

May 1974

Department of Health and Social Security

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Democracy in the National Health Service

Membership of Health Authorities

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DEMOCRACY IN THE NATIONAL HEALTH SERVICE

MEMBERSHIP OF HEALTH AUTHORITIES

Introduction

May 74

1. The Government announced in the Queen's Speech its intention to review the working of the reorganised National Health Service. The Secretary of State for Social Services has made it clear that the Government consider the system of management which started to operate in the reorganised Service on 1 April 1974 to be undemocratic and out of tune with the needs of local communities.
2. It would have been quite impracticable for the Government which took office on 5 March to defer the date of operation of the reorganisation. Arrangements were far advanced, delay would have caused severe disruption which would have put at risk the health of individual patients and the public to whom our first responsibility lies. The Government is also acutely aware of the uncertainties and stresses which staff in the National Health Service are inevitably facing at the present time, and has no wish to add to them. The Government is therefore not proposing any fundamental structural changes in the reorganised Service now, though it will keep its working under review and propose whatever changes seem desirable in the light of experience.
3. In the short term, however, within existing legislation and without disturbing appointments already made, changes can and should be made to make the Service more responsive to the views of the people it serves. The Government also believes that changes are needed to take greater account of the contribution which all those who work in the Service can make to its management. This Paper explains why the Government is not satisfied with the present arrangements in England, and sets out its proposals for changes. The position in Scotland and Wales will be dealt with separately.

The democratic process and the National Health Service

4. The Labour Government published Green Papers, one in 1968 (also covering Wales) and another in 1970, aimed at stimulating discussion on the reorganisation of the National Health Service in England. The Conservative Government published a Consultative Document in 1971 and a White Paper in 1972; separate papers were published for Wales. These led to the National Health Service Reorganisation Act 1973 which covered both England and Wales. Many features of this Act were controversial and strongly criticised during its passage through Parliament; criticism concentrated on the bureaucratic, appointive and undemocratic nature of the reorganisation. The Local Government Act 1972 for England and Wales, which has had a major influence on the structure of the reorganised health service, was also controversial and did not follow the recommendations of the Royal Commission on Local Government accepted by the previous Labour Government. There has been already, therefore, very extensive consultation on many of the central issues. It is against this background of public and Parliamentary debate that the proposals in this Paper should be assessed.

5. The National Health Service Reorganisation Act 1973 deliberately separates responsibility for managing the health service from responsibility for representing the views of the public as the consumer. This representative function is given to new Community Health Councils (CHCs), one for each health district. Members of CHCs are at present debarred by the Act from serving as members of Area Health Authorities (AHAs) or Regional Health Authorities (RHAs) and have no executive powers. The health districts in some cases cover very large areas. The boundaries have been defined administratively by central government within the context of health care. The boundaries of the local government district authorities, which are responsible for housing and environmental health, have in turn been drawn up in the light of local government considerations. The health districts and local government districts in consequence bear in many cases no relation to each other, which presents some administrative problems and makes any direct democratic representation on Community Health Councils difficult to achieve. 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.

6. The Government's objective is to develop a structure for the National Health Service which will allow real devolution to those operating the service locally without detailed intervention from Whitehall or from the region. This is only acceptable if there is a strong democratic element in the local administration to reinforce the national democratic control already provided by the Secretary of State's responsibility to Parliament. The same principles apply to the region. In marrying national with local democracy, and national responsibilities with local devolution, we need to consider several inter-related matters—the role of CHCs; the constitution of AHAs and RHAs and the role of their members; and the mechanisms through which the Secretary of State's national responsibilities can best be discharged without unnecessary involvement in local and regional affairs or in matters which are primarily the concern of the health professions themselves.

7. This paper contains proposals on all the subjects mentioned in paragraph 6 except those relating to the Secretary of State's national responsibilities. The setting of standards and redressing inequalities of care and provision in the health and social services are fundamental responsibilities of central Government. The Secretary of State needs to be kept informed about the state of the services and the quality of care, and to ensure that appropriate action is taken to remedy deficiencies. There are many different means for doing this. A major method is the selective allocation of scarce national resources. Methods also need to be further developed for providing those working in the field with any necessary advice for improving the services in the public interest. This is relevant not only to the NHS, but also to related services including those which are provided by local authorities. Proposals on these subjects will be announced separately as soon as possible for consultation with the interests concerned.

Role of Community Health Councils

8. The structure and role of the Community Health Councils is of vital importance. The previous Government extensively revised their original proposals for CHCs, so as to make them more representative of community interests. The relevant London borough, county and district councils, together with the local voluntary organisations (selected by the Regional Health Authority after consultation with the appropriate local authorities), now directly appoint five-sixths of the membership of each Council. The Councils are also more independent of the Area Health Authority than originally proposed; and there is provision in the Act for the establishment of a national body to advise and assist the Councils. The CHCs have been given powers to obtain information about the health services in their district and to enter and inspect hospitals and other health premises, and they must be consulted before decisions are taken on any substantial development or variation in services. The District Management Team (DMT)—a small group of senior health service officers and practising doctors which is responsible to the Area Health Authority (AHA) for the management of most health services in the district—is expected to establish close working relationships with the CHC but there is no formal link. Each CHC has a direct relationship with the chairman and members of the AHA who are required to meet the CHC at least once a year. The CHC will make an annual report on its activities to the Regional Health Authority (RHA) which the CHC itself will publish, and on which the AHA must publish its comments including an account of steps taken on advice or proposals put to it by the Council. In addition, the meetings of CHCs, AHAs and RHAs will be open to the public and the press in the same way as meetings of local authorities.

9. These are innovations intended to provide a new means of representing public opinion on the health services to the authorities responsible for managing them, and more public reporting by the press. The task now is to develop the CHCs into a powerful forum where consumer views can influence the NHS and where local participation in the running of the NHS can become a reality. It will be important to establish a constructive dialogue between the CHC and the DMT of its district. It is particularly important that CHCs should be consulted about developments in the services in their district at a formative stage when their views can influence decisions. Both CHCs and DMTs are new concepts and need time to establish their own working methods and mutual relations, which should evolve in the light of experience. The Government does not wish to impose a rigid pattern nor to rule out local experimentation and variation; it will however take a particular interest in the ways in which CHCs are consulted on developments, and will consider in the light of experience whether more detailed guidance on this is needed.

10. The Government has already reached certain decisions which will strengthen the role of CHCs. These, together with proposals for a National Council to advise and assist CHCs, are set out in paragraphs 23-24.

Constitution of AHAs

11. The 1973 Act provides for consultation and collaboration between AHAs and local authorities. They provide services which are closely related but

separately administered. Given this separation of functions, the new arrangements for joint planning and consultation through statutory Joint Consultative Committees (JCCs), supported by groups of officers, are certainly needed. But there are fewer elected local authority members serving as members of AHAs than were envisaged in 1970, and the Government consider this to be a serious weakness in the present arrangements. In particular, outside the metropolitan districts and the London boroughs, there are no arrangements for ensuring the appointment to AHAs of members of the district authorities responsible for housing and environmental health. At present most AHAs have 4 members directly appointed by the county, metropolitan district or London borough councils; a few have from 5 to 8. The Government wishes a third of the members of each AHA to be members of local authorities, the proportion proposed in the 1970 Green Paper. Proposals for increasing the number of local authority members and for providing a direct link with the membership of the CHCs are in paragraph 18.

12. The Government also believes that it is essential that the National Health Service should take more account of the contribution which all those who work in the service can make to its management. In addition to the development of procedures for effective staff consultation, it would like to see members of AHAs drawn from amongst all who work in the health service in addition to doctors and nurses who already serve. Proposals to this end are made in paragraph 22.

13. The proposals in paragraphs 18-22 would mean an increase in the size of AHAs. At present most have about 15-19 members, eight have more than 21 and the largest has 28. Implementation of the new proposals would mean that 59 of the 90 AHAs in England would have 25 members or less. Their strict application would produce a number of AHAs with more than thirty members. The Government is conscious of the undesirability of authorities becoming too large. For these authorities, a balance must be struck between the desirability of increasing the elected membership and avoiding the creation of unwieldy authorities; the Government will give special consideration to this in making decisions on their total membership. There will be opportunity to look again at the total and balance of membership within AHAs when the tenure of those already appointed ends in three years time.

Regional Health Authorities

14. The Government is considering urgently the report of the Royal Commission on the Constitution in relation to Scotland and Wales, and will be making proposals. These may affect the health service. The Royal Commission's report will also be studied in relation to England. In view of this the Government is making no proposals at present for changes in the functions of the English RHAs. The number of members drawn from local authorities at present varies considerably from one RHA to another. The Government wishes to secure that each RHA has about one third of its members drawn from local government. Proposals for the addition of more local authority members and of staff are made in paragraphs 20 and 22.

Role of the Members of Health Authorities

23 15. The Government does not believe that it would be in the interests of the health service if members drawn from other organisations or groups were to act as a lobby either within the health authority or within the body by which they were nominated. All members of health authorities should participate fully and objectively in the counsels of the authority and must share equally in responsibility for all its decisions and its use of resources provided by the Secretary of State with the authority of Parliament. It will not be their responsibility to represent local authority, staff or Community Health Council interests.

24 16. Members from local authorities will bring with them their knowledge of related local government services, and provide a link with the people whom they have been elected to represent on the local authority. Cross-membership will enrich the contribution members can make to both the bodies on which they serve, and their first hand knowledge of each will enable them to promote an informed understanding between authorities. This will be particularly valuable and will reinforce—but in no way replace—the vital network of working relationships and statutory consultation between health and local authorities in which the Joint Consultative Committees have the central role.

17. NHS staff members will contribute their individual knowledge and working experience. They will be aware of the views of their fellow workers, and will help to ensure that authorities are fully responsive to the importance of staff relations in all aspects of their work. They will provide a valuable complement to the statutory professional advisory committees and also to the separate arrangements for staff consultation, the development of which the Government regards as highly important.

Proposals

(i) Membership of Health Authorities

25 18. As a general rule, each CHC should elect two of its own members, at least one of whom would be a district councillor, to be appointed by the RHA to serve for 2 years as a member of the AHA responsible for the CHC's district; CHCs in single-district areas should elect four of their members including at least two district councillors, providing a minimum of four CHC members for each AHA. To ensure that one third of the total membership of the AHA is drawn from local government one or two additional appointments should where necessary be made by the local authority or authorities matching the AHA. As mentioned in paragraph 13 these arrangements will need to be modified in areas where the result would otherwise be large AHAs.

26 19. The 1973 Act precludes members of CHCs serving on AHAs so that unless the Act were amended members elected from the CHC would have to resign from the CHC while serving on the AHA; it would be desirable that they should, wherever possible, then be reappointed to the CHC. There are arguments for and against a member of a CHC serving simultaneously on the AHA; the Government would welcome views on this in the light of which it will consider whether legislation should be introduced to allow concurrent membership.

20. Additional appointments should be made by the Secretary of State to Regional Health Authorities to ensure that one third of the members of each RHA are councillors drawn from local authorities matching the AHAs. In the first instance it will probably be necessary to invite nominations from all such authorities which do not have a member already on the RHA and for the Secretary of State to select those to be appointed, but the Government proposes that in future the local authorities concerned should arrange among themselves to nominate whatever number of councillors the Secretary of State determines for appointment by her to each RHA.

21. AHAs already have a minimum of two doctors and one nurse amongst their members, appointed by the RHAs after consultation with the professional organisations. Such appointments will continue but the Government believes that it would be preferable for the professions themselves to elect or nominate the persons to be appointed instead of putting forward a larger number of names from which the RHA selects. Similar arrangements for appointment of medical and nursing members of RHAs would in the Government's view also be desirable. The Government will welcome the views of the professions on this and on methods of election or nomination, which might perhaps be linked to the procedures evolved by these professions for elections to Medical and Nursing Advisory Committees under Section 8 of the 1973 Act.

22. Two members drawn from staff employed in the NHS, other than doctors and nurses, should be appointed by the RHA to each AHA and by the Secretary of State to each RHA. The Government will consult staff interests through the Staff Side of the NHS General Whitley Council on methods of choosing these members. The Government believe it is for the staff interests to decide whether or not to have direct elections, and if they so wished the Government would arrange for AHAs and RHAs to conduct them. A maximum of two such members is fixed with regard to the existing number of medical and nurse members and the need not to make the authorities too large as explained in paragraph 13.

(ii) Community Health Councils

23. The decisions referred to in paragraph 10 which the Government has already taken to strengthen the role of Community Health Councils are:

- (a) Because of the very important part their Secretaries will have in influencing how successful the CHCs will be, the posts should be filled by open competition so as to give the greatest possible scope for attracting suitable candidates;
- 27 32 (b) One or more spokesmen of the DMT should attend CHC meetings when invited, where they would answer questions in public session;
- 28 (c) In addition to the arrangements described in paragraph 18, CHCs should be among the bodies consulted by RHAs before making appointments to AHAs; the Government hopes that RHAs will attach weight to prior service on a CHC;

2 7 (d) In future appointing bodies should not feel inhibited from inviting NHS employees or family practitioners to serve as members of CHCs unless they are also members of Regional or Area Teams of Officers or District Management Teams; it will be for each individual to decide whether to accept an invitation;

(e) CHCs should have a special responsibility in relation to hospital closures. The Government is currently reviewing the procedures for consultation on proposed closures. But the establishment of CHCs enables it to make one change in the present arrangements without further delay. Guidance already issued to health authorities makes it clear that CHCs should be consulted about all hospital closures. At 30 present all closures are subject to specific authorisation by the Secretary of State. In future where the CHC accepts the proposed closure this 31 authorisation will not be required. If a CHC wishes to object to closure then it will be expected to make a detailed and constructive counter- 32 proposal, with full regard for the factors, including restraints on resources, which have led the health authority to propose the closure.

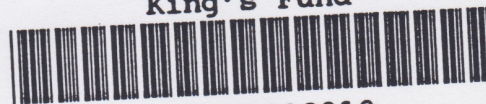
33 [These are firm decisions, about which health authorities have already been informed, and are not proposals for consultation.]

34 24. In addition the Government considers that there should be a National Council, with a budget drawn from central Government funds, to advise and assist CHCs. It believes that such a body could make a vital contribution towards enabling the CHCs effectively to fulfil their role as the local representatives of the users of health services. It would provide a national voice for CHCs; it could, for example, arrange conferences for members and staff of CHCs, promote and if necessary finance research into methods of ascertaining the 35 views of users of the health services, and undertake or arrange surveys of user opinion on behalf of CHCs. To be effective it would need its own Director and this would be a key appointment. The Government hopes and believes that CHCs will welcome the establishment of a representative National Council and it intends to enter into discussion with them as soon as is practicable about arrangements to this end.

Action

25. In the light of comments received on the proposals in paragraphs 18-24 the Government will take action as soon as possible, including laying before Parliament the orders necessary to increase health authority membership. Written comments on these proposals should be addressed to Division HS1C, Department of Health and Social Security, Room A507, Alexander Fleming House, London. SE1 6BY. Comments are requested not later than 31 July 1974.

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