hospital but are not well enough to be discharged into the community – has been a feature of recent government policy in health and social care, specifically designed to solve the problems caused to the health service when elderly patients 'block' hospital beds which cannot then be used to reduce waiting lists, a key priority for hospitals. A conflicting priority for social care has always been the pressure to reduce the use of expensive residential care and to support users in (cheaper)

community settings as long as possible: intermediate care services are thus designed to enable elderly patients to leave hospital for a period of rehabilitation or whilst suitable residential care can be found for them. Intermediate care services thus often do meet both health and social care agencies' needs: however, they do not necessarily provide what users consider to be important. Research has shown that services users, particularly older service users, value remaining in their own home as long as possible, want reliable, high quality services that provide *help* and *support* in a way which meets their needs, are co-ordinated with help and support provided by family and friends, are under their control, and do not place them in any financial risk (or risk of losing their home). If they do end up in hospital older people often would prefer to remain there until they have recovered sufficiently to be able to return to their own homes, with the above-mentioned array of services in place (Bryant *et al.*, 2001; Kharicha *et al.*, 2004). Whilst the NHS may want them out of hospital beds, older patients may prefer to remain in them, where care and board are free at the point of delivery and regarded as being of high quality, than be transferred to a facility which may or may not be near their home, may or may not provide high level medical and nursing care, and may or may not simply be regarded as the stepping stone to residential care. Integrated services are highly likely to be designed to meet the needs of the policy makers, funders and providers of services rather than reflecting the priorities and aspirations of users and their families.

Partnership and the citizenship challenge

There are therefore several issues and challenges for citizens that arise from partnership working in the welfare state. Firstly, there is the concern that the policy emphasis on partnership working in health and social care deviates resources, energy and attention away from respective agency failures to deliver on their core objectives and meet citizens' needs. Secondly, and related to the first set of concerns, is the issue of agencies and professionals' attention being diverted to meeting the partnership agenda and away from directly improving access to and the range and quality of services available to users. Thirdly is a set of concerns deriving from the evidence that shows that partnerships tend to result in changes in the planning and delivery of services which meet the needs of the agencies and professionals concerned, and that these needs may not necessarily be the same issues that citizens would prioritise themselves, given the power to do so. Indeed, partnership working that only involves the 'usual suspects' of health and social care may well be involving the wrong partners altogether, if citizens' concerns about transport, crime, leisure, poverty and other issues are to be addressed. A fourth set of concerns derides from the lack of evidence that partnership working *per se* delivers improved outcomes for users, and related to that issue is the concern that the improvements that do result for users tend to be indirect, and the result of improvements aimed at meeting agencies' and professionals' needs, not users' needs. Finally, there is a real danger that the policy focus on developing and improving partnership between agencies works against improvements in involving citizens in meaningful ways in the planning and delivery of services – in other words, that partnership working strengthens the role of agencies in a way that can disempower citizens and lead to their social exclusion.

Nevertheless, we should guard against throwing the baby out with the bathwater. Indirect improvements to services can certainly be attributed to partnership working, and the dangers of users and patients falling between the gaps of health and social care services

is certainly one which the state should be aiming to prevent. But partnerships have been held up to be the panacea for all that ails welfare services, particularly health and social care, and citizens should be aware that this is not the case: partnerships can be bad, as well as good for your health. It may be better from a citizenship perspective to aim for 'holistic governance' (6 *et al.*, 2002) rather than focusing on partnership working between selected branches and sectors of public sector provision. This remains a significant challenge.

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