Political & Ideological Aspects of Health Policy

Health policy is inevitably shaped by politics, and the ideological aspects of political forces. Political goals, such as control or short term cost savings, are often incompatible with the proper functioning of a large organization like the National Health Service. Politicians and managers rarely understand the roles and circumstances of the other, due to poor communication and competing objectives. This ‘disconnect’ is often blamed for poor policy decisions and misguided reform efforts, as well as NHS failings. However, it is most often the case that both politicians and health service staff are striving to improve the service, but work at cross-purposes that undermine their efforts.

The institutional structure of the political system and the timeframe of political cycles often prevent even well-intentioned politicians from achieving policy goals. Politicians are bound by a re-election cycle that rewards immediate results, despite adverse long-term consequences. In the past 55 years, there have been 23 Health Ministers, giving each an average of 2.5 years to accomplish their reform goals. Even those who are prepared for the role can rarely accomplish more than two objectives in their term of office, and accomplishing these objectives depends on an effective political strategy. Too often politicians seek a ‘magic formula’ that allows them to see the results of their investments rather than giving reforms a chance to take effect. Chronic and short-lived reorganizations only serve to decrease the ability of the health service to meet patient need and deliver better service.

Regardless of their political objectives, Ministers have an obligation of accountability for health service performance. Public accountability must be maintained, despite a shortage of information about how the service is working in practice or what contributes to good outcomes, leaving politicians in a difficult position. The centralized nature of UK Government exacerbates this tension as central government has responsibility for the health service without the actual power to affect its functioning. The key challenge is to balance proper demands for accountability with the fact that successive interventions and micromanagement are destructive.

At the other end of policy changes are the health service staff charged with implementing them. Health service clinical and managerial staff generally respond to directives to the best of their ability given financial and time constraints. However, frequent reorganizations and changing performance targets often frustrate efforts and require substantial time to redirect resources. Managers, who are often most impacted, accept the reality of political intervention, but are rarely effective in achieving policy goals envisioned in new directives. This may be due to
the fact that managers are improperly trained, or that directives are contradictory, unrealistic or even detrimental to the system. Managers, like politicians, may try to micromanage change when given too much control of the system. This can lead to further problems with clinical and other lower level staff. Morale is often negatively affected and essential workers lost. Meanwhile, innovations in care and service delivery generated from ground level staff may be ignored or lost in the effort to meet centrally imposed standards.

Given the incompatibility and resulting friction between the political process and the running of the health system, some means must be identified to reduce the negative consequences of their inevitable interaction. The question is not how to isolate the policy and political processes from one another, but how to make their intersection more productive. The participants in the Judge Institute conference on the future of health policy considered these inherent dilemmas in policy making and systems operation. Experience and perspectives were wide ranging and the emphasis was on means of improving current processes.

What is needed

Traditionally, NHS policy has been driven by events. Rarely has the future of the NHS been based on a long term plan. The NHS Plan may be the key exception to that rule providing a blueprint for all parties to work from. Fewer interventions resulting from a unified strategy may minimize the destructive consequences of political involvement. While the volume of reforms has created huge costs for the system, the extent of intervention has been a ‘direct response to system failure’. These failures have led to necessary changes including transparency, accountability and shared information.

The context for change will be one of uncertainty, but this is nothing new to health system reform. Uncertainty creates real pressures for politicians but those can be coped with and, in certain circumstances, even allow politicians to act well. Change should also involve those outside of government. Those in philanthropy and the private sector have important contributions that should be considered. Policy capacity will be improved by learning about and from each other and harnessing wide-ranging talent. ‘Solutions happen when professional boxes are left behind’ and the most productive change may in fact come from these external actors working jointly with Government to solve problems. Most importantly, leadership should be determined not by traditional roles, but by moral adventure and moral authority.
**Principles**

Firstly, it is important to identify and maintain the key principles in the new structures and design. These principles must be clearly marked and strongly protected; they should not be subject to ministerial whims. If principles are made clear, then reorganizations become the ‘dependent variable’ rather than the driving force. Secondly, it will be important to re-think the roles of all involved. Relationships between the NHS, the state and consumers are being restructured.

**Structural change**

Many agreed that the ‘correct’ organizational structure is the one that is requisite for the task at hand. As that task changes, so too will the appropriate structure of the health system. Robust structures of local accountability will be needed to counteract the need for central involvement. But systems and organizations to promote accountability are necessary at the center as well. New ‘arms-length conventions’ are being brought into the NHS for the first time that may introduce accountability, but also increase the complexity of systems management and relations.

**Devolution**

Devolution may be the most important structural change affecting health policy and the NHS. Major issues will arise in the process of devolution that could create opportunities for policymakers and NHS staff to develop new and more productive methods of working together. As devolution forces people to address issues locally, clear determinations should be made as to what issues are best addressed at each level.

Local Government needs to be reintroduced and strengthened to ‘bring contestability and a legitimized challenge to the center’. There is a clear need for ‘senior local leadership to engage with central leaders – not avoid decisions but help politicians make change’. There are many good examples of how managers and clinicians can effect change. With clinicians ‘on board’, new coalitions are changing reform dynamics. Disenchantment with politicians can create local consensus for leadership from other sources. But devolution will also challenge what is meant by local democracy as tensions are often ‘more pronounced at the local level’. There is a need to reinvent concepts such as ‘neighborhoods’ to develop local drivers. Local legitimacy will also help determine how resources are best allocated.

**Relationships**

Coalitions are needed between doctors, professionals, patients, unions and Government to create new social partnerships. People charged with delivering services must be included in developing the new models if they are to be
appropriate and achievable. This may require a return to a more conventional structure where all key players share an understanding of political aims, and a move away from ‘governing by legislation’. New ways of working will also reinforce the importance of ‘selling’ reforms and their objectives to staff and those responsible for implementation. Top-down ‘cascades’ of directives will not work in a structure of devolved authority.

Management
Despite real tensions between the roles of politicians and managers, it is ‘easy for the management cadre to criticize the center’ when it may need to take greater ownership over reforms. Too many top managers now ‘use the excuse’ that they are directed from the center and claim that their situation is uniquely difficult. However, private sector managers have their own external directors in the form of boards, stockholders, banks, etc that limit their authority seemingly without diminishing their responsibility. There may be a real shortage of talented managers in the NHS. A raised professional status for NHS managers may give them the authority they need to do their job and create professional accountability for those who fail to perform. In turn, politicians need to recognize the complexity of the manager’s job and invest in managers and their training so that they can do their difficult job well.

Role of the Patient
The role of the patient must be reconsidered in future reform efforts. Patients can and should be political drivers for reform and improvement of the health service. Politicians and managers must think about the health system from the patient perspective: how it is experienced by users. The role of the consumer in health care makes management of the health system different and more complicated than other fields. But public confidence is key to a successful - and stable - NHS.

Leadership
Courage and the ability to challenge convention will be needed to successfully reform the NHS. These may come from politicians, managers, doctors or patients. Moral courage is often ‘curiously selective’ and may appear in a range of disparate constituencies. The center may not prove to be the best leader and moral courage should be welcomed regardless of its source. Traditional roles are less important than achieving consensus. Turning ideological goals and policy ideas into practice is difficult. Good managers find consensus and create positive change. Politicians bring to the table the ability to get things done. All of these skills will be required and will become increasingly interdependent. Only by maximizing contributions from all levels of the health service and all levels of government will NHS reform goals succeed.
Fundamental issues about the role of the Executive, the role of the nation state and supra-national bodies and the role of the legislature will emerge and require answers. New checks and balances may be introduced into the system as greater ‘separateness’ is encouraged between professions and government. The fitness for purpose of existing institutions and organizations may also be challenged. Partnership is likely to emerge as the most appropriate model and subtle leadership may be required to encourage public involvement and debate. Regardless of the new roles and structures, it is imperative that the values of the NHS be protected and maintained.