

Part 2

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## Analysing key policy issues



# Who's going to govern?<sup>1</sup>

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A factor central to the future of UK health policy is the role the state will play in terms of healthcare provision and the promotion of improving health status for the population. In the UK, the state still provides 80% of healthcare, funded through taxation and free to all at the point of delivery. The commitment to 'socialised medicine' and to the belief that health is fundamentally 'a public good' creates a special relationship between the state and society (Dawson and Sausman, 2005). This in turn creates a special relationship between the electorate, politicians, civil servants, those involved in the NHS as patients, carers, clinicians and executives, and those involved from various sectors in areas which affect health status but which are not part of the NHS (Mulligan and Appleby, 2001).

This chapter considers the role of the state and issues of governance in future UK health policy. Health policy in the UK continues to be highly centralised in terms of planning and provision, at macro and micro levels, despite some devolution to the home countries. So why is the state involved in healthcare? There are two reasons. The first is that healthcare in the UK is mainly funded through taxation, and the second is that health is conceived as a public good. The state is therefore held responsible for meeting certain expectations. These include delivering value for money, ensuring high quality and preventing what is perceived as avoidable ill health and disease. A major challenge for public policy is that of ever-rising expectations fuelled by scientifically-revealed possibilities (*see* Chapter 7), international comparisons and a sense of what is 'right' and what are 'individual rights' (*see* Chapters 2 and 3, and the section on 'Information, evaluation and benchmarking' in Chapter 9).

Issues emerging from a wider consideration of the state in UK health have been selected because of their potential impact on UK health (including public health) or because of their current status in health policy (such as patient choice). Dawson and Sausman (2005) suggest a framework for analysis which includes a focus on the scope of the system (state responsibilities, citizens' entitlements); ownership of the

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<sup>1</sup> The authors use the word 'govern' to refer to the 'conduct of policy and affairs of [a state, organisation or people]'. In this context, it is a state, describing a political-geographical entity: 'a nation or territory considered as an organised political community under one government' (OUP, 1999). Dunleavy and O'Leary (1987) identify two sorts of definitions of the state: organisational and functional. Functional definitions may be *ex ante* – 'a set of institutions which carries out particular goals, purposes and objectives' – or *ex post*, in which case the state is defined by its consequences. Organisational definitions tend to conceive the state as 'a set of governmental institutions ... synonymous with the elected ministers who are formally in charge in the departments' (Dunleavy and O'Leary, 1987); often used interchangeably with government, and meaning the Executive.

system (funding, organisation and accountability); stakeholders (including patients, society and the workforce) and 'dynamics' (a term used to describe the mechanisms that drive the system). Each of these is relevant to the role of the state because it is the state that specifies entitlements, funding arrangements and dynamics.

## The role of the state in health policy

In considering the overall policy canvas for state involvement, it is important to bear in mind that a range of involvement across a range of arenas is possible (Rice, 1995). Typically, policy and analysis tend to focus on the National Health Service (NHS) as an institution and the use of public money in health. Yet many factors relating to health, such as developments in technology, or the physical and social environment, lie in other arenas. Regarding the governance of future health policy, the state has a far greater impact owing to its activities across other arenas, and far greater scope for intervention than is often perceived to be the case.

Coupled with this is the notion of who does what within the health system. Klein (2005), for example, has identified a move away from the identification of one institution in the provision of health services, namely the NHS. This is reflected in greater and more explicit use of private providers and the 'third sector'. At the same time, within a single policy area there are ranges of functions which a state may assume and the resulting landscape of state provision, regulation and *laissez faire* is influenced by historical, economic and ideological considerations. One important area for future consideration in the UK is the relation of social care to health and healthcare. While ministerial responsibility for both is combined, the role of government with regard to each differs. For social care, government is perceived as determining the underlying policy values and regulating activities but taking an 'arm's length' role in relation to funding and direct provision through means-tested access to public provision. On the other hand, with regard to most of what is called 'health' care, the role of government has been to determine the underlying policy values, to regulate activities and directly to fund and provide services free of charge at the point of access. This creates an immediate source of political and public confusion and will need to be addressed in the future.

This chapter focuses on what is considered to be of most relevance to the present and future health policy agenda of the UK: the role of the state in relation to other governance authorities, to markets, and to the professions and individuals. In doing so, it is worth remembering that the involvement of any state could be either much more or much less, it could even have a different role, depending on historical, economic and social factors.

This chapter focuses on scope and stakeholders through an examination of the state's relationships with other actors in the policy system. There are four main sections:

- the state as embodied in central government and its relationship to supra-national, UK home country and local government
- the state and the market
- the state and the health professions – particularly in relation to regulation and performance management

- the state and the citizen – with particular emphasis on the role of the patient and public in health.

Themes and examples are designed to be illustrative and are not exhaustive.

## The state and other governance authorities

A key driver of the shift towards governance is the devolution and potential 'hollowing-out' of the state (Rhodes, 1996). Hollowing-out involves passing responsibility upwards to supranational bodies, such as the European Union (EU), and downwards to devolved countries, or further, to regions. It suggests that nation states will become increasingly redundant in the future. The likely impacts of this on future UK health policy are considered in turn.

### *The European Union*

European law takes precedence over national law. Three tenets of European law with direct implications for health are:

- free movement of goods, e.g. medical technology, pharmaceuticals
- persons, e.g. patients, health professionals
- services, e.g. health services.

In two landmark cases in July 2000, the European Court of Justice (ECJ) ruled that patients were entitled to seek treatment in another member state without prior authorisation by their national health service, unless treatment could be provided domestically without 'undue delay' (BMA, 2003).

European legislation is impacting on healthcare services in other ways, with the implementation of the European Social Chapter and the Working Time Directive limiting the hours medical staff are permitted to work. Implications for NHS staffing are significant as organisations such as hospitals strive to increase medical staff numbers and redesign staffing models. The impact of the European Convention on Human Rights, enshrined in the UK Human Rights Act, is also anticipated to have a profound effect on health and healthcare in the UK in future (*see* Chapters 2 and 5). Article 152 of the Amsterdam Treaty (1997) specifically extended public health governance to the EU.

Since its inception under the Treaty of Rome in 1957, the EU has left direct competency for healthcare to its member states. Subsequent treaties, such as the Single European Act (1987), the Maastricht Treaty (1992) and the Amsterdam Treaties (1997), failed to enlarge EU competence in health beyond aspects of public health, including health service provision and health system financing. Few direct powers have so far been ceded, although the impact of the EU may be felt more indirectly in future. What is emerging is somewhat complicated. The proposed constitution is explicit about not extending EU competence to healthcare. At the same time the four freedoms of the EU – freedom of movement of goods, services, capital and people – are all being enforced by the European Court of Justice with ramifications for health services. For example, freedom of movement has been interpreted as freedom to use health services in another country while billing the NHS, and freedom of services means countries cannot discriminate against professionals from anywhere else in the EU. The Services Directive reinforces this

trend, resulting in some concerns that the EU will, in time, regulate many aspects of UK healthcare policy (Greer, 2005). However, the Services Directive was revised in May 2005. The likely impact of this is still unclear.

### *The home countries*

With regard to devolution to the home countries within the UK, 'the extent of policy divergence since devolution has surprised many' (Greer, 2004). This makes any discussion of UK policy as a whole somewhat problematic. Although health policy within each of the four countries is framed within the same statutory framework and they each face similar broad future challenges (BMA, 2004), the differences between them are substantive (BBC, 2004a,b,c,d). The countries diverge over how to meet goals but there are few signs of learning going 'upwards' in terms of sharing of best practice or policy solutions from one country to another. One advantage of this divergence is that it provides a natural experiment. If governments are committed to improving health policy based on evidence, one of their roles might be to better understand and evaluate divergence. Leatherman and Sutherland's (2005) study of quality in the NHS does find differences between countries.

### *Localising policy*

Another aspect of devolution central to the provision of healthcare is the move to empower frontline staff, with an increased policy focus on 'responsive' public services. Thus, *Shifting the Balance of Power: the next steps* (DH, 2002) aimed to move from a top-down approach, emphasising national standards and accountability, towards local leadership and accountability. Few would argue that this agenda has been successfully pursued (Baggott, 2004). Indeed, *Shifting the Balance of Power* was itself published against a backdrop of greater central control – in the form of the establishment of the Modernisation Agency, CHAI, NICE and National Service Frameworks (NSFs), for example – as well as increasing centralisation of funds attached to central initiatives (Baggott, 2004). Focus is on central targets with regular and intrusive monitoring (Day and Klein, 1987 cited in Walshe, 2002) and local commissioners continue to commission within a centrally-defined framework.

This has led to some discussion of the need to redesign the health service to allow greater freedom from government. The Commission on the NHS has suggested that the NHS be established as a public corporation with a constitution protecting its founding principles, its own board and operating freedoms (Hutton, 2000). A King's Fund report (2002) also argued for the separation of government and health service through the establishment of an NHS corporation. Government would establish policy objectives and allocate resources, but the NHS corporation would decide how to meet these objectives and assume responsibility for standards and regulation, as well as local resource allocation (*see also* Dewar, 2003).

There are, however, issues of jurisdiction and responsibility. Politicians may think that they would not and should not relinquish control, since most healthcare in the UK is funded through public money. Baggott (2004) argues that separate agency status will not resolve the issues of ministers needing to take responsibility. The desire to empower the frontline and maintain accountability and control is an old dilemma on which there has been little progress towards a resolution.

According to Smee (1995):

*Ministers and the centre are finding it difficult to reconcile devolved accountability with the demand for detailed monitoring created by parliamentary interest in operational issues. In consequence, the centre is drawn into a whole range of issues, from hospital catering standards to freedom of speech for hospital staff, that it once expected to leave to the discretion of local management. The dilemma is that without substantial operating freedom, trust management cannot be expected to produce better performance ... but that with such freedom there is bound to be diversity of behaviours and performance. The existence of outliers is there to be seen – by press, auditors and politicians – as a cause for central regulation.*

Complicating matters further is the fact there is more to health than healthcare, although the relinquishing of direct control over the healthcare system does not necessarily imply a retreat of government from other arenas relevant to health. Some (for example Dewar, 2003) argue that new arrangements would result in greater democratic deficit and that such reforms are impossible anyway because universal health has to be centralised and hierarchical to achieve the wider goals. Bambra *et al.* (2003) point out health is an inescapably political activity and should not be taken out of the political arena.

The wider determinants of health are amenable to political action: health is not equally distributed and improving health requires collective activity at the societal level – ‘health can only be improved through the organised activities of communities and societies. The organisation of society, in most countries, is the role of the state and its agencies’ (Bambra *et al.*, 2003). Health is perceived to be a social right (Marshall, 1963) and is therefore relevant to citizenship. Increasingly too, health assumes a political relevance in the context of increasing globalisation.

Important issues need to be addressed regarding the central-local balance. Should the ‘outliers’ to which Smee (1995) referred, for example, be viewed as a social menace or benign inevitabilities? Will communities prefer local responsiveness or national standards? What if local choices impact on population health? Localisation may also imply a greater role of local or regional government, or a shift in ownership of the healthcare infrastructure (Bosanquet *et al.*, 2003). Will this negate the idea of a ‘national’ service, and will it matter?

If these basic questions can be answered, then the policy issue becomes one of designing appropriate structures and instruments. There may be scope to learn from examples in Wales, where a more localist agenda has been pursued (Greer, 2004). It is clear, however, that for the most part attempts to shift the balance within current healthcare arrangements have hitherto been unsuccessful, instead resulting in more centralisation of purpose and control. Walshe (2002) suggests that NHS regulation looks like a strengthening of central control over managerial and clinical practice. Various regulatory bodies are set up and funded by the Department of Health and then charged with enforcing national regulations, thereby eliminating scope for local variation. Walshe (2002) argues that this is not inevitable if politicians can be persuaded to ‘let go’.

## The state and the market

Many post-1979 UK government policies reflect an ideological preference for markets over state bureaucracies. In UK health policy, three major shifts have occurred in terms of state–market relationships. The first is greater use of the private sector to deliver services. The second shift is the attempt to mimic markets within the health system itself, following the arguments put forward by the American economist, Enthoven (1985).<sup>2</sup> This is reflected in a purchaser–supplier divide and greater use of contracts, for instance. These are best described as ‘quasi-markets’ since the purchasing powers are not with the individual. The third shift is the state’s abandonment of direct provision of some services, for example dentistry, optician services and many ancillary services.<sup>3</sup> Thus, players in UK health markets include suppliers, intermediaries and recipients/buyers – in and between the ‘internal’, commercial and third sector markets – and representatives and individuals in civil society.

Healthcare services have not shifted wholesale to the private sector, but current policy, in England at least, looks certain to make more use of the private firms. A recent *Guardian* article suggests that PCTs have been instructed to include one private provider among the choices offered to patients (Dean, 2004). In a recent review of health policy in England, the former health policy advisor to the Prime Minister, Simon Stevens, explained how government is stimulating a mixed economy, or ‘plurality’, ‘to expand capacity, enhance contestability and offer choice’ (2004). Both major political parties support greater use of private providers in healthcare (Conservative Party, 2005; Reid, 2005).

The following section identifies some of the contested issues about the use of markets in UK healthcare:

- democratic deficit in accountability for policy and practice
- the principle of public money being used to fund private firms
- the impact of markets on values and the precedence afforded to ‘market’ values over more ‘social’ values – efficiency, choice and quality rather than equity and planning and the ability of markets in health to support choice.

While greater ‘plurality’ charts the apparent direction of public policy, there is a continuing debate about the ideological bases and practical consequences of policies and practices that create an ever-uncertain policy context.

### *Democratic deficit*

The blurring of the line between public and private, and the fragmentation of the state, impacts on democratic control and accountability (Rhodes, 1996). It increases central government’s proclivity to regulate and audit, and runs counter to current policy attempts to re-engage citizens and rejuvenate democracy. This in turn may

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<sup>2</sup> Enthoven’s (1985) efficiency and responsiveness argument rested on rewarding the most efficient providers, which did not happen in practice in any systematic sense in the 1990s reforms. It remains to be seen what happens with payment by results.

<sup>3</sup> The NHS still provides some dentistry and more complicated optician services.

contribute to declining social capital, which has direct implications for health (Harper, 2002; Lynch *et al.*, 2000; Rothstein, 2004).

### **Public money for private enterprise**

Whether the expansion of private provision of public services can legitimately create surplus value for private appropriation is questionable. Following on from this, is use of the private sector distorting relationships and diverting policy? A recent MORI poll found that a large minority (38%) of respondents believed that 'private companies should not be involved in providing public services under any circumstances' (MORI, 2004). At the same time, a study by the National Consumer Council, suggests that service users do not care who provides the service, as long as it is good (NCC, 2004).

The role of private provision in supporting the overall aims of UK healthcare is not clear either. Pollock *et al.* (2002) argue that Private Finance Initiative (PFI) hospitals are planned on the basis of financial, as opposed to clinical, need and by means of an expensive process. Ultimately, their argument proceeds, the PFI hospitals reduce staff numbers 'in direct contradiction to government policy' and offer fewer public beds than are needed. Nonetheless, there is considerable press coverage on the role of Treatment Centres in reducing costs within the system overall (Hawkes, 2004; Kavanaugh, 2004; Timmins, 2004).

Private sector treatment is, however, often more expensive (Hawkes, 2004), not necessarily of better quality (Higgins and Wiles, 1992) and not always able to perform the difficult and expensive procedures (Baggott, 1998). Typically, the private sector has provided care in areas that are more straightforward and profitable (Baggott, 1998). Some expect this to continue as Treatment Centres spread. The Centres will choose to treat people whose condition is not complex and difficult, while expensive cases will be treated in the NHS, undermining the value of equity, which is said to underpin the health service.<sup>4</sup>

While considering the role of the private sector in any major segment of society, government will be aware of its role in industrial development and economic prosperity. The life sciences industry embraces pharmaceuticals, medical devices and a whole range of facilities, services and goods, in addition to private sector health and social care suppliers. Beyond its direct activities, the state has relevance to higher education as an employer of highly-skilled workers and as a sponsor of research. For all these reasons the relation of the state to the health market extends beyond this discussion and forms an important part of the policy context for UK health.

Future policy anticipates a much closer relationship between the public (government and the NHS) and private industry in health technology development (Department of Trade and Industry, 2003; HM Treasury, 2003). Governments may have to convince the private sector that it is worthwhile for them to innovate within the cost-constraints of the NHS, while persuading a cynical public that such links are positive ones. A recent article in *The Economist* noted how the pharmaceutical

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<sup>4</sup>Incidentally, the same concerns are expressed within the NHS PCTs and Hospital Trusts in the context of payment by results and patient choice, where poor outcomes resulting from treatment of high-risk patients will result in patients with choice choosing to go elsewhere (Mythen and Coffey, 2004).

industry was taking public relations advice from the tobacco industry (*The Economist*, 2004).

### **Market versus social values**

The use of commercial organisations may also result in a displacement of values. If future governments wish to remain committed to the core principles of the NHS as currently stated (Wanless, 2001), this mismatch should be addressed.

There are three areas of concern regarding values relevant to the state and future health policy. First, policymakers face choices between 'conflicting goods' in some regards (Maynard, 2005), and should understand why certain values are privileged over others (Williams, 2005). Second, even if values are explicit they are not always coherent (Greener, 2004). Third, current espoused values underpinning policy are not always reflected in practice. For example, increasing empowerment of the individual patient sits alongside a broadening and deepening of compulsion in the proposed Mental Health Bill in England.<sup>5</sup>

The value of choice is attracting particular attention. The private sector is seen to be central to this for increasing capacity overall and supporting more individualised care. A number of complex issues regarding values, however, are bound to arise. There is confusion about the meaning of 'consumerism' in health. Public services, of which health and social care are part, exist to fill 'market failures', and many entanglements with them are enforced differently to other services (for example, those subject to treatment under the Mental Health Act), or take place when things go wrong (Clarke, 2004). The corollary is that public services may not all be amenable to marketisation and a consumer orientation. Greener found, for instance, that people were 'bewildered' by the idea of choosing a GP and relied on their GP to select appropriate treatment for them precisely because of his or her expertise (Greener, 2003).

For markets to bring about choice and efficiency, patients need good information and the absence of dependency on particular providers. In practice, these conditions are not often met: information is often poor and/or poorly used;<sup>6</sup> patients have limited 'voice' and still more limited 'exit' options; and there are power asymmetries in patient–professional relationships. Greener (2003) argues that continuous 'reform' makes markets less calculable. Healthcare users' current priorities appear to relate to quality more than choice.

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<sup>5</sup> Comparing new and proposed mental health legislation in England and Scotland provides a neat example of several of these tensions, as the Scottish Act has accepted a lack of evidence and is based explicitly around values (Rushmer and Hallam, 2004).

<sup>6</sup> Findings from the US show that purchasers and consumers of healthcare, in general, do not use performance data in making choices (Page, 2004; Schneider and Epstein, 1998). The first explanation is that people simply do not have time to 'shop around' between needing help and accessing it (Hibbard *et al.* 1996). Other issues include comprehension problems (Vaiana and McGlynn, 2002), particularly with technical data (Robinson and Brodie, 1997); a generalised lack of trust in official data (Bentley and Nash, 1998), together with a tendency to prefer informal information (Mennemeyer *et al.*, 1997); fatalism (Hibbard and Jewett, 1997); and a lack of motivation to compare organisations due to the logistical constraints of lack of alternatives or distance from home (Schneider and Epstein, 1998). All these factors have serious implications for the success of the current choice agenda.

If erstwhile patients become consumers, the dynamic between citizen and state is potentially altered. This may be counter-productive in the context of limited resources and concerns about declining social cohesion.<sup>7</sup> Clarke (2004) argues that the 'consumer' represents an individualist, privatised relationship 'mediated by the anonymity and autonomy granted by the cash-nexus'. By contrast, the 'citizen' embodies a 'collectivist conception of rights or entitlements, solidaristic relationships mediated by political agencies and public institutions'. Neither is inherently right or wrong, but each forms part of a different political project and has different implications.

There is also a debate as to whether consumerism is possible (when considering system capacity) or even desirable to individuals (Greener, 2003); whether consumers are able to make 'appropriate' or 'reasonable' choices (Clarke, 2004); and whether the current concept of choice is so narrowly defined (DH, 2004b) that it will have little significant impact (Appleby and Dixon, 2004). Furthermore, health services are still provided within a rationing culture (Office of Public Services Reform, 2002).

## The state and the clinical professions

The state remains the largest trainer and employer of health professionals in the UK. A detailed consideration of the care workforce is given in Chapter 5, while this chapter focuses on whether and how the state should intervene in the practice and governance of healthcare. The state's relationship with health professionals is changing with the continued growth of performance management in the NHS. This is characterised by new regulatory mechanisms and explicit target-driven frameworks, which aim to ensure adequate levels of quality and performance and to hold individual organisations accountable within the NHS.

From the mid-1970s, there has been a diminution in medical dominance and autonomy within the NHS (and more generally). Greer (2004) would argue that this trend is less in evidence in Scotland, where doctors have maintained their status more successfully. Doctors have grown accustomed to practising within the 'biomedical model'<sup>8</sup> according to self-regulatory codes agreed by peers (Harrison and Ahmed, 2000). The powerful position they hold is derived from their control over diagnosis and treatment, evaluation of care, the nature and volume of medical tasks and their contractual independence. Expanded roles for management in the NHS, NICE guidance, the Health Commission and NSFs all reflect a changing

<sup>7</sup> Clarke gives a neat example of the privatisation of water, after which 'consumers' did not view it as their responsibility to use water 'responsibly' during a shortage, but blamed shortages on supply.

<sup>8</sup> The biomedical model is characterised by 'mind-body dualism' (assuming that the mind and body can be treated separately); a 'mechanical metaphor' in which a body is repaired like a machine; the 'technological imperative' which privileges technological interventions; reductionism, in that it focuses on the individual body as presented without considering wider social or psychological factors; and rests on the 'doctrine of specific aetiology', which describes the assumption that every disease is caused by a specific, identifiable entity (Nettleton, 1995). This has been challenged in terms of efficacy (McKeown, 1979), context (Engel, 1981), disease as a social construction (White, 1991) and 'professional medical dominance' as a socio-political project (Nettleton, 1995).

relationship between the state and the profession, as well as the patient and public (Ham and Alberti, 2002). The medical profession has also agreed to new (negotiated) contracts of employment, oversight by the Council of Regulation of Healthcare Professions, statutory re-licensing every five years and a National Clinical Assessment Authority to assess doctors' performance (Stevens, 2004). Ham and Alberti (2002) suggest that this entire movement towards performance assessment and greater public accountability has caused significant shifts in governance between all players within the healthcare system.

### *Clinical governance*

Clinical governance can be described as the 'system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (Scally and Donaldson, 1998). It links standards of care with organisational performance, and has promoted cultural change within NHS hospitals. In 1999 Chief Executives in the NHS became responsible for clinical standards in their organisations with the Duty of Quality set out in the Health Act of 1999, and individual clinicians became accountable to them for delivering quality care. Clinical governance reflects a fundamental change in powers and responsibility of managers and individual clinicians. Consultants are no longer autonomous individuals but have a mutual responsibility to patients with a trust. Views on the impact of clinical governance are mixed. Donaldson (Donaldson and Gerard, 1989) argues a positive effect. Degeling *et al.* (2003) suggest that current arrangements for clinical governance could be improved, for example by re-establishing 'responsible autonomy' for clinicians. Whatever the specific mechanisms, clinical governance seems likely to remain an important part of policy in future, and with it regulation and audit, as a means of holding both clinicians and managers to account for the quality of care.

### *Regulation and audit*

For future UK health policy there are two important questions: should the state intervene in the practice of medicine and, if so, how should it do so? On the one hand, the role of the state in ensuring efficient use of public money or better quality provision seems legitimate. Although measuring quality proves notoriously difficult (Klein, 2005), a recent study by Leatherman and Sutherland (2003) concluded that quality in the NHS was, on balance, improving. Their subsequent study (2005) remains positive overall, whilst identifying some 'areas of concern', suggesting that monitoring can contribute to improvement. Evidence of improved productivity is less clear (ONS, 2004a).

On the other hand, Clarke and Newman (1997) suggest that trends for greater state regulation of clinical activity have a negative impact on public services: organisations focus inward, reducing their capacity to deal with complexity and uncertainty, and rendering working across boundaries more difficult. There is recent evidence, for example, that NHS hospital trusts have been forced to spend considerably more than normal to purchase extra capacity from the private sector in order to meet end-of-year targets (Donnelly, 2004).

It can also be argued that increased intervention by the state has undermined professional autonomy (Ham and Alberti, 2002). In so doing, some argue that it has dissipated resources and made it more difficult for the professions to get on with their work (Maynard, 2005). Power (1994; 1997) refers to an audit explosion, and Walshe (2002) discusses 'inspectoral overload'. Regulation can be expensive. Walshe (2002) notes that, 'The costs of regulating the public sector in the United Kingdom in 1995 was estimated to be ... 0.3 per cent of public expenditure'. There are additional potential costs in terms of goodwill on the part of those being regulated and diversion of purpose, for example through the dysfunctional effect of performance management. Chapter 3 notes how target setting and regulation can create a tension for those working in the system between reconciling the interests of the patients and the demands of the system (*see also* Chapter 9).

If the state takes responsibility for protecting and promoting health, it has to find appropriate ways of doing so. If it is accepted that government has a role in regulation, the challenge for the future involves getting the structures and processes right. While the need to prevent overload and to ensure better coordination between different regulatory bodies has been recognised, the issue of perverse incentives needs careful consideration in the context of target setting. There may also be issues regarding developing goodwill amongst staff. Winstanley *et al.* (1995) note that shifting responsibilities requires ensuring that stakeholders are equipped for their new role. This is still a concern in the context of PCTs and their commissioning capacity.

## The state and the public

There is increasing acceptance (at least on the part of governments) that the state cannot improve the population's health without greater engagement and participation from citizens. This leads to notions of 'co-production' (Halpern and Cockayne, 2004) and the 'fully engaged' patient with 'rights and responsibilities' (Wanless, 2002).

Pierre and Peters (2000) identify what they term a 'fundamental paradox'. The public expects government to have control over governing while at the same time resisting that control, either in terms of overt resistance, or by the way in which citizens interpret their role in policy-making and participation. Pierre and Peters (2000) argue that this may not mean that the government is becoming less powerful, but instead that state and society are more tightly bound through the process of governance because of the decline of deference, for example, increasing complexity. Indeed, they suggest that states might actually be strengthened through this process: whilst ceding some power in policy formulation they gain more control over implementation having 'co-opted social interests that might otherwise oppose its actions' (Pierre and Peters, 2000).

This section explores two discernable trends in the relationship between the state and the individual: public and patient involvement in health policy, and the individual and state in public health. Again, such issues in the UK context are tightly bound to the close identification of health policy with the publicly-funded NHS.

## Public and patient involvement in health policy

Some attempts have been made in England to improve public input into healthcare services. These include Patient Forums,<sup>9</sup> patient representation on NHS boards and the election of boards for Foundation Hospitals. Whether these will prove effective remains to be seen (Newman, 2001), though there is little evidence to suggest much public interest in this sort of engagement.<sup>10</sup> Twenty per cent of locally-elected governors seats for foundation hospitals, for example, were uncontested (HSJ, 2004).

Florin and Dixon (2004) define public involvement as 'the involvement of members of the public in strategic decisions about health services and policy at local or national level'. They view this as distinct from patient involvement, which refers to 'the involvement of individual patients, together with health professionals, in making decisions about their own health care'. A further issue relates to determining who may be deemed appropriate representatives of the public, as 'lay people' and those able to represent the views of the 'general' public. (For a further discussion of public involvement, see Nolte and Wait, in press; Wait and Nolte, in press.)

Although input from the public is sought, how this input is integrated into decision-making remains a rather opaque process. Furthermore, as currently organised, these arrangements reinforce fragmentation of the system because they are attached to individual NHS organisations, rather than crossing boundaries.

This leads to an important question regarding whether public involvement actually creates shifts in governance within healthcare systems. Rowe and Shephard (2002) suggest that public involvement is an instrument to inform decision-making rather than a process that actually devolves power to local communities. Governments may use public involvement initiatives to contain criticism and unrest, thereby deflecting 'political heat' and giving legitimacy to otherwise unpopular policy decisions, especially in the field of rationing (Church *et al.*, 2002; Lupton *et al.*, 1997; Redden, 1999). There is evidence, however, that some public involvement models have evolved away from the 'top-down, paternalistic efforts to extract information from participants' of the past (Abelson *et al.*, 2004; Farrell, 2004; Nolte and Wait, in press). The success of public involvement is contingent on policy-makers' genuine willingness to yield power to the public and the public's genuine engagement in the health policy process. Many public involvement initiatives have been criticised for assigning to the public a reactive rather than a proactive role. Ultimately, managers and policymakers still hold the power to decide how to incorporate the public's input into decision-making in the NHS (Milewa *et al.*, 2002; Wait and Nolte, in press).

Too often public involvement policies are implemented without an explicit evaluative framework, thus precluding the possibility of assessing their impact or

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<sup>9</sup> For example, Patient and Public Involvement Forums replacing Community Health Councils, and making public involvement statutory in section 11 of the Health and Social Care Act of 2001.

<sup>10</sup> In an editorial for the *British Medical Journal*, Professor Klein of the London School of Economics said he believed Foundation Hospitals have been greeted by 'a wave of apathy from the public and their own staff' and that government plans to involve local people in the running of the hospitals have so far 'largely failed'. In his article, he cites the case of Bradford Teaching Hospital NHS Trust where less than 1% of the population voted for the governors (Klein, 2004).

achievement of desired objectives (Nolte and Wait, in press). For example, Crawford *et al.* (2002) conducted a systematic review of 337 studies of public involvement and found that only 42 studies (12%) reported the effects of involving patients in the development and planning of healthcare. They found that involving patients did contribute to changes in the provision of a range of services, although the effect of involvement strategies on the quality and effectiveness of services was more difficult to ascertain (Crawford *et al.*, 2002). Cayton (2004) has asked '[are we] engaged in a radical rethinking of the relationship between health care providers and the people who pay for them or are we just trying to use patient [and public] compliance to manage the system better?'

### *Individual responsibility, the nanny state<sup>11</sup> and public health*

In his review of UK health, Wanless (2002) introduced the idea of the 'fully-engaged patient', one who undertook 'health-seeking behaviour' and spent more time with a GP but less time actually ill. Full-engagement, according to Wanless, is also associated with lower healthcare costs overall. Again, there is a moral imperative and a pragmatic one. There are two distinct aspects to full-engagement: disease management and prevention.

Least problematic for the state is the accumulating evidence that a patient's engagement in the management of their own condition produces positive outcomes. The role of self-care in future UK health is considered in more detail in Chapters 2 and 3. For the state, however, this creates an incidental issue of boundaries and entitlements in terms of what counts as healthcare, social care, self-care, what kind of support is available to the self-carer and the informal carer, and who pays for what. This is especially relevant in the current English context.

The issue of prevention is politically more problematic. The fully-engaged patient will be expected to take more responsibility for maintaining their health, and the role of government will be conceived mainly in terms of addressing information deficit (DH, 2003; Kennedy, 2003; NHS, 2004) and building health literacy.<sup>12</sup> Libertarians would argue that this is only proper – individuals should have the freedom to pursue their own lives without interference from the state, as long as their actions do not harm others and resist the development of the 'nanny state'.<sup>13</sup>

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<sup>11</sup> Some question the negative connotations of the 'nanny' (Ashley, 2004) arguing that not all individuals are in the same social position to use information and act upon it, so some will need more help. In particular, it is affluent households who have freedom of choice as well as freedom to deal with the consequences of poor choice. Those who need help with debt, poor housing and poor diet may not see the 'nanny' in quite the same way. This is an empirical question about values and experiences. What is more, Navarro and Shi (2001) compared OECD countries, and found that 'political traditions more committed to distributive policies (both economic and social) and full-employment policies ... were generally more successful in improving the health of populations'.

<sup>12</sup> Health literacy can be defined as 'the degree in which individuals have the capacity to obtain, process, and understand the basic health information and services needed to make appropriate health decisions' (IOM, 2003).

<sup>13</sup> This debate can be reproduced in the entitlement to healthcare. It has already been noted that UK citizens have the right to healthcare free at the point of delivery. This is largely supported by the political elites and the citizenry, but arguments can be made for the 'rolling back'

Hill (1996) argues that it is legitimate for citizens to expect states to play a role in their health, but the state can hold individuals accountable for life-threatening behaviour, and protect society from incurring the consequences of others' behaviour. The state has the right to hold its citizens accountable when they face the consequences of their irresponsible behaviour. A Civitas paper (Bosanquet *et al.*, 2003) also makes a distinction between ill health that is unfortunate and ill health that results from 'irresponsible' behaviour. In terms of entitlement, it can be argued that UK citizens pay taxes and receive healthcare in return. Indeed, it is through social rights that the UK public define their citizenship (Conover *et al.*, 1991). Paton (2000), for example, argues that the tax-funded NHS relieves employers of any obligation to contribute to the healthcare of their workers, and Lister (2005) notes an absence of occupational health services in the UK.

Yet, an individual's health is not only an individual concern. It has ramifications for wider social networks and societies, both in terms of the costs of disease and the risk of infection (hence concerns about parents choosing not to have their children given the MMR vaccine). Nor is health exclusively about individual choice, but partly predicated upon community circumstances, for example, pollution and food preparation. Individual choice can be tightly constrained by powerful commercial interests or by circumstances of employment.

If UK governments are serious about improving health and meeting health targets (DH, 2000; 2004a), they need to be prepared to embark on more comprehensive strategies. The determinants of health are complex and varied (Monaghan *et al.*, 2003) and unevenly distributed across societies. (For more discussion, see Determinants of health in Chapter 9.) Individuals face different incentive structures (Halpern and Cockayne, 2004) and governments face conflicts. Health promotion, for instance, is not the only role of the state: for departments of government responsible for economic growth and employment, the manufacture and sales of tobacco (ASH, 2004), alcohol (Institute of Alcohol Studies, 2003; Prime Minister's Strategy Unit, 2004) and food, are beneficial. Typically, UK governments have been reluctant to introduce advertising bans, or to impose some product specifications if the item is legally available. Weak regulation is usually justified in terms of being appropriately liberal, but may also reflect the influence of commercial interests over public policy.

Protecting consumers from food-borne illness is politically unproblematic, and any government not undertaking such arrangements would be considered remiss. Yet, around 50–60 people a year die from food poisoning (Food Standards Agency, 2000). Somehow the inspection of meat is not a violation of libertarian values, yet the regulation of ready meals is. Similarly, it is estimated that 2115 people died from illegal drugs in 1997 compared with 5500 from alcohol in 2000 (ONS, 2004b). In addition, libertarian arguments possibly overstate 'lifestyle' factors in health status. The physical environment, social policy, housing, transport and education are all relevant to health (Yach, 2005).

Arguably governments should be prepared to act on behalf of their citizenry, because 'without minimum levels of health, people cannot fully engage in social

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of state-provided healthcare in order to provide better incentives to individuals to guard their own health. Socialised medicine, it is argued, spreads the risk, allowing feckless individuals to free-ride, whilst imposing constraints on the freedom of other citizens.

interactions, participate in the political process, exercise the rights of citizenship, generate wealth, create art, and provide for the common security' (Gostin and Bloche, 2003). If the key question is how the state can contribute to better health and wellbeing for its citizens, states need to be prepared to do some rethinking. They face two difficult issues: first deciding where to draw the line on state versus personal responsibility<sup>14</sup> and second which tools to employ in the latter case<sup>15</sup> (Abel-Smith, 1994; Gostin and Bloche, 2003; Wanless, 2003). Selection of policy tools has to be sensitive to individual circumstance and psychology (Halpern *et al.*, 2004). Different attitudes towards the future risks and 'deferred gratification', for example, can be extremely important in a health context, particularly when trying to change present behaviour to effect future health benefits (for example, forgoing smoking to avoid a heart attack in the future).

It is questionable whether a key role of the state is to provide a countervailing force to individualism and consumerism (which is not to argue that people should tolerate poor quality services at the whim of unaccountable providers) and to support a return to the more collectivist attitudes of the past (Pierre and Peters, 2000). The NHS – which forms such a central role in national consciousness – might be a vehicle in which increasingly different populations are brought together in common endeavour, with the possibility that health policy could be reconfigured to support coherence and equity.

### **Public health law**

There are additional concerns regarding the inadequacy of current public health laws (Monaghan *et al.*, 2003). Article 11 of the European Social Charter requires states to 'remove the causes of illness, prevent disease and advise citizens on how to look after their health' (Montgomery, 2003). The post of Under Secretary of State for Public Health was first created in 1998.<sup>16</sup> The interpretation of this function has been fairly open, with a role for local authorities who 'provide a variety of environmental health services aimed at protecting public health, ranging from pest control and noise pollution to the inspection and registration of food premises. Other local authority responsibilities such as housing, education, waste disposal, and the provision of sport and leisure facilities also have the potential to make a major contribution to UK health' (Yach, 2005). Despite its long history (Montgomery, 2003), there are still concerns that current public health legislation is inadequate, with no clear duties or specific responsibilities (Monaghan *et al.*, 2003).

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<sup>14</sup> These include fiscal and monetary interventions (incentives and subsidies), regulation, direct provision, participatory guarantees, R&D, information and education (Milo, 1986, quoted in Abel-Smith, 1994).

<sup>15</sup> Power to tax and spend, power to alter the informational environment, power to alter the built environment, power to alter the socio-economic environment, direct regulation of persons, professionals, and businesses, indirect regulation through the tort system, deregulation: law as a barrier to health (for example, laws restricting the sale or provision of syringes and needles).

<sup>16</sup> The Under Secretary of State for Public Health as specified in 1998 is responsible for cancer, coronary heart disease, tobacco policy, communicable diseases, immunisation, health inequalities, drug and alcohol misuse, and sexual health issues.

Under the European Social Charter, the UK state is obliged to provide care for the sick who are unable to provide care for themselves. 'This commitment does not require states to provide a comprehensive health service, as it only covers the treatment of illness, not health promotion, and extends only to those unable to purchase care privately' (Montgomery, 2003). Predating the European Social Charter, and only relevant to healthcare services, is the National Health Service Act of 1997 under which the Secretary of State for Health is bound 'to continue the promotion in England and Wales [Scotland has a separate Act] of a comprehensive health service ... and, for that purpose to provide or secure the effective services in accordance with this Act', ensuring the provision of, though not necessarily providing, services they deem 'appropriate', 'necessary' and 'reasonable' (McLean and Mason, 2003). For further discussion on public health, *see* Chapter 3.

## Conclusions

Pierre and Peters (2000) note that systems of governance always change. In general, states in the UK are making less use of coercive policy instruments, are deliberately courting and cultivating the private market, have restructured their own institutions to produce 'arm's-length' agencies and quangos, and have separated the policy and operational functions (Winstanley *et al.*, 1995). In turn, this has created a greater need for regulation and control, undermining traditional accountabilities (Day and Klein, 1987; O'Neill, 2002). The embedded role of the state in UK health policy is firmly established and likely to remain in the future.

Health policy involves choice between conflicting goods – two desirable but mutually exclusive choices. Trade-off decisions will always present themselves between the need to support economic growth and yet control healthcare spending, or the need to support the autonomy of citizens and yet protect a population's health. These questions go to the heart of the question of what sort of democratic society we wish to inhabit. There will always be a role for the state and elected politicians in health. The state will always have relations with players in markets, professional experts, devolved jurisdictions and citizens.

This chapter has discussed the emergence of the policy context of the UK and where it may be headed. Although much debate will depend on political persuasion, there is one vital area for development which is up to central government: to be steadfast in holding a focus on a system of health, rather than a health (care) system (Yach, 2005). This alone will create a huge agenda for bold choices and trade-offs between the parties discussed in this chapter.

## Policy recommendations

- The state should acknowledge it does and should provide a broad and values-based policy context for health as most of the risks to health fall outside the healthcare system.
- The state has a key role in setting the 'health' agenda beyond ensuring the provision of healthcare as cost-effectively as possible.
- Not everyone will become expert patients and literate in health, which will influence individual health status and needs to be addressed in policy.

- Commitment to market-based values as a basis for policymaking in a public healthcare system should be reviewed, particularly as this is associated with a social trend to move away from political, and, debatably, civic engagement.
- There needs to be greater clarification of the state's role in regulating the practice of doctors, including education and training.
- Regulation needs to be anchored within a robust system of intelligence designed to inform individuals and organisations with an interest in the performance of the system.
- A regulatory framework should look to the long term, and address:
  - individual choice and community and population concerns
  - the tax-funded system accountable to public and patients
  - the performance of healthcare professionals
  - the mixed economy of public and private sector providers.
- Mechanisms need to be developed for public involvement to address the accountability of the individual within the state system as well as any 'democratic deficit'.
- Real choice will depend on good patient information and the reduction of dependency on providers.
- Greater focus on individual responsibility raises questions about the role of the state in providing information to enable individual choice and in embracing policies to protect or promote health.
- More funding and time should be given to assessing the effectiveness of public health interventions and innovation projects, such as ensuring that the state has the power to protect the health of the public.

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