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Mutuality in the provision of Scottish healthcare

Introduction

The backdrop to this article is provided by the *Better Health, Better Care Action Plan* (Scottish Government, 2007), Section 1 of which is entitled ‘Towards a Mutual NHS’. *Better Health, Better Care Action Plan* (hereafter known as *Better Health Better Care*) was published in November 2007 by the Scottish National Party (SNP), who had some 6 months earlier gained minority control over the Scottish Parliament from the previous Labour/Liberal Democrat coalition. *Better Health, Better Care* allowed the SNP to offer a policy, which was different to *Building a Health Service Fit for the Future* (Scottish Government, 2005) and published by the previous Labour/Liberal Democrat coalition. According to *Better Health, Better Care* (Scottish Government, 2007:5): “*Mutual organisations are designed to serve their members. They are designed to gather people around a common sense of purpose. They are designed to bring the organisation together in what people often call ‘co-production.’*”

The aim of this article is to précis the current knowledge of mutuality in the provision of Scottish healthcare. In detail, it will: introduce the ‘mutual’ organisation; offer a historical perspective of mutuality; suggest why healthcare mutuality is important; and briefly, detail the differences in mutual health care policy in England and Scotland. It is hoped that this analysis will help researchers and practitioners alike appreciate further the philosophy of mutuality in the provision of Scottish healthcare.

A mutual organisation

The mutual health vision aims to value all stakeholders as co-producers of healthcare with a ‘common sense of purpose’. This vision contrasts with situations characterised by adversarial or competitive relationships between stakeholders, typical of the privileging of teleological action and of consumerist approaches to healthcare (Howieson, Sugden, & Walsh, 2013). Of note, a mutual organisation of healthcare does not necessarily exclude competition as an economic or even social mechanism for driving up quality and driving down cost (Howieson & Walsh, 2010). Yet, it does mean that more than a narrow set of commercial or managerialist values are mobilised in decision-making and that competitive mechanisms are critically reflected upon. It (the mutual organisation) is an attempt to lead, to integrate, to coordinate, and to co-produce healthcare based on the values of co-operation and collaboration. Moreover, the ‘common sense of purpose’ is not that of a unitary organisation; rather, it is the common purpose of localities — enabled by local organisation — in

order to reflect the diverse social milieu of communities that make up Scotland today. This, then, is perhaps the beginning of a public sector version of local self-help for communities regarding healthcare.

Mutuality in the provision of healthcare: turning ‘full circle’

In the UK in 1911, over 3 quarters of those covered by the newly created national insurance scheme were already members of mutual aid associations (MAAs). These organisations (MAAs) gave paying members protection if they become too ill to work. Based on membership payment, there was a sense of contribution, ownership, and equality not present in charitable activities. As Green (1999: 25) notes: *“This tradition of reciprocal obligation treated people as capable of exercising responsibility. It sought to increase their human capital and, by fostering civil society, to increase their social capital so that no one stood alone.”*

The welfare state that replaced mutual aid was built, it is suggested, in opposition to these doctrines of reciprocal obligation. Perhaps, then, that the national insurance models — and subsequently, the NHS — effectively normalised and separated people’s contributions from their local support networks.

History shows that post-1948 (as the National Health Service (NHS) came into being), mutual models faded away as they could not survive this separation, nor were they politically acceptable forms of governance. This, it is considered, commenced a growing trend with people becoming increasingly passive recipients of comprehensive state-led social support. This was subsequently challenged by the Thatcher, Major and New Labour Governments based on the grounds that the public service monopoly — that was the NHS — had become too inefficient and unresponsive and this led to the emulation of private sector market-based solutions, which valued choice and competition. Disillusionment with repeated market reforms and subsequent failures in public service delivery through the 1990s came to a head during the large scale market failures associated with the banking crises of 2007/2008. Since then, both traditional hierarchies and market-based systems of public service provision are under question, and more mutual, collaborative approaches are now again being discussed (Conservatives, 2010; Liberal Democrats, 2010; Policy Network, 2011; Mills & Yeoman, 2013).

Indeed, the private sector in the UK is now leading the way on co-production. Businesses surveyed by Nesta¹ are now placing greater reliance on ‘user’ and ‘open’ innovation, relying on customers, partners, and staff to provide innovative ideas and testing grounds.

In considering the general development of mutual enterprises, Lea & Mayo (2002: 8) identified mutuality within industry as “*an institutionalised value-based model of reciprocity*”. More recently, however, a new phase of mutually-established community organisations has been created, initially on a small scale but growing in number through, for example, a range of social enterprises, credit unions, and housing co-operatives.

Looking specifically at health care in the UK, Ham (2009) acknowledges that the *Building a Health Service Fit for the Future* (Scottish Government, 2005) was the catalyst for the current approach to health policy in Scotland. With a devolved Government able to consider Scottish-specific health issues, this policy (*Building a Health Service Fit for the Future*) provided a convincing case for the need to tackle the relatively poor health of the population compared to the other home countries in the UK and European comparators and for a range of different structural measures, which would be necessary to progress the health improvement agenda.

Better Health, Better Care aimed to move this thinking forward in terms of a mutual NHS being ‘more than an idea’, specifying: “*This Action Plan contains a number of proposals that shift ownership and accountability to the people of Scotland*” (Scottish Government, 2007: v). The aspirations focus initially on a more even relationship between NHS Scotland and the public through increasing public participation with patient rights and local democracy developments through elected health boards. *Better Health, Better Care* also expressed the additional aspiration for NHS Scotland staffs as key stakeholders: “*as partners or co-owners*” (Scottish Government, 2007: v). In essence, this builds on the concept of partnership working and by inference, the expression of enhanced engagement hints at the need to progress the leadership agenda through the idea of personal leadership from all stakeholders.

Why is health mutuality important?

The general concept of mutuality is broad in scope and can be interpreted in different ways according to the lens of the person interpreting it. It becomes no easier to interpret when considered in relation to healthcare. It is important, however, to expand on why the Scottish Government has

¹Nesta is an independent charity with a mission to help people and organisations bring great ideas to life (see: <http://www.nesta.org.uk/>).

pursued it with such vigour and the associated advantages and risks to the organisation, staffs, and importantly, patients.

In the Scottish context, NHS Scotland is a public service — a service that is used and paid for by the public. This mutual approach, then, may be the most appropriate approach for this publicly-funded body in terms of the funders having a greater say in their service, and making decisions about the shape and structure of healthcare services across Scotland. Mutuality may also help with greater individual and community responsibility in healthcare, and broader organizational and societal responsibilities in enabling people and communities to have or even take power over their own health.

It is also considered that there is a clear mandate for NHS Scotland to enact more collaborative policies; for example:

- One of Beveridge's 3 principles supporting the creation of the NHS was that: "*Social security must be achieved by co-operation between the State and the individual*" (Abel-Smith, 1992).
- With reference to 'Adam Smith liberalism', Green (1999) notes that the more moral responsibility that was assumed privately, the less the need for coercion. And the more people practised private responsibility, the more their moral faculties developed so that the sphere of coercion could diminish still further.

Arguably, and in this respect, the only viable long-term solution to ever-increasing service demand is enhancing the responsibility and ownership of health and healthcare by service users.

In terms of the actual case for general user-involvement, this is typically divided into 3 separate arguments (Chute, 2012). First, it can be seen as a way to improve services, aligning them to the needs of local communities. Many patient groups, especially for long term conditions (LTCs), have deep knowledge and understanding about how to make services better. This knowledge is often highly local or personally-specific, and is difficult to simply diffuse through centrally-mandated best practice (Bunt & Harris, 2009). Second, it can be argued that user-involvement represents a technology of local accountability and that local health service decisions are legitimized by involvement. Third, international evidence shows that involving patients in their care and treatment improves their health outcomes, their experience of the service, their knowledge and understanding of their health status, and their adherence to the chosen treatment (Bunt & Harris, 2009).

There are also a number of independent and interdependent benefits that can be achieved by greater mutuality or public participation in any given organisation. Lewis *et al.*, (2006), for example, argue that mutuality is an 'intrinsic good' that leads to individuals having greater control of their own

health, which in turn improves health outcomes. Elsewhere, Lea & Mayo (2002) offer that ill health results from inequalities of stress and economic circumstance, while Scotland's previous Chief Medical Officer, Professor Sir Harry Burns, argues that by adopting a 'health assets approach', people can take control in improving their own individual health (Royal Society for the Arts, 2014).

A mutual NHS may, then, provide a conceptual framework that allows for a focus on the broader determinants of health inequalities and impact rather than current position of focusing on short-term funding (Lea & Mayo, 2002). Mutuality in NHS Scotland may also help to build community cohesion and social capital through public engagement with an increased sense of ownership of services and citizen participation. Of note, social capital is increasingly being used to describe the extent and nature of community relationships, based on the belief that where social capital is strong, the cohesion of the community will be reinforced (The Scottish Mutuality, Equality, and Human Rights Board, 2008). In his seminal work *Bowling Alone*, and in his work looking at social capital and government effectiveness in post-war Italy, Putnam defined social capital as features of social organization, such as networks, norms, and trust that facilitate coordination and cooperation for mutual benefit (Putnam *et al.*, 1993; Putnam, 2000). He (Putnam) provided evidence to suggest that a decline in social networks resulted in the reduction in the strength of community ties and norms. More generally, Petrou *et al.*, (2007) and Petrou & Kupek (2008) found that when people felt connected in cohesive communities, their social capital increased, resulting in, among other things, improved health outcomes.

With evidence pointing to a positive correlation between social capital, social cohesion, and health and life outcomes (Islam *et al.*, 2006), this is undoubtedly something Governments have been keen to investigate and, increasingly, base policy on. An essential component of this cohesion is the 'active' model of nationality or citizenship, where the citizen is, and feels, engaged with political and social processes 'on the basis of mutuality and equality' (The Scottish Mutuality, Equality, and Human Rights Board, 2010).

Differences in health policy

In Agenda Item 5 (Mutuality – Communications), The Scottish Mutuality, Equality, and Human Rights Board (2009) state: *"The development of a more mutual NHS puts further distance between NHS Scotland and some of the more 'market-based' models of healthcare delivery adopted elsewhere in the UK. It looks for change to be driven on the back of a commitment to better understanding and responding to the views/experiences of patients/carers and staff rather than through the operation of internal markets."*

Better Health, Better Care also equates mutuality with partnership working, a theme carried forward and elaborated upon in *The Healthcare Quality Strategy for NHS Scotland* (Scottish Government, 2010). So, rather than the decentralisation and transfer of governance of health care from Government to publicly-owned bodies, as in England, mutuality in NHS Scotland seems to be about: patient experience; a sense of ownership as opposed to the transfer of actual assets and risk from Government to publicly-funded mutual bodies; cooperation; partnership working; a collaborative and integrated approach; and engaging with stakeholders — the various ‘publics’ that avail themselves of the health service and staff.

In the previous 20 years, health provision north and south of the border has ebbed and flowed between convergence and divergence. At present, there is further divergence through the respective predominant concepts of patient choice and mutuality. In summary, there are a number of features that are particularly pertinent to the relative position between NHS Scotland and the NHS in England in relation to delivering a mutual NHS:

- The level of structural rationalisation to create clarity and associated stability in Scotland has been significantly greater relative to England. In Scotland, the performance management agenda has been more quickly embedded supporting both a stronger platform and increased confidence to progress with ideas evolving health delivery, including those of mutuality.
- Commonality of Governmental approach to NHS service delivery has been a factor in creating divergent directions of travel in health provision. In England, the market approach never completely disappeared as it did in Scotland — this continued to influence the approach to health delivery structure.
- Although a mutual NHS could have similar consequences to the prevailing idea of patient choice, in England (taken within the context of a more market-oriented system) this has created the possibility of more variation rather than the ‘driver’ for Scotland of achieving mutuality of approach at a national level.

Summary

However defined and stated, a mutual health policy does seem sensible. It does, however, require a breakdown of the typical role relationship between professionals and community people. Moving towards a mutual health system, and its subsequent delivery, will require new ways of thinking about health and health care. What may be required will be a move, over time, to a more inclusive relationship — a relationship where patients and the public are affirmed as empowered communicative partners rather than merely recipients of care. Indeed, if strategic decisions in health in Scotland are to be made in the public interest, a concern with such communication and community

would seem to be sensible and importantly, pre-requisites. This will have implications for the many healthcare quality frameworks that have emerged since the 1980s including the Institute of Medicine's (2001) framework that is currently central to the NHS Scotland Quality Strategy. While these frameworks do emphasise the centrality of patients or citizens in the determination of quality, and point towards greater inclusiveness, they assume that citizens are empowered or that the service providers are generally empowering. Yet ironically — and whilst implying much — these frameworks actually say little explicitly about empowerment and how this might be achieved nor about the implications of empowerment for ownership and accountability and normative regulation of healthcare. Perhaps then, ownership and accountability, in particular, must necessarily take on new meanings and roles in mutualistic healthcare.

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