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On: 18 January 2014, At: 00:12

Publisher: Routledge

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Critical Public Health

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/ccph20>

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Published online: 18 Jun 2008.

To cite this article: Robin Bunton (2008) Public health and public involvement, Critical Public Health, 18:2, 131-134, DOI: [10.1080/09581590802166627](https://doi.org/10.1080/09581590802166627)

To link to this article: <http://dx.doi.org/10.1080/09581590802166627>

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EDITORIAL

Public health and public involvement

Involving the public and stakeholders in public health initiatives is so much a routine part of public health that we hardly ever reflect upon it, either as a principle or a process. Versions of ‘the New’ public health and health promotion in particular have centralised public and stake-holder involvement, the latter placing involvement at the heart of its enterprise; ‘health promotion is the process of enabling people to increase control of and improve their own health’ (WHO 1986). A quarter of a century after this definition appeared, we can see significant developments in participation in health across a broad political and ideological spectrum. European member states have committed to numerous public health engagement programmes, often deliberately drawing upon social movements and patient rights groups and perspectives (Brown and Zvestoski 2005). In the UK, for example, the NHS has developed NICE’s Public and Patient Involvement Programme (NICE 2008). *Citizens at the centre. Deliberative participation in healthcare decisions*, by Davis *et al.* (2006), reviewed in this issue by Gavin Mooney, highlights the growth of deliberative democracy in UK health policy, plotting the arrival of Citizens Councils established under the auspices of the National Institute for Health and Clinical Excellence (NICE), the standard setting body of the UK NHS. Health research, too, has seen a growing commitment to representing public, stakeholder and community voices. Participative models of evaluating community public health programmes have been popular in the UK over the last decade and drawn upon several models approaches including that of the ‘theory of change’, originating in the Aspen Institute (Baud and Judge 2001). The wide-ranging arenas for public engagement and involvement in public health present a dizzying range of techniques and methodologies, many of which have been drawn upon and discussed in *Critical Public Health*. Mooney’s book review points out the need for more assessment of the processes and the outcomes of the different methods involved. We probably need more critique of the creation of expertise citizenship in public health and more assessment of the capacity of such approaches to empower, alienate, co-opt, manipulate, etc. Critiques of ‘surveillance medicine’ have drawn attention to the potential for techniques in public health to discipline and govern populations, communities and subjects (Armstrong 1983, Castel 1991). Public health practice actively builds particular forms of subjectivity, citizenship and community. We can see that participatory methods have a variety of inclusion and empowerment possibilities, sometimes providing genuine ownership whilst at others providing mere token involvement. Public involvement initiatives involving users have not always been successful, and there may be lessons to learn from other fields of research, such as disability studies. Stern and Green’s paper ‘A seat at the Table? A study of community participation in two health cities projects’, illustrates the type of issues that arise when a public health programme is committed to participation in principle but not in

detailed practice. Getting around the table might be a step in the right direction, but the outcome of such involvement hinges upon how agendas are set, who gets to talk and how information is distributed. It provides the type of detailed discussion and critique of participation that breaks through the assumption of participation as a self-evidently positive force.

The idea of public involvement is so central to contemporary public health that it often escapes critical gaze and we can mistakenly assume that public involvement, public debate, participation and public health practice led by public health authorities is self-evidently ethically and politically sound. Some distance on the issue is offered by social analysis of the public sphere. Critics have pointed to the historical and geographical specificity of the cherished notions of 'the public' and 'the public sphere'. From this starting point, Jurgen Habermas has plotted the emergence of the 'public sphere', placing it firmly within European bourgeois social structures and the arrival of commercialised cultural forms, such as popular printed literature and social and artistic criticism (1989). Habermas observes that the division between the 'private' realm of the family and the 'public' world of commerce underscored the development of state-governed areas of 'public authority'. Amongst other things, the emergence of a public space allowed public health matters to be discussed and legitimated and public health measures to be implemented by governing authorities. The idea of the public sphere is important because it is where public health practice is legitimated. It is also a place for public debate and critique. Theorists of the public sphere tend to see public space as the basis for deliberation and critical reasoning on ways to construct and change our worlds. Reasoned, responsible citizens, backed by state authorities, are capable of redressing injustice and protecting the broader population. There has been some questioning of this state-centred (Westphalian) version of the public sphere, however. Fraser has pointed out that globalisation has drastically reduced the opportunities for single states to intervene in public issues such as health (Fraser 2007). Moreover, transnational communities and identities make public debate more complex and challenging for deliberative discussion and ethical agreement. The emergence of a transnational Muslim public, for example, represents a challenge to a normative framing of a state-centred public sphere (Salvatore 2007). In the face of these changes there has been a call for an institutionalised transnational sphere and transnational ethic (Fraser 2007).

This broader debate on the nature of the public sphere can help us to reflect on the challenges of identifying and engaging 'the public' in public health. We might adopt a more plural notion of the public (or 'publics'), questioning unitary or universal notions of 'the public' and perhaps of related singular concepts such as 'the community'. Lai Fong Chiu highlights the importance of such awareness in this issue reflecting on a number of initiatives that have used the Community Health Educator model. She draws lessons from working with communities with mixed ethnicity, religion and language and argues that public health approaches need an understanding of community and ethnicity as fluid, socially constructed categories. 'Whiteness', for example, can mean a great many different ethnic groups: Scottish, Welsh, Irish, Northern and Southern English, etc. In her work, common language was often a more useful working definition of community.

To develop a critique of participation, it is useful to hear of the experience of participants and in their paper in this issue, Rapport *et al.* explore participants' experiences of a participative approach to sustainable health care in Wales, addressing issues of social deprivation, exclusion and ill-health. This programme

managed to gain substantial support fusing multi-methods and drawing upon approaches recommended by the World Health Organisation, and reports high levels of enthusiasm for this approach. Carr and colleagues similarly draw upon a combination of methods in order to empower communities and allow them to participate in health promotion discourse, and to engender community participation, self-reliance and self determination.

A critical stance on participation in such programmes can highlight the nature of inclusion – who is around the table and who is not, what rights of discourse they have, etc. This raises some familiar issues of equity and power. A further issue occurs, however, when we consider the new genetic technologies, which have the capacity for changing the ‘nature’ of those subjects who are yet to be at the table. There is an issue of ‘inter-generational’ equity which makes the consultation process and resulting governance structures all the more critical (Evans *et al.* 2007). Jill Haddow and her colleagues take up this theme in this issue, examining the consultation of stakeholders and publics at the conceptual stage in the Generation Scotland – a genetic database for prospect study of complex, multi-factorial conditions such as cancer, heart disease, strokes and mental health. The issue of consultation and governance is crucial to the development of bio-banks, even to their very existence, because large amounts of public trust and co-operation are needed in for them to be constructed. The authors of this study point out that the concerns raised by the majority of participants have not been taken up in subsequent policy and governance developments, which is sobering in terms of the possibilities for public involvement in public health genomics.

In developing critique in public health, then, we will develop critical perspectives on public participation and involvement. This work will acknowledge that public health is always a network activity and that despite our best efforts to make policy and practice scientifically sound, the uptake of research evidence is dependent upon those networks, as de Leeuw and colleagues illustrate well in their paper in the previous issue of *Critical Public Health*. The critique of involvement will highlight the values and interests at work in the development of this public sphere work and also the ways that methods of engaging publics are, at times, ways of keeping important matters private.

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