Nursing Focus March 1980

Would community health councils be missed?

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A personal view that these consumer watchdogs represent the voice of ordinary people; that they are useful and part of the democratic process.

It is doubtful whether bureaucratic restructuring has ever saved a penny, and it is politically significant that the Government in *Patients First* has called into question the future of the two democratic elements in the NHS, community health councils and local authority members of AHAs. "Will CHCs be missed?" is a political question, just as it was a political decision to put them there, originally by a Conservative government as a buffer to protect the service from the patients, and strengthened by Labour so that they could be influential. Similarly Labour increased the numbers of local authority representatives on AHAs.

Two key messages from CHCs over the past five years have been that patients must come first, and that managers must be accountable. My argument is that the extent to which CHCs will be missed depends on how much the staff care about patients, and that it should not be surprising either that the government should want to get rid of CHCs or that managers will not miss them.

A Service for Staff

I see the NHS as a microcosm of the current socioeconomic situation, where the level and quality of service that can be given is limited by the wage packet. The refusal of successive governments to fund pay awards fully and their wish to impose cash limits has made it increasingly clear that the interests of staff and patients are not the same, however much individuals may wish to act as if they were. The main objective of workers is job security, and as long as the total wage bill increases and there are no redundancies, cuts in patient services are accepted. Thus fewer patients are seen, waiting times grow, food and amenities are trimmed, numbers of staff diminish through freezes.

All over London people from teaching hospitals have been putting up their hands at authority meetings to close small non-teaching hospitals. The workers' wage is used to limit the amount of service which can be given, and the strongest interest rather than the needs of ordinary people dictates what happens to patients. This is the dilemma of capitalism, and it is paralleled by Leyland, where Longbridge workers voted for the closure of small units like Abingdon, and Abingdon voted to say alive.

The logical absurdity is hospitals full of staff and no patients. Institutional momentum has taken over, and increasingly we are getting a service for staff. Why is it that acute hospitals burst at the seams when rationalisations are threatened, but can be half-empty at Christmas? Why do you need just as many workers to boil eggs when cooked breakfasts are cut out as part of "revenue savings"? Why do you haul all those well women into hospital for ante-natal checks, when you know more will actually come if you see them in the health centres? This is what happens if you leave out the voice and power of the consumer.

Collaboration

Many staff are concerned about these absurdities, but their own hierarchies treat their concerns about patients as unwelcome information, don't allow them to care. They tend to tell the CHCs that the hard boiled eggs are gumming up the old people's teeth; that for efficiency's sake prostaglandin abortions are being carried out on open wards; that ECT is being carried out on an open ward; that long stay patients are getting almost no medical attention; that there's no fire door from the sleeping area of a long stay ward; that old ladies can't have their own knickers because personal clothing is not an administrative priority.

Divisions

Between staff and their own managers, and between CHCs and AHAs, on the whole

it's a them-us situation. Managers are appointed from above and do not represent their workers, and similarly most health authority members represent special interests and not constituencies. (The new structure would make this even more prevalent.) Can we not aim for a system in which workers could make their managers accountable, and authority members could hold workers responsible for the appointment of managers, and take them to task for managers who fail to deliver the goods for patients? None of us likes to be criticised for the way we do our jobs, and when we are powerless to do otherwise buck-passing becomes the rule. If management were appointed by constituent workers, many of the criticisms which now seem personal, and are therefore unpalatable, would be straightforward criticisms of management techniques. Various people probably would not have the jobs they now hold if there were such a system: workers would then have to defend their appointments in the same way as we as citizens cannot now dissociate ourselves from the activities of our government unless we didn't vote for it. Democratically elected authority members, relating to constituencies rather than special interests, could relate to democratically appointed management.

Democracy

The absence of democratic control has meant that the NHS's main issue, establishing guidelines for standards of patient care, cannot be tackled. Since reorganisation authorities have been given remit upon remit — through such instruments as *Priorities for Health and Personal Social Services,* RAWP, the National Development Group on Mental Handicap Services, *Better Services for the Mentally Ill,* the Health Advisory Service's work on geriatrics — to allocate money rationally, according to need. But the system of financial allocation is based on interest, not need, and with money actually getting tighter even gestures towards fulfilling the remit have been fruitless. Some pragmatic officers have sought ways around the information processes, and specifically around consultation, to facilitate faster decisions. Neither members nor workers have been in control.

It has been demonstrated quite clearly that in the main "caring" area, that of long stay services, the major group of workers — the nurses — can't pull in resources. It is not surprising that CHCs have moved into the position of saying that long stay services should belong to the local authority, because the constitution of democratically elected representatives enforces a better standard of care — nor is the defensive response of nurses to the Jay report on mental handicap staffing surprising.

We must come to terms with the need for democracy in the health service, and to abolish CHCs and reduce local authority representation on health authorities would be two steps backward. The government has said that its proposals for restructuring are based on dissatisfaction, but no dissatisfaction has been expressed by the public with CHCs except that they are not powerful enough. CHCs have involved the community in the NHS through their survey and planning activities; they have helped vulnerable people and pressed for better services for the most vulnerable client groups; they have explained and personalised the service; they have drawn attention to gaps, inequalities, malpractices, irrationalities, waste and mismanagement; they have studied the services and the community and have turned information into plans, intuition and common sense into policy.

The members come from constituencies, whether it be a voluntary organisation or local authority, and this is where they get their power. That CHCs have constituencies, are independent and have the ability to see that their information is not ignored, even though they cannot control decisions or money, makes them far superior to the consumer councils of the other nationalised industries. They belong to a democratic structure, but as long as the rest of that structure is incomplete they cannot be fully effective. To avoid the issue by getting rid of them is not an answer. The activities of CHCs and the resistance they have met have shown the way forward and should help us recognise that the real argument is not about management structure or even the need for more money, but about democratic control.