NHS REFORM:

CONSUMERISM OR CITIZENSHIP?

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SUMMARY

Reform of the NHS is progressing rapidly, but it is difficult to discern a clear underlying theme or sense of direction of that reform.

The Government has committed greatly increased funding to the NHS on the basis that it is accompanied by thorough modernisation and reform. If the aim is to improve the health and well-being of people in England, the health service needs to be designed in a way which is most likely to deliver this objective.

To date, it seems that the reforms embrace both a consumerist and a citizenship approach. The consumerist approach, making use of familiar tools and techniques of the market, has played an increasing part in public sector reform over recent decades, in an endeavour to improve efficiency. Such an approach in the long-term will not result in a system designed for the best interests of patients, nor will it be in the wider interests of communities.

This paper suggests that the citizenship approach is the more appropriate basis for reform of the NHS for the twenty-first century, and that it is more likely to provide a platform to change attitudes towards health issues, and encourage greater responsibility for personal health.

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1. Trying to understand NHS reform

"Commissioning a Patient-led NHS" signals another major step in NHS reform. PCTs are to become commissioning-led organisations with their service provision reduced to a minimum. Although the blanket policy ordering PCTs to divest themselves of service provision has now been modified, so that PCTs are now to act as providers of services only where it is not possible to have separate providers, the broad direction of travel is clear.

This latest document appears to be the cue for the creation of new types of providers of services, for independent providers to start competing for a share of the primary care market, and for ambitious foundation trusts to grow their business and secure more income. For sure, such change will result in significant upheaval for those working in primary care, and those who depend on the services. It will be worth going through such change if the end result is a better designed system, providing improved services for patients, which are more responsive to local needs. But what is the overall direction of reform, and how do the dramatic changes now proposed in primary care fit into it?

"Patient-led" is based on the concept of choice (for patients); choice over which provider delivers their healthcare. The commissioners have a responsibility to provide patients with a range or "plurality" of providers (including the private sector) from which the patient can choose. The PCT (the state) is becoming an enabler, a mechanism to allow choice, not a provider.

"Patient choice" is a feature of a consumerist approach, giving the patient a kind of market-place from which to choose a healthcare provider paid for by the NHS. From the providers' point of view, it brings with it another familiar feature of the market – namely competition. Competition is a well-known method of driving out inefficiency, and driving up quality, as the market (consumers) invariably chooses the best supplier. Patient choice will ensure that those providing the best and most efficient service will thrive at the expense of those who do not.

The introduction of competition is certainly not the first feature of the market-place to be brought into the NHS. Other features which are familiar in a market-based context have been introduced over recent years: the use of commercial contracts; payment by results; using private firms to undertake NHS functions; the encouragement of "entrepreneurs". These are all the sort of thing one expects to find in the market-place, and which have been introduced into the NHS.

To some extent the ground had already been laid for this sort of approach by the Conservative reforms begun in the early 1990s with the introduction of the internal market, which created and separated the two roles of procurer (nowadays commissioner) and provider. By establishing within the NHS a separate body of commissioners, the objective was to enable those commissioners to hold providers to account through contracts, and to ensure that value for money was obtained. It is all to do with creating a mechanism to drive efficiency and success.

The purpose of reform is to get improvement; improvement in the service received by users; improvement in efficiency and value for money for the payer; and improvement in working conditions and job satisfaction for those delivering the service. Market-based features such as those just identified have been introduced into the NHS to secure improvement. Such features are seen to work well in the market and to secure clear benefits (driving efficiency and success), and therefore seem appropriate to introduce into the NHS to deliver similar benefits.

Is this the rationale behind NHS reform over recent years – introducing market-based features to drive efficiency and success – and is this what will continue to guide future reform?

Brief review of some key policy documents

The NHS Plan published in July 2000 heralded sustained increases in funding together with far reaching reforms.

Subtitled "A plan for investment; A plan for reform", the NHS plan acknowledged that there had been too few doctors and nurses and other key staff to carry out all the treatments required. There was to be a substantial increase in funding to provide the additional resources, but this was to be accompanied by reform of what was considered to be an out of date system.

The conclusion reached following a review was that the principles of the NHS were sound, but its practices needed to change. Changing practices meant not just working-practices on the front-line, but a coming together of social care and NHS, and the devolution of power from the Department of Health to local health services. At the centre of the vision for reform was the concept of redesigning the NHS around the needs of patients.

The NHS Plan – a progress report was published in October 2003, reporting on progress achieved in the year October 2001 to September 2002.

The NHS Plan had identified a number of key areas where reform was needed. It identified a lack of national standards; old-fashioned demarcations between staff and barriers between services; a lack of clear incentives and levers to improve performance; and over-centralisation and disempowered patients. The progress report provided an update on increased capacity and resources, improvements in quality, and a broader range of services as well as newly configured services.

The progress report also highlighted an important principle that was central to modernising and improving the delivery of services, namely choice. Patients are no longer just to have the old "take it or leave it" care on offer. Instead they are to have a choice of where they go for treatment. In order to provide this choice, it was recognised that a plurality of providers needs to evolve.

Four years after the NHS Plan, ***The NHS Improvement Plan: Putting People at the Heart of Public Services*** was published (in June 2004).

This document set out the priorities for the NHS for the next four years. A central feature of this document was the continuing theme of choice, giving patients the right to choose from at least four to five different healthcare providers, paid for by the NHS. This would include independent providers, who by 2008 would provide up to 15% of procedures on behalf of the NHS. In primary care too, PCTs would have new flexibilities to commission care from a wider range of service providers including the independent sector.

The NHS Improvement Plan saw patient choice as a key driver of the system, with resources able to flow to hospitals and healthcare providers that are able to provide high-quality and responsive care. PCTs would control over 80% of the NHS budget through which they would be able to secure the best possible deal for patients.

The White Paper ***Choosing Health*** developed the theme of choice in the context of improving health and preventing disease, but beyond just providing treatment for those who

are ill. An extensive consultation had established that people wanted to take responsibility for their own health, choosing their own diet and lifestyle (not being told by the Government how to live their lives), and the role of the state was to support people in making those choices. Providing information to enable people to make healthy choices as consumers; supporting children, young people and those caring for them in developing a healthy framework for life; promoting healthy living, providing a healthy environment, addressing health inequalities, providing a good working environment, all of these were important in promoting physical and mental well-being and preventing illness.

When looking at these and other NHS policy documents (including Commissioning a Patient-led NHS), it is difficult to identify an underlying vision or theme underpinning NHS reform. Indeed, the accumulation of a substantial number of policy initiatives makes it difficult to comprehend the overall direction, or to be able to summarise what is happening. It seems that many answers are being provided, but it is not clear what the question is.

If the unifying theme of reform is to follow a market-based approach and to use the techniques and tools of the market as the basis for reform to drive efficiency and success, then this is not overtly stated in the policy documents.

But if, as increasingly appears to be the case, the tools and techniques of the market are being introduced into the NHS, then what is the vision underlying NHS reform?

2. The fundamental question

The NHS Plan does not really address this. As already mentioned, it heralds increased funding for the NHS, but on the basis that increased funding is to be accompanied by necessary reform (a recurring theme for New Labour in public service reform).

Many areas are identified as needing reform, and these are being and or have been addressed one by one. But some of those reforms themselves open up fundamental questions about the direction of travel, effectively prior questions which do not appear to have been asked first.

The NHS Plan does state that the NHS has examined other forms of funding healthcare – and found them wanting. The conclusion was that the "principles of the NHS are sound but its practices need to change."

What can we glean from this? Probably that two things are not up for discussion; namely the funding of healthcare from central taxation; and a continuing statutory responsibility for the state to ensure that there is a health service which is free at the point of delivery. These are at the heart of NHS legislation, and it is assumed that these areas are not up for change; they are the givens.

So what does that leave which might be subject to reform? We can see now that it leaves more or less everything that comprised the NHS in 2000; namely the services being provided; how the services are provided; and who provides the services. As the NHS Plan stated "over the next few years, the NHS will be modernised from top to toe".

Such a comprehensive review must start from a clear vision of what the NHS is for. Perhaps the most succinct statement of purpose used to appear on the DH website: "Our aim is to improve the health and well-being of people in England". That appears to be a timeless vision, which was just as applicable in 1948 as it is today.

But the NHS only plays a part in health and well-being. Before even considering health and social care, it is important to recognise that there are other more significant determinants of health and well-being than care: namely genetics, life-style, and broader social, cultural and environmental conditions. From a policy perspective, health and well-being are inextricably linked with housing, education and employment, to name just the most obvious areas. Any broad review of the NHS has to take account of this, and of the necessary interplay between a structure primarily focussed on the delivery of health and social care and this wider context into which a reformed NHS must fit.

In modernising the NHS therefore, the aim must be to provide a health service which is designed to achieve its purpose, and which is as efficient and as successful as possible at delivering it. This involves providing services and playing a part in the wider field of determinants of health and well-being. It follows that wholesale or "system reform" as it is called involves looking at the health service afresh, and not being tied to the structures, practices and philosophies that were put in place in 1948 and thereafter. In short, it involves deciding what sort of health service is most likely to improve the health and well-being of people in England today and for the foreseeable future.

The starting point is basically a statist one – an NHS owned and controlled by the state. Whilst such a model was a necessary stepping-stone to achieving a *national* health service in 1948, the statist approach is now believed by many to have outlived its useful life. Central

ownership and control no longer appear to be the best way to improve the health and well-being of people in England.

The fundamental question at the heart of NHS reform is this: if the statist model for the NHS is no longer the best way to improve the health and well-being of people in England, what is?

From developments and reforms over recent years, it is possible to identify themes which suggest two possible answers to that question: a consumerist model, and a citizenship one. To date as will be shown below, NHS reform appears to be hedging its bets by adopting features of both of these approaches. At some point, a choice needs to be made; the fundamental question needs to be asked, and answered.

3. First option – the market-based or consumerist approach

If you are trying to improve state-run services, making them more efficient, better value for money and more responsive to the users' needs, market-based approaches are irresistible to governments of any political persuasion. The reason for this is that the market is seen as a good way to drive efficiency and success – the private sector is thriving, by delivering what it sets out to achieve.

Why is the private sector model so successful?

The basic reason is that the business models used for private businesses *are designed to achieve their purpose*, namely to provide a financial return to investors. Their reason for existence is to generate this return. The investors (shareholders) are the owners of the businesses, and through the power of ownership they can ensure that the business delivers *their* priority of making a return. And the whole system is underpinned by a legal framework which imposes duties on those running businesses (directors) to ensure that nothing comes before that duty to make a return for the investors.

It is this alignment of purpose, ownership and power, underpinned by law, that makes the private sector model so effective at driving efficiency and success. Investors must have their return. The only way to deliver that is by running a successful business to deliver the profits which the investor requires.

Putting the interests of investors at the top inevitably means that those of customers, employees and the wider community come second. However, whilst the business is providing good products or services, generating jobs and not visibly damaging the local environment, then the fact that somebody else is making a profit is not normally a particular issue for customers, employees and the local community. But be clear: the *purpose* (or reason for existence) of an investor owned business is to make a return, not to provide a service. The business (providing a service) is merely the means to an end.

Private sector bodies succeed by competing with their rivals, on cost and quality, and winning business. This enables them to increase their profitability or margins, and pay a higher return to investors. This in turn can fuel the growth of the business and an increase in its capital value, to the benefit of its investor owners.

Competing means trying to beat those trading in the same area, and ideally through take-over or failure of competitors to become the only or the dominant provider. Investor-owned businesses are therefore inherently competitive, in order to make a return for their investors. Their preference would be to have no competitors, so that they could maximise their return to investors, but for many years now the law has regulated monopoly situations and sought to ensure competition, in order to protect customers. Competition is therefore seen as a feature of the market-place, and playing a key role in driving efficiency. It drives prices down, and quality up, so the customer benefits.

Being an investor involves risk. The rewards may be good when the business succeeds, but if the business fails, then the investor can lose everything. One of the ways in which businesses seek to reduce risk is by entering into contracts – legally binding agreements whereby (commonly) one party promises to provide goods and/or services, and the other party promises to pay money.

Contracts allow parties to enter into future and often long-term arrangements, and therefore enable companies to structure and plan their business so that they can develop and grow.

And because contracts are enforceable at law and allow an injured party to recover damages when the contract is broken, they are an important mechanism for controlling the risks inherent in a business plan.

Another important factor in the success of the private sector is its ability to offer high rewards to attract the innovative, entrepreneurial individuals who are most likely to make businesses succeed. A career as an executive of a private business is most likely to attract those whose ambition is to maximise their income. Investors who want their business to outshine their competitors recognise the need to offer the best package to attract the best talent. One way of doing this is to include in the package shares in the business, so that the talented manager can not only see the fruits of their entrepreneurial skills reflected in greater profitability, but can also obtain personal gain through increased share values.

These are some of the reasons why the private sector – investor owned businesses – are so successful. These tools and techniques have been developed over the last 200 years or more, and enabled investor ownership to become the cornerstone of the most prosperous nations.

It is not difficult to see why reformers of public services find the tools and techniques of the market so attractive. Improving efficiency is always at the top of their list of objectives, and borrowing the tools and techniques which seem to work so well in another context seems an obvious thing to do.

The key question is whether such tools and techniques can be successfully transferred to another context. Will the NHS be more efficient and successful if the providers are or behave like private sector bodies, and if patients are treated and behave like consumers?

There seem to be two basic problems with this.

The first concerns the idea of providers acting like private sector bodies, effectively competing with each other, in seeking to achieve their own objectives. Whilst some degree of contestability is important in order to avoid the “take it or leave it” syndrome where there is no drive for improvement, it is clear that all parts of the NHS need to work together in co-operation with each other in meeting the needs of patients. This was expressly recognised with the introduction of a legal *requirement* in 1999 for NHS bodies to co-operate with each other.

This is a difficult concept, and the need to try to force bodies by law to co-operate with each other is revealing. It is hard to force complex organisations to do something as broad as this, and imposing a legal obligation is not a solution in itself. What is needed is a context, and particular types of organisations, such that there is an inherent desire, or a default setting amongst people working for them to co-operate with colleagues elsewhere. As is clear from Choosing Health, such co-operation needs to go far beyond co-operation just between NHS bodies – it needs to include all agencies and bodies able to have an impact on people’s health and well-being.

So the first problem is that co-operation to meet the needs of patients is in conflict with the basic instincts of investor-owned or private sector organisations which are inherently competitive.

The second problem relates to the relationship between the patient and the NHS in the consumerist approach. The consumer normally pays for something, and is then entitled to demand what has been promised. The consumerist relationship is a commercial one, where the consumer has no interest in how well or badly the provider is trading. The consumer’s only interest is in receiving the service, to which they are legally entitled. And as consumer,

the individual is entitled to exercise their choice of provider entirely at whim, and without regard for anybody else. There is no other relationship with the provider.

It is very difficult to see how this kind of relationship can be the platform from which to pursue the enormously challenging objective of changing peoples' attitude towards health so that greater responsibility is taken by individuals to live healthy lives to reduce health costs. The consumer's response will be: I have paid for the service, you must provide it. The consumerist approach shifts responsibility back to the state; there is no incentive to reduce the cost burden.

There is a third and perhaps even more significant problem with moving towards a consumerist or market-based approach for the NHS. This concerns traditional NHS values, and the centrality of the patient in every aspect of the design and operation of the NHS, which continues to be emphasised in policy documents. The problem is this: the market is an environment in which the investor is the owner, and the interests of the investor come first, before the customer or patient, the employee or the local community. It is a system designed to produce profits for the investor, a system which is incidentally a very efficient way (so many believe) of providing goods and services. It is not an environment in which core NHS values and principles can survive.

In truth, the market is an environment in which the patient can never be confident that their interests come first. A consumerist relationship is one in which the patient is unable to trust the physician to advise what is best from the patient's point of view, rather than what is best for the business. If the patient is to remain at the centre, the "system" needs to be one which reflects this and is designed around it.

Great care therefore needs to be taken in importing into the NHS the tools and techniques of the market-place.

Whilst some features of the consumerist or market-based approach may still be appropriate if they serve a useful purpose in a different environment, reform of the NHS founded on a consumerist or market-based approach seems inappropriate.

4. The second option – the citizenship approach

The introduction of a number of market-based approaches in NHS reform has been discussed.

At the same time, a number of other reforms have also been introduced which appear to show an intention to enshrine citizenship as a feature of a reformed NHS.

The first of these reforms was the introduction of Patients Forums in 2002. Legislation required there to be a Patients Forum for every NHS trust, in the context developing patient and public involvement in health. This was the first step in creating a formal (legal) role for patients and the public in the structure of NHS trusts, providing a voice for users of NHS services. Suggesting a different trend from the consumerist approach (where there is just the single commercial relationship), this was more redolent of the traditional mutual sector, where customers are or can be members of the organisations with whom they trade.

The second and by far the most significant reform in terms of the citizenship approach was the creation of foundation trusts by legislation in 2003. Here for the first time, patients, public and staff were now able to have a fully-fledged legal relationship as members of their local trust, whose structure was modelled on traditional co-operative and mutual societies.

The significance of this reform is still little appreciated. For the first time, ownership of public services have been transferred by the state to local communities. These bodies are now accountable to their local communities, not the Secretary of State. For the first time, local communities have an enforceable legal right to a say in how their services are planned and delivered.

To date only a limited number (32) foundation trusts have been created, but the intention remains to prepare all NHS trusts (acute, mental health and other specialist trusts) for foundation status by April 2008. This ambitious programme suggests a serious commitment to local ownership, and to devolving power from the centre to local communities.

Whilst it is still early days, the purpose of providing local ownership and accountability by offering membership to patients, public and staff is to create a different relationship between service-provider and community. Patients are not just consumers, and staff are not just employees – if they want to be, they can also be members, able to play a part in the governance of the foundation trust.

The opportunity to participate in the affairs of the trust introduces the concept of citizenship, and it does so in the following way.

The traditional mutual organisations came into existence through people getting together in local communities to create an organisation which could provide a service for their community – a service which was not otherwise available. For this to work, they needed to bring their trade to the organisation, and only if a sufficient number of people did so, could it create a viable business. The viability of the business therefore depended upon their support; and if they withdrew their support (taking their trade elsewhere as the typical consumer would do), then the organisation might not survive and they might lose a local service.

The traditional mutual organisations provided a differentdriver for quality. If customers were dissatisfied with the quality of service, or the price, then the solution was to seek an improvement in the service through the avenues open to them as members: voicing their

dissatisfaction at a meeting; lobbying board members; ultimately seeking election to the board and helping to bring about improvement. As active citizens of their local community, they could improve the services available to their community. If they behaved like consumers, then they would have to accept the consequences, which might include the discontinuation of a local service.

This starkly illustrates the difference between the consumerist approach, where the dissatisfied customer who has no other mechanism for dealing with their dissatisfaction and simply withdraws their custom without regard for the potential impact on their community; and the citizenship model, where the dissatisfied member seeks to redress their concerns by helping the organisation to improve.

This is the mechanism by which a mature locally-owned provider of services is continually driven to improve by input from and accountability to local users and staff. It is a very different mechanism for driving efficiency from the one used in the market or consumerist model. It is a model in which people are encouraged to take responsibility, and drive improvement. Local ownership (membership) is the mechanism by which the efficiency of the organisation is driven, fuelled by the interest of those who have paid for the service, those who use or rely on it, and those who work for it.

It is a very different approach from the consumerist one, where the consumer has no incentive to do more than sit back and insist on their rights. The citizenship model works by encouraging people to participate, by opening up opportunities for them to be engaged, and by giving them ownership of the organisation providing them with the service.

An organisation which is set up on this basis needs to be designed and committed to serving the interests or trading for the benefit of its community. This was and still is the underlying purpose of the traditional mutual organisations – they exist to provide a service, not to make a profit. They need to make a profit to survive, and to invest for the future, but making a profit is a means to an end, not an end in itself as is the case in investor ownership.

This is the basis on which the foundation trusts have been set up – owned by and accountable to their communities, trading for the benefit of their communities, and with those communities having the power to influence the services they provide. It can be seen that the traditional mutual and the foundation trust concept similarly aims to align ownership, purpose and power. Like the early mutuals, foundation trusts need to secure the loyalty of their members as customers in order to maintain their income stream through Payment By Results.

The foundation trust also seeks to embody the theme of co-operation between the key statutory, voluntary and local bodies in its structural design, by providing for their representation on its board of governors. This design of corporate governance should in time lead to the constant and continuing desire for such bodies to work with other organisations which have an ability to improve the health and well-being of people, for that is their underlying purpose. This will only fully happen if the trading arrangements and funding are designed to achieve the same objectives

There are other recent initiatives within health, but outside the foundation trust programme which illustrate an appetite for an approach committed to serving local communities, rather than generating profits for investors, and which incorporate the principle of co-operation or partnership working with other bodies. The recent change in responsibility for out of hours cover has led to the creation of approximately twenty new mutual providers of out of hours services. Although not yet offering membership to patients and public, these organisations nevertheless reflect a broadening of outlook from the former GP co-ops (which were owned and controlled by GPs), by offering membership to other clinical and non-clinical staff as

well. They also provide seats at strategic board level (in a similar way to the boards of governors of foundation trusts) to other key bodies involved in unscheduled care. They similarly embody a commitment to co-operating with others.

Although general practice has traditionally been “private sector” in the sense that it is owned and controlled by general practitioners, the developments in out of hours reflect a preference amongst a significant number of GPs to establishing organisations trading for the benefit of their communities. Some are looking at a similar approach for practice based commissioning, and even for the GP practices themselves, concerned that otherwise the trend of reform towards a consumerist approach will ultimately undermine the doctor/patient relationship.

There are also examples of citizenship type structures being set up on the initiative of local communities. Standish Community Health in Gloucestershire, and two healthy living centres in Salford are both seeking to establish local mutual organisations to own and operate assets for the benefit of the local community, built on a co-operative basis at strategic board level.

These are important illustrations of initiatives emerging from communities, and from professionals themselves. They are further confirmation that the citizenship model can have a wide variety of applications, and is attractive to communities and professionals as well.

The citizenship approach would appear to provide a basis for NHS reform which keeps the patient at the centre.

Of equal importance, it might provide a platform to start to address the wider objectives of engaging people in making healthier choices. In the consumerist model, the extent of the user’s interest is in securing the service to which they are entitled, whatever the cost. There is no incentive, for example, for those managing long-term conditions to help to reduce the cost of provision, because the result will just be to increase the profitability of the provider. In other words, it is limited by a narrow self-interest.

In the citizenship model where the individual is owner and member of the organisation providing the local service, the starting point is a potential relationship with the provider which could encourage the individual to behave differently. Decisions which might help to reduce healthcare costs start to have a potential benefit for the individual and the local community, because savings can be used to provide other services. The underlying driver might still be self interest, but it is a wider and more community focussed self-interest. This could become the basis for generating peer pressure and encouragement within communities and ultimately changing attitudes, which is the necessary pre-condition for influencing life-style choices.

5. An NHS owned by local communities

The analysis above suggests that there are only two possible options for an underlying direction of NHS reform: the consumerist and the citizenship model. This may appear simplistic, but in practice there is a narrow range of choices. This is dictated by the limited range of available options for ownership, for it is ownership at the end of the day that we are talking about, and which is the unspoken issue at the heart of system reform.

As stated earlier, NHS reform is seeking a different form of ownership from state-ownership. The problem with state-ownership is it is centralised, bureaucratic, and delivers the agenda which the owner (the state) wants. An owner invariably uses their ownership to achieve their objectives – what is the point of owning something otherwise? It seems unarguable that the NHS should be delivering what the customer (the general public/taxpayer) wants, not what the state wants; an obvious way of achieving this through the design of the system is by giving ownership to the community.

The creation of 32 foundation trusts for the first time transfers ownership from the state to local communities. It was radical step, but an extremely important one in charting new waters. By 2008 the state is looking to create the opportunity to transfer all NHS trusts into local ownership.

The recent paper "Commissioning a Patient-led NHS" signals another major step towards the state relieving itself of ownership – this time of primary care services. Primary Care Trusts are emanations of the state, and while PCTs provide services, the state remains the owner of NHS services. For good reasons, it does not wish to continue to be the owner. The question for primary care services is who the new owner should be.

When looking for an alternative to state ownership, the traditional answer in this country is private ownership. For the reasons already explored, a number of market-based features have been adopted in NHS reform as they seem to be appropriate ways of addressing problems arising from state-ownership. But aside from the political difficulties in overtly advancing such a policy (privatisation) as a basic theme for NHS reform, a market-based or consumerist approach seems unlikely to be a viable basis for an NHS seeking to improve the health and well-being of people in England.

The citizenship model, however, based on local ownership, trading on a non-profit distributing basis and drawing on features of traditional mutuality may be. Such organisations would include state-sponsored entities such as foundation trusts, organisations promoted by professionals and employees wishing to trade on such a basis, and social enterprises emerging from communities. There are further good reasons to consider the possibility of an NHS based on service-provider organisations which are locally-owned, non profit-distributing and legally committed to serving their local community, beyond the benefits already identified.

The first concerns the role of healthcare providers within local communities. It is well-understood that they need to work with other bodies and agencies in local communities – local government, education, community safety, housing, voluntary and charitable bodies, to name the most obvious. Trading organisations legally committed to a social agenda (rather than a profit-generating and distributing one) are culturally suited to working in partnership or in co-operation with other such bodies. It makes sense for them to include in their governance structure at strategic level (as foundation trusts do in the board of governors) representatives of key local organisations; they are more likely to achieve their objectives if they do so, because they can thereby secure support and commitment from such other organisations, and effectively enshrine a strategic partnering culture in their organisation.

The second concerns the role played by those involved in the delivery of health and social care. The clinician or carer relationship with the patient is fundamental to the service being provided. There is a strong, if not unanswerable argument in favour of employee participation in the governance of organisations providing such services, in the interests of patients, the success of the organisation, and of employees themselves.

The third concerns change, and the ability to adapt to changing circumstances. This is a serious issue in any area of service-provision, but particularly so in health and social care. Everything is subject to change – the science, medical knowledge, techniques and procedures, the work-force, the local population, the local environment and economy. Those organisations dedicated to improving the health and well-being of their local population need to be able to adapt to these changes, in a controlled way which ensures their adherence to their core purpose. Being close to their communities (patient, public and employees) and with governance structures which include representation for other relevant trading bodies, they are best placed to respond to changing circumstances.Most importantly, they are best-placed to ensure that ongoing change is informed by the best interests of those for whom the service exists, not the interests of the state, or of investors.

There are valuable lessons that such businesses can learn from the private sector. They need to be able to operate as independent businesses, which means being profitable, innovative, making hard business decisions, and behaving more like commercial organisations. But this is on the basis of a commitment to trading for the their specified purpose of serving their community.

The citizenship model – based on local ownership and accountability, established on democratic principles, committed to carrying on business for the benefit of the community, but operating on a proper business basis – is a powerful form of ownership and likely to be more effective in achieving the objective of improving health and well-being.

6. The Future

If the underlying theme of NHS reform is to be one of citizenship – local ownership, engaging patients, public, staff, carers, volunteers and everyone with an interest in health and healthcare as a platform to drive efficient local services, and to start to build a different public understanding of health and health issues, then might does the future hold in terms of further reform?

First and most immediate – primary care services. There is no reason in principle why those services currently provided by PCTs could not become locally-owned or mutual organisations, trading on a non profit-distributing basis for the benefit of the community, and providing services on a contractual basis to the PCT. Such organisations could be owned by public, patients and staff, and build into their governance arrangements role at strategic level for other statutory, local and voluntary bodies. This will only be possible where a robust and sustainable business plan can be produced for such services to be operated as a viable business. The sustainability will depend upon the commissioning policy of the PCT, and the ability of the new organisation to secure its income for a sufficient period into the future to weather the remaining years of major NHS reform.

Second, but longer term – what is the role of the state if local ownership becomes the dominant theme of a reformed NHS?

For sure, the state has a continuing interest in monitoring national standards to ensure that healthcare does not fall below minimum standard in any part of the country. The establishment of national standards has been a key feature of the NHS Plan, and creation of the Healthcare Commission is the basis for maintaining such standards.

But the state (through the Secretary of State) still has a responsibility for ensuring that there is a health service in England and Wales. This means ensuring, in each part of the country, that certain services are available. The mechanism of the internal market, which has been in development since 1990, is to impose statutory duties upon the holder of funds – the commissioner – to secure the relevant services. This provides a mechanism for the Secretary of State ultimately to compel the commissioner (or in default to take over the commissioner's function and himself or herself) to commission the relevant service.

A different approach has been introduced with the creation of foundation trusts. Because the Secretary of State needed to be able to guarantee the provision of particular services in those areas covered by foundation trusts, a mechanism was designed whereby foundation trusts were "authorised" to provide specified services, which they then have a legal obligation to deliver. In this way, the foundation trust can be an independent legal body, and at the same time the Secretary of State can be satisfied that the required service will be delivered. The regime established with Monitor provides the basic statutory framework to support and ensure this arrangement. The system has some similarities with the licensing arrangements for certain utility services.

Some mechanism is needed to guarantee the availability of relevant health services throughout the country, if a national health service funded by central taxation is to continue. It seems inevitable that the state should have a substantial say in the basic, additional and specialist services to be provided, but there are strong arguments for allowing local communities or regions a greater role even in this area. It is a logical extension of the argument for local and not state ownership. Where the dividing line should be is a matter for significant debate.

However this leads into the other main area of state involvement, namely the state's interest in public health. Whatever local communities, regions, or indeed the entire population thinks should or should not be included in their health services which are funded by central taxation, the state has a legitimate interest in the spending of those funds, arising from its wider responsibility for its citizens.

Both of these functions, guaranteeing the availability of all relevant services, and attending to the public health agenda – can be achieved through the combination of an authorisation regime which secures the continuity of provision of core services through locally owned providers, and emanations of the state at local level controlling the funds to a range of providers committed to carrying on business for the benefit of communities. The "commissioning" role in the citizenship model is not so much a performance managing mechanism for providers as a manager of financial incentives and penalties. Performance will also be driven by local communities, continually pressing for better local services and focussing on the more subjective aspects of service. The commissioner can support that in a well-developed contracting regime based on outputs and other measurable factors.

The role of individual people as proactive members is the cornerstone of the citizenship model. Is it likely to happen?

The cynics will argue that most people have better things to do with their spare time, and there will never be enough interest. It is true to say that formal involvement along these lines is not a common feature of modern society which has become more consumerist and inward-looking over the last 25 years. If it is to happen, then it will be a new departure – a change is needed.

For those who are either themselves managing long-term conditions, or supporting others who are doing so, for those employed within the NHS or local authorities involved in social care, and for those already giving up time as a volunteer or making other commitments (including blood and organ donors), the starting point may be rather different than for those with no current connection with health issues.

The first wave of foundation trusts are alive to the fact that they need to work at developing interested, active members. Resources are needed for this, and skills that have not been required before. It will take some time to build up an understanding within communities of what being a member means, and why it is worth bothering. It will be essential that in the early years foundation trusts deliver to their members, and show that local ownership works.

Another important ingredient if the citizenship model of ownership is to succeed is the right sort of leadership. Different types of organisation need different leaders and executives with different skill sets. The foundation trusts are already working through the fundamental change in attitudes which are needed if they are to succeed: operating as businesses, absolutely focussed on succeeding financially because if they do not, they cannot survive and continue to deliver healthcare; but if they do succeed, able to use that success to improve their services, responding to what their community wants.

Individuals with entrepreneurial flair and ambition are identifying opportunities which have not previously existed. These are not the entrepreneurs of the market-place, the corporate chief executives who are driven by the challenge of delivering share-holder return. They are ambitious business men and women, driven by the challenge of achieving financial success and profitability, but in order to provide services to people.

The final area of development to mention is the evolution in the citizenship model of local health economies. History, geography and local politics will ensure a wide-range of different approaches and balances between primary, secondary and specialist providers. If local

ownership based on traditional mutual organisations becomes a common theme, this may lead to the development of federal bodies, where a number of frontline providers of services combine together to create a federal organisation to provide themselves with services which they cannot economically provide individually. This may become an alternative approach to the traditional private sector approach of using contracting arrangements.

7. Conclusion

If the aim is to improve the health and well-being of people in England, the health service needs to be designed in a way which is most likely to achieve this objective.

The starting point is not a blank sheet of paper, but an NHS which is nearly sixty years old, with some well established and respected values and principles, comprising more than a million people, hundreds of trusts, agencies and practices, billions of pounds worth of buildings and equipment, and something over 50 million people to serve.

This Government has committed greatly increased funding to the NHS on the basis that it is accompanied by thorough modernisation and reform. Whilst a great deal has been achieved by way of reform since 2000, the underlying theme or principle of that reform remains unclear.

At the end of the day, it is a question about who should be the owners of the NHS, and what model of ownership is most likely to improve the health and well-being of people in England. It is a question which is not being expressly asked, or not asked in this way, but it is the question which NHS reform is, in practice, answering.

To date, it seems that the reforms embrace both a consumerist and a citizenship approach. At some point soon, a decision needs to be taken to opt for one or the other. It is far too big a decision to be made by default, or without clear intent. An informed debate is needed before such a choice is made.

This paper suggests that the citizenship model is the appropriate one for the NHS for the twenty-first century. If anybody has a better idea, they need to say so.

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25th October 2005

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