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Editorial

# *Decentring health systems: Narratives, agency and resistance in critical public health*

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The concept of 'health systems' is pervasive in contemporary public health policy and scholarship. Health systems are invoked as objects that can be strengthened, made resilient or reformed through better design, improved governance arrangements or more rational use of evidence. Yet, as much work in critical public health has shown, health systems are not neutral, coherent or stable entities. They are made and remade through the actions of situated actors, drawing on particular historical trajectories, ideas and interests, and they routinely reproduce social and health inequalities (e.g. Asefa 2023, Bambra et al. 2021, Stewart & Dodworth 2023, Wiltshire et al. 2017).

This Special Issue of *Journal of Critical Public Health* brings interpretive and decentred approaches on public governance to bear on a set of empirical cases that span European economic governance, European Union (EU) meta-regulation, multistakeholder food policy partnerships, housing policy, place-based public health, integrated care reforms and healthcare within prisons. Collectively, the papers ask: what happens when we stop treating health systems as unitary structures or technocratic projects and instead treat them as contingent, contested practices? In doing so, they invite us to rethink how we conceptualise 'systems', and what it might mean to pursue more just and inclusive forms of public health.

## Decentred Theory: Traditions, Dilemmas and Meanings in Action

This collection generally draws on decentred theory. Decentred theory uses humanism and historicism to emphasise agency, contingency, and context, and thereby to challenge the reifications, mechanisms, and formalisms that dominate much social science (Bevir 2003, Bevir 2013). It rejects the hubris of mid-level or comprehensive explanations that claim to unpack the essential properties and necessary logics of social and political life. For example, it suggests that neither the intrinsic rationality of markets nor the path dependency of institutions properly determines whether health policies and practices are adopted, how they coalesce into systems of governance, or what effects they have. Decentred theory conceives of policies and practices, instead, as contingent constructions of actors inspired by competing beliefs that are themselves rooted in different traditions. Decentred theory explains shifting patterns of public health by focusing on the actors' own interpretations of their actions and practices and by locating these

interpretations in social and historical contexts (Bevir & Needham 2017, Bevir & Waring 2020). It replaces aggregate concepts that refer to objectified social laws with narratives that explain actions by relating them to the beliefs and desires that produce them.

Because decentred theory emphasizes beliefs, agency, and contingency, it suggests that social scientists focus on a particular set of empirical topics. Here, decentred theory highlights the meanings that inform the actions of the individuals involved in public health practices. It focuses on the social construction of public health through the ability of individuals for meaningful action. Decentred theory encourages social scientists to examine the ways in which health systems, including institutions and policies, are created, sustained, and modified by individuals. It encourages social scientists to recognize that the actions of these individuals are not fixed by a formal rationality, institutional rules, or a social logic of modernization. On the contrary, actions arise from the beliefs individuals adopt against the background of traditions and in response to dilemmas. Decentred theory entails a shift of focus from institutions to meanings in action. It suggests that policies arise as conflicting beliefs, competing traditions, and varied dilemmas generate, sustain, and transform diverse practices. It focuses attention on the diverse ways in which situated agents make and remake policies as contested practices.

This special issue explores some of these contested practices and the forms of knowledge embedded in them. The papers explore a range of policies and practices, but they all draw on decentred theory and related approaches. They use a range of methodological tools to decentre health systems by exploring:

- Narratives: the different stories and beliefs by which actors make sense of health systems whether they be policymakers, bureaucrats, professionals, staff, or communities
- Traditions: the diverse historical inheritances that influence the beliefs and so actions of various actors
- Dilemmas: the creative agency of actors in responding to new ideas, policies, and circumstances
- Resistance: the ways in which narratives, traditions, and agency give rise to speech or other actions that negotiate, contest, or subvert official policies and discourses, often leading to policy failure.

## Re-imagining Health Within Broader Economic and Regulatory Governance Systems

Three contributions examine how economic and regulatory projects that impact on health are shaped by particular ideas, narratives and historical trajectories relating to policy and economy, as well as by the actions of interested parties, including corporations.

Godziewski and Henrichsen's article applies an interpretive form of discourse network analysis to documents produced by EU institutions in the wake of COVID-19 (Godziewski & Henrichsen 2026). Rather than treating the EU as a coherent actor, they trace how different parts of the EU apparatus articulated the relationship between economic recovery and health, identifying three overlapping 'idea clusters': Economic and Monetary Union, Social Europe, and European Health Union. By mapping these clusters and the connections between them, the paper shows how narratives of health security and socioeconomic protection bridge otherwise competing visions of economic governance.

Brooks' paper brings a genealogical method to the EU's Better Regulation agenda, which is commonly framed as a technical tool for improving policymaking, but which has been resisted by many public health non-governmental organisations who believe it promotes corporate interests (Brooks 2026). Brooks traces how Better Regulation has been assembled over time from different strands of neoliberal and market-centred thinking, while also being reinterpreted, resisted and partially reworked by actors with other ideas and interests.

Across both papers, the EU's economic and regulatory architecture appears not as a distant backdrop but as a site of active meaning-making, where actors draw on inherited policy traditions and confront new dilemmas.

Ralston's article takes a more specific, national perspective, examining a UK food policy partnership to explore how corporate power operates within multistakeholder governance (Ralston 2026). Drawing on post-politics and decentring, the analysis shows how the narrative of partnership is maintained through the informalisation of decision-making, which marginalises civil society organisations and renders contestation less visible. Here, decentring directs attention to the rationalities and coping strategies of policy actors, including efforts to preserve the ideal of consensus, and to the forms of quiet resistance and exclusion that follow.

## Decentring Health System Reform and Integrated Care

A second set of contributions focuses more directly on efforts to reform national-level health system governance in England, highlighting how actors negotiate dilemmas and how reforms are experienced at the front line.

Waring, Bishop and Roe (2006) combine decentred theory with the 'negotiated order' tradition to examine the introduction of local integrated care system (Waring et al. 2026). Rather than assuming new governance arrangements produce new forms of collaboration, the authors explore how local actors interpreted and negotiated the dilemmas posed by system-level imperatives. They show how different organisational traditions around, for example, autonomy, accountability and clinical priorities, shaped actors' responses to integration agendas and generated variable practices of accommodation, adaptation and resistance.

Clarke's paper explores a similar set of health system reforms in England, but zooms in further on everyday interactions, combining decentred theory with interaction ritual chain theory. This emphasises the importance of expectations and people's sense of belonging during periods of disruptive change (Clarke 2026), focusing on how integrated working was reshaped during and after the pandemic through shifts to remote and hybrid working. Here, 'system change' is traced not through formal restructuring but through disrupted rituals, shifting power relations and attempts by staff to repair or reconfigure relationships in the face of considerable strain.

Sheard and colleagues' contribution explores a health system under even greater strain, examining experiences of prison healthcare during the COVID-19 pandemic (Sheard et al. 2026). Applying a decentred approach, the paper reconstructs the conflicting narratives articulated by prisoners, healthcare staff and decision-makers, against a backdrop of long-term austerity, chronic understaffing and policy neglect. The analysis surfaces divergent accounts of responsibility and accountability, as well as the resistance encountered by the research team itself when seeking to document these experiences.

These three papers offer a nuanced account of contemporary health system reform in England, from high-level integration agendas to the micro-politics of collaboration. They show how actors draw on competing traditions and narratives to make sense of change, and how reforms are sustained, adapted or resisted through everyday practices.

## Decentring Place, Housing and Lived Experience

The final two papers move beyond a focus on formal health systems and clinical services to foreground place and housing as key facets of people's health experiences.

Garnham and colleagues use systems mapping workshops with policymakers, people with lived experience, and research evidence to explore the links between housing and health (Garnham et al. 2026).

By juxtaposing these three perspectives, they highlight overlap and tensions. For example, while the housing-health system maps created by local communities foreground everyday insecurity, stigma and bureaucratic barriers, these experiences do not feature in policy or evidence-based maps. The authors use these contrasts to argue that 'systems science' should not be viewed as a technocratic tool to help achieve evidence-based policies, rather it is set of practices that can help decentre dominant ways of seeing and instead foreground the agency and experiences of those most affected by housing-related health inequalities. This exemplifies how interpretive work can be integrated within emerging systems science methodologies in ways that help resist the dominance of historical assumptions and interests.

Lorne and Lambert's article focuses an exemplar of 'place-based' public service reform (Lorne & Lambert 2026). Drawing on conjunctural analysis in dialogue with decentred approaches, they conceptualise place as an 'open articulation' of multiple histories, narratives and spatial relations, rather than a bounded local territory. Examining how public health has been reconfigured, they show how local actors drew on particular traditions of municipalism, community engagement and fiscal constraint, and how these interacted with national policy agendas and austerity politics to shape the 'Wigan Deal'. Place-based public health emerges as neither a straightforward solution nor a simple extension of neoliberal rationalities, but as a contested project shaped by political struggles over the meaning and future of place.

These contributions connect a decentring perspective to longstanding concerns in critical public health about the social and spatial determinants of health, while also extending interpretive analysis beyond formal healthcare organisations.

## Towards a Decentred Critical Public Health

Across different empirical domains, the papers in this special issue collectively demonstrate the value – and necessity – of decentring health systems if we are to understand, and contest, the political and social determinants of health.

First, the contributions show how narratives and traditions shape what counts as a policy problem and what responses are considered feasible. Across the papers, we see actors drawing on inherited ideas about markets, responsibility, security, deservingness, evidence and place. These narratives are integral to how health systems are made, legitimised and contested (Bevir 2013).

Second, a decentred lens foregrounds agency and resistance in spaces often portrayed as technocratic or consensual. From local negotiations around health system reforms, to community accounts of the factors shaping (often harming) their health, the papers recover the ways actors (including those in the research community) improvise, push back and attempt to re-narrate systems that constrain them.

Third, the special issue makes a strong case for interpretive and qualitative methodologies as central tools for critical public health. These approaches enable us to recover meanings in action, trace how dilemmas and traditions interact, and explore the uneven effects of reform across differently positioned actors and places (Schwartz-Shea & Yanow 2012, Wagenaar 2011).

Finally, decentring health systems is not simply an analytic move. It is also a normative and political project. By challenging narratives that naturalise current arrangements and bringing marginalised voices into view, this work invites a more reflexive, historically attuned and politically engaged public health. In that sense, it sits squarely within, and pushes forward, broader efforts to move beyond narrow, evidence-based accounts of 'what works' to grapple with the complex interplay of ideas, interests and inequalities that shape health (Smith 2013).

We hope that the papers collected here will encourage further dialogue between decentred governance theory, interpretive policy analysis and critical public health, and that they will support ongoing efforts, within and beyond academia, to imagine and enact health systems that are more attentive to people's lived experiences and more accountable to those they routinely marginalise.

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