TABLE 5.4

APPOINTMENTS SUB-COMMITTEE:

DISTRIBUTION OF MEMBERS BY APPOINTING BODIES

NORTHERN REGION

Appointing Body	Members						CHC Members
	Elected		Ex officio		Total		
	N	%	N	%	N	%	%
Local Authority	24	47	16	47	40	47	50
Voluntary Body	15	29	5	15	20	24	33
RHA	12	24	13	38	25	29	17
Total	51	100	34	100	85	100	100

Source: CHC inaugural meeting minutes.

It can be seen that the RHA appointees were over-represented on the elected membership of the sub-committees (24% compared with an expected 17%) at the expense of local authority appointees (47% instead of 50%) and voluntary body appointees (29% instead of 33%). When the total CHC representation on the sub-committee (including chairmen and vice-chairmen) is taken into consideration the RHA appointees are even more over-represented because of the high proportion of RHA appointees elected chairmen (59% compared with an expected 17%). This may well have had some influence upon the selection of candidates, with a potential bias towards NHS personnel, particularly when the fact that 10 of the 17 CHC, and therefore sub-committee, chairmen were RHA appointees.

the secretaries: In fact 9 out of the 17 CHC secretaries appointed were serving NHS officials but this does not appear to be related to the representation of RHA appointees. The overall situation was further

complicated by multiple applications and by some applicants being offered more than one post. Altogether 121 people made a total of 531 applications for the 17 posts. A break-down of appointments by age, occupation and locality of previous employment of secretaries is given in Table 5.5.

TABLE 5.5

CHC SECRETARIES IN THE NORTHERN REGION

CHC	SECRETARY			
	Age	Sex	Last Occupation	Locality of previous appointment
Hartlepool	47	M	Education Admin.	Sunderland
South Tees	46	M	NHS AHA Admin.	York
North Tees	24	M	NHS RHA Admin.	Newcastle
West Cumbria	29	M	ex-Methodist Min.	Shetland Isles
S. W. Cumbria	55	M	Soc. Service Admin.	S. W. Cumbria
East Cumbria	30	F	NHS RHA Admin.	Newcastle
S. E. Cumbria	25	M	NHS AHA Admin.	Newcastle
S. W. Durham	50	M	NHS AHA Admin.	S. W. Durham
Darlington	42	M	NHS AHA Admin.	Teesside
N. W. Durham	33	M	NHS AHA Admin.	Durham
Durham	32	M	DHSS Admin.	Newcastle
Sunderland	28	M	NHS AHA Admin.	Kent
N. Tyneside	60	M	Ret'd L. A. Admin.*	Tynemouth
S. Tyneside	54	F	Housewife	S. Tyneside
Northumberland	34	M	NHS AHA Admin.	Manchester
Gateshead	53	M	Vol. Body Admin.	Durham
Newcastle	46	F	Vol. Body Admin.	Newcastle

* Part time (retired borough treasurer)

Source: RHA co-ordinater

Although coming from diverging occupations the secretaries (with one exception) all had a background in administration. Fifteen of the secretaries had previously been employed in administrative posts,

one who was not employed in gainful occupation (S. Tyneside) had a substantial record of unpaid administrative work including membership of a New Town Development Corporation. Only the West Cumbria secretary, who was an unemployed Methodist Minister, had no substantial administrative experience.

There was a wide range of ages amongst the CHC secretaries, between 24 years and 60 years with a mean of 40 years. The distribution of the ages falls between two blocks, between 24 and 34 (8 secretaries) and between 42 and 60 (9). Seven out of the eight younger secretaries were career NHS or DHSS administrators, 5 of whom saw a job in a CHC as enhancing their NHS career prospects.[28] All members of the older age group were committed to public service administration, although only one (S. Tees) expressed an interest in a continuing career in mainstream NHS administration. Most of the older secretaries therefore saw their first commitment as being towards public service in general and had no career interests within the NHS which might influence their work as CHC secretaries, whereas 5 out of the younger group who were committed to a future career within the NHS would have divided loyalties in a conflict situation between the CHC and the NHS authorities. Three of the secretaries in fact made it quite clear in private conversation that they wanted to keep "in the good books" of the NHS authorities in order to further their career opportunities. If the 1974 Labour Government had not rescinded Sir Keith Joseph's advice that CHCs as a matter of course be staffed by career NHS officials this problem would no doubt have been larger. It is interesting to note that the calibre of secretaries appointed from outside the NHS was in general very high which discounts Sir Keith Joseph's fear on this score.

Table 5.6 compares chairmanship and membership of the CHC appointments sub-committees with the previous employment of secretaries. One half (5 out of 10) of the CHCs with RHA appointed chairmen chose NHS

personnel to be secretaries, whereas over one half (4 out of 7) of the CHCs whose chairmen were not RHA appointees chose NHS personnel, and all three CHCs with no RHA appointee on the sub-committee chose NHS personnel whereas both of the CHCs with a majority of RHA appointees on the sub-committee chose non-NHS personnel. Therefore there is no evidence to support the hypothesis that the RHA, by insisting upon the immediate election of an appointments sub-committee thereby biased the CHCs in favour of appointing career NHS personnel.

TABLE 5.6

COMPOSITION OF SUB-COMMITTEES AND PREVIOUS EMPLOYMENT OF SECRETARIES: NORTHERN REGION

CHC	Sub-committee		Secretary
	Chair	Members	
Hartlepool	LA	2 VO, RHA, LA	Non-NHS
South Tees	LA	2 LA, 2 VO	NHS
North Tees	RHA	3 LA, RHA	NHS
West Cumbria	LA	2 LA, RHA, VO	Non-NHS
S. W. Cumbria	RHA	2VO, RHA, LA	Non-NHS
East Cumbria	RHA	2 LA, RHA, VO	NHS
S. E. Cumbria	RHA	2 LA, VO, RHA	NHS
S. W. Durham	LA	3 LA, VO	NHS
Darlington	LA	2 LA, VO, RHA	NHS
N. W. Durham	RHA	2 VO, 2 LA	NHS
Durham	LA	2 LA, VO, RHA	Non-NHS
Sunderland	VO	2 VO, 2 LA	NHS
N. Tyneside	RHA	2 RHA, 2 LA	Non-NHS
S. Tyneside	RHA	2 LA, RHA, VO	Non-NHS
Northumberland	RHA	2 LA, VO, RHA	NHS
Gateshead	RHA	2 LA, VO, RHA	Non-NHS
Newcastle	RHA	2 RHA, 2 LA	Non-NHS

Abbreviations: LA = Local Authority; VO = Voluntary Organisation.
Source: CHC minutes and RHA Co-ordinator

the first six months: between July 1974 when most of the inaugural meetings were held, and the end of the year most CHCs managed to hold 4 meetings although a minority which had decided to hold bi-monthly business meetings held only 2. In general, progress was slow, the CHC secretaries only took office in October and it was the end of the year before accommodation, secretarial help and servicing functions were fully operational. This slowness off the mark was a national rather than just a purely regional phenomenon.[29]

It was very much a familiarisation period, a time for the CHC members to get to know each other and get some idea of the workings of the NHS. For the secretaries the main job was opening channels of communication, between the CHC and the NHS and between the staff, officers and members of the CHC. At the CHC meetings there appeared to be five main preoccupations: accommodation; staffing; gleaning information about the operation of health services; hospital visits, and the raising of issues by individual CHC members.

Some CHCs were able to settle immediately into accommodation provided by the AHA. Often the easiest solution was for the CHC to take over old Executive Council accommodation in cases where the now Family Practitioner Committee had moved in with the AHA. This course of action was favoured by South Tees, South West Cumbria and East Cumbria CHCs. Some CHCs, notably Gateshead, Durham, Southern Tyneside and South West Durham were quite happy to accept offices in hospitals whereas others such as Newcastle, Sunderland and South East Cumbria chose non-NHS accommodation.

Staffing occasionally created difficulties, apart from the general problem of availability of clerical and typing staff, Members of South Tyneside CHC at its first meeting questioned the need for an administrative secretary and Darlington CHC (by a majority vote) doubted the necessity for its secretary to have any clerical or typing assistance

at all. Overall this initial period for CHC secretaries was a difficult one, they had no precedents to work on, no formal training and no detailed job description.

In the pursuit of information about local NHS facilities all the CHCs invited area and/or district officials to meetings to discuss the administration of the NHS. This was supplemented by the seminars organised by the RHA for chairmen and secretaries and by the one-day conferences organised by the AMTs and DMTs for individual CHCs. Most of the CHCs asked for further sessions with the management teams to enable them to get to know local services and problems.

All the CHCs also entered enthusiastically into a round of hospital visits. This took up more time than any other aspect of their activity during this period. It was one of the few tasks which members could get involved in immediately and enabled them to familiarise themselves with the health service facilities in their areas. Hospital visiting was the role in which members in general, and ex-HMC members in particular, felt most comfortable and was one aspect of the work where members had a precedent to work from. Indeed the reports of most hospital visits by CHC members are reminiscent of the days of HMCs where catalogues of cracked lavatory pans, dirty kitchens and uncurtained windows predominate.

In the first few months each CHC raised a host of issues which related to the specific interests of individual members. These ranged from local authority toilet facilities (technically not within the province of CHCs) through cervical smear facilities to the fluoridation of water supplies. More time was spent on these issues than on major capital development and hospital closure plans referred from the RHA. One CHC unanimously supported without discussion a multi- million pound project put to them by the area administrator

which would have a major long-term impact upon the health care services of the district, while at the same meeting spending forty-five minutes discussing a proposal to discontinue Sunday postal collections from a local hospital.

the impact of the Northern RHA upon its CHCs: in its non-directive phase the Northern RHA had an impact upon its CHCs' size, voluntary body membership, accommodation and budget. The Northern region's CHCs were (overall) larger than average. Except for the incident concerning representation of War Pensioners and Miners Rehabilitation Centres' interests (involving only 5 CHC seats out of a total of 447 - less than 2%) it gave free rein to voluntary bodies in their appointment of members. This resulted in an under-representation of special care groups when compared with the national average. While it would probably have led to more effective patient group representation if this imbalance had been corrected it was at least a fair representation of voluntary body interest in the region and overall it was probably better that the RHA did not intervene. The RHA's activities over accommodation predisposed the CHCs towards accepting NHS premises but excluded the possibility of CHCs being accommodated adjacent to AHAs, ATOs or DMTs. The RHA's proposed budget was near the average for all regions, but not enough information is available about the costing of CHC activities for this figure to be very meaningful.

In its directive phase the RHA had an impact upon RHA appointees, the CHCs' initial orientation and the election of officers. The RHA intentionally biased its own selection of members towards ex-NHS (and specifically towards ex-hospital) authority members thereby giving CHCs both a sound information base about the NHS (and particularly the hospital sector) and a bias towards being NHS management oriented. The RHA chairman's introductory remarks at the inaugural meetings were

heavily NHS management oriented rather than public representation oriented which, being the initial introduction to CHC membership, had considerable impact. Finally, the RHA's insistence on immediate election of officers at inaugural meetings led to massive over-representation of its own appointees among CHC chairmen. Whether this was (a) a necessary result of its actions or (b) deliberate, is open to conjecture but the fact that the RHA did insist and the fact that its appointees were over-represented gives support to the hypothesis that it was deliberate (and even more support is given when it is remembered that in one instance the RHA chairman strongly recommended an individual CHC member - a RHA appointee - prior to the election of chairman). It must be remembered that the Northern region had the highest proportion of RHA appointees as chairmen of any region. The position of CHC chairman was of crucial importance to the development of these new bodies and the over-representation of RHA appointees in these posts in the Northern region has had and undoubtedly will continue to have a considerable influence in the development of the effectiveness of these CHCs.

CHAPTER 6: SUMMARY AND CONCLUSIONS

The time has now come to attempt to answer the questions posed in the Introduction. Before tackling this the main points in the process of creating CHCs are summarised.

Summary: the creation of CHCs

the Conservative Government: in the Consultative Document, where the idea of CHCs first saw the light of day, the over-riding emphasis was on management. "A strong management structure" was the basic aim of NHS reorganisation. Even CHCs were defined in terms of management - "the community's reaction to management". The CHC was to be nothing more than a sounding board on behalf of the community. The AHA would select suitable members, would staff, finance and accommodate the CHC and would read its annual report.

Because the CHCs were peripheral to the main Government concern over reorganisation - a sound management structure - the Secretary of State was willing for changes to be made in the CHC concept so long as the effects of these changes did not impinge upon the management structure. It was also useful for the Government to be seen to make concessions to molify critics. The Government agreed that local authorities and voluntary bodies should choose members, that the CHCs should be able to produce reports when they wished and that the AHA should be given the duty of replying to CHC reports. But along with these changes in the details of CHC establishment and functioning a major change in emphasis had taken place by the time the White Paper had been published. The role of the CHC had been transformed from expressing the community's reaction to management to representing to the AHA the interests of the public in the health services in its district.

When the NHS reorganisation bill went through Parliament the Government allowed further changes to be made. Now the RHAs, not the AHAs,

were to establish, staff, finance and accommodate CHCs. It was laid down in the Act that local authorities were to appoint one half and voluntary bodies were to appoint one third of CHC members. But the Government would not allow CHCs to select their own staff or accommodation. The Labour Opposition took very little interest in CHCs. It was left to a few individual MPs acting independently to badger the Government into making the changes which did occur.

DHSS regulations and guidance: perhaps the most significant feature about the regulations and guidance was the amount of power they devolved to the RHAs. The RHAs were given a great deal of scope with regard to voluntary body appointments, CHC size, staffing and accommodation. The RHA was also made the final arbiter in disputes between the CHCs and the AHAs over the AHAs' duty to provide CHCs with relevant information. This was all unnecessary, DHSS could well have taken upon itself the task of interpreting the legislation so that all CHCs could have started on a more or less equal basis. The extent to which the framing of regulations and guidance is a political as well as an administrative act can be seen by the number of changes the incoming Labour Government of 1974 made.

the Labour Government: as well as the changes it made to CHCs the 1974 Labour Government also gave the AHAs and RHAs a more representational character by increasing the proportion of local authority appointments to one third of the membership and by stressing their representational function. This had the effect of blurring the distinction so forcefully made by the preceding Conservative Government between management on the one hand and representation on the other. The effect of most of the changes made to CHCs was to make them more community based and less powerless. Secretaries were to be appointed after open competition and the emphasis in their job description was shifted towards communicating with the community. Besides this CHCs were strengthened in terms of their

relationship with AHAs and DMTs generally. Unfortunately in the particular case of hospital closures the new role given them by the Labour Government considerably weakened them.

the RHAs: placing the burden of implementing the legislation upon RHAs had a profound effect upon CHCs. RHAs were free, as they saw fit, to create large or small CHCs, to choose the voluntary bodies which were to appoint members, to choose CHC accommodation and to control the flow of information from AHAs, as well as having the informal channels of influence they were bound to have as establishing authorities. The Northern RHA chose a path which was to lead to large CHCs, complete self-determination among the voluntary bodies over appointments and considerable freedom of choice for the CHCs in finding accommodation. If the guidance over staffing had not been changed it would have staffed its CHCs in the first instance with retiring NHS officials. But the most important impact the Northern RHA had on its CHCs came about through informal rather than legislative factors. The style of CHC establishment, particularly with regard to the inaugural meetings, had a considerable impact upon the choice of CHC chairmen and probably upon CHC activities, at least in the first few months of their existence.

Conclusions

What impact did the participation movement have upon the creators of CHCs? The 1970-74 Conservative Government took an unequivocally managerial approach to NHS reorganisation and saw no place in the management hierarchy for consumer participation. The Government started from an anti-participatory position, but the fact that it did create a consumer consultation mechanism indicates that the participation movement had some influence upon it. CHCs were created partly in response to Crossman's promise to include local community representation in NHS management, which in itself was a gesture to the participation lobby. It would have been

politically inexpedient for the Conservatives not to have created some such body. It is doubtful whether CHCs would have been created at all if Crossman had not made this promise - they were only thought of after the management structure had been planned, were created (according to a minister) "almost by accident", first mooted in a meeting discussing the involvement of voluntary bodies in the NHS, were in the Consultative Document version extremely weak bodies and, although later strengthened, were never allowed by the Conservatives to be strong enough to interfere with management. The participation movement thus led the Conservatives in spite of their managerial commitment to create a mechanism for consumer representation.

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

At no time from the inception of the CHC idea to the drafting of regulations did the creators of CHCs take heed of the experiences of other consultative bodies. During Commons committee stage the minister (Michael Alison) said they had - "we are taking the role of (CHCs) extremely seriously and we have learned the lessons of some of the earlier consultative committees"[1] - but it is difficult to know to which bodies he was referring. He could not have been seriously referring to the councils investigated by the Select Committee on Nationalised Industries because his government blatantly refused to implement - and indeed broke a ministerial undertaking over - the Select Committee's major recommendation, that of independence from the authorities. Similarly his Government refused to grant CHCs access to the minister in cases of dispute with the AHA - another lesson from the consumer councils. The minister was either extemporising indiscretely, using incorrect information or being less than totally truthful. Indeed if the Conservatives had learned the lessons of the existing consultative councils then they used them not to strengthen but deliberately to weaken CHCs.

What is the potential for public representation in the NHS?

Any government, even if totally committed to public participation, would have difficulty in creating a completely participatory authority structure for the NHS. First it is extremely difficult to ensure genuine and effective grass roots participation in a large scale enterprise. More importantly the medical profession has consistently refused to allow the NHS to be managed by local authorities, which, for all their faults, are at least formally participatory bodies. However, the acceptance of Crossman's plans, backed up by BMA resolutions endorsing the notion of some public representation, show that it was possible to give public representation a considerable, but not overwhelming, role in management. The idea of district sub-committees of the AHA with a representative membership and representational role, again accepted by the professions, further demonstrates this.

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

Both types of participation have their strengths and weaknesses. Consultative councils, if properly constituted, are unambiguously bodies serving the public interest; they are the consumers' watchdogs and can be seen as a "counter-bureacracy". However, they have no executive power, they cannot control the services, they can only influence them. Public representation on management, on the other hand, takes a direct part in controlling services and if a majority of authority members are representatives they can ensure that services are provided in what they consider to be the public interest. There is however a considerable danger of "representative members" being colonised by management, i.e. by the salaried officials who run the service. Furthermore, representative members unless elected to their posts are not directly accountable to the public for their actions.

If the majority of authority members are directly elected then in theory public representation on authorities has a greater potential for effectiveness than even the best consultative council. In practice because of the dangers of over-identification with management the situation may well be different. And in the NHS where there is no possibility at present of public representatives either having a majority of members or being directly elected it is impossible to ascertain apriori which would be the most effective.

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

These differences in approach can be explained at both a practical and theoretical level. The practical explanations are almost certainly the most relevant. Richard Crossman on behalf of the Labour Government said he wanted to "wobble health care as near the local authorities as I could"[2] and including local authority members (as public representatives) on NHS authorities was a step in that direction. Sir Keith Joseph on behalf of the Conservative Government wanted to separate management from representation in order to provide a more "efficient" service.

The theoretical ramifications of these practical stances lead to different conceptions of the nature of local representation. For the Labour Party the ideal solution was local public control (subject to national guidelines) of the NHS by public representatives - members of the local authority. Failing this then local public representatives should participate in management. Therefore representatives should manage the service in the public interest. The Conservatives on the other hand saw management as "taking the right decisions", a job not for representatives of the local public but for people with management abilities, and saw representation as the community's reaction to management. They gave a very stern warning about "the dangers of confusion between the direction of services and representation of those receiving them".[3] In the

Consultative Document the criticism was general, any body which had both a representative and a managerial function was bad.[4] This was toned down in the White Paper where the criticism was of a body where some members were chosen to be representatives and some were chosen to be managers.

It is worth noting that while this distinction can be made in theory, in practice it tends to become blurred. This is because the Conservatives, as well as the Labour Party, wanted some local authority councillors on AHAs. It is true that they wanted less than Labour (27%, 4/15, rather than 33%) and that they wanted them to be "managers" rather that "representatives" but this is something which cannot be legislated for and overall in practice it is difficult to believe that individual local authority appointed members would alter their behaviour to fit in with either a "representative" or "managerial" appointing ethos. The medical profession in addition insisted upon being represented on the management authorities, further diluting the purity of managerialism.

Why were the Conservatives' original CHC proposals so weak that they were universally criticised? Why were the Conservatives willing to make some amendments to these proposals but not enough to ensure CHC effectiveness? Why did the Labour Opposition virtually ignore the CHC proposals? 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?

The answer to these questions is that all these parties took a limited interest in consumer representation and in CHCs. The Conservatives' interest was minimal and wholly related to political expediency. The Labour Opposition was totally uninterested and the Labour Government was ambivalent towards CHCs, strengthening them in response to its commitment to "democratising" the NHS and weakening them over hospital closures merely to ease ministers' and civil servants' workloads on these

contentious and time consuming issues. The recessive role taken by DHSS can be explained partly by the lack of commitment of its political masters and partly by the wish of its officials, already inundated with extra work on reorganisation, not to take on any more burdens.

Why were RHAs - contrary to ministerial undertakings - given so much power over CHCs and how did they use this power? Part of the answer to the "Why?" question has been given above - because of DHSS's recessive role - but it must be remembered that right from the beginning the Conservatives wanted CHCs to be controlled by NHS authorities. The granting of formal establishment powers to DHSS was merely a diversionary tactic. The "how" question has more important ramifications. It has been shown in Chapter 5 above that many RHAs used their discretionary formal powers as establishing authorities to affect CHCs in their own interests. Crucially, as the case study demonstrated, an RHA even without using the powers delegated to it by DHSS could exert enormous influence informally by the style of its relationship with the fledgling CHCs. This is unavoidable even if RHAs are given no formal discretion at all.

Can CHCs effectively represent the public interest to the health authorities? It is impossible to answer the question "are CHCs effective?" without recourse to an empirical study of CHC activities over a period of time but it is possible to answer the question "can they be effective?" Effectiveness in representing the public interest to health service authorities depends upon two factors, first ascertaining the public interest and secondly ensuring that its representations are taken adequately into consideration by the authorities. A CHC which effectively ascertains the public interest without influencing management at all is of little use and a CHC which effectively represents views not in the public interest is positively harmful.

ascertaining the public interest:* this cannot be a mechanical operation relying completely upon hard data about mortality and morbidity rates and health care facilities and cost benefit analysis. These factors are necessary but not sufficient for ascertaining the public interest. In drawing up priorities it is necessary to find out the public's wishes and perceived needs. The intangibility of "the public interest" is open to dangers for CHCs, the most important of these is the temptation for CHCs to see the views and interests of their own members as representing accurately the views and interests of the community. One of the most disheartening attributes of many of the newly established CHCs in the case study region was a tendency to assume that the CHC - or its most vociferous members - had its or their finger upon the community's pulse. The only way in which a CHC can even hope to be able to ascertain the public interest is by (a) getting relevant technical information from the AHA (possibly problematic) and (b) by communicating with the community and gaining public confidence.

effectively representing the public interest: in circumstances where the AHA agrees with the CHC's recommendations this is no problem but how can a CHC convince a sceptical or hostile AHA? The easy and most disastrous way for a CHC to cope with this situation is not to press its case, an approach a CHC not determinedly independent of the NHS could easily fall into. The only way a CHC can press its case upon an unwilling AHA is by creating and mobilising public support. Public support for the consumers' watchdog will only be given if the CHC projects itself in the public image as an independent unambiguously community and consumer oriented body.

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* This section is based upon an article by the author in Health and Social Service Journal, Vol. LXXXV, No. 4466, 1975, p.2613.

These were: planning; managerial; executive, and advisory. The RHB's planning tasks included the appointment and deployment of senior medical staff, definition of hospital use, and planning and executing capital works. Its managerial functions included allocating finances between HMCs, control of HMC establishments and the appointment of chairmen and members of HMCs. Its executive functions covered the provision of such services as blood transfusions, computing, mass X-ray facilities and the provision of expert staff. Their advisory functions related to the employment of legal officers, architects, medical and nursing officers and to staff training.

The HMC's function was "to control and manage the hospital or group of hospitals on behalf of the (regional hospital) board."[5] In practice this normally meant: the appointment of all hospital staff (except senior medical staff); maintaining premises; procuring supplies; liaising with other health authorities; dealing with the public, and ensuring that "hotel" and clerical services were provided. An HMC might have been responsible for more than one hospital. Some HMC groups were based on functional areas and catered for e.g. mental illness patients. Some were "all purpose" groups, the hospitals of which would provide a broad spectrum of care, not unlike that of a district general hospital. At the outset of the NHS there were 377 HMCs[6] but owing to increased grouping there were only 330 by 1968.[7] There was a wide divergency of size and scope of HMC responsibilities. The Acton Society Trust found that there were 25 HMCs each responsible for less than 250 beds whereas over 60 were each responsible for more than 2,000.[8]

membership: The 15 RHBs[9] had a membership of between 22 and 32.[10] The chairmen and all members were appointed by the Secretary of State for a period of three years. Before making appointments he consulted: the relevant University, representatives of the medical profession; local

It is possible for CHCs to be effective bodies - but it will not be easy. Even if the AHA is helpful and sympathetic the CHC will have a hard job on its hands in creating effective communication channels with its public. If the AHA and RHA are not sympathetic the CHC faces possibly insuperable barriers to effectiveness. It will be difficult to get necessary information from the AHA about services, to fire the public's imagination in order to rally the support of public opinion - its only ally in such an adverse situation - and to operate at all, being staffed financed and accommodated by its adversary.

Finally it may be useful to mention some steps that could be taken to help CHCs gain a greater potential for effectiveness: first they could be given the right of appeal to the minister in cases where the AHA either refuses to disclose information or where the AHA and CHC differ irreconcilably over a major issue; secondly they could be given a strong national and regional voice through the establishment of a national body with regional offices (this process has begun on a limited scale with the establishment of a national council for CHCs); thirdly they could become totally independent from the NHS (this could be achieved by the national council taking over staffing and servicing functions). All of these steps could be taken without amending the Act in any way. One final step is to reconsider CHC membership composition with a view to depriving RHAs of the right to appoint consumer watchdog members. This would require an amendment to the Act.

CHCs as they are presently constituted do stand some chance of effectively representing the public interest, but they would stand a much better chance if the above-mentioned modifications were made. It is a pity that they were not made in the first place when CHCs were being created. There is no excuse for them not having been made because the parliamentary Select Committee on National Industries - as well as most other commentators on existing consultative councils - had pointed the way in the very year CHCs were thought of.

APPENDIX 1: HEALTH AUTHORITIES IN THE TRIPARTITE NHS

The National Health Service Act 1946 imposed upon the Minister of Health the duty "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people in England and Wales and the prevention, diagnosis and treatment of illness."[1] Prior to reorganisation the service was comprehensive but its administration was split into three separate parts, the hospital sector, the general practitioner services and the local health authority services. Total NHS expenditure allocation was divided between them as follows (on 1968/9 figures): hospitals 57%, general practice 23½% and local authority 14¾% (the other 4¾% going to central administration, welfare foods etc.).[2] The three wings of the service each had a different formal relationship with the central department, a different administrative structure and a different procedure for representing the public.

The hospital sector

Excluding teaching hospitals which were administered separately, there were two statutory administrative tiers in the hospital service, regional hospital boards and hospital management committees.

functions: the Act prescribed RHBs' functions as follows:[3]

> Subject to the exercise of functions by Hospital Management Committees . . . it shall be the duty of a Regional Hospital Board . . . generally to administer on behalf of the Minister the hospital and specialist services provided in their area, and in particular -
>
> (a) to appoint officers required to be employed at or for the purposes of any hospital providing such services, other than a teaching hospital:
> (b) to maintain any premises forming part of or used in connection with any such hospital;
> (c) to acquire on behalf of the Minister and to maintain equipment, furniture and other movable property for the purpose of any such hospitals.

In practice the major task of RHBs had been in the planning, provision and supervision of the hospital and specialist services in their regions. The Acton Society Trust has classified RHB work under four headings.[4]

health authorities; professional societies; hospital associations; trade unions; employers associations, and any other organisations as he saw fit.[11] At least two members were required to have had experience in the mental health services.[12] Owing to the wide divergence of HMC size their membership has fluctuated widely in terms of number, the smallest having nine and a few having thirty. Membership was normally between fifteen and twenty.[13] The chairmen and members were appointed by the RHB after consultation with: local health authorities, executive councils; senior hospital medical and dental staff, and other interested organisations such as social service organisations, Trades Councils and the traditional medically orientated voluntary bodies.[14] Members were appointed for three years.

public representation: There seemed to be a dual standard with regard to the role of RHB and HMC members viz a viz public representation. Individuals were in no way representatives, yet total membership was asserted to be representative of various health service interests. RHB members were chosen only for their individual merits, "it is a first principle of the system that members are selected as individuals on their merits and not as representatives or delegates of any organisation".[15] The sole right to appoint members was vested in the minister. The Guillebaud Committee (of enquiry into the cost of the NHS)[16] approved of this, and of individual merit being the basic criterion for selection:[17]

> we have no doubt in our minds that the health ministers must reserve to themselves the sole right to decide who should be appointed to the Regional Boards, and that members must be selected solely for the contribution they can make to the efficient running of the hospital service. The present system is an essential corollary of a service organised on an agency basis.

The committee then went on however to assert that consumer interests were, or should have been, represented on RHBs thus:[18]

> The ministers must aim - as we believe they do - to preserve a central pattern of membership which will take account of all the interests concerned in the Service, including the local health authorities, the consultants, the general practitioners, the voluntary organisations, the 'consumers', and people whose life interest had been in the hospital field. (emphasis added).

It seems therefore that whereas individual members should be selected purely on the basis of personal qualities, the membership of the RHB as a whole should reflect the views of a wide range of interests, of which the "consumer interest" is only one. If it is considered that the public can be considered as "the consumer" then the public interest was seen to be represented.

The situation was similar with regard to HMCs except that members were chosen by the RHB and not the minister (or secretary of state). Again "it is a strict principle that each members is appointed in his personal capacity and not as representing an organisation."[19] At the same time there appears to have been a similar desire by RHBs to see a balance of interests on HMCs as there was by ministers regarding RHBs: "The broad intention has apparently been to secure about one fifth local authority members, one fifth medical, and a broad representation of trade union, employers and voluntary organisations from the area served. Nominations are sought from a wide range of interested bodies."[20] Thus R. G. S. Brown claimed "the pre-1974 hospital management committees have, albeit ineffectively, combined a managerial role with a quasi-representative one."[21]

It has been claimed that the system of 100% appointment to RHBs and HMCs was not undemocratic. The Guillebaud Committee supported the claim as follows: "Against the suggestion that the system is undemocratic . . . the Minister himself is responsible to Parliament, and . . . there are good grounds therefore for giving him the right to appoint the agents who are to carry out his policies in the hospital regions."[22] Mr. Crossman

was sceptical about the democratic content of such a system, with particular regard to HMC membership: "Members of hospital management committees, as agents of agents of the secretary of state, have a particularly slender democratic basis."[23]

General practitioner services

The main function of an executive council concerned the provision of all general practitioner services within the area, which usually coincided with the administrative area of a county or county borough council. It entered into contracts with individual practitioners and administered the terms of service, particularly the nationally negotiated remuneration schemes. It had the general function of planning health centres, and in particular planned GP services in new towns and redevelopment areas. It administered statutory disciplinary arrangements and made arrangements for the integration of local services.[24] The secretary of state appointed less than a quarter of its members. The rest of its membership of 30 was appointed on a representational basis, one half representing the local medical professions and just over one quarter representing the local health authority. Presumably the main purpose of direct LHA representation on the executive council was to help it in its job of integrating services. Beyond that its membership fulfilled no representative function.

Local authority personal health services

The local authority personal health services were provided by "local health authorities" which were (outside London) county councils and county borough councils. They could delegate some of their powers to non-county borough councils, urban district councils and rural district councils. Their functions under the 1946 Act were: to provide health centres; to make arrangements for the care of expectant and nursing mothers and of children up to five years old; to secure the adequate

APPENDIX 2: MEMBERSHIP OF NORTHERN REGION CHCs

General membership characteristics

This information was abstracted from the statistical appendix to the Klein and Lewis study.[1] The regional response rate was 67.2%.[2]

age - the Northern region had the highest proportion of the over 65s of any region (after taking the overall population structure of each region into consideration) and one of the lowest proportions of the 15-44 group (shown in detail in Table A1). Throughout the country the general picture is of over-representation of the middle age group (column (g) in the table). The older age group appears to be under-represented but this is because the over 70s have been included in the national and regional figures whereas, although there were appointments to CHCs of people over the age of 70, DHSS guidance advised that 70 should be the upper age limit.[3] The figure in column (f) for the age group 65-69 would be 6½%.[4] Details for this age group in the other columns are not available but it is clear that the 65+ age group is in fact heavily over-represented nationally (column (g) would probably be around 150%-200%). This means that the Northern region is heavily over-represented in this age group over and above the national over-representation.

TABLE A1
AGE OF CHC MEMBERS: NORTHERN REGION AND NATIONAL

Age Group	NORTHERN REGION N = 315				NATIONAL N = 3796		
	(a) Survey %	(b) Total Pop. %	(c) (a)/(b) %	(d) Rank (out of 15 RHAs)	(e) Survey %	(f) Total Pop. %	(g) (e)/(f) %
15-44	24	51	47	11th	28	51	55
45-64	58	31	187	8th	57	31	184
65+	18	17	106	1st	14	18	78

Sources
Columns (a), (b) and (e) from Klein and Lewis, Table 2A, p.179.[5]
Column (c) is derived from columns (a) and (b).
Column (d) derived from Klein and Lewis ibid.
Column (f) is derived from Annual Abstract of Statistics, 1975, Table 11, p.15.[6]
Column (g) is derived from columns (e) and (f).

provision of midwives; to make provision for health visitors; to provide for home nursing; to make arrangements for vaccination and immunisation; to ensure the provision of an ambulance service; to make arrangements for prevention, care and after-care of illness, and to provide domestic help where necessary.[25] LHAs also provided family planning services and undertook epidemiological work.

Under the NHS Act the local authority itself was the 'local health authority and so all county and county borough councillors were local health authority members.[26] Day to day running of LHA services was left to the health committee but the local authority itself was responsible for its actions:[27]

> Every local health authority shall establish a health committee and . . . all matters relating to the discharge of the functions of a local health authority shall stand referred to the health committee, and the local authority, before exercising any such functions, shall consider a report of the health committee with respect thereto.

All councillors were elected as representatives of the people and acted corporately as managers of the local health services. Those on the health committee were involved closely with the running of the service. LHAs therefore incorporated local public representation within the health service management structure.

sex, social class and education: 54% of the Northern region CHC members were men. The average for all regions was 56.5% with a range between 48% and 71%. The Northern region therefore had a slightly smaller than average proportion of men on its CHCs.[7] The percentage of males in the general population of the Northern region was 49, which is the same as the national average. The distribution of social class membership on the Northern region CHCs was near the average for all regions, but there were more manual workers and fewer professional and intermediate workers than the average. This is shown in Table A2.

TABLE A2

SOCIAL CLASS MEMBERSHIP OF CHCs: NORTHERN REGION AND NATIONAL

Social Class	Northern Region		National
	% N = 315	Rank (out of 15 RHAs)	% N = 3796
Professional and Intermediate	51	9th	54
Other non-manual	27	6th	27
All manual	18	5th	15
Not classified	5	3rd	5

Source

Derived from Klein and Lewis, Table 3A, p.180.[8]

A low proportion of Northern region CHC members attended public school, 19% compared with a national average of 26%; grammar school attendance was near average, 50% compared with 51% nationally;[9] and 55% of Northern region members had no full time higher education compared with only 47% nationally.[10] Only the Mersey region had a larger

percentage with no higher education (57%). In the light of this it is not surprising that the Northern region had the lowest percentage of members who had attended university (17% compared with 23% nationally) which might be partly accounted for by its lower than average professional and intermediate social class representation.

church and political party membership: the Northern region had slightly higher than average church membership (57% compared with 53% average, 5th highest),[11] distributed in similar proportion to the average between Church of England, Free Church and Roman Catholic (34%, 15% and 6% respectively for the Northern region, 30%, 14% and 5% nationally). Political party membership was slightly lower than average (51% compared with 55%) but, because the range was small (between 62% and 47%) the Northern region had the next to lowest membership of all regions (South Western being the lowest with 47%).[12] The region did have however a considerably higher than average Labour Party membership (39% compared with 30%) and lower than average Conservative and Liberal party membership (13% and 2% respectively, compared with 18% and 5%). The Labour Party was therefore well represented in the Northern region, to the detriment of Conservative and Liberal party representation.

local authority, voluntary body and health authority membership: the following information refers to total CHC membership responding to the survey, not just to members appointed by local authorities, voluntary bodies and the RHA respectively. Forty-five per cent of respondents in the Northern region were currently councillors compared with an average of 42%.[13] The Northern region CHC membership had an unusual configuration of voluntary body membership, as can be seen from Table A3 over.

TABLE A3

VOLUNTARY BODY MEMBERSHIP: NORTHERN REGION AND NATIONAL
PERCENTAGE OF MEMBERS BELONGING TO DIFFERENT VOLUNTARY BODIES

Voluntary Body	Northern Region N = 315 (a) %*	(b) Rank (out of 15 RHAs)	National N = 3796 (c) %*	N. Region as % of National (d) (a)/(c)
Special Care Groups				
Mental H'cap	10	13	13	77
Mental Health	4	15	10	40
Disabled	13	15	16	81
Elderly	24	7	25	96
Children and Maternity	8	13	10	80
Health and Soc. Service Groups				
Hospital Friends	12	13	17	71
H & SS Providers	37	10	39	95
Professional Orgs.	10	10	11	91
Other H & SS	13	8	13	100
Civic, Community or Action Groups				
Womens Groups	22	2	17	129
Mens Groups	10	7	10	100
Community Groups	17	15	24	71
National Action Groups	7	13	10	70

* Some members belong to more than one body, so percentages do not add up to 100.

Source
Derived from Klein and Lewis, Tables, 6A, 7A and 8A, pp.183-5.[14]

It can be seen that all the special care groups were under-represented in the Northern region compared with the national average; marginally in the case of the elderly; significantly in the cases of maternity and children, mentally handicapped and disabled; and massively in the case of mental health. In the health and social services category there were no cases where the Northern region had better than average relevant voluntary body membership. Forty-six per cent of Northern region CHC members had previously been members of health committees compared with a national average of 39%. Only 2 regions had higher memberships. The Northern region had 2nd highest ex-HMC membership and 2nd highest ex-local health authority membership.[15]

characteristics of members relating to their appointing bodies

Only local authority and voluntary body appointees will be dealt with here because there is no reliable information on RHA appointees published in the Klein and Lewis study.

local authority appointees: the local authorities were free to choose non-councillors when appointing CHC members. The local authorities in the Northern region used this opportunity less than local authorities in most other regions. Only 8% of local authority appointed members were not councillors, compared to a national average of 17%,[16] and only 5% (compared with an average of 11%) had never been councillors.[17]

voluntary body appointees: although Klein and Lewis noted the voluntary body membership of all members by region they provided no information about the appointing voluntary bodies by region. Table A4 compares their results on members for the Northern region with categories of appointing voluntary bodies. When the two sets of figures are compared they show a remarkable similarity. Even when computations are made to exclude the voluntary body appointees from column (a) it can be seen that the voluntary bodies which appointed members were representative of the voluntary bodies to which the CHC members in the Northern region

as a whole belonged. It is interesting to note that the general paucity of representation of special care groups in the Northern region CHCs is mirrored in the voluntary body appointments. This is particularly true with regard to the bodies concerned with mental health. The Northern region had the lowest representation of this group in the country.

TABLE A 4
MEMBERSHIP OF VOLUNTARY BODIES AND VOLUNTARY BODY APPOINTMENTS IN THE NORTHERN REGION

Voluntary Body	(a) Vol. Body Membership of all CHC members %	(b) Vol. Body Membership of vol.body appointees %	(c) Vol. Body Membership (excluding vol. body appointees) %
Special Care Groups	(31)	(34)	(32)
Mental Handicap	5	5	6
Mental Health	2	2	3
Disabled	7	10	6
Elderly	13	9	14
Children and Maternity	4	8	3
Health and Social Service Groups	(39)	(41)	(37)
Hospital Friends	6	9	5
Other H & SS Orgs.*	33	32	32
Civic, Community and Action Groups	(30)	(25)	(31)
Women's Groups	12	11	12
Men's Groups	5	6	5
Local Community Groups	9	5	10
National Action Groups	4	3	4
	N = 587	N = 160	N = 427

* It was not possible to differentiate accurately between Klein and Lewis' sub-headings here.

Source
Column (a) from Klein and Lewis, Tables 6A, 7A and 8A, pp.183-5.[18]
Column (b) compiled from Northern regions CHC handbooks.
Column (c) computed by subtracting the numerical values of (b) from (a) and converting to percentage.

The percentages in this table are percentages of total voluntary body membership/appointments in the region and so, in this case add up to 100.