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Community governance or corporate governance? Two models for primary care provision in England

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Abstract

This article discusses two models of primary care provision in England: a now-dominant corporate-led approach, and a voluntary-led approach. Recent case study data are used to identify the differing implications of these contrasting ways of organising care. The two approaches are examined with reference to claims that neoliberal welfare is characterised by a parallel shift from 'passive' to 'active' welfare, or from the citizen as recipient to the citizen as participant. In this analysis, the individualised, privatised self is encouraged by – and supports – a privatised welfare regime.

By contrast, this paper finds that the increasingly hegemonic corporate-led model of welfare can actually inhibit the development of service users into active citizens. Instead, a voluntary-led model may be more flexible and more likely to promote welfare systems with citizen participation. However, the corporate-led model is increasingly favoured by the UK government, which is keen to include such firms in service planning as well as service provision. This creates a disjuncture between economics and governance that causes rhetorical and practical problems for neoliberal welfare regimes.

Key words

governance, neoliberalism, primary health care

1. Introduction

This paper examines contemporary modalities of governance through a comparison of "healthy living centre" and "one-stop shop" models of primary health care provision. I argue that the growing dominance of the latter represents a key contradiction between policy discourse and policy practice, and that this is linked to the corporate transformation of welfare. This theme is explored by contrasting primary care provided through corporate-led (NHS Local Improvement Finance Trust) and voluntary-led (Healthy Living Centre) programmes.

In particular, I focus on whether the programmes encourage the governance identified by many as characteristic of "advanced liberalism" (Rose 1996). In "post-disciplinary societies", Rose argues, the locus of control shifts: citizens *control themselves* through internalised ethical codes, often involving "health".

> [T]he active and responsible citizen must engage in a constant monitoring of health, a constant work of modulation, adjustment, improvement in response to the changing requirements of the practices of his or her mode of everyday life.
>
> (Rose 2004:28)

But which organisational arrangements facilitate this individualised governance through health, and what are the specific effects of recent government policies?

2. The data

Middletown Healthy Living Centre

Data used here are chiefly drawn from research into primary care re-organisation in "Middletown", with supporting material from three comparator areas and national data. I conducted thirty interviews and observed a similar number of meetings and seminars.

Served by three (pre-reconfiguration) primary care trusts, Middletown is a deprived urban area with considerable ethnic and cultural diversity. Local health services have long been underfunded, yet there are some innovative projects including a Healthy Living Centre that promotes "social entrepreneurship", using art and business to enrol residents in health programmes.

HLCs were introduced by the UK government in 1999 and are intended to move beyond a "sickness service" to offer broadly health-related activities. This could be read as evidence that postmodern capitalism has produced a turn from reactive care towards health promotion; individuals take responsibility for regulating their own health, rather than waiting for the state to intervene when they become sick (Bunton, Nettleton, and Burrows, 1995).

Middletown HLC became an early model for the NHS LIFT initiative, nationally and locally. Many interviewees involved in LIFT reacted positively, some negatively: but all acknowledged its importance.

> Everyone talks about it! And I get a bit bored with it, to be frank with you!
>
> (Director, Middletown LIFTCo board)

LIFT in Middletown

NHS LIFT is a series of "public-private partnerships" for primary care premises (there are 51 in England), based on the now hegemonic PFI model. Each area creates a majority corporate owned LIFT company (LIFTCo), with exclusive rights to develop any primary care premises in its area during a twenty-year "partnering agreement". A LIFTCo builds, designs, and owns primary care centres, renting them back to local NHS organisations, other care providers (such as dentists), and "retail units" (such as cafés). It runs some support services, such as buildings maintenance. LIFT structures are highly complex and relatively expensive, with long contracts and bureaucratic structures. They are intended to ensure the inclusion of large private firms in primary care planning (UNISON, 2006).

LIFT marks a shift away from traditional methods of providing primary health care premises in the UK. For the past six decades, these have mostly been owned by individual GP practices or the NHS itself, with some provision by specialist landlords. The HLC programme saw a patchwork of ownership, some centres using existing NHS buildings. By contrast LIFT creates local, private monopolies that will come to own the majority of primary health care buildings in their area, with the option of selling shares on the "secondary market" after buildings have been constructed. Local NHS and other organisations pay rent to use LIFT centres; for NHS organisations this is for twenty-five years.

During the case study research, Middletown's first LIFT building became operational. This paper compares its services with those provided within Middletown HLC. As I discuss elsewhere, discourses supporting both centres often refer to entrepreneurial virtues allegedly absent from mainstream public sector provision (Anonymised, forthcoming). These virtues tend to include flexibility and an ability to enrol service users as active rather than passive citizens. So how does this play out in practice in different organisational structures? Are wider trends encouraged by these different methods of primary care provision?

3. The national healthy living centres programme

The national HLC programme is based around a philosophy of community engagement and participation in health; broadly conceived, in accordance with the WHO definition:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
>
> (World Health Organization, 1948)

The programme started in 1999 when 257 HLCs were set up with Lottery funding. According to the Department of Health (1999), HLCs should mobilise community activity to improve health and reduce inequalities; bring disparate interests together for health promotion in its widest sense; and improve mainstream services, or provide an alternative, for currently excluded groups. A Devon HLC's website provides a GP perspective on the programme:

> I firmly believe in using a self-determined programme of stimulating creative, leisure and social activities and learning opportunities as a vehicle for rekindling a person's love of life and rebuilding community spirit.
>
> (Twomey, 2002)

HLC discourse redefines 'patients' as individuals acting within 'communities': in the DH (1999) letter, 'community' or 'communities' are mentioned 23 times, with no mention of patients. Even the GP's text only mentions 'patients' twice against 5 mentions of 'community' and 7 of 'communities'. These and other HLC documents (discussed in Anonymised, 2006) support the idea of a shift away from the concept of health as absence of illness, towards "complete physical, mental and social well-being".

This seems empowering: the passive connotations of 'patient' are well recognised, as are the constraints of the 'sick role' (Lorber and Moore, 2002). But could targeting better health through individual and community action lead to the creation of failed health consumers (c.f. Bauman, 1998) or even whole communities being labelled as problematic, if they reject the healthy living approach? This is certainly not the aim of many involved with the programme, yet they operate within difficult environments.

The politics of Healthy Living

Like much official discourse around health, the HLC approach is contradictory and can be read positively or negatively. It resonates with Foucauldian analyses that characterise contemporary health discourses as promoting self-surveillance by individuals and communities, enabling the exercise of bio-power through bodily management routines and the imperative to maintain wellness (Petersen, 1997). The Devon GP's description of HLCs evokes the active individual determining a range of opportunities for herself, creating herself through healthy discourses and practices (Novas and Rose, 2000). Enthusiasts marry service user empowerment with community self-determination. Tom Heller, a senior lecturer and GP who helped to set up a Sheffield HLC argues (undated):

> Power has to be redistributed in order for these centres to work. Local people will have to have the ability to run the activities that they want. This will almost certainly be different in different

localities and be dependent on the needs, cultures and preferences of the local community. Decisions of this sort are too important to be left to the usual decision-makers. Currently, it tends to be the local health service managers and doctors who have the power to set up services, and this ethos simply does not work.

Community engagement here becomes not just politically attractive, but a guarantor of success. In the age of evidence-based policy, this is seductive, but there is a catch. Heller also wants to promote "political activity to try to counteract the things that are making their population unhealthy", yet *this* goal is clearly separate from that of enabling local people to organise "music activities, health walks, dancing sessions". The politics of challenging power is not connected to the politics of user involvement in service delivery. While community self-determination has long been a goal of progressive politics (e.g. Gorz, 1999), this discourse has been subtly shifting as it becomes institutionalised under a neo-liberal welfare regime. While many aspects of the HLC programme can be seen as positive, it is important to recognise limits and constraints.

HLCs are not fully determined by hegemonic discourses, and like health promotion discourses themselves can develop differently depending on local circumstances. They may embody contradictory themes: the “entrepreneurial self” may be at odds with the idea of collective empowerment through shared art-work and other creative pursuits (Froggett and Chamberlayne, 2004). Service users do not necessarily see centres in the same way as do policy-makers and staff. Nevertheless, HLCs now face pressing financial constraints as the programme’s Lottery funding has expired.

4. Middletown healthy living centre

The local HLC includes a medium-sized GP surgery, but foregrounds community and social enterprise aspects of its practice. Like local LIFT buildings, it is an NHS facility, but its genesis and management differ significantly. Its non-LIFT structure is less formal and bureaucratised; it is locally owned by the church thus does not have to satisfy shareholders. Relatively generously funded through grants and other sources, it runs consultancy services, including regular tours. I took a tour with two GPs from another LIFT area ('Said' and 'Hilary'); modernisers, critical of 'traditional' GPs and NHS structures alike. According 'Dave', our guide, most participants currently come from LIFT areas around the country to learn how to apply the model to their local LIFTs.

The HLC has a powerful local creation myth, embedded in its nineteenth century church building. Dave told us that in the 1980s, it was "another dying church with eight or ten pensioners attending". The church was saved by a "trendy young vicar" who opened up the space to the wider community, including other faith groups. He has a legendary reputation in the centre, representing its heroic early period: charismatic, unconventional and innovative (virtues to which the private sector is generally connected in pro-LIFT discourse).

The HLC prides itself on creating win-win solutions, building on underused capacities and informal exchanges. Local artists enjoy free studio space in exchange for running community art classes; local parents run a community nursery. Although the local NHS funds many activities, the HLC uses its *distance* from traditional NHS services as a selling point for consultancy services. Dave described it as a break with local NHS provision, emphasising the building's openness and tactful security; "a fifteen foot fence that doesn't look like a fence" and shutters that disappear into window frames.

Active patients, social boundaries

Part of the Centre's philosophy is to "turn clients into helpers". A gardening group brings together people with physical disabilities and "young mums stuck at home". "Instead of two client groups, we have two helper groups". Dave celebrated volunteers' bottom-up learning, comparing it with professional protectionism. He said: "It's about control – the council and the NHS were worried about the potential for a bunch of amateurs to muck it up."

Art is seen as a way of enrolling people in the HLC's philosophy and programmes. Its buildings are full of health-related artwork, some created by a walking group led by a receptionist. Local students have helped organised picnics to "get the health message across". Art by the Asthma Club, twenty children with previously poor self-management, depicted causes of asthma including cigarettes, pets, and dust mites.

Dave said: "We pick a target group, choose a subject, and get them making art around the subject." A portrait artist paints children as they wait for vaccinations. Dave commented: "A little trick like that can keep immunisation rates higher." Sewing groups are used to encourage Bengali women to try other activities. Said commented wryly: "Interviews for the partners and doctors must be interesting." By contrast, 'Alexa', a GP, stressed the practice's ordinariness (the surgery is run as a traditional partnership): "We are a normal GP surgery. We want to find out if they're competent." However, she admitted to "slight culture shock" on arrival.

> [It] is everyone's space, so we don't talk about patients in the coffee room. The informality helps get health messages across: I sometimes leave leaflets on my desk for patients to take, and find that they've picked them up while I wasn't looking.

Dave said that many GPs initially struggle with shared space. "They keep worrying that a patient's going to roll up their trousers in the kitchen and show them their leg ulcer. But I think people *do* respect boundaries." The PCT has offices in the building, and requested some private space, to

Dave's disapproval: "I don't think they should have that door. They can come and go without seeing the rest of us."

Despite diverse sources of revenue, the HLC is under constant pressure to expand, currently refurbishing a building to house its "social businesses". The turnover of these companies has increased five-fold in two years. The most successful, a landscaping business, has benefited from the large scale transfer of local council housing: many new landlords have commissioned the company to work on the estates. But "social enterprise" discourse did not guarantee the dominance of financialised rationalities. Not all businesses are expected to make a profit, especially the café, which Dave described as "one of the heart and souls of the place." He said: "There's no such thing in the world as a community café that makes money."

The HLC managed to re-construct social boundaries and barriers in a gentler form of governance than that symbolised by the unwelcoming architecture so prominent locally. This was visible in the centre's design: the gates that did not look like gates, the shutters that disappeared during the day. It was embodied in relationships between staff and service users. GPs were not exactly de-professionalised, but operated within a relatively informal ethos more rooted in the voluntary sector than the NHS.

This soft governance can benefit doctors. Patients knew that it was not appropriate to start a consultation in the shared coffee room. In a centre manager's words, "patients start to realise how hard doctors work" if they see them "behind the scenes". As Alexa argues, "informality helps get health messages across". Rather than democratising the patient-doctor encounter, it may enable the doctor to transmit health information more effectively. This may have many advantages, but is not a transformation of the patient-professional relationship.

Nevertheless, like other staff and service users, GPs participated in informal mutual surveillance. Apart from the sacrosanct space of the individual consultation, private spaces were viewed as suspect. 'Clients' became 'helpers', ambassadors for the Centre who encouraged others to participate. Governance was seen as personal and flexible: against bureaucratically rigid rules associated with the public sector, centre staff believed that the people involved would ensure that leadership remained legitimate, and prevent abuse.

'politics' and/or 'Politics'

The HLC's approach separates political campaigning or lobbying from the 'small-p' politics of how the centre is run. The former is dealt with by centre managers with access to policy networks, while the latter is seen as a community domain. It is easy to see why many people, not just

modernisers, find the HLC inspirational. However, it can be used to justify an anti-NHS narrative, potentially encouraging privatisation. Its consultancy services portray it as an alternative to the NHS, and for one of the GPs accompanying me on the tour, its success clearly reinforced her hostility to the NHS.

The separation of 'Politics' from 'politics' constrains the themes addressed by the centre. The Asthma Club pictures featured hazards at home, yet not the respiratory hazard of local pollution. By contrast, joining the two types of politics could have led to advocacy work aimed at monitoring and improving local air quality.

Instead, the Centre's participatory work seemed more limited. One flagship project had sought to "re-brand the area", focusing on redecorating a particularly unpleasant roundabout. An artist involved spoke enthusiastically about how "young people led on the consultation…it was like jazz." It did not embarrass him that several years on, the roundabout remains in its original state, lacking pedestrian crossings. For me the story spoke of integrating young people into an unhealthy environment, rather than mobilising their energy for social change.

The roundabout represents the area as a place to be traversed by commuters from affluent suburbs, and is hazardous for local pedestrians. I was struck by the symbolism of encouraging young people (disproportionately victims of road crashes) to beautify this sign of their powerlessness. Creating "active patients" has positive aspects, but risks obscuring unhealthy social structures, and encouraging individuals to take responsibility for social problems.

The rhetoric of (social) enterprise sometimes conflicts with the goal of creating 'responsibilised' individuals and communities. Using financial criteria, the café should have been shut and funding shifted elsewhere; yet it was seen as too socially valuable to close. Enterprise discourse is used flexibly to create enclaves sheltered from hegemonic discourses; but 'social enterprises' remain vulnerable to financial constraints and takeover by larger and/or private sector organisations. A private sector interviewee said that there was nothing to stop a large private company being a social enterprise. Only the public sector seems excluded by definition, showing that social enterprise discourse can encourage neoliberalisation. Other local 'social enterprises' spun off from public services have already been taken over by large private firms.

In theory and practice, the HLC concept marks a break from traditional notions of health and care, turning recipients into participants. Surveillance is not carried out remotely and technologically, but gently applied by helpers and staff. Community artwork, gardening, walking, and many other activities not traditionally associated with health can draw in diverse communities, many of which are considered 'hard-to-reach'. This does indeed seem to fit with Hardt and Negri's (2001:23) definition of

biopower “regulat[ing] social life from its interior”. More prosaically, “active welfare” is embedded within the model, ensuring that communities participate in service delivery.

I now turn to the increasingly dominant LIFT model, and examine the contrasting approach to service provision that it encourages. While the HLC programme did not promote the development of new buildings, and often entailed adapting existing sites to develop new types of service, LIFT is focused on the provision of new buildings offering “co-location” of existing services on one site. This has implications for the ways in which power is deployed within LIFT sites and the kind of identities fostered by them.

5. The LIFT model

> The one-stop-shop principle is an important component of NHS LIFT – allowing the patient to be treated in their locality in so-called "One-Stop-Centres" or Primary Care Centres that are modern, convenient, easy to access and staffed by a wide range of healthcare professionals.
>
> (DH, 2006a)

This DH guide to LIFT links the programme to particular types of building. It does not mention the HLC model, prioritising the "one-stop shop" containing NHS, local authority, and other services. Two key DH website documents give as examples LIFT buildings built or in preparation across the country, demonstrating the DH’s preferred models. *What will LIFT deliver?* (DH, 2006d) argues that LIFT is providing "practical support to help make healthy choices", using as examples centres with a leisure centre and a “healthy living café”. It promotes the inclusion of acute care services, dentistry, housing, and welfare services. The strategy imagines health and social services moving into LIFT buildings together, rather than communities being engaged in new ways to participate in service provision. This is corroborated by *Case Studies* (DH, 2006e), which refers to "the policy of LIFT in co-locating health and social services under one roof".

All DH case study centres involve GPs. Other services in or planned for such centres include police, housing staff, social workers and voluntary sector services. Overall, the most commonly mentioned additional services are district nursing, health visiting, "community health professionals", dentistry, pharmacy, and minor surgery, with additional services described as relocating from acute settings. The webpage focuses on including additional health and welfare services within new LIFT buildings, particularly promoting large centres departing from the traditional GP-based model.

“Modern” buildings for “modern” health care

LIFT forums organised by the Future Healthcare Network brought together participants from the private and public sectors, and helped me to examine LIFT’s direction of travel. One keynote speaker was a designer who has worked closely with the DH to produce general guidance, and on specific LIFT projects. Presenting one project as an exemplar, he said: “We wanted a corporate and neutral sense inside; that was a conscious decision. It is an intimate exchange that takes place inside and we decided not to stamp the building with a doctor or patient identity.” He argued that health planners had to be “more entrepreneurial”, borrowing from the commercial banks’ approach to administration and support services (i.e., outsourcing or even off-shoring).

His description demonstrated the dominance of a new build approach under LIFT, which I noted in Middletown and the comparator areas.

> The construction schemes that we've asked LIFT to get involved with around refurbishment is not something that they push forward very quickly, because it's not particularly very profitable.
>
> (Senior manager, PCT)

Prioritising new build projects fits in with the rejection of converted premises. Managers said "it's not modern health care" (referring to existing premises), associating “modern” buildings with “modern” care provided inside them. The DH LIFT FAQ states that "many GPs work in converted residential buildings, which have poor access for patients." This equates converted buildings with poor access by definition; one could compare this with the HLC philosophy that does not privilege new premises (Middletown HLC uses a mix of new and old buildings).

LIFT's stress on new buildings suggests a power shift in the patient-doctor relationship, dominant constellations of power symbolised increasingly by 'corporate and neutral' spaces. By contrast, Middletown HLC – like the traditional practice model described in Berger and Mohr 1967 – mobilises the power of the interpersonal, embracing the 'intimate encounters' taking place in consulting rooms. It uses experiences of wellness and illness to transform patient and staff identities: for example, using patient artwork to creates a sense of community ownership of the centre. HLC staff did not locate their artworks in a discrete “exhibition space” as in the designer’s model; works are placed all over the centre by patients and staff.

Yet this reliance on corporate space can cause problems for LIFT developments. It hampers the mobilisation of patient and doctor identities and blocks the use of local history to encourage

community consent. Middletown's HLC could mobilise and transform traditions embedded in its church building, while the LIFT building had nothing similar to draw upon.

Losing a sense of lifestyle?

NHS managers struggle to bridge LIFT's "affordability gap" (UNISON, 2006) and at forums, participants described how adding housing could increase projects' financial viability. The most popular model was mixed tenure flats about a health centre, providing extra income through flat sales and grants, whilst keeping additional costs low. In theory, housing attached to health centres could create self-governing communities focused around health-related amenities at the bottom of the block. This could continue a philanthropic tradition associated with charitable organisations, placing the moral uplift of workers and residents centre stage (c.f. Grit and Dolfsma, 2002). One could imagine this tradition combined with modern technologies: wireless networks linking health providers and residents, where people could interact and share tips for healthy cooking, or organise walks and picnics.

However, such possibilities were neither raised in interviews nor discussed in forums: participants appreciated the economic rationale for housing, but not its potential *social* rationale. At the second LIFT forum, a non-executive director's presentation discussing the possible use of LIFT to address "long-term impacts [of housing] on health" was met with bemusement. This NED worried that LIFT would fail to create ecologically sound, friendly neighbourhoods: "The danger is with the push for cost and efficiency, we lose a sense of lifestyle." He argued that LIFT could provide adaptations to enable disabled and elderly people to remain living at home. However in the very brief discussion that followed, one person seemed to speak for the meeting, saying dismissively: "I can't see how it fits into the LIFT model, how it's funded and how the funders [large commercial banks] would see this."

At the third LIFT forum, one bullish LIFT director spoke about how her company had ensured success in their developments:

> The commercial agent is a retail expert. We don't build buildings unless we have an end user, although we do take some risks. Each element is funded separately, so there are separate risks.

This rigorous financialisation helped to guard against void units. However, LIFT supporters' claims that the private sector challenges "silo thinking" (Anonymised, forthcoming) seem undercut by the creation of these new silos, now based around funding packages and, increasingly, private sector providers rather than public sector service demarcations. This LIFT director had managed to secure a supermarket for the development, which contrasts with the promotion of local food schemes within HLCs (Bailey, 2005). It distinguishes a wholly corporate, financialised 'regeneration' from one seeking

the moral uplift of communities: the cross-subsidisation and quasi- or non-financial arrangements (based on goodwill or exchange) supporting the case study HLC.

LIFT's financialisation makes it harder to involve the voluntary sector, according to meeting participants and interviewees. Traditionally the voluntary sector uses low-cost, low-quality buildings: it cannot afford expensive LIFT rents. Nor does a reliance on grant funding fit with a commitment to a long-term tenancy. By contrast, a housing developer, supermarket or local authority may seem like a much more reliable potential long-term tenant or partner, further reinforcing a top-down, 'one-stop' model as distinct from an HLC model. The next section discusses how this model has played out in Middletown's first LIFT building.

6. The first LIFT building

Searching for the "heart and soul"

The first LIFT building contains three GP practices, district nursing, health visitors, dentistry, and pharmacy, and some acute services, but no voluntary, community, or local authority services. Clean and clinical, it is a great improvement on the severely substandard facilities previously endured by one incoming GP practice. The central reception area is shared (with additional reception areas on other floors), but GP practices are clearly demarcated. Professional groups had rejected the idea of shared space and reorganised the facilities themselves. The PCT chief executive hoped that staff would move towards administrative integration: "The physical space allows a single infrastructure."

Here as in the DH webpages, the HLC philosophy had mutated into the belief that centres should have a "community café", seen as in itself creating local community ownership. As the local PCT's Chief Executive described:

> There is a space which we had originally intended as a community café, and that partly was based on looking at things that had gone on in [the HLC], which brings in all sorts of other activities into a single location. We haven't yet been able to make the community café as an idea work, because commercially, the various providers we've gone to haven't been able to make that a viable concern ... there may well be other ideas we can use for the same thing, so we draw people in. So it's not just seen as a sickness centre but a slightly wider sense of a health facility.
>
> (PCT Chief Executive)

However, as such facilities cannot meet the profitability test, units have remained void, potentially suggesting a void at the heart of LIFT. Moreover, using one-stop shops to house medical services currently provided in hospitals risks importing an acute care ethic into community services. This too could counteract any attempts to enable community-led development within these centres.

Filling the "units": what are we endorsing?

LIFT's one-stop model may deter the creation of the community-focused, responsible individuals encouraged by the HLC approach. While Middletown HLC uses social enterprise discourse, it possesses sufficient institutional, economic, and discursive space to ensure that this is used pragmatically and not always at the expense of non-profitable areas. By contrast, LIFT's financial rationality tends to prioritise tenants that can provide the desired rate of return. In a PCT Capital Planning Group meeting, managers discussed renting the empty café space to alternative practitioners and "health care navigators", but these could not afford to commit to £15,000 annual rent (relatively high for the area). Community groups – even poorer – were not considered.

The spaces involved remained clearly separate and the priorities financial. This contrasts with the café in the HLC which is run in-house and seen as a symbol of the local community, connecting other services within the building. In the LIFT building, the café area is a discrete space to be tendered commercially. The amount of shared space in the whole building is low, with places for staff and patients clearly bounded. Coffee areas, offices, and consulting rooms belong to different staff groups, and waiting areas are reserved for patients.

Instead of broadening 'health' and expanding patient and provider roles, LIFT tended to do the opposite. The LIFT company had initially wanted to install a chain pharmacy store, rather than rent space to local pharmacists. Finally, a consortium of local pharmacists had been granted the space, but the area was small and the rent high compared with their previous premises, limiting their ability to develop services. The local pharmacists' representative was disappointed with the whole experience, saying that by treating pharmacy as an income generator rather than a service provider, LIFT was preventing innovation. She argued that a big business "production line" model was replacing community pharmacists' "active consultations".

7. Conclusion

Financial and institutional constraints

Middletown's NHS managers argued that there were constraints preventing the HLC model from being applied universally. They claimed that the HLC received considerably more funding than comparable centres, and felt that it was unfair to be judged against a model that could not be generalised, given current f resources.

> [The HLC] is really, really good. But it gets given a lot of money in a way that other centres don't get given it... When you've got money coming in, it's quite easy to make things work.
>
> (Senior manager, PCT)

Local NHS managers felt that they had a much greater responsibility for services than did HLCs, which were intended as additional services. They portrayed the holistic model of health as an unaffordable luxury, and felt under pressure to deliver existing services. There are real resource constraints, particularly in deprived areas.

Yet material constraints were not purely financial; they included institutional barriers created by the LIFT model. Letting space in a LIFT building in a complex process. As with PFI the building does not belong to its occupants, and cannot easily be altered by them, even trivially. Thus cheap or free initiatives are blocked, sometimes in favour of expensive solutions provided through LIFTCo, which can be resented by those using the buildings. This stopped clinicians and others using art as the HLC did, as these extracts showed.

> GP1: I do think [the café] was a big thing missed. Diet is a major issue round here.
> GP2: 'Cause one of the things this centre was supposed to be was something called a healthy living centre, a bit like the [local] model, and I don't think we've achieved any of that.
> GP1: No.
> GP2: There is no community art. We've got fabulous artwork on the walls here, but it's come from some posh art collective in [trendy area]! Done by professional artists trying to make a living or find a space to show off their art!
> ...
> GP1: Well, we're not allowed to put [community art] up on the walls even if we had it!
> GP2: There's no art therapy. There's nothing like that. Strict rules about what you can and cannot use. We can't use Blu-Tac on the walls, we can't use posters – there's no posters in the waiting area at all. We're not allowed any.
>
> (GPs, first LIFT building)

Here GPs spontaneously bring up the example of Middletown HLC, to demonstrate that they are keen to work with a more holistic concept of health, including the use of cookery and art. Although the LIFTCo has mimicked the HLC's use of artwork, the GPs claim that it is a corporatised façade more likely to speak to middle-class urbanites than to the working-class service users. The artwork's purpose, they argue, is commercial rather than therapeutic: some schools art has been added by LIFTCo, but this is “not like community art”; it is separate from the centre and the patient-professional relationships within it.

The LIFTCo general manager explained clearly that LIFT and the HLC had different philosophies and origins. Talking about lessons learned from the HLC, his use of the terms “functions”, “units”, and “economic sense” spoke eloquently of the distance between the two.

> [The HLC] has come from a different kind of ethos, in that it was the community itself felt they needed something, whereas in our case we're going through the health and social care route, saying we believe you need something. It's really a different starting point. However, [the HLC] shows that you can combine seemingly disparate functions in a single unit, to the benefit of the community. Providing, of course, that it makes economic sense.
>
> (General manager, LIFTCo)

An economic discourse subsumed the HLC's social economics; a purely financial rationality did not seem to be able to mobilise the "community itself". Using LIFT to transform service users is not a central concern of those involved; instead, a managerialist agenda concentrates on the hierarchical organisation of managers and staff below them (Anonymised 2006). The LIFT board's chair, who has been involved with Middletown HLC, complained at the lack of community participation and contrasted it with the HLC's approach.

> What [the HLC] has provided, is an opportunity for people to be more than patients or more than consumers of health care ... an opportunity for people to be enterprising in the sense of observing a problem or a gap and thinking about how to fill it and develop it themselves.
>
> (Chair, LIFTCo board)

Given the political imperatives to speed up LIFT's highly bureaucratic processes, investing in 'community ownership' can seem even more time-consuming and even counter-productive. One manager argued that building "from scratch" was easier. Community members are unlikely to complain about a wholly new centre, but residents often feel protective towards existing buildings. Changes could mobilise 'community ownership' to threaten rather than support LIFT. However, the "new building" philosophy seemed to further alienate users and staff. It failed to build upon their existing attachments to the local area (and in some cases existing local buildings), instead substituting a model designed and created from above, through top-level meetings excluding patients and marginalising clinicians.

Community governance or corporate governance?

Health promotion models, as embedded within healthy living centres, conflict with the corporatised and increasingly dominant LIFT structures. HLC models are relatively low-tech, employing community-oriented and user empowerment philosophies, influenced by voluntary sector as well as health promotion discourses. Sometimes this is expressed in philanthropic rhetoric aiming to improve

individuals and communities through “governing souls” (Rose, 1999) while sometimes it is married to a social enterprise discourse. However, the case study HLC has an ambiguous relationship to entrepreneurial discourse, and often – as in the case of the café – governing souls took precedence over financial logics. The HLC approach seems to fit well with active welfare (Ellison, 2006).

HLCs can work to reinforce power relations: the dark side of the post-Foucauldian model. Middletown HLC encourages centre users to work as unpaid 'helpers', and modify their own behaviour rather than challenging the power structures that circumscribe their lives. It accepts donations and sponsorship from companies such as the supermarket whose nearby branch had led to the closure of local shops. However, the HLC agenda is not identical to corporate or neoliberal agendas and may even conflict with such interests. Part of Middletown HLC's declared mission is to improve local economic infrastructure, ensuring that jobs and revenues remain in the area. While it does not challenge corporations, and accepts their money, it does not provide them with direct profit-making opportunities. This allows some independence from corporate priorities.

By contrast, LIFT centres represent corporate-led development, driven by multinational corporations with long, remote supply chains. Such a model may damage local economic infrastructure, moving jobs out of the area (Lichtenstein, 2006). In Middletown, LIFTCo's maintenance contractor is owned by a well-known multinational corporation, its call centre based outside the area. A supermarket supply model is the path of least resistance within LIFT. While the inclusion of small “social businesses” as per the HLC model might encourage community participation, it is more costly. The NHS would have to meet any additional costs, and the private sector companies might well veto disruption of their established supply chains.

The prioritisation of rent maximisation within LIFT buildings gives larger firms an advantage. Company chemists could offer initially attractive deals to enter buildings, then control the market after their local competitors have disappeared. Indeed, in Middletown’s first LIFT building this almost happened. LIFT structures encourage NHS managers to think of services in terms of immediate financial considerations, leaving community involvement unvalued because it cannot be easily costed (and financial benefits may appear only gradually).

When it comes to cultural change, LIFT focuses on NHS managers rather than service users. The complex managerial structures are designed to encourage NHS and private sector managers to work closely together; they do not encourage the adoption of HLC models by managers or by service users. Only two local interviewees consistently expressed themes from HLC discourse – and these two had previously been closely involved with the HLC. Both expressed discontent about the way in which the LIFT programme was proceeding, and its failure to target service users. Other interviewees’

language shifted the focus away from service users: when managers referred to "users" they meant staff.

LIFT therefore illustrates some potential fault lines between neoliberal economics and governance strategies, which often disappear in entrepreneurial discourses that seamlessly wed flexible capital to flexible services, and celebrate market dynamism (Anonymised 2006). Yet the place of the market in 'actually existing' neoliberalism is ambiguous; ideologies of enterprise may conflict with corporate expansion. Contemporary capitalism involves concentrated constellations of power, whereas enterprise discourse is closely associated with an ideal of the heroic small entrepreneur. In primary care, where GPs can easily attach themselves to this ideal, LIFT's bureaucratic structures groan under the weight of entrepreneurial expectation.

Moreover, while active welfare can detach individuals from traditional welfare provision, it may not simply carry them over to the large private companies now increasingly involved in public services. It can instead construct them as new economic actors that compete with large companies and obstruct their attempts to benefit from privatisation. The existence of existing small business interests (such as pharmacists) and their ability to mobilise social entrepreneurialist and community involvement discourses complicates the picture further. While neoliberal policies may appear to mesh smoothly with self-governing, entrepreneurial individuals (such as HLC 'helpers'), the discourse in action tells a more complex and contradictory story.

8. Bibliography

Anonymised (forthcoming) Closed policy networks and broken chains of communication: stories behind an entrepreneurial policy. *Critical Social Policy* 27(1).

Anonymised (2006) Governing 'local health economies': neoliberalism and NHS LIFT. PhD Thesis, Department of Sociology, Goldsmiths College, University of London.

Bauman, Z. (1998) Work, consumerism and the new poor. Buckingham : Open University Press. 106pp.

Berger, J. and Mohr, J. (1967) *A Fortunate Man: the story of a country doctor*. Allen Lane: Harmondsworth. 155pp.

Bunton, R., Nettleton, S., and Burrows, R. (eds.) (1995) *The Sociology of Health Promotion*. Routledge: London. 253pp.

DH (1999) Health service circular: Healthy living centres. http://www.dh.gov.uk/assetRoot/04/01/19/33/04011933.pdf accessed 07/08/2006.

DH (2006a) About NHS LIFT. http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/AboutNHSLIFT/fs/en?CONTENT_ID=4000519&chk=D3TGGB accessed 26/7/2006.

DH (2006d) What will LIFT deliver? http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/AboutNHSLIFT/fs/en?CONTENT_ID=4126225&chk=MXqOMo accessed 03/08/2006.

DH (2006e) Case studies: examples of NHS LIFT in practice http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/NHSLIFTSchemesAndContracts/LIFTSchemesContractsImageArticle/fs/en?CONTENT_ID=4126224&chk=T6TbIy accessed 07/08/2006.

Ellison, N. (2006) *The transformation of welfare states?* Routledge: London.

Froggett, L. and Chamberlayne, P. (2004) Narratives of Social Enterprise: from Biography to Practice and Policy Critique. *Qualitative Social Work* 3: 61-77.

Gorz, A. (1999) *Reclaiming Work: Beyond the Wage-based Society*. Polity: Cambridge. 185pp.

Grit, K. and Dolfmsa, W. (2002) The dynamics of the Dutch health care system: a discourse analysis. *Review of Social Economy* 60: 377-401.

Hardt, M. and Negri, A. (2001) *Empire*. Harvard University Press: Cambridge, MA. 478pp.

Heller, T. (undated). New Ways of Working: Healthy Living Centres http://www.open2.net/theservice/new_ways/newways.pdf accessed 27/02/3006.

Lichtenstein, N. (ed.) (2005) Wal-Mart: the face of twenty-first century capitalism. New Press: New York. 349pp.

Lorber, J. and Moore, L. J. (2002) *Gender and the social construction of health*. Rowman and Littlefield: Oxford. 192pp.

Novas, C. and Rose, N. (2000) Genetic risk and the birth of the somatic individual. *Economy and Society* 29: 484-513.

Petersen, A. R. (1997) Risk, governance and the new public health. In: Petersen, A. R. and Bunton, R. (eds.) F*oucault, health and medicine*. Routledge: London. pp. 189-206.

Rose, N. (2004) Becoming Neurochemical Selves, in Nico Stehr (ed.) *Biotechnology, Commerce And Civil Society*. Transaction Press: New York. pp. 89–128. Available from http://www.lse.ac.uk/collections/sociology/pdf/Rose-BecomingNeurochemicalSelves.pdf

Rose, N. (1999) *Governing the Soul*. Free Association Press: London. 320pp.

Rose, N. (1996) Governing "advanced" liberal democracies. In: Barry, A., Osborne, T., and Rose, N. (eds.) *Foucault and Political Reason: liberalism, neo-liberalism and rationalities of government.* UCL Press: London. pp. 37-64.

Rose, N. and Novas, C. (2005) Biological Citizenship. In Ong, A. and Collier, C. (eds.) *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*. Blackwell: Oxford. pp. 439-463.

Twomey, P. (2002). A personal view: Upstream Healthy Living Centre http://www.upstream-uk.com/pages/ProjectDetail.asp accessed 07/08/2006.

UNISON (2006) *In the interests of profit, at the expense of patients.* UNISON: London.

WHO (2003: 1948) Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

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