CHAPTER 2: CHCs INVENTED: THE CONSERVATIVE GOVERNMENT 1970-74

In Chapter 1 doubts were raised about the 1966-70 Labour Government's enthusiasm for local public representation in the NHS. The situation with regard to the 1970-74 Conservative Government is much clearer, although at first sight paradoxical. This Government created a new institution for local public representation (the CHC) but was in no way enthusiastic about it.

This apparent paradox can be explained simply. The NHS structure proposed by Sir Keith Joseph (Secretary of State for Social Services) was so managerial in nature that it had no place for public representation, so either the NHS had to remain without public representation, or a new consultative body outside the management structure had to be created. The second alternative was the only politically acceptable one, as Klein and Lewis note:[1]

> Upward accountability (the cornerstone of the hierarchical structure) is scarcely compatible with accountability to local communities or professional peers (and if representative members were not so accountable then what was representative about them?) But the political consequences were distinctly uncomfortable. It meant that, following the massacre of HMC members which at a stroke removed the largest element of lay participation in the management of the NHS, there was a conspicuous absence of anything remotely resembling consumer representation in the reorganised service."

CHCs were thus added on to the main structure after it had been designed but not so late as Dr. David Owen mistakenly asserted - "during the process of legislation, being grafted on to the Bill."[2] Informed sources claim that initial discussions on CHCs took place in DHSS meetings on the subject not of public representation but of integrating local services.[3] One of the ministers involved is reported as saying, "the idea suggested itself as soon as we had decided to go for unrepresentative AHAs."[4] This supports Haywood's claim that "the low degree of priority given to local consumer representation in the reorganisation

of the NHS is not an oversight and it is a reflection of the lack of importance attached to it by those who run the service."[5]

The development of the concept

The Government's plans: the idea of CHCs first saw the light of day in a DHSS pamphlet, National Health Service Reorganisation: Consultative Document,[6] known as the Consultative Document. It was modified in the White Paper National Health Service Reorganisation: England.[7] CHCs were dealt with in section 9 of the National Health Service Reorganisation Bill,[8] which underwent several changes before the National Health Service Reorganisation Act[9] was passed. Details of CHC structure and function were dealt with by statutory instrument (regulations)[10] and DHSS circular (guidance).[11]

CHCs were given scant attention in the Consultative Document and little in the White Paper, the main concern in these was the NHS management structure which was based on Crossman's plans but with the following differences. The regional tier was to be strengthened making AHAs directly responsible to regional health authorities (RHAs). All RHA members were to be appointed by the Secretary of State. Membership of AHAs was to be composed as follows: of a total membership of normally fifteen, nine were to be appointed by the RHA, four by the local authority, one by the university, and the chairman by the Secretary of State.[12] Finally there would be no statutory tier at district level, but each district would have a statutory consultative council - the CHC.

The Conservatives' plan, although similar in structure to Labour's, had a very different emphasis. The Consultative Document which set the tone of the Conservatives' stance was unequivocal in its emphasis upon effective management: "As the document's brief statement of the Government's proposals for a new health services structure makes clear, their essence - and their basic difference from earlier proposals - is

the emphasis they place on effective management. The importance of good management in making the best use of resources can hardly be overstated."[13] More specifically its basic credo is as follows "there should be maximum delegation downwards, matched by accountability upwards, and . . . a sound management structure should be created at all levels."[14] This strong emphasis upon chains of accountability (delegation was always given less emphasis) and managerial efficiency leaves no place in the authority structure for local public representation, and the Consultative Document was strongly critical of Crossman's proposals of giving NHS authorities a representational character, on the grounds that this "would have led to a dangerous confusion between management on the one hand and the community's reaction to management on the other."[15]

The document was extremely vague about the bodies whose job it was to express the community's reaction to management. Only the following information was given: CHCs were to be established by AHAs, their members were to be appointed by AHAs after consultations with "a wide range of interested organisations;" they were to be consulted by AHAs on the development and operation of health services and were to issue an annual report; CHCs were to be set up to ensure that "in making plans and operating services, area authorities take full account of the views of the public they serve."[16]

In response to strident criticisms of CHCs' lack of independence (discussed below) proposals were put forward in the White Paper for local authorities to appoint one half of CHC membership and for the AHAs to appoint the other half "mainly on the nomination of voluntary bodies concerned locally with the NHS."[17] The CHC role was redefined as "to represent to the AHA the interests of the public in the health services in the district."[18] AHAs were to be given the duty of replying to any

report the CHC might wish to issue and there was to be an annual meeting between the AHA and CHC.[19]

While the Government was strengthening the structure of CHCs the team which was making detailed plans for the reorganised NHS was weakening CHC functions. The NHS Management Study Steering Committee comprising DHSS officials, management consultants and academics had in 1971 in its First Tentative Hypotheses laid stress upon CHCs participating in health service planning[20] but when the final report was published in 1972 (Management Arrangements for the Reorganised National Health Service - the Grey Book) CHCs were completely excluded from any management or planning functions. The report dismissed CHCs thus: "The composition and function of the Community Health Councils were not examined since this was covered in the White Paper"[21] - but the White Paper made no mention of CHC involvement in planning.

The first draft of the Bill was similarly vague over CHCs. Matters dealt with in Section 9 were: the duty of AHAs to establish CHCs; the duty of the CHC "to represent the interests in the health service of the public in its district," and the right of the Secretary of State to pay expenses to members. Matters delegated to regulations by the Bill were: membership; the appointment of chairmen; proceedings; staffing and financing by AHAs; the right to inspect NHS premises; procedures for CHCs advising AHAs; the publication of CHC reports and the publication of replies by the AHA.[22]

The Bill had an unusual passage through Parliament, starting in the Lords instead of the Commons. This was because of the crowded timetable of the 1972-3 parliamentary session. The stages the Bill passed through were as follows:

15.11.72, Lords First Reading: no debate[23]

12.12.72, Lords Second Reading: all speakers criticised the lack of independence of CHCs, the minister gave an undertaking to improve this.[24]

23.1.73, Lords Committee Stage: the minister agreed to put composition of CHC membership in the Bill and to make more flexible provisions for staffing, finance and accommodation.[25]

3.2.73, Lords Report Stage: the minister introduced amendments which made the Secretary of State responsible for establishing, staffing financing and accommodating CHCs and gave him the right to delegate this duty to RHAs; he also introduced amendments which provided for membership appointment procedures to be laid down in the Bill.[26]

27.2.73, Lords Third Reading[27]

26.3.73, Commons Second Reading: a national CHC body was suggested.[28]

15.5.73, Commons Committee Stage: the minister suggested guidelines for CHC activity.[29]

12.6.73, Commons Report Stage: amendments were passed prohibiting cross-membership of CHCs and NHS authorities and permitting the establishment of a national CHC body.[30]

19.6.73, Commons Third Reading.[31]

5.7.73, Royal Assent.[32]

Section 9 of the Act was considerably longer than that of the first draft of the Bill. There were four major additions: first the membership composition of CHCs was written into the Act in considerable detail; secondly cross-membership of CHCs and NHS authorities was prohibited; thirdly, the Secretary of State was given the power to make regulations providing for the creation of a national body to advise and assist CHCs and to perform any other functions as may be prescribed, and fourthly provisions could be made by regulation concerning AHAs furnishing information to CHCs. In addition there were three important alterations - first it was now the duty of the Secretary of State not the AHA to establish CHCs; secondly regulations were to be made about the election rather than the appointment of CHC

chairmen, and thirdly the AHA was no longer given the duty of staffing, financing and adcommodating CHCs.[33]

The regulations were laid before Parliament (without debate) on 31st December 1973. Their purpose was to "make provisions as to the establishment of community health councils and the performance of functions by such councils and for their membership, staff, premises and expenses."[34] Departmental guidance was issued in a NHS reorganisation circular in January 1974.[35] DHSS officials had been working on the regulations and guidance for several months, and a draft of suggested regulations and guidance was circulated in August 1973. Only a few minor changes were made between this draft and the final publication.

reactions to the plans: the original CHC plans met with at best an unenthusiastic and at worst a highly critical responses. In the British Medical Journal the BMA General Medical Services Committee cast doubts upon CHC effectiveness[36] and an article in the Lancet claimed that CHCs would be inadequate as bodies to represent the public interest.[37] In a parliamentary debate on the Consultative Document Mrs. Shirley Williams made the following swingeing criticism:[38]

> This is the strangest bunch of administrative eunuchs that any Department has yet foisted upon the House - a kind of seraglio of the Secretary of State of utterly useless and emasculated bodies which have no powers. I am sorry - they can visit hospitals. How nice for them. So can most of us. They can, if they wish, produce an annual report, but nobody would read the annual report because the community health councils have ho power to affect anything at all. They are to be appointed, just to ensure that they are totally powerless, by the area health authorities.

After the publication of the White Paper only one enthusiastic commentator could be found in the academic press - Malcolm Johnson of the Nuffield Centre for Health Services Studies at Leeds University. He said "community health councils, if they are

developed in the spirit of the White Paper, are a new and exciting innovation in the NHS. They are an implicit recognition of the delicate balance of social exchange which underlies the concept of socialised medicine."[39] Others were still not happy. Peter Draper and Tony Smart, in a paper published by Guy's Hospital Medical School, insisted that "to develop genuine public participation management powers would have to be introduced."[40]

During the passage of the Bill no member was happy with CHCs - except the ministers who had a vested interest in them. Dissatisfaction ranged from outright condemnation of the managerial concept with its exclusion of public representational mechanisms from the management structure (the official Labour Party line) at one end of the spectrum, to support for the concept of consultative councils but opposition to the powerlessness and lack of independence of CHCs as expressed in the Consultative Document, White Paper and Bill at the other end.

Changes in the concept

In response to this concerted criticism several important changes in the CHC concept were made when the Bill was amended in Parliament. Heartening though this may be to supporters of the sovereignty of Parliament the main reason was the Conservative Government's lack of interest in CHCs. As one minister said "(we had) no fixed ideas on how (CHCs) should be constituted or how they should work. We were much happier to make concessions on this part of the Bill than on the management structure. And it always helps politically to make some concessions."[41] Even so the Conservative Government was in a strong parliamentary position. It had a majority of 31 in the House of Commons and a traditional inbuilt majority in the House of Lords. It was therefore able to force its NHS Reorganisation bill (and in particular the section dealing with CHCs) through Parliament without

amendment if it could be assured of support from within its own ranks (which it could on this issue.)

The Government was in a position to insist upon any point about which it felt strongly. Therefore any changes to be made to CHCs during the passage of the Bill were either approved of by the Government or were on matters which it considered to be relatively insignificant, and it can be assumed that the Government would not give way on any matters which it considered to be important.

Before discussing the actual changes made as the Bill passed through Parliament it is worth introducing the major protagonists. The three government ministers with a responsibility for CHCs were Sir Keith Joseph, Lord Aberdare and Mr. Michael Alison. Sir Keith Joseph who was Secretary of State for Health and Social Services, and in overall charge of the Bill, is a most unusual politician. Universally respected for his integrity (if not his wisdom) he is not afraid to hold unconventional views and is one of the Conservative Party's leading theorists. He popularised the "cycle of deprivation" theory of poverty and was an uncompromising disciple of the managerialist movement. When at the Ministry of Housing and Local Government he pioneered the development of high rise flats. Never afraid to admit his mistakes (a rare attribute in politicians) he has revised his earlier views on the advantages both of high density council housing and managerialism.

Lord Aberdare who was Minister of State for Health, had the task of piloting the Bill through the House of Lords. He performed this task conscientiously but succumbed to occasional outbursts of impatience, on one occasion accusing the whole House of Lords of being unduely difficult over CHCs,[42] and on another accusing Lord Garnsworthy of "turning a hostile face and thumping the table"[43] - much to Lord Garnsworthy's and the House's surprise. Mr. Michael Alison, Under

Secretary of State for Health was, on the contrary, a model of urbanity and was a skilled debator, on one occasion making Richard Crossman (no mean debator himself) look decidedly foolish by pointing out with considerable irony that in Crossman's plans for a "participatory" NHS the medical profession would have the same proportion of AHA members as would the consumers.

The Government of course was not the only agent at work. Her Majesty's Opposition played a part in the proceedings and its stance can be evaluated, with some surprising results. More important than the Opposition's activities though were the efforts of a few individual members who engineered significant changes in CHC structure without party support. In the House of Lords Baroness White, the indefatigable ex-chairman of the Fabian Society, was the most influential member. She wrung concessions from the Government on CHC establishment, staffing, finance and accommodation and ensured that membership provisions were written into the Bill. She also attempted unsuccessfully to get permissive powers for election of CHC members to be written into the Bill. She was closely involved with voluntary organisations, particularly the National Council of Social Service.

In the House of Commons Mr. Christopher Mayhew ensured that two fundamental amendments were made to the Bill prohibiting cross-membership between CHCs and NHS authorities and permitting the creation of a national CHC body. He too represented voluntary body interests in Parliament, being a spokesman for the National Association for Mental Health (MIND) from which the idea for a national CHC body first came. He was one of those brave (not to say foolhardy) Members of Parliament who have crossed the floor of the House, resigning the Labour Whip to join the Liberals.

The changes made to the CHC concept during the passage of the Bill and subsequently in the regulations and guidance will be discussed under the following headings: establishment; membership; staff, finance and accommodation; terms of reference; and a national body.

<u>establishment</u>: on the first occasion when the Bill was debated (Lords second reading) there was an outcry from both sides of the House about CHCs being established by AHAs. Not a single back bench speaker spoke in favour of this, which led the minister to give assurances that improvements would be made.[44] In the course of the committee stage however it soon became apparent that there were few viable alternatives to the AHA as establishing authority. The two most popular alternatives were the local authority and the Secretary of State. The Government ruled out local authority establishment as being impracticable. It also disapproved of the Secretary of State being given the duty of establishing CHCs. The minister said "I should have thought that this was the very last thing he should do. There would be grave difficulties if that were to happen."[45] He went on to explain that the central department could not possibly set about finding members, staff and accommodation for 200 local bodies.

Eventually though the Government did come to see the force of the argument against AHAs establishing CHCs and the minister introduced an amendment giving the Secretary of State the duty of establishing them. But he then insisted again that DHSS could not possibly do this itself and would delegate the duty to RHAs - thereby giving the House a hollow victory.[46] The major argument against AHAs establishing CHCs - the threat to their independence - is only slightly less strong against the RHAs. However this was probably the only practicable alternative to establishment by the AHAs and little further criticism of it was made.

membership: the debate on membership was far more heated because there was a greater variety of choice in the matter and it had longer-term significance. At Lords' committee stage the minister stated the Government's commitment to making CHCs representative and then explained why the AHA had been chosen to appoint members:[47]

> The important matter on which we are all agreed is that the community health councils should be representative of local opinion and it has been our thought hitherto that it would be easiest and more effective if the appointments were actually made by the Area Health Authority - although we are open to suggestions about this - simply because within the Health Service, which is the body in which these community health councils will be engaged, this is the most local body we can find who will know the local conditions.

This is a revealing statement. Appointment by the AHA is certainly the easiest way but it is difficult to believe that the Government could consider it to be the most effective way. The Government had been criticised right from the publication of the Consultative Document through to the drafting of the Bill on this point and it is difficult to believe that they would really think it appropriate to have a HMC-type appointment procedure for a body which was to represent the community rather than the health service. Such an appointment procedure would lead to the antithesis of Joseph's "community's reaction to management" - it would be "management's appointees' reaction to management."

The Government was willing to change the Bill but had no ideas itself on how membership composition should be organised: "We will put forward amendments on report in the light of the further discussions we may have today on what the composition should be."[48] It would appear from this that as far as membership was concerned the Government was not particularly committed at all to achieving genuine local representation and just took the easy way out with AHA appointments.

The minister's statement concerning 50% local authority appointments - "this immediately means that the Area Health Authority cannot have a majority of members on the community health council,"[49] - adds further weight to the hypothesis that the Government thought of the AHA appointees as "NHS representatives" rather than "community representatives". Furthermore at no stage did the Government consider the possibility that health authorities need not appoint any members to CHCs, i.e. at no stage did they consider the possibility of totally independent membership for CHCs. The argument was fought on the basis of levels and types of dependence. The appointment of members by AHAs may or may not have been a deliberate attempt by the Government to weaken CHCs, but it was certainly something on which they were willing to give way, if only gradually.

During the Lords report stage the Government moved a series of amendments which would enshrine the composition of membership in the Act (one half local authority, one third voluntary body and one sixth RHA appointees.) This was very much a compromise because it still gave NHS authorities a great deal of control over appointments (though it was now the RHAs, not the AHAs). The minister said "the decision on which voluntary bodies shall have the right to make appointments to this one-third is to be decided by agreement between the regional health authority and the equivalent local authority."[50] This would have passed unnoticed apart from the vigilance of Baroness White who asked if arrangements could be made for voluntary bodies to decide amongst themselves which of their number were to make appointments.[51] The minister replied:[52]

> Our intention was that if, for example, there were ten places to be filled by voluntary bodies, the regional

health authority and the local authority concerned would nominate ten voluntary bodies, each to put up one. This is something that we could think about again but that was our intention.

The minister accepted in principle that voluntary bodies themselves could choose which of them was to appoint a member but the regulations relevant to this when drafted gave the RHAs considerable freedom of choice. They had to prepare lists of voluntary bodies with an interest in the NHS, and from these lists had to determine "after consultation . . . which voluntary bodies shall be invited to take part in appointing members."[53] Then these voluntary bodies had to determine which of their number were to appoint members. Therefore an RHA could still choose e.g. ten bodies to fill ten places and it could certainly exclude any individual voluntary body from appointing members thereby retaining control over the character of CHC voluntary body membership.

On two occasions Baroness White unsuccessfully introduced amendments which would permit direct election of some CHC members at a future date. An attempt by Dr. Shirley Summerskill in the Commons committee stage to increase the proportion of local authority members on CHCs also failed. One change concerning membership proposed by a backbencher was successful. This was Christopher Mayhew's amendment prohibiting cross-membership of CHCs and NHS authorities which was accepted without debate or division. The proposal was fully in accord with the Select Committee on Nationalised Industry's conclusion that cross-membership of councils and authorities can only be harmful to the councils' independence but was counter to the interests of Labour Party policy. Its implications will be dealt with in Chapter 3.

The Government was therefore willing to make some changes in membership appointments but still insisted that the health authorities should exercise control over one half of CHC membership.

staff, finance and accommodation: the Government's willingness to rethink over these matters was expressed by the minister in Lords committee as follows:[54]

> Finance, premises and staff are again matters which we wish to look at. I think that we have not got them quite right at the moment . . . .. When we come to the matters of staff and expenses in general, I am not sure that the Bill is flexible enough at present with staffing and premises, which all need considering in the light of local circumstances in each district.

In the Lords report stage the Government introduced amendments which would take away from AHAs the duty to staff and finance CHCs. It now became the Secretary of State's duty, which again could be delegated to the RHAs. Over finance this would make little difference to the original intention, and over staffing none. The Government still insisted that the RHA, not the CHC, would choose CHC staff, although the CHC would have the right of veto. The minister said the Government thought this would work to everyone's advantage: "The officers concerned would enhance their value to the National Health Service, and therefore their career prospects in the service."[55] He neglected to mention however that this would be a most effective way of muzzling potential criticisms of the service by CHCs. It would not enhance the career prospects of an officer in the NHS to complain about the actions of his employers, colleagues and peers - a task which a conscientious CHC secretary might need to undertake.

This was one issue which raised the Labour Opposition in the Commons from its apathy over CHCs. Its criticisms prompted the Government to show their hand on this matter and thereby to reveal the inconsistencies of their position. In committee, the Under Secretary of State said: "I am able to give . . . the specific undertaking that my right hon. Friend (Sir Keith Joseph) is anxious to secure at all costs the clear independence of the community health councils . . . ..

We do not want to inhibit the community health councils in any way."[56] He then went on immediately to break the undertaking by stating that the RHA not the CHC would choose the CHC's accommodation the CHC only being "consulted". Sir Keith Joseph himself said about staffing: "I am . . . asserting that we think that the right staff should be culled or chosen from people who are in the NHS as a career"[57] (emphasis added) and "I should have thought that the career of any sensible administrator in the health service ought to include a stint with a community health council. So far as lies in our power to do so, we shall ensure that this is the attitude."[58]

Their power being not inconsiderable they were able to ensure that the RHA not the CHC was in control of CHC staffing. Under the regulations the RHA had to appoint a secretary to the CHC who was acceptable to the CHC, and the guidance lists in order of preference for the posts: serving NHS officers within the region, recently retired NHS officers and finally "people from outside the NHS with experience of voluntary work in the health or social services field who would be interested in holding a CHC secretary post for a limited period."[59] (emphasis added)

There is a contradiction between the Government's claim "to ensure at all costs the complete independence" of CHCs and their attitude over staffing and accommodation.

terms of reference: there was surprisingly little discussion of this during the passage of the Bill. Apart from the inclusion of a subsection allowing for regulations to be made concerning the consultation of CHCs by AHAs[60] the only important thing to emerge was a checklist of possible CHC activities given by the minister during the Commons committee stage. It was as follows: monitoring the quality and adequacy of services; criticism and comment on plans; surveillance, criticism and monitoring of proposed changes; commenting

on the extent to which local standards match up to national norms; patient facilities, waiting lists etc.; catering; acting as a "patient's friend", and ensuring that complaints procedures work well.

The regulations however introduced a new retriction over the disclosure of information by AHAs to CHCs. If an AHA refused to disclose any information requested by the CHC then the "decision of the establishing authority (i.e. the RHA) as to whether the information is reasonably required by the council in order to carry out its duties or as to whether the area authority may regard the information as confidential shall be final."[61] This regulation, the content of which was not alluded to in Parliament, is a deliberate and serious limitation on the potential effectiveness of CHCs. It deprived the CHC of the right of access to the Secretary of State. There is a further problem in that different RHAs might impose difference definitions of what is reasonable.

<u>a national body</u>: this was suggested first by the National Association for Mental Health and proposed by Christopher Mayhew at Commons second reading. Neither the Government nor the Opposition had thought about it, which is surprising considering both the Consumer Council's and the Select Committee on Nationalised Industry's, recommendations about the advisability of national bodies, as noted in Chapter 1. John Silkin and Timothy Raisin (two unlikely collaborators) followed up Mayhew's proposal in committee where the minister gave an undertaking honoured in the report stage that the Government would introduce amendments to enable such a body to be created at a later stage if desired.

CHCs defined*

The Act, regulations and guidance provided the Conservative Government's definitive framework for CHCs. It is as follows:

establishment: it was the duty of the Secretary of State to establish CHCs. That duty was delegated to RHAs who were expected to have all CHCs established by the end of April 1974.[62]

membership: CHCs would normally have a membership of between eighteen and thirty. Half of the members were to be appointed from each local authority whose area, or part of it, was included within the CHC's district. It was up to the relevant local authorities to decide amongst themselves how many appointments each should make. In case of dispute the RHA had the power to intervene. One third of CHC members were to be appointed by voluntary organisations with an interest in the health services in the CHC's district. Deciding which voluntary organisations should make appointments was a convoluted process which gave the RHA considerable freedom of choice. The remaining members were to be appointed by the RHA itself, after consultation.[63]

terms of reference: CHCs were given the duty to keep under review the operation of health services in their districts, make recommendations or otherwise advise AHAs and to produce annual reports.[64] CHCs were given the right to be consulted by AHAs on any proposals for substantial development or variation of health service provision; to obtain information from AHAs about the planning and operation of health services as may reasonably be required to carry out their duties; to

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*This section, which contains only factual information, is based upon part of an article by the author entitled 'Community Health Councils' in Jones, K. (Editor), The Year Book of Social Policy in Britain 1974, RKP, 1975, pp.101-118.

enter and inspect any premises controlled by AHAs except staff residences and general practitioners' surgeries; to receive written replies from AHAs to annual (and any other) reports and to meet the AHA at least once a year.[65]

staff, accommodation and finance: "the establishing authority (RHA) shall appoint a person acceptable to the council to act as secretary to the council."[66] DHSS guidance made it quite clear that NHS personnel were to be given first choice for the post of secretary. "It shall be the duty of the establishing authority to provide a council with such office and other accommodation as that authority considers necessary." The CHC had no right either to reject premises offered it or to find its own premises (but it could find its own premises if the RHA agreed.)[67] "It shall be the duty of the establishing authority to approve such expenses as that authority considers may reasonably be incurred by a council. The payment and accounting facilities of the relevant area authority should be used and a separate bank account should not be necessary."[68]

constitution: members were to hold office for four years except in the case of first appointments, where half the members were to hold office for only two years.[69] Membership could be terminated by the appointing body if a member had not attended meetings for a period of six months. Members were not to serve more than two consecutive terms of office. Elections were to be held for the posts of chairman and vice-chairman. CHCs could appoint sub-committees and these sub-committees could co-opt up to one half of the number of CHC members serving in each sub-committee. Meetings were to be held at least once every three months and the quorum was one third of the membership.[70]

Potential effectiveness of CHCs

By the time the Conservatives' plans were finalised CHCs had taken the form of fully fledged consumer consultative councils - their role was to represent the public's interests to the NHS authorities. Therefore the structural criteria for effectiveness discussed in Chapter 1 (independence, wide terms of reference and sufficient powers) can be applied to them. As the non-structural criteria (concerned with the personal qualities of chairmen, officers and members, and the councils' effectiveness in publicising themselves) are relevant only to bodies which are in operation they cannot be used here.

independence: that is total independence from the "industry" in terms of establishment, membership, staffing, finance and accommodation. CHCs do not do very well on any of these counts. They were to be established, staffed, financed and accommodated by NHS authorities (RHAs). In addition the authorities themselves were to choose CHC staff from among NHS personnel (the CHC only having the right of veto, not the right to choose) and to choose CHC accommodation (with the CHC not even having the right of veto.) The authorities were to appoint one sixth of CHC membership and to have considerable control over a further third (voluntary body appointees.) It is true that all this is considerably better than in the original plans where the AHA had complete control over all these factors, but it still left CHCs totally dependent upon NHS authorities. On the plus side establishment by RHAs could enable CHCs within a region to have much more contact with each other and with the RHA than they might otherwise have had, but this is no substitute for independence.

terms of reference: here CHCs did much better. Their terms of reference were wide enough to enable them to consider any matters relevant to the public interest. The duty of AHAs to consult CHCs on major developments was written into the Act and the checklist of possible CHC activities given by the minister in Commons committee and repeated in the guidance gave CHCs as much scope as they needed.

sufficient powers: that is, a statutory right to be consulted, right of access to the minister, a national structure with independent advice and research facilities. CHCs do well on the first of these factors but no so well on the second. The only right of access to the minister given them concerned their establishment, staffing, finance and accommodation. In the crucial area of disputes between them and the AHA the regulations specifically forbade them right of access to the minister. This seriously weakened their powers. On the third factor the door was left open with permissive powers being given for the establishment of a national body at some future date.

Overall the potential for CHC effectiveness was mixed. Other things being equal they were given wide enough terms of reference to be effective - but other things were not equal. The CHC's total dependence upon the RHA for staffing, finance and accommodation was not only restrictive from the point of view of public confidence, it was positively detrimental to independent thought and action, as was the RHA's appointment of one-sixth of CHC membership and control over a further third. The denial of the right of appeal to the minister in cases of dispute again put CHC's firmly in the lap of the RHA. CHCs therefore could only be effective if RHAs and AHAs wanted them to be. Even with the widest terms of reference possible a CHC totally dependent upon NHS authorities and with no right of access

to the minister could not be effective if the authorities - and the CHC's own staff- did not wish it to be. This nullifies the whole point of consumer consultative councils. They should be able to be effective irrespective of the wishes of the authorities.

Political perspectives

the Conservative Government: in terms of potential effectiveness as defined here the Conservative Government's final CHC plans were badly flawed. If the Conservatives were as committed to effective local public representation as they said they were then the only possible explanation is that they could find no practicable way of making CHCs stronger. On first sight this explanation appears to be attractive. There is a good case to be made for RHAs establishing CHCs; in the establishment timetable which was envisaged RHAs were the only bodies which could have taken the job over from the AHAs. Secondly it was realistic to ask the RHAs to staff, finance and accommodate CHCs. A case can also be made for the RHA appointing one-sixth of CHC membership - these members could provide CHCs with valuable expertise - and an argument can be put forward for the RHA having a co-ordinating role in the appointment of voluntary body members.

On a close inspection however the picture becomes radically different. The Government broke a ministerial undertaking on the independence of CHCs by giving RHAs - not CHCs - the power to choose CHC secretaries and accommodation. There was no technical problem whatsoever (as the 1974 Labour Government demonstrated) about allowing CHCs to choose their own staff and premises. Nor was there a problem in financing CHCs from central DHSS funds. Even though they only had delegated powers by statute the RHAs were given the right by regulations to have complete control over which voluntary organisations could appoint CHC members even though the minister had agreed in principle to

the voluntary bodies having the right to choose from amongst their own number (and again as later events demonstrated there was no problem involved here - and even if there had been, voluntary bodies could have been given the right to attempt to choose from amongst themselves in the first instance). Finally the regulations without parliamentary mandate deprived CHCs of the right of access to the minister in the cases of dispute with the AHA. All of these actions were unnecessary curtailments to the potential effectiveness of CHCs.

Having discounted the only explanation completely consistent with the Government's stated commitment to creating effective CHCs there are only two possible explanations left, first (giving them the benefit of the doubt) that the Conservatives <u>were</u> committed to creating effective consultative councils but were using an extremely unusual definition of "effective" or secondly that they <u>were not</u> committed to creating effective CHCs but pretended that they were.

Were they working with a different definition of "effectiveness"? This is an attractive possibility, it leaves Sir Keith Joseph's reputation for integrity intact and fits in well with his advocacy of managerialism so forcefully expressed in the Consultative Document. Management is seen as a scientific undertaking where skilled professionals with no axes to grind make impartial, rational, correct decisions taking long, medium and short term factors into consideration as well as the relationship between national policies and local circumstances. The hierarchical authority structure with a system of monitoring and accountability ensures that nothing goes wrong. In this context consumer consultative councils are effective if they ensure that (as the Consultative Document put it) "local attitudes are known and safeguards built in". According to this approach any CHC which overtly disagreed with management would be acting in either a misguided or

mischievous fashion and CHCs should therefore be made dependent upon NHS authorities who can guide and educate them. Naive though it is, this approach is the only one which appears to be consistent with both the Government's stated commitment and its actions, and it is only consistent if one considers the breaking of a ministerial undertaking on CHC independence as an unfortunate aberration.

It is uncharitable, but perhaps more realistic, to affirm the second explanation - that the Government was not committed to effective CHCs but pretended that it was. This is the answer which best explains the initial lapse of memory - forgetting to create a consultative mechanism - and the lack of any complete plans even when the Bill had been drafted. Furthermore even if the doctrine of managerial infallibility is accepted there is still no real argument for refusing to give CHCs independence, certainly some CHCs might act irresponsibly during the early days, but if management is always right then surely it can demonstrate this and surely it is better for management to suffer a little inconvenience if the reward is public trust in its watchdog's independence.

The refusal to grant independence to CHCs is all the more baffling in the light of the Select Committee on Nationalised Industry's categorical insistence that "only when the consultative councils' independence is clearly recognised will the great amount of voluntary effort that goes so ungrudgingly into their working be requited". The Conservatives, when creating CHCs, either neglected to take note of or else ignored the Select Committee's recommendations.

The only sensible explanation of their actions is that the Conservatives, in spite of their protestations to the contrary, had no commitment at all to making CHCs effective. Once this explanation is accepted everything falls into place. After Crossman's promise of

increased local involvement in the NHS and the 'massacre' of HMC members in Joseph's plans it would have been politically damaging not to have created some sort of mechanism for representing local public interests. The Conservatives could not have done less than they did, in the Consultative Document they tried to create a totally ineffective body but were forced to improve their proposals in the White Paper and during the passage of the Bill. Even then they only gave way grudgingly on matters such as membership and establishment and never gave way at all on such crucial matters as staffing and accommodation. They engaged in a delicate juggling operation, on the one hand making political capital (or avoiding political damage) by creating a public representation mechanism, and on the other hand safeguarding the sanctity of management by attempting to ensure that public representation would not interfere with the running of the NHS.

The creation of CHCs was therefore nothing more than an act of political expediency. If the Conservatives had been wholeheartedly committed to CHCs they could have created a really worthwhile and effective system of community representation - but they were not and did not. It is a pity that such a rare opportunity for creating a valuable new social policy innovation was not used to its best advantage.

<u>the Labour Party</u>: at the end of Chapter I two possibilities were discussed concerning the 1966-70 Labour Government's stance: the first was that their stated principle of local participation might have been merely an expression of political expediency and the second was that it might have been deeply felt but impossible to operationalise because of the pressure of the medical profession.

Richard Crossman's statements when Opposition Health Spokesman throw light on the question. Unencumbered by the necessity for

diplomacy inherent to ministerial office he came into the open and said that local authority control was the best answer:[71]

> It is easier for me to say this now that I am not in office but there is, in reason, no case for saying that the great new local authorities, with very extensive powers, should not take over the health service. That would be infinitely more logical. It would have solved at one stroke the appalling division between the local authorities and the health service. There would have been proper democratic representation; we know why it is not being done - because the medical profession vetoes common sense in this respect. (emphasis added)

In passing it is worth noting that Sir Keith Joseph did not contradict this assertion, he merely stated "and there are financial reasons."[72] Crossman's statement is a very firm commitment to local authority control of the NHS with its "proper democratic representation." He went on to say "whatever we do will be a compromise which is not very satisfactory." This helps explain the inconsistencies in the previous Labour Government's plans for a "democratic" NHS.

The situation however becomes more complicated because of this. If the Labour Party accepted that whatever happens would be an unsatisfactory compromise then its best course of action would not be to wash its hands of the affair but to try to negotiate the best possible compromise. This would have to be done on two fronts: first by attempting to increase local public representation on the AHAs, and secondly by striving to ensure that matters concerning CHCs were dealt with in delegated legislation so that they could be changed without amending the Act on the occasion of Labour's return to power. The Labour Opposition did attempt, with no hope of success, to achieve the first of these aims but made no attempt at all on the second one (which it could have achieved with ease).

From Labour's point of view two depressing conclusions can be drawn from the passage of the Bill: first they would have been better off if no amendments at all had been made to the Bill - the first

draft was very vague and left almost everything to delegated legislation. Secondly it was their own members whose efforts led to the Bill being amended in such an unhelpful way. It was Baroness White who ensured that membership proportions were written into the Act thereby denying Labour the chance of giving local authority members a majority of CHC seats and it was Christopher Mayhew who introduced an amendment prohibiting cross-membership of AHAs and CHCs thereby excluding the possibility of CHCs becoming de facto district committees of AHAs, which was what the incoming 1974 Labour Government wanted to achieve.[73]

All was not lost though. The Secretary of State's duty to establish, staff, finance and accommodate CHCs was written into the Act and Labour peers had achieved this. Also the Labour MPs' attack on behalf of CHC independence did have the effect of bringing out into the open the Conservatives' intransigence over this.

Overall however Labour's showing was dismal. Arthur Blenkinsop, who had been Bevan's Under Secretary in 1946 when the NHS Act was passed, stated "we battle on in a manful way to try to get modest amendments made, to make the Bill less disagreeable and to improve its provisions."[74] - a hollow boast in the light of what they could have achieved if they had thought out their strategy and made a concerted effort. In spite of its brave words the Labour Party did more harm than good to its cause. Labour's commitment to democratising the NHS could not have been strong and its overall apathy towards CHCs left it in an embarrassing situation when it came into power eight months after the NHS Reorganisation Bill received Royal Assent and one month before it was due to be put into operation.

CHAPTER 3: A CHANGE IN EMPHASIS: THE LABOUR GOVERNMENT 1974

Changes and proposed changes

The February 1974 General Election which led to the formation of a minority Labour Government came at a bad time for the Labour Party with regard to NHS policy. For its policy (expressed in an Opposition Motion in December 1973) was to "postpone the coming into operation of the new service pending a full scale enquiry."[1] By the time it came into office in early March the Appointed Day for NHS reorganisation (1 April, appropriately enough) was less than a month away and it would not have been feasible to have postponed it.

The Government had inherited the reorganised structure and had to make the best of what it considered to be a bad job. Mrs. Barbara Castle, the newly appointed Secretary of State for Health and Social Services stated on March 18th, 1974 that "the Government was considering how, within the existing legilation and without overturning appointments already made, it could move to greater democracy within the structure."[2]

With regard to CHCs the first step the Secretary of State took was to send a "Dear Regional Administrator" letter asking RHAs not to appoint any CHC secretaries until the previous Government's guidance had been amended.[3] On May 16th, the Guardian reported that Mrs. Castle "does not believe that (CHCs) are either strong or democratic enough to function effectively" and that as a first step to strengthen them non-NHS employees were to be given a chance to become CHC secretaries.[4]

Meanwhile in Parliament on May 8th, a question was tabled about NHS employees serving as CHC members. Mrs. Castle, in a written answer, asserted that the guidance given by Sir Keith Joseph was too restrictive. She stated that appointing bodies should not feel inhibited from inviting NHS employees to be CHC members except with regard to members of regional and area teams of officers and of DMTs.[5] This was formalised in a second "Dear Regional Administrator" letter on

May 13th.[6] Yet another circular letter was sent to the RHAs on May 16th,[7] which related to CHC secretaries and contained guidance superseding that previously given by the Conservative Government. The basic points are: first that each CHC should choose its own secretary; secondly that CHC secretaryships should be advertised without restriction; thirdly that as part of their jobs CHC secretaries should make wide contacts in the community, and fourthly that a CHC secretary must have the ability "to represent the views of the CHC resourcefully whilst at the same time maintaining friendly relations with the officers of the AHA."

Further guidance issued on May 23rd, stated that: a spokesman of the DMT should attend CHC meetings whenever asked, to answer questions in public session; that CHCs should be consulted on appointments to AHA membership; that CHCs should have a special function with regard to hospital closures (to be discussed in detail below) and that CHC members should be resident in the CHC's district.[8]

On May 30th, 1974 yet another conultative document, <u>Democracy in the National Health Service: Membership of Authorities</u>[9] was published. This contained proposals for "democratising the NHS" which are as follows: first that each CHC should elect two of its members (at least one of whom would be a district councillor) to be appointed to the AHA and that in single district (unitary) areas the CHC should elect four members (including at least two district councillors) to the AHA. To ensure that at least one third of AHA members were local authority councillors the relevant regional health authority should if necessary appoint one or two extra councillors to the AHA;

Secondly, "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, whenever possible, then be reappointed to the CHC."[10] This convoluted proposal was of course made necessary by an amendment to the Bill prohibiting cross-membership proposed by a Labour MP and unopposed by the Labour Opposition;

Thirdly that the Secretary of State should make additional appointments to RHAs to ensure that one third of their members were local authority councillors; fourthly that medical and nursing personnel at present appointed to AHAs by the RHA after consultation with the professions should be chosen by the professions themselves and that similar arrangements should be made with regard to the RHAs; fifthly that two members should be appointed to each RHA and AHA drawn from NHS staff other than doctors and nurses; and finally "the Government considers that there should be a national council, with a budget drawn from central Government funds, to advise and assist CHCs."[11]

Not all of these proposals were put into practice. In July 1974 the Secretary of State announced that one third of RHA and AHA members should in future be appointed by local authorities and that two non-medical non-nursing staff should be appointed to RHAs and AHAs.[12] The recommendation in the consultative document about CHCs electing members to AHAs was dropped after strong criticism, not least from among the CHCs themselves. As a way of increasing communication between CHCs and AHAs guidance was issued asking AHAs to invite one member from each of their CHCs to attend AHA meetings with the right to speak but not to vote.[13]

The Government's decision to promote a national council for CHCs at first met with a mixed response from the CHCs themselves. The national advisers to CHCs which the Government appointed, Lady Marre and Councillor Ken Collis, found that some CHCs were strongly against the idea. (their criticisms have finally been overcome and a National Assocation of CHCs was formally established on June 15th 1977).

Implications

These changes were made during the process of establishing CHCs and one of the major effects was a psychological one. In press releases, interviews with journalists and in the consultative document ministers emphasised the importance of CHCs. This brought them into the limelight and enabled CHCs, if nothing else, to feel important. The implications of the changes for the actual functioning of CHCs were however mixed. On the plus side, apart from the Government's good intentions, were: the open advertisements for the secretaries' posts; the emphasis upon the community orientation in the secretaries' job description; the extra links with the DMT and AHA, the appointment of national advisers, and (although not to be discussed here) moves towards setting up a national council. On the minus side was the new "special function" of CHCs with regard to hospital closures.

CHCs, pluses: open competition for the post of CHC secretary was perhaps the most important single step the Labour Government took to make CHCs potentially more effective. The only job definition hinted at by the outgoing Conservative Government related to the career prospects for CHC secretaries within the NHS and to working relationships between the CHC secretary and other NHS personnel.[14] The incoming Labour Government placed an emphasis upon the CHC secretary working within the community; "CHCs may expect their secretaries to maintain links with every section of the community, to attend meetings of voluntary associations when invited, to have regular meetings with trade unions and other types of local organisations and generally to collect views about the working of local health services."[15] Given that the duty of CHCs is to represent local public interests in the NHS this approach is all to the good.

The new links with the DMT and the AHA were also a valuable addition because no such links had been previously specified. Previously it would therefore have been possible that the DMT might have refused to send a representative if asked and it would have been highly likely for any AHA to refuse to allow a CHC member to speak on request at their meetings. This formalising of links with the DMT and AHA was bound to increase communication between the CHC and the health authorities and therefore (hopefully) also to increase the potential for effective public representation.

The appointment of the national advisers was a useful step in enabling communication to take place between CHCs in different regions. Communication between CHCs within regions was helped by the series of seminars the RHAs had been asked to undertake and the advent of the advisers, travelling from region to region collecting and disseminating ideas, was of use in enabling much wider cross-fertlisation to take place.

<u>CHCs minuses</u>:* on the other hand the "special function" which the Labour Government gave CHCs with reference to hospital closures is a recipe for damage to CHCs' potential effectiveness as representatives of the public's interest. This is not to say that a special function with regard to hospital closures could not have been defined which would have enhanced CHCs' potential effectiveness. If the AHA's duty to consult all interested bodies had been delegated to CHCs (along with sufficient funds to carry it out effectively), if CHCs had been given the opportunity to investigate thoroughly any possible alternative policies and if the CHCs' final decisions were binding upon the AHA the CHC could perform a very useful role in representing the public interest. The actual "special function" created, however, put CHCs in a double bind situation.

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*This section is an extended version of part of an unpublished paper the author gave at the Social Administration Association Annual Conference in 1975 entitled <u>The Concept of Democratic Involvement in Health Care</u>.

The function of CHCs was made explicit in the consultative document thus:[16]

> At present all closures are subject to specific authorisation by the Secretary of State. In future when the CHC accepts the proposed closure this authorisation will not be required. If a CHC wishes to object to closure then it will be expected to make a detailed and constructive counterproposal, with full regard to the factors, including restraints on resources, which have led the health authorities to propose the closure.

This is an invidious move which saves the health authorities a great deal of trouble and puts the CHC in a difficult situation. Prior to this new instruction the health authority had to undertake exhaustive consultations with interested parties and of course had to submit to much local critcism if it decided to close a hospital.

It is now the CHC which has to undertake these consultations. It is the CHC which is blamed if any interested party is not consulted. The CHC now gets the blame if it agrees to a closure (and in so doing automatically prohibits any interested group from its last line of defence to the Secretary of State whose specific authorisation is no longer necessary). In addition the CHC has to finance the consultation from its own budget.

So the CHC is in an almost intolerable position as "representative of the local public's interests" if it agrees to a closure. Yet if it does not agree then "it will be expected to make a detailed and constructive counterproposal." Even if the CHC could find the money, the information and the professional personnel and could, in the limited time available, put forward a detailed and constructive counterproposal <u>it still would not have the power to stop the proposed closure</u>.

Klein and Lewis give the reason for this move as follows: "The NHS authorities were given a direct incentive to consult CHCs about hospital closures - always a contentious issue, likely to stir up local

passions - in order to avoid the long delays involved in seeking DHSS sanctions."[17] (emphasis added) Dr David Owen who played an important part in creating this special function justified it as follows: "It was said that councils would never agree to any closure - yet up and down the country, community health councils are agreeing," and "when opposed closures to hospitals for instance come before Ministers - community health councils can be sure that ministers will read carefully what the community health council says if they put up sensible alternatives - as the final arbiters ministers must look for a reasoned sensible case with an alternative costed option."[18] (emphasis added)

That this burden be imposed on CHCs in the name of "Democracy in the NHS" and "strengthening Community Health Councils" is utter hypocracy. It would have been easy, as noted above, to have given CHCs a role concerning proposed hospital closures which would have enhanced both local public representation and the local service provided by the NHS. A role such as this would have been an important step towards strengthening CHCs. The "special function" which was actually created put CHCs into a position where they could not win and left AHAs in a position where they could not lose. The Labour Government had with regard to hospital closures enabled AHAs to abrogate their responsibility and had taken away from CHCs the power to do their duty - represent the public interest. Thus the Labour Government, just like its Conservative predecessor, was willing to strengthen the hand of management at the expense of community representation.

implications for local public representation: CHCs had been strengthened in some respects and weakened in others. But over and above this AHAs had been given a representational - or more appropriately a quasi-representational - status. Additional local authority councillors were appointed to AHAs (and RHAs) so that one third of members were "elected representatives". Labour's original reorganisation plans envisaged representational authorities but no consultative councils; the

Conservatives proposed non-representational authorities and consultative councils and the 1974 Labour Government provided the NHS with both representational authorities and consultative councils. This is a recipe for confusion.

The Labour Government's stance

As noted at the end of Chapter 2 the Labour Party when in opposition took very little interest at all in CHCs. Even when coming into power it was much more interested in the RHAs and AHAs and by introducing new regualtions was able to ensure one-third local authority representation on them.[19]

It did start to take an active interest in CHCs though, for as Dr David Owen said "when the Labour Government took office in 1974, three weeks before the appointed day for reorganisation, a basic decision was taken to strengthen and enhance the role of the community health councils."[20] It had an uphill task because as noted above its lack of vigilance while in opposition left the Act prescribing in detail the parameters of membership and proscribing cross-membership of CHCs and health authorities. The proposals in the "Democracy in the NHS" consultative document for CHCs to elect members to AHAs suffer because of these restrictions. There was therefore little it could do to strengthen CHCs and although it took some useful steps it undid much of its good work by imposing upon CHCs the "special function" with regard to hospital closures.

It is perhaps unfair to judge Labour's commitment to local public representation just on the evidence of its approach to CHCs. It could make more substantial gains by tackling the seats of power (the RHAs and AHAs) which it did, and it was never in favour of CHCs as such. But, given the political realities of the situation - that further structural change in the NHS was not feasible (and that the medical profession would anyway veto local authority control) - it is surprising that the Labour Government actually went out of its way to weaken CHCs

on the fundamental issue of hospital closure. Not only were CHCs put in an untenable position but their public image (crucial for a consumer consultative body) was bound to suffer when hospital closures were being discussed - whatever they did.

The Labour Government took some steps to enhance and some steps to reduce CHC effectiveness. This very inconsistency is the one consistent attribute of the Labour Party towards local public representation. Right from Crossman's "participatory" NHS with equal representation for the community and one group of NHS workers (doctors), through its vacilating approach to CHCs when in Opposition, to its contradictory actions when in office the Labour Party has been consistently inconsistent.

Both Labour and Conservative parties, while in government and in opposition, have acted short-sightedly and inconsistently over CHCs. In so doing they have between them created an institution which is flawed and lacking in potential effectiveness. By taking a minimal amount of trouble they could have ensured that CHCs were potentially much more effective. CHCs may eventually become effective bodies, but if they do it will be more in spite of than because of the actions of their governmental creators.