Health Boards (Membership and Elections) (Scotland) Bill

Response from BMA Scotland

BMA Scotland welcomes the opportunity to provide the Health Committee with written evidence on the Health Boards (Membership and Elections) (Scotland) Bill which would require direct elections, by members of the public, to seats on NHS Boards in Scotland.

We appreciate that the Scottish Government hopes to deliver greater public engagement and more transparent decision making on matters regarding local NHS service delivery. However BMA Scotland cannot support plans for direct elections to NHS Boards.

A service can only be responsive to its users if those users, and potential users, are involved and engaged in the provision of those services. We are committed to supporting mechanisms which will achieve this effectively, and allow for engagement of all those in our society, including those who have traditionally found it difficult to make their voice heard.

However, BMA Scotland does not believe that direct elections to NHS Boards will improve public engagement or resolve the underlying problems of dissatisfaction around service change. We are particularly concerned that:

- Evidence from other countries indicates that elections to health governing bodies have not achieved the anticipated improvements in engagement and public confidence.

- There is very little practical detail outlined in the bill. Draft regulations to accompany the bill should be made available before the completion of Stage 1.

- The provisions in the Bill under section 2 allow for the appointment of individuals to elected seats and the potential self-selection of candidates without the requirement for an election. This will not increase accountability to local communities, patients or the public.

- The cost of direct elections, even for the pilots, will divert much-needed resources from front-line services at a time when investment in the NHS is slowing.

- There is no published detail available on the Scottish Government’s commitments to strengthen and improve other areas of public and patient participation. A debate on the introduction of elections should be considered in the context of the wider alternatives that exist and with consideration of proposals to improve meaningful consultation and the improvement of existing public involvement structures.

It is important to note that the Scottish Government has acknowledged that responses to the consultation on the Local Healthcare Bill showed no clear consensus in support of the introduction of Health Board elections\(^1\). BMA Scotland is

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\(^1\) Scottish Government (2008) Local Healthcare Bill Consultation: Analysis of Responses
concerned that this policy is being driven by political imperative rather than a clear evidence base.

This submission provides the BMA’s views on the general principles of the Bill, specific comment on particular sections of the Bill and finally, proposes some alternatives to legislation which it believes would be more effective in involving local communities in decisions about local service delivery.

The principle of elections and the evidence base

The Scottish Government has committed to delivering and developing services based on the best available evidence. We know of no evidence that introducing direct elections will improve public engagement and have only found evidence of concerns regarding elections to Health Board bodies where these have been introduced in other countries².

Health systems in other countries are similarly exploring new ways to engage patients in the decision making process for service provision, some of which have introduced elected members to governing health bodies. However, evidence from these countries shows that such measures have not resulted in the benefits anticipated. A report prepared for the Commission on the Future of Health Care in Canada in 2002 considered various initiatives to increase public participation and citizen governance, including direct elections to regional health boards in Saskatchewan. It concluded that:

“the experience [in Saskatchewan] has demonstrated that health board elections are costly, cumbersome and produce low voter turnout and have failed to foster a more active, engaged citizenry committed to common goals. In light of these experiences, their continued use should be questioned if efficient, effective participation and public commitment are desired goals”³

Similarly, research into elections to district health boards in New Zealand, introduced in 2001, has suggested that “the electoral component of the DHB [District Health Board] system is failing to make a substantial contribution to the democratisation of health care governance in New Zealand”⁴

The Scottish Government has stated that it believes that introducing direct elections to NHS Boards will change the way the public and patients view the NHS and promote confidence in the way in which services are planned and delivered. The evidence from elsewhere strongly suggests that this is unlikely to be the case, merely resulting in the diversion of much needed resources from front-line care and a reduction in available funding to improve current mechanisms for engagement which are more likely to be effective.

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³ Abelson, J & Eyles, J (2002), p12
⁴ R Gauld (2005)
Politicising the NHS

As the Scottish Government’s analysis of responses to the consultation on the Local Healthcare Bill confirmed, there is considerable concern regarding the potential politicisation of NHS Boards and the detrimental impact that this could have. Politics inevitably has a role in the health service and it is right that Scottish Ministers should be responsible for allocation of funding, setting the broad national strategy for health and establishing an ethical framework within which policy and practice should evolve. Elections to NHS boards would create an additional, and possibly conflicting political environment at the local level, and there is a significant risk that decisions could be made to secure future votes rather than to evolve, innovate and develop services. It is not clear how the inevitable dual accountability of elected members to local electorates and Scottish Ministers will establish itself in practice.

Evidence from the Canadian experience of elections to district health boards showed that only those with the most to lose or to gain stood for election, usually as a result of threats of service closures. Research carried out into the experience of elected board members in Saskatchewan, Canada, found that 32% of board members admitted that public pressure sometimes forced their boards to make decisions that they would otherwise not have made and 41% had found that their position as a board member had provoked resentment from those in their community. There is therefore significant concern that areas which have not always gained widespread public sympathy or support, such as addiction services and services for those with long term mental health conditions, could be negatively impacted by any moves to determine priorities based on public demand.

Lack of Genuine Representative Engagement

In addition to the concerns regarding candidates outlined above, BMA Scotland does not believe that directly elected members will necessarily be representative of the community they seek to represent. Those who are arguably most reliant on NHS services, such as the elderly, recent immigrants, those who are seriously ill on a chronic basis and single young parents, are the least likely to stand for election to a body which is likely to require engagement and discussion on complex issues with professionals and senior managers, whilst also requiring significant and regular time commitments. Yet, these are the very people with whom the NHS needs to engage to ensure that services meet the needs of all those in our society, not just those who can make their views most volubly known. Sensitive and supportive engagement methods are needed to ensure that the most vulnerable in our society also have a voice in the process of determining service development and priorities. BMA Scotland does not believe that the process of electing members to Boards will ensure a representative approach to public and patient involvement in NHS decision making.

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The BMA has significant concerns regarding section 2(2)12 (Vacancies) of the Bill which sets out provisions for “elected” members to be appointed if vacancies arise between election cycles. In such circumstances, these individuals will be “deemed to be an elected member” despite the fact that they have no democratic support or mandate from the constituency that they will be representing. This appears to undermine the argument for locally elected community representation and suggests a political tokenism, rather than a genuine attempt to engage local communities and patient representatives in effective, accountable decision making.

Voter Turnout

BMA Scotland has concerns regarding the potential level of turnout and participation in a local Health Board election process on a sustainable basis. Initial interest and publicity may encourage higher rates of participation in pilots but evidence from elsewhere suggests that voter turnout in such elections may be much lower than the Scottish Government anticipates over the longer term.

There has been a significant decline in voter turnout across the UK in the past three decades. Despite the interest and attention stimulated by the advent of Scottish devolution, turnout in Scottish Parliament elections has failed to reach any higher than an average of 58%, even for the first devolved elections in 1999. National elections, which in Scotland have been dominated by health issues, are naturally accompanied by high profile media coverage and debate on a scale unlikely to be matched by local Health Board elections, particularly as they are unlikely to be held on the same day across the country.

Experience in other countries also indicates that turnout and participation in elections may be an issue. For example, NHS Foundation Trusts in England conduct local elections to a Board of Governors. A report in the Daily Telegraph found that “as few as one in 1,500 people” were voting in elections for patient governors. The Telegraph provided an example from the Clatterbridge Centre for Oncology on the Wirral where 1,502 people voted out of a patient population of 2.3 million. As well as organising elections, Foundation Hospitals recruit local people to become “members” but the Telegraph found again that the record is poor. Sheffield Children’s NHS Trust only managed to sign up 1,161 members out of a population of 1.8 million and the Queen Victoria Trust in East Grinstead, West Sussex, which served a population of around 4.5 million only achieved 13,000 members. Similar difficulties were found in Saskatchewan health board elections in Canada, with only 10% turnout in 1999 elections.

There is therefore a risk that individuals with political aspirations or representatives from single issue campaign groups could seek election to NHS Boards to progress their own political careers or to use the NHS Board as a mechanism to further a single cause. Coupled with the likely low turnout for elections, this could mean that relatively small numbers of votes could secure a position on a Board for such

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8 Health Boards (Membership and Elections) (Scotland) Bill, Section 12
9 G Wilson “Blair’s pledge over flagship hospitals branded a sham”, The Telegraph, 15 November 2006
candidates who could have a disproportionate influence over decisions which may not necessarily reflect the needs of the wider local community.

It would appear from the drafting of this Bill that the Scottish Government is paying little more than lip-service to democracy in local Health Boards. Paragraph 7 of Section 2 (2) (Conduct of election) makes a provision for uncontested elections whereby if the number of nominated candidates is equal to or less than the number to be elected then there will be no election but these individuals will be given a seat on the Board and will be declared to have been “elected”. This is little more than self-selection and means that the public will be represented by people who do not have a mandate to speak on their behalf.

Board Effectiveness

The Bill and accompanying memorandums fail to provide the level of detail required to assess many of the potential operational issues which will influence the effectiveness of the new Board governance arrangements. BMA Scotland would encourage the Health Committee to demand that the Scottish Government publishes the draft regulations referred to in the Bill during Stage 1 consideration to allow for greater understanding and consideration of the extent of the Government’s proposals, particularly given the inflexibility of primary legislation. It is important that when considering the principles of this Bill that the parliament has full knowledge and understanding of the Scottish Government’s intentions.

Given the level of detail to be contained within regulations, the BMA would also recommend that regulations are subject to affirmative parliamentary processes to ensure appropriate scrutiny.

One of the key issues to be determined by regulations relates to proposed membership of Boards. The policy memorandum accompanying the Bill suggests a number of members to be appointed by Ministers, including senior NHS staff. There is concern that the political drive to ensure a majority of elected members on the Board will inevitably reduce the number of internal stakeholders and staff who are required to participate in decision making in order to ensure organisational effectiveness. As a result, the Board would either be forced to limit key NHS staff participation or expand the size of the Board to an unworkable size to ensure a majority of elected members.

Financial Implications

The Scottish Government has indicated in the financial memorandum that the cost of introducing elections is estimated at £13.05 million although it is inevitable that this figure will rise over time as the details and operational implications become known. The introduction of the proposed pilots alone is estimated at £2.86 million, but much of this estimate is based on guess work dependent on a number of unknown factors. BMA Scotland is disappointed that, despite the acknowledgement by the Scottish Government of widespread concern regarding the costs associated with introducing direct elections, the financial calculations seem lacking in detail and are rudimentary.
at best\textsuperscript{11}. The method of estimating the roll out cost of the pilot processes appears particularly rough and ready, calculated merely by multiplying the cost of the pilot in two Health Board areas by five to assume 100\% coverage of the population.

For example, we have particular concerns regarding the calculation of the estimated costs of additional remuneration of elected members. The financial memorandum clearly states that the estimated costs of the pilots are based on these running for two years, including additional remuneration costs for this period\textsuperscript{12}. In estimating the full cost of the roll out of the pilots to the whole of Scotland, the memorandum indicates that this has been calculated by multiplying the cost of the two pilot sites by five to represent 100\% coverage. However, as the full cost of the roll out would require four years of remuneration to members between each election cycle, this estimate fails to include the cost of the additional two years. In addition to this, there are 14 Health Boards, not 10, and each Health Board will require remuneration for its elected members. It is also important to note that these estimates are based on the minimum number of elected members possible on each Health Board\textsuperscript{13}. It therefore appears that there has been a significant underestimation of the costs of additional remuneration of elected members for each four year election cycle by £1.8 million\textsuperscript{14}.

The fact that this has been overlooked does not promote confidence in the accuracy of other aspects of the financial projections, which have already risen from an estimated £5 million in the original consultation to £13.05 million in the financial memorandum accompanying the bill.

BMA Scotland is also concerned that the estimated budgets do not include any of the subsequent costs to Health Boards to support the newly elected Board members, such as training, administrative support or organisational development activities to promote understanding of the role of elected members within the NHS.

There is considerable concern that the cost of introducing and supporting direct elections is to be found from existing NHS budgets, particularly at a time when health spending is slowing for a number of economic reasons. The cost of the pilot alone could pay for:

- the treatment of 1,668 patients during an average inpatient stay in a Cardiac Care Unit
- the care of 40 premature or sick babies in a special care baby unit
- an additional 85 nurses

\textsuperscript{11} Scottish Government (2008) "Local Healthcare Bill Consultation: Analysis of Responses"
\textsuperscript{12} Paragraph 61 of Explanatory Notes accompanying the Health Board (Membership and Elections) (Scotland) Bill, p11
\textsuperscript{13} Paragraph 15 of the Policy Memorandum accompanying the Bill indicates that there will be a minimum of 10 appointed members of the new health boards, including a local authority councillor.
\textsuperscript{14} Based on the figures provided in the financial memorandum, the accurate estimated cost of additional remuneration for elected members per 4 year elected cycle would be £50,000 per year, per board – a total of £2.8 million. The policy memorandum suggests it will be £0.20 million (estimated cost of additional remuneration from the 2 pilot sites) x 5
BMA Scotland believes that if elections to Health Boards are to be piloted the Scottish Government should provide the additional funding to finance this in order to prevent reductions in the provision of currently funded NHS services.

The Pilot Process

BMA Scotland welcomes the commitment to evaluate the pilots but has concerns about the independence of the evaluation process. It is important that the evaluation is carried out on an entirely independent basis, commissioned through a competitive tendering process. Confirmation of this by the Scottish Government would be welcome. It is also worth noting that pilot projects are often accompanied by additional energy, support and resources, resulting in positive outcomes and evaluations. Subsequent roll out of pilots, implemented without this initial level of interest and funding, can sometimes fail to generate the same results. It is important to establish realistic outcome measures on which the success or otherwise of these pilots will be determined. In the interests of public transparency these should be made public before the pilots are established. Much of the previous research has focused on quantitative issues, such the number of people involved and how often, rather than their contribution to defined outcomes and their effectiveness.\(^\text{15}\)

Effective Patient and Public Involvement – Alternatives to Elected Health Boards

As expressed in our response to the original Scottish Government consultation on a Local Healthcare Bill\(^\text{16}\), BMA Scotland believes that there are more effective ways to engage with users and potential users of NHS services than the introduction of elected Health Boards. The Scottish Government has announced a number of initiatives and policies to improve patient and public involvement in decision-making and to encourage further transparency in the way in which decisions are reached. These include the introduction of standards for consultation to be developed by the Scottish Health Council, the establishment of Independent Scrutiny Panels and measures to strengthen and support the Public Partnership Forums (PPFs) of Community Health Partnerships.

It is unfortunate that more detail on many of these initiatives has not yet been made available. This reinforces concern that much of the policy emphasis on patient and public involvement will be focused on elected Health Boards to the detriment of other approaches, many of which BMA Scotland believes will prove much more effective in genuinely engaging with patients and the public to work together to improve services and build public confidence in the NHS.

The role of the Scottish Health Council

The Scottish Health Council (SHC) was established in 2003 to improve the way in which the public, patients and other stakeholders are involved in service design and decision-making in the NHS. It has a key role in the assessment and support of Health Board practices which aim to achieve this in each local area. It is inevitable that this new body would require a number of years to build up a picture of public


\(^{16}\) BMA Scotland response to the Scottish Government consultation on a Local Healthcare Bill, 2008
and patient engagement across the NHS in Scotland before further strategies and initiatives could be planned to improve these. The responses to the Scottish Government consultation on a Local Healthcare Bill confirmed that there was still confusion regarding the role of SHC and a belief that it should have a more clearly defined and enforceable role in relation to Health Board activity in public involvement, as well as a higher profile among the public\textsuperscript{17}. We believe that these issues should be actively addressed by the Scottish Government to enable the SHC to fulfil its potential.

It is clear from the work that the SHC has undertaken that Health Boards need to understand that consultation creates an opportunity to develop ownership of decision-making and to be open and honest about the very real constraints within which services are provided\textsuperscript{18}. It is hoped that this will be encouraged in the anticipated standards for public consultation to be developed by the SHC.

**Independent Scrutiny Panels and Public Confidence in Service Change**

As stated in our response to the consultation on Independent Scrutiny Panels earlier this year\textsuperscript{19}, BMA Scotland welcomes the introduction of measures which would result in increased public confidence in the way that proposals are developed with regard to service changes, particularly where difficult decisions may have to be made. Since the introduction of the NHS Reform Act in 2004, it has been a legal requirement for Health Boards to consult with their local populations on service change. However, this process has, in some cases, lacked full public confidence and created the perception that public opinion does not count. It is important that this situation is addressed to instil public confidence in the provision of safe, effective and equitable health services for all in Scotland.

There is concern that the multiplicity of initiatives proposed by the Scottish Government to address this issue, including both the introduction of independent scrutiny panels and elected Health Boards, will in fact ‘muddy the water’, confuse accountability and delay important decisions. It is our belief that Independent Scrutiny Panels should be allowed time to establish and allow for evaluation of their contribution to public engagement in decision making within the current system.

**Strengthening the role of Public Partnership Forums**

Community Health Partnerships (CHPs) were established in 2004 with the aim of devolving resources and decision-making to front-line staff, working in partnership with local communities and stakeholders. They were intended to bring together secondary and primary care stakeholders and clinicians to aid the development of clear patient pathways which would improve the patient experience and promote efficient use of resources. One of the key aims for CHPs, set out in statutory guidance, was to “involve the public, patients and carers in decisions concerning the delivery of health and social care for their communities” and ensure “effective public, patient and carer involvement by building on existing or developing new

\textsuperscript{17} Scottish Government (2008) “Local Healthcare Bill Consultation: Analysis of Responses”

\textsuperscript{18} Scottish Health Council Annual Review 2007

\textsuperscript{19} BMA Scotland response to the Scottish Government consultation on Independent Scrutiny Panels, 2008
mechanisms\textsuperscript{20}. One of these new mechanisms involved the statutory requirement for each CHP to establish a Public Partnership Forum (PPF). Each CHP is required to have at least one representative from the PPF on their Board to ensure communication between the Board of the CHP and the membership of the PPF.

PPFs have developed in different ways across Scotland, engaging with local communities and stakeholders in a variety of approaches dependent on local circumstances and geography. Feedback has suggested that they are viewed positively by stakeholders. However, capacity to support and undertake participatory activities at this level is varied and a more consistent approach to resourcing is required. It is disappointing to note that few CHPs have a dedicated budget for their PPF\textsuperscript{21}. These forums provide a real opportunity to engage with local people to support effective service development and to facilitate the shift towards delivering more healthcare outside hospitals. It is our belief that if these structures were resourced and empowered to operate as originally intended, PPFs could become a fundamental part of the local decision making process and achieve the objectives set out in the Bill without the need for costly Health Board elections. It is at this level that BMA Scotland believes public engagement would be most meaningful.

BMA Scotland is not advocating complacency with current structures and initiatives, but for the opportunity for these to be supported and developed further to ensure that they are able to fulfil their early potential. Public awareness of existing mechanisms for engagement must be promoted to ensure their continuing development, along with dedicated and sustainable funding for public involvement activities at local levels.

**Conclusion**

BMA Scotland does not support the principles of this Bill. There is a lack of evidence to suggest that directly elected Health Boards will improve public engagement. Indeed much of the evidence that exists points to the failure of this approach in engaging local communities in the decision making process.

The application of this bill appears to pay little more than lip-service to the democratic process with the ability to appoint ‘elected’ members to fill vacancies and for candidates to obtain a seat without election if the number of candidates is equal to or less than the number of seats available.

Alternatives exist to improve public engagement and it is disappointing that the Government has not given the Scottish Parliament the opportunity to consider these in conjunction with this bill.

BMA Scotland would urge the Health Committee to reject the principles of this Bill and instead consider conducting an inquiry into how the existing range of mechanisms can be improved to achieve greater public confidence and engagement in local decision making.

\textsuperscript{20} Scottish Executive Health Department (2004) “Community Health Partnerships Statutory Guidance”, p5-6

\textsuperscript{21} Scottish Health Council (2008) “Public Partnership Forums: What direction and support is needed for the future?”
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