The User Generated State: Public Services 2.0

By Charles Leadbeater and Hilary Cottam

Caroline Tomlinson disabled teenage son Joe had a problem. He wanted to go to school with all the other teenagers in Wigan, on the bus. But when Caroline approached the social services department to see whether that would be possible they pointed out they already had a block contract with a local taxi firm to transport Joe to school and sending him on the bus would be an additional cost they were unprepared to pay, especially as in the department's assessment Joe would need to be accompanied by two care workers to make sure he came to no harm.

A few months later however Caroline and Joe enrolled on an initiative called *In Control* run by a social enterprise for the Department of Health which helps young people with learning disabilities take control of their own care. Everyone going on *In Control* gets their own annual budget – the cash equivalent of what they would have got in services – and help to decide how to spend it on the kind of support they need. Caroline and Joe quickly drew up a plan to get to school on the bus, with the help of two fellow sixth formers who were studying for care qualifications. Joe was happy. He and Caroline were managing the risk rather than the department, so the social workers were content. And as Caroline puts it : "You give me ten pounds and I will make sure it goes much further for Joe than any local authority."

Joe and Caroline Tomlinson, and the other families enlisted by Wigan council onto the project found their relationship with public services was transformed. Where once they were dissatisfied, complaining consumers, in an adversarial relationship with service providers and professionals, they found themselves turned into participants and co-investors in finding better outcomes for themselves. They sought and paid for professional advice and support, but within the context of their own plans. In the past, all too frequently, it had felt the other way around: Joe and Caroline fitted into plans and

strategies drawn up by the professionals, trying to bend their lives to fit within the provision the council made available.

It is often assumed that the public have to rely on professionals to deliver public services because in the economic jargon there is an information asymmetry: the doctor or teacher knows more than the patient or pupil. Yet the families of these children have fine grained knowledge about what they really need: when they need two carers to support them and when only one will do; what risks to take on a trip out to the zoo and so on. The *In Control* initiative draws out this latent, tacit knowledge of users that is largely kept dormant and suppressed by the traditional delivery approach to services in which professionals are largely in control, assumed to have all the knowledge and so consumers are largely passive because they are assumed to lack the capability of taking charge of their own care, health, learning or tax.

Caroline Tomlinson summed up the benefits of In Control, this way: "You get longer term funding. Its not week-by-week so you can genuinely plan for how you will use the money. It gives you something to build around – for example planning a trip out that you might save up for – rather than just managing the service, getting by. It gives you much greater flexibility to commission the mix of services you need, when you need them. For example my son wants a social life, he wants to be able to go out, without his family, like other 17-year olds. So on those occasions he wants to be accompanied by a 17-year old. That's not something that would be possible under social service rules."

Making *In Control* work is not simple however. Turning service users into commissioners and designers of service solutions is tricky as Caroline explained: "You need help to start planning and designing what you need. I was not used to seeing opportunities and possibilities. I just thought in terms of getting by. You get used to accepting your lot, what you get given. You need planning tools to help you visualise and shape the services you want and that needs to be a continual process, which you adjust. You have to go step by step, building up your confidence to take risks and do things a little differently. It is not easy being on In Control, it's like running a small business,

constantly juggling people and money and time. But it's a darn sight better than having to fit into a larger system."

The benefits of *In Control* do not just come from giving Caroline and her son an individualised budget to spend as they see fit. That brings additional benefits: it mobilises their ideas and know-how to make the money go as far as possible. When they were service-users they had no incentive to innovate. Now they have lots of incentives to add their innovations because they stand to benefit and through the community of families on the In Control programme those innovations are likely to spread.

As *In Control* shows services that enlist users as participants are more likely to unlock user-led innovation. Lead users tend to have more extreme and intensely felt needs which put them at the leading edge of change in a field. Lead users often have greater knowledge, they use products more intensively and they have skills that allow them to adapt products. What they want now, other consumers will want in due course. Many technology and computer games companies are well versed in working with their most demanding and innovative lead users to work out ideas for future products and applications. Caroline Tomlinson is a lead user of public services. Her family's complex and intense needs highlight how more mainstream services, for example care of elderly people, long term conditions, learning programmes could be reformed.

In modern media, software, games and cultural industries, user generated content is all the rage, spawning social networking sites like My Space and Bebo, mass computer games like the War of Witchraft, volunteer created encyclopedia like Wikipedia and Citizendium, news services such as Oh My News in Korea which has 55,000 citizen journalists, trading systems such as Graigslist and eBay and the fast growing virtual world of Second Life. Most of these examples are built on a dynamic relationship between a company or core organisation that provides the kernel or platform and a large community of users who generate, shared, amend and distribute content. What would the public sector be like if it too mobilised mass user generated content for care, health, safety and education? For the past decade most of the debate about public service reform

has focussed on delivery, making the public sector value chain work more efficiently, to resemble reliable private service delivery. But you cannot deliver complex public goods the way that Fed Ex delivers a parcel. They need to be co-created. That is why these emerging models of mass user generated content are so intriguing. They point the way to a user generated state. Or put it another way. Most of these emerging business models enlist users as participants and producers at least some of the time: they move from consuming content, watching and listening, to sharing, rating, ranking, amending, adding. A public sector which just treats people as consumers – even well treated ones – will miss this dimension of participation which is at the heart of the most successful organisational models emerging from the interactive, two-way Internet, known as Web 2.0. What would public services 2.0 look like?

In Control provides a glimpse of what public services 2.0 would look like: by turning people into participants in the design of services, they become innovators and investors, adding to the system's productive resources rather than draining them as passive consumers, waiting at the end of the line. But *In Control* only works when professionals play a quite different role. The family chooses which support workers to employ, what hours they should work and uses money flexibly to spend on treats, outings, different modes of transport, technology at home. The basis for this spending is usually a personal plan drawn up through intensive consultation between the client, their families, and social workers. The person centred plan provides the focal point for organising all care – formal and informal, provided by professional and friends and family. This is not a formal process of assessment like a means test. It does not involve lots of forms. Person centred planning has to be collaborative, down to earth and colloquial and plans have to adjust and adopted, as people change, they grow in confidence or their needs change. Critically people know from the outset roughly what kind of budget they are working with.

By turning people into participants in the process, rather than dependent service users, the clients and their families are more likely to commit their own time, effort and resources. They have an incentive to do so because that makes the money from social services go further. With more people becoming participants public services should be able to get

higher productivity, better outcomes, more satisfied clients without spending vast sums more on professional services. The current model of professional service provision means to get more education you have to employ more teachers and build more schools. That is why public sector output only goes up in proportion to inputs and spending. But what if you could break through that constraint which so limits public sector productivity and do what computer games companies have done. A computer game with 1m players only needs 1% of them to be player-developers, adding back content to the game, and it has an unpaid workforce of co-developers of about 10,000 people. Imagine that logic applied to public services: it would untap vast new sources of innovation, ideas and effort. Traditional professional public services will be more effective the more they are designed to help and motivate users to generate their own content and solutions.

That at least is the promise. But the user generated state will only be possible, as In Control shows, if participative public services are well designed to make sure professional opposition is allayed or defused; risks are properly assessed by participants and professionals; spending it accounted for; people are given support, advice and tools to make informed choices; those with least confidence and resources are given additional support to make the best use of the choices available. Above all these approaches need to motivate people to want to help themselves and one another. Public services must not just serve people but motivate them to want to do more for themselves.

Traditional methods to squeeze more productivity and higher quality out of public service value chains – targets, inspection, outsourcing, downsizing, workforce flexibility – are painfully slow at delivering real improvements in efficiency and outcomes. They are running out of steam. That is why promoting participation should be at the heart of a new agenda for public services. Not participation in formal meeting or governance but participation in service design and delivery. Participation offers a way for people to devise more effective, personalised solutions, at lower unit cost than top down professional services. What would it take to apply the principles of *In Control* to much of the rest of the public sector to create user generated public services? How far could it

extend? What kind of benefits would it bring? What are the potential risks and downsides of public services 2.0? We believe these five principles should be at the heart of this shift.

Five principles for Public Services 2.0

People are not consumers or users but participants

People will only become participants in creating service solutions if they play a much larger role in assessing their own needs, often through consultation with professionals and devising their own plans, for their care, education, re-entry into the workforce, long term condition management, local amenities.

In social care, for example, a large share of the system's resources are taken up with professionals assessing user need and then allocating services to them. Service users are largely passive in the process. The assessments use professional and bureaucratic language are beyond the grasp of most users. Filling out these forms is frustrating and time consuming for many carers: a Mori survey in Scotland found form filling was one of the most significant activities unpaid carers engaged in.

People will need simple to use tools to allow them to better self-assess and plan for their needs. In Bolton for example our design team developed a deck of cards for diabetics to use to self-assess they way they manage their condition and how it could be improved. In the Brazilian city of Curitiba, which has pioneered innovative approaches to participatory budgeting and service design, families in deprived neighbourhoods have been given comic books to guide them to self-assess their needs. Person centred planning techniques of the kind used in the *In Control* programme allow people to visualise the kind of life they would like to lead and how their care would have to be organised to make that possible. People make videos and draw pictures to explain what they need. All long term public service users whether in health, social care, education or welfare should be encouraged to self-assess and plan, using simple tools to help people visualise the support they currently get, the life they would like to lead and the kind of supports, formal and informal, that would require.

This process of self-assessment is often only possible with the advice and support of peers and professionals. At the moment professionals tend to assess people's eligibility in a formal, arms length process designed to ration eligibility to state services. A more personalised approach would require professionals to engage in a more informal but also more intimate conversation with clients, over a period of time to draw up and revise plans together, looking at solutions which lie beyond public services.

Financial frameworks

Giving users greater say will count for very little unless money and resources respond to these choices. The financial frameworks for public services will need to change to support greater participation. In social care, education and health that will mean taking a wider view of the total resources available for social care. If service users can be encouraged to become co-producers, with their carers, then they become part of the productive resources of the social care system not just consumers of those resources. The development of preventative and community-based care services, to relieve demand on professional and public services, will only be possible with long term growth in volunteering and scaling up the capacity of voluntary organisations. The unpaid and volunteer services, provided within families and the community, will be vital to the long run sustainability of the system as a whole. Helping to further develop that volunteer, collective, community infrastructure, should be a priority for social care investment.

Public sector budgets need to change as well with more joint commissioning of services and buildings. Councils commission many services – transport, care packages, meals - as block contracts to reap economies of scale that come from standardisation. External providers, including the voluntary sector, like such block contracts because they provide them with stability. Yet such block contracts can also mitigate against personalisation by locking resources into inflexible contracts. Councils would need much more flexible models of contracting that would allow people more choice over services.

But we also need something much more radical: give the money to the people and trust them to use it wisely. The experience of *In Control* is that users feel greater control when they can assess how budgets are being spent on their behalf. That also encourages them to take more responsibility for their care and to devote more of their time and effort to it. The key, however, is to find financial solutions that meet people's needs rather than following a rigid formula for disaggregating budgets. Direct payments and fully individualised budgets work for people when they have self-confidence to make choices, the information they need to compare options, advice and support from peers and professionals. However handling direct payments, including employing your own staff, also brings anxieties and responsibilities that many people do not want. Indeed some clients given an individualised budget may choose to spend it on the service they are already receiving. People should have a range of options for how budgets are distributed, with direct payments and individual budgets at one end of the spectrum and traditional services and top down budget allocations at the other.

Most public services are a public-private finance initiative at the micro level of the family, mixing private, family, voluntary and state resources. The same is true of care for people with long-term health conditions and investments in education. An effective public service would mobilise all these resources not just the state's portion.

Professionals and workforce reform

Participative public services will only work with the support of staff as well as clients. Professional opposition to ceding control to clients or pupils who "cannot be trusted" will be one of the major obstacles. In many settings people will still want a professional solution. Someone going into hospital with a hernia does not want to be an active participant in the operation. They want to be well served by well-trained professionals. But often we need professional support to find our own solutions rather than a professional service upon which we come to depend. Indeed more participative approaches which relieve some of the management burdens from the shoulders of professionals may allow them to get back to their original professional vocation rather than acting as risk assessors and gate keepers.

Professionals would still play a critical role within a participative system but they would have to give up some of their power in exchange for a better quality of work. They would have to share assessment, planning and risk assessment with clients. They might have to accept working alongside para professionals. Professionals would play several roles as :

- Advisers, helping clients to self-assess their needs and forge plans for their future care.

- Navigators, helping clients find their way to the services they want.

- Brokers, helping clients to assemble the right ingredients of their service package from different sources.

- Service providers, deploying their professional skills directly with clients.

- Risk assessors and auditors, especially in complex cases involving vulnerable people who might be a risk to themselves or other people.

Take social work as an example. Social work could be made more attractive and satisfying as a profession if social workers had less management responsibility, paperwork and bureaucracy. Yet that would mean social workers ceding management control to others. The development of para-professionals, such as social work assistants and expanding the role of care workers, would relieve some of the burden on social workers who sometimes seem to do jobs they are over-qualified for. The re-design of the role of social workers would need to trigger a re-design of the skills, responsibilities and roles of the wider social work workforce, including managers, para-professionals and unpaid carers.

Creating a wider market for services

There is no point giving users greater say over the services they want and even the budgets to commission services if supply is unable to respond to shifting demand. Participation in planning public service provision will mean nothing if services are trapped in rigid blocks, as in the case of Wigan's taxi service to take Joe to school. The following principles should guide how services are organised to support participation:

- Flexibility, so that provision can be reconfigured easily to meet shifting needs. If service resources are tied up in inflexible contracts or in building based services, they will not have the flexibility needed to meeting changing demands.

- Integration, so that different services – housing, social care, health and education - can be combined, to create a joined-up experience for service users. That will require more joint commissioning of services, more joint planning of provision and more work in partnership between different services. People with complex needs rarely find the services they want within a single department or even within a single local authority. They need support from several different sources. Those supports need to be integrated to be effective.

- Variety, to provide people with real choice over the style of provision. Choice between two standardised services is no choice at all. People should be offered a variety of modes of provision, which might for example, demand more or less of them as participants.

- Innovation, so that they social care system develops new service options for people. A prime example is exploring the role digital technologies might play in more personalised, home-based care support, by allowing more remote

monitoring of the health of frail and elderly people to allow more timely interventions to prevent crises or respond to them more effectively.

Participative and personalised public services will require far more flexible use of resources to give users more say over the services they get so that differing needs can be met in differing ways.

New measures of success

Too often public service users and staff report that the measures of success reflect macro performance targets and budgets that pay too little attention to user experience of services. Feedback loops in public services are very extended. Service improvement is not driven by direct user choices or complaints but by external regulation and reviews of services, acting at one remove, often after the event.

More participative approaches to planning services would only work if the participants also define more of the standards and outcomes. We need more person centric measures of success in education, health and social care, to complement the top down and macro measures of targets and standards. User panels should be more directly involved in the formal regulation and inspection of services. Users also need more effective direct triggers to force a change in services when they fail to meet agreed standards. Some public service users feel they have no option but to accept the service that is available, no matter how bad it is. Users need to be given a right to options, such as direct payments or individualised budgets, to be able to commission alternative provision if the public services they are getting do not come up to scratch. Imagine the eBay rating system applied to public service provision, or a service like TripAdvisor, the travel site where people rate and comment on hotels they have stayed in. Public services users need similar sites and services

These five themes should be at the heart of more participative approaches to public services:

- Tools to give users more choice and voice, to encourage them to become participants in shaping the services they get and so to take more responsibility for them, investing their own resources and ideas in better outcomes.

- A new financial frameworks to encourage investment in community-based prevention, allow integration of different public service budgets around shared social goals and devolve more spending directly to users so services are commissioned around their plans. At a micro level of the family all care, welfare, health and education is a public-private finance initiative.

- A new division of labour within public service workforces, with the growth of para-professional assistants, support workers and managers, that will in turn allow a revival in professional vocational roles. social work based around the roles of adviser, navigator, advocate, broker, counsellor, risk assessor and designer.

- Continued development of a mixed economy provision so that user choices can be translated into service provision. That will require services that are more flexible, integrated, diverse, innovative and cost-effective.

- New measures of performance which give users greater say over service quality and new rights for users to switch services when quality falls below an agreed threshold.

Radical innovation rarely starts in the mainstream. It often starts in marginal markets with committed, educated and knowledgeable users creating radically new products or services. In the private sector, especially in media, music and culture, the margins are becoming the mainstream faster than ever: eBay went from 122 participants in 1995 to 122m participants in 2005. In the public sector innovations in the margins like *In Control* often get trapped on location, they never develop and propagate. How would we take the principles of participative public services developed by *In Control* into mainstream

public services. There is no better example of why that is needed and how it could happen than health.

A health service 2.0

~~The medical establishment has become a major threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic. Neither the proportions of doctors in a population, nor the clinical tools at their disposal, nor the number of hospital beds is a causal factor in the striking changes in overall patterns of disease in developed societies.~~

~~Professionals have an inbuilt tendency, despite the best intentions of many individuals, to become cartels, a kind of priesthood. They are not just gatekeepers of knowledge, resources and status. They determine what is valid, legitimate, needed or deviant. They tell us where we are deficient in our learning, health or behaviour, and what we need to do to correct our shortcomings. The public service professions may have started life with a vocation to serve, by providing specialist expertise but they have now exert a self-justifying monopoly over many areas of life. Education has become what teachers deliver in school. Doctors and hospitals define what it is to be healthy. Care is what social and care workers organise for us. Professions may serve us but at the price of ensnaring us in their language, protocols and codes and in the process they disable us, by rendering us confused and dependent. A person going into hospital quickly becomes redefined as a condition to be diagnosed and treated. A child going to school quickly becomes defined by their progress against bewildering key stages which set out what they should be learning by when.~~

~~Our debates about public goods – what it means to be healthy, educated, cared for – quickly degrade into debates about professions and their institutions: how they should be funded, who should get access to them, how they should be managed and held to account.~~

By definition what is not professional, institutionalised and properly accredited – the self-taught, the self-administered – must become odd-ball and maverick, drop-outs and deviants, not to be trusted. As professionals extend their dominion over our lives our confidence in our abilities to make decisions and provide solutions for ourselves diminishes. We become incapable of acting without prior professional approval. When we do not get the service we have come to expect, when doctors are not available, or cannot dispense the miracle cure, we become angry and resentful. Professionals even control what tools we get to help ourselves – over the counter medicines for example – and how we use them.

That is a brief sketch of ideas articulated 30 years ago Ivan Illich, a nomadic and iconoclastic Catholic priest and arch critique of industrial society. Illich set out his ideas in a series of short, polemical and passionate books – more like pamphlets – in which he set about the failings of modern institutions and the professionals who organise them: *Deschooling Society*, *Limits to Medicine*, *Disabling Professions* and *Tools for Conviviality*.[1]

As he put it in *Deschooling Society* : "The pupil is "schooled" to confuse teaching with learning, grade advancement with education, a diploma with competence, and fluency with the ability to say something new. His imagination is "schooled" to accept service in place of value. Medical treatment is mistaken for health care, social work for the improvement of community life, police protection for safety, military poise for national security, the rat race for productive work. Health, learning, dignity, independence and creative endeavour are defined as little more than the performance of the institutions which claim to serve these ends, and their improvement is made to depend on allocating more resources to the management of hospitals, schools and other agencies in question."[2]

[1] Illich's books have been reprinted many times and are published in the UK by Marion Boyars Publishers, www.marionboyards.co.uk and distributed by Central Books.
[2] Deschooling Society, Marion Boyars, first published 1970, reissued 2002

Illich was writing for a different time, when Mao was in power, before Watergate, when the left was still counter cultural, utopian and radical, the Vietnam war was being prosecuted and the welfare state was in its prime, before the rise of the free-market right, globalisation and single issue politics. Yet Illich was ahead of his time by being behind the times: his critique of industrialisation harked back to pre-industrial, communal forms of organisation, as well as foreseeing a world of networks and webs long before the Internet.

For much of the 1970s he was a darling of the left, sharing some intellectual common ground with Herbert Marcuse and the Frankfurt School's critique of a one dimensional society, run by large corporations in which were insidiously encouraged to see everything as a commodity. He was an environmentalist before the movement had been born and lived a spartan life with few possessions. Yet Illich was no lefty. Although he was deeply at odds with the Vatican, he never left the Catholic priesthood. He dismayed many of his left-wing fans with a withering attack on Castro's Cuba and his defence of the traditional gender roles, which enraged feminists. Indeed many on the right would have found aspects of his ideas attractive. Illich was in some respects profoundly conservative and anti not just industrialisam but all things modern. But he was also a libertarian, an early advocate of a version of education vouchers and individual choice in public services. Illich died in 2002, from a cancer he had for many years but which he refused to have treated by doctors. He believed modern society encouraged the delusion that life could be lived without pain and suffering. Towards the end of his life his writing became more apocalyptic, at times melancholy and pessimistic.

Yet in a short, golden period in the mid-1970s, Illich set out not just a critique of industrial era institutions and professionals but also some highly suggestive ideas on how they might find a more supportive, realistic and balanced role in society. Those ideas now have even more purchase on a world were people are less deferential, professionals are less trusted, consumers are better informed and more assertive, and knowledge is available from many more sources. Illich's ideas deserve revisiting.

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The UK National Health Service is one of the largest remaining planned economies in the world and the debate is all about how to bring an element of perestroika to a system that like the Soviet Union of old depends on people queuing for a long time, rations treatment and provides highly variable quality. All over the developed world the assumption is the same: health is what hospitals and doctors deliver. The more that hospitals can produce high quality, personalised, mass customised treatment, along a more or less linear patient pathway which looks something like a production line, the better health care we will get. The patient goes in at one end ill, is worked on by doctors and nurses, and emerges out the other, like a finished product, well again.

The scale and significance of the hospital reform programmes, focussed on acute care, should not be minimised. Quality of care in hospitals is still too variable. But most hospital focussed health reforms seem to be addressing the symptoms of professional stress and organisational breakdown, rather than the underlying causes. The hospital based health care system was a response to the spread of contagious and acute disease born by urbanisation and industrialisation in the late 19th century. Now this system of professional diagnosis, prescription and monitoring has to deal an epidemic of chronic disease, much of it associated with a society in which people live for longer. Even cancer is becoming more like a long-term condition to be lived with and fought against. It is no longer an automatic death sentence.

In the UK, 45% of the adult population have one or more long-standing medical condition. Amongst the population more than 75 years old, the fastest growing group of the population, the figure is 75%. By 2030 the proportion of 65-year olds with a long-term condition will double. In 1990, heart conditions and cancer were responsible for 19% of deaths: most people died too young to be troubled by chronic conditions. In 2004 circulatory diseases and cancer were responsible for 63% of deaths. They are one of the main reasons people go to see doctors. About 80% of consultations with a general practitioner are about as aspect of a long-term condition. Another 10% are for minor

ailments and conditions that are best dealt with through self-treatment and over the counter drugs. General practice is increasingly a reassurance service for people who have minor ailments that doctors can do little or nothing about or long-term conditions that are also incurable. Chief among these chronic is diabetes. In the UK more than 2m people are diagnosed diabetics and a further 1m – the missing million – are diabetic without realising it. Internationally the rate of diagnosed diabetes has doubled in 20 years and will double again in the next 20 years. If type two diabetes, which is linked to lifestyle, is caught early its development can be kept in check. Yet between 40% and 50% of diabetes is not diagnosed until it is too late. Then people become dependent upon regular insulin injections, which in the UK involves repeat visits to the doctor. Diabetes, in principle a preventable and manageable condition, costs the NHS £5m a day, 5% of total NHS expenditure and 10% of hospital in-patient costs. The hospital based health system, with heavy fixed costs of buildings and professional staff, is ill designed to prevent and manage these i-diseases: chronic conditions that arise from lifestyle and need to be managed in the community.

The closed, professionalised system is too centralised, cumbersome and closed to cope with the epidemic of chronic conditions which mainly stem from people's lifestyles. The front line of health care is not in hospitals nor even general practice waiting rooms, but in people's living rooms and kitchens, pubs and clubs, supermarkets and restaurants, gyms and parks. By the time someone realises they have a chronic condition that warrants a visit to the doctor it is too late. We need a health system which catches conditions early, even better prevents them altogether and allows people to take action without having to wait to see a doctor. Such a health system would have as its prime aim enabling people to stay healthy and well. That in turn would mean patients and users becoming participants in and producers of their own health: user generated health care. The best way to imagine what such a system would look like is to think of a health system organised primarily around people, their families, homes and communities, supported by hospitals and doctors, rather than a system which is dominated by high fixed cost hospitals.

A user generated health care system would have to be highly distributed. Knowledge and resources could not be centralised in specialist hospitals or even surgeries. People want health care close to home. Public investment should not be going into more big hospitals, but creating a home-based health care capacity, that is more flexible, personalised and lower cost. The challenge of chronic disease is to enable to change their lifestyles. That cannot be done through a consultation with a doctor. It has to happen in situ, as people shop, eat, walk and work. People need help, advice, support and tools close to hand, without having to visit a doctor for reassurance and advice. We need to shift towards much greater self-assessment and diagnosis. New generations of intelligent sensors and monitors will allow many of the tests that GPs do to be done at home. The average diabetic sees a doctor or nurses perhaps six hours a year for a check up, but spends 8,000 hours self-managing their condition. The big gains will come from improving what happens in the 8,000 hours of self-management. The distributed resources of the new health system would include an expanded role for pharmacies, which conduct 600m consultations, twice as many as GPs.

Solutions would have to be co-created between people and professionals. Giving people a sense of control should be one of the central goals of a user generated health system. If someone spent nine months with the support of a life coach to prevent the onset of diabetes, the cost would be less than 15 years dependence on insulin injections and regular consultations with doctors, which is invariably the result of late diagnosis. Co-created solutions emerge from interaction and conversation not from a professional delivering a solution to a passive and dependent patient. The central aim should be to equip people with tools, knowledge and motivation to better look after themselves and one another.

People would need to help one another peer-to-peer as the families on *In Control* in Wigan found. As consumers their main relationship was with their service providers. As participants they started to look sideways to one another for help and support. Medical professionals do not have all the solutions, even to purely medical issues. They are not the best people to turn to for advice about the social, personal and emotional aspects of

health. The best source of support for those issues will not be doctors but other people who have lived with the condition themselves. A participative system would see patients and their carers as part of the distributed knowledge base. We need to create new platforms and spaces – both social and digital – to allow people to share and collaborate. Imagine an open source approach to building up knowledge about diabetes management, in which people can find different modules relevant to their particular position, lifestage and needs, or an eBay system for trading help and equipment or a way of learning about health through a computer game like the Sims.

All of this would require new organisational models and professional roles. Chronic conditions arise from our subtlety different lifestyles. A centralised organisation that relies on a cadre of specialised, knowledgeable professionals, is too cumbersome to deal with such complexity. It cannot hope to gather all the information it needs to work out what needs to be done in highly dispersed and different settings. Far more needs to be done by self-help groups and online forums. Dipex.org, for example, is a site where people with different conditions can post their own narrative accounts for others to learn from. More and more people are turning to the Internet, chat rooms and discussion groups for help, support and information on health.

We will only reduce the toll of chronic disease if we encourage far more, distributed participative solutions that also encourage people to help one another. Participation will only flourish if it also breeds collaboration. We will only create better public health by influencing many, many private healths. Fifty years ago daily life – getting to and from work and the shops – involved the equivalent of walking a marathon a week. In 1952 the British cycled 23bn miles a year, compared to 4bn now. Only 20% of men and 10% of women work in physically demanding occupations. Activity has been designed out of our routines. A quarter of the English population is officially judged to be obese. Lack of adequate physical activity is closely connected to chronic conditions. A national network of peer-to-peer personal trainers and health clubs – Active Mobs - might be one of the best long term health investments we could make.

We will not deal with the health challenges of the 21st century – ageing and chronic disease – with a professional service, hospital health system designed for the contagious diseases of the 19th century, which leaves people dependent upon doctors for solutions they usually cannot deliver because it is too late to do much. People need to become participants in and producers of their own health rather than passive patients. A healthy society is not what doctors deliver to us, but what we produce together. Social innovation by the masses not just for the masses is what we need. Motivation is the new medicine. Public services will more effective the more they to motivate, support and educate people towards more effective self-help: the user generated state.

From Rehtoric to Reality

The government has at least started to acknowledge the need to shift in this direction in some areas, most obviously in social care, with the 2006 White Paper Our Health, Our Say, which envisaged a move towards much greater individualised budgets. In education personalised learning should open the space for more participative approaches. Already the tax system relies on regulated self assessment and other areas could follow suit. The most impressive welfare to work programmes, for example those run by Work Directions in Birmingham, rely on mobilising the motivation of participants to follow through their plans. The 2006 local government White Paper envisaged greater decentralisation of power and budgets – double devolution – which should encourage greater community participation in decision making. Responses to climate change will require large changes in individual behaviour as well as investments in new infrastructures for energy and transport.

Yet despite the rhetorical backing for more participative approaches the progress on the ground is more limited for three main reasons. First, established, mainstream services still gobble up most of the resources, most clearly in the health system. It is difficult to create a new community based and participative health care system when most of the resources are still locked up in servicing large hospitals. Second, most attempts at promoting participation are locked into the current system: they are sustaining innovations designed

to make the current system work better rather than radical and disruptive innovations designed to create something new. The prime example is the expert patient programme which enlists people to become better patients within the NHS system rather than promoting wider change. Thirdly, creating more participative approaches is not easy and as In Control shows it takes not just thoughtful design but also a good deal of political struggle to fight off opposition from vested and professional interests.

Attempts to create the user generated public sector will have to confront ten main issues:

- **Economics: is it too costly?**

The assumption is that participative approaches require lots more support from professionals to tailor solutions to individual needs and people will tend to want to claim and spend more. The evidence from *In Control* is that participative approaches do have to be more expensive so long as authorities employ realistic cost controls and encourage people to mobilising complementary resources.

- **Equity: is it just for the middle classes?**

The assumption is that opportunities for choice and participation will be taken by the most articulate and confident. The professionally controlled state system at least protects the vulnerable with some guarantee of equity. Yet In Control has managed to give voice and control to some of the most vulnerable and at risk people in society. Mass state services do not guarantee consistency and equity: they can be highly arbitrary and capricious in the way they allocate funding and make decisions. Well designed participative approaches benefit those least able to benefit from the current system. The implications for equity depend on how they are designed and who they are designed for. Choice and participation can benefit the least well off if the systems are designed for them.

- **Fraud and risk: will greater freedom be abused?**

Previous experiences with co individualised budgets such as Individual Learning Accounts suggests there may be considereable scope for fraud and abuse. Yet *In Control*

suggests not: most people do not try to over claim and they are very careful spenders of their money. Once it becomes their money they tend to look after it very well, as Caroline Tomlinson says getting maximum value for money from it.

- **Changing roles of professionals**

Professional power is at the heart of public service system of assessing need, regulating risk and measuring quality of outcomes. More person centred approaches to planning would challenge professional power and so provoke resistance. Successful *In Control* authorities have developed approaches that bring clear compensating benefits to professionals, for example by restoring professional vocational roles. Strategies for workforce reform and expansion – bringing in a wider range of skills and support – will be critical. Strategies for professional development and workforce reform need to be central to the shift to PPS.

- **Supply side response**

Most public service provision is organised around inflexible blocks of services: schools, hospitals and prisons or block contracts for care. This rigidity, justified by economies of scale, limits the ability to services to respond to specific needs. Users tend to be fitted into the service boxers available to them. Public authorities will have to develop different ways for services to be procured that allow for more personalisation and flexibility. However it is also essential there should be "backwards compatibility" : the new system must also provide room for elements of traditional services that some people will want.

- **Audit and accountability**

How should individuals account for the money they spend? Fear that individuals might mis-spend money is one justification for continued professional control over budgets and onerous requirements to account for spending. *In Control* recognises people need to account for how they spend the money but this is made as simple as possible and linked to their care plan. The most effective way to kill off participative approaches is to distribute funding through individualised budgets but then re-regulate and audit in great detail what people can spend their money on: giving with one hand but taking back with

the other. Finding realistic, robust but simple forms of accountability will be essential. This needs to be linked to new person centric measures of outcomes.

- **Regulation and Risk**

In social care authorities will be concerned that greater individual discretion to shape care might lead people to take risks which would put the authority in jeopardy of a breach of duty of care. Person centred plans must involve a redistribution of risk assessment and responsibility away from professionals. But this needs to be made clear: giving people individualised budgets means them also taking on more responsibility for handling risk.

- **Regulation and Innovation**

Participative approaches will be at odds with regulation, that might punish rather than reward or encourage innovation. Innovating authorities need to know how regulators and inspection regimes will respond. Most public service regulation and inspection is designed to guarantee consistency and delivery of standards. In participative public services inspection would need to encourage and endorse far greater diversity of outcomes.

- **Building participant confidence.**

Different participants will come with different levels of confidence, support, networks, friends and family. A participative approach would have to be very responsive to their different needs, starting points and resources. Not everyone is ready or wants to be a participant. Most people, some of the time, will want to be consumers. Some people will want to be in that position all of the time.

- **The role of the voluntary sector**

The voluntary sector will be vital to provide additional support and services for people to self-help. Building the voluntary sector's capacity to support person centred services will be vital. But some voluntary groups see their main role as advocates for better services with the traditional professional service model.

- **Political leadership**

The scale of the transformation and the risks involved will require committed political leadership at central and local level to meet professional opposition to ceding control, media scare stories about risk and fraud and public concerns that participative solutions are really a back door route to cut services.

- **Scaling up**

The biggest challenge in all social and public innovation is how to scale up promising ideas. What is being scaled up? (An idea, a set of principles, a set of tools, an organisation?) How is it being scaled? (Through franchising, policy prescription, campaigning, organisational growth?) *In Control* is an alliance between enlightened professionals, participants, carers and councils to create a new set of solutions tailored to individual aspirations. The *In Control* community has an open source feel to it: ideas and improvements are readily shared. Simon Duffy's *In Control's* director talks of it as an operating system for social care, which can be adapted and amended in different contexts applied to different needs. Scaling will also be helped by making the system quite modular, so that people can pick, choose and improve just what they want to focus upon. Most open source software projects that attract a large developer community have this modular structure which allows many people to participate in its development. The technology writer Tim O'Reilly calls this an "architecture of participation" – which encourages many people to make contributions and ensures they all add up. The web has an architecture of participation: it invites people – most people – to take part. Public services do not always come with such a welcome.

Participative solutions cannot be mandated top down. The centre can help create the conditions for them to emerge – for example by promoting individualised budgets for social care and long term conditions – but it cannot mandate what outcomes should be achieved. Particpative public services are far more likely to spread by word of mouth, peer to peer, just as social networking has.

Public Services 2.0

We need a new way to create public goods that take their lead from the culture of self-organisation and participation emerging from the Web that forms a central part of modern culture, especially for young consumers and future citizens. Increasingly the state cannot deliver collective solutions from on high: it is too cumbersome and distant. The state can help to create public goods – like better education and health – by encouraging them to emerge from within society. The tax system increasingly depends on mass involvement in self-assessment and reporting. Welfare to work and active labour market programmes depend on the user as a participant, who takes responsibility for building up their skills and contacts. Neighbourhood renewal has to come from within localities, it cannot be delivered top down from the state. Public goods are rarely created by the state alone but by cumulative changes in private behaviour.

The chief challenge facing government in a liberal and open society is how to help create public goods – like a well educated population, with a appetite to learn – in a society with a democratic ethos, which prizes individual freedom and wants to be self-organising and "bottom-up". Government cannot decide on its definition of the public good and impose it from above, at least not continually. But nor can it stand back and accept whatever emerges from self organising systems. Government's role is to shape freedom: getting people to exercise choice in a collectively responsible way and so participate in creating public goods.

Productivity should rise because highly participative services can mobilise users as co-developers and co-producers, multiplying the resources available. Participation allows solutions to be tailored more readily to individual needs and aspirations; people have to share responsibility for outcomes and devote some of their own inputs. Participation is the best anti-dote to dependency if they equip people with tools so they can self-provide and self-manage rather than relying on professional solutions and services. Participative approaches are not only vital to create more personalised versions of existing services – like health and education - but also to address emerging needs and issues – such as waste and recycling, community safety and long term conditions – where public outcomes depend on motivating widespread changes to individual behaviour. Participative public

services connect the individual and the collective in new and far more powerful ways than seeing people as taxpayers, occasional consumers and even more infrequent voters.

The triumph of the modern industrial public sector is ~~is~~ the creation of institutions on a vast scale, which provide services such as education, health and policing, that were ~~might have~~ once ~~been~~ limited to just a few. These universal systems aspire to deliver services that are fair and reliable. Yet that in turn requires codes, protocols and procedures, which often make them dehumanising. ~~After Ivan Illich trained as a priest he went to work in a poor Puerto Rican neighbourhood in New York and he was struck by how many other institutions seemed to be modelled on the church and how many professions seemed to take their cue from the priesthood.These institutions and the resources they control become the power base for the new priesthoods: the public service professionals. The dominance of professions, creates two big problems, according to Illich: counter productivity and dependency culture.~~

As people become more dependent on the expert knowledge of professionals so they lose faith in their own capacity to act. The rise of professional power is mirrored by a loss of individual responsibility. We become cases to be processed by the system. Education and health come to be commodities to be acquired rather than capabilities we develop in ourselves to live better lives. We now identify services delivered by professionals with the ultimate goods we want as a society: health, learning, safety, order, justice.

~~First, p~~Public institutions and professional should educate us towards self-help and self-reliance as much as possible. As Ivan ~~he~~ Illich put it in *Deschooling Society* in 1972: "Good institutions encourage self-assembly, re-use and repair. They do not just serve people but create capabilities in people, support initiative rather than supplant it." ~~Almost thirty years later the Wanless Review of health spending reached exactly the same conclusion. We will only become a healthy society if we restore the proper balance between professional service and self help.~~ The golden rule must be that instruction by

professionals must never outweigh opportunities for independent learning; any service must be designed to motivate and enable self-help.

We need much greater emphasis on intelligent self-assessment and self-evaluation. That is already the lynchpin of the tax system and should play a greater role in education and health. The education system schools us to think of assessments as exams, something we do at the end of the pipeline, checked by a professional. We need an education system that builds up capacity for intelligent self-evaluation, so that we are better equipped to assess and solve problems under our own steam, with the help of our peers and professionals if needed. An education system for the 21st century would have constant self-evaluation, much of it through peer to peer criticism and support, at its core.

In *Limits to Medicine* Illich described ~~goal of making~~ health as a personal task, which people must take responsibility for ~~for this way~~: "Success in this personal task is in large part the result of the self-awareness, self-discipline, and inner resources by which each person regulates his own daily rhythm and actions, his diet and sexual activity…The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population." ~~The implication is that the chief goal of p~~

These ideas are not appropriate to every aspect of public services. People in need of urgent and acute surgery do not generally want to be participants in the process: they want a good service, delivered by professionals. Too often the ethic of self-help can be used to get us, the users, to do more of the work ourselves. Self-service is not the same as participation.

Yet the range of ways we can create public goods is expanding. In energy, for example, nuclear power might provide part of the solution to global warming but so too could highly distributed, domestic micro-generation. Schools and hospitals will continue to exist but in an environment where more learning and health care can be delivered,

informally and at home. People will want to be consumers some of time, participants at other times, when it makes sense for them.

And just for a moment think ahead. Imagine what it will be like in ten years time, as public services seek to serve people who have grown up with Bebo and social networking, MSN instant messaging, buying and selling on eBay, looking up stuff on Wikipedia, getting their music via My Space, playing multi users games and broadcasting themselves across YouTube and its successors. Across much of culture and commerce a huge shift is underway: as technology lowers barriers to entry people are slowly finding their voice. The people we used to call the audience are taking to the stage, or at least the stages they want to set up. And they are getting used to copying, mimicking, commenting, rating and ranking whatever they see. A public sector that does not utilise the power of user generated content will not just look old, outdated and tired. It will also be far less productive and effective in creating public goods. The big challenge for public service reform is not just to make services more like Fed Ex, more efficient and reliable. There is now another big challenge: to make public services as participative, communal and collective as the best of what it emerging from the new collaborative culture. That is why in future every public service must carry with it an invitation to participate.

~~*Public services and their professionals have developed through a process of sedimentation.*~~

~~*Schools, hospitals and welfare institutions started through acts of charity or faith. Professionals began life as independent advisors. They were brought together in the 20th century into systems that could deliver public services at national scale, for everyone, at reasonable costs and standards through an uneasy truce between professional discretion and industrial process. Since the 1980s that has been overlaid by the growing weight of the "McKinsey state" of performance management, targets, contracting out and quality standards. Current initiatives to extend choice will provide a thin topsoil of consumerism to systems that are still largely planned, rationed and dominated by professionals. Public spending programmes, by default or design, entrench and embed this industrialised model of service delivery. Despite a doubling of spending since 1997 the current crisis in hospital funding, is squeezing out resources for preventative and social care. In education a massive capital programme is Building Schools for the Future, many of which will look alarmingly like schools of the recent past, with jazzier architecture. We incarcerate more people than ever, in prisons that look very like Strangeways opened more than a century ago.*~~

~~*At the edges of these vast, asset heavy, inflexible systems we cansee just the first signs of what post-industrial public services might look like: Kent's home based social care programme; the In Control initiative to give services users individualised budgets; the development of distance and peer-to-peer learning; the 2006 social care White Paper which foresees the creation of a stronger infrastructure of community based services. More important still, many of the most dynamic emerging business models are highly collaborative, peer-to-peer and distributed, from eBay and Craigslist to Linux open source software and computer games such as the Sims.*~~

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forthcoming book We-Think: the power of mass creativity which is available in draft at his website at www.wethinkthebook.com.

Social work may be an extreme case. But that gap between the public service professionals' avowed aims and the reality of their work is gnawing away at all public service professions. Piecemeal reforms seem to create as many problems as solutions. Workforce reform, the creation of para-professionals such as teaching assistants, to take some of the burden off full professionals, provoke worries that control is being diluted. Professionals could relinquish their role as gatekeepers of resources, with all the angst and paperwork that goes with that, but probably only by giving the consumers – patients, parents, children, clients – more choice over how they want to spend the resources allocated to them, perhaps in the form of direct payments or individualised budgets. This makes many professionals defensive. They argue that their clients often lack the knowledge and skills to make intelligent choices. Professionals do not like being managers, yet nor do they want to be managed. So in social work, for example, the best professionals are often promoted into management, so losing direct contact with their clients and working peers. Meanwhile, schemes designed in part to divert demand away from professionals, such as NHS Direct, seem to have made little difference to the sense of pressure.

Declining trust has also gnawed away at professional relationships with clients. Doctors and social workers have lost the ability they once enjoyed to speak without challenge about their patient's ills. Misdiagnosis, maltreatment, cover-ups of malpractice and political mobilisation by aggrieved patients combined mean that third party regulators are now often inserted into the relationship between professional and client. But as a result feedback loops from dissatisfied users back to the professionals tend to be very extended; they go via inspectors and ombudsmen. Professionals feel less trusted, but users do not necessarily feel more empowered.

Many professionals have responded by reaching out to their clients in new ways. We turn to professionals primarily for their specialist knowledge, to provide us with diagnosis and explanation, to guide us to the best course of action if we want to learn maths, get

~~*our knee fixed or become a better parent.*~~[3] ~~*The reasons and justifications we accept are determined by the relationships we have with people. The more intimate and equal our relations – partners in a marriage – the more nuanced, thoughtful and considerate the explanations we expect. An off hand or high handed explanation would insult or hurt a close friend or partner. Yet if we have a quite distant and episodic relationship with someone – a neighbour we bump into on the street – an over elaborate and intimate explanation of their actions would seem out of place. The more distant and hierarchical our relations, in general, the less information and consideration we come to expect. Power is the ability not to have to explain what you are doing, or at least to do so in language so esoteric that it renders the listener dumb or makes them feel slow. Some people are attracted to professions because they have a vocation to serve; others because being a professional confers status and power.*~~

~~*Many professionals – especially doctors perhaps – have been trained to give explanations that keep the patient at bay. Consumer culture, combined with the spread of alternative sources of information and knowledge, now means that people do not want to be talked down to. They want to be treated as intelligent participants in a conversation, that takes places at a speed and in a language they can contribute to. People like metaphors and simple stories of cause and effect. Professionals often lapse into specialist codes, probabilities, risks and technicalities. Translating technical issues into accessible language is a skill that not all professionals have. Promotion and advancement within professional communities comes from talking the language that the profession uses rather than the clients. Academics and scientists who are good at communicating publicly and so acquire a popular following do not always find that makes them popular among their peers. In a more demanding and less deferential age professionals must make themselves more easily understood. But one suspects even that will not get to the root of the problem.*~~

~~*Take health as an example, a classic example of where even employing many more professionals and paying them more does not guarantee results. Despite a doubling of*~~

[3] Why? Charles Tilly, Princeton University Press, April 2006

~~*health spending since 1997, waiting times for routine operations are set to climb in 2006/7 because of the funding crisis within the NHS. Much of the additional spending has gone to employ more nurses and doctors. The 2002 Wanless Review of the future of the NHS, commissioned by the Treasury, suggested on current trends health spending would have to double again in the next 20 years to keep pace with demand. That is inconceivable. The problem is rooted deep within the professional model of public service delivery.*~~

~~*An modern health system, built around hospitals, is working efficiently when the beds are full as much of the time as possible. The aim must be to fill up the hospital. A healthy society is one in which people do not need to go to hospital or to see doctors. The best definition of health is not needing a service. The fact that we associate good health care with hospitals that are full is a sign of just how skewed our thinking has been by systems of industrial production applied to social issues. The more that hospitals can produce high quality, personalised, mass customised treatment, along a more or less linear patient pathway which looks something like a production line, the better health care we will get, we think. The patient goes in at one end ill, is worked on by doctors and nurses, and emerges out the other, like a finished product, well again and if they are lucky they get some after-sales service from social services.*~~

~~*The hospital focussed health care system emerged in response to the spread of contagious and acute disease born by urbanisation and industrialisation in the late 19th century. The aim was to provide a place where specially trained people – doctors and nurses – could repair people who were ill, a bit like a garage repairs a broken down car. But now this system of professional diagnosis, prescription and monitoring, has to face a challenge for which it was not designed: an epidemic of chronic disease, in a society in which people live for longer.*~~

~~*In the UK, 45% of the adult population have one or more long-standing medical condition. Amongst those 75 years old, the fastest growing group of the population, the figure is 75%. By 2030 the proportion of 65-year-olds with a long-term condition will*~~

~~*double. In 1900, circulatory diseases, like heart conditions and cancer were responsible for 19% of deaths: most people died too young to be troubled by a chronic condition. In 2004 circulatory diseases and cancer were responsible for 63% of deaths. About 80% of consultations with a general practitioner are about as aspect of a long-term condition. Another 10% are for minor ailments and conditions that are best dealt with through self-treatment and over the counter drugs. Chronic conditions are often linked together: people with five long-term conditions generally get more than 50 different prescriptions a year. About 650m prescriptions a year go to people with long-term conditions. Chief among these conditions is diabetes. In the UK more than 2m people are diagnosed diabetics and a further 1m are diabetic without realising it. If type-two diabetes, which is linked to lifestyle, is caught early its development can be kept in check. But a system in which expertise is inside clinics and hospitals does not allow us to diagnose diabetes early enough. Between 40% and 50% of diabetes is not diagnosed until it is too late. Then people become dependent upon regular insulin injections, which in the UK involves repeat visits to the doctor and difficult changes to what they eat, how they cook and the rest of the their lifestyle. The hospital based health system, designed around professional expertise to treat contagious disease and cure people, is ill-designed to prevent and manage chronic long-term conditions.*[4]~~

~~*This mismatch between a professionalised, hospital focussed health service and the needs of society will not be solved by employing more para-professional nurses, tighter regulation of medical ethics nor doctors talking in the vernacular to patients, though all have their place. We need a much more radical rethinking of the role of professions, their relations with their clients and the organisations that bring them together. We have created systems for the mass production of public goods through schools, hospitals and social work departments run by professionals. In future more of the emphasis will have to be production by the masses not for them. Which is where Ivan Illich comes in.*~~

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[4] Co-creating Health, Red Paper 1, Hilary Cottam and Charles Leadbeater, The Design Council, 2004; xxxx, Robin MurrayPape 2005