ESTABLISHING COMMUNITY HEALTH COUNCILS

An analysis of the creation and implementation of an innovation in social policy

by

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DECLARATION

The section entitled 'CHCs defined' in Chapter 2 (pp44-46) is based upon part of an article by the author entitled 'Community Health Councils', in Jones, Kathleen (Editor), The Year Book of Social Policy in Britain 1974, RKP, 1975, pp 101-118.

Part of the section entitled 'implications' in Chapter 3 (pp 57-61) is an extended version of part of a paper given by the author at the Social Administration Association Annual Conference 1975, entitled The Concept of Democratic Involvement in Health Care.

Some of the concluding comments in Chapter 6 (pp 123-124) are an amended version of part of an article by the author in Health and Social Service Journal, vol. LXXXV, No. 4466, 1975.

Part of the section entitled 'the Northern RHA's approach' in Chapter 5 (pp 75-95) is based upon a short factual article written by the author in collaboration with two colleagues: J. D. Emerson, J. S. MacKeith and D. Phillips, 'Establishing Community Health Councils: the Northern Region's approach', The Hospital and Health Services Review, April 1975, pp 131-133. The complete script of the article is given in Appendix 3 below.

ABSTRACT

The dissertation deals with the creation of Community Health Councils (CHCs) by the 1970-74 Conservative Government and their establishment by Regional Health Authorities (RHAs) under the guidance of the 1974 Labour Government. A detailed account is given of the establishment process in one region.

The origin of CHCs is related to: the participation movement; existing consumer and consultative bodies, and the 1966-70 Labour Government's plans for NHS reorganisation. The evolution of the CHC proposals is examined in relation to both the Conservative Government's plans for a managerial reorganised NHS and the activities of the Labour Opposition and other interested parties. Conclusions are drawn about the Government's level of commitment to local public representation in the NHS and about lessons learned from other consultative bodies. The 1974 Labour Government's approach to CHCs is then critically appraised.

The administrative procedures for establishing CHCs and possible alternative strategies for RHAs as establishing authorities are discussed, prior to an examination in detail of CHC establishment in one region. In the case study attention is focussed upon the impact which the RHA had upon the CHCs both in its formal role of executor of delegated legislation and informally in the style of its relationship with the fledgling councils. Comparisons are drawn with the activities of other RHAs. Membership, staffing and initial activities of the CHCs in the case study region are examined. After some conclusions are drawn about the process of creating CHCs suggestions are made about possible ways of enhancing their effectiveness.

KEY TO ABBREVIATIONS

AHA	Area Health Authority
AMT	Area Management Team
ATO	Area Team of Officers
BMA	British Medical Association
CHC	Community Health Council
CTCC	Central Transport Consultative Committee
DCCC	Domestic Coal Consumers Council
DHSS	Department of Health and Social Security
DMT	District Management Team
ECC	Electricity Consultative Council
FPC	Family Practitioner Committee
GCC	Gas Consultative Council
HMC	Hospital Management Committee
LHA	Local Health Authority
POUNC	Post Office Users National Council
RHA	Regional Health Authority
RHB	Regional Hospital Board
RTO	Regional Team of Officers
TCC	Transport Consultative Committee

INTRODUCTION

Community Health Councils (CHCs) were established under Section 9 of the National Health Service Reorganisation Act 1973. Their duty is to represent the interests in the health service of the public in their districts. In England there is one CHC for each health district or unitary area. Each CHC has between 18 and 36 members. At least half of CHC members are appointed by the relevant local authorities, at least one third by voluntary bodies with an interest in health and the remainder by the relevant Regional Health Authority (RHA). No member of a CHC may also be a member of a RHA or an Area Health Authority (AHA). CHCs have the right to visit health services premises (subject to certain restrictions), to be consulted on proposals for the development of services by the AHA and to meet the AHA at least annually. They must produce an annual report to which the AHA must reply. The Secretary of State for Social Services was given the responsibility for establishing CHCs, a duty which he was able to delegate, and did delegate, to RHAs.

The main purpose of this dissertation is to chart and analyse the process of creating CHCs in an attempt to answer the following questions:

What impact did the "participation" movement have upon the creators of CHCs?

To what extent did the creators of CHCs utilise the experience of the existing consultative and consumer councils in making their plans?

What is the potential for public representation in the NHS?

Can the public interest in the NHS be better met by external consultative mechanisms or internal public representation on management authorities?

Why did the 1966-70 Labour Government choose internal representation and the 1970-74 Conservative Government choose external consultation?

Why were the Conservatives' original CHC proposals so weak that they were universally criticised?

Why were the Conservatives willing to make some amendments to their original CHC concept but not enough to ensure CHC effectiveness?

Why did the Labour Opposition virtually ignore the CHC proposals in the National Health Service Reorganisation Bill?

Why did the 1974 Labour Government take some steps to strengthen and some steps to weaken CHCs?

Why did DHSS play such a recessive role in the establishment of CHCs contrary to the spirit of the legislation?

Why were RHAs - contrary to ministerial undertakings - given a great deal of power over CHCs and how did they use this power?

Finally can CHCs effectively represent the publis interest to the health authorities?

This last question cannot be answered here with complete confidence because the fieldwork of this study was completed in Spring 1975, only six months after CHCs had been established and before they had had the opportunity to demonstrate their effectiveness.

The study commenced in January 1974 and was undertaken in three different phases each relating to a different policy making level. The first phase relating to national government level embraced the conception of the CHC idea, the creation of a legislative framework for their establishment and functioning, and the issuing of guidance by the Department of Health and Social Security (DHSS). The second phase at RHA level involved interpretation of the legislative framework and guidance as the RHAs discharged their duty of providing for the establishment of a CHC for each of their health districts. The third phase at health district level concerned the CHCs themselves, electing chairmen, appointing secretaries, and setting about the task of representing the public interest.

Each of these phases required a different treatment. Because the research project commenced after the NHS reorganisation Bill received Royal Assent the study of the first phase had to be undertaken retrospectively using government publications as a major source of information. The second phase entailed different problems because in England there are 14 RHAs and they were given considerable latitude by the legislation

and guidance in their role as establishing authorities. In addition there were problems of access to information. Because of these constraints it was decided to study one RHA in detail rather than to attempt to obtain more general but inevitably shallower coverage.[1] It was thus possible (thanks to the wholehearted co-operation of the RHA concerned) to monitor closely the whole process of establishing CHCs in one region. This was followed through in the third phase by attending the inaugural meetings of all seventeen CHCs in the region and by attending as many of the second and third of the CHC meetings as was physically possible. All CHCs except one were visited at least twice, most were visited three times and further contact was made with chairmen, vice chairmen and secretaries at regional training sessions and seminars.

The choice of studying one region in depth was made easier by the knowledge that the only other large scale investigation of CHCs[2] included both a survey of all CHC members in England and Wales and a collection of all CHC minutes. With the knowledge that a national survey was being undertaken the major limitation of this study, that of parochiality, was lessened. The detailed regional information could be fitted into the more general national picture that was being drawn.

This limitation still exists, however, because the generality of the national information and the short time span of the regional study preclude the possibility of drawing precise conclusions about the specific impact which each RHA in its role as establishing authority had upon the development of the CHCs in its region. There are doubts, however, whether it would have been possible to reach these conclusions unless a very long term study had been carried out.[3] Klein and Lewis, who undertook the national study, found that even a three year research programme was too short for any definite conclusions to be drawn. They say: "we have become convinced that, given the slow pace of institutional evolution, our initial assumptions about the possibility

of reaching any firm conclusions on the basis of a three year study were over optimistic, even if the process of administrative change had not been so slow."[3] This statement was made in the context of evaluating the overall effectiveness or otherwise of CHCs but is equally applicable to effects on CHCs of the different activities of the authorities which established them.

What can be achieved by this kind of study is analysis in depth. It is possible to trace the ramifications of decisions made at the legislative and departmental levels through to the executive level and finally to CHCs themselves. A more general and less concentrated approach would miss the vital importance of the choices made by those bodies whose duty it is to interpret legislation, regulations and guidance and establish new institutions. In the first few weeks of their existence CHCs had to make decisions about their chairmanship, had to appoint secretaries (who are probably the most important agents in the development of individual CHCs) and had to make decisions about their accommodation. These decisions, as well as the nature of the relationship between the CHC and the NHS managers, can be (and were) very much influenced by the activities of the RHA members and officials who had been involved in setting up the CHCs. With regard to the establishment of CHCs the actors who came between the idea and the reality, between the conception and the creation, played a vital part: a part which only a study in depth can identify.

The dissertation is divided into two parts: the first is concerned with events at the national level where major decisions were taken, and the second referring to regional and district levels where the decisions were executed and the CHCs came into being. The three chapters in Part One deal with the background to CHCs, the 1970-74 Conservative Government's legislation on CHCs and the 1974 Labour Government's modifications to the plans. Part Two commences with a discussion of the

stablishment process followed by the regional case study. The final

apter is addressed to the questions posed above concerning the genesis

and functions of CHCs.