

Democratic engagement in the local NHS

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Introduction

Any examination of democracy in the NHS is troubled by confusion and complexity. The 'NHS' itself is a term which needs unpacking and arguably it would be more accurate to say 'health system'. Significant elements of the English health system, on which this essay primarily focuses, now lie outside the NHS proper. Public health has been transferred to local authorities. Local authorities also host both the Health and Wellbeing Boards, which oversee health strategy and foster greater integration of health and social care and more joined-up commissioning; and health scrutiny committees, which review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area.

Additionally, the 2012 Health and Social Care Act builds on New Labour policies to extend market principles and diversity of provider so an increasing number of health service providers will be from the 'independent' sector and by 2016 organisations supporting the commissioning function of clinical commissioning groups (CCGs) may also fall outside the public sector.

A source of confusion lies in the multiple forms of participation and involvement which proliferated, particularly under New Labour's public and patient involvement (PPI) agenda, but which did not necessarily contribute to *democratic* accountability or democratic determination per se. Both democratic determination and democratic accountability matter. By democratic determination, I mean the ability as citizens, rather than as consumers, to shape the overall direction of policy and the principles upon which that policy rests and to shape in broad terms the allocation of resources. The ultimate test here is whether it is possible that citizens can require commissioners and senior managers to change course when they would otherwise not have done so.

Democratic accountability refers to the requirement to give an account for one's actions before the public and the public's elected representatives and to be held responsible for those actions, suffering punishment if necessary. This essay focuses on influence exercised locally rather than nationally and on citizen rather than consumer engagement. This is a conceptually fraught area¹ but where consumers (service users and carers) are concerned more

with individual experiences of received services, citizens have a wider remit in considering not only the consequences for themselves but also the consequences for different groups in society and for different aspects of our socio-economic and politico-cultural lives.

Changing arrangements for local ‘voice’

There is nothing new about a democratic deficit in the health service. The NHS of 1948 was notably paternalistic and medically dominated with a system of accountability which went upwards to ministers but not outwards to patients, public and local community. This was addressed to some extent through the creation of Community Health Councils (CHCs) in the 1970s. These were far from perfect: they were under-resourced relative to the scope of their activities, operated under a complex accountability structure, and had no right to be consulted on matters of service design or strategic planning. However, some of them proved very effective in handling complaints and in focusing public opposition to unpopular local policy proposals and their abolition under New Labour was controversial.²

Their combination of championing individual patients, ascertaining local views and rallying local citizens to challenge unpopular policies has not been re-created in any single body and the replacement arrangements comprise an array of patient and public involvement mechanisms. The immediate successors to CHCs were themselves abolished in 2008. These institutions were subject to criticism for fragmentation, incoherence, difficulties in recruiting members, lack of independence and limited powers.³

Overall, the repeated disruption of systems for patient and public representation undermined the ability of individuals and institutions to build up knowledge, skills and experience in effective intervention. That this occurred during a period in which the health service was restructured along market lines and service reconfiguration was rarely out of the headlines reinforced the impression among critics that governments welcomed consumerist models of involvement but sought to make it impossible for people to mount an effective challenge to policy as citizens.⁴

So, although a plethora of modes of involvement was developed under New Labour’s PPI agenda, most of these did not amount to democracy⁵ and indeed may even have undermined it by conferring a spurious legitimacy upon policies determined by local health decision-makers. The very volume of channels for participation may have distracted attention away from the scantiness of real power.

Under the coalition government, the flagship engagement policy is Healthwatch, but this, too, does not look as if it will offer a strong means for democratic engagement. Each local authority is required to contract an organisation to provide a local Healthwatch, established as a social enterprise. Local Healthwatch is charged with providing feedback to providers about service user experiences in health and social care; representing the views of patients and public to the Health and Wellbeing Board and ensuring they are taken into consideration in needs assessment; and reporting concerns about quality to Healthwatch England (a national body).⁶ Healthwatch has a right to refer matters of concern to the local overview and scrutiny committee.

Early criticisms of Healthwatch have emphasised its under-resourcing, role confusion and role dilution, the steep challenges it faces in becoming a representative body and its possible incorporation or part incorporation through membership of the Health and Wellbeing Board (along with being contracted by the local authority).⁷

Barriers to democratic engagement

Before considering genuine opportunities for democratic engagement, it is worth considering some of the barriers. One concerns the scepticism with which citizens may approach engagement in formal involvement mechanisms. For example, a frequent complaint surrounding local consultation exercises is that local managers have made their decisions prior to the consultation.

Second, bodies charged with championing the patient and public interest have typically in recent years had weak powers. Healthwatch, for example, has no right to compel the directors of relevant institutions to attend meetings and answer questions. This lack of powers pushes the organisation to see representation and championing as a matter of technical and procedural accomplishment rather than as a political process characterised by tension, negotiation or conflict between counterposing powers over differences in values and interests and competition over resources. These organisations might even pride themselves on being studiously *apolitical*. This can reinforce a view that involvement is intended to be carefully managed.

Third, would-be participants can find themselves swamped by the complexity and sheer scale of organisational structures and processes. This is compounded by repeated restructuring in which it takes months or even years for those working within the system and other experts (never mind patients and citizens) to comprehend new processes, functions and relationships and a changed distribution of resources. Alternatively, participants can get bogged down in involvement processes focused on the details of implementation and lose sight of the overall direction of local or government driven policy.

On a more practical level, some of the involvement mechanisms, such as local authority or CCG meetings, whilst held in public, take place during the working day. Business is conducted in an arcane language, incomprehensible to many people, and documented on an industrial scale. Documents for some Trust meetings can run into hundreds of pages. Even briefer documentation can cover complex issues and be presented in a way which makes it difficult or impossible for those outside the organisation to follow and interpret. The

challenge of navigating this vast and difficult terrain – with documentation for some meetings sometimes released only one week in advance - can be even more off-putting if the would-be participants suspect official documents are deliberately used to hide information which local managers and decision-makers would prefer not to be noticed. As is the case across public services more widely, members of the public must also grapple with technical details which often in modern governance become central to arguments designed to justify certain policy preferences. For instance, technical arguments based on specialist knowledge feature prominently (and sometimes inaccurately) in arguments surrounding proposed service reconfigurations (e.g. the argument that bigger, fewer units will produce better outcomes).⁸

Finally, in some respects the big bang system reform enshrined in the 2012 Health and Social Care Act with the dramatic extension of the market model, itself and at a very fundamental level, undermines the abilities of citizens to hold health service providers to account. An increasing portion of health services will be provided by commercial providers who are not required to answer information requests under the Freedom of Information Act and whose NHS clients are not protected by human rights legislation.

It will also be difficult for the public to keep up with which organisation has which contract, which contracts are up for tender, and what precisely different companies and third sector organisations are providing. Furthermore, it will be an arduous matter to hold the relevant public commissioning authority to account for services they no longer deliver. This is likely to become all the more complex under the new principal contractor-subcontractor model whereby a large contract for NHS services is signed with a single provider which can then *sub*-contract to other providers. Again, these difficulties will be encountered in other public service sectors where comparable market policies are being implemented.

Strengthening local democracy in health

If we consider where democratic engagement might be real and effective, it is in the local authority that perhaps the greatest potential for genuine citizenship influence over decision-making is to be found. Local authority committees include and are chaired by locally elected councillors. The health overview and scrutiny committees (OSCs) were established following the Local Government Act of 2000 and took on the function of scrutiny and the powers to consult previously held by CHCs. Currently these committees typically embrace scrutiny of social care as well. Although variable in effectiveness, they have become particularly significant in relation to controversial local, regional or national plans to reconfigure health services, especially where local services are threatened with closure.

As well as responding to NHS consultation exercises, citizens individually – but, more effectively, collectively through campaigning – have been able to ensure their views are heard by addressing their concerns to the OSC. OSCs have the power to require health service managers to supply information and to account for their proposals and decisions and for their provision and they also have the power to refer key decisions about substantial health service changes to the Secretary of State for review (another power inherited from CHCs). In the case of the reorganisation of children’s heart surgery across England, for example, this power has had a major impact in halting the proposed changes.

Changes introduced under the coalition government (section 190 of the 2012 Health and Social Care Act) expand the remit of OSCs to encompass independent sector providers which are equally (with public providers) required to provide information, attend meetings, answer questions and consult when substantial changes to health services are proposed. The changes also transfer both the duty of scrutiny and the power to refer to the council as a whole. This means that a larger group of people would need to be convinced of the benefits of a referral - but also that any referral made would carry greater legitimacy. Any campaign which hopes to succeed in halting unpopular reconfiguration proposals must expect to have to convince the OSC first.

The establishment of an Independent Reconfiguration Panel in 2003, charged by the Secretary of State to review contested proposals, gives citizens a third opportunity to ensure their views are heard. There are some important caveats: legislative changes have raised the bar in terms of the criteria the OSC must consider before referring a decision to the Secretary of State and the impact of these is yet to be seen. Of course, the extent to which OSCs and council chambers as a whole are minded to support local opponents of reconfiguration decisions is likely to be shaped to some extent by party political matters as well as local sentiment and the wider prevailing debate.

Overall, I would see OSCs as one of the few elements of public engagement in the health system which really has teeth – that is, where citizens have, under certain circumstances, been able to shape important decisions (e.g. where campaigners halted plans to downgrade Horton General, Banbury, in 2008).⁹ This space is created partly through exploiting local political tensions and partly through the distance that local councillors have from the NHS itself. Perhaps the more the perspectives of councillors and NHS senior personnel converge, the greater the likelihood that this space for effective lobbying by organised citizens will shrink.

It remains to be seen whether the other key local authority committee, the Health and Wellbeing Board, is able to offer the same potential. It may be that precisely as greater responsibility for health transfers to local authorities, the more local councils will be tempted to ignore, defuse or re-route rather than champion local opposition to health service decisions. Health and Wellbeing boards include in their membership senior personnel from NHS commissioning organisations and social care services, so the critical scrutiny perspective of OSCs will not be replicated exactly. On the other hand, councillors may on occasion see political capital in responding to local concerns.

Local democracy in health could be strengthened through reducing the scope of the ‘exempted information’ which public and private organisations are not required to give to the OSC (Schedule 17 of the 2006 NHS Act).¹⁰ This includes information which could be described as ‘commercially sensitive’ such as the value and terms of contracts to provide services. This constitutes precisely the sort of information in which local citizens could legitimately expect to have an interest given that public services and public funds are at stake.

Democracy could also be strengthened through enabling local Healthwatch to plan for an adequate programme of work by good funding levels and through extending its powers to enable it to compel personnel from any local health and social care organisation (public, third sector and private) to attend meetings and answer questions. Perhaps above all Healthwatch needs to develop a robust culture in which it is prepared to criticise and challenge NHS bodies, providers and the Health and Wellbeing Board vociferously if needed. It is difficult to see how this last can be achieved whilst Healthwatch continues to be contracted by the local authority since a Healthwatch which challenges the functioning of the local health service could find itself branded as troublemaking and its contract unrenewed.

Conclusion

In conclusion, one of the inbuilt problems of public involvement in the health system is the unavoidable fact that the terms of consultation and involvement are always set directly by the government or by the institution concerned within a legislative framework. This does not matter so much when one presumes a consensus in the health world and sees the improvement of public involvement as a question of technical challenge within a time- and resource-constrained context. It does matter, however, if one perceives conflicting interests and if one doubts that exhortations to public involvement reflect genuinely held desires to empower patients and public. Through this latter perspective, involvement systems are set up which can both deliberately limit the influence of patients and public and *create the impression* of real influence.

The real measure of the seriousness with which public and patient involvement is taken is the ability to get things changed. Getting things changed at the level of detailed implementation does have value but it reflects less power than getting things changed at the level of the overall policy framework, locally or nationally. The question is could public engagement ever result in local commissioners or managers doing something they otherwise would have wished not to do. This does occasionally happen but not, usually, as a result of formal public involvement mechanisms alone but rather as a result of a sustained extra-organisational political campaign, some of the energies of which might be directed into the formal processes.

Notes

¹ Needham, C. (2003) *Citizen-Consumers: New Labour's Marketplace Democracy*. London: Catalyst Forum

² Klein, R. and Lewis, J. (1976) *The Politics of Consumer Representation: A Study of Community Health Councils*. London: Centre for Studies in Social Policy; Hogg, C. (2009) *Citizens, Consumers and the NHS: Capturing Voices*. Basingstoke: Palgrave Macmillan; Royal Commission on the NHS (1979) Report. Cmnd 7615. London: HMSO.

³ Baggott, R. (2005) 'A funny thing happened on the way to the forum? Reforming patient and public involvement in the NHS in England', *Public Administration* 83 (3) 533-551; Hogg, 2009; House of Commons Health Committee (2003) *Patient and Public Involvement in the NHS. Seventh Report 2002-03*. London: Stationery Office.

⁴ E.g. see Milewa, T. et al (2003) *Public involvement and democratic accountability in primary care organisations*, in B Dowling and C Glendinning (eds) *The New NHS: Modern, Dependable, Successful?* Buckingham: Open University Press

⁵ E.g. Chandler, D. (2001) *Active citizens and the therapeutic state: the role of democratic participation in local government reform*, *Policy and Politics*, 29 (1) 2-14; Hogg (2009)

⁶ Healthwatch (2013) *Understanding the legislation: An overview of the legal requirements for local Healthwatch*. Healthwatch; Secretary of State (2013) *The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations*. London: The Stationery Office

⁷ Gamsu, M. (2012) *Healthwatch set up to fail? A Local Democracy and Health Discussion Paper*.
<http://localdemocracyandhealth.files.wordpress.com/2012/02/Healthwatch-discussion-paper2.pdf>

⁸ E.g. Ruane, S. (2007) *Report Commissioned by Rochdale Borough Council Re: The Healthy Futures and Making it Better Proposals for Health Services in Rochdale, Rochdale MBC*.

⁹ Ruane, S. (2011) 'Save our hospital campaigns in England: Why do some hospital campaigns succeed?' in J Lister (ed) *Europe's Health for Sale: The Heavy Cost of Privatisation*. Southampton: Libri Books

¹⁰ The National Health Service Act 2006.
<http://www.legislation.gov.uk/ukpga/2006/41/schedule/17>