

Machines, markets and morals

The new politics of
a democratic NHS

Neal Lawson





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I'd also like to thank Anna Coote for spending time telling me that this should be about the prevention of health problems and a decisive movement away from the NHS as a sickness service. Anna is absolutely right, not least because a focus on resources around prevention would help equalise health inequalities. There is an excellent article on this by Anna on this in *Renewal* (Vol. 11, No. 3). But this piece of work turned into a political analysis about the democratisation of the NHS – a process which I hope

that will lead to Anna's vision of a service based on symptoms not cures.

This is essentially a political pamphlet aimed at getting the left thinking about the politics of public service reform. It is not a managerial treatise on health policy. It is about the underlying philosophy of the NHS in particular and public services in general and how we perform that difficult trick of pursuing 'traditional values in a modern setting'.

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Responsibility for the final words of course rests entirely with me.

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Executive summary

- After the financial ravages and upheavals of the Thatcher years, New Labour came to save the NHS. Huge improvements have been made over the last decade. By redefining staff and professional roles through Agenda for Change, developing new points of access through NHS Direct or walk-in centres, finding ways of involving staff and patients in more imaginative and better managed trusts and in particular massively increased funding the NHS under Labour has been saved.

- At least for now. The service faces huge social, economic and political pressures. Financial problems, closures, job losses, low staff morale and patient uncertainty about the quality and extent of service all add to an air of crisis about the service. The Tories are vigorously challenging Labour on its home turf.

- But Labour has a second chance to breathe new and lasting life into the NHS. Next year the NHS celebrates its 60th anniversary. Now it faces the opportunity of a new Prime Minister and a new political leadership. Gordon Brown has described the

NHS as his 'priority'. Alan Johnson, the new Secretary of State for Health, has announced a year-long review of the NHS under the leadership of Professor Lord Darzi and there are expectations of a new NHS constitution being published. Johnson has called it a 'once in a generation review' into the future of the NHS.¹

- But the opportunity is only valuable if it is taken. Initiatives like polyclinics may improve the service but there are more profound and structural issues that need to be dealt with if the NHS is to become a practical and political success for Labour. The establishment of 14 private sector companies, including US giant UnitedHealth, to take over the commissioning of the bulk of NHS services is a very worrying trend back towards privatisation.

- There needs to be a profound change of political and cultural direction, not just a change of personnel at the top. The predominant method of NHS reform, focusing either on centralised targets or the commercialisation of the service, has created a

The four broad methods of governance

CENTRALISATION

What: Targets, plans and regulation

Why: Important because it is the basis of equality; those who get the worst services would love a big dose of uniformity if it meant their services were raised to the standards of the best

How: As little as possible to ensure the maximum amount of equality

PROFESSIONALISM

What: Ethos, training, judgement and experience

Why: Because doctors, nurses and other staff have unique expertise and experience that will always be an essential ingredient of any successful programme of modernisation, and can work on long-term goals

How: As much as possible while ensuring it is accountable and responsive

DIVERSITY

What: localism, working with or learning from private and third sectors, organisational autonomy, challenge, contestability and choice

Why: Important for innovation and local involvement and freedom to experiment, to learn from best practice and from mistakes; localism also allows for setting of local priorities

How: As much as possible commensurate with the demands of equality

VOICE

What: Participation, democracy and co-production

Why: Because it is the only route to sustainable reform improvements

How: As much as possible, in all circumstances and at all times up to the point that citizens and workers want no more of it; care must be taken to ensure all voices are heard otherwise there can be a clash with equality.

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cocktail of fears about health inequalities as well as a host of unintended consequences and inefficiencies. It has led to the alienation of staff and widespread uncertainty among the public.

- Crucially, the long-term foundations for a reform and modernising agenda based on the enduring values of the left – equality, liberty and solidarity – have not yet been established.
- The improvements that have been made come in spite of the politics of centralisation and commercialisation, not because of them.
- That is because neither the market nor the central state machine can get to grips with the essential paradox at the heart of the NHS between our desire for equality and the need for diversity. We want the NHS to guarantee equal opportunity for health and wellbeing to all, but as pluralists we also want experimentation, innovation and local input from workers and patients. The two are at odds with each other. This paradox cannot be wished away but has to be managed.
- There are essentially just four types of governance decision that can manage the NHS. All are necessary, but what matters is the balance between them. The challenge for the new leadership of the NHS is to establish a framework in which the paradox of equality and diversity can be best managed between centralisation, diversity, professionalism and voice.
- The central argument of this pamphlet is that the management of the equality–diversity paradox is best executed through as much direct involvement as possible of the people who produce, create and use the service, to improve the service through voice, not just through exit.
- The democratisation of the NHS, using all the tools of voice, participation and empowerment, could revolutionise the experience of the patient and the efficiency of workers. In addition it could establish an even more popular basis for future support and funding of the NHS.
- But this requires, above all else, a shift in the culture of leadership of the NHS, away from the heroic CEO model of command and control (especially where it commands greater use of the private sector) towards a more collegiate, gradual but purposeful reform process that sees the design and redesign of the service based on the direct input of all the people who work in and use the NHS.
- The types of democratic reform that now need to be considered and trialled include:
 - * general practices to have annual general meetings of patients, and virtual notice and complaints boards, and the mutualisation of general practice services
 - * hospitals to be held to account through commissioning
 - * general practices and primary care trusts (PCTs), advised by the new health and social care regulator
 - * PCTs to be subject to local accountability through a range of possible measures like local council overview and scrutiny committees, the election of local health boards, the election of PCT CEOs, the merger of PCTs and local authorities, and the election of health regulators
 - * national governance of the NHS through citizens' juries with binding decision-making powers; the implementation of a NHS charter or constitution decided by the public, patients and workers
 - * the mainstreaming of co-production throughout the NHS and the development of methods such as self-directed teams to ensure that staff and the public are consistently and coherently involved in the design and redesign of health services.
- If the democratic impulse is not applied to the NHS then we will experience another round of reforms that turn everyone in the service on their head once again – with little if any discernable impact on service improvement. After its heydays in

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the 1950s and 1960s the NHS has first been pummelled by the wave of neo-liberalism that swept the country after 1979 and then by the disorientation of targets, further re-organisation and commercialisation under New Labour. The next looming threat is David Cameron's vision of there being such a thing as society but it not being the same thing as the state. The new Tories will claim that the statist NHS is too cumbersome and centralised. And they will have a point. But their response will be to break it up and fill the gaps with the third sector and more of the private sector. But this will decisively undermine the NHS as a vehicle for the collectivist and egalitarian instincts of the

left. Labour must take this last opportunity to get the politics of the NHS right – that means democratising it.

- A report from the Department of Health in October 2007 on the health profile of the nation showed that more people consider themselves to be in poor health than when Labour came to power in 1997, and the inequalities between the north and south of the country are wider than ever.² State intervention to redistribute and equalise life chances is what the NHS exists for. Neither the market model nor the machine model can achieve this goal.

Introduction

Why should I write about the NHS? I'm not a doctor, I'm not a health specialist and I've rarely ever used the NHS (touch wood). The reason is that the NHS is probably the most politically important public service institution for the centre-left.

Comprehensive secondary schools run the NHS close but have yet to find the same place in the nation's heart as the NHS. The NHS is seen by the overwhelming majority of British citizens as 'the most valuable institution for this country' – far more important in this regard than Parliament, the police, the BBC or the Royal Family.³ The NHS is one of the institutions in which the values of the left – those of equality, liberty and solidarity, and the resolution of the tensions between them through democracy – are protected, sustained and embedded in our society. This pamphlet is about how the NHS functions in relation to those values now and how it might function better in the future.

Those who support the principle of the NHS as a force for equality and solidarity have been on the defensive for more than two decades because of a perceived resistance to modernise. The issue is not whether we want to reform and modernise but whether change can be managed in a way that is aligned with left values.

We live in an age of autonomy but the NHS was conceived in a world of deference. By that I mean people now want to be able to express and act on their desires and beliefs. The end of the era of deference means people are much more likely to want to self-manage their lives, at work, home and through the state and civil society. But there are different means by which the demands of this age of autonomy can be met: either by feeding consumerism or by deepening social citizenship. The two are not always irreconcilable and clearly both have a role. But is it our roles as consumers or citizens that the NHS should primarily champion and nourish?

In researching this pamphlet I spoke to a lot of people. Perhaps the most poignant discussion was with Paul Corrigan, the then health policy adviser to Tony Blair in Downing Street. To give what I hope

is a fair caricature, our debate revolved around my concern about individual choice and Paul's insistence on encouraging it. On reflection both positions feel like nightmares. The NHS cannot be either a stifling bureaucracy or a rampant free market. The reality, as I hope to show, is that New Labour's reforms exhibit some of both tendencies – both a machine to control and a market to foster competition – and that they combine in rather unhelpful ways.

New Labour should be praised for addressing the historic under-funding of the NHS and taking spending to record levels. The fact that all parties now talk about investment in public services before tax cuts is perhaps the major political victory for the left since the 1980s. There are 20,000 more consultants and general practitioners (GPs), 70,000 more nurses, and more than 250,000 new NHS staff overall since 1997. Neo-corporatist processes like Agenda for Change have helped manage staff engagement and morale during difficult negotiations over grades and structures; 118 new hospitals have been opened or rebuilt; waiting lists are down; and some services like cancer treatments have been transformed.

But the tragedy is that this record investment in staff and infrastructure might be squandered because of ill thought through, wrong-headed and often conflicting reforms. Somehow New Labour has managed to spend record amounts on the NHS and commit huge amounts of energy and political capital to it but still emerge, at least temporarily, behind the Conservatives as the party best placed to run this national treasure. In part this pamphlet tries to explain the chasm between political action and public perceptions of the success of investment and reforms of the last decade.

The latest polling evidence from Ipsos MORI tells a sorry but highly contradictory tale. When asked whether the NHS is going to get better or worse over the next few years, 33 per cent of respondents think it will get worse. Only 2 per cent think it will get much better while 13 per cent believe it will get much worse.

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In terms of satisfaction with the job the government is doing overall there is a net dissatisfaction rating of 36 per cent. But when asked what people think about the local NHS provision, 47 per cent are satisfied. If you ask people whether they were satisfied with their last hospital visit the figure jumps again, to 62 per cent. And satisfaction rates of local inpatients have risen from 65 per cent in 2003 to 80 per cent for the most recent Ipsos MORI figures. If everything has gone so right why does it feel that it has gone so wrong?

Those who work in the NHS or know someone who works in the NHS like the service less than other people do

Healthcare remains at the top of the political agenda, just behind crime as the nation's number one concern. 59 per cent think the NHS is one of the best health services in the world and 74 per cent think that 'The NHS is critical to British society

and we must do everything we can to maintain it'. Incredibly, though, the Tories have enjoyed a 4 per cent lead over Labour as having the best policies on the NHS – despite the fact that they don't really have any policies for health. That has now changed since Gordon Brown has taken over – someone viewed as less enamoured of the quest to commercialise the NHS and more likely to manage it effectively.

New hospitals, more staff and some better performance has clearly lifted people's experience of the service. But there is a massive disjuncture between local experience of success and national perceptions of failure. The improvements that have been made are largely to the result of the huge increase in investment and the hard work put into modernisation by staff and professionals at all levels of the service. But these performance and investment increases are now set to tail off. There is widespread confusion about trust deficits, ward and specialism closures, job losses and local campaigns against cuts. Morale among staff from managers to consultants, junior doctors, nurses and ancillary staff is at rock bottom. Some workers like midwives

are incredibly angry at being over worked and under valued.

Ipsos MORI figures show that those who work in the NHS or know someone who works in the NHS like the service less than other people do: 36 per cent of those who don't know anyone working in the NHS are satisfied with the service; 25 per cent of those who know someone who works in the NHS are satisfied; and only 14 per cent of those who work in the NHS are satisfied. If you are a nurse then your £20,000 salary is 25 per cent more than you got before 1997 but it won't get you on the housing ladder. Doctors are fed up with being told what to do. Support staff and ancillary workers have seen their work outsourced and been told that they and their unions are dinosaurs who are unwilling to modernise.

You cannot rebuild or properly modernise any institution by demoralising the workforce or by positioning every reform as being against them – 'them' being essentially Old Labour, which New Labour continually defines itself against. Increased pay has helped, but GPs are one of the most negative groups despite their large pay increase. What motivates health professionals at all levels is not just pay but doing a job well in a service they believe in. Happy staff produce happy patients.

It's not just in the polls that the people are revolting. Out on streets people are taking action. Thousands have marched and formed human shields to stop closures. Tens of thousands have signed petitions. All of this is being exploited by the Tories who now claim to be the party of the NHS.

Competing views of the state; competing views of the citizen

The huge tail wind of 1997 in favour of investment in public services is in danger of turning against the left unless a qualitative leap in the substance and style of health provision can be created. The money and good will is drying up. Improvements based only on providing extra funding or creating top down targets are unlikely to be the driving force for perpetual and long-term modernisation of the NHS

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in tune with left values. But a new Labour prime minister, the Darzi Review and the 60th anniversary of the NHS provide an opportunity to think afresh and learn the lessons of New Labour – the successes and the failures – to build a health service that is both new and Labour. The process of modernisation cannot stop but it must be in tune with Labour's core values of equality, liberty and solidarity. The stakes are now very high. This is not just about whether New Labour or the Tories will win the next election, important as that is, but whether we can modernise the NHS and more broadly our public services in tune with the values of the left. The public are unlikely to give us another chance.

The central belief of the right is that people have both the propensity to be individualistic, selfish and greedy and that these are the most appropriate forms of behaviour

New Labour's claim has been that only its particular method of increasingly commercialised reform will save the public services in general and the NHS in particular. The other two parties would in essence go further and faster in the same direction of travel. The argument in this pamphlet is that

other potentially more successful methods of reform are still available. New Labour has adopted an aggressive form of new public management, which sees the government primarily as a service commissioner and people as consumers. The role of the state is to facilitate delivery through increasingly autonomous vehicles whether private or third sector, to cut costs, increase efficiency and provide choices, albeit in limited form, for consumers. This model is counterpoised to the 'old' centralised state model based on top-down control that was viewed as too costly, inefficient and insufficiently consumer friendly. This is the 'supermarket state' triumphing over the 'corporatist state'. Neither will do.

Behind these competing views of the state are competing views of the good citizen. On the right good citizens are autonomous individuals pursuing their own rational self-interest. This version of the

good citizen is law abiding and bound by 'duty' but is not obliged to interact. On the left the good autonomous citizen not only has a much greater awareness of and commitment to social and political activities but believes that we are made better citizens through social interactions. But the left has traditionally viewed citizens as too passive in its rather paternalistic view of reform from the top.

But this debate takes us to the heart of the NHS as a key institution of the left where competing views of human nature either take root or wither. The central belief of the right is that people have both the propensity to be individualistic, selfish and greedy and that these are the most appropriate forms of behaviour, which need to be encouraged through the institutions that right wing politicians either build or destroy because they are too solidaristic in intent. The left on the other hand champions the values of cooperation, care and compassion. The truth of course is that we are a mixture of both character types – individualistic and socialistic, greedy and generous. We are born with certain traits and characteristics and are socialised into certain behaviour patterns, beliefs and values. There is little we can do about our particular DNA but there is a lot we can do about the way in which we are socialised as we pass through key institutions like the NHS.

The value of the NHS is not just its instrumental worth – does it make us healthier? Of course this is vital but it is a necessary not sufficient component of a reform agenda. There has to be a moral underpinning too. The difference between left and right is that we see the intrinsic worth of an institution like the NHS because of its capacity to build and foster social citizenship and the egalitarian spirit that goes with it. It is the moral underpinning of the NHS that can re-enforce public commitment to it and so increase its instrumental performance. Our goal must be the creation of a virtuous cycle of experiential and emotional commitment to key public institutions like the NHS.

The Thatcherist view of social institutions and New Labour's response

The right understand the key role that institutions play in shaping the political agenda. Mrs Thatcher

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Whatever imaginative attempts are made to argue that some ideal version of the market could actually redress such inequalities, all evidence and analysis shows that the actually existing health service market being created by New Labour is likely to exacerbate the terrible social injustices of unequal access to health care and unequal health outcomes

once famously remarked ‘Economics are the method, but the objective is to change the soul.’⁴ What she was advocating was a form of social and political engineering; that through the use of the economy and the reform of public institutions she would help shape people in her preferred image as possessive individuals. The economic means was privatisation of nationalised industries, council housing and public services to create more privatised and less socialised people. The economy would be shaped and developed in a way that encouraged competition and choice and therefore

individual advancement over collective needs. Thatcherism believed that people could only advance when the burden of the state was lifted from their back. In this way Thatcherism and its neo-liberal creed set out to shape society in their image by building institutions that encouraged beliefs and behaviour that fitted their view of the good society and the good life. By taking people to the market, rational choice theory would become the daily habit of the population. The market allocates everything, values everything and directs everything. Freedom, or at least its market variant, would be forced on to the people.

New Labour has given a contradictory response to Thatcherism in its view of social institutions like the NHS. It came to save the state by modernising its processes and investing in it. Unlike Thatcherism,

New Labour believed in the active role of the state to help people survive and thrive in the global economy. But the nature of global competitive economy and the stringent demands it makes on nation states, governments and societies was never questioned by New Labour. Indeed it was actively embraced.

Tony Blair wrote that ‘complaining about globalisation is as pointless as trying to turn back the tide’.⁵ In this sense New Labour presented itself as a form of enlightened neo-liberalism or perhaps more succinctly neo-Labour. By accepting the rules and the end point of the global economy New Labour also accepted the means; this overwhelmingly meant the values and process of the market in the form of competition, choice and consumerism. As such New Labour is fatalistic about the context in which we find ourselves. Alan Milburn, the former Secretary of State for Health, said ‘Like it or not, this is a consumer age.’⁶ Such fatalism then directs political strategy as Milburn later went on to argue in an article for the *Guardian* that unless Labour made public services more like the market first, the Tories would just do it on their terms. So Labour members and supporters are left having to support policies the Tories would have enacted .

What are we creating, citizens or consumers?

But the ideological question is: What are we creating, citizens or consumers? This is the central rift within Labour’s rank; between those who think that essentially it is the values of the market that can save the public sector and in particular the NHS, and those who think that individualistic means cannot create what is essentially a service of solidarity. Both sides would argue that they are remaining true to the mantra of ‘traditional values in a modern setting’. The Blairite view is that we must accommodate to the modern setting of the consumer age and global markets, without betraying traditional values, which in the case of the NHS rests on being ‘free at the point of need’ and paid for out of general taxation. But ‘free at the point of need’ is a necessary but insufficient slogan for the NHS if the values and culture of the service are

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being undermined by a mix of markets and overbearing centralism. The soothing mantra is being broken de facto if not de jure. Prescription and now dental charges mean there is no line in the sand. As social care is taken down the route of individualised budgets, co-payments and top ups are bound to feature. Under an increasingly commercialised NHS the determination of what is provided 'free' and at what 'point of need' and therefore for whom has become gradually more and more distorted through growing health inequalities. Work by Danny Dorling shows that the relative gap between the mortality rates of infants in the different social classes and life expectancy rates among upper and lower social classes is widening.⁷ Whatever imaginative attempts are made to argue that some ideal version of the market could actually redress such inequalities,⁸ all evidence and analysis shows that the actually existing health service market being created by New Labour is likely to exacerbate the terrible social injustices of unequal access to health care and unequal health outcomes.⁹

The argument of this pamphlet is that means always shape ends and that we must stop running from market forces and start building an alternative model of personalised, responsive, efficient and democratic public services, starting with the NHS. By deploying the processes of choice, competition and consumerism, what you end up with looks and feels more like the market than a democratised state. Then we breed only selfishness and cynicism. New Labour's strategy is akin to the GIs in Vietnam whose approach was to 'burn the village to save the village'. Even on strict instrumental grounds there is little evidence of success when it comes to greater efficiency.

In rejecting the old centralising state we don't have to accept the market as the only alternative. If we do, then we corrode the purpose of politics itself. If democracy is not for a higher social good, then what is it for? People start to switch off. It is no coincidence that the high water mark of electoral politics in the UK matched the high water mark of equality in our society. We can't debate tax anymore for offending Rupert Murdoch and the *Daily Mail*

and therefore will find it impossible to sustain high investment in the NHS. So spending declines or relies on private finance initiative. Both re-enforce a sense of political disconnection and the ratchet slips another notch tighter. The danger is that a vicious cycle is created whereby politics close down and we are left with competing technocrats arguing about who can best manage public service delivery through a hybrid system of commercialisation and centralisation.

New Labour has taken a huge gamble with the NHS. It thinks that an instrumental, individualistic and mechanical view of reform will bind in the middle classes and show that all the investment is paying off. But the evidence and public sentiment is beginning to run against the government. Cries of more time and more reform – worryingly close to No Turning Back – inspire less and less confidence.

The key problem is the mix of commercialisation and centralisation. This view of the NHS as part machine and part market denies the possibility of self-sustaining reforms in which professions, producers and users are key. Instead we should look at the NHS and our requirements of it as essentially paradoxical. There are tensions within the NHS, primarily between the desire for diversity and the need for equality, that cannot be solved – only better managed. The tensions emerge when cabinet members campaign locally against hospital cuts that are the product of decisions made round the cabinet table and in the anxiety caused by the availability of drugs like Herceptin in one postcode but not another. The pamphlet therefore describes ways in which four governance tools – professionalism, commercialisation, centralisation and regulation, and most importantly participation – can create better outcomes and sustainable improvements in the NHS.

I came at this whole issue thinking a new blueprint for the NHS could be applied and the problem could be fixed. I know now this is clearly impossible. What matters are the processes, spaces, practices and institutions through which all NHS stakeholders can own the debate and determine the

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direction of this enormous, complex and priceless public service. Means always shape ends – that is why democracy and socialism are two sides of the same coin.

The pamphlet starts by contextualising the NHS within the market society in which it operates. The second chapter critically analyses the machine

model that has dominated NHS thinking; the third chapter is on the market model and the commercialisation of the NHS. The final chapters examine the NHS as a paradox and the democratic means needed to manage this contradictory, difficult but hugely significant beast in a way that maintains its political role and values but modernises its approach.

The NHS as a political entity

Between two rights force decides

Karl Marx¹⁰

To understand the politics of the NHS we must understand the context it operates in. The reason why the left supports the NHS is that the principles that underpin the NHS are those of the left. It aspires to treat everyone equally on the basis of need, not ability to pay. It is an institution that provides collective insurance against ill health and therefore is a site of social solidarity. Its professionals and staff work not only for personal monetary reward but from the sense of pride and purpose that comes from serving the public good. And, nominally at least, it is controlled and managed democratically by us through the state. As we will see later, the reality of an undemocratic, bureaucratic and rather paternalistic NHS has proved to be its weakness in changing times.

The NHS by definition is not owned privately. It is not run for a profit. The products and services are not commoditised for individual payment and private consumption. There is only a limited market for health care with providers such as BUPA and private nursing homes, and the market for cosmetic surgery and alternative medicines which is growing fast. But that doesn't make the NHS wholly public. The NHS is not purely anything. It was founded on the ideals of the left but does so as a bubble or bridgehead within a broadly capitalist society where the values, practices and institutions of the market are dominant.

Mike Prior and Dave Purdy have described the conflict between the egalitarian and collectivist 'socialising factors' of the NHS with a market society that dominates and contains it as 'the most fundamental principles of social organisation and action ... locked in combat'.¹¹ Crucially general practices remained private small businesses and consultants retained the right to practise privately. Public health policy remained vulnerable to the distorting influence of an expanding and increasingly powerful private pharmaceutical industry. An uneasy compromise with private interest was therefore part of the NHS DNA. The funding of the NHS depends, in part, on the performance of the capitalist economy and it is income

and wealth inequalities that largely determine inequalities in health.

The NHS is not just a creature of the largely capitalist economy in which it was created but was also a creature of its time. The dominant model of public administration in 1948 was a centralising cocktail of Fabiansim and Leninism. Aneurin Bevan wanted a regional model for the NHS to increase accountability but much like today none was available. So it took on the form of a top down and therefore centralised bureaucracy.

The NHS like most political entities was and is a pragmatic fudge. It reflects the competing ideological forces of political interests of the day. It is a paradoxical and contradictory entity; founded on values of equality and solidarity but operating in a capitalist economy.

Capitalism is a restless and dynamic beast. It does not sit still but endlessly searches for new places to make profits. Whether it retreats or advances depends on the strength of its ideas and forces compared with those of society. The forces can balance out and then we live in relatively harmonious circumstances. But this never lasts. The search for new profits from 'common goods' like public services means the market will try to find a way to commoditise those services or products.

If we understand the relationship between the market and society as one of an evolving and fluid contest between competing public and private sets of forces, institutions and values then the NHS becomes a prime site of political contestability. Below the surface calm our world is shaped in large part by the ebb and flow of the interests of markets versus the interests of society. Often those interests can coincide, but not always.

The NHS was a product of the socialising wave that swept the globe in the middle of the last century. After the horrors of mass wars and the depression years of the 1930s the forces of social advance held the upper hand. Intellectuals, like Keynes and Beveridge, illuminated the way and showed that not only could capitalism be managed in the interests of society but also institutions could be founded that provided an alternative to the market. The growing and vociferous

The NHS as a political entity

working class, organised through the trade union movement, provided resources and electoral strength. And the Labour Party acted as the political wing of that movement. The market was in retreat and had to accept a new settlement with these socialising forces, which led to the mixed economy of the post war years. The forces of the right had also seen what had happened in Russia and knew they had to concede ground to 'buy-off' the working class in the West. The jewel in crown of this post-war settlement between the market and society was the NHS.

We should remember though that the very notion of public services are not a twentieth-century social democratic creation but Victorian. These early high priests of capitalism understood that the business world could corrupt politics and society just as the political and social world could corrupt that of business. What was needed was a balance between the two. Indeed when it came to issues like sanitation and the mobilisation of mass participation in the workforce or for war, their enlightened self-interests led them to the path of municipalism and public services.

But times and social forces change. The market is once again on the front foot. In part this is because the top down welfarism of the post war years, including the NHS, lost democratic legitimacy and was therefore always vulnerable to renewed attack by the market. The failure to adapt to new times and new demands opened the door to the already growing ideological revival of the right in the guise of free market neo-liberalism.

The setbacks suffered by the organised working class and the intellectual disarray on the left – following the absolute collapse of socialism in the East and its relative decline as a reformist force in the west – meant there was no counter charge to defend public goods like the NHS. According to David Marquand, 'On strict neo-liberal assumptions, the NHS was ... unashamedly collectivist, not to say socialist: it was run by professionals whose ethic ran counter to the shibboleths of the free market.'¹² The right hate the NHS because it treats people as equals not as rational choice makers, because people are treated on the basis of need not wealth, and most of all because it is a

challenge to their fundamentally held belief that competition and individualism is better than cooperation and collectivism. In the battle for political ideas and institution, the NHS is an arrow aimed at the heart of neo-liberalism.

One of the problems of the old NHS is that it was based on a purely mechanical notion of reform. Its value was instrumental. Either it did the job or it didn't

But the NHS was, in the words of Nigel Lawson, close to being 'a national religion'. It meant that Mrs Thatcher, she of There Is No Alternative, or TINA, had to admit that 'the NHS was safe in her hands'. She trod carefully. There would be no wholesale privatisation. Instead she snipped at the edges

with the contracting out of ancillary services while only dentistry was effectively privatised. Eventually the purchaser–provider split was introduced and with it the creation of an internal market and the beginnings of shadow or quasi market to try and make the service more cost conscious and responsive. She also starved health of funds. This led to a deteriorating service, low morale among staff and a flight to the private sector by those who could afford it. The notion of the NHS as a contradictory entity was therefore further embedded.

How and where to corral the forces of the market in the interests of society

The issue for the left is always how and where to corral the forces of the market in the interests of society. The central problem of New Labour was not the feasibility to manage capitalism more effectively but the desirability of such a challenge. The central tenet of New Labour is that the forces of globalisation are to be adapted to, not managed and regulated for the good of society. Once we give up this central political struggle then the unconstrained market floods into every corner of the once public realm. Alan Finlayson, a particularly astute observer of New Labour, has written, 'The space between the private activity of market exchange (self-oriented and instrumental in its approach to the

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world) and the public activity of society-making (other-oriented and ethical in approach) is becoming lost. Society as a whole needs the dynamism of selfish market activity, but if left unconstrained this has corrosive effects.¹³

One of the problems of the old NHS is that it was based on a purely mechanical notion of reform. Its value was instrumental. Either it did the job or it didn't. As such New Labour is much like Old Labour based on the concept of 'socialism is what Labour government do' or in the modern vernacular 'what works'. But 'what works' is a moral question. Who defines 'what works'? Works for whom and how? For the interests of society, the market or the individual? Now or in the future? The left never placed enough value on the morality of the service or the reform process. This is the intrinsic value of being served as an equal, through the forces of solidarity and democracy. We forgot or never realised that such values could be not only be more 'efficient' but could also make us feel better about our lives and our place in the world.

If form follows function, and the function of the NHS is to make people well regardless of their wealth, then the form the NHS should take should be different from profit-maximising enterprises. Walking into an NHS hospital or a community health centre should feel uplifting – like walking into a cathedral or chapel. The NHS is a very special social space. The oxygen, the ambience, the culture should feel different from the high street. Unless it does it will be judged on the same instrumental grounds of consumer style satisfaction.

Too often, though, the reality was that patients didn't feel special or equal. They might not have to worry about paying the bills like they did before 1948, but the NHS failed to engage them as citizens. It was too bureaucratic and paternalistic. But it was the absence of a moral case for the welfare state that precipitated its decline in the 1970s. If institutions like the NHS are only valued on the narrow basis of what works then what happens if for some reason it stops working? If there is an external economic shock like an oil crisis or rampant inflation then there is no public support to fall back onto – no other value or reason for its existence.

The politics of 'what works' always begs the question: What happens when things don't work? This is what happened in the 1970s and resulted in the death of the post war settlement and the rise of neo-liberalism. If we don't want to repeat that era then the moral case for society over the market needs to be put. Of course the NHS has to provide a brilliant service but not only is that not enough, we must also make the case that a brilliant service can only be based on the values of equality and solidarity and organised in a way that is in tune with such values. The NHS can only be brilliant on terms that embed long-term legitimacy and popularity. Neither the machine model nor the market can do this.

The limits to the scope of the market in the NHS

In a speech to the Social Market Foundation (SMF) in 2003 Gordon Brown quoted the economist Arthur Okun as saying 'the market needs a place and the market needs to be kept in place'.¹⁴ It is worth going back to this speech in some detail as it spells out why, for the left, there should be limits to the scope of the market in the NHS. In the speech Brown said:

In healthcare we know that the consumer is not sovereign: use of healthcare is unpredictable and can never be planned by the consumer in the way that, for example, weekly food consumption can. So we know ... that the ordinary market simply cannot function and because nobody can be sure whether they need medicinal treatment and if so when and what, individuals, families and entire societies will seek to insure themselves against the eventuality of being ill ... that in every society, this uncertainty leads to the pooling of risks.

Take the asymmetry of information between the consumer as patient – who may, for example, be unknowingly ill, poorly informed of available treatments, reliant on others to understand the diagnosis, uncertain about the effectiveness of different medical interventions and thus is not sovereign – and the producer'.

With the consumer unable – as in a conventional market – to seek out the best product at the lowest price, and information gaps that cannot – even over

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*the long term – be satisfactorily bridged, the results of a market failure for the patient can be long-term, catastrophic and irreversible. So even if there are risks of state failure, there is a clear market failure.*¹⁵

Brown went on to describe the features of the NHS that make it difficult to commercialise, namely:

- the need for guaranteed security of supply, which means that, generally, a local hospital could not be allowed to go out of business
- the need also for clusters of mutually reinforcing specialities (trauma, pathology and emergency medicine for example)
- a high volume of work to guarantee quality of service
- the economies of scale and scope making it difficult to tackle these market failures by market solutions
- and – as the US system has also demonstrated – the difficulty for private sector contracts to anticipate and specify the range of essential characteristics we demand of a health care system.

He summarised that in health:

- Price signals don't always work.
- The consumer is not sovereign.
- There is potential abuse of monopoly power.
- It is hard to write and enforce contracts.
- It is difficult to let a hospital go bust.
- We risk supplier induced demand.

But the enlightened progressive economic analysis of Gordon Brown or anyone else, while a necessary starting point, is not sufficient to hold back the advancing tide of the market. Huge private profits are at stake from the commodification of NHS services. Against the backdrop of the perceived superior logic of the market – that inefficient organisations fail while the efficient succeed – the floodgates to the commercialisation of public services like health and education are being pushed open. It is not just theory

that closes these gates but active and organised countervailing social forces and interests.

The iconic status of the NHS and the barrier of democracy

There is a further big political problem that has implications for the NHS and those who work in it and rely on it. As politicians withdraw from the big decisions that shape our society – about the relationship between the market and the state – because they feel there is nothing they can or should do about regulating global capitalism, they focus instead on what they feel they can do to both justify their high position and to exaggerate the managerial distinction between themselves and their political opponents. So the management of the NHS is analysed, reviewed and reformed again and again. For New Labour and its attachment to modernism the urge to quicken the pace of renewal by a constant critique of what exists is irresistible. Good or bad, what matters is showing who is 'in control' of the modernisation process being enacted and then re-enacted. It is a permanent revolution of upheaval on which no lasting basis of reform can be laid. Anna Coote has explained the importance of the NHS to us in these terms:

*The NHS has taken on an iconic status – in the eyes of government and electorate – as politics have become less readily defined by ideology. We may not want to believe in the market or the state any more, or in socialism or capitalism, but it seems we can all believe in the NHS. It defines and unites us as a nation. It shows that we can all pull together and look after each other, but it does reassuringly practical things and does not threaten existing power relations. Very tempting, then, for ministers and prime ministers (whatever their political complexion) to pin their colours to the NHS mast, to promise to rescue and improve it, and to ask to be judged accordingly – without looking beyond the mechanisms of service delivery.*¹⁶

Have we gone beyond the point of no-return? Are the values and institutions of the society so weak, demoralised and incoherent that there is no defence against the market? The final barrier is democracy itself. Democracy has flourished in an era not just of amazing

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economic growth but huge advances in equality. This is no coincidence. Equality as voting citizens only has any meaning if we are relatively equal in economic and social terms as well. The high point of democracy – as measured by electoral turnout in the 1950s and 1960s – matched the era when Britain was the most equal it has ever been. As Britain has become steadily less equal – as a direct consequence of the spread of the market – democracy itself has lost its value. What is the point of voting if all parties converge around a largely neo-liberal agenda that leaves too many in greater relative poverty? It is not just the frontiers of the state that the market wants to roll back but the frontiers of democracy itself. In the market you can vote with your trolley everyday for what you want as a consumer. The march of the market means that democracy itself is being brought into question if there are not enough common bonds to sustain the purpose of democratic action. The NHS is an institution that makes democracy worthwhile – but in turn requires a healthy democracy to sustain it. Zygmunt Bauman, the eminent sociologist, has written: ‘Without collective insurance, there is no stimulus for political engagement – and certainly not for participation in a democratic game of election.’¹⁷ The exodus from politics becomes almost complete as local solutions cannot compensate for global problems. John Gray encapsulates the downward spiral when he writes ‘We lack the common values that would allow a collective choice to be made on the boundaries of the market. In these circumstances, the idea that public services will be improved by the introduction of market forces is practically irresistible, for it trades on one of the few common values to which we cling – the sanctity of consumer choice.’¹⁸

The depth of the retreat is made clear by the former Labour health adviser and academic Julian Le Grand: ‘As a public sector professional myself, I would far prefer to work in the context of a quasi-market than under the dead hand of command and control.’¹⁹ We should refuse to accept such a false and unedifying dichotomy as if it’s some simplistic forward or backward choice we face – where forward means swallow the market and backward means be a dinosaur. There is more than one route to the modernisation of the NHS. We can decide to move on from the past without accepting the

straight jacket of globalisation, commercialisation and quasi-markets.

To restate: the issue is not one of absolutes, the market or society but of finding a better balance between the two. Markets don’t volunteer balance – they just take. Only a democratic society can determine where the points of balance should be but it needs to tools and forces to do so. How can we effect a balance between the dynamism of the market and the needs of society? This does not preclude progressives using the market. Ken Livingstone took the brave decision through congestion charging in London to show that the market can be used for progressive ends, as it potentially can for carbon trading. But what is important is that the market is not enshrined as a matter of doctrine and dogma and that there are the means to correct its failures and circumscribe its application.

The point is that we have to be constantly on our guard attending to the vitality of non-market spaces through the values, institutions and tax base to pay for them. But to do this we must value the kind of public realm the NHS represents. That is tough when the fortress of the public realm has become too undemocratic, unresponsive and unaccountable. But the answer is never less democracy, but more!

How institutions shape political preferences and desires

What the centre-left has to understand is the importance of institutions in shaping political preferences and desires. These are the sites in which politics is played out. Their nature, form and purpose shape and determine the political battleground. Politicians through the ages have been aware of this. The Fabian view was that public administration builds socialism. And so it did in its day. Only the mass, bureaucratic, centralising and paternalist Fabian model ran its course some time ago. There is no turning back. Thatcher insisted on a new model – that of the market. Civil servants under her jurisdiction famously remarked that whatever the question the answer was always the same – create a market. The market is the institution of the right. In part the argument is about efficiency – but only the bean counting efficiency of profit. Markets sort the

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winning wheat from the losing chaff. But the market case for efficiency is a profoundly anti-democratic project. Markets work best by closing down the space between individual consumers and producers. Only then can signals between the two be easily and cheaply transferred. Democracy and democratic institutions, in this light, are viewed as inherently inefficient and therefore eminently disposable. Local government, unions, corporatist forums, even political parties themselves are disposable because they take time and energy to discuss, debate and find answers. For the right the 'invisible hand' of the market is all we need for moral guidance and operational efficiency.

In such a world view the welfare state and in particular the NHS is relegated to a second order value behind the needs of the economy. It becomes not a site of welfare, protection and social citizenship but part of the support economy. It exists not just to ensure people are fit for work but must do so on the basis of the efficiency of the market by mimicking it. In this way it plays a dual purpose for the market: it is a site for the expansion of profits through privatisation but crucially conditions people to become global consumers by promoting choice, competition and individualism. We learn through the increasingly commercialised NHS not how to be citizens, in it together, but how to be consumers, in it on our own. Managers learn to compete and become businessmen; patients learn to choose and become consumers. So we have a new one size that fits all: the market.

We are left with a 'permanent revolution' – defining ourselves against the past and our own people, copying the market's desire endlessly to renew and re-engineer. For New Labour the historic struggle to make society the master of the market is over. That is why 'It's always the economy stupid.' All we can do is more humanly help individuals stand on their own two feet in a world where everything can be reduced to rational choice theory. In such circumstances the prophecy that 'there is no such thing as society' can become a self-fulfilling.

We are in danger of shifting from an 'age of equality' to an 'age of ego'. This is the Hobbesian 'war of all against all' where a strong state is used to police a free market,

unless of course the left does its job of building the defences against the market to create the space within a public realm where people can be truly free. This is what the Ancient Greeks called the 'agora', the territory in which we encourage people to be compassionate, caring and cooperative. It is institutions like the NHS that facilitate such beliefs. The agora is the space where first and foremost we can be citizens. Those who would bring it down and put the market in its place, those who wish to destroy these public spaces for fear they will stand before the market, are the agoraphobics.

For his 2004 Labour Conference speech Gordon Brown went beyond the mechanical reasons for the limits of the private sector in the public realm he set out in the SMF speech the year before. This time he spoke about the moral difference between the market and society:

I have seen this ethic of public service at work. I have seen doctors and nurses who show not only exceptional skill and professionalism but extraordinary care and friendship; carers whose unbelievable compassion and support can transform despair into hope; home helps and support staff whose dedication, commitment and humanity show that there are values far beyond those of contracts, markets and exchange and that public service can be a calling and not just a career. The ethic of public service summed up best in poetry:

'It is the hands of others who grow the food we eat, who sew the clothes we wear, who build the houses we inhabit;

'It is the hands of others who tend us when we're sick and lift us up when we fall;

'It is the hands of others who bring us into the world and who lower us into the earth.'

So we are not isolated individuals but we depend on each other.²⁰

But to make this happen we have to recognise that machines and markets are largely inappropriate as reform models for the NHS.

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If we understand the relationship between the market and society as one of an evolving and fluid contest between competing public and private sets of forces, institutions and values then the NHS becomes a prime site of political contestability

If we understand the NHS as a site of political contestability between left and right then what of the form it takes? The NHS is still the product of the era in which it was born – the era of centralisation. Karl Marx had a point. The economic base does have at least some influence on the super-structure of society. The height of mass centralised production was perhaps in 1948. The top down mobilisation for the

war, Henry Ford's mass production, Lenin-inspired Soviets and paternalistic Fabianism defined an age of the centralised machine and the administration of the world from above.

In this era the NHS was only ever going to follow a mechanical metaphor – defined by an all knowing, seeing and controlling centre. Politics itself could not escape the same fate. Labourism became culture of the party and still largely is now. This based everything on one party winning elections and then directing state power, and through public administration. Socialism was what a Labour government did. Democracy was therefore just a means to an end – the end being the control of the state machine.

The language of the machine seeps into the phrases of post war politics – of delivery, levers of power, stepping up a gear and having no reverse gear. The job of the party was to be the delivery mechanism that won power for an elite to make the right decisions and bestow their enlightened magnificence on those below them.

Jake Chapman, who has written extensively on systems theory, has said, 'At the heart of the

mechanical world view is the presumption that control is possible and that if you can control causes you can have predictable effects.'²¹ It is this belief in predictability and order through a controllable machine that still defines how the NHS is run.

New Labour in all its control freakery and desperation to show 'it is in charge' and 'can deliver' has taken centralisation and the machine metaphor to new heights. More power than ever has been focused around the office of the prime minister. In part this is because few others could be trusted. Blairism was always a vanguard. Only a few true believers understood the modernisation revolution – the 'project'. The majority had to be defined as Old Labour to prove the contrast and willingness to change to New Labour. A small magic circle endlessly debated and decided the new course. Everyone else had to follow or be defined and crushed as dinosaurs. But the urge to control extended to much more than style. Where Stalin would only dare to have five-year tractor plans New Labour would settle for nothing less than a ten-year plan for its NHS. Simon Caulkin, the *Observer's* astute management columnist, has written: 'Despite its professed dedication to market disciplines, New Labour is the most micro-meddling administration in history, creating detailed specialisations and prescriptions for everything.'²²

But the machine model and in particular the targets that now go with it is deeply flawed. It can work for a while – for a war when people are prepared to sacrifice themselves for a bigger cause or for some contained production processes like making cars. But across increasingly complex, less deferential and decentralised organisations and societies the machine model is too inflexible and leads to too many unintended consequences. The £6 billion spent on IT systems is a classic example of a centrally driven approach that has failed to deliver value for money according to industry experts.²³ Targets are the reason the Soviet Union collapsed. If it couldn't work in Minsk in 1950, why on earth does anyone think it will work in Manchester in 2007?

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Applying systems theory to the NHS

Instead of a machine model based on levers of control we need to adopt the more organic model of systems theory. This sees entities like the NHS not as a machine with separate cogs that can be directed from the centre but as a whole organism whereby activity in any one part of the system inevitably affects all other parts. Take the target of ensuring that 100 per cent of A&E patients are seen within four hours. The cost is huge and the total probably unknown. Derek Wanless in his review of progress on the NHS recently described it as 'daft'. In his report for the King's Fund, Wanless accused the government of failing to recognise the complexity of the service and how various elements fit together and also condemned the repeated re-organisations that are costly not just in terms of finance but disruption.²⁴ He concluded that the additional funding of health services is not having the impact it should. This is politically very worrying.

People can only manage what is in their power to control. This is what distorts the rest of the organisation in the struggle to meet their targets

Organisations like the NHS are by necessity complex, often with contradictory elements and goals and therefore by definition cannot be controlled from the centre or anywhere else. Even record amounts of spending and more targets than an army rifle range cannot save a system

based on the myth of the machine. The key problem is targets and how they fit with human nature and the law of unintended consequences. As soon as the centre decrees that one outcome is more important than any other things start to break down. This is especially true if people are incentivised to meet the target. As soon as there is any kind of reward, especially financial, for hitting a target you can bet anything that NHS managers will start to hit the target. Whether it's in the 'right' way and what else may be sacrificed along the way is another matter. Managers will strive to meet a target even if it means destroying the organisation in the

process. People can only manage what is in their power to control. This is what distorts the rest of the organisation in the struggle to meet their targets.

There is more than one kind of target. The simplistic ones that have numbers attached to them, like waiting times, are good for media headlines but distort healthcare priorities. However, there were some excellent targets proposed by National Service Frameworks. These included structural recommendations and best practice examples to be emulated. And they were created by consensus groups of health professionals, social workers, patients and carers working together for months, and both voluntary and professional bodies contributed the results of surveys and consultations.

It is the use of crude targets that is in part creating the current financial crisis in the NHS despite the record investment. Simon Caulkin has written, 'How can the organisation be meeting all its performance targets and be in financial crisis, despite absorbing record amounts of money? Because in the absence of a systems view of improvement, performance goals can be met only at the expense of missing others, in this case financial ones.'²⁵ The machine decides what targets to hit but can't account for what goes wrong in the process. So, for instance, waiting times become a political priority but without sufficient cost-benefit analysis to understand what the true impact is. Frontline staff meet the political imperative of reducing waiting lists but the resource input required is unknown and unquantified.

Jake Chapman has identified four problems with targets: first, people face the wrong way – the target not the citizen becomes the focus of all activity; second, the goal becomes achieving the target, not improving the quality of the service; third, data is manipulated to meet the target or gaming takes place (an example of which is being passed around the health system because no one wants you to mess up their figures); and finally, collecting data takes time and resources and detracts from the real job of care for patients.

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Whatever targets are set there will always be unintended consequences. If trusts are given a target to reduce waiting lists then low priority cases will be given immediate priority and there will be a lack of follow up because there is no target for this. If you enforce a target for fewer deaths during operations doctors just stop doing riskier operations.

Consultants end up with a 25 per cent pay increase for doing less work because the centre doesn't and can't have all the necessary information about their previous workload. If trusts are given targets to reduce deficits then corners will be cut, leading to problems such as more patients bring sent home prematurely and the rise in MRSA. Of course the government's target to cut MRSA was missed. The 50 per cent reduction was deemed unachievable by science researchers. But even if the target had have been met it would have led to a drain in resources and attention elsewhere. It's the classic water bed effect. Pressure exerted in one spot always leads to a reaction somewhere else.

The psychological basis for the machine model is elitism. Essentially what the politicians are saying is that they don't or can't trust people to provide a popular and responsive service and therefore they must be directed and controlled. But mistrust is always a self-filling prophecy. If you treat people as if they can't be trusted then they will act in a way that proves they can't be trusted. Tighter control mechanisms are put in place to rectify the 'lack of control problem' and we end up with a fully fledged vicious cycle. This destroys morale still further and leads to the growth of a clunking big government machine as the process of tinkering and meddling takes on a life of its own. The definition of madness is doing the same thing again and again and expecting a different outcome. Simon Jenkins, the staunch proponent of localism, says this: 'To Thatcher, as to Blair, government was the agent of perpetual change. It was Lenin's light burning bright in the Kremlin turret, never sleeping, ever planning, ever driving forward, always frustrated by the crooked timber of mankind.'²⁶

The machine mindset, in part, is the reason why New Labour has never won the cooperation and

support of those at the heart of the system; those who work in it. At best reforms have been carried out to those in the service – at worst they have been done against them. The workforce cannot be trusted other than as tightly organised cogs in the machine. They need to be controlled, disciplined and if necessary incentivised to 'deliver'. Where performance is improved it is the victory of the centre.

The machine was the only model available at the birth of the NHS. Sixty years on the world has changed. What makes us healthy, or not, is incredibly complex and getting more so. Once it was chronic disease that could be treated through more straightforward delivery systems. Increasingly it is the environment we live in, our diet and the fact that we live in an ever more unequal society that determines how healthy we are. In the world of prevention, where the NHS should be focused, the machine breaks down. One size doesn't fit all. Services can and must be personalised wherever possible. Machines are bad at personalisation.

It's not just that machines don't work on their own terms – they rule out better options. If all that matters is what can be counted, measured and audited then what can't be captured in raw figures is disregarded and devalued. Any notion of public value and the intrinsic benefits of a collectivist NHS are forgotten in the rush to win the battle of the targets. As soon as you try to measure quality it becomes quantity. The government is using one-dimensional measures like financial performance to account for multi-dimensional value.

Of course people need to be held to account in the NHS and across the all of the public and private sectors. But targets aren't the way to do it. James Strachen, the chair of the Audit Commission, has said: 'Sticks will not promote excellence. They will merely discourage failure, which is not enough.'²⁷

Finding alternatives to target setting

Politicians are going to have to learn that the answer to better services is not target setting but

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the evidence that commercialisation either creates increased efficiency or is in any way a response to public demand for increased choice is hard to find

hard continuous reform, feedback loops and producer and user engagement in a slow but purposeful movement towards systemic improvement. There is no instant fix for the NHS so that come an election the politicians can say they did it.

The cult of the heroic

leader must die. The future of the NHS must be a collective. Neither workers nor users should be viewed as passive receipts of the service. Instead they must be engaged and consulted. The most efficient organisation in the world is deemed to be Toyota. Year in and year out they refine their production system to increase efficiency and innovation. Patients would benefit from such patience.

We need to find new ways to deal with complexity, accountability and responsiveness. New Labour thinks it has found the answer – the commercialisation of the NHS. But just because the Soviet Union failed it doesn't mean that the USA is the answer. Enron, don't forget, was the most target-orientated organisation on earth.

The new Brown administration has promised a 'bonfire of government targets'²⁸ with all but a handful of priority targets being superseded by local agreements determined by councils and PCTs. But whether the instinct to meddle and a new culture of pluralism is to be allowed to take root only time will tell. Perhaps we need to go as far as the Canadians who have abandoned all measurements except one: raising satisfaction among the public about the services they receive by 10 per cent – which they duly did. Some targets, some of the time, can help develop a step change in services but they are not a recipe for the kind of continuous in-built performance and moral improvement the NHS needs.

The NHS as a market

One of the key reasons why New Labour centralised control over the NHS was to use its increased powers to usher in market orientated reforms. This was the one way in which Blairism was willing to let go: to the private sector. It is only a strong centre that can dictate the terms of the commercialisation revolution taking place in the NHS. But before 2001 there was little evidence that future terms of debate about the NHS would be the extent of private sector involvement and the three Cs it implied: choice, competition and consumerisation.

Let's be clear. It is not privatisation in the sense of selling off wholesale the service to the private sector. But it has meant a growing share of the service being provided by the private sector, with the public sector increasingly forced to compete with private providers by mimicking them. The overall effect has been the commercialisation of the service and the treatment of patients as consumers.²⁹

The central argument of the commercialisers is that neither professionalism nor producer interest can be trusted to make the system efficient or responsive. Only competition forces managers to be held to account through the rigours of the market as hospitals fight for resources and 'customers' are given a wider range of choices about the service on offer. The threat of 'exit' is everything.

The key driver is the use of market forces or the closest approximation that is possible. Here there is some confusion at the heart of government. In 2005 Patricia Hewitt, then Secretary of State for Health, said, 'I do not believe we are turning the NHS into a market, and nor do I think we should, it would be a pretty odd market where the user cannot pay and the providers cannot compete on price.'³⁰ But Tony Blair told the BBC's programme *Breakfast with Frost* in December 2004 that Labour election manifesto would 'drive through market-based reforms in the health service'. The truth is that because no payment actually changes hands the NHS can't be called a market but the mix of incentives, competition, choice and private sector companies takes us to a world of at the very least quasi markets.

But the evidence that commercialisation either creates increased efficiency or is in any way a response to public demand for increased choice is hard to find. A YouGov poll for UNISON in February 2006 found that 61 per cent of patients want providers to cooperate rather than compete. Only 19 per cent wanted competition. They are right to be concerned.

Competing institutions lies at the heart of New Labour's NHS reform; either trust against trust or public providers versus private companies. At least the government is now being honest about its support for an NHS based on competition. Soon after the last election Patricia Hewitt said it was competition rather than the popular New Labour euphemism of 'contestability' they were aiming for. She memorably remarked that the 'instability' caused by competition was 'not only inevitable but essential'. She developed the argument by saying, 'Yes, money will follow the patient. But why should choice, innovation, competition and financial discipline be confined to private markets?'³¹ In a pamphlet for the New Health Network Hewitt wrote, 'We are bringing greater risk into the system by challenging the NHS monopoly and creating incentives for providers to meet patient's needs.'³² The risk she is talking about is the closures of services based not on public need but market style rigour.

To achieve a system of quasi-markets Labour has built on the Tories' internal market and turned it into an open market. Often the market is rigged in favour of private providers. For instance independent sector treatment centres (ISTCs) are being paid long-term contracts at a premium above the rest of the NHS, which is struggling to cope with the replacement of block contracts with more unpredictable payments procedures. Private treatment centres were not supposed to be able to poach NHS staff – now they can poach staff and premises. Rules are bent and broken but only in favour of private providers. The presumption is always in favour of profit maximisers. And the problem with profit maximisation is just that – it puts money before need. Here is one interpretation

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of the impact from the British Medical Association (BMA): 'A system of winners and losers seems inevitable, in which funding flows away from unpopular providers, possibly trapping them in a cycle of decline in which they have a higher proportion of the more complex and "unprofitable" cases but fewer staff.'³³ In 2004 Professor Peter Smith from the Centre for Health Economics at York argued that 'providers tend to pick patients rather than the other way around. They pick those that will be most profitable and the least trouble – just like schools.'³⁴

King's Fund research in May 2006 found that those with formal education chose the best hospital and those least well educated opted for the local hospital

Competition between institutions in the NHS has huge implications for the provision of services and their financial stability. While services in such a huge organisation clearly need to be rationalised, this should be secured through proper long-term management of resources, consultation

and, where possible, democratic agreement. Not the forces of the market. The current wave of unrest about hospital, ward and specialism closures is fed by the lack of any discernable decision-making process the public can access. This is not to argue against rationalisation but against imposed decisions either from the centre or based on quasi markets. Much of this 'instability' is starting to be driven by shifting consumption patterns. Now that patients can choose their hospital small shifts in patient choices that see money follow the patient can have dramatic effects on hospitals, all of which have very high fixed costs. This is why supermarkets, which also have high fixed costs, fight so fiercely for customer loyalty and are vulnerable to that loyalty switching.

As money and patients shift around following the rules of the market the notion of an integrated and

holistic system starts to fall apart. Cross subsidies can no longer flow from those with surpluses to those in deficit. We might not want cross-subsidies to take place – but it is a complicated issue that requires a negotiated outcome. As specialisms close, the need for shared services like cleaning can become harder to support threatening the viability of the whole hospital unit. Unintended consequences of the market's 'invisible hand' abound. Public servants lose competences as they get cherry picked by the private sector, who by definition don't have their experience to do the job. They then get charged back to the NHS at a higher rate in the name of efficiency. In April 2006 the Royal College of Nursing (RCN) threatened to withdraw unpaid overtime – an example of dedicated staff acting on the basis of rational choice theory and not public service ethos. The NHS itself turns into a brand like Nike, which was the claim that led to the resignation of John Ashton the regional director of public health in the north west. He said we were heading towards a two-tier system after the fifth re-organisation he had faced. Hospitals are developing their own brands and strap-lines and will inevitably start advertising for patients.

The problem with choice is that in an unequal society some can always make better choices than others thus paving the way for greater inequality. New Labour ministers argue that the system was already unequal and they are only trying to create a level playing field where all have choice. But this really is a baby and bathwater issue. Just because inequalities in health exist doesn't mean we should adopt a market-based system that is bound to exacerbate the gap between winners and losers. Health inequalities exist primarily because of income inequalities. The real answer is to close the income inequality gap. Second, inequalities exist because the middle classes play the system better. By creating more choice it just provides the space for greater middle class advantage. That is why the NHS must be a haven away from some people's ability to make better choices than others.

The New Labour argument is that choice is inevitable in the NHS because it is the meta-value

The NHS as a market

for the rest of the society. You can't stop people going on the internet to find out about what the best hospital might be or what new services and cures there are. Indeed you can't and neither should we try. We should welcome a more personalised NHS and encourage patient interest and responsibility for their health. If this is what ministers mean by choice then fine. But up until now it wasn't. It is the elevation of choice as a key driver of policy and practice we should object to – at least in terms of it being a proxy for the market. Choice in terms of an abundant range of actual suppliers of health care, like the choice of a supermarket, is just not feasible. Nor is it desirable because of its distorting impact on the public service ethos of equality and citizenship. The thing we must distinguish is choice of provider (which most people don't want unless it is the only way off a long waiting list) from 'shared decision making' between health professional and patient. The latter is not a new thing, but has got more sophisticated as the patient has access to more information. But even in shared decision making, we mustn't forget the people who want the doctor to decide for them.

By establishing a set of superior and inferior providers inequality becomes systemic. King's Fund research in May 2006 found that those with formal education chose the best hospital and those least well educated opted for the local hospital. John Appleby of the King's Fund has argued that there is a parallel with schools – the middle classes tend to gravitate towards what they perceive as the best schools. If this happens in health care we could potentially see a widening of health and health inequalities between those with formal education and those without.

In a speech to the Fabian Society Patricia Hewitt in 2005 said, 'Far from entrenching inequality – it (choice) will help us create a more equal society.'³⁵ This is Orwellian double speak. Just because the poor can go to Matalan to buy cheap designer clothes doesn't make it a more equal society if the rich get to make even more extravagant purchases on Bond Street. It just legitimises the market system in a place it doesn't belong. In echoes of Alan

Milburn, she went on to say, 'It would be a major mistake – a mistake the Conservatives are just waiting for us to make – to deny people choices over their health and health care, leaving us out of step with irreversible changes in society and out of touch with the people we seek to serve ... people want a really good local hospital: but more choice means more chance of having a good local hospital.'³⁶ Choice for James Purnell, another New Labour minister, is 'an end in itself'.³⁷ So we tell people that choice will give them a good hospital when the reality around the country is that it leads to the closure of services and provision. Hewitt finished her speech in a flourish, 'My appeal to progressives and supporters of the NHS is: don't oppose greater choice and control for individuals and communities; don't just grudgingly go along with it; but embrace it as part of the way in which we renew the values of the NHS for modern times.'³⁸

The elevation of choice to the high principle in the NHS opens up a can of worms in which individual advancement is prioritised above collective interest, which brings about market failure as a few patient switchers cause chaos to highly geared-up services like big hospitals. The objective of the democratic left should not be to deny personalisation but to explore how much more meaningful collective choices can and should be made about the nature of the service. The NHS should primarily be an institution that promotes equality, liberty and solidarity. Of course in a largely capitalist society it will also reflect some of the dominant values of that society, like choice, but they cannot be the meta values of the service without the NHS losing its rationale as a socialising force. This is not just my view but also that of Robert Hill, a former health and public services adviser at Downing Street. He has written recently: 'Choice and markets are powerful agents for change. But they are not the only club in the modernisers bag.'³⁹ John Denham MP, now Secretary of State for Higher Education, endorsed this view when he wrote, 'Choice, diversity and contestability should be in any model of public service reform, but they do not define the ideal approach.'⁴⁰ Choice in the NHS inevitably gives some more of what is 'free at the point of need'

The NHS as a market

than others. It is little surprise that New Labour's own Healthcare Commission recently reported that the choice of hospital is irrelevant to patients. What mattered was the quality of care.⁴¹

But choice is also difficult to argue for on grounds of efficiency. By definition to offer a meaningful choice supply must outstrip demand, which leads to waste. This is why the supermarkets throw away so much of their stock every night – by pricing in the cost of such waste. This cannot be a model for the NHS.

But we are not given a choice about choice. The Department of Health appears to have removed research from its website that showed there was no appetite for the choice agenda. The research commissioned by the Department found that people did not want to select a hospital while they were ill, preferring to trust their GP. The research also said there was no evidence that greater choice would improve the quality of care, and good reason to fear it would only benefit the wealthy and articulate.⁴²

These findings fit with other research. Johnston Birchall and Richard Simmons in a paper to the Treasury in June 2005 wrote that 'service users did not want their own preferences to take priority over the preferences of others if this was going to lead to an "unfair" outcome'. They went on: 'Choice simply represents a measure of rational preferences made on the basis of available options. The aggregation of these choices may or may not add up to the public good... Choice appears to have a more limited range than voice; it is based on a more limited set of assumptions.'⁴³

In complex systems where there are clear asymmetries of information between producers and patients simple versions of top down choice are insufficient to empower citizens. It is not passive and individualised consumers that will transform the efficiency and quality of the NHS but active citizens. Consumerism is just about the right to pick and choose and exit if you don't like it. Public services and especially health can't work like this. They are about rights and responsibilities. Theodore

Dalrymple wrote, 'To be a customer without the responsibility of paying for goods or benefits received is to be an egotist permanently resentful at not getting what you want immediately, which becomes the only criteria for satisfaction. To be a doctor constantly confronted by such customers is to wish to have chosen another career.'⁴⁴ You cannot contract your way out of chronic diseases as a consumer. Consumerism encourages the view that problems can be fixed by over the counter drugs with no input or effort. According to David Walker of the *Guardian*, 'The very basis of social policy is assessment of need, followed by distributive decisions that give relatively more to one group than another. This isn't like consumption in the market for retail groceries.'⁴⁵

There are plans to ask Virgin and Tesco to offer rival services to general practices and private companies are being asked in to look at the takeover of the management and commissioning functions of PCTs

But if people are treated like consumers then that is how they start behaving. It is one reason why there has been a 75 per cent increase in the number of emergency calls in the last decade. It is now people's right as consumers to demand an ambulance even for the most frivolous of cases. Like frenzied consumers, people want it all and they want it now. The new

generation in particular feel no obligation to conform or wait its line. But we aren't consumers of the NHS but citizens. The NHS is not like shopping. People don't consume more health than they need.

For David Marquand the implications of this commercialisation agenda are profound. He writes, 'Incessant marketisation, pushed forward by the core executive at the head of the most centralized states in Western Europe, has done more damage to the public domain than low taxation and resource starvation. It has generated a culture of distrust, which is corroding the values of professionalism, citizenship, equity and

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service like acid in the water supply.⁴⁶ A little later Marquand continues:

New Labour has pushed marketisation and privatisation forward, at least as zealously as the Conservatives did, narrowing the frontiers of the public domain in the process... Though it sometimes talks the language of community, it refuses to acknowledge that community loyalties can be forged only in a social realm protected from market power... When they say they are new, they (New Labour) mean they have abandoned the old social-democratic dream of mastering or remodelling capitalism.⁴⁷

Patricia Hewitt called for choice and competition but says in the same breath that the NHS is 'a beacon of compassion and an ethic of care, of fairness and social solidarity, mutual responsibility one for one another, in times that so often feel harsh and individualistic. In everything we do, in every change we make, we will not compromise those values.'⁴⁸ But she advocated practices and processes that are antithetical to compassion and care. Competition is not about compassion but the survival of the fittest. Opposition to such values is not about being anti-market but knowing when and where they can work best.

The new Brown administration has applied the brakes to some aspects of the commercialisation of the NHS. The next wave of ISTCs are being halted in their tracks. But the signals are mixed. There are plans to ask Virgin and Tesco to offer rival services to general practices and private companies are being asked in to look at the takeover of the management and commissioning functions of PCTs.⁴⁹ The private sector is expected to have a key role to play in delivering new general practices and health centres, and there are moves under way to induce greater competition for patients.⁵⁰ Primary care could be turning into the new frontier for the marketisation and privatisation of the NHS, a process that could disrupt the continuity and engagement that will be so essential to tackling new health challenges, and undermine the integrity and equity of the entire system. The potential takeover of PCT commissioning by the private sector opens the system up to wholesale influence by market forces and

competition. Companies like UnitedHealth and McKinsey will be able to access sensitive and privileged data and be able to extend their influence into more profitable areas of health. This could be contracting out on a grand scale. Suspicion and mistrust in the search for profit will then replace goodwill and cooperation. The patient pathway through the system may become a vicious minefield of competing interests.

Another worry is the growing support for individualised budgets in social care in particular. Again the issue is one of emphasis. While there may be a role for people to make more personalised decisions there are problems. On a practical level, if people become their own commissions then the scope for inefficiency, duplication and fraud grow – as we saw with individual learning accounts. The system will find it harder to plan and patients are faced with what can become the tyranny of choice. At an intrinsic level we should be concerned about a step towards Tory vouchers for public services and the implications for the individualisation and consumerisation of services. And some will always make better choices than others. That's fine on the high street but shouldn't be the case in public services where top up payments could easily take us towards a two tier service.

We are ending up in the worst of all worlds, with an NHS that is part machine and part market. It's neither under tight central control nor is it subject to the real rigours of the market based on price competition. New Labour has not gone beyond the old left and the new right into some new synthesis but has simply combined the two into a disfigured hybrid. Above all the guiding philosophy of New Labour is that people can either be bossed or bribed into accepting their reform agenda. Simon Jenkins has called it regulated privatisation. The big stick of the centralised state is being used to force people into the 'freedom' of the market. Under New Labour to be 'successful' the NHS must increasingly behave like the thing it was created to replace – the vagaries and injustice of a market-based system of health provision. It's little wonder that in 2006 the then Secretary of State for Health announced that 'there is a sense that the service no longer knows where it is going'.⁵¹

The NHS as paradox

The brilliance of capitalism is its single minded pursuit of profit. That's all it knows how to do. If it is given the chance to profit from hip operations than it will try to make a profit from knees next. It is irrepressible unless we decide collectively where it is morally and practically right and wrong to go.

As Alan Finlayson argued in 2004: 'True choice, unlike market choice, requires the possibility that we might change the terms on which choices are offered to us.'⁵² Public services like the NHS are inherently political and cannot be reduced to the self-interested decisions of individuals. This is important because the market doesn't just corrupt and corrode the NHS; it also makes us ill. Obesity, diabetes, drug abuse and mental illness are all in part a result of the market madness that consumes our society and creates the social recession. The market is not the answer to the future of the NHS; it is part of the problem. We are not just rational choice theorists working purely for money or self-interest. People working in the NHS – doctors,

nurses, ancillary staff, therapists, porters, cleaners, cooks, receptionists – have many motives for what they do, like pride in the job, or working in a place that has a remarkable ethos. Patients and the wider public don't want just what is best for them but know that need comes before greed. This is not how markets function.

If the commercialisation of markets and centralisation of the machine are of limited value to the mechanical and moral development of the NHS, then what? Before we attempt to answer this question it is vital that we examine and understand the NHS as a paradox. It has already been established that the NHS is riven by tensions due to the fact that it is a social democratic bubble in a sea of capitalist values, institutions and forces. A further tension arises over the pretence that rationing doesn't exist. It clearly does, and is either being solved by professional decisions or by your postcode. But there is a wider and irresolvable tension at the heart of the NHS: between our desire for equity and our need for diversity.

The four broad methods of governance

CENTRALISATION

What: Targets, plans and regulation

Why: Important because it is the basis of equality; those who get the worst services would love a big dose of uniformity if it meant their services were raised to the standards of the best

How: As little as possible to ensure the maximum amount of equality

PROFESSIONALISM

What: Ethos, training, judgement and experience

Why: Because doctors, nurses and other staff have unique expertise and experience that will always be an essential ingredient of any successful programme of modernisation, and can work on long-term goals

How: As much as possible while ensuring it is accountable and responsive

DIVERSITY

What: localism, working with or learning from private and third sectors, organisational autonomy, challenge, contestability and choice

Why: Important for innovation and local involvement and freedom to experiment, to learn from best practice and from mistakes; localism also allows for setting of local priorities

How: As much as possible commensurate with the demands of equality

VOICE

What: Participation, democracy and co-production

Why: Because it is the only route to sustainable reform improvements

How: As much as possible, in all circumstances and at all times up to the point that citizens and workers want no more of it; care must be taken to ensure all voices are heard otherwise there can be a clash with equality.

The NHS as paradox

This is a paradox and as such holds within it fundamental contradictory forces that cannot be resolved; only managed to the best of our ability. The fundamental paradox at the heart of the NHS is that we want health equality, as nothing can be more fundamental than the right to live as long and as well as anyone else. The accident of birth, both who you are born to and how healthy your body is, cannot be allowed to shape the quality of your life. Health equality demands state intervention through an institution like the NHS. But as pluralists and democrats we know that local decisions are crucial to build buy-in and support for the NHS and that diversity and experimentation are essential to innovation and the kind of creativity that will see the service modernise to meet new demands and challenges.

In essence the paradox between equity and diversity speaks to a deeper tension that is the driver of human development and progress – between our need for security and our desire for freedom. We want certainty and to be free of anxiety and insecurity but we also want to be liberated to ‘do our own thing’. These competing desires are engine that fires our restless nature as we struggle to satisfy both competing instincts.

However, diversity, the freedom side of our dual nature, leads to difference and difference can sit in conflict with equality, at least some of time. This is a problem because we know that the centralising machine metaphor doesn't work: it neither controls, because control is impossible, nor – as history has shown – does it sufficiently equalise. If we impose rigid standards from the centre on everything then there is no space for local input or innovation. We also know that just letting go is a recipe for unacceptable inequity. The areas with the richest people will inevitably end up getting the best service and private providers will cherry pick the most profitable procedures and patients. Poor people always get the poorest service without active state intervention to ensure greater equality.

However, the big problem is not the paradox but the refusal to admit it exists. Politicians refuse to

accept there is a core tension that cannot be resolved and so end up going through endless rounds of reforms to try and do the impossible: simultaneously to satisfy the need for diversity and equality. The result is wasted time, resource and the frustration of not being able to square such a circle. Polly Toynbee has written that ‘Tony Blair has already reorganised the NHS three times: this fourth attempt now puts back and sharpens the Tory internal market he dismantled’.⁵³ This inevitably undermines the popularity of the service.

Arguing that you can have both equity and diversity without any tensions or trade offs is just misleading spin. Instead, we have to find a means by which the paradox can best be managed. The issue is how? There are in essence four basic systems of governance for the NHS, which need to be mediated and determined via democratic decisions wherever possible. The following matrix sets out the four broad governance methods:

Pluralism

The battle between localisers and centralisers must come to an end. We need both. But both must be democratically accountable. Equality for the left is sacrosanct because it provides the resources for people to express their freedom. But the non-market improvements being made in Scotland and Wales show why diversity is also important. Scotland is developing the concept of patients as partners in decision making and empowering and equipping staff. The Scottish Parliament's Health Committee has come out in favour of direct elections for Scotland's area health boards. The war against professionals must stop but the way professionals operate must be brought in line with the less deferential age we live in. Voice must be given the priority of resources and time it needs to work. Instant fixes, blame and the extremes of the free market or top down targets must take a back seat.

John Kay has written about an approach called ‘disciplined pluralism’, which he describes as ‘decentralised choices with accountability’.⁵⁴ The objective is to replicate the more complex and fluid operation of teams who achieve common goals via

The NHS as paradox

Without sufficient equality and solidarity as expressed through new and democratic forms of collectivism we are just left with the pseudo freedom of the neo-liberal right

cooperative activity effected through individual decisions. The centre-left has so far failed to come to terms with the need for diversity and pluralism. This is primarily because of the clash with equity. It is, however, more helpful to identify equality as a means to an end rather than an end itself. The end for the left should be the

ability of people collectively to manage their lives and the institutions around them, especially important ones like the NHS.⁵⁵

A crucial component of such liberty or autonomy is greater equality. To be free agents we need the resources to put the theory of freedom into practice. I'm free to go to the best doctor on Harley Street but in practice I don't have the money. Equality is one route to freedom. The second is solidarity. We can only self-manage our world when we do it together. Most of the big issues are impossible for us to address acting as individuals. Without sufficient

equality and solidarity as expressed through new and democratic forms of collectivism we are just left with the pseudo freedom of the neo-liberal right. What we cannot do is deny the human need and ability to create, experiment and innovate. This demands diversity and the space to be free. Diversity, by definition, comes up with different and therefore unequal outcomes. This is made more problematic by the notion of diversity as a form of contestability or competition, although we have to accept that public service institutions must be open to challenge and that quite rightly there is open competition for job vacancies in the NHS. The issue is how they should be challenged. Competition between providers in health is not the answer, but diversity does not necessarily equate to the profit motive. It can and should mean the democratisation and decentralisation of the state as well as other service providers, as long as employment standards and other egalitarian regulatory benchmarks are enforced. Ways of working need to be challenged to ensure that the quality of service doesn't deteriorate. Much of that could happen through better management, sufficient resources and political leadership that builds rather than undermines staff morale.

As Compass has consistently argued, the answer is to dare more democracy.⁵⁶

The NHS as a democracy

The solution to the equity–diversity paradox of the NHS lies in giving the people who work in and use the service the ability to help determine the trade offs and compromises that inevitably have to be made. There is a limit to how meaningful participation can be effectively enacted through individual choice. Individuals can only pick different services that are right for them. They cannot try and determine the overall nature of the service. This is a political and therefore a democratic demand. It is collective voice of users and producers that can allow the problems of the equality–diversity paradox to be owned, shared, understood and acted upon. Any externally imposed ‘solution’ is only ever going to exacerbate the frustration and tensions inherent in the system. The market’s invisible hand cannot resolve such tensions; nor can another round of top down reforms. The possibility of exit just provides a temporary safety valve, which allows some ‘consumers’ to make a limited range of choices. A target culture is fundamentally disempowering. The reform solution will not come from without, but only from within the system.

By helping us manage the paradox, democracy and voice provide ways of making the service more responsive, trusted, efficient and productive. And through active engagement the ethos of the NHS is reinforced, and the willingness to pay for it through progressive taxation is underpinned. Through democracy and voice we create the conditions for a virtuous cycle of sustainable improvement in the NHS. The value is instrumental, in that it makes the system work, and also intrinsic, as it builds the moral fabric that underpins the NHS and therefore collectivism more widely in society.

But to date democracy and wider participation has been largely absent from the NHS as voice doesn’t fit with either the machine or market models. There are few democratic structures within the NHS. Indeed the Secretary of State is still the first elected representative you meet in the service – and the last. This is largely the fault of a Labour movement that has never recognised nor cherished the role of democracy in public service delivery and always preferred to trump accountability and participation with elitism. That was possible in 1948. It is impossible now. The age of blind loyalty and deference has gone. Public servants cannot

act just how they want – although as we shall see there is a role for professional discretion, which should not be obliterated by the force of markets or targets. The privilege of being backed and resourced by the public must be associated with public accountability and where possible collective participation in shaping preferences.

Jack Stilgoe and Faizal Farook have argued that ‘while people are imagined as consumers sending signals to the health service through their choices, they are seldom seen as having much of a role to play once their choice has been made’,⁵⁷ while the BMA has suggested that ‘the democratic deficit in the NHS’ has been one of its key weakness since its inception, and that ‘finding ways of strengthening local accountability’ may be ‘the key challenge ahead of us’.⁵⁸

It is the superiority in the NHS and other public services of voice above choice that the left must develop and champion. Johnston Birchall and Richard Simmons wrote: ‘Voice acknowledges the complexity and political nature of public services ... it recognises that there is often a need for (i) negotiation over sensitive political issues and (ii) trust-based mechanisms of control. This means give and take on both sides, which in turn depends on the resolution of structural and cultural differences... It (voice) is more fluid and flexible.’⁵⁹

Choice assumes only a limited set of pre-determined options. Voice is not pre-determined; everything and anything is possible. And collective voice can be a much stronger driver of change and improvement than individual exit. Take your local general practice. If you are unhappy with the service your doctor’s surgery is providing the answer now is to move somewhere else. But this is not easy. First you have to find an alternative practice with the space for you. If you can you might benefit from this move but you are taking a risk. It’s not like switching from Tesco to Asda or making easy price comparisons. It takes time and you can’t easily switch back. Information on what general practice might be best is available but it’s not very revealing. Pro-market reforms would call for more information, but that means more bureaucracy. Anyway, if there is more information it will be exploited more thoroughly by those most able to do so: the better off.

The NHS as a democracy

But what does this kind of switching do to the service as a whole? Does it send a signal to general practices to make them sharpen up their act and become more efficient and user friendly? Well, over time perhaps, but only if enough people leave their surgery. But more will join just because of local demographic changes. So the signals to the general practice will be very unclear. If there are any contestability impacts they are likely to be messy and very slow. As the practice loses its most mobile and articulate patients the service is likely to deteriorate. But what if the full logic of contestability is realised and exit leads to the closure of the surgery? Those with cars might be fine, even if other surgeries can soak up the new demand. As ever, it will be the poor who will suffer most.

But wouldn't it be quicker and more efficient if there was a form of collective voice which allowed problems and potential solutions to be raised, discussed and actioned before anyone had to think about leaving? If one patient leaves a general practice the signal is minuscule. But if twenty or a hundred say they are unhappy about someone or something, or want different opening hours or more specialist nurses, and say so through a collective action like sending a mass email or signing a petition, then the signal would be loud and clear. It is worth considering whether the Child Support Agency fiasco would have lasted so long if those entitled to payments could have dismissed its chair. Would farm subsidies have been paid more quickly if the Payments Agency Board was elected by farmers? Voice is a more effective system of accountability than exit in the NHS.

Voice allows difficult decisions to be determined by deliberation and consensus. Hospital closures and other forms of rationalising and good planning may well be justified but they need to be explained to workers and to local users if protest campaigns and general disillusionment are going to be avoided. It is their hospital or social care centre and they must have some say over its future. If it is the public's service then the public must be part of its governance. A service provided with them, not just done to them. Ultimately we need a choice about the balance between choice and voice.

The government can talk a good fight on voice but do they deliver? The Picker Institute think not. A report in October 2007 claimed that a £43 billion increase in NHS spending over the past five years has failed to create the patient-centred service that everyone claims they want. The Institute found that almost half of hospital patients were not as involved as they wanted to be in decisions about their care, with no change in views since 2004.⁶⁰ A similar report from Which? found that half the patients treated in NHS hospitals are unhappy with aspects of their care but few thought it worth complaining, and of those who did complain, only a quarter felt their complaints were well handled.⁶¹

Complexity, trust and better health

The case for voice over choice is made by the complexity of the NHS and the inability of either control or commercialisation to manage satisfactorily a system where, according to Hilary Cottam and Charlie Leadbeater, 'innovation is widespread but difficult to propagate'.⁶² In the NHS, know-how, effort and expertise are distributed resources that require collaboration, co-creation and constant innovation. For example, to deal with chronic rather than infectious diseases requires continuous support close to users that is adaptable, joined up and 'assembled round people'⁶³ and their distinctive needs. A machine can't do this and a market leads to unacceptable levels of inequality. But it is also the case that you can't transact your way out of chronic diseases. There are no over-the-counter answers that can be bought. It's about behaviour, environment, culture, family, diet, happiness and poverty. The issue is not just to dispense health in some simple top down system but how to run what is inevitably a complex process where people can be helped to manage their own health better through mentors, facilitators, improved knowledge, coaching and feedback.

Cottam and Leadbeater see the NHS as akin to e-Bay – a mass peer-to-peer complex system that is highly distributed but popular and effective. It is an involved process where people learn through participation, sharing, co-operating, talking and listening. In the same paper they argued: 'In the 20th century, public goods were created by professionals working in dedicated, hierarchical organisations, delivering packets

The NHS as a democracy

of services to waiting, deferential users; doctors made you better... In the 21st century, public goods and services will be created interactively, through partnerships between professionals and users and by user collaboration. These alliances, partnerships and communities will co-create new services.⁶⁴

The trust required of the NHS is different from trust afforded to a private company like an airline. We may trust BA to fly us safely to New York but that doesn't mean we trust them to serve our interests all of the time or know how to balance our interest against the legitimate interest of others. They will charge us as much as they can to take the trip regardless of our ability to pay. With a GP, surgeon, nurse or care worker we have to have absolute trust that they are acting fully in our interests, although that doesn't mean we don't ask questions and push for what we think is best for us. Peter Taylor-Gooby argues: 'Work in psychology and sociology indicates that trust has two main components – a cognitive judgement that an agency is competent and efficient, but also an emotional belief that it operates in one's interest – there is little point in putting ones trust in a health service which has the highest standards of expertise, but which can't be relied on to use it when you need it.'⁶⁵

Commercialisation undermines trust because it is based on vested interest and therefore suspicion. Market systems detest professionals and try either to eradicate them or to tie them down through audit, regulation or consumer power. This replaces trust with the threat of exit or competition and fuels the legitimisation crisis within the NHS. As David Marquand has said: 'The market domain consumes trust; it does not produce it.'⁶⁶

The NHS could be transformed on the basis of trust relationships that come from debate, dissent, consensus and, yes, difference. It is a mature citizenship we should be aiming for, which is the very opposite of the widespread cynicism we see today in our commercialised world because people are either treated as passive targets or consumers.

Voice and efficiency

Trust born of voice and participation is not just an intrinsic good but an instrumental one. Trust cuts transaction costs. Productivity in the NHS, despite

the claims of the commercialisers that only markets are efficient, is flat or falling. Neo-liberalism will always argue that the problem is that markets aren't free enough. Experience to date would suggest this is not an argument we should entertain. Because the government piles reform on top of reform, undermining improvements that have just been made, the idea that the system is inherently inefficient is now widespread. When asked what they think of the extra spending on the NHS since 1997, 72 per cent of the public think 'a lot has been wasted'.⁶⁷ Like any organisation some money will be wasted. 'Choose and book' should have cost £65 million and now stands at £200 million and they still can't get it to work. Millions are paid in fines to suppliers because of the delayed IT system; £2 billion worth of cuts per year have only recently been identified by ministers when the system should be getting more productive through new technology like new replacement hips that last much longer than the old ones.

A report by the TUC shows that the common justification of market efficiency and public waste for cuts and savings is unfounded. In fact the public sector delivers services with far fewer managers than the private sector. It also has fewer administrative jobs than financial services, including the City. The report, drawing from the Labour Force Survey, draws the following conclusions:

- Managers make up 7.5 per cent of the public sector employee workforce compared with 17.2 per cent of the private sector employee workforce.
- There are roughly 6 employees for every manager in the private sector compared with roughly 14 employees for every manager in the public sector.
- In large workplaces employing 250 or more employees, 9.6 per cent of the public sector employee workforce are managers compared with 18.7 per cent in the private sector.
- Managers make up 27 per cent of the private sector financial services employee workforce and 21 per cent of business services compared with 12 per cent in public administration.

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- Private financial services also employ the most administrative workers, at 34 per cent, compared with public ‘administration’ at 26 per cent.⁶⁸

The democratic left must start to make the case that voice and participation increase not only fairness but also efficiency in complex public services like the NHS. This view of the creation of ‘public value’ is in tune with the basic progressive belief that given the right inputs of time and resource people who deliver and use a service can make the right long-term decisions about its effectiveness. Lasting efficiency and productivity gains built into the system cannot be imposed externally through the bullying of the machine or the bribery of the market. Voice can create a virtuous cycle of efficiency. According to Simon Caulkin, ‘Organisations that treat people as optimists who want to do a good job can create the conditions in which creative optimists succeed, abolishing the need for expensive control... A company that functions on the basis of trust and co-operation creates a system, in which co-operating people flourish. The more it flourishes, the more the norm is reinforced. The self-fulfilling prophecy makes the company quite literally into a force for good.’⁶⁹

Greater user involvement can also help us see beyond crude targets to ways of maximising true public value, which is always more complex and has an irreducibly experiential dimension. New thinking about patient and public involvement is looking at how the notion of ‘experience-based design’ can be brought into the NHS; finding out about how patients experience the service and using this to ‘co-design’ services. Paul Bate and Glen Robert have pointed out that the NHS has focused on designing processes and pathways, but less on patient experiences: ‘one can have the perfect process (fast, efficient, not bottlenecks) or pathway (evidence-based) but an incredibly poor experience’. In experience-based design ‘the traditional view of the user as a passive recipient of a product or service gives way to the new view of users as the co-designers of that product or service, and integral to the improvement and innovation process’.⁷⁰ This could be an important part of the solution to what Madeleine Bunting and Simon Parker have called ‘the tragedy of the call centre’ – reforms that might

on paper seem to help a service meet efficiency or performance targets but which actually result in an impersonal, frustrating and alienating experience for the user that erodes trust and loyalty.⁷¹ There are many examples of patients being involved in redesigning ‘patient pathways’ – to stop people going round in circles, which wastes their time and that of the health professionals; often it means there are more local decisions and delivery.

Finally, voice and participation through a democratised NHS helps make the case for funding and the sensible allocation of resources. Through greater involvement and participation the criteria for setting priorities becomes more transparent. People learn that not everything can be funded – what they want to know is what can be funded and whether they can influence funding decisions. A more deliberative process makes the case for taxes to increase for the NHS because it becomes ‘our’ service and allows consensus about the trade offs that have to be made. In a report for the National Consumer Council Johnston Birchall and Richard Simmons⁷² summed up some of the benefits of voice in this way:

- Public service participation engages the less well off in society.
- Time constraints are an initial barrier but once they start people find the time to participate.
- Users are often motivated to participate through concern about issues such as poor quality or ‘putting something back in’.
- People say they participate for others, not primarily for themselves – collectivist incentives are the most important at all points of participation.
- The longer their participation the more people align themselves to collectivist rather than individualistic factors.
- Loyalty was strongest if it was felt providers were receptive.
- Knowing the option of voice was available even if they didn’t use it was important.

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Starting the democratic transformation of the NHS

The transformation of the NHS into a more self-sustaining and self-managed entity must be based on producer and user participation and voice in shaping the nature of the service and managing the equity–diversity paradox. There should be an easily accessible menu of democratic and participatory options so people can use voice when and where they want. They would be ladders of participation which take people onto the next stage of engagement if that is where they want to go. Often people first engage on issues about the structure of the service but end up focusing on values. It cannot be about spin. Voice must be a meaningful system of control accountability and motivation – not just about what the service is doing but what it should be doing.⁷³ If people perceive it as just a PR exercise with no resulting shift in power they will quickly withdraw and are unlikely to return – then instead of a constituency of concern there will be a constituency of cynicism.

To date the government's major focus has been a mix of centralisation and targets alongside commercialisation and marketisation. Both are anathema to voice and participation. There is a fledgling programme of patient and public involvement (PPI) but the systems of voice and participation offered by the government since 1997 have been confused and ineffectual. Brian Fisher, practising GP and PPI lead for the NHS Alliance, said: 'At present the NHS is not accountable to its users or to the public.'⁷⁴ The Picker Institute analysed data from 2004 and 2005 from Australia, Canada, Germany, New Zealand, the USA and the UK on the quality and extent of patient involvement in their health systems. The UK was lowest on all six indicators. The NHS came top of a comparative ranking of health systems recently published by the US-based Commonwealth Fund because of its high levels of equity, efficiency and quality care, but here again the UK scored the lowest on patient engagement measures.⁷⁵

It's little wonder. In 2000 New Labour abolished community health councils (CHCs) to replace them with the Commission for Patient and Public Involvement in Health (CPPIH). But this was abolished before it ever really got going. CHCs were

replaced by the PPI forums but the problem with the PPI forums is that they are under-resourced and of very uneven quality. Now the Healthcare Commission has some regulatory responsibility for participation and engagement but that is being merged with the Commission for Social Care. Adding social care to its responsibilities is not the problem; the problem is that it doesn't have teeth. Local Involvement Networks (LINKs) are supposed to address the local democratic deficit but no one knows what impact they will have. It remains to be seen how members of LINKs will be recruited, supported and developed in their roles, and how it will be ensured that disadvantaged groups have a fair opportunity to be involved. There are also concerns that they will be unable to review contracts drawn up with independent providers and that their powers to enter and view premises of service providers do not extend to private sector companies. Foundation trusts have over 500,000 members but are little more than empty vessels when it comes to real accountability as they are starved of information and focus only on minor issues. The accountability gap in most foundation trusts is likely to come back to haunt the senior managers as soon as there is a financial or operating crisis. The mutual element of foundation trusts was a last minute add on to sell the principle of independence to sceptical Labour backbench MPs. Patient Opinion, the online forum for feedback on the quality of service, may be a step in right direction, but again it is based on informal feedback not formal accountability whereby views translate automatically to action. Real power is not transferred to either the workforce or the people. All the time that either command and control or choice are the meta-values of the reform agenda voice cannot be mainstreamed.

There is a clear gap between people's experience of involvement in local health decisions and what they want. The Joseph Rowntree Reform Trust Annual State of the Nation Poll 2006 found when they asked 'How much influence do you think you have affecting public services in you local area?' that when it came to hospitals just 2 per cent thought they had a lot, a further 6 per cent thought they had a fair amount and 57 per cent thought they had none at all. Asked 'How much influence should you have on hospitals?', 81 per cent thought they should have a great deal or a fair

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amount. There is then considerable untapped participatory potential.

Not everything could or should be decided by a vote or user and worker voice. But the broad direction of travel and management, delivery and accountability of the service should be governed democratically. There should be no big bang to this democratic reform agenda and certainly no imposed solutions. Instead, experimentation and trial should be unleashed and then mainstreamed over time. Democracy is never a quick fix. It is a complex and time-consuming search for ways of making change popular and lasting change happen that is rooted in values but which allow continuous improvements and changes to be made. At different levels there will be different answers to the democratic deficit the NHS faces. There are lots of ways in which voice, participation and democracy can be established. The following provides an indication of the kind of areas that are worth considering in the NHS.

General practices

General practices are perhaps the easiest place to develop greater democratic accountability because like schools there is a high level of community investment in the surgery through frequent use, often over time periods that are much longer than our temporary interest in schools. An annual general meeting of patients would be easy to organise as a starting point to generate ideas for improvement and complaints. An actual or virtual notice board to trigger issues would also be simple and cheap to set up as would an annual survey of patient satisfaction. General practices and groups, which now have a huge influence because of practice-based commissioning, could instigate citizens' juries for major decisions or develop and deepen the role of informal patient participation groups. Perhaps the biggest and most radical step would be to consider mutualising GP services, either through democratic ownership by patients or extending the model of general practice co-operatives developed to provide out-of-hours services to involve all healthcare staff and registered patients. We could also create opportunities for communities – particularly those communities that have poor primary health care provision – to employ their own salaried GPs. Currently only PCTs can do this but we should seek to create local opportunities for

people to own and shape their own healthcare services.⁷⁶ But at the same time as looking for ways of decentralising control over services we will need to ensure this does not exacerbate inequalities between different localities or groups of users. This could be a particular danger where mutualisation is combined with patient choice initiatives that create a competitive market in which 'successful' practices find ways of 'cream-skimming' the more desirable patients.⁷⁷

Similar issues arise with the increasing role of social enterprise in the delivery of primary and community care, which has been promoted by the government on the grounds that mutuals and other 'third sector' entities are uniquely placed to mobilise staff commitment and involve patients and communities.⁷⁸ We need to look at ways of developing models of provision that are co-owned by staff and patients as an alternative to the profit-seeking multinationals that are now moving into the primary care sector.⁷⁹ But it is essential to ensure that such initiatives do not result in a deterioration of employment standards or the development of a competition for service delivery contracts that will subordinate social values to commercial imperatives.⁸⁰

Hospitals

Hospitals are highly complex organisations, which do not have a long-term client group in the way that schools and general practices do, which is one reason why current foundation hospital governance, involving self-selected members, does not yet work. There is no natural constituency with sufficient interest to vote out an underperforming directorate. General practices and PCTs are hospitals' long-term clients and so hospitals could be democratically accountable to local commissioners, advised by the new health and social care regulator to be created from the merger of the Healthcare Commission and the Commission for Social Care Inspection. If the general practices and PCTs are more accountable to their local community then at least some line of indirect accountability the public can be maintained.

But the movement is away from big general district hospitals. Micro-surgery, personalised drug treatments based on patients' genetic make up, and mobile and easier diagnostics all point towards more local and less

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costly treatment outside hospitals. We could see a complete change in the process of health delivery in the NHS – moving away from GP consultation, referral, diagnostic, waiting list and eventually hospital treatment towards something that is more immediate and engaging – less administered to patients and more created by them. The potential of these advances is what is fuelling the demise of the district general hospital and the rise of poly-clinics and primary care centres. This creates a double opportunity for the greater development of voice. First, people will want to be engaged in the decisions about the closure of hospitals and will rightly be suspicious that the redirection of funding will make services more remote and inaccessible. Ensuring that changes to the pattern of service provision are based on independent clinical assessment and open to local public scrutiny and challenge has rightly been raised as a key issue for the current review into the future of the NHS being conducted by Ara Darzi.⁸¹ Second, the benefits of this technological change will not be captured for the most excluded and disadvantaged unless there is a direct involvement of citizens in the way resources are used, designed and controlled. This arena could be a new battleground between the large multinationals that will produce the equipment and processes that produce and market the technology and the patients and staff that use it. In effect patients will be confronted directly by the large private companies delivering these new methods of treatment much more directly – without the intermediary roles of consultations, commissioners and hospital bureaucracies.

Primary care trusts

At the local or regional level there is huge scope for radical reform. Local authorities could scrutinise primary care trusts (PCTs) in the same way that select committees scrutinise government departments. Local council health overview and scrutiny committees could be given a more formal role to call witnesses and demand papers. It is interesting that Hereford is looking to merge the post of chief executive of their local authority and PCT into one. This could be the first of a single democratic structure covering local councils and local health systems.

Martin Rathfelder of the Socialist Health Association has said that the abolition of community health

councils was a mistake and something like them should be instigated again. This idea should be examined. Can health boards be transformed into regionally elected boards and at what level? Much could be learnt from the best practices of initiatives like the New Deal for Communities and Sure Start. The government has considered allowing local communities ‘to choose who runs their PCT’ – which would certainly be a better way of ensuring their accountability than pitching them into competition for patients.⁸² In Scotland there is growing support for directly elected seats on health boards alongside representation for local councillors, patients and staff. The new coalition government in Wales has promised to ‘reform NHS trusts to improve accountability both to local communities and to the Assembly government’.⁸³ The BMA has proposed the creation of local health councils, elected by and from the public, to represent local views, raise issues and allow community discussion about service development.⁸⁴ The chief executives of PCTs could be elected as an equivalent to local mayors.

All of this speaks to a deeper democratic issue for the NHS – that greater local accountability of health is predicated on the revival of local government. Shortly before the formation of the new Brown administration, Andy Burnham, the then Health Minister, argued, ‘In this more local world, a piece of unfinished business is how to ensure that powerful commissioners, taking vital decisions for the community, have more local legitimacy and are better held to account... Direct elections to PCTs are an option,’ he suggested, ‘but I would prefer a solution that better engages Councillors and MPs in the day-to-day work of the PCT.’⁸⁵ These sentiments have been echoed in a number of ministerial statements since Gordon Brown’s arrival in Number Ten.⁸⁶ By merging health into local government this could be just the kickstart that local democracy in Britain needs.

An important objective must be to ensure that there is adequate public involvement in key decisions about commissioning or service reconfiguration at an early stage, so that we do not have a repeat of the situation in Derbyshire where a local resident successfully took the PCT to the High Court for failing to consult

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before handing general practice services to a major multinational corporation.

Another democratic avenue worth exploring has been suggested by John Denham MP. He recognises that it can be hard for elected managers to implement change because they know they will have to face the voter's verdict and could be too prone to caution. Denham therefore suggests that inspectors and auditors could be elected.

National governance

At a national level, citizens' juries or a people's assembly could be used to discuss, debate and come to conclusions about the trade offs necessary when it comes to the postcode lottery or the adoption of new medicines like Herceptin. But here the government has to be careful. Citizens' juries work if their decisions are binding. They cannot be engagement camouflage for decisions already taken or being made elsewhere.

The National Institute for Clinical Excellence, which issues guidelines on the clinical and cost-effectiveness of expensive treatments with the aim of clarifying universal patient entitlements, runs a citizens' council made up of thirty people drawn from all population groups to contribute to thinking about the value judgements that inevitably influence such decisions. This has been described as 'a unique experiment in deliberative democracy for the NHS and seemingly for almost any healthcare system in the world'. But its role remains marginal and relatively underdeveloped, and it is arguable that much more will be needed along these lines if the NHS is to navigate successfully the crises of legitimacy that are likely to attend such 'rationing' decisions.⁸⁷

One reform being touted as a possible measure for the new premiership under Gordon Brown is for the executive management of the NHS to be floated off to an independent board just like the Bank of England Monetary Policy Committee. The BMA in particular is keen. But this would just signal the political defeat of the service. Running the NHS is not just an issue of ensuring there is better management but involves intensely political decisions about funding and the trade offs between equality and diversity. It is an admission that politicians can't be trusted to take the

right long-term decisions. As Niall Dickson of the King's Fund said recently, 'The trouble is that healthcare is not just a technical function – it is riddled with value judgements. It involves balancing competing priorities and interests. It is highly political.'⁸⁸ The idea for an NHS charter is a better idea – but only if it is determined by the public, patients and NHS workers. Not just by politicians.

Co-production⁸⁹

The democratisation of health is a necessary but insufficient step towards the purposeful modernisation of the service. The transformation of the NHS also lies in the development of co-production. This is the idea that all employees and patients should be at the heart of producing and reforming the service. Unlike customers in a shop, where all we have to do is choose and pay, in a hospital or local surgery we are jointly responsible for making the service work. We have to turn up on time, take our medicine, provide feedback and learn to manage our own conditions.

In a recent article Charlie Leadbeater calls this the 'DIY state'. He says, 'Instead of imposing yet more targets and performance management, we need a different picture of how public services could be organised. The key to this will be to see service users not as consumers but as participants.'⁹⁰ Leadbeater talks about an ethic of participation and self-management based on such successful web-based peer-to-peer systems as MySpace, eBay and Wikipedia. These semi-public initiatives provide a glimpse of a new notion of common goods. The problem with the Leadbeater analysis is that it is overly individualised. Instead we should aim for the 'DIO state' – the 'Do It Ourselves state' – because of the recognition that individuals can only change so much – but acting collectively we can achieve so much more. Cabinet Office Minister Ed Miliband has rightly warned in a recent Demos pamphlet that 'involving users and communities must not be an excuse for the withdrawal of the state – a form of "DIY welfare" in which patients get less support and services get less funding'. It must be a progressive vision of co-production that the centre-left aspires to.

An example of how comes from RED and what they call public service 'mobs'. RED applies the lessons of

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design to public service reform. The challenge was to get patients fit after care. One method was to give them money or vouchers to spend in a private a gym – a classic private sector answer. But gyms rarely work. People usually give up after a month or so. Instead RED encouraged patients who lived near each other to go out walking or running together. The cost was virtually nil but the peer group pressure and camaraderie sustained physical outdoor activity that worked. Participation as co-creators of the service was better than commercialisation, which would have looked at choice and commoditisation as the answer. Examples like this need to be worked up into a systematic alternative to the machine or the market. Not least because as Robert Putnam and others have found, engagement, trust and the building of networks and social capital makes us well. People who join and participate live longer than those who don't.

Empowering staff

Placing staff at the heart of the reform process is the key. As the Chartered Institute for Personnel Development has stressed, successful public service reform depends on 'the commitment, motivation and innovative contributions of all those who work for the public'. The key to this will be the 'quality of the relationship between people and their employer' and the government's ability to 'energise, enable and empower' all staff in the cause of service improvement.⁹¹

Here is at least one lesson we can learn from the best of the private sector. Successful companies like Virgin argue that their most important stakeholder is their staff. If they keep their staff happy and involved then they know their customers will be satisfied. Happy customers means happy shareholders. This argument is backed up by Terry Leahy of Tesco, one of the government's favourite advisers on public service reform: 'The beating heart of Tesco is the checkout assistant and the shelf stacker... What our staff do is determined by how they feel about the company, not by rules and targets... We spend most of our time making people feel good about themselves and the job they do. In the main they don't ground with criticism ringing in their ears.'⁹²

I was struck recently by the BT internet engineer who came to get me back online after a move. First he said how useless BT was now it's been broken into different profit centres with no one accepting responsibility for the whole service as the customer falls helplessly between the network and the server. But it was the way they have made the engineers' working day 'more efficient' that jumped out. Before they would meet in a café and decide between them who would do what jobs. It made sense to stick to one area each to cut down on travelling. These meetings provided the engineers with an opportunity to tell each other about particular issues at certain locations if they had specific knowledge of it. The system worked well and they enjoyed it. Now they never see each other. The jobs come down the line and sometimes the engineers criss-cross London all day. They never get to discuss local problems and solutions. Different profit centres mean they can't guarantee to customers that they can get the service to work for them. Morale has dropped. Work is harder and much less rewarding for them, less efficient for BT and provides a worse service for customers. But BT, like the NHS, is in the grip of people who have only been trained to run machines or markets.

Despite this there are examples to learn from and build on. The home care workers of the Birmingham UNISON branch won central government funding to facilitate a new relationship with their managers – primarily over work rosters. Before relations with managers were to say the least difficult. The work was hard enough and badly paid but inflexible work hours made it harder still, especially for parents. Managers spent the bulk of their time trying to sort out the complex rostering requirements. Through the partnership fund the home care workers took complete control of their daily work load. They began to manage themselves. They became more flexible but more efficient and responsive to those they cared for. The managers were freed up to take on new tasks and in the process the relationship between the two was constructively transformed. Everyone was better off.

An NHS Trust delivering mental healthcare and services to people with learning disabilities in Nottinghamshire, Yorkshire and Leicestershire came to a partnership agreement with staff side trade unions which included a commitment to develop new ways of

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involving employees in reshaping services. Across professional and ancillary services groups of staff with interdependent tasks and common goals could apply to become 'self-directed teams' (SDTs). Each SDT had a clear mission and relevant partners including patients, carers and external agencies. Facilitators worked with the teams to help them generate their own ideas for improving and developing services. Working within policies and procedures established by the Trust, SDTs were empowered to make many operational decisions without having to refer them to senior management. Team members were given greater responsibility for scheduling their own work, looking for innovative ways of improving patient care, and communicating directly with patients, partners and stakeholders.⁹³ Adeline Hunt, a facilitator and staff side rep, has written that 'the SDTs promote real involvement, deliver flexibility, create a climate of innovation and bring decision making closer to the patient'.⁹⁴

In Chester a new mental health facility was developed on the basis of full involvement of managers, employees, unions and service users. 'Building User Groups' were brought together to feed into the design specification for the new building and help with planning the layout of the wards, reception facilities, dining room and other departments. Involvement at these early stages ensured the whole building was fit for purpose and provided for the safety and dignity of those using the service. One innovation was the construction of a mock-up room to give all staff and users a clear idea of what the new facilities would look like. Feedback led to over 100 changes to the layout, including to the location of beds, furniture and lights to enable nurses to monitor patients effectively. High levels of staff involvement have been built on through better communications, involvement in decision making, and enhanced training and personal development, and staff now feel more confident in suggesting changes to the service knowing that systems are in place to take those changes forward. The outcome is more appropriate care being given to users and people being put at the heart of the service and treated with respect.⁹⁵

And it's not only localised examples – some of the most important and extensive innovations the NHS has seen

in recent years have been made possible through the vital contribution and involvement of staff committed to the service. NHS Direct, which gives patients direct telephone access to health service professionals, was the result of a call for new ideas from staff issued by the new Labour government in 1997.⁹⁶ The nurse-led service has proved hugely popular with users, and has been hailed by UNISON as 'public services at their best'. And trade unions played an absolutely vital role in the design and implementation of Agenda for Change, a radical redrawing of professional and occupational boundaries aimed at ensuring the NHS has the right people in place to deliver high-quality, flexible and responsive care to patients.⁹⁷

Until now these experiences have been the exception rather than the rule, and policy makers have yet to seize the opportunities that could be created by empowering and mobilising public service employees as leading agents of change. Co-production has not been mainstreamed. But more recent government statements give some hope that a new start is possible. Earlier this year Andy Burnham, then still minister at the Department of Health, reported back to Patricia Hewitt on the lessons learned from his days spent shadowing NHS staff. He had realised that 'the NHS is not good at giving its front-line staff a sense of empowerment. People with good ideas do not feel that they can easily put them into action; there is a prevailing sense that those decisions are taken by somebody else.' The future for the NHS lay not with more targets and top-down management but 'bottom-up empowerment of not just patients, but staff too', developing 'innovative systems – such as the LEAN management system – to equip staff with the skills to lead change in their area. Changes instigated and developed by staff are more likely to succeed.'⁹⁸ There is a wealth of international evidence to suggest that involving employees as partners in change could have a transformative effect on levels of productivity and innovation.⁹⁹

The NHS Institute for Innovation and Improvement has suggested that the service needs to move on from 'planned or programmatic approaches to change' to a deeper engagement of NHS staff.¹⁰⁰ Don Berwick of the Institute for Healthcare Improvement in Boston said when visiting the NHS: 'Prevailing strategies rely

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largely on outmoded theories of control and standardisation of work. More modern, and much more effective, theories of production seek to harness the imagination and participation of the workforce in reinventing the system.¹⁰¹ On this basis the NHS could come to resemble something akin to a social movement – based on the recognition that large-scale change in organisations relies not only on ‘external drivers’ but the ability to connect with and mobilise people’s own ‘internal’ energies and drivers for change, in so doing, creating a bottom-up, locally led, ‘grass roots’ movement for improvement and change.¹⁰² As a vehicle for socialising engagement the NHS could be much more open and participative – allowing us all to contribute in more active ways than simply paying our National Insurance and raising money for a new scanner. There is a huge amount of good will to build on – ranging from volunteers in the WRVS café, volunteer drivers, visitors and so on through to the huge effort people display in giving blood. Full-time staff need to be paid properly but additional aspects of service and provision could be developed and served by wider social responsibility.

Renewing professionalism

Professionals have been under attack since the ascendancy of neo-liberalism in the early 1980s. Rational choice theory holds that professionals will only act in their own best interests and cannot be trusted to serve the public interest. One of the key challenges for a new left is to re-establish the legitimate role of professionalism in public services – but in a modernised form that takes into account the end of the era of deference and paternalism in which professions once flourished.¹⁰³

Professionals are defined by their training, independently validated expertise, qualifications and therefore rules of entry into the profession. They can and must think about the public interest over the long term for the good of society precisely because they are not elected and not slaves to the market. Their driver is not profit but should be pride in a job well done and a sense of civic duty. Professionals have to be trusted at the point of advice or decision. It is an elitist concept.

They know more because they have been trained and educated in ways the public haven’t. There is a tension between this exclusivity and the rights of citizens to participate and have a voice. Better informed citizens because of the internet are already producing a different relationship with professionals. But it will always be professional judgement that has a huge bearing on the quality of public service delivery especially in health. Their judgement cannot be regulated, audited or commercialised away without services deteriorating. Neo-liberals hate professionals because they represent a ‘rigged market’. According to David Marquand, professionalism is not just ‘non-market but anti-market’.¹⁰⁴ The underlying premise of professionalism is that society will be better off if competition is not free and prices are fixed.

The democratic left needs to back a modernised form of professionalism in the NHS. It’s not as if professionals are putting up a fight against the involvement of the public. In a survey by Involve, 93 per cent of health professionals say that ordinary people should have a say in how their local health service is run and that this would improve the service.¹⁰⁵ But the job of working out how professionalism can still fit with our less deferential times is a key task.¹⁰⁶

Deepening democracy, empowering staff and developing a new professionalism will not be easy. Building trust, confidence and governance capacity will take time. We need to acknowledge how difficult it is to get input from citizens and patients from all sections of society. Most forms of public/patient/user input attract the ‘usual suspects’. One of the reasons for this is that some of the questions are highly complex, and the formats of consultation assume a level of education (and use of English) that not all possess. And then there are the ethical problems: the danger of lack of support for services whose users may be stigmatised. It will take investment and resources to facilitate meaningful dialogue and decision making. But everything else has been tried and has failed to unlock the systemic and holistic improvement the service needs. Democracy is the last hope.

Conclusion

The left believes in public services because they are one of the most important means of ensuring the redistribution of life chances. After all, 'we are all equal in our pyjamas'. Since 1997 the NHS has become a better service. Cancer and heart services are significantly improved. Staff are better paid and there are more of them. New institutions like NICE have proved a success. And the terms of debate about tax cuts versus public service investment have been effectively turned around. The 2001 general election campaign around National Insurance increases was the high watermark of this progressive trend. But the space and time that has been won to reform the NHS effectively over the long term is being squandered.

markets have no morality, they are as happy to sell us organic food or chips, diet pills or chocolate, cigarettes or Nicoret patches. It doesn't matter what it is as long as it sells.

The public believe the NHS is now in permanent chaos. Neither the machine nor the market is working. A mix of competition and control is failing to deliver. The worry is that the improvements are a one off bought by the huge increase in investment that can't and won't be sustained without a change in the culture and operating

practices of the service and those who lead it. David Cameron, like a benign vulture, is waiting in the wings if things continue to go wrong.

Politics is about gambles made on values and instincts. New Labour's gamble to date has been that a mix of commercialisation and centralisation will keep the middle classes on board through more choice-driven services. The gamble of the democratic left is that democracy and participation is the answer to the paradox at the heart of the NHS and our need for equality and our desire for diversity.

In choosing choice New Labour has attempted to force its view of freedom on us. 'Freedom' is to be

handed down through targets, bureaucracies, incentives or a limited range of choices that are pre-selected for us. Their goal seems to be a nation of health service switchers, like those who scour the *Mail on Sunday* finance pages for the best deal on their mortgage. But markets have no morality, they are as happy to sell us organic food or chips, diet pills or chocolate, cigarettes or Nicoret patches. It doesn't matter what it is as long as it sells.

Martin Newland, writing in the *Guardian*, said: 'Despite being in government for nine years, New Labour has never really learned how to govern. It has bypassed the boring, methodical process of civil servant-assisted government in favour of eye-catching initiatives, quangos and paid advisers. Spending in key areas has become diverted away from the front-line – away from actually making people healthier.'¹⁰⁷

The democratic left have a different conception of freedom. This is not just the freedom to purchase goods and services as individuals but to be free to determine what kind of NHS, hospital and social care we want. This is freedom based on collective voice and is about control over our lives and our world. Such freedom can only be won from the bottom up and created by the people who work for the NHS and use it.

To work, the NHS has to be a family, but after ten years the staff and patients don't love the government and the government, at least until recently, has shown little appetite to love them. All that money spent, all those plans and reforms, all those speeches and initiatives, and where have they got us? At best on contested terrain with the Tories. This is not preparing us for the future. The Nobel Prize winning scientist Sir Paul Nurse predicts that the entire system of private medical and life insurance will shut down in 40 years because of genetic predictability. Only the NHS offers a way forward. Brown offers an opportunity for a fresh start. It is an opportunity that cannot be wasted again.

The NHS is one of the few remaining places where the values of the left resonate. The strength of

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public commitment to be 'free at the point of need' and therefore notions of social justice have so far weathered the storm of neo-liberalism. But the patience of the patients is not infinite.

The NHS prefigures the kind of world we want to live in. The NHS must be a cathedral of social healing valued for what it is – not just for what it does. The NHS is there to make people better but so is BUPA. For the left there has to be a difference, otherwise the market will rule everything. We cannot live secure and free private lives without public services that secure for us economic and social rights which make us equal citizens. Equality is not some Old Labour baggage that we just have to nod to. Rather it is the prerequisite of a modern, open and progressive society in which all benefit and all contribute. Citizens are by definition equal and market rewards are by definition unequal. That is why we must fight for a modern NHS built on Labour values.

The left has been in retreat in part because the fear of the unregulated and unaccountable state is greater than the fear of the unregulated and unaccountable market. Unless we can show that the state can be democratised and personalised then the market will continue to win. David Marquand sums up the challenge well when he writes, 'The state ceases to be a commander or a controller, and becomes learner along with other learners – and, of course, a teacher along with other teachers.'¹⁰⁸

So the narrative of reform has to be dramatically changed. It will take a long time and there is no final destination. All of this must be explained and people allowed to respond. They are waiting to be treated as responsible grown ups. The starting point is the observation of Peter Kostenbaum that 'our institutions are transformed the moment we decide they are ours to create'.¹⁰⁹

In 1946 Bevan sent a pamphlet to every household about the future of the NHS. It is time to instigate another great debate about the most important institution in our society. The moment is right to do it again – only for our age and our time.

Brown could be opening the way to a new era of social democratic advance, by creating new mechanisms that could deepen people's democratic involvement with social issues and social goals

On 4 July 2007 the new Secretary of State for Health Alan Johnson announced a fundamental review of the NHS to be led by Professor Ara Darzi. The aim, Johnson said, was to have an NHS that was 'clinically led, patient-centred and locally accountable'. Encouragingly, he recognised that this could not be a matter of imposing another blueprint from above:

'The best of the NHS sits not at the top of the organisation, but in the millions of complex, diverse relationships which exist across the country between dedicated, devoted professionals and their patients. The success of the review will depend on gaining access to these relationships, and stimulating a range of lively, local, provocative debates.'¹¹⁰ The goal: 'a new, closer, more robust social partnership between patients, practitioners and policy makers, based on trust, honesty and respect'.¹¹⁰ Following the initial publication of an interim report identifying immediate priorities,¹¹¹ Lord Darzi is inviting the views of patients, public and staff through a major online consultation and debate combined with specialist forums and local events.¹¹² This will form the basis for the publication of a new 'vision for a world class NHS' to be published in June 2008 in time for the 60th anniversary of the NHS. This may be accompanied by the publication of proposals for a NHS constitution as part of 'a new and enduring settlement for the NHS' that would 'enshrine the values of the NHS and increase local accountability to patients and public'.

These aspirations can be seen as continuous with the broader project that Gordon Brown has begun to sketch in terms of rebuilding public trust and confidence in state action and social provision by

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finding new ways of democratic engagement about the public good. In his first statement to the House of Commons to launch his new programme of constitutional reform, the new prime minister set out his goal of forging 'a stronger shared national purpose – by a new relationship between citizens and government that ensures that Government is a better servant of the people'.¹¹³ In his characteristically cautious, incremental, yet strategic way, Brown could be opening the way to a new era of social democratic advance, by creating new mechanisms that could deepen people's democratic involvement with social issues and social goals. An inclusive debate about the future of our National Health Service, and a new NHS constitution that could secure its values at the same time as embedding democratic deliberation as central to its day-to-day working, could be a critical element of this story. But the success of such an initiative will depend crucially on the active contributions of patients, staff, user groups, trade unions, local

communities and the public at large; and a government that is genuinely prepared to listen and bold enough to act on what it hears. If we had started with this sense of purpose and direction ten years ago then sustainable progress would now be being made. But it is never too late to do things right.

In September 2007 Gordon Brown made a speech about democratic renewal in which he said, 'I don't agree with the old belief of half a century ago that we can issue commands from Whitehall and expect the world to change. Nor can we leave these great social changes simply to the market alone ... it is people who are engaged in changing the world as individuals, parents, neighbours and active citizens.' He went on to say that his vision was 'a politics built on engaging with people, not excluding them'.¹¹⁴ No issue is closer to the people's hearts than the NHS. If they don't engage on this issue they won't engage on anything.

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