POLICY-MAKING IN AREA HEALTH BOARDS:

THE ROLE OF THE BOARD MEMBER

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Ignorance over how public policy is formed in Scotland is prevalent in all spheres of activity and at all levels of decision-making.[1] The Scottish Health Service is no exception. The endeavours of Wiseman[2] and his colleagues at the Scottish Institute for Operational Research have provided valuable insights into policy-making activity at the centre (i.e. within the Scottish Home and Health Department), but there remains a lack of knowledge about local policy-making activity in health care. Ostensibly, the fifteen area health boards in Scotland are the agents of the Secretary of State for Scotland, although, as Bevan pointed out in 1948, there is a world of difference between authorities which are agents of a central department and those which are merely its creatures.[3] In practice, health boards exercise more discretion over resource allocation and priority-setting than is often acknowledged. Contrary to received wisdom, policy rarely emanates from the centre in order to be faithfully implemented, without distortion, by agents in the field. This can occasionally happen; for instance, a policy goal of a 100% institutional confinement rate for childbirth has all but been achieved because there exists, unusually, a strong consensus among resource allocators at all levels that the policy is the right one. More commonly, as Brown observes, 'most initiatives come from the grass roots - from the desire of people at the point of delivery for developments that would make their own work more useful, interesting or satisfying'.[4] Specific developments like these comprise the policy-making activities of health authorities and central government's involvement in the detail

of such allocations is almost nil. It is often more appropriate, therefore, to regard policy as effectively 'made' by those who implement it - policy and implementation merge and policy-makers are also implementers.[5]

Despite the persistence of inequalities (both geographic and those relating to services) after attempts by successive governments to remove them, studies of policy-making in the NHS have, by and large, focused on the national (i.e. United Kingdom) level.[6] Of course, this perspective is important since the centre sets the overall context in which the NHS and its field agents operate. However, given the persistence of the imbalances and inequalities in the Service, which surely suggests the ability of local health authorities to subvert central norms and guidance, it seems odd that these authorities should have escaped scrutiny for so long. Certainly, the Royal Commission on the NHS had little to say on the matter beyond asserting that 'Ministers must face the need to make their priorities stick'.[7] Observers who pursue such a hierarchical approach to policy, viewing it from the top down, will continue to conclude that the solution to problems of implementation must also proceed in a top down fashion. Policy failure will be explained by maintaining that the system is in some way defective, not that the whole hierarchical, policy-chain approach may be misconceived. Only by examining the environment in which implementers practice can a better understanding emerge of the processes actually involved. In the NHS, this means, inter alia, addressing issues and problems arising from the existence of appointed bodies responsible, in large part, for determining priorities in health services. In particular, there are important questions concerning the accountability of these bodies to the public and concerning the ability of part-time lay persons to influence events which are, for the most part, the preserve of full-time professional officers. The remainder of this paper is devoted to these, and related, matters.[8]

Health Boards: Origins

Health boards emerged from the 1974 reorganisation of the Scottish Health Service, replacing the 150 or so bodies previously responsible for administering the Service. Health board members, of whom

there are 276 compared with over 1500 lay members serving on pre-1974 authorities, are appointed by the Secretary of State for a four-year term, the appointments being so organised that half of the members of each board retire every two years in order to ensure continuity. Appointments, which can be renewed, are made on the basis of nominations received by the Secretary of State from a variety of interested bodies including local authorities, trade unions, voluntary bodies, business groups, churches and professional associations. Since members are not elected, they lack a power base in the community. They are appointed for their contributions as individuals and not as representatives of their respective nominating bodies. Members are not directly accountable to the local community for what their board does, or does not do, but are accountable upwards to the Secretary of State.

The official justification for an appointment system is that 'direct popular election of board members has not, in the past, met with any support'.[9] While this may be true, the assertion is not based on empirical evidence but on the assumption that if turnout at local government elections is low then it must be even lower in the event of elections for health authority members. A merger between health and local authorities has also been repeatedly ruled out. The unofficial justification for an appointment system rests on two arguments: first, given that the NHS is a national service financed almost entirely from general taxation, it is considered, for reasons of financial propriety and public accountability, that the Minister should have direct control over what happens in the Service; and, second, appointing members is a useful source of patronage for a Minister wishing to repay favours or reward loyalty. It should be noted, however, that the Minister appoints within constraints which limit his freedom. For instance, he is obliged to appoint members from specific groups and geographical areas.

Although health boards were conceived primarily as management bodies, their precise role has become somewhat confused following the last Government's efforts to overcome what was widely perceived as management bias pervading the reorganised NHS. A document[10] issued in July 1974 suggested changes designed 'to make the system more re-

sponsive to the views of those it serves and to take greater account of the contribution which those who work in the service can make to its management'. But the proposed changes did not involve any moves towards elected boards, amounting to little more than tinkering with the status quo. In an attempt to secure a better balance in the composition of health boards a specific number of places were allocated to nominees drawn from trade unions, local government and the health care professions and staff. The result is that about a quarter of the membership on each board are local government nominees, 2 or 3 are trade union nominees, 5 have been nominated by the health care professions, 1 or 2 by universities and the balance (ranging from 4 to 7) have been nominated by other bodies.

Criticism of appointed boards centres on the fact that they are not really accountable to anyone and float in organisational space. They therefore raise disturbing questions about how policy is formulated, and priorities reached, in the health service. Cameron,[11] for instance, argues that 'where there are scarce resources there will always be a problem of how best to use them. No appointed body can possibly say how this would best be done in a particular locality'. He believes there is a danger that appointed boards may 'pay more attention to the occupation and amusement of professional people than to the health needs of the community'.[12] This criticism seems particularly pertinent in view of the argument mentioned earlier that policy is quite often formed, as well as implemented, at local level, and also at a time when the Government is engaged in a further restructuring of the NHS intended to increase local control over services in order to secure a more flexible, responsive Service that is sensitive to varying local needs .[13]

In practice, this means allowing local health administrators greater discretion and responsibility. Whereas in England a substantial overhaul of the structure is envisaged to achieve this, in Scotland the proposed changes are more modest. They are aimed at simplifying the administration of the Service, principally through the transformation of multi-district areas into single-district areas by abolishing districts in most of the 10 boards which have them. The remaining adjustments are intended to strengthen management at unit

(single hospitals) and sector (group of hospitals or grouping of hospitals and community services) levels. It is uncertain whether the present arrangement of authorities and appointments will facilitate, or hinder, the achievement of a more local and diverse Service. What is clear is that neither the composition nor the role of health boards has been questioned.

Indeed since 1974 there has been practically no discussion of the position of members of health authorities. Neither the Royal Commission on the NHS in its report nor the Government in its consultative paper on the future shape of the Scottish Health Service consider this matter and both endorse existing practice. Greater awareness of members' difficulties is shown by a review[14] of the working of the NHS undertaken at the request of the Royal Commission. What this study, and my own research,[15] show is that more important, perhaps, than the arguments over election versus selection (including control of the NHS by local government), which continue to exercise the minds of critics of the undemocratic nature of the NHS, is the problem of whether members are able to perform satisfactorily the role prescribed for them and whether, in fact, this role is one for which members are best suited. The performance by members of their functions suggests that neither an appointment system nor a system of elections makes, or would make, a great deal of difference to the final outcome although a system of elections may be a desirable reform in itself, particularly in securing the legitimacy of health authorities. The difficulties local councillors face in asserting control over services for which they are supposedly publicly accountable warn against such easy assumptions.[16] Usually, though by no means always, it is the officials who are the major influence on policy-making. To confine discussion to the means by which health board members find themselves on boards is to overlook the problems they face in making sense of their prescribed role.

My observations of two health boards (hereafter referred to as Alpha and Beta)[17] revealed numerous constraints which hindered a full realisation of members' potential. These may be grouped under four headings: (1) the composition and functions of boards; (2) their organisation; (3) the demands on members; and (4) the relationship between members and officers.

(1) Composition and Functions

Since the 1974 reorganisation of the NHS, the role of board members has been conceived primarily as a policy-making, rather than as a representative, one. This remains the case despite attempts, mentioned earlier, to blur the distinction. Membership is essentially arranged on the basis of individual management ability (defined broadly in terms of monitoring the activities of chief officers) as opposed to interest representation. Therefore, members have a managerial role in their policy-making and monitoring activities, while executive management rests with officers at area and district levels. Since reorganisation, and because of it, much decision-making responsibility has been delegated to officers which previously rested with members of former Boards of Management (BoMs). Chief officers operate as members of consensus management teams and it is largely in these forums that policy is made and priorities are set. A consequence of this is that members often receive recommendations that have all but been decided and which carry too much professional support to be deeply challenged. Members really only influence events on the rare occasions when the management team is divided. Then authority members act collectively as arbiter. It is, in any case, physically impossible for the small number of health boards to take, or explicitly confirm, the same number of decisions as their predecessors. On any count, the points at which important decisions involving lay members are made with regard to the local operation of health services have been drastically reduced. There are only fifteen key points of decision-making which involve lay members and these are located at area level, while districts (which exist in ten of the boards) are run solely by teams of officers whose members are individually accountable to their area counterparts.

Table 1 shows the breakdown of membership among the various groups entitled to nominate members to boards (in this case Alpha and Beta). As already mentioned, members are not drawn entirely from outside the NHS, but include a high proportion of health care professionals who, in theory at any rate, are present in a personal capacity and not as representatives of particular professional interests.

TABLE 1

Breakdown of Health Board Membership

	Max.no.of members	Local govt nominees	Trade union nominees	Health care profs.noms.	Univ. noms.	Other noms.
Alpha	20	4	3	5	1	7
Beta	18	4	2	5	1	6

Notes: 1 Numbers exclude chairmen of boards

2 Normally there is (as above) 1 member from the regional local authority and 1 from each district local authority.

Health board chairmen are part-time and receive a part-time salary for their services. Ordinary members are also part-time but serve on a voluntary basis, receiving only allowances for attendances at meetings. The majority of members on Alpha and Beta, as on other boards, were males in their middle-age or over, the average age being around the mid-fifties. Nominees coming under the last column in the table came from a wide variety of backgrounds and some of the appointments reflected the nature of the area served by a particular board. Most boards had a token housewife and usually two or three of the members were retired.

A health board's purpose, as officially defined, is to deal with 'major policy, strategic planning decisions, the broad allocation of resources and matters of substantial interest to the community',[18] while officers, as noted, have delegated to them a wide range of powers to make decisions without having to refer them to the board for approval, as well as implementing those decisions which must be referred to the board. Even the strategic policy-making role reserved for board members will be largely influenced by the kinds of information supplied by officers. The overall effect of these arrangements has been to contract considerably the role of board members and to expand greatly the role of officers. In practice, this can mean that lay members are restricted to a policy-approving and monitoring role, leaving detailed management and the formulation of policy to officers. Given the difficulty of setting specific objectives in the NHS and the lack of satisfactory measures of output, the monitoring function in particular has confounded many members. Activities cannot be monitored

unless there is agreement on what they are intended to achieve.

Evidence obtained from Alpha and Beta (and supported by data from elsewhere) suggests that members experienced great difficulty in identifying with the official rather broad, and vague, definition of their role, and in ascertaining precisely what was expected of them in performing it. Many were critical of their role for two reasons: (a) because of a lack of involvement in decision-making and (b) because a great deal of decision-making over resources and priorities had been taken out of their hands and placed in officers' hands. A common complaint was that health boards were little more than 'rubber-stamping' agencies. An observer of the reorganised NHS in England wrote that authority members 'experienced a fleeting impression of being trapped in a web spun by theorists and management consultants.'[19] Members of Scottish health boards have experienced similar impressions, though perhaps not so fleeting.

The official view of the member's role is that although boards will on occasion be concerned with detail, this would be selective and not general. Health boards, according to a senior official in the SHHD, had to avoid becoming 'enveloped in a welter of detail'. In this, he was recalling the argument first put forward in a report which appeared in 1966 and foreshadowed many of the management practices that later found their way into the reorganised NHS.[20] The report attempted to make a clear-cut distinction between the activity of policy-making on the one hand and that of administration on the other by clarifying the respective roles and functions of members and their officers. 'Only if boards concentrate their attention on the wider issues and delegate to officers the maximum degree of responsibility, while retaining their function of overall direction and control' will the best use of resources be achieved.[21] It was hoped, indeed intended, that the relative roles of members and their officers would move in the direction of the relationship between Ministers and civil servants.

Few members interviewed were clear about what was meant by the terms 'major policy', 'strategic planning decisions', or 'the broad allocation of resources'. When pressed to define what they understood by them, most members referred to capital schemes or to projects in-

volving some physical, or institutional, development. The association between planning and capital schemes was also noted by Hallas in his study of community health council members in England. His remarks are equally applicable to health board members. He wondered why it was

> that very often council members and officers discuss 'planning' as if it was all about buildings? Time after time, especially when 'strategy' documents are debated, the talk centres around the provision of new accommodation, the possibilities of change of use of buildings, and the probabilities of closures. It rarely happens that a member of a study group of the council remarks that planning is more a question of rearranging services to the patient or client.(22)

Similarly, in their review of the working of the NHS, noted above, a research team found a tendency among respondents (including health authority members) 'to confuse planning of capital projects with the whole planning operation...'.(23)

Apart from apparent confusion over terminology as to what constituted planning, members partly focused on new buildings because they liked to see things get done. What better indication could be given of their ability to develop the Service in an area than the establishment of a new District General Hospital, or maternity unit, or whatever. Developments like these were highly visible, whereas with community care services which, arguably, are in much greater need of development, the opposite situation obtains, improvements in this sphere, like employing more health visitors, having a low profile and the benefit to the patient by increasing staff establishments being difficult to measure and to visualise.

A further aspect of the inability of members to feel at ease with a broad policy-making remit might be that, apart from capital projects (which form only a part of planning activity), Alpha and Beta did not indulge in much conscious policy-making. In the words of one medical member, 'there is no conscious planning process in the NHS - priorities are buried within "shopping lists" of developments and deficiencies and board members have little role to play in decisions of this nature'. A board Secretary shared these views: 'there aren't enough policy decisions to make it worth their (i.e. board members') while'. This had led to problems in finding sufficient work for the board and in Beta (probably elsewhere too) agendas

for board meetings were occasionally 'manufactured' in order to occupy members.

If board members experienced role confusion, then health board chairmen and officers had even greater difficulty in defining a board's role in any but the vaguest of terms. The Secretary of Beta thought that the term 'policy-making' had not been defined and nor had the role of members. 'It might have been useful if the Department had given board members a job description... . Board members are asking what are we here for... . It's very difficult'. The chairman of Beta explained that he would put under the term policy 'almost everything because it does tend to percolate up (from the districts, to the area, to the board)'. But this chairman, along with many board members from both boards, was concerned at his lack of involvement in the formation of policy. 'It has been troubling me for some time that we were not really formulating any policies at all'. There were numerous explanations for this state of affairs, many of which lay outwith the board's competence. For example, the board had inherited commitments to projects from the pre-1974 authorities; there were the cuts in the growth rate of the NHS; and there were the policies which the SHHD was imposing on health boards, for example, the setting up of a family planning service and the implementation of the junior doctors' pay award. Boards were obliged to comply with these. Members of Alpha and Beta, with one or two exceptions, experienced a general feeling of impotence. When the SHHD published its memorandum on priorities in 1976, it was received enthusiastically by many members for it provided them for the first time with guidelines and criteria, albeit rather general, by which to measure progress in their respective boards.(24)

Part of the confusion about functions lay in members reluctance, or outright refusal, to accept or adhere to the managerial overtones of the role as officially prescribed with its emphasis on broad policy-making. This was acutely evident among those members who had been members of health authorities before reorganisation when their role had been indisputably a representative one and one that involved them in considerable detail. Because Boards of Management controlled and managed either a single hospital or group of hospitals

on behalf of the Regional Hospital Boards, the scale of operation enabled members to become closely involved in the detailed operation of hospitals. In addition, the system of 'house' committees operated by many boards encouraged members to intervene in decisions of day-to-day management. Members concerned themselves with a range of highly specific, and fairly minor, matters. For example, one committee was shown a counterpane which had shrunk to half its proper size - it was resolved to investigate the matter; on another occasion, a committee resolved that a boiler-house pipe which had burst frequently should be lagged or boxed to prevent a recurrence. Much of the time of boards and committees was taken up with similar matters. This is precisely the sort of detail which health board members are now expected to leave to officers to handle.

However, adjusting to a new conception of the member's role has not been easy. A health board member with long experience of health service administration commented:

> Members have a different function now and not, so far, one which I have found rewarding in comparison with the old BoM. As far as I can see, the health board is a 'rubber stamp' rather than an active participant... . I don't find my role now rewarding - I'm too far away from the people on the ground... . I'm frustrated, I'm not contributing a great deal at the moment. In the old set-up I did feel that we got our teeth into things and we were near the grass roots.

Another member doubted whether a fairly rigid separation between policy and day-to-day administration was helpful.

> It's awfully easy to say that the executive groups at area and district levels should be involved in the detail but I think it could be a bad situation if we stuck strictly to the letter of our remit and confined ourselves to a policy-making role. I don't think we could possibly have the knowledge to be policy-makers without being involved at a lower level... .

A consultant member believed that the policy-making role for members had two disadvantages: (a) a member lacked full knowledge of any problem; and (b) a member was, of necessity, dependent on officers for information. Invariably, the recommendations of the area executive group (AEG) were accepted by members with little discussion or probing. It was, claimed this member, very difficult to do otherwise.

'If members want to influence decision-making then it's not sufficient for them to read agendas, minutes and attend meetings'. It was not easy for members to perform a policy-making role without detailed information and knowledge of a particular problem, or development. However, in acquiring such in-depth knowledge there was a risk that members would stray into areas which were labelled day-to-day administration and, therefore, strictly the responsibility of officers. Where to strike a balance between the two extremes of complete detachment and complete involvement was not easy to decide.

The role of members in the allocation of development funds illustrates some of the frustration they felt and shows how easy it was for them simply to rubber-stamp decisions effectively taken elsewhere. Each year a board receives funds for developments (i.e. growth money) which can be used for improving or expanding existing services or for starting new ones. Health boards must decide how they want to allocate these funds which are never sufficient to meet all claims upon them. In Alpha and Beta, the allocation process surrounding development funds for new staff was dominated by a small number of key actors who determined how the funds were to be spent. This group was comprised of officers at area and district levels and it was their task to assemble the list of proposed allocations that went before the board for approval. Although board members were presented with an opportunity to query proposals for new staff, it was in practice difficult for them to do so since they were not conversant with the background to each development request. The allocation process was structured in such a way that it insulated the key decision-makers from lay involvement. All meetings over development funds prior to the boards' pro forma acceptance of the final package were conducted in private. In addition, requests for funds were not generated from within the board but, in most cases, were demands from staff which were transmitted up the management hierarchy to area level. Therefore, the operation of the resource allocation process in regard to development funds safeguarded those with discretion (i.e. the officers) from public demands, as expressed through board members, and from visibility. The process was further obscured through the practice of presenting members with a shopping-list of deficiencies with no explanation of their origin

or importance. Members had no idea whether the proposed developments placed before them were vital to the achievement of board priorities or whether they might be detrimental to their attainment. Nor were members given alternatives, where possible, to the proposed developments. Of course, members were free to probe these matters and insist upon more and better information but, given their generally weak position, they were reluctant to do so. It might have been different, however, if they had been positively encouraged to ensure that development requests were in line with board priorities instead of being excluded from this exercise and kept in ignorance. Some possible reforms are considered later in the paper.

At the centre of all these difficulties is the possibility that the policy-making role itself may be based on a misconception. Haywood maintains that 'the view of them (i.e. board members) as policy makers, thirsting to choose between options presented to them by officers may influence management structures but it hardly matches either the abilities or preferences of many public representatives'.[25] It was clear from members' own conceptions of their role that, while a few might pay 'lip-service' to its policy-making dimension, most in fact performed their functions differently, often undertaking the kinds of tasks that the former BoMs undertook and which local health councils were established to undertake. As mentioned already, many members, especially those with previous experience of the NHS, felt insufficiently involved in their authorities' decision-making. Members, naturally enough, liked to make a positive contribution and see the results of their efforts in direct, practical ways. Partly to overcome feelings of remoteness and to familiarise members with the services and facilities under their supervision, Alpha and Beta (and other boards) organised visiting programmes to hospitals, clinics, health centres and so on. A visiting programme was considered to be essential in enabling members to carry out their strategic policy-making role in an informed manner. However, for members either unsure of, or unenthusiastic about, their role, the visiting programme was perceived rather differently and as more than an educational device. Members predisposed towards the sorts of tasks performed by members of BoMs, outlined earlier, found visits a way of becoming in-

volved in detail. In Beta, the visiting programme was revised to enable particular individuals to concentrate on particular institutions and to act as intermediaries between them and the board. While this was an appropriate arrangement for a BoM, doubts were expressed about its applicability to health boards where an overview of the area and its services was deemed to be necessary. There was a possibility, therefore, that visits could encourage members to press the interests of a particular ward or clinic at the expense of other wards or clinics which were suffering from similar deficiencies. The vice-chairman of Beta conceded that members on visits were 'inclined to learn about the bits they were walking round'. They would pick on the deficiencies

> because this is what the local staff expected you to do. They took you to places where they wanted you to see something. The visit was an opportunity for staff to show board members things they (i.e. the staff) were complaining about. The tendency was to go back to the board and raise the matter there, whereas board members should have been scanning the picture as a whole and trying to see how it fitted into the general health board set-up.

Up to a point, visiting programmes were a throwback to past practices when members of BoMs were in and out of hospitals regularly. Of course, health board visits were on a much larger scale both geographically and in terms of services which had to be visited although visits to hospitals continued to dominate the programmes.

Members, on the whole, found it difficult to refrain from representing a particular view or group, and some were of the opinion that this was what a member <u>should</u> be doing. Clearly, the way in which the appointment system operates makes it hard to visualise how, or why, members should think otherwise. After reviewing the range of interests entitled to submit nominations, Brown[26] concluded that 'it hardly seems likely that this will throw up groups who will be able to look sectional interests in the face and decide what is best for patients. Membership will be on the basis of interest representation rather than management ability'. Comments from members support this assertion. One member of Alpha said: 'I know one's not meant to represent one's own area, but one is bound to stand up for one's area on certain occasions. Inevitably one knows more about it than anywhere

else'. This was an important consideration when it was 'beyond anyone's capacity really to take an overall view (of the service)'. Another member observed

> You tend at times to say "I can't make a contribution to the total object of the service in the whole area, therefore I'll try to make a contribution to a part of it" - the part you are residing in and about which you can get real information.

Apart from the potential for geographical specialisation, there was also scope for functional specialisation. Certain members had leanings towards particular services. This was obviously true of medical and nursing members. A few members with previous knowledge of the NHS tended to be hospital oriented, while some local authority members saw themselves as spokesmen for particular community interests. The tendency for members to represent areas or interests can partly be explained on the grounds that in a state of general ignorance, they confined their attention, quite understandably, to the familiar, that is, to places and/or services about which they already knew something. After all, members receive no training or formal preparation for their tasks. It is simply a matter of learning 'on the job'. Like that of the councillor, the health board member's job is one which is learned by doing, and there is little effort made to facilitate the process by advance preparation. Consequently, the job depends heavily upon what a member decides to make of it, if anything.

Some officers maintained that members could not be prepared for their role since working patterns had to evolve between members and officers in each board and these would naturally differ. Nevertheless, at least one member of Alpha was of the opinion that more could be done to assist new members by, for example, running in-service courses at which members could be introduced to the various types of information they would be dealing with, and making use of, in reaching decisions. New members, in particular, revealed in interviews that they had to resort to 'whispering, and asking, and running to someone and wondering what's this all about? Who do you run to? Another board member? Or to the Secretary? They (i.e. members) may be afraid to seek assistance in case they reveal their ignorance'. The view expressed by one experienced member probably summed up what the

majority felt.

> There is a difficulty in health matters in that so much of it is clinical, technical - the terminology used and the graphs and charts produced for us which, if we were honest with ourselves, would prompt us to ask where are we going, is this bad, is this good, is it to be altered and, if so, how? I find it extremely difficult to cope. We call for information and a lot of it is a little beyond our understanding.

Members were reluctant to divulge whether or not those without a professional background on boards deferred to professional members. Yet there were obvious divisions and imbalances present in the very composition of boards. A medical member of Alpha admitted that he felt at an advantage over lay members. 'It must be extremely difficult for them to cope... . The complexities of the NHS make it very difficult for an uninformed member to understand issues or to make an effective contribution'. Even if such deference is not overt, it can exist in other, more covert, ways. For example, some members felt inhibited at meetings and were reluctant to articulate their views in the presence of professional members.

(2) Organisation of Health Boards

The operation of the two health boards - the timetable of meetings, their frequency and duration, the existence and membership of standing committees - had an impact on members' performance. The procedure adopted by Alpha was to meet in full each month while Beta met bi-monthly principally because the amount of business did not justify monthly meetings. Attendance at board meetings was generally high but if a member does not attend over a period of six months or so, the Secretary is empowered to discover the reasons for the prolonged absence.

Full board meetings are open to the public and the press, although, on occasion, a board will go into committee if delicate matters are under discussion. The system of standing committees which boards have is a useful means of bypassing public scrutiny. Some members justified the existence of the committees on the pretext that people are more restricted when the press and public are present. In the event, most of the work of both boards was done in committee. Therefore, more important in many ways from a decision-

making angle than full board meetings were the standing committees.

Guidance from the SHHD on committee structure envisaged a policy and resources committee (PRC) and general practitioner service committees. The PRC, because of its remit, would become the board's major committee. The idea was that 'Policy', embracing the planning of integrated services including priorities for capital programmes, and 'Resource Allocation', covering finance and staff, should be brought together into one committee in order to facilitate coordination and budgeting. These developments were akin to those resulting from local government reform in the mid-1970s.

The PRC's main tasks were to: (a) decide broad area policies and priorities in the light of information produced by the area executive group; (b) approve budgets and short-and long-term plans before these were submitted to the Secretary of State; (c) approve the allocation of financial and manpower resources among services and districts within the area and to review the overall effectiveness of health provision; (d) review the performance and adequacy of services within the area in the light of reports from the AEG or from ad hoc committees of the board; and (e) take particular major decisions over and above the routine (e.g. a hospital closure) and decisions specifically affecting the provision of services provided by matching local authorities or adjoining health boards. The second main standing committee, which most boards, including Alpha and Beta, had established although this had not been recommended in guidance from the SHHD, was responsible for: (a) appointing senior officers and senior clinicians in accordance with procedures laid down nationally; (b) approving arrangements for training and recruiting staff; (c) approving arrangements for dealing with staff appeals; and (d) approving arrangements for consultations with staff.

Of the two committees, the PRC was where members could, potentially, make a significant contribution to decision-making. Whereas full board meetings could be cumbersome affairs, with twenty odd members present, plus the four chief officers, and other individuals in attendance by invitation, which occurred in the public gaze, meetings of the PRC were more intimate gatherings where business was conducted well away from public scrutiny. By the time proposals reached the

board for approval, they would have already been thrashed out, or quietly accepted, by the PRC. Board members were aware that the PRC was the most important component of a board's decision-making apparatus and that it was largely responsible for what was put up to, and finally approved by, the full board. In the words of Beta's vice-chairman, 'in practice the PRC is the more important (of the two committees), in theory no. One should be talking about money, the other about people. But you can do nothing without money'. Often, certain items would not go beyond the PRC unless a member wished to raise a matter at a board meeting that had already been considered, and approved, by the PRC.

The significance of the PRC in decision-making led to problems concerning the shape of committee structure a board should have, and the relationships of committees to the board. Powerful committees like the PRC added to feelings of isolation and remoteness among some of the members who were not also members of these committees. As one board member put it:

> if you're not on the PRC, it's more difficult for a board member to put forward his view. You're at a disadvantage. The major decisions are taken in this committee - (it is) where priorities are (set), where the money is allocated. While it's true that these things come to the board in the form of a minute, people who're not on the PRC have got to have a strong point of view backed by local knowledge if they're to question the proposals in any serious way... . But there is a dilemma. Short of having everyone on the PRC I don't see any way round this (problem)... . The fact remains that if you're not on the PRC I don't think one is fully involved.

Therefore, while there were sound reasons for establishing a PRC, one of the effects of having such a committee was to concentrate business in its hands and to limit discussion at full board meetings. In the words of one Secretary, 'the PRC is virtually the health board in all but name'. In both Alpha and Beta, a second standing committee was established to placate board members who were not on the PRC. Some means had to be found to occupy them since many felt a need to become more closely involved in the running of the health service than a brief monthly, or bi-monthly, board meeting allowed. The solution to this problem was to have a second standing committee, al-

though it was questionable how necessary it was beyond performing a symbolic role for members. Its only real value was in providing new members with an opportunity to 'cut their teeth' before graduating to the more important work of the PRC.

Alpha and Beta had different selection procedures for committee membership. In Alpha, the AEG put up names for a range of activities, including committees,for which members were required. The Secretary played an important part in the selection process for committees (a method chosen by board members themselves) and, inevitably, this gave him considerable influence over their composition. Board members were free to reject the names put forward but they had never done this. New board members were not, as a rule, appointed to the PRC. They 'found their feet' on the second committee. This arrangement tended to emphasise, however unintentionally, the fact that there were differences in status between the two committees with the PRC being the more important of the two.

In Beta, selection for committee membership was undertaken by a Special Purposes Committee, comprising the chairman, vice-chairman, and the two convenors of the standing committees. As the vice-chairman observed, 'there is no democracy about it'. Membership was decided on aptitude, although if someone expressed a preference for one committee rather than the other, then his or her wishes would be met if at all possible.

The committee structures of Alpha and Beta were important elements in determining the extent to which a board member could contribute to the development of the Service in the area under his jurisdiction. It mattered a great deal which committee a member was on, since only the PRC was of importance when it came to resource-allocation and priority-setting matters. This was where the 'spade-work' was done, and where 'the basic questions (concerning) the development of the service and the resources available were raised'. As one member expressed it, 'this is where the real meat of the decision-making process may be found'. Obviously much depended on the calibre of the members themselves - their personal qualities, experience, skills and enthusiasm for the task were all important factors. But the structural framework within which board members operated was also important.

For example, if a keen, active member was not, for whatever reason, a member of the PRC, then the opportunities open to him to make a contribution to the board's activities were somewhat diminished. As mentioned, the system was flexible and could accommodate those with particular skills and interests. But as a further constraint operating on members, particularly new ones, it is worth noting.

Finally,mention should be made of programme planning committees which have been established by health boards usually as sub-committees of the PRC. They were not studied in Alpha and Beta since they were in the process of being set up. Their purpose is to assist boards in the formulation of long term policies for particular services, like primary care, and for certain care groups, like the elderly and mentally ill. Membership is multidisciplinary and includes two board members, one of whom is normally chairman. In an examination of these committees in the Greater Glasgow Health Board, Boddy reports that 'overwhelmingly, the impression gained was of a group of people who were dissatisfied with the way the committees were working, and with the results obtained'.[27]

(3) Demands on Members

The demands upon board members are greater than those that were placed upon their predecessors on the pre-1974 authorities. This is principally because the responsibilities of members have expanded with integration (members are now responsible for primary care services, e.g. general practitioners, dentists, pharmacists and opticians, and community care services, e.g. maternity and child welfare, health visiting and community nursing, in addition to the hospital service) and there has been a sharp reduction in the number of lay people running the Health Service; in one board, for example (not Alpha or Beta), there are 21 lay members responsible for the services in the area whereas prior to reorganisation there were 159 lay members responsible for fewer services.

The role of board chairman differs from that of ordinary board members as well as carrying with it extra responsibilities. The chairmen of Alpha and Beta took the view that it would be wrong for them to interfere in the work of the officers who ought to be left alone to

run the services. However, both saw themselves as more involved in administrative activity than ordinary members. The Secretary in each board fixed the agendas for board and committee meetings but the chairmen approved them and often suggested items for inclusion.

Apart from the personal qualities members possessed, what dictated the degree of involvement in health board affairs above all was the time at the disposal of members. Few were in a position to give up vast amounts of this precious commodity to health board business even if they had wanted to do so. The amount of time a member could spare for such work determined, to a large extent, whether that member became heavily involved in board business or whether he remained on the periphery. Depending upon what a member made of his role, and how conscientious he was in performing it, it could be a time-consuming activity. Local authority members, for instance, might express a deep interest in certain health care issues, but the time they could spare in order to pursue these interests in greater depth was strictly limited because of other commitments.

Estimates of the time spent by members on health board business are not especially useful since practice varies so widely. Members are not required to spend a specific amount of time on board work. Farquharson-Lang produced some figures on time spent by BoM members on various duties, but these are not applicable to health board members with different tasks. However, for what it is worth, the Farquharson-Lang report recommended that, on a monthly basis, the maximum amount of time that members should be expected to devote to their duties should not exceed twelve hours.(28) For smaller boards, the time expected should be well below the recommended limits.

In the case of health boards, at a minimum there was the pure business side - board meetings and committee meetings, all of which involved some homework in the form of reading background papers. Each member was on one of the two main standing committees. Beyond these commitments, some members took on heavier workloads, including sitting on appointment committees, service committees, special sub-committees and programme planning committees. In addition, there were the numerous visits to institutions which took place each month, designed to

familiarise members with the services in their area. There was also the public relations function which involved members in social engagements such as the opening of a hospital, or ward. The demands on members' time could, therefore, be negligible or quire considerable. A member could perform his tasks with a minimum of advance preparation (simply glancing through papers the night before a meeting), or he could probe deeply into certain issues that interested him, or caught his attention. The average member would probably spend half a day each month on the board meeting; half a day each month on one of the standing committees; and with various other duties he could spend an additional one to one-and-a-half days per month, making a total of around two days each month for board business. Beyond this, there would be the read ng of minutes, reports and background papers. Of course, some members spent more time than others on board work, and this often depended on whether they were retired, and therefore had more time at their disposal, or whether they were local authority members, say, in which case the chances were that they did not become much involved in health board business.

(4) Relationships between Members and Officers

The atmosphere and operations of a board are determined to a large extent by the kinds of relationships which exist between members and officers. Haywood suggests that this is a problem in most public authorities but that in the NHS it is exacerbated by the power of the doctors.

> It is a very brave member who will challenge requests for additional consultant appointments or expensive technology or new acute units even if it is realised that such developments often produce comparatively marginal improvements in health status and only continue to denude Cinderella services of resources.(29)

Members of Alpha and Beta were understandably reluctant to criticise officers or to disagree with the line they took on policy issues. In fact, most headed in the opposite direction, praising officers for their efficiency and for their willingness to assist members with problems or queries. However, beneath the surface charm, there existed frictions and tensions.

In a setting where part-time lay members, many of them with

commitments elsewhere, are advised by teams of full-time professional managers, it happens naturally that officers, ostensibly the servants, quietly become the masters. Members, inevitably, are heavily dependent on them for information, guidance and assistance. The relationship verges on the parasitic rather than the symbiotic. The vice-chairman of Beta said that 'accusations that all the health board is doing is rubber-stamping schemes evolved by the AEG are to some extent...true'. After all,

> the officers know the needs and the background of their own staff. This happens mainly in development schemes. Unless a board member is prepared to do a lot of leg-work, visiting sites and talking to people, he's in no position to originate schemes himself, so the work will come to us from the AEG who in turn get it from the district executive group. I take these statements at their face value.

The vice-chairman of Alpha expressed similar views.

> Our function as a board is to discuss policy. We do this with the assistance of the executive group (of officers) and 99.9% of the time we agree with and accept their advice because we are not knowledgeable enough to say that a particular scheme should have priority.

All members interviewed perceived the relationship with officers in similar terms - it was one marked by dependence and, hopefully, trust and confidence. The relationship was not a conspiratorial one, with officers plotting and scheming behind members' backs and then ruthlessly pushing proposals through the various committees. There was no need to resort to Machiavellian tactics when the system so favoured the professional managers.

Some board members maintained that boards could be more effective, and the imbalance between members and officers redressed, if a number of changes were introduced. One chairman said

> there was a tendency for us just to see things that they (i.e. officers) had decided on and not always to see the things they had rejected. We weren't always terribly clear of their reasons for selecting some things and rejecting others. I have asked that in future we get more detail of the way in which the process works out, particularly so far as objectives are concerned so that we have some knowledge of what these are.

A number of members wanted to see a greater range of options presented to them to enable them to reach a decision, as opposed to the board

being a rather placid bystander to what often turned out to be a fait accompli. In the words of one member,

> the AEG prepare papers for the board having talked it (i.e. the matter requiring a decision) out and having heard all sides of the argument, but there may have been a strong argument put up on the other side which board members might be tending towards but because they have not heard the other side of the argument they feel that the experts know best. You really haven't heard all sides of the argument because the papers arrive at one conclusion rather than present a range of options. Discussions within the executive groups are lost to board members. If, as a board member, you have reservations about the argument that's being put before you, you mask your reservations in temerity because you feel here is all the expertise favouring this particular argument and you don't know that there may have been an alternative that supports your view. Or, maybe not having heard another argument, you're agreeing to what's there, whereas had you heard the other argument you might have been in favour of it. Papers present the ideal and an alternative but it's the ideal that's built up and the alternative which is without back-up. It's not entirely the fault of the executive group. We, as board members, don't ask enough questions concerning back-up information.

There are those, like Haywood, who favour opening up decision-making in health authorities and making options more explicit. There are difficulties associated with such a strategy such as slower decision-making (although possibly more effective in the long run), and the danger of information overload. Haywood would like to see 'members and senior officers...open up the conflicts inherent in the choice of local priorities and invite argument from interested parties rather than obscure them by presenting a list of proposals as is so often done at the moment.'[30] As noted earlier, this problem is certainly evident in development fund allocations, where lists of staffing requests are presented to a health board for approval, the decisions on which categories to develop having already effectively been taken by the officer groups at area and district levels. Board members confronted with these lists experience extreme difficulty in trying to determine where the board's priorities lie. Yet, staffing developments are important when over 75% of total NHS expenditure goes on salaries and wages. Decisions taken in this area dictate the direction in which the

Service as a whole moves and decisions on staffing are a commitment on future resources. For example, if more domiciliary nurses and health visitors are appointed and fewer hospital nurses in acute services, then it is possible to argue that a board's priorities lie in the community care sector. But these priority decisions tend to remain implicit and are rarely made explicit.(31)

Despite feelings of frustration, dissatisfaction and occasional impotence, board members were united (not surprisingly) in their view that some form of lay input in NHS administration was desirable and that it would be quite wrong to run the Service with just officers accountable to the Secretary of State. According to one member,

> if you abolished health boards and left it to the officials I've no doubt that for the majority of cases for a majority of the time you wouldn't notice any difference. Whether it's a desirable practice in the long run is another matter. On balance, with something so close to people's needs as the NHS, I agree with the principle of lay involvement. There is no other serious alternative.

In other words, the board acted as a check on officialdom and was a counterweight to what would otherwise be a totally closed system. The vice-chairman of Beta claimed the board was essential in a purely practical sense. 'The AEG still needs somebody to hold the balance (i.e. to act as umpire or arbiter). If we weren't there, they'd have to invent a chief executive or a committee in (the Scottish Office)'. One of the chairmen believed that 'there has to be an avenue where you pick up what is wrong with the Service... . Health board members have an outsider's "finger on the pulse" and I think there is a place for them, no matter how good the officials are'.

Officers were equivocal in their opinion of board members. Although critical of their performance, they did not think members were unnecessary. While officers could be sceptical of the value of members, they accepted the need for some form of lay input in health service management and decision-making. One Treasurer's views were reasonably typical of what officers in Alpha and Beta generally thought of members:

> One must have public participation in such exercises (i.e. health service management) but my experience to date both of regional hospital boards and health boards would

> tend to suggest that health board members find it very difficult to appreciate a total problem. They tend to look at isolated problems and discuss these fully because they understand them and know of them. It may be that we don't give correct information to members. On the facts that I have it is easier to get through the board a large chunk of expenditure than it is to get through a few hundred pounds. Are members educated properly into providing the sort of function they should be providing? Are members given the knowledge which would enable them to ask the correct questions? They are required to monitor us. They are required to take policy decisions. Are they educated to take policy decisions? Do they know how to? They get no education...to enable them to take a decision. They learn as they go along. Perhaps we're not teaching them properly. You can't give members too much information or they become swamped. But you have to give them enough to look at the whole problem... . It's a difficult problem. I don't know if we as officers are enabling members to exercise their prerogative.

Although officers valued board members in a broad sense as being in a position to exercise some form of accountability to the public for the way in which the NHS is run ('members at times have a humanising effect'), they did not look upon members as being in a position to exert much influence on decision-making.

Concluding Comments

Evidence in regard to the board member's role suggests that there exists considerable uncertainty and 'mismatch' between prescribed practice and actual practice. Much of the responsibility for this lies with the appointment system. Nominees to health boards come from sectional interests and may be expected, rightly or wrongly, and occasionally or frequently, to push, or to ally themselves with, these interests. The dichotomy between, on the one hand, the official role of board members and, on the other hand, the backgrounds and experiences of those who become members has led to some confusion among members concerning their purpose, or raison d'être.

From official statements one could be forgiven for thinking that health boards, as the governing authorities, would be quite influential. But the reality leads one to a different conclusion. Interviews with members indicated strongly that perhaps the role designed for them is not one that can ever be adequately performed by

part-time voluntary lay members (it is even doubtful if it could be performed by part-time voluntary non-laymen). It may be that the role requires rethinking since the present demands upon members are, in many cases, not only beyond their capacities, but are also beyond their preferences. Moreover, what is irrefutable is the imbalance which exists between the know-how of professional members and the relative ignorance of lay members, even allowing for the fact that the latter may possess useful skills. A similar imbalance is also evident in the relationship between lay members and permanent officers. What is more, in an attempt to overcome their ignorance, board members in Alpha and Beta were likely to lose sight of their prescribed role as they became more involved in detail and in day-to-day administrative concerns. This, in turn, placed them in a sensitive position vis-à-vis local health councils, thus compounding their role confusion.

Solutions to some of these difficulties can be separated into two types: the macro, structural reform kind, and the micro, low profile, process kind aimed at altering behaviour. Those of a macro persuasion favour separately elected health authorities or a merger between health and local authorities. But whether either of these solutions would do much to combat the problems described in preceding sections is doubtful. If appointed boards are to continue, as seems certain, then more attention should be focused upon what members can usefully contribute to policy-making. This means considering micro-level changes aimed at introducing counterpressures into the decision-making arena. Moves of this kind are more urgent than ever given the Government's preference for a more local health service and given the prevailing public spending climate where choices in all policy fields have been sharpened by cuts. While the NHS has emerged reasonably unscathed from these, its growth rate is minimal and insufficient to fund many new developments. This has far-reaching implications for various categories of user, particularly those in historically underfunded sectors like the elderly, the mentally ill and mentally handicapped. While there are also pressures on acute services, these services have been given a much higher priority over the years.

The key to resolving the dilemma that has existed since 1974 with the attempt to separate the policy function from the administra-

tive one, leaving members to look after the former while managers focus on the latter, may be to encourage members to feel less comprehensive responsibility for the internal management of the Service and more concern for the current and future impact of health services on the community. The misleadingly managerial orientation of early official statements may have introduced too much overlap into the officer-member relationship. Health authorities (and members) exist to 'legitimise local autonomy' - to provide open arenas for political debates about health policy rather than to act as instruments of management and planning.(32) They should, therefore, be concerned with providing the means for communication and consultation between the health services and the communities they serve and with securing community support for decisions on priorities and changes. Members will remain involved in strategic policy-making and in allocating resources between competing needs, but they will operate in a context of relating priorities to community needs rather than to management needs.

In addition, a range of initiatives might be launched which would assist members in the performance of their role. Of particular importance is an initial training programme to introduce new members to the structure of the NHS and their duties and responsibilities within it. Training should not be regarded as a one-off event and members should be given regular opportunities to refresh their knowledge. In-service courses could be made available for this purpose, supplemented by 'on the job' learning through the medium of study groups and seminars on issues of concern in an area. Also, project or task groups might be more appropriate than standing committees which not only divert authority from the full board but which often have insufficient business to occupy them. Officers should be required to present members with a wider range of options than is customary in order to promote debate. This process could be facilitated by providing members with more relevant information in the form of programme budgets (which has been tried in Grampian Health Board) which would show members where resources were being channelled by moving away from the 'shopping list' mentality.(33) More controversially, members may be helped in their task by having access to sources of advice and information other than their own officers - in the way that Parliamentary

Select Committees draw on expert advice to challenge the views of government departments and civil servants. Finally, health authorities could be required to produce annual reports setting out what they have been doing including impact statements on how their actions have affected the health of the populations they serve.

These counterpressures, which may offset the grosser imbalances in influence between members and officers, will not have an immediate effect and must be pursued with the utmost vigour if they are to succeed. The obstacles to be overcome are considerable. Decision-making and priority-setting processes in boards are characterised by a small number of key participants (i.e. officers at area and district levels) who determine how available funds are to be spent with minimal lay involvement. This might just be defensible if the decision process was complex and technical. But much of it involves political judgements concerning priorities. Significantly, while accepting the value-laden nature of priority-setting, one administrator is of the opinion that the obstacles to worthwhile lay participation are so great that 'decisions about priorities will, of necessity, be made by professionals - administrative, medical or political - even if this introduces an element of paternalism'.(34) These comments are directed primarily at local health councils but they have a direct bearing on the feelings of frustration experienced by many board members in Alpha and Beta and elsewhere. Such views must be resisted at all costs. Whether in the NHS, local government or elsewhere, as Cornford has written, 'the moves to strengthen public scrutiny, control, initiative and participation have been cautious, reluctant and trivial in comparison with the growth of administrative power'.(35) How to reverse this trend remains a challenge facing not only the Scottish Health Service but also Scotland's democratic tradition.

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