Victory for volunteerism? Scottish health board elections and participation in the welfare state

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This paper presents findings from a multimethod study of pilot elections held to choose members of health boards in the National Health Service in Scotland. We begin by proposing that much current public involvement practice is dominated by a volunteerist model, in which members of the public with time and skills to offer play essentially supportive and non-challenging roles within health care organizations. This model contrasts sharply with the adversarial, political model of electoral democracy. Nonetheless, drawing on a postal survey of voters, non-participant observation of Boards, and semi-structured interviews with candidates, elected Board members and other stakeholders, we demonstrate that the introduction of elections did not overcome the volunteerist slant of current public involvement with health care organizations. Far from offering a 'quick fix' for policymakers seeking to ensure accountability of health care organizations, elections may produce remarkably similar outcomes to existing mechanisms of public involvement.

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Introduction: The volunteerist model of participation in social services and the electoral alternative

Establishing and evaluating public involvement in health care has long been a challenge for policy and practice. On one hand, public participation in decisions that spend public money and affect public services, employment, and health is desirable on democratic grounds and for its contribution to responsive, accountable, and appropriate health services (Tenbensel, 2010). On the other hand, defining, creating and evaluating effective democratic accountability and public involvement have been a stumbling block in many different health systems (Conklin, Morris & Nolte 2010, Klein and New 1998, Martin 2008).

One of the recurrent problems described in studies of public involvement is that the people who voluntarily participate in making and implementing health policy have distinctive characteristics. They are generally better educated, older, wealthier, and often whiter than the overall population (Church, Saunders, Wanke, Pong, Spooner & Dorgan 2002; Flinders, Matthews and Eason 2011; House of Commons - Health Committee, 1997). There are multiple dimensions of representation (Urbinati & Warren 2008) that are negotiated in public involvement practice (Martin 2008). Nonetheless, there is a clear tension between volunteers' self-selectedness and thinking of them as representatives. The distorting effects of self-selection are widely acknowledged as a key challenge for new 'participatory' modes of public engagement (Warren 2009; Cain, Dalton & Scarrow 2003). These self-selected participants also frequently understand their role in ways that frustrate advocates of greater democracy (Litva et al 2002; Tritter & McCallum 2006): rather than representatives of the full range of community needs and views, ready to challenge

the decisions of the established organizations, it is common to find that those willing to engage more closely resemble meliorist volunteers. By meliorist volunteers we mean participants who seek simply to support organizations to do their jobs better. This may, in keeping with the wide range of roles fulfilled by volunteers in health systems (Naylor, Mundle, Weaks & Buck 2013; South, White & Gamsu 2013) and in line with the preferences of people who prefer to avoid overt politics (Eliasoph 2011) make it easier to run an organization, but it will rarely offer the kinds of scrutiny and challenge envisaged by advocates of democratic health care.

In response to discontent with existing practices of public involvement, and perhaps a sense that decision-making in general could be more effective, a variety of governments in New Zealand, Scotland, England and Canada have experimented with direct elections to health boards that provide or purchase a large part of their health care (Gauld 2010). This entails the introduction of the key tool of representative models of democracy – elections – into a field conventionally dominated by participatory or deliberative democratic modes of engagement. While diverse, and rooted in different historical experiences and structures, these experiments tend to test a hypothesis that elections will increase accountability and diversity of boards, shifting them away from a class-, age- and ethnically- biased composition with a volunteerist ethos toward one that better reflects community demographics or preferences.

This article examines the extent to which the intervention- direct elections to health boards- overcomes the strong tendency of public involvement to fall into what we characterize as a volunteerist model with both demographic and behavioral characteristics. We first sketch out the volunteerist model of public involvement, and why elections might introduce people, ideas, and motivations outside that model. We

then discuss a multimethod inquiry into direct elections in two Scottish health boards designed to investigate how far elections displace the volunteerist model by changing the membership or the behavior of boards.

The volunteeristic model of public involvement

Existing literature on public involvement in health emphasizes problems of conceptualization and definition (Wait & Nolte 2006; Contandriopoulos 2004). This is an area replete with practical accounts but unusually dominated by a small number of theoretical models which categorize public involvement by the degree of 'empowerment' it offers (Stewart 2013). The most notable instance of this is Arnstein's (1969) ladder of participation which plots participation along a continuum from the bottom rungs of therapy and manipulation to the author's goal of citizen control of services. This basic conceptual structure – ranking instances of public involvement by the degree to which they offer empowerment – has been the basis for a range of models of public involvement in health (Tritter & MacCallum 2006; Charles and Di Maio 1993; Feingold 1977; Thompson 2007). Despite the tendency to disaggregate involvement into multiple options, many of these conceptual frameworks demonstrate a disjuncture between change-oriented activities drawing on a democratic understanding of involvement, and a less challenging consumeristic perspective from which effective public involvement may look very similar to thorough market research.

In this paper, based on extensive data collection from our case study, we explore the implications of a specific reform in the Scottish NHS. We contrast volunteerism with political activism. These are two recognizable, but rarely articulated, ideal types (in the Weberian sense) of public involvement. There are

tensions between them, which come across more strongly when we think of them as contrasting conceptions of how public services like healthcare should be governed, rather than points on a continuum. These tensions were starkly illustrated by our case study, in which elections to health boards forced real decision-makers to address these tensions in very practical ways.

We propose that much public involvement in health services – including strategic public roles such as Board membership – is normally volunteerist rather than activist. In a literature that often starts from the assumed benefits of any participation (Putnam, 2000), the distinction is not consistently articulated (Harre, 2007). The substantial sociological literature on volunteering – that is "any activity in which time is given freely to benefit another person, group, or organization" (Wilson 2000, p215) – preoccupies itself with the predictors and consequences of volunteering activity (Wilson 2000; Wilson 2012). Volunteering is argued to yield a range of benefits for the individuals and the societies in which they volunteer (Verba, Schlozman & Brady 1995; Oman, Thoresen & McMahon 1999; Harlow & Cantor 1996; Casiday 2008). In tune with these positive findings, creating opportunities for members of the public to volunteer within health care organizations is increasingly seen as a progressive step, associated with improved information-sharing and outcomes (Naylor, Mundle, Weaks, & Buck, 2013; South, White, & Gamsu, 2013).

More relevant to our thesis is the vexed issue of the relationship between volunteering and activist (or at least change-oriented) pursuits. Simply put, are public involvement roles a cog in an organizational machine, or do they transform the organizational machine from the inside? Wilson argues that the categories of volunteerism and activism are mere social constructions, between which individuals will shift as circumstances change and that accordingly "there is no good sociological

reason to study them separately" (Wilson 2000, p217). However, other authors have fruitfully done so: Markham and Bonjean (1995) distinguish 'establishment-oriented' and 'confrontational' tactics of volunteers in a women's organization; Caputo (1997) investigates the extent to which female volunteers sought to 'change social conditions'; Eliasoph (2011) explores the complex interplay of 'empowerment' and bureaucratic routine in civic associations. We propose that pursuing the distinction between activism and volunteerism in accounts of public involvement in health can be analytically valuable. In health boards, for example, members of the public serve as directors alongside senior executives. Whether they automatically approach those directors as collaborators, or foresee situations in which their interests could conflict with those of the wider public, may have profound implications in practice.

A 'volunteerist' model of public involvement emphasizes collaboration and service over challenge and opposition. The core concept of the volunteerist model is that members of the public who choose to engage with health policy and planning, for little or no remuneration, are engaged for a distinct set of reasons. Volunteers are often semi-retired or retired professionals, frequently from the public services, who seek to continue their contribution to the public good, and use their managerial or technical skills by participating in health services decision-making. This set of descriptives more or less predicts that they will be disproportionately higher-income, more highly educated, and older. They will tend to have professional backgrounds, frequently in public services, which they have been socialized to believe provide the skills to ameliorate social problems (Wilson 2000: 219-23). Because their interest is meliorism, perhaps inspired by gratitude or a sense of obligation, rather than a specific issue, they will not usually have special reliance on health services due to

current poor health, disability, or caring responsibilities. Activists, or aspiring professional politicians, would presumably have somewhat different demographics.

Beyond their demographics, a volunteerist model suggests participants will have a coherent ideology with the following characteristics:

- a community orientation, focused on the community as a whole without highlighting specific interest groups (and possibly actively hostile to perceived special interests);
- the ability to accept an institutionally bounded definition of community, serving the community assigned to the relevant public institution;
- a resistance to party politics, and to the instrumentalization of local decision-making by those interested in political careers; their politics are by avocation rather than vocation, in Weber's terms.
- a desire to contribute to the welfare of an organization, accepting its basic ongoing activities and values;
- a willingness to defer to the organization's hierarchy rather than confront it.

In short, a volunteerist model would suggest that people willing to engage with health care organizations are people who wish to help the organization on its own terms, without substantially questioning its basic activities or seeking to introduce contentious politics. The idea is to reinforce and support, rather than critique or change it. This does not imply that these volunteers do not have valuable, and in some cases, specialist skills to offer. There is strong evidence that NHS organizations, and many other health systems have many ways to work within a volunteerist paradigm in order to benefit from the knowledge and skills of such outside volunteers (Naylor, Mundle, Weaks & Buck 2013). Rather, the skills and experience of these individuals are put to work in the service of an organization,

rather than in the service of a mission to make that organization substantively different.

The electoral alternative

The volunteerist model of public involvement - participatory opportunities populated by supportive members of the public who overwhelmingly share demographic characteristics and an eagerness to be helpful – makes the day-to-day life of an organization easier, but will rarely yield thoroughgoing or transformational engagement. What kinds of policy changes, treatments, could overcome the biases in the volunteerist model of public involvement? Elections are perhaps the ultimate tool to establish popular accountability for decision makers: while elections might be used for a variety of reasons (Barnett et al 2009), replacing unelected rulers with elected representatives is universally taken as a sign of some democratization.

Having elections is not always better than not having elections, but elections can bring important benefits. In principle, they could bring communities in, both by allowing the electorate to choose board members who more closely resemble themselves in ideological or demographic terms, and by forcing board members to be more attentive to potential community discontent, opposition, and benefits when they make their decisions. If the offices attract serious campaigns, especially campaigns run by political parties, they might also benefit from the proven expertise of parties in mobilizing voters and gaining attention, thereby further increasing the visibility and accountability of the board while meshing it into the broader political system. It might produce uncomfortable situations for managers and ministers, since it might lead to ambitious young party politicians, local campaigners, interest group

representatives and even local celebrities serving on boards, and it could create incentives for members to take constantly oppositional stances.

Conflicting logics

What happens when an electoral logic is introduced into organizations, such as the middle tier of health services, which are still accountable to ministers for their budgets and priorities? One possible outcome would be a victory for the logic of elections: that interest groups and political parties will support candidates who agree with them, that candidates will try to establish public profiles, taking popular stances and trying to identify themselves with concrete benefits, that candidates will be integrated into larger political contests, both seeking careers in politics and using their positions to score points for their supporters (by, for example, using a seat on a board to criticize government health policy). In other words, elections could significantly affect the role.

An alternative would be that the properties of the health organization would muffle the impact of elections. Limits on the powers of the organization, and the limited powers of a board would mean that it would continue to attract the same kind of volunteers. In such a scenario, the restrictions on board members, and the organizations themselves, within the context of NHS systems where power lies in the government, would mean that political parties, campaigns, and interest groups would not focus on electing and influencing board members. Instead, advocates, ambitious politicians, and interest groups would continue to focus on more important elected offices and leave the health services to now-elected volunteers.

We expect that the volunteerist model will trump the electoral model of public participation, even in the extreme case of direct elections to health boards. We expect that this will be because, despite the availability of remuneration (£8000 a year), citizens who engage will be interested in health board membership for the same reasons that they are interested in other volunteer positions: a sense that the organization is providing a worthwhile public service, and that its objectives and procedures are sound. We expect that this victory of volunteerism would happen because in public consciousness, administrative practice, and law, the powers of bodies such as health boards are limited and real power lies with the minister and legislature. As a result, people interested in a fundamental critique of the health services, in contesting particular policies, or in having a political career, will direct their energy elsewhere and leave participation in the health organization to those who have extra time and would like to assist the organization; volunteers, of the sort already involved in public engagement.

Data and Methods: Identifying volunteerism at work

Our objective is to contribute to the international literature on public involvement in health policy by determining whether volunteerism was the dominant model for public participation via elected positions in this case, rather than more thoroughly democratic and conflictual approaches. Our case study is a multimethod study of an experiment in Scotland, where two National Health Service Boards (out of a total of fourteen territorial Boards across Scotland) introduced direct elections to their governing boards in 2010. Our research was conducted from early 2010 until late 2012.

Identifying volunteerism at work

Our strategy for identifying the volunteerist model at work has two mutually reinforcing components. One is demographic and quantitative, and implies that this kind of time-consuming, bureaucratically demanding volunteerism, with its basically community-service orientation, will continue to attract people with time, skills, and good health, rather than a cross-section of service users.

The second is behavioral, best tested with qualitative interview data. We examine the expressed motivations of those who seek to participate, and their interpretations of their current or potential roles. A volunteerist model suggests they will express their support in terms of contribution, help, and support rather than opposition, or fundamental criticism. They should see their 'constituency' as the broad population for which the organization is responsible rather than specific groups, agendas, or interests. We would also expect those in the volunteerist mode to shy away from party political activity and clearly defined political agendas.

Our specific hypotheses are therefore:

Hypothesis 1: Volunteerist participants in elected health boards will be older and better educated than the general population, and not have clear user interests as carers, parents, or patients.

Hypothesis 2: Volunteerist participants in elected health boards will be interested in contributing to, rather than critiquing, the organization and its decisions, and will show this by not seeking out opportunities to publicly critique the organization, and will accept constraining norms of board member behavior dating to before the elections.

The Scottish health board pilots of 2010

Our data comes from a multimethod research project, undertaken as part of a statutory evaluation of the Health Boards (Membership and Elections) (Scotland) Act 2009. This Act provided for the Scottish Government to pilot changes in the composition of the boards that govern Scottish health boards. Traditionally, members of the public were appointed by the minister after independent vetting. Now, most would be elected.

Scotland's fourteen territorial health boards are impressively large organizations, responsible for the planning and provision of almost all health services in their areas in Scotland's non-marketised health system (Greer 2004). In 2011/12 the territorial Boards received 9, 615 million GBP of a total NHS Scotland budget of 11,714 million GBP (Audit Scotland 2012, p7). Despite these significant powers, they are constrained by a number of central Government requirements, including the need to break even in each financial year, and are held to a defined range of performance targets known as HEAT targets (Audit Scotland 2012). There is no formal representation of the territorial Boards at central level (as is the case with the NHS Confederation in England), but senior officers from the different regions "meet regularly and have easy access to ministers and officials in the Scottish Government" (Steele and Cylus 2012, p26). Therefore while health boards are major budget-holders, they are conventionally seen more as 'policy-takers' than 'policy-makers'. Decisions taken (and not taken) at Board level have consequences for the wider organization, but are rarely dramatic and frequently incremental. While it is not unheard of for Boards to criticize central Government, it is extremely rare, and the

sense of accountability to central Government is strong. This has implications for their visibility and relationship with the publics that they serve. When asked about lines of accountability, Health Secretary Nicola Sturgeon stated explicitly at the 2010 induction for newly elected Board members that she expected Boards would remain accountable to her, despite a majority of their members being elected.

"Board" in the Scottish NHS can refer both to these large organizations and to the group of directors overseeing each of them. The governing boards include directors who are also senior managers, representatives of interest groups, and others selected from among the general public served by the board. NHS Boards have governing boards of directors responsible for "strategy" and "governance" (Committee on Standards in Public Life 1995). This group of directors are involved in overseeing the actions of professional managers (by, for example, reviewing annual accounts) and making particularly important or high-profile decisions. They are not supposed to involve themselves in 'operational matters' and nor do they fulfill much of an "external role" (Skelcher 1998, p104) dealing with the public and other stakeholders, except in a quasi-ceremonial figurehead capacity.

It was into two of these governing boards that direct elections for members were introduced in May 2010, following central government concern that some controversial Board decisions including contentious hospital closures had "ridden roughshod over community opinion" (Sturgeon, quoted in The Scottish Government 2009).

The two board areas chosen to pilot elections, NHS Dumfries and Galloway and NHS Fife, both had their boards reconfigured so that directly elected Non-Executive Directors plus a local councilor nominated by local government and appointed by the minister would have a majority. The rest of the boards were

composed of Executive Directors (on the board ex-officio, e.g. the Chief Executive) and a few traditional, appointed, Non-executive Directors. The elections took place ending in May 2010, following a communications campaign devised and implemented by staff of the two Boards. Standing as a candidate and voting were presented in advertising materials as 'exciting' and 'new' opportunities. They were postal votes, with a limit of £250 campaign expenditure, and candidates were not asked for a deposit. Candidates were invited to write a 250 word electoral address. These addresses were bound into a book and sent to eligible voters along with a ballot. The elections used the Single Transferable Vote mechanism.

Methods

We used a mixed-methods approach to develop a fully rounded picture of both public engagement and Board functioning during the pilots. The University of St Andrews Teaching and Research Ethics Committee granted ethical approval for the research.

We surveyed a random sample of 6000 names from the electoral register, 3000 each from Fife and from Dumfries and Galloway. We sent a survey form to electors' registered addresses within a few days of the election, with two reminders if required, asking whether they had voted in the Health Board Elections. It also asked how much information they had about the elections and how interested they were in them. The survey collected data on age, sex, ethnicity, education, length of residence in the Board area, disability, carer status, dependent children, general health and contact with the NHS (a copy of the survey form is available as supplementary data to this article). All forms were marked with an identifying number that allowed us to confidentially link electors' responses to a postcode, which

showed responses were not coming disproportionately from electors living in affluent or deprived areas. This survey attracted a fair response rate of 31%, as calculated from the official electoral register. That register will not be perfectly up-to-date (Wilks-Heeg *et al* 2010) and forms sent to out-of-date addresses will have artificially reduced the response rate. Given the quasi-official nature of our survey, we were not able to use established techniques such as in-person follow-up or financial incentives to increase that response rate (see Dillman 2000). We were also surveying over the summer, and low turnout in the election itself raises questions about how salient this subject was for electors (see Martin 1994).

We also sent survey forms to all the candidates, which collected similar demographic data and requested interviews. Eighty three (64%) of the 130 candidates replied.

Qualitative data collection included longitudinal non-participant observation and over 200 semi-structured interviews between March 2010 (two months before the election) and April 2012. All candidates were invited to take part in an interview and 85 (of 130) candidates were interviewed. We interviewed 55 Board members both prior to and post election. We requested interviews with all elected non-executives, all existing non-executives (including those whose appointments were 'terminated' to make space for new elected members), and key executive members of each Board. The 55 interviews completed include all elected members, 10 executive directors and 13 appointed non-executives who remained in place (including councilors and Chairs) . After the elections, the total number of Board members in Fife and Dumfries & Galloway was 42, and we are confident that there are no significant omissions in our qualitative sampling. Additional interviews were conducted with selected NHS staff (for example, those responsible for

communications or public involvement strategies) and other stakeholders (for example, representatives of local voluntary sector organizations) in each Board area. Semi-structured interviews were conducted by three of the authors working with a common interview schedule, but informed by our observation of Board meetings and committees. Many Board members were interviewed on multiple occasions during the pilot.

We also observed the induction for newly elected members, as well as meetings of the full Boards and a number of their committees over the duration of the study, to understand how the views expressed in interviews played out in the day-to-day business of Board functioning. While spending significant amounts of time in Board events and interviewing members, we took a non-participant role, aiming to minimize the impact of our presence. All parties were aware of our remit as Government-commissioned independent evaluators of the pilot, and at times may have moderated their behavior accordingly. However our confidence in our findings is increased by the prolonged period of fieldwork, coupled with extensive triangulation of data sources.

All authors discussed emerging themes regularly during data collection, and an initial thematic framework of empirically-grounded ‘sensitising concepts’ (Blumer 1954) developed from these discussions. This emphasized how candidates and Board members described their own roles (for example, their goals for their Board membership, whether they understood themselves as representing the public, and whether and how they interacted with members of the public as a Board member). This framework was refined as interview transcripts were analyzed by two of the authors using NVivo software and was informed by field notes. Data was analyzed within categories and then compared within Boards to ensure appropriate awareness

of context. Coding was regularly shared and discussed within the team. The descriptive, empirically-grounded thematic framework was developed into the higher level conceptualization of volunteerism during research team discussions, and clarified with reference to existing relevant literature.

Results

We test Hypothesis One primarily with quantitative data: did the demographic characteristics of candidates, voters, and victors differ significantly from the characteristics of people appointed to non-executive director positions, or resemble those of the two board areas' populations? We test Hypothesis Two with qualitative data: did directly elected board members choose to challenge and campaign, or did they view their contribution in terms of support and advice?

Demographics

We have a broad idea of the demographics of appointed non-executive directors across Scotland: the Office of the Commissioner for Public Appointments in Scotland (OCPAS) produces an annual report. These figures are for all public appointments in Scotland, but health boards follow a similar pattern. Most applicants for public appointments in 2010 were male (69.5%), white (97.7% were not from minority ethnic groups) and aged at least 49 (78.9%) (Public Appointments Commissioner 2011:5). How different were directly elected non-executives, candidates, and the voters who chose them?

The 64% of candidates in the elections who responded to our surveys were actually demographically similar to typical volunteers for public appointments. We found that the candidates were typically well-educated and lived in relatively wealthy postcodes. 96% described themselves as white; unsurprising in two overwhelmingly white areas of Scotland. However, we were surprised to find that few were intense users of the health service. Most were relatively healthy themselves and did not report long-term caring responsibilities. 36% of candidates were aged 41-60, and 51.8% were aged 61-80. One was under 18. In total, 71% of the candidates were men.

Election turnout was low (Table 1) and many voters reported feeling poorly-informed about the election. Our survey showed that the voters who did turn out substantially mirrored the age profile of the candidates. Older electors were much more likely to vote, and a person aged 60-80 was more than twice as likely to vote as somebody aged 18-40 (Table 2).

[insert ##Tables 1,2##]

Third, the eventual victors for the non-executive board positions were all aged over 40, with 60% of them over 60 (Table 3). While their gender balance was almost equal (equal in Fife and 60% male in Dumfries and Galloway), the level of educational qualifications was markedly higher than the average for their areas (all but 3 of our respondents had at least college-level qualifications, many had university or postgraduate degrees). Most did not have significant caring or childcare responsibilities, and did not report serious ill health (although one disabled-rights activist was elected).

In other words, the demographics suggest that this was an election dominated by relatively healthy, retired or semi-retired, often professional, people. Such a population fits with the demographics we would expect of a volunteerist model in Scotland. As we expected, time-consuming, bureaucratically demanding board activity with an important managerial component attracted people with time, managerial skills, and good health. This coincides with the literature on volunteering patterns, which shows that demanding and time-consuming volunteer roles, especially in the health sector (Wilson 2000,p221) tend to attract older, well-educated volunteers who are in reasonable health. Revealingly, Wilson found that older people tend to volunteer for meliorist, helping roles: confrontational activism tends to attract younger volunteers (Wilson, 2000).

[Insert ##Table 3##]

Board behavior

Elected members received two days of joint induction training, and the two Boards each organized two days of local induction at their own sites. This induction differed from the normal induction process for new Board members insofar as new members typically arrive as individuals or as very small groups. Beyond this the content of induction was broadly consistent with that offered to an appointed Board member. That is, training concentrated on getting new (and in some cases comparatively inexperienced) Board members ‘up to speed’ with NHS management and Board procedures. It did not direct attention towards reshaping the non-executive role. However elected members arrived onto Boards with their own mandate, and with

little central direction as to how they should conduct themselves as regards the public.

Once on the boards, the question is whether the directly elected board members did actually behave according to the volunteerist model- did they view their activity as contributing to the board on its terms, or challenging the decisions of the board and the government policies it implemented?

There was one elected member out of 25 who did adopt a fully oppositional attitude, engaging in traditional political activities such as writing to the press, organizing public meetings, asking to have her dissent minuted in board minutes, raising new agenda items in public meetings, giving quotes to journalists and seeking to carry out promises she made in her 250-word election address in opposition to existing Board policy. This person had long experience as a local political activist, and eventually left the board to campaign for local health care outside its constraints while seeking other electoral office, describing the decision thus:

> “If you introduce an elected members system into a region where there has been community concern about something like the Community Hospital closures you have to accept that there may be members of the health board elected who have been community campaigners. I would have thought it was fairly inevitable and it really is very unfair then to expect that community campaigner to stop being a community campaigner and just somehow knuckle down and toe the line. (Interview, elected non-executive director)

This raised obvious tensions given that boards are constrained by government policy.

A local hospital campaigner who was also elected gave some personal quotes to the press, which was unconventional compared to appointed members, but otherwise integrated into the board. Other directly elected board members, some with extensive local political experience and ambitions, kept a low public profile or conducted their media activity in coordination with the Chair and communications staff of the boards. In other words, contrary to the fears of those who expected damaging politicization, the result of elections was that the amount of political activity, campaigning, and publicly voiced dissent increased only marginally.

One reason for this consistency with previous Board practice was the strength and durability of norms of 'corporate responsibility', whereby members are collectively responsible for the decisions of the Board, and will publicly support them. This is not to say that individual views are not aired in appointed health boards, but this mostly takes place prior to the decision, and by convention any vigorous disagreements would be conducted privately, outside of Board meetings. Notably, though, most of these norms are informally known and enforced, with little about the Board member's role enshrined in statute. Newly elected members, particularly given their critical mass with large numbers elected onto each Board in a highly unusual influx of new members, could have sought to reimagine 'how things are done' in Boards. Boards greeted their new members with suggestions about policies regarding, for example, media relations for individual board members ("gave them guidance" as one established member put it). The newly elected members largely accepted these approaches.

The reason for the reluctance of elected members to redefine their roles in keeping with the political manner of their recruitment lies in their own motivations for seeking office. The interviews we conducted with board members suggest that the

overwhelming majority did not join the Board in the pursuit of particular agendas. Asked why they ran, most elected Board members used volunteerist language of contribution and representation rather than oppositional or politicized language of challenge:

> I felt I could give something towards the community really ... with sort of that knowledge that I've got about the health [service]. (Interview, elected non-executive director)

> I had felt that I wanted to do something … worthwhile seems to be the right term, that seems a bit worthy. But something that I would enjoy doing, that was valued but not in a commercial organisation. That was what I wanted to do. (Interview, elected non-executive director)

> I've got some background on the thing, understanding about the various problems in society and obviously on the health issues and I thought `maybe if I went on there I can maybe help them out and give them some support'. (Interview, elected non-executive director)

For a small number of elected members, their motivation to stand was rooted not merely in conservative loyalty to the existing organization but in explicit opposition to the principle of elected Boards, and fear about the consequences of politicization for the board:

> Now even being the elected Board member, I personally think [the pilot election] is a disaster and to a degree I put myself forward a little bit 'tongue in cheek'. (Interview, elected non-executive director)

It is worth noting that a desire to contribute to an organizational mission - rather than change it - was also the stated motivation of many of the appointed non-executive members before the pilots began. The key motivational difference between the appointed and elected members was that conventionally appointed members often identified their personal contribution as specific to their professional expertise and skills, often in finance or law. By contrast elected members were more likely to identify themselves as offering the perspective of an 'ordinary member of the public' or, in the case of the health professionals, knowledge of the health system from the frontline.

In short, and to the relief of many who had speculated that boards with elected majorities would fill with dissenters and ambitious politicians, the actual behavior of most elected board members was consonant with a volunteerist model. They adopted the norms and roles of Non-Executive Directors with minimal modification. The member who sought to introduce the challenge and oppositional critiques of a normal democratic legislature had an exhausting experience and resigned in frustration to pursue other political and campaigning routes.

Discussion

The rhetoric that accompanied the political launch of the pilot elections in Scotland suggested a radical departure from existing models of health service management:

“[Elected Boards] are the best way of ensuring that boards will no longer be able to ride roughshod over community opinion, as has happened in the past. The voices of people whose taxes pay for the NHS will now have to be listened to and acted upon” (Sturgeon, quoted in The Scottish Government, 2009). Appointed to evaluate the impact of the pilots, we spent two years observing and hearing about a far more moderate outcome. Our evidence suggests that, in the absence of direction from central government on how to ‘be’ an elected member, the profile and motivations of those members of the public who engaged with the elections remained consistent with a volunteerist model of involvement .

Our quantitative evidence suggested that participation in the two Scottish health boards elections was predominantly confined to the 41-80 age brackets. Candidates, and especially victors, were generally in a good state of health and educationally well qualified. Given that it was very easy to declare candidacy (and that restrictions on campaigning limited the resources required), the pronounced age pattern in the candidates suggests that a chance to influence the middle range of health services management in this way does not necessarily engage the poor the young, or other marginalized groups.

Our qualitative evidence shows that the vast majority of elected board members did not challenge the board, falling instead into a volunteerist paradigm of assisting the organization in its work of good governance, oversight, and discussion of strategic initiatives. Only a few members made any effort to challenge board procedures in an oppositional mode that would permit more campaigning, critique, and opposition, and they either ceased their efforts or, in the most articulate case, left the board.

The reasons why the apparent high hopes of policymakers were thwarted by 'business as usual' are complex, but we argue that the minimal impact of the elections stemmed from the nature of Boards, and the public's relationship with them. Boards are arms-length bodies that act within the confines of central government policy. For several decades Boards have epitomized a managerialist, technocratic approach to managing health services, working within regimes of performance measurement and management (such as central government targets) (Ferlie, Ashburner, Fitzgerald & Petticrew 1996). Board members are far from irrelevant: they can clearly influence some aspects of organizational behavior. However individuals who wish to bring about significant change, rather than to offer oversight of continuing performance, are likely to spend their limited time on other 'outsider' tactics. Given that most citizens have limited political energies to devote to the day-to-day administration of public services (Warren 2009), those individuals who volunteer (or self-select) for duties, even when these duties are presented as opportunities for participation and empowerment, are unlikely to have radical aims.

For some, the philosophical case for direct election of local decision-makers negates any scope for cost-benefit analysis of electoral outcomes. In the case of adding an additional layer of representation to organizations already 'vertically' accountable to the public through central government, however, we argue that it is reasonable to look for demonstrable change in return for the financial costs and upheaval of the intervention. A concern with the 'value for money' of elections, while at odds with a principled commitment to them, was the key reason cited for the abandonment of elected Boards in a number of Canadian provinces (Lomas, 2001; Saskatchewan Health, 2001). In New Zealand, where elected health boards have a

long and significant (if interrupted) history, Laugesen and Gauld (2012) argue that attachment to them is ‘instinctive’.

Elections to health care organizations are persistently ‘sold’ as radical shake-ups of existing management models. Yet the enduring social underpinnings of public engagement in health care policies are those of volunteerism rather than contentious politics. Elections will not change the management of public services, it seems, if they empower only the same categories of public-spirited people who staff other public engagement efforts by serving as lay committee members and participating in public consultations for organizations whose basic accountability lies elsewhere, in the government.

Conclusion

Much literature on public engagement in health remains rooted in a 1960s approach to community participation that simply regards the point of public engagement as increased public power over decisions (Arnstein, 1969). When applied to the question of elections to health bodies, this assumption has two issues: elections give public services a new set of ‘horizontal’ accountabilities which may conflict with their established ‘vertical’ accountabilities to nationally-elected ministers and legislatures (Dixon, Storey & Rosete 2010); and many public participants in public services obstinately seem to hold values and seek ends other than the control over the organization that many scholars impute to them (Tritter & McCallum, 2006).

The implication for the literature on public participation is that those people in a community who wish to vote for or occupy an electoral office in health service management may well turn out to be volunteerist in demographics and orientation.

Other mechanisms, including designed (not self-selecting) mini-publics (Warren, 2009), might be more practical ways to seek the opinions of those segments of a community that do not have a volunteerist orientation. Elections will not be enough to incorporate their views, or have the radical consequences Arnstein (1969) sought, if elections reproduce volunteerism in candidates, electors, and victors.

The policy implication is simple: it is not clear that governments will get pronouncedly different results from elections as compared to existing mechanisms of public involvement: lay committee members, consultations and standing consultative groups, and public opinion investigations such as surveys and focus groups. In Canada (Lomas 2001), in England (Dixon, Storey & Rosete 2010), and now in Scotland, elections to health bodies have failed to deliver the transformational changes promised in policy rhetoric. Scotland's experiment suggests that elections offer no viable halfway point between politics and volunteerism, and that many of the people involved prefer volunteerism.

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