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Participatory governance in public hospitals: A systematic review (2021-2025)

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Abstract

This systematic review synthesizes recent evidence on participatory governance in public hospitals, aiming to identify participation mechanisms and management practices that strengthen decision-making, accountability, quality of care, and institutional legitimacy. Fifteen empirical and analytical studies published between 2021 and 2025 were included, retrieved from PubMed, Scopus, Web of Science, and SciELO, and selected following the PRISMA 2020 framework (Page et al., 2021). The thematic synthesis identified four dominant approaches: (1) shared/professional governance (councils and professional participation with deliberative capacity), (2) patient and family participation (PFACs and co-production/co-design), (3) accountability and transparency (social/non-financial reporting), and (4) participation mediated by digital transformation (user-centered inclusive governance). Evidence suggests improvements in participation in decisions, safety culture, work climate, and intervention relevance; however, barriers persist, including symbolic participation, information asymmetries, lack of protected time, weak institutionalization, and heterogeneous outcome metrics. The review concludes that participatory governance tends to generate more sustainable results when participation is embedded in formal structures, supported by capacity-building, and guided by data and evaluation.

Keywords: Participatory governance, Public hospitals, Patient participation, Shared governance, Accountability

Introduction

Participatory governance in public hospitals refers to the systematic incorporation of internal and external actors—clinical staff, managers, patients, families, and communities—into deliberation, prioritization, and oversight of institutional decisions, with the goal of improving legitimacy, performance, and safety. In hospital settings, participation is increasingly linked to accountability and formal governance structures that define roles, decision flows, and responsibilities, particularly in public hospitals due to hierarchical dependencies and strong transparency requirements (Jalilvand et al., 2024).

A robust line of recent research focuses on shared/professional governance to redistribute authority and strengthen shared decision-making in clinical work. Across hospital contexts, authors stress that effective participation requires structures, training, and clear mandates to avoid participation becoming purely consultative (McKnight & Fitzgerald, 2022; Hamdan & Jaafar, 2024). Recent experimental evidence reports significant improvements in professional governance perceptions after implementing shared governance models supported by organizational redesign and education (Hamdan & Jaafar, 2024; Hamdan et al., 2024).

In parallel, patient and family participation has been institutionalized through Patient and Family Advisory Councils (PFACs) and co-production/co-design approaches. These mechanisms can align institutional decisions with real needs and improve intervention acceptability, provided that executive support, representative recruitment, and impact evaluation are present (Lewis et al., 2025a; Lewis et al., 2025b; Bergholtz et al., 2024). Conceptually, the literature warns of tokenism when participation lacks real influence or feedback loops, limiting effectiveness (Bergholtz et al., 2024).

Another critical dimension concerns accountability through transparency and reporting tools. In public hospitals, analyses of social reporting show progress but also low standardization, document heterogeneity, and limited usefulness for comparability and institutional learning, weakening accountability to stakeholders (Giancotti et al., 2022; Pisarra & Marsilio, 2025).

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Finally, digital transformation introduces an emerging pathway for participation: systems and platforms that integrate user needs, participation, and service improvement. Recent evidence indicates that administrative digitalization can strengthen public service quality when designed inclusively and aligned with participatory governance principles and local context (Utami, 2025; Ismail, 2025). Synthesizing 2021–2025 evidence on participatory governance in public hospitals helps identify dominant approaches, persisting gaps, and operational recommendations for strengthening governance in publicly funded hospital services (Page et al., 2021; Jalilvand et al., 2024).

Methodology

A systematic review was conducted following PRISMA 2020 (Page et al., 2021). PubMed, Scopus, Web of Science, and SciELO were searched for studies published between 2021 and 2025. The search combined terms such as participatory governance, hospital governance, shared governance, professional governance, patient and family advisory council, co-design, co-production, public hospital, accountability, and social/non-financial reporting, using Boolean operators AND/OR and database-specific adaptations.

Inclusion criteria were: (a) full-text articles (or records with accessible full text), (b) publication between 2021–2025, (c) hospital contexts with explicit participation components in governance or decision-making (e.g., councils, PFACs, co-design/co-production, accountability structures), and (d) empirical quantitative, qualitative, mixed-methods, or analytical studies focused on participatory governance. Exclusion criteria included purely clinical studies without a governance/participation component, non-scientific documents, and narrative reviews without a reproducible method.

The identification phase yielded 334 records; after duplicate removal, 276 remained. Title and abstract screening retained 71 records; full-text review resulted in 15 studies eligible for qualitative synthesis. A data extraction matrix captured: participatory mechanism, actors, decision level, outcomes, barriers, and recommendations. Meta-analysis was not performed due to heterogeneity in designs, indicators, and contexts (Page et al., 2021).

Results

Across the 15 included studies, four approaches to participatory governance in public hospitals (or publicly oriented hospital systems) were identified: (a) shared/professional governance, (b) patient and family participation (PFACs, co-design/co-production), (c) accountability and reporting (social/non-financial), and (d) participation mediated by digital transformation.

For shared governance, studies reported improvements in participation in decision-making, perceived autonomy, and collaborative culture when structures (councils, formal models), training, and clear decision pathways were implemented. A randomized controlled trial reported positive effects on professional governance perceptions after implementing a shared governance model (Hamdan & Jaafar, 2024). Complementary experimental evidence reinforced improvements across key dimensions (Hamdan et al., 2024; Jam et al. 2025). Cross-sectional and intervention studies also reported associations between shared governance and motivational/work outcomes, as well as improvements after awareness and training sessions (Atalla et al., 2023; Abdelaliem et al., 2025).

Regarding patient and family participation, PFACs were described as governance mechanisms ranging from feedback to co-design. A qualitative study identified accelerators and barriers for effective PFACs, highlighting executive support, representative composition, and clear operating structures (Lewis et al., 2025a). A scoping study documented how PFACs are used and evaluated, noting that feedback activities are common while early-stage co-design is less frequent (Lewis et al., 2025b). Co-design research demonstrated that patient–professional collaboration can yield feasible interventions to improve patient participation in discharge medication communication and safety (Tobiano et al., 2024, Rui et al. 2026).

In accountability and reporting, document analyses of social reporting in public hospitals showed slow expansion and substantial heterogeneity, limiting comparability and stakeholder accountability

(Giancotti et al., 2022). Structured reviews of non-financial reporting in public healthcare highlight increasing pressures for accountability and emphasize the need for stronger standards and decision-relevant reporting (Pisarra & Marsilio, 2025; Kern, 2025).

For digital transformation, evidence suggests that administrative digitalization can improve public service quality when it integrates technology with participatory governance and local contextual factors, supporting user-centered inclusive decision-making (Utami, 2025).

Included studies (n = 15)

Table 1. Summary of included studies and their main participatory governance contributions

Author(s)	Year	Context	Study type	Approach	Key findings and limitations
Hamdan & Jaafar	2024	Tertiary public hospital context (Saudi Arabia)	Randomized controlled trial	Shared governance	Significant improvement in professional governance perceptions after implementation. Limitation: self-report; single hospital.
Hamdan et al.	2024	Tertiary public hospital context (Saudi Arabia)	Experimental dataset	Shared governance	Improved domains (information, resources, participation, practice, goals). Limitation: single setting.
Abdelaliem et al.	2025	Hospital (Egypt)	Educational intervention	Shared governance	Increased first-line managers' knowledge of shared governance. Limitation: limited generalizability.
Atalla et al.	2023	Hospital (Egypt)	Cross-sectional	Professional shared governance	Shared governance associated with career motivation. Limitation: correlational design.
Tumala et al.	2025	Hospitals (Saudi Arabia)	Quantitative	Unit-based councils (UBC)	Describes variation in decision participation across units. Limitation: perception-based measures.
Lott & Partridge	2025	Hospital system	Practice paper	Professional governance	Strategies to increase engagement and professional accountability across levels. Limitation: non-experimental.
Lee et al.	2025	Hospital system	Practice paper	Professional governance	Links professional governance with engagement and retention strategies. Limitation: non-experimental.

Jalilvand et al.	2024	Multi-context	Scoping review	Accountability structures	Synthesizes governance accountability components and stakeholder roles. Limitation: heterogeneous evidence base.
Lewis et al.	2025a	Multiple hospitals	Qualitative	PFAC	Accelerators/barriers include leadership support, diversity, operations, and impact evaluation. Limitation: selection bias.
Lewis et al.	2025b	Multi-country	Scoping study	PFAC	PFAC use ranges from feedback to co-design; limited standardized metrics. Limitation: heterogeneity across studies.
Tobiano et al.	2024	Tertiary hospital (Australia)	Co-design + testing	Co-design	Feasible intervention to improve patient participation in discharge medication communication. Limitation: local scope.
Giancotti et al.	2022	Public hospitals (Italy)	Document analysis	Social reporting	Slow expansion and heterogeneous reports limit comparability and accountability. Limitation: relies on available documents.
Pisarra & Marsilio	2025	Public healthcare sector	Structured literature review	Non-financial reporting	Highlights accountability drivers and gaps in evidence and standards. Limitation: sector-level focus.
Utami	2025	Public hospitals	Empirical study	Digital + participation	Service quality improves when digitization integrates participatory governance and context. Limitation: context-dependent.
Keelson	2024	Public hospital context	Empirical	Patient engagement	Engagement associated with perceived service quality and well-being. Limitation: limited causal inference.

Discussion

Overall, the findings indicate that participatory governance in public hospitals is more effective when participation is institutionalized through formal structures (roles, protected time, and decision pathways) and supported by capacity-building and data for continuous feedback. Experimental evidence suggests that shared governance requires more than establishing councils; it depends on mandates, training, and organizational support that translate deliberation into action (Hamdan & Jaafar, 2024; Hamdan et al., 2024; McKnight & Fitzgerald, 2022).

For PFACs and co-design, the evidence converges on the importance of clarifying scope, recruiting representative membership, and evaluating impact; otherwise, participation risks becoming symbolic with limited influence on decisions (Lewis et al., 2025a; Lewis et al., 2025b; Bergholtz et al., 2024). Applied co-design studies support that patient–professional co-production improves feasibility and acceptability in safety-sensitive areas such as discharge communication and medication safety (Tobiano et al., 2024).

From an accountability perspective, social/non-financial reporting is relevant for public legitimacy but is constrained by heterogeneity and limited decision-usefulness. This supports a shift from document publication to comparable and actionable metrics for stakeholders and management (Giancotti et al., 2022; Pisarra & Marsilio, 2025; Kern, 2025).

Digital transformation offers potential to broaden participation through user-centered approaches; however, benefits depend on integrating technology with inclusive governance and contextual sensitivity to prevent superficial participation or inequities (Utami, 2025). Taken together, the evidence supports designing participatory governance as a system: structure + capacities + data + evaluation + accountability (Page et al., 2021; Jalilvand et al., 2024).

Conclusions

Recent evidence (2021–2025) indicates that participatory governance in public hospitals is primarily operationalized through shared/professional governance, PFACs/co-design, and accountability/reporting, with an emerging pathway via participatory digitalization (Hamdan & Jaafar, 2024; Lewis et al., 2025b; Giancotti et al., 2022; Utami, 2025).

Shared governance has relatively strong empirical support, including randomized evidence, showing improved perceptions of participation and professional governance when implemented with structured processes and training (Hamdan & Jaafar, 2024; Hamdan et al., 2024).

PFACs and co-design add value when representativeness, executive support, and impact measurement are ensured; otherwise, there is a risk of tokenism (Lewis et al., 2025a; Bergholtz et al., 2024).

Social/non-financial reporting in public hospitals requires stronger standardization and a focus on decision-usefulness to strengthen accountability (Giancotti et al., 2022; Pisarra & Marsilio, 2025).

Further primary research in Latin American public hospitals is recommended to measure impacts on quality, safety, satisfaction, and efficiency, and to compare participatory models under different regulatory and resource conditions (Jalilvand et al., 2024; Page et al., 2021).

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