The Mutual Health Service
How to decentralise the NHS

Institute of Directors and New Economics Foundation

by Ruth Lea and Ed Mayo

The mutual state in action 2

This paper is written as a concept paper for those concerned with health policy and the future of the National Health Service (NHS). It is a collaboration that draws on work over recent years by the Institute of Directors (IoD) on economic and organisational issues in healthcare and the New Economics Foundation (NEF) on innovations in participation and social enterprise.[1]

We aim to present and to illustrate the previously overlooked approach of mutuality in healthcare as an alternative to state-oriented centralisation or market-oriented privatisation. The report covers issues of effective mutual organisation and engendering a new relationship between healthcare patient and provider. It does not attempt to address all issues and challenges facing the NHS, from innovations in medical treatment through to new needs around staff training.

The report focuses primarily on the NHS as it is run in England. However, although there are important structural and some other differences with the NHS in other parts of the UK, we feel that this does not detract from the main points of our case throughout.

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Summary

The National Health Service cannot, or can no longer, be understood as a single service organisation offering healthcare in a uniform way across the nation.

Centralised models of public services can perform poorly in terms of innovation, responsiveness and efficiency, so the starting point for this report is that health policy faces the challenge of effective decentralisation. However, the record of the current government on health decentralisation is patchy. NHS Trusts appear typically to be answerable to as many as forty different agencies, a number that is going up as an array of new health agencies and layers comes into being.

The central issue facing healthcare today is arguably how and whether decentralisation can be made to work. This report explores the relevance of mutuality as a practical organising principle for decentralisation.

This includes the far wider extension of the proposals for 'Foundation Trusts'. Rather than see Foundation Trusts as autonomous non-profit agencies, these should:

- become full, self-governing mutuals, operating in a co-operative network of healthcare and related public services;

- open up health services to comprehensive citizen participation, helping to enable people to take greater responsibility for their own health.

A long-term programme of building a mutual health service will require institutional innovation and culture change. In particular, mutuality should engender a 'new professionalism' across the NHS. The first steps required include:

1. establishing a new legal model for a 'public interest company';

2. opening-up Foundation Trust status to a first wave of Primary Care Trusts and a wider range of NHS Trusts;

3. setting a democratic template for governance of Foundation Trusts based on the involvement of multiple stakeholders, including a new Governance Quality Standard;

4. creating a new Health Regulator, accountable to parliament, and initiating an NHS Regulatory Review to cut through the confused and ad hoc reporting and lines of accountability required of NHS Trusts;

5. introducing a duty on Primary Care Trusts to treat patients as partners in healthcare;

6. trialling a new system of public health incentives, to reward investment in public health and self-help initiatives;

7. the publication of annual social audits by all NHS Trusts.

A non-profit, mutual health service can be more efficient and appropriate at delivering health services than for-profit private companies. A greater diversity of health service provision will reduce health inequalities and raise standards more effectively than the attempt to continue to run a uniform, national service.

A mutual NHS, the report concludes, is an inter-dependent NHS, that provides a re-working of its founding spirit that wouldn't be out of place in the 21st century.

1 The Promise of Decentralisation

1.1 National or Mutual – What's in a Name?

The great myth of the NHS is the myth of its name – that it is a single, primarily national, service. In reality, the NHS has been in continual flux since its creation in 1948, with a complex interplay between national and local level and different elements of healthcare.

Successive governments of all political hues have organised and reorganised the NHS. Health authorities have come and gone, with various boundaries from time to time. Margaret Thatcher's Conservative Government developed the "purchaser-provider split", between healthcare commissioning and the delivery of healthcare services, only for part of the resulting system, GP (general medical practitioner) fundholding, to be abolished with the advent of a Labour Government.[2] And while the NHS appeared to be set up as a centralised system in 1948, it was only from 1997 that explicit central standards and mechanisms for inspection came into force.

Nevertheless, all governments seem to have acted as if the myth were true, that ultimately the State should plan, direct and control the NHS, so that it can act in the best interests of all. It is this thesis that we wish to challenge, setting out practical proposals for what might be characterised as a 'Mutual Health Service', based on a more decentralised and diverse system of non-profit providers, combining the entrepreneurialism of the private sector with the ethos and values of the public sector.

With around one million workers, the largest workforce in the world except perhaps the Chinese Army and the Indian Railways, and a diverse collection of hospitals and primary care providers, the NHS is truly unmanageable as a single organisation. It can only operate in reality as a complex and adaptive system. But, while there is increasing recognition of the case for decentralisation, including most recently the King's Fund[3], there has been less thought about the nature of the organisations that operate within the system, the way they are led, governed, resourced and incentivised, the way that they inter-relate with each other and, above all, the people they are designed to serve.

Because poor health outcomes in the UK are not simply a product of poor NHS management, inadequate funding or political fashion, they reflect a deeper issue – which is about individual responsibility and the role of the state. On its own the health service – any health service – cannot create either a healthy nation or healthy individuals. This can only be achieved by the active involvement of people themselves. After all, one of the most significant wasted resources in the NHS is time. This is not the hours of NHS workers but the time of individual citizens, who could be enabled to take more responsibility for their own healthcare.

The mutuality in health that we explore represents a re-engineering of the NHS away from paternalism to find appropriate ways to share responsibility and make the most of the willingness and desire of individual citizens to improve their own health.

1.2 The Failure of Command and Control

It is now widely acknowledged by Government, many clinicians and others, that the NHS is over-centralised and predominantly run as a top-down bureaucracy. New Labour, in its 1997 General Election Manifesto, promised to move away from unresponsive and heavily centralised monolithic government structures.[4] But the record to date is unconvincing. The management of the NHS still falls too easily into the mindset of Sidney Webb – the early Fabian champion of the central state and of 'command and control'.

A strategic consultancy review in 2000 from the Virgin Group, commissioned by the Secretary of State for Health, referred to the "dead hand of bureaucracy stifling [NHS] staff who had lost pride in their jobs".[5] The Virgin report blamed over-centralised bureaucracy for the poor state of too many dirty hospital wards, chaotic arrangements for booking treatments and a lack of consideration for patients.[6]

Another commentator put it as starkly as, "people are dying while the health service is being distorted by targets".[7] This is not merely about the limitations of the process-oriented (former) waiting list target, but a reflection of the fact that asking people working in huge bureaucratic organisations to focus on targets very likely produces an effect of managing the statistics rather than making improvements. In the old saying quoted by David

Boyle of NEF in his book The Tyranny of Numbers, 'you don't make sheep fatter by weighing them.'[8]

In the private sector, there is increasing recognition of the failings of command and control structures. US management writer, W. Edwards Deming estimated that 85% of corporate failures arise from bad systems, not bad workers.[9] In hierarchical organisations, Australian governance expert Shann Turnbull estimates that a remarkable 98% of information passed from the bottom to the top is missing or incorrect.[10] The private sector has learned the lesson that management is, in part, about institutional renewal. As a result, business has flattened its hierarchies and opened itself up to more dynamic and fluid ways of organising. In a similar way, the 'managerial state' favoured by the public sector now needs to open up to more decentralised and participative models of operation.

Box 1
Consensus on the Problem

"Try to impose central controls on this [the NHS], and ... you fail, exacerbating the very ailments you are trying to cure; and you create huge counterproductive frustration among professionals who need not management but excellent administration."
Simon Caulkin, The Observer.[11]

"We believe it is time to move beyond the 1940s monolithic, top-down, centralised NHS towards a devolved health service, offering wider choice and diversity ..." [12]
Rt. Hon. Alan Milburn MP, Secretary of State for Health, April 2002.

"The NHS cannot be run from Whitehall."
The NHS Plan presented to Parliament by the Secretary of State for Health, July 2000.[13]

1.3 The New Localism

New resources for the NHS have gone hand in hand with the promise of decentralisation. In the 2002 Budget, the UK Government announced an increase in NHS spending on the lines of, but slightly higher than, the recommendations of Derek Wanless in his review of future health spending needs.[14]

There is planned to be a 7.4 per cent average annual real term growth in UK-wide NHS spending for each of the next five years. This would raise the total spending up to £72.1 billion in 2002-2003 and £87.2 billion in 2004-2005, rising to £105.6 billion in 2007-2008. NHS spending as a share of Gross Domestic Product (GDP) would then have gone from 6.6 per cent in 2002-2003 to 7.5 per cent in 2005-2006 and 8.2 per cent by 2007-2008. The figures for total spending on healthcare (NHS plus the private, independent, sector) are: 7.7 per cent of GDP in 2002-2003, rising to 8.7 per cent in 2005-2006 and 9.4 per cent by 2007-2008.[15]

Productivity will have to increase, Wanless stressed, as the current use of information & communitcation technology (ICT) in the NHS is extremely poor. There is scope for better management and less bureaucracy, he added.[16]

The Chancellor of the Exchequer, Gordon Brown, promised that the extra funds would be matched by reform and a new system of accountability. There is to be a new independent audit system, the Commission for Healthcare Audit and Inspection (CHAI) reporting to Parliament annually on how the extra money is being spent and what the result of the spending has been.

Alongside these reforms, two other key innovations are underway. The first is the rise of Primary Care Trusts (PCTs). From 1 April 2002, 302 PCTs covering all parts of England were set up to control healthcare locally. Their performance and standards are monitored by 28 new Strategic Health Authorities (SHAs). The new structure replaced the NHS Executive, eight Regional Offices of the Department of Health (DoH), 99 Health Authorities and 481 Primary Care Groups. In 1997 the former GP fundholders controlled 15% of the NHS budget. At present, the PCTs have been made responsible for around 50% cent of the NHS budget. Within two years they are meant to control 75%.

The second is the proposal for the best-performing NHS Trusts providing secondary care to be able to elect to gain 'Foundation Trust' status. In making this proposal, the Secretary of State referred to our work, pointing out that *'... organisations like the Institute of Directors - ... and ... the Co-operative Movement – have been examining the case for new forms of organisation such as mutuals or public interest companies within rather than outside the public services and particularly the NHS.'*[17]

The overall model for NHS reform is characterised by Ed Balls, Chief Economic Adviser to HM Treasury, as the 'new localism':

"The Department of Health and the NHS Executive are the strategic centre, setting objectives and shaping incentives. There is growing devolution of money, multi-year budgets and flexibility down to Primary Care Trusts and Hospital Trusts, with money increasingly following patients. And there will also be new, tough and streamlined audit and inspection with two national regulators for health and social services with an annual report to Parliament and local reporting."[18]

The extent of Treasury commitment to localism was tested in the public dispute between Gordon Brown and Alan Milburn, before a compromise was struck on the devolution of financial powers to NHS Foundation Trusts. It is likely to be tested again. Decentralisation cannot work if it is not accompanied by commensurate financial decision-making.[19]

The NHS Plan (and equivalents in Scotland, Wales and Northern Ireland) set out many commendable and ambitious aspirations to create a "patient-focused" set of health services. Trying to do this from the top down is really quite a contradiction, but in the words of Nigel Crisp, Chief Executive of the NHS, "what matters is national standards with a diversity of providers, whether NHS-run, charitable or private".[20]

Devolution has also made its mark. Following the new template for health service re-organisation in 1997[21], the English NHS focused on health service outcomes and market strategies; Wales boldly targeted health, not service, outcomes and regarded the NHS as merely one powerful tool to influence health outcomes; Scotland trod an intermediary path focussing on health service outcomes and how the NHS should reach out to promote health improvement. In Northern Ireland the integration of health policy with the peace process makes it a special case.

These reforms unquestionably move in the right direction. Of course, there are qualifications. Some, including the King's Fund, have estimated that perhaps 40% of the Budget increase would be spent on increased pay and prices within the NHS.[22] Increases in National Insurance Contributions in the financial year 2003-2004 will also effectively not add to NHS investment. Compensation claims are up and proposals for a new law on corporate manslaughter[23] could also in principle have a significant effect on NHS finances, but also governance if Trusts as a whole or even individual directors on Trust boards were to be held liable for manslaughter. (Although the Government currently plans to exclude bodies such as NHS Trusts from any new law, some of the debate has highlighted the unfairness of any new regime that could apply to the private but not the public sector.[24])

But the weakness of the reforms is that they do not go nearly far enough. The cultures, habits and systems of centralisation are not ended by declarations. To take just one example, the DoH has reduced the number of central instructions to the NHS through Health Service Circulars. In 1996 there were 298 circulars issued. In 2001 this was reduced to 26, and in the first quarter of 2002, only five.[25] Yet one Circular in 2001 is reported to have contained 429 performance indicators.

A more significant case study is NHS Trusts themselves. When the first NHS Trusts started in December 1990, they were intended to be fully self-governing. The legislation stated clearly that these were now independent organisations. And yet, in reality, NHS Trusts were soon sucked back in, as if to orbit as dependent moons around the weighty mass of Whitehall. With appointed boards, extensive implicit direction from Whitehall and an army of different agencies monitoring, setting policy and planning and regulating them (Table 1), they were never given sufficient chance to take up their promised freedoms. From the array of organisations listed in Table 1, it appears that a typical NHS Trust may be answerable to as many as forty different agencies, a number that is growing rather than decreasing over time.

Table 1
Organisations with monitoring or regulatory roles in respect of an NHS Trust

Monitoring	Regulatory
• Secretary of State	• General Medical Council
• Modernisation Board	• Medical Education Standards Board
• Department of Health	• National Clinical Assessment Authority
• NHS Logistics Authority	• Council for Professions Supplementary to Medicine
• NHS Purchasing and Supply Agency	• Human Fertilisation and Embryology Authority
• NHS Estates Agency	• Medical Devices Agency
• Permanent Secretary & Chief Executive of the NHS	• Medicines Control Agency
• Modernisation Agency	• National Radiological Protection Board
• Government Regional Offices	• Public Health Laboratory Service
• NHS Appointments Commission	• Microbiological Research Authority
• NHS Information Authority	• National Blood Authority
• NHS Litigation Authority	• UK Transplants Support Services Authority
• Health Authorities	
• Local Modernisation Boards	
• Local Authority Scrutiny of NHS	
• Independent Local Advisory Forum	
• Patients' Forum	
• Primary Care Trusts	
• Care Trusts	
• Independent Reconfiguration Panel	
• Audit Commission (District Audit)	
• Commission for Health Improvement	
• Health Service Commissioner	
• National Institute for Clinical Excellence	
• Audit Commission	
• Royal colleges and specialist associations	
• University/medical schools	

The array and confusion of lines of accountability is mirrored at staff level. Management within the NHS can be pictured as a two-dimensional matrix, in which the various professional groups make up one dimension and the actual patients and other stakeholders make up the other. Unfortunately, in the matrix there are very few intersections that would be expected to occur if there were genuine lines of management accountability and responsibility. Thus nurses, health visitors and physicians may have had their own channels of communication and professional demarcations, which may or may not have coincided with those who were supposed to have management responsibility for the organisation.

One experienced Health Service manager has reported of isolated projects underway in parts of the NHS, about which nobody seemed to care whether they were ever completed. One newly formed NHS Trust is said to have had its first senior management meeting no less than eight full months after the Trust's formation.

By comparison with many organisations, many doctors are not actually managed. Professor Karol Sikora, formerly in the NHS as clinical director at the Hammersmith Hospital, now working in the private pharmaceutical sector, tells the tale of having had eight consultants under his management when he was in the NHS.[26] He described them as unmanageable. *"The chief executive can't tell them what to do, no one can ... In my company ... if I'm told to get on a plane ... tomorrow, I go – that wouldn't have happened in the NHS".*

The paradox is that while the NHS overall has become more centralised, NHS Trusts themselves are inverted organisations with considerable control residing in front-line professionals. This does not argue that professionalism in the NHS should carry any less respect, but as with law firms and other partnerships, such respect does not have to come at the cost of organisational management and efficiency. Innovation in clinical practice is best supported and replicated if there is effective management. But like many a state service, the NHS has suffered from 'producer capture'.

An illustration of poor management and of the central/local dichotomy is in information and communication technology (ICT) projects.[27] In 1998, a target was set for 35% of large hospitals to reach "level three" (out of six) with regard to electronic patient records. By the target date of April 2002, only 2% (five hospitals) were reported to have reached this point. In this case, the response has been to centralise ICT in terms of a strategic programme. There is good sense in doing this for standards and protocols to ensure that ICT systems are truly interoperable. But at the same time, previous governmental attempts at big ICT projects have failed. ICT systems have to be adaptable over time, so that even with an investment in central infrastructure, it is good to foster local capacity. The moral is that the tension between central and local is not one of crude trade-offs, but of balance and complex interaction.

The NHS Plan reflects this insight, by establishing several new quangos and other public bodies, in part to build the local capacity for decentralisation to succeed. However, the result appears to be further layers of bureaucracy (absorbing both management time and some of the new funding injection into the NHS). The opportunity cost to the NHS of the present set-up of intra-NHS reporting must now amount to hundreds of millions of pounds. At the very least it diverts senior management time from their main task.

There is now to be a Commission for Patient and Public Involvement in Health (CPPIH), taking over the role of Community Health Councils in England from the beginning of 2003. This is intended to be an independent national body for patients in England, made up of people from local bodies, the NHS and the voluntary sector. But CPPIH is to have a key role in appointing members to lower-level bodies. What started as a worthwhile approach may end up as further top-down dirigisme. It is hardly an example of devolved autonomy.[28]

A further example of the frittering away of resources is the move to give local authorities power of scrutiny and overview of NHS Trusts from January 2003. As Donna Bradshaw and Kieran Walshe argue in the Health Service Journal *"the scrutiny from local authorities will sit alongside an increasingly complex array of other bodies charged with regulating, inspecting or overseeing what the NHS does"*.[29] Local government is meant to be able to scrutinise the NHS, at a time when all too many local councils are themselves failing (in the Government's own view) to deliver adequate services to the public.

This will further dissipate public resources and management time, especially as local councils will have no actual authority over NHS bodies. As Dr Matt Muijen, Director of the Sainsbury Centre for Mental Health puts it, the concern is *"whether the sprawling bureaucracy of supra-structures will not merely allow but, above all, empower innovative modernisation plans in imaginative partnerships. The layers of leadership – from ministers to the Department of Health, regional offices for health and social care, SHAs, PCTs and Trust boards – weigh heavily on local managers and clinicians. Then they have the labyrinthine networks of modernisation, inspection, regulation, professional and education agencies."*[30] Interestingly, and more recently, the Government's Better Regulation Task Force has addressed the problem (not addressed at the NHS as such) of overlapping accountabilities within the public sector amidst a whole array of institutions and concomitant reporting.[31]

The NHS has seen many a restructuring plan. Our proposals are different. They are about setting free the existing structures, which are settled and people want to make work. Plus to do this on a voluntary basis, as parts migrate to mutual status when they are ready and when they choose, avoiding one-size fits all models and learning what works.

2 Mutual Trends

Our approach to decentralisation is that of mutuality. In 1830, the flannel weavers in Rochdale formed the Rochdale Friendly Co-operative Society after a strike. It started with subscriptions for sickness benefits before moving on to a small library service and, in 1833, a co-op shop. The initiative failed in 1835 after giving too much credit to its members. But in 1843, after two years of another strike, two original members persuaded starving weavers to try again. They registered a new co-op in October 1844 which began trading two months later. This time, the co-op prospered, and with it came a new mass international co-operative movement (See Box 2).

The original idea of mutuality – in some sectors such as with certain building societies and insurance companies – has now been whittled down to nothing more than an annual vote in some, and demutualisation of many of them came as no surprise. But there is a new wave of mutuality that is emerging, albeit on a small scale so far. You can see it in the mutually-owned community businesses, starting in Strathclyde in 1979 and growing from there to the range of social enterprises – from informal voluntary groups to industrial and provident societies – that have emerged, dedicated to community benefit.[32]

In its 2002 Social Enterprise Strategy, the Department of Trade and Industry has highlighted the remarkable upsurge in competitive social enterprises – credit unions, social firms, housing co-operatives, fair-trade and ecological enterprises, managed workspaces, farmers' markets, recycling initiatives, employment services, community shops, arts ventures, social care co-operatives and time banks.[36] In health, friendly societies such as Benenden Healthcare Society and Simplyhealth have long offered competitive mutual healthcare, covering both the funding and provision of healthcare.

Then there are the tenant-owned housing organisations taking over local authority housing stock. Or the new generation of community banks, such as the London Rebuilding Society, that have meanwhile emerged to finance the new community-based social enterprises.[37] Or the range of mutuals that have taken over other services from local authorities including leisure and transport. These are a series of experiments and initiatives that have attracted little publicity but could yet signal a revolution.

Box 2
What is a mutual?

There is no exclusive definition of mutuality. At its most simple, mutuality is an institutionalised, value-based model of reciprocity. But a mutual is not a single legal form. Some general points are:

- A mutual is an enterprise owned by its members, which provides a variety of services to its members for their benefit.
- Mutuality may be used to describe mutual models of ownership or decision-making, mutual methods of doing business or simply a mutual ethos.
- Historian Dr Bob James describes mutuality as *"a contractual arrangement, which may be unspoken, between a group of people, as few as two, wherein it is understood that no member of the group stands in a superior position to any other in terms of voting power, ownership rights or accrued benefits."*[33]
- Examples of mutuals include agricultural co-operatives, building societies, banking mutuals and credit unions, communications co-operatives and co-operative Internet service providers, consumer co-operatives, energy co-operatives, fishing co-operatives, health provision and insurance mutuals, housing co-operatives, mutual insurers, tourism, and worker co-operatives.
- There are over 700 million members of such organisations worldwide.[34] In the UK the largest sectors are in agriculture and consumer co-operation (the Co-op, which has an annual turnover in retailing of some £10 billion, plus banking and insurance assets of around £30 billion[35]). In other countries, other sectors are more prominent, such as credit unions in North America, and worker co-operatives in some other parts of Europe.

The idea that social enterprises might run public services – either as employee mutuals or stakeholder mutuals – goes back to 1979, when social services in Ealing Borough Council were deciding how to organise transport for clients. Initially the new organisation was set up as a voluntary organisation, with an 'endowment' of four buses from the council. The team proved successful at winning contracts from the social services department,

and the following year reconstituted itself as a mutual industrial and provident society. One of its first steps was to finance the purchase of four new buses.

In 1996, it set up ECT Recycling, which now offers a diverse range of recycling services, including the first ever paint exchange scheme. From a small non-profit start, ECT has since diversified into a group comprising four separate companies, employing over 200 staff and providing recycling and community transport services for eight local authorities – six in London and two outside. It is the national pioneer in kerbside recycling and provides direct services to over 425,000 households.[38]

Something similar has occurred in Greenwich, where Greenwich Leisure was converted from a local authority department into a social enterprise in order to escape the financial constraints imposed on local authorities. The result was a highly successful enterprise, which has increased the number of leisure facilities in Greenwich from seven to eleven and trebled income in the last six years to over £9 million. At the same time it has more than halved the cost to the local authority for providing the service – and won quality marks under Investors in People, Charter Mark and ISO 9002.

One of the keys to Greenwich Leisure's success is structure. The creation of a separate enterprise, where staff – now numbering 1,000 – have a say in governance through a co-operative structure, has freed them up to act more as entrepreneurs, and giving them a direct stake in its success.

Greenwich Leisure has itself taken over the management of five centres for the London Borough of Waltham Forest. It has also helped to replicate itself in 13 other local authority areas, from Bristol to Teesside. And although the original version of the model placed a premium on staff empowerment, user involvement is now being examined.[39]

Rather than focusing simply on short-term funding, social enterprises can aim to build a long-term business with a clear focus on the good of their community. In many cases, they have saved money for the public sector, because they are able to generate increased income and raise private finance, including grants and social investment. They have also created an asset for the benefit of their communities.[40]

Dr Johnston Birchall, at the University of Stirling and an associate of NEF, is an academic working in the mutual sphere. He has examined the contemporary case for mutuality in a whole range of public services[41], from water and rail to local authority services. Clearly, the various different models of mutual ownership and participation are something that the NHS could afford to learn from.

3 The Case for Mutuality in the NHS

3.1 Systems Solutions

Professor David Hunter of the University of Durham has set out four ways of controlling the NHS – see Table 2.[42] His preference is for the loose-tight approach (option C), but he argues that governments (including the present Government) typically opt for the tight-loose mode (option A). In this mode, the focus is on the means of driving up standards, by focusing on operational practicalities, reinforced by best practice learning, standard setting, performance reporting and inspection.

In this report, we explore the loose-tight model (option C). We don't attempt to deal with the full range of operational issues facing the NHS, from the life of dentistry practices to the challenge of tackling teenage depression. Instead, we focus on the incentives, values and purpose of operational units, drawing on the theme of mutuality, leaving scope for diversity, experimentation, learning and self-management in relation to the practical means.

Of course, if you want to enable local management to make decisions, then local management should be up to the job and take responsibility for those decisions, with no more buck-passing. There are concerns about the quality of management of the NHS, which has suffered from centralisation. In many ways, the culture of decision-making in the NHS is closer to a model of administration than true management, let alone the social entrepreneurialism that the Prime Minister, Tony Blair, has called for in public services (Table 3).

The mindset of the social entrepreneur – people like John Bird of the Big Issue, Tim Smit of the Eden Project, Richard McCarthy of the Peabody Trust or the late Lord Young – is about adapting and reinventing organisations to be fit for social purpose, driven not by profit but by public interest (Table 4).

Table 2
Systems Thinking: 3 Ways to Run the NHS [43]

Option	Means	Purpose
A	Tight	Loose
B	Tight	Tight
C	Loose	Tight
D	Loose	Loose

Table 3
Systems Culture: 3 Ways to Make Decisions in the NHS

Approach	Focus	Outcome
Administration	Target-oriented	Compliance
Management	Target-oriented	Compliance
Social Enterprise	Outcome-oriented	Innovation

Table 4
Mindsets in the NHS

Issue	Public Servant	Social Entrepreneur
Goal	Public health	Public health
Concern	Programme quality and staff competency	Development of an effective social enterprise
Use of public money should:	Underpin maximum choice and mobility for patients	Support institution building
Timescale	Short-term, mirroring the year-to-year mentality of public funding	Long-term approach to programme development
Improvements come from:	Structural policy shift	Practical reinvestment

3.2 The Case for Mutuality

Both authors have independently argued that NHS Trusts for both hospital and community care should be taken out of the public sector and become independent non-profit-making mutuals.[44] Others have recently made similar suggestions (see Box 3).

Professor John Kay, director of London Economics[45] has set out several reasons for bodies such as hospitals becoming mutuals. There are specific needs that a competitive market may not meet well. These include situations where:

i. customers alone have knowledge that is specific to the business;

ii. there are not only individual, but community, benefits from the activity;

iii. the service is a local monopoly;

iv. the market has missed an opportunity.

For health services the last three of these apply. With regard to point iii, with the NHS there is a divorce between the users and the suppliers of services; there is no link between the financing and provision of services, and users cannot generally go elsewhere as the NHS is virtually a local monopoly. In principle, mutuals can therefore be the most efficient way to provide current health services.

There are, of course, different types of mutuals. A traditional distinction is between consumer mutuals and those owned by staff – producer mutuals. Both have potential merits in terms of healthcare – giving a say to patients or to staff. However, it is also the case that one group alone running a mutual can exercise a bias towards their interests over those of others. For this reason, we recommend a stakeholder mutual – where a balance of different interests is represented

The starting point for Foundation Trusts to date has been hospitals. These have the advantage of a clear public profile and potential for involvement. Most people could name their local hospital, but few their local Primary Care Trust. Yet the nature of primary care, being lower-tech and often involving longer-term relationships, is in many ways more open to the active and meaningful involvement of patients. For Primary Care Trusts, despite

the complexity of being both commissioners and providers of healthcare, mutual status could therefore represent a significant opportunity. What is needed, however, is not an imposed solution, but a licence to experiment, including the freedom to move beyond the current configuration of primary and secondary care, for example testing the scope for a single co-operative network of local health provision.

But there is another intriguing set of reasons for exploring mutuality in relation to health. To a degree, ill-health, and particularly who gets ill, may be the result of the atomisation, stress and anonymity of a less than mutual society and economy. Successive reports over the last twenty years have highlighted that poor health is unevenly distributed, affecting the most disadvantaged and vulnerable.[46]

The epidemiologist Richard Wilkinson demonstrates how illnesses from the common cold to cancer and heart disease are associated with the inequalities of stress and economic circumstance. He argues that, "*To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings can dominate people's whole experience of life, colouring their experience of everything else. It is the chronic stress arising from feelings like these which does the damage.*"[47]

Many of the drivers of ill-health, therefore, lie outside of the traditional remit of the NHS. This opens up wider questions, such as the costs of inequality and the scope for a 'health promoting economy'[48] but also point to the potential value of health-care models that help to underpin trust and mutual security.

Box 3
Consensus on the Solution?

- Liam Fox, Conservative Shadow Health Secretary, has pledged that every hospital in the country would be free to become a "foundation hospital"[49] (October 2002).

- Tony Blair has promised that *"foundation hospitals will be independent, not-for-profit institutions, broadly similar to hospitals in other parts of Europe, with operational freedom combined with much stronger representation of the community…hospitals…will be directly accountable to a 'stakeholder' board rather than to Whitehall officials"*[50] (September 2002).

- The Public Services Policy Commission of the Liberal Democrats has argued for extensive NHS decentralisation, including a potential role for new non-profit 'public benefit organisations'[51] (August 2002).

- Professor Anthony Giddens, Director of the London School of Economics (LSE), has also endorsed ideas of looking at more extensive partnerships and non-state groups in the running of key public services.[52] These could include *"mutuals, social enterprises, not-for-profit Trusts and public benefit corporations"*[53] (2002).

- The Institute for Public Policy Research has commenced a one-year project on not-for-profit models for public services[54] (2002).

- The Public Management Foundation has been pursuing the decentralisation concept, including legal issues around, a "public interest company" that might be applied in all various circumstances to oversee and run public services[55] (in 2001 onwards).

- The Adam Smith Institute, which has proposed mutual applications in education and health[56] (2001).

- The Association of Friendly Societies which has published a major report on mutuality and the welfare state[57] (2001).

- Professor Chris Ham (University of Birmingham, and now Director of the Strategy Unit at the DoH) wrote a Demos booklet in which he proposed experiments on moving from state to community ownership of healthcare providers[58] (1996).

- The Independent Healthcare Association, which has published on and advocated on healthcare mutuals[59] (1994)

The concept of non-profit mutuality has attracted three forms of criticism. The first is that it is privatisation by the back door. Professor Alyson Pollock, critic of the Private Finance Initiative (PFI), argues that *"no matter how anyone dresses it up, whether on the left or the right ... it's not putting the public first; it's putting needs of small entrepreneurs first"*[60]. This is a complete misreading of the idea. It assumes that the only way a public organisation can be public is because it is run by the state. Conflating state with public is not a rational definition but one that reflects a particular political tradition. There is no profit-seeking or profit-taking in the models we have outlined, and a lock on the assets of the new mutuals will ensure that they cannot subsequently be broken up or sold off for private gain. As Tony Blair has said, *"creative ideas for public sector reform should not be mistaken for privatisation."*[61]

The second criticism is that it is in some way a return to pre-1945 provision. In terms of recreating the innovation of some of the proud and pioneering health experiments of the first half of the twentieth century,[62] it might be – the Peckham experiment in London of the 1930s or the Great Western Railway Medical Fund Society in Swindon, funded by the collective voluntary subscriptions of railway workers, and which is said to have been studied by Aneurin Bevan as a model for the NHS itself.[63] But the patchy pre-1945 service was something quite different from a modern health service, funded out of central taxation and provided locally on the basis of need.

The thrust towards decentralisation, should not discard all elements of a central approach. The pooling of risk inherent in health services with universal access requires them to operate at scale, to accommodate risk, maintain open access and avoid liquidity crises. A number of welfare co-operatives in the late nineteenth century failed for this reason.[64] This is one reason why we couch our proposals for mutuality within the context of a continued strong role for health expenditure funded from taxation. There is a case for experimentation with mutual contributions – and indeed an argument that the result would be a deeper more resilient approach to mutuality. Mutuality grows where money flows, is an old co-operative saying. But it will not be easy to recreate the tens of thousands of friendly societies that used to act as health mutuals – and at any rate this could not be done in central decision, only by social and market change. The goal, as indeed Beveridge saw it, should be for non-state contributions to continue to be complemented by the necessary scale of social insurance systems.

The third criticism is that it will lead to variation in standards. This is the fear that, without uniform services across the board, standards will diverge to the detriment of worse performing hospitals and their patients. However, with suspicions also lingering over the role intended for the private sector, the former Secretary of State for Health, the Rt. Hon. Frank Dobson MP, has raised fears over the dangers of a 'two-tier system'.[65] His comments remind us that the hardest thing ever to ask of politicians is for them to let go.

Our argument is that uniformity is a myth, and that the pursuit of uniformity has had a uniquely detrimental impact on standards, in discouraging initiative, innovation and improvement. To this extent diversity is strength. A great diversity of ways of delivery healthcare is what is needed.

At the moment, given a uniformity of provision, there is no single-tier system. Hospitals may be the same organisational form, but their standards are far from uniform. Government and media tend to be preoccupied by what is in fact one only issue of "equity", which is geographic equity of access to healthcare services. This is a legitimate concern, in the current or any future system, with the need to secure a minimum (rather than average) floor for quality services. But there are other types of equity, such as equity of access for equal health need, equity across ethnic groups and gender, equity in relation to the use of scarce resources when new treatments emerge or indeed the equity of health itself.[66] The history of the post-war welfare state shows that apparently equal, uniform services do not in fact guarantee equal access. Over that period, the inequalities of service delivery have become obvious. Keeping the system as it is will not provide equal access.

A more decentralised approach simply acknowledges the diversity of need and population that exist, while giving opportunities for improvement and appropriate specialisation. We make no assumption that the big gains from decentralisation are going to be captured by those that are the current best performers rather than the worst performers, but this is in any case not a zero-sum game. One Trust improving does not, even if it contributes to a great variety of performance overall, mean that the

patients of another are worse off in real terms. Indeed, in so many complex systems in the natural environment, it is diversity that generates and regenerates advance and evolution, while uniformity decays and fails in the face of risk.

These criticisms are at best a misunderstanding of what mutuals can and do achieve.

3.3 The Mutual Health Service Action Plan

A fully mutual health service will take time to evolve and require patient experimentation. The essence of our proposals is to make a series of first steps, focussing on institutional change that can licence a wider process of learning and adaptation. In themselves our proposals do not constitute fully-fledged mutuality, but a move towards it. In particular, we argue that the NHS should be demerged, governance opened up to wider input, in particular from staff and users, and that management be devolved, by the following steps:

1. Establish a new legal model for a mutual health 'public interest company'.

2. Open invitations to a first wave of Primary Care Trusts to elect for Foundation Trust status, offering full independent status and management freedom within a regulatory framework. Given that a full performance framework is not yet complete for Primary Care Trusts, Foundation Trust status should be awarded on the strengths of the bids received.

3. Trial a small selection of 'combined' Foundation Trusts, bringing together primary and secondary care into a single co-operative local health economy.

4. Open invitations to a wider group of NHS Trusts to elect for Foundation Trust status.

5. Set a democratic template for governance in the form of a multi-stakeholder approach to membership and the board.

6. Establish a Governance Quality Standard, to ensure the application of good governance processes to all NHS Trusts, including those that have not previously applied these, and a Participation Standard, setting out good practice in relation to staff and patient involvement.

7. Once the first wave of Foundation Trusts have started, the Office of National Statistics should set out an opinion on whether they should be classified as public sector or, like universities and social housing, independent, with the more comprehensive financial freedoms this would imply.

8. Set a duty on all Primary Care Trusts to treat patients as partners in healthcare, in order to make the most of opportunities to involve patients, not just in their own healthcare, for example, but in the design, oversight and evaluation of low-tech services.

9. Reorient existing funding contracts to create greater incentives for effective performance. Trial a wider system of public health incentives, in which Foundation Trusts are compensated for cost savings in the health service (the 'social return on investment') achieved through public health and self-help initiatives, such as around obesity and reduced smoking.

10. Set up a new Health Regulator, accountable to parliament, and initiate an NHS Regulatory Review to cut through the confused and ad hoc reporting and lines of accountability required of NHS Trusts.

11. Set a template for Trusts to complete an annual social audit, to report on healthcare and healthcare outcomes performance alongside the publication of its financial accounts.[67]

Our proposed target is that by 2010 over half the Primary Care and NHS Trusts will have won Foundation Trust status. However, the most important measures of progress will need to go beyond the classification of organisations to test the extent to which mutuality is able to inform a deeper culture change around healthcare. The best measure of the new relationships and responsibilities, around which a mutual health service can be built is, perhaps, trust.

Trust is the single most important factor in the success of collaborative or co-operative ventures, and there are increasingly, good standardised measures of trust available.[68] By 2010 the new partnership models should

be well on their way to re-engineering the NHS around mutuality, promoting service-level innovation, public participation and citizen responsibility for health. The end result over time would be far more diversity of provision, along with greater accountability and a freeing of the creativity and innovation that already exists within the workforce of the present NHS.

4 Foundation Trusts: building blocks of a Mutual Health Service

4.1 Flying free

NHS Trusts were intended to be independent organisations. But they never succeeded in flying from the nest of Whitehall control. The managerialism of the Department of Health and the logic of the bidding culture held them fast.[69] In response, and drawing in strong part on our work, the Labour Government has come up with the idea of Foundation Trusts.

In his speech to the New Health Network on 15 January 2002, Alan Milburn, Secretary of State for Health, outlined what these might mean. Starting with the best-performing Trusts, the intention was to free these from the strict financial and management control by the Department of Health. *"What we envisage" he said "is a fundamentally different sort of NHS. Not a state run structure, but a values based system, where greater diversity and devolution are underpinned by common standards and a common public service ethos."*

Foundation Trusts are meant to have the current freedoms of Trusts as well as enhanced capabilities arising from the Government's aim of 'earned autonomy'. These include:

- greater freedoms over human resources;
- management freedoms;
- finance – for example, keeping receipts from land sales, and enhanced private finance rights;
- more inclusive governance and broader participation involving for example staff and users and other important stakeholders;
- reduced central regulation and monitoring.

Another speech by the Secretary of State moved things on. This was on 22 May 2002 to a conference of top managers from the UK, and from other European countries (Spain and Sweden) where there is a record of success in delivering healthcare via decentralisation within the state-run health service and use of the Foundation model.[71]

Box 4
Intended freedoms of NHS Foundation Trusts

- a clear public service ethos and not-for-profit basis;
- giving greater control to patients and service users and opening up options for greater accountability to local communities;
- more active involvement and control for staff and management;
- offering freedom from 'top-down' management from Whitehall;
- immunity to take-over by organisations which will not provide such benefits.[70]

At the time several of the best-performing NHS Trusts, (the "three star" Trusts), had given firm notice of interest in becoming NHS Foundation Trusts. These were Addenbrooke's NHS Trust, Norfolk and Norwich University Hospital NHS Trust, Northumbria Healthcare NHS Trust and Peterborough Hospitals NHS Trust.[72] The first Foundation Trusts are intended be operational by mid 2003. What the Secretary of State has so far described could well become the formal building blocks of a Mutual Health Service. The development of such new organisations in the UK will require a basic template, around which experimentation can take place. These include: legal form, democratic governance, financial powers, regulation and accountability.

4.2 Do We Need a New Legal Form?

Public bodies including existing NHS Trusts and authorities derive their power – and much of their reporting obligations – from Acts of Parliament and Statutory Instruments. The post NHS Plan Health Service still contains a large number of public bodies (including quangos) which are essentially accountable to Parliament, and whose boards are appointed. In the NHS the NHS Appointments Commission carries out that latter function. Public bodies are accountable to politicians. Their terms of reference can be – and often are – changed by politicians (at national level in the case of the present NHS).

Outside the public sector the primary legal form adopted by enterprises of all sorts is that of the company. One of the current requirements is that the constitution of a company contain a memorandum and articles of association. The former will contain an objects clause, setting out the scope of activity of the company; i.e. just what it is permitted to do. If a company acts outside its objects clause it is "ultra vires". Whether or not a company acts ultra vires as it affects shareholders has now been interpreted by the courts of law as having little to do with the contents of the objects clause.[73] One aspect of the current company law debate is whether there should be such an objects clause. This is relevant to the debate around devolved governance within the context of the NHS. Much of the general debate is occurring around the Government's review of company law.[74]

There is no legal definition of a mutual in the UK, although there may be an attempt to bring in such a definition under Scottish law in due course, via the Scottish Parliament. Mutuals have operated under both company law and industrial and provident society law. Examples of the former include worker co-operatives. Examples of the latter include the friendly societies and many retail consumer co-operatives.

The issue of having a lock on the public assets of the NHS Foundation Trusts is, of course, vital. The Institute of Directors, the New Economics Foundation and the Public Management Foundation in its pioneering work on the public interest company have all given prominence to this aspect.[76]

The existing assets of NHS Trusts that convert to Foundation Trust status will have been financed by public revenues for the purpose of public healthcare. There is a clear interest in ensuring that such assets cannot be distributed to private individuals or companies and therefore lost to the wider public good. The clearest case of this is upon dissolution. As in the case of registered charities, this would mean that where a Foundation Trust is dissolved, the assets should not be distributed to private individuals but held for the public purpose provided (for example by distribution to another Foundation Trust or back to the state). This provides an assurance that the organisation is not broken up for private gain.

This is a 'lock on asset distribution' as opposed to a 'lock on asset use'. The latter would represent a more extensive straightjacket in terms of financial powers. A 'lock on asset distribution' would not deny a Foundation Trust in the pursuit of its public purpose mission the freedom, subject to prudential regulation, to dispose of

Box 5
Types of Company[75]

Type	Note
Limited by shares:	
Private limited company	Most common type
Public limited company	May be Stock Exchange listed, or unlisted
Limited by guarantee	E.g. charity, professional association
Unlimited company	Rare
Incorporated by charter	E.g. universities, the Institute of Directors
Incorporated by statute	Housing associations

assets on commercial terms or enter into joint ventures, using its assets as security.

Could this be provided by existing legal forms? One option could be to ensure that in the company articles of association (or in the equivalent clauses in the rules of an industrial and provident society) the nature of activities to be undertaken would need to be stated, along with proscriptions against fundamentally changing these without referral to the Secretary of State for Health, or his appropriate regulator. Additionally, in the dissolution clauses that on a winding-up, the net assets should revert to the State or to a similar Foundation Trust with the same lock on public assets. Part of the monitoring role of the State would be to ensure that Foundation Trusts were not acting ultra vires.

However, there are a number of other characteristics required for the legal form that is used for the roll-out of Foundation Trusts. These include the ability to trade on a non profit basis; non-profit distribution[77] ; an effective and inclusive governance structure; the power to borrow; and stakeholder ownership, with the benefits of limited liability.

There are three existing legal models relevant to Foundation Trusts:

- Company limited by guarantee (CLG) - here members 'own' the company but there is no share capital and hence there are rights of control but no rights to residual earnings.

- Industrial and provident society (I&PS) – bona fide co-operative are for the mutual benefit of their members, with any surplus being ploughed back into the organisation to provide better services and facilities. Each member has at least one share in the society and control is vested in the members equally.

- Industrial and provident society – society for the benefit of the community (I&PS bencom) – here members 'own' the organisation but there is no distribution of share capital and hence there are rights of control but no rights to residual earnings. This organisation may or may not be registered as a charity.

The company limited by shares is not readily adaptable for Foundation Trusts. It has private 'external' shareholders who are the owners of the company and have a right to the residual profits after all creditors have been paid. Legally there is a duty specifically to create returns for shareholders, which is not commensurate with a primary commitment to quality healthcare and related objectives.

Table 5 shows that the company limited by guarantee and the industrial and provident society for the benefit of the community meet the primary conditions for Foundation Trusts, with the exception of having a lock on assets.

In other fields of activity, these legal models are combined with regulation – such as for charities and for social housing – that effectively enshrine a lock on assets. This would be a reasonable fall-back option for health. A more effective approach, however, would be to fill the legal and institutional gap that exists through a new model that ensures this, and related powers, directly. This would be the public interest company – which was developed, in concept, by the Public Management Foundation. It has some similarities to the US public benefit corporation – although with the scope for more significant and meaningful participation by stakeholders.[79] The Strategy Unit in its recent review of the voluntary and wider not-for-profit sector endorsed this model, using the term 'community interest company'.

The advantage is that a purpose-built vehicle would be created, with the guarantee of asset integrity. Given the long-term importance of the Foundation Trust model, the development of a public interest company model seems an appropriate investment of legislative time and attention.

Table 5 [78]
Existing Legal Models for Foundation Trusts

Key Characteristic	1. Company Limited by Guarantee
A. Ability to trade and generate a surplus to be used for furthering the aims of the Trust	**Met.** CLGs can trade in the same way as a company limited by shares. Further specifications of activities or of the aims of the Trust and the use of the surplus could be spelt out in the articles of association and memoranda.
B. Non-profit-distribution	**Partly met.** Organisations can put a non-profit-distribution clause into their constitution; but this can be changed by a vote of members.
C. Lock on Assets (i.e. that they are devoted in perpetuity to public benefit objectives)	**Not met.** Section 30 registration requires such a clause in the constitution. However, the company can still be wound up and the assets transferred; and in practice, evidence from solicitors suggests that companies can remove themselves from the Section 30 constraints even without having to go through this process. Companies can make use of contracts to minimise the chances of conversion, but this cannot provide an absolute safeguard.
D. Flexibility to implement a variety of inclusive stakeholder governance structures	**Partly Met.** The CLG form is highly flexible, and allows for a range of membership and board structures. The constitution can be changed by special resolution (75%) of the members. Governance structures are not really dependent on the CLG form but true control ultimately legally resides with those who are the specified 'members'.
E. Ability to access a range of appropriate finance	**Partly met.** High-profile CLGs have successfully tapped the bond market; others have had varying success. Cannot attract equity shares but are able to use quasi-equity investment which is risk capital without share stakes and where a return can be based on performance (although probably limited).
F. Stakeholder ownership with limited liability	**Met.** Ownership is through 'members' who are specified in the memorandum and articles. They have rights ofcontrol but not rights to residual profits. Members' liability is limited to the amount of the guarantee (which is usually nominal).
Concluding notes	Meets the main criteria except lock on assets and access to all forms of finance. The former point is probably more important than the latter.

2. Industrial & Provident Society (I&PS) bona fide Co-operative	3. Industrial & Provident Society (I&PS bencom)
Partly met. Co-ops can and do trade; this is for private member benefit but membership can be open to anyone. Bona fide I&PSs are designed to distribute profits to the key stakeholder group or retain these for further investment. Clearly agreement could be made that they were not to be distributed but this is not built into the model.	**Met.** Built into the design and specifics can be accommodate in model rules.
Not met. Possible but the model is predicated on full 'ownership' rights of control and access to residual earnings.	**Met.** Bencoms are prohibited from distributing profits to members.
Not met. Subject to high voting thresholds, two membership ballots can resolve to demutualise and distribute assets to members. Could be written in but non-enforceable.	**Not met.** In theory, assets must be transferred to a body with similar purposes on dissolution. However, an I&PS can always convert into a company and then be sold, with assets distributed to members. Careful drafting can reduce the risk of this happening. Housing associations and credit unions are safeguarded under separate legislation.
Not met. There are strict rules emphasising equality among membership; members elect officers. Not really since predicated generally on one ownership group – usually employees or customers. Not really able to support multi-stakeholder governance.	**Met.** Governance model run on co-operative principles. Have to run organisation 'for the benefit of the community'. Are able to adopt a variety of multi-stakeholder governance models.
Partly met. The poor level of interest or understanding amongst financiers hinders access to funds. Most forms of finance including limited equity stakes but not clear that it offers full access to equity.	**Partly met.** Cannot attract equity shares but are able to use quasi-equity investment which is risk capital without share stakes and where a return can be based on performance (although probably limited). The poor level of interest or understanding amongst financiers also hinders access to funds, except where strong assets and income flows are established.
Met. Ownership by specified stakeholder group such as employees or customers. Rights to control and limited rights to residual profits in the form of dividends.	**Met.** Ownership is through 'members' who are specified in the model rules. They have rights of control but not rights to residual profits. Members' liability is limited to the amount of the shareholding which is nominal.
Could meet some of the objectives but these are not built into the legal model itself and does not support multi-stakeholder governance.	Meets the main criteria except lock on assets and access to all forms of finance. The former point is probably more important than the latter.

4.3 A multi-stakeholder model for Foundation Trusts

The legal model, however, is a basic template. It does not dictate the way that a organisation is run, is overseen or is accountable. There will be a benefit in leaving some of this open to interpretation and innovation, so that Foundation Trusts can in future gravitate towards the most successful approach.

The legal model, for example, should enable a variety of governance models to be designed and implemented. Across all legal models there is still only limited good practice of innovative and inclusive governance models. Just as much work will therefore need to be done in designing the appropriate governance model as in deciding the appropriate legal form.

The tasks of a NHS Trust Boards were set out some years ago by the Institute of Directors, working with the NHS.[80] They have been revised and revisited by the Department of Health, most recently via the NHS Appointments Commission.[81]

Examples of good practice are to be found in the Combined Code, which relates to Stock Exchange listed companies in the UK. Other types of body have drawn up their own codes of conduct on corporate governance, some based on the Combined Code. General principles of corporate governance have also been formulated at international level, for example by the Commonwealth Association of Corporate Governance and the Organisation for Economic Co-operation and Development.[82]

In NHS boards as they exist at present, there is a very significant governance gap:

- Boards of directors have little financial independence.
- Boards cannot exercise strategic leadership (this is largely dependent on Whitehall).
- Boards cannot therefore exercise full responsibilities as to various stakeholders such as patients, employees, suppliers, local residents and health-related charities.

Box 6
Good Governance
The Combined Code (1998) for UK listed companies: 6 principles for Directors[83]

1. Every listed company should be headed by an effective board, which should lead and control the company.
2. There are two key tasks at the top of every public company – the running of the board and the executive responsibility for the running of the company's business. There should be a clear division of responsibilities at the head of the company, which will ensure a balance of power and authority so that no one individual has unfettered powers of decision.
3. The board should include a balance of executive and non-executive directors (including independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.
4. The board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties.
5. There should be a formal and transparent procedure for the appointment of new directors to the board.
6. All directors should be required to submit themselves for re-election at regular intervals and at least every three years.

Applying these principles, Foundation Trusts will (as now) need an appropriate mix of executive and non-executive directors. The executives could be drawn from the same base as at present, so that there would continue to be posts such as chief executive, finance director and medical director.

Mechanisms need to be devised to allow accountability in terms of appointment and possible removal of board members, e.g. by time-limited periods of office of non-executive directors. For all actual and potential board members, induction and continuing professional development would play an important part in building high quality governance. But rather than the present system in which non-executive directors are nominated by another public body, there is a strong case for a recognition and link with the different stakeholders behind the Foundation Trust.

In Foundation Trusts, the directors would be appointed by the members, quite possibly a range of people representative of or drawn from wider stakeholders. Rather than a self-selected model in which the only members were directors (which is quite often the case in the charity field), the mutual model is better suited to a 'multi-stakeholder' approach.

The key stakeholders are likely to be people from the local area (or in the case of an organisation providing specialist and tertiary care, the area it serves); staff; partner organisations in the local area – for example from voluntary organisations or the local strategic partnerships; NHS commissioners; local education, training and research bodies. A key advantage of the multi-stakeholder mutual model for Foundation Trusts (rather than a narrow, self-selected non-profit model) is that it offers a way to build co-operative relations with strategic stakeholders, such as social services, and build a more effective governance of the wider local health economy.

The Foundation Trust would be owned by and accountable to these members. But ownership would mean something more limited than for existing company forms. Full shareholder ownership implies two rights: the rights to control and the rights to residual profit after all other claimants (e.g. employees, creditors etc) have been paid. The members of Foundation Trust would only have ownership rights in terms of rights to control rather than any rights to residual profit and the corporate model must ensure this.

However, whatever the actual mix of executive and non-executives, on the board, and whatever interest groups or constituencies are involved the board as a whole must always pursue the interests of the Trust and not merely their own vested interests. In other words they must have a "fiduciary duty" to the organisation as a whole. An active engagement with different stakeholders can throw up new ideas and information, improving the quality of governance. But it would also be quite possible to set up boards where the individual members regarded themselves as delegates of some particular interest group, rather than having a fiduciary duty to the corporate entity itself. This should be avoided.

There are a number of creative ways in which participative governance models consistent with these principles could be developed. This could include members chosen by lot, as in jury service, or widely dispersed voting rights among staff or the local population. Gareth R. Thomas MP has argued that each adult member of a geographical area might be offered (one should not impose membership of a mutual) a nominal share in a Foundation Trust and a vote in electing the non-executive directors.[84] That would have some similarities with local government, insofar as voting rights were concerned.

Foundation trusts could experiment with the spectrum of possible involvement of stakeholders. Johnston Birchall sets out a range of these in his work on multi-stakeholder mutuals, ranging from nominal representation (using proxies or organisational representatives) through to indirect or direct representation (using devices such as selection by lot, as in juries, or direct elections).[85] Professor Henrietta Moore of the LSE sets out that, in any collective organisation, the involvement of local people should range from deciding not to participate in the operation of the trust, to seeking information about what it does, to wanting a copy of the annual report, to wishing to attend a meeting or to stand for an official position.[86] Equally, the right to dissent and to offer criticism can be a powerful tool for service improvement.

> *"I am personally not convinced that the best way of encouraging the best community involvement between the local community and the local hospital that serves it, is simply by an independent appointments commission appointing five non-executive directors. I do not think that is the best way of doing it. I really do not."*[87]
> Alan Milburn, June 2002.

This is about individual people. But the involvement of local partners as stakeholders is also important to a mutual approach. Intermediary, community based organisations play an increasingly important role in healthcare. One way to engage the community, practised by many health mutuals overseas[88], is to use groups of people, such as self-help groups or those with an interest in health promotion, or particular disease conditions. The multi-stakeholder approach helps to engage interest groups while providing for a balance of different interests.

This is important to get right. Breast cancer has rightly become a popular issue, with a range of active women's groups, but prostrate cancer among men has not attracted the same degree of self-help and advocacy. If having different stakeholders involved brings issues of resource use and opportunity costs out into the open, then it may be possible to resolve them in a democratic way, while still encouraging the kind of self-help and public engagement that in the case of breast cancer has had such a positive effect – raising women's awareness and exposing anomalies and inconsistencies in the historic way it has been treated.

Spreading good practice on governance is urgently needed in the NHS and other public services. Establishing a Governance Quality Standard, to ensure the application of good governance processes and a Participation Standard, setting out good practice in relation to staff and patient involvement would assist in this process. However, as David Aaronovitch has put it, *"the best practice in spreading best practice is to have people wanting to adopt it (and adapt it) rather than enforcing it…They have to become self-starters."*[89]

4.4 Follow the Money

If conspiracy theorists believed that Foundation Trusts were never going to be allowed to be independent, they should, as the saying goes, follow the money. Financial freedoms are likely to be the lifeblood of effective Foundation Trusts. That is not because health outcomes are determined primarily by money[90], but because without full financial management powers, the management of health systems operates within a straightjacket.

Within the existing NHS there are already various new forms of finance in place, including the PFI and other types of Public Private Partnership (PPP). The Government has also introduced a pilot scheme run by the Local Improvement Finance Trust.[91] This is intended to give health authorities, local authorities and GPs equity stakes in privately-financed one-stop primary care centres.[92]

These models of finance fall short of offering the financial management freedoms required by Foundation Trusts. They are, in essence, ways of rationing additional market-based project finance in ways that are conducive to centralised control. But centralised rationing does not necessarily accord well with the micro-economics of allocating capital in the most effective manner possible.

At present, Foundation Trusts are intended to remain as public sector organisations, with freedom to borrow, although this will be counted as part of the DoH expenditure limit. This has the elegance of testing out the importance and quality of the borrowing, but is ultimately not sustainable if Foundation Trusts are to extend across the NHS. The issue of whether Foundation Trusts are to be counted as part of the public sector borrowing requirement should be tested after an initial phase, with the Office for National Statistics holding the say on whether they are sufficiently independent for it to make no sense to classify them as public sector bodies.

Regulation has a role in ensuring that Foundation Trusts use finance in a prudent way, without excessive risk to core services or facilities. But it makes sense that expanding facilities to provide future services to patients could be paid for in part by future generations through the mechanism of borrowing today.

And, while the prime focus is on debt finance, where the ownership of assets does not pass over to the private sector, Foundation Trusts may require the facility to use limited amounts of equity finance, with limited control rights and possibly a capped return, as in the model of industrial and provident societies, in order to finance risky investments rather than fund them through loans or retained reserves.[93] This would need to be integrated into the development of the legal model. At the same time, some of the risks of excessive diversification could be managed by enabling this to be achieved through a group structure.

The autonomy of financial management, within a regulatory framework, is a basic guarantee of the ability of NHS mutuals to achieve their results in the way they feel is best. "Foundation" hospital directors in Sweden can borrow money on the open market to fund new premises, and in Spain they can set local pay and terms for employees[94] – which is also an issue that needs to be tackled in the UK to begin to address labour shortages in many parts of the NHS. It is important, therefore, that

they should be empowered to borrow money in the normal way – and perhaps in new ways with 'public health bonds'. This kind of bond could be issued by any public sector or voluntary sector body of long-standing, that wants to run projects where there is a proven likelihood of public savings from improved health. These would work rather like bonds that raise finance for business, and might be guaranteed by the contract provider (Primary Care Trusts for example) and paid back over a similar period. They could repay the money, with interest, either in the normal way or possibly by clawing back future savings – much as a conventional bond issue would do for future earnings – and bundle them up so that the project can raise the finance it needs.[95]

4.5 Performance Contracts

The goal for funding systems is to align incentives and outcomes and set an accountability framework. The goal must be to create stable contracts that tie funding to social performance, in the form of outputs or results actually delivered to target beneficiaries. This supports a more entrepreneurial approach to securing the social return on investment required by government or other funding parties.

Social performance contracts of this form have a similar philosophy to the 'Community Investment Tax Credit' proposed by the Social Investment Task Force, and now adopted by the Treasury.[96] Both seek to incentivise entrepreneurial activity for social outcomes, but social performance contracts operate through public expenditure rather than public revenue foregone, so they are both more straightforward administratively and they have a potentially wider application across public services.[97]

Compared to existing funding contracts channelled through PCTs, this model is a formal legal contract between independent entities and places a greater emphasis on outcome funding rather than fixed budgets and penalties. While the current model is easier in terms of relatively static financial planning, social performance contracts operate more effectively in terms of incentives (so that where you do well, you get more funding and vice-versa) and, in terms of investment planning, can offer a clearer, more stable revenue stream. However, the approach works well where a health outcome – such as stopping smoking – can be clearly distinguished, but is less appropriate where there is room for dispute over outcomes, so that a balance is required in the overall funding regime.

4.6 A New Regulator

There should be a Health Regulator supervising the NHS. One of us (Ruth Lea) has already proposed that the role of the NHS as such should be to become the regulator and funder.[98] Indeed, the Department of Health already holds a range of regulatory functions.[99] An independent audit system, the Commission for Healthcare Audit and Inspection (CHAI), is in place, but there is probably a case for separating out the culture of inspection, intended to provide independent quality assurance, from that of regulation. If the regulatory functions of the Department were passed to a more formal regulator, accountable to the Secretary of State and to Parliament, the result would be a slimmer Department of Health, better integrated with devolved administrations, focused on policy development and acting as a strategic facilitator of the overall health system.

One of the aims of regulation is to move away from an informal system of influence in health, dominated by the bidding culture for resources, towards a more formalised system, that is stable and transparent, capable of allowing diversity and focused on supporting appropriate incentives and values among Foundation Trusts as the building blocks of a Mutual Health Service.

The key regulatory functions required for Foundation Hospitals would therefore be:

- A licensing function enables already constituted organisations to receive certain forms of grant or contract. The process can be thorough, and involves an assessment of an organisation's purpose and accountability, its financial plans and general management capacity.

- A range of appropriate and relevant reporting mechanisms can be used to review progress, including social and financial audits.[100]

- Prudential guidelines would, for example, regulate diversification into activities that are not core health.

- Enforcement, would give options to the regulator to achieve enforcement or coercion.[101]

The introduction of a senior health regulator of this form, operating at operational arms length from ministers, would provide an opportunity to complete a NHS Regulatory Review. This would bring the multitude of agencies monitoring and regulating the NHS more into line, to ensure more consistent, streamlined and coherent oversight, instead of the current array of ad hoc and confused demands made of NHS Trusts.

With clear regulation, a new independent legal form, a participative governance structure and funding contracts designed with incentives in mind, Foundation Trusts are the building blocks of the Mutual Health Service. They will allow for diversity and innovation, while being clearly accountable to those that matter. In many ways, accountability (and where appropriate 'contestability'[102]) plays the same kind of role that competition plays in privatisation. It keeps health providers efficient and effective, but without the narrow efficiency that can damage the quality of service by privatised bodies if the bottom line becomes all that counts.

5 New Mutuality: the patient role

5.1 A Public Sense of Ownership

What makes new thinking on mutuality different from the traditional model is its emphasis on participation. We have lived through a period where mutual building societies – the main area where people found themselves involved with mutualism – were indistinguishable from non-mutuals. Membership was expressed by an annual vote, normally just to rubber-stamp nominated members of the board. Thanks to the dominant political debate during the 1940s, mutualism was about 'ownership' – and little more than a narrowly legalistic interpretation of it.

While participation without ownership can clearly be patronising and exploitative, ownership without participation is often meaningless – as it was with many of the building societies. That is why public ownership all too often does not mean a public sense of ownership. The new mutualism tries to redress this balance, realising that in the NHS – as with other public services – professionals can't succeed without active involvement with the public.

There is a growing – though not yet universal – understanding of just how much healthcare depends on the co-operation of patients. Doctors complain that it is hard to get patients to change their lifestyles, eating, lack of exercise or smoking. Alcohol and drug rehabilitation programmes can't work without the enthusiastic co-operation of the people involved and they must also have a support group.

The same is true for bypass surgery or hip replacements. Patients will not recover without some kind of support group who make sure they are not lonely, that they have food in the house, and that they have somebody to turn to if they succumb to depression.

Equally, mutuality implies that they too can have responsibilities. It may not be the formal, legal responsibilities of the market and commercial exchange, but mutuality can have a hard edge to it if it sets clearer notions of the responsibility that patients have. This might be in terms of something like diet or self-diagnosis (after all, self-help and mutual aid have always gone hand in hand) or simply in turning up to appointments, avoiding free riding that sees some patients waste resources, to the cost of others.

5.2 Public Health

All too often, we still organise health with technical solutions to cure people, rather than involving them to keep them well in the first place. Up to 30% of the premature death and disease experienced in western societies is preventable. Around half of the current NHS expenditure goes on treating preventable illness.[103] As budgets rise in the future, preventative healthcare is going to rise in importance and that means a different relationship between patients and professionals.

In scenarios developed by HM Treasury for the Wanless Review of the NHS, the degree of individual self-help was identified over twenty years as the single largest variable in terms of costs. High levels of public engagement, compared to present rates, are estimated to deliver savings of £30 billion per annum by 2022 (a saving that approaches half of today's NHS Budget).[104]

In other sectors, such as housing, education or social care, alternative community-based approaches to funding and providing services are far more advanced and well documented. The diversity of independent schools and colleges, operating successfully as charities or community enterprises are still able to deliver educational services to nationally agreed standards. And when it comes to social services and palliative care – the voluntary sector plays a vital role in running community care services – support for carers, hospices, childcare and day care facilities for a variety of different vulnerable groups. But when it comes to our primary healthcare service, the story is very different.

The spirit of voluntarism lives on in the many volunteers still active in hospitals today, through the League of Friends and the Women's Royal Voluntary Service, who help provide a friendly face or a cup of tea when it is most needed. But time-giving in hospitals is declining. The only place within the health service where people are getting more involved is through patient-support groups. These groups use newly gained knowledge to challenge a sometimes arrogant medical establishment and also provide valuable support to others who are managing a similar condition. Meanwhile, the evidence that social capital – one of the outcomes of getting involved with friends, relatives or community groups – is good for your health is growing.

Other mutual approaches to providing healthcare are also emerging. Time banks running in health centres as a way of providing 'social' prescriptions – a friendly chat or a supportive phone call that increasingly GPs don't have the time or the ability to provide, but which they know is just as important as the treatment – are now well established.[105] They show how to unlock the time not just of health professionals but of patients.

5.3 The Other Resource – Time

Some problems – like hospital waiting lists and the annual flu epidemic and the resulting hospital bed crisis come round with familiar regularity – it seems no matter how much money the government promises and says they are spending to sort the problem. Ministers realise that they have to make a difference to these perennial problems if they are to retain any political credibility. But to do this they need to tackle root causes rather than merely addressing the symptoms. In the case of hospital waiting lists it is often because too few beds are available.

A classic example is the problem of finding appropriate care for older people in the community so that hospitals can send them home. Birmingham Royal Infirmary suffered from severe bed blockage during winter 2000-2001 and cancelled all elective surgery, simply because they could not send older people home – there was no one to look after them. Time banks – and other systems for involving patients in the delivery of health services – are methods for tapping into the enormous wasted resource of people's time. It clearly costs money, but not in the way that health investment normally does. And the evidence from the USA suggests that mutuality of this kind – based on time banks – can save considerable sums on treatment.

Also, while we invest in ever increasing complex – and expensive – technologies to treat patients, like micro-surgery and genetic screening, we are in danger of neglecting the essential community-based back-up systems, that are essential to getting better and may even help prevent them getting sick in the first place.

The pilot community time bank was developed in partnership between the New Economics Foundation and the Rushey Green Group Practice, based at two locations in Catford, in South East London. Interest in developing a time bank at the practice was sparked by GP Richard Byng, who was keen to explore and develop alternatives for tackling isolation and depression. Initial research found that both staff and patients supported the idea and felt that the scheme had the capacity to generate much-needed social support for the most isolated older people – as well as families and provide low level practical help to enable older people to stay in their own homes.

The time bank is run by a broker on the end of a phone. People earn time 'credits' by helping out, and spend them when they need help themselves. The range and type of services include: befriending, running errands, giving lifts, arranging social events, woodwork, poetry writing, teaching sewing, babysitting, gardening, lifting that requires muscle, swimming, fishing, teaching the piano, catering, form-filling, design work, drawing and giving local knowledge.

Initial research at the practice found that – as well as the volunteer support to local people who need it generated by the time bank – it has also helped to build people's confidence and self-esteem by shifting the emphasis from areas where they are challenged or failing, to activities and skills that they enjoy and can share with others

In this way, the scheme has given a sense of self-worth to people who had previously been passive recipients of care. Many of the members are elderly or disabled and cared for, at least to some extent. The time bank has also given them the opportunity to give and become 'carers' themselves in different ways in the community.

By blurring the distinction between givers and receivers and encouraging more vulnerable people, such as the elderly and those with mental heath needs, to get involved and share their time, the time bank is helping to build more community based self-help and mutual support:

This kind of mutual volunteering can provide very real benefits to health services. First of all, by offering health centres access to complementary, community based support – run by local people for local people and in this way reducing patient overload on staff. Secondly, they offer patients benefits, by focussing on what they have to

offer rather just on where they need help. This approach can have particular benefits for many people with mental health needs, who are often stigmatised as mental health service 'users.'

The evidence so far shows that people involved in time banks are more likely to call on each other for help than go to the GP. Through their involvement in the time bank they become more active in their community, often going on to take up more formal volunteering opportunities.[106]

We are not presenting time banks as the only way to involve patients more pro-actively in the NHS. They are simply an illustration. But there are many, many more such community health projects that are starting to make dramatic inroads into some of the more intractable public health issues.[107] There are expert patient schemes, training patients to mentor people who share difficult conditions with them. There are patient involvement workers, an approach pioneered in Scotland.[108] A number of PCTs have experimented with partnerships to address fuel poverty, a major cause of death in winter among elderly people.

The Participation Matrix (table 6) provides a way to look at various initiatives that are being used or piloted. The left side of the matrix represents a ladder of participation running from ad hoc forms of involvement through to some direct responsibility. The matrix suggests that the NHS has not yet found ways to engage and incentivise a wider set of people, either in limited or more significant forms of involvement. This is a conclusion borne out by relevant research.[109]

An example is the crisis in volunteering in hospitals – there need to be efforts made to create some flexible forms of participation which will engage a variety of people with different skills. As Professor Jessica Corner of the Institute of Cancer Research comments *"inhumanity is enshrined in the hospital system; it is reflected in the myriad incidents of carelessness and seemingly trivial aspects of care that are neglected."*[110] In primary care there is a marked deficit in engagement and accountability.

A similar exercise could be completed for staff empowerment and involvement in decision-making. The 'top-down' model of management has served to demotivate NHS staff and restrict creativity. The state has effectively been a monopoly purchaser of the labour of health professionals. That has enabled government artificially to depress wages, saving costs but further contributing to low morale and recruitment problems. One of the goals of the move away from a centralised approach should be to find better ways of harnessing the ideas and energy of the large, experienced and diverse workforce of the NHS. Research by the Public Management Foundation has recommended far closer attention to the issue of motivating and valuing doctors as managers – the same would hold true more widely for nurses and other staff.[111]

Staff involvement is no less important than the inclusion of patients. As one nurse commented *"If we are not involved – why should patients be?"* Frontline staff can feel just as excluded as patients from the decision-making process. Yet, if their good work is rarely valued or rewarded then there is little opportunity for managers to build on the fact that frontline staff are repositories of significant amounts of knowledge, expertise and critically trust. The public experience of healthcare depends on the quality of frontline workers at the interface of service delivery, from surgery receptionists to community nurses and midwives. The new mutuality in healthcare needs to develop in ways that value and include frontline staff – without whom little can be accomplished.

Table 6
Participation Matrix for Health

Level of participation	Acute hospitals/ Foundation hospitals	Primary care	Broader health economy	Local governance
Governance	Mutuals Primary Care Trusts	Non-executive directors	Social care co-operatives involving users and staff	
Direct involvement in decision making over policy or resource use	Stakeholder councils and multi-stakeholder governance models	Health Panels	Local Strategic Partnerships Health Partnership Boards Neighbourhood Forums (in New Deal for Communities area)	Local Strategic Partnerships Neighbourhood Forums Citizen Juries/Panels Participatory budgeting
Involvement in delivery of service	Peer-support Patient support groups Volunteering: League of Friends etc Carer Support Workers	Healthy Living Centres Expert Patient programme	Healthy Living Centre Time banks Mentoring	Time banks Volunteering
Two-way Provision of information	Patient Forums Commission for Patient and Public Involvement in Health		Participatory Appraisal	Participatory Appraisal New models of civic education such as NEF's 'Democs'
Consultation and community engagement	Patient Advocacy & Liaison Service in each hospital National Institute for Clinical Excellence, Citizens Council			

Of course, participation in health services is only one component of increasing the responsibility of individuals for their own health. But a culture of mutuality helps to set a tone quite distinct from that of NHS patients as passive beneficiaries of someone else's expertise. Instead, as in the case of the friends and family of mental health patients, the mutual ethos could affirm them as partners, with a distinct contribution to make. Table 7 sets out some of the different ways in which health and social service professionals have traditionally treated them. Only a mutual model starts to recognise their true value in terms of health and well-being.

Moreover, the example of time banking demonstrates ways in which health services can be re-engineered to equip and enable people, with information, technology, systems and incentives to play an active role in self caring. The Department of Health now estimates that for every £100 spent on encouraging self-care, around £150 worth of benefits can be delivered in return.[112] If ideas of public health disappeared into the mire and dilemmas of tobacco sponsorship, mutual health models might offer one way back to a system promoting well-being rather than treating sickness.

Both in Maslow's hierarchy of needs and the more contemporary 'human needs matrix', being explored in pilot research by NEF, well-being is a function not simply of physical capacity but of a wider sense of flourishing going well beyond health as traditionally defined.[113] The needs that underpin well-being are universal, but the ways in which they are satisfied will vary over time and across cultures. The implication is that tomorrow's health policy needs to be as focused on issues that shape well-being such as identity, participation and idleness/renewal, as on the symptoms of physical health. An example is the proposal made by the National Heart Forum for a national plan for children's and young people's health and well-being, covering the breadth of issues required to improve nutrition, cut smoking and increase physical activity.

Table 7
Four Ways of Seeing Friends and Family of Mental Health Sufferers

Medical	Innocent secondary victims
Criminal	Dysfunctional, as contributors to mental illness
Administrative	A resource, for example for supervising medication
Mutual	Partners

Table 8
Health Rather than Sickness? The human needs matrix[114]

Well-being	**Needs**
1. Existing *(survival – living)*	Subsistence Security
2. Co-existing *(community – living together)*	Love Understanding Participation
3. Developing *(renewal – flow – vitality)*	Idleness Creativity Identity
4. Flourishing *(fulfilment – spirituality)*	Freedom Meaning

And while no more than one in four adults today are classified as being informed and proactive around their own health, there are strong signs that this is on the rise. There are already 10,000 health information websites. Health-related goods and services are also growing fast, with sales of homeopathic medicines rising at 5% per annum (alongside huge sales of traditional pharmaceuticals) and health and fitness clubs at 11% per annum.[115]

But even with personalised approaches, individually focussed interventions (such as taking responsibility on smoking) have been shown in a worldwide review to influence the behaviour of between 3% and 20% of the populations who engage in them. Approaches that focus on the social context, building participation, for example, can influence 25% to 50% or more of those taking part.[116] Mutual approaches may, therefore, be the most effective way of supporting people to take responsibility for their health.

There is a huge amount of evidence on tokenism in this area, especially in the context of black and ethnic minority group representation in participatory efforts. The role of intermediary community based organisations may be critical to the success of the mutual approach. These are playing a growing role, for example, in helping to reduce hospital admissions – such as in Bath where Age Concern provides 'home from hospital' services and in Scunthorpe, where patients can call on community-based support after being discharged early from hospital.[117]

Community development experience suggests that one important aspect of stakeholder involvement, that engenders the trust of all parties, is the ability to voice dissent, to criticise. Dissent is a very powerful tool for change, especially if it is constructive and there is scope for skills and self-esteem training to enable patients to engage in critical appraisal.

5.4 The importance of participation

All the evidence is that mutuality requires participation to make it real, and that participation can make a major difference to people's experience of the NHS, to their health and to the cost of curing people and keeping them healthy. Yet despite the rhetoric in the new NHS Plan, shifting power from central to local, there is no corresponding ambition to decentralise power to the ultimate consumers of health services. And in particular, despite a range of innovative experiments in minor forms of health participation, there have been no experiments – as far as we have been able to discover – to devolve any budget-holding responsibility to patients.

There clearly needs to be considerably more experimentation – preferably in long-term, adaptable projects at the heart of Primary Care Trusts – with deeper forms of participation that can take the NHS beyond simply inviting patients onto committees. These experiments need to test out the need for training, the ways to engage people across ethnic and socio-economic groups, how far it is possible to go handing budgetary control over to local patients, and in other lay-led management, so that patients can be encouraged to set the local health agenda, rather than simply participate in projects that are handed down by professionals or administrators. They should include staff just as much as patients – in many instances they are just as excluded and unheard.

More specifically, these experiments could lead up to a duty on PCTs, written into contracts, to involve clients as equal partners in the delivery of health. There should be guidelines about how this should be achieved, and handbooks for off-the-shelf solutions that can be adapted for any neighbourhood – but exactly how this duty should be met must be left open to encourage innovation.

It might, for example, include a participation role for dedicated staff in a PCT, or perhaps a new role for health visitors, or time banks in GP surgeries – or a range of other possibilities outlined earlier in the report. It might also include a time bank attached to all hospitals to make sure that hospital discharges are planned properly, and there are volunteers to make sure people settle in back at home.

That means that health professionals need to be trained in the purpose and techniques of participation as part of their undergraduate and postgraduate degrees, and at other levels of training. There also needs to be wider dissemination of how participation can cut costs in the NHS, and better championship of the ideas of partnership inside the professions.[118]

Vision and Conclusion

The NHS has been called the national religion. There is a great deal of goodwill towards it. At the same time, there is an evident need for reform and improvement. Foundation Trusts are a step in the right direction. More now needs to be done.

In the longer term, mutuality may be the key to reforming the NHS, because it provides a chance to break the log-jam between public and private that has beset public services for the past half century. Mutuality provides a new conceptual framework and a method of innovation in health delivery, which allows for a focus on the broader determinants of health inequalities and impact. It can provide an answer to tough questions – how do you motivate a sense of public service in an entrepreneurial culture and how do you provide accountability in a vast public bureaucracy? If mutual structures provide potential answers, they can reach out across the political divide.

The time is right for this idea. Devolution, and the different approaches to the NHS that this has engendered, and the creation of PCTs focusing on public health and primary care locally is shifting interest towards a wider constellation of health-care and improvement than an NHS universe that revolves around acute hospital-based medicine. At the same time, mutuality will require further culture change to allow it to take root and be sustainable. Above all, mutuality must come to underpin a new kind of professionalism – not the aloof kind that was encouraged by a central NHS bureaucracy, nor the accounting kind that has grown up as an accretion along with certain privatisations, but something different.

This is a new professionalism that is aware of its vital role in people's lives, but also its dependence on ordinary people too. A mutual NHS is an inter-dependent NHS, and that provides a re-working of its founding spirit that wouldn't be out of place in the 21st century.

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Notes

1 Both the Institute of Directors (IoD) and the New Economics Foundation (NEF) have an interest and have done work in this area. For example, our publications that cover some of the ground have so far been:

- Healthcare in the UK: the need for reform, Policy Paper, by Ruth Lea, February 2000, revised June 2000 (IoD);
- Healthcare in the UK: the need for reform, Economic Comment, by Ruth Lea, October 2000 (IoD);
- Management, Mutuality and Risk: Better Ways to Run the National Health Service, Research Paper, by Geraint Day, October 2000 (IoD);
- New paths for the provision of healthcare. Comment, by Geraint Day, July 2001 (IoD);
- Report of a Survey of Views on Healthcare Provision, Healthcare Provision Policy Study Group, by Geraint Day, October 2001 (IoD);
- The Mutual State How Local Communities Can Run Public Services, by Ed Mayo and Henrietta Moore, 2001 (NEF),
- Putting the Life Back into Our Health Services, by Sarah Burns, David Boyle, Karina Krogh, 2002 (NEF).
- Building the Mutual State, edited by Ed Mayo and Henrietta Moore, May 2002 (NEF and Mutuo).

2 Although there is still a purchaser-provider split for secondary healthcare.

3 See The Future of the NHS, King's Fund, London, January 2002 and "Winging it", Steve Dewar & Sir Cyril Chantler, Health Service Journal, 14 March 2002, pp 24-27.

4 New Labour New Life for Britain [1997 General Election manifesto], Labour Party, London, 1997, for example p 6. Interestingly, in the recently revised Fabian Society rulebook, rule 2 reads: "… seeks to promote where appropriate the social and co-operative ownership ofeconomic resources. It argues for strong and accountable public institutions …".

5 "Patients' champion for every hospital", Anthony Browne & Gaby Hinsliff, The Observer, 23 July 2000.

6 "Virgin team highlights NHS shambles", John Carvel, The Guardian, 22 July 2000.

7 "On target to achieve nothing", John Seddon, The Observer, 27 August 2000.

8 The Tyranny of Numbers, David Boyle, HarperCollins, London, 2001.

9 For background, see for example the British Deming Association home page: www.deming.org.uk/demintro.htm.

10 A New Way to Govern, Shann Turnbull, NEF, London, 2002.

11 "Admin's not sexy – just vital", Simon Caulkin, The Observer, 21 April 2002.

12 Delivering the NHS Plan next steps on investment next steps on reform, Presented to Parliament by the Secretary of State for Health, Cm 5503, The Stationery Office, Norwich, April 2002, para. 3, p 3.

13 The NHS Plan A plan for investment A plan for reform, Cm 4818-I, Crown Copyright, The Stationery Office, Norwich, July 2000, p 30, para. 2.31.

14 "Cash flows into NHS, delivery another matter", Sylvia Pfeifer, The Business, 21/22 April 2002.

15 "Health and social care", epxNews, 18 April 2002. In the Government's Comprehensive Spending Review 2002 the private sector was assumed to have a constant 1.2% proportion of GDP for the financial years 2002-2003 to 2007-2008.

16 Gallery News, 17 April 2002.

17 Alan Milburn, speech at a New Health Network event, London, 15 January 2002.

18 "The New Localism": Speech by the Chief Economic Adviser, Ed Balls to the Chartered Institute of Public Finance and Accountancy annual conference, 12 June 2002. (www.hmtreasury.gov.uk/Newsroom_and_Speeches/Press/2002/press_55_02.cfm).

19 For example, "A tough question at the heart of the third way", Nicholas Timmins, Financial Times, 29 July 2002, and "In the public interest", editorial, op. cit., 5 August 2002.

20 "First person: Nigel Crisp", Business Voice, June 2002, p 16.

21 Divergence and Devolution?, Greer, Nuffield Trust, 2001.

22 "Rise in NI [National Insurance] payments will cost public sector £1.2bn", George Jones & Andrew Sparrow, The Daily Telegraph, 23 April 2002.

23 "Costing dear", Danny Lee, Health Service Journal, 2 May 2002, pp 12-13.

24 For example the Confederation of British Industry has commented that businesses could be convicted when they have no reasonable way of anticipating or reducing the risk, and state bodies such as prisons and NHS trusts would have immunity: "Dying for action: Five people a week die in workplace incidents", Oliver Robinson, Guardian Office Hours, The Guardian, 12 August 2002.

25 Policy, Labour Party, April 2002.

26 "Nurse, is it still breathing?", Anne Burns, Human Resources, July 2000, pp 46-51.

27 "Blair's £40bn gamble on IT", Michael Cross, The Guardian, 25 April 2002.

28 "Hearing voices", Judith Allsop, Health Service Journal, March 2002, pp 28-29.

29 "Powers of observation", Donna Bradshaw & Kieran Walshe, Health Service Journal, 18 April 2002, pp 28-29.

30 "When worlds collide", Matt Muijen, Health Service Journal, 17 January 2002, p 18.

31 Local Delivery of Central Policy, Better Regulation Task Force, Cabinet Office, London, July 2002. It quoted an executive of a Regional Development Agency in England as saying, "For the last 3 months I've been involved in nothing but navel contemplation. Shortly we are actually going to stop doing anything apart from reporting on ourselves" (ibid., p 41, section 9.5).

32 Brave New Economy, NEF, London, February 2000, CD-ROM.

33 "Mutuality", Dr Bob James, May 2000, at www.takver.com/history/mutual.htm. He argues that this equality holds: no matter what the legally sanctioned position held by any individual within the group might be; no matter what the length or kind of membership or contribution of any member might be; no matter what financial arrangements may be entered into to raise capital; and no matter what administrative arrangements may be entered into to enhance the expertise of the group.

34 See the International Co-operative Alliance website, at www.coop.org/ica/index.html.

35 Some Useful Statistics, Co-operative Union Ltd, October 2001. See also www.coopunion.coop/summary_stats.htm. There are also many examples of mutual social care models. These include West Midlands Co-operative Society, which runs care homes for elderly people. There are many Italian social care co-ops – in Northern Italy in particular. Some of these are run by the employees or by employees and volunteers, including relatives of those in receipt of care. These are really types of worker (or producer) co-operative. A third type is a community co-operative, with a wider membership and with mutual benefits to the community at large. They are organised as democratically controlled businesses but with some state subsidy. Both the legal and political context in Italy (Northern Italy in particular) have historically been more conducive to the formation of co-operatives in general. A mutual model for UK long-term care is being worked up, funded by the DoH, and the Co-operative Insurance Society, and backed by The Co-operative Bank, West Midlands Co-operative Society and Cobbetts solicitors.

36 Social Enterprise: a strategy for success, Department of Trade and Industry, London, July 2002.

37 The State of Community Development Finance 2001, Sam Collin et al, NEF, London, 2001.

38 The Mutual State: how local communities can run public services, Ed Mayo and Henrietta Moore, NEF, London, 2001.

39 Ibid.

40 Value Led, Market Driven: social enterprise solutions to public policy goals, Andrea Westall, IPPR, 2001.

41 For example, A Mutual Trend: How to run rail and water in the public interest, Johnston Birchall, NEF, 2002. See also The New Mutualism in Public Policy, edited by Johnston Birchall, Routledge, London, 2001.

42 Managing for Health, David Hunter, Institute for Public Policy Research (IPPR), London, 1999, referred to in Healthcare in the UK: the need for reform, revised edition, IoD Policy Paper, Ruth Lea, IoD, London, June 2000, note 16 on p 94.

43 Adapted from "Social Enterprise", presentation by Ed Mayo at "The Citizen State" conference organised by the Gorbals Initiative, Glasgow, 23 May 2002.

44 The idea of changing the NHS into a system where the state still provides most of the funds but the delivery of healthcare is devolved as much as possible was proposed by Ruth Lea. She suggested that healthcare in the UK be delivered by self-governing mutuals rather than by a vast array of public bodies that are all supposedly responsible to the Secretary of State for Health. This idea was further explored in the Autumn of 2000 in a Research Paper produced by Geraint Day of the IoD's Policy Unit: Management, Mutuality and Risk: Better Ways to Run the National Health Service, IoD Research Paper, Geraint Day, IoD, London, October 2000. The concept of the Mutual Health Service was floated in The Mutual State by Ed Mayo and Henrietta Moore which set out the scope for mutuals and non-profit bodies to take a far wider role in public service provision (The Mutual State: how local communities can run public services, NEF, London, 2001). The findings from a website-based project were published as Building the Mutual State, edited by Ed Mayo & Henrietta Moore, NEF and Mutuo, London, May 2002.

45 "The recipe for mutual success", John Kay, Financial Times, 9 August 2000.

46 For example, the Black report on Inequalities in Health, which was commissioned by the Callaghan government, showed how universal rights to health and relatively equal outcomes in health were not occurring in the 1970s. Sir Douglas Black's report was the most comprehensive enquiry into the health of the nation in the post-war period. The Black report showed that

men and women in unskilled households had a two and a half times greater chance of dying before retirement age than their professional counterparts. The report also showed that for infants the mortality rate among unskilled households and the poor was three and a half times higher than for professionals. Moreover, evidence in the Black report showed that this gross inequality in health (both morbidity and mortality) had reverted to a similar state to that prevailing at the turn of the century when highlighted by Seebohm Rowntree. See Prevention: a key component of physician training? Alberti, G, Ph Com. The Newsletter of the Faculty of Public Health Medicine, Vol 3 No. 3:6, 2002.

47 Unhealthy Societies – the Afflictions of Inequality, Richard Wilkinson, 2001.

48 This concept was pioneered by the radical economist James Robertson. See, for example, Transforming Economic Life, James Robertson, NEF/Schumacher Society, 1999.

49 Policy watch, Jann Bettinga, The Guardian, Wednesday October 9, 2002, http://politics.guardian.co.uk/tories2002/story/0,12295,807363,00.html

50 The Courage of Our Convictions: why reform of the public services is the route to social justice, Tony Blair, Fabian Society, London, September 2002, p 31.

51 Quality, Innovation, Choice, Report of the Public Services Policy Commission, Liberal Democrats, Paper 53, 2002.

52 Where Now for New Labour?, Anthony Giddens, Fabian Society, Polity Press, Cambridge, 2002, pp 54-68.

53 Ibid, p65

54 Factsheet:not-for-profit organisations, IPPR, London, 2002.

55 The Case for the Public Interest Company: A New Form of Enterprise for Public Service Delivery, Paul Corrigan, Jane Steele & Greg Parstons, Public Management Foundation, London, 2001.

56 The New Shape of Public Services, Volume 1: Health & Education, Dr Eamonn Butler & Dr Madsen Pirie, Adam Smith Institute, London, 2001, p 18.

57 Welfare and the Consumer Society New Opportunities for the Third Way, Professor Nigel Waite, The Canford Centre for Customer Development, for the Association of Friendly Societies, London, September 2001.

58 Public, Private or Community: What Next for the NHS?, Chris Ham, Demos, London, 1996.

59 Towards a More Co-operative Society, Stephen Pollard, Terry Liddle & Dr Bill Thompson, Independent Healthcare Association, London, 1994.

60 Professor Alyson Pollock of University College London, quoted in "Mutuals 'are return to pre-1948'", Tash Shifrin, Health Service Journal, 31 January 2002, pp 6-7.

61 "Blair's warning angers unions", Patrick Wintour, The Guardian, 4 February 2002.

62 David G. Green: Working Class Patients and the Medical Establishment: Self-Help in Britain from the Mid-Nineteenth Century to 1948, Gower, Aldershot, 1985.

63 A Century of Medical Service, Bernard Darwin, Great Western Railway Medical Fund Society, Swindon, 1947, reprinted by the Health Hydro Management Committee of the Borough of Thamesdown [now Swindon], October 1991.

64 Citizenship, Work and Welfare, Julia Parker, 1998. A further example of beneficial central initiative is in the case of negotiations on price with the large drugs companies, where pooling the purchasing power of NHS Trusts and perhaps even hospitals abroad, can keep a lid on costs.

65 "Milburn's 'Railtrack of the NHS'", John Carvel & Michael White, The Guardian, 16 January 2002.

66 Economics, Medicine and Health Care, second edition, Gavin Mooney, Harvester Wheatsheaf, Hemel Hempstead, 1992, p 103.

67 There is an analogy here with the Operating and Financial Review for "economically significant companies" (roughly speaking, public companies with an annual turnover of more than £50 million or private companies exceeding £500 million a year) to address opportunities and threats in a qualitative as well as quantitative way. This could include relationships with employees, suppliers and the wider community, where considered relevant. This is expected to become a legal requirement in 2003, although the details have yet to be worked out following the deliberations around the Government's Company Law White Paper, Modernising Company Law, Command Paper Cm 5553, Presented to Parliament by the Secretary of State for Trade and Industry by Command of Her Majesty July 2002, HMSO, Norwich, July 2002.

68 What's Trust Worth, Alex MacGillivray, NEF, London, 2002.

69 The Health and Social Care Act 1990 provides the legal framework for NHS Trusts. The Act empowers the Secretary of State to establish bodies 'to assume responsibility … for the ownership or management of hospitals … or to provide and manage hospitals'. This was subsequently expanded to include other related healthcare services. While subject to a range of limitations, including the scope for the Secretary of State to intervene in or close failing Trusts, the Act states that each Trust is a body corporate and that NHS Trusts are independent and the Trust is not a servant or agent of either the Crown or the Department of Health.

70 From a speech in January 2002 by Alan Milburn. Taken from Press Release 2002/0022, DoH, London. See http://tap.ukwebhost.eds.com/doh/Intpress.nsf/page2002-0022?OpenDocument.

71 See Press Release 2002/0240, DoH, at http://tap.ukwebhost.eds.com/doh/Intpress.nsf/page/2002-0240?OpenDocument. The IoD produced a document, Management, Mutuality and Risk: Better Ways to Run the National Health Service, IoD Research Paper, Geraint Day, IoD, London, October 2000 which also refers to overseas experience, including reference to a definitive United Nations survey published in 1997, of healthcare mutuals worldwide, including organisations that provide healthcare, fund healthcare or do both: Cooperative Enterprise in the Health and Social Care Sectors A Global Survey, United Nations, New York, 1997.

72 From the text of the NHS Foundation Hospitals speech delivered by the Secretary of State for Health, the Rt. Hon. Alan Milburn MP, on 22 May 2002.

73 The Company Director's Guide, Tony Renton & John Watkinson, Kogan Page, London, for the IoD, 2001, pp 21-22.

74 Company Law White Paper, Modernising Company Law, Command Paper Cm 5553, Presented to Parliament by the Secretary of State for Trade and Industry by Command of Her Majesty July 2002, HMSO, Norwich, July 2002.

75 The Company Director's Guide, Tony Renton & John Watkinson, Kogan Page, London, for the IoD, 2001, pp 3-18.

76 The UK is not alone in such debates: it is interesting to note that in Poland, following recent health service reforms in which local government owns the local hospitals, it is unclear whether managers have the right to sell or to close facilities or to sell assets: see "Tackling high male mortality in Poland. Proposals for reform", Jesse Selber, Eurohealth, Spring 2002, pp 23-25.

77 The implication of non-profit distribution here is that the surplus or profit generated cannot be distributed to the owners of the organisation. In other words, all of it will be reinvested back into the activities of the Trust. This is the general definition of a 'not-for-profit'. It does not mean "losing money". For many organisations this is appropriate because they can fund their operations or growth from internal revenues or from accessing debt finance from external finance providers.

78 Adapted from an Annex in the forthcoming Performance and Innovation Unit (PIU) report.

79 The Public Interest Company as a mechanism to improve service delivery, Charles Brecher, Public Management Foundation, London, April 2002.

80 Criteria for NHS Boards Good Practice for Directors, IoD in collaboration with the NHS Executive, the then National Association of Health Authorities and Trusts, and the then NHS Trust Federation, London, 1996.

81 The NHS Appointment Commission document, Induction Guide for Chairs and Non-Executive Directors (www.doh.gov.uk/nhsacc/index.htm) has been commended by George Cox, IoD Director General (see "How to Help NHS Reform", George Cox, IoD News, August 2002, p 3).

82 See The Effective Director, edited by Chris Pierce, Kogan Page, London, 2001. See also The Chartered Director Code of Professional Conduct, IoD, London.

83 The Effective Director, edited by Chris Pierce, Kogan Page, London, 2001, p 41.

84 "Power to the consumer is in everyone's interest", Gareth Thomas, The Co-operative News, 21 April 2001, p 6.

85 A Mutual Trend: How to run rail and water in the public interest, Johnston Birchall, NEF, 2002.

86 Building the Mutual State, edited by Ed Mayo & Henrietta Moore, NEF and Mutuo, London, May 2002.

87 House of Commons Health Committee on 12 June 2002 (from www.parliament.the-stationery-office.co.uk/pa/cm200102/cmselect/cmhealth/uc934-i/uc93402.htm: paragraph 40).

88 For instance the Group Health Cooperative, Washington State, USA. See www.ghc.org.

89 "Is this the last chance for public services?", David Aaronovitch, The Independent, 17 July 2002.

90 "When too much care can be bad for your health" John E. Wennberg, New Scientist, 17 August 2002, p 26.

91 "NHS to be given equity in new joint ventures", Nicholas Timmins, Financial Times, 8 June 2001.

92 These could include dental, pharmacy and social services and possibly so-called intermediate care facilities intended for short-stay patients. The Trust will co ordinate matters centrally, helping to buy out premises leases and remove general medical practitioners and dentists who have negative equity. It will also provide assistance with project management. These new forms of PPP were planned to commence initially in Barnsley, Camden and Islington, Sandwell, Newcastle and North Tyneside, East London and the City, and there is to be a joint initiative in Manchester, Salford and Trafford, although it is expected to take up to the third quarter of 2003 before the new facilities are in place. Up to 500 such primary care PPPs are planned in all.

93 There are several equity vehicles developing which are designed as social venture capital where there are both limited returns and an acknowledgement that control rights would not be given in the company. Some social enterprises have adopted company limited by shares format in order to make use of social or mainstream venture capital. In this case they are often designed so that the majority shareholding is by the core stakeholders (with or without any distribution of surplus to them) so that control is maintained by them but that small equity stakes are available for finance providers but which may have no or limited voting rights for example through preference shares.

94 "Tories inspired by German health service", David Chater, The Times, 10 July 2002.

95 This would require detailed agreement about expected savings. It would require some kind of agreement with the funder, and maybe agreement that is underwritten by central government – and some idea of how long is needed to recoup investment with a reasonable interest added – so that the savings are shared between the funder and the investor.

96 Enterprising Communities: Wealth Beyond Welfare, Social Investment Task Force, Social Investment Forum with New Economics Foundation and Development Trusts Association, London, 2000.

97 The Prince's Trust, for example, operates a social performance contract with the Department for Work and Pensions (DWP) to support young people finding employment. Targets of the numbers of young people to be helped into employment are set annually, based on agreement between DWP and Prince's Trust. The Trust provides business support, mentoring and start-up financial awards – primarily business loans – to eligible youth as part of their normal programme activities. Lump sum 'outcome' payments are made by DWP to Prince's Trust on a quarterly basis for each young person provided with an award. The DWP's aim is to assist people find long-term unemployment. That's why an additional 'survival' payment is made to Prince's Trust for every individual who is still employed trading after 12 months. This provides an added incentive for Prince's Trust to provide high quality support. This kind of funding from the performance contract with DWP represents a secure and stable source of revenue. It delivers both results and ultimately the best use of scarce public funds.

98 See Healthcare in the UK: the need for reform, revised edition, IoD Policy Paper, Ruth Lea, IoD, London, June 2000, pp 91-92 (this point was also included in the earlier edition of February 2000).

99 It issues guidance to local authorities and health authorities on all aspects of service commissioning, provision, regulation and inspection in the social care and health fields. Its guidance includes regulation of the providers of domiciliary care, national standards for residential care homes, and national service frameworks for mental health and older people's services. The Department is responsible for the Social Services Inspectorate, which works with the Audit Commission to regulate Social Service Authorities.

100 This would include submission of accounts and annual returns and any additional specified documentation, including a copy of the external auditor's management letter. But it would also include an annual social report, to report on healthcare and healthcare outcomes. Such models of social reporting, pioneered by the New Economics Foundation, are now quite widely practiced in the private sector. A variety of inspection mechanisms can also be used. The most thorough is likely to be at the point of registration.

101 These might include statutory rights: to appoint board members or remove board members or officers during or following an inquiry (although this should be used only in extremis, for it would act against the principles of devolved governance which we have been advocating); to direct a merger or transfer assets following an inquiry: another historical power, which has been used from time to time; to take action where insolvency threatens; to direct recovery of unlawful payments and benefits; to require production of documents; to disclose information to other statutory bodies.

102 Chris Ham, *Public, Private or Community: What next for the NHS?* Demos, London, 1996.

103 Prevention: a key component of physician training?" Alberti, G, Ph Com. The Newsletter of the Faculty of Public Health Medicine, Vol 3 Number 3:6, 2002.

104 Derek Wanless Securing Our Future Health: Taking a Long-Term View, HM Treasury, London, April 2002.

105 Funny Money: in search of alternative cash, David Boyle, HarperCollins, London, 1999.

106 The Time of Our Lives: summary of two-year research consultation, Gill Seyfang, Time Banks UK/NEF, 2002. See also, Putting the Life Back into Our Health Services, Sarah Burns, David Boyle, Karina Krogh, NEF, London, 2002.

107 Citizenship, Work and Welfare, Julia Parker, Basingstoke, Macmillan; St Martin's Press, New York, 1998.

108 Putting the Life Back into Our Health Services, Sarah Burns, David Boyle, Karina Krogh, NEF, London, 2002.

109 Perceptions of Partnership: a documentary analysis of Health Improvement Programmes, Elson J and Fulop N, Public Health: 207-213, 2002. See also "CityNet Partnership Evaluation" Pre-publication Working Paper, Pamela Gillies and Pennington, University of Nottingham, 2002.

110 Corner, Jessica, Queen Elizabeth the Queen Mother Fellowship Lecture, Between You and Me: Closing the Gap between People and Health Care, delivered at The Royal Society of Arts, London, Wednesday 20 June 2001, www.nuffieldtrust.org.uk. See also Angela Coulter, The Autonomous Patient, John Fry Fellowship, forthcoming, 2002, Nuffield Trust.

111 Optimising Value: the motivation of doctors as managers in the NHS, Jane Steele & Alison Graham, Public Management Foundation, London, August 2001.

112 Derek Wanless, Securing Our Future Health: Taking a Long-Term View, HM Treasury, London, April 2002.

113 Well-Being, Ed Mayo & Nic Marks, unpublished, New Economics Foundation.

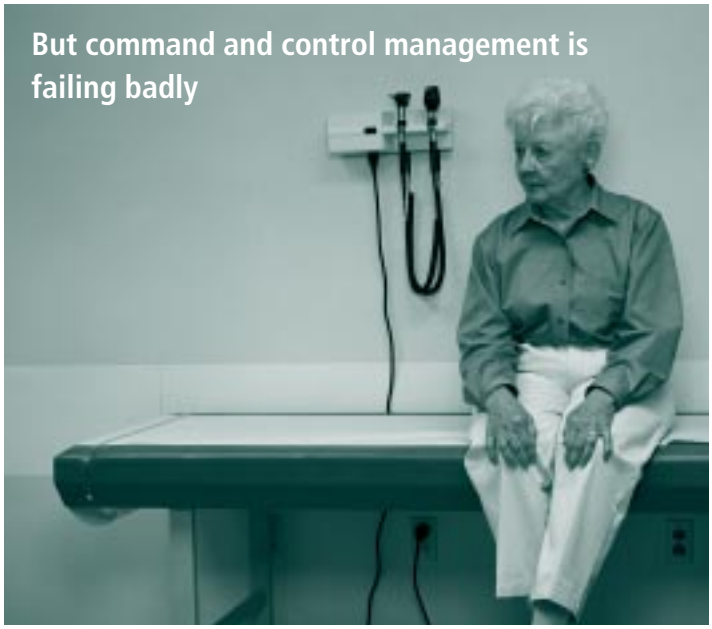
114 Ibid.

115 McKinsey & Co, Expectations of the 2020 UK Healthcare System, in Health Trends Review: proceedings of a conference, Barbican Centre, London,18/19 October 2001, unpublished.

116 "Effectiveness of Alliances and Partnerships for Health Promotion", Gillies P A, Health Promotion International, Vol 13, No. 2: p 99-120, 1998.

117 Intermediate Care Models in Practice, King's Fund, London,1999.

118 See, for example, The medical profession, the public, and the government, Chris Ham and K G M M Alberti, British Medical Journal, 2002; 324: 838-842.



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