Bringing senior clinicians into the heart of policy making learning from experience

A working paper by Liz Carolan and Michael Macdonnell

What this paper addresses:

- In the past three decades, there has been a significant increase in the formal involvement of practicing clinicians at the most senior levels of government health policy making, and current proposals present an opportune juncture to reflect upon these experiences, to distil learning which may contribute to future opportunities being utilised effectively.
- In light of this, we set out to analyse the institutional roles that clinicians have filled in national policy making over the last dozen years or so; to summarise what has been learned about the efficacy of these different roles. Taking the lessons from these experiences, we outline a number of ‘conditions of success’ which we suggest should be considered when further appointments are being made.

Provisional recommendations:

- Decisions on new clinician appointment should be based upon an assessment of the needs of the task at hand; the required levels of authority, impartiality, accountability and ability to advocate should be carefully assessed and matched to the most suitable role.
- However, evidence from previous experience, outlined in this paper, point us to suggest a number of potential ‘conditions of success’ which could be considered when any new appointment is being made, regardless of the role.
  - Appointees should be seen as advocates as well as experts.
  - They benefit from enjoying clear and consistent political support;
  - As well as a discrete remit and autonomy
  - They should have appropriate skills and competencies for policy making, over and above expertise.
  - They require adequate civil service support.
  - Flexibility should be considered for clinicians who continue practising medicine.

This short working paper is a joint endeavour by the Institute for Government and Imperial College London’s Centre for Health Policy, building on the work and research of both institutes. More information about the work of these can be found at www.instituteforgovernment.org.uk and www3.imperial.ac.uk/globalhealthpolicy

The authors may be contacted on liz.carolan@instituteforgovernment.org.uk and m.macdonnell@imperial.ac.uk
In the past three decades, there has been a significant increase in the formal involvement of practising clinicians at the most senior levels of government health policy making, with the appointments of a Medical Director for the NHS, over twenty Clinical Directors and the first health minister with an active medical career. Current proposals which aim to fundamentally redesign the architecture of health policy making may increase opportunities for this involvement even further through, for example, the proposed National Commissioning Board. These proposals present an opportune juncture to reflect upon the experience of these previous appointments and to distil learning which may contribute to future opportunities being utilised effectively.

In light of this, we have set out to analyse the institutional roles that clinicians have filled in national policy making over the last dozen years or so. From our discussions with those formerly and currently involved at the senior levels of policy-making, we summarise what has been learned about the efficacy of these different roles. Taking the lessons from these experiences, we outline a number of ‘conditions of success’ which our research suggests should be considered when any further appointments are being made.

This short working paper is a joint endeavour by the Institute for Government and Imperial College London’s Centre for Health Policy, building on the work and research of both institutes. The authors would like to thank those who gave freely of their time to share their experience and analysis with us in preparation of this report, including those who attended our initial findings seminar in April 2011.
Learning from experience

Under the previous Labour government, clinicians were offered opportunities to influence policy in a variety of formal and informal ways. For the purposes of this discussion we focus on different types of formal or institutional roles; defined government offices or positions with a bearing on national policy making. This is not to deny the importance of informal sources of influence which in some cases may be at least as important as those in government roles.

We have identified five broad types of policy-making roles which have been filled by clinicians in recent years - ministerial appointments, the professional offices, national clinical directors, and positions with arms length bodies and reviews and commissions. The following analysis is based upon the findings of a mixture of desk based research and interviews with current and past holders of these posts, including some political figures who worked with them. Our initial findings were put to a group of those formerly and currently involved at the senior levels of policy-making, who helped to distil lessons.

We began by examining if there was one particular role currently available which could be considered the ideal model for appointing clinicians to senior policy making positions. Those we interviewed were quick to point out that each type of role had institutional strengths and weaknesses in terms of the requirements of a policy maker - namely the relative levels of authority, accountability, impartiality, and the ability to advocate for change (summarised in Figure 1). What became clear is that the crucial factor is ensuring that the requirements of the particular task for which the clinician has been recruited are assessed and that the appointment is made to the most appropriate role available.

<table>
<thead>
<tr>
<th>Type of institutional Role</th>
<th>Executive Authority</th>
<th>Accountability</th>
<th>Perceived Impartiality</th>
<th>Ability to Advocate Systemic Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministerial appointment</td>
<td>• Political confidence • Powers to direct civil service</td>
<td>• Lords appointments raise conditional issues</td>
<td>• Board by collective responsibility</td>
<td>• Full freedoms to advocate publicly</td>
</tr>
<tr>
<td>The Professional Offices</td>
<td>• Civil service support • Political confidence</td>
<td>• Clear reporting structure</td>
<td>• Limited by DH role • Declines over long tenure</td>
<td>• Tended to be issue specific</td>
</tr>
<tr>
<td>National Clinical Directors</td>
<td>• Civil service support • Differs by CD</td>
<td>• Differs by CD</td>
<td>• Limited by DH role • Declines over long tenure</td>
<td>• Issue specific • Varying advocacy skills</td>
</tr>
<tr>
<td>Arms-length bodies</td>
<td>• Few formal levels • Often rely on others' authority</td>
<td>• Usually fine with some exceptions</td>
<td>• High perceptions of impartiality on specific issues</td>
<td>• Limited although NICE may be an exception • Highly variable • Tendency to be issue specific</td>
</tr>
<tr>
<td>Advisory bodies, reviews &amp; commissions</td>
<td>• Limited to advice</td>
<td>• Few problems arise</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1: The different types of institutional role and their relative strengths and weaknesses under headings identified through our interviews
Further examination of the impact of these relative strengths and weaknesses, and of the experience of individuals who have taken up these roles, revealed some lessons which appear to be applicable across appointments. We pull these together towards the end of this section, which form the basis of a set of ‘condition of success’ we recommend for future appointments in the final part of this paper.

**Ministerial appointments**

Ministers can enjoy unparalleled executive authority and are able to advocate their policies with few restrictions. This is in part as they are able to direct and draw on the civil service, but at the same time it crucially depends upon them enjoying the confidence of the political leaders that have selected them, including the secretary of state and potentially the Prime Minister. This executive authority was a key consideration for Lord Darzi who saw the authority to oversee the early phases of implementation as critical to the success of his Next Stage Review.

However practicing doctors and nurses have only very rarely been appointed as ministers.\(^1\) This is largely because, in the Westminster constitutional system, most ministers are traditionally drawn from the Commons to preserve accountability to the elected chamber, to maintain a constituency link and for reasons of political patronage. While ministers have always been appointed from the House of Lords, the practice of appointing non party affiliated persons with outside experience or expertise to the upper house in order to be made ministers only became widespread in Gordon Brown’s first Cabinet (the so-called ‘government of all the talents’ or GOATs).\(^2\) As they are not formally accountable to the Commons, Ministers appointed in this way have raised some accountability issues, although this is primarily a concern for secretary of state appointments.

However this is not the only reason. An additional key disadvantage to Ministerial appointments is the perceived loss of impartiality through being bound by collective responsibility. Impartiality can be important for formulating contentious policies from which governments wish to appear removed, and which are often deliberately put at arm’s length from government (for example, rationing decisions taken by the National Institute for Health and Clinical Excellence). Policy-making in government is inherently political and those who see themselves as experts or technocrats may find those compromises uncomfortable. Ministers are also ordinarily required to carry out a vast and varied range of functions\(^3\), and it is worth noting that Lord Darzi’s appointment was exceptional in the understanding that he could concentrate on completing the specific task he was recruited to carry out.

Other counties appear much more experienced at appointing senior clinicians to ministerial roles than the UK. France and Brazil are very rarely without a minister with serious medical credentials, and both the Netherlands and Germany have over the last eleven years had clinician ministers about one quarter of the time (see Figure 2). The principal difference is the political system - other Westminster states such as Canada and Australia show similarly low levels of ‘expert’ ministers.\(^4\)

Non-Westminster systems offer routes into senior political decision-making not available in the UK. In France, Brazil, Germany and the Netherlands, ministers can and regularly are drawn directly from outside parliament. This, however, does not lead to political outsiders being appointed ministers, rather, it facilitates the appointment of ‘hybrid’ ministers who have developed both
technocratic and political skills. All of the 'expert' health ministers identified across these four states fall into this hybrid category, and have tended to be senior clinicians who have developed political skills as leaders in the party or by holding regional positions. Vitally, they have been able to have these political lives while still building their medical careers, as they are free of the requirement to become involved directly in representative politics.

Figure 2: Comparative number of months with a clinician as minister 2000-2010

Of these four countries, the two countries with the highest levels of expert ministers were both presidential systems: France and Brazil. Presidential systems give the head of state power and freedom in the selection of ministers typically unmatched by Prime Ministers in parliamentary democracies. The fact that the relatively unconstrained French and Brazilian presidents have appointed health ministers with a clinical background much more frequently than is seen in the Netherlands and Germany may lead us to conclude that when given the choice, a 'hybrid' expert health minister is a preferable option.

The Professional Offices

Of the professional offices, which include the Medical Director (MD) and the Chief Nursing Officer, the Chief Medical Officer (CMO) is the oldest, dating from Victorian times, and was traditionally the principal way in which governments drew on medical expertise. More recently, the CMO’s responsibilities have increasingly centred on public health. For this reason, a Medical Director was appointed in 2007 to focus on the NHS’s “illness service”. Lodged as they are in the civil service structure, these roles have significant executive authority, yet unlike conventional civil service roles, appointees retain the freedom to advocate change.

Their power of advocacy has at times been augmented by the perception that they are able to remain slightly aloof from the government of the day and therefore have greater impartiality. The arguments put forward by Sir Liam Donaldson for a full smoking ban—which trumped the initial caution of his political masters—is a case in point.

Nevertheless, the perception amongst those we interviewed is that when it comes to systemic reforms, the professional offices have had limited influence. This seems to be for two reasons. First, because they are typically appointed to long terms of office which can span multiple ministerial tenures, their influence over individual secretaries of state is variable. This level of political
confidence, typically highest in those individuals a Secretary of State has had a hand in appointing, is closely related to the policy influence the professional offices have enjoyed. Second, they tend to have issue specific influence. The strong position of Sir Liam on the smoking ban, for instance, derived from the CMO’s acknowledged authority on public health matters. It will be interesting to see how the role of the MD develops under the Coalition government: arguably this position is more central to systemic reforms that it has been in the past.

National Clinical Directors (CDs)
The first National Clinical Director, Professor Sir Mike Richards was appointed in 1999 with the remit to improve cancer services in the UK. The subsequent NHS Cancer Plan, published in 2000, still serves as an exemplary model of national policy making with systemic implications led by a senior clinician. In many respects, Professor Richards’ position was similar to a ministerial appointment: he had strong backing from the Secretary of State, to whom he effectively reported, high levels of executive authority (including ring-fenced resources) and the ability to act as a forceful advocate for policy reforms.

However, the impact of subsequent CDs has been diluted. There are now over twenty, which is regarded by those we interviewed as too many. There is also a perception that CDs have at times been appointed reactively, rather than strategically or following a sober assessment of the nation’s health needs. The level of influence exercised by each is highly variable, and not only because of inevitable personality differences. Also important is the public profile of the clinical area - many simply cannot compete with the high political salience of cancer for instance - and the varying degree to which CDs have been given control over civil service support and, crucially, budgets.

Arms-Length Bodies
Several non-departmental public bodies provide clinical input into national policy-making. Perhaps most important is the National Institute for Health and Clinical Excellence (NICE) which judges the effectiveness of new medical technologies, therapies and other interventions as well as developing quality standards. Other important arms-length bodies led by clinical experts and responsible for aspects of national policy have included the Health Protection Agency (HPA) and the National Patient Safety Agency.

Although these bodies speak with great authority on their specific issues or areas of policy - partly because of their distance from Ministers - they are generally not advocates of systemic change as they exist primarily to provide technical expertise. Current proposals also appear set to diminish this authority, with, for example the HPA function transferred to a new executive agency, Public Health England.

Ad hoc advisory bodies, reviews and commissions.
Finally, a range of advisory and review bodies have been set up on an ad hoc basis to provide clinical advice on specific areas of policy. Typically these are asked to review a specific aspect of the health system, although sometimes standing bodies have been appointed on a semi-formal basis to advise the Secretary of State. Public inquiries with senior clinical membership may also have ramifications for national policy.
These bodies have the benefit of providing specific clinical expertise on a temporary basis. The impartiality of their findings can often be a powerful driver of change. But the trade-off is that they remain 'outside' advisors whose advice can be ignored or substantially reshaped by the real decision-makers.

**Conclusions: lessons from previous experience**

An important point to emerge early in our research was that no one role could fit all circumstances; there appears to be a set of tradeoffs between the different requirements of policy makers, including authority, accountability, impartiality and ability to advocate. Having said this, the analysis above points to a number of overarching lessons from the experiences of senior clinicians across the range of roles. The most striking of these is the function of clinician appointments as government policy advocates.

The singular advantage clinicians can bring is their professional credibility and their ability to lead and publically advocate for policy change- this is often more important than technical expertise. The benefit clinicians bring in medical expertise for designing discrete policy with a significant technical dimension is obvious, so too non-medical expertise, in particular knowledge of the culture of the NHS and an understanding of how to achieve change. However many of those we interviewed stressed that expertise alone is seldom enough. Good policy making is about being able to blend the technocratic and the political, and involvement in policy making requires a strong understanding of skills in this other dimension.

Sometimes this has meant advocating for change in the media and publically; for example, the Chief Medical Officer’s role in successfully arguing for the smoking ban. In other cases, persuading one’s peers and other NHS staff of the need for change has been the focus; for example the development of the NHS Cancer Plan and Lord Darzi’s Next Stage Review.

Additional lessons emerge when the above cases are analysed through this lens. Having a defined and specific objective emerges as important for maximising the effectiveness of clinicians in this advocacy function. It also appears to be vital that the clinician in question has adequate support- their authority is in the main dependent on political support, regardless of role. Other supports, in terms of access to budgets and civil servants, appear to be an important factor, as seen with some of the later Clinical Director appointments.

A final point which emerges most starkly through a glance at international cases is the importance of career paths into senior clinical roles. This means ensuring that there is a sufficient pool of clinicians who have political skills and competencies from which appointees may be drawn, and that the medical professions allow for flexibility for individuals with an interest to take up temporary roles.
Considerations: conditions of success

Any decision on a new clinician appointment should be based upon an assessment of the needs of the task at hand. The required levels of authority, impartiality, accountability and ability to advocate should be carefully assessed and matched to the most suitable role. However, evidence from previous experience, outlined above, point us to recommend a number of potential 'conditions of success' which should be considered when any new appointment is being made, regardless of the role.

- **Advocates as well as experts.** As stressed above, acting as an advocate for change has been a critical aspect of successful clinical involvement in senior policy-making - and more important than the simple provision of technical expertise. Individuals perceived as rising above the sometimes 'tribal' nature of the profession have been most credible when it comes to fulfilling this advocacy function within the NHS system.

- **Clear and consistent political support.** Clinicians derive their authority in the main via the confidence they enjoy of the political leaders in the Department and the centre of government. One of the key advantages enjoyed by Ara Darzi in his role as health minister was the explicit political confidence of both the health secretary and the Prime Minister of the day. This has equally been the case with the more successful National Clinical Directors, and to an extent with the CMO.

- **Discrete remit and autonomy.** Several of those we spoke to noted that clinicians appointed to senior policy roles need a clearly delineated remit within which they can operate with considerable autonomy. Again, Ara Darzi’s experience is a case in point: appointed to lead a review of the next stage of NHS reforms, he was given wide freedoms to conduct the work and produce recommendations. Clear remits and acknowledged autonomy have also been a feature of successful clinician-led policy in other countries including Mexico, China and, most recently, Norway.

- **Appropriate skills and competencies.** Experience shows that seniority or technical skills are insufficient for successful policy making—a discipline which requires strategic as well political skills. Any individual being approached to take up a policy making role should possess these skills, which can include leadership and judgment, the ability to build constructive relationships, an understanding of political processes and a willingness to listen.

- **Adequate support.** Some clinical policy makers have been provided with insufficient support from the civil service and/or have had no budget at their disposal. Others have actively sought to ignore the civil service. This has tended to prove crippling for clinical policy makers who require not only assistance but also a place in the structure of authority.

- **Flexibility for practising clinicians.** To retain their skills and authority, clinicians need to remain connected with the medical community. Some may continue to practise or feel the need to return to clinical work after a fixed time in government. This requires flexibility in contractual and other working arrangements. It may also mean that certain duties should be
relaxed; the group discussed, for instance, the understanding that Ara Darzi would not perform the full range of parliamentary duties.

These conditions do not pretend to offer a comprehensive framework, but rather aim to provide a set of considerations when making appointments. At a time when the architecture of health policy is being fundamentally overhauled, it is important to consider the lessons from previous experience, and to ensure that we put in place conditions which will allow clinicians to continue to contribute through their expertise and advocacy capabilities.
End notes

1 Lord Owen, a former doctor, was appointed as Parliamentary Under-Secretary for Health and then Minister of State for Health in 1974. Former nurses have also been appointed to the Ministerial team including Ann Keen in 2007 and, currently, Anne Milton. Lord Darzi was the first and only practicing doctor to be appointed as Minister.

2 See Ben Yong and Robert Hazell, Putting GOATs amongst the wolves: Appointing Ministers from Outside Parliament, Constitution Unit, January 2011

3 See Peter Riddell, Zoe Gruhn and Liz Carolan The challenge of being a minister: defining and developing ministerial effectiveness, Institute for Government, May 2011

4 In the 11 years 20 December 2010, Canada has not had a senior clinician as junior or senior minister, while just one of Australia’s ministers, an MP and Liberal Party deputy leader, had a medical background.

5 See Yong and Hazell, Putting Goats Amongst the Wolves

6 For ease we have grouped these two roles together although we recognise they have substantially different remits.

7 The newest CMO, Dame Sally Davis, has also taken on responsibility for health research and acts as the Chief Scientific Advisor for the Department of Health.


9 For instance, the MD has responsibility for the development of the NHS Outcomes Framework recently announced by the Secretary of State, Andrew Lansley—a key tenet of the Coalition’s reform plans.

10 It was a matter of some contention amongst those we interviewed whether the Royal Colleges have a national policy. We conclude that although they certainly have influence, they have no formal institutional role; indeed, they are probably best thought of as trade groups.

11 For instance, under Patricia Hewitt.

12 For example, the Bristol Royal Infirmary Inquiry had very powerful implications for national policy.

13 Although it was broadly acknowledged that non-clinicians could just as easily possess this type of expertise