What are the challenges to the Big Society in maintaining lay involvement in health improvement, and how can they be met?

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ABSTRACT

The UK Coalition Government’s Big Society policy has highlighted the value of the contribution that local people can make to well-being in their own communities, and plans to increase the contribution of community groups and third sector organizations in delivering services. This paper attempts to unpick some of the challenges to delivering health improvement interventions within the Big Society framework, and offers suggestions to reduce risk and preserve the value of the unique contribution that local people can make. The challenges identified are: supporting and developing skills in social enterprise; demonstrating effectiveness to commissioners; supporting local enterprise while mindful of inequality; guarding against the third sector losing its dynamism; using volunteers to replace or complement existing services. We conclude that the drive to increase community sustainability through the involvement of individuals is laudable, and responds to potential flaws in the welfare state. In order to protect the most vulnerable, and ensure equity, any change will take time and resources. More efficient ways of meeting society’s needs must be sought, but we recommend that a stepwise, supported and appropriately evaluated approach is essential, and equity of provision across communities and organizations must be a primary concern.

Keywords management and policy, public health, services

Introduction

The UK Coalition Government’s Big Society policy has highlighted the value of the contribution that local people can make to well-being in their own communities, and plans to increase the contribution of community groups and third sector organizations in delivering services. Local, non-professional people are already involved in providing health improvement services across the UK, including for example, Health Trainers, breastfeeding support and smoking cessation workers. There are also examples of community programmes that address health outcomes through partnership working and engagement with local people (e.g. New Deal for Communities). This paper attempts to unpick some of the potential challenges faced by the NHS, local organizations and communities in delivering health improvement interventions within the Big Society framework, and offers suggestions to reduce risk and preserve the value of the unique contribution these groups can make.

What is the ‘Big Society’?

The Big Society concept was launched by the Conservative Party in the run-up to the May 2010 general election and then, post-election, taken forward by the Conservative-Liberal Democrat Coalition Government with an agreed policy launched on the 18th of May 2010. This commitment was reinforced by the appointment of Nick Hurd as Minister for Civil Society, and Nat Wei, a social entrepreneur, as a Life Peer and unpaid advisor for the Big Society. In a speech on July 19 2010, David Cameron, the Prime Minister, clarified his government’s vision for the policy, identifying three key actions: social action; public service reform and community
empowerment. He set out the three ways in which these actions will be achieved: decentralization of power; publically available information (e.g. local crime figures) and providing finance to assist smaller organizations with ‘start-up’ capital from a ‘Big Society Bank’. He went on to say ‘You can call it liberalism. You can call it empowerment. You can call it freedom. You can call it responsibility. I call it the Big Society’.7 The wide scope of this statement will undoubtedly have broad appeal. However, challenges may arise in operationalizing the policy in a neo-liberal, capitalist democracy where socio-health inequalities are as bad as ever.6

The full details of the policy are yet to emerge but the principles are relatively clear: the State should pull back, and decision-making and action should occur as close to the people as possible. Communities will be empowered to be more resilient to the effects of the inequality which is inherent in a capitalist society, with the least well-off further assisted by welfare provision. But rather than being provided solely by the State, in the Big Society welfare will also come from community, voluntary and other third-sector organizations (TSOs) underpinned by charitable giving and altruistic volunteering.

The interpretation of the rationale underpinning the Big Society is key to the criticisms that will be made of it: it will appeal to those on the right because it rolls back State interference in daily life (and cuts welfare and other public service costs). Leftist commentators will argue that building community resilience and devolving local services, even if successful, is putting a sticking plaster over the wound caused by macro-structural inequalities in power and resources. It is not the purpose of this paper to rehearse these political arguments. More, the purpose is to anticipate the likely effect on the delivery of public health and health improvement programmes by reflecting on previous experiences of projects using community members and social enterprise (SE).

To this end, Government foresees an increased role played by SEs in providing services, stating: ‘We will support the creation and expansion of mutuals, co-operatives, charities and SEs, and support these groups to have much greater involvement in the running of public services’.4 Furthermore, the possibility of public sector employees setting up independent cooperatives to sell services back to the State is envisaged. Here, for example, the White Paper outlining the proposed restructuring of the NHS describes an aim ‘to create the largest social enterprise sector in the world by… giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprise’7—although it remains to be seen whether there is widespread enthusiasm for this approach among the workforce. It is also likely that there will be a new focus on the contribution that volunteers can make to delivering local services, potentially as an alternative to existing paid workers.

One critical point, which has apparently escaped policy discussion to-date, is the difficulty in defining what, precisely, constitutes a ‘SE’. The Social Enterprise Coalition (SEC) defines SEs as ‘businesses driven by a social or environmental purpose… [which] compete to deliver goods and services… social purpose is at the very heart of what they do, and the profits they make are reinvested towards achieving that purpose’.8 Within this, four main types of organization are identified: (i) community interest companies (CICs), (ii) industrial and provident societies (the common model for mutuals and cooperatives), (iii) companies limited by guarantee or shares and (iv) charities.9 However, in an interview with SE magazine in July this year Andrew Lansley suggested that the SECs definition was inadequate for the Government’s purposes, saying ‘There’s a risk of defining SE so narrowly that others are not included’. He went on to suggest that NHS Foundation Trusts, in their current form of public benefit corporations, could be seen as SEs. This was contested by Peter Holbrook, CEO of the SEC, who said ‘While we want to see social enterprise principles integrated across the private sector and public sector, there is a danger that the fundamentals of social enterprise will get lost or distorted in the process’.10 The critical point is that the Big Society policy appears to bring together under one definition organizations ranging from small local groups running on a shoe-string, to large national charities whose services may look and feel very similar to existing public sector provision. As we will argue further, the need to recognize this heterogeneity of scale must cut across any attempt to assess how the Big Society policy will impact on health and related service delivery.

**Challenge 1: SE in a market environment: supporting and developing skills**

While SEs may be better placed to serve their communities, the Big Society concept recognizes that some groups and organizations will require support to set up, bid for and deliver services.11 This requirement was reinforced by the Prime Minister in his 19 July speech.5 Extra support may be needed due to resource limitations, or difficulties in meeting the legal and governance standards required by public sector commissioners. Some SEs find the administrative demands of public sector provision challenging, and commissioning organizations are increasingly unable to support providers in bidding rounds due to EU regulations.12 To remedy this, the
Big Society will provide ‘Independent “intermediary” bodies which have already demonstrated a track record in identifying, working with, funding and supporting organisations’ to support less experienced social entrepreneurs. However, in the Birmingham area alone, it is estimated that there are around 1300 community interest companies. With such numbers, it is unlikely that intermediary support will be available for all, and the support allocation decision process will need to be transparent and equitable. Some organizations providing the most needed services may also require the most support, while others may not be addressing the most acute community needs and require relatively little: support requirements and population need will have to be balanced. In addition, provision must take account of the fact that some providers are likely to have ongoing support needs in the medium term as services grow and develop. It is also vital that intermediaries are monitored, to ensure that they are building skills and creating sustainable organizations, rather than simple ‘hand-holding’, creating dependency. There are likely to be conflicts of interest between intermediaries and newer organizations, which may be competing to provide services in the same area. In short, intermediary support for SEs has the potential to be very valuable, but its financial costs must be moderated, support must be equitable, and systems must be in place to guard against the creation of a very lucrative ‘social entrepreneurship consultancy’ industry that short changes small organizations.

**Challenge 2: demonstrating effectiveness to commissioners**

A perpetual challenge for policymakers, commissioners, providers and researchers is the measurement of outcome and effectiveness of interventions. SEs are no exception, and will have to demonstrate their value, but they may experience particular problems due to the complexity of the interventions they deliver. Demonstrating the effectiveness of services has become increasingly important as evidence-based practice has embedded itself in NHS culture. The post-credit-crisis austerity faced by the UK public sector has also brought effectiveness into sharp focus. Andrew Lansley, the Health Secretary, speaking at the Faculty of Public Health conference on 7 July 2010 stated that ‘We must only support effective interventions that deliver proven benefits. We must be certain that every penny invested will achieve better health outcomes’. David Cameron also highlighted the importance of monitoring outputs in his July speech: ‘We believe in paying public service providers by results. It encourages value for money and innovation at the same time’. Few would argue against making treatment and funding decisions based on ‘what works’, and many who have worked in the NHS have observed waste in the form of untested, inadequately evaluated activity. However, all interventions are not created equal: some lend themselves to evaluation and measurement far more than others, and community-based health improvement interventions are often complex in nature.

‘Easily evaluated’ interventions tend to be simple, single-step activities with a handful of outcomes of interest which are often measureable in the short- to medium-term, and lend themselves to controlled experiments. Examples include drug treatments, surgical procedures and one-off education sessions. Complex interventions rarely lend themselves to such evaluation and measurement. They involve many steps, require changes in behaviour, have outcomes that emerge months or years post-intervention and are influenced by societal factors that are challenging, if not impossible, to adjust for. For example, a Health Trainer, employed with the primary goals of addressing diet, smoking, exercise and alcohol, may be unsuccessful in assisting a client to lose weight. However, he may start the process of change by helping the client to address his loss of self-esteem resulting from unemployment. Traditional approaches to evaluating interventions do not always capture or value this sort of activity, yet it is widely acknowledged that it is key: the Health Secretary himself has highlighted the importance of self-esteem and empowerment in improving health. It is possible to evaluate complex interventions, but the black-and-white fund-or-not outcomes so often sought by commissioners and practitioners alike are difficult to come by, even with expensive trials and evaluations undertaken by the best academics in the country. It is unlikely that SEs working in the Big Society model will have the time, skills or the funds available to measure systematically the effectiveness of the more complex interventions that they provide. There is a risk that small, vulnerable local organizations may fail if they cannot demonstrate effectiveness in the traditional way. Some organizations may begin to focus on the measureable but less meaningful process outcomes at the expense of valuable health improvement activity. Commissioning organizations will need to work closely with SEs to agree satisfactory, achievable outcome measures for their services, to ensure that potentially valuable interventions are not written off for ‘failing to work’ in an environment where we are ‘all accountable for results, not just processes’. The academic community needs to facilitate this by working with providers to develop pragmatic alternative methods for measuring complex intervention outcomes that value the full range of activity, in addition to traditional health outcomes such as BMI and blood pressure.
Challenge 3: supporting local enterprise while mindful of inequality

‘Big Society-ready’ SEs are unlikely to be evenly distributed across communities, nor are community volunteers with the capacity to work with them. SE is notoriously difficult to measure, and at present the distribution according to deprivation is not known (H. Buckingham, personal communication). The distribution of interventions will need to be monitored across the country to ensure that health and social inequalities are not widened as a result of failures to develop Big Society interventions in the most disadvantaged areas, or by certain groups in society being underrepresented in community enterprise, and thus having little voice. The inequality in community participation was illustrated by the recent Pathways Through Participation literature review undertaken on behalf of the NCVO/IVR. It concluded that those who participate in local decision-making ‘generally are more likely to be white, older, better educated, richer, middle-class males’ while volunteers were typically ‘women, of higher social grades, in managerial positions, degree educated, and middle aged’. Participation is easier for middle-class communities because they tend to have more control over their ‘discretionary time’. Availability of time is a key factor in individuals’ decisions to cease volunteering.

The Big Society aims to address potential inequalities in provision by encouraging established SEs to develop services in areas that are underserved. If the aim is to build capacity in these communities, it must be recognized that sustainability and self-sufficiency are essential in any services developed. In addition, it is likely that significant groundwork will need to be undertaken to engage with these communities and to build trust and engender participation. Such groundwork is costly both in time and in resource, and these pressures may lead to larger organizations ‘parachuting in’ successful interventions from elsewhere without additional work to support the community or to adapt interventions to meet local needs.

Challenge 4: guarding against SE losing its dynamism

The flexibility, responsiveness and diversity of community and SE activities are often what make them attractive to Government as options for addressing some of the more complex problems in society. These organizations are less constrained by corporate structures and regulations, and are able to do ‘what feels right’, and to innovate, and Andrew Lansley has reiterated the Government’s commitment to using ‘local voluntary and charitable organisations more . . . encouraging innovation’. However, for every case study of an exemplar SE that has delivered great things, there will be others that did not meet their objectives. In some cases this is because the organization was not up to the task, but in other cases the gamble of innovation simply did not pay off this time. Funders of ‘Big Society’ activities must find a way to foster innovation and mitigate the risk to SEs when a new, plausible idea does not work as planned. Otherwise, in order to survive, SEs may increasingly stick to well-trodden paths and shy away from the increased risk associated with innovation.

There are also bureaucratic challenges: if SEs are required to devote capacity to adopting the complex commissioning, contracting, accounting and employment procedures of the public sector rather than the traditionally ‘lighter touch’ approach of the Third Sector, costs may rise and capacity may fall. Commissioners must recognize this, and consider developing more streamlined processes to reduce the burden of bureaucracy, alongside the provision of support from ‘intermediaries’. It may be that certain areas of work are not considered suitable for SE provision, either because they are high risk (e.g. child protection), or because the burden of contract management would be too great (in highly complex activities). Alternatively, smaller local SEs may be taken over by large SEs which have the requisite infrastructure and governance arrangements to support complex or high-risk work. This poses a potential threat to the localization and dynamism of the Big Society agenda as small reactive SEs may be increasingly subsumed into larger monoliths.

A further element of Third Sector and SE work which differentiates it from public sector provision is SE independence from the State. This means that organizations reach individuals who might not ordinarily engage with statutory services. Many local SEs have a strong identity, and act as passionate advocates for their community, trusted by local residents and able to speak out against social injustices. They must be able to maintain this, even when increasingly delivering services on behalf of the State.

Challenge 5: the use of volunteers—to replace, or to complement existing services?

The key tenet of the Big Society policy is to get communities working for themselves, rather than dependent upon the State for services: it is not explicitly about cost-cutting. The Government Big Society rhetoric has not stated a desire to cut costs, although the pre-election Conservative
Party policy document describing the concept describes the poor spending of money invested in the Third Sector by Labour. Reducing spending is likely to be at least a secondary aim in light of the large cuts to public sector funding in the coming years.

The media debate around the Big Society has documented fears about the replacement of existing public services with volunteers in order to reduce costs and reduce the size of the state. Prominent child experts Camilla Batmanghelidjh and Tanya Byron have suggested that voluntary workers should be used to complement, rather than provide, essential statutory services, particularly for the most vulnerable, where trained professional support and continuity of care are vital. Relatively high turnover, and the related recruitment and training requirements, are an accepted part of volunteer work. Although volunteers do not have salaries to be paid, there can be significant support costs and difficulties providing continuity of service. The ability to recruit sufficient willing volunteers with the right skills, in the right place, at the right time, may also vary, particularly to work with ‘less desirable’ client groups and localities. Of course, many SEs are experienced in working with a volunteer workforce, and understand and respond to these challenges—but the Government, and commissioning organizations must appreciate them too. Volunteers carry huge advantages in terms of their altruistic intentions, commitment to the community, local knowledge and flexibility. However, it would be rash to suppose volunteer service provision always to be a cheaper, easier or more sustainable replacement for State services.

Further consideration must also be given to staff currently paid to deliver health improvement services, who may struggle to find alternative employment if services are decommissioned. This is particularly true in areas of high unemployment, and for workers at the entry level of NHS pay-scales. Health Trainers are a particular example, where local people from disadvantaged neighbourhoods are recruited to work with community members to address unhealthy lifestyles. Becoming a Health Trainer provides local people with employment, training and the opportunity to move on to other, higher paid roles. This ‘skills escalation’ is of high value to the individual, and also to the worker’s family and wider community. In a Big Society model, would this kind of work be expected to be provided for free by volunteers? In an area of high unemployment, there is often a dearth of entry-level jobs with the opportunity for career progression. Removing some of the few posts that exist is unlikely to contribute to the community’s self-sufficiency and sustainability. Volunteering is valuable, but most individuals would see it as an adjunct, not an alternative to paid work, except where income from other sources is at such a level that paid work is not necessary. Any move to increase levels of willing volunteers active in their communities must be welcomed, but not at the expense of paid work for local people, and particularly not low-cost entry-level jobs in areas experiencing the highest levels of disadvantage.

Conclusions

The drive to increase community self-reliance and sustainability through the involvement of individuals is laudable. It responds to potential flaws in the welfare state, first voiced back in 1948 by Sir William Beveridge when he expressed concerns about a lack of ‘room, opportunity and encouragement for voluntary action in seeking new ways of social advance…services of a kind which often money cannot buy’. There is undoubtedly scope for increased involvement of local people in the well-being of their community, including in the delivery of health improvement services. However, in order to protect the most vulnerable, and ensure equity, there will always be a role for the State in providing some services. We must also guard against a sudden shift from Big State to Big Society: any change will take time and resources.

Given present economic circumstances, there is no question that more efficient ways of meeting society’s needs must be sought. However, in the face of a yet-untested model of support for citizens, a stepwise, supported and appropriately evaluated approach is essential. Such an evaluation needs to recognize that the larger SEs will be more able to satisfy conditions of the market, monitoring and evaluation and that this might favour them over smaller local SEs, in turn threatening the localism and dynamism that are stated aims of the Big Society policy. Moreover, the context within which the Big Society policy is rolled out needs careful consideration, specifically the resource and capacity implications of the Government’s Comprehensive Spending Review (CSR) of 20 October 2010. The CSR recommended substantial cuts to budgets across national and local government—a key source of income for Big Society providers. Concerns have been raised by voluntary and community sector leaders about the combined impact on capacity of spending cuts, declining donations and VAT increases. This is against a background of potential increased demand for services resulting from cuts to existing state provision. Overall, invigorating the community sector through SE and related activities is likely to be a real challenge in a climate of deep cuts.
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References

14 Lansley A. A new approach to public health. UK Faculty of Public Health Conference, 7 July 2010.