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WHAT NEXT? — FUTURE PERSPECTIVES FOR CHCs

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"COMMUNITY HEALTH Councils stand at a crossroads, and are showing some uncertainty about which direction to take." Thus Ipswich CHC introduces its most recent annual report.[1] The CHC goes on to enumerate the functions of community health councils as set out in the establishing circular HRC(74)4, and to examine what CHCs are actually attempting to do, concluding that they risk 'straying' into other areas of concern, and have to retain a clear conception of what the health needs of their district really are, and to concentrate their energies on making sure that the health authorities are moving decisively toward meeting those needs in terms of the services they provide.

By contrast, it has been argued that "a new perspective on health and health care, entailing a shift from a narrow, service-oriented model of health to one that embraces the total 'health field' is the first requirement."[2] Taking the WHO definition of health as a state of physical, mental and intellectual well-being, a number of CHCs have argued that their interests are far wider than the service needs of their own community, and that even domestically they must be looking at matters such as housing, employment, education, transport and public health, which have an implication for the 'total health field' of the population. Hence the keen interest in developments such as Joint Care Planning; Inner Cities Partnerships and Programmes, and most recently, Government proposals for the revision of Section 11 of the Local Government Act 1966 to widen the scope of grant aid to meet the needs of ethnic minorities.

Proponents of both viewpoints would agree on the need for a clear conception of what they are about. Knowing your objectives are crucial, and it has been observed of CHCs that the most impressive are those which have a clear underlying 'theme'. The dilemma observed by Ipswich CHC concerns the choice of theme, and derives from the interpretations placed by CHCs on HRC(74)4.

The establishing circular was imprecise, reflecting the 'wait and see' attitude of the DHSS to the not-yet-formed councils, and contented itself with listing a number of questions to which CHCs could direct their attentions. It very quickly became clear to CHC members that they would have to stake out their own territory; negotiate for the information they could expect to receive from the health authorities, and lay claim to the relationship they could expect to enjoy with the health and local government authorities which would be collaborating in the planning and provision of services. Subsequent regulations have defined the position of the CHC in the health care planning process and in the procedures for closure or change of use of NHS premises, and CHC representatives have been given observer rights at AHA meetings. Beyond this, however, the ground that CHCs have been able to cover has depended on the relationships they have established and the priorities for action they have set themselves, but principally on the conception each has evolved of the role of public representation in the health services.

THE PRESENT SITUATION

NO HEALTH district in the country is the same in geographic or population terms as its neighbour, nor are there any two districts in which the development of health services and access to them are identical. It would therefore be no surprise if CHCs stood in slightly different positions today even if they all had interpreted HRC(74)4 in the same way. In fact it is no more realistic to attribute a similar position to CHCs as a generality than it would be to expect each health authority or family practitioner committee to be a mirror image of the next. Moreover, the upshot of staking out its own territory is that each CHC tends to move a little further from the others according to its own direction and the success it achieves, while at the same time entering consciously or unconsciously into competition with the others, in order to prove its own effectiveness. This may have been of benefit to the public in creating a dynamic for CHCs which the regulations alone would not have provided but it has been an additional source of diversity.

There are however a number of common elements in the development of CHCs up to the present that deserve mention. Apart from the meetings with AHAs, the involvement in the planning cycle and the production of annual reports which are common obligations, CHCs have developed an advice service for the public, dealing with information, queries and uncertainties about the health service, as well as advising on complaints. Without exception this advisory role is taken seriously, as evidenced by its formalisation in the form of information handbooks (Hackney, Ealing, Newcastle and others).

It can also be said of every CHC that its members are involved as councillors or voluntary activists in the community they represent, and that by the production of information leaflets about itself and its activities; by lectures and talks given to local groups; by the use of exhibitions, surveys of public opinion, the local press and radio or TV where possible; by building links with members of Parliament and the local authorities, and by inviting the participation of the public in its meetings and in its working groups by co-option, it actively endeavours to make itself a part of the community in which it operates. In this way, although they are only one organ of public representation in the Health Service (RHAs, AHAs and FPCs all include a lay component) CHCs have taken a unique interest in making themselves accessible to the people.

Without impinging too closely on the accompanying paper, it is also possible to list some of the achievements of CHCs to date which are of relevance to this discussion. Reports prepared by Councils[3] have had an important influence on official thinking in their own districts on the topics covered, while the publication of evidence from the CHCs of Kensington, Chelsea and Westminster (NE District), Haringey and South Tyneside (and their Scottish counterparts from South Ayrshire and West Lothian) in the first report of the Parliamentary Select Committee on the Ombudsman[4] 1977-78 is a minor achievement on its own. Other official statements have been complimentary to CHCs, and reference is made to these later.

To sum up: it has been argued so far that CHCs have attempted to provide a service to and develop a relationship with the public, and that they have also secured some successes in policy matters. Acknowledging the limitations on both endeavours, it is nonetheless

the case that in aggregate they have had a noticeable effect, shifting the centre of the argument to include the reaction of the public among the considerations, and that this shift is probably irreversible. The question is, where are the CHCs themselves left standing, and the answer, not so much at a crossroads, as at a five-way junction.

CHCs are on a traffic island, looking at the hospital, clinic and community services of the NHS; the Family Practitioner Service; Social Services and other local authority functions with 'health field' implications; the broader public health issues, and at health education. They have to decide how far to venture down each route and how wide to set their horizons, allowing for their other responsibilities, their small staff and limited finances. There are no clear answers, and each avenue has its own attractions. These facts are at the centre of the debate about what CHCs should be doing.

There is general agreement among CHCs that the Family Practitioner Service, as the first and most obvious point of contact between the public and the NHS, is a legitimate area of interest, and that they should have a role in expressing the public concern about it. There is also a considerable measure of unanimity about Health Education: it is the business of CHCs to raise the level of public awareness on health issues, rather than to engage in health education campaigns, which are the concern of Health Education Officers locally and the HEC nationally. Within this framework, numerous CHCs have used health education campaigns as a medium for airing the issues *(Prevention and Health*, and *Fit for the Future* are good examples) or for bringing their own services to the knowledge of the public.

Local government functions and public health issues require a broader philosophical approach, and are at once more difficult and more controversial. This is also true of 'health' questions with national policy implications, and the brief of the CHC — to observe the provision for the health care needs of its own district by the competent AHA — is frequently invoked as a reason for not venturing too deeply into matters concerning other departments of central or local government, particularly since the resources for doing so are severely limited. Considerations of this nature formed part of the debate about the desirability of an Association of CHCs; perhaps the existence of the Association gives some clues as to how the inherent problems might be resolved. Meanwhile, there is pressure from among CHCs for a reappraisal of their role and objectives, involving a review of staffing and membership regulations, and of the relations with RHAs, as the establishing and funding authorities.[5]

FACTORS COMPLICATING THE POSITION OF CHCS

A CONSIDERABLE measure of criticism has been levelled at community health councils, not least from the family practitioner committees, whose 1978 conference charged CHCs with breaching confidence, and with denigrating the services provided by family practitioners.[6] As early as April 1976, the Hospital and Health Services Review claimed that district administrators were pessimistic as to the effectiveness of CHCs as consumer councils or in planning matters. Commenting on a working party report from Chief Administrators, the Review said: "There are considerable doubts about CHCs generally. *Although none of the doubts are groundless*, the councils are here to stay so it is to be hoped that administrators will learn to live with them . . . . ." More disturbing are the comments quoted by Prof. Kogan and colleagues in the first research paper published for the Royal Commission.[8] After describing CHCs as "an unavoidable encumbrance", the paper continues with the specific complaints from members and officers of NHS authorities that in a search for political advantage "members indulged in personal views rather than representing the whole public interest"; that CHCs "tended to deal with niggling parochial issues" while "some were not attending to issues which required pressure"; that they were "not technically competent to monitor the health service" and that they "abused openness of procedure" with demoralising effects. The paper comments that "these complaints of irresponsible and overcritical behaviour came from virtually all levels of the health service and all disciplinary groups."

CHCs can be under no illusion about their popularity within the NHS. However warmly they may be received when visiting, and however many annual reports may speak of the excellent relationships developed with the DMT, it is clear that NHS attitudes are at best ambivalent, and at worst deceitful. In mitigation, it can at least be said that the NHS is a complex organism, and that CHCs represent an injection of alien matter which is bound to set up an irritation. That is one of the difficulties they face, but if the analogy stands up, the outlook is hopeful. Kogan in fact concludes:

> "The principle . . . was generally accepted although there were reservations about both the ways . . . . CHCs interpreted their role and the receptiveness of health authorities . . . . ."
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> "*More carefully worked out processes of ascertaining, evaluating and publishing facts are needed* if the CHCs are to develop their full role and to work in a more appropriate relationship with the service. None of these changes would derogate from the fact that CHCs are part of the legitimate politics of health."[9]

There is more than just hope for CHCs in this: there is justification, and a prescription that could make them much more powerful in the future.

The record would not be complete without reference to the perceptions of CHCs from other quarters. By contrast with the view of the chief administrators, the DHSS in 1977 argued that a special role had been assigned to CHCs in the planning process, and that the CHCs "have recognized and accepted this responsibility."[10] Similarly the Dyson inquiry into the management of Liverpool AHA: "the two CHCs have provided a hard-working and enthusiastic service to the patients and public of Liverpool" . . . . . "it is not too surprising that the AHA and the CHCs have clashed from time to time" . . . . . "We were impressed by the imaginative approach both CHCs displayed in their work and in their evidence."[11] And the Normansfield inquiry: "The CHC members were readily able to detect deficiencies which those more closely concerned, and with a statutory duty to do so, apparently failed to do," concluding "we express our gratitude to the Council for the immense trouble its members have taken. They played a valuable part in monitoring and exposing serious deficiencies in the service at Normansfield."[12]

Finally, referring in his annual report to the part played by CHCs in advising the public on complaints, Sir Idwal Pugh wrote that he had found "this year particularly that many Councils are acting very effectively in this way, and I welcome the help which they can and do give by explaining my powers and helping aggrieved persons to formulate complaints."[13]

Some other complications to the position of CHCs have already been touched upon, and may be itemized as follows:-

(i) *modus vivendi with health authorities*: on the one hand the necessity to go on living with the AHA and local management when the CHC has had to be critical and relations have become strained, and on the other hand the client relationship with the RHA which controls budgets and funding, and may take a strong position on staff appointments.

(ii) *representation of the public interest*: raising the philosophical question of what constitutes the public, and the practical questions (a) of the CHC's role as a public representative by comparison with that of the lay members of the health authorities and the FPC, and (b) of links and/or overlap with MPs and the Ombudsman. It also raises the question of how far the public can be roused to interest in the complexities of positive health issues unless they are an immediate personal concern;

(iii) *the manner in which health issues are presented:* the media tend to present health issues in terms of failure to provide, or of curtailment. If this presentation can be dramatised into a conflict betwen authorities and public, so much the better. In this context, the title of 'public watchdog' is something of an embarrassment, as it is presupposed to mean a protagonist in this struggle, giving an easy news line, but frequently distorting the real situation;

(iv) *staffing:* facing the AHA with its resources of administrative, financial, professional and technical manpower, the CHC has a Secretary and one or two assistants to provide all the management and intellectual support for the council, to absorb and interpret all the information coming in, and to make policy and campaigning recommendations. It may be correct to criticise CHCs for making statements based on inadequate research and technical knowledge, but as Kogan comments (op.cit.p83) "they can hardly do their job properly if they do not have secretarial resources enabling them to relate effectively to the authorities and to their potential clients."

Add to these the role uncertainty discussed earlier and the variability of the quantity and quality of information provided to CHCs by the health authorities and a formidable array of obstacles begins to materialize. In the following section, attention will be given to some of the positive indicators also emerging.

HOW THE SITUATION MIGHT DEVELOP

THE PROBLEM of role uncertainty is not unique to CHCs. It recurs regularly in discussion of the operation of health authorities of every kind, and has been exacerbated by the climate of cutback and restriction that has existed ever since 1974. Clarification of the identity and standing of the various authorities, professions and consultative mechanisms would do much to alleviate anxieties (and therefore hostilities) that exist. This position could improve very much during the coming twelve months.

A first step for CHCs would be to acknowledge that they are not part of the administrative structure, but are in fact a consumer service. Recognition of this would alter the terms of the argument considerably.

Speaking in North London in 1975, Dr. David Owen described the health district as potentially one of the most successful products of health service reorganization, and the "basic building brick of the NHS."[14] CHCs are established in districts and therefore have an interest in their development: if the next stage of evolution of the health service were to bring greater authority to the districts, it would also enhance the role of CHCs currently operating in multi-district Areas.

The creation of CHCs was "an attempt to differentiate management from representation" (Kogan, op.cit., p.82) and established an important, if difficult precedent in the health service. There is much value in separating the two functions, thus enabling public representatives to act as critics within a framework of continuing and constructive responsibility, but without the *management* axe to grind which causes members of authorities to adopt a proprietary attitude toward their own policies and reject criticism. The location of member management bodies at the same operational level as CHCs with clear objectives and an understanding of their separate functions could lead to a highly productive contact and conflict interaction: this could develop whichever way the trend to single-district authorities progresses.

In the planning process, CHCs could concentrate on using the imaginative faculty observed by Dyson. They are in contact with the organised public if not the public ar large, and they have the facility, without departing from the letter of HRC(74)4, to make use of advice and feedback from local interest groups, and to draw on their own experience in dealing with consumer problems, in order to introduce original concepts and innovative schemes. This potential is recognized in *The Way Forward*, and needs to be acknowledged on a wider scale, perhaps even by some CHCs themselves.

A role for the Association of CHCs emerges clearly from this discussion. This falls into three parts:

— assumption of the wider "public health" interests of CHCs, so that such questions can be debated in a national context, freeing CHCs locally to concentrate on matters of immediate significance

— taking responsibility for publicising the work (and limitations) of CHCs; raising public awareness of their existence and potential, and arguing their case at every level of debate

— development as an information/research arm for CHCs.

There is a degree to which all three components are being recognized and their practicality tested. The Association could become a highly valued part of the CHC armoury if it can absorb these functions and carry them out effectively.

Much lip service is paid in literature and in policy statements to the concept of the patient as a member of the therapeutic team. If the politicians and the moulders of opinion intend to turn that conception into reality, then the function and status of CHCs will have to be advanced, and their position as the grit in the NHS oyster accepted. At this point, it is worth considering specific ways in which their development can be facilitated.

A MANIFESTO FOR CHCs

COMMUNITY HEALTH Councils "need access to the full flow of relevant information. Yet they need independence of health authorities and thus should be able to advertise for and appoint their own secretariat . . . ." "They also need technical resources . . . . to assess the impact of health services on clients and patients . . . ." Professor Kogan's research team, having completed a hair-raising survey of the criticisms of CHCs, then looked at the principle of consumer representation in the NHS, and attempted to identify the factors inhibit-

ing its effectiveness. The conclusions they reached are not greatly different from the considered views of CHCs themselves, as they now look at their functions and their relationships with the NHS. Some of the principal proposals for improvement are the following:

(i) health authorities should provide working information in a manageable form to CHCs. There should be no argument as to what is necessary for them to do their work, and the information should be supplied in adequate quantity, in good time, and with reasonable allowance made for its absorption and any queries arising. Authorities should approach CHCs to agree the information to be provided and the form of presentation, and should given an undertaking to make such alteration to the range of information as the CHC may periodically request.
Information coming freely to CHCs should include reports and other items of public interest, including those prepared by advisory services and inspectorates, as well as the reports of inquiries, working groups or project teams within the authorities themselves. There should never be any question of the CHC participating in any study or investigation and not being informed of the outcome. It is not reasonable to assume that CHCs will deal less responsibly than other bodies with matters of genuine delicacy.

(ii) CHCs should be given an extra staff member to deal with the information coming in and to conduct the necessary research to enable its interpretation and presentation to members in a purposeful way.
There is no desire on the part of CHC members to become large organisations or important consumers of NHS finance. It is however the case that the small existing staffs of CHCs work considerable hours at high intensity to try to inform, guide and motivate their members effectively. With few exceptions, it would be agreed that the output demanded of staff is such as to warrant an additional person: the effective use of information on an enhanced scale would make enlarged staffing a necessity.

(iii) the control that establishing authorities have over CHCs should be relaxed in two important ways.
First, the notion that they are somehow financing CHCs out of their own pocket should be discredited. CHCs are a NHS commitment, and as such are the responsibility of Government. RHAs are the administrative machinery whereby money is fed through to them. Once this is understood, it becomes reasonable to argue that having set the total budget (or cash limit) for a CHC, the RHA should then give the CHC budgetry freedom within its allocation. The CHC can decide whether to spend its money on staff, on premises or publicity, or some other way, subject to normal monitoring and financial checks. This would involve no change of status on either side.
Second, CHCs should be free to make their own staff appointments without outside pressure. Enlargement of staff numbers would necessitate a review of staff gradings, and the opportunity could be taken to establish appropriate gradings for permanent and temporary staff and a code of practice for their employment. It would then be up to CHCs to agree terms with prospective employees, and regional or area personnel officers would be available to give advice when needed. The formal provision whereby the establishing authority is regarded also as the employer of CHC staff may have to be reviewed, but need not necessarily be altered.

(iv) CHCs should be given a defined role in relation to family practitioner services. Without begging any questions concerning the function of FPCs, the status of family practitioners or the involvement of the Ombudsman in complaints, CHCs could beneficially be involved in the planning of family practitioner services and their integration or coordination with corresponding services provided by the health authority.

(v) the DHSS should set aside a sum of money for publicising the functions of CHCs, and should use the COI to make sure that a suitable publicity programme is undertaken using all principal advertising media. This could be of benefit to staff in the NHS, as well as to CHCs and the public.

CONCLUSION

COMMUNITY HEALTH Councils are in the business of representation and advice as distinct from that of management, or the handling of complaints, for which separate machinery exists. Their work however inevitably impinges upon both these functions, as it does on other health and local government services. CHCs themselves are anxious not to cast their net too wide, and are therefore engaged in taking stock of their activities.

Their achievements to date are limited, but it is wrong simply to criticize, since given greater autonomy, fuller information and better understanding of their role by the members and staff of health authorities, they have the potential to be much more effective, and if the political will exists also, they almost certainly will become so.

Whether or not CHCs are the best attainable form of democratic representation in the NHS at this stage is an argument outside the scope of this paper. They have frequently been described in discussion of the reorganisation of the NHS as an "experiment". The opportunity now exists to turn the experiment into a longer term success.

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