Democratic Control and Public Representation in the NHS

Paper given to the BSA Medical Sociology Group Conference
at York, September 1979.

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Introduction

It is one of the paradoxes of the development of health services in the U.K. in the 20th century that as state involvement in the provision of services has increased, so democratic control, defined as control by elected bodies, has declined. The formation of a National Health Service in 1948 resulted in the majority of hospitals being taken out of the hands of local authorities and transferred to appointed bodies, hospital management committees and regional hospital boards. Again, the reorganisation of the NHS in 1974 involved the transfer of a number of personal health services, including responsibility for providing health centres, health education, health visitors and ambulance services, from local authorities to the newly appointed regional and area health authorities. Consequently, if we look at public representation in the NHS today, we find that this occurs at three points: through the formal accountability of the Secretary of State for Social Services to Parliament; through the members of health authorities; and through community health councils. The purpose of this paper is to look at each of these channels of public representation, and then to examine possible future scenarios in the light of the report of the Royal Commission on the NHS.

Parliamentary Control

It is part of the received wisdom about the NHS that the tripartite administrative structure introduced in 1948 was the limit of what was politically possible at the time. Willcocks has traced the debates leading up the creation of the NHS, and has described the bargaining and negotiation which took place[1]. Compromise and adjustments between different interests were the predominant values, hence the rather cumbersome structure eventually agreed on. Aneurin Bevan confesses in In Place of Fear that local control of the NHS by elected rather than appointed authorities would have been preferable.[2] It was not possible because the existing local government units were not suitable for the administration of health services.

Bevan hoped that a future restructuring of local government would enable health services to be taken over by local authorities. The opportunity presented itself in 1974, with the simultaneous reorganisation of the NHS and local government. It was not taken for two reasons. First, it was argued that the medical profession was opposed to such a move; and second, there were financial complications in transferring a service as big as the NHS to local government. The merits of these views will be explored later. The important point to note here is that rejection of local government control has meant that the only point at which those running the NHS are accountable to an elected body is at the top of the structure: through the accountability to Parliament of the Secretary of State for Social Services. The principal justification for this accountability is financial: the NHS is financed mainly out of general taxation and National insurance contributions; its revenue is voted annually by Parliament; hence, Parliament seeks to know how the money is being spent and holds Ministers and senior civil servants accountable and answerable for this. There is no other, more local, form of accountability. The chain of command stretches through DHSS and on to regional and area health authorities and accountability passes back in the other direction.

The corollary of accountability is control, and Parliament exercises control over the NHS in a number of ways: MPs ask questions and raise adjournment debates on specific, often local, health issues; there are more general debates on health policy and legislation; and the Expenditure Committee and Public Accounts Committee spend a part of their time examining NHS issues. The reports which come out of these Committees are often a mine of information for the student of health services and policy[3].

In its turn, DHSS exercises control over the NHS in a number of ways. At the most general level, the Department (subject of course to Treasury control) has complete financial control over NHS expenditure in the sense that it allocates funds to health authorities. However, these allocations are block

allocations; and there is little central control of how they are distributed between services, client groups and areas. Because of this the Department has on a few occasions introduced earmarked grants, but the failure of these grants to promote the building of secure units for psychiatric patients has brought into question their efficacy as a means of control.

Finance apart, the Department issues policy advice through documents like Priorities for Health and Personal Social Services in England and through circulars. Here, the NHS Planning System introduced in 1976 is important as an attempt to secure greater conformity at the local level with national policy guidelines. A third means of control is the power of the Secretary of State for Social Services to appoint members and chairmen of regional health authorities, and chairmen of area health authorities. The other side of this particular coin is the Secretary of State's power to suspend health authorities and replace them with a board of commissioners which he appoints. This power is very rarely used, though it was recently invoked in the case of the Lambeth, Southwark and Lewisham AHA(T). Finally, there are the regular and frequent contacts between NHS staff and DHSS civil servants. This side of the Department's work was strengthened in 1972 when, during an internal reorganisation, a new regional liaison division was set up.

It is interesting to note that DHSS relates not only to health authorities, but also to local social security offices and local authority personal social services departments. To oversimplify, the administration of social security is organised on centralised, bureaucratic and hierarchical principles (though still leaving important and controversial elements of discretion and judgement to local officials); the administration of personal social services is organised with the emphasis on local control; and the administration of the NHS comes somewhere in between. In fact, despite the controls available to DHSS, health authorities have considerable discretion on how to spend the money they are allocated, and the NHS Planning System has yet to be proven as a means of greater central direction. Successive studies of variations in levels of

health service provision in different areas have demonstrated the scope of local discretion. (It should be noted though that these variations can be interpreted as evidence of the failure of the central department to exercise its control, as well as evidence of the autonomy of health authorities.)

To return to the theme of ministerial accountability to Parliament, it seems clear from the above discussion that while the powers available to the Secretary of State allow some measure of control to be exercised, they do not carry with them the control which the statutory position would seem to require. Hence the situation in which, simultaneously, health authorities complain of too much interference by DHSS, and DHSS lack the powers needed to carry out its statutory responsibilities. As the Royal Commission noted, "detailed ministerial accountability for the NHS is largely a constitutional fiction".[4] Nevertheless, in the absence of local accountability, ministerial accountability to Parliament does provide some kind of democratic control over health services. The point is whether this control is adequate and whether it is appropriately located at the national level: a point we return to later.

Health Authority Members

In the absence of local government control of health services, members of health authorities are the main means of public representation in the NHS at the local level. The role which members play is somewhat confused. At the time of reorganisation, members were given an unequivocally management role. They were to be appointed as individuals and not representatives, and they were to be chosen for their managerial abilities. The representative role was hived off and given to community health councils, whose experiences we consider below. These moves were consistent with the search for improved management efficiency in the NHS, pursued unrelentingly by Sir Keith Joseph, Secretary of State for Social Services in the 1970-74 Conservation Administration which was responsible for passing the reorganisation legislation, with the assistance of the management consultants, McKinseys. Also involved was the Health Services Organisation Research Unit at Brunel University, whose

industrial consulting approach influenced the detailed management arrangements laid down in the 'Grey Book',[5] the management bible of reorganisation.

The outcome was not just the separation of management from representation, but also the decision to keep authorities relatively small bodies to enable them to work as effectively as possible; to advise against the establishement to standing committees of members; and to identify a strategic policy making role for members, leaving detailed managerial tasks to officers. These ideas were remarkably similar to those advanced in 1966 by the Farquharson-Lang Committee, which reported on the administrative practices of hospital boards in Scotland.[6]

However feasible the management role of members was in theory, in practice it was soon overturned by the Labour Government which took office in 1974.. A mere two months after taking up post, the new Secretary of State for Social Services, Barbara Castle, issued a consultative document, "Democracy in the NHS", which described the reorganised structure as "bureaucratic, appointive and undemocratic"[7]. The document was particularly critical of the separation of management from representation, stating "The Government do not accept that it is possible or desirable to make such a clear cut distinction between management of public services and representation of consumer interests and views. Our whole national democratic process as it has evolved over the years is a complex interweave of management and representation. While there are at times considerable advantages in the close definition of responsibility and even the separation of functions, to embark on total separation is to challenge in a fundamental way the essence of democratic control".

After such powerful rhetoric, the eventual consequences were rather meek: the proportion of local authority nominees on health authorities was

increased to one-third; and it was decided in principle to add representatives of health workers other than doctors and nurses to authorities. Thus, a representative element was added to the original managerial role of members, leading to the current confusion.

The ambiguity surrounding the members' role has been noted by Brown in his study of the impact of reorganisation in Humberside,[9] and by Kogan in his research report for the Royal Commission[10]. The ambiguity stems from the fact that as managers, members' duties may overlap with officers', While as representatives, their functions overlap with CHCs. What is more, the management and representative roles may themselves conflict, and when this happened in Lambeth, it was the representative role which won out. Rather than make the cuts in expenditure required by central government policy, the area health authority decided to tell the Secretary of State that in the community's interests the cuts could not be made, thereby provoking its own suspension.

In other cases, though, it is the apparent impotence of members in relation to officers which has been remarked upon. A number of factors contribute to this impotence: consensus management among officers tends to result in members being presented with proposals which are difficult to challenge and change; members' lack of involvement in committees means that they do not have the detailed knowledge to question recommendations put to them; and evidence from Elcock and others indicates that the key role played by authority chairmen, who receive a salary for their part-time duties, is in support of officers. In his study of two RHAs, Elcock found that "The chairman, vice-chairman and RTOs of both authorities meet before each RHA meeting to discuss the items on the meeting's agenda and can therefore agree on a common approach to items which are likely to cause contention. At times chairmen tended to play a role not unlike that of a local government chief executive officer at the head of his management team ..."

Seen in these terms, it is not surprising that authorities are described as rubber stamps with little apparent power. However, this is to view power in one dimensional terms only: it may be that in these 'caucus' meetings of officers and chairmen, the participants agree on a common approach which they know will be acceptable to the members. Here, the second dimension of power, or the rule of anticipated reactions,[12] would be in operation, locating power as much with members as with officers. More research is needed to identify such elusive uses of power.

In the meantime, what evidence there is indicates that those members who are most assertive are those nominated by local authorities. It is these members who by virtue of their election can claim the legitimacy which most other members lack. Practice seems to vary up and down the country, but it is in London and other metropolitan areas that local authority members of health authorities appear to be most inclined to exert their influence. Despite this, the conclusion intimated by our analysis is that the role of members is unsatisfactory and unrewarding because it is ambiguous and confused; and the power which members are able to exercise is circumscribed by their lack of legitimacy and the dominant position of officers and authority chairmen.

Community Health Councils

The third channel of public representation is CHCs, who were established in 1974 specifically "to represent the interests in the health service of the public in (the) district".

The membership of CHCs ranges from 18 to 36, and members are nominated by local authorities (one-half), voluntary organisations (one-third) and regional health authorities (one-sixth). Each CHC receives a budget of around £15-20,000 a year. Most of this is spent on the salaries of the officers, usually a Secretary supported by an assistant, and on office accommodation (which most CHCs prefer to be in easily accessible High Street locations). The CHC Secretary has a key job which includes acting as committee secretary, press

officer, and contact person with the public and health authorities. Secretaries come from a variety of backgrounds, including health administration, industry and commerce, and voluntary organisations.

CHCs have few formal powers. Following consultation on "Democracy in the NHS", CHCs were given "observer status" at area health authority meetings, which means that a CHC representative can attend authority meetings and speak but not vote. The DHSS has also recommended that family practitioner committees (FPCs) should accept CHC observers at their meetings, but has not required FPCs to do this. At the last count just over one half of FPCs had accepted CHC observers. Similarly DHSS has recommended that CHCs should be represented on the multidisciplinary district planning teams (these are sometimes known as health care planning teams) which have been set up to prepare development proposals for particular services. Again this is only a recommendation and no requirement has been laid down. The most important power of CHCs, however, is to withold approval from plans to close hospitals or change their use. If an AHA cannot obtain the approval of a CHC to such plans, then they are referred to the Secretary of State for Social Services for decision.[13]

With such limited resources and powers, what can CHCs do and how effective have they been? Very broadly, the job which CHCs do can be considered under two headings: helping the community, and acting as pressure groups[14]. CHCs help the community in a number of ways: they prepare guides to local health services; members visit and report on conditions at hospitals and other health service buildings; sometimes actual services are provided, like the children's health club run by the St. Thomas's CHC (see below); and assistance is given with problems and complaints. On the last point, CHCs have no power to investigate complaints, but what they can do is to help individuals work through the complaints' procedure. In some cases, a CHC Secretary has acted as the "patient's friend" at service committee hearings of complaints against general practitioners. In other cases, CHCs have gathered together information on problems and complaints to present a profile

of patients' experiences of the NHS. Often CHCs are approached not with complaints but simply with requests for advice and information. Their role is then akin to that of a citizens advice bureax for the NHS.

CHCs act as pressure groups on a variety of issues. Their power to oppose hospital closures often results in CHCs lobbying MPs, holding marches and demonstrations, using the local media and engaging in other forms of pressure group behaviour. This is not to suggest that CHCs always and inevitably oppose closure proposals: in nearly all cases they have agreed to AHA plans with little fuss or argument[15]. But where they have put forward objections, then the Secretary of State has almost always decided in favour of the AHA and against the CHC[16]. One of the problems CHCs face in these circumstances is that they are requested to put up detailed counter proposals - a gargantuan task in view of their scarce resources.

Another problem is that health authorities have tried to avoid the need to consult CHCs by carrying out what they have termed "temporary closures". CHCs who have considered challenging these moves in the courts have found the likely legal costs to be prohibitively high. And recently, the Secretary of State has informed health authorities that they have the right to make cuts without formal consultation if they are short of time.[17] These would seem to represent a considerable curtailment of the ability of CHCs to influence closure decisions.

A second area in which the CHC pressure group role is displayed is in particular campaigns, such as the one led by the Merthyr and Cynon Valley CHC over the heart drug, Eraldin. What happened here was that a patient approached the Merthyr CHC for help in obtaining compensation from ICI, the makers of Eraldin, for side-effects suffered as a result of taking the drug. The CHC publicised the case through CHC News, the national newsletter of CHCs, and discovered there were many instances of patients having suffered harmful side effects. A national campaign was then launched to make sure

that patients received adequate compensation and to improve the system of issuing and monitoring new drugs. This issue illustrates the potential of concerted action by CHCs, a potential enhanced by the setting up of a national coordinating body, the Association of CHCs in England and Wales, in 1977.

A third area of CHC pressure group activity is over particular local services and issues. A much-quoted example is the survey of the needs of the elderly, carried out by the Worthing CHC. The survey was conducted by workers employed by the CHC under the job creation programme, and resulted in the publication of two impressive reports which identified the needs of old people in Worthing, and formed the basis of a campaign to press the health authority and other relevant agencies to take action to improve services.

This, then, is a summary of what CHCs do, but how effective have they been? After five years in action, there is an emerging consensus that CHCs have been "one of the very few success stories of the reorganisation of the National Health Service. Councils are now becoming well established, and are acquiring a very realistic and thorough knowledge of the health needs of their District"[18]. These are the words of the Health Advisory Service, whose favourable verdict has been echoed by the Royal Commission on the NHS. The Commission asserted that "CHCs have made an important contribution towards ensuring that local public opinion is represented to health service management"[19] and recommended that they should be given extra resources to enable them to function more effectively. Again, Ron Brown, in the most thorough study of the impact of NHS reorganisation, has argued that "An unexpected bonus has been the increased accountability of health service managers, through community health councils, to interested members of the publics they serve"[20]

The views of health service managers have been less complimentary. A number of surveys have indicated that the majority of managers resent

the intrusions and demands made on their time by CHCs, and are doubtful of the ability of CHCs to make a meaningful contribution to decision making. At the same time, there is a widespread feeling that AHA Members are just as representative of patients' views as CHC members[21]. It follows that one of the main problems CHCs have faced is how to establish a satisfactory working relationship with health authorities. While nearly all CHCs have found themselves in disagreement with authorities at some stage in their short lives, consensus rather than conflict has been the dominant style of CHC-NHS relationships. As I argued in an earlier paper, this may be because, in the face of unhelpful attitudes among health service managers and health authority members, "It is so much easier for councils to take on the job of a complaints' bureau - cum - hospital visiting committee rather than accept the challenge to become critical enquiring consumers' champions"[22] On the other hand, some CHCs have taken up the challenge, and have actively asserted consumers' interests, not shirking conflict where it has arisen. Yet there is no guarantee that this approach will be effective: as the Secretary of one CHC which used "every weapon in the community activists armoury" in a campaign against a hospital closure noted, "for all the effect that community protest has had we might just as well have stayed home"[23]

One reason why CHCs are sometimes held in low esteem by managers is that their claim to be representative of local communities is rather tenuous. Being neither elected nor typical of the wider community in terms of their personal characteristics, CHCs have to seek some other kind of legitimacy. Accordingly, great effort has gone into reaching the public, and the methods used include: regular slots on local radio and space in local newspapers; arranging for stalls at fetes and exhibitions; hiring a "publicity bus" to tour the health district and reach more remote sections of the community; leafletting houses and public places; and speaking

at meetings of other organisations. In view of these efforts, it is somewhat dissapointing to read of Anderson's finding "that less than two per cent of adults know about CHCs, and that these few are mainly educated and middle class"[24]. While other surveys have found more widespread knowledge - usually 10% or more[25] - public awareness of CHCs is still limited.

CHCs have gone to some length to overcome the ignorance and apathy which would seem to lie behind these figures. In Manchester, for example, the CHCs organised a special discussion workshop on mental handicap, attended by parents, professional workers and CHC members, in order to identify more clearly consumer views[26]. And in Islington, the CHC has adopted a policy of actively co-opting members of the public onto working parties as a means of widening its power base. The CHC has more than doubled the number of people involved in its work in this way, and is therefore able to more justifiably claim to represent the community.

But, it may be asked, what different have CHCs <u>really</u> made? Ask any CHC Secretary, and he or she will usually be able to list a number of changes brought about by CHC activity. Often, these are of a minor but nevertheless important nature: the introduction of a Well Women's Clinic here, the provision of extra facilities for long-stay patients there, and so on. Much less common are claims that CHCs have influenced major decisions like hospital closures: we know, for instance, that the Secretary of State has, in deciding on closures referred to him, come down in favour of CHCs on only a handful of occasions[27]. Lack of 'clout' on big issues is not really surprising given the limited resources available to CHCs. It is true that councils can mobilise support through the local media, councillors, MPs, trades unions, and other interested parties, but ultimately their absence of sanctions is a major constraint on what can be achieved.

Two qualifications need to be made to this assessment: first, as we argued in the case of health authority members, it is important to examine the exercise of power not only in overt conflicts, but also in preventing conflicts arising. For example, it may be that the existence of CHCs has prevented some hospital closures being proposed in the first place. More research is needed to identify non decisions of this kind, which must be included in any balance sheet of CHC success and failure[28].

The second qualification is to recognise that CHC effectiveness is concerned with what CHCs do to help the community as well as with what they do as pressure groups. Producing guides to local health services, providing advice and assistance with enquiries, and helping aggrieved patients with complaints are as important in their own way as influencing the 'big' decisions. To take a specific example, the work being done by the St. Thomas's CHC with children, which involves a health club designed to promote a healthier lifestyle among children and a better understanding of the factors which impinge on people's health, is already beginning to have an effect. The organisers report that the children involved have altered their ideas about health since attending the club, and there have been changes in eating habits as a result of what has been learned. This work is now continuing with financial support from the Lambeth inner area partnership.

These sorts of activities need to be included in any assessment of the effectiveness of CHCs. Indeed, they may become more important if the early pronouncements of Patrick Jenkin, the Secretary of State in the new Conservative Administration, are to be taken seriously. Speaking at the annual general meeting of the National Association of Health Authorities, Jenkin was reported as saying: "I want to see them (i.e. CHCs) develop so as to become informed, concerned, and

responsibe local forums for local discussion of local health care. If CHCs do these things, they will help you in your managerial role and the discharge of your statutory function. Providing they resist the temptation to become some kind of pressure group for patients, you will not be threatened by CHCs"[29].

The kind of role envisaged here would represent a major shift in emphasis, and is unlikely to be received favourably in the CHC world. As I have argued in this paper, a major part of the job of CHCs is precisely to be a "pressure group for patients". Any move away from this would threaten the already strained credibility with which many community activists look on CHCs. On the assumption that CHCs are to continue, what is important in the next 5 years is to build on the foundations which have been laid in order to create the conditions in which a diversity of approaches and styles - including the pressure group style - can continue to flourish.

Conclusions and Speculations

What conclusions can be drawn about democratic control and public representation in the NHS today, and what future scenarios are there? Three conclusions suggest themselves: first, that while the formal accountability to Parliament of the Secretary of State for Social Services offers some degree of control, health authorities enjoy a large measure of autonomy and detailed ministerial accountability does not exist; second, the role of health authority members is confused and unrewarding, and the present arrangements are a poor way of securing public representation in the running of the NHS at the local level; and third, that CHCs have proved an important means of increasing the accountability of local health service managers and of providing a channel of public representation, although their own lack of representativeness and formal powers has limited their impact.

What then of the future? Here, it may be helpful to consider three possibilities: the transfer of the NHS to the control of local government; the implementation of the Royal Commission's recommendations; and the plans of the Conservative Administration.

i) Local Government Control

The case for local government control of the NHS is a strong one. Health service expenditure is currently £8,000 million per annum, decisions on the use of this money involves questions of values, and it is best if these decisions are made openly by democratically elected authorities accountable to local people. Only in this way, it can be argued, will authorities acquire the legitimacy needed to run the service independently. What is more, the integration of the NHS with local government will bring about closer collaboration between health services and other related services like education, housing and personal social services. These arguments have been restated recently with some force and pursuasion by John Stewart. [30]

The Royal Commission considered but rejected local government control at the present time. The Commission felt that another major reorganisation 'should be avoided at least in the short term'. [31] The Commission believed that the question might be raised again if

regional government in England became a possibility.

Apart from the need to avoid another organisational upheaval, there are three main arguments against local government control. First, it is argued that local authority responsibility for health services would mean greater variation in standards of service provision because authorities would have more independence than health authorities as currently constituted. It would mean that local autonomy and accountability would prevail over territorial justice as the predominant value in the organisation of health services. In short, it would result in less of a national health service. What this argument overlooks is that there are already very wide variations in local standards, and that these variations may be justified by different local circumstances. According to this school of thought, more variety rather than less is needed if services are to be provided equitably, and local authority control would help bring about this variety. On the other hand, the opponents of local authority control tend to gloss over the fact that in the battle for scarce resources it is the Cinderella services which will continue to suffer. The record of local authorities in providing community care for groups like the mentally ill and handicapped is uneven, and there is no guarantee that authorities will do any better with health services.

There are two other reasons for rejecting local government control: the opposition of the medical profession, and problems of finance. The latter can be solved in one of two ways: either through an enhanced rate support grant, or, less likely, by giving local authorities the power to raise local taxes. Professional opposition is essentially a problem of political will: a government which was strongly committed to local government control could surely carry it through. It may be necessary to make concessions to professional interests, for example by setting aside a certain proportion of seats on the appropriate council committee for professional representatives, but these are matters of detail rather than practice.

Where would this leave ministerial accountability and CHCs? Detailed ministerial involvement would no longer be necessary. The role of the central department would be to issue policy guidance, pilot through legislation, fight for the health service share of the public expenditure cake, and hold certain reserve powers of direction for use against recalcitrant authorities. In other words, the role would be like that of the Secretary of State for Education. The future of

CHCs would be open to debate. In one sense they would become redundant, for public representation would occur through more direct channels. In another sense they could continue as a kind of ginger group to monitor the operation of local services, perhaps with increased voluntary organisation membership and reduced local authority representation.

How likely is this scenario? It has to be said that its chances of coming about are highly unlikely at the moment. As the Royal Commssion reminded us, not only is there professional opposition to local government control, but also there is opposition from trade unions and health service administrators. More importantly, there are no indications that the Conservative Government favours this option. A future Labour Government may be more inclined to support the local government lobby: indeed one of Richard Crossman's hopes was that coterminority of local authority and area health authority boundaries would pave the way for an eventual transfer. However, increasing union opposition may tie a Labour Government's hands in the way that professional opposition tends to tie the Tories! In short, it seems improbable that local government control of health services will come about in the foreseeable future.

ii) The Royal Commission

The Royal Commission made three positive recommendations relevant to democratic control and public representation. First, the Commission recommended that a Parliamentary select committee on the NHS should be set up. The justification for the select committee was 'that it would make a valuable contribution to public debate on the NHS, and, provided it were properly served, with the power to examine health ministers, civil servants and expert witnesses, would enable Parliament to influence health policy and keep in touch with the work of the NHS in a more systematic way' [32]. Second, the Commission recommended that CHCs should be strengthened through being given extra resources, the right of access to Family Practitioner Committee meetings, and more resources to enable them to act as the patient's friend in complaints procedures. Third, and most controversially, the Commission recommended that responsibility for services should be developed to RHAs. This would mean a reduced role for DHSS, and much greater contact between MPs and RHAS.

Looking at the recommendations in turn, the select committee proposal is a sensible extension of present practice. It echos a

suggestion made last year by Rudlof Klein, who argued that the current arrangements, whereby the social services and employment sub- committee of the Expenditure Committee occasionally investigate health service issues, should be replaced by 'a permanent House of Commons committee charged exclusively with the affairs of the NHS'.[33] And in fact in the coming Parliamentary session, a new system of select committees will be instigated, involving a separate committee to investigate the activities of the DHSS. Clearly, this goes a long way towards meeting the Royal Commission's recommendations.

The proposal to strengthen the CHCs is also to be welcomed, and requires no further comment except to add that the recent controversy over the powers of CHCs in relation to closure proposals adds force to the Commission's recommendations that CHCs need 'further guidance from the health departments on their role'.[34]

Much more problematic is the suggestion that RHAs should be directly accountable to Parliament. Brian Abel-Smith has listed the difficult questions the Commission has not faced up to here.[35] What would happen if RHAs decided to ignore the Secretary of State's policies? Would ministers still have the power to issue directions? Could RHAs appeal to Parliament over the Secretary of State's head? And would MPs accept these arrangements? Clearly, this proposal has not been thought through properly, and it appears to be a tortuous way of bringing about a rather limited increase in direct Parliamentary control. However, if the proposal were developed there is a chance that it would find favour with the Conservative Government, whose plans we discuss next.

The Conservative Government's Plans

The detailed intentions of the Conservative Government have not been announced at the time of writing. However, it is possible to engage in a number of speculations on the basis of what has been said by Patrick Jenkin, the Secretary of State. First, it seems likely that there will be a continuing though reduced role for CHCs. The Secretary of State's statement, quoted earlier, that CHCs should concentrate on local issues and should avoid becoming pressure groups for patients, together with his decision that health authorities do not have

to consult with CHCs on closures if they do not have time, indicates the way the government is thinking. It seems improbable that CHCs will be given more resources and strengthened in the way the Royal Commission recommended: more likely is the abolition of the Association of CHCs in England and Wales as part of the campaign against quangos, and a restriction of the role which CHCs play in complaints.

As far as health authorities are concerned, the indications are contradictory. On the one hand, Jenkins has said that he wants to reduce the role of DHSS and devolve responsibility to health authorities. At the annual general meeting of the National Association of Health Authorities in June, he told delegates that 'the main thrust of policy should be to make the NHS far more of a local service', and that he was committed to 'removing the role of the "nanny" in government'.[36] On the other hand, the one firm action taken by the government to date has been to suspend the Lambeth, Southwark and Lewisham AHA (T) for not following Conservative policies on expenditure cuts.

How will Jenkin square this particular circle? The answer may lie in greater delegation coupled with a return to the management type health authorities established in 1974. Getting rid of rebellious and independently minded Labour councillors on health authorities and replacing them with a smaller number of non local authority members chosen for their managerial abilities may bring about more local responsibility and conformity with national policies. Given the key role of authority chairmen noted earlier, the appointment of chairmen sympathetic to the Conservative philosophy in the next round of appointments will be crucial in ensuring this.

Finally, all the indications suggest that DHSS itself will be considerably reduced in size. Leaks to the Guardian have shown that Jenkins has ordered staff reduction options of 10, 15, and 20 percent to be prepared. Again, this is consistent with what Jenkins told the National Association of Health Authorities.

This , the most likely scenario, is bleak indeed for those who argue for greater democratic control and public representation in the NHS. Other options, such as control by separately elected health authorities have not been considered because they seem even less

probable than the ones discussed here. In the immediate future, it will be interesting to see how the Conservative plans develop. NHS watchers will no doubt keep a close eye on the new Parliamentary select committee and the development of CHCs. It is through these channels that the future of public control and involvement would seem to lie. In the longer term, though, it is difficult to see how more fundamental changes like local government control can be kept off the agenda.

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September 1979

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12. The phrase comes from Carl J. Friedrich, but see the discussion of the different faces or dimensions of power in P. BACHRACH and M. S. BARATZ: Power and Poverty (Oxford University Press, New York, 1970) and S. LUKES: Power: A Radical View (MacMillan, London, 1974).

13. I have discussed the role which CHCs play in NHS planning and hospital closures more fully in C. J. Ham: Community Health Council Participation in the NHS Planning System. Social Policy and Administration forthcoming 1979.

14. There is a useful discussion of what CHCs do in P. Gordon: Producers and Consumers - A View of Community Health Councils, in D. Black and G. P. Thomas (eds.): Providing for the Health Services (Croom Helm, London, 1978).

15. For example, between June 1974 and March 1977, CHCs gave their approval to 97 out of 106 closure proposals. See Ham, 1979, op. cit.

16. To date, the Secretary of State has supported CHCs in four cases only.

17. Reported in The Guardian 4 September 1979.

18. Health Advisory Service: Annual Report for 1976 (HMSO, London, 1977) p. 59.

19. Op. cit. p. 156.

20. Op. cit. p. 196.

21. I have reviewed the evidence on this in Ham, 1979, op. cit.

22. C. J. HAM: Power, Patients and Pluralism in K. BARNARD and K. LEE: Conflicts in the NHS (Croom Helm, London, 1977) p. 104.

23. C. Langridge: 'The Closures Game' CHC News November 1977.

24. R. Anderson: 'Public Awareness and Interest in CHCs' Health and Social Service Journal March 1979 pp. C 29-31.

25. See for example F Eskin and P Newton: 'Public ignorance of the health service' Health and Social Service Journal 10 April 1976.

26. R Faulkner: 'Involving the Consumer' Health and Social Service Journal 17 September 1976.

27. See note 16.

28. A similar point is made about health authority members (see above) See also R. Klein and J. Lewis: The Politics of Consumer Representation (Centre for Studies in Social Policy, London, 1976) p. 145.

29. Reported in Hospital and Health Services Review August 1979, p. 280.

30. J. D. STEWART: An Essay in the government of Health - The case for local authority control. Unpublished paper, University of Birmingham, 1979.

31. Op. cit. p. 265.

32. Ibid. p. 300

33. R. KLEIN: Parliamentary accountability and the NHS: need for separate committee BMJ 3 June 1978 p. 1501.

34. Op. cit. p. 156.

35. B. ABEL-SMITH: Who should watch over the NHS? New Society 16 August 1979 pp. 348-49.

36. See note 29.