King's Fund

Two Cheers?

Reflections on the health of NHS democracy

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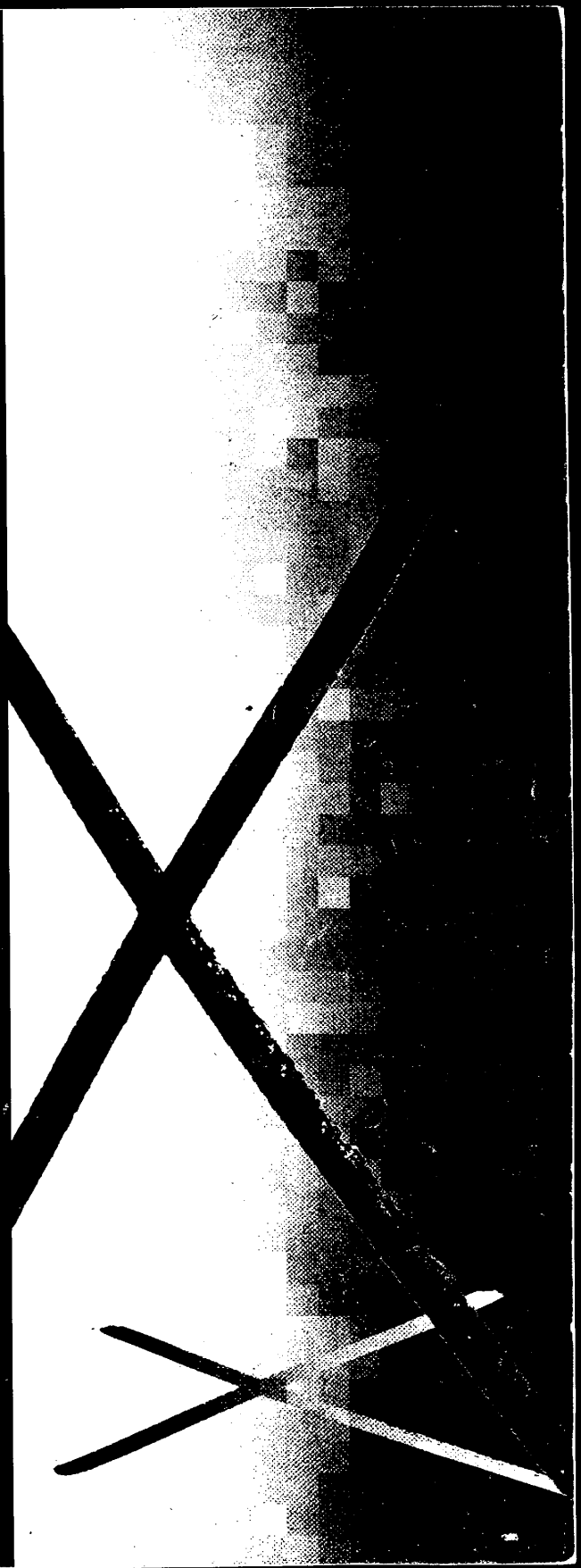

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Executive summary

- Democracy is about more than voting and party politics; it includes notions of transparency, pluralistic debate, accountability, freely available information and non-arbitrary decision-making.
- The NHS is predominantly centrally funded from general taxation. Accountability 'upwards' to the Secretary of State, who is constitutionally responsible for all aspects of the service's activity, is therefore inevitable and essential.
- Much therefore depends on the effectiveness of Parliament in calling the Secretary of State to account. Various mechanisms exist and could be strengthened.
- As an alternative, there are now significant arguments in favour of developing local forms of democracy in the NHS, including participatory innovations such as citizens' juries and even transferring control of health care purchasing to local government.
- Although these innovations have benefits, a move toward formal local democracy also has costs: it would not avoid awkward political choices; it would create conflict between local and national accountability; and may entrench geographical inequity.
- Individual choice, however desirable in its own right, is not an alternative to political, collective decision-making – essential in the NHS where provision is based on assessments of need under conditions of scarcity.
- The White Paper, *The New NHS*, says little about democracy and accountability. Its proposals reinforce the need for traditional 'upwards' accountability, by introducing more central agencies. This further increases the possibility of central accountability 'overload'.

The word 'democracy' is often invoked in debates about the NHS. This paper explores its many meanings, seeks to define some criteria for assessing whether or not there is a 'democratic deficit' in the NHS, as so often argued, and examines the policy options that have been put forward for making the NHS more 'democratic'. The aim is not to advocate any particular solution or model but to bring some clarity into a debate which mirrors the confusion created by the chameleon nature of the concept itself.

In doing so, our concern is with the governance of the NHS: the institutional arrangements which determine the relationship between the service and citizens. For 'democracy', whatever else it may or may not mean, is about the process of political decision-making – the manner in which decisions are taken, at all levels in the NHS, about what services are to be delivered to whom and how. It is not about the relationship between managers and users of the service. Nor is it about the relationship between individual doctors and patients. We may well want managers to involve users more in the design of services, just as we may want doctors to see patients as partners in the process of health care delivery. The way in which the governance of the NHS is organised – whether it is more or less 'democratic' – may have an important influence on the style of service delivery, but it must not be confused with it.

In all this, it must be further stressed, our concern is with political democracy, not the democracy of the market place. The NHS is based on the principle that scarce resources should be allocated according to need: while political decisions determine its budget, professional decisions determine how need will be defined and met. It is a principle which is at odds with the language of consumerism: the notion that the service should respond to consumer demands. To anticipate our conclusions, consumer sovereignty and the NHS are incompatible partners, pulling in opposite directions.

In the first section we analyse the various ways in which 'democracy' is understood, and develop a set of criteria for testing the democratic credentials of government institutions. Then we look at central governance and the inevitable need for central accountability in any service funded out of general taxation. In the next section we turn to the possibility of local democracy in the NHS – both the justifications and problems associated with introducing formal local accountability into a 'national' service. The following section briefly looks at whether individual choice can act as a substitute for democracy. Finally, we review what the recent White Paper implies for the NHS.

A word and its meanings

Democracy means rule by the people. However, dictionary definitions do not get us very far. As Rousseau pointed out more than 200 years ago ... 'If we take the term in its strict meaning, no true democracy has ever existed nor ever will ... It is inconceivable that the people should be in permanent session for the administration of public affairs'. So while there may be scope for participatory or direct democracy – defined as decision-taking by the people – in certain circumstances, this is not particularly helpful when it comes to the governance of large, complex societies or organisations. Hence the competitive struggle to impose meaning on the word, a struggle which has produced a vast academic literature. If democracy has become the 'most promiscuous word in the world of public affairs',[1] it is precisely because it has become the rhetorical flag which everyone seeks to capture. In what follows we shall therefore try to unbundle the notion and to identify the elements that make up a democratic style of governance.

First, there is general agreement that democracy requires the governors to be elected by the governed. But while that may be a necessary condition, it is not a sufficient one. There are plenty of examples, past and present, of regimes whose constitutions provide for regular elections

but which nevertheless would generally be described as dictatorships. The second necessary condition for anything approaching democracy to exist is therefore that there should be an opportunity for the governed to make the governors answerable for what they have done and, if they fail to satisfy, to throw them out. In short, competition between rival, would-be governments would seem to be essential.

But while it easy enough to identify regular elections, and competition for the people's vote as the essential prerequisites of democracy, it is not self-evident that these define the core of the notion itself. This is more complex and elusive, and has at least as much to do with the way in which governments conduct their affairs as with the way in which they get into office. While the people's mandate may give governments their legitimacy, it does not necessarily provide protection against elective tyranny: i.e. the abuse of power by those given a temporary licence to rule. Hence the preoccupation – from Aristotle, through the American Founding Fathers, to modern constitution designers – with devising means for regulating, even restricting, the freedom of action of elected governments. So, for example, the case for a written constitution and a Bill of Rights – now receiving much attention in the UK – rests on the perceived need to ensure that both individual citizens and minority groups are protected against arbitrary government actions.

If democracy is defined (as it often is) in terms only of the way in which the rulers are chosen, it therefore remains a poor notion devoid of much significance at least in societies which have already achieved the minimum conditions necessary. The fact that a particular government or local council has been elected does not, of itself, satisfy the demands of democracy in the full sense. It is, at best, a prerequisite. If, however, democracy is defined (as it should be) as a style of government, then we can move forward to listing some of the conditions necessary for its achievement: a list which will necessarily be incomplete – possibly also contentious – but which at least allows us to move forward to defining the criteria to be deployed when talking about 'democracy' in the context of the NHS.

The first criterion must, clearly, be that the governors are accountable to the governed. This is a somewhat vacuous assertion: everyone will nod agreement since the notion of accountability is itself almost as multi-dimensional as that of democracy.[2] There is accountability in the strong sense. This demands that there should be sanctions if the performance of the governors fails to satisfy and they cannot give a convincing account of their conduct. In ancient Athens, it has been reckoned, more generals died as a result of the sentences passed on them than on the battlefield. In modern times, the sanction tends to be less drastic: a forced resignation or loss of office following an election is the worst likely to happen.

There is also accountability in the soft sense. This is the requirement to justify performance, even in the absence of direct or immediate sanctions: that there should be an opportunity to cross-examine, as it were, the governors and make them answer for their actions. In turn, this prompts other requirements: that the decision-making process should be transparent, that even decisions taken in private must be defensible in public and that there should be a free flow of information. Here the only sanction may be that of a public shaming. But accountability in the soft sense is no less crucial for all that. Elections come round only rarely and when they do so, they tend not to revolve around the performance of a single service. Hence the crucial importance of soft accountability, seen as a process which gives visibility to the process of governance and provides an opportunity to challenge the actions of those in charge.

The second criterion, which is as crucial as it is difficult to pin down with precision, is that the process of decision making should be permeable. That is, the decision-making process should allow opportunities for the interests concerned in the outcome to voice their views and so to influence

the outcome. From this perspective, democracy is all about the dialogue: the mobilisation of consent. In other words, any mandate has to be constantly renewed – it is not a once and for all affair decided at elections – by testing the acceptability of the way in which it is being used in specific circumstances. Here the underlying notion is that of pluralism: democracy is defined not in terms of a majority deciding on behalf of society – or some mystic notion of a general will – but as a constant search for a coalition of support among the many, competing interests that together make up society. So a democratic style of governance is all about accessibility and visibility in policy making and implementation by governments and public agencies.

The third criterion is that the actions of the governors must not be arbitrary: that they conform to rules of conduct designed to ensure equity in the treatment of citizens, that they are based on the powers bestowed by the law and that they reflect decisions taken after full consideration of all the relevant evidence. From this flows the requirement that there should be machinery for reviewing decisions and actions: that the individual citizen should have powers of redress. So, for example, even a dictatorship (whether elected or not) might be required to demonstrate that its tyranny is impartial as between individual citizens and that it is following due process, even though it is not accountable.

There we have it, then. If we want to test whether or not the NHS is 'democratic', in any of the many senses of the word, we have to ask three questions. Is it accountable? Is it permeable? And does it afford protection against arbitrariness? In the following section, we therefore apply our APA test to the present governance of the NHS before turning, in subsequent sections, to looking at alternative models.

The central governance

The NHS is unique among public services in this country, and indeed among health care systems in the western world, in that it is predominantly funded out of general taxation and is the direct responsibility of central government. The one flows from the other. The method of funding determines the line of accountability.[3] It is because the NHS is overwhelmingly funded out of general taxation that the Secretary of State is answerable to Parliament for the way in which public money is spent. And, in turn, because the Secretary of State is answerable to Parliament, he or she cannot avoid responsibility for the running of the NHS. Enter Bevan's famous bedpan doctrine: 'when a bedpan is dropped on a hospital floor', Bevan pronounced, 'its noise should resound in the corridors of the Palace of Westminster'. In this respect, the NHS differs from other services in the UK and from health care services in other countries. Education and social services in the UK, though funded to a large extent by block grants from the centre, are the responsibility of local government. Health services in other West European countries are the responsibility either of local government or insurance funds.

Flowing from the 'bedpan doctrine', there is a further characteristic of the NHS, highly relevant for our inquiry. This is that the health authorities responsible for delivering health care, and the trusts responsible for delivering it, are the 'agents' of the Secretary of State. The phrase is, once again, Bevan's. Public accountability demands a chain of command running from the centre to the periphery and is incompatible with the notion that health authorities should have a source of legitimacy independent of the Secretary of State. The full logic of this was blurred in the early decades of the NHS when health authorities included members nominated by professionals (doctors and nurses) working in the service and by local authorities. But the 1991 reforms pushed the logic of public accountability to its ultimate conclusion: the non-executive members of purchasing authorities and trusts are now the nominees of the Secretary of State although in practice he or she delegates the task of choosing them, picking the chairmen or women and then leaning heavily on their advice. Indeed this could

be seen as a necessary condition for effective accountability in a centralised system, although it raises awkward questions when we come to consider what 'local democracy' might mean.

The starting point for our inquiry into the state of 'democracy' in the NHS must therefore be the way in which the service is run from the centre. Before doing so, however, two sources of tension must be noted. First, there is the question of the degree of discretion allowed to health authorities and trusts: the precise relationship between the principal (the Secretary of State) and the agents carrying out his commands. If the notion of a national health service is to be taken at face value, then there should be very little if any discretion: the same package of health care should be delivered to the same standard everywhere. But in practice variation remains the norm in the NHS, justified on the grounds that national policies should be adapted to local circumstances. There would appear to be a trade-off between uniformity and responsiveness, between the pathologies of rigid centralisation and the anarchy of localism. Throughout its history the NHS has never resolved this ambiguity: there has been a recurring cycle of devolving responsibility followed by a return to centralisation. And, indeed, successive Secretaries of State have exploited this ambiguity in order to claim credit for successes and to diffuse blame for failures.

Second, the chain of command has some crucial missing links. The professionals managing and delivering health care are not employed by the Secretary of State but by the health authorities and trusts. This has the result, to take a recent example, that the Secretary of State cannot take disciplinary action against managers charged with financial impropriety.[4] Moreover, the doctrine of professional autonomy means, in effect, that doctors cannot be held accountable for the way in which they use public funds. And the introduction of GP fundholding has introduced still more grit into the machinery of accountability: it is not at all clear to whom they are accountable, and for what, in the way they use their budgets.[5] In effect, therefore, the NHS is a broken-backed hierarchy: while the line of accountability runs, in theory at least, directly from the point of service delivery to the Secretary of State, the Minister does not directly control those who are actually responsible for the care of patients.

The machinery of accountability

Bearing these reservations in mind, we now move to examining whether the central governance of the NHS matches the requirements of our APA test, starting with accountability. How, in practice, does Parliament hold the Secretary of State to account? How does the 'bedpan' doctrine operate in the context of the 1990s?

The small change of accountability is the parliamentary question: MPs asking the Secretary of State to respond (either in person on the floor of the House of Commons or in writing) to their queries, usually on behalf of their constituents or particular lobbies. In any one year, the Department of Health is likely to deal with some 3,000 parliamentary questions: more than any other government department.[6] Many of these questions deal with highly local and specific issues – see Box 1.

The parliamentary question is, of course, a somewhat limited instrument of accountability. Civil servants are artists in providing bland replies for Ministers, designed to avoid embarrassment, and question time in the House of Commons provides little opportunity for probing supplementaries. However, the importance of the parliamentary question lies less in its public impact than in the preparations that go into framing the replies: they prompt inquiries from the centre on behalf of Ministers. Public defensiveness may thus conceal private scrutiny and criticism. In addition, MPs may take up constituency issues in personal correspondence with Ministers, a form of intervention which may be all the more effective for not involving the gaming element of questions in the House. Finally, MPs may use adjournment debates – short discussions which end without a vote – to raise specific issues.

Box 1: A sample of parliamentary questions: 22 July 1997

Mr John M Taylor: To ask the Secretary of State what is his policy towards the undertakings provided by the former Minister for Health on 20 March 1996 regarding services at Solihull Hospital, with particular reference to 24 hour accident and emergency facilities; and if he will make a statement

Mr Nicholas Winterton: To ask the Secretary of State for Health if he will make a statement on the role and responsibilities of NHS Trusts and their non-executive directors

Dr Tony Wright: To ask the Secretary of State for Health what assessment he has made of whether operations are being performed by appropriately qualified and supervised doctors

Ms Beverley Hughes: To ask the Secretary of State for Health if he will make a statement about hospital waiting lists in (a) Stretford and Urmston and (b) Greater Manchester

Mr Pickthall: To ask the Secretary of State for Health if it is his Department's intention to put insulin pen needles on prescription

Mr Willets: To ask the Secretary of State for Health how many retired peope he expects to relinquish private health cover as a consequence of the loss of tax relief

Mr Fabricant: To ask the Secretary of State for Health what plans he has to visit the Premier Health NHS Trust headquarters in Lichfield to discuss efficiency savings in the National Health Service

Mr Gray: To ask the Secretary of State for Health if he will list the names by sector of the nursing home and residential care providers used by Wiltshire health authority indicating the percentage of clients funded by Wiltshire social services at each and the average weekly cost to Wiltshire County Council per resident at each home

Parliamentary questions are rather erratic searchlights, which mostly do not produce much illumination : their main purpose (political drama apart) is to keep Ministers on their toes. But MPs have other opportunities to scrutinise the performance of the NHS and to call Ministers to account for their actions more systematically. Here the cross-party Parliamentary Committees are of crucial importance.

First, there is the Public Accounts Committee (PAC). The primary function of the PAC, serviced by the National Audit Office (NAO), is to examine the way in which public money has been spent – see Box 2 for topics covered during the 1990s. The NAO regularly scrutinises the accounts of the NHS. And the PAC takes up specific issues – conspicuous examples of waste or doubtful practices – cross-examining the Chief Executive, Permanent Secretary and other officials concerned. So, for example, in the early 1990s the PAC carried out major inquiries into the way two regional health authorities had conducted their affairs. One involved the Wessex RHA, which had wasted 'at least £20 million' on introducing a new regional information system, subsequently abandoned.[7] The other involved the West Midlands RHA which had wasted 'at least £10 million' on its services organisation.[8]

Box 2: House of Commons Committee of Public Accounts.
Topics covered in the 1990s include:

Maternity services
Patient transport services
Hospital catering
Health of the Nation
Preventive medicine
Community pharmacies
Financial management in NHS trusts
General practice fundholding
Day hospitals for elderly people
Outpatient services
Competitive tendering for support services
Clinical audit
Health and safety in hospitals

Box 3: House of Commons Health Committee.
Topics covered since 1995 include:

Priority setting in the NHS
London's ambulance services
Breast cancer services
NHS responsibilities for meeting continuing health care needs
Public expenditure and resource allocation

This is accountability in the traditional and narrow sense: making sure that the rules governing the spending of public money have been followed. The emphasis tends to be on regularity and propriety in following due process. But while the focus may be narrow, the PACs inquiries – largely because they are supported by the expertise of the NAO – give visibility to the way in which the NHS goes about its business. The PAC reports, as it were, lift the lid on the decision-making process in Whitehall and the NHS. And the awareness in Whitehall that private decisions may be publicly scrutinised – that civil servants and others may be made to answer for what they have done – is, in itself, a powerful deterrent to possible abuses of power.

Second, there is the Health Committee of the House of Commons. This has a more wide-ranging role. Not only does it carry out an annual inquiry into the Government's expenditure plans (this allows it to examine the adequacy – or otherwise – of the NHS's funding and the way in which resources are allocated) but it also carries out inquiries into specific aspects of the NHS's performance. For some examples, see Box 3.

In carrying out its inquiries, the Committee can call as witnesses, and cross-examine, independent experts, officials, people working in the NHS and Ministers. Its reports, and in particular the accompanying volumes of evidence, thus complement the activities of the PAC in providing a picture of how the NHS operates and in forcing Ministers to explain and justify their policies.

The Health Committee, while potentially a powerful instrument of accountability, works under constraints which limit its effectiveness. The fact that it is a cross-party committee – with strong incentives to produce unanimous reports – means that it may avoid issues likely to divide its members. In addition, inquiries may lack cutting edge. The convention that all committee members must have their turn when cross-

examining witnesses often results in a failure to push the logic of questioning to its conclusion : no sooner has a particular line of questioning been opened up, then it is the turn of another MP to take up the examination.

Lastly, the Committee is serviced only by a small professional staff drawn from the Clerk's Department of the House of Commons. The Committee therefore relies heavily on part-time specialist advisers – often drawn from the universities – appointed for specific inquiries. And the choice of advisers tends to influence – if not to determine – the verdict of the inquiry.

There are, therefore, weaknesses in the system of parliamentary accountability. The interest of MPs in making Ministers answer for the performance of the NHS may be intense but it is also, as already indicated, sporadic. The searchlight of parliamentary interest flickers through the sky but seldom provides a complete picture. The ability of Ministers and officials to obfuscate issues, and to retreat behind smokescreens of verbiage, is considerable.

Equally, however, there is scope for remedying some of the weaknesses in the present system for parliamentary accountability. The promised Freedom of Information Act will help by improving access to the files and documents that lie behind government decisions : in New Zealand, for example, even the briefing paper written by the Permanent Secretary for incoming Ministers is publicly available. So, too, will strengthening the ability of the Health Committee to conduct its inquiries more systematically. For example, there is an argument for adopting the model of Congressional Committees in the US, which appoint a counsel to conduct cross-examinations (although MPs might balk at limiting their freedom to pursue their own hobby-horses).

More important still, there is a case for giving the Health Committee the kind of support which the National Audit Office provides for the PAC: the capacity to review the NHS's performance in terms of access , adequacy and quality, in the same way that the NAO reviews the accounts.

This could be done in a variety of (not necessarily mutually exclusive) ways. One option would be to extend the remit, and expand the capacities, of the NAO. Another would be to use an independent source of expertise, such as the King's Fund Policy Institute. Finally, it might be possible to establish closer links between the Health Committee and the Audit Commission.

The Audit Commission is the joker in the pack of NHS accountability. Originally established to audit the performance of local government, its remit was extended to the NHS as part of the 1991 package of reforms. Since then it has generated more information about the activities of the NHS than any other body.

On the one hand, its auditors examine the books of health authorities and trusts. The annual management letters – i.e. the reports to the boards concerned – not only provide a picture of the financial state of the organisations but also, increasingly, of the way in which resources are used. On the other hand, the Audit Commission publishes national studies illuminating policy issues

Box 4: Audit Commission.
Topics covered since 1995 include:

- Accident and emergency services
- General practice fundholding
- Hospital medical staffing
- Management structures in the NHS
- Ensuring probity in the NHS
- Supplies management
- Maternity services
- Management of hospital waste
- Staff turnover
- Information management

– see Box 4 – which subsequently are often followed up by the local auditors. These have included studies of fundholding, the use of medical manpower and maternity services.

The agenda of the Audit Commission is set by its own board, reflecting the fact that it was originally set up to deal with local government. So we have the paradox of the audit of a national service being carried out by a quasi-autonomous body. Hence the case for involving the Health Committee both in setting the agenda and in using the information generated.

At present much of the information produced by local audit is difficult to decode.[9] The aim is to inform those being audited rather than the public. And it is not self-evident on whom responsibility rests for following up the audits – i.e. making purchasers and trusts answer for their performance. There is therefore a gap in the chain of accountability, which might be filled if there were a closer link between the Health Committee and the Audit Commission.

A larger conclusion follows. Accountability has two dimensions in the case of the NHS, as of all organisations.[10] First, there is the process of giving visibility to the activities of the NHS: of making its performance more transparent for public inspection. Second, there is the process of making those responsible for running the NHS answerable for their performance. In the first case, there has certainly been an increase in the degree of visibility and transparency. More information is available. The Department of Health may have stopped collecting some statistical series, to the dismay of academic analysts. But there has been a great increase in the quantity of information directed at the public, even if its quality and relevance may sometimes be dubious : for example, the NHS Performance Guide.[11] However, it is not quite so clear that our collective capacity for using the available information to call Ministers and their officials to account has increased proportionately.

Permeability of the policy process

So much for accountability in the central governance of the NHS. Next we turn to the second of our criteria of 'democracy': the permeability of the policy process – the degree to which it is open to a variety of influences and provides opportunities for the various interests involved in the delivery of health care, whether as consumers or professionals, to engage in dialogue.

Here the limiting case is the introduction of the 1991 reforms of the NHS. The way in which these can be introduced can be seen as an example of elective dictatorship; a powerful reminder that majority decision-making by the elected representatives of the people is an inadequate definition of what we mean by 'democracy', whether at the national or the local level. The 1989 White Paper, setting out the Government's plans, was the product of a small hand-picked group of Ministers and others chosen by the Prime Minister. There was no attempt at consultation or a coalition of support for the proposals. The proposals themselves met acrimonious opposition, both political and professional. But the Government used its majority in the House of Commons to drive them through.

The violence of the opposition reflected, in itself, the sense that the Government had abandoned the conventions that had previously governed policy making in the NHS. The 1991 reforms are therefore a limiting case in that the policy-making process was perceived to be exceptional, a departure from the established way of doing things. For example, one might contrast the 1991 experience with the way in which Sir Keith Joseph – in an earlier Conservative Government – introduced his 1974 reorganisation of the NHS: an elaborate exercise in trying to achieve a consensus by consulting everyone and seeking to satisfy all the interests involved.

The result satisfied no one, and the 1974 model was soon modified and ultimately abandoned.

Which is a reminder that the notion of consulting everyone in the policy process does not necessarily produce satisfactory outcomes even for those involved: the consequent compromises may lead to incoherence or excessive complexity. Nor, in this respect, is the case of Sir Keith Joseph's reorganisation an isolated example.

Permeability carries its own kind of costs. Witness, for example, the perennial difficulty of trying to close hospitals or accident and emergency departments. Here the balance sheet of a 'democratic' style of governance – whether at the national or local level – is complex. On the one hand, the readiness of Ministers to listen to local protests can be seen as responsiveness, demonstrating a willingness to consider public opinion. On the other hand, the delays and expenditure involved can be seen as a victory for local lobbies over the national interest (which may demand more efficient and effective hospital services).

Similarly, the success of the motor-racing lobby in securing temporary exemption from the ban on tobacco sponsorship in sport demonstrates both the permeability of the policy process and the fact that this may not always lead to desirable outcomes. We revisit these issues under 'local democracy' below.

Here we encounter a general difficulty or puzzle about 'democracy' seen as pluralistic bargaining. This is that it may privilege certain groups in society. There may be an asymmetry in the process between concentrated, well-organised groups and more diffuse, unorganised interests. So, for example, the medical profession – the most conspicuous and powerful group in the health care policy arena – was affronted by the 1991 reforms precisely because they challenged its veto power over the policy agenda. But, of course, it is not self-evident that any group should be able to claim such power.

More generally still, there is the problem that concentrated producer lobbies will usually outweigh consumer interests in any process of pluralistic bargaining, simply because they are organised to defend their own interests. And even among consumer interests, there may well be asymmetries in their ability to organise themselves and to articulate their views. In the case of health care, organised groups representing those with well-defined needs for specific services, or single cause lobbies pressing for particular changes, will quite clearly have the advantage over consumers in the more general, contingent sense of people who are concerned about policy in the NHS because one day they may require treatment.

Defining 'democracy' in terms of the accessibility to the policy arena – and the openness of the process – does not therefore necessarily give us easy answers when trying to assess whether or not it has been achieved. There is a dilemma here: sometimes, possibly, there has to be an assertion of power by central government if the tyranny of an intense, concentrated minority is not to prevail.

There remains a case for opening up the policy process further. In particular, there is a case for parliamentary hearings before governments present their legislative proposals as tablets of stone. If parliamentary committees could call witnesses and evidence at the Green Paper stage – while Ministers were still open to persuasion – the result would be to widen the opportunities for influencing the policy process. But it would still be important to guard against the danger that such opportunities would be exploited chiefly by those interests and lobbies which are best organised, thus biasing the whole process.

Protection against arbitrariness

One of the characteristics of a democratic society, in the widest sense, is that individual citizens should have an opportunity to seek redress if they feel aggrieved at, or oppressed by, the actions of those carrying out the tasks of government. Does the NHS meet this test? There is certainly an elaborate machinery for hearing complaints, a machinery which was redesigned in 1996.

As from 1996, all health authorities, trusts and general practitioners have been required to have in place a system for dealing with complaints.[12] If a complainant is not satisfied by the explanation received, he or she can ask for an independent review panel to be appointed. The decision whether or not to appoint such a panel is made by a non-executive member of the health authority or trust. Finally, if the citizen still feels aggrieved – either because the convenor refuses to set up a review panel or by the outcome of the review – the complaint can be taken up with the Health Service Commissioner. The Commissioner reports to Parliament both on individual cases and on the themes that emerge from his investigatory work ; in turn, Parliament may through its specialist committees, follow up either the cases or the themes, cross-examining witnesses from the authorities or trusts criticised by the Commissioner.

In all this, the Health Commissioner is the key. Not only do his reports on individual cases identify shortcomings in the delivery of care: a role which is likely to increase in importance since, as from 1996, his office has been able to investigate clinical issues previously excluded from his remit. But, more crucially still, he is the guardian of the integrity of the new system for the local resolution of complaints: in effect, an instrument of central governance acts as the monitor of local performance in the way that complaints are handled. Thus in the first year of the new procedures, the Commissioner received 353 complaints about the decisions of convenors and a further 45 about the conduct of panels.[13]

It is too early to come to any judgment about how the new system is working. It is clear from the Commissioner's reports over the years that some health authorities and trusts have in the past frequently been sloppy in the way they have handled complaints; examples of inadequate investigations and tardy or perfunctory responses have been all too frequent. Whether the new machinery will produce a new sense of urgency therefore remains an open question.

Equally, the new system for convening independent panels – 362 were set up in the first year of the new procedures – has yet to prove its worth and its ability to command public confidence: the Commissioner's most recent report suggests that both convenors and panels still have problems in defining their role and adopting appropriate processes. Much in all this may depend on the ability of Community Health Councils to support aggrieved citizens in seeking redress and helping them to frame and articulate their complaints.

There remains the role of the courts.[14] These have a dual function. On the one hand, they deal with malpractice litigation: i.e. with citizens seeking compensation for injuries suffered while undergoing treatment. On the other hand, they provide redress for citizens aggrieved by the decisions of health authorities: i.e. citizens can ask for judicial review of such decisions.

It is the second role which, in principle, provides protection against arbitrariness. However, UK courts – in contrast to their American counterparts – have tended to define it restrictively. That is, they review the process of decision-making rather than the substance. So, for example, they recently determined that North Derbyshire Health Authority acted unlawfully in imposing a blanket ban on the prescription of beta interferon without taking into account guidance from the Secretary of State which required them to develop a policy for targeting the drug on appropriate patients.[15] But, in this as in previous judgments, the courts have taken the view that their responsibility is limited to examining the process by which decisions are taken. If the correct processes have been followed, they do not question the way in which health authorities use their resources.

Thus they have resisted all attempts to draw them into the rationing debate and balked at substituting their judgment about what health care should be provided for that of purchasers. While all citizens have a right to access to health care, they therefore do not have a right to any specific form of treatment.

Summing up the APA test

Overall, then, applying our APA test suggests that a reasonable degree of 'democracy' in the NHS – at the national level of central governance – has been achieved. There is, as we have argued, scope for improvement. But we are left with a puzzle. This is that while the machinery of accountability has if anything been strengthened and the flow of information has turned from a trickle into a torrent over the past 20 or so years, the perception of a 'democratic deficit' has grown.

There may be a number of reasons for this. One could be that our 'democratic expectations' have also grown during this period in line with social change, higher levels of education and the growing role of the media. Another may be that the very process of strengthening accountability at the centre may produce accountability overload. The over-enthusiastic pursuit of accountability – both for dropped bedpans and the overall performance of the NHS – may create its own pathology. On the one hand, the result will be to drag decision-making to the centre, however much Ministers may stress their zeal for devolution to the periphery. On the other hand, the process may produce too much information (if often of the wrong kind) for the capacity of either Parliament or the media to digest.

If this is indeed the case, then it may be a mistake to concentrate on strengthening or improving accountability at the centre. This could turn out to be counter-productive. In the next section, we therefore examine what invoking the word 'democracy' implies at the local level.

Local democracy

It is curiously hard to find a definition of local democracy. This may be because the difficult question is how to define 'democracy', regardless of where it takes place. Beyond that, whether one's democracy is 'local' or 'national' does not appear to be a problem of definition but rather one of justification. Problems of defining democracy, as we have seen, are difficult enough.

Another reason for this omission may lie in the association which tends to be made between local democracy and the institutions of sub-national government, as indicated by academic reflections on the topic.[16] Typically, when notions of local democracy are evoked one's first thought is of a county or district council: the organisation of local education, housing and road sweeping. 'Local' in this sense refers to a particular geographical area significantly smaller than the nation state.

But in these days of 'globalisation' and European integration, such assumptions are less reasonable. For many elements of public policy, it is European bodies which make the laws binding on member countries. Clearly not 'local', such actions are not even 'national'. From the perspective of European lawmaking and democracy, it is the national governments which are 'local'. Subsidiarity, indeed, is the current intellectual fashion in European debates, a concept implying that all things good in democratic practice start from more 'local' decision-making – that is, decisions made by national governments.

But within nations, intellectual fashions lie elsewhere. In the UK, for example, there is a 'growing recognition' that 'strengthening local government is ... a necessary step in overcoming the problems of an over-centralised state'.[17] Here the wish is to move decision-making away from the national government. Indeed, some 'local' councils have themselves been considered as too remote and over-bureaucratic in the past – the Greater London Council is a case in point.

Clearly, 'local democracy' is a relative concept: its meaning depends on the standpoint of the observer. If anything, local democracy seems to be less an identifiable institution in a physical location, than a movement, tendency or aspiration. Advocates of local democracy urge us, wherever possible, to relocate our decision-making into smaller units, involving less populous communities. In health care, such tendencies are echoed in some of the arguments in favour of GP commissioning.

Decisions about health care provision should move as 'close' to the people as possible.

The desire for local democracy may be a reaction to the 'remoteness' of politicians, be they on the national or international stage. But there is little indication that anyone knows where this tendency should stop, where the equilibrium rests. The search for and justification for local democracy has, in this sense, some of the features of the search for a holy grail. If only the proper location of local democracy could be found, then many of our political problems would be avoided. Before returning to this possible motivation for more local democracy, we first examine some standard justifications, and then look in more detail at the forms local democracy might take.

Why local democracy?

The tendency to move toward smaller units of decision-making contains a clue as to why local democracy is considered important: the possibility for participation. Local democracy may be the best means of enhancing democracy itself: by making it easier for people to participate in political activity, and develop the capacity for political judgment, the institutions of democracy in general will be supported and sustained.[18] So, if participation is the key, it is not hard to see why centralised systems of democracy make this harder to achieve. Westminster and Whitehall are not practically suited to involving even a tiny fraction of the 50 million people on whose behalf they legislate. Local institutions of government may very often not be particularly well suited themselves to such participation – indeed, as we shall see, it is not obvious what participation means – but at least in principle it should be easier to achieve a lower ratio of governors to governed.

There are a number of other possible justifications for local democracy. One is simply as a corrective to 'over-centralised power'. The danger of concentrating decision-making in Whitehall is that decisions become remote, insensitive – possibly even arbitrary and corrupt. The more avenues open for keeping a check on the exercise of power, the less it is likely to be exercised improperly. This is, of course, ultimately an empirical question – there are many examples of corrupt, secretive and 'remote' local governments.[19] And, after all, voter turnout is low in local elections.

But perhaps the point is that local democracy need not be perfect in itself, merely a counterweight. It is able to challenge the actions of central rulers. If power (regardless of its wise or democratic use) is genuinely decentralised, then it can be used to keep in check those who might otherwise run away with it. This 'checks and balances' argument must, however, be distinguished from arguments for democracy – local dictatorships could equally act as a balance to overbearing central power.

Another possibility is that local democracy is the best way of responding to the particular needs of different communities: in order to be sensitive to the circumstances of localities, one must have decision-makers operating in those localities.

> *A service, such as a health service, which aims to serve a local community must be responsive to both the needs of that community and to local values and priorities; indeed, these are hardly separable from each other*[20]

Of course, in this case a local dictatorship would probably not do. There must be responsiveness; this is more likely, it is assumed, if some form of democracy is instituted at a local level. Those who make decisions which affect people's lives should live amongst those people, both better to understand their needs and account for actions taken. Such arguments are commonly made with respect to the operation of health authorities: even if they are not considered 'democratic' now, they should be protected from further centralisation.

Another way of viewing this case for local democracy is to emphasise the importance of variation. Local democracy allows innovation and the development of new ideas, in contrast to centralist democracy which may promote rigidity

and conservatism.[21] Thus, since the 'solution' to political problems is indeterminate – there is no single, right answer – the best method is to let a thousand flowers bloom.

We can all learn from each other's successes and failures. Local communities should challenge the prescriptions of the centre, since by doing so they develop democratic 'muscle' – that is, they do not become acquiescent and passive, uninterested in the activities of the rulers. Erroneous thought is the stuff of freedom; uniformity encourages the reverse.

The case in favour of local democracy – that it allows participation to strengthen democracy generally, is able to reflect more sensitively local needs, and encourages innovation and positive variation – sounds reasonable enough, even positively uncontentious. There are certainly difficulties in practical terms with any particular method as we shall see. But in principle, at least, the case for local democracy appears strong.

Nevertheless, local democracy is not without costs. Take efficiency: society's desire to achieve goals without wasting resources. In the NHS, for example, as in any form of human endeavour, certain forms of expertise are likely to be in short supply. This may make it difficult to recruit sufficiently well-qualified people for a large number of administrative units – one consequence of a highly localised system of democratic control.

Furthermore, consider the evidence suggesting that some acute procedures would benefit – in terms of better outcomes – from being organised across geographical areas rather larger than those for which health authorities are currently responsible.[22] Treatments for rare cancers – such as gynaecological cancer – provide one example where the ideal population served is millions rather than hundreds of thousands. If there is strong democratic accountability to small populations, such 'regional' provision could be difficult to organise.

Then there is the objective of fairness. As we noted above, the resolution of political issues is rarely achieved with unanimity. For example, one community may decide that priority should be given to the elderly, another that low birth-weight babies have a superior claim on resources. These represent different judgments about a non-technical question. 'Need' can rarely be unambiguously quantified; it is therefore open to reassessment both over time and across geographical space. Different communities are likely to disagree about priorities even when they are faced with identical circumstances. There may be no difference in the 'need' for care of the elderly or for low birth-weight babies in the two regions; it is simply that different judgments are made.

But a democratically legitimate decision may not accord with our sense of social justice – of all belonging to a wider community.[23] We also seek a fair society in which individuals who have no relevant differences are treated equally. Few of us would argue that a 'relevant' difference is one's place of residence. And yet if we pursue greater local democracy, unreasonable and unacceptable variations may be legitimised, at least in purely electoral terms. Some variations in service provision are inevitable, particularly if the practical problems of removing them are insurmountable. But our reluctance to ignore such inequity does serve to remind us that local democracy, indeed democracy in general, is not the only goal of modern societies.

But before these philosophical difficulties are revisited, we must first unpack what the components of local democracy might consist of, and see if in practice they live up to the high ideals expected of them.

Voting, elections and representation

It is probably reasonable to assume that when most people think of democracy, they think of voting. It is also reasonable to assume that this imagined vote is not cast in local elections. Democracy, in short, conjures up an image of voting in a national

General Election – a key moment of democracy at the *centre*. Certainly, voting for representatives who are to govern us for the next five years is vitally important. However, some commentators believe there can be no improvement in democracy without introducing some form of electoral accountability. For example, writing in response to the *Local Voices* initiative, which is viewed as 'marking the demise of local democratic accountability', one author speaks up for the potential of local government for NHS 'democratisation':[24]

> *regardless of their political opinions, people identify with and value the role of their local authorities in decision making .... There is no reason to believe that [the people] would not support a more democratic health service* (p. 536)

This passage is not quoted for its rather unremarkable assertion that people would support more democracy, but for its identification of democracy with elected authorities. As our APA test indicates, elections, voting and political representation constitute only one element in a democracy, whether central or local.

Nevertheless, NHS boards as currently constituted do not have any directly, or indirectly, elected members. They are all appointees, formally accountable in one way or another to the Secretary of State. Before analysing the potential for more electoral representation, it is worth briefly reviewing this situation in relation to some common criticisms.

Are these boards representative of the wider community? 'Representativeness' is an awkward concept. On small boards it is simply impossible to mirror all the socio-economic characteristics of a particular area. Furthermore, the typical parameters which are chosen to monitor representativeness – ethnic minorities, women, social class and so on – fail to include such basic categories as the elderly (or the young, for that matter). Why do we not ensure that boards have the same proportion of people over the age of 70 as live in the wider community? They are, after all, the principal users of the NHS.

Nevertheless, a recent publication from the Department of Health, *Public Appointments Annual Report 1996*, indicates that on some measures boards are doing rather well. Tables 1 and 2 set out the proportion of women and ethnic minorities on various boards at 1 April 1996.

The figure for ethnic minorities approximately matches the national figure for the population as a whole, whilst the figure for women is closer to 50 per cent than in many other institutions, not least the democratically elected House of Commons. Perhaps locally appointed boards are more

Table 1: People from ethnic minorities at 1 April 1996

	%
Health authorities	5.9
NHS trusts	5.0
SHAs	5.5
Executive non-departmental public bodies (ENDPBs)	9.9
Total	**5.3**

Table 2: Women at 1 April 1996

	%
Health authorities	40.7
NHS trusts	39.6
SHAs	36.6
ENDPBs	37.4
Total	**39.6**

'representative' than commonly supposed? It should be noted, however, that the average figures may hide particularly unrepresentative boards in some areas.

The Report also records employment type, and here certainly the overwhelming majority of members are middle class, perhaps inevitably so if one of the criteria for appointment is 'the necessary skills and expertise relevant to the running of the NHS'.

The Report also notes members who have taken part in 'significant political activity'. However, declarations of such activity are only necessary for appointments after July 1995 and thus only a very few have been made. The suspicion remains, therefore, that NHS boards are full of 'political' appointees – placemen and women, serving only the interests of the Secretary of State rather than the local community. The actions of the new Secretary of State have done little to remove such suspicions.

But we have seen how the financing of the NHS – predominantly by central taxation – requires central accountability to the Secretary of State. If this is to be achieved successfully, it could be argued, then political appointments are essential. Only those who are committed to the policies of the elected government – and who can be removed if they fail to implement government policy satisfactorily – are suitable for the duties implied by NHS board membership. How otherwise can the Secretary of State be sure that government policies are implemented?

Nevertheless, such a suggestion is not in the mainstream of policy thought on NHS accountability. The prevailing view is that elected bodies of some kind are the key route – possibly the only route – to making the NHS more democratic. Many firmly believe that:[25]

> *the convention of ministerial responsibility to Parliament, while theoretically respectable, fails to deliver adequate democratic accountability. The dominant influence of political parties, the relationship between the executive and the backbenchers, and the sheer scale and complexity of public services have rendered Parliament unequal to the task*

A number of options for reforming this system have been suggested.[26] The first is a return to pre-1991 arrangements, whereby a proportion of health authority members were elected local authority nominees. These local authority members were not directly elected to the health board which, for its part, also consisted of a number of appointees accountable to the Secretary of State. Health boards were consequently something of a hybrid.

The second option is to institute direct elections for health board membership. The principal uncertainty with this proposal is the degree to which such an election would engage popular interest, adding as it would to existing local and national elections. The third proposal is for local (government) authorities to take responsibility for health on top of its existing responsibilities. The arguments for doing so are threefold:[27] to produce a direct democratic input, to offer integrated health and social care planning and purchasing, and to include health treatment into a policy arena which includes some of the determinants of ill-health.

The first difficulty with all of these proposals is the potential for muddled accountability. If reforms such as these were introduced, upwards accountability to the Secretary of State – essential to any system overwhelmingly funded out of general taxation – would be compromised by downwards accountability to the local community. If there is conflict between these two sets of political masters, who is to have precedence?

Local government control also implies that finance would be raised locally, at least in part, raising questions of the appropriate balance between local and central funding, and the fiscal capacity of local government. If this proves

awkward, then the logical solution may be that the NHS should be given over entirely to local government, including responsibility for raising finance. This, at least, might clarify accountability – the UK would then have a large number of Local Health Services. However, such a move may simply be impractical; local government lacks the necessary fiscal capacity. The question remains, furthermore, whether it is appropriate for health expenditure to be decided on criteria other than objective assessments of need according to a single, national standard, however democratically local assessments were taken.

Conflict between local and central accountability does not invalidate policies to devolve power. There is no doubt that twin, competing lines of accountability are possible – they exist already for a wide range of local government controlled services.[28] Indeed, local government as a whole depends on central grants for most of its funding; thus local and central government each exert legitimate political influence over policy. In education, in particular, the introduction of a national curriculum and grant maintained schools reflected central government's belief in recent years that the local 'political' influence had become too great.[29]

The difficulty, therefore, is one of the *increased* potential for conflict. Although central government has the constitutional right to direct and restrain the activities of local authorities, this is typically achieved only at significant political cost. In the context of this analysis, twin lines of accountability foster tension between the political authority of the national government and that of locally elected councils. The NHS has to some extent avoided these conflicts by remaining an agency of central accountability; moving away from the present system would create the potential for greater conflict in the future.

Regardless of questions of confused accountability, do any of these options for local elections in the NHS necessarily improve democracy in the wider sense? Our definition of democracy involves accountability, pluralistic debate, transparency, responsiveness to citizens and protection against arbitrary decisions – summarised as the APA test. But systems of local, electoral representation have significant difficulties which mean that these criteria are seldom satisfied. Many of these difficulties apply also to central government, but are brought into sharp relief in the local sphere. UK local government, as currently constituted, is not a particularly encouraging model for a more democratic NHS.

Some of the weaknesses are acknowledged by those who are amongst its foremost advocates. The principal obstacle to local democracy based on formal electoral activity is the 'limited representative base'.[30] Britain lags behind most of our European partners when turnout for recent sub-national elections is measured, with only 40 per cent.[31] Clearly, a significant proportion of the electorate are not formally taking part in the democratic process, and are therefore not encouraging representatives to respond to their wishes, one of the criteria for democracy. Furthermore, it weakens the claim of local government to legitimately act as a check on the actions of the centre (which has a much stronger electoral base), another of local democracy's key justifications.[32] Could we expect voters to take a greater interest if there were elections to health authorities and trust boards?

There is another problem. The current electoral system produces results which do anything but represent the range of views in the community: some local councils are little more than mini one-party states, with Labour or Conservative representatives exercising a permanent hold on power. This is closer to elected dictatorship than democracy.

Proportional systems of representation would certainly improve matters. But even so, the political complexion of local communities is bound to display more stark extremes than the overall national picture. Some urban areas will always have an absolute majority of Labour voters, for example –

it is hardly a democratic ideal for the values of a particular section of the community to be in permanent opposition. One commentator has gone so far as to say that he 'is sceptical about the supposed traditional virtues of elected authorities ... finds it difficult to equate, automatically, local democracy and local authorities and ... is not sure that local democracy, in that sense, is a necessary part of democracy in late twentieth-century Britain'.[33]

There is another concern about introducing direct electoral accountability into the running of health services. Regardless of the precise institutional arrangements, such a move would risk national party politics intruding on local issues. Local voting often reflects national changes in support for central government: there is a tendency for voters to use local elections as a signal to the national government that they either support or disapprove of its performance. If so, this weakens the case for local democracy's importance in reflecting *local* needs – already weakened by low turnout.

Referendums offer another possibility for introducing direct electoral accountability for certain kinds of issue.[34,35] At first sight nothing could seem to be so purely democratic: each citizen having an equal opportunity to cast their vote one way or another on a matter of public concern, the result binding on political masters. Here, surely, is an infallible form of accountability and democratic control?

But direct electoral control has even more fundamental dangers, not least the proper conduct of politics.[36] Direct majority rule – for that is essentially what referendums entail – very rarely measures up to the criteria for democracy outlined above. For all its faults, representative methods elect individuals to make decisions on behalf of the whole community, and to answer for those decisions when made. Minority interests are protected: we cannot cause a few to suffer terrible hardship for the aggregate benefit of the many. If such a policy were to be suggested, we would know who is responsible and would be able to hold them to account.

However, rule by referendum takes away this responsibility for overall welfare, and for the interests of minorities and, paradoxically, *reduces* accountability. People vote, if they wish, without any obligation to consider the issue, or to debate and challenge one another on their decisions. After the vote is cast, who is to be held to account for the (unforeseen) consequences? Why should people pass judgment on an issue without demonstrating competence – or at least due consideration?

Even if minority rights are enshrined in a constitution, this may not protect the interest of drug users, for example, in the competition for health resources if a local poll indicates that rehabilitation should not be funded.[37] Indeed, the case has been made that no form of democratic influence ought to be allowed to deny certain rights to health care, regardless of the form this influence takes.[38] Some types of 'democracy' can be the very antithesis of what we have outlined as essential to democratic conduct.

Nevertheless, there remains a concern that the local 'magistracy' – unelected boards – also fails to match the minimum democratic criteria as they stand.[39] If representative and direct electoral reforms are too blunt or too dangerous to do the job on their own, how else might democracy be improved?

Participation and 'shared' decision-making

If democracy is in part judged on how well it includes all interests in public debate, how responsive the governors are to its citizens, and how, precisely, it accounts for its actions, then democracy must be about more than voting. It must involve citizens in the decision-making process, by hearing their voice rather than simply totting up the total number of crosses on ballot papers. Such activities are often dismissed as adding little to democratic procedure because there is no formal, legal sanction. However, shame, ridicule and bad publicity can be underestimated in their ability to keep politicians and administrators in check.

Whilst there is certainly a need for some formal sanction at some point in the political process, the operation of open debate and criticism can act to control decision-makers *ex ante*. That is, the fear of future sanction can provide sufficient motivation for governors to adjust their actions in advance.

It is also worth noting that participation in decision-making is not confined to local democracy. In all its forms it can also occur at the national level. However, if one of the principal justifications for local democracy is that it enables people to become more involved in the political process, then this is likely to happen for the greatest number of people in smaller communities. Thus 'direct involvement of the ordinary citizen is largely limited to the local sphere'.[40]

There are a number of forms of participation, of which direct demonstration against the incompetence or unresponsiveness of the governors is only one. The first involves a range of activities which originate with the citizen making his or her views heard in the political process: in the words of the most comprehensive study of this kind of participation, activities 'such as writing to [a] Member of Parliament, working in a group to raise a local problem, going on a protest march, or canvassing for a political party'.[41] It is easy enough to think of examples in the health care field: citizens could campaign for a political party to promote certain policies, organise a patient interest group, write to their local health authority, or go on a demonstration to stop a local hospital from closing.

In this conception of political participation there is no formal involvement of the citizen in making decisions; the participation simply involves making one's voice heard. Community Health Councils can be viewed as an institutional means for facilitating this process. But having one's voice heard may have more influence than is commonly supposed. Governors may *wish* to hear the views of the population, if only as a safeguard against introducing policies which will create a damaging backlash. Activities such as these can raise issues and promote change by the prospect of public humiliation. These activities are thus a proper part of democratic politics; how 'successful' the democracy becomes will depend in part on political institutions such as health authorities facilitating participation by providing many points of access for citizens to communicate their views.

In which case, it might be argued, the NHS is in a state of rude democratic health. There are regular demonstrations and political campaigns. Individual citizens contact the local media, local councillors or MPs. Patient interest groups have grown in scope and influence over the last twenty years, with almost every disease or disability represented by an organisation advocating the interests of patients. Certainly, one could argue that health authorities might develop more points of access for the citizen. But this would always be possible, and in any event does not diminish the importance of other democratic activities.

However, what we hear instead is how the NHS suffers from a 'democratic deficit'.[42] During a demonstration to preserve a local hospital, it is not a commonly expressed opinion of the protesters that their action represents an important element of local democracy. Quite the reverse: such action is only necessary, the demonstrators argue, because of an absence of democracy in the first place. If the decision to close the hospital is carried through, this will be seen as an 'undemocratic' act, insensitive to the views of local people. From their perspective, what use is 'voice' if action is not taken? Developing political maturity is scant reward for not having one's interests satisfied.

Democracy may be confused, for these protesters, with achieving the outcome they desire, just as a defendant only remarks on the justice of the British legal system if cleared of wrongdoing. Democracy involves a political choice between competing interests. The decision-makers in the hospital closure case – the local health authority – may argue that the interests of the local community would be better served by amalgamating services on one site so as to provide a more efficient use of

resources. Those living near the local hospital may feel aggrieved if it closed, but an appropriate decision must involve weighing up the whole community's interests – including those of people who are not demonstrating.

So local democracy by our criteria can be in reasonable working order, and yet leave the individual citizen disenchanted. Citizens suspect that their actions do not make any difference – even in terms of getting their voice heard. On the other hand, public officials feel, like Plato, that the mass citizenry is a poor decision-maker. Political representatives may believe they can legitimately ignore the claims of certain groups as having no moral or democratic authority, given that they are often uninformed about the issues, and are not required to enter into reasoned debate.

This tension has led to the development of a second strand in participatory democracy which attempts to bridge the gap between citizen and political master: shared decision-making. In this model citizens are directly involved, given the time and space to think issues through, and the opportunity to debate them with one another and with elected or appointed officials. They are formally engaged with the processes whereby decisions are made. For some commentators, this type of participation is so important that they 'advocate the introduction of statutory duties which will make it clear in what circumstances the public and individual patients can expect to be involved in health and health-care decision-making'.[43]

Numerous institutional forms are being developed, and the pace of change is such that the names and range of examples change rapidly. A recent review included: citizens' juries, health panels, issues forums, deliberative opinion polls, future search conferences, and 'round tables'.[44] Partnership and involvement with individual clinical decision-making also constitutes an important element in new forms of participation.[45] Here the decision-maker (the allocator of health care resources) is the clinician, who decides what treatment, if any, to give the patient. 'Patient partnership' sees the patient as sharing this decision-making process with the clinician, shaping what he or she receives or wishes not to receive. In essence, the idea is that participation provides both a more considered and legitimate view from the citizen, whilst at the same time ensuring that those views and opinions are integrated into the decision-making process and thus less likely to be ignored. The citizen is reassured that his or her opinions are heard at the heart of political institutions, bolstering support for democracy itself.

The impulse for change originates in a belief that the UK suffers from a 'dysfunctional democracy'[46] based on a 'limited approach to democratic practice'.[47] There is limited dialogue coupled with significant 'distance' between rulers and ruled, the media further distorting what relationship does exist. Shared decision-making will, it is argued, reinvigorate democracy by reinventing the active, involved citizen. There will be less need to adopt partisan, tribal positions on issues – as with the hospital demonstrators – and more likelihood that a consensus can emerge on the basis of rational reflection and debate.

One innovation which has provoked particularly wide interest in recent years are citizens' juries, the subject of two separate pilot studies involving health authorities during 1996 and 1997.[48] Box 5 summarises the outcome of the King's Fund pilots.

The citizens' jury serves to illuminate many of the possibilities of this form of participation as well as its limits and difficulties. Between 12 and 16 citizens are recruited at random from a particular local community (only one national jury has so far been tried), and given the opportunity to interrogate witnesses and deliberate amongst themselves over a number of days about an issue of public policy. In the health care pilots, the issues considered were typically ones which health authorities felt were of current importance, and which involved a choice between various options, each of which had supporters amongst various pressure groups and 'experts'. The jury could offer its 'verdict',

Box 5: King's Fund citizens' juries

Sunderland Health Authority

The Question

A number of services are currently available from GPs. Would local people accept some of these services from any of the following:

- a nurse practitioner
- a pharmacist
- another (salaried) doctor

Conclusion: a qualified yes, with nurse practitioners to work only as part of a GP's team, and pharmacists to be responsible only for repeat, not first, prescriptions.

East Sussex, Brighton and Hove Health Authority

The Question

Where should women with gynaecological cancer who live in Brighton, Hove and East Sussex be offered treatment?

- at their current location
- at centralised services in Brighton
- at specialist cancer centres outside the county

Conclusion: option two, qualified by a desire to investigate an alternative centre outside Brighton (where parking and accessibility is difficult) in the future.

Buckinghamshire Health Authority

The Question

Should Buckinghamshire health authority fund treatment from osteopaths and chiropractors for people with back pain? If yes, given that (a) these services are not currently purchased by the health authority, and (b) no extra resources are available for back pain services, should some of the money we currently spend on physiotherapy be spent on osteopathy and chiropractic?

Conclusion: yes, on a pilot basis, and with the possibility of introducing chiropractors and osteopaths into physiotherapy departments as staff leave these departments, or through increased funding.

along with other recommendations, and the authority was expected to respond, either outlining how the recommendations of the jury are to be implemented or indicating why not, if that were the case.

Although the juries had no formal authority over the health authority's decisions – they were considered to supplement rather than replace the traditional channels – the rigour, time and expense devoted to the activity, and the public nature of the deliberations and recommendations, did significantly impact on the standard decision-making process. This was reflected in the nervousness of many authorities taking part, concerned that they would be unwilling or unable to implement the recommendations of the jury and that this would be awkward for their public relations.

Experience with citizens' juries has been largely positive, according to the published literature, and demonstrates the potential for deliberative and participative methods more generally. The ordinary citizen has shown him and herself able to grapple with complex problems, including resource allocation issues, and to devote considerable time and energy to them. More often than not, given time and skilled moderation, consensus within the jury has emerged. Health authorities have been struck by the 'ordinary wisdom' which lay members of the public can bring to bear on issues of public policy. Jurors themselves have almost invariably been enriched by the process, according to their own testimonies.

It is still much too early, though, to make a judgement about what this means for democracy – local or otherwise. If the goal is to reinvigorate democracy, then the test will be whether such innovations can influence how the wider community perceives decisions made in this way. If a citizens' jury decides, after all, that a local hospital should be closed because the benefits from doing so are sufficiently great to outweigh the costs, will this be seen as a democratic decision by those not taking part? If the process is rigorous, then a non-involved citizen may have more confidence in decision-making processes which involve other 'ordinary', disinterested citizens, with no policy axes to grind, who are not part of the bureaucratic machine. They may be more likely to go along with politically contentious decisions made in this way. Consent may be sustained and legitimacy improved.

But, equally, the wider community may continue to view with scepticism a process run by 'bureaucrats' they have grown to mistrust. Just another fix by the politicians to persuade the people of what's good for them, to make the life of managers easier, and probably save money into the bargain. Who are these citizens taking part anyway? Why should twelve people from the community be trusted, when the number of people affected runs into tens of thousands?

There are more specific rumblings of discontent. In all these 'shared decision-making' processes, it is difficult to obtain a representative sample of the community, particularly reflecting ethnic and other minority interests. It has also proved awkward to recruit enough people who are interested in taking part – the public may be 'reluctant' to participate.[49]

Jurors, and lay citizens taking part in other processes, are not themselves strictly accountable to the wider community – they may discuss ideas amongst themselves and with professionals, but they do not have to go on a public platform and explain the decision more widely. The process has potential for abuse: corruption, or other forms of bias, might easily find their way into such decision-making processes, particularly when the outcome has significant financial repercussions.

Participative forms of democracy offer potential, but they will never involve everyone: they will always be 'imperfect'. But perhaps this is not the fault of the processes themselves, but of how we conceive democracy. As we have seen, democratic procedures can be blunt, particularly when they involve voting. When the procedures invite selected individuals to take part, they immediately appear exclusive and incomplete, invoking fears of special interests and elitism. But these imperfections are only failures if we look on democracy as a solution.

We have argued that democracy is essentially a style of politics, a style which is indispensable in modern societies, but nevertheless one which does not resolve or change the nature of political disagreement. When some people must lose at the expense of others, democratic forms may be the best way of deciding how these gains and losses are to be parcelled out, but they do not necessarily remove the pain of loss.

Do we need more local democracy?

What, then, do we make of appeals for more local democracy? We might agree that democracy is

about more than voting and the election of representatives. Elections are an intermittent activity, allowing for pluralistic debate and accountability on infrequent occasions. In certain localities political parties exercise almost hegemonic dominance, likely to persist even with proportional voting systems. Minority views may become lost; political debate skewed to certain interests. Local democracy, then, must also involve protesting, demonstrating, and civil action of all forms; participating and sharing in decision-making; sufficient transparency and openness to facilitate a wide pluralistic debate where all voices are heard; and a free flow of information to enable these processes to take place.

Currently, local democracy, according to our APA test, is limited in the NHS. Formal accountability is to the Secretary of State at the political centre; the flow of information to the individual citizen from local boards is limited and of variable quality. There are no local representatives, directly or indirectly elected; this role, such as it is, is undertaken by the non-executive directors.

Permeability is greater than it once was: since the *Local Voices* initiative, health authorities have been encouraged to engage with their local communities, hence the range of participatory techniques and opinion surveys we noted above. Furthermore, health authority and trust board meetings must all now be open to the public.[50] However, apart from the Community Health Council, there is no formal channel for the citizen to take part in the policy debate. Those channels that exist, do so at the discretion of the authorities concerned.

Complaints procedures, although recently reformed and apparently more responsive to individuals wishing to complain, still represent a 'top-down' initiative.

Matters could no doubt be improved – perhaps with Community Health Councils acting as a filter for the growing mass of information that is becoming available,[51] or by formalising the use of such innovations as the citizens' jury. There is no doubt that local democracy has many powerful and persuasive justifications, and may indeed support democracy more generally. There is also no doubt that the NHS as currently instituted has difficulties of legitimacy in the way it takes many controversial decisions, both within provider units and by health authorities. But is the strengthening of local democracy unambiguously beneficial? Or should we acknowledge that there may be good reasons for a national system of accountability and control?

Our discussion has uncovered a number of possible reasons for hesitating before strengthening or formalising local democracy. First, it will not do away with political conflict. Those who advocate local democracy occasionally give the impression that it will resolve the difficult decisions involved in allocating the limited resources in the NHS. But disagreements will remain and could, indeed, be brought into sharp relief by a more open policy process. This may be necessary, even healthy, in a modern state – a sign of maturity that a community does not avoid confronting its problems. But the problems themselves will not be avoided in the quest for ever more local forms of democracy.

Second, local democracy implies a second line of accountability in addition to that which runs upwards to the political centre, and which will continue to do so as long as there is national funding. The local agents of the Secretary of State will be faced with an alternative set of political masters, perhaps with different priorities. Clarity over the direction of policy could become muddled and accountability confused. Simply citing the existence of dual accountability in the operation of local government does not justify its application to the NHS. Few would claim that the relationship between central and local government has in the past provided the best background for reasoned policy debate. Very often, policy arguments have simply been swamped by disputes over the appropriate *location* for policy-making.

Finally, society has other objectives which must, on occasion, compete with democracy. Equity and fairness hold a special place amongst the NHS's guiding principles. How different are local communities from each other – and how different should they be *allowed* to be? Priority for AIDS patients, and the drugs to help them, varies from region to region even when the incidence is similar. Infertility is not restricted to those health authority areas where fertility treatment is available. Long term nursing is 'needed' everywhere, but its availability varies widely.[52] In fact, inappropriate variations in medical availability and outcome are of prime concern to many commentators on health care matters.

These variations exist already within the NHS. But strengthening local democracy could make it harder to address those variations which are considered unfair. Policy differences will be defended as the will of the people: they will gain legitimacy.[53] Both practically and in principle, geographical fairness could suffer. Practically, because central administration (essential to any form of supra-local equity) will find it more difficult to effect change when faced with local agencies with their own power base; and in principle because local communities will argue that, simply, their values are different. AIDS patients are lower down the queue, infertility is not a 'disease' and priority should be given to saving the lives of low birth-weight babies. At the same time, individuals within those communities will peer over the fence and see others, in identical circumstances to themselves, receiving quite different treatment.

The growing power and influence of the media will determine how significant such differences are in the future. Examples of variable care are increasingly unlikely to remain unobserved. The question is whether individual citizens will accept these variations if the process by which they were arrived at is legitimate, or whether they will consider that a fair *outcome* is more important. In other areas of social policy, the conclusion seems to suggest that outcome is what matters (or at least what politicians believe matters). For example, in education policy, a national curriculum was introduced as central government attempted to impose some degree of standardisation on what is taught in schools, partly to address variation and inequality of opportunity.[54] It is likely that some similar central guidance will be required if local government were given responsibility for health care.[55]

Efficiency, too, is an important goal of society: we should not waste resources in achieving objectives. Democracy does not come cheap, as the 'No' devolution campaigns in Scotland and Wales reminded us. But more fundamentally, democracy is about the fuzzy, awkward business of politics, in which there are no right answers. We could, quite conceivably, discuss issues of democratic and political importance endlessly. But at some point choices have to be made; 'too much' democracy may have a cost in terms of decisions unmade. The old style health authorities were often criticised for wasteful processes. A balance must be struck here too between democracy and getting things done.

Individual choice: the ultimate democracy?

So far in our discussion we have neglected what, to many, seems the ultimate form of democracy: the ability of individuals to exercise choice about where and how to be treated. The case for choice can, of course, be made from a number of different perspectives. So, for example, choice would seem to be an essential precondition for consumer autonomy: in its absence, there will inevitably be an asymmetrical relationship of power, reinforcing the asymmetry of information, between consumers and providers. Choice would therefore seem to be an essential pre-condition for establishing a dialogue of equals between patients and clinicians and of forcing providers to be responsive to the demands of consumers: an acknowledgment of the principle that the individual patient is the only person who can ultimately decide which balance of harms and benefits is appropriate for him or her.

This is a persuasive line of reasoning. But further still, it has been argued that choice within a public system represents the 'most effective mechanism for enhancing individual influence 'and thereby 'generating civil democracy',[56] an argument also developed by others.[57] It is this latter, more ambitious and contentious claim that we examine in this section.

Democracy, as we have seen, is essentially a political concept. It is about the process for making decisions about how collective power should be exercised. In contrast, the case for choice is about enhancing individual power. The former is about voice i.e. engaging in debate as citizens; the latter is about exit, i.e. taking decisions as consumers.[58] It is therefore not self-evident that the case for choice – however strong it may be in its own right – can sail under the flag of democracy. The relationship between the two is much more complex than the simple equation of consumer choice with democracy might suggest; indeed it can be argued that in some respects the two may pull against each other.

Consider the case of Sweden, whose experiment in promoting consumer choice promoted the observation – quoted above – that it is an instrument for 'generating civil democracy'. Here the aim was to give consumers the freedom not only to choose between general practitioners but also between hospitals, if necessary crossing administrative boundaries. The ambitions of this programme of reform have subsequently been considerably modified.[59] But it is clear that adopting this kind of approach puts extra burdens on the collective decision-making process rather than being a substitute for them.

First, there have to be mechanisms for ensuring that money follows the patient. Second, there have to be collective decisions about to cope with the possibility that one hospital may become so popular that another institution (still cherished by many) becomes financially unviable. Third, there have to be collective decisions about what services should be available. Ultimately, if we believe that consumer preferences should rule – the logic of embracing choice as the driving force in health care – then they should also trump collective decisions about priorities.

The point can be further illustrated in the context of the NHS. This is a system based on meeting need, as defined by providers: it is, for example, clinicians who decide which patient to admit next from the waiting list according to their own criteria of need. Similarly, central government decides how to allocate resources geographically according to a need-based formula. Indeed the equity principle – the moral foundation stone of the NHS – requires that there should be equal access to treatment for equal needs. It is difficult to reconcile this with a demand-led principle implicit in the doctrine of consumer sovereignty, i.e. allowing consumers to define their own needs and, by so doing, shape the configuration of the health care system. And most important of all, it is impossible to reconcile with a fixed budget that inevitably means that some demands will be frustrated: hence the current debate about rationing. We are back to collective decisions both about setting the budget and determining the distribution of resources among competing priorities, whether nationally or locally.

Publicly-funded, national systems of health care therefore inevitably set limits on the scope for consumer choice, although the opportunities for choice will clearly vary with the generosity (or otherwise) of the budget set. There is a trade-off, too, between efficiency (seen as the intensive use of resources) and choice (which requires spare capacity).

It is therefore difficult to resist the conclusion that if choice is to be our measure of 'democracy', we would have to replace the NHS by a health care system that is driven by consumer preferences rather than paternalistic definitions of need. One option might be to move towards something like Enthoven's model of competing health agencies within the public domain between which consumers can choose. But the ultimate logic of

taking consumer choice as our lodestar is the 'democracy' of the market place. Which suggests, perhaps, that equating 'democracy' with choice leads to a dead-end which few would wish to explore. Enhancing the opportunities for citizens to exercise autonomous choice should be one of the aims of the democratic process, but cannot be a substitute for it.

The White Paper and beyond

So far in our analysis we have concentrated on the NHS as it is and the options for change if we want to make it more 'democratic': options which depend, as we have seen, on the way in which that chameleon word is interpreted. However, for the immediate future, the course has now been set by the Government's 1997 White Paper.[60] Accordingly, in this final section we ask how the 'new NHS' looks like scoring on our APA test. The White Paper does not address the question of 'democracy' in the NHS explicitly – despite Labour's preoccupation with issues such as the composition of boards while in opposition – but its proposals clearly have significant implications for many of the concerns which have been discussed in this paper.

Most crucially, the White Paper in many ways represents the apotheosis of Bevan's 'bedpan doctrine'. The ability of the centre to determine what happens at the periphery and to make those responsible for implementing policy accountable will be strengthened. There will be national service frameworks for major care areas and disease groups. The new Commission for Health Improvement will be able to intervene locally to secure the implementation of these frameworks and of the guidelines produced by the new National Institute for Clinical Excellence.

The Primary Health Care Groups, the basic building blocks of the commissioning process, will be accountable to Health Authorities, who will have the power to 'withdraw some or all of the devolved responsibility'; the Health Authorities, in turn, will be accountable to the Secretary of State through the regional offices of the NHS Executive. In both cases, there will be 'accountability agreements' against which performance can be assessed. Finally, 'the NHS Executive will be able directly to intervene to rectify poor performance in any part of the NHS'.

This emphasis on a clear line of accountability reflects, in turn, the White Paper's stress on promoting 'national standards' and clarifying what patients 'can expect from the health service'. In this respect, then, the White Paper can be seen as an attempt to make a reality of the promise of the NHS when it was launched: to ensure geographical equity in the availability of services. It remains to be seen, of course, whether this attempt will succeed : the tension between pursuing national policies and allowing local commissioners freedom to adapt national policies to local circumstances, which has been such a conspicuous feature of the NHS throughout the first 50 years of its existence, remains. So, too, does the tension between national standards and clinical autonomy. The temptation for Secretaries of State to diffuse blame, by invoking the need for local or professional discretion in the interpretation of national standards, will remain although the logic of the White Paper proposals may make it more difficult.

The notion of local discretion is, however, problematic. Here the central question, to return to a theme that has run through this paper, is: what gives local decision-making legitimacy? If the justification of allowing discretion is that this is a necessary condition for responsiveness to the interests, values and needs of the community being served and the users of the service, how can we be sure that the commissioners accurately reflect and represent those interests, values and needs? Further, in a new 'national' NHS, what scope should there be for local communities to come to policy conclusions about, say, purchasing new drugs and technologies, which differ from central 'guidance'?

The White Paper offers little help in answering these questions. The key assumption (never fully

spelled out) seems to be that the Primary Care Groups will, by definition, represent the interests of patients : 'they understand patients' needs and they deliver most local services'. This is a rather heroic assumption. Family doctors and community nurses cannot necessarily be taken as adequate consumer-proxies; in some circumstances they themselves, after all, may be the reason why the needs of patients (as defined by themselves) are not met.

Moreover, since Primary Care Groups will in effect be fundholding collectives with a monopoly in any given geographical area, it will be more difficult than ever for patients to exercise either the exit or the voice option: protesting may carry the risk of retaliation if the only opportunity is to switch between practices working in the same consortium and following the same commissioning strategy. If the rhetoric of choice in the 1989 Conservative White Paper was largely illusory, Labour's 1997 Labour White Paper ignores the issue.

If the new NHS offers little leverage to consumers to influence local decision making, it does nothing to improve the ability of citizens to make their views tell. The White Paper stresses the Government's wish to have 'a strong public voice in health and healthcare decision-making', pats Community Health Councils on the head and promises to 'explore new ways of securing informed public and expert involvement'. Similarly, Health Authorities and Priority Care Groups will be required to 'involve the public'. But, exhortation apart, there are no firm commitments. However, the White Paper does promise improvements in public access to information: NHS Trusts will be expected to publish more information about their performance and no management information will, in future, be classed as 'confidential' because of possible commercial implications.

In summary, then, applying the APA test suggests the following conclusion. First, the White Paper proposals clarify and strengthen upward accountability. However, the result of this will be – in the absence of other changes – to increase accountability overload at the centre and to strain still further Parliament's capacity effectively to call the Secretary of State to account. They will, however, do little to strengthen downward accountability, apart from giving more transparency to the activities of the NHS; not surprisingly, perhaps, given the overall emphasis on moving towards national standards.

Second, the proposals leave the permeability of the policy process unaffected. Third, the situation in regard to protection against arbitrariness will remain unchanged, though conceivably the promised new Patient's Charter may offer consumers more safeguards. Overall, therefore, the conclusion must be much the same as would have been given before the publication of the White Paper: two (perhaps rather grudging) cheers for democracy in the NHS. And perhaps also that we should be more sparing in the use of the ambiguous, contestable and contentious notion of 'democracy' as a hurrah word in debates about the NHS.

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democracy *n.*, **1.** government by the people or their elected representatives. **2.** a political or social unit governed ultimately by all its members [from Greek *demokratia*: government by the people]

There has been much talk about the 'democratic deficit' of the NHS. As one set of placemen and placewomen succeed another on the boards of health authorities and trusts, so there is a widespread perception that the Secretary of State is 'unaccountable' in an increasingly centralised service, and that local communities have too little influence on NHS decision-making.

But how accurate is this perception? This paper argues that the notion of democracy – the most promiscuous word in the English language – needs to be unpacked. Accordingly, it applies the APA test – accountability, permeability and non-arbitrariness – to the governance of the NHS both centrally and locally.

At the centre, the system performs reasonably well on the APA test, although there is scope for improvement. But the price to be paid for this is 'overload' and centralisation. Accordingly, the paper examines various options for devolving more power to local communities and the scope for experiments. Here the price of any switch is likely to be even greater variation in the services provided.

If consumers are to be put in the driving seat (another version of what democracy is sometimes taken to mean), then the logic of this points in the direction of a market-based system. In effect, it would mean abandoning the fundamental principles of the NHS.

The authors therefore conclude that while 'democracy' in the NHS – in its many meanings – may fall short of some of the rather over-optimistic assumptions about what it can deliver, it does deserve two cheers.

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