Control, Participation, and the British National Health Service

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I N JULY, 1978, THE BRITISH NATIONAL HEALTH SERVICE (NHS) celebrated the 30th anniversary of its birth. But the debate about how to run the NHS organization—the issue of democratic control, in its widest sense—continues. This suggests that it is far easier to create the organizational framework for a national health care system than to solve the problem of making it socially accountable and responsive. This paper explores the history of the debate and the policy options currently being canvassed to delineate the dilemmas inherent in designing a national health service, whether in the United States or any other society that subscribes to the traditions of liberal Western democracy.

The British NHS is unique among Western health services in a number of respects. It is a *national* health service in the full sense, in that the Secretary of State for Social Services[1] is directly answerable to Parliament for its operations; the field authorities—regional and area health authorities—are his agents, responsible to him (Fig. 1). The NHS is financed by central government mainly out of general taxation; direct payments by users of the service are individually

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[1] The Secretary of State for Social Services is the Cabinet Minister overseeing the Department of Health and Social Security (DHSS), which is responsible for the administration of the National Health Service in England.
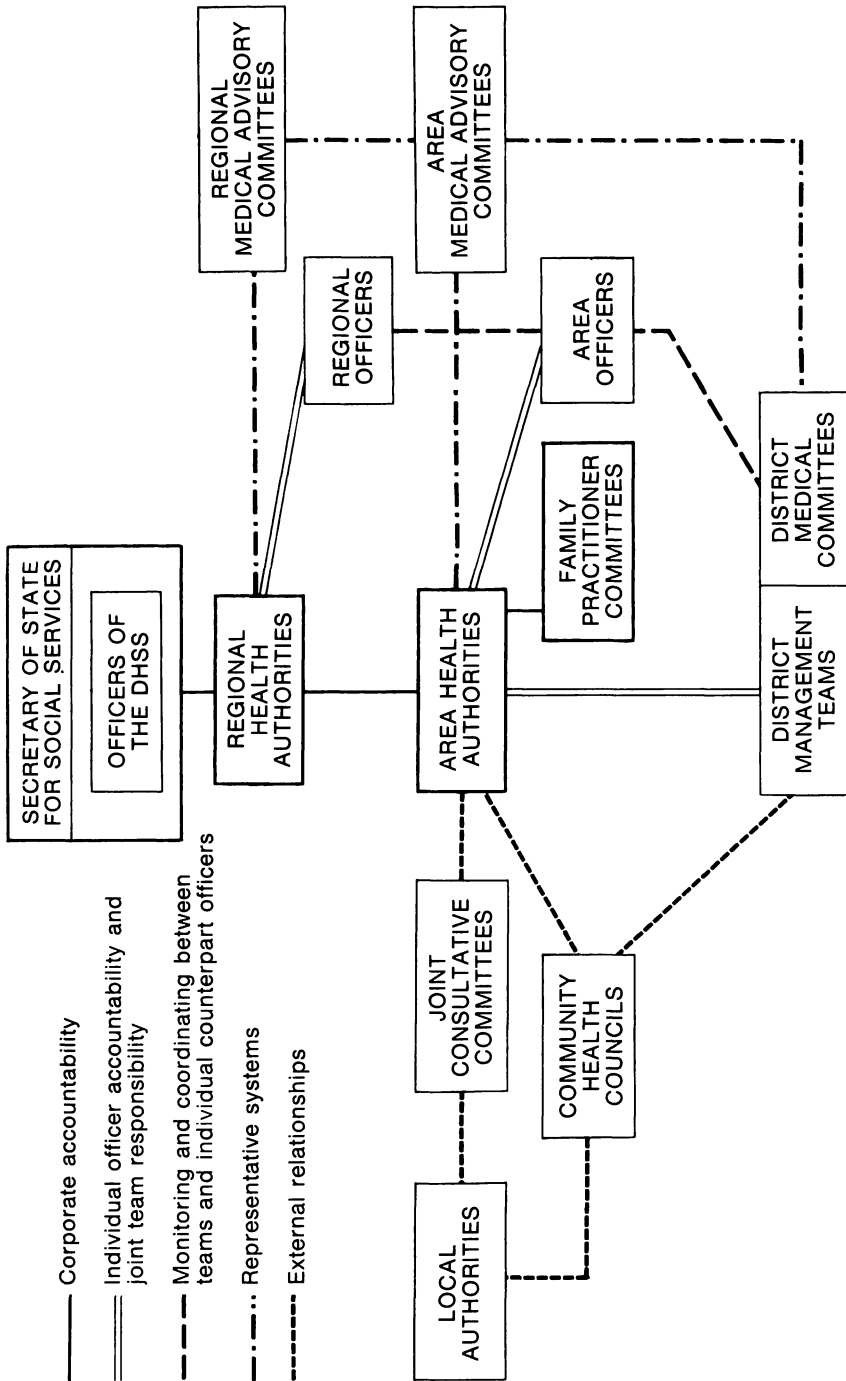
Corporate accountability

Individual officer accountability and
joint team responsibility

Monitoring and coordinating between
teams and individual counterpart officers

Representative systems

External relationships

FIG. 1. Diagram showing the organizational structure of the National Health Service (NHS) in England. *Source*: Office of Health Economics (London), © March 1974.

SECRETARY OF STATE FOR SOCIAL SERVICES

OFFICERS OF THE DHSS

REGIONAL MEDICAL ADVISORY COMMITTEES

AREA MEDICAL ADVISORY COMMITTEES

REGIONAL OFFICERS

AREA OFFICERS

REGIONAL HEALTH AUTHORITIES

AREA HEALTH AUTHORITIES

FAMILY PRACTITIONER COMMITTEES

DISTRICT MEDICAL COMMITTEES

DISTRICT MANAGEMENT TEAMS

JOINT CONSULTATIVE COMMITTEES

COMMUNITY HEALTH COUNCILS

LOCAL AUTHORITIES

small and unimportant in total. In contrast to Sweden, local authorities play no role; in contrast to France and Germany, there are no *caisses* or *kassen* to collect contributions or represent the consumer. Lastly, the British NHS is a near-monopoly health care provider; the private sector is small (Klein, 1979) and the great majority of the population look to the NHS for provision of health care.

Doctrine of Accountability

The architecture of the NHS—although modified by the reorganization of 1974—reflects, in its basic design, the egalitarian aspirations of its designer, Aneurin Bevan. The aim of the NHS, as he explained to Parliament in 1946 (*Hansard,* 1946a) was to "universalise the best, that we shall promise every citizen in this country the same standard of service." Hence the need, Bevan argued, for a *national* service—given the diversity, in terms of both population and financial resources, of local authorities. Indeed, it was precisely this decision to create a national service that represented Bevan's main innovation, diverging from the plans for a much more federal, local authority-based service that he had inherited from the wartime coalition government (Willcocks, 1967). Implicit in this approach was the assumption that distributional equity could only be achieved by means of central direction and planning. Nor was this surprising, given the history of public health care provision in Britain, which from the days of Chadwick (Finer, 1952) and Sir John Simon, (Lambert, 1963) had largely been a struggle against the parochial self-interest of the municipalities.

In actuality, central control did not lead to the hoped-for measure of distributional equity. In particular, the distribution of hospital resources—by far the most expensive part of the NHS—continued stubbornly to reflect the inherited inequalities between different parts of the country (Buxton and Klein, 1975). One of the main objects of the 1974 reorganization of the administrative machinery, carried out by a Conservative Government, was therefore to strengthen central control of resources and introduce a more effective planning system (Brown, 1973: 70–83). Although widely criticized as managerial in inspiration, this reorganization could also be, and was, presented as an attempt to make democratic accountability more effective. For how could the Secretary of State

be accountable to Parliament if he did not exercise effective control over the execution of policy in the NHS?

The emphasis on central control, whether in the original 1948 model or in the revised 1974 model, has had a further consequence. Persons appointed to serve on the health authorities—the Regional Hospital Boards and Hospital Management Committees before 1974 (or on the Regional Health Authorities and Area Health Authorities thereafter)—were the creatures of the Minister of Health (or, as he later became, the Secretary of State for Social Services). It was constantly stressed that they were not to be regarded or to think of themselves as representatives of special interests, whether occupational or geographic. Just as the Secretary of State was accountable to Parliament for the expenditure of public funds, so they were accountable to him and to no one else. Accountability, in the NHS and in the British tradition of public administration, is a one-way street and does not permit dual loyalties.

The doctrine is clear; the practice turned out to be somewhat less so. At least one occupational interest was strongly represented in the service created by Bevan, even though there were no "representatives" in the most limited sense of that ambiguous word—men and women answerable to their constituency (Pitkin, 1967). The medical profession was strongly in evidence everywhere, excessively so in the view of the Guillebaud Committee, which reported in 1956 on the operations of the NHS (Ministry of Health, 1956). The Committee pointed out that in 1954–1955 almost one-third of all Regional Hospital Board members were doctors, and that the proportion exceeded two-fifths in one case. Similarly, the medical membership of the Hospital Management Committees was about one-quarter physicians, although it too reached two-fifths in some instances. Further, in the case of the Hospital Management Committees, the lay members were chosen precisely because they were active members of their local communities—often as elected councillors—although they were not, in any formal sense, chosen to represent those communities.

The element of syndicalism was more evident still in the case of the Executive Councils, which are the local bodies responsible for running the general practitioner, dental, pharmaceutical, and ophthalmic services. On these, under the terms of the legislation, doctors, dentists, chemists, and ophthalmologists had half the membership, thus perpetuating the strong position of the medical

profession in the administration of general practice, first conceded in
1911 when health insurance was introduced (Klein, 1973). No doubt
this form of organization largely reflected political expediency—the
need to conciliate family practitioners, the most militant section of
the medical profession. But Bevan's defense, or rationalization, is
worth recalling (*Hansard,* 1946b):

> I have never believed that the demands of a democracy are necessarily
> satisfied merely by the opportunity of putting a cross against
> someone's name every four or five years. I believe that democracy ex-
> ists in the active participation in administration and policy. Therefore,
> I believe it is a wise thing to give the doctors full participation in the ad-
> ministration of their own profession. . . . [W]e do not want the opposite
> danger of syndicalism. Therefore, the communal interests must always
> be safeguarded in this administration.

So although the theory of syndicalism was thus explicitly repudiated,
the reality of professional representation was, in effect, conceded in
this area of the NHS.

The 1974 Reorganization: Representation and Interests

The 1974 reorganization did not affect the composition of the
Executive Councils, which changed only in name to become "Family
Practitioner Committees" (see Fig. 1). Otherwise, however, the
membership of the various authorities continues to reflect the
hierarchic nature of the system of accountability. In the case of the
14 Regional Authorities, the members are appointed by the
Secretary of State. To quote the 1972 White Paper that introduced
the legislation (DHSS, 1972: 24):

> Their authority will derive from the selection and appointment of their
> chairmen and members by the Secretary of State, who will be required
> before making this choice to consult with the appropriate interested
> organizations including the Universities, the main local authorities and
> the main health professions.

In turn, the members of the 90 Area Health Authorities—the next
administrative tier below the regions—are appointed by the regions,
although the chairmen are directly nominated by the Secretary of
State.

The 1974 reorganization had a number of other significant

features as well. In each Area, four members were to be nominated by the matching local authorities; one of the main aims of the reorganization was to align the administrative boundaries of the health authorities with those of the local authorities in order to promote the coordination of services. In addition, the membership was to include at least one doctor and one nurse, but it was stressed that they were not to have a representative role. They were to see themselves as being exclusively responsible for the management of services, not as being accountable to any interest groups. To the extent that there was to be any representative role for professional interests, this was to be performed by the various advisory committees with which the new health authorities were liberally festooned.

The representation of public interests was, in the 1974 reorganization model, to be the role of a new institution, the Community Health Council. There were to be 206 of these, one for each district of the NHS, i.e., they were the basic administrative unit below the area level. Half of their members were to be nominated by local authorities, one-third by voluntary organizations, and the rest by the regional authorities. The logic for choosing this composition was not entirely clear, and seems to have reflected a mixture of motives rather than explicit principles (Klein and Lewis, 1976: 19–20). In the outcome, however, it meant representation both for geographical communities (represented by the local authority nominees) and special health service client groups like the mentally ill, the elderly, and the handicapped (represented by the voluntary organization nominees). There was some ambiguity as to whether Community Health Councils should represent "the views of the consumer" or "the interests of the public in each health district" (ibid., 17). Both phrases were used by government spokesmen, as though the interests of the actual consumers of health care were identical with those of the community at large. But it was quite clear that the Community Health Councils should have an explicit, and indeed exclusive, representative role as spokesmen for the public—however defined. They were to have no managerial function whatsoever. Their powers were limited to the right to information, to access to health service facilities, and to kick up hell if their views were ignored.

The rationale for adopting this system of introducing community interests into the NHS was set out in the 1972 White Paper. This pointed out that:

> The expression of local public opinion can be catered for in one of two ways. It can be done by including in the membership of the health authorities local people serving in a representative capacity. Or it can be done more directly, through bodies specially set up for this purpose.

The Government preferred the second option (DHSS, 1972: 27) because "it avoids a confusion between the direction of services and representation of those receiving them." This conclusion reflected two considerations. First, there was the doctrinal emphasis on the need for a clear hierarchy of accountability. Second, there was pragmatic evidence of the actual workings of the NHS, which suggested that lay members of the Hospital Management Committees tended to identify themselves with the interests of the service providers rather than those of the service consumers. This evidence had been elicited in the course of a number of inquiries into scandals in the neglected long-stay sector of the NHS (Klein, 1971).

Persistent Policy Aims of the NHS

There have been minor changes in the organization of the NHS since 1974, with the arrival of a Labour Government in office, but, in all its essentials, the administrative structure remains as described. It reflects an attempt to accommodate a number of policy aims that are worth reiterating before turning to the analysis of the on-going debate about community and worker representation and the issues raised by this.

First, there is the view that an *egalitarian* NHS requires effective central control over the disposition and use of centrally financed resources.

Second, there is the view that a *democratic* NHS requires both accountability to Parliament and responsiveness to local needs.

Third, there is the view that an *effective* NHS requires coordination with other social services operated by local authorities.

Fourth, there is the view that there ought to be a voice—of one kind or another—for those working in the NHS.

Lastly, to take up a theme that has so far not surfaced from the discussion but which will emerge strongly in the subsequent analysis, there is the view that an *efficient* NHS requires the basic units of administration to be large enough to provide reasonably comprehen-

sive health care for most of its population for most of the time. Thus, the population of the majority of districts falls in the range of 150,000 to 350,000 (although the minimum is 86,000 and the maximum is 530,000).

It is precisely because these various policy aims do not necessarily point in the same direction—and may, indeed, conflict—that the debate about the future "ideal" structure of the NHS is still unresolved. Furthermore, it is precisely because the considerations involved raise general issues of principle, common to all attempts to devise a national health care system, that the experience of the British NHS is relevant to other countries as well.

Attempts to Square the Circle

In the discussions that have taken place both before and since reorganization about what is wrong with the NHS, one of the main preoccupations has been how to make it more "democratic." But, of course, democracy tends to be used as an emotive term of rhetoric (Klein, 1976). The definition of "democracy" depends on the values and preconceptions—seldom articulated explicitly—of those using the word. In analyzing the policy options that have been put forward or adopted in Britain, it may therefore be helpful to set them into the framework of theoretical assumptions that are implicit in the arguments of their advocates.

A Clash of Values: Centralism vs Localism

A helpful starting point is the distinction drawn by Robert Nisbet (1970: 70) between two streams of thought in European radicalism. On the one hand, there is the tradition stemming from Marx: "centralized, nationalist socialism." On the other hand, there is the tradition stemming from Proudhon: "decentralist, pluralist anarchism." The former "was as hostile to localism, community, and cooperation as was the line of utilitarian liberalism that reached from James Mill to Herbert Spencer." The latter rested "upon localism, with the small community—rural and industrial—the essential element." Leaving aside the much debated question as to whether the Marxian tradition represents a correct reading of Marx's views, we find that Nisbet's distinction remains a useful analytical tool for

examining the different approaches to the issues of accountability, representation, and participation in a monopoly social service like the NHS.

The 1948 NHS was, as we have seen, a triumph of centralized socialism. So, too, was the 1974 reorganization—although perhaps it is possible to detect the influence of utilitarian liberalism, as well. The reorganization, in essence, was an attempt to make the NHS more effective in achieving the aims of the original model; centralization was emphasized because a more egalitarian and efficient use of resources was thought to be desirable. And, indeed, since 1974 a Labour Government has used the planning system to try to move toward developing "norms" for the distribution of resources (DHSS, 1976b), an approach that is also characteristic of the highly centralized Eastern European health services (Zhuk, 1976).

The critique of the NHS has, increasingly, come from those whose views stem (usually unconsciously) from the opposite tradition of localism and participative self-government. It can be seen as part of a wider reaction—drawing on support from both the Left and Right—against "big" government, against bureaucracy, and against professionalism. The critique is by no means limited to the NHS. Just as the 1948 NHS reflected a general move toward the centralization of power—as exemplified by the various nationalized industries like coal, electricity, and gas—so the current critique of the health service reflects a more general disillusionment with what is perceived to be a "technocratic solution" to social and political problems.

So, in effect, there is a clash of values. What is being stressed, on the one side, are the values of egalitarianism (fair rations for all, decided nationally) and efficiency, and, on the other side, the values of self-determination and democracy-as-participation. And, as the ongoing debate about the organization of the NHS shows, the problem of designing a national health service derives from the fact that different values imply different organizational solutions.

The present NHS represents a monument to the liberal definition of democracy as accountability. Without necessarily accepting the criticisms of Pateman (1970) and others of this definition, it must be conceded that the practice of accountability has, in fact, lagged behind the theory. The capacity of Parliament to call the Secretary of State to account for all that happens in the NHS is circumscribed. MPs can, and do, ask questions about specific cases or issues. But

their ability to influence policy is limited. Parliamentary committees—in contrast to Congressional committees—have virtually no staff (Klein, 1977b) and are therefore in no position to carry out a systematic surveillance of policy-making and policy execution. This is not to argue that Parliamentary influence is non-existent, or that accountability is a fiction. It is to argue, however, that accountability is bound to be erratic and spasmodic, given the sheer size and heterogeneity of the NHS. Moreover, the system of centralized accountability tends to have pathological side-effects. The fact that the Secretary of State is in theory answerable for everything that happens in the NHS means that the center has to exercise detailed control over the periphery, with a consequent growth in bureaucracy (DHSS, 1976c).

Constraints on Local Democracy

One much-canvassed option for dealing with the problem of over-centralization is to transfer control over health services to the local authorities. These, in Britain, already administer most of the social services: education, housing, and social care. And, indeed, this transfer was the policy advocated by the Labour Party in the debates preceding the 1974 reorganization (*Hansard,* 1973). However, no Labour Government has adopted this solution in office. And the reason for this is not simply tactical; the fact is that the medical profession—and some of the trade unions representing health service workers (Confederation of Health Service Employees, 1977)—is opposed to such a transfer.

The main objection was spelled out by Richard Crossman (*Hansard,* 1970) when, as Labour's Secretary of State for Social Services, he explained why he did not include a transfer of responsibility in his own reorganization proposals. If the local authorities were given the power to run health services, he told Parliament, "No responsible Government could permit them to run those services with the degree of independence which they take for granted in running their other services." A health service, he stressed, must be planned nationally. In short, the values of egalitarianism—with all they imply for the distribution of resources and the equalization of access throughout the country—constrain the scope for local democracy in the shape of control by local

authorities. In practice, central government can and does impose sharp limits on the freedom of local authorities, even in the case of the other services—like education—for which local authorities are responsible. So a strong measure of central control over locally administered services is possible. There are norms for the number of school teachers, just as there are norms for consultant posts in the hospital service. But, as a recent committee of inquiry has recognized (Department of the Environment, 1976), such central control blurs local accountability. Why should citizens bother to turn out to vote in local elections if all the important decisions are taken centrally? In fact, unsurprisingly, turnout in British local elections is very low. Widespread apathy seems to be the price paid for the emphasis on egalitarian values and the suspicion of diversity (Klein, 1977c). Moreover, in contrast to the other social services, the NHS is exclusively financed from national taxation—thus compounding the arguments against a transfer of control to authorities who would be making no financial contribution. Lastly, local authority boundaries were not determined with the needs of the health service primarily in mind; many of them can therefore not even begin to deliver a comprehensive range of health care.

Given these arguments against the decentralization of control in the NHS, it is not surprising that the main emphasis has been on ways of trying to square the circle. How best can the NHS be made responsive to the views, demands, and needs of the public? How can a national service include an element of local accountability? Different answers have been given to these questions, at different times and by different governments. But none of them has, as yet, come up with a wholly satisfactory solution.

Strategies for Modifying the NHS Structure

Community Health Councils: Advocacy, Adversary, and Authority. The 1974 reorganization introduced, as already mentioned, Community Health Councils. These translated the concept of consumer representation to mean consumer advocacy: they are, in effect, public bodies with the legitimacy to voice and promote the views of local interest groups—whether these interests are defined geographically or in terms of specific clients. But the experience so far suggests this approach raises a number of difficulties.

The first difficulty stems from the general lack of clarity about the concept of community. To quote the 1968 edition of the *International Encyclopaedia of the Social Sciences* (Sills, 1968: 157):

> Little attention has been devoted in contemporary community power research to the problem of defining a community . . . For the most part, a conventional perspective has been adopted and a 'community' has been defined as a population living within legally established city limits.

Indeed, often the term "community" appears to be used as though it were synonymous with "popular control," with no precise definition at all. In the case of the Community Health Councils, the community has been defined as "the population living within the legislatively established NHS districts." These, as already mentioned, range in size from 86,000 to 530,000. Yet, as shown by earlier research in Britain (Royal Commission on Local Government Control in England, 1969), community, as defined by the inhabitants' self-identification with a particular district, tends to be strongest in areas with a population of less than 30,000. It is therefore not surprising that many Councils have found it difficult to establish a constituency and to maintain contact with the public they are supposed to represent (Klein and Lewis, 1976: 116–119).

The second difficulty stems from the problem of not knowing whether a community should simply be seen as an aggregation of individuals who happen to live in a particular area or as an aggregation of interest groups. The membership of Community Health Councils embodies both concepts. It represents an attempt to bias the membership to ensure representation for disadvantaged groups whose interests might otherwise be swamped by a majoritarian view. In other words, the composition of the membership is a deliberately paternalistic attempt to load the democratic dice. As such, it is an interesting experiment in rigging the system so as to ensure a voice for weak minorities. But it is out of line with conventional one-man, one-vote democratic theory.

Lastly, and perhaps most important, there is the question of power. The Labour Government, which took office in 1974, gave the Community Health Councils some additional weapons, notably, the right to delay changes, such as the closure of hospitals, by health authorities. But, aside from the ability to obstruct and protest, the Councils have no formal decision-making powers, as already pointed

out. This indeed is implicit in the advocate or adversary model. In practice, however, the Councils have sought to involve themselves in the decision-making process; they have actively sought the responsibilities, and inhibitions, of authority. In the outcome, therefore, their members often perceive their role in much the same way as the appointed lay members of the Area Health Authorities (Brown, Griffin, and Haywood, 1975: 100). The assumption that representation can be externalized from the running of the NHS—to avoid contamination and absorption by professional and technocratic values—has, in reality, turned out to be an over-simplified concept.

Area Health Authorities.   Alternatively, then, is it possible to make the members of the Area Health Authorities themselves more representative? This, in fact, was the course adopted by the 1974 Labour Administration. As part of its proposals for "Democracy in the National Health Service" (DHSS, 1974), it increased the proportion of Area Health Authority members nominated by local authorities. Similarly, and introducing a new theme for the first time, it proposed that each Area Health Authority should include two members drawn from the NHS staff: a proposal which, at the time of this writing, has yet to be implemented because of a continuing argument as to how these two members should be chosen. This argument revolves around both the machinery of election and the question of eligibility to vote (DHSS, 1976a).

Such changes in the membership of the Area Authorities cannot solve the dilemma of central accountability. The collective responsibility of the Authorities for the management of the NHS means, by definition, that they cannot be representatives of, in the sense of being accountable to, local interests. Local councillors may, by virtue of their office, bring with them a wider knowledge of local problems and the experience born of contacts with their constituents. But, unless democracy is defined in terms of "communication," it is difficult to see how the presence of local councillors makes health authorities more "democratic." A similar consideration applies to Authority members nominated, in one way or another, from the NHS staff. If there are Authority members drawn from the ancillary and clerical workers in the NHS, they will—like the doctors and nurses who are already present—bring a different view to bear on decisions, simply by the fact of their own experience and background. But they will not represent their constituency, and thus will not be able to speak with

the authority of the formal representatives of the trade unions acting through the normal channels of industrial negotiations.

Evaluation of Modification Strategies. These attempts to modify the existing structure of the NHS thus suggest that there are severe constraints on any strategy designed to meet radical critiques within a framework that reflects the values of "centralized, nationalist socialism." The circle obstinately refuses to be squared. The next, and concluding, section therefore analyzes some of the options that become available—and their implications—if the assumptions about desirable values and policy aims are changed. In particular, it examines the problems that would arise for an institution like the British NHS—or indeed any national health service—in trying to translate the concepts of community control and workers' control into organizational practice.

Political Theories and Policy Options

The future design of the British NHS is currently being considered by a Royal Commission whose appointment reflected widespread dissatisfaction with the present administrative structure of the health service. A useful starting point for analyzing the options currently being discussed is therefore the evidence that has been submitted to the Commission: particularly the evidence coming from those organizations with a special interest in increasing involvement by the community (taking this word in its widest sense) and by the workers.

Labour Party Proposal: National Priorities and Local Execution

The evidence of the Labour Party (1977)—drafted by a working group under the chairmanship of Mrs. Barbara Castle, Secretary of State for Social Services from 1974 to 1976, and one of Bevan's disciples—states that one of the aims of any further reorganization should be to secure:

> [A] new surge of popular identification with the health service by making it accountable to the public which use it and the staff who work in it.

But, having made this pronouncement of principle, the Labour Party's document then candidly discusses the difficulties involved in trying to translate it into practice. These will be familiar from the earlier discussion. Taking the view that "central government must retain ultimate control over national priorities," the Labour Party recognizes the problems involved in handing over responsibility to local authorities. For example, it argues (Labour Party, 1977: 52–59):

> The fair distribution of manpower—particularly highly skilled and talented professionals—would be much harder to achieve without imposing central government controls. The present mechanisms need to be not just maintained but considerably strengthened.

So, recognizing the dilemma while yet striving to move toward control by elected representatives at the local level, the Labour Party document concludes by tentatively suggesting a new solution. This is that, while central government would continue to direct service strategy and to decide on priorities, the execution of policy would be left to local health authorities "with one third of the members being elected by all the staff in the NHS, one third directly elected by the local electorate and one third nominated by the Secretary of State in recognition of the fact that the service was wholly financed by central government."

Unfortunately, the document does not explain how financial accountability to central government would be reconciled with electoral accountability to workers and community. Nor does it address itself to the crucial question of why there should be local interest in participating in elections if there is not also freedom for local health authorities to differentiate themselves in terms of the policies they pursue (Monsen and Downs, 1971). If their main responsibility is to execute *national* priorities, then, by definition, there is going to be only limited scope for discretion by elected members, and little incentive to invest time and interest in participation.

National Union of Public Employees Proposal: Limited Devolution

The same difficulty is raised by the proposal submitted by the National Union of Public Employees (NUPE) (1977: 15–20), whose membership includes many of the less-skilled ancillary workers in

the NHS. Again, the proposed solution is to maintain a national ser-
vice with administration devolved to locally elected district com-
mittees. Only, NUPE proposes that half the membership should be
elected "from and by all grades of NHS staff," while the other half
should be elected by the voters.

Confederation of Health Service Employees Proposal: Consensus Management

Taking a somewhat different line, the Confederation of Health
Service Employees (COHSE) (1977: 38–40), whose membership in-
cludes the less highly qualified nurses and some of the semi-skilled
workers in the NHS, argues for the formal representation of trade
unionists on Community Health Councils. This, COHSE argues,
would "enhance the experience and working ability" of these Coun-
cils, who could then "act as a valuable bridge for staff to become
aware of public feeling about the service."

More interesting, still, is COHSE's position concerning another
problem inherent in worker representation. Its document (ibid.)
states: "We take the view that staff who become members of an
employing authority will not be (and should not be) accountable to
the staff for their actions." Consequently, COHSE stresses,
"[T]here is room for worker-participation in the sense that there
must be full involvement of staff *before* decisions are taken which are
likely to affect them." This is, in effect, a different theory of par-
ticipation, namely, participation through direct involvement in the
decision-making process, as an implicit right, rather than through
more representative managerial bodies.

The theory is not developed explicitly in the COHSE state-
ment, but, clearly, it is suggested as an alternative perspective on the
problem of community and worker control in the NHS, and requires
further analysis. The first difficulty inherent in this approach is that
of knowing under what circumstances involvement can be equated
with control. That, crucially, depends on the form of involvement.
Like participation, involvement is a hold-all concept; it can, at one
extreme, mean simply the right to be consulted, and, at the other end
of the spectrum, veto power over all decisions (Klein, 1975). Thus, a
strongly developed form of this theory might imply that all groups
with a recognized interest in the operations of the NHS—whether as
members of the public or as members of the staff—should have the

right to veto any decision. This is the principle of consensus manage-
ment in its most complete version. In turn, it raises some questions.

Costs of Consensus Management. The first set of questions is
about the costs of introducing a fully developed form of consensus
management that includes all the groups with a claim to involve-
ment. Multiplying veto power also multiplies, by definition, the
power to stop things from being done. It consequently strengthens
the ability of the various groups to maintain the status quo when
change threatens their interests. Thus, veto power may have a
tendency to freeze the existing distributions of resources and make it
more difficult to secure a more equitable distribution.

The point can be illustrated by the recent history of the NHS.
As already noted, it has been Government policy to try to alter the
inherited historical imbalances between different parts of the country
by applying a formula designed to match funds to needs, as defined
by a set of objective criteria (DHSS, 1976d). At the same time,
Government has attempted to switch resources from specialties
judged to have an excess of resources—notably, maternity, where the
declining birth rate has produced a crop of empty beds—to those
that have been relatively neglected, like geriatrics and mental handi-
cap (DHSS, 1976b). Both operations imply—particularly under the
current conditions of resource constraints in Britain—closing wards
and hospitals in order to free resources for reallocation. But this has
met opposition both from Community Health Councils, concerned
with maintaining local facilities (Community Health Council, 1976:
26–30), and from workers, concerned with maintaining local jobs
(National Association of Local Government Officers, 1977). In
other words, creating more scope for involvement may also mean
creating more opportunities for resisting change. These oppor-
tunities are precisely the kind that, in the first three decades of the
NHS, have been exploited by the one group that has often had effec-
tive veto power over proposed changes—the medical profession
(Klein, 1977a).

In opposition to this interpretation, it is argued that involve-
ment creates a sense of responsibility; when people are engaged in
the decision-making process, they become educated to take a less
parochial, self-centered view of their own interests. This appears to
be the belief of those who argue for a system of direct organizational
democracy, as against the liberal democratic form of representative

institutions. Thus, Pateman (1975: 22–23) argues that "parochialism and selfishness may be less likely" because participatory citizenship "would make explicit what liberal democratic formal separation of roles obscures—that individuals do belong to more than one stakeholder or interest group." Possibly this may be so, but the status of such an assertion is that of a declaration of belief or article of faith. What evidence there is points in the opposite direction, on British experience, although it can always be maintained that this is only because the participation is partial and inadequate.

The Scale for Consensus Management.   The second set of questions is about the conditions necessary for introducing anything like a fully-fledged system of direct participation by workers or community, as distinct from strengthening representative institutions. For the theory of democracy as involvement depends crucially on the element of direct, personal participation. In doing so, its advocates—who come from a long line of political theorists running through Aristotle and Rousseau—stress the importance of small size. Direct involvement, they argue, is only possible in small units. Hence, of course, the interest in workshop democracy as the arena for precisely this kind of direct involvement on a scale that makes it feasible (Pateman, 1970: 67–103). As Weber pointed out (1947: 338), it would be possible to escape from the domination of bureaucracy "only by reversion in every field—political, religious, economic, etc.—to small-scale organizations."

Does, then, a national health service offer the necessary conditions for such a reversion to small-scale organizations? And what would be the implications of so doing? On the face of it, a health service would seem to provide precisely the right kind of laboratory conditions for democracy through direct participation. The delivery of health care is the responsibility of a multiplicity of individual hospitals and group practices of family doctors, although over the decades there has been a tendency to concentrate these resources in ever-larger units—whether larger hospitals or health centers. But this process of concentration already indicates one of the clashes of values (large size equals more equipment and more expertise) and participatory values (small size equals more democracy). For example, one of the achievements of the British NHS—as seen by those who took part in its creation (Godber, 1975: 17)—was precisely the physical concentration of specialist staff and resources into larger

hospitals. This involved the elimination of small cottage hospitals where part-time surgeons had frequently put their patients at risk because of their lack of experience.

Professional Autonomy and Public Accountability

But, size apart, there are further problems about envisaging a health service as a series of self-governing republics as an alternative to the present highly centralized, inevitably bureaucratic, NHS. They stem from the fact that health services involve professionals who, like the doctors, insist on their own autonomy (Freidson, 1971) and organizational units that cannot be autonomous. In other words, the difficulty is how to reconcile the insistence of the medical and other professions that they must be free from any interference in the exercise of their craft and the organizational reality of health services, involving the coordination of a large variety of skills and institutions, the rationing of scarce resources, and the management of relations with other, complementary, social services.

Autonomy is indeed compatible with self-government. More than that, it may be argued to be the necessary condition for it (Dahl and Tufte, 1973: 21), for how is it possible to have self-government without the right to make one's own decisions? But whether such autonomy, for professionals and others, is compatible with the organizational aims of a health service is another matter. In the case of a factory, for example, the workers deliver a well-defined product, and, assuming its price and design appeal to customers, it does not matter how they organize their work schedule or whether they work an 8- or 24-hour day. Similarly, if they get their investment priorities wrong, it is their jobs that will be in peril.

In the case of a health service, however, it is precisely the way in which the organization is run that determines the quality of the service provided. And if the investment decisions are wrong, it is the patient who suffers. There is no market mechanism to mediate between workers and community, to translate signals about preferences and make the producers listen. Indeed, one of the characteristics of health service organizations—in contrast to most factories—is that many of the decisions are already taken by small autonomous groups: whether by the surgeon and his team or a small group of nurses running a ward for the mentally handicapped. And it is precisely the introverted, introspective nature of these

teams—whose values may not necessarily be those of the community at large—which has caused criticism of excessive professional autonomy.

Imbalance in Worker and Community Interests

The theorists of democracy through direct worker participation have, admittedly, sought to introduce an element of community participation into their organizational schemes. More than 50 years ago, Cole (1920: 101–110) argued that all public services, whether health or education, should be based on self-government by the "smallest natural units of control." The service would thus be run by a series of "Health Guilds." But Cole recognized that "education and health are matters in which every citizen is intimately concerned, and upon which he must be assured of the fullest opportunity of bringing his opinion and influence to bear." So he proposed elected "Health Councils" to represent the community interest. The relationship between the Councils representing the producers and the consumers would, he believed, "be essentially not an antagonistic but a co-operative and complementary" one. And much the same optimistic assumption about a basic harmony of interests is made by recent advocates of organizational democracy.

But this approach fails to take account of the basic imbalance in worker and community interests, whether represented in elected bodies or in direct participation. The producer, by the very fact of working in the service, has total involvement in what is happening. Members of the community do not. The balance of incentives to invest in participation is therefore very different. By definition, those members of the community with the greatest incentive or capacity to invest effort in participation or representation will be atypical of the population at large (Klein and Lewis, 1976: 27–59). Additionally, and particularly relevant to the health service, any theory of participation that fails to recognize differences in knowledge is bound to be inadequate. To transfer theories of worker control from the factory setting to the health care setting, without taking into account the problem of the imbalance in incentives and information in the political market, is therefore to ignore the real issues involved.

So the paradoxical conclusion would seem to be that a system of worker control would only be compatible with community control in a health service based on a free market economy. If, in fact,

members of the community were to buy their health care from whichever producer-cooperative provided the services best tailored to their requirements, then, of course, they would be able to signal their preferences. They could exercise control by virtue of their ability to take their patronage elsewhere. In fact, ironically enough, it would seem necessary to recreate something suspiciously like the present health care system in the United States. But, in practice, the logic of this argument is flawed. It assumes a symmetry of knowledge and bargaining power among producers and consumers, and the equal distribution of both among the latter. It is thus likely to be rejected on exactly the same grounds that the present U.S. system is so widely criticized.

Community Control or Consumer Control

In making this last point, community control has been discussed as though it can be identified with consumer control. In fact, the two concepts are distinct, if related. One of the problems about much of the discussion of community control is that it tends to conflate concepts of the public-as-citizens and of the public-as-consumers. In the former role, the public are presumed to be other-regarding, paying attention to what might be called "the general interest" insofar as this term has any meaning. In the latter role, the public are presumed to be self-regarding, paying attention only to their own self-interests.

The distinction is of more than theoretical importance. It has direct implications for any national health service, in particular, for the question of whether the aim of policy should be to create a national monopoly, thus narrowing or even eliminating the scope of the private sector (always assuming that the latter course of action is politically feasible or desirable). If the object is to encourage the public-as-citizens, then it can be argued that a state monopoly should be created. Only so will the public be forced to take an interest in the health service. If there is no opportunity to exit, then the incentives to exercise political voice are all the greater (Hirschman, 1970). If, on the other hand, the object is to encourage the public-as-consumers, then competition between the national health service and a private sector ought to be encouraged. For then the public will vote with their feet, and the private sector will act as an indicator of dissatisfaction.

In practice, the antithesis may be too neat. It may well be that the opportunity to exit into the private sector is a necessary condition for encouraging the use of voice in the public sector. Particularly in the case of Britain, where the opportunities to shop around among different doctors are limited by the increasing concentration of resources, as has already been noted, the use of voice may be constrained by the inability to exit (Birch, 1975). If the patient offends his doctor, or other health service personnel, in asserting his rights as a citizen to criticize or demand change, he may imperil his interests as a consumer. He may prefer to keep quiet for fear of retaliation. Hence, it would seem that a democratic health service—meaning an organization that is both sensitive and responsive to public demands—requires both the safety valve of a private sector and the existence of institutions like Community Health Councils, which can act as proxy for citizens, thus lowering the cost of political activity and protecting individuals.

The Dilemmas of Democracy

The aim of the analysis in the previous sections has been twofold. First, it has been to delineate the particular practical problems encountered in the British NHS in trying to achieve a satisfactory balance between centralized control and some elements of community and worker involvement. Second, it has been to demonstrate, using a more theoretical perspective, that these problems do not just reflect the special local situation of the NHS but also point out some more general dilemmas.

These dilemmas, to sum up, spring from the fact that a national health service embodies a variety of values, and fills a variety of functions, some of which may be incompatible with the values and organizational imperatives inherent in a move toward more community or worker control. If a national health service is seen as a device for rationing scarce national resources in an equitable and egalitarian manner, then immediately the scope for decentralization of power is inescapably limited. If a national health service is seen as a way of introducing national priorities, which may run counter to those embodied in the power structure of the professions and occupations within the system, then participation may be the enemy of the required changes. If a national health service is seen as part of a

complex system of interrelated social services, then this may dictate that the size of any administrative unit should be determined by the needs of administrative coordination rather than by considerations of participatory autonomy.

So the ongoing debate about the structure and organization of Britain's National Health Service represents a necessary dialectic, and one which is likely to continue without any final resolution. Different aims of policy—embodying different values, all desirable in their own right but not necessarily compatible with each other—pull in different directions. In this situation, there may well be a constant reassessment of the weighting to be given to individual values, and their relationship with each other, but it is unlikely that everything will be sacrificed to the achievement of one particular objective to the exclusion of all others.

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