

HEALTH BOARD ELECTIONS (SCOTLAND) BILL

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The Health Board Elections (Scotland) Bill was introduced to Parliament by Bill Butler MSP on 31 March 2006. The aim of the Bill is to allow for the majority of members on each of the 14 Area NHS Boards to be democratically elected by the public. This is in response to a perceived democratic deficit in the governance of the NHS in Scotland. This briefing outlines:

- the main provisions of the Bill
- the current system of accountability and governance
- the main arguments for and against the Bill
- recent experience of elections in other health systems

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EXECUTIVE SUMMARY	3
BACKGROUND	7
HISTORY OF NHS GOVERNANCE AND ACCOUNTABILITY	7
NON-DEPARTMENTAL PUBLIC BODIES	8
EXISTING AVENUES OF ACCOUNTABILITY AND PUBLIC INVOLVEMENT	9
CURRENT STRUCTURE OF BOARDS	10
PUBLIC ATTITUDES TO THE NHS IN SCOTLAND	10
PERCEPTIONS OF PUBLIC INVOLVEMENT IN NHS DECISION MAKING.....	11
BILL CONSULTATION AND SUBSEQUENT PROVISIONS	11
OTHER PROVISIONS IN THE BILL	12
REACTIONS TO AND OPINIONS ON THE BILL	13
THE HEALTH COMMITTEE’S CALL FOR EVIDENCE.....	13
ARGUMENTS IN FAVOUR OF THE BILL	14
ARGUMENTS AGAINST THE BILL.....	15
SPECIFIC ISSUES WITH THE BILL	17
EVIDENCE FROM OTHER HEALTH SYSTEMS	18
NEW ZEALAND	18
ENGLISH FOUNDATION TRUSTS	19
COST	20
ANNEX 1 – CURRENT NUMBER OF NON-EXECUTIVE MEMBERS AND REMUNERATION	22
SOURCES	23

EXECUTIVE SUMMARY

Background and Current System

The Bill seeks to redress public dissatisfaction with NHS decision making by allowing for the majority of Area NHS Board members to be elected by the public. This has been prompted by a number of high profile campaigns against NHS service reconfigurations. ([p7](#))

Since the inception of the NHS, management and decision making has been devolved from central government to regional bodies (in various forms) with accountability to the Secretary of State/Ministers. Debates about central or local governance of the NHS have continued since this time. ([pp7-8](#))

Among the reasons for having non-departmental public bodies like NHS Boards, is that they can operate with a degree of independence from Ministers and provide expert independent advice on technical, scientific or other complex and sensitive issues. ([p8](#))

Existing avenues of accountability and public involvement in the NHS include annual Board reviews with the Health Minister; a statutory duty to involve the public, the Public Partnership Forums of Community Health Partnerships, the presence of local authority members on Boards and the Scottish Health Council to oversee the quality of consultation in the NHS. ([pp9-10](#))

At present, NHS Board members are either appointed by Ministers (non-executive members, including the Chair) or hold a place by virtue of their position (executive members). Appointments are made via an open and competitive process. At present there are a total of 194 non-executive members (lay=117, stakeholder=77) and 100 executive members on the 14 Boards. ([p10](#) & [Annex 1](#))

A survey in 2004 found that 73% of the public felt that they had little or no influence over the way the NHS is run. This was up from 57% in 2000. ([pp10-11](#))

Main provisions of the Bill ([pp11-12](#))

The Bill proposes that:

- 50% plus no more than two Board positions should be directly elected by the public. Board Chairs would still be appointed by Ministers
- elections would take place every four years (outwith the local government and Scottish Parliament election cycle) with the first elections on 1st May 2008
- each elector would have one vote and those elected would be the top ranking candidates equal to the number of posts available (e.g. if there were five places, the five candidates with the most amount of votes would be elected)
- constituency areas would mirror the 14 existing Area NHS Board boundaries
- in order to stand for election, candidates should be eligible to vote in local government elections for wards within the Board area and should receive 10 nominations from local community members
- campaign expenses would be limited to £500 for each candidate and £250 provided by third parties. Each candidate will be allowed to produce a 250 word communication for each elector's household
- elected members would receive no remuneration
- a person would be entitled to vote if they are registered to vote in a local government election in an area which falls within the Board area, and they are entered on the local government register at an address within the Health Board area

- voting would be by postal vote only and the Returning Officer would be the Returning Officer for the largest local authority within the Board area. Funding for elections would come from Board budgets

Reactions and Responses

85% (n=136/160) of responses to Bill Butler's consultation on his Bill proposal, supported the principle of the Bill ([p11](#))

52% (n=17/33) of responses to the Health Committee's call for evidence on the Bill, supported the principle of the Bill ([p13](#))

Arguments for the principle of the Bill ([pp14-15](#))

The main arguments used in favour of the Bill are that:

- high levels of public expenditure require democratic accountability. Those in charge of such large amounts of taxpayers' money should be directly answerable to the public
- elected members would represent the public and not Ministers
- elected Boards would improve public involvement and consultation
- it would depoliticise the NHS, as Boards would be more responsive to their local communities and establish their own priorities in line with the needs of local people
- there is no need for Boards to be at arms length from government as they do not have a regulatory or semi-judicial role

Arguments against the principle of the Bill ([pp15-16](#))

The main arguments used in opposition to the Bill are that:

- NHS Boards are already accountable to Ministers and the Scottish Parliament
- NHS Boards are already improving public involvement and consultation in the NHS and the changes need time to bed in (e.g. Community Health Partnerships, statutory duty to involve the public, the Scottish Health Council)
- elections will politicise the NHS, lead to short-term decision-making, single issue candidates, will distort priorities and delay difficult decisions from having to be made
- elections could lead to 'postcode lotteries of care' and undermine the planning of regional services
- the NHS is complex and Boards benefit from having members chosen for particular skills and experience
- voter turnout may be poor which could undermine the legitimacy of the Boards
- it may not improve public satisfaction, as in cases when local authorities close services and face public anger e.g. school closures
- elections could be costly and remove money from frontline services

Specific issues with aspects of the Bill ([p17](#))

Some specific issues raised about the practicalities of the Bill include that:

- although the policy memorandum describes the voting system as 'First-past-the post', respondents to the Committee's call for evidence claim it is actually the 'Single Non-transferable Vote'
- postal voting may exclude people with disabilities and those who do not speak English
- as the posts are not remunerated, this may narrow candidates to those who are retired and affluent

- the size of NHS Boards may either have to increase significantly to accommodate a simple majority of elected members, or a number of existing positions will have to be removed and replaced with those who are elected. The Bill does not specify which
- the size of the electoral area (i.e. the whole Board area) may lead to under-representation of people from rural areas

Experience from Other Countries

New Zealand District Health Board Elections ([p18](#))

In 2001, New Zealand held its first elections for membership to its District Health Boards. The elections are held using the single transferable vote system and the electoral constituency is the whole Board area. This is a change from the first set of elections in 2001 where first-past-the-post was used and the Board was broken down into smaller electoral wards.

Seven of the eleven places on Boards are elected by the public and members receive remuneration of NZ\$24,000 per annum. Boards are primarily responsible to central government as they do not set their own objectives and Ministers can impose sanctions for poor performance.

Turnout for the 2001 elections was 50%, falling to 42% by 2004. However, in 2004 the turnout was skewed by 15% of ballot papers being filled in incorrectly or being left blank. Other findings include that:

- the number of candidates per seat in 2001 was 7.4, falling to 3.5 candidates per seat in 2004
- woman and Maoris are under-represented among elected members
- most of those elected in 2001 came from a professional background (health, business, law). 10.9% had a background in community work or advocacy

English Foundation Trust Elections ([pp19-20](#))

Each Foundation Hospital Trust in England must have a Board of Governors which is elected by 'members' of the Trust. Membership of the Trust is drawn from the public, patients and staff and is usually done on an opt-in basis.

In the first wave of elections the average voter turnout for Trusts with an opt-in membership was 52%. This compares favourably to turnout at English local government elections (37%). It is questionable as to whether this turnout gives an indication as to likely turnout at Scottish NHS Board elections as the electorate had opted in and are therefore likely to have a higher interest in health services. At the one trust where all patients were assumed to be members unless they opted out, the turnout was 18%.

85% of public posts and 73% of patient posts had more than one candidate. Conversely, this means that 15% of public posts and 27% of patient posts had only one candidate. A review of the elections by the Healthcare Commission found no evidence that single-issue pressure groups were 'disproportionately represented'. However, other research found that:

- women are underrepresented on Boards of Governors, holding 45.5% of posts
- a high proportion of governors representing the public were drawn from the retired population

No significant difference was found between Foundation Trusts and NHS Trusts in relation to patient experience, the attitude of staff and the provision of services, although this may change with time. The review concluded that it is too early to assess the impact of the Trusts and whether there is greater accountability.

Cost ([p20](#))

The Bill estimates that with a turnout of 30%, elections would cost £1.2m (£0.3m per annum), with a turnout of 60%, elections would cost £2.4m (£0.6m per annum). This is based on the experiences of Stevenage Borough Council which has piloted 'postal vote only' elections.

The Financial Memorandum does not include an estimate of costs that may be incurred on general publicity for elections.

There is also no consideration of potential savings that may be made from the remuneration paid to existing Board members, as members elected under the Bill would not be remunerated. At present, expenditure on non-executive members' remuneration is approximately £1.28m per annum. However, as it is unclear what the final configuration of the Boards would be (e.g. whether the non-executive stakeholder members would remain on the Board and still be remunerated), the total potential saving cannot be calculated.

BACKGROUND

In recent years, a variety of different factors have resulted in the need for major service redesign in the NHS. Most notably these factors have resulted in a tendency for some acute and specialist services to be centralised in fewer hospital sites. All significant service redesigns are consulted on at a local level and require the approval of the Health Minister. However, on many occasions there has been public anger at the closure of local services, accompanied by a feeling that the public's opinion is not taken into account, and that consultation and involvement in decision making is tokenistic.

Such cases have ignited the debate over the accountability of Health Boards. This was most visibly demonstrated by the election of Dr Jean Turner to the Scottish Parliament, in 2003, on the back of a campaign to prevent the downgrading of Stobhill Hospital in Glasgow.

The 2003 Scottish Labour manifesto did contain a commitment to '*consult on introducing a directly elected element to all NHS Boards*' (Scottish Labour, 2003). However, this commitment did not appear in the Labour and Liberal Democrat coalition Partnership Agreement (Scottish Labour Party and the Scottish Liberal Democrats, 2003).

On the 31 March 2006, Bill Butler MSP introduced The Health Board Elections (Scotland) Bill. The Bill aims to address a perceived democratic deficit in the NHS by ensuring that the majority of members on the 14 Area NHS Boards are elected by the public.

HISTORY OF NHS GOVERNANCE AND ACCOUNTABILITY

The respective merits of central or local democratic accountability for the NHS have been debated since before the inception of the service in 1948. Prior to its creation, Aneurin Bevan fought for central government control against strong opposition within the Labour party which would have preferred to give responsibility to local authorities.

Before 1948, many health services were provided by local government (e.g. hospitals, maternity services and ambulances) but much of this was removed with the creation of the national service. Bevan's vision of the NHS was essentially technocratic in that his intention was for the members of the Regional Boards and Executive Councils (in charge of hospitals and general practitioners) to be drawn from the medical profession, the area health authorities, the medical schools and those with experience of voluntary hospital administration. It was also in line with post-war socialist ideology which advocated central state planning of public services. Bevan stated that:

"I have never believed that the demands of a democracy are necessarily satisfied merely by the opportunity of putting a cross against someone's name every four or five years. I believe that democracy exists in the active participation in administration and policy" (House of Commons, 1946, pg 52).

At the time of the Royal Commission on Local Government in Scotland, in 1968, the issue of local authorities assuming responsibility for health services was raised again. However, the medical profession both north and south of the Border was opposed to such an idea, primarily on the basis of the varying quality in service provision witnessed in different areas:

"The variation in the quality of local government at the moment...is such that we feel that the functions which they should be carrying out are not uniformly or universally

being carried out to the full.” (BMA giving evidence to the Royal Commission on Local Government in Scotland, as quoted in McTavish, 2005)

However, in response to the 1969 green paper on the structures of the NHS in Scotland (Scottish Home and Health Department, 1969), most County Councils were of the opinion that they should run the NHS. A submission from Glasgow Corporation is of note in that it writes that it:

“[F]elt that the lack of public participation in the planning and administration of the NHS has been to the detriment of the service” (Glasgow Corporation, as quoted in McTavish, 2005)

Following the green paper, Scotland’s Health Boards were established by the National Health Service (Scotland) Act 1972. Debates over democratic accountability and public representation were evident during the passage of the Bill. However, despite a number of structural and system changes since this time, NHS Boards have continued to operate at arms length from Ministers with Board structures a mix of appointed members and those there by virtue of their position.

NON-DEPARTMENTAL PUBLIC BODIES

The Scottish Executive [webpages on public bodies](#) sets out what it sees as the reasons for having non-departmental public bodies (NDPBs):

- they can operate with a degree of independence from Ministers, and provide expert independent advice on technical, scientific or other complex or sensitive issues
- they can deal with government functions, which for legal or other reasons must be free from political interference or direct ministerial input
- they can operate flexibly, in ways that may not be open to Executive departments - for example, in building partnerships with other organisations, taking commercial and entrepreneurial decisions, and operating at a local level
- they allow the public sector to benefit from the skills, knowledge, expertise and commitment of the lay people who sit on their boards
- they can focus in depth on clear and specific functions and purposes
- they are the best and most cost-effective way in which to deliver some of our public services

Nevertheless, the perceived proliferation of non-departmental public bodies (NDPBs) has received much criticism in the past and, prior to being elected in 1997, Labour promised a ‘bonfire of the quangos’. Consequently, in 2001 the then First Minister, Henry McLeish, launched a review of Scotland’s NDPBs (Scottish Executive, 2001a) stating at the outset that he would only support public bodies which:

- have a distinct role to play and functions to perform that are best done by a public body
- are clearly accountable to Ministers and the people whom they serve
- work in a joined up way with others and draw new people into the processes of government
- are properly run, efficient and effective, and deliver value for money

Following this review, 52 of the 180 public bodies in Scotland were recommended for abolition or merger and 61 for further detailed review (Scottish Executive, 2001b). At the time, the NHS in Scotland was made up of 15 NHS Boards overseeing a total of 28 NHS

Trusts. The [review report](#) recommended a move to 15 unified NHS Boards, thereby effectively abolishing Trusts, though Boards essentially remained the same.

EXISTING AVENUES OF ACCOUNTABILITY AND PUBLIC INVOLVEMENT

At present NHS Boards are accountable to Scottish Ministers and the Scottish Parliament. There are a number of existing avenues designed to ensure NHS Boards are accountable and involve the public in decision making. These are described below.

NHS Board accountability reviews

Each NHS Board is subject to an annual accountability review with the Minister for Health and Community Care and Scottish Executive officials. In October 2004, the Minister, Andy Kerr MSP, announced that accountability reviews with Boards would be held in public. This is intended to improve the openness and accountability of Boards ([Scottish Executive, 2004](#)).

Board accountability reviews are underpinned by the Performance Assessment Framework (PAF)¹. The PAF essentially comprises a number of qualitative and quantitative indicators of Boards performance such as waiting times, hospital acquired infection and healthy life expectancy. Boards' performance is also assessed against standards produced by [NHS Quality Improvement Scotland](#).

The National Health Service Reform (Scotland) Act 2004

The NHS Reform (Scotland) Act 2004 implemented a number of measures intended to improve accountability, public involvement and consultation in the NHS. These were:

- ***Abolishing NHS Trusts*** – this created a single tier of management and was intended to simplify lines of accountability
- ***Community Health Partnerships (CHPs)*** – established within NHS Board areas as a means of devolving decision-making and responsibility for local services to frontline staff and the public. CHPs should have a Public Partnership Forum which will act as a means for involving patients, carers and the public in the decision-making of CHPs
- ***Duty to Involve the Public*** – a duty on NHS Boards to involve and consult the public on the planning and development of services and in significant service redesigns
- ***Ministerial Powers of Intervention*** – Ministers now have a direct power to intervene in the case of service failures
- ***Creation of the [Scottish Health Council](#)*** – to oversee the quality of consultation in the NHS and ensure that the views of patients and the public are properly taken into account by NHS Boards. Each Board area has a Local Advisory Council of up to 15 volunteers who advise the Council on how their Board is performing. The Council reports on the progress made by each NHS Board annually. It also assesses the adequacy of each consultation carried out by Boards for significant service redesigns. Boards are guided in their consultations by the Executive's policy document '[Patient Focus and Public Involvement](#)' (Scottish Executive, 2001) as well as interim guidance (Scottish Executive, 2002). Final guidance to NHS Boards is expected by the end of the year.

¹ At time of writing, the Executive is developing a new system of performance management information providing research and information services to the Scottish Parliament

Ministerial approval for significant service redesigns

Since the publication of guidance in 1975, NHS Boards have been required to gain ministerial approval for major service changes. In granting approval, the Minister is guided by the report of the Scottish Health Council on the adequacy of the consultation that has taken place, and Boards must demonstrate that they have acted in accordance with guidance (Scottish Executive, 2002) and their statutory duty of involving the public. The guidance states that "end-process consultation is not acceptable" and Boards should also explain their reasons for not choosing a particular option. The Minister may require further consultation if it is felt that public involvement has been inadequate.

Instances of when the Health Minister has not approved Board proposals are rare. One notable example of this was in 2004, when the Health Minister did not approve proposals by Greater Glasgow NHS Board to close the Queen Mother's Maternity Hospital.

Councillors on Boards

Following the publication of 'Our National Health: A Plan for Action, A Plan for Change' (Scottish Executive, 2000) the composition and membership of NHS Boards was changed in 2001 to allow councillors nominated from each Local Authority within the Board area to be members of the Board. Each local authority that falls within a Board area can nominate one representative to sit on the Board.

CURRENT STRUCTURE OF BOARDS

NHS Boards are made up of:

- **Executive Members** – NHS Board Chief Executive and Board Directors (e.g. Directors of Finance, Nursing, Public Health)
- **Non Executive Stakeholder Members** –local authority representatives, Chair of Area Partnership Forum, Chair of Area Clinical Forum, Member of the University Medical School (where appropriate)
- **Non Executive Lay Members** – NHS Board Chairs and lay members appointed via open competition

Non-Executive lay member positions are selected through the public appointments procedure. All appointments are publicised and open to members of the public. The size of Boards varies widely from 13 on Orkney to 36 in Greater Glasgow & Clyde (See Annex 1). The total number of non-executive members in Scotland is 191.

The current level of remuneration for Board members totals approximately £1.69m per annum. Approximately £408,000 of this goes to Board Chairs and the remaining £1.28m to other non-executive members.

PUBLIC ATTITUDES TO THE NHS IN SCOTLAND

Health and the management of the NHS are consistently identified in opinion polls as priority issues for voters. While this may reflect a lack of satisfaction with health services it does not indicate whether people are dissatisfied with the current system of appointing NHS Boards or opportunities to get involved in decision making.

PERCEPTIONS OF PUBLIC INVOLVEMENT IN NHS DECISION MAKING

In 2004, The Scottish Executive commissioned a survey on 'Public Attitudes to the National Health Service in Scotland'. A previous survey in 2000 found that 57% of the public felt they had little or no influence over the way the NHS is run. In 2004, this had risen to 73% (Scottish Executive, 2004). The following table outlines the findings in more detail. This shows that there is a discrepancy between the levels of influence the public think they have and the level of influence they think they should have.

Table 1 – Public perceptions of influence in NHS decision making (Scottish Executive, 2004)

	How much influence do you feel the public have over the way the NHS is run at the moment?	How much influence do you feel the public should have over the way the NHS is run?
Great deal	4%	32%
Some	20%	54%
A little	33%	10%
None	40%	2%

BILL CONSULTATION AND SUBSEQUENT PROVISIONS

During June to September 2004, Bill Butler undertook a consultation on the proposed Bill, receiving 160 responses in total. Of the total received, 85% agreed with the general principle of the Bill. Table 2 outlines the preferences expressed by the majority of those in favour of Board elections and how each issue was translated into the Bill itself:

Table 2: Consultation responses on key aspects of the proposal and how they were subsequently translated into the Bill

Issue Consulted On	Consultation Respondent Preferences	Bill Provisions
Proportion of Board Members to be elected	At least 50% or more Board places should be elected	⇒ Section 1(1) - Simple majority required (50% plus no more than 2) on the 14 area Boards (but not Special Health Boards) ⇒ Section 1(1) - The chairman would still be appointed and elected members would receive no remuneration.
Electoral constituencies	No consensus	⇒ Electoral constituencies to mirror the boundaries of existing Board areas
Method of election	Elections should use the first past the post electoral system (although there was significant support for the single-transferable-vote system)	⇒ Schedule 1, Section 7(2) - First-past-the-post. Board positions will go to those with the highest share of the vote e.g. 6 places would be filled by the top 6 candidates ⇒ Section 7 - Elections shall take place by postal ballot only
Election cycle	Staggered cycle of elections	⇒ Section 1(4)& (5) - Single cycle of elections outwith the cycle of local government elections
Frequency of elections	3 or 4 year term of office	⇒ Section 4 - First elections to be held on 1st May 2008 and the first Thursday in May every four years thereafter ⇒ 4 year term of office (but no limit to the number of times a member can hold office)

Issue Consulted On	Consultation Respondent Preferences	Bill Provisions
Nominations	Candidates should be nominated by local people within the Board area	⇒ Schedule 1, section 4(2) Before standing, candidates need to secure a nomination signed by 10 members of the local community
Qualification for nomination and election	Qualifying criteria should be applied	⇒ Section 2 - Qualifying criteria - Prospective candidates should be 18 and be eligible to vote in a local government election within the health board area. A candidate's principal home should be within the Board Area.
Disqualification for nomination and election	Disqualification criteria should be applied	The main disqualifying criteria for nomination, election and holding office includes Section 3(1) : ⇒ The Chief Officer of the Health Board; any person directly accountable to the Chief Officer or the Board; any person paid by the Board who gives advice to it on a regular basis, or who speaks to the media on its behalf ⇒ Members appointed to the Board by Scottish Ministers ⇒ MEPs, MPs, MSPs and local government councillors ⇒ Medical staff who have been disqualified under NHS legislation ⇒ Anyone who has been imprisoned for more than 3 months in the previous 5 years ⇒ Anyone incapacitated by physical or mental illness
Voting age and minimum age for candidates	18 should be the minimum age for voting and for standing as a candidate	⇒ Section 2(a) and Section 5 - Age 18 for both voting and standing as a candidate
Restriction on publicity and expenses	Candidates should have the opportunity to send a brief election statement to electors and election expenses should be kept to a low level	⇒ Schedule 1, Section 2(3) - Candidates are allowed to send a 250 word communication to electors ⇒ Schedule 1, Section 39 - Candidates to spend no more than £500 on their campaign ⇒ Schedule 1, Section 40 (1) & (2) Prohibits any third party (or groups of third parties) from spending more than £250 in total to back or disparage candidates

OTHER PROVISIONS IN THE BILL

Structure of the Boards

Section 1 of the Bill sets out that a Board would consist of:

- A chairperson appointed by Scottish Ministers
- Such a number of other appointed members as Scottish Ministers “think fit”

providing research and information services to the Scottish Parliament

- Members elected by virtue of the legislation

The Bill does not make it clear what the final structure of the Board would be and which positions would remain (e.g. executive members or non-executive stakeholder members such as councillors).

Entitlement to vote

Section 5 sets out that in order to vote in an NHS Board election, a person must be registered to vote in an election for a local authority which wholly or partly falls within the Board area, and be registered on the local government electoral register at an address which falls within the Board area.

By-elections

Section 1(6) requires that an election must be held within 3 months of:

- a vacancy arising due to the death, resignation or disqualification of an elected member
- Scottish Ministers increasing the number of appointed members so that elected members no longer constitute a majority

Resignations and removals

Section 4 provides that if an elected member wishes to resign from office, they must do so in writing to the Health Board's Chief Officer. Also, an elected member may be removed from office by the Board if they have not attended a meeting of the Board for six consecutive months, unless the absence was due to illness or the person is able to attend meetings within a period deemed reasonable by the Board.

Returning Officer

Section 6(1) provides that the returning officer for the Health Board Elections will be the returning officer for the local authority with the largest number of councillors in an NHS Board area. Expenses incurred by the returning officer will be reimbursed by the NHS Board.

Uncontested elections

Section 7 of Schedule 1 provides that if the number of candidates nominated is less than the number of positions reserved for elected members, then the returning officer shall publish a notice inviting additional nominations over a period not exceeding two weeks. If at the close of nominations the number of candidates is equal to or less than the number of elected positions (following the further notice), the returning officer will declare that there is no poll and those candidates will be declared elected.

REACTIONS TO AND OPINIONS ON THE BILL

THE HEALTH COMMITTEE'S CALL FOR EVIDENCE

The Health Committee issued its own call for evidence on the Bill between 15 May and 25 August 2006, and received [33 submissions](#) in total (Scottish Parliament Health Committee, 2006). Opinion as expressed in responses to the Committee's call for evidence was divided more equally than in Bill Butler's consultation, although there were not as many responses. Of the 33 submissions, 17 supported the Bill. Those who opposed the Bill generally came from NHS Boards and bodies representing health professionals (e.g. the Royal College of

Nursing and the British Medical Association), while those supporting it included Councils and public campaign groups.

The following sections outline some of the main arguments used in support of and in opposition to the Bill.

ARGUMENTS IN FAVOUR OF THE BILL

Most of the arguments used in favour of the Bill centred on dissatisfaction with the current set up of NHS Boards.

High levels of public expenditure require democratic accountability

Some respondents expressed the opinion that it is inappropriate for unelected organisations to be in charge of billions of pounds of taxpayers' money, especially given the level of public expenditure on the NHS in Scotland. In 2007-08, the planned spend on Health and Community Care is £10.25bn (32.8% of the Executive's total managed expenditure), most of which (approximately 60-70% - based on allocations for 2005/06 & 2006/07) goes directly to NHS Boards (Scottish Executive, 2006a). These respondents felt that it is essential that bodies in charge of such large amounts of taxpayers' money should be open, transparent and able to explain and accept responsibility for their actions. This would then prevent 'buck passing' between Boards and Ministers.

Elected members would represent the public and not Ministers

Some respondents claimed that appointed members are seen as supportive of government policy and become 'yes men':

"We have seen too many appointed members become 'yes men' when contentious issues are discussed and voted on. Too often those who wish to object are held back by fear of removal from the Board by a chairman directed by the SEHD." (John Winton, Scottish Parliament Health Committee, 2006).

Respondents felt that having elected members would mean that Boards would aim to retain office by supporting the interests of the public instead of Ministers.

Inadequate public involvement and consultation

One of the most cited reasons for supporting the Bill is the perception that the public have little or no influence in NHS decision making and the consultation that does take place is tokenistic.

Significant service redesigns must undergo public consultation and need the approval of Ministers. However, many Board proposals that have been put to the Minister have not had the support of the public, yet it is rare for the Health Minister not to give approval. Respondents therefore felt that elected Boards would give the public a real voice and influence, meaning that it is unlikely elected Boards would take decisions without proper and meaningful discussion (Scottish Parliament Health Committee, 2006).

UNISON also felt that democracy would ensure the general public would participate and influence the policy making process by helping to develop desired outcomes and the methods to achieve them, not just commenting on 'plans drawn up in private' (Scottish Parliament Health Committee, 2006).

Matching local priorities

Although Boards operate at arms-length from central government, criticism exists that local and clinical priorities are skewed by central government (e.g. through the setting of national targets such as waiting times). Proponents of the Bill argue that creating local accountability would depoliticise the NHS, allow Boards to set their own priorities and better meet the needs of their local population.

No need for boards to be at arms length from Government

The Scottish Council for Voluntary Organisations (SCVO) contend that unless a body has a semi-judicial or regulatory role (e.g. the Parole Board, the Care Commission) there is no reason why a body charged with providing a service should work at arms length from government (SCVO, [online](#)).

ARGUMENTS AGAINST THE BILL

Boards are already accountable and engage the public

A number of submissions pointed out that NHS Boards are already accountable to Ministers and the Scottish Parliament, with Boards experiencing a greater level of scrutiny since devolution and that the lines of accountability are clear. Other submissions pointed out a number of other ways in which Boards are held accountable and where public involvement has been improved, namely:

- The presence of Councillors on Boards
- Community Health Partnerships and their Public Partnership Forums
- 'Patient Focus, Public Involvement' and guidance to Boards on involving the public
- The Scottish Health Council
- Statutory duty to involve the public
- Ministerial power of intervention

It was felt that introducing elected Boards may blur lines of accountability and that many of the changes that had been implemented need time to bed in properly.

Politicising the NHS and distorting priorities

Many of the responses in opposition to the Bill felt that introducing elected Boards would politicise NHS decision making. At present, central government health targets are often criticised for skewing NHS priorities for political gain at the expense of clinical need. Some respondents felt that this would worsen if NHS Boards were locally elected.

The following points were raised by consultation respondents regarding the possible effects of elected Boards and a resulting 'politicised' NHS:

- Boards could become even more unwilling to take difficult decisions, and so it could stifle innovation and development in services
- Could lead to short-term decision making
- Could lead to 'single issue' candidates who would not represent the whole population
- Decisions could be based on sectional interests rather than clinical need and cost-effectiveness
- Boards may choose to allocate resources based on moral judgements. Examples of morally contentious health services included family planning services, abortion clinics and drug treatment programmes.

Post-code lotteries of care

The issue of introducing 'post-code lotteries' of care was another point raised by a significant number of respondents. The concern expressed is that introducing a greater degree of local governance in health services may increase the likelihood of inconsistencies in service provision between different areas, something which has traditionally been unpopular with the public.

In recent years, a number of measures have been implemented to mitigate this, for example, the creation of national standards by NHS Quality Improvement Scotland and the provision of prescribing guidance by the Scottish Medicines Consortium. However, if elected Boards were in place, there is a possibility that regional variations may be exacerbated as decisions became geared towards local priorities. There are parallel examples of 'post-code lotteries' in local authority services at present, for example, charging for non-residential care services.

Similarly, concerns were expressed that increasing local accountability would undermine planning for regional services.

Need for appropriate skills and experience on Boards

Respondents opposed to the Bill felt that given the complexity of NHS management there needs to be a way to ensure that Boards have the appropriate skill mix required. They felt that the current system is adequate, as the appointment process is open, transparent and competitive, yet allows Boards to benefit from the skills and experience of candidates.

Declining participation in election processes

A commonly cited argument against the Bill is that there is already low voter turnout in Scottish Parliament and local government elections, given that less than half of electors did not vote in 2003, and that it is likely Health Board elections would also suffer from voter apathy. Low voter turnout could affect the perceived legitimacy of the elected Board.

May not improve public satisfaction

Some respondents questioned whether elected boards would have any effect on public satisfaction with NHS governance. For example, Greater Glasgow Health Council claims that:

"[I]n respect of the Greater Glasgow Acute Strategy which is highly controversial, that strategy was approved by the health minister and subsequently by the Scottish Parliament after a vote. The fact that it was approved by the Scottish Parliament did not make it any more legitimate or appealing to those who feel dissatisfied with aspects of the strategy." (Butler, 2004)

Transforming Public Services

In June 2006, the Scottish Executive launched a consultation document entitled 'Transforming Public Services' (Scottish Executive, 2006b) which is seeking opinion on how to overhaul local government and other public sector bodies, including the NHS. One of the principles that the document is built around is "ensuring strong accountability". A number of respondents felt that the timing of the Bill did not complement the consultation.

Opportunity cost

A number of respondents expressed concern that the Bill would be costly and remove money from frontline services.

SPECIFIC ISSUES WITH THE BILL

The following section outlines specific issues that have been raised about the Bill which do not pertain to its general principle, but would be of significance if the Bill was passed.

Voting system

Although the policy memorandum describes the voting system as 'First-past-the post', respondents to the Committee's call for evidence claim it is actually the 'Single Non-transferable Vote' (Scottish Parliament Health Committee, 2006). They felt that this voting system would not allow a fair and balanced representation of the local community. They also claim that experience of this type of system shows there is a large potential for tactical voting and voter management. Instead they suggest that the 'Single Transferable Vote' system would ensure fairer representation and be in line with local government elections.

Equal opportunity issues

A number of respondents felt that limiting voting to postal votes only may affect the participation of people with disabilities, sensory impairment and those who do not speak English. Also, given that the elected members would receive no remuneration, concern was expressed that this may limit the type of person who would stand for election. Specifically, it was suggested that it may lead to an over-representation of retired and affluent candidates.

Final size and make-up of the Boards

Boards are made up of a mixture of executive and non-executive stakeholder members (there by virtue of their position) and non-executive lay members (appointed by Ministers). In order to accommodate a simple majority of elected members, the size of NHS Boards may have to increase significantly or a number of existing positions will have to be removed. The Bill does not specify which.

Size of the electoral area

The Bill wishes to use the entire Health Board area as the electoral ward. It has been suggested that this would reduce the representation of people living in rural areas and smaller towns. This was also raised as an issue in the New Zealand elections (see below) where the 'at large' system which allowed people to rank all candidates in a district board area, was criticised for favouring candidates from highly populated areas. This is because voters are unlikely to vote for candidates they do not know and so this disadvantages candidates from rural areas.

EVIDENCE FROM OTHER HEALTH SYSTEMS

The principle of the Bill is not unheard of, as there are examples from other countries where health services (and sometimes their financing) have been devolved to locally elected bodies (e.g. Sweden and Finland). The following outlines experiences from two cases where local elections to governing health bodies have recently been implemented.

NEW ZEALAND

System

The New Zealand Public Health and Disability Act 2000 created 21 District Health Boards (DHBs) each with 11 Board members, seven of whom are elected every three years under the single transferable vote system. The other four members are appointed by Ministers. Elected members receive remuneration of about NZ\$24,000 per annum for approximately 30 days work.

The elections for DHBs are held at the same time as local government elections and use an 'at-large' structure (i.e. the Board area is not broken down into wards). Initially in 2001, the elections used the first-past-the-post system with smaller electoral wards within the Board area. However this was changed to the 'Single Transferable Vote' and an 'at-large' structure in 2004. Voting is conducted entirely by post, in line with local government elections in New Zealand.

DHBs are accountable first and foremost to central government as opposed to the electorate. DHBs are given a set of objectives by the Ministry of Health and they have autonomy in how they choose to achieve them. However, if a Board or individual member is assessed as not performing satisfactorily, a number of sanctions can be implemented including withdrawal of funding or being sacked.

Turnout and number of candidates

Turnout in the 2001 elections was 50%, falling to 42% by 2004 (Gauld, 2005). However, the 2004 results were undermined by the fact that 15% of the ballot papers were returned either blank or incorrectly filled out (possibly down to the change in the voting system).

The number of candidates per seat in 2001 was 7.4 (1084 for 146 seats) which by 2004 had fallen to 3.5 candidates per seat (518 for 147 posts) and one seat had only one candidate.

Characteristics of candidates

Women were under-represented, in that 55.5% of elected candidates were male in 2001 and by 2004 this had risen to 57.1%. Similarly, Maori candidates were also under-represented despite a rise in the proportion of elected Maori candidates from 2.7% in 2001 to 7.5% in 2004.

In the first round of elections, 37.4% of those elected had a background in the health professions (medicine, nursing, midwifery and pharmacy), 30.6% had worked in business or law and 10.9% had backgrounds in community work and advocacy. In 2004, 11.6% of those elected were employed by the DHBs they were elected to and almost 35% had prior experience in local government.

ENGLISH FOUNDATION TRUSTS

One of the aims of Foundation Trusts in England was to ‘introduce a new form of social ownership, where health services are owned by and accountable to local people rather than central government’ (Healthcare Commission, 2005). As a result, Trusts hold elections for positions on the Board of Governors.

System

Each Foundation Hospital Trust in England must have a Board of Governors which is elected by ‘members’ of the Trust. Membership of the Trust is drawn from the public, patients and staff. Most Trusts require that an individual must opt-in to be a member of the Trust, although in the first wave of elections, one Trust (University Hospital Birmingham) assumed all patients were members unless they opted out.

Turnout and number of candidates

A study by the Nuffield Trust showed that for Trusts with opt-in policies the average turnout at elections was 52%, with individual turnouts ranging from 31% to 77% (Day & Klein, 2005). This compares favourably to the 37% average turnout at local government elections in England.

A review of Foundation Trusts by the Healthcare Commission found that:

“Many of the elections were competitive and there was more than one candidate for 85% of the posts of governor drawn from the public and 73% of the posts drawn from patients.” (Healthcare Commission, 2005)

While the Commission reports this positively, this also means that for 15% of public posts and 27% of patient posts there was only one candidate. In addition, although turnout was generally higher than local government elections, it should be borne in mind that the electorate are those who have opted to be members of the Trust and could therefore be considered as actively interested in healthcare provision. This might suggest that turnout amongst the general population would be lower. In fact, in the one Trust which assumed all patients as Trust members unless they opted out (University Hospital Birmingham) the turnout was 18%.

An article in the British Medical Journal (Klein, 2004), looking at voter turnout in the first wave of elections, claimed that the assumption that local people want to be involved in the running of the NHS was over-optimistic and one of the challenges for Trusts was how to overcome apathy. Day & Klein (2005) report that the total number of patient and public members (in 2005) was 185,038. However, almost 41,000 of these memberships could be accounted for by the opt-out policy of Birmingham University Hospital, with the remainder divided between 19 Trusts. Taking this into account they conclude:

“[T]he figures look considerably less impressive as an indicator of interest and involvement in what is supposed to be a new form of institutional democracy”. (Day & Klein, 2005)

Characteristics of candidates

The Healthcare Commission review (2005) found that there was no evidence of ‘single-issue’ pressure groups being disproportionately represented in the membership of the Trusts.

The Nuffield study (Day & Klein, 2005) examined the known characteristics of the elected patient/public governors and concluded the following:

- Women were underrepresented (45.5%)
- A high proportion of governors representing the public were drawn from the retired population

The study also found insufficient evidence to judge whether political ‘entryism’ was taking place. Governors are expected to declare any ‘political interest’ but there is ambiguity as to how this is being interpreted.

Outcomes

The number of governors on Boards ranged from 18 to 39, with an average of 33. The Healthcare Commission (2005) found that larger groups allowed wider representation of the local community, access to a broader range of skills and experiences, more capacity, and less opportunity for those with single-issue agendas. However, on the downside, large groups could slow the process of decision-making and required more support.

The review (Healthcare Commission, 2005) found no significant differences between foundation trusts and NHS trusts in relation to the experience of patients, the attitude of staff and the provision of care. However, this may change as Foundation Trusts bed in.

The Commission did not reach a definitive judgement on the governance structures of Trusts, stating that:

“It is still early to assess the impact of the major changes in governance, in particular whether there is greater accountability in practice to the local population and what are the costs and benefits.” (Healthcare Commission, 2005)

COST

The Financial Memorandum of the Bill outlines the intention that the cost of elections would be borne by NHS Boards and spread across the four year electoral cycle. Estimates are based on experiences of Stevenage Borough Council, which found that the cost of running a postal ballot works out at £1 per vote cast:

Table 3: Potential Cost of Health Board Elections in Scotland

Turnout	Total Annual Costs	Notional average cost per annum per Health Board	Cost per registered elector per annum
30%	£300,000	£21,000	7.5 pence
40%	£400,000	£29,000	10 pence
50%	£500,000	£36,000	12.5 pence
60%	£600,000	£43,000	15 pence

Source: Health Board Elections (Scotland) Bill Financial Memorandum

The costs outlined in the table are the annual costs that would be expected based on 4 million registered electors and spread across 4 years. Therefore, it does not show the estimated total cost of each election (depending on turnout) which, based on the above estimate, would range from £1.2m (30% turnout) to £2.4m (60% turnout). This equates to 30p – 60p per registered elector and 24 – 48p per person in Scotland.

In addition, the costs are those associated with the election itself and do not take into account additional expenses such as activity to publicise that the elections are taking place.

Also, as the Bill proposes that Board members will not receive any remuneration, a saving may be incurred from the spend on Board remuneration which at present is approximately £1.69m per annum and due for an increase of 1.7% in the coming year (Scottish Executive, 2006c). Excluding remuneration for Board Chairs, who would still remain (£408,000 per annum), there is a potential saving of £1.28m per annum. Some of this will be accounted for by non-executive stakeholder members (e.g. local authority members) but as the Bill does not specify whether such positions will remain on the Board, the exact saving to be made cannot be calculated.

ANNEX 1 – CURRENT NUMBER OF NON-EXECUTIVE MEMBERS AND REMUNERATION

The following table outlines the number of Board members in each and the associated level of remuneration (valid as of 1 April 2005). The levels of remuneration (per annum) apply to non-executive members and Chairs of NHS Boards (Scottish Executive, 2005). It does not include Executive members who are employees of the NHS Boards.

Table 4: Number of Members and remuneration by NHS Board

NHS Board	Number of Executive Members	No. of Non-Executive Lay Members (including Chairs)	No. of Non-Executive Stakeholder Members	Chair's Remuneration	Total Non-Executive Members' Remuneration
Ayrshire & Arran	9	9	6	£27,795	£132,655
Borders	5	7	3	£27,795	£95,205
Dumfries & Galloway	7	6	4	£27,795	£95,205
Fife	7	9	4	£27,795	£117,675
Forth Valley	8	7	6	£27,795	£117,675
Grampian	6	8	7	£29,935	£134,795
Greater Glasgow	9	16	11	£37,420	£232,160
Highland	6	11	5	£27,795	£140,145
Lanarkshire	9	8	4	£29,935	£112,325
Lothian	10	12	8	£37,420	£179,730
Orkney	5	5	3	£25,655	£58,345
Shetland	5	4	5	£25,655	£63,015
Tayside	8	9	7	£29,935	£142,285
Western Isles	6	6	4	£25,655	£67,685
Total	100	117	77	£408,380	£1,280,520
			Total Spend	£1,688,900	

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