COMMUNITY HEALTH councils are referred to in Working for patients only in passing, and that is just to say they will be retained — a bit like the chair of a football club saying the manager's job is perfectly safe. This has inevitably raised the issue about how and where CHCs will fit into a market oriented NHS.

In the world of consumer oriented healthcare, the argument goes: 'Who needs CHCs now that health authorities are required to meet the needs of their populations?' This infers that as health authorities become sensitive to population needs, the traditional role of the CHC as the patient's friend is no longer tenable. In a market economy where the consumer is sovereign, those who ignore the wishes of customers do so at their peril. At least, this is what the conventional wisdom is purported to be. And followed to its logical conclusion, there is no need for any statutory body to be charged with the responsibility for monitoring the NHS and representing the views of its users.

The trouble with the market as regulator is that it is more fiction than fact. And this is never more true than in healthcare. Looking at the US, it is evident to all but the most biased that the market is an imperfect mechanism for healthcare delivery.

In the US, money talks: if you lack the cash, you can obtain your healthcare needs, but if you lack resources you are confined to a healthcare netherland. The medical profession and third party payers (health insurance companies) influence demand, not the customer.

That is not a scenario which most people either working in or associated with the NHS would wish to come about. But its reality is more likely without CHCs than with them. At present, CHCs have the right to visit NHS facilities, to receive information on health services activities, to be consulted about changes to services and on future plans. As the NHS becomes more fragmented and the boundaries between public and private healthcare become more indistinct, the potential for CHCs to perform a pivotal role between providers and users is increased.

CHCs' new destiny is partly under their control and partly in the hands of others. While others' influence is important, the way CHCs seek to adjust to the new age will determine whether support is forthcoming. The Association of Community Health Councils for England and Wales (ACHCEW) stated in its 1998-99 annual report: 'CHCs should have a responsibility for monitoring all of the healthcare provided in their districts. It also needs to be recognised that they should have the right to visit and inspect services provided outside their area, to which NHS patients are sent under contract by their DHA or by local doctors. There must also be a close involvement in the contractual arrangements.' What ACHCEW is saying is that no one is better placed than CHCs to understand and protect the interests and needs of healthcare consumers.

Consider the validity of their position. Many commentators have reviewed CHCs' performance since their inception and while recording mixed reviews of their effectiveness, have nonetheless argued for their retention because, overall, they do a good job. But variations in performance are expected, given such limited resources. The average budget of £35,000 pays for staff (usually two full timers) and office accommodation, covers the administrative costs of servicing the council, responding to patient queries and complaints, and to the flow of consultative documents. CHCs do represent value for money, but is this enough?

Perhaps now is the time to end the quibbling over their role and value. It would make sense if CHCs were cut loose from their somewhat subservient link to regional health authorities, especially concerning funding.

CHCs should be supported centrally, possibly through a block allocation from the Department of Health to ACHCEW, which could then be distributed to individual CHCs according to their population base. In this way the larger CHCs, in population terms, would be able to do their job more effectively. Health authorities cannot be relied upon to respond effectively to consumer concerns. They have too many other competing interests to juggle.

Allied to the issue of financial resources is the question of human resources. Two distinct but related matters arise: career structure and pay. There is no career structure for CHC secretaries — becoming one is a bit like being in limbo. Once in the job it is difficult to move into health service management, as if being a CHC secretary is a non-job. And yet, given its breadth and depth, it is perhaps one of the better training positions for those with management ambitions. Thought should be given to a career structure for CHC secretaries and their assistants. Moreover, any career structure must be based on proper rates of pay.

One way of achieving both might be to have clear differentials between CHCs of different population size, so that the larger ones would be graded higher than smaller ones (reflecting the scale and range of responsibilities), along the lines of general management of family practitioner committees.

Those who believe CHCs serve no useful function would do well to remember that one of their major roles is dealing with patients' complaints. If the NHS is so good at responding to patients' needs, why do so many people turn to their local CHCs for information about local services and for help with recalcitrant doctors and bureaucrats?
First, CHCs are often the only source of information for people who wish to know more about local services. Health authorities, until recently, have not been too anxious about keeping the public informed. Furthermore, CHC advice and information is generally seen as objective. Another useful task they perform is that of patient advocate; ensuring the local population knows about healthcare services and facilities. But perhaps the most interesting role would be that suggested by NALGO, whereby CHCs would act as local inspectorate not only for NHS facilities but also for the private health sector. This might make the watchdog’s bite more effective than its bark.

One of the changes that should occur is that the composition of CHCs must more closely reflect the demographic pattern of the population. In essence this means fewer middle class white members and more from working class, ethnic and age related backgrounds. One way of achieving this might be to introduce stricter appointment criteria. A more democratic method would be to hold elections. Members would then be responsible to a local constituency, but this would not necessarily reflect variations in the population.

The voluntary sector representatives are the only elected members of the CHC, even though voting is restricted to the membership of local agencies. However, the principle is of paramount importance here. But above all, for CHCs to remain credible they must be a lay body drawn from the local community.

Most CHCs regard the white paper proposal for self governing trusts as a direct challenge to their statutory right to be consulted on all changes to health services. Working for patients and its supporting documents make it clear that anyone can put forward a unit for self governing status. No consultation is necessary.

Consequently, it is common to find that most units nominated have been put forward by small groups of vested interests. CHCs are quite right to be concerned that major decisions are being taken in the health services, ostensibly in the patients’ interests, but without seeking their views.

CHCs have a moral obligation, if not a legal one, to ensure that the self government option does not result in a less accessible service to patients than at present. The primary criterion for self governing ought to be that the main objective will be better access to healthcare and not the so-called unshackling of management.

The white paper’s concern that health authorities should meet the needs of their population is well placed because this has remained the substance of rhetoric rather than reality. CHCs have a substantial role to play here. They are probably better informed about local healthcare needs than the health authority because they make it their business to find out. CHCs usually know the local networks. Local knowledge such as this is invaluable in constructing a population needs profile.

But while networks are useful they do not of themselves ensure a comprehensive picture. Local knowledge should be complemented with sound market research. Granted, any competent agency could do this, but credibility and trust should be the guiding prerequisites. CHCs might be more acceptable to the consumer than health authorities when it comes to gathering information about needs.

The CHC’s strength lies in its independent nature, and people may be more forthcoming in response to CHC-led surveys. But if CHCs are to undertake this role, it must be done properly, with access to professional advice or market research expertise and sufficient resources for the task.

CHCs are naturally concerned with the quantity and quality of the healthcare delivered in their areas. They are rightly worried that the push towards a market approach will lead to cost containment at the expense of quality.

The current uncertainty over whether CHCs should be involved in the process of contract negotiations does not instil confidence in the ‘patient’s friend’ that patients’ real needs will carry any weight at all in determining contracts. ACHCEW has called for additional powers to enable CHCs to monitor and validate the progress that health authorities and NHS trusts make towards providing a guaranteed quality of care, whether as providers or purchasers. Additionally, there is a case for extending this responsibility to all aspects of healthcare, including the private sector.

The healthcare industry, whether public or private, should welcome such a step, especially if it is genuinely concerned with meeting the needs of the public on whom it is dependent.

As the wave of change generated by the white paper begins to break over the NHS, CHCs see themselves as besieged defenders of its founding principles. Their viability and credibility is being questioned by those who would rather remain unaccountable. It is time to end the uncertainty. They should be given the credit they deserve and sufficient resources to do the job properly: to represent the views of health service users and to ensure that patients’ needs are put first.
What does the government have in store for community health councils? A rare insight into the Department of Health's thinking is contained in a discussion paper circulated confidentially to regional general managers — and obtained by the Journal.

The DoH's officials counsel against CHC independence of the HA/FPC structure. R/HAs should continue to act for the protection of state in dealing with CHCs, and ensure that they give value for money. However, the Audit Commission might also comment on the effective use of resources by CHCs.

It goes on: 'CHCs can be a valuable source of feedback on NHS services. However, the rights provided by regulations and the flexible way in which these allow CHCs to determine their role, can combine with the political element of their membership to produce an occasionally hostile attitude to health authorities and national policies.'

An earlier draft had prompted complaints that the DoH had 'recruited' RGMs' 'right to exist'. The DoH had 'revalued' the role of CHCs. The DoH had 'discouraged' the development of CHCs. The DoH had 'misled' the public on the role of CHCs. The DoH had 'misled' the public on the role of CHCs.

The DoH has had to respond and to make changes in the details of CHC rights and responsibilities without frustrating its ministers' wishes to leave CHCs essentially as they are, and simultaneously satisfying managers by 'encouraging CHCs to concentrate on the activities in which they are potentially most useful'.

The DoH: a balanced package to curtail CHCs' political activities

The future role of CHCs is being hotly debated by ministers and RGMs — with civil servants in the middle. Ray Jobling reveals what each side is thinking

The Association of Community Health Councils for England and Wales' own proposals for the future of CHCs are examined in an appendix. ACHCEW's desire for an expanded remit, greater resourcing, and internal accountability would, it is said, contract ministers' wishes.

Nevertheless, it is commented that 'it may however be difficult as well as undesirable to ignore the proposals completely, especially as ACHCEW have already met FSH (the health minister) to express their views — and a blanket rejection may seem too negative, and could undermine confidence in ministers' commitment to CHCs as a legitimate channel for consumer views'.

The DoH has, therefore, sought to construct a balanced package in which extensions of CHC activities in some respects to non-NHS providers are offset by reductions in others (eg, curtailment of 'political' activities).

Reins tighten up for future CHCs

Ray Jobling is chair of Cambridge community health council.

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WATCHDOG CHAINED TO THE MARGINS

The foxy ways of Whitehall are our topic once again this week. The Journal is able to afford its readers a rare insight behind the scenes thinking at the Department of Health as it grapples with that thorny issue, the future of community health councils. The NHS is reorganised into an internal market with providers and purchasers.

It would be unfair to pillory the civil servants who prepared the discussion paper circulated confidentially to general managers (see news focus, page 278). Their proposals, though unattractive in many respects, are an adroit attempt to square the circle and produce a compromise solution which is politically acceptable to ministers, doctors, and the toots of regional general managers and might just get past the Association of Community Health Councils for England and Wales. It would be all too easy to wax indignant at the manoeuvring and machinations revealed to be accompanying this process. They are an inevitiable element in democratic decision making and the stock in trade of any civil service.

That said, however, the fate being hatched for those poor relations of the NHS, the CHCs, is a disappointing one — all the more so for its timid avoidance of the opportunity to really empower the consumer in the health service.

Under these proposals, CHCs would have no formal involvement in monitoring contracts, and no formal role in relation to GP fund holders. They would have no formal rights to visit healthcare premises operated by local authorities, the voluntary or private sectors, unless such rights had been specified in a contract with a health authority.

HAs in turn would be under no formal requirement to consult CHCs on details of individual contracts. CHCs would have no automatic right to attend self governing trusts' board meetings or sit in on the working parties of HAs or family practitioner committees. Neither would they gain any independence from the HA/FPC structure. The emphasis throughout is on CHCs depending increasingly on informal links with HAs and FPCs. After each proposal is appended the legend — in a tone of self congratulation, perhaps — no new legislation is required.

All this is a far cry from ACHCEW's own ideas on how CHCs could meet the challenge posed by the white paper reforms. It is a far cry too from junior health minister Roger Freeman’s emollient performance at ACHCEW’s annual general meeting last year. There, community health council delegates had worked themselves into a state of some agitation as they pondered what might be their fate once Working for patients had been implemented. Mr Freeman adopted an approachable and conciliatory mood.

On the repeatedly expressed wish that CHCs should be able to attend self governing trusts’ meetings he said: ‘We have said we expect self governing boards to be open and free and work with their CHCs. I have not said what you might have said. Judging by the sense of this conference, either all or most of these board meetings should be open.’

He also promised to reflect on the resources available for CHCs. The DoH discussion document concludes that the case for more resources for CHCs is ‘not self evident’. It vages on the cynical by adding: ‘There may be a case for arguing that better resourced CHCs would provide a more effective consumer voice, but this is not a logical consequence of the NHS review changes.’

There’s the rub. As we have remarked before, the NHS review changes pay only lip service to putting the consumer at the heart of the health service. They add up to a managerial revolution, not a consumer revolution. Hence CHCs find themselves not at the forefront of change, but perched firmly in Queer Street, looking quizzically about for someone to restore their sense of direction.

As far as the DoH is concerned, that direction should be resolutely towards CHCs shedding the role some have acquired, especially in inner cities, of political troublemakers — in the DoH’s phrase, legitimate critical comment ‘shades’ into ‘political action against the policies of the government of the day’.

Undoubtedly, CHCs are attractive vehicles for some with political axes to grind. But it would be all too easy to caricature much forceful and wholly legitimate criticism in those terms. The temptation to stifle embarrassing and politically inconvenient comment is growing too prevalent throughout the public sector. It is hard, reading this DoH document, to resist the conclusion that it plays an important part behind current thinking on the role of CHCs. If these proposals should be adopted, CHCs will become subtly marginalised and their role will gradually be eroded — until, a few years off, they will be ripe for abolition altogether. That would serve the consumer ill in the NHS of the 1990s.
Buckle down for a bumpy ride

Reports of the death and delay of the health service reforms are premature and exaggerated, but smooth takeoff may not be easy to achieve and we may be in for a bumpy ride, according to King's Fund policy analyst Dr Chris Ham.

Referring to significant shifts in the Department of Health's thinking on the white paper and the recent change of emphasis, he claimed it would be five to 10 years before all the pieces were in place. But the next year would be crucial for success.

It was clear that most HAs were struggling to maintain existing services, let alone introduce the most radical changes to the NHS since its inception, he said.

But implementation was being strongly driven from the centre and regions, with the clear implication of sanctions if districts did not deliver.

Financial tasks laid out for providers

The first two years of the NHS reforms should be used as a "lead-in period" towards setting up cost and volume contracts, director of finance at Herefordshire health authority Tom Jones advised a session on finance tasks for providers.

"Things are not to worry about 1991 — because you will miss it — but to miss is deliberately so you can put resources into developing information bases while block contracts are in place," he said.

He believed block contracts would stay in place until 1992-93, then cost and volume contracts would take over.

Mr Jones said providers were heavily dependent on information supplied by patient administration systems (PAS) to bill purchasers. But half of hospitals had got the "wrong" PAS system for supplying that information.

Ditching the systems or enhancing them would be "extremely expensive", he warned.

Mr Jones advised providers to draw up their business strategy, followed by their business plan.

They should then decide on their "product range" and seek contracts. And he stressed the importance of training existing staff, including managers, in financial management and information technology.

Civil servants admit target fears

Department of Health officials admitted they shared 'anxieties' that the targets in the new GP contract might reduce uptake rates for cervical smear.

'There is an anxiety which we share that the picture might actually go down rather than up,' said John Shaw, undersecretary in charge of family practitioner services, in a face to face session between civil servants and family practitioner committee chairs and managers.

But he pledged that if after two years there were shown to be 'discrepancies, anomalies or downright unfairness', the government would not hesitate to make adjustments to the contract.

He also promised that if minor surgery by GPs fell as a result of the targets in the contract, that part of the contract would also change.

Brian Smith, assistant secretary in charge of management of FPCs, told one questioner that new family health services authorities would continue to meet in public.

'Secrecy is not on,' he said. 'It doesn't seem to me to follow that, because we are talking about crisp, businesslike decision making bodies, such decisions have to be taken in camera.'