Connected Communities

New Connectivities: Civil Society, the 'Third Sector' and Dilemmas for Socially and Economically Sustainable Healthcare Delivery

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CONNECTED COMMUNITIES

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The U.K. is now taking highly significant – and historic -- steps to open up the NHS to a wider market   Among the proposed changes, as laid out in the recent NHS White Paper, 'Equity and Excellence: Liberating the NHS' (2011) and the Health and Social Care Bill (2012), is a greater role for civil society organisations and social enterprise, as well as the private sector (DOH, 2007; 2010).

The effects of a more open market in healthcare on civil society groups, however, remain unclear and under-theorized. Traditionally held up as mediators between the state and the communities they serve, they are now being encouraged to perform new roles in a post-welfare world, including functioning as healthcare providers themselves, as well as patient advocates, in a competitive landscape where patients (or service users) can make choices under the 'any qualified provider' model laid out in the NHS White Paper (Ashton, 2010). Crucially, how will their traditional connectivities with user communities be affected – for better or for worse? What new relationships and networks are they forming to meet new challenges in this fast-changing landscape? And finally, how sustainable are these models of service delivery in an era of austerity and funding cuts?

This project examined these issues by directly engaging with civil society organisations (charities and voluntary groups) state and non-state actors in the health and wellbeing sectors. Data were collected through intensive workshops, focus groups and a symposium led by the researchers and including invited experts from Canada, the Netherlands and the U.K.

Researchers and Project Partners

The researchers (Dr. Lim, Prof. Annandale and Prof Ruzza) have established relationships with the Leicester City Council and their department of business services to address the issues described above. Participants in the study include 24 local civil society organizations (charities, social enterprises, voluntary groups) representing a diverse mix of communities. Other participants include businesses and social enterprises, Health commissioners, volunteers and CEOs of a number of voluntary sector organizations gave their input throughout the process of data collection.

Key words

Connectivities; Civil Society organizations, Third Sector, Sustainable Healthcare; Health and Wellbeing; Healthcare Delivery

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Executive Summary

This project aimed at better understanding the development of new forms of connectivity between health-related civil society organisations, user communities and healthcare stakeholders. Currently, there is little understanding of the strategies of civil society organisations for combining different, and often competing, social and political blueprints of their service delivery roles (Kendall 2009), how they 'select' sources of financing, their normative criteria for targeting specific populations (which may not fall neatly within a narrowly-defined category of 'illness' or 'disease') and what input they actually have on policy-shaping and implementation.

Also of concern was whether, and how, civil society groups felt they were able to innovate and achieve their transformational potential in a new marketised landscape of healthcare provision and delivery (Ashton, 2010; Dickinson and Miller, 2011). Relatedly, the research sought to discover how these objectives might affect the expression of 'social compassion' among civil service groups and, if it did, how the leaders of those organizations would choose to align themselves with prevailing economic, cultural and political imperatives.

It was felt at the outset that international comparisons would be extremely beneficial for the project since the success of state-backed social entrepreneurialism in other European and North American contexts (Kuhlmann and Annandale, 2012; Peattie and Morley, 2008) has been based upon forging new ties with the public, commercial as well as community sectors to exploit untapped markets in hard-to-reach areas and communities (Borzaga & Defourny 2001). In Europe and the U.S., social enterprises have been able to combine commercial   practices with their social mission in ways which promote economic inclusion among societal groups.

In summary, the scoping review undertook:

- To analyse the implications of the *potential loss of traditional forms of connectivity* between civil society organisations, communities and various healthcare stakeholders.
- To identify and trace the *formation of new forms of connectivity* between civil society organisations, communities and various healthcare stakeholders.
- To synthesise international research on the combinatorial possibilities of business-led practice and social passion which social enterprises in the U.K. can exploit to forge new community programmes based on economic prosperity and social inclusion.

- To uncover and evaluate evidence that forms of connectivity driven by social passion and benevolence can be economically and socially innovative and transformational for 'health communities' and end-user groups.
- To discover how volunteers within the third sector mobilise forms of 'informational connectivity' and what the current fissures are in these efforts – technological, social and political – in order to propose evidence-based policy solutions.

Activities

The scoping study was designed, therefore, to fulfil two aims: first, to instantiate a strong participatory role for civil society groups from the outset, and, second, to focus on discovering the real-time effects of proposed NHS reforms by the Coalition government upon the third sector. Data collection was guided throughout by these two objectives.

After a period of planning and coordination, several meetings were held with the Leicester City Council and relevant departmental heads to discuss two sets of activities: a full-day workshop and a formal symposium which featured invited experts from the Netherlands, Canada, Germany and the U.K. The workshop took place on the 24th of May 2011 and the symposium on the 25th of December 2011. Both were well attended and highly successful. Feedback given by participants was excellent across the board.

The workshop used an innovative format comprising brief presentations to orient participants to the issues, followed by five concurrent focus group sessions and ending with in-depth individual and group interviews. Following a short break, the 24 invited delegates from local civil society organisations (CSOs) were introduced to each other at various focus group tables. Each focus group had a moderator and a note-taker. Each person was asked to discuss give their views with others and to comment upon the research questions. These focused on issues of connectivity, community cohesion and the impact of funding cuts upon connectivity and community. The discussions were audio-recoded (with individual consent).[1]

The symposium in December 2011 followed on from these findings and was aimed at deepening thinking among a group of volunteers who had attended the Workshop , additional community group leaders and academics working in other cultural and political contexts. Several thought-provoking presentations were given by international experts in the area of healthcare delivery, community diversity and national policy.

Dr. Lim and Prof. Ruzza presented their analysis of focus group data in "Health services and the Advocacy Role of Community Organizations: Implications for

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[1] The consent forms were reviewed and approved by the University of Leicester's ethics committee on 18 May, 2011.

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Vulnerable Groups and Individual Choice". Prof. Annandale summarised some of the themes which came out of the May Workshop on the implications of the proposed new commissioning models for existing connections between CSOs and their under communities : "You can't just Chase the Money: the Third Sector, Patient Communities and the Changing NHS". Professor Oliver Schmidtke, (Jean Monnet Chair in European History and Politics, University of Victoria), spoke on 'Accommodating Cultural Diversity in the Healthcare System: Does Civil Society Advocacy Matter?' and Dr. Christian Bröer (University of Amsterdam) presented, 'Policy Impact, Advocacy and Health Risks in the Netherlands.'

Oliver Schmidtke's presentation described how cultural diversity is both addressed and also problematized in Canadian public policy, particularly with regards to the contribution of civil society groups in addressing issues of limited access and inequitable services for migrants and minorities in a universal health care system (Falge, Ruzza & Schmidtke, 2012). This 'intercultural aperture,' as he calls it, is at odds with the egalitarian spirit of universal access but is also to be expected in a time of scarce resources and uncertainty over how those ought to be allocated to specific groups. While individual initiatives to accommodate diversity in the Canadian context have succeeded, there is still no mainstreaming of institutional change.

Christian Bröer focused on 'patients' rights' in the Netherlands amidst changing norms in New Public Management, mandatory insurance, competition, ranking, reporting and demand steering. New forms of professionalism were emerging in the form of the entrepreneur, the activist, the pretender, the bureaucrat and the performance manager. The risks and challenges of the 'citizen-patient' model this presentation highlighted were extensively debated by all delegates at the symposium. His presentation shed light on existing literature which aims to identify the potential for performative roles to emerge in a competitive landscape within the European Union (Thomson, Foubister and Mossialos, 2009).

Dr. Eva Elliott from Cardiff University spoke on 'Connecting Communities for Better Health: Passions, Pitfalls and Problems'. Dr. Elliott's work analyses the centrality of the concept of 'social capital', arguing that it did not always have to be co-opted by academics to explain large-scale social transformation but could also be about people "getting by" in the face of adversity on an individual/neighbourhood level. Thus, affirmations by people in various ways to each other on micro-sociological, pragmatic levels *is* community. Thus, major interventions might not always be necessary or appropriate in addressing health inequalities.

The scoping review undertaken at the symposium led to several conclusions and directions for future research, viz., how can neo-institutional theories help frame research on healthful communities (especially in multicultural contexts), how does the 'patient-citizen' role in developed economies affect healthcare policy and delivery, how can we improve research and evaluation to understand the relationship(s) between social structure, community processes and health

outcomes, and last, but not least, should or can research support both communities and policy makers?

To further clarify how the learning from research can be embedded in future action to achieve deeper connectivities between the third sector, civil society groups and healthcare policymaking, the following findings from our two events are presented in the next section.

Findings and Implications

Initial findings (based on analysis of the interview and focus-group data) from the workshop in May 2011 indicate that new dilemmas were already emerging for civil service organisations and charities. Key among these were that civil society groups were both united against, and divided by, budgetary constraints in a time of austerity and continued uncertainty about the role of the third sector in England. We found that the impact of budget cuts was disproportionately bigger on smaller organizations than on larger ones. One reason for this was the fact that smaller organizations were already struggling in the wake of increasing demands for outcome reporting and shrinking funds prior to the economic crisis.

A consequence of this phenomenon was a weakening in community diversity and representation. For instance, faith-based CSOs were reproached by other organizations of only really accepting as representatives people of their own faith and ethnic group, thereby reducing the ability of civil society organisations to aggregate consensus.

The NHS was also criticised for not welcoming what one delegate called 'effective and permanent change' in how they would work with the third sector in the future. There was also the feeling that local authorities and county councils spent too much time and far too many resources on 'PR strategies' that tried to put a good face on its efforts to serve communities when, in fact, many personnel were seen by third sector and civil groups as not really able to accept cultural diversity.

Ironically, third sector organizations would be called upon by the NHS to deal with individuals or groups where English was not widely spoken or understood or with 'difficult' communities. Yet, the funding for these activities would be extremely challenging to secure.

The structure of CSOs and their representativeness

The selection of community representatives by local authorities was criticised by participants as inappropriate since these choices were often based on a concern with compliance and political expediency rather than on what was best for the communities involved. Thus, local governments would typically select community representatives who they believe represents communities but who are, in fact, people well-connected to NHS trusts and who were not necessarily embedded in the communities they are supposed to represent. One leader of a charity commented that 'more often than not, these representatives "*represent just themselves* and yet they are listened to far more than is, than their

opinion would legitimately, should legitimately, allow them to". "Another participant noted that people had been selected as NHS spokespersons whom their community of reference "thought...were dead, so absent from community life they had been".

Thus, community leaders felt they were best able to choose representatives who were most connected to them *for real*, on a day-to-day basis. If the local authorities took on this role, severe healthcare delivery shortcomings would result and would not be sustainable because these artificial choices were not based on existing, long-term connections between individuals and their communities. One recommendation by participants, therefore, was that that local politicians and the council needed to "learn to listen" to the third sector a lot more if healthcare delivery was to be effective and sustainable. Such beliefs range from a general emphasis on refraining from PR exercises to suggestions for a better identification of community representatives.

When the question of how existing connections would be altered under the 'any qualified provider' model of care was raised, the data show that CSOs were dubious about the tendency to 'chase the money' for contracts. Figure 1 sums up our findings as to how community leaders and volunteers regarded the distinction between their organizations and mainstream NHS provision, encapsulated under a distinction between 'social' and biomedical' models:

Third sector	Mainstream NHS/GP and private sector
• **Concerned with Social value added**	• **Concerned with Economic value ('Big society'= Big Market)**
• **Genuine connections with communities as collectivities**	• **Restricted connections with 'users' via individual (un)representatives**
• **Community-focused/ownership**	• **Destroys community**
• **Empowering**	• **Controlling**
• **Individual-centred and collectivist**	• **Individualistic e.g Personalisation agenda**
• **Social model**	• **Biomedical model**

Figure 1. Perceived differences between the third sector and the NHS' model of care

We found that while it was important for third sector organisations to distinguish themselves from the NHS and the private sector in order to carve out their unique provider status in the market, there were many reasons why a hard, binary distinction was not easily sustained in practice. It was felt by participants that they either had to try to survive at the margins of the NHS or to try and engage with it by becoming part of it or inhabiting it. The ideal for many participants would be to work in partnership with the NHS on a 'different, but equal' basis, but most of them were not optimistic that this would happen in the near future.

Outputs

Three publications are now under preparation for submissions to internationally peer-reviewed journals in the field of public policy, social policy and healthcare. These are: *Critical Social Policy*, *Voluntary Sector Review* and the *Journal of Civil Society*.

We have also presented our preliminary findings at conferences and to policy audiences.

- **England**: Attended and participated in a panel on 'Social Enterprise: New Models and Practices' at the Social Enterprise Annual Conference; King's Fund 'Big Society', London.

- **Europe**: Two papers to the European Sociological Association Conference, Geneva 2011; C. Ruzza 'Health services and the advocacy role of civil society organizations on behalf of vulnerable groups', and E. Annandale 'New Connectivities? Civil society, the Third Sector and the UK National Health Service.

- **South America**, **Buenos Aires**, International Sociological Association World Forum (Aug. 1-4 2012). E. Annandale and C. Ruzza 'The third sector, patient communities and the changing NHS in England'.

In addition, the researchers have presented their findings at Departmental seminars at the University of Leicester.

The findings have been disseminated to a diverse set of audiences through features and op-eds in national and local newsletters, including Radio Leicester and *Leicester Speaks,* a widely-read blog and newsletter for the voluntary sector in Leicestershire.

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The Connected Communities

Connected Communities is a cross-Council Programme being led by the AHRC in partnership with the EPSRC, ESRC, MRC and NERC and a range of external partners. The current vision for the Programme is:

> "*to mobilise the potential for increasingly inter-connected, culturally diverse, communities to enhance participation, prosperity, sustainability, health & well-being by better connecting research, stakeholders and communities*."

Further details about the Programme can be found on the AHRC's Connected Communities web pages at:

www.ahrc.ac.uk/FundingOpportunities/Pages/connectedcommunities.aspx