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Memorandum submitted to the Health Select Committee inquiry into Public and Patient Involvement in the NHS January 2007

About us

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He is co-author, with J. Mohan and T. Willis, of *Mutualism and Health Care: British hospital contributory schemes in the twentieth century* (Manchester University Press 2006) and this memorandum draws on that work. He is also the author of 'Hospital governance and community involvement in Britain: evidence from before the National Health Service', published on the History & Policy website and available at: <http://www.historyandpolicy.org/archive/policy-paper-40.html>.

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Summary

- This memorandum describes the historical background to public and patient involvement in the British health system.
- This is not a new phenomenon but extends back at least to the nineteenth century, in the form of voluntary sector governance of GP and hospital services, and in local government control of health care.
- The growing role of the central state in health provision undermined existing broadly-based forms of public and patient involvement, which were finally ended with the coming of the NHS in 1948. However this was unopposed because the goals of a universal, comprehensive and free service satisfied users' major requirements of the health system.
- Patient consumerism expressed through voluntary sector activity began to develop from the 1960s. A formal mechanism of patient and public involvement in the NHS was established in the 1970s with the Community Health Councils, which for the first time separated representative from managerial functions.
- Consideration of these earlier forms suggests some inherent features, such as the tendency for power to remain with medical professionals and administrators rather than users, the scope for conflict between doctors and representatives of the public, the possibility that local choices may conflict with uniform national standards, and the tendency for voluntary representative bodies to attract those already active in public life.
- History suggests that broad issues which policy-makers need to consider are: the specification of parameters for real local decision-making by patients and public; and the need to ensure consistently high levels of public awareness of representative structures in order to attract a wide range of participants.
- Present proposals for strengthening local government's consultative and community advocacy role could represent a return to the main direction of policy pursued prior to the NHS, of ensuring democratic responsiveness of health services through the local ballot box.

1. Introduction: an historical perspective on Public and Patient Involvement (PPI)

1.1 The recent series of reforms which replaced Community Health Councils (CHCs) with new forms of PPI in the National Health Service (NHS) are apparently driven by two dominant political assumptions. These are:

- a. An understanding of the citizen as critical consumer, and no longer the deferential recipient of services.
- b. The premise that welfare states fall prey to producer interests and that these must be tempered by user input.

1.2 Although both these assumptions suggest that PPI in the health system is a new issue, it has an extensive history, stretching back long before the inception of the NHS in 1948. Earlier forms of PPI include:

- a. The oversight of general practitioners (GPs) by friendly societies before the introduction of National Health Insurance (NHI) in 1911.
- b. Public involvement in the governance of voluntary hospitals before these were nationalised under the NHS.
- c. The local democratic processes to which municipal health services were subject before 1948.
- d. The creation of CHCs as an aspect of the 1974 health service reorganisation

1.3 This memorandum provides an historical perspective on the Committee's second and third terms of reference, consideration of the different forms of PPI and the background to the reform process. It will discuss in turn these earlier experiences, and show why PPI has been weak within the NHS.

2. Before National Health Insurance: Public oversight of GPs

2.1 The central state's involvement in primary care delivered by GPs dates back to 1911 and the coming of National Health Insurance. Prior to this sickness insurance was widely provided by non-profit, mutual organisations known as friendly societies.

- a. Benefits were a cash payment to replace lost income and GP attendance to certify and treat the sickness.
- b. Membership expanded from the 1850s. By 1911 probably some 40% of all adult males had sickness cover.
- c. Friendly societies had strictly observed electoral procedures through which working-class members could serve on management committees.

2.2 GPs were employed locally by friendly societies to provide services, usually on an annually renewable contract. The contractual basis of employment meant that management committees exercised direct leverage over the appointment, conduct and costs of GPs.

2.3 In the early 20th century friction between GPs and societies had developed. The bacteriological revolution raised the status of medicine and GPs resented being subject to committees of workers.

- a. The British Medical Association (BMA) instigated the ‘battle of the clubs’. It documented local disputes and drew up guidelines for members to follow in dealings with friendly societies.
- b. Conflict was mostly over the question of remuneration and lack of deference on the part of patients.
- c. But GPs also argued that independent medical judgement might be sacrificed if they were beholden for their livelihood to the whims of users, as expressed through management committees. Examples included over-prescribing of drugs, colluding with malingers and unnecessary home visits.

2.4 NHI substantially increased the numbers of citizens with sickness coverage. It also reconfigured the relationship between users and GPs in favour of the doctors.

- a. Friendly societies became agents of public policy as ‘approved societies’ for the administration of NHI, but without their previous leverage over GPs.
- b. The annually renewable contract was replaced with a per capita fee for participating GPs serving a ‘panel’ of patients.
- c. Panel GPs were now answerable to a local Insurance Committee, in which user representation was diluted.

2.5 Conclusions:

- a. A form of PPI in primary health care dates back at least to the 1850s.
- b. The ‘battle of the clubs’ demonstrates that PPI can be a source of conflict between medical professionals and users.
- c. Behind this conflict there was a status asymmetry presumed by doctors between themselves and users, founded on social class and scientific expertise.
- d. The doctors’ dislike of PPI cannot be ascribed solely to self-interest. Concerns that independent medical judgement should not be compromised by lay people remain current today.
- e. User power was diminished as a result of state intervention, though coverage, quality of service and GP remuneration all improved.

3. Before the NHS: Public involvement in the governance of hospitals.

3.1 Prior to 1948 most acute hospital care was provided in the voluntary sector. The establishment of independent voluntary hospitals began around the 1750s and their main features were:

- a. Reliance on voluntary funding sources, originally philanthropy.
- b. Honorary and unpaid service by hospital consultants.
- c. Volunteer management by unelected lay trustees.

3.2 Voluntary hospital management committees were self-selecting bodies drawn from local industrial and professional elites and religious activists. Their powers included:

- a. Appointment of doctors, though this was ceded in the later 19th century to medical committees.
- b. Control of admissions, also increasingly ceded to doctors in the later 19th century.
- c. Management of income and expenditure.

- d. Regular visiting of the hospital and oversight of medical care on behalf of patients and donors

3.3 After 1914 the composition of management committees became more representative of hospital users. This was because of the changing structure of hospital funding.

- a. From 1914 charity was superseded by user fees and payments from working-class hospital contributory schemes.
- b. Contributory schemes provided voluntary insurance against hospitalisation. For a small weekly sum, workers were exempt from means-tested user fees on admission.
- c. Contributory schemes had strictly observed workplace electoral procedures allowing ordinary subscribers to serve on hospital governing bodies.
- d. Trade unionists and friendly society leaders figured prominently amongst those who took such positions.
- e. Typically these 'worker governors' were in a minority on hospital management committees, with a third of the seats.

3.4 Despite their minority position the worker governors exerted some leverage over hospital policy because contributory income was essential to finance. For example:

- a. They expressed patient concerns over issues such as waiting times, visiting rights, and medical treatment. This was a minor part of their work.
- b. They ensured that contribution rates were kept low relative to local wages.
- c. In some areas they rejected means-testing and kept the hospital free at the point of use.

3.5 Occasionally worker governors expressed strong preferences arising from the special interests of local contributors. This placed them in conflict with doctors and hospital authorities. For example:

- a. Gloucester 1920s: anti-vaccinationist governors wanted the voluntary rather than the isolation hospital to treat smallpox patients. They were overruled.
- b. Sunderland 1930s: worker governors wanted to sack hospital doctors taking industrial injury cases on behalf of coal-owners. They were overruled.
- c. Nationally: They supported trade union actions to improve pay and conditions of nurses and ancillary workers. Here their dual role as guardians of contributors' funds meant disputes tended to be resolved consensually.

3.6 Conclusions

- a. A form of PPI in hospital governance dates back over two hundred years.
- b. Voluntary governing bodies were not directly representative of users. Initially they were dominated by wealthy philanthropists. When they became broader, working-class representation fell to those already active in the labour movement. This tendency for voluntary representative bodies to attract those active elsewhere in public life is likely to be repeated today.
- c. Worker-governors were most successful in defending user interests in respect of equitable funding and free access to services, both principles later enshrined in the NHS.
- d. Worker governors were least successful when they expressed local preferences at odds with medical or managerial opinion. Ultimately power remained with medical and professional elites. Localism had clear limits where it was at odds with national priorities and the same is likely to be true today.

4. Before the NHS: municipal health services and local democracy

4.1 Prior to 1948 much public expenditure on health services was made through local government. It came principally from local taxation, although some services were part-funded by Treasury grants. The major municipal health services of the interwar period were:

- a. Isolation hospitals, mental hospitals, long-stay hospitals (originally the Poor Law workhouses) and by the 1930s some general acute hospitals.
- b. Environmental services including sanitation, housing and waterworks.
- c. Tuberculosis (TB) dispensaries and sanatoria.
- d. The school medical service
- e. The maternity and child welfare (MCW) services, including midwives, clinics and hospitals.

4.2 These services were overseen by committees of county borough, county or district councils.

- a. Public health committees were made up of elected council members, with a permanent public official, the Medical Officer of Health, acting in an advisory capacity.
- b. Committee structures varied between councils. In large cities and counties health responsibilities were also exercised by education, mental health and public assistance (Poor Law) committees.
- c. Local health policy and expenditure levels were therefore subject to local democratic procedures and committee makeup largely determined by party composition.

4.3 There was considerable variation between local authorities with respect to levels of health spending and the comprehensiveness of services.

- a. Spatial variation is now criticised as a 'postcode lottery', but government in the 1930s regarded it as a desirable manifestation of local choice in action.
- b. It sought to aid disadvantaged areas by refining the central grant mechanism, so that greater Treasury support for health expenditure went to poorer authorities with greater need.
- c. None the less geographical unevenness remained on the eve of the NHS.

4.4 There is no clear research evidence that local choice expressed in the ballot box directly influenced local health policy.

- a. A key determinant was wealth: richer areas spent more on health, poorer areas spent less.
- b. There was a weak positive correlation between Labour representation on councils and greater expenditure on TB and MCW. However these services were those sustained by Treasury grants which privileged poorer areas likely to return Labour councillors. There may therefore be no causal link with party policy.
- c. Another measure of 'progressive' health policy was the degree of improvement of Poor Law hospitals. Councils led by all political parties undertook this. Party programmes were not the key determinant.

4.5 Conclusions

- a. Another form of PPI with which Britain experimented before 1948 was the situating of health services within local government, thereby making them subject to local democracy.

- b. In practice local choice influenced committee make-up although more specific democratic influence on health policy is hard to detect. Health was only one among many issues on which voters made their choices at local elections.
- c. Local policy was therefore determined largely by the resource base and by public officials.
- d. Localism led to uneven provision. It was, and perhaps still is, inherently at odds with the goal of universal high quality services.

5. The coming of the NHS: what happened to PPI ?

5.1 The NHS Acts of 1946 and 1947 ended all these arrangements.

- a. The Insurance Committees overseeing GPs were replaced by Executive Councils with a similar lay/professional mix.
- b. Both voluntary and municipal hospitals were nationalised and placed under the control of Regional Hospital Boards (RHBs) and local Hospital Management Committees. Their members were appointed by the Minister of Health.
- c. Most personal health services were removed from local government, leaving only environmental health, domiciliary care, school medicine and some maternity care subject to local democracy.

5.2 There was no significant political opposition to these changes.

- a. The Labour Party had previously favoured a local government-run NHS, but this proved politically difficult due to the objections of the BMA. The nationalisation and regionalisation scheme was a pragmatic alternative.
- b. The contributory scheme movement accepted its demise, although existing worker-governors strenuously protested their exclusion from the new hospital management structures.
- c. Aneurin Bevan, architect of the NHS, assumed that democratic control of health services would be enhanced through ministerial oversight and parliamentary scrutiny. He had had first-hand experience in South Wales of earlier forms of PPI, through his positions in a local Medical Aid Society, and as a voluntary hospital governor. Bevan did not lament the loss of these structures.

5.3 In contrast to earlier arrangements there was no direct user representation on the RHBs.

- a. In practice RHBs were dominated by doctors, local politicians, academics and the professional and industrial elites previously active in voluntary hospital management.
- b. There was a preponderance of elderly males on these boards.
- c. There was no structural provision for the retention of existing worker governors.
- d. The new system of ministerial appointment led to the under-representation of the labour movement. Bevan's reluctance to appoint trade unionists was probably a concession of to pacify opponents of the NHS.

5.4 The absence of PPI was not deemed problematic in the 1950s and 1960s, and it is only in the last 30 years that a new concept of 'patient consumer' has emerged.

- a. Opinion poll evidence from the 1950s showed very high levels of public satisfaction with the NHS.

- b. Voluntary sector groups representing health care users were initially few in number and did not exert pressure on policy.
- c. Only with the arrival of the Patients Association (1963) can the first signs of the health consumerism of today be clearly identified.
- d. Patient groups linked to specific diseases or to public health issues began to proliferate in the 1970s and 1980s. Their emergence was an aspect of a broader consumer movement in industrialised societies, with a focus on consumer rights and standards of services.

5.5 Conclusions

- a. The advance of state agency in health provision terminated existing arrangements for PPI.
- b. This had no significant opposition because the goals of a universal, comprehensive and free service satisfied users' major requirements of the health system.
- c. The managerial structures bequeathed by Bevan privileged the interests of providers – doctors and administrators – over those of patients.
- d. Therefore the NHS was poorly equipped to accommodate the emergence of the patient consumer from the 1960s.

6. The Community Health Councils 1974-2003

6.1 As yet there has been no detailed historical evaluation of the CHCs, although there has been limited contemporary policy research.

6.2 CHCs were established in the 1974 NHS reorganisation.

- a. This aimed to tackle the unsatisfactory 'tripartite structure' of the NHS by creating new tiers of area and district health authorities. CHCs were created at the district level.
- b. They were not initially a policy response to the new consumerism in health but were proposed during the consultation process to compensate for further reduction in the role of local government.
- c. However in the parliamentary debates they were championed by consumer interests, which lobbied strongly for their autonomy.
- d. Government reluctantly conceded greater financial and political independence for the CHCs from area health authorities. Thus for the first time a representative mechanism was created which was separate from the health system's managerial structure.

6.3 The structures and functions of CHCs were as follows:

- a. They consisted of nominees of local government (1/2), voluntary organisations (1/3) and regional health authorities (1/6).
- b. This method produced a membership which was a 'distorting mirror'¹ of the population, being disproportionately middle-aged, male and middle class, and already active in other areas of public life.
- c. However, the voluntary sector membership brought in new people, particularly from health related associations, and later from new movements, such as women's and minority groups.

¹ R.Klein, and J.Lewis, *The politics of consumer representation: a study of Community Health Councils*, Centre for Studies in Social Policy, London, 1976, p.29

- d. The CHC's role was to act as community watchdog (overseeing services and assessing local needs) and patients' advocate (providing assistance and advising on complaints), and to participate in health planning (through consultation procedures).
 - e. The detail of how CHCs would carry out these activities was largely unspecified and no criteria for assessing their effectiveness were developed. CHCs interpreted their roles in different ways, with some more passive than others.
- 6.4 CHCs subsequently had a long, but insecure existence and were abolished in 2003.
- a. The Thatcher government considered their abolition in 1982 during its purge of quangos, but pulled back fearing a defensive outcry.
 - b. The coming of the internal market undermined their status, both because it provided a new mechanism for assessing patient demand, and because consumer protection was now directed to the individual not the community.
 - c. There is some evidence that CHCs were easily disregarded. In 2002 the vast majority of CHC referrals to the Secretary of State were over cases of inadequate consultation with health authorities or trusts.
 - d. Labour was a staunch defender of the CHCs in the 1990s. However once in power it proposed their abolition on the grounds that they were outdated, lacked teeth and suffered from low public awareness.
 - e. One leading historical assessment of this volte-face claims that government sought to appease provider interests by removing an oppositional body and replacing it with the weaker Patient Advocacy and Liaison Service.²

7. General conclusions:

7.1 Historical perspectives on forms of PPI

- Although current debates about PPI are framed as a response to contemporary health consumerism, the involvement of public and patients in the organisation of health services has a long history in Britain.
- Like today earlier forms of PPI sought to represent the interests of those who paid for and consumed health services, to those who provided them: doctors and administrators in the public or voluntary sector.
- Under these earlier forms of PPI power and authority in the British health system tended to remain with provider interests rather than users.
- At every stage the advancing role of the state reduced the power of PPI structures, although the achievement of universal access, comprehensive provision and equitable funding in 1948 meant that this was uncontested.

² Charles Webster, *The National Health Service a political history*, Oxford, 2nd edition 2002, p.245

7.2 Historical perspectives on the design of PPI

- Provider interests (eg. ‘club’ doctors, voluntary hospital administrators) have tended to be wary of PPI (friendly society committees, worker governors) as a potential source of opposition.
- However this may not simply be a case of professional or bureaucratic monopolisers protecting self-interest. Localism has in the past been inimical to medically optimal policies, to rational resource allocation and to uniform national standards. Policy makers need to specify clearly at the outset the scope for real local decision-making by PPI bodies.
- In the past, participants in voluntary forms of PPI have been self-selecting, likely to represent special interests or to be drawn from limited social constituencies defined by age, gender and social class. Given contemporary evidence for high levels of passive citizenship (poor local election turnout, low levels of voluntary association membership) the same is likely to be true today. Mechanisms are needed for ensuring consistently high levels of public awareness of PPI structures in order to attract a wide range of participants.
- The alternative approach was to use the ballot box, and there are some current indications that local government may again take a larger role. In addition to the establishment of local authority Overview and Scrutiny Committees there are moves towards greater joint working between the NHS and local government on health and social care. Present proposals for strengthening local government consultation and community advocacy³, could represent a return to the main thrust of policy before the NHS, of ensuring democratic responsiveness by situating health services within local government.

³ Department of Health, *Our health, our care, our say: a new direction for community services*, Cm 6737, The Stationary Office, January 2006, pp.158-61