

‘Creating NHS local’ – the relationship between English local government and the NHS

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In July 2008, the UK government organised lavish celebrations to mark ‘NHS 60’ (the sixtieth anniversary of the creation of the National Health Service). Up and down the country, there were local, regional and national events, as well as the publication of a draft NHS constitution (Department of Health, 2008a). Despite all these celebrations, 2008 also marked the sixtieth anniversary of a second - albeit less well known - key development in UK welfare services – the passage of the 1948 National Assistance Act. In contrast to the attention lavished upon the NHS, this second landmark (the founding legislation for post-war adult social care) received much less positive attention – indeed 2008 also witnessed a widespread recognition from government that the system of adult social care created in 1948 is no longer fit for purpose in the early twenty-first century and requires an urgent overhaul (HM Government, 2007, 2008).

While birthdays are a time for celebration, they can also be a time for reflection. Against this background, this paper provides a brief overview of repeated calls for a local government-led system of health care, arguing for the need for a fundamental rethink of the relationship between the NHS and local government. Inevitably such a paper adopts a very broad-brush approach and to some extent offers a deliberately provocative summary of the issues at stake as a contribution to wider debates about future welfare reform.

The health and social care divide

With a separate health service and a parallel system of national assistance for those in need of care and support, the 1946 NHS Act and the 1948 National Assistance Act formalised an ongoing division between health and social care which continues to cause difficulties for service users, practitioners, managers and policy makers to this day (see Glasby and Littlechild, 2004; Glendinning *et al.*, 2002; Means and Smith, 1998 for an overview). Essentially, these two of 1940s pieces of legislation created a system that assumed it is possible to distinguish between those who are *sick* (who are defined as having *health* needs met free at the point of delivery by the NHS) and those who are merely *frail or disabled* (who are seen as having *social care* needs that fall under the remit of local authority social care and for which service users are means-tested and charged). Arising out of this historical division comes a series of practical barriers to more effective joint working which continue to frustrate service users and staff and to consume significant management time (see Box 1).

Box 1 The health and social care divide

- Health care is accountable nationally to the Secretary of State for Health; social care is part of local government and accountable to locally elected councillors.

- Health care is free at the point of delivery; (adult) social care often entails a means-test and user charges.
- Health care tends to be based on GP registration (which is often based on catchment areas around individual practices); social care is based on strict local authority geographical boundaries.
- Health care is often dominated by medicine and looks to the sciences for its education and training; social care is much more influenced by the social sciences.
- Health care often focuses on curing the individual; social care places greater emphasis on seeing the individual in context and potentially intervening socially and politically rather than always individually.

(see Glasby and Dickinson, 2008 for an overview)

Historical debates

While finding a solution to the problem of health and social care fragmentation remains a key concern of policy makers (see, for example, Department of Health, 2007), current reviews of the future of the NHS and of local government (see, for example, Darzi, 2008; Department of Health, 2008b; Lyons, 2006) run the risk of neglecting the longstanding nature of these debates. Writing 50 years after the publication of the 1944 Wartime Coalition White Paper, “A National Health Service”, Powell (1994) revisits the history of the foundation of the NHS, summarising arguments put forward at the time and more recently for a local government-based health service (see also AMA, 1991; Gorsky, 2006; Harrison *et al.*, 1991; Knowles, 1993; White, 2004). Although ultimately overruled by the then Minister of Health, Anuerin Bevan, Ministry of Health officials and Labour Party policy both initially emphasised that health care should be run by locally elected representatives. Support for this position also came from a series of leading figures within the post-war Cabinet and from the Conservative opposition, as well as from a series of more recent official reviews (see, for example, Royal Commission on Local Government, 1969). As Campbell (1987, p. 177, quoted in Powell, 1994, p. 339) has argued:

All the fundamental criticisms of the NHS can be traced back to the decision not to base services on local authorities... In retrospect the case for the local authorities can be made to look formidable, the decision to dispossess them a fateful mistake by a Minister ideologically disposed to centralization and seduced by the claims of professional expertise.

In 1992, Regan and Stewart set out a ‘case for local authority control’ of health care. In particular, they argued for the importance of control at a local level by an *elected* as opposed to an *appointed* body, and for the potential to integrate health care more fully into the broader range of community services provided by local government. Essentially, these are the same two arguments as those identified by Powell (1994) that run throughout historical debates about the foundation of the NHS – the

importance of a local government-led approach in terms of achieving “*democracy*” and “*integration*” (Powell, 1994, p. 339).

Building on this analysis, Hudson (1998) identifies the same two issues (lack of local democratic control, legitimacy and accountability, and a negative impact on collaboration), whilst also suggesting a third issue (the underdeveloped nature of health care commissioning). He describes these as three ‘deficits’ (democratic, collaborative and commissioning) – arguing the case for local government-led health care commissioning (similar to proposals put forward by Glasby *et al* in 2006). Fascinatingly, recent Department of Health policy continues to emphasise these same three issues, and it seems timely to revisit these longstanding debates about the relationship between health and local government (see Table 1).

Table 1 Ongoing NHS ‘deficits’, policy responses and local government options

NHS deficit (Hudson (1998))	Ongoing government responses (very selected)	The potential of a local government-led solution (Hudson (1998))
Democratic	<ul style="list-style-type: none"> • Ongoing attempts to boost public/patient engagement • Draft NHS constitution (but with very few rights) • Representation of wider stakeholders on Foundation Trusts (often seen as symbolic rather than real involvement) 	<ul style="list-style-type: none"> • Greater local democratic control of health care commissioning
Collaborative	<ul style="list-style-type: none"> • Emphasis on ‘joined-up solutions to joined-up problems’ • Legal duties to co-operate • New duty of Joint Strategic Needs Assessment 	<ul style="list-style-type: none"> • Scope to integrate primary and community health care commissioning with broader local government functions
Commissioning	<ul style="list-style-type: none"> • World class commissioning agenda to boost NHS commissioning • Practice-based commissioning to engage general practitioners • Guidance on joint commissioning 	<ul style="list-style-type: none"> • Scope to move beyond poor NHS track record through more integrated approaches

What is striking about some of the policies briefly summarised in Table 1 is an ongoing failure to rethink existing approaches. Thus, as an example, there have been repeated attempts to boost mechanisms for public and patient engagement ever since the creation of Community Health Councils in the 1970s, but with various different approaches all criticised for tokenism, lack of co-ordination and underfunding (see

below for further discussion). In contrast, we argue that if having separate health and local government systems has consistently created problems of a lack of local accountability, a lack of collaboration and, more recently, a lack of commissioning capacity, then repeating previous piecemeal ‘solutions’ is unlikely to be effective. Instead, this paper suggests that the time is now right for a fundamental reconsideration of the relationship between health and local government.

Why is the time right for a new relationship?

Building on previous analysis (Glasby *et al.*, 2006), we believe that the NHS and local government need each other now more than ever. While much previous discussion has explored topics such as joint commissioning, integrated provision, pooled budgets and joint appointments, this paper focuses more on the *overall relationship* between PCTs and local government. In particular, we argue that health and local government are now so important to each other that the nature of their relationship will have to change if either or both are to be successful. Crucially, the two partner agencies have scope to benefit each other in two main ways:

- Health services are so important to local people and to people’s sense of place and identity that local government must be able to influence and work with PCTs if they are to be effective community leaders and ‘place-shapers’ (Lyons, 2006).
- PCTs must move beyond traditional NHS notions of corporate governance to become embedded in and fundamental to their local communities, thus enabling them to fulfil their ‘voice’ function in reflecting the views and demands of local people within their funding and commissioning decisions (Department of Health, 2006a). This is both about their future stability and survival, but also about gaining local accountability and legitimacy for the decisions they take (for example, when managing scarce resources, reconfiguring hospital services or rationing access to particular treatments). In doing this, they need to learn from the best of local government and tackle what is often described as the ‘democratic deficit’ in health care.

Thus, local authorities need PCTs to help them ‘place-shape’, while PCTs need local government for legitimacy and community engagement. To date, we are not convinced that recent developments (such as practice-based commissioning, Local Strategic Partnerships or health scrutiny) are sufficient to achieve this broader relationship (see, for example, Coleman and Harrison, 2006; ODPM, 2005; Wade *et al.*, 2006), but instead argue that a more fundamental and new approach is required.

Against this background, this paper explores three key elements of a potential new relationship between PCTs and local government:

1. The importance of health (services) to people’s sense of place.
2. The need for PCTs to find better ways of assuring legitimacy and public engagement, especially in relation to how they manage scarcity and prioritise resources.

3. The available models of how the relationship between PCTs and local government could be different and beneficial to both organisations.

1. The importance of health (services) to local people

Central to the Lyons Review of local government (Lyons, 2006) is the notion of local authorities as ‘place-shapers’ – building and shaping local identity, representing the community, regulating harmful and disruptive behaviours, maintaining the cohesiveness of the community, helping to resolve disagreements, working to make the local economy more successful, understanding and meeting local needs and working with others on complex challenges (p.8). In many ways, this builds on previous ideas such as the notion of local authorities as ‘community leaders’, but develops these into a more explicit and fundamental recognition that local government is the main body responsible for (and potentially capable of) taking responsibility for the well-being of an area, reflecting its distinctive identity, and promoting its interests and future prosperity (p.8). In pursuit of these aims, the Review make a number of recommendations around issues such as targets and local priorities, resources and the balance between central and local powers.

However, early in the Lyons Review, there is a crucial recognition that this involves services beyond those under the remit of current local government and, in particular, must involve health services. When asked which services were most important in making somewhere a good place to live, people in 82 per cent of local authorities rank health services as the first or second most important factor (Lyons, 2006, p.22). In many ways, this is hardly surprising, as the NHS touches the lives of everybody in ways that specific local authority services may not. For some people, health services are provided in an emergency, and the rapid availability of high quality ambulance, hospital and surgical services can quite literally be a matter of life and death. For others, contact with services is life-changing – whether it be through the birth of a new baby, an accident or the onset of illness, the death of a partner or family member, or increasing frailty in older age. For another group of people, the existence of a chronic or long-term condition means that health care becomes a fundamental part of their everyday lives – crucial to whether they are able to live chosen lifestyles or not. As a result of this, health care (and the services that embody health care at a local level) is a key aspect of all our lives. Although the rest of this section of the paper focuses on the importance of health services to local people in their role as service users, many health services can also be crucial to local areas as a major source of employment (particularly large district general hospitals in small or medium sized towns) and are sometimes considered to be an important source of upward social mobility for local people.

On an even deeper level, some of these services may even be of central importance to us as a nation and in terms of our identity. In a rapidly changing world, it is hard to find things that help to define us and to sum up who we are and what we value about our society. In the wake of the July 7th London bombings, Gordon Brown discussed the concept of Britishness and what it means within a modern context. In an address to the Fabian Society, Brown (2006) suggested “*shared values – not colour, nor unchanging and unchangeable institutions define what it means to be British in the modern world*”. In other words, it is not institutions (such as the NHS or BBC) which

define Britishness, but the values which underlie their creation. In 2005 YouGov conducted an online poll asking people throughout Britain which characteristics define Britishness. The results indicated that 90 per cent thought that a sense of fairness or fairplay was very or fairly important in defining Britishness. Given that the NHS was founded on a core value of fairness - universal access to health care founded on need, not ability to pay – we might suggest that the NHS is the institutionalisation of this British value. Thus, if we asked the average man or woman on the street what made them proud about their country or what makes them British, the National Health Service is likely to figure highly (despite the fact that the NHS is actually quite different in England, Scotland and Wales); it is characterised as British by its appeal to the underpinning value of fairness. Regardless of whether one subscribes to this concept, the importance of the NHS has been reflected by the value placed on it by all major political parties - from Margaret Thatcher's 'the NHS is safe with us', to Tony Blair taking personal responsibility for NHS reform.

In terms of people's stated priorities, we know that health services are crucial. At a national level, health care is the single issue identified by most of the public as being very important in helping them decide how to vote. In 2005, for example, 67 per cent of people said that this was very important in deciding how to vote, with education (61 per cent) and law and order (56 per cent) ranked second and third (Mori, 2005). At a local level too, health services are paramount to local people, and those local authority surveys that explore both council and non-council services find that health is frequently top of the list. In Lewisham, for example, a regular residents' survey found that people were concerned about crime, levels of council tax and congestion, but that the two specific services that were most important to local people were health (21 per cent said it was one of three areas of most concern) and education (21 per cent). This was significantly ahead of other services, such as public transport (11 per cent) and provision for older people (9 per cent) (TNS, 2006).

Nowhere is the importance of health services more clearly apparent than in Kidderminster, where proposals to downgrade the local hospital led to fierce protests and, ultimately, to the formation of a new political party, control of the local council and the election of a new independent MP (Raftery and Harris, 2005) (see Box 2).

Box 2 The power of public protest

“When campaigners fighting to save Kidderminster Hospital swept all before them at the 1999 local elections their critics said it would never last. A year later the good people of Wyre Forest went back to the ballot box and instead of returning to their traditional allegiances the electorate made the Health Concern group the most powerful in the district. The group, which is fighting for a complete return of accident and emergency services at Kidderminster Hospital, now boasts 19 seats on Wyre Forest District Council and is the largest member of the ruling Rainbow Alliance.”

(Thorne, 2001)

“It used to be perceived wisdom that independent candidates, deprived of the clout of a national political machine, could not win under the British political system... Now in Worcestershire’s Wyre Forest, a traditionally Conservative seat turned into a Labour marginal, there is a growing possibility that the underdog may ... have his day. Dr Richard Taylor, a 66-year-old retired consultant physician at Kidderminster general hospital is making all the running in his local campaign. His issue is the local hospital and it is every health planner’s and party politician’s nightmare. Last September, Kidderminster lost its accident and emergency department and 192 acute beds... Kidderminster... was much-loved. It has just received millions in what is now wasted new investment and its planned down-grading coincided with controversial plans for a privately financed new hospital at Worcester, some 18 miles but often a 40-minute journey away on busy roads. The constituency erupted.”

(Timmins, 2001)

Hospitals occupy an important symbolic role within British public life. This is illustrated in the Kidderminster example, but also by the quotes from government sources in Box 3. Hospitals are much more than buildings where healthcare is delivered, but the physical incarnation of the NHS and its values within a particular locality. Under New Labour the NHS has undergone its biggest ever programme of hospital building, with more than £10 billion spent since 1997 (Carvel, 2006). *The NHS Plan* (Department of Health, 2000) suggested that a third of hospitals being used by the NHS were built before it was created, and many showed the effects of neglect. For most people, healthcare means hospitals – they are the establishments within an area which people most associate with the NHS. Therefore, the symbolic role of hospitals means that this neglect is amplified to illustrate a system-wide lack of investment within the NHS. Thus, building new state-of-the-art hospitals sends a strong message to local populations that the NHS is being invested in within their area. Although this would suggest a strong healthcare symbol which could be mobilised in place-shaping, this also highlights the problem that PCTs encounter with this process. Healthcare is synonymised with identifiable local hospitals, rather than the more anonymous and ever-changing PCT. Moreover, this means that health, for much of the population, is symbolised by the provider, rather than the commissioner.

Box 3 The importance of hospitals

“One hundred years ago public buildings were often the pride of Britain’s towns and cities. We need to rediscover in this generation a renewed sense of community and civic pride. I believe that we in Britain find focus for it in the values of fairness and decency that are at the heart of the National Health Service. Today our country’s hospital building programme gives us the opportunity to find a new way of giving lasting expression to our pride in those values.”

(Alan Milburn, in Department of Health, 2001c, p.1)

“Hospitals are public monuments and are important sources of civic and community pride as well as practical buildings for the delivery of health care. So the appearance and design of the building should enhance, rather than blight, the locality. New NHS buildings should not be anonymous and utilitarian concrete blocks, but should express the value that the community place in them.”

(Department of Health, 2001b, p.12)

2. Engaging local people

Public involvement in priority setting

The value of involving the public in decisions about setting priorities for health funding is well documented in the research literature. For example, Ham and Coulter (2001) assert that *“in an era of ever-increasing medical possibilities, publicly financed health care systems face the challenge of determining what services should be covered for the insured population”* (p.163). They examine some of the international experience of seeking to develop more systematic approaches to determining health funding priorities (Oregon, The Netherlands, New Zealand) and note that (p.164):

“An important motivation in this context is that choices in health care involve making judgements about the relative priority to be attached to different objectives and services. It follows that these choices need to be informed by an understanding of community preferences if they are to gain acceptance among those affected.”

The importance ascribed by Ham and Coulter to gaining an understanding of community preferences is at the heart of our discussion here, about the need for the NHS to develop more effective ways of taking decisions about health funding that are legitimate (and indeed comprehensible) in the eyes of the general public. Ham and Coulter develop their arguments further by drawing on the work of Klein (1998), who asserted that in debates about priority setting, there was a need to strengthen the institutional basis of decision-making. Klein viewed priority setting as *“inescapably a political process”* (p.959) in which debate among divergent interests was inevitable. Holm (1998), in an analysis of experience of priority setting in the Nordic countries, shows how policy makers have increasingly turned their attention to ways of strengthening decision-making processes to generate legitimacy for health funding decisions, arguing that this was necessary as more technical approaches proved to be limited.

NHS policy making

Throughout its history, the NHS has struggled to find meaningful ways to engage with patients and the public. Known internationally as one of the most centrally managed and controlled health systems in the developed world (Ham, 2004), the NHS has traditionally been much better at developing and implementing national approaches to

the organisation and delivery of care than it has in relation to ensuring that services meet the specific needs and priorities of local communities. Policy making in the NHS reflects this tendency to a central approach and continues to be largely the responsibility of the Department of Health. It is instructive that even an attempt in the 1990s to relocate many Department of Health functions away from London to Leeds has, over time, retracted back to a situation where the majority of ‘significant’ directorates of the department are firmly based back in London (although a similar process with recent BBC staff moves suggests that this may not be unique to health care). This concentration of policy development within the capital was also lent weight by the abolition of regional health authorities (RHAs) in 1996. RHAs had an explicit role in the interpretation and implementation of national policy, taking account of regional circumstances, and their removal and replacement with regional offices of the Department of Health confirmed that policy making and priority setting for the NHS was a clearly more national than regional or local activity.

This national focus is consistent with the Labour government’s desire to ‘modernise’ the NHS and improve its performance (Department of Health, 2000) and with their use of a large number of central targets and sanctions as a way of concentrating NHS attention on a specific set of national priorities (such as waiting times in accident and emergency departments, waiting times for hospital admission, access to a GP, offering patients choice of time and place of care, etc.). Ironically, this central and target-driven approach to service improvement took place at a time when the declared policy direction was one of ‘shifting the balance of power’ towards ‘frontline’ NHS staff and local people (Department of Health, 2001a). In the opening section of *Shifting the Balance of Power*, the following statement was made:

“Reform in the NHS has to come from within the NHS. The balance of power must be shifted towards frontline staff who understand patients’ needs and concerns. A shift in the balance towards local communities so that they reconnect with their services and have real influence over their development” (Department of Health, 2001a, p.5).

Patient and public input to NHS decision-making

In terms of the ways in which local people and patients have been able to influence NHS decision-making, there have been relatively few changes over the past three decades. Following the NHS reorganisation of 1974, community health councils (CHCs) were created as the main mechanisms for providing the ‘patient’s voice’ within the NHS; having a dual role as patient advocate in relation to making complaints about NHS care, and as providing the patient voice and challenge to NHS planning and decision-making. CHCs were abolished in England in 2002 and replaced by patient forums, there being one forum for each NHS provider and members having a remit in relation to commenting on services provided by that trust or PCT.

Critical commentary of patient forums is characterised by a sense that they are a pale imitation of the CHCs they partly replaced, and that the CHC role as a challenger of plans and decisions has largely been lost within the NHS. Indeed, some commentators have pointed to the need for greater clarity and co-ordination of the whole area of user involvement in the NHS (Florin and Dixon, 2004). Within the

theme of user involvement in the NHS there has long been a debate as to whether individuals should be involved as consumers (i.e. service recipients) or citizens. Clearly, both conceptualise different roles and rights for the user. Yet, this distinction has been somewhat blurred by the “Third Way” approach of New Labour, which perceives greater choice and improved “customer service” as compatible with, and complementary to, a stronger voice in public services (Baggott, 2005). Thus, within the user involvement agenda, there are currently a number of involvement strategies which serve to undermine each other, with some serving the consumer and others the citizen. At the time of writing it remains to be seen whether new LINKS (Local Involvement Networks) will be any more successful with respect to user involvement.

Developing a stronger public voice in commissioning

NHS commissioning is a much discussed and debated function, but a particularly helpful definition is set out below.

“Commissioning...tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes” (Woodin, 2006, p.203).

The role of commissioning as the activity that is concerned with deciding what health care should be funded (and hence provided) or not, is central to the discussion in this paper. Since the inception of the NHS market in 1991 (Department of Health and Social Security, 1989), there has been a division within the NHS between the payers (initially referred to as ‘purchasers’ and now termed ‘commissioners’) and the providers. There has been regular reform of the payer (or demand) side of the NHS since 1991, with major organisational reform taking place in 1991 (creation of health authorities and GP fundholders), 1994 (merger of FHSAs and health authorities), 1996 (health authority mergers and abolition of RHAs), 1999 (creation of primary care groups), 2000 (initial development of PCTs), 2002 (abolition of health authorities and creation of SHAs and PCTs) and 2006 (mergers of SHAs, mergers of PCTs). This periodic organisational turmoil has made it very difficult for NHS commissioners to prove effective (Walshe *et al.*, 2004; Smith *et al.*, 2004; Bramley-Harker and Lewis, 2005; Smith *et al.*, 2006).

This lack of effectiveness of NHS commissioning has, among other things, been due to the difficulty faced by health authorities and PCTs in developing and sustaining necessary relationships with provider organisations, partner agencies, local people and their representatives. Interestingly, in parallel to the watering down of patient and public engagement in NHS decision-making, there has been an emerging and strengthening discourse about the need for greater public ‘voice’ within commissioning. However, this interest is not new; the NHS changes of 1991 and the publication of *Local Voices* (Department of Health, 1992) precipitated a flurry of interest from District Health Authorities in how they could consult the public to ensure that, “*their decisions reflect, as far as practical, what people want, their preferences, concerns and values*” (Department of Health, 1992, p.3). Brian

Mawhinney- then Minister for Health - conducted a series of speeches during 1993 in which he stated that by April 1994 every health authority should be able to demonstrate that it was taking systematic action to seek and act on the views of CHCs, voluntary bodies, the wider public and their representatives. Yet, despite this pledge, by 1994 only 21 per cent of health authorities were deemed good, 57 per cent acceptable and the remaining 22 per cent unsatisfactory in the performance of this role (Mawhinney, 1994). Thus, public involvement in commissioning decisions is not a new concept; there has been sustained, but largely unfulfilled, rhetoric surrounding this issue for much of the past decade.

The periodic reorganisation of the bodies that are charged with making fundamental decisions about NHS funding priorities and investment, along with the scaling down of public and patient involvement mechanisms, has resulted in an ever more noticeable ‘democratic deficit’ in NHS decision-making. Nowhere has more vividly demonstrated than in Kidderminster where local people resorted to the use of the local and national ballot box as a way of registering their protest at what they perceived as a lack of attention to their views by NHS managers and boards. What Kidderminster points to is a lack of faith on the part of the general public in the decision-making processes in place within the NHS, processes that are caricatured in the media as being in the hands of ‘unaccountable NHS bureaucrats’.

PCT governance and public involvement

The accountable body for local NHS decisions is the PCT board. This is comprised of NHS executive directors (chief executive, finance director, director of public health, etc.) and non-executive directors, the latter being six or seven members of the local community who have been recruited (by the NHS Appointments Commission) to help plan for the future of local health services, ensure that the management team meets its targets, ensure the proper management of finances, and assist the board to work properly in the public interest and keep the public and patients properly informed. This model of board was introduced along with Hospital Trusts in the White Paper *Working for Patients* (Department of Health and Social Security, 1989). These self-governing Trusts were introduced with the expectation that they would “*earn revenue from the services they provide. They will therefore have an incentive to attract patients, so they will make sure that the service they offer is what patients want*” (Department of Health, 1989, p.4)- i.e. they would become more corporate along “business lines” (p. 5). In the Government’s eyes this would make Trusts more responsive to consumer preferences, and create much more space for a user voice within them. Yet, most Hospital Trusts would not be characterised by their high levels of public involvement and in this sense the role of the PCT corporate board seems somewhat anachronistic.

Indeed, the use of the corporate board model of governance for NHS commissioning bodies has been called into question in previous NHS Alliance and HSMC research. This has highlighted the inadequacy of a board as a means of ensuring public ‘voice’ within NHS decision-making and its consequent problems in terms of PCTs’ inability to demonstrate proper local legitimacy in respect of the decisions they make (Wade *et al.*, 2006). The researchers note (p.19):

“Securing appropriate ‘voice’ within NHS commissioning ... requires the consideration of a new approach to PCT governance, that is, of how PCTs can properly act as and claim to be the ‘NHS Local’. In statutory terms, the representation of the public in healthcare decision making is currently through the non-executive directors on the boards of PCTs, and through patient forums. The extent to which these are seen by the public as effective mechanisms for exerting influence is extremely questionable, however, and to achieve a real and sustainable form of public engagement, alternative models need to be explored.”

This paper seeks to do what Wade *et al* called for – explore alternative models for public engagement in healthcare decision-making, focusing explicitly on what the NHS could learn from the development of a closer and different relationship with local government.

Re-examining what we mean by public involvement

Underpinning our analysis is the need for a re-examination of the institutional basis of local health decision-making. The specific roles that can be played by the public within such health decision-making have been explored by Lomas (1997) in what is considered a seminal paper about public input to health care priorities. Lomas asserted that the public can adopt any one of at least three roles when providing input to public decision-making:

- Taxpayer
- Collective community decision-maker
- Patient

He suggested that each of these potential roles could be mapped onto three areas of public policy decision-making in health care: funding levels and organisation for the system; the services we choose to offer under public funding; and the characteristics of those who should receive services. In this paper, we are primarily concerned with public input to health decision-making within the role of taxpayer and collective community-decision maker, and more specifically, how PCTs can secure such input. Lomas, having reviewed the range of methods of public involvement typically used by health decision-makers, suggests that:

“There appears to be no best method for obtaining public input that overcomes the common problems of poor information on which to base priorities, difficulty in arriving at consensus, poor representativeness of participants, and lack of opportunity for informed discussion prior to declaring priorities” (Lomas, 1997, p.103).

Lomas does go on to suggest that panels of citizens or patients, convened on an ongoing basis, offer the most promising way forward. What is interesting is that Lomas, having examined the wider roles of the public in decision-making about health care, reverted to techniques that are to be used by those with the technocratic or political power to make such decisions, rather than suggesting specific institutional arrangements that might lend a certain level of legitimacy or transparency to decisions.

We now set out some suggestions about how institutional arrangements for decision-making within healthcare might be changed within England in order to bring a greater degree of legitimacy and democracy into what is currently largely a technocratic process carried out by managers and appointed board members. In short, we use experience from overseas, other parts of the UK, and sectors beyond health to explore how PCTs can develop arrangements for commissioning and decision-making that properly enable the development of ‘NHS Local’.

3. What needs to change?

Having argued that health services are crucial to local authorities’ ability to ‘place-shape’, and that PCTs need to learn from the best of local government in order to develop more local accountability and legitimacy, we now set out some broad ideas of how things could be different in the future. In particular, this leads us to examine a number of different models for developing a new relationship between local government and the NHS which would have the potential of assuring a greater degree of ownership of health issues by local government and more legitimacy for decisions taken about health funding priorities. In choosing which options to explore in more detail, we are conscious of three different approaches that could be taken:

- 1) A local authority-led approach (that is, taking NHS commissioning and bringing it to local legitimacy).
- 2) Changing current NHS approaches to make them more locally accountable (that is, bringing local legitimacy to NHS commissioning).
- 3) Developing a new single and locally accountable commissioning body in between the NHS and local government.

Of course, each of these approaches has potential strengths and limitations, and some may be more politically feasible than others in the current context. However, our thoughts about possible models are set out below, less as a proposed blueprint for the way forward than as an illustration of what the world could be like if we were to engage seriously with the analysis put forward in this paper.

A local government-led approach

With the current emphasis on separating NHS commissioning and provision, one way forward would be to transfer health care commissioning to local government, leaving PCTs as NHS provider organisations. A local government-led system would give local legitimacy and might be more responsive to local priorities. Social services departments also have substantial experience of managing cash-limited budgets and of managing a mixed economy of care (both current issues in the NHS), and a local government-led system might also offer greater opportunities to focus on health inequalities and public health (arguably overshadowed by acute concerns in the current NHS). Despite these potential benefits, some local authorities might require

substantial support and development in order for elected members to be able to engage effectively with such new responsibilities.

Key strengths

Key limitations

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| <ul style="list-style-type: none"> • Creates a single health and social care body locally and democratically accountable. • NHS responsibilities could boost turnout for local elections and help to reinvigorate local politics. • Scope to view health in its broadest sense (health as well-being) rather than focusing on illness and acute care. • Removes some of the current tensions in the NHS reform agenda (for example, where GPs are both commissioners and providers of services). | <ul style="list-style-type: none"> • Elected members may need considerable support and development to take on this new role. • Would need a different balance between central control and local autonomy so that this did not become <i>local administration</i> rather than <i>local government</i> and so that there is sufficient flexibility to do things differently. While this might remove ministers from direct responsibility for local adverse events, they might also find this lack of direct control difficult. • Local government has a different approach to the NHS to the split between provision and commissioning – while this might also be a strength, it would need detailed exploration. |
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Changing NHS structures to make them more locally accountable

While previous approaches (for example, elected members represented on District Health Authorities, Joint Consultative Committees, health scrutiny etc.) have attempted to make the NHS more locally accountable, two more fundamental models are direct elections to NHS Boards and a Foundation Commissioning Trust:

a) Direct elections to NHS boards

In New Zealand, a country that is regarded as a pioneer in applying some of the technical approaches to health priority setting such as the use of clinical scoring, there has been a move to address the public nature of the institutional basis of health decision-making. This has taken the form of having a proportion of the membership of district health boards determined through direct public elections. New Zealand has

21 district health boards (DHBs) that have a responsibility for planning, funding and purchasing services for their local population, for managing local hospital and community health services, and for contracting with primary health organisations whose responsibility it is to improve health and develop primary care. DHBs are governed by a board of up to 11 members, the majority of which are elected. Central government appoints up to 4 members of the DHB. There is upwards accountability to the Minister of Health, but significant emphasis is placed on local, co-operative and collaborative arrangements (Cumming *et al.*, 2003).

Key strengths

Key limitations

- | Key strengths | Key limitations |
|---|---|
| <ul style="list-style-type: none"> • Introduces a degree of local democracy into the NHS. • Could introduce a broader range of views and experiences into the decision-making process. • Could be symbolically important (but also runs the risk of tokenism). | <ul style="list-style-type: none"> • Current NHS non-executives are appointed for their skills and experience, and can be very high calibre people – would such people be deterred from standing in an election, and are there sufficient high calibre people to fulfil the range of local public roles that now exist (councillor, school governor, magistrate etc)? • Would this be subject to the party system or would candidates be independent? • Elections could be complex to administer (although could be held at the same time as local authority elections). • Would successful candidates be executive or non-executive? • If people are elected on an individual basis, is there a danger of competing legitimacies and a reduction in corporate responsibility? • Might need significant development to enable some local communities to engage in this process in an informed way. • Retains a split between local government and the NHS. |

b) Foundation Trust (for commissioning bodies)

Foundation Trust status has been introduced in the NHS in England as a new form of governance that is open to NHS provider organisations (NHS Trusts). Foundation Trust status takes the legal form of a public benefit corporation, a separate legal entity for the provision of public services that includes features such as a lock on public assets (meaning that these assets can never be sold outside the public sector) and a requirement for external regulation by a new Foundation Trust regulator, Monitor. Foundation Trusts are considered to be more autonomous than NHS Trusts, being at arms length from the usual NHS/Department of Health performance management

arrangements, and having a governance structure that is based first and foremost on a membership of local people, staff and patients. This membership elects governors of the Trust who in turn appoint the Trust board. In this way, the Trust accounts to its members and not directly to NHS line management. The relationship of the Foundation Trust with the NHS is dealt with through a contract that the Trust holds with the regulator, Monitor, and it is considered that this form of accountability to the regulator is both more locally sensitive (due to the new governance arrangements) and potentially more robust (with the likelihood of some protection from centrally imposed reorganisations) than might traditionally be the case with NHS Trusts (Walshe, 2003).

Foundation Trust status is now being explored for PCT provider services (Community Foundation Trusts - see Department of Health, 2006b). What has not yet been discussed is the potential of using the Foundation Trust model for NHS commissioning bodies (PCTs or practice-based commissioning clusters). This is surprising, for arguably, it is commissioning bodies that most need to have a strong public 'voice' function and a close connection with the views, aspirations and priorities of local people. That the NHS has, in recent times, paid more attention to the development of stronger community governance for provider organisations than for its commissioning and funding bodies is a reflection of the general lack of attention that has typically been paid to the development of commissioning in the NHS. As now would seem to be the time to address this issue, consideration of stronger and more effective governance of PCTs beyond the traditional corporate board/report to the Department of Health model is an urgent priority.

Key strengths

Key limitations

<ul style="list-style-type: none"> • Symbolically inclusive with a potential for meaningful local involvement and accountability. • Makes commissioning as accountable to local people as providers are meant to be (in theory). 	<ul style="list-style-type: none"> • Questions over who is a member and who can vote/stand in elections. • Doubts remain about the local legitimacy and accountability conferred by Foundation status. • Scope for competing legitimacies between Foundation Trust providers and Foundation Trust commissioners. • Concerns that current Foundation Trusts may be more accountable to a national regulator than to local people. • Retains a split between local government and the NHS.
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A new entity in between the NHS and local government

If local authority-led health care or democratised health commissioning are not the best way forward, could some other entity in between health and local government help to cement relationships? Here we have reflected on models such as the University Council (Universities operate relatively independently under a Royal Charter and are governed by a Council which typically includes a range of nominated lay people, staff and students) or the potential for Local Strategic Partnerships to co-ordinate cross-cutting issues. However, an interesting example of an entity between the NHS and local government is derived from the policy authority model - police authorities are made up of a mix of elected members (nominated by relevant local authorities), magistrates and independent members selected following local advertisement and recruitment. The role of police authorities is to set the strategic direction of the police force and to hold the chief constable to account on behalf of local people. This involves setting a precept on the Council Tax, setting the annual police budget, appointing the chief constable, setting local priorities and consulting local people. In a health and social care context, such an approach might entail a combination of elected members, clinicians and independent members fulfilling similar functions with regards to the local NHS. Despite their important functions, important questions remain about the capacity of some police authorities to engage fully with local people and to balance national and local priorities.

Key strengths

Key limitations

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| <ul style="list-style-type: none"> • Could give elected members and lay people more influence in local health care than at present. • Creates an expectation of a joined-up approach. | <ul style="list-style-type: none"> • Police authorities may often be seen by local people as being a committee of the local authority, rather than as an independent entity. • How executive or non-executive is this body, should members be elected or appointed and what powers should they have? • Similar in nature to elected member representation on former District Health Authorities (which were perceived as not delivering the democratic accountability or the new relationship discussed in this paper). • How would such a body relate to current local government? |
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Conclusions

Having called for a new and deeper relationship between local government and PCTs, our preferred model is for a system of local government-led health care. For us, this model creates a single and locally accountable commissioning body for both health and social care, which democratises the NHS as well as holding the potential to increase engagement with local democratic processes. In practical terms, such an arrangement might also bring scope to shift resources towards ‘care closer to home’ and public health, as well as to learn from local government approaches to managing cash-limited budgets and a mixed economy of care. Nevertheless, this might only work if there was sufficient local autonomy and flexibility to do things differently –

giving local government responsibility for administering a centrally planned and managed health service would not be attractive to elected members and would achieve little more than the current system. Such an approach would also depend on the ongoing modernisation of local government, with elected members and officers capable of taking up this new role.

However, what is at stake here is not so much our preferred model, as the diagnosis on which this is based. Essentially, we argue that local government needs the NHS to be a successful place-shaper, and that the NHS needs local government for local legitimacy and accountability. Whether we bring NHS commissioning to local legitimacy (a local authority-led approach) or bring local legitimacy to commissioning (democratising NHS structures), a new relationship between local government and PCTs is crucial. Moreover, if the previous history of the health and local government divide is anything to go by, then only a fundamental rethink is likely to be able to resolve some of the democratic, collaborative and commissioning deficits which have been all too apparent in the past.

References

- AMA (1991) *Local government and the NHS: time for a change?* London, AMA
- Baggott, R. (2005) A funny thing happened on the way to the forum? Reforming patient and public involvement in the NHS in England, *Public Administration*, 83(3) 533-551
- Bramley-Harker, E. and Lewis, D. (2005) *Commissioning in the NHS: challenges and opportunities*. London, NERA Economic Consulting
- Brown, G (2006) *The future of Britishness*, keynote speech to the Fabian Future of Britishness conference, 14th January. Full text available at http://www.fabian-society.org.uk/press_office/news_latest_all.asp?pressid=520, accessed 24/08/06.
- Campbell, J. (1987) *Nye Bevan and the mirage of British socialism*. London, Weidenfeld and Nicolson
- Carvel, J. (2006) Ministers approve £1.5bn hospital building proposal, *The Guardian*, 19th August
- Coleman, A. and Harrison, S. (2006) *The implementation of local authority scrutiny of primary health care, 2002-2005*. Manchester, National Primary Care Research and Development Centre
- Cumming, J. et al (2003) *Interim report on Health Reforms 2001 Research Project*. Wellington, Health Services Research Centre, Victoria University of Wellington
- Darzi, A. (2008) *High quality care for all (the Darzi Review)*. London, TSO
- Department of Health (1992) *Local voices: the views of local people in purchasing for health*. London, NHS Management Executive
- Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. London, Department of Health
- Department of Health (2001a) *Shifting the balance of power*. London, Department of Health
- Department of Health (2001b) *The NHS plan: investment and reform for NHS hospitals*. London, Department of Health
- Department of Health (2001c) *The biggest ever hospital building programme, the best ever hospital design*. Press Release notice 2001/0553, 16th November
- Department of Health (2006a) *Our health, our care, our say*. London, TSO
- Department of Health (2006b) *Health reform in England: update and commissioning framework*. London, Department of Health

- Department of Health (2007) *Commissioning framework for health and wellbeing*. London, Department of Health
- Department of Health (2008a) *The NHS constitution: a draft for consultation*. London, Department of Health
- Department of Health (2008b) *World class commissioning: commissioning assurance handbook*. London, Department of Health
- Department of Health and Social Security (1989) *Working for patients*. London, HMSO
- Florin, D. and Dixon, J. (2004) Public involvement in health care, *British Medical Journal*, 328, 159-161
- Glasby, J. and Dickinson, H. (2008) *Partnership working in health and social care*. Bristol, The Policy Press
- Glasby, J. and Littlechild, R. (2004) *The health and social care divide: the experiences of older people*. Bristol, The Policy Press
- Glasby, J., Smith, J. and Dickinson, H. (2006) *Creating 'NHS local': a new relationship between PCTs and local government*. Birmingham, Health Services Management Centre.
- Glendinning, C., Powell, M. and Rummery, K. (eds) (2002) *Partnerships, New Labour and the governance of welfare*. Bristol, The Policy Press
- Gorsky, M. (2006) *Hospital governance and community involvement in Britain: evidence from before the National Health Service*. Available online via www.historyandpolicy.org (accessed 25/07/2008 - since published in 2008 in the *International Journal of Health Services*, 38(4), 751-771).
- Ham, C. (2004) *Health policy in Britain* (5th ed.). Basingstoke, Palgrave Macmillan
- Ham, C. and Coulter A. (2001) Explicit and implicit rationing: taking responsibility and avoiding blame for health care choices, *Journal of Health Services Research and Policy*, 6(3), 163-169
- Harrison, S. *et al* (1991) *Health before health care*. London, IPPR
- HM Government (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care*. London, HM Government
- HM Government (2008) *The case for change: why England needs a new care and support system*. London, Department of Health
- Holm S. (1998) Goodbye to the simple solutions, *British Medical Journal*, 317, 1000-1002

- Hudson, B. (1998) Circumstances change cases – local government and the NHS, *Social Policy and Administration*, 32(1), 71-86
- Klein R. (1998) Puzzling out priorities, *British Medical Journal*, 317, 959-960
- Knowles, D. (1993) IHSM Conference focus, *Health Service Journal*, June, 13
- Leutz, W. (1999) Five laws for integrating medical and social services: lessons from the US and UK, *Milbank Quarterly*, 77(1), 77-110
- Lomas, J. (1997) Reluctant rationers: public input to health care priorities, *Journal of Health Services Research and Policy*, 2(2), 103-111
- Lyons, M. (2006) *National prosperity, local choice and civic engagement: A new partnership between central and local government for the 21st century* (Lyons Inquiry into Local Government). London, Lyons Inquiry/HMSO
- Mahwhinney, B (1994) *Purchasing for health: involving local people*, speech at the National Purchasing Conference, Birmingham, 13th April
- Means, R. and Smith, R. (1998) *From poor law to community care*. Basingstoke, Macmillan
- MORI (2005) *Health and the election: a briefing from the MORI health team*. London, MORI
- ODPM (2005) *Evaluation of Local Strategic Partnerships*. London, ODPM
- Powell, M. (1994) The forgotten anniversary? An examination of the 1944 White Paper, “A National Health Service”, *Social Policy and Administration*, 28(4), 333-344
- Raftery, J. and Harris, M. (2005) *Kidderminster’s health: monitoring and evaluating the reconfiguration of the NHS in Worcestershire*. Birmingham, HSMC
- Regan, D.E. and Stewart, J. (1992) An essay in the government of health: the case for local authority control, *Social Policy and Administration*, 16(1), 19-43
- Royal Commission on Local Government (1969) *Report, Cmnd 4040*. London, HMSO
- Smith, J., Lewis, R. and Harrison, A. (2006) *Making commissioning effective in the reformed NHS*. Birmingham/London, HSMC/the King’s Fund
- Smith, J, Mays, N., Dixon, J., Lewis, R., McClelland, S., Mcleod, H. and Wyke, S. (2004) *A review of the effectiveness of primary-care led commissioning and its place in the UK NHS*. London, Health Foundation
- Thorne, A. (2001) Blood-letting politics over Health Concern, *Birmingham Post*, 2 February

Timmins, N. (2001) Anger over local hospital gives real bite to underdog doctor's campaign, *Financial Times*, 28 May

TNS (2006) *Lewisham residents survey: report*. London, Taylor Nelson Sofres

Wade, E., Smith, J.A., Freeman, T. and Peck, E. (2006) *Commissioning in the reformed NHS: policy into practice*. Birmingham, HSMC/NHS Alliance

Walshe, K. (2003) Foundation hospitals: a new direction for NHS reform?, *Journal of the Royal Society of Medicine*, 96, 106-110

Walshe, K., Smith, J.A., Dixon, J., Edwards, N., Hunter, D.J., Mays, N., Normand, C. and Robinson, R. (2004) Primary care trusts – premature reorganisation, with mergers, may be harmful, *British Medical Journal*, 329, 871-872

White, J. (2004) *From Herbert Morrison to command and control: the decline of local democracy*. Available online via www.historyandpolicy.org (accessed 25/07/2008)

Woodin, J. (2006) Health care commissioning and contracting, in Walshe, K. and Smith, J. (eds) *Healthcare management*, Maidenhead, Open University Press, 201-223