COMMENTARY

Power, democracy, and the NHS

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When the history of the National Health Service in the mid 'seventies eventually gets written—say, in the year 2000—it is unlikely that the greatest prominence will be given either to reorganisation or even to financial crisis. These may be the current preoccupations. But, more significant for the future, has been the shift of power within the NHS: a transformation which, although it is only beginning, could turn the NHS into the first example of a public service largely controlled by those working in it.

In the past the NHS has often been described as a syndicalist organisation.¹ But it has been syndicalism—that is, workers' control—of a limited kind: largely confined to the general practitioners and the hospital consultants and mainly referring to their power of decision-making at the point of delivery—over the use of beds, the admission of patients, and so on. Nevertheless, it is now beginning to make sense to talk about syndicalism in a wider sense: the participation of all those who work in the NHS in the decisions about how to manage the Service.

Participation by the workers

For this, indeed, is the aim of the present Government's decision to include two elected representatives of the staff on all health authorities, at both the regional and the area levels. First enunciated in a consultative document published in 1974,² this policy is now being implemented: proposals for holding elections have already been circulated,³ and the Department of Health and Social Security is now mulling over the reactions to its paper.

The implications of this development are considerable for both the medical profession and the public. Two elected staff members on regional and area health authorities may not, in themselves, make all that much difference to the balance of power on these bodies. But conceding the principle of elected representatives represents a major and fundamental change of policy. It raises several crucial questions which so far have been scarcely debated, since the Government has introduced the changes by a statutory instrument⁴ and not by legislation, with the result that there has been no full-scale Parliamentary discussion.

Firstly, the change prompts doubt about the position of the two doctors and one nurse on each of the health authorities. These are in no sense representatives: the philosophy of reorganisation emphasised⁵ that members of health authorities should have no representative role but should have an exclusive loyalty to the management of the Service. But the whole point of elections is to produce people who speak on behalf of their constituents. If there are to be staff representatives in this sense, then the position of nominated, ostensibly non-representative doctors and nurses is going to look increasingly anomalous.

So the Government's decision to introduce elected staff representatives may well lead to demands for elected medical and nursing representatives. But in that case, how are such representatives to be chosen? The difficulties are well illustrated by the Government's own proposals for the election of staff members. These try to tackle the problem of securing representation for the heterogeneous staff of the NHS through two elected members, and succeed only in illustrating that it is virtually impossible to do so without excluding some interest.

Influence of the battalions

Thus the Government's proposals raise the possibility that the two members should represent different groups of staff. One

might represent ancillary staff; another might represent administrative staff. But what, in that case, will happen to the representation of technical and professional staff? And if these latter are included, one of the other two groups has to be knocked out. Clearly, if there was only one across-the-board election, the results would be effectively determined by the large battalions of COHSE or NUPE, and the smaller groups of workers would find themselves excluded from representation. But if there is to be a voice for these smaller groups, then the pure milk of democratic doctrine has to be watered and representation has to be by interest groups rather than by numbers.

Whatever solution is adopted for the time being, in the long term there is therefore likely to be increasing pressure to extend the system of representation and the number of representatives to provide more opportunities for the many variegated groups of workers which make up the NHS's labour force. And the same problems and pressures will arise if, as seems quite possible, the medical and nursing professions decide to elect their representatives. For example, should one of the medical members represent the consultants and another the junior hospital doctors? Should there be one member for hospital medical staff and another for general practitioners?

Moreover, sooner or later, someone will challenge the existing distribution of members. There are 10 times as many nurses in the hospital sector as doctors: should they also have 10 times as many representatives? And, given that the principle of representation according to numbers is rejected, what other theory can be invoked to justify the distribution of seats on health authorities? The present distribution is the result of history modified by political bargaining and party prejudice, and it would be silly to pretend that it is immutably fixed for all time.

Introducing the concept of representation raises other problems as well. There is the immediate problem of paying for the costs of elections at a time of financial stringency. There is the more important long-term problem of how to decide on eligibility to vote. Present proposals would limit the right to vote to members of staff organisations represented on the Whitley Councils or national recognised negotiating bodies. In fact, the DHSS does not even have figures of trade union membership in the NHS, and it is therefore impossible to know how all-embracing such a franchise would turn out to be and how many people would be excluded. Moreover, there is an important difference of principle between representation for all those working in the NHS and representation limited to those belonging to staff organisations and trade unions.

Problem of accountability

Equally important are the implications of these developments for the public at large. The reason why so much emphasis was placed on "accountability" in the reorganised NHS was not so much that this reflected some managerial fad but that this is crucial if the NHS is to be run by a Secretary of State accountable to Parliament. If the members of health authorities are not accountable to the Secretary of State, then he or she cannot in turn be held answerable for what happens.

But, to the extent that the members of health authorities become representatives, so the idea of accountability inevitably becomes blurred. Strictly speaking, these are accountable to the people who voted them in—and to tell them (as the Government did in its consultative document outlining its proposals for introducing elected members) that they are not to act as spokesmen for their particular interests is simply a futile attempt to

square the circle. If they do not speak for their constituencies, they will doubtless be voted out next time round; if they do speak for their constituencies, then the idea of exclusive corporate loyalty to the management body goes by the board.

As the idea of worker representation takes roots and spreads, so it may become more difficult to pursue policies which (rightly or wrongly) are assumed to represent the national interest and to reflect the democratic process as represented by ministerial answerability to Parliament. While Richard Crossman complained about the problems of introducing change against the opposition of a self-perpetuating oligarchy of consultants,⁶ his successors may well lament the problems of introducing new priorities against the institutionalised opposition of an oligarchy of elected representatives.

All this may suggest that the idea of worker representation in the NHS is dangerous nonsense. This would, however, be a mistaken conclusion. The medical profession has for long insisted that it is wrong to take decisions in the NHS without the consent of those who have to implement them: hence the proliferation of advisory committees and such devices as the consensus district management team. It is therefore not surprising if others working in the NHS draw the same conclusion—but push it one step further. Moreover, given the current debate about how best to introduce a greater degree of worker participation in the running of industry, it would be surprising if the NHS alone were to escape the influence of this trend: indeed, the medical profession, by its increasing adoption of militant trade union tactics, has made it more difficult to argue that the NHS is different from other large-scale enterprises.

participation in management by all those working in the NHS is inevitable, but that much more discussion is required about how best to bring this about. For example, it is by no means self-evident that representation on management bodies is preferable to a system of hospital councils which the decision-makers would be obliged to consult in the policy-making process. Nor is it clear how giving more power to those working within the NHS can be made compatible with the principle of the NHS's accountability to Parliament: there is a conflict between what might be called internal and external democracy, between the concept of democracy as self-government and that of democracy as responsiveness to the community at large. If the NHS is about to move into a new era—and there are clear signs that it is—then there is an overwhelming case for doing so after deliberate debate, and an exploration of all the possibilities, rather than drifting from one expedient to another.

References

- ¹ Klein, R, *Political Studies*, 1974, **22**, 1.
- ² Department of Health and Social Security, *Democracy in the National Health Service*. London, HMSO, 1974.
- ³ Department of Health and Social Security, circular to Administrators, N/H223/2. January 1976.
- ⁴ Statutory Instruments 1099-1101. London, HMSO, 1975.
- ⁵ Secretary of State for Social Services, *National Health Service Reorganisation: England*, Cmnd 5055. London, HMSO, 1972.
- ⁶ Crossman, R H S, *A Politician's View of Health Service Planning*. Glasgow, University of Glasgow, 1972.

Need for deliberate debate

The real conclusion to draw is that a greater degree of par-

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Appendix V: Amendments to the Articles, By-laws, and Second Schedule to the By-laws

The Annual Report of Council was published in the BMJ on 1 May (p 1085).

Amendment of Articles

Article 9—(i) In the first sentence delete the words "prescribed by" and substitute therefor the words "prescribed in accordance with the By-laws"; (ii) delete the second and third sentences and substitute therefor:

"In the case of Members or Overseas Associates the said subscription shall be considered due in advance on the 1 January each year or in the case of Members or Overseas Associates elected during the year at the time of election. In the case of Temporary Members or Associate Members the said subscription shall be considered due in advance at the time of application for election as a Temporary Member or an Associate Member as the case may be and shall cover a period of 12 months from the time of such application."

Article 11—In the second line add the word "or" immediately after the word "Association" and delete the words "or an Associate Member"; in the sixth line delete the words "or associate membership."

Article 12—Delete the existing wording and substitute therefor the following:

"12(a) Every Member or Overseas Associate shall remain a member or overseas associate (as the case may be) until his membership or overseas associateship (as the case may be) is terminated in accordance with the provisions hereinafter contained.

"(b) Every Temporary Member or Associate Member shall remain a Temporary Member or an Associate Member (as the case may be) until the anniversary of his election or until his Temporary Membership or his Associate Membership (as the case may be) is terminated in accordance with the provisions hereinafter contained (whichever is the earlier)."

Article 13—Delete this Article in its entirety.

Article 14—In sub-paragraph (c) add the following "or (viii) in the case of a Temporary Member if he ceases to be eligible for Temporary Membership under Article 4."

Article 43—(i) In subparagraph (2) delete the words "the next sub-paragraph" and substitute therefor the words "Subparagraphs

(3) and (4)" and (ii) insert a new subparagraph as follows:

"(4) Notwithstanding anything contained in subparagraph (2) hereof it shall further be lawful for the Representative Body to resolve that a member of the Association who is not a member of the Representative Body shall be at liberty to propose to the Representative Body a Motion which has been referred to the Representative Body by the Joint Agenda Committee and in such event such person may address the Representative Body and take part in any subsequent debate on the motion he has proposed but not vote thereon" and

(iii) Renumber subparagraph (4) to read (5).

Amendment of By-laws

By-law 21(1)—Delete the words "1 July in that year" and substitute therefor the words "such date in any year as the Council may from time to time determine."

By-law 37—Add a new paragraph reading as follows: "(3) Each Regional Council and