HEALTH AND TRUST RELATIONS

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ABSTRACT

The paper is a critical review of the problems and implications of trust and in managing health in the British health system. It is a system in need of strong management in the light of the global downturn in recently. Despite of policies on leadership in health in the UK, the macro issues for why the needs of diverse groups are not met are difficult to understand at particular levels of analysis. The central problem has been lack of 'trust' relations. The paper detangles the implications of different forms of trust in order to understand health relations in health contexts which has implications for practitioner, policy makers and medical personnel.

INTRODUCTION

Trust is loaded with a range of problems in the UK. For example, health legislation has in the past decade received scantily uncritical policy acclaim. Integrating health and social care policy based on the triumvirate of 'autonomy', 'empowerment' and 'choice' was endorsed by many commentators as the political and philosophical panacea for alleviating the deep and destructive problems confronting the health system in the UK. However, this article shatters assumptions surrounding health policy. The broken relationship between professionals and older people has been placated on distrust. A close and cogent examination of the emergence of health policy in the UK raises serious questions about its main intentions. In other words, it

is “expert” led with no understanding of diversity and experiences of service users.

It is significant to denote that health policy fails to convey in any strong sense alternative definitions of truth or different visions of health truth based on older people’s subjective experiences (Biggs and Powell 2000). Rather, the agism of health policy has perpetually directed its gaze downwards towards older people thus reinforcing ‘an overall impression that these are the people who need to be researched, these are the ones who are out of step with ‘social norms’ or who are causing the problems’ (Smart 1984: 150-1). Superfically, health policy does not gaze upwards to look at ‘the locally powerful’ (Smart: 1984) who in the case of older people would be health managers. The lack of any critical analysis of the role and daily practices of health managers constitutes a major weakness of the implementative process of the policy process in the UK in terms of accountability and sensitisation of diversity in managerial philosophy and practice.

‘Trust’ itself is an essentially contested concept. Trust can extend to people with a sense of shared identity (Gilson 2003, Tulloch and Lupton 2003). Individuals produce trust through experience and over time. It cannot be immediately and with purpose be produced by organizations or governments without dialogical interaction with people on issues affecting their lifestyles and life-chances such as health, pensions, employment and political representation (Walker and Naeghele, 1999). Möllering (2001) takes the

relational theme further by distinguishing between trust in contracts between individuals and the State in areas such as pension provision; trust in friendships across intergenerational lines; trust in love and relationships, and trust in foreign issues associated with national identity. There is a multiplicity of ways that trust has been defined but the central paradox is how to creation of the conditions of building conditions of trust across personal-organisational-structural tiers in an increasingly uncertain world. The article explores policies on health policy and navigates the ways trust relations can capture stronger bonds and relationships between health managers and user groups such as older people in the UK.

HEALTH IN THE UK: CONTEXTUAL BACKDROP

Contemporary health policy emerged due to three significant factors during the dominance of the Conservative administration in the UK from 1979 onwards to 2018 and had seen a resurgence in 2010 with more "financial reforms" in light of world economic recession. Firstly, one of the central planks of UK government policy throughout the 1980's was the genesis of marketisation into the public sector. Government reforms in education and the health service, for example, constructed a quasi-market with internal commissioning and provider roles to stimulate the 'buying' and 'selling' of in-house services (Means and Smith 1997). Simultaneously, new legislation required local authorities to embark upon a phased programme, determined by central government, through which many of its services had to be

subjected to compulsory competitive tendering, with the strategy of decreasing the role of local authorities and stimulating instead the private sector. The value which underpins all of these policy initiatives is a belief that a competitive market and a 'mixed economy of welfare' will inevitably provide better, cheaper services than a protected and bureaucratised public sector (Means and Smith 1997). This policy essentially channelled public sector funds into the private institutional sector while leaving the domiciliary sector chronically under-resourced and led to a 'perverse incentive' that undermined the commitment to policies on-based health. Private residential homes flourished and in the absence of policies on services, older people as 'consumers' had little 'choice' other than the decision about which institution they might enter in the 'residential private sector plc'.

Policies on health has been used as a vehicle for the marketisation of the public sector. Thus, a 'contract culture' was to be applied to the provision of personal social services and social services departments would need to develop processes to specify, commission and monitor services delivered by other agencies. The organisation of service delivery was to be instigated through assessment and health management including devolved budgets and decentralisation (Powell 2010).

Health managers were seen as central in this process. Yet the political issues for health managers to implement policies on health policy has not focused at all on managing users groups with leaderships sensitised to diversity. Worse, is that the trust process has become in policy-practice-theory

matrix so broken it requires a novel way of *theorizing trust* to help bind professionals and users to each other to help leadership and communication flourish otherwise a fragmented policies on health system will further fragment the broken relations between managers and users in the UK. Managing diversity requires diverse understanding of different levels of trust.

NAVIGATING TRUST IN HEALTH MANAGEMENT WITH USERS:

INDIVIDUALS, ORGANISATIONS, POLICIES ON AND SYSTEMS

The first key focus for theorising trust has been the interpersonal qualities of the individuals involved. Sztompka (1999) challenges theorists who consider interpersonal forms of trust as the primary form based on face-to-face encounters while subordinating all other forms of trust, collectively referred to as social trust. Rejecting any differentiation between interpersonal trust and social forms of trust, he proposes that the ever-increasing impersonal nature of relationships in systems is underpinned by our experiences of trust in face-to-face relations between health managers and users. This reliance on the interpersonal aspect of trust suffers from similar problems to Giddens (1990) use of 'ontological security', a product of early childhood experiences, as a prerequisite for individuals being able to form trusting relationships. This conservative element leaves those without positive childhood experiences stuck in a psychoanalytic mire with no potential for trusting, or by implication being trustworthy, while also failing to offer any means of recovery. A number of theorists (Davies 1999, Giddens 1991, Mechanic 1998) note the expectations lay people have of experts or

professionals while at the same time this interpersonal level provides the human aspect or 'facework' for more impersonal forms of trust. Expectations of professionals include the following: specific competencies, specialised areas of knowledge and skills, disinterestedness and disclosure. Of particular importance are communication skills and the ability to present complex information. Alongside, run role expectations that demand experts act ethically and with integrity as true agents of their clients, requiring them to put personal beliefs and interests aside and acting to maximise benefit and to do no harm. Creating specialized spaces reinforced by fiduciary norms arising from: the custody and discretion over property, the opportunity and possession of expertise and the access to information; regulates the power/knowledge relationship between expertise and laypersons (Giddens 1991, Shapiro 1987).

The second level of trust is at policies on level. Evidence exists of a positive correlation between levels of interpersonal trust and levels of social capital (Putman 1993, Rothstein 2000), leading in part to calls for increasing the levels of civility and policies on responsibility in everyday life. However, while theorists (Misztal 1996, Putman 1993, Taylor-Gooby 1999, 2000, Sztompka 1999, Rothstein 2000, Dean 2003) support the idea of social norms and values overriding rational models of human behaviour, they say little about how these norms and values become established. Rothstein claims that the link between interpersonal trust and social capital is weak, as are propositions about the direction of policies on relationships in managing

diversity – health managers are bound up in this process. Rejecting functionalist explanations linking norms to the established configurations of power, he proposes a theory of 'collective memories' creating social norms in communities as a strategic political process. The essential ingredient is the creation of conditions of policies on relationships built on common values and aims of both health managers and users in communities.

The third key issue is on trust and organisational context. Challenges to the 'trustworthiness' in organisations, regardless of whether they are public or third sector organisations, can have profound effects on confidence in that system. Producing increased demands for regulation, information and transparency; that is, increasing the demands for distrust. Policies on health organisations are central to this and need to facilitate trust so that interactions with users are transparent and trust facilitated.

The fourth major area of concern for theorising trust has focussed on the declining trust in both state mediated social systems such health and social health and the professions embedded therein (Davies 1999, Phillipson, 1998, Welsh and Pringle 2001). Conceived as impersonal or systems trust (Giddens 1990, 1991, Luhmann 1979) this form of trust is developed and maintained by embedding expertise in systems that do not require the personal knowledge of any individual by another. Such systems employ a range of techniques of distrust i.e. audit processes, target setting and third party inspections (Gilbert 1998, 2005) which could alienate professionals and users.

IMPLICATIONS OF TRUST IN POLICIES ON HEALTH

Part of the confusion concerning the different levels of trust rests, according to Möllering (2001), with the failure to distinguish between the functional properties of trust and the foundations of how trust is created in policies on health. The former are the outcomes of trust i.e. expectations, concerning issues such as: order, co-operation, reducing complexity and social capital. While the latter concern the nature or bases of trust, which, due to the assumption that they are rational, become lost and therefore not explored. Moreover, individuals make decisions on partial knowledge, a mix of weak inductive knowledge and faith regarding the consequences of an action. Möllering suggests that in some circumstances relational aspects producing either confidence or reciprocity might support decision-making. However, this knowledge moves us close to confidence, which according to Seligman's (1997) is a different quality. Nevertheless, building on Möllering's theory, Brownlie and Howson (2005) argue that trust is relational and impossible to understand in isolation. Trust occurs as individuals extract the known factors while bracketing off or suspending the unknown factors to avoid confusing decisions with uncertainty.

Gilson (2003) takes up this relational aspect of trust and claims that relationship issues provide the main challenges for policies on health practices and services. Making the link between systems and social capital, she compares UK and US health health systems. Concluding that the general acceptance by the UK population of the altruistic element of the UK health system stands in stark contrast with the distrust, which accompanies health

health in the USA where there is a belief that the system is organised to maximize the benefits for the medical profession. Gilson argues that trust involves both cognitive and affective elements. The former relates to a risk calculation where the costs and benefits of an action are calculated alongside of the degree of uncertainty derived from the dependency on the actions and intentions of another while the latter is linked to the generation of emotional bonds and obligations. Altruism provides a special case of trust where trusting and trustworthiness promote the social status of those involved in giving thus enhancing trust relations between health managers and users.

Other writers draw distinctions between trust and hope. Both Sztompka (1999) and Gilbert (1998, 2005) discuss trust and hope, with hope representing a situation of relative powerlessness, a situation exemplified by Gilbert who concludes that trust is a discourse of professionals and experts while hope is a user discourse. Seligman argues that trust, conceived as it is in this debate, is unique to modernity. In traditional societies, trust has quite different bases. Moreover, sociological theories, which suppose a general change in modernity (cf. Beck, 1992, Giddens 1994), assume that with the erosion of traditional institutions and scientific knowledge trust becomes an issue more often produced actively by individuals than institutionally guaranteed. To resolve these tensions we propose Foucault's Governmentality thesis as the means to identify the role of trust, along with the mechanisms for the deployment of trust and the role of professional expertise. Social institutions such as policies on health disseminate a particular ethic of the self into the

discrete corners of everyday lives of the population. Supported by a discursive framework promoting co-operative relations between people, communities and organisations this ethic is future orientated and promotes qualities and values that sustain trust-based relationships and forms of action. In the process of building co-operative relations, the role of professionals and professional authority is established. The next section healthfully examines the conceptual possibilities for articulation of trust and governmentality.

LINKING HEALTH MANAGEMENT WITH TRUST AND GOVERNMENTALITY

Conceptually there are tensions but also interesting theoretical possibilities between late [high] modern and post-structuralist conceptions of society. Both identify the fragmentation of traditional forms of authority and expertise, and acknowledge the increasing complexity this produces through the availability of multiple sources of information and different lifestyle choices. As noted earlier late [high] modern conceptions of trust, acknowledge uncertainty and risk as the basis for necessitating trust and point to the failure of rational choice theories as evidence of the existence of social trust. Likewise, governmentality theorists, discuss risk and uncertainty at length (Rose 1996, 1999, Osborne 1997, Petersen 1997), but leave the discussion of [social] 'trust' to an observation that trust, traditionally placed in authority figures, has been replaced by audit (Rose 1999). The problem of creating co-operative relations between individuals and within groups and communities, both in the present and for the future, is left unresolved. Foucault's summary of the working of the state provides a useful starting point for this discussion:

> "it is the tactics of government which make possible the continual definition and redefinition of what is within the competence of the State and what is not, the public versus the private , and so on; thus the State can only be understood in its survival and its limits on the basis of the general tactics of governmentality." (Foucault 1979:21)

Our contention is that the 'governmentality thesis' as it has been developed by writers such as: Rose and Miller (1992), Burchell (1991), Rose (1996, 1999), Osborne (1997), Petersen (1997) holds the potential to overcome many of the problems experienced in theorising trust. It provides a means of extending the critical debate over trust. Linking discussions concerning the bases of trust: the conditions Möllering (2001) describes as essential for trust to happen with discussions focusing on the outcomes of trust i.e. social capital, systems or impersonal trust and interpersonal trust (Putnam 1993, Seligman 1997, Luhmann 1979, Giddens 1990, 1991, Sztompka 1999, Rothstein 2000).

Moreover, governmentality provides the means for identifying the mechanisms for deploying particular rationalities across the social fabric. In particular, the interplay between state intervention and the population that institutionalizes expertise as a conduit for the exercise of power in modern societies (Johnson 2001). Institutionalizing expertise establishes a range of specialized spaces: at once both hidden and visible, providing opportunities across the social landscape for a range of health managers. Experts who work on individuals inciting self-forming activity and individual agency,

producing the self-managing citizen central to neo-liberal forms of government, 'enterprising subjects' or what Burchell (1991: 276) terms 'responsibilisation'. Thus enabling an explanation of trust that avoids resorting to a functionalist argument or an overly deterministic approach limited to either class action or the meaning-giving subject. Furthermore, governmentality can overcome the condition laid by Sztompka (1999) that trust cannot exist in conditions of discontinuous change. Indeed, in the context of discontinuous change, particular rationalities and their associated technologies become politicized, leading to increased conflict in the relationship between the state and expertise making trust an evermore valuable commodity.

In analysing the activities of government, Rose and Miller (1992: 175) argue, we must investigate 'political rationalities' and technologies of government - 'the complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions'. In this case, rationalities, operating as discourses and social practices embodying a particular practical ethic, work to reproduce the norms, values and obligations associated with trust. Producing a subject position that values trustworthiness as both a personal characteristic and a characteristic sought in others. Both experts/professionals and the user/customer of health services emerge as the self-managing ethical subjects of neo-liberal rule (Miller 1993, Davidson 1994, Rose 1999).

For governmentality theorists an analysis of neo-liberal regimes reveals individuals as inculcated with values and objectives, orientated towards incorporating people as both players and partners in marketised systems including health and social health. Participation in markets along with the potential for unbounded choice are inextricably entwined with a creative tension, an ethical incompleteness, where private [selfish] desire and public [selfless] obligation produce the rational self-managing actor of neo-liberal rule. In a dialectical relationship that works to form individual identity through the exercise of a modern consumerist citizenship (Miller 1993). Such regimes exhort individuals; indeed expect them to become entrepreneurs in all spheres, and to accept responsibility for the management of 'risk'. Government is concerned with managing the conduct of conduct, the processes through which people 'govern' themselves, which includes an obligation to manage one's own health (Petersen 1997).

Theorists of modernity such as Putman (1993), Sztompka (1999) and Rothstein (2000) leave trust to arise organically through the interaction of individuals within groups and communities. The idea that increasing the levels of social interaction to effect a positive consequence on the levels of social and individual trust has a benign attraction, but it tells us little about how or why these norms, values and obligations associated with trust exist in the first place. Alternatively, the analysis of governmentality recognizes these discourses and social practices as the outcome of something more ordered. Not ordered in the sense of designed and managed but the consequence of

what Foucault described as strategy: loosely connected sets of discourses and practices that follow a broad trajectory with no necessary correspondence between the different elements (Dreyfus and Rabinow 1982).

One tactic, increasingly used within the strategy of government as they struggle with the challenge of managing populations across an ever more complex range of social contexts, is the promotion of co-operative relations within different programmes and technologies. This works to promote, establish and maintain an ethic of co-operation and trustworthiness producing the trusting subject as a version of the disciplined subject, socially valued and malleable. Evidence of this can be found in a range of policy initiatives disseminated by national and local government drawing on communitarian discourses and including an endless array of devices promoting partnerships and active citizenship e.g. Caring about Healthrs (DoH 1999), Choosing Health (DoH 2004), Independence, Well-being and Choice (DoH 2005). Devices targeting communities and neighbourhoods through initiatives promoting policies on activities often focussed on a variety of locally based independent and autonomous groups. In areas where co-operative relations have failed and require rebuilding the deployment of discourses of empowerment is evident, inciting 'damaged subjects' to self-manage (Rose 1996). Located in initiatives such as Health Action Zones, Policies on Development Projects and Public Health activities a range of experts and lay volunteers work on individuals encouraging them to take

responsibility for their health and engage in self-forming activities, self-health and self-help (Rose 1999).

Alongside this promotion of co-operative relationships, neo-liberal rule increasingly repositions the state as the co-ordinator of activity rather than the provider [cf. Modernising Social Services (DoH 1998), Every Child Matters (DoH 2003b), Choosing Health (DoH 2004) and Independence, Well-being and Choice (DoH 2005)], progressively drawing communities into the provision of welfare and the management of social problems (Clarke and Newman 1997, Rose 1996, 1999). New, often contradictory, rationalities of competition and co-operation, of participation and consumerism, substitute for earlier forms of public provision. Nevertheless, these contradictory rationalities maintain sufficient coherence to provide the basis for state intervention through professional and lay activity.

One such example is the restructured relationship between the private health sector and the British National Health Service [NHS] (DoH 2002, Lewis and Gillam 2003). Until recently, the private health sector distanced itself from the NHS arguing quality and choice while those committed to a public health service rejected private sector values. Now, a range of policy initiatives such as the use of private sector surgical facilities, the ability to have particular treatments at a facility chosen by the patient (DoH 2003a) and Private Finance Initiatives [PFIs] have blurred the boundaries between the public and private health sectors. Fixing large sections of the private sector as the reserve capacity of the NHS expanding and contracting on demand without the

political consequences of public hospital closures. Furthermore, the use of private capital shifts fiscal liabilities from the present to the future while at the same time distancing the state from responsibility for the maintenance and refurbishment of hospital and other health service facilities and equipment.

Such developments suggest a re-articulation of the discursive structure of private, voluntary and statutory sector organisations in what Clarke and Newman (1997) describe as processes of colonisation and accommodation. Alongside State interventions aimed at provoking co-operative and trust-based relationships, such movements point to the way major institutions of society can become repositories of trust, providing both the example and the experience of trusting while also building the capacity for trust-based relationships across the social fabric. However, in contrast to functionalist conceptions of social institutions as repositories of trust e.g. Misztal (1996), we need to identify the dynamic interplay between the state and the means of intervention at its disposal.

The challenges faced by the state over the last twenty-five years or so such as the increasing health costs of an ageing population (Rose 1999, DoH 2005) have been matched by rapid social change. One effect of this has been the fragmentation of welfare away from a monolithic state organisation to one co-ordinated and financed by the state but disciplined by market mechanisms such as commissioning and competitive tendering (Clarke and Newman 1997, Lewis and Gillam 2003). Another effect has been the politicization of the technical i.e. professional expertise (Johnson 2001), where a variety of forms of

expertise competes for dominance. Under such conditions, trust is also politicized (Gilbert 1998). Trust becomes a commodity for exchange (Dasgupta 1988). Demanding new forms of governance and producing a paradox, autonomy for organisations and professionals released from direct management by the state is matched by ever more-complex forms of surveillance and control (Rose 1999, Gilbert 2001).

Since the 1980s, claims of a decline in the authority of the professions accompanied this process. Public perceptions of failures of professional self-regulation articulate as institutionalized self-interest (Davies 2000), paralleled by the increasing power, or resistance, of health service users and welfare consumers to discipline professional activity. Managerialist techniques such as contracts and demands for transparency in exchanges unite managerial and user based discourses in an uncomfortable marriage (Rose 1999, Shaw 2001, Stewart and Wisniewski 2004, McIvor *et al.* 2002), frustrating the radical voice of user movements (Clarke and Newman 1997). Alongside, a massive increase in the access to the information, particularly through the internet, further complicates the situation. Specialist information, once the sole privilege of the professions, is now widely available, changing the relationship between professionals and laypersons once again challenging professional authority (Hardey 2005).

For Rose and Miller: 'governmentality is intrinsically linked to the activities of expertise, whose role is not weaving an all-pervasive web of "social control" but of enacting assorted attempts at the calculated

administration of diverse aspects of conduct through countless, often competing, local tactics of education, persuasion, inducement, management, incitement, motivation and encouragement' (Rose and Miller 1992: 175). This web of activity and the specialized spaces created for expertise, work to construct professional authority, condensing the different levels of trust: interpersonal, systems and social capital; into the facework of experts. The fragmentation of expertise, once embedded in the directly managed institutions of the state, has enabled the dispersal of this expertise throughout the third sector leading to a re-articulation of the discourses that support professional activity and trust in expertise.

It is notable that despite the conflicts of the 1980s, the health managerial professions appear to carry on relatively unscathed leading to the conclusion that the decline in the authority, power and popularity of the professions has been overstated. One key factor is that certain tasks and activities demand professional competence especially in circumstances where the outcome cannot be pre-determined (Clarke and Newman 1997). Once again, revealing the paradox of autonomy and increasing regulation in the relationship between the state and professional activity. Returning to the earlier quotation from Foucault, what has occurred in this period is the re-articulation of government objectives and a re-structuring of the realms of professional jurisdiction and authority (Johnson 2001). Regulation and control of expertise through audits and contracts are disciplinary techniques that have modernized the tricky issue of governing professional activity. Accompanied

by a re-articulation of professional discourse objectifying the activity of expertise rendering it both manageable (Rose 1999), and enabling the surveillance of professional activity across a landscape no longer defined by institutions and buildings of the poor law. At the same time policy documents such as 'Choosing Health' (DoH 2004) and Independence, Well-being and Choice (DoH 2005) are unashamedly consumerist, demonstrating shifts in the way policies on health is managed.

Central to this process is a paradox where the need for experts to manage complex and unpredictable situations has led to trust in professional autonomy becoming almost exclusively located with the management of risk (Rose 1996, 1999, Petersen 1997, Kemshall 2002). Competence in the management of risk is therefore the central basis, which maintains the professional status of health and social health professionals. Failure in this respect can lead to very public examinations of the competence of individual professionals, in particular where there is danger of a legitimation crisis. Professionals who, despite evidence of system failure, experience a form of symbolic sacrifice and public humiliation, recent examples include Dr Marietta Higgs [Cleveland Child Abuse Inquiry], Lisa Arthurworrey [Victoria Climbie's social worker] (James 2005) and Professor Sir Roy Meadows [expert witness in child death cases (Laville 2005)].

Challenges to traditional or institutionalized expertise by new or non-conventional forms of expertise also demonstrates this re-structuring of the objectives of government and the jurisdiction of professionals. Some problems

have persistently frustrated traditional forms of expertise in health health and social welfare at the same time widely dispersed and contract based activity enables entry for alternative approaches. Here again the dynamic quality of Governmentality, demonstrates processes of colonisation and accommodation. Lee-Treweek (2002) explores this process in the context of a complementary therapy, cranial osteopathy, describing how traditional medicine accepts elements of complementary practice on condition that the alternative approach accepts particular rituals and the primacy of the existing medical hierarchy. The need to manage chronic conditions such as skeletal and muscular pain, areas where traditional medicine has failed to provide a reliable treatment, enables a new form of expertise to institutionalise itself with the state. Securing trust in this specialized space enables this form of expertise to contest the hegemony of risk to its advantage.

CONCLUDING COMMENT

One of the central problems of facilitating any leadership or rapport for health managers with older people in the UK has been the issue of 'trust'. As we have seen, there is an array of ways that trust has been defined but the central paradox is how to creation of the conditions of building conditions of trust across personal-organisational-structural tiers in an increasingly uncertain world. The paper has assessed policies on health policy and navigated the ways trust relations can capture stronger bonds and relationships between health managers and user groups such as older people in the UK. This is an immense conceptual and experiential challenge. What

emerges is a fusion of consumerist, traditional, alternative and complementary discourses articulated with discourses of co-operation, partnership and trust in health and social health providing an matrix of spaces where a wider range of expertise, in both type and numerically, than ever before is embedded. At one level, experts identify risk at the same time as providing a general surveillance of the population, at another level they work within systems legitimated by a myriad of mechanisms of distrust while simultaneously working at another level on individuals to promote a general ethic of trust. Thus, the mechanisms constructing the contemporary authority of expertise are established. Managing diversity is inextricably linked to trust. Condensing trust in the facework of health managers places users of health and social health in a dynamic context. Policies on health policy continually redefines previous patterns of social relationships both within health and welfare agencies and between those agencies and their customers. Gilbert *et al*. (2003) identified professionals in health and social health agencies responding to policy pressures by managing the expectations [trust] of different individuals and groups with potentially conflicting interest's e.g. individual users, parents/healthrs and the local policies on. These experts engaged in a process of change and consolidation managing conflict while furthering both organisational and political aims related to policies on health.

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