Royal Pharmaceutical Society of Great Britain

MODERNISATION STEERING GROUP

DISCUSSION PAPER ON THE CONSTITUTION OF THE COUNCIL

What will the Council look like in the future? (2) Getting the balance right

This paper is the second in a series on the constitution of the Royal Pharmaceutical Society's Council. The first paper broadly examined the Council's future responsibilities and composition. This paper looks at whether the Council's make-up should reflect devolution and/or fields of practice and whether at least some pharmacist members of the Council should be appointed. It also considers the Council election voting system. The papers are intended to promote discussion and prompt comment from all those with an interest in the governance of the Society, to help the Modernisation Steering Group formulate proposals for consideration by the Council.

HOW YOU CAN CONTRIBUTE TO THE DEBATE

Written comments should be submitted by 25 July to the project manager for the Society's modernisation programme (see Section 8 below). Readers of *The Pharmaceutical Journal* may also respond to the first two papers by completing a questionnaire distributed with the 29 June issue.

1. BACKGROUND

1.1 In May 2002, the Council decided that the Society should retain its integrated regulatory and professional roles within a reformed organisation, meeting modern regulatory requirements and firmly based on the public interest. Within this framework, the Society's principal duties would remain those of regulating, developing and leading the profession of pharmacy in the public interest.

1.2 We are working to a tight timetable. The Government plans to establish the Council for the Regulation of Health Care Professionals by early 2003. This Council will oversee the bodies regulating health professionals and will look for consistency between them. Subject to Parliamentary approval, it will have power to require changes to a regulatory body's rules. By the end of this year, we need to be able to demonstrate that our plans for reform are well advanced.

1.3 In April 2000, the Society's Health Act Working Party conducted a preliminary consultation covering some of the topics contained in this paper.[1] The feedback received then is summarised below:

Should Scotland and Wales have reserved places on the Council? Thirty-four per cent of respondents favoured reserved places on the Council for Scotland and Wales but with no clear view emerging on how this should be achieved. Sixteen per cent opted for the status quo, with no reserved places for any of the home countries.

Should sectors of practice have reserved places on the Council? Sixty-nine per cent of respondents thought that sectors of practice should have reserved places, although some advocated reserved places for one or two sectors only. Views on whether the places should be filled by election or appointment were mixed. Thirty-one per cent favoured the current arrangement, with no sectors of practice having reserved places. (NB. At the time, it was envisaged that all regulatory functions would be delegated to statutory committees. The Council would have dealt only with professional issues that lay outside regulation, hence a greater need may have been seen for sectoral representation.)

Should the voting system for Council elections be changed? Among respondents who commented on the voting system, about 76 per cent favoured the "X" system and about 24 per cent wanted to retain the Single Transferable Vote. This question was referred to the modernisation steering group by the Council.

Note: No options were specified in this preliminary consultation, so the percentages shown are of those selecting the most popular responses in each case.

2. CURRENT SITUATION

2.1 The Council governs the Society. It comprises 21 elected pharmacists and three lay members, appointed by the Privy Council. There is no geographical representation within its membership. No places are reserved for specific fields of practice within pharmacy.

2.2 The Chairmen of the Society's Scottish and Welsh Executives (committees of the Council) are invited to attend Council meetings (excluding the confidential sessions) and contribute to debate but may not vote. They are also invited to the table when there are vacant seats.

2.3 All members of the Society are entitled to vote in the election of Council members. Voting is by single transferable vote, allowing members to vote for each candidate in order of preference.

3. Appointment or election of Council members

3.1 Whatever system of election or appointment is used, Council members, because of their collective responsibilities, would not be mandated representatives of particular constituencies or groups. However, it would be appropriate for the Council's composition to reflect the stakeholders who have a legitimate interest in the Society's work. These include public, professional, service and higher education interests.

3.2 It is anticipated that the appointment of lay members would be through open advertisement, following the guidelines for public appointments. The advertisements would not seek members as representatives of particular groups but would aim to attract relevant experience, knowledge and skills.

3.3 Pharmacist members of the Council could be elected, appointed or a mixture of both. Appointment of some pharmacist members could provide a means of ensuring that the Council includes expertise from areas of practice that might not be brought in through an election system, such as academia or industrial pharmacy. This could be an alternative way of bringing in this knowledge and experience rather than via an electoral system (see Section 5).

3.4 Any electoral system should reflect the principles of effectiveness, inclusiveness, accountability and transparency. It should be operationally feasible and have the confidence of the profession and the public.

3.5 The pre-reform structures of the General Medical Council, General Dental Council and General Optical Council all included members appointed by professional or educational bodies on their councils. In the new GDC, all professional members will be elected. The Government has accepted the GMC's proposal for 21 professional members, 19 of whom would be elected and two of whom would be appointed, one by the Academy of Medical Royal Colleges and one by the Council of Deans of Medical Schools. This is now subject to public consultation. The new GOC includes 11 professional members who are elected and four who are appointed. Three optometrists are appointed by the College of Optometrists and other academic bodies, and one dispensing optician is appointed by the Association of British Dispensing Opticians in consultation with academic bodies. All professional members of the Nursing and Midwifery Council and the Health Professions Council have been appointed initially but will be elected in the future. The council of a royal college might include members elected by the membership and representatives of college faculties or boards, possibly with additional appointed members.

3.6 The nearest equivalents within pharmacy of the bodies appointing members to the GMC would be the Committee of Heads of Schools of Pharmacy (not all of whom are pharmacists) and the College of Pharmacy Practice. These examples are illustrative but not exclusive. Any appointing bodies should be independent and should not present any conflict of interest with the Society. This would exclude trade bodies or trades unions.

3.7 Council members could potentially be co-opted to ensure the inclusion of relevant skills and knowledge. However, this would not be as open and transparent a process as election or appointment.

What do you think? **Should all pharmacist members of the Council continue to be elected or should some be appointed? If some should be appointed, who should have the right to appoint?**

4. Reflecting devolution

4.1 The impact of devolution and how to reflect that impact needs to be considered alongside various aspects of the modernisation programme, including the constitution of the Council.

4.2 All the health professions except pharmacy have regulatory bodies with a UK-wide remit. The Society operates across Great Britain. Northern Ireland has its own Pharmaceutical Society.

4.3 Professional regulation has not been devolved from Westminster. When the NHS Reform and Healthcare Professions Bill is enacted, the Society will be accountable to the Westminster Parliament for the exercise of its regulatory functions across Great Britain. Although professional regulation is a reserved power, both the National Assembly for Wales and the Scottish Parliament have health policy responsibilities and are developing their own strategies and priorities. Service delivery differs in the three home countries. Scotland has separate legislative and education systems. The Welsh Assembly can pass secondary legislation. The new approach to professional self-regulation is implicit in documents emerging in Scotland and Wales. It will therefore be important to ensure that the Society's modernisation proposals are politically acceptable to the devolved administrations.

4.4 In other health professional regulatory bodies, 11 of the dentist members of the GDC will be from from England, with two from Scotland, one from Wales and one from Northern Ireland. On the NMC, the 12 professional members will comprise one nurse, one midwife and one health visitor from each UK country. The elected medical members of the GMC will comprise 15 from England, two from Scotland, one from Wales and one from Northern Ireland. And the 11 elected professional members of the GOC include six optometrists (three from England and one each from Scotland, Wales and Northern Ireland) and five dispensing opticians, elected on a UK-wide basis.

4.5 For comparison, the Society's membership statistics areas follows: Within the Society's membership as a whole, the percentages of the total are: England, 74; Scotland, 9; Wales, 5; overseas, 11. Within the Society's area of authority, the percentages of the total are: England, 84; Scotland, 10; Wales, 6.

4.6 Extrapolating these figures for the purposes of illustration, a Council with 13 or 16 pharmacist members would include 11 or 14 from England, one from Scotland and one from Wales. This strict proportionality would not reflect the higher number of pharmacists in Scotland than in Wales and it might be appropriate to reduce the number of Council members from England to allow that difference to be reflected.

What do you think? **Should there be reserved places for pharmacists from England, Scotland and Wales on the Council?**

4.7 If there were to be reserved places for pharmacists from the home countries, they would need to be appointed or elected. Elections could take place among pharmacists in those countries, forming constituencies, or among all members of the Society.

4.8 Advantages of Society-wide elections include:

- Extensive voter choice: all members being able to influence the election of all pharmacists standing for Council, rather than only those in their own country
- The opportunities for smaller groups, including members from specialist areas of practice, to secure their participation through the election of nationally-known figures
- This makes it clear that all Council members share a collective responsibility and are not mandated to represent the interests of particular constituents
- Avoidance of the situation where new candidates are unwilling to challenge an established Council member in a constituency, possibly deterring valuable new members
- Members living overseas are not disenfranchised or combined with England
- Simple to administer

4.9 An earlier working party on the Council's constitution commented on this point: "We believe that this unity of approach (ie, election by all members of the Society) gives the Council great strength and should not be lightly discarded."[2]

4.10 Disadvantages of Society-wide elections include:

- Voters may be faced with large numbers of candidates, many of whom they do not know. It has been argued that this tends to lead to low voter participation
- The danger that "single issue" candidates will secure election: this is not consistent with the overall responsibilities of the Council and the obligation to act in the public interest
- Dialogue with voters may be less easy

WHAT DO YOU THINK? **If there are elections to reserved places for pharmacists from the home countries, should they be elected by pharmacists in those countries, forming constituencies? Or should they be elected by all members of the Society?**

4.11 If Scotland and Wales were to form constituencies to elect pharmacists to the Council, it could be argued that England, comprising 84 per cent of members resident in Great Britain, was too large to form one constituency.

4.12 For comparison, the GDC has decided to retain England (with the Channel Islands and the Isle of Man) as a single constituency. In particular, it was felt that dentists working outside general dental practice might be less likely to secure election if the English constituency were divided. The NMC also proposes to treat England as one constituency. The GOC treats England as a single constituency for the election of its optometrist members (dispensing opticians are elected on a UK-wide basis).

4.13 The GMC plans to divide England into five constituencies. One driver for this change is that 336 candidates from England stood in the GMC's last election, making voting a daunting task.

4.14 If Scotland, Wales and England (including overseas members) were each to form one constituency for elections to the Society's Council, this could offer a way of preserving the advantages of a wider electorate (Paragraph 4.8) to some extent. The disadvantages of a wider electorate would also apply (Paragraph 4.10).

4.15 A recent development that might have an impact in the future is the Government's White Paper offering regional assemblies to English regions that want them.[3] It remains to be seen how many of the eight English regions outside London (which already has an assembly) will take up this offer. Health care would not be among a regional assembly's specific responsibilities but public health would be included.

WHAT DO YOU THINK? **If Scotland and Wales were to form constituencies to elect pharmacists to the Council, should England form one constituency or be divided?**

5. REFLECTING FIELDS OF PRACTICE

5.1 Another question is whether placesshould be reserved on the Council for pharmacists in particular fields of practice, so as to achieve a more balanced membership and to help inform the Council's decisions.

5.2 This issue is more complex than that of whether there should be places for the three home countries. It would be necessary to define the fields of practice that would be entitled to reserved places. Criteria to determine the eligibility of candidates for those places would need to be drawn up. It would also be necessary to determine how members would be chosen to fill those places.

5.3 Currently, the Society does not hold robust data to allow it to administer elections to the Council on any constituency basis other than geographical constituencies. Data on fields of practice will be collected in the future, raising the possibility of practice-based "constituencies". Pharmacists who were retired, not working, or working outside one of the fields of practice having a reserved place on Council could be disenfranchised. This might be addressed by linking eligibility to participate in Council elections to some form of "licence to practise" in the future, as for doctors.

5.4 The election process would be considerably more complex, particularly if both geographical and practice-based constituencies were used. The pros and cons of constituency vs Society-wide elections (see 4.8 and 4.10) would also apply to practice-based constituencies. It would be important to make clear that members were not mandated to represent particular constituents.

5.5 One option would be to define fields of practice with reserved places so that if no person from that field was successful in the election, the successful candidate with the fewest votes would be displaced by the candidate from the missing field with the highest number of votes. Again, this would complicate the electoral process significantly.

5.6 Another possibility would be to have reserved places on the Council for pharmacists from particular fields of practice but to allow all members of the Society to vote for all candidates, with no practice-based constituencies. Combining this with geographical constituencies would make the election process more complex.

5.7 Another way of ensuring a more balanced membership on the Council would be to reserve places for pharmacists appointed by external bodies in those fields which it was considered should be included in the Council's make-up and were unlikely to achieve this through the electoral process.

5.8 Reserved places for fields of practice could allow some pharmacists to gain a seat on Council who would find it difficult to do so under the current system. It could also, by restricting the eligibility criteria for places, mean that some potentially valuable members would not be able to gain a place on Council. This question was last considered in 1989, when the outcome was: "We conclude that sectional representation itself is not an aim to be pursued, provided that the Council makes satisfactory use of all the channels for informing itself".[2] Fields of practice are developing rapidly and demarcations are blurring. Pharmacists are increasingly working across different sectors. The composition of the profession is changing and becoming more differentiated. Attempting to reflect that composition within a relatively small Council might prove quite inflexible.

5.9 The Council will never be able to include expertise in all pharmacy practice specialisms. Given that the Council will focus on strategic and broad policy issues, the value of this expertise may be greater at the stage of policy implementation. Once the constitution of the Council has been decided, it will be necessary to consider how best to bring in the broader range of knowledge and experience that should inform the Society's work. Ways of achieving this might include any or all of: ensuring expertise within committee structures; having a forum to take forward professional issues; using panels of experts, or through formal or informal liaison with other pharmacy bodies.

5.10 The new GMC, GOC and GDC structures do not include any sectoral representation among elected professional members (other than to ensure that the GOC's membership includes both optometrists and dispensing opticians). The GMC and the GOC both include appointed professional members, who could bring in expertise not provided through election. The NMC and the HPC do not have sectoral representation, other than to ensure that their Councils include members from each of the professions regulated by that Council ie. the NMC includes nurses, midwives and health visitors and the HPC includes one member from each of the 12 professions that it regulates.

WHAT DO YOU THINK? **Should the Council include reserved places for specific fields of practice? If so, which fields of practice and how should this be achieved?**

6. Method of election of pharmacist members

6.1 At present, pharmacist members of the Council are directly elected by the membership. This places power clearly in the hands of individual pharmacists. If direct election of these members is to continue, the method will need to be determined.

6.2 It is the general experience across the regulatory bodies for health professionals that the level of participation in Council elections is declining: typically it is below 30 per cent of the electorate. Looking across a wider group of professional or learned bodies, levels of participation of 10–20 per cent are seen, both in bodies using the "X" system of voting and those using the single transferable vote (STV).

6.3 The STV system was introduced for Council elections in 1976, replacing a simple "X" system. Voters rank the candidates in order of preference. Where a voter's preferred candidate is eliminated, having secured too few votes, or where a preferred candidate has a surplus of votes, the votes are redistributed to other candidates according to the order of preference.

6.4 The 1989 working party on the constitution of the Council commented: "We were aware that whenever this subject has been put to the membership opinion has been equally divided on the merits of the two [STV and "X"] systems." There is no evidence from other professional bodies that changing the system of voting would achieve an increased poll.[2] By contrast, the Health Act Working Party's preliminary consultation and recent branch representatives' meetings have indicated strong views in favour of returning to an "X" system of voting.

6.5 The STV system is widely used in professional bodies and is broadly seen as fair. The GDC has decided to continue to use the STV system for its elections. The GMC commissioned a report on alternative electoral systems, which advised: "The advantage of STV is that it maximises voter choice, noted as a vital characteristic of a democratic electoral system. [Voters] can, if they wish, rank all candidates listed on the ballot paper in order of preference. Thus, the system puts maximum trust in the capability of the electorate, allowing them to prioritise candidates with certain characteristics (such as gender, areas of experience or ethnic group). A disadvantage of STV is that the counting mechanism is complex and opaque but there is little evidence to suggest that this feature of STV alone reduces participation. Another disadvantage of STV is the possibility that it offers too much voter choice."[4]

6.6 The decision on whether constituencies should be formed for elections to the Council will have a bearing on the voting system. The GMC has been advised that, when STV is used, "there is no evidence to suggest that constituencies of regional size (rather than national) would make it harder for minority groups; whereas a first past the post system in single member constituencies would undoubtedly do so". This suggests that, if the Society is to have any constituency returning a single Council member in the future, the STV system should be retained.

What do you think? **What voting system should be used to elect pharmacist members of Council in the future?**

7. Further aspects of the Council

7.1 Decisions will also be needed on:

- Frequency of elections
- Canvassing rules
- Whether changes are needed to the positions of Officers of the Council
- The terms of these positions and any limit to the number of terms served
- Whether there should be any change to the rules concerning eligibility to stand for Council
- Whether there should be a limit to the terms of office that a Council member may serve
- Whether there should be an age limit for Council members.

A further discussion paper will be issued seeking views on these topics.

8. How to make your views heard

8.1 No decisions have yet been taken on the future constitution of the Council. The Modernisation Steering Group needs your views to help it to formulate its proposals to the Society's Council.

Please send your comments by Thursday 25 July 2002 to Christine Gray, Project Manager, Modernisation Programme, Royal Pharmaceutical Society, 1 Lambeth High Street, London SE1 7JN, or e-mail to cgray@rpsgb.org.uk. If you are replying on behalf of a group or an organisation, please state whose views your comments represent.

The first discussion paper, which broadly examined the Council's future responsibilities and composition, was published with the 15 June issue of The Pharmaceutical Journal. *Reader of* The Journal *will have the opportunity to respond to both papers by returning a questionnaire that is to be distributed withe* The Journal *of 29 June.*

Any queries relating to this exercise should be addressed to Christine Gray; contact details as above, telephone 020 7572 2206, fax 020 7572 2501.

References

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4. General Medical Council The new GMC: Discussion Paper on the Election of Medical Members to the Council.London: GMC; 2001.

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