Equality, Liberty and the Limits of Person-centred Care's Principle of Co-production

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The idea that healthcare should become more person-centred is extremely influential. By using recent English policy developments as a case study, this article aims to critically analyse an important element of person-centred care, namely, the belief that to treat patients as persons is to think that care should be 'co-produced' by formal healthcare providers and patients together with unpaid carers and voluntary organizations. I draw on insights from political philosophy to highlight overlooked tensions between co-production and values like equality and liberty. Regarding equality, I argue that co-production compounds both problems of gender inequality in the distribution of care labour and the challenges associated with securing equal access to care. Turning to liberty, I identify important commonalities between co-production and republicanism in political philosophy, given their shared insistence on common citizens' civic virtue. Then, I use against co-production some liberal arguments against republicanism, to highlight a problem of over-demandingness. In bringing my argument to a close, however, I wish to caution against hastily rejecting co-production as a policy programme.

Introduction

This article aims to draw on insights from political philosophy to highlight several drawbacks of an important component of person-centred care (PCC) policies, namely, the co-production of healthcare between, on the one hand, formal health services and, on the other hand, patients, families and communities. Together with analogous notions like patient-, consumer- and family-centred care, the concept of PCC has been around for several decades. Especially after 2001, when the American Institute of Medicine published an influential report listing patient-centredness among the essential components of high-quality healthcare, PCC has been strongly advocated by many among health policy commentators and governmental and non-governmental organizations around the world.[1]

PCC is notoriously difficult to define because it means somewhat different things to different proponents of the idea. Vikki Entwistle and Ian Watt explain that all models of PCC are united by the belief that patients should be treated as persons; however, depending on the focus of the model in question to be treated as a person might be conceptualized differently—as being treated as more than an ill body, an average member of a patient population, a means to the pursuit of the bureaucratic targets of healthcare providers and so forth (Entwistle and Watt, 2013: 29–30). This article focuses narrowly on a single element of PCC, although one of great relevance to policy debates, especially in recent English health policy—and this is co-production, or, to use another catchword, the idea that health services should rethink their role as being to a good extent about supporting patients, families and communities to 'self-manage' disease (Ahmad et al., 2014; National Voices, 2015). This idea is grounded in the commitment to treating patients as active participants in their own care and as capable of taking greater responsibilities for their health, which often figures in general characterizations of PCC (Epstein et al., 2010: 1490; Mead and Bower, 2000: 1089–1090).

Co-production has many things to recommend it. My goal is not to deny this fact, or even to conclude that on balance the drawbacks of co-production outweigh its advantages. However, I aim to highlight a tension between co-production and important values that has so far been overlooked but should instead be carefully considered in the academic and public debate before any conclusion is drawn regarding the desirability of greater co-production of healthcare.[2] Critical work on PCC is urgent because PCC has a rhetorical pull that goes beyond its actual merits. Not only is quality-of-care

talk known to have a potentially obfuscating rhetorical power (Goldenberg, 2012) but personalization in particular is described as a benign-sounding but vague concept that tends to build consensus while masking tensions and unresolved issues (Cribb and Owens, 2010: 310–311). With the help of political philosophy, I aim to bring some of these tensions and issues into relief to enable a richer debate over co-production.

My argument starts by reconstructing co-production as advocated in England, which provides an excellent case study due to the impetus enjoyed by co-production and the richness of the proposals for making it a reality. The first step of my critical analysis is to focus on the tension between co-production and a concern for equality, relative both to the unfair burden that co-production would place on the shoulders of women and to its detrimental effect on equality of access to care. Next, I discuss the tension between co-production and liberty by arguing that calls for co-production amount to calls for civic virtue, and then by drawing on traditional objections to the constraining character of the approaches to political philosophy that place civic virtue centre-stage. In conclusion, however, I wish to sound a note of caution about the implications of my critical analysis. The version of co-production currently dominating English policy does not exhaust its conceptual space. Moreover, even if we decided to remain focused on that version, the question of whether any feasible policy programme is in the end preferable to it would be so complicated as to fall beyond the scope of this article.

Co-production of Healthcare in England

In England, co-production is advocated by a wide range of stakeholders. Almost invariably, the recent advocacy for co-production that I will discuss depicts itself as an attempt to develop and put into effect the vision for the National Health Service (NHS) that was laid out in 2014 by Simon Stevens, the chief executive of NHS England, in his *Five Year Forward View*. He sets to explain how a publicly funded NHS that provides citizens with universal access to comprehensive healthcare is still doable. A huge challenge to its sustainability is posed by long-term conditions (LTCs), which already drain 70 per cent of its overall budget. With an aging population, the prevalence of LTCs will grow further, increasing the pressure on the NHS budget and creating a funding gap that will

already amount to £30 billion a year in 2020/2021 (Stevens, 2014: 5–8).

It will be impossible to close that gap without an increase in NHS funding, which Stevens proposes should be £8 billion more a year. However, he also believes that the NHS can only be sustainable if it finally sets to harness 'the renewable energy represented by patients and communities' (Stevens, 2014: 9). In other words, the NHS must transform itself into what Stevens calls 'a social movement' where support is offered for patients to ramp up their self-management efforts, for unpaid carers to best help their loved ones, and for communities to do more volunteering, e.g. in the area of healthy lifestyle education (Stevens, 2014: 14).

The great attention paid to the patient activation measure (PAM) in England fits within this vision. PAM is a 13-question survey that asks patients about their knowledge of their conditions, their practical self-management skills and their confidence in taking action. Based on their responses, patients are assigned a score measuring how capable and motivated they are to be full collaborators in their care (Hibbard and Gilburt, 2014). PAM was first piloted by five clinical commissioning groups, which are England's local health authorities, and by the UK Renal Registry.[3] In 2016, NHS England opened a call for more clinical commissioning groups to apply for free 5-year PAM licences. In this way, the use of PAM is rolled out widely, reaching up to nearly 2 million NHS patients.[4]

If healthcare professionals know the PAM score of a patient with an LTC, they can meet her where she is; they can assign her the tasks that she has the skills and confidence to perform, be they relative to medication, lifestyle change or healthy lifestyle maintenance. Also, patients with low PAM scores can be offered services that can activate them by improving their health literacy, skills and confidence, therefore preparing them to take up further self-management tasks. Patient activation is linked to the sustainability of the NHS because there is evidence suggesting that patients with higher PAM scores tend to use formal healthcare services less often, in particular accident and emergency services.[5]

As explained in an independent report evaluating the initial pilot, the use of PAM in the NHS is often built into another pillar of English PCC, namely, personalized care and support planning (Armstrong et al., 2016). Personalized planning provides a systematic approach to the regular meetings between patients with LTCs and healthcare professionals—meetings that should focus (among other things) on what matters to patients and how to plan carefully for the next steps to be taken. According to NHS England, the overarching aim of

personalized planning is 'to support people who live with LTCs to develop the knowledge, skills and confidence to manage their own health', creating a clear link with co-production (NHS England, 2015b: 11). In fact, in its practical guidance regarding personalized planning, NHS England acknowledges that measuring the PAM scores of the patients with whom care is being planned is important for healthcare professionals to fully exploit their potential for self-management (NHS England, 2015c: 11–13).

Alan Cribb and Vikki Entwistle draw on the philosophical literature stressing the relational dimension of autonomy to criticize the standard definitions of patient activation, which picture knowledge, skills and confidence as if they were fully 'in the control of the patients themselves' (Cribb and Entwistle, 2013: 36). They warn against the risk of using PAM without acknowledging the fundamental contribution of the 'contexts in which people live and act' to the self-management of LTCs (Cribb and Entwistle, 2013: 36). Cribb and Entwistle's point is important, but to prepare the ground for my own critique of co-production, it is useful to stress that the NHS appears to know that there can be no effective self-management unless a rich network around patients is also activated.

Starting with personalized care and support planning, the guidance issued by NHS England explains that unpaid carers are crucial. When analysing who should be involved in the discussions with healthcare professionals, it points out that '[t]he inclusion of unpaid carers, such as family members or friends as the people involved in the individual's immediate support network is very important' (NHS England, 2015b: 12). As we have seen, NHS England thinks of personalized planning as aimed at self-management support. And as underlined by National Voices, the English coalition for care charities, in a guide that informs much of the work of NHS England in this area, carers are key to supporting the management of medicines and appointments, changes in diet and exercise routine and so forth.[6]

Still on personalized planning, NHS England's guidance also highlights the role of communities. A healthy lifestyle is key to the successful self-management of many LTCs. Therefore, it is important that voluntary organizations locally provide healthy cooking classes and physical activity schemes such as gardening groups. Also, they can offer peer-support groups, where persons with similar conditions share experience-based insights into self-management and encourage each other. NHS England also discusses voluntary befriending schemes, presumably for their ability to improve confidence (NHS England, 2015c: 13). In sum, for personalized planning to achieve its aims, healthcare professionals must be able to connect their patients with a solid network of relevant voluntary services. To make this possible, NHS commissioners must accept that part of their job is to incentivize such services when they identify local gaps in provision (NHS England, 2015c: 14). This is in line with Stevens' vision, which identifies the encouragement of more community volunteering as a key goal (Stevens, 2014: 13–14).

Zooming in on PAM, NHS England acknowledges that the only way to widely activate patients is to realize the value of communities.[7] *Realising the Value* is an NHS England-funded research programme, conducted by think tanks Nesta and The Health Foundation, that advocates person- and community-centred care. Its practical recommendations echo what we have just seen regarding personalized planning and underline the importance of not only voluntary peer-support schemes but also befriending and the voluntary provision of group activities 'from exercise classes, to cookery clubs, community choirs, walking groups and gardening projects' (Wood, Finnis, Khan and Ejbye, 2016: 31). In sum, the basic idea behind co-production really is that the greatest untapped resource for the provision of healthcare is common citizens, including persons with LCTs as well as their unpaid carers and simple community members.

The Tension with Equality

To critically analyse co-production does not mean to deny that it has merit. The stewardship of common healthcare resources in the face of growing demand is a very important goal. Moreover, it is argued that in pursuing that goal, co-production would also have a positive impact in other respects. Co-production has the potential to create behavioural change in at least some LTC patients, in turn leading to improved clinical outcomes, e.g. in the form of better blood pressure and glycaemic levels for patients with diabetes. Also, it can contribute towards reducing stress, creating a sense of empowerment and otherwise improving quality of life. Finally, it is praised for giving long-due recognition to the expertise of patients and carers (Bodenheimer *et al.*, 2002; de Silva, 2011: 3–9; Hibbard and Gilburt, 2014: 11–15). Still, given the strong rhetorical pull of quality-of-care talk and, more specifically, of personalization, it is crucial to investigate the drawbacks of co-production, so that they can be carefully weighed against its benefits.

A critical analysis of co-production could take several forms. For example, Cribb and Entwistle note that the stress placed on the expertise of patients risks downplaying the important ways in which there will always be a difference in knowledge and skills between patients and clinicians (Cribb and Entwistle, 2013: 15–17). My argument takes a different route, claiming that insights provided by political philosophy can be of great help in identifying the flaws of co-production. More specifically, my aim is to stress the tension between it and political values such as equality and liberty.

On the face of it, co-production might seem strongly egalitarian. As reflected in the *Five Year Forward View*, in England co-production is primarily sought to rescue a system, where access to NHS care is *universal* and divorced from ability to pay. Moreover, the proposed rescue strategy has egalitarian undertones: to maintain universal access to the NHS, the supporters of co-production might say, *each and every one of us* common citizens will have to pick up the slack and do a little more. The rest of the section aims to demonstrate that to a good extent, the egalitarian character of co-production is just apparent, with regard both to the social groups that are likely to take up the slack and to access to care.

Compounding Gender Inequality

The section 'Co-production of healthcare in England' explained that NHS England acknowledges that activated patients can generally only be successful in carrying out new self-management tasks if their unpaid carers also ramp up their support for the management of medicines and appointments, for changes in diet and exercise routine and so forth. The problem is that this added burden for unpaid carers will not be spread evenly across society but will mainly be shouldered by women. Care work is disproportionately performed by women, and England is no exception. Around 6 in 10 British carers are female,[8] and the imbalance further increases among young carers and even more so in middle age; in 2011, one in four women of age 50–64 years performed care work, to be contrasted with one in six men (Carers UK, 2014: 3–4). Consequently, the added responsibilities for unpaid carers that figure in co-production's vision for society will be disproportionately shouldered by a group that is already socially disadvantaged in many ways. Moreover, the over-representation of women in care work has traditionally been discussed as a serious problem of gender inequality in its own right, and adding to the responsibilities of carers will compound this specific problem as well.

The specific problem with the over-representation of women is not just that care labour is in many ways like 'standard' labour and, therefore, it is just wrong that it generally goes unpaid. The problem is not even simply that women's disproportionate investment of time and energy in caring and other household labour makes them weaker on the job market and at times forces them out of work altogether, rendering them less able than men to fully pursue their life plans outside the household. Indeed, this comparative difficulty for women to compete for jobs and to advance in their careers also contributes to power differentials between men and women within heterosexual households, sometimes to the point of creating dependency on the male breadwinner and making it difficult to exit unsatisfactory or even abusive relationships. Connecting with other structural problems of gender inequality in the workplace, the gendered division of caring labour therefore contributes to what Susan Moller Okin famously calls the 'cycle of vulnerability' of women in society (Okin, 1989: 134–169).

Elizabeth Brake recently started from Okin's and other feminist analyses of the gendered division of caring labour to outline how caring for the ill and the elderly should be organized in society to be fair to women. My analysis develops at a less general level than hers, focused as it is on co-production. However, Brake's argument is relevant, especially where it suggests that no state-funded effort to simply coordinate and support carers can suffice to solve the problems with the over-representation of women in care work (Brake, 2017: 145–146). To really tackle the obstacles to the pursuit of life plans and the sheer vulnerability that, compounded by co-production's increased expectations regarding care labour, constitute a serious problem of gender inequality, care should be provided either by workers paid through tax-funded salaries or by relatives who, however, receive from the state an allowance that at the full-time rate is as rich as those salaries.[9] Therefore, zeroing back in on England, the tension between co-production and gender equality would not be solved even if local authorities managed to overcome their current problems with the initial implementation of the commitments for better support and coordination included in the *Care Act 2014*.[10]

Obviously, ensuring that care work is paid through taxation, either as workers' salaries or as equally generous allowances for family members, is utterly inconsistent with the ultimate goal of co-production as detailed in the section 'Co-production of healthcare in England', namely, to contain public expenditure. Therefore, it is important that the public debate recognizes that, given

the increased role that would be played by mainly female unpaid carers, co-production's merits should be weighed against the compounding of gender inequality that would be involved. In closing, I would like to anticipate the possible counter-objection that the added burden for carers would not constitute too serious a problem for gender equality because co-production's vision for society involves not only activated patients and activated carers but also activated communities that, through voluntary work, would better share in the burden of care. As claimed by Brake in a similar context, the socialization of women as caregivers and the fact that many more women than men work part-time make it likely that the added volunteers in this area would be disproportionately female (Brake, 2017: 145–146). This outcome is certainly to be expected in Britain, where voluntary activities related to health and disability are much more often performed by women than by men,[11] and would add to the unfairness created by the disproportionate share of the burden of care already carried by women.

Unequal Access to Care and the Specialness Thesis

Co-production is in tension with equality also in another sense, which zooms out from the previous sub-section's focus on women and shifts attention from inequality in shouldering the burden of care to inequality in access to it. Indeed, co-production is bound to deepen the challenge of ensuring that the provision of healthcare in society reflects its *special* moral importance. In philosophical jargon, to say that healthcare is special is to say that access to it should be independent from ability to pay and, more in general, from other goods that are distributed unequally in society. Access to special goods should be distributed equally or at least in a broadly egalitarian manner (Segall, 2007: 343–346).

The intuition behind the specialness thesis about healthcare is powerful and can be found at work in many public policy discussions. It was reflected in the public opposition that the British government had to overcome in 2008 to allow NHS patients to 'top up' NHS care with privately purchased treatments (Roberts, 2008). It is also connected to the public discontent over and constant attempts to tackle the so-called 'postcode lottery', i.e., the fact that depending on the area they live in, patients might receive different levels of certain NHS treatments (Rameesh, 2011). In philosophy, the specialness thesis was given its classic justification by Norman Daniels, who grounds

specialness' commitment to a broadly egalitarian distribution of access to healthcare in the liberal principle of fair equality of opportunity and in the idea that good health greatly contributes to our opportunities to pursue life plans (Daniels, 1981). Although the specialness thesis has recently been criticized, it has been defended both by strengthening Daniels' original equality-of-opportunity argument (Badano, 2016) and by suggesting brand new foundations for the special moral importance of healthcare, such as the intrinsic value of caring relationships (Engster, 2014; Rumbold, 2017) and the importance of removing the fear and anxiety attached to illness and its financial consequences (Wolff, 2012).

Assuming that at least one of these replies to the critics of the specialness thesis is successful, the question is: How will co-production help or hinder equal access to healthcare services? The section 'Co-production of healthcare in England' explained that the proponents of co-production assign a crucial role to the voluntary sector, which is expected to substantially scale up its contribution to the health of LTC patients through self-management support, therefore diminishing their need for formal NHS care. However, it seems fair to presume that the amount of voluntary self-management support available would vary widely from one local area to another, clashing with specialness' commitment to broadly equal access to key support.

Existing statistics appear to confirm the presumption that given its largely bottom-up nature, volunteering is very open to variation. In a 2015/2016 Cabinet Office survey, the percentage of respondents who declared to have volunteered through an organization in the previous month ranged from 17 per cent in London and in the North East of England to 33 per cent in the South West and in the East and West Midlands. Similarly, the percentage of those who had volunteered over the previous year varied across different regions from 25 to 50 per cent (Community Life Survey Team, 2016: 29–32). The number of voluntary organizations also varies greatly, from 1.7 per 1000 persons in the North East to 3.2 per 1000 persons in the South West (Keen, 2015: 5–7). Finally, it has been found that a social gradient exists in volunteering, with persons from more disadvantaged areas in England less likely to volunteer (Volunteering Matters, 2017).

As a further confirmation of my suggestion that co-production's increased reliance on voluntary efforts would make access to much-needed support less egalitarian, it is worth noting that virtually all philosophical arguments for specialness are framed in terms of a connection between it and a close involvement of the state in

healthcare. For example, Daniels pits the special moral importance of healthcare against a large use of markets in the field (Daniels, 2008: 19–20), while others stress the link between specialness and tax-funded care.[12]

The connection between specialness and close state involvement is not the subject of explicit discussion, but it is not difficult to see the link between them. The state can rely on a uniquely large administrative apparatus that reaches across all regions in a country. This apparatus is uniquely well placed to harmonize, at least in broad terms, the care delivered in different regions, backed by the large amount of money that the state can raise through taxation. Among other things, this money can be used to recruit workers and pay allowances to families, as needed. Classic analyses of the historical development of the large bureaucratic structure of modern states stress how it has centrally been aimed at securing standardization (and therefore a sort of equality) across large territories (Porter, 1995). Even where states have gone through a degree of devolution to local authorities, the widespread use of benchmarks, targets and other indicators for monitoring purposes preserves a good ability to create standardization (Desrosieres, 2015).

This is not to say that there are no challenges in implementing the special moral importance of healthcare where the state is closely involved. However, it stands to reason that generally *the farther the state is* from the organization and control of care, *the harder the challenges will be.* In reaching this conclusion, my discussion of specialness helps to give foundation to a recurring complaint, voiced against Stevens' *Five Year Forward View* in the public debate—the so-called 'retrenchment' of the state in relation to health, whose faults can be effectively highlighted based on the philosophical discussion over specialness (Birtwistle, 2014).

It is important that the debate over co-production pays close attention to this convergence between statistics about volunteering and theoretical arguments about the link between state involvement and standardization. Among other things, this is because of a strategy commonly used to argue for co-production, which structurally tends to obscure problems with possible variations in the available resources to deliver voluntary services. It is important that future discussions strive to compensate for this effect.

The strategy I have in mind is the 'success story' approach, which consists of publicizing the operations of a series of trailblazing organizations from the voluntary sector that have already managed to complement NHS services and have an impact on patients. This strategy is perfectly natural because it concretely demonstrates that co-production is possible and can be highly beneficial.

However, an important feature that tends to get lost when we explore these collections of success stories is that the individual organizations they focus on tend to be geographically concentrated, either in a single area or at most in a few of them, and hardly ever span the whole of England.

A typical success story is that of Headway, an East London centre opened by patients with acquired brain injuries that—thanks also to its large peer-to-peer volunteer programme—has succeeded in improving the situation of a patient group that traditionally lacks focused support (Nesta, 2011: 52–54). Another typical example is Dadly Does It, a project run in Salford by the social enterprise Unlimited Potential, which has noted how services tend to be targeted at mothers and decided to specifically involve dads in peer-support groups, helping one another help themselves and their children (Ejbye and Holman, 2016: 41–44). Other stories focus on voluntary groups doing excellent work on personality disorders in Croydon (Nesta, 2011: 17–19), the involvement of young people in Rotherham (Rippon and Hopkins, 2015: 38–40), living with HIV across London (Ejbye and Holman, 2016: 8–12) and many more areas.

These stories demonstrate that those organizations have made a much-needed difference in their areas. But how can we be confident that the voluntary efforts channelled into acquired head injuries in East London, father–child relationships in Salford, personality disorders in Croydon and so forth can *all* be replicated everywhere else across England? This question is never asked when success stories are discussed. However, co-production is meant to work as a reform programme across England. Given the appealing arguments supporting specialness' commitment to broadly equal access to support, it is very important that that confidence be well grounded. This is why this sub-section's arguments, focused on volunteering's structural openness to variation, would be a helpful addition to public debates over co-production.

Before concluding this sub-section, let me discuss a possible reply and provide a clarification. A reader might counter-object that NHS England does not plan to rely on volunteering exactly as it is, and incentives could ease the problem of variation in voluntary self-management support. For example, the plan is to smoothen the collaboration around self-management support between formal NHS providers and volunteers. Also, NHS England supports the introduction of tax breaks for health-related volunteers (Stevens, 2014: 13–14). However, given the ultimate goal of containing public expenditure, the incentives employed by NHS England are bound to stop far short of paying citizens

for their service or employing the rest of the full potential for creating standardization in support provision that only comes with close state involvement. Therefore, the tension between co-production and the broad equality in access to support that is required by the specialness thesis is there to stay and should be carefully considered when debating the pros and cons of co-production.[13]

To clarify, I am not denying here that volunteering is good. It can be extremely fulfilling for many persons, and it is a generous and public-spirited way of spending one's time and energy. However, the state cannot pretend that everyone does voluntary work, or that there is no large variation in available voluntary support, when looking for solutions to serious problems of sustainability of NHS services. Therefore, the state cannot simply decide to move to the next level of reliance on the voluntary sector without paying a price in terms of inequality in access to care.

The Tension with Liberty

This section turns to the tension between co-production and liberty, broadly understood. To highlight such tension, it is first necessary to demonstrate that the calls for co-production in healthcare qualify as calls *for a more virtuous citizenry*, where virtue is understood in a very specific sense of the term that figures prominently in so-called republican approaches to contemporary political philosophy. Republicanism, which is most famously associated with Philip Pettit, is characterized by its conception of political freedom as non-domination or independence from the arbitrary will of others (Pettit, 2007). The content of the republican conception of freedom, however, is just irrelevant to my argument, and we can therefore bracket it. What matters here is that republican theorists generally stress that for societies to work as they should, it is instrumentally important that civic virtue be widespread among public officials and common citizens. Specifically, civic virtue is understood as the willingness to 'do one's part in supporting the public good', especially when 'the advancement of personal or sectional interest' is hindered in the process (Lovett, 2017). In the words of Bruce Jennings, who embraces republicanism in public health ethics and identifies the importance of virtuous citizens as one of its defining traits, it is crucial to avoid 'a loss of the capacity to work *and sacrifice* for the sake of the good of the republic' (Jennings, 2007: 46, emphasis added).

It is beyond the scope of this article to investigate whether the republican understanding of virtue is defensible from the perspective of a philosophical analysis of the concept. This section is only interested in the objections that can be raised against seeking to spread and relying on practices that republicans generally identify as civic virtue, whether it is philosophically correct to call them 'virtuous'. In turn, I only focus on those practices because the structure of civic virtue as understood by republican theorists maps well onto the structure of co-production in healthcare, as I now turn to suggest.

In the case of co-production, the *public good* to be supported is the sustainability of a free-at-the-point-of-use universal health service. For that to be guaranteed, citizens are called upon to make *personal sacrifices*; LTC patients, unpaid carers and simple community members are all asked to put more time and greater energy into the management of LTCs, through a better management of medicine and appointments, lifestyle change and healthy lifestyle maintenance, greater volunteering efforts and so forth. Of course, caring for ill health might well be what some of these persons have always wished to do with their lives, but for many others co-production involves a degree of personal sacrifice, especially at the increased level its supporters would like healthcare to be co-produced. This overlap between republican theories and co-production creates the room for a further objection to co-production, which I adapt from a traditional argument against republicanism's insistence on civic virtue.

The objection I wish to adapt from the critics of republicanism is that calls for a virtuous citizenry appear *overdemanding* for citizens. Take co-production's message that citizens should do more, in their personal lives, for the sustainability of national health services. This message, which is already influential in countries like England and might one day become dominant, is extremely slippery. By this I mean that health services represent but one among many important areas of public service whose long-term sustainability would be greatly helped if common citizens stepped up their efforts. For example, environmental protection agencies would greatly benefit if citizens were continuously attentive to the environmental implications of their daily choices, and police agencies would be helped if citizens participated more in crime watches. Also, democratic institutions would be on much firmer ground if they could rely on politically active citizens, who get informed in their own time before voting and who monitor public officials and protest against them in case of bad behaviour.

Consequently, accepting the logic of co-production's message in healthcare does not just mean to expect citizens to take on greater burdens, which can already be

rather heavy, for the sake of a sustainable national health service. Accepting such a message also means to be at the top of a logical slippery slope leading to a scenario where common citizens are expected to step up their efforts, in their personal lives, to also participate in the co-production of environmental protection, policing, corruption-free political processes and much more.

In this scenario, the room left for citizens to put together and pursue their own life plans, in association with fellow citizens of their choice, appears reduced to a minimum if not completely eliminated by all the taxing requirements of civic virtue. This is not to deny that many citizens give the environment or the main focus of other areas of public service a place of honour in their life plans and should be free to do so. But in the scenario under consideration, citizens are expected to make no other choice but to pursue a life plan that is centrally about the active production of a long list of public goods. And according to an attractive view of society, the point of state-backed social cooperation should be to build a fair structure of benefits and burdens that is ultimately aimed at giving everyone the liberty to choose from within a good range of life plans and then pursue the plan they prefer.

This view of society is typically liberal. For example, it is at work in Thomas Pogge's critique of those theories in political philosophy that emphasize the importance of shaping the ethos of individuals, so that it promotes the common good. For Pogge, those theories tend to impose implausible burdens on common citizens and their ability to choose their life plan from a wide-enough range of life plans (Pogge, 2000). In the narrower field of public health ethics, Stephen Latham's critique of republicanism resonates well with this objection to co-production. Even if he only focuses on the vigilance over political decision makers required by republican public health ethics, Latham claims that civic virtue would take 'too many evenings', therefore draining too much time and energy away from writing novels, falling in love, shooting Vines and other activities citizens might want (and should have a right) to devote a large part of their lives to. Accordingly, he suggests, the state should remain the primary actor in securing the common good (Latham, 2016).

Conclusion, or What my Argument Is *Not* Meant to Suggest

Thus far we have seen that the logic of co-production as reconstructed in the section 'Co-production of healthcare in England' pushes towards a scenario where

common citizens are expected to sacrifice so much for the common good that they are left with little room to choose among life projects. Also, co-production adds to the unfairness generated by the gendered division of care labour and makes access to care more unequal, violating its special moral importance. In this conclusion, I aim to add a note of caution about the implications of these points, first by noting that they are not completely generalizable and next by stressing how difficult it is to translate them into practical recommendations.

However influential, the view of co-production dominating Stevens' *Five Year Forward View* (and the work of the numerous stakeholders who, as described in this article, have developed it) does not exhaust the conceptual space of co-production. That view is closely focused on the projected NHS funding gap and the need to save public money. However, it is possible to imagine an ethically stronger case for co-production that is independent of its impact on public resources, implying that co-production should be pursued even if it was more expensive than current arrangements.

This alternative justification for co-production rests on the recognition that care for patients with LTCs is already largely shouldered by patients and their families. For example, patients with diabetes and (in the cases where they are present) their carers are constantly in charge of monitoring glycaemic levels, administering insulin, following the right diet and so forth, while clinicians might only meet them every few weeks. The contributions of patients and families are nothing new; on this view of co-production, we now urgently need formal health and social care services to finally step up their efforts in supporting them.

Glimpses of this view of co-production can be seen in those places where the supporters of co-production describe it as being about changing the pattern of public services, not reducing their cost (de Silva, 2011: vii), or about ensuring better value per public money spent (Boyle and Harris, 2009). This view is also reflected in a few success stories that are at times labelled as 'co-production', where the state increases its responsibilities more clearly than other actors. For example, Nesta describes Nurse–Family Partnerships, where in the case of mothers from disadvantaged backgrounds, extra visits from trained nurses take place periodically during pregnancy and until the children are 2 years old (Nesta, 2011: 37–39).

If appropriately developed, this view would be better placed than the one I have analysed in this article to deflect my criticisms, especially the ones based on equality. Given that the justification behind this view is independent from co-production's impact on resources, it could be taken to require that considerably more public

money be put into the system for the care of LTCs, even to the point that we get close to paying allowances to carers within families and taking key forms of support out of the voluntary sector. In attempting to make my liberty-based objection less serious, the supporters of this view could also claim that, whenever possible, any new commitment expected of LTC patients should be made similar to those co-production activities that strike the observer not as a burden, but as something that patients would generally welcome and seek for their own sake (e.g. singing groups in the case of Chronic Obstructive Pulmonary Disease).[14]

Against the background of my critical analysis of a view of co-production focused on the need to save public resources, it is important to show how that view does not exhaust co-production's conceptual space. At the same time, it is perfectly legitimate to decide that we should keep the projected gap in public resources centre-stage during our discussions, returning to co-production as analysed in this article. The NHS funding gap is an objective problem. Also, some issues become philosophically more, not less, interesting when we remain focused on resource scarcity.

If we adopt this perspective, however, it becomes important to clarify that I do not mean to recommend that all things considered, co-production should be rejected as a way of tackling the NHS funding gap. In light of my objections to co-production, an obvious first practical step to consider in the face of the funding gap would be to challenge the current level of public spending for healthcare in England, which lags way behind European countries like Germany and The Netherlands, and to propose that it be raised all the way to their level.[15] To the extent that NHS's sustainability crisis can be fought through extra public funding, not greater co-production, the resulting arrangement would seem better placed to allay the concerns discussed in this article, regarding both equality and liberty. Also, there seem to be alternatives to co-production that should be evaluated for their ability to help better manage NHS resources while avoiding co-production's problems. For example, can better integration of formal NHS services with one another and with social care services really help in this area, and is it actually conceptually distinct from co-production? (Goodwin *et al.*, 2012)

These are extremely complicated issues. The gap in resources might well turn out to be unavoidable, and evaluating existing alternatives to co-production would be very difficult. Therefore, I must leave practical recommendations for another day, when we might well learn that co-production is the least possible evil; the take-home message of this article is simply that we should have more debate on the merits of co-production relative to its alternatives, conducted in a way that is sensitive to the problems highlighted by my argument.

Funding

Notes

1. Among many others, see Berwick (2009), Epstein *et al.* (2010), IOM (2001), NHS England (2013), Mead and Bower (2000) and WHO (2015). For a list of organizations committed to PCC, see http://personcentredcare.health.org.uk/resources/person-centred-care-around-world.

2. This article's goal is complementary to the one pursued by Munthe, Sandman and Cutas (2012), who explore the limitations of a component of PCC that, although related to co-production, is distinct from it—shared decision-making between patients and clinicians in setting the goals of care.

3. https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pamlearning/.

4. https://www.england.nhs.uk/2016/04/person-centred-support/. PAM takes centre-stage in a consensus statement on PCC that NHS England (2015a) co-authored with NHS leaders, healthcare professionals, patients and carers.

5. Hibbard, Greene and Overton (2013) quoted in https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/.

6. http://www.nationalvoices.org.uk/sites/default/files/public/publications/guide_to_care_and_support_planning_0.pdf.

7. https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/.

8. Carers UK (2015, 2–3). British women are also more likely than men to be 'sandwich carers', caught between caring for young children and caring for older persons with health problems.

9. State-funded salaries and allowances remain important also for feminist authors who stress the additional need to change our society's culture, ensuring that men will perform as much care work as women. For example, see Fraser (1994).

10. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted. For a report detailing how support for

carers is still far from the spirit of the legislation, see Carers UK (2016).

11. https://data.ncvo.org.uk/category/almanac/voluntary-sector/volunteering/.

12. See the references to healthcare systems that should be 'publicly funded', 'publicly subsidized' or 'funded through taxation' in Badano (2016, 183), Engster (2014, 154) and Rumbold (2017, 501), respectively.

13. A further possible counter-objection is that my argument appears to wrongly assume that voluntary work can only benefit persons similar to those who are volunteering or, at least, living in their same area. I am happy to reject this assumption; voluntary work can sometimes be organised so as to benefit persons located in distant areas from those where volunteers normally reside, as demonstrated by the distances travelled both within and across countries by volunteers responding to the ongoing refugee crisis. However, as confirmed by the success stories that I have recounted, the assumption behind co-production's call for greater voluntary action is that such action would normally happen within local communities. The image is not one of travelling long distances to respond to a crisis but one of adding extra voluntary work to citizens' local routines. Therefore, my points about geographical variation remain relevant.

14. https://www.blf.org.uk/support-for-you/singing-for-lung-health.

15. https://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally. In June 2018, British Prime Minister Theresa May made an announcement that went in the right direction by pledging an extra £20 billion a year for the NHS. For this, see: https://www.independent.co.uk/news/uk/politics/nhs-funding-theresa-may-20-billion-2023-tax-brexit-a8402566.html.

Acknowledgements

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