Mutuality, Empowerment and the Health-Wealth Model:

The Scottish Context

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INTRODUCTION

The relationship between health and wealth is clear and well-established (Hunter & Richards, 2008); however, by understanding the importance of empowerment to health, Howieson & Walsh (2010) argue the importance of mutuality as a model of healthcare delivery and stress the importance of people-centred healthcare. The backdrop to this paper is provided by Better Health, Better Care (2007), Section 1 of which is entitled ‘Towards a Mutual NHS’. Better Health, Better Care sets out how the Scottish Government will strengthen public ownership of the NHS by: improving the rights to participate; embedding patient experience information in the performance management of the NHS; and further strengthening the collaborative and integrated approach to service improvement. According to Better Health, Better Care (2007, p5): “Mutual organisations are designed to serve their members; to gather people around a common sense of purpose; and to bring the organisation together in what people often call ‘co-production.” Whilst the Scottish NHS is not constituted legally as a mutual, the concept of a mutual organisation — as interdependence of stakeholders — sits ‘extremely comfortably’ with the objectives of healthcare delivery in Scotland; for example, commitments to stronger public involvement, improving the patient experience, clearer patient rights, enhanced local democracy ... and independent scrutiny of proposals for major service change (Better Health, Better Care, 2007, Section 1.1). The mutual organisation of healthcare is said to value all stakeholders in co-production of healthcare, rather than seeing adversarial or competitive relationships between stakeholders, typical of the privileging of teleological action and of consumerist approaches to healthcare. Such mutuality does not necessarily exclude competition as an economic or even social mechanism for driving up quality and driving down cost (Howieson and Walsh, 2010). Yet, it does mean that more than a narrow set of commercial or managerialist values are mobilised in decision-making and that competitive mechanisms are critically reflected upon. This, then, is perhaps the beginning of a public sector version of local self-help for people. It is an attempt to
integrate, coordinate and co-produce care based on the values of co-operation and collaboration. This paper will offer an alternative paradigm to healthcare delivery by introducing the concept of mutuality and empowerment into the health-wealth model. In detail, it will: revisit what is meant by mutuality; briefly explain the differences between the health policies of Scotland and England; advance the meaning of the ‘Public Interest’; explore empowerment and community empowerment and its relationship to health; and offer a model which tries to link these concepts and terms together. Finally, a ‘way forward’ will be offered. It is hoped that this analysis will help researchers and practitioners alike further appreciate the important role of mutuality and empowerment into the existing health-wealth model.

**MUTUALITY**

In the Introduction to *Better Health, Better Care*, the Cabinet Secretary for Health and Well-Being says (p2):

> “The best way to make progress on health and healthcare is by galvanising the people of Scotland with new rights and responsibilities. That is why this document sets out a new vision for the NHS. That vision is based on a shift from the current position where we see people as "patients" or "service users", to a new ethos for health in Scotland that sees the Scottish people and the staff of the NHS as partners, or co-owners, in the NHS. I want us to move to a more mutual NHS where partners have real involvement, representation and a voice that is heard.”

The Cabinet Secretary writes about moving to a more mutual NHS, but one might ask, what exactly is a mutual NHS? At present, the mutual philosophy is more commonly associated with financial firms [for example: the mutual organization (where customers derive a right to profits and votes); mutual insurance (where policyholders have certain ‘ownership’ rights in the organization); and the mutual fund (a professionally-managed form of collective investments)] insurers, unions, entities to promote
solidarity economics, trade associations, and religious movements. Originating from an adaptation of guild system in the 18th century and widespread at the 19th century, today there are many mutualist associations worldwide integrated into modern society. It seems surprising then that although we have known about — and derived advantages of — mutuality for a very long time (especially in economic theory), the literature on and philosophy of ‘health mutuality’ is somewhat limited. There are, of course, mutual healthcare providers (for example, the Benenden Healthcare Society) but little, to date, has been written about healthcare and its delivery in terms of mutuality.¹ Mutualism — as defined by the Concise Oxford Dictionary (1995) — is the doctrine that mutual dependence is necessary to social well-being. In simple terms, mutual organisations are designed to gather people around a common sense of purpose and in a health context, this would suggest that a mutual NHS is consistent with the founding values of the NHS, particularly in Scotland.² In this Scottish context, NHS Scotland is a public service, a service that is used for, and paid for, by the public. It would seem sensible then that this mutual approach may be the best philosophy for this publicly-funded body in terms of the funders having a greater say in their service, and making decisions about the shape and structure of services across Scotland. Mutuality is also associated with a process with individual responsibility in healthcare, and broader organisational and societal responsibilities (at the strategic, operational, and tactical levels) in enabling people to have power over their own health. Mutuality in healthcare provision necessitates that all people with a significant interest in that provision (whether as actual or potential users; patients and their families; friends and associates; nurses, midwives, doctors and other ‘deliverers’) seek awareness and accommodation of the interests of the public, and thereby seek to enable the people who make up those publics to enhance their

¹ In the field of biology, there are significant lessons for healthcare and its delivery: for example, mutualism is the way two organisms biologically interact, where each individual derives a fitness benefit (i.e. increased reproductive output). It can be contrasted with interspecific competition, in which each species experiences reduced fitness, and exploitation, or parasitism, in which one species benefits at the expense of the other. A well known example of mutualism is the relationship between ungulates (such as cows) and bacteria within their intestines. The ungulates benefit from the cellulase produced by the bacteria, which facilitates digestion; the bacteria benefit from having a stable supply of nutrients in the host environment. Mutualism also plays a key part in ecology. For example, mutualistic interactions are vital for terrestrial ecosystem function as more than 48% of land plants rely on mycorrhizal relationships with fungi to provide them with inorganic compounds and trace elements. In addition, mutualism is thought to have driven the evolution of much of the biological diversity we see, such as flower forms (important for pollination mutualisms) and co-evolution between groups of species.

² For a Scottish historical perspective, further reference should be made to McLachlan (1987).
wellbeing. Indeed, a health policy that is truly founded on mutuality, therefore, must enable articulation of the public interest. Two further questions then arise: what is the public interest and without empowerment/enablement, can the public interest, and therefore, mutuality ever be realised? This is not clear from Better Health, Better Care. Indeed, the verb ‘to enable’ is mentioned once, with no entries at all for empowerment.

THE UK CONTEXT

At this stage, it is helpful to consider values. At present, in England there has been a radical change in values guiding policy decisions with an intended 45% reduction in management, the use of free market principles, and a shift away from targets that have been seen as rewarding activity over outcome (Howieson & Walsh, 2010). In Scotland there is similar economic pressure but a different situation. Scottish values in NHS policy though are less likely to change. In particular, there is a commitment to seeing the producers and users of health services as part of an interdependent relationship. It is embedded in the Quality Strategy for the NHS in Scotland (2010). It differs from the ‘market’ values in English NHS policy in emphasising partnership over market forces. Mutuality

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3 In the UK public sector, decisions have always involved a choice between spending money in alternative ways (‘opportunity costs’). But the current deficit in public finances means there is less money available to divide up between public services and less money in the hands of the public to spend on anything. Less money means either massive gains in efficiency or cutting lower priority areas. These can be either small ‘incremental’ cuts across the board affecting all who use or produce NHS services or more selective more ‘radical’ cuts. How are these choices to be made? What differs most between health systems around the world is not clinical needs of populations but the values that guide patient, clinical and healthcare policy decisions and the quality and quantity of behaviours, processes and infrastructure through which they are implemented. The difficulty is whose values guide choices in healthcare? And whose values will guide the choices about changes to the way money is spent in the next twelve months and over the next few years? Unless there is an intelligible public debate about this, there is a risk that the values deciding the future of the NHS in Scotland will be seen, later, as selfish and destructive.

4 For example, see page 17 to this strategy: “We are continuing to build the basis for our mutual NHS through pioneering work such as the Patient Rights (Scotland) Bill, the Patient Experience Programme, the development of a Carers Strategy and the improvements in support for the self-management of long-term conditions and for people at high risk of developing these. Through this mutual approach our NHS will continue to learn from, and improve on, what is most important to the people of Scotland, taking into account the needs of our diverse population – this approach will permeate all our programmes of work. In the Quality Strategy, we seek to embed the mutual approach of shared rights and responsibilities into every interaction between patients, their families and those providing healthcare services”.

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is meant to be the transparent and ‘reasoned’ deciding of actions in the public sphere. Its importance lies in the way that it actually promotes the efficiency and effectiveness of the NHS.

Of note, the key task for NHS management in the next period is to create conditions for higher trust in decisions and actions — from patients, carers, families and communities, clinicians and non-clinicians — as a way to obtain sustainable productivity gains. At a time of severe budget constraints, a lack of trust is pernicious. One benefit of mutuality is that the risk of breakdown in trust can be ameliorated through partnerships that are expressive not oppressive. Mutuality is unlikely to change in Scotland with the re-election of the Scottish National Party in May 2011. The key question, however, is that if mutuality is to guide patient, clinical and healthcare policy decisions and the behaviours, processes and infrastructure of the NHS in Scotland in the next few years, how will this be done.

**THE PUBLIC INTEREST**

For John Dewey (1927), the consequences of an act — for example, a strategic choice or a step in pursuit of that choice — might impact significantly not only on those directly undertaking the act but also on others (Sugden, 2010). The interests of the direct participants, in this act, are said to be private, whereas those of the others (those affected by the act) are public. Moreover, an act might be associated with more than one public (Dewey, 1927); the idea is that a public has ‘a shared concern’ with an act’s consequences (Long, 1990, p. 171) and that there might be a variety of shared concerns. In this respect, the interests of publics are known about, accommodated and met. The polar opposite to this is the strategic choice approach. The strategic choice approach asserts the importance of economic power and rejects determinism. Sugden (2010) states: “The strategic choice approach has provided a characterisation of different realities by focusing on the governance of socio-economic processes and systems, and the actors therein, in the sense of analysing which people make strategic decisions, on what basis and to what effect. The contention of this approach is that the critical determinant of what does or might occur in production activity is its governance. Each and every type
of socio-economic process, system and organisation is argued to be characterised by a particular type of governance, and different types of governance are associated with different efficiency and distribution effects”. In ‘governance by direction’, there is a hierarchical system in which those who determine the processes for creating and using knowledge, plan activities, make strategic choices and in a broad sense allocate resources, do so in pursuit of their own, private interests, regardless of the agreement or resistance of publics.

To pursue the implications of this analysis in greater detail, and to provide a richer perspective on mutuality, the focal point of empowerment could be interpreted in terms of the public good, more specifically public interests (as distinct from the weaker notion of stakeholders). Indeed, Newbrough (1980; as quoted in Rappaport, 1981: 18) offered a vision of what he called the participating society. From a review of a variety of writers on justice, values, society, bureaucracy, politics and community life, he suggested that: “The public interest is the empowerment of people”. The idea underlying the spectrum is that one extreme is governance by direction, associated with the pursuit of specific private interests and the exclusion of publics, whilst the other extreme is governance in the interests of publics, which is — it is argued — mutuality. Between are degrees of direction, corresponding with degrees to which specific private interests override the interests of publics. Or, viewed from the opposite end of the spectrum, corresponding with degrees to which governance is characterised by an awareness, accommodation and meeting of the interests of publics, via effective deliberation founded on particular values. The point seems to be that mutuality in healthcare provision seeks to enable the people who make up those publics to enhance their wellbeing. Following Sacchetti and Sugden (2009) and their use of Dewey’s analysis, what this would actually require is that a community of people — seeking to act in the public interest — would need to jointly embrace the procedural rule of democratic deliberation based on its necessary values, *inter alia*: the bracketing of controlling influences; positive freedom; inclusion on equal terms; informed participation; the desire to reach a consensus; sympathy; mutual respect; reciprocity; and continuous learning (Howieson, Walsh, and Sugden (2011)). Such deliberation would provide the basis of empowerment and community
empowerment for the public good.

**EMPOWERMENT, COMMUNITY EMPOWERMENT AND HEALTH**

From the literature, it would seem that there is much confusion about what empowerment is and what it means (Tengland, 2008). Indeed, practitioners and academics have often used ‘empowerment’ very casually and it appears that it is used by different people to mean very different things (Laverack, 2004). In its widest and most radical sense, empowerment concerns combating oppression and injustice and is a process by which people work together to increase the control they have over events that influence their lives and health (Centre for Health Promotion Research, 2010). In healthcare, this process encompasses both the individual responsibility in healthcare and the broader organisational or societal responsibilities in enabling people to assume responsibility for their own health. Most definitions accept that empowerment is a complex process and it can occur at an individual, organisational or community level. This is shown at Figure 1.0.

![Figure 1.0: Levels of Empowerment](image)

Figure 1.0: Levels of Empowerment
Individual empowerment — also referred to as psychological empowerment — includes building people’s confidence or self-worth, boosting their self-esteem, developing their coping mechanisms or enhancing their personal skills in order for them to make health-related choices. Individual empowerment basically means people feeling and actually having a sense of control over their lives. Research tells us that this ‘sense of control’ is particularly important, as it has a direct effect on improving an individual’s mental and physical health (Centre for Health Promotion Research, 2010). Empowerment can also be viewed either as a process or as an outcome (Gibson, 1991). The process entails mutually beneficial interactions that strengthen the mediating structures between the individuals and larger society (Rappaport, 1984; Simmons & Parsons, 1983). The outcome is community empowerment. Moreover, power is at the core of empowerment. There are several different interpretations of social power: power-from-within (personal power as an inner strength or feeling of integrity); power-over (the ability to influence the actions of others, even against their will); and power-with (the ability to share forms of power-over to increase people’s power-from-within rather than to dominate or exploit them). With this perspective, empowerment is not characterised as achieving power to dominate others, but rather power to act with others to effect change. Green & Raebum (1988) see empowerment and enablement as similar concepts and they see enablement as returning power, knowledge, skills and other resources to the individual, community or population. In addition, to understand and define the outcome of empowerment (community empowerment), it is important to be clear what we mean by community. Although there are many definitions, the majority include people and area, common ties, and social interaction (Laverack, 2004). The exact meaning seems to vary from area to area, from individual to individual, and is cultural and faith specific. A community includes several key characteristics and a working definition — like the concept of ‘publics’ — may suggest that they are organised groups that are important enough to their individual members that they identify themselves, in part, by their group membership. This interpretation implies that within the geographic or spatial dimensions of community, multiple communities exist and each individual may belong to several different
communities at the same time. Community empowerment concerns power relations and intervention strategies which ultimately focus on challenging social injustice through political and social processes. Indeed, the overall aim is to allow people to take control of the decisions that influence their lives and health. It is: “A social-action process that promotes the participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of life and social justice.” (Rappaport, 1981). Participation in, and influence of, a group or organization is an important stage of both psychological and community empowerment (Green, 1986; Florin and Wandersman, 1990). The emphasis on community action as a core component of community empowerment (Brown, 1991) is also consistent with the principles of health promotion (Miner and Ward, 1992). Community empowerment has been described as both a process and an outcome; it is, however, most consistently seen as a process in the form of a continuum. While there is no specific research documenting an increase in a psychological state of empowerment leading to improvements in physical health, there is ample evidence that groups without power, or who report feeling powerless, experience worse health (Rissell, 1994). Looking ahead, the notion of social capital suggests that inequalities in health are in part influenced by power imbalances in society and the ability of communities to empower themselves in redressing a lack of equity. By building community empowerment, we can also build social capital. This is expanded further by Laverack (2004) who says: “Our health is enwrapped in our experiences of community. Research increasing affirms that social justice (sharing), social capital (caring) and empowerment (the capacity of choice) are key determinants of our health: as individuals, as communities, and as societies”. He goes on to say: “But when you ask people about the last time they felt healthy, when you personalise the question, responses include: sense of purpose in their lives, some control over their fate, doing enjoyable activities, feeling energetic and vital, being loved, enjoying good relationships with friends and being connected to the community.”
A MODEL

However defined and stated, a mutual health policy does seem sensible. It will, however, require a breakdown of the typical role relationship between professionals and community people. For example, prevention suggests professional experts fixing the independent variables to make the dependent variables come out right. Empowerment needs to be based on divergent reasoning that encourages diversity through support of many different local groups rather than large centralised special agencies and institutions which control resources, use convergent reasoning, and attempt to standardise the ways in which people live their lives. In this respect, perhaps, we are far too willing to intervene, label, and tell others how to cope with life without understanding how the diversity of settings in which people actually do live well, operate. Most of our advice is drawn from a very limited set of personal or professional experiences in settings designed and controlled by professions for others. As Illich (1976) has so well pointed out in the domain of physical health, the pervasive belief that experts should solve all of our problems in living has created a social and cultural iatrogenesis which extends the sense of alienation and loss of ability to control life even to one’s own body. This is the path that the social as well as the physical health experts have been on, and we need to reverse this trend. Indeed, the implications of an empowerment ideology force us to pay attention to the mediating structures of society i.e. those that stand between the large impersonal social institutions and individual alienated people. This means that empowerment will not only look different depending on what sort of problems in living one is confronting, but it may look different in each setting that it operates. Thus far, perhaps we have only considered the professional clinician’s perspective.5

For Friere (1973), education should have as one of its main tasks to invite people to believe in themselves. It should invite people to believe they have the knowledge. His central premise is that education is not neutral and takes place in the context of peoples’ lives. About this context, Freire asks, who does education serve and for what purpose? Does education socialize people to be objects and accept their limited roles within the status quo, or does it encourage people to question critical issues of the day and fully participate in the social and political life of society? To Freire, the purpose of education should be human liberation so that learners can be subjects and actors in their own lives and in society. To promote this role, Freire proposes a dialogue approach in which everyone participates as equals and co-learners to create social knowledge. The goal of group dialogue is critical thinking by posing problems in such a way as to have participants uncover root causes of
Moving towards a mutual health system, and its subsequent delivery, will require new ways of thinking about health and health care. What will be required will be a move, over time, to a more inclusive relationship — a relationship where patients and the public are affirmed as empowered communicative partners rather than teleological recipients of care (Howieson & Walsh, 2010). This has implications for the many healthcare quality frameworks that have emerged since the 1980s including those Maxwell (1984), Donabedian (2003), and the Institute of Medicine (2001) that is currently central to the NHS Quality Strategy in Scotland (2010). While these frameworks do emphasise the centrality of patients or citizens in determination of quality, and point towards greater inclusiveness, they assume that citizens are empowered or that the service providers are generally empowering. These quality frameworks can be seen as responding to the perception of disempowerment or oppressiveness of earlier health systems. Yet ironically — and whilst implying much — these frameworks actually say little explicitly about empowerment and how this might be achieved nor about the implications of empowerment for ownership and accountability and normative regulation of healthcare.

Indeed, lessons learned from the Communities First programme in Wales suggest that whilst community members were able to contribute to decision making at the local level, statutory agencies did not respond fully to the community’s agenda. For example, there was little evidence of community influence over budgets, service delivery or prioritisation of issues. Similarly, the National Institute of Health and Clinical Excellence (NICE), in their review of community engagement to improve health, reported 14 studies where the (mis) use of power by officials had been a constraint on the process and outcome of community engagement programmes.
Ownership and accountability, in particular, must necessarily take on new meanings and roles in mutualistic healthcare. By focusing on empowerment, citizens are not just consumers — with only rights — but as owners with both rights and responsibilities. It is the process of empowerment which enables people to gain power, authority and influence over others, institutions or society. A lot has been said about health and its (vice-versa) relationship to wealth, but empowerment is the key via ordinary local people taking more control — and more responsibility — over their own lives but not in the teleological consumerist sense but in the more reflective morally conscious communicative sense. In this way, the importance of communication, participation, being listened to and having the opportunity to play a stronger part within health and wealth system may be enacted. With empowerment at the centre of healthcare delivery, there can be a shift from the current position where we see people as ‘patients’ or ‘service users’, to a new ethos for health that sees people and the staff of the NHS as partners, or co-owners and co-producers, in the NHS. In this way, empowerment can make a major contribution to a healthier society and its three main components of health improvement, tackling health inequality and improving the quality of health care. The model at Figure 2.0 may help with this understanding.
A Scottish health policy, which is based on mutuality must enable articulation of the public interest. This enabling practice is empowerment. Rather than leading in a private (strategic choice) interest, for mutual healthcare policy and its delivery, it will be important to lead in a public (shared concern) interest. The output of empowerment is community empowerment. The outcome of public interest ‘leading’ is leadership and the outcome of leadership, then, is to build/make community. By building community, this, in turn, may contribute to better health.

6 The implications of our discussion of mutuality, empowerment and public interests suggests that healthcare provision is not only poorly served by the widely accepted notions of leadership, but also that those forms of leadership may prevent healthcare from being provided in ways that enable the people who make up publics enhancing their wellbeing. Current leadership frameworks, especially in clinical and NHS settings, tend to focus on present rather than future capabilities; promote observable competencies and behaviours in preference to relations, ethics and emotions; and identify ‘leaders’ as the source of ‘leadership’. These tend to reinforce individualistic (perhaps ‘private’) practices that dissociate leaders from the relational environment in which they could operate and might, arguably, inhibit the emergence of more inclusive and collective forms of leadership (Bolden, 2005).
THE WAY FORWARD

_Better Health, Better Care_ was published by the Scottish Government in 2007. Some four years on, there is still significant confusion/misunderstanding as to what mutual healthcare means intellectually and in practice; for example, the real or potential dissonance between the aspirational intent of mutuality as described in this paper and accompanying literature and the concept as described in _Better Health, Better Care._

Perhaps the end point is a re-thinking of mutuality: what it means and how it is executed. To take this forward, it would seem sensible to consider a dual development path:

- Handling the here and now by solving a set of actual problems immediately with mutuality lacking (but not entirely absent, at least all of the time).
- Creating spaces immediately for mutuality to evolve and thrive over a longer period with a strong focus on solutions where and when they are needed.

The model shown at Figure 2.0 may then be tested and evaluated in this ‘creation of spaces’. This model will clearly require further research and modification and to do this, it is suggested to pilot the development of public interest healthcare forums with 2/3 NHS Scotland Health Boards. These forums may offer the Chief Executives (of these Health Boards) a practical way forward in giving them a way to deal with Government policy and making it a prominent issue in their Health Board, without taking them away from day to day operations.

Advantages of this approach may include:

- Discussion or deliberation of some areas that perhaps would not otherwise have been addressed.
• Allowing the Scottish Government to demonstrate (and influence) how their belief in ‘doing it together’ can be communicated to the public and be focussed on the delivery of effective, safe and people-centred healthcare.

• Helping clarify roles and responsibilities across the organisation and translating these into a clear set of expectations and way of working.

• Help to maintain enthusiasm, currently in danger of flagging, among policy makers for trying to establish community values and preferences.

• Supporting engagement of currently uninvolved citizens through discovery of latent interests and concerns, the emergence of new health-interest leaders and the mobilisation of potential energies of this in both local more independent health improvement and more general NHS welfare planning.

This dual development approach may offer a way of evolving mutuality in practice as it might affect all the issues of healthcare, and it needs to sit alongside an appreciation of how immediate issues might be addressed short of that mutuality. Then it is not all or nothing: not simply mutuality in the future, something else today. An advantage of this is that it may be politically appealing. The main point is that the advantage is really that mutuality, as an evolving reality, requires now not only spaces, but also engagements on the basis of certain values that address today’s problem right now. Without the link, mutuality could never evolve successfully. In simple terms, if we have not got very advanced forms of mutuality, we need processes (i.e. spaces) that allow them to emerge, but those spaces will not emerge if their underpinning values are simply absent from everything else that we do e.g. the experiences of consultation and facilitation that we do have are experiences we need to build upon to evolve mutuality to an advanced stage.
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