COMMENTARY

Parliamentary accountability and the NHS: need for separate committee

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In any discussion of the future shape of the National Health Service, there is one phrase which acts as a kind of "no entry" sign. This is the magic phrase "parliamentary accountability." Options such as setting up a National Health Service corporation or devolving managerial responsibility to the regions tend to be ruled out of court on the grounds that they are incompatible with the Secretary of State's accountability to Parliament. So long as the NHS is financed out of general taxation, so the argument runs, the Secretary of State must be answerable for the way in which the money is spent. Furthermore, any diminution of his ability to control what happens in the NHS would also undermine Parliament's ability to call him to account: it would, in effect, snap the vital link in the chain of democratic control over the Service.

In practice, it is difficult to avoid the conclusion that the doctrine of parliamentary accountability is often used as a fig-leaf for the reality of Treasury control. Even so there is a real problem. Given that none of the health authorities—regional or area—are directly elected, Parliament's job is clearly crucial. The members of the authorities are the creatures of the Secretary of State, in that they are responsible to him for the management of the Service. So to whom is the Secretary of State responsible, if not to Parliament? Of course, this would radically change if control for the Health Service were to be transferred to local authorities or elected regional councils. But, without such a dramatic transformation, any attempt to insulate the NHS from political pressures would also be a move to insulate it from any form of democratic control.

But can parliamentary accountability be equated with democratic control? Is the phrase more than a form of verbal incense? In theory—as the school textbooks tell us—Parliament has to approve the NHS's budget; it has to pass any legislation affecting the Health Service, and it can compel the Secretary of State to resign if he loses the confidence of the House of Commons on some specific issue. In practice, of course, the annual estimates are inevitably approved; legislation is routinely passed with only minor changes; and no Secretary of State has resigned in living memory. Though the House of Commons has recently shown an increasing tendency to defy the whips—witness the devolution debate—there is as yet no sign of this affecting the NHS.

From this, it would be only too easy to conclude that parliamentary accountability is a sham. But this would be mistaken. There are various ways in which MPs can, and do seek to exert influence. And though it is difficult to document specific instances where MPs have directly shaped policy or determined Ministerial decisions—with the exception, perhaps, of abortion law reform—there is no problem in documenting parliamentary activity. If parliamentary accountability is indeed a sham, then MPs do not appear to have realised the fact. In the first place, MPs can take up specific issues, either in private correspondence with the Secretary of State or by asking questions in the House of Commons. As the table shows there was a considerable increase in the number of oral questions asked between 1950 and 1970: from 629 to 1961. (In the first quarter of 1978 398 questions on health—mostly written—were answered by DHSS ministers.) This is what might be expected, given the growing political salience of the NHS—though the figures must be treated with some caution, since the numbers in any year are affected by the length of the parliamentary session and changes in the rules

governing the tabling of questions. Moreover, as the analysis also shows, MPs tend to use questions to raise national policy issues, even though the impetus may often come from constituency problems. In 1970, for example, 24% of the questions were about the availability or quality of hospital services, and another 26% dealt with the facilities for treating specific diseases.

*Parliamentary oral questions on NHS matters, 1950-70. (Figures in brackets show % of total)**

	1950	1955	1960	1965	1970
Local	220 (35)	317 (30)	295 (37)	211 (38)	680 (35)
National	408 (65)	725 (69)	504 (63)	345 (62)	1281 (65)
Others	1 (<0)	3 (<0)	0	4 (1)	0
Total	629 (100)	1045 (100)	799	560	1961

*The figures are drawn from the relevant volumes of *Hansard*.

Waiting lists, surprisingly, accounted for only 4% of the questions.

Blunt instrument?

But parliamentary questions are a blunt instrument of control. If a politician is appointed Secretary of State it will be partly at least because he has proved his ability to side-step and parry questions on his way to the top. Moreover, MPs have limited opportunities to press their questions home, and to ask supplementaries. The importance of questions, therefore, probably lies in the fact they draw the Secretary of State's attention—and that of his department—to what is going on in the Health Service at the point of delivery. For even though questions may well be flies on the back of the elephant, in terms of their impact on policy, they are taken seriously by civil servants: one of the complaints frequently advanced is that they generate a great deal of detailed inquiries from the centre, thus adding to the work load at the periphery.¹ The price of parliamentary accountability, it is tempting to conclude, is to generate more paperwork.

If MPs think that their questions are not having any effect, they have got a further means of nobbling the Secretary of State. This is the adjournment debate. Late at night—and sometimes early in the morning—MPs can force short debates on constituency matters, when the main business of the House of Commons is finished. These are important in that they permit MPs to illustrate the effects of national policies on their constituencies. Equally, they give those affected by these policies—whether the medical staff or patient pressure groups—an opportunity to use their MP to transmit their views: in effect MPs short-circuit the long chain of command within the NHS, and bring local grievances directly to the attention of the Secretary of State and his junior Ministers. Thus, while parliamentary activities may generate extra paperwork, they also represent a means of cutting through the NHS's various layers of bureaucracy.

The issues raised in recent adjournment debates tend to fall into two categories. On the one hand, there are the debates which

voice opposition to the Government's policy of centralising facilities in district general hospitals and closing down local facilities. If efficiency is the watchword at the centre, accessibility is the main concern at the periphery: new hospitals are often seen as a threat to existing, much-loved if often antiquated facilities. For example, earlier this year Mr Clement Freud voiced local opposition to the closures proposed in the King's Lynn health district as a result of the rationalisation plans drawn up in anticipation of the opening of a new district general hospital in 1980.² On the other hand, there are the debates which are designed to make out a case for extra resources for a particular district. For instance, in March Mr John Ovenden raised the problems of inadequate facilities in Kent: the problems of an underprivileged area in a region which, under the RAWP formula, is designated as relatively overprovided.³

But, interestingly, the adjournment debates are not just opportunities for special pleading or for the MP to capture the headlines in his constituency newspapers. They do in fact highlight real problems in the implementation of national policy. Thus they have drawn attention to the difficulties caused by the extra costs of bringing new hospitals into service not just in the notionally overprovided regions, but are also in those which will actually benefit under the RAWP formula—such as Trent⁴ and the North.⁵ Again, adjournment debates may be used to ventilate wider policy issues. Thus Mr Terence Higgins took the opportunity to draw attention to a report of the Health Commissioner which had suggested that health authorities should be under a clear-cut, formal obligation to admit emergency cases⁶: this flowed from the Ombudsman's finding that a particular area health authority had failed in its responsibilities in one specific case. In reply to the points raised by back-bench MPs in adjournment debates, the Minister on duty tends—conventionally—to be both emollient and non-committal. The facts rehearsed in the debate, he assures the House of Commons, will be taken into account when the Secretary of State comes to make his decision or to review that of the regional authority. But, the Minister also tends to emphasise, local grievances must be seen in the context of national resource constraints and priorities—which inevitably limit the extent to which particular interests can be satisfied.

So it is difficult to be sure whether or not adjournment debates actually affect policy. They certainly stir things up: they compel the local health authorities to explain their plans to the Department of Health in more detail than they might otherwise have to do. To this extent, they are a safeguard against steam-roller tactics and an extra input of information into policy making. They help to prevent the isolation of the Secretary of State from the facts of life in the NHS and provide a check on the Civil Service monopoly of advice to him. Moreover, it is important that those working in the NHS—and those using the services—actually should be able to use Parliament to voice their grievances, traditionally the first duty of MPs. So adjournment debates are certainly more than formal charades, even if they do not lead to identifiable changes of policy.

Small change of accountability

All this said, both questions and adjournment debates are at best the small change of parliamentary accountability. In the last resort, both may be shrugged off by the Secretary of State and his civil servants as a time-wasting but irrelevant distraction from their task of actually running the NHS. For they provide only a fitful and erratic searchlight on the affairs of the NHS. They may illuminate local problems, which is not unimportant. But they provide no indication of the extent to which local grievances represent national problems: indeed, it might well be argued that it would be inequitable to give special treatment to a particular constituency or individual case simply because of the energetic advocacy of an MP. Bending national policy simply to meet the complaints of a specific constituency or pressure group might well create new grievances.

The importance of both questions and adjournment debates therefore lies primarily in the extent to which they show where the shoe rubs in implementing national policies. Unfortunately, while Parliament has a highly developed system for taking up individual or constituency grievances, it lacks an effective system for reviewing national policy: for using detailed information to identify larger issues. There is an asymmetry in the machinery of accountability which encourages ministers and civil servants to be dismissive of parliamentary activity and prevents the House of Commons from playing a constructive part in reviewing major policies.

Admittedly, once or twice a year the House of Commons will stage a full-dress debate on NHS matters. Although on 20 April the Opposition used one of its "supply days" for a six-hour debate on the Health Service in which over a score of MPs spoke on its national and local problems⁷ such debates usually deal with either immediately urgent issues—such as industrial action—or the financial plight of the Service. But major policy documents which raise complex issues and do not lend themselves to a tidy confrontation along party lines tend to be ignored. Perhaps this is as well: any worthwhile discussion of, say, RAWP or the DHSS's priorities document⁸ requires the careful analysis of information rather than political confrontations. But the result is that the policy context for particular grievances—accountability for strategy rather than for day-to-day decisions—tends to be neglected.

This weakness in the parliamentary system is neither new nor limited to the NHS. Since the 'sixties, there has been pressure to improve Parliament's machinery for reviewing policy.⁹ To an extent, this pressure has been successful. In the early 'seventies the Expenditure Committee was set up. This complements the long-established Public Accounts Committee, whose remit is to carry out a post-mortem examination on past spending—and which has, for example, drawn attention to the tremendous rise of the Liverpool teaching hospital's costs.¹⁰ But, while the Public Accounts Committee does not examine the underlying policy issues (should we still be building teaching hospitals?), this is precisely the task of the Expenditure Committee. This has a series of subcommittees, each one of which is charged with reviewing a particular area of policy.

Underequipped committee

For the NHS the relevant subcommittee is that which deals with the social services and employment. As its title implies, it is responsible for reviewing the policies of both the Department of Health and Social Security and the Department of Employment. Given this impossibly large task, not surprisingly it has been able only to take a fitful interest in the affairs of the NHS: instead of being able to review all major policies systematically, it is forced to flit from subject to subject. Thus in recent years it has carried out two major inquiries into the NHS—those on facilities for private patients¹¹ and on preventive medicine—but has not been able to deal with such major issues as resource reallocation or priorities. Currently it is preoccupied with the problem of the employment services.

Quite apart from being overburdened with responsibilities, the Social Services and Employment Subcommittee is under-equipped with resources. In common with other parliamentary committees, its permanent staff is one House of Commons clerk. There is no research staff to prepare the ground for an inquiry, though part-time specialist advisers may be hired for specific inquiries. As a result, the inquiries largely take the time-consuming form of cross-examining witnesses. No permanent stock of skill—to counter that of the Government departments—is built up. Not surprisingly, perhaps, the Expenditure Committee often finds it difficult to attract sufficient MPs committed to the work: absenteeism rates are high. Again, many reports suggest that too many political prejudices have chased

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depressed this GP was the slow progress in persuading his colleagues to improve the practice.

My own experiences of northern GPs contrasted sharply with this tale. Indeed, I had spent the afternoon in an excellent group practice, joining one of the partners for a surgery session. I had been most impressed, the picture light-years from my evening neighbour's black canvas. It can, of course, be dangerous to judge on anecdotal evidence. An experienced GP restored the balance—and my faith—by observing quietly that the country was getting an unbelievable bargain in its general medical services. He for one would be quite content to be ill—if he had to be ill—in his neck of the woods.

Geriatric care, however, was causing a problem in the region. One consultant estimated that his area had 3/5 of the number of beds needed. A young GP complained of the long waiting time—up to 10 days—for acutely ill geriatric patients to be admitted to hospital. (Surgery, too, suffered from long waiting lists, though gynaecology was only a few days, a target that all departments should aim at, I was told.) The local city doctors had become demoralised because they had looked forward to new hospital beds being opened as a welcome relief for their waiting patients. Unfortunately, other beds had been closed and with nursing shortages causing problems the delay in admissions seemed little altered. And ill elderly people at home without adequate care meant extra burdens for the GPs. This looked like continuing, as the planned next phase of hospital construction had been deferred to the mid 'eighties. There was bitterness about the nursing shortage, which some attributed to budgetary economies, for not so long ago the Northern region "exported" qualified nurses. In one hospital the administrators' car park had been resurfaced for £10 000. Why couldn't the money have gone on nurses?

Social services "bankrupt"

The social services, whose support was particularly needed when patients couldn't be admitted, were dismissed as "bankrupt" by one senior GP. "Staffed by long-haired louts and confused young women interested only in case conferences" was the brusque judgment of a young GP. Social workers seemed unaware of the doctor's work load, rarely did any practical work, and were reluctant to visit patients in their homes. The generic social worker was acidly described as a disaster. The inevitable anecdote was wheeled out: a GP had called in the social worker to arrange for the hospital admission of a patient who was hearing voices, but she had demurred, maintaining that such phenomena

were quite natural. The doctor had wondered whether he ought to have had her certified instead.

While the GPs I met seemed very busy the juniors admitted that by and large they were not overworked. Indeed, two teaching hospital house jobs had been difficult to fill because they were on a one in two rota and thus very busy. A teaching hospital registrar had plenty of time for teaching students, but SHOs had to organise their own postgraduate studies. The general impression among the juniors was that medical students were receiving less bedside apprenticeship than, say, five years ago, this change presumably reflecting the rise in their numbers.

The complexity of the junior doctors' contract was causing headaches. One of the registrars I spoke to said that it was easy for the BMA to claim that the spirit of the agreement was in the juniors' favour, but health authorities were interpreting individual contracts to the junior doctors' disadvantage. It was proving difficult to work out prospective cover arrangements because of unpredictability of planning holidays months ahead. There was the expected criticism on the reverse differentials between consultants and senior registrars. An example was quoted of a "one in two rota" senior registrar earning £3000 more than his boss. Someone else was annoyed because a community physician under 30 had been appointed three rungs up the consultant ladder while a senior surgical registrar in his mid-thirties had been placed on the bottom rung. There were complaints about anomalies in travelling and removal expenses for rotating registrars: some seemed to be ineligible because they were technically in post for a year only. All the juniors felt that the hospital practitioner grade should be open to all clinical assistants: the present scheme would create unfair financial discrimination in their view.

And what were my impressions? One thing was clear: young and old, the doctors I met were still committed to the NHS. They realised the financial difficulties; some saw more responsible prescribing in and out of hospital as making a modest contribution to solving these; the juniors, by and large, accepted the inevitability of some form of audit, which could also help; and all wanted a less top-heavy administration and more effective medical advice, which would certainly save money. How to provide decent geriatric care worried consultants and GPs, as did the shortage of good quality nurses, while relations with social workers seemed to have reached a nadir in some quarters. Spirits were flagging. But if the DHSS found more money, reduced its influence, and dismantled some administration the prospects would brighten. And morale and goodwill would rise accordingly.

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too few facts: the inquiry on private practice in the NHS is a case in point.¹² Given the circumstances in which the committee has to work, it is not these weaknesses which are remarkable but the fact that it actually manages to carry out any worthwhile inquiries at all.

All this would seem to suggest that any proposals for changing the institutional structure of the Health Service should also deal with the machinery of parliamentary accountability: Royal Commission please note. So long as there is a centrally financed and centrally controlled Health Service so there will be a need for some form of parliamentary accountability. The real problem, therefore, is how to make it more effective. Two conditions would seem to be essential. Firstly, there should be a permanent House of Commons committee charged exclusively with the affairs of the NHS. Secondly, it should have sufficient staff to collect the evidence for a systematic and continuing review of national policies in the light of their impact (or lack of it) at the periphery. If it is the job of the DHSS to monitor the health authorities; it is the responsibility of Parliament to monitor how the department is carrying out this task.¹³

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- ⁴ Hansard, House of Commons, 27 June 1977, col 202.
- ⁵ Hansard, House of Commons, 16 December 1977, col 1143.
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- ⁷ Hansard, House of Commons, April 1978, col 682.
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