Public Health and Health and Wellbeing Boards: Antecedents, Theory and Development.

Peter Murphy

Nottingham Business School, Nottingham Trent University

Abstract

The 2012 Health and Social Care Act transfers responsibility for Public Health in England from Primary Care Trusts to local authorities. This article traces the theoretical and policy antecedents of the proposals and highlights some key changes since their original conception in the 2010 Public Health White Paper. It suggests the development of Health and Wellbeing Boards and their objectives can best be understood by viewing them through the theoretical prism of Public Value or New Public Service Theory and concludes with some recommendations for their implementation and development.

Key Words: Health and Wellbeing, Public Health, Public Value, NHS.

Introduction

The 2012 Health and Social Care Act will transfer responsibilities for Public Health in England, at the local delivery level, from Primary Care Trusts to local authorities as from the 1st April 2013. To facilitate and enable this change, 152 Health and Wellbeing Boards are being established in every part of England as the primary multi-organisational governance arrangement to implement delivery, facilitate public reporting and assure the continuing public accountability of public health services in the future (Department of Health 2012).

This article traces the theoretical and policy antecedents of the current proposals and highlights some key changes to the proposals since their original conception in the 2010 Public Health White Paper (Department of Health 2010). It looks at their theoretical and practical development and draws from some recent research that looked more specifically at the development of the Boards in practise by examining on-going arrangements in the City of Nottingham and the County of Nottinghamshire (Murphy 2013).

Legislative and Theoretical Background.

In order to understand the legislative and theoretical background it is helpful to trace the antecedents of the current proposals through two parallel sets of policy and delivery programmes in UK public services since the late 1990s. The first of which is the public health policy agenda itself.

Throughout the period of the labour administrations in the UK from 1997 to 2010 the previous governments increasingly acknowledged both the need to tackle the social determinants of health (see figure 1) as well as the long term need to integrate the

delivery of health and social care in the light of the UKs aging population (Department of Communities and Local Government 2006).

Insert Figure 1 about here

The second policy agenda relates to the previous governments' attempts to tackle or mitigate long term, social, economic, environmental and often intractable problems within local communities, sometimes called the "wicked" issues. These are issues that in the past have not been amenable to single agency resolution or mitigation. They have therefore increasingly been approached on a multi-agency, and essentially collaborative basis, by a combination of public, private and third sector agencies operating to a common purpose, organised around a collectively agreed or adopted, and explicitly 'public' strategy.

a) The Public Health Agenda and increasing Health Inequalities.

Throughout the period between 1979 and 1997, and subsequently, a number of reports and studies have documented the continuing public health and health inequalities challenge (Black 1980, Whitehead 1987, Acheson 1988, Dorling 2010). It is also well documented that between 1997 and 2005 the Labour Governments' investment in Healthcare generally, and the NHS in particular, led to sustained improvements in the all-age all-cause mortality rates for all classes and across all communities. The issue that the government was still recognised however, was that the richer communities and sectors of society were improving their longevity and quality of life at a greater rate than the poorer sectors, not least because they had more of the wherewithal to respond to public health messages and make changes in their lifestyle and as a consequence health inequalities and disparities continued to grow, as the 2006 Local Government white paper acknowledged (Department of Communities and Local Government 2006).

The reduction of health inequalities and the desire to integrate health and social care were therefore a prominent objective in many Local Area Agreements (Local Government Improvement and Development 2012) and were subsequently reflected in the 2007 Local Government and Public Involvement in Health Act. In 2008 the World Health Organisations' investigation into the social determinants of health published its much anticipated final report (WHO 2008) and in February 2010 the Marmot Review, published its recommendations for the future of public health (Marmot 2010), three months before the general election brought the coalition government to power. The latter report was subtitled 'a strategic review of health inequalities in England post 2010'. It is this policy and legislative discourse that formed one of the two key antecedents to the recent 2012 Health and Social Care Act.

b) The development of multi-agency responses

If the policy antecedents help to explain what the 2012 Act is trying to do (and why it is worth doing), it is the 'how' question that generates the second theme of the recent reforms and in particular the 2012 Act's intentions for the new Health and Wellbeing Boards. The ageing demographic, spiralling costs of health and social care, continuation of poor health outcomes for some groups and individuals within our communities, and the persistence of health inequalities clearly constitute a "wicked" issue i.e. along term and seemingly intractable issue that has not been amenable to single agency resolution or mitigation and therefore has increasingly been approached on a multi-agency basis.

Since the Crime and Disorder Act 1998, the Health Act of 1999 and the Local Government Act of the same year, the previous government sought to tackle these issues through multi-agency partnerships and collaborative action. The Crime and Disorder Reduction Partnerships, Local Public Service Agreements, Local Strategic Partnerships (LSPs), Children's Partnerships, Local Area Agreements (LAAs) and the Total Place initiatives were key staging posts in an increasingly complex, sophisticated and generally successful response (Audit Commission 2009) to these seemingly intractable local problems by what Parker and Gallagher have termed the development of the "Collaborative State" (Parker and Gallagher 2007). In terms of public management theory these initiatives can best be understood through the theoretical prism of the increasing development and application of Public Value or new Public Service Theory from its original neo-liberal setting in the USA (Moore 1995) to the UK, Canada, Australia, New Zealand and European contexts today (Bennington and Moore 2011).

Throughout all of these initiatives, both in terms of policy intentions and their delivery or practice "on the ground", Health and Social Care have been encouraged to increasingly integrate around common objectives articulated in a co-produced plans or strategies, based primarily upon community or population outcomes (Mulgan 2009). The final incarnation of the LAAs all contained Health and Social Care themes, overseen by Health and Social Care Committees or panels of the LSPs, while the 13 Total Place pilots or pathfinders attempted to tackle particularly difficult or outstanding multi-agency issues or new innovations. Although the new Secretary of State for Local Government, quickly announced the termination and abolition of Total Place and Local Area Agreements (Department of Communities and Local Government 2010), the latter are three year programmes of action, some of which will only terminate in 2013. In other words the organisational infrastructure of LSPs and Health and Social Care Committees were still in place when the 2010 Public Health White Paper (Department of Health 2010) was published and many were still in place when the 2012 Act was passed. They are the foundations upon which Health and Wellbeing Boards are being built in practice.

Health and Wellbeing Boards - from proposals to enactment.

The coalition government came to power in the general election in May 2010 and published its white paper Equity and Excellence: Liberating the NHS on 12th July shortly after it came to power. There was no consultative green paper and precious little forewarning of the proposed extent of the reforms from either of the parties election manifestos (Conservative Party 2009, Liberal Democrats 2009) or the coalition agreement (Cabinet Office 2010). The negative response from both the public and stakeholders led to the government announcing the unprecedented "Listening Exercise" in April 2011, to be overseen by a Future Forum panel of health experts, health workers and patient groups (Department of Health 2011). The listening exercise closed in June 2011 and received around 15,000 website responses and approximately 750 letters. It produced its first report on 13th June 2011 (NHS Future Forum 2011) and the Government's response to the report was published on 20th June 2011 together with some briefing notes on amendments to the Health and Social Care Bill on 27th June 2011.

On 10 January, 2012, the Forum sent its second set of reports (NHS Future Forum 2012) to the Secretary of State for Health, together with a series of recommendations which sought to improve the quality of patient care and achieve better patient and community outcomes. The forum concluded that integration should be defined around the patient,

not the system and that patient outcomes, incentives and other drivers within the system need to be aligned with this overriding objective. The forum recommended that the new Health and Wellbeing Boards should drive local integration, through a "whole-population, strategic approach that addresses local priorities". This time the government responded to the report on the same day (10th January 2012) and accepted all of its recommendations. It published its updates to the bill, which was by then going through parliamentary procedures, and after more than a year of debate and several last-minute attempts to overturn or delay the legislation, the bill was passed at the end of March 2012, albeit with several last minute changes.

Since the Act was passed the Department of Health (DoH 2012b, DoH 2012c), the Local Government Association (Local Government Improvement and Development 2012) the NHS Confederation (NHS Confederation 2012), and the Kings Fund (Ham *et al* 2012), have continued to issue a series of guidance notes and advice designed to facilitate or assist in the implementation of the new Boards.

Previous and on-going exploratory research has also looked at its early implementation in practice in one part of the country (Murphy 2013). This article is an attempt to illustrate the changes made to the proposals and suggest that the theoretical or conceptual confusion evident in the White Paper and the original Bill have gradually been clarified, (although not completely eradicated), from the current proposals. It also argues that the roles, responsibilities and operating environment in which the new Boards will exist, is best understood by adopting a New Public Service Theory approach rather than trying to understand them from the vantage point of Public Choice or New Public Management. It highlights the reducing influence of the marketization, commercialization or privatisation of the particular parts of the Healthcare reforms relating to Public Health and the work of the Health and Wellbeing Boards – which is not necessarily the case in other parts of the reforms. In so doing it will draw attention to the reducing influence of the Secretary of State and the increasing influence of the emerging NHS Commissioning Board. This may have been expected and anticipated, as the policy turned from proposals and legislation to implementation and delivery, but some key incidents or milestones accelerated this changeover.

The following figure attempts to illustrate or capture the theoretical, conceptual, and political changes that occurred during the period from June 2010 and March 2012. It also highlights three notable incidents that did not of themselves cause significant changes to the government's proposals, but do illustrate the strength of public interest and concern over the proposals as they were developed over the period prior to the Coalition Government reshuffle of September 2012 when the previous Secretary of State was replaced with the current incumbent.

Insert Figure 2 here

Public Agency, Public Choice or Public Value Theory?

There are three broad explanatory theories in public management which are often seen as a spectrum that range from a fairly straightforward relationship of top down influence between politician and public manager to greater reciprocity and complexity in the relationship (Hughes 2012). Each will be appropriate at certain times and in different places, in illuminating the complex subject that is the practice of public management.

Public Agency or Principal Agent theories regard governance structures as simultaneously enabling and constraining the actions of public managers. In simple terms politicians create governance structures in a top-down fashion and hold managers accountable for mandated results. Politicians, are the primary drivers of change, and they control public managers as agents through constitutional powers such as monitoring, finance and legislation. Public managers' actions reflect the mandates (spelt out in pre-election manifestos) of elected local and national politicians.

New Public Management or Public Choice theories emphasise a more agile, responsive or innovative approach to governance, extolling the responsiveness of the private sector and the market. Governance structures are the product of on-going competition and compromise. The public interest is no more than an aggregation of individual self interests but public managers are not mandated by politicians, rather they are constrained, supported or vetoed by elected representatives through a complex process of negotiation. However, as Hughes (2010) points out their flexibility can also conflict with popular preferences around the provision of services and changing demands of accountability to the public.

Public Value and New Public Service Theory (Moore 1995, Bennington and Moore 2012) draws on ideas around democratic citizenship, community and civil society and focuses increasingly on governance with citizens, communities of interests or populations at the centre. Co-producing policy and systems of delivery with key stakeholders and the public, managers have to help build a shared notion of public interest, and not merely aggregate individual preferences. Policies and programmes that effectively meet public needs are achieved through collective and collaborative processes that emphasises the importance of citizens over customers and people over productivity. Public managers are accountable to a much wider set of demands, rather than just the market, as they must also respond to statutory and constitutional law, community values, political norms, professional standards and citizens interests (Hughes 2012).

Privatisation and competition on the basis of price, or collaboration and competition on the basis of quality?

The change in this aspect of the debate is most easily discerned by examining the dialogue around the introduction of competition into the NHS. Even the most casual perusal, let alone any textual forensic analysis, of the collective speeches of the previous Secretary of State for Health, will reveal that throughout 2010 and the first half of 2011 whenever he was referring to increasing competition into the NHS, he was referring to increasing *price* competition in the NHS and expanding the role of market. Competition has always been a part of the NHS but it has generally taken the form of patient centred quality of care. Doctors generally want the best or the most appropriate care for their patients and investigate the provider market to find it. As the Nicholson Challenge (NHS 2009) and the Quality, Innovation Productivity and Prevention programme make clear, this can drive up standards of care and drive down costs. However it was only late in the 'Listening Exercise' that the former Secretary of State claimed that it was competition on the basis of quality of care that he was advocating and not competition driven by price. The national newspapers saw it differently and the headline in the Financial Times the next day was unequivocal 'Lansley U-turn over NHS price competition' (Timmins 2012).

The influence of, neo-liberal ideology and the creation of policy based evidence as opposed to pragmatism and the creation of evidence based policy.

In addition to this damascene conversion over competition, there were two other incidents that changed the dynamic and influence of two of the key figures in the NHS reforms. One concerns a Loughborough rap artist and the other a nurse at the Annual Congress of the Royal Colleges of Nursing (RCN) in April 2012. These two figures contributed significantly through the release of a rap song on You Tube (You Tube 2012) and the asking of a rather well disguised question to the former Secretary of State at the Congress(RCN 2012). As a result they both became instant "celebrities" within the NHS community and among campaigners wishing to amend the governments' proposals. The "Lansley Rap" went viral on release and featured on the national news and on the Newsnight programme before being withdrawn from the BBC website the next day and forbidden to be played on NHS computers. At the RCN the former Secretary of State became drawn into a conversation with a nurse in the audience who, apparently, wanted to congratulate the government on its approach to crime and the reporting of crime by the public. Having gradually drawn the Secretary of State into this conversation she finished by saying she wanted to report a crime namely that somebody had stolen half of her pension and she didn't know who had done it. All of which, including the Secretary of States aghast reaction was, caught on national television. These two very public incidents helped to undermine the credibility of the Secretary of State. As a consequence it increased the influence the NHS Commissioning Board who were advocating a more pragmatic approach to implementation (Alford and Hughes 2008, Murphy 2012).

Conclusions and Recommendations

If the interpretation and analysis of this article is correct then the drafting of secondary legislation, and the development of advice and guidance relating to implementation, delivery and the future operating environment for Public Health and for Health and Wellbeing Boards should be predicated on the principles of Public Value. The Health and Wellbeing strategies should be focused on the development of community or population based and therefore explicitly public strategies as defined by Mulgan (2009). They should include an agreed local vision based upon a clearly articulated common purpose and they should be implemented through multiple agency collaboration with exercising appropriately robust horizontal scrutiny to complement existing vertical and external scrutiny exercised by the government, the NHS Commissioning Board the Care Quality Commission and Monitor. The responsibility for implementation (similar to the Duty to Co-operate in the 2007 Local Government and Public Involvement in Health Act that produced the LAAs), should be placed upon both the local health community and the key local public service deliverers that significantly affect the wider determinants of Health at the local level.

The policy and implementation proposals above, if they are to be sustained, need to be complemented by a continually improving Joint Strategic Needs Assessment and robust evidence base, allowing real time, remote and open access with built in quality assurance mechanisms. The JSNA itself should be embedded in a wider community resource such as the Insight Nottingham website (One Nottingham 2012). This was originally developed in Nottingham for the LAA but is now used for a much wider range of research, delivery, education, evaluation, good practise and diffusion activities (Murphy 2013). New techniques for collaborative or network capacity building, innovation and individual and collective organisational development and infrastructural

support will also be needed, In these circumstances the growing literature and experience that draws on Social Network Analysis (Stephenson 2011) and wider partnership working for service improvement are clear pathways to explore.

References

Acheson, D (1988) *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function*. London HMSO

Alford, J., and Hughes, O, E., (2008) *Public Value Pragmatism as the next phase of Public Management.* American Review of Public Administration, 38 June pp 130-148.

Audit Commission (2009) *Final score: The impact of the Comprehensive Performance Assessment of local government 2002-08* Audit Commission London

Barton, H. and Grant, M. (2006) *A health map for the local human habitat*. The Journal for the Royal Society for the Promotion of. Health, 126 (6). pp. 252-253.

Black,. D. (1980) *The Black Report: Inequalities in Health: Report of a research working group*. DHSS 1980

Bennington, J. and Moore M.H. Eds (2011) *Public Value Theory and Practise.* Palgrave Macmillan Basingstoke England

Cabinet Office (2010) *The coalition documentation* available at http://www.cabinetoffice.gov.uk/news/coalition-documents

Conservative Party (2009) *Returning Power to Local Communities: Policy Green Paper* Conservative Part HQ London

Department of Communities and Local Government (2006) *Strong and Prosperous Communities - The Local Government White Paper Volume 2 Chapter 2 Health and Well being.* Cmnd 6939-1 HMSO

Department of Communities and Local Government (2010) *Local government accountability* available at http://www.communities.gov.uk/statements/corporate/localgovaccountability

Department of Health (2010) *The white paper: Healthy lives, healthy people – our strategy for public health in England.* Cm7985 HMSO

Department of Health (2010a) *Equity and excellence: Liberating the NHS*. Cm7881 HMSO

Department of Health (2011) *NHS listening exercise* available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/DH_125865

Department of Health (2011a) *Government response to the NHS Future Forum report* *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443*

Department of Health (2012) *Public Health Outcomes Framework* DoH available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

Department of Health (2012a) Government accepts Future Forum Recommendations at http://www.dh.gov.uk/health/2012/01/forum-response/

Department of Health (2012b) *JSNAs and joint health and wellbeing strategies - draft guidance.* Department of Health. HMSO

Department of Health (2012c) *A short guide to Health and Wellbeing Boards* available at http://healthandcare.dh.gov.uk/hwb-guide/

Dorling D (2010) *Injustice: why social inequality persists*. The Policy Press, England,

Ham, C., Dixon, A., and Brooke B., (2012) *Transforming the delivery of health and social care The case for fundamental change*. Kings Fund London available at http://www.kingsfund.org.uk/publications/transforming-delivery-health-and-social-care

Hughes, O, E., (2012) *Public Management and Administration* 4th Edition Palgrave McMillan.

Local Government Improvement and Development (2012) *LAA tracker*. Available at www.idea.gov.uk/idk/aio/10958567 LGID was formerly the Improvement and Development Agency for Local Government.

Liberal Democrats (2009) *Making it Happen* Liberal Part HQ London

Marmot, M. (2010) *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010.* The Marmot Review, Institute for Heal Equity University College London

Moore, M. H. (1995) *Creating Public Value: Strategic Management in Government.* Harvard University Press Cambridge MA

Mulgan, G. (2009) *The Art of Public Strategy: Mobilizing Power and Knowledge for the Common Good* Oxford University Press

Murphy, P. (2012) *The National Health Service in 2012 An interview with Sir David Nicholson KCB CBE Chief Executive of the National Health Service.* International Journal of Emergency Services Volume 1 Issue 2

Murphy P (2013 forthcoming) *Sport, Physical Activity and the establishment of Health and Wellbeing Boards in Nottingham and Nottinghamshire* Managing Leisure.

NHS Chief Executive's Annual Report (2009) *The Year 2008/09* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099700.pdf

NHS Confederation (2012) *Resources for Health and Wellbeing Boards* available at http://www.nhsconfed.org/Publications/Pages/lresources-health-wellbeing-boards.aspx

NHS Future Forum (2011) *NHS Future Forum recommendations to Government* available http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

NHS Future Forum (2012) *NHS Future Forum Reports* available at http://healthandcare.dh.gov.uk/forum-report/

One Nottingham (2012) *Nottingham Insight – Shared Evidence* Base available at http://www.nottinghaminsight.org.uk/

Parker, S and Gallagher, N (Eds) *The Collaborative State: How working together can transform public services*. Demos collection 23 London

Royal College of Nursing (2012) *Annual Conference London* available at http://www.rcn.org.uk/development/researchanddevelopment/rs/research2012

Stephenson K (2011) *The Quantum Theory of Trust: Power, networks and the secret life of organisations* Prentiss Hall Pearson England.

Timmins N (20120 *Lansley does U-turn over NHS price competition* (Financial Times Public Policy Editor) http://www.ft.com/cms/s/0/d0b2f0f0-450a-11e0-80e7-00144feab49a.html#axzz28Fa5ai00

Whitehead, M (1987) *The Health Divide: inequalities in Health in the 1980s* The Health Education Council London

World Health Organisation (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health: Health equity through action on the social determinants of health* Final report WHO 2008 http://www.communities.gov.uk/statements/corporate/localgovaccountability

You Tube (2012) The *Andrew Lansley Rap* available at http://www.ft.com/cms/s/0/d0b2f0f0-450a-11e0-80e7-00144feab49a.html#axzz28Fa5ai00

I would like to thank the two anonymous reviewers of this article and Professor Ian Shaw of Nottingham University for his comments on an earlier draft.

Figure 1. The wider determinants of health

Source Barton and Grant (2006)