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Would an independent NHS board put the politicians in their place?

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Not everything that the Labour Government has recently touched has turned to gold. It is disappointing, for example, that despite the allocation of an additional 2 to 3 per cent of the country's gross national product to the NHS many parts of the health service seem under severe financial pressure. Opportunities to extend innovative forms of pharmaceutical care have, along with other potential improvements, been curbed as a result.

But one Labour reform that is widely regarded as an unalloyed success was Gordon Brown's early decision to make the Bank of England, and within it the Monetary Policy Committee, more independent. This action freed setting the official interest rate from direct political control. Such a distancing of national interest decision-making from the hands of politicians — who may on occasions value immediate electoral gains more than long-term public wealth (or even health) — has been welcomed by all sides.

It is little wonder, then, that the idea of making the NHS a more independent agency, free — this concept's proponents would argue — from inappropriate political meddling, is once again attracting attention. Past inquiries rejected this option. But with public disquiet about the NHS continuing despite the extra money invested, the establishment of an independent NHS board has once again gained currency.

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One of this approach's most influential advocates has been Steve Dewar, director of funding and development at the King's Fund. In 2003 he wrote a report called "Government and the NHS: time for a new relationship?". This argued that establishing an independent "agency type" board at the head of the NHS would not disenfranchise politicians or weaken their legitimate role as public health guardians. Rather, it would allow them a proper place, focused on strategic rather than managerial governance. Steve Dewar restated this case in November of this year, at a breakfast discussion held at the King's Fund's London headquarters.

His fellow speakers at this occasion were Paul Corrigan, the Prime Minister's special adviser on health, and Nicolaus Henke, head of health practice at the consultants McKinsey. (A report from McKinsey preceded last year's departure of chief executive Nigel Crisp from the Department of Health, and opened the way to the subsequent reorganisation of the NHS leadership and functioning in England.)

They also noted the potential advantages of an independent NHS board. Yet with others present they raised questions about the extent to which — rightly or wrongly — political leaders such as past and possible future Secretaries of State for Health will accept being "put in their place".

The NHS itself has a special position in British politics, in part because it has for half a century served to legitimise political authority throughout the UK. The King's Fund — with Prince Charles as its patron — arguably reflects the British establishment's even longer standing awareness of the importance of respecting popular health concerns and the needs of the most vulnerable as a price to be paid for winning reciprocal public respect, and an acceptance of the slowly evolving social order.

Political leaders everywhere can be expected to be reluctant to step back, once the fruit has been tasted, from being positioned as the ultimate providers of health care to "their" people. Awareness of the power of this role may sometimes have underpinned attacks on the independence of health professionals in societies as disparate as the old Soviet Union and modern Britain.

At the King's Fund discussion it was suggested that in practice a "second best" solution will probably need to be found, in which MPs and ministers keep their visible roles at the head of NHS policy and high level decision making, but with their powers moderated. One benefit of this could be the prevention of "boom and bust" funding cycles driven by deals done, publicly or privately, in the run up periods to general elections.

Surges in pay levels coupled with highly publicised ministerial pressures to meet raised performance targets have been followed by apparent spending cuts that dismay NHS users and employees alike. Moderated targets, designed to foster stability alongside better quality treatment, might not always look like vote winners to political planners. But the Bank of England's experience indicates that they might well promote better long-term health outcomes than more dramatic alternatives.

Conservative socialism

Contributors to the NHS board debate claimed that an advantage of the UK approach is that it does not guarantee individual health service users rights of access in the way that other social insurance based Western European systems do. In the latter there is typically a priced tariff of specific services that the insured are entitled to, and that providers compete to deliver. This drives activity rates. But it also increases costs, in part because hospitals and other institutions invest in spare capacity to ensure that they can provide treatment when their individual customers want it. Otherwise they will go elsewhere.

Some commentators put the price of maintaining such spare capacity at one per cent of gross domestic product. By contrast resource allocation in the NHS is driven by collective, population-oriented decision making. Against the cost of individuals not being sure that they will always get the care they feel entitled to, and clinicians and other NHS staff sometimes having to struggle to meet public expectations, this may in overall terms deliver services more equitably and efficiently than is possible in the US and most other EU states.

Towards a more rights-based approach?

At this level of analysis there is much to be said for the traditional NHS, enhanced where possible by greater competition between both primary and secondary care providers. Although countries such as the Netherlands are now experimenting with a hybrid private/public insurance model, in which the cost of better services will ultimately show up in the shape of extra premiums that individuals may or may not choose to pay, the strengths of the old NHS are considerable.

If a new NHS board could make its decision making feel more acceptable to the modern public it could well be worth establishing it. But even if ministers were eventually to accept such a path, simply putting a new head at the summit of what would in essence remain a top down regulatory bureaucracy may not prove enough. The pill that both the King's Fund and traditional socialists might one day have to swallow is that a more diverse and empowered British population will eventually refuse to settle for benign paternalism dressed in any form. Its members will rather demand personal rights, and a clear definition of what the NHS does and does not guarantee between the cradle and the grave.

The opportunities that modern health professionals such as pharmacists have in this context relate to being sensitively aware of the human realities underlying the choice between individual care rights and population-based service commissioning. Politicians may strive to reduce professional autonomy and standing. But tomorrow's health professionals should still be able to support "their" patients by standing between bureaucratic and market forces, and achieving a balance based on expert knowledge tempered by personal relationships.