REPORT OF OVERSEAS STUDY TOUR

July/August 1985

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District Health Councils Program

Health Department Victoria

INTRODUCTION

The proposal to establish district health councils (DHCs) was first announced in September 1983. The broad parameters of the proposed Program were set out in that announcement.

From the earliest stage it was recognised that the proposed Program was quite an innovative development within the Victorian context and that careful attention to overseas models would be wise.

In 1984 a research paper, "Can Consumers Contribute?", was prepared by Ms P Price of the Planning Division. This paper reviewed the experience of comparable initiatives in Australia and overseas and referred to some of the theoretical work around the notion of consumer/community involvement.

The District Health Councils Program Discussion Paper was published in December 1984 and a thorough consultation was undertaken during the period December 1984 to May 1985.

Prior to finalising the directions that the Program should take, it was judged worthwhile to look at some of the most relevant overseas models with a view to getting a first hand understanding of the practical details of operation, and being better able to predict the practical consequences of different design options.

Accordingly, the DHC Coordinator undertook an overseas study tour during the perdiod July/August 1985, spending three weeks looking at community health councils in England, one week looking at district health councils in Ontario, Canada, and one week looking at current developments in health service plannrng in the USA.

The present report presents the findings of the study tour, a discussion of selected topics, and recommendations arising from overseas observations for the development of the District Health Councils Program.

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1. UNITED KINGDOM

1.1 VISITS TO CHCs

GREENWICH COMMUNITY HEALTH COUNCIL

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I was referred to the Greenwich CHC by Tony Smythe at ACHCEW. He referred particularly to the work of Graeme Bett, focusing on the Black Report and seeking to find ways of implementing some of its insights at the local level. He indicated that Graeme Bett is sharing the secretaryship with May Clarke who has been Secretary for a long time but is now moving to a part-time role.

I spoke first with Graeme Betts who is a young Scottish medical sociologist who is job sharing with the permanent secretary, working on a specific project designed to repond to the issues raised by the Black Report. (See below for description of this project, 'The Greenwich Health Rights Project').

I spoke with Graeme Betts also about the issue of RAWP being used to determine intra-regional allocations. He pointed out that in fact this is an issue which divides the Community Health Councils. Many of the RAWP under-resourced regions and districts might sympathise with the harsh consequences experienced by inner London but see that, in a time of overall constraint, any new resources to their area depend upon the redistribution away from central London.

While I was at Greenwich CHC a woman walked in with a story of having had a sterilisation operation some two to three weeks earlier at which time, so she learned afterwards, her bowel was perforated and sewn over (following which the surgeon went ahead with the sterilisation). She was inquiring how to handle any possible complaints. (She already had a painful, tender swelling in the abdomen wall.) I had a useful discussion with Graeme and May Clarke. It became clear that their response would be to assist her to work through the formal and somewhat bureaucratic complaints procedures acting as the patient's friend although often not allowed to speak on the patient's behalf during complaints hearings.

I was surprised to find that there was no perception of there being system problems involved. There was no notion that they might approach the District Health Authority with respect to whether or not there are regular D&C meetings, and whether or not this particular episode has been discussed at a D&C meeting. The issues of peer review medical audit and quality assurance are apparently not seen as CHC issues.

I then spoke with May Clarke who has been the Secretary for eight years.

The CHC meets monthly, alternating special topic discussions with regular business discussions. Among the special public discussions recently, hospital closures have. dominated. They have also been discussing hospice development and the development of community residential units for intellectually disabled.

The CHC appointed half through the Borough (the Local Authority) and since this

is a Labour Party Burrough these will be mainly Labour Party members. One third are respesentatives of local voluntary groups with the remainder appointed by these regions. May· agreed that there is some scope for political division in this formula but suggested that eventually they develop the consensus. She cited a conservative dominated CHC within the region which recently wrote to their Local Authority criticising them for not opposing the cuts and suggesting they should resign.

The present membership of the Community Health Council includes people who are nominated by voluntary organisations, by the South East Thames Regional Health Authority and by the London Borough of Greenwich. Those who are nominated by the voluntary organisations include:

PC, representing the British Associatio·n of Social Workers, who is. a disabled person (in a wheelchair) who has been active in bereavement counselling and has also done work on medical students. She represents the CHC on the Health Care Planning Team for services to the elderly at the district level.

ND represents the National Association for the Welfare of Children in Hospital. She is a most energetic person who has been active in primary care developments in Tower Hamlet.

OF represents Greenwich MIND, is an ex psychiatric nurse and runs one of the Greenwich Council's mental health hostels.

US represents the Gr.eenwich Council for Racial Equality and is employed by that Council. She has recently arranged for the translation of some' of the Council's leaflets.

GW, representing Greenwich Council for the Mentally Handicapped. He is the father of a disabled person. He is an active worker for the CHC.

NW, representing the Charlton Women's Health Group, who is a young mother as well as being a baker.

Three members are nominated by the South East Thames Regional Health Authority. These include:

FE, who is also active within the National Association for the Welfare of Children. in Hospital.

GM, whose main efforts have been put into the Still Births and Perinatal Deaths Group, a self help group for parents· who have lost infants. She herself lost twins.

GE, who is a retired social worker involved in MIND.

Amongst those who are ·nominate·d by the London Borough of Greenwich are:

Councillor GW, who is Chairperson of the CHC (a Labour Councill.or).

Councillor JC, who attends but not a very active participant.

VD, a teacher, who is very active in the affairs of the CHC.

Councillor BJ, who is an elderly chap, of a strong Labour background.

HA, who is something of a lapsed activist (attends irregularly if ever).

ST, who is a Labour Party activist. She works at the London School of Economics and is interested in one parent families.

EF, another Labour Party member, who is a very useful active member; and

AG, who is a Tory member, represented by the Borough, and an active member of the CHC.

I asked May about the main achievements of the CHC.

She cited the Terminal Care Support Team/Hospice Service which has been developed.

She cited an episode in 1979 when one of the local hospitals was under threat of closure. CHC acted and eventually saved it.

She cited particularly the role of this CHC in the area of mental handicap. The District has a old Victorian style mental handicap hospital with over one thousand places ("Darenth Park"). The Regional Authority and the District had determined to close it and the plan was to replace it by two hundred bed units. The CHC opposed this plan, pushing for the use of small thirty bed hostels instead. They had considered smaller five bed units but local parents and Men Cap were opposed and the thirty bed model was adopted. Now the District has two units one which is fairly old, made up of two joining houses, and one which was specially purpose built. There are plans in train for two special purpose units to be developed. In addition, Greenwich Council is developing a range of community facilities. The region has instructed the District Health Authority to look for more houses.

Another incident related to Brooke and District General Hospital which has two wards for the elderly and, under some pressure from the CHC, has recently developed a "personal clothing system". A similar system has also been introduced at St. Nicholas Hospital (which is due for closure).

Another issue which was taken up by the CHC was that of maternity services. The local maternity hospital was closed, although not without strong opposition by local women. Out of that opposition a lot of women thought about why they were opposed to closure and developed an appreciation that they were concerned about style of care, about the autonomy of the mother. Under pressure from this movement the District Hospital has adopted a system of community midwives who follow the mothers before and after delivery and come into the hospital to help with the delivery. In what I believe to be a separate incident, the District Hospital proposed to close its antenatal classes and the CHC opposed this.

I returned to the question of whether the local hospital has D&C meetings. May was not aware whether they did or not. She is aware of the maternal death inquiry and of the monthly unit meetings looking at infant deaths. (She doesn't know if they look at 'near misses' as well). From time to time suggestions have been made that the hospitals should embark on medical auditing. However in

discussing it she appeared to be referring to utilisation reviews. (She referred to reviews of length of stay as between hospitals.)

May emphasised that the medical staff are very much in control of what goes on in the clinics and that management is quite intimidated by this situation of medical control. Indeed she sometimes gets the feeling that management is quite grateful for CHC complaints because it strengthens their position.

She comments that often the administrators at" district or regional level know less than the CHC about what is going on. Sometimes there is no point in the CHC's asking questions of the district and region administrators. On a more general plane, May made the point that the CHCs ask a lot of good questions but the DHA and the RHA are often not in the position to pry answers. Often indeed the questions are not even_ acknowledged.

Abortion delays. May sighted one case which had a two week delay for the consultation and a one month delay for the D&:C. I'm not sure how general this is.

We talked about cervical cytology; it appears to be quite a prominent issue. A recent study demonstrated that although the number of cervical smears taken was reasonably good, most of them are done as a routine on first patients visiting the gynaecology clinics and the community coverage might not be as good as it should be. Very few are coming from the GPs and even fewer are coming from the special cytology clinics set up for this purpose.

Because of the advisory relationship built into the C::HC/DHA relationship, the contribution of CHCs to service development is sometimes deliberately understated. May recalled attending the opening of a hostel for mental handicap people recently. This CHC had been in the forefront of fighting for this particular hostel but its role was not acknowledged at the opening ceremony.

The local DHA has also recently opened a Womans Wellness Centre. This is a proposal that the CHC had initiated and promoted and now it has happened. However the local DHA took full responsibility at the opening •

In May's view the CHC is very successful in getting things on to other bodies' agendas.

On the question of complaints handling, May expressed a firm view that the CHC should not in fact be handling individual complaints in the way that it does. She urged that a DHC program should avoid complaints handling.

Liaison with the local DHA is currently surprisingly good. This is probably related to the siege mentality in this inner London DHA, under serious threat from the region in terms of meeting RAWP targets. For example, the District General Manager rang the Chairman of the CHC urgently to ask him to go to the RHA meeting tomorrow night to protest about the transfer of the neurology/neurosurgery unit from the Brooke and District General Hospital to regional teaching hospitai.

On the question of staff, May felt that two or three staff is the m1mmum required for maintaining morale and movement in the office. Two would be a minimum.

On the question of whether a shopfront or backroom office is desirable she felt inclined to the shopfront (such as the Greenwich CHC operates from); not so much to be available for complaints and inquiry handling as to maintain an image and keep in touch.

We talked about the present environment of cost cutting in the NHS. May commented that some of the central bureaucrats adopt a crusading additude to reducing costs, taking the view that there is always scope for more efficiency (c.f. Griffiths). CHCs which oppose cuts are accordingly designated "mindless". In fact, this particular CHC has opposed some cuts and not others. For example, it certainly did not oppose the closure of the big mental handicap hospital (Darenth Park), because it was being replaced by more appropriate facilities. The cost constraining crusade of the central bureaucrats has received inadvertent support from "McKeownism" and its emphasis on improvements in mortality statistics being unrelated to improvements in health care technolgy. The anti-technological message has been hijacked by the cost constrainers.

I asked about discretionary servicing rates but they are not available. They have not been asked for either. I would cite this as being evidence of the need for central support, both educational and statistical, for the CHCs.

We got on to the question of infant mortality and May referred me to the work of Kenneth Boddy ("Obstetrics in the Community", Scottish Medicine April 82, Volume 2, No 1), which has demonstrated the effectiveness of community health nursing in reducing infant mortality. This work was referred to me by other CHCs also subsequently.

We talked about a project which the CHC had mounted, focusing on waiting times in outpatients at the Brooke and at St Nick's. The CHC Secretary and several members went into the outpatient clinic and asked people how long they'd been waiting. They had initially proposed to ask whether they were satisfied but the doctors insisted that this be removed as a condition of their coming into the hospital.

I asked how active the committee of this CHC is and she says often very active. I asked whether the membership of this committee represents a "raiding" of other local active bodies. She says yes to a large extent but this is because of the way the appointments are made. I asked whether there is scope for activating previously inactive people and getting them on to CHCs. She agreed that there is scope but none of the CHC members would fall into that category.

While I was there, May received a call from a newly appointed consultant psycho geriatrician who is upset because he had been promised a twenty-four bed unit for assesment and rehabilitation but the opening of the unit had been deferred, possibly to the 86/7 financial year. Shortly before, the NHS nurses had received a pay award which the DHHS had announced would have to be met from existing resource allocations. Apparently the psychogeriatric unit was to be one of the casualties of the nursing pay award. May indicated that she will ring the District Health Authority and find out what is going on. It was the second approach in a few days (neurosurgery/neurology and now psychogeriatrics).

We talked about the election of voluntary members to the CHC. The region (RHA) contracts with a local voluntary organisation as a resource group to notify and organise the elections. Last time there were 11 nominations for three places and between 20 and 40 groups eligible to vote.

We talked about the Chelton Womens Health Group which arose out of the controversy regarding the closure of the Hospital For Mothers and Babies. The CHC had organized a meeting about womeris' health and a group arose out of that meeting to continue working on this issue.

The CHC has been seminal in setting up other special purpose groups such as the Greenwich Council on alcoholism.

Another group which was formed by the CHC is a group for parents who lose an infant. The CHC had received a complaint concerning the death of a set of twins. The twins were only five months gestation and had breathed only briefly. Three weeks later the mother was rung from the hospital asking would she organise the funeral. The issue was picked up by a member of the CHC who had also lost a twin. The CHC approached the Greenwich District Hospital to change its procedures in dealing with people who had still births and infant deaths. Part of this was to offer to make the funeral arrangements. The group is still providing a counselling service to families which lose infants.

Greenwich Health Rights Project

The Greenwich Health Rights Project was funded through a direct fund from the Borough, of Greenwich to the Community Health Council. It covers the cost of one worker. It was initially expect that it would last for three years, but with the prospect of rate capping, the CHC is looking elsewhere for financial support.

The general aims of the project are:

> to help local people in one area of Greenwich to identify their health needs, evaluate their services and press for improvements;
>
> to encourage better use of NHS services;
>
> to help people become more aware of the relationship of health to the environment - for example, health and safety at work, lead pollution, housing, stress and lifestyle.

The project clearly stems from the inference of the Black Report, following up the national data in that report with a much more local focus. The project identified one Ward within the Borough on the grounds of it being "the most deprived Ward in Greenwich". The first step was a detailed survey of morbidity and mortality patterns and use of services and attitudes to service use. Quite a detailed report has been produced, mainly reproducing the- findings of Black, identifying some areas for improvement in the local services which are available, particularly general practice, and sketching some directions in which future service development might go and for a possible community of development approach to the preventative task. In this latter respect, the factors which are identified include social isolation, unemployment, inadequate housing, recreation facilities, child care, etc. The need for more appropriate information and health education is also identified.

Minutes and Reports

"Health in Glyndon", report of a survey on health in Glyndon Ward, Greenwich (a Greenwich Health Rights Project, May 1985).

Greenwich Health Rights Project, a summary of the first year's work, 1984/5.

"It's Your NHS", the Greenwich Community Health Council Annual Report for 1981/2.

> I'm not sure why I did not come away with any subsequent annual reports. It may be that this one is the most recent, in which case it's not exactly annual. It is worth listing the subheadings in the Annual Report: calls for help, psychogeriatrics, orthopaedic waiting lists, improving the NHS, health in the community, local health clinics, well women's clinics, children, lead free air, maternity services, abortion, mental handicap, care in the community, brain surgery, cardiac surgery, visiting health premises.

"Greenwich CHC Survey of Local People's Views About St Nicholas Hospital".

> The results of a survey conducted by the CHC in the locality, documenting_ the attitudes of local people to a hospital for which closure was being mooted (and now appears to be proceeding).

"Cancer of the Cervix".

> A briefing paper prepared for the Greenwich CHC, presenting a discussion of the nature of the cancer and focusing on the need for cervical screening, where it is presently provided and how effectively it is presently being delivered.

Minutes. A sheaf of minutes of meetings of the Greenwich CHC during 1984 and the first half of 1985.

CITY AND HACKNEY CHC

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Tany Smythe at ACHCEW had recommended that I speak with Fidelma Winkler at City and Hackney CAC. He emphasised that its a tough area with a lot of community based activists and that Fidelma is good at getting research money and special project money. One of the things that Tony was impressed by was the advocacy for non-English women in relation to maternity services.

I arranged to visit the CHCHC and to attend a monthly meeting of the committee. Fidelma was not in attendance as her father had died recently. Prior to the meeting I had a short discussion with Erica Dans, who is the Chairperson. She mentioned two issues which would be discussed. One would be the St Bartholomew's Obstetric Service; the other being the closure of a local 70 bed hospital. She cited this closure as illustrating conflicts between community activists on the CHC who might pull their punches on some issues whilst pushing harder on others compared to the activists in the "outer community" who felt that nothing should be closed and a major fight should be developed in the face of all potential closures. I think the message was that criticism from outside activists is one of the crosses that CHC people have to bear as one of the prices to be paid for being responsible.

I attended the meeting. Some of the prominent participants in the meeting were:

Alex is a local GP but works in another district. He was appointed by the Borough (a Labour Party Borough) and (according to Helen Rosenthal) has been a very useful member.

Maree is a community worker employed by the Anglican Mothers' Union. She's also active in the Council for Racial Equality. She chairs the Multi-Ethnic Women's Health Project. According to Helen, she is a key member of the CHC as she belongs to the same social class as the bureaucrats and the doctors and can go and talk to them on equal terms.

Robin works for the Forum for Services for the Elderly. She was active on the Brent CHC before joining this one.

Chris is a recent (Labour Party) appointee by the Borough. He works for Age Concern.

Erica, the Chairperson, is a Labour Party activist appointed by the Borough. She is a civil servant (a museum curator).

Theo, the Vice Chairperson, is another Labour Party member appointed by the Borough. He works at the London Hospital as an EDP person.

Helen R was initially a representative of the local Trades Council. She has a Social Administration Diploma and has worked at the

London Hospital. She presently works with London Community Health Resource (see page •••)•

Ted represents a Hackney organisation for mental handicap.

Mr. B is a Tory who was voted on to the CHC through the voluntary organisations. He is active in the League of Friends of the local hospital.

Also attending the meeting, although not a member, was Andrew, who is an ex-psychiatric patient and an activist in the Mental Health Patients Union. Andrew appeared to know more about some issues than some of the members.

The first issue to be discussed was the Wendy Savage case. Wendy Savage is a female obstetrician who has placed a major emphasis on 'community obstetrics' (? exact details). She has been criticised by her colleagues, apparently on technical grounds, and suspended by the RHA. It is alleged that the usual procedures for considering professional criticisms of this sort have not been followed because her (male) colleagues have refused to work with her. There is a widespread feeling among London CHCs that her suspension is related to her being a woman and to her challenging conventional medical approaches to childbirth.

At this stage Wendy Savage had appeared before the Tower Hamlets DHA. The DHA had received a "independent" report, the credibility of which had somewhat suffered since they hadn't interviewed Wendy Savage in preparing it. The Chairman of the DHA has revealed that "further allegations" have arisen against Wendy Savage but he has not revealed these further allegations to fellow members of the DHA or to Wendy Savage. (Recall that the Chairman of the DHA is appointed by the RHA whereas several members of the DHA are appointed by the Borough directly.) Wendy Savage had at this time taken the DHA to court. The DHA offered to reinstate her after one year's suspension, but as a community obstetrician only (with no beds). The other obstetricians in the district have said they will not work with her. The report on Wendy Savage was given by Alex, the GP, who indicated that he had actually worked with her and was very impressed with her dedication to community obstetrics and to giving the patients maximum decision making. He indicated that she may have made occasional mistakes but the main issue at this time is her style. He commented that there is a protocol for handling complaints about consultants which in this case has been clearly breached. The decision of the group was to lobby the DHA and to support the Tower Hamlet CHC in coordinating the Save Wendy Savage Campaign.

The next issue to be dicussed was the annual subscription to ACHCEW. City and Hackney CHC can't afford to pay and did not attend the AGM.

The next issue to be discussed was community antenatal care. The District Health Authority has produced a document on community antenatal care, including protocols for management and scheduling of visits to the hospital. A report from the Womens Health Group was tendered regarding this district plan. The plan is based on the Edinborough work of Kenneth Boddy. (See notes on Greenwich CHC for reference.) The report from the Women's Health_ Group was critical regarding the separate records to be held by midwives and doctors but supportive of the notion that women would hold their own records. There was some doubt as to how important the scheduled visits to the obstetrician at the hospital were but the general feeling was that it was going in the right direction. A pilot is being

developed at Lower Clapham but there is apparently some difficulty in getting the consultants to co-operate. One of the issues which turned up was the question of routine ultrasound, which is built into the district protocol, and some doubt was raised as to whether it is necessary.

Still in the obstetric field, the forthcoming appointment of a new obstetrician within the district was discussed. The issue of appointing female obstetricians had come up repeatedly and the CHC had made representations to the DHA suggesting the need for women to be included among the lay members of the appointment committee. The DHA nevertheless appointed two men as the lay members of the appointment committee. Apparently there are no women on the short list. The Hackney Health Emergency Committee has organised a demonstration against the appointment of a male to this position on equal opportunity grounds.. Will this CHC support the demonstration? The district apparently has a draft EO policy which is being considered at this time.

Then followed a report by Theo regarding a recent meeting of GLACHC. Theo reported that the researcher had reported what he was doing. He was collating data about resource allocation in London, doing a comparison on a Borough by Borough basis.

Theo reported that GLACHC is organising a seminar on homelessness and health for London CHCs.

Robin reported about an issue to do with the status of the CHC representative on the Social Services Committee of the Local Council.

Then followed a discussion of the proposed management structure for the District Health Authority. There is some uncertainty regarding the level at which the District Nursing Officer will be placed.

It is proposed that the City and Hackney DHA will have two units (the next level down in the management hierarchy) which will consist of:

1. St. Bartholomew's Hospital,
2. Hackney and everything else.

Also arising from a recent meeting of the District Health Authority was the proposal to appoint a consumer research officer to the District staff. Some discussion then followed as to whether this is an attempt to take over the function of the CHC. The discussion drifted from there, through the possibility of the position being used for liaison with the CHC, to the possibility of its being a quality assurance person. The discussion drifted from there to doubts about the standards of nursing care in the wards of the local District Hospital and the role of the CHC in maintaining such standards. (Although this did not come out overtly in the discussion, I was informed later that the nurses who were being complained about are black and that there are some sensitive racial aspects to the issues.) The CHC resolved to visit the hospitals concerned. The question of what to do about the proposed appointment of a consumer research officer to the DHA was allowed to lapse.

The next issue to be discussed was the proposed early- day motion in the House of Commons regarding the regulation of homeopathy and herbal medicines.

There was an announcement of a training day to be held by the North East Thames RHA on "how to run an effective CHC under the new management arrangements".

In the questions section at the end of the meeting, Andrew (see above) embarrassed the CHC leadership by referring to a report put out by the Health Advisory Service which allegedly had criticised the City and Hackney CHC for its failure to monitor psychiatric services in the district.

Newsletters

The CHCHC produces a monthly one page newsletter with eight to ten items, mainly about the NHS in the local district and presumably taken from matters discussed at CHC meetings. The newsletter also serves as a public notice regarding each CHC meeting (although it does not replace the formal agenda distributed for members). The newsletter seems to me to be a very useful communication tool.

Annual Report (December 1984)

This is a well produced, 32 page report covering over a score of topics, including:

services for elderly people,
hospital waiting times,
orthopaedic services,
patient advocacy and ethical issues,
women's health,
maternity services,
multi-ethnic women's health project,
food, service,
services for children,
transport,
services for mentally handicapped people,
GP services,
CHC visits,
issues in mental health,
the dilemma of Barts,
care of the dying,
appointments to the District Authority,
Hackney Hospital,
advice, inquiries and complaints,
various CHC matters.

Each section highlights current issues and events and most sections have a few "statutory questions", questions to which answers are formally required from the District Health Authority. There are a total of 51 questions, all of which appear eminently reasonable to me.

Leaflets and Pamphlets

Pregnancy and Birth in Hackney and the City of London: How to Make the Maternity Services Work for You in City and Hackney Health District (a guide prepared by City and Hackney Community Health Council). This is a 40 page, nicely illustrated guide which arose out of a women's health group, formed through the CHC. It discusses the various services, what one can expect from

the different phases of childbirth, an account of the senior consultants, some advice about how to look after yourself. It is a most impressive pamphlet.

Multi-ethnic Women's Health Project: Health Advocacy for Non-English Speaking Women. This is a short (eight page) pamphlet describing this project.

Day Care Abortion Service. This is a one page leaflet produced by CHCHC advocating a day care abortion service to reduce the delays between referral from the GP and to reduce the load on the gynaecology staff and to provide a more economic service. The leaflet documents the various surveys and discussions and decisions which have occurred in relation to this matter over the last 10 years. It is not clear from the leaflet why the health authority has been so reluctant to establish this service. It appears that a large proportion of women from this district have private sector abortions, many of which are in fact day care services. However, they are expensive (90 pounds).

THE GREATER LONDON ASSOCIATION OF COMMUNITY HEALTH COUNCILS (GLACHC)

I met Andy Thompson and Amanda who are the GLACHC staff at the Islington CHC.

Fallowing the publication of "Chronic and Critical", a review of the impact of current moves within NHS on London (produced by a group of London CHCs), the need for a more formal association was appreciated.

With support from the Greater London Council the London CHCs of the four Thames regions came together in this association. The background to the problems of London focuses on the impact of RAWP. The four Thames regions are designated 'over-resourced' areas and have been targetted for continued resource reduction. The four Regional Health Authorities strategy plans envisage a total transfer of around ninety million pounds from the Thames regions to other regions (per annum recurrent costs in real terms) and another ninety million pounds within the Thames regions from the London (GLC Area) to the country ends of the Thames regions (again in per annum recurrent expenditure in real terms).

Andy Thompson referred to the Acheson Report which apparently demonstrated a serious lack in community health facilities in London. He also acknowledged that there may be good arguments for some of the closures and rationalisations and for the general thrusts of resource redistribution.

GLACHC was funded by GLC to study the impact and implications of RAWP for inner London, to look particularly at the priority (Cinderella) areas and to see whether they are being given priority and to collect sound quantitative data on these matters. GLACHC is seen as an up-front voice for the CHCs on London wide matters.

What happens to GLACHC after the GLC goes is not clear.

Andy Thompson commented on the CHCs in London generally. They are generally under-resourced, given the range of activities they're expected to undertake, providing the "consumer voice", responding to relevant documents, participating in various policy and planning meetings and intervening where necessary. Not all CHCs see their role as being in an adversary relation to management. They range from those which perform an advisory role but don't rock the boat to those which see themselves primarily as a pressure group and rock the boat by any means possible.

The Brent CHC perhaps is the closest to this latter stereotype. At the risk of over simplifying, it appears that Brent takes the line that the CHC is largely ignored except where it can be used to legitimise decisions of management. Accordingly we will ignore the approved processes and go. out and raise public consciousness. One of the campaigns that Brent has mounted is a focus of racism in the NHS through a black women's group.

Another stereotype among the CHCs are the "pamphlet producers". A lot of the CHCs produce or translate pamphlets about access or specific preventative services

or advice services. One can't help wondering whether they are not doing the job of the district health authority health· education units.

We-talked about shopfront versus backroorn models. Islington Community Health Council did not choose a backroom model but it is quite happy to·be working from one.

Some of the other contrasts within the CHC movement include counselling versus campaigning, empire building versus small is beautiful. The City and Hackney Community Health Council was cited as an example of the entrepreneurial spirit, attracting lots of grants and embarking on lots of ·projects. Hounslow on the other hand employs one and a half people and hasn't had time to produce an annual report.

Andy Thompson emphasised that CHCs are not democratically elected. They have three quite separate constituencies: the RHA, the local voluntary organizations (in our terms voluntary providers) and the Local Authority. These constituencies are not demanding that their interests be attended to at all times. However, it is clear that the functions that we have envisaged (for Victorian DHCs) and referred to as 'systematic listening capacity' and as grass roots educational activities are not facilitated by the structure of the CHCs.

I asked about the quality of statistical information available to CHCs. Andy recalled an episode when he had been working at one of Manchester CHCs when concern arose about access to local hospital services. The CHC asked the DHA for relevant statistical information. They were provided with reams of statistics which turned out to be shoddy in quality and inappropriate data sets. We then went on to talk about the work of John Yates at Birmingham University in developing comparative indicators and the work of Christopher Pollitt at the Open University and the work of the DHSS in producing performance indicators. We talked about the Korner Report and the possibility that it would produce improved datasets within the NHS in due course.

During this discussion I was reinforced in my view that the prov1s1on of good statistical information to DHCs in an accessible format and with brief but relevant commentary will be of great value to our DHCs. Likewise, the almost total absence of such a service for the CHCs has been a significant weakness.

Thoughts on the meaning of equity with respect to health. Does it mean equality of access, or equality with respect to utilisation, or equality with respect to outcome (of health care), or equality with respect to health status?

Andy Thompson told me a long story about a patient satisfaction study that he had done some years ago. At that stage he was working· as a medical sociology postgraduate research worker and a member of the one of the Manchester CHCs. He did quite a detailed patient satisfaction study (the pro forma is included in the file) and he involved the other members of the CHC in developing the pro forma.

One hospital· which came out vert badly on the patient satisfaction study was rung five years later and asked what they had done to correct the situation which had been revealed. They had done _nothing; "oh! we didn't realise you expected us to act ...".

The central Manchester CHC produced a lot of questions for the District Health Authority arising from the results of the study. They sent these questions to the

District Administrator who initially gave no response. They then met the DMT, who were very defensive. At least according to Andy Thompson's account the DMT was not willing to discuss an agenda which was put in terms of "points for discussion", but insisted on the CHC listing their "demands".

Actually getting into the hospitals was not easy. Central Manchester CHC faced severe opposition from the Senior Nursing Officer and the District Medical Officer although the Senior Administrator at that time actually supported the project.

In another CHC there was a big faction fight as to whether patient satisfactions are appropriate or inappropriate activities for CHCs to do. (My judgement, arising from hearing about this story, is very clearly that they are not an appropriate activity for CHCs. That is not to say that CHCs should not put a lot of pressure on district management, or in our case on hospital management or on regional management, to do such studies.)

Andy appears to have flown into a lot of flak in regard to this patient satisfaction study. The District Medical Officer in one district was strongly opposed and threatened to "black" the project. The opposition of the union was aroused; "he didn't consult me about who comes into my hospitals".

There are several messages in this story. One is that patient satisfaction studies are quite technical if they are to be done properly and perhaps it was a mistake to identify the CHC so closely with the development with the questionnaire. However, more importantly, this story reveals the insecurity of some of the health service providers when their assumptions of professional hegemony are challenged.

I asked Andy Thompson about the role of CHCs in primary prevention of a "community development" character. He indicated that tobacco advertising has never been a big issue with the CHCs, nor has smoking generally. Likewise, dietary causes of disease have not been picked up in any high profile way. There has been a tendency to leave the question of food to the London Food Commission which is looking at the health aspects in context with economic and commercial aspects.

Annual Report

The first Annual Report (1984) includes an introduction by the Chairperson, a report by the Policy and -Planning Committee, a report by the Research Committee, a list of some issues facing Londoners, and contributions from individual CHCs in the London metropolitan area.

The Chairperson's introduction gives some background to the development of GLACHC and lists some of the major concerns, these being a perceived lack of accountability within the NHS with the establishment of general managers at district and regional level, the "relentless application of the RAWP dogma to London's services" and some other more positive matters.

The report of the Policy and Planning Committee describes some of the work which GLACHC has done over the previous year. Most interesting is an action list provided by the Director of MIND, advising CHCs about what they might do in tackling mental health services.

The report of the Research Committee is- mainly an account of housekeeping and of the broad research strategies.

The contributions by individual CHCs describe the main concerns and activities over the preceding 12 -months (see Appendix •••)•

GLACHC Research Protocol

I also have a copy of the research protocol guiding the· GLACHC research.

It gives a useful background to the development of GLACHC and an interesting account of some of the methodological and conceptual issues in relation to such research. The research. project focuses on the needs of the elderly, but is very much designed with a view to the likely impact of the cuts in public expenditure in London (associated with the implementation of RAWP), and the kind of services which should be developed to meet more effectively and equitably the needs of the local population.

At this stage the research program is mainly one of data collection. Options for further development are presented.

A Patient Satisfaction Questionnaire

Andy Thompson gave me a copy of the very extensive tick box questionnaire which· he had used when he was working with the Manchester CHCs (see above text).

ISLINGTON COMMUNITY HEALTH COUNCIL

Islington Community Health Council is housed in a almost unmarked building which is set well back on a block used by a local community health centre (see photographs). It is clearly not one of the shopfront CHCs.

I spoke with Angela Greatly, who has been with the CHC since its inception, and with Roy Gopaul, who is the assistant seeretary.

Angela began by emphasising some aspects of the original development of CHCs. I should recognise that CHCs began as a "sop" to local communities following a reduction in democratic control associated with the 1974 reorganisation. At this time the responsibiliUes of hospital management committees were transferred to the District Management Team and the role of the Local Authority in personal health services (community dental services, school nursing, immunisation, district nursing, health visiting) were transferred to the District Management Team also. Environmental health services remained with the Local Authority. As a result there were a lot of HMC members without a job. Some of these would have joined the newly created area health authorities but the establishment of CHCs provided another opportunity for their being given alternative involvement. Likewise there was a perception of personal/community health services being transferred from a locally accountable structure (the Local Authority) to the bottom tier of a centralised bureaucracy. The CHC served a compensatory, stablising function in providing for the "patient's voice" in this situation. Thus a lot of CHCs had members who were ex of the health committee of the Local Authority, ex of the hospital management committees and a few local activists.

It is interesting to reflect on the contradiction between the consensus philosophy expressed in the DMT and the adversary philosophy expressed in the notion of the CHC as the "patient's voice".

More recently, with the implementation of Griffiths' recommedations and the introduction of the general management function at the district level and the establishment of an authority structure at the district level the confusion between the roles and responsibilities of DHA members has grown. This is particularly so in view of the tight managerial control exercised from DHSS to region through to district management, bypassing to a considerable extent the membership of the District Health Authority. There is confusion now about the roles of the DHA and the CHC.

Angela commented on the backroom style of the Islington Community Health Council. She indicated that the CHC is located in this office not by choice but because it was available. However, if given a choice, she still would not have chosen the High Street shopfront model. She regards it as advantageous to be less involved in counselling. She comments that perhaps the DHA should be running the shopfront premises for purposes of patient education and health education. This would be a position that I would strongly support".

Angela was quite discouraged about the influence and power of CHCs. In her view they suffer through not having a more definite power base, no leverage. She commented on the statutory power of the CHC to hold up hospital closures but indicated that this can be bypassed through the use of "temporary closures" and is subject to appal to the Minister.

Angela was not very clear about the more specific meanings of her reference to the CHC not having 'leverage'. In one sense I think she was being pessimistic, implying that any single institutional structures could have successfully held up the massive resource shifts which are presently being implemented. In part she may be underestimating the real influence that CHCs have had both in relation to the mainstream resource issues and in respect of a variety of smaller special purpose projects. However, notwithstanding these factors I think we should listen carefully to Angela's expressions of disappointment and ask why the promises and expectations of the CHCs have not been realised. What is it that she is referring to with her references to CHCs having no niche and no leverage? I do not think that the answer lies in having greater formal executive or statutory powers. I suspect that the answers have more to do with the quality of the grass roots linkages between the CHC and various groups which make up that local community, the activjty of the "systematic listening capacity", the activity of the CHC in terms of grass roots community education about health and health care. I draw attention in this context to the inadequate educational support available to CHC members, staff and supporters and the poor quality of available statistics.

Roy Gopaul reinforced Angela's comments. In his words the CHCs were an afterthought; "squaring the circle of elites in the NHS". He suggests that there was not nearly enough thought about what CHCs were supposed to do before they were set up.

We talked about CHC staff, what should we be looking for. Clearly the two main elements should be community development skills and health expertise. Roy wonders whether we could actively seek community health nurses as having the expertise and the orientation we need and just needing some community development training.

Annual Reports

Islington Community Health Council has over the last several years adopted a most interesting way of presenting its annual reports, namely, on the back of a large (400 x 600 mm) poster. The annual reports themselves make good reading. The graphics on the other side convey a useful message in each case, as well as being decorative.

I don't know why, but the Islington Community Health Council does not avail itself of its statutory right to request answers to questions or issues in its annual report from the DHA.

Newsletters

The CHC produces a one-page brief newsletter prior to each publicly opened meeting of the CHC with a brief comment on local and current issues and agenda items. Some of the issues covered in the newsletters that I have picked up are comments on changes in management structure within the NHS, cuts to ambulance services, adequacy of cervical cytology screening, changes to prescription charges and the DHA strategy plan.

Minutes of CHC Meetings

I have a collection of minutes from recent meetings. These give a useful feel as to the p'rocess of CHC business.

Leaflets, Pamphlets and Posters

What is the CHC? A one-page slip describing the CHC and inviting people to enter their names upon the mailing list for the monthly newsletter.

A Simple Guide to Using Your Health Services. An eight-page small pamphlet about the range of services available in and around the Islington area.

The Purpose of the National Health Service, a large promotional poster.

It's Your Health _Service, a handbook to help older people use the National Health Service in Islington and Hornsby. A 24-page large type account of matters of concern to older people and services relevant to their concerns.

First Impressions of the NHS. A brief report by a couple of senior high school students about local services.

Having a Baby in Islington. A glossy leaflet about services, issues and choices, produced by the CHC.

Abortion in Islington and Hornsby. A less glossy leaflet about abortion services - questions, choices, etc.

A report of a meeting on the Islington Well Woman Service.

A report of a special meeting held to mark the 10-year anniversary of this service, giving an account of the work of the service and its achievements.

WESTON CHC

I met Edgar Evans in Bath on a rainy day in very crowded circumstances outside the Bath Abbey. We went out on a pleasant pub lunch. I later visited Weston CHC (see photographs).

Weston is in the Bristol/Weston District of the NHS with 400,000 people in a strongly tory constituency. It is unique in that it has two Community Health Councils in one District. Weston CHC is based on Weston Supermere and its surroundings. Weston Supermere is a busy seaside resort (see pictures) with a population of 60,000 and another 60,000 in the surrounding district.

Among the projects which Weston CHC has conducted Edgar mentioned particularly the Mastectomy Group and Counselling Service, the Well Women's Clinic set up in association with the Family Planning Association, exhibitions of ADL appliances and a conference to consider the recommedations of the Warnock Committee (see attached papers).

Weston has a shopfront presence in the town of Weston Supermere. This town is in fact the only large town in the area and the only large shopping centre. The CHC has about 80 drop-ins per week.

The CHC has one meeting per month but it rotates the venue around the 11 parishes of the CHC area. The parish councils are invited to attend. The chairman of the parish is given due recognition and a guest speaker may be invited. Part of the procedure will include a "speak out" from the floor. Edgar claims that his CHC has a very high profile in the area.

Another major strategy used by the Weston CHC is high profile press publicity. Edgar is an ex-journalist, he was Public Relations Officer with Cadburys. He has been with this CHC since its establishment.

We talked about the career structure of CHC secretaries and Edgar expressed some resentment at his perceived exclusion from a career in line management with the NHS, or other voluntary agencies for that matter.

We talked about the educational support provided for CHC secretaries. Generally speaking there has been very little guidance, although Edgar did refer to an early course of lectures which had been set up to educate the CHC secretaries about what the Government had in mind when it set the CHCs up.

We went on to talk about the original purpose of the CHCs. Edgar referred to the role of hospital committees of management pre 1974 and the continuity which the CHCs provided in this respect. However he regarded it as a major breakthrough to have a structure which provides public opportunities to ask awkward questions about health services management.

We then talked about the membership of the Weston CHC.

> Mrs N is the Labour member of one of the County Boroughs. She has been active in the Elderly and Physical Disability Working Party.
>
> Mr R G E is a manager of a Weston based, church concern, Weston Care.

Councillor H is a local farmer, the Tory leader of one of the parish councils.

Ms_; H is the owner of a residential home for the elderly (? a special accomodation house), nominated by the voluntary organisations group.

Mr Rds is a nursing home owner. He is a representative of the Church and Civic Society.

Mrs Rf is a housewife and part time worker at Bristol University. She is the CHC observer at the Family Practitioner Committee.

Mr S is a representative of Rotary and owns a residential home for the elderly. He and the other private enterprise representatives on the CHC have been very useful in responding to criticisms of private enterprise nursing home care by organising a working .group to put together a code of practice and encouraging the local operators to adhere to that code.

Mrs T is a representative of one of the county boroughs. She is the new chairperson of the CHC. She is a liberal Tory.

Mrs O, who is a leading light in the maternal and ehild care working party, is a retired NHS nursing officer. She used to be the night supervisor at the Weston General Hospital. She is a voluntary organisations nominee.

Mrs D, SRN, is a multiple sclerosis sufferer, secretary of the Family Planning Association and chairperson of the Weston Well Women's Group.

Mrs J N, SRN, is a representative of the Women's Institute and runs a mother and babies class.

Mr P is a nominee of one of the County Boroughs. We think he is a Liberal. He works for Southwest Gas, is a local Commissioner for St. Johns Ambulance and a leader of the Primary Care Working Party within the CHC.

Mrs P G is an NHS employee who works in the stores area (not in this district). She is the Trade Union representative nominated by the Regional Health Authority.

Mrs F is a hotelier, a representative of the County Borough and a Tory. She is a member of the Primary Care Working Party.

Mr L is a Labour nominee of another County Borough. He is a training. officer with British Telecom and a member of the Primary Care Working Party.

Councillor P is a Tory representative of another County Borough.

Mrs W_ is a representative of the Citizens Advice Bureau.

Mr R W E is a farmer. He is nominated by the Weston Society for Mental Handicap.

Mrs L is an independent.

Mrs McK is another housewife nominated by one of the local authorities, a parent of a mentally handicapped child.

Mrs T, as chairperson over the last 12 months, has spent up to one and a half days per week on CHC work. Mrs N, as vice chairperson, spends in excess of one day per week on CHC work.

The CHC has a first class relationship with Local Authorities. The CHC provides guidance to all the Local Authorities in respect to health matters. They look to the CHC for advice in responding to consultative documents.

The CHC has a representative at the Family Practitioner Committee meetings. The attitude of the FPC has been a bit distant, a bit formal; perhaps because of the role of the CHC secretary as 'patients' friend' at complaints hearings. (The CHC secretary may advise the complainant but is not allowed to speak at complaints hearings.)

Edgar is reluctant to comment on the impact of the new general management function as it has only been operating for about six months. So far the CHC has a good relationship with the District Manager as it does have with hospital management.

Edgar attends DHA meetings regularly. He observes that newly appointed members come quite quickly to identify with the service for which they are responsible, comparable to company directors. The CHCs play the role of patients' advocate in policy and in individual instances. Edgar believes that all the CHC members (notwithstanding their politics) identify themselves with the patient, see themselves as patient advocates.

We explored in more detail some of the key achievements of the Weston CHC.

Edgar mentioned the building of a new hospital, the Weston General Hospital, which will open in April 1986 with 250 beds. In 1982, when the area tier was removed and it was proposed that Weston would lose separate district status, 3000 people marched through Weston Supermere demanding a new hospital. They were compensated for their loss of district status by retaining their CHC and by getting their new hospital. I would not underestimate Edgar Evans' skills as a publicist in this and other episodes.

Edgar cites the development of the obstetrics service in Weston as another key achievement. Despite the trend towards centralisation of obstetric services, a trend pushed by the Royal College, an obstetric service will be established in the General Hospital. Local people believe that a 25 mile journey to Bristol is too much.

Another fight has concerned the administrative structuring of the new Weston/Bristol District. It was initially thought that this might be on a program basis but the Weston people have pushed very strongly for Weston as such to be a separate unit with its own unit manager and hence a mini district. This objective was strongly pushed by the CHC but they had an alliance with the local doctors

because such an arrangement would give the local doctors a say in management and more chance of a role in the. local hospital.

Edgar estimates that up to 30% of the population of the area would know of the existence of the CHC. He agrees that this wciuld be far in excess of the novel situation with respect to other CHCs. He points out .that it is a coherent community with 12 parishes and one town only and relatively small with only 130,000 people. However, he does get an average of 40 column inches per week in the local press compared to the Bristol" CHC which is lucky to get 10 column inches.

On the general question of press coverage, Edgar commented on the attitude adopted by the CHCs to the Wendy Savage controversy (see p 9 above). Out of 150 topics discussed .at the ACHCEW conference, the one which was picked up and highlighted by the Health and Social Services Journal was the Wendy Savage issue. In Edgar's view this was unfortunate. It wiU be viewed by the Minister as interfering with the prerogatives of management and with the internal affairs of the Royal College. This is the way it is· seen by the Weston CHC.

On the question of quality assurance, Edgar commented that local management sees standards as being a high priority but the public has generally a good view of NHS standards and no readiness to ask critical questions. Most patients are very ready to accept whatever the consultant says and are willing to accept the conditions in their hospitals.

On the complaints function, Edgar indicated that he handles this fairly close to the chest. He generally doesn't discuss it at CHC meetings but takes individual instances to the DMT (or more recently the District General Manager) at liaison meetings. If he wants to highlight a trend, as opposed with an individual case, he will set up one of his members to ask a question of the District General Manager. Edgar sees himself as being the leader of his CHC and in his view it is better to handle complaints this way.

Edgar made some comments on the appointment procedures. The local authority representatives tend to be the least well informed but the best at using meeting procedures. They may sometimes inhibit the representatives of the voluntary organisations with their use of procedural tactics. Nonetheless they do appreciate the role of the CHC in providing expert health advice to council deliberations.

On the question of education of CHC members Edgar mentioned seminars which are held twice per annum (organised by the secretary/chairpersons' group) and members are encouraged to go to other more specialised seminars. Nevertheless it may take a new member up to two years to start to differentiate between the various broad sectors in which the CHC is ·involved, social security, social services, housing, health_, etc.

On the question of information and statistics, Edgar commented that the members already complain about being given excessive amounts of paper. They receive the Health Services Bulletin from the DHA, extracts from relevant policy documents, special statistics reports, annual reports of region and district and· comparative indicators. The members are particularly interested in waiting list statistics.

Annual Report

I have a copy of the 10th Annual Report (1983/4), which features on the front cover "Weston CHC's Proudest Moment", the visit by Princess Anne to open an exhibition on aged daily living, sponsored by the Weston CHC.

The Annual Report is very informative about the membership and operations of the CHC and the issues which the CHC has directed its attention to over the last 12 months.

The comments made by the Weston CHC are much more politely expressed than those of London CHCs, although they draw attention to some quite important issues and make some very useful suggestions:

There is a section in the Annual Report entitled "Points for consideration and recommendations from our Annual Report" which takes advantage of the statutory right of the CHC to have a health authority response to its concerns.

Reports

Caring for the Carers, report of a special conference organised by the CHC in March 1984 and focusing on identifying the needs of family members and volunteer community members who are involved in various ways in assisting sick people or frail aged. or disabled people. The delegates included people from voluntary sector organisations (Men Cap, MIND, Association for the Blind, etc), a variety of CHC members, representatives of local authority, social service departments-, nursing staff from various local hospitals, people from private nursing homes, people from various social service groups. Undoubtedly some people could criticise the thrust of this conference as being in conformity with the cost cutting within the NHS in that it focuses attention on the family members and the voluntary sector. On the other hand, the needs of health professionals who work within the community and of relatives and friends are real and there are some interesting and helpful discussions of these sort of problems. The report itself is an edited version of the transcript. It is not clear whether specific action flowed from the conference.

Report of Seminar on Warnock Committee on Human Fertilisation and Embrology, - the verbatim report of the proceedings of a seminar organised by the CHC (November 1984} to discuss the ethical and social issues associated with reproductive technology. Following its public meetings and further deliberation in response to the Warnock Report, the CHC has made a submission to the Committee of Inquiry into Human Fertilisatiqn and Embryology, making some points about access to parenthood, destruction of embryos, surrogate motherhood, sex education, rights of children and the problems of childless couples.

EXETER DHA AND CHC

The Exeter (District) Health Authority·

Exeter is a rural district encompassing Exeter town itself with arciund' 100,000 people, seven market towns between five and 15,000 and four seaside/holiday resorts. Exeter returns Tory MPs to Westminster although I was informed they're often quite independent Torys. The Local Authorities are a mixed bag politically.

David King is the District General Manager. He used to be District Administrator. The units which have been adopted for sub district administration include a community unit, a district. general hospital unit, a mental handicap unit and a mental health unit. It is intended that as the large institutions are closed the mental handicap unit and the mental health unit will be absorbed into the community unit.

I spoke with Reg Harding who is a Planning Officer in the District Health Authority.

Reg commented on the good links between the District and the CHC and the active and constructive role of the CHC in ·this District. He described the care with which senior officers of the District Management Group look at the annual report of the CHC and prepare a detailed reply which is also published. There is little in their report which would fall into the category of 'carping'. The CHC has prod1,1_G,ed several useful reports, most recently the one on the management .of brain damaged people. The DHA found this report very useful. The CHC has been very supportive of the strategy of locality planning as implemented by the District. The current chair of the DHA is an ex-chair of the CHC. The immediate past chair of the CHC has joined the DHA.

Reg described the planning process as taking place in two streams, the formal and the locality streams.

The formal planning process is ·based on the strategy document, which covers a ten year projection and is revised every five years. It is significant in terms of its being the basis for local and central consultation. In addition the annual program (which used to be referred to as the operating plan) projects developments for the next two financial years.

Reg comments that planning used to be based on DHSS guidelines and college norms relating different types of facility or health resource to population ratios or utilisation rates to population ratios. In recent years, the DHSS has emphasised the local autonomy of the district in respect to this sort of program planning, although it has exercised tighter control with respect to resource use. It has focused on certain programmatic areas but primarily because of their resource implications.

In recent years Exeter DHA has moved away from the 1970s progammatic planning based on the districts planning teams (DPTs) and is moving towards locality based planning, initially nine localities but now working with 11 localities· plus Exeter city. Groups of up to 25 people have been formed as local consumer representatives. plus local professionals meeting to discuss necessary developments in each locality. The process is administered through the Community Services

Unit. The Community Unit Administrator goes along with the Chief Nurse to each meeting. CHC representatives go along to most of these meetings also. At locality group meetings the questions asked include 'what are your problems'? Many of the problems can be 'solved locally once they are identified. Some problems are due to poor co-ordination between the different arms of the NHS, the Local Authority, the District Health Authority, the region, the FPC. Michael Court (the deputy District General Manager), who had just joined us, commented that this locality planning is an important activity of the region. It is important that it be seen as relatively informal and involving local groups.

The old programmatic model based on district planning teams "didn't seem very real" particularly in **view** of the way in which it was constrained by norms and standards. The perception is that the District has worked for ten years on a "top down approach" involving norms, guidelines, standards, etc. Now Exeter is moving towards tighter, more centralised controls.

We talked for a while about the ministerial reviews and the regional reviews and the way in which these focus on prior,ity areas only and the prominence of performance indicators in these reviews. Much less emphasis is placed on consumer feedback in the context of these centralised **reviews.**

Reg commented that the Exeter Health Authority is seen as having made some useful achievements and that these are attributed to the locality planning system. He comments that the locality planning may of course be another manifestation of unusually good management (in the form of Michael Court and David King) rather than the only cause of the good achievements. As achievements he cited the de-institutionalisation of mental handicap and mental health and active involvement in patient education and health education.

I asked about the attitude of the DHA to issues of quality assurance and about its involvement in such issues. It has conducted one survey only, which was a survey of quality with respect to obstetric services. The report was shelved because it was unpopular with the doctors and nothing has been done since.

Reg Harding's final message is the importance of adequate leadership in making the locality planning groups work.

The following day, after having spoken with Tony Day at the CHC, I met with David King who had not been available on my first day in Exeter.

David King confirmed the high degree of medical autonomy which is structured into the NHS. The consultants' contracts are held at the regional level. The Family Practitioners Committee which operates at what used to be called the area level reports directly to DHSS. The FPC used to be purely a conduit for funding but it is likely that part of the present Governments' strategy will be to require increased accountability and possibly increasing planning functions from the FPC.

David King talked about the planning process which has been undertaken in relation to the care of the elderly: He described a situation where representatives of the Oist♦ict Health Authority have to sit down and negotiate with the consultants and with the family practitioners in putting together a coherent district plan.

It is worth emphasising the democratic and representative nature of family. practitioner representation on the FPC and of consultant representa_tion at the

level of the District Consultants' Group as compared to the top down appointment process whereby other management personnel are appointed.

David King talked about the region/district review process. Previously there had been some loose definition of objectives and no indicators. More recently, indicators have been tightened up but one wonders how effectively one can plan without adequate resources. In the recent round of region to district reviews it was clear that the RHA was very constrained by the parameters set by the DHSS in the DHA to region reviews. David King emphasised the way in which targets based on performance indicators have now joined the more familiar RAWP targets in setting the framework within which district and region are expected to plan.

I was impressed with the Health Education Unit, which is prominent in the foyer of the District Health Authority office and which I was told is very active in patient education as well as more general preventative health education. The Unit has a multi tape telephone service (like that of the College of Health) and. has started to put together a library of videos for patient education. The initial titles will be 'psoriasis' and 'home cytotoxics'.

The Exeter Community Health Council

I met with Tony Day at the office of the Exeter Community Health Council (see pictures).

I commenced by commenting on the reputation of the Exeter Community Health Council as working closely with the Exeter DHC. Tony Day pointed out that he has been criticised by some of the other CHCs as having been co-opted. Nevertheless he argued that the Exeter CHC tries to act as the public conscience of the Health Authority, to monitor it, to constructively criticise and to provide an idependent voice. The fact that the Authority is working well means there is less need to criticise.

Tony cited two reasons why the CHC has good relations with the DHA. One is that health services in Exeter are generally good and the problems of central London do not have any local counterpats. Secondly, David King is in fact committed to public accountability and responsiveness as distinct from more widespread attitudes amongst district health authorities.

David King comes to meetings whenever possible (more than half of the meetings) and expresses a personal and positive interest in responding to complaints, questions arising from hospital visits and issues raised in the annual reports. He ensures that substantive answers are developed and has publicly stated his belief that the CHC plays an important role.

He has also provided some "backdoor" financial support (eg, not billing for cleaning or photocopying).

The locality planning strategies demonstrate the commitment of the Exeter Health Authority to being in touch with the community feelings. I asked whether CHC might see the locality planning activities as moving into the CHCs area of work. Tony Day states that in fact both have moved in parallel. The CHC has established four mini CHCs and where parallel structures are working this reinforces the locality planning work. There are two types of locality planning; one which involves lay people and the other which involves only the local service

providers. Where the locality planning groups do not include lay people the CHC has set up a "health forum" which is made up entirely of lay people and works parallel to the planning team.

The members of the CHC were very nervous of the initial health forums, worried about what might happen if they provided a different point of view, worried that the DHA might go directly to the health forums and bypass the CHC. For the first health forum the CHC appointed the chairperson (a regular CHC member). However at the second health forum a non CHC member was elected chairperson and this happened at the third and fourth forums. The health forums as described by Tony Day appear to come very close to the systematic listening capacity which we have talked about in relation to District Health Councils.

There is a quarterly discussion between DHA and CHC representatives and David King attends if he is available. This meeting focuses on complaints and an anonymous summary of 1311 complaints received is circulated. Against each complaint is a note of how it was handled. The trends come out very clearly in this quarterly review. Three complaints about the same issue constitutes a very firm trend.

The formal complaints process is in fact quite intimidating. The patient is required to complain about some breach in the doctor's terms of service and to go through a complex bureaucratic process including an intimidating hearing.

The doctors are still the untouchables of the NHS. The general public attitude is one of great respect. Tony commented that the NHS is seen by many people as being some kind of charity, something to be grateful for. The doctors service within the NHS is likewise seen as something to be greatful for. Recurrent allegations about scroungers and imposters (especially in relation to the social security system) rubs off on the health side and there is a fairly widely prevailing feeling of guilt associated with bothering the very busy doctors in the NHS. If this speculation corresponds to reality the introduction of a nationalised health scheme has served to reinforce medical autonomy rather than to enhance accountability.

I asked about the links between the CHC and the community physician. This has not been very productive in Exeter although the CMO occasionally attends meetings. Perhaps it depends upon the quality and enthusiasm of the community physician.

I asked about systematic listening capacity and the scope for using the CHC to educate the public about health policy and health service matters. Tony Day regards the main value of the CHC as being in expressing the gut reaction of consumers, not necessarily informed gut reaction. In this context he cites the role of the CHC in fighting for the retention of GP obstetrics without being very conscious of the technical aspects of the arguments. The CHC plays an important role in articulating the values and attitudes of the man in the street tempered by a general understanding of the structure of NHS.

Although Tony discounted the importance of the CHC becoming technically informed, one of the projects which he regards as an achievement of the CHC, the head injury survey, did in fact involve the members of the CHC becoming well informed about this technical area.

Tany Day described the project which eventually led to the locality planning system. It commenced three years ago looking at medical services in rural areas.

It was initially an attempt to obtain the views of local consumers and providers about needs. The CHC went to the parish councils with a questionnaire covering access, identified problems, local initiatives, etc, and asking whether they would like a speaker at the parish council or at the annual parish meeting. About 46 meetings were held with CHC representatives and people were invited to speak out and air their views at each meeting. There were between half a dozen and a dozen councillors and up to 50 to 60 members of the public. The 'speak out' brought forward first and second hand experiences, a few complaints, a few specific problems and several patterns and trends. It is this rural project which eventually evolved into the present notion of locality planning as conducted by the Health Authority. It has attracted considerable attention nationally (particularly among the pharmacists to whom it gave a opportunity for involvement).

Another project was the brain damage study. Members of the CHC came on visits to facilities where people with brain damage were being cared for and commented on drafts prepared by the staff. Their enthusiasm was critical to the success of the study.

We talked about career advancement for CHC secretaries and again the point was made (by Tony) that there are no opportunities for career advancement within this hierarchy and there are real dangers of burnout. At a time of unemployment there is a risk that people who have lost enthusiasm will remain in their jobs, slow down and become quite unimaginative but not resign. On the other hand, Tany Day would agree that CHC secretaryship should not necessarily be a step in a career path within health services management. Howevet he would suggest that sideways movements should be facilitated, ie, to other CHCs. He refers to one colleague who is now into his third CHC.

RUGBY CHC

Rugby is the smallest health district in the UK (89,000). It was created in 1982 out of what had been a three district Area, the Warwickshire Area.

I spoke with Tony Pitts in his second floor (very much backroom) office (see picture). Tony Pitts is an ex-radiographer who subsequently worked as an executive with General Electric before becoming CHC secretary. He is also a keen rugby official and fan. I spoke with him mainly because of his role as secretary of the Community Health Councils of Secretaries Society.

Tony Pitts indicated that Rugby does a lot of the usual things that CHCs do, patient advice and assistance, etc, but its main focus has been in the planning area, struggling to get more resources for Rugby and district, indeed fighting in 1982 to ensure that Rugby remained as a specific district. It is intriguing that in 1982 almost all the CHC members were appointed to the DHA.

We talked about options for the employment of CHC secretaries. At the moment they are RHA employees, outposted to service in the CHC. By analogy could we talk about appointing the DHC staff to the central DHC Unit or to the regional office and then outpost them? In making appointments of CHC secretaries, the RHA plays the role of advisor with veto power but the majority on the appointment committee is always made up of CHC members. There are usually observers from the CHC Secretaries Society or from the personnel branch of neighbouring regions.

Tony talked about the staff morale and the isolation of CHC secretaries as being serious problems.

Tony's **view** is that the salary grading of CHC secretaries is far too low. I indicated the sort of level that we had been thinking of and he felt that it was also too low.

Tony Pitts talked about the way in which CHC membership had changed over the decades since 1974. The initial make up of the CHC (he generalised) included:

ex-servicemen, especially ex RAF (10-15%),

pre-retirement health service administrators (25%),

genteel do gooders, eg. the divorced vicar (10-15%),

radical activists (30%),

various health professionals (10%).

In contrast, the present pattern (he estimates) is as follows:

early career health administrators (less than 10%)

genteel do-gooders (5%),

various health professionals (10%),

post research academics, eg. PhD, MA, medical sociologists (25%),

radical activists (50%).

This last category 'radical activists' is quite heterogeneous. It includes people who have a main focus on reforming health care; it includes some people who are more political than health; it includes some people with a disadvantaged group's focus.

Tony reviewed for me some salient features of the development of the NHS, its various reorganisations, the changing boundaries and hierarchies and the evolving relationship with Local Government.

COMBINED MANCHESTER CHCs

At the suggestion of Tony Smythe (of ACHCEW), I visited Manchester with a view to meeting Nick Harris. Tony had indicated that three CHCs shared the same office in Manchester and had combined to share overheads and share the work. He mentioned Nick Harris of the Central Manchester CHC particularly as being "plugged" into a lot of political and trade union networks. Amongst the achievements which Tony cited were involving the Chinese community in thinking about health care, setting up an AIDS counselling service, looking at the problems of teenage boys' sexuality, and a Huntingtons Chorea Gro_up.

I met Nick Harris at the end of a long day and he was clearly a bit exhausted. I did not get a very full interview with him and I only recorded a few scattered pearls.

Nick Harris strongly supports CHC membership being less than or equal to eight years (two· full year terms).

On the question of career structures he commented that he is very aware personally that there will be no jobs in the NHS for people like he who, as part of their work with the CHC, attract considerable media coverage and often in quite a critical role.

I suggested that providing generous conditions for further in-service training for CHC secretaries might be a reasonable compensation. He agreed with that.

He identified as a major need for CHCs assistance with research design and grant applications. He didn't really indicate how that should be provided.

WEST LAMBETH CHC

I met Sue Thorne at the West Lambeth Community Health Council. I had been advised to seek an appointment with her at the time I visited the Department of Community Medicine at St. Thomas' Hospital. Sue used to work at that Department and for a long time she was Walter Holland's golden haired girl. They had a subsequent falling out over her "bleeding heart" tendencies impairing her hard nosed objectivity. The main issue was the fight over the closure of the Lambeth General Hospital, which from the St. Thomas' point of view was not such a bad thing if it took the pressure for resource stripping away from St Thomas'. She subsequently became the initial Secretary of the West Lambeth CHC.

I commenced my interview with Sue by asking about the systematic listening capacity and the accountability of the CHCs. She recalled that early in its career the CHC had lacked credibility because of its lack of links to local people, a lack of accountability to local people. Responding to this problem, the CHC determined certain "constituencies of interest" and sought deliberately to make contact with representatives of those constituencies. Thus, in relation to mental handicap the CHC sought the views of clients appearance. In relation to major initiatives in hospital development (or closure) the CHC sought to identify the catchment area and give precedence to the views of people living in that catchment area.

In 1975 the proposal to close the Lambeth Hospital was announced. This is a 500 bed hospital which traces its origins back to a work house infirmary, subsequently a county hospital. The proposal included the construction of a thousand units of staff accomservices and facilities provided at that time by the Lambeth Hospital would be integrated in the St. Thomas' complex.

The CHC organised interviews with local residents on the housing estates, play groups, old people's groups, etc. Local people were happy for the "high technology services" to go to St. Thomas' but there was a strong preference expressed for a local hospital to remain. The old Lambeth Hospital had been seen as a friendly place convenient and accessible. Staff were seen as very informal, quite different from the high pressure at the big teaching hospital. Local people said that if the hospital was to be razed there were other needs apart from nurses' housing, people's housing, an old persons' home, a new local smaller hospital or facilities for mentally handicapped people which should also be taken into consideration.

Concurrently a debate was going on more generally about the possible role of community hospitals versus centralised teaching hospitals. The CHC investigated the community hospital concept, visited and video taped a community hospital in the country and showed the video tape locally. It was warmly received and a campaign was developed based on proposals put forward by local people.

Ultimately the new "community hospital" was built and I was taken around it by a very proud Sue Thorne. It is architecturally very attractive and provides a very nice environment for low level impatient care. It is 20 to 30 beds, something of a mixture between a community health centre and a nursing home.

Sue referred to the CHC secretary as being something of a broker between local people and bureaucrats, educating both sides about the views and perspectives of the other. Accordingly, one risks being attacked by both sides.

In respect of educational support for CHC secretaries, Sue mentioned a counselling and bereavement course which she had taken found very helpful in a very broad range of ways in her role as CHC Secretary. She told me a story about a minor tension that she had had with the CHC members over a period of time which perhaps underlines the importance of good administrative training for CHC secretaries also. It appears that it was Sue's custom to produce very detailed minutes after CHC meetings, giving a ball by ball account of the debate. Some of her members felt that briefer minutes were desirable, but in her view it was necessary to show the less confident participants that they had in fact participated. She did not seem very impressed with the notion that people like. brief minutes so they can read them quickly.

Training for CHC secretaries is officially the responsibility of the RHA, through their personnel departments, but such training programs as they have produced have tended to be boring and inadequate. In this region the CHC secretaries got together, reviewed their own needs and resources and planned to meet two monthly with a business session in the morning, a lunch together and an afternoon spent on a topic led by one of their own or an outside speaker.

Again the question of burnout arose and Sue emphasised the importance of training in group skills so that CHC secretaries don't take everything too much to heart. She also mentioned adequate time off for CHC secretaries.

Sue commented that the program produced by Chris Ham from the Centre for Advanced Urban Studies in Bristol was a good program but quite expensive. Sometimes the CHCs have used the Kings Fund College to run their own seminars.

In the Lambeth area the Local Authority has established neighbourhood councils on a very small local area basis which. meet regularly, usually with borough councillors in attendance. Sue feels that these neighbourhood councils should be part of the CHC constituency as well as feeding up to the borough. In addition "local advisory groups" have been established to provide a forum for regular meetings between staff of local clinics and local users. These tend to be six weekly meetings discussing what is going on, and what plans are developing. Comparable meetings are proposed for all local facilities.

The lack of a career structure for CHC secretaries was again seen as a problem. It might well be appropriate that CHC secretaries do not have a career structure but some form of compensation should be provided for. Sue believes that generous opportunities for further vocational training, eg, after five years in the job, would be an appropriate compensation.

One of the problems of CHCs is the lack of adequate specification of their objectives and goals. Many CHC members don't quite know what they are doing. She urges that we specify broad goals but push CHCs to adopt priorities and strategies. Perhaps some kind of accountability and review process.

Sue was involved in discussions when CHCs were initially being established. She recalls attending a seminar at the London School of Economics (LSE) also attended by Brian Abel Smith. Another attender was a Father Birelli, a priest who had been working with urchins in Naples. She recalls Father Birelli listening to Brian Abel Smith and saying to him "You are giving the people a lollypop to suck:. Brian Abel Smith appears to have agreed and said, "Well, what should we do?". The point she was making was that 15 years ago "consumerism" was not very well understood.

On the question of complaints Sue has tended to bypass the official complaints procedure and go straight to the consultants. She believes that a straight approach very often leads to a quick resolution without the unpleasantness which can be associated with the formal complaints procedure.

1.2 INTERVIEWS WITH VARIOUS COMMENTATORS

TONY SMYTHE AT ACHCEW

I spoke with Tony Smythe on several occasions, first at the ACHCEW Conference in Nottingham and subsequently in his office in London.

Tony gave me a very broad briefing covering individual CHCs and covering many of the issues of relevance to the continued development of the CHC Program, including the relationship between the CHCs, the NHS and the DHSS.

I also took the opportunity whilst at ACHCEW to browse through their library and to follow up some specific matters concerning the history of the CHC Program.

Most of the facts and insights that I picked up at ACHCEW are documented elsewhere in this Report (although not always attributed).

HELEN ROSENTHAL AT LCHR

Helen is a member of the CHCHC and I visited her in her office at the London Community Health Resource (68 Chalton Street, London NWI, 01-3880241), a few days after the meeting I had attended.

She commented on the different styles adopted by CHCs in opposing the central London cuts. Brent CHC has organised picketing, disruption of meetings and is generally regarded as being quite beyond the pale. City and Hackney CHC has supported the Hackney Health Emergency Campaign but at arms length. Its ambivalence in this respect is because it is also committed to other projects which need DHA co-operation such as equal employment oportunities.

Helen commented that the CHC critique may be more sophisticated than some of the "outside" community activists are willing to accept. Does this represent a failure to educate their grass roots or a lack of resources or a lack of commitment by members? The tendency to appoint to the CHCs people who are already expert in health issues through their involvement in one group or in another or through their professional work means that the CHC membership is on the same side as the providers with respect to knowledge and perhaps less sensitive to the need to educate their grass roots constituency then we have been assuming in our planning for DHCs. This may be a matter of accountability as well as an issue of community education.

RUDOLPH KLEIN

I visited Professor Klein in his deparment at Bath University. He is an intelligent and insightful albeit conservative academic who has been watching the NHS and the CHCs for a long time.

He started by asking me to describe the DHC proposal. He commented that if DHCs are designed as a means of achieving "democracy" or "participation", envisaging these states as being "ends in themselves" then he would be extremely sceptical. Notions of democracy and participation have featured highly in rhetoric regarding CHCs but, in Klein's view, if you evaluate their achievements against those objectives you would have to be quite depressed. His depression is no less intense in relation to the democratic and participatory achievements of the members of the District Health Authorities and Area Health Authorities and Regional Health Authoriti_es.

I responded by clarifying the proposed role of DHCs in terms of being part of a strategy to reshape the inherited power structures with a view to helping the health system to adapt to change more smoothly and more appropriately. I indicated that the kind of restructuring we were envisaging in relation to the balance of power was tied to the implementation of certain specific policy directions (e.g. more effective primary prevention, redistribution of resources toward the "cinderella services", more accountability in clinical decision making). I pointed out the emphasis that we have been placing on representing the consumer interest and recruiting members from previously relatively excluded groups in the context of this strategy. Klein was more willing to accept the possibility of success in relation to DHCs as he came to appreciate that their introduction relates to certain specific policy objectives in respect of the health service and that the proposed arrangements correspond to those objectives.

However, when I outlined the proposed electoral college ideas he was again sceptical, arguing that on the basis of the CHC experience all that really mattered was having a good chairman and a secretary. I initially defended the DHC proposed model in terms of accountability to a local consumer/relatively disadvantaged constituency. Klein was not impressed. However, on further consideration I think that more fundamental reasons for the kind of electoral college structure we have envisaged relate not so much to any diffuse notions of accountability as such as to more specific questions of grass roots education and systematic listening. Since this talk with Klein I have come increasingly to identify the systematic listening capacity as a major source of DHC legitimacy, and the grass roots educational role as a major source of DHC power. These considerations underline again the importance of providing adequate information support and education support to the DHCs. They also illuminate some quite important differences between the CHCs as operating and the DHCs as we have envisaged them.

I was impressed with Klein's warning about getting too involved in more general concepts of democracy, participation and accountability rather than identifying the quite specific policy objective one is seeking to achieve and the structures and arrangements that will be necessary in order to achieve those objectives. These considerations recall some of the opposition expressed by Local Government during the DHCP Consultation.

One might comment that the democratic justification for the DHC Program stems ultimately from the constitutional basis of the State Government. We are not seeking to establish a competitive representative/democratic structure in competition with Local Government. We are establishing a means for sampling the experiences of a range of consumers and creating an educational network.

CHRIS HAM

Chris Ham is a political scientist at the Centre for Advanced Urban Studies at Bristol University. He used to work with Jack Hallas at Leeds.

While he was at Leeds he worked with Ruth Levitt in putting together what was at that stage the major training program for CHC members in the UK. They put together an induction course for members and secretaries and a handbook. They also ran workshops for the more experienced secretaries, seeking to address the problem of "burnout" which has occurred not infrequently. They have also run workshops for assistant CHC secretaries, a neglected group who are often extremely stressed. I'm not sure how many of these courses are current and how many have been run in the past.

Chris Ham emphasised the variety of opinion among CHCs with regard to their interpretation of their job, whether they see their role as being passive or more active.

Chris made some cautious comments on the make-up of the CHCs. Perhaps there are too many Local Authority members. Perhaps the voluntary sector representatives come from a relatively narrow social spectrum (noblesse oblige).

Chris explained that 1984 saw, for the first time, the appointment of voluntary representatives on the joint consultative committees (JCC) and with a view to electing these representatives, an electoral voting system encompassing the various voluntary sector groups had to be drawn up. This has led to some degree of formalisation of the election of voluntary sector representatives on CHCs also.

Training programs for DHA members are also quite inadequate, both in terms of preliminary induction training and refresher training.

The NHS Training Authority, which is also based in Bristol, is working with the Centre for Advanced Urban Studies on the development of video programs for training.

Chris Ham underlined very firmly the need for training and support of health authority members and chairpersons.

Chris Ham then went on to talk about some of the various initiatives presently happening within the NHS, initiatives which are recounted elsewhere in this report. These include the Korner Inquiry, accountablility reviews, the Yates comparative indicators, the DHSS performance indicators, the Work of Iden Wickings at Kings Fund College on clinical budgeting.

Wickings' work on clinical budgets has been taken over by DHSS under the heading of management budgeting and is being explored in four regions.

Chris Ham mentioned his interest in cultivating improved relationships between community physicians and CHCs. He described what happened in Oxfordshire where Nick Black (from the Open University) worked with the Oxfordshire CHC secretary and the community physician on a range of projects and training initiatives for CHC members. One project he mentioned was focused on perinatal mortality differences between two areas.

Chris also talked about the locality planning initiatives which had been explored in Exeter with close cooperation between the CHC and the local DHA. He cited David King as being a CHC supporter and talked about the "mini-CHCs" based on the parish organisational unit.

JACK HALLAS

I met Jack Hallas for a very relaxed morning's discussion at the Nuffield Centre for Health Services Research in Leeds.

Jack Hallas is an ex-administrator who became a policy analyst/academic after the 1974 reorganisation. He has been particularly interested in the work of the CHCs although he had very insightful comments in relation to the whole of the NHS.

He agrees that CHCs are not helped by having a shopfront presence. He supports the backroom office.

In relation to CHC secretaries, he lists as important qualities, a capacity for leadership and a capacity to work in isolation as well as the more obviously liaison/lobbying/publicising/clerical work.

We talked about the accountability review processes. In his view the DHSS/RHA review is working very well. He referred to a parallel review system which Victor Page is attempting to set up which runs parallel to the Ministerial/ Chairperson Review and involves the Chairman of the Management Board (that is Victor Page) with the RHA general manager. This latter model is only recently established and is still quite controversial.

At the next level down, the review between regional chairperson and district chairperson (supported by regional and district management teams) is patchy. The relation between the regional general manager and the district general manager is somewhat problematical. It is not a line management relationship although there is unspoken authority stemming from the superior role of the region with respect to the district. Most regional general managers hold monthly "liaison meetings" with district general managers for "briefing purposes".

The review between district general manager and unit management is in early days yet, too early to comment.

We talked about the increasing emphasis on performance indicators in the context of these reviews. Jack used the term "a do-it-yourself hanging kit" in relation to some of the objectives and targets which regions and districts have been manoeuvred into adopting. By promising undeliverables they are inviting future trouble.

The first set of PIs was not good but they clearly will be improved.

Jack gave me some background to the appointment of the Griffiths Review. Apparently the Parliamentary Public Accounts Committee had been very critical of a succession of Ministers for their lack of knowledge about labour force matters and expenditure. Following the Griffiths Review, Griffiths himself was appointed as a member of the Supervisory Board and more recently the Management Board has been established with Victor Page as the Chief Executive. Jack comments that it is believed that Victor Page is by no means the first choice for this job. Commenting on the very centralising tendencies in the current managerial environment Jack quoted Cliff Graeme (who is apparently a major actor, having been a member of the Griffiths enquiry as well as being Chairperson of the JGPI) as having said "we must centralise before we decentralise."

We talked about the FPCs. Jack commented that both David Owen and Barbara Castle (between 1974 and 1979) had been urged o grasp the FPC nettle but had not done so. Jack analysed the present situation in the following terms. As part of giving the FPCs statutory authority status, the Government's strategy will be to hold FPCs much more accountable for expenditure. I presume this means to give them global budgets and to make them responsible for meeting various Pls with respect to access to family practitioners' services in their territory. He predicts that the FPCs under this 'pressure will find alliances with CHCs quite useful.

Back on the question of the career structure for CHC secretaries, Jack emphasised the problems of isolation and stagnation and warns me particularly against thinking that I have visited typical CHC secretaries. It is quite common for their enthusiasm to become blunted and for them to become unmotivated. He wonders about short term contracts with reviews based on performance and/or a grading related to salaries. He strongly supports a generous educational supports system so that they can move to other jobs.

Jack emphasised that one can't guarantee getting the "right people" for the CHC secretaryship but he emphasises going through the right processes. These would include thinking very carefully about the duties and qualifications statements, involving the Regional Directors and the Chair of the DHC and members in the appointments panel involving the DHCC or Deputy and having outside assessors on the appointments panel; above all taking time to make the appointment. Listen to the referees, get the applicants to write something, check them out socially. I was not entirely clear what this last rather English. reference means. I think it means taking them out to lunch at a good restaraunt and checking their manners.

Jack suggested that I might have given more emphasis to the Scottish Local Health Councils in my study tour. Scotland has a much smaller population than England and it is much more dispersed for geographical reasons (mountains and lochs). The Scottish counterpart of the CHC is referred to as an LHC and these work with much smaller populations. The Scottish Home and Health Services Department is very centralised and it doesn't much like LHCs. Jack Hallas believes that LHCs are treated with a policy of "malignant neglect" as compared to England where they are treated with "benign neglect".

Scottish Local Health Councils

I spoke with Linda Hedland of the Association of Scottish Local Health Councils by telephone from Jack Hallas' office.

Of particular interest is the variety of geographical and federative arrangements.

In Glascow there are five LHCs covering different parts of. the city (one million people); in Edinborough there is one council for half a million people; in Dumphries/Galloway there are four councils which have some kind of federative relationship and in Borders there are "territorial sub units" which are centrally managed. The very dispersed model has a high administrative cost and Linda would urge against it, particularly if ove_rall resources are limited.

None of them operate with a shopfront presence.

MAUREEN DIXON

I spoke with Maureen Dixon, who is also at the Kings Fund Centre. She has studied Canadian District Health Councils over a long period of time and gave me some useful contacts and insights.

She was particularly interested to hear about the District Health Councils Program as we are conceiving it and commented on some aspects of the proposals as I outlined them.

She urged that we pay the executive officer the equivalent of twenty five thousand pounds UK.

She pointed out that if we proceed along the 'staged development' path towards an electoral college system we may need an extra staff person to handle the bureaucracy.

MARCIA FRY AND ROSEMARY MARINER AT DHSS

At the DHSS I spoke with Marcia Fry and Rosemary Mariner about CHCs and other matters.

They showed me some organisational charts indicating where their office fits in. Their group includes three policy officers plus a small support staff. Their responsibilities include community health councils, policy on hospital complaints procedures, patient confidentiality, euthanasia, etc. Clearly Community Health Councils is a very small part of Marcia Fry's work.

Rosemary Mariner deals with enqu1r1es and correspondence from regions, ACHCEW, authorities, CHCs, FPCs, etc.

This unit provides a buffer between the CHC and the DHSS. It hears appeals against regional decisions, eg. disqualification of an individual as a member. (The regulations provide for excluding people who have been dismissed from the NHS or who have served a prison sentence, etc).

Rosemary and Marcia commented on some of the dissatisfactions of CHC secretaries. For example, they often complain about feeling constrained in criticising their region because that is where their salary and appointment comes from. They sometimes complain that their consultation powers are inadequate.

I asked whether Rosemary and Marcia felt that the CHC should focus as much attention as they do on complaints handling and on being a source of information about health and health care. As an alternative I asked. perhaps whether they might put more work into local politics, eg, in relation to tobacco advertising. Marcia and Rosemary were shocked at the suggestion. They felt it was appropriate to keep the CHCs working on relatively safe matters because otherwise their continued existence would be jeopardised.

I asked whether perhaps CHCs might be encouraged to direct more attention to issues such as quality assurance. Rosemary and Marcia agreed that would be a good idea but felt it would be the death knell to the CHCs if they tried and therefore they should be discouraged from doing so.

My impression from Marcia and Rosemary was that to some extent they see their job as preserving the CHC Program by keeping CHCs ineffective and non controversial. Marcia and Rosemary would like to reduce the involvement of local authority representatives who tend to be political, vis-a-vis voluntary sector representatives.

We discussed further the current structure of Local Government and. the· evolution of that structure, particularly with respect to the relationship to the NHS.

·I.3 INTERVIEWS ABOUT OTHER ASPECTS OF NHS

LINDA DUFFIELD AT DHSS

I had arranged an appointment with Cliff Graham, who had been a member of the Griffiths Inquiry and is also Chairman of the Joint Group on Performance Indicators. Unfortunately he was not available, owing to a more •urgent engagement.

I was fortunate to have the opportunity of speaking with Linda Duffield, Principal Regional Liaison Officer with DHSS, responsible for liaison with the_ South West Thames Region.

Ms Duffield discussed the status of the CHC within the present political environment. She indicated that it had been judged politically difficult to dismantle CHCs at this time. The appointment of an authority structure at the district level has added some confusion owing to the overlap between the two, both with respect to representing the local community and with respect to feeding in a consumer view to planning.

Ms Duffield introduced me to the changes in planning strategies which have evolved within the NHS over the last few years.

We had a brief discussion of clinical budgeting/management budgeting. I queried whether the basic computer systems were in place at this stage, but she assured me that they are.

She introduced me to the principles and practice of the accountability review process.

IDEN WICKINGS AND CASPE

I had a valuable hour or so with Iden Wickings. Most of what he told me is covered in the material which I purchased from the CASPE Group.

He commented that there is no difficulty in controlling the total resource allocation to the NHS (as distinct from the USA), but ensuring its most efficient utilisation is a problem and it is to this problem that the PACT system is directed. PACT stands for Planning Agreements with Clinical Teams. In the case of MEGA PACT it refers to planning agreements at the divisional level.

Some of the technical problems still being looked at include the question of apportionment of costs and the handling of capital, the use of DRGs to quantify volume and profile of service provision, and changes in behaviour within the organisation. In relation to this latter point he cited the possible role of medical consultants in controlling nursing staff allocations (although in the material that I have since looked at, the nursing staff costs are not incorporated as variables within the PACT system). He indicated that he is not yet using DRG based measures of throughput but is working towards that.

In the long term he envisages the development of outcome measures such as the existing performance indicators both for research purposes and for feedback to management teams.

JOHN YATES

I rang John Yates at Birmingham to talk about the Interauthority Comparisons and Consultancy's Project.

He indicated that he encompasses 34 Specialties and 32 indicators with 200 possible screen formats on his system. There are 150 districts participating.

The information is not made public because the co-operation of the RHAs and DHAs is contingent upon confidentiality. However he believes that this will be loosened up in due course.

John sent a packet of samples and descriptive material which covers what he explained over the phone.

THE CHCs OF THE NHS:

ISSUES OF RELEVANCE TO THE DHC PROGRAM

The Planning Environment

The context within which Community Health Councils in the UK are operating has to be appreciated. With the decline in the British economy there has been a gradual nibbling away of the welfare state. The resources available to the NHS have been almost frozen with an average of 0.5% increase per annum in real terms in recent years.

The main policy objective from the National Government has been cost constraint, and this policy objective has been promoted through the use of RAWP targets and tighter management control.

Within this resource freeze, the emphasis on central planning and policy leadership has been reduced. Regional and district management have increased discretion with regard to the distribution of resources and local planning.

The use of RAWP as a central tool in reducing expenditure means that the planning environment in "RAWP over-resourced areas" is very different from that in "RAWP under-resourced areas".

In inner London, which on RAWP criteria appears to be significantly over-resourced, there is a constant pressure to reduce expenditure. However, since the "excess" resource levels take the form of teaching hospitals, the existing inadequate services in the chronic care and community care areas have to fight even more vigorously for relatively meagre resources just to provide a basic service. Thus, the teaching hospitals are fighting to survive and are looking for Community Health Council support. The CHCs seek to keep their teaching hospitals but to expand other services as well.

Outside the CHCs in Inner London there is a significant group of activists who are conscious of the proposals to reduce beds and are critical of the CHCs for what they see as cooption and halfheartedness in their opposition to cuts. Brent CHC stands out as the one CHC which has refused to be "coopted". It has "taken to the streets" in its opposition to all cuts. The other inner London CHCs have developed ambivalent relationships with management and with providers, with fluctuating alliances, sometimes with the teaching hospitals and sometimes with the chronic care and community health providers.

The inner London situation has no parallel in Victoria.

In the ."RAWP under-resourced regions" the situation is much more positive. These are regions which have a "right" to substantially increased resources and at a time when there is increasing devolution of managerial and planning discretion. This provides opportunities for creative planning and constructive alliances.

The different planning environments in which CHCs operate affect the way in which they .are seen, sometimes as antagonistic and sometimes in partnership.

Typical Planning Initiatives

I learned of interesting and creative planning initiatives which had involved CHCs at every CHC I visited.

Most CHCs appear to have been involved in discussions and planning regarding deinstitutionalisation-- programs with respect to intellectual disability and mental health services.

A lot of CHCs have given thought to community based antenatal care and ways in which such care can be provided so as to reach out to those in most need. The high level of interest from CHCs in the Wendy Savage affair must be seen against this background.

Several CHCs have been involved in planning for the establishment of hospice care and terminal support teams.

Several CHCs have assisted in the planning for and implementation of well women clinics, for family planning, cervical cytology, etc.

A mastectomy group, which also provides a counselling service, has been established in Weston Supermere with the active involvement of the Weston Community Health Council.

An infant loss support group has been established out of an initiative which started with the Greenwich Community Health Council.

A comprehensive study of the needs of brain damaged younger people was done by a group sponsored by the Exeter CHC, although with the involvement of other professionals as well.

An inner urban community hospital was established as an initiative of the West Lambeth Community Health Council.

The styles and strategies through which CHCs contribute to local planning activities and facilitate the input of local community groups vary.

In Rugby, a campaign sponsored by the CHC was successful in retaining the Rugby area as a separate district as an alternative to its being incorporated into a larger district.

A similar campaign was organised through the Weston CHC to ensure that the local area would be administered as a unit, subordinate to the local district rather than having programmatic units with corresponding less opportunity for local input into planning.

The locality based planning initiatives arising initially out of CHC activities and taken over by the Exeter CHC have attracted national attention as a model for locality based planning.

The West Lambeth Community Health Council in a quite different environment (inner urban) took a different approach to the identification of specific constituencies and to the forging of direct links between the CHC and those constituencies.

I formed the opinion that CHCs have in fact made a major impact in the planning area across a wide diversity of issues large and small and across the range of CHCs. One particular function that the CHCs perform is to get a particular issue or a set of needs on the agenda of more formal planning and management bodies, or to assist other advocates in doing so. By the time the planning process culminates in the opening of a new facility or service the original advocacy role of the CHC is often not acknowledged. I think that the planning role of CHCs has been widely under appreciated because of this fact.

Special Projects

From the experience of the CHCs it is clear that a capacity to mount special projects, be they surveys or feasibility studies, is very important. However, in most cases such projects should be undertaken in conjunction with local providers and perhaps local management. It should be recognised that CHCs are not designed to be technical research or planning bodies and that special projects often require technical input such as statistical or survey .expertise.

We should ensure that there is a capacity for the DHC to call upon research advice in a consultancy or other relationship. It should not be assumed that DHCs have research and survey skills.

If a special project is being planned, it is presumably with a view to some change in current practices. It would usually be desirable to involve providers in the project from the earliest time so that it is seen as a partnership activity; so that the results of the project are mutually owned. The alternative, of presenting the providers with a project at a relatively complete stage, may produce a defensive reaction.

Technical Quality of Care

Technical quality of care is not a high profile issue within the NHS. There is a survey and inspectorate function in relation to chronic care. Acute care services are assumed to be well looked after by the professionals.

Since issues related to technical quality of care are not talked about a great deal within the NHS, it is not surprising that they are almost unheard of amongst the CHCs.

Either the technical dimension of quality of care is uniformly excellent in the NHS or the professional monopoly of this issue remains intact and unchallenged. It may be that both are true to some extent.

If DHCs are to ask useful questions about quality of care they will need lots of support.

Style of Care

It is my impression that CHCs have made quite a significant impact with respect to style of care. Among the topics which have been studied or where projects had been mounted are outpatient waiting times, patient satisfaction, the need for female obstetricians, interpreters, nursing home care and a "personal clothes

system" in a chronic care hospital. It would seem important to involve providers in considering such issues from an early stage.

The NHS is large and has some conservative aspects. It may be that there are a lot of areas where there is considerable need to challenge the customary style of care.

Complaints

The complaints procedures within the NHS are complex, bureaucratised and intimidating. The CHCs have been structured into this process as the "patients' friend". Many CHCs (particularly those with a shopfront style of accommodation) spend a lot of time handling individual complaints.

It is not obvious that the detailed CHC involvement in the complaints procedure is necessary nor valuable. Owing to confidentiality requirements, it is one particular area of the secretary's work which is not generally shared with members and the role of a representative body is therefore a bit problematical. The role of the CHC as the "patients' friend" in the complaints procedures constantly emphasises an adversary element in the CHC relationship with providers and in doing so may sometimes impair communication and partnership.

Some secretaries informed me that they bypass the official complaints procedures. One secretary indicated that she normally goes direct to the consultant concerned. Another secretary goes direct to the district manager.

It may be better to have complaints handled through a separate structure, preferably non intimidating and as little bureaucratised as possible.

The desirability of separating complaints handling from DHCs does not mean that OHCs should not have access to trends and patterns in complaints. This is very valuable.

Prevention

Initiatives directed towards the prevention of ill health are not prominent in the work plans of most CHCs. Nevertheless, quite a few good projects have been developed around the topics of cervical cytology, community antenatal care and well women clinics.

Some CHCs appear to have been sidetracked into a heavy leaflet/pamphlet handling role. Although it may be reassuring for the staff to have such an obvious task, it might be better that it be done by the health education unit of the local health authority. If the provision of health education material is a main function of CHCs one can't help wondering about need for a representative membership.

Notwithstanding the controversy over the Black Report, I did not come across a great deal of creativity and energy in the implementation of a "community development approach to prevention". Some people talk about it but the main focus even there is still on access to services rather than conditions of health.

Few CHCs have picked up tobacco or diet as issues. For some it would be "too orthodox" (seen as victim blaming), for others it would be "too radical", but for most it would be too difficult.

I was referred to an initiative in Oxfordshire where the CHC has worked particularly closely with the district community physician. I was not able to visit this particular CHC but there seem obvious advantages which would flow from this sort of liaison.

Morale

In general the morale among members and staff of CHCs in the UK appears to be quite low. There is something of a "siege mentality"; most people believe that the Government would dispose of the CHCs if it could.

In this environment the role of the central support unit in DHSS is to keep the CHCs out of trouble. This is to some extent incompatible with providing dynamic leadership.

The CHC movement appears to be languishing to some extent. There is no clear policy leadership and no clear statement of purpose and goals. More recently, there has been uncertainty regarding the relative role of the CHC vis-a -is the DHA.

There is a widespread lack of appreciation of the very real achievements of the CHCs, despite inadequate information support and inadequate educational support.

A lot of CHC secretaries work in relative isolation and this is not good for their morale. The lack of a clear career structure is also a source of dissatisfaction among secretaries.

Resources

Many people suggested to me that the CHC program is under-resourced. The relatively low salary scale on which secretaries are paid was mentioned several times, particularly with comparison to the administrative high fliers with whom the CHC secretaries have to deal.

In my view, certain areas of the CHC program are quite under-resourced, in particular federative structures such as ACHCEW and GLACHC and information and educational support services.

However, allowing for the fact that one can always see more to do if one had more resources, I believe that on the basis of the CHC experience, the levels of funding and the salary scales which are proposed for the District Health Councils Program in Victoria are workable.

Lack of Clarity about Purpose and Objectives

It appears that the initial conception of CHCs (in 1972) was as a compensating or stabilising device at a time when opportunities for local input into health decision making were being reduced owing to the abolition of the hospital management committees and the transfer of community services from local government into the NHS. The membership arrangements with which the CHCs have operated date back to this time and reflect this original, quite pragmatic purpose. Insofar as the initial reason for conceiving the CHCs was to reduce criticism and to provide

an opportunity for displaced committee members to continue to participate, there was no real need to consider exactly what the CHCs were to do.

In 1974 the new Labor administration inherited the CHC proposal and adopted it quite willingly. There was obvious scope for using the CHCs as a countervailing force against the major bastions of power within the NHS. The Labor administration appears to have added an adversary flavour to the role of the CHCs, particularly in providing for very strong consultative rights with respect to hospital closures and other major planning initiatives. However, there was still some confusion about the purpose of the CHC program, the specific strategies that they should follow and more particularly, the kind of infrastructure support that they would need, in particular educational and information support.

The lack of a clear analysis of context and statement of purpose may be responsible for the lack of provision for adequate information services and adequate educational support. There has been not enough attention to the need for federative arrangements and a lack of central leadership with regard to policies and strategies. It may also be that the membership arrangements which were initially conceived could have been more carefully thought about.

The criticism that the basic purpose and goals of the CHC program had not been sufficiently clearly set out was one that I heard from several commentators.

Membership

As indicated above, the membership structure was originally determined to provide somewhere for displaced committee members and as a defence against the opposition of local government to the transfer of community health services.

Local government appointments. Local government appointments to CHCs are sometimes actual elected members who choose to be nominated to the CHC. Where this happens they often tend not to attend because of other duties. When local authority members do come they tend to be less well informed about the health issues but better able to determine the direction of the meeting because of their facility with meeting procedures. Often local authorities are represented by non elected people who are nominated by local government because of their expertise and interest in health. These tend to be quite valued members who are more likely to be regular attenders.

Perhaps, partly because of its part ownership of CHCs, local government generally tends to appreciate the role of the CHC as a source of considered advice about health matters.

The voluntary sector representatives on CHCs tend to be voluntary sector providers, indeed sometimes private sector providers. In these circumstances the CHC may be a useful planning forum but its role in representing community opinion is not fulfilled.

RHA appointees. The kind of people appointed by the region to the CHC varies widely. Often they have been "headhunted" by the CHC and recommended to the region.

The fact that CHC members are appointed by the regional health authority appears to reduce the pressure upon them to relate to community groups within their

constituency. Hence the very important functions of systematic listening and grass roots education are discounted.

One consequence of the arrangements through which CHC members are appointed is that they do in fact represent the values and perspectives of their different communities. The CHCs are quite heterogeneous in their attitudes and policies. This was particularly well illustrated in relation to the Wendy Savage affair. Some CHCs were violently in support and others were equally opposed.

Education of Members

Many people who are appointed as members to CHCs are already part of the health service and are able to pick up any extra knowledge that they need on the run. This diminishes the pressure for providing more substantial educational opportunities for CHC members. Those members who do not come already equipped with a general knowledge of health services have to learn, through a long apprenticeship.

Since educational support is not structured into the CHC program, those academic and other bodies which have sought to provide it (for example, the Nuffield Centre and the Bristol Centre) have had to charge. Accordingly, whether or not a CHC decides to send new members along for education will depend upon its priorities and resources. My conclusion in relation to the education of members and staff for DHCs is that this should be a protected budget item.

The different perceptions about the role which CHCs are expected to play allow for quite different emphases on educational need. One person with whom I spoke expressed the view that the role of CHCs is to express the community "gut reaction" and accordingly they don't need much technical information. If this is the case then one would not expect CHCs to make any significant impact on issues which have a technical component. One would not expect them to gain a higher degree of credibility in relation to the substance of the reports and advice. This issue emphasises the importance of a clear statement of the purpose of the program. The present lack of clarity about the overall purpose of the CHC program allows for a considerable diversity in the interpretation of the role of CHCs and hence the educational needs of members.

In fact, of course, the experience of serving on a CHC is highly educative in itself. Quite a few of the district authority members appointed over the last two or three years actually served an apprenticeship as members of CHCs.

Information Services

The quality of statistics and descriptive information available to CHC members appears quite patchy, depending upon the energy and talents of the CHC secretary amongst other things.

There appears to be little systematic attention given to the kind of data that CHCs need and to ensure that it is provided.

This again reflects the lack of clear statement of purpose, objectives and goals. If the purpose of CHCs is obscure then the kind of information which members would need is also obscure.

Information requirements of the DHC Program should flow from an understanding of the broad purpose of that Program.

The Education of Secretaries

Variable provision for the education of CHC secretaries has been made. Several courses were mounted in the mid '70s when the program started (particularly noteworthy is that from Nuffield in Leeds). However, if programs for the education of secretaries are not structured into the CHC program as a protected budget item then they have to be mounted by an external body and paid for by the CHCs. In this case they have to compete with other priorities of the CHCs.

Officially the education of secretaries is the responsibility of the personnel branch of the regional health authority. These officers might not be the most appropriate•.

CHC secretaries generally try and get together to organise their own programs and seminars but such voluntary programs are not fully satisfactory.

Burnout is a major problem for CHC secretaries, underlining the need for reassurance and support for CHC secretaries. One person with whom I spoke suggested that there is a high need for grciup skills and counselling skills in the CHC secretary task, particularly in order to counter the stress of isolation and the need to be a self starter. There are more obvious needs such as administrative training also. The lack of appropriate educational support to CHC secretaries is compounded by the lack of a clear career structure.

The lack of adequate provision for the education of CHC secretaries reflects the general lack of clarity about the purpose of the whole program. There being no clearly stated goals for the program, the pressure for adequate educational support is somewhat diffused as between different approaches to educational content which correspond to different ideas about what CHCs should do and how they should do it.

Career Structure for CHC Secretaries

This issue was mentioned to me repeatedly and is clearly of personal concern to many CHC secretaries.

That it is also a matter of concern to the program as a whole was mentioned to me by several commentators also. At a time of high unemployment, CHC secretaries whose morale slips but for whom there are no obvious career opportunit_ies tend to stay on, but the CHC degenerates.

Several CHC secretaries indicated that they would like to have the opportunity of moving into health service administration from the CHC. However, several of them saw their association with the CHC as being a barrier and a basis for discrimin.ation against them. On the other hand, I know of at least one district manager who used to be a CHC secretary.

It may be that it is the nature of this program that there are not many opportunities for career advancement within the program. Nevertheless, the problems of lack of career opportunity are real and have to be considered.

Perhaps the best approach would be to ensure a generous and ampie opportunity for in-service education for people while they are DHC executives (perhaps after three: years) so that they have further career opportunities arising therefrom.

There will, of course, be some career opportunities within· the DHC Program, particularly from executive officer to regional project officer and perhaps to special project officer on the staff of the DHCP coordinating unit. Some movement between these positions should be encouraged.

Federative Structures

One· of the more obvious weaknesses of the CHC program is the exclusive focus on the district as the level at which the "patient's voice" is to be expressed. Although it is obvious that many issues are determined at the area level (eg, the family practitioners' committee) or at the regional level (eg, policy regarding consultant contracts) or at the level of the DHSS in London, there was no prov1s1on made in the original design of the program for CHCs to work together at different levels of the hierarchy.

Where federative structures have been formed they have proved very useful but their formation has not been facilitated by the way in which the program has been designed.

In Manchester, three CHCs share a common office and share common resources. This has been associated with some problems but also with several advantages.

The national body, ACHCEW, originally had a grant but now depends entirely on subscriptions. One CHC has decided that, having regard to its other priorities, it cannot afford the 750 pound annual subscription to ACHCEW. The national body, which would otherwise be providing extensive information, policy and educational support, is under funded and limited in what it can do. The heterogeneity in terms of outlook amongst CHCs means that some members are quite happy to work in their own corner without any significant national or regional presence.

GLACHC (the Greater London Association of Community Health Councils)- was very late in getting· started, notwithstanding the obvious need for a London-wide "patients voice". In the end, it needed a grant from the Greater London Council to be established. This casts some doubt on its future since the Greater London Council is being abolished.

In addition to metropolitan-wide and national federative arrangements, there is sometimes a need for neighbourhood relations between CHCs. There is no obvious provision for resourcing such activities in the CHC ·program. as it presently is structured.

Implied in the above comments is the assumption that if all the resources for the DHC Program are committed to individual DHCs the parochial imperative will make hierarchical federative arrangements and ad hoe neighbourhood aggregates much more difficult to achieve.

Consultative Rights

One of the most impressive aspects of the CHC program are the consultative rights which are written into the regulations under which the CHCs operate. These consultative rights include:

the right of the CHC to be represented at DHA, RHA arid FPC meetings;

the right to receive responses to comments and questions;

the right of timely opportunity to comment about closures and major changes in use.

In addition some DHAs ensure that they are also represented at CHC meetings.

It may be that the firmly expressed consultative rights of the CHCs reflect the 1974 emphasis on their accountability role in the NHS.

Style of Premises

CHCs vary according to whether they operate from a shopfront or a backroom office. Generally the people associated with each style tend to advocate the style with which they are familiar.

The shop front lends itself to complaints handling, to counselling and to a health education function. It tends to focus the attention of the staff on a stream of individuals and to divert resources away from the groups and issues which don't walk in the front door. It keeps people busy, talking, helping and perhaps helps to maintain morale.

The backroom office model frees the staff from individual case pressure and allows time to close the office and go out and relate to community groups in their own environment. It allows time to consider broader issues, to devote adequate time to more difficult technical tasks. However, the backroom office also fosters isolation and if the pressure for doing these broader things is not there, it fosters boredom and low morale. Thus, the use of. the backroom office underlines the importance of attention to community development skills and drive from within the CHC itself.

My conclusion is that for the DHC Program we should go for the backroom model but we should build into it:

company, ie, share it with others,

motivation, and

support.

Systematic Listening Capacity

In the DHC Program proposals We have placed great emphasis on the value and legitimacy of the patient's experience as an input t? planning and on the need for

the consumer experience to be systematised and interpreted through informed sympathetic advocacy.

There does not appear to be any such emphasis in the CHC movement, although some CHCs have adopted a style of work which certainly expresses this approach.

The pluralism of the CHC program with respect to this important issue is another expression of the lack of clearly stated purpose and leadership in that program.

Grass Roots Educative Function

The role of CHCs in educating the local community about health and health services have not been greatly emphasised in that program. Their role has been much more frequently characterised as the "patient's voice". This again expresses some lack of clarity about the. objectives and purpose of the program.

Many members are in fact already part of the health system themselves and tend to focus "centrally" and "upwards" on the NHS (eg, planning projects, policy issues) rather than "downwards and outwards" in terms of educating local community.

On the other hand several CHCs which I visited have put a lot of emphasis on community links and on community education through such links.

The vigorous use of the press by at least one CHC that I visited raises some slightly., different issues in relation to a "grass roots educative function" because of the limits to the press's role in educating people.

Press Publicity

Because of the special skills of the CHC secretary, the Weston CHC has had a very high media profile.

Whilst there may be limits to the usefulness of the press in educating the public, it is an essential tool in creating and shaping the image of the CHC, which in turn is a critical determinant of the influence of the CHC.

Considerable thought needs to be given to techniques and style in achieving press coverage of the DHC Program and of individual DHCs. Attention should likewise be given to the kind of image to be promoted. For example, an image of "patients in partnership" would be much better than the more adversary implications of the "patient's voice".

Image

Clearly one should not seek to replace achievements by image. However, the image that 0HCs will_ achieve will be quite critical in determining their success.

Several of the CHCs that I visited cited a range of initiatives in which they had quite a seminal influence but for which they achieve no recognition. On the other hand, at least one other CHC that I visited regularly achieves considerable media coverage.

It may be helpful to consider image in relation to different constituencies. For example, it seems that local government sees the CHC as a useful source of advice, professionals within the NHS tend to see it as a threat because of its role in the complaints function and managers tend to see it generally as a nuisance but occasionally as a possible ally to be manipulated.

Conclusions

The special problems of inner London and the inner suburbs of the other large metropolitan areas do not have any parallel in Victoria. Various accounts of CHCs (including this one) should be read with that in mind.

The present review emphasises the importance of having a clear statement of purpose and goals for the DHC Program. The goals of individual DHCs must also be clearly stated.

There are significant differences between the CHCs of the NHS and the DHCs of Victoria. Nevertheless there are a lot of areas where the similarities are close enough to be worth working with.

Wherever possible, special projects, particularly in the planning field, should be mutually owned from the start, "planning in partnership".

If DHCs are to ask useful questions about quality of care they will need a lot of support.

In respect of style of care the DHCs have a major role potentially but we need to think carefully about how to lock the providers into a joint consideration of such issues from the earliest time.

Complaints. It is appropriate to keep DHCs at arms length from the complaints process.

Prevention. Prevention is not easy, particularly the "community development approach to prevention". A lot of thought will be needed. I believe we are correct to emphasise the role of the health education professionals in the handling of pamphlets and leaflets. These are not functions for DHCs, although there is considerable scope for a close relationship between DHCs and the pamphlet producers. There is likewise considerable potential for a close link between DHCs and a community physician role.

Appreciation. DHCs will need continued, repeated and appropriate recognition.

The resource levels which we are presently planning with are probably adequate as a first run. We should watch and review.

The proposed collegiate membership base makes sense, seen against the UK experience; although we cannot yet be confident that it is entirely practicable. It is worth proceeding with at this stage.

The education of members is very important and needs protected funding.

Information support to members is likewise important and likewise needs protected funding.

The education of the executive officer is of critical importance and needs a lot of thought. It is important in terms of the success of the DHC, in terms of the morale of the staff and in terms of the possible career opportunities for DHC staff. In view of its importance and the various uncertainties associated with the Program it might be best to start from a position whereby we develop a specially tailored educational program for each individual staff member of the Program.

The career structure issues are likewise of great importance. I believe their solution may lie in the question of educational opportunities.

The capacity for federative structures is of great importance and probably needs protected funding.

The consultative rights built into the CHC program are good and we can borrow fully from them and build upon them.

Style of premises. I would favour a backroom style, provided we can ensure that the DHC staff have access to colleagues in a similar line of work and with the proviso that we should ensure a lot of support from above and from below and keep an eye on the kind of motivational context in which DHC staff are working.

Systematic listening. The importance of systematic listening is emphasised by everything I learned in the UK. There are a lot of ways of doing it (not just EHC). It must be subject to a lot of discussion so a lot of people become more familiar with the idea and the creativity of people at the workface can be mobilised in developing new ways of carrying out this function.

The grass roots educative function is likewise of great importance and again there are a lot of different ways of doing it. We should encourage discussion about this function.

Press. The press coverage of DHC activities will be critical. We will need to think carefully about the issues which we would wish to have covered in the press and those issues which would be better communicated through other channels. We need to think about the different constituencies with which the DHC will relate and the image that we wish to project with each constituency.

CURRENT MANAGEMENT INITIATIVES WITHIN THE NHS

Preamble

The observations to be presented in this paper were picked up during a three week tour of England, designed primarily to look at the work of Community Health Councils. Nevertheless current managerial initiatives are relevant. On the one hand they provide part of the context in which CHCs are operating; on the other, there are lessons regarding health administration in Victoria to be gleaned from a careful review of overseas activities.

History

It is useful to review some key dates in the development of the NHS.

In 1834, with the reform of the Poor Law, the workhouses were obliged to establish infirmaries for the treatment of the sick paupers. Within a short time the pressure for admission from outside the workhouses by sick people who were also poor led to the development of a series of poor house hospitals. Under the strict control of the guardians, the medical superintendents of these hospitals developed a reputation for being primarily concerned with controlling costs and accordingly being restrictive with respect to admissions and being mean with respect to payments to local doctors providing services to patients in poor law hospitals.

In 1929 with the Local Government Act the poor law hospitals were brought under the control of Local Government. In 1948 with the establishment of the NHS were brought into the National Health Service.

In 1911 Lloyd George introduced National Insurance after having been very impressed with Bismarck's system in Germany. The significance of this occasion, in terms of present structures, was the establishment of insurance committees to take over the job of paying the doctors their capitation fees for the panel of patients that they looked after. Prior to 1911 general practitioners received their capitation payment from the local lodge or friendly society or trade union body. With the reforms of 1911 the general practitioner gained more of a say in the control of this system. The insurance committees were continued on after 1948 as executive councils and then after 1974 as family practitioners' committees, which were made statutory autonomous bodies in 1982.

In 1939 under the pressure of World War 2 the Emergency Medical Service was established. This pulled together in a single national health service all the voluntary hospitals and local government hospitals and private practitioners. It undoubtedly laid the groundwork both in terms of expectations and administrative links for the NHS. 1948 saw the formal establishment of the NHS.

In 1966 the Working Group which produced the first of the Cogwheel Reports was appointed. These reports were to do with the organisational structure of medical services within hospitals and recommended a strong divisional structure encompassing and overseeing the work of "teams". In the first Cogwheel Report it was suggested that the chairman of divisions should be appointed by the hospital authorities but this proposition was rejected in the consultation which followed and in the second Cogwheel Report (1972) it was agreed that successful divisional structures could be established with elected chairmen of divisions.

The chairmen of divisions were to come together in the Medical Executive Committee which after 1974 appointed a member to the District Management Team.

The significance of Cogwheel in the context of the present account is that it reflects the strength of the medical profession in preserving its autonomy, its basic democratic processes, notwithstanding the hierarchical structure of the National Health Service.

The continued independence of the consultants through the democracy of Cogwheel divisions, associated with the withering of professional medical administration after the NHS had been established, have led to a situation which the present Government is trying to reverse. (The Griffith's Report of 1984 strongly recommends the development of new structures through which doctors can be more involved in managerial decisions and more accountable for such involvement.)

During the period 1984 to 1974 the NHS had a firm "tripartite" structure: a hospital service, a family practitioner service and a local government sector through which personal health services at the community level and environmental health services were provided.

The hospital service was based on 15 regional hospital boards; these did not encompass the teaching hospitals which had 36 separate teaching hospital boards. Under the aegis of the 15 regional hospital boards there were 400 hospital management committees which were responsible for supervising hospital services. Both the voluntary hospitals and the local government (ex poor law) hospitals were encompassed within the hospital management committees (excluding the teaching hospitals)".

The second main arm of the service were the family practitioner services (including general medical practice, dentistry, optometry and pharmacy) which were supervised by 138 executive councils. The continuity with the insurance committees of 1911 has been mentioned.

In addition there were 148 local authorities which, whilst they no longer managed what had been their hospitals, still supervised ambulances, home help, midwives and health visitors, as well as environmental hygiene.

In 1974 the personal health services, which had up until that time been administered through local government, were brought into the NHS, at the district level. The 400 hospital management committees were replaced by 90 area health authorities supervising both hospital and community health services.

The area health authorities corresponded geographically to the local government structures which had been established in the local government, reorganisation of 1975. (These were the county, outside the metropolitan areas and the large metropolitan districts.)

In the reorganised NHS. (post 1974) the 90 areas were further subdivided into 206 districts. Districts did not have an authority but had district management teams, including administrator, treasurer, nurse, medical officer, with the participation of the family practitioners and the consultants. The district management teams were supposed to operate on a consensus basis; there was no formal management hierarchy.

The 1974 reorganisation was not regarded as a great success and a Royal Commission into the NHS was established in 1976. The new Tory Government (of 1979) accepted broadly the findings of the Royal Commission and released in 1981 the "Patients First" document, indicating how it proposed to reorganise the NHS again.

In 1982 the second reorganisation took place. This saw the abolition of the area level within the hierarchy. Under the new structure, authority was transmitted through the DHSS to 14 regional health authorities to 192 district health authorities which controlled hospital and community health services in the district. The 1984 reorganisation strengthened the statutory autonomy of the family practitioners' committees, of which there were 90, operating at what had been the level of area, broadly speaking, the area of the county or metropolitan district. Again it is worth noting that whilst some members of the FPC are appointed by the district health authorities, the medical members are elected from their peers.

An issue which has surfaced every time the NHS has been restructured is whether the consultants' contracts should be held at the level of the district health authority or, as at present, at the level of the region.

In 1984 the Griffiths Report was published. This report recommended a stronger line of managerial authority and accountability through the establishment of general managers (as opposed to the previous consensus teams) at both regional health authority and district health authority levels. In addition, Griffiths gave support to the continued development of accountability reviews and to the development of management budgeting.

Fiscal Context

Before proceeding too far during an examination of the NHS within the UK it is worth appreciating that Britain spends a relatively small amount of money on its health services.

In US dollar terms the United Kingdom spends a little more than Italy, under half of Australia's expenditure and less than a quarter of Swedish per capita expenditure on health services.

Recent and Current Managerial Initiatives

Trying to develop any kind of comprehensive understanding of so complex a system during a three week study tour directed at something else is optimistic, to say the least. Nevertheless, some features of the managerial environment are worth commenting upon (at the risk of some clumsiness or inaccuracy). These include:

The Health Advisory Service (1969)
The NHS Planning System (1976)
RAWP (1976)
The Health Service Information Review (Korner, 1980)
Annual Accountability Reviews (1982)
Performance Indicators (1982)
General Managers (1984)
Management Budgets (1984).

The Health Adviso.ry Service is mentioned mainly to point out that it does not represent the mainstream of administrative activity at this time. The Health Advisory Service was set up following the scandal at the Ely Hospital, reinforced by several subsequent scandals associated with long stay hospitals. Initially the Service provided a visiting advisory service inspectorate which looked at intellectual disability services, mental health, aged care and children in care. A separate structure was subsequently established to 'focus on intellectual disability services. Similar structures have at no stage been established to look at acute care services. The concern for accountability with regard to quality of service which was expressed in setting up the Health Advisory Service is not a leading feature of present rhetoric.

Another area of NHS rhetoric which has waned in recent years is the central role in policy development and planning. In 1976 a complex planning system was promulgated involving central guidelines being handed down the hierarchy from DHSS to region to area to district, and operational and longer term strategic plans being drafted and submitted and approved upwards. The central guidelines generally took the form of norms relating the disposition of health service resources to populations of various types and establishing norms for. service prov1s1on in some areas. At the district level a series of district planning teams were established to put together program proposals which addressed local needs within the framework established by the norms and guidelines provided from above.

The Resource Allocation Working Party (RAWP), which reported in 1976, provided a per capita based formula for the distribution of recurrent and capital funds from the national government to the regional health authorities. Over the period since then RAWP targets have been established for every region and progressively, in the annual distribution of funds, the various regions have been brought closer to their RAWP targets.

Some regions have suffered quite badly over this time. The four Thames regions, based on London, are shown by the RAWP formula as being substantially 'above target'. Over the period 1977/8 to 1982/3 the Thames regions' real growth has been restricted to a total of between three and seven percent. This compares with corrected growth rates of up to 20% over thie time for some of the previously 'under-resourced' regions.

A matter of high controversy is the applicability of the RAWP, per capita formul, to resource allocation decisions below the region, between districts. Several. of the Thames regions, under intense pressure from the National Government to move closer to their RAWP targets are using the RAWP formula to reduce ex.penditure in the Inner London districts. A substantive critique of the use of RAWP at this level has been mounted. Some of the factors which have been highlighted include:

- the relevance of standard mortality ratios as indicators of need, particularly for outpatient services,
- the adequacy of the correcting factors for teaching hospitals,
- the high day population of London and the very high cross district flow.

There are few commentators who defend the use of RAWP for allocations between districts but the pressure to reduce expenditure in Inner London is such that it is being used nonetheless.

The Korner Review of NHS Information was established following the report of a committee of three regional health authority chairpersons which was invited by the Minister (1978) to review aspects of NHS administration. A major criticism which they came, up with concerned the quality of information services. Korner has produced, a series of reports focusing on minimum data sets which should be available to the district office and, in an attenuated form, available to the region and national government. The Korner Review is a long-term endeavour since it envisages actually changing the collection forms and processing systems. The enthusiasm for Korner at DHSS is waning as the expense of substantially improving the information systems becomes more evident.

One of the most dramatic innovations introduced under the current Tory Government is the introduction of annual accountability reviews. These started in 1982 in the form of Ministerial reviews with regional chairpersons but have been extended to include regional chairpersons' reviews with district chairpersons and in due course is likely to extend to district chairpersons' reviews with unit general managers. ('Unit' refers to the administrative level below the district. This could be the district general hospital itself or could be programmatically defined, such as mental health services within the district, or could be geographically defined, such as a particular area within the district.)

For the purposes of the first accountability review between the Minister and Northern Region, a series of performance indicators were put together to provide a common data base for that review. Each year since then DHSS has published a book of performance indicators, more recently a floppy disc accessible through microcomputers (see below).

The work of DHSS in producing performance indicators has borrowed heavily from the work of John Yates and his team at the Health Services Management Centre in Birmingham. For some years Yates has provided to district and regional authorities, on a consultancy basis, reports in the form of inter authority comparisons which he refers to as indicators (rather than performance indicators).

Yates' initial work focused on mental health and mental disability services but he has extended it more recently to acute care services. The clients of Yates' system buy a BBC microcomputer with a Torch program package and receive, on an annual basis, a floppy disc containing district and regional information. The program provides for colour graphics and clear display on the basis of scattergrams and histograms and other graphical presentations of the series of indicators.

DHSS established a Joint Group on Performance Indicators (JGPI) in July 1983 which has recently reported (January 1985) and has suggested a relatively small number of PIs covering acute care, children's services, aged care, estate management, manpower, mental handicap and support services. It is likely that the recommendations (of the JGPI) will form the basis of performance indicators in NHS until Korner recommendations are implemented and the quality of information available is improved.

It is worth noting that there is considerable debate about some of the implications of the new emphasis on performance indicators. It appears that the main thrust from above down is going to be directed to expenditure control and PIs will be used to pinpoint areas for pressuring recalcitrant authorities. The priorities adopted by under-resourced authorities in adopting development plans of their own are unlikely to be as stringently monitored from the centre as the PIs which reflect possible areas for cost cutting in the "over-resourced" areas.

The spreading down the hierarchy of this combination of annual reviews based on RAWP targets and PIs provides some basis for concern at the lower echelons with respect to quality of service and access to service.

The PIs which have been adopted. focus mainly on throughput; measures of current service activity and to a lesser extent, of resource levels. They reveal very little about prevailing needs, the degree to which needs are being met and the degree to which high priority needs are being met ahead of lower priority needs. They also provide very little information about the quality of service. Of some concern is the- rhetoric which is repeated from several levels and which identifies these input and throughput measures as being output measures. The identification of PIs as being output measures appears to express the assumption of senior management that its responsibility ends with the provision of a certain number of bed days or units of service.

As the focus on performance indicators as a method of demanding service cuts to achieve cost controls percolates down the hierarchy and comes closer to the direct service interface, there is increasing pressure both on the managers from above and those responding from below to look for comparable indicators of need and of quality of service to provide some kind of defence against the cost oriented pressures from above. Three separate responses to this problem are evident.

At the central level there would appear to be a studied indifference to the possibility that the PIs being developed either reflect need or quality of service. The rhetoric of devolution of responsibility would appear to underwrite such indifference. (In reality, the acceptance of continued medical control at the service level reflects an assumption that, judgement of need and of quality can be and should be left in the hands of the doctors, as it has been for so long·.)

A second contending theme postulates that it is possible to develop a set of PIs which reflect need and quality of care. This school of thought acknowledges that the existing PIs measure throughput rather than output but starts to talk about health status indices, quality adjusted life years, disability/distress quotients, etc, with a view to "balancing" the existing range of PIs. The Office of Health Economics has sponsored several initiatives along this track. This school of thought has not gone unchallenged. Klein, Yates and Hallas are all respected commentators who have in one way and another cast scepticism towards the notion that subjective aspects of the health care interaction can be properly quantified.

The third school of thought would agree that need and quality are hard (often impossible) to quantify and that attention should therefore be drawn to the structures and procedures which control decisions about access and which determine the pattern of care.

The saga of the Black Report (Inequalities in Health) illustrates the political sensitivity associated with the issues of need and access to services. Sir Douglas Black and his team were appointed in 1977 to examine the gap in health standards between social classes and bring forward recommendations. The Report was handed to the subsequent Government in April 1980. Only 260 duplicated copies of the typescript were distributed and it is clear that the Government would have been quite happy for the Report to have been buried. ·The Report has since been published as a Pelican and is widely available. The Black Report demonstrates that the social class gradient in mortality and in disability and morbidity is as marked as it ever was. Age specific mortaHty, from infancy to old age, shows a gradient which favours social class ·one and expressed a marked disadvantage with

respect to social class six. This gradient is evident in relation to most of the major causes of death. More significant are figures from Black which show that the gradient itself has increased. When expressed as the ratio of mortality rates of social classes three, four and five as a proportion of the mortality of social classes one and two, the differential mortality has actually increased. Whilst the Black Report identified the inequalities in health it is not clear that any single group knows what to do about it. The Government officials would prefer it went away. Black and his colleagues recommended considerable expenditure which in the present climate seems unlikely. Many liberal commentators are "wringing their hands". The NHS itself as a health service organisation has not addressed itself to the problems raised by the Black Report.

Another major initiative associated with the 1984 Griffiths Report is the introduction of a general management function at the level of region and district and in due course at the level of "unit". Most general managers at the regional and district level have now been appointed but it is a little early to comment on the experience following their appointment. It seems likely that much tighter control from above down and accountability from below up (particularly with respect to cost factors) will be facilitated by the appointment of general managers.

Another initiative which was endorsed by Griffiths is the introduction of management budgets (clinical budgets) into units within the health service. The lead work with respect to clinical budgeting has been done by the CASPE group led by Dr Iden Wickings. The system being promulgated and tested by CASPE Research is referred to as the PACTS system (Planning Agreements among Clinical Teams). The PACT system follows a fairly conventional approach to clinical budgeting and will play an important role in the development of "management budgets" in the NHS.

I have reservations about the degree of development of this system. I am not sure that the information systems in the NHS are ready to carry the kind of load associated with this effective clinical budgeting. In several of the hospitals where it has been tried out a considerable effort has been expended manually in collecting data from one area (even on a sampling basis) and carrying it to the research computer where it gets entered manually in order to produce the budget reports. I am not aware of hospitals where clinical budgeting has been established on a single, integrated, automated information system. I also have reservations with respect to the handling of staff as a constant rather than as a variable. In view of the predominance of staff costs I am not sure how much impact clinical budgeting can make it if focuses only on drugs, tests and bandages.

Clearly both of these reservations might be explained by the status of the PACTS system as a research project. Presumably, if DHSS itself has decided that a more effective and more thorough implementation of clinical budgeting was to take place then they would ensure an integrated and automated information system was established and the accounting conventions would allow for the recognition of staff time as a variable.

Conclusions

The overall context in which current initiatives in the NHS must be viewed is set by the decline of British industry and the associated unemployment and falling living standards.

Increasing pressures for reduced Government expenditure and the nibbling away of the welfare state come at a time of increasing poverty and increasing health needs.

There are some conflicting themes to be discerned among the various Government responses to this situation.

The Labour Government of the late 1970s sought to achieve equity in the distribution of the diminishing cake. It introduced RAWP with a view to improved geographical equity and more formal planning arrangements against centrally promulgated guidelines in order to promote a programmatic redistribution towards the "Cinderella" areas.

The reforms of the Conservatives of the early '80s have established much tighter central control over resource use by region and by district, whilst allowing greater flexibility at the local level with regard to how the diminishing resources are used.

In **view** of the continued dominance of the medical profession in clinical and service development decisions, the discretion available to district and unit management actually reflects an acceptance of medical definitions of relative need and service priorities.

In keeping with the general polarisation of British society, private sector health care is expanding rapidly to provide for those who wish to buy out of the deprivations and delays of the NHS.

There are some minor themes which are quite positive, including creative local planning initiatives and some of the discussion around the Black Report. Generally, however, it is hard not to be gloomy about present trends in the NHS.

2. **ONTARIO**

2.1 ONTARIO MINISTRY OF HEALTH:

DISTRICT HEALTH COUNCILS PROGRAM

Charles Bigenwald is the Director of the District Health Councils Program in Ontario, Canada.

As Director of the DHC program he has a major planning role as well as supporting the district health councils. Within his Toronto office the Director of the Program has six area planning coordinators who liaise between the various district health councils and the Ministry of Health and who, in their own right, take a significant role in planning.

I arrived in Toronto at a time when the Torys had been thrown out of Provincial Government for the first time in 40 years. The people I spoke with, both in the district heealth councils and at the Ministry, were all a bit uncertain as to what the SDP would do with the DHCP.

Charles started by talking about the setting up process, basing his comments on the Toronto experience but directing them to the Victorian situation. He says don't force DHCs. In several instances the Ministry of Health has held back and waited until it was approached by groups in an area or town which are concerned about particular health needs or the need for better coordination. The Ministry then says to them, had you heard of district health councils; they say yes, and the Ministry says well, why don't you ask the Minister to set up a steering committee. The steering committee is established and given responsibility for a geographical district. It includes "consumers" as well as providers and local government The steering committee holds several meetings and discusses the need for a DHC and holds a public meeting. They then make a recommendation to the Minister which, if positive, is followed by the Ministry setting out a DHC. The Area Planning Coordinator will go out and help with the practical aspects. Typically, the first focus of the new DHC will be to carry out what was the original project, either using their newly appointed staff or asking for a special projects grant. (The Ministry has $750,000 per annum in special projects money. Grants range between $5000 and $100,000.)

The statutory base for the DHC program is quite general (see attached papers). They are not incorporated bodies but are "Class 3 Agencies". Their staff are not civil servants. The staff are employed "off the street", generally a health administrator or health professional; for example the assistant director of a hospital might work for five years with the DHC and then go back to the hospitals.

Some hospitals and some doctors still view DHCs with slight susp1c10n. The big hospitals still relate directly to Parliament; although around the province, many hospitals have understood that it is in their interest to get DHC support in the priorisation process. Very few projects get funded if they are not supported by the DHC. A hospital which was confident of getting its project funded even without DHC support might still choose to go down the DHC path because the issue would be bounced back to the DHC anyway, with a resultant delay.

Very few projects get funded which are not supported by the DHC. Approximately 40% of DHC recommedations are acted upon prom.ptly. Forty-per

cent are approved and are being worked up. Fifteen per cent have been referred for further consideration.

Charles indicated that a lot of the DHCs get frustrated by delays at the Ministry in processing their recommendations. What they sometimes don't appreciate is that the Ministry often does not have the policy capacity to appreciate, and hence judge yes or no in relation to some of the more technical proposals they might bring forward.

Initially set up the DHC. Then do the sector specific study, whatever were the initial problems. Then allow five to ten years for maturation of the DHC. During this period the DHC gains credibility among the providers, develops sophistication in the handling of hospitals and other agencies and technical sophistication in conducting detailed planning.

The reproduction of the DHC, replacing retiring members, starts with the "nominating committee", a committee of the DHC which includes two current members, one ex-chairperson and one outside person, perhaps an academic or a public health person and this group advertises for and interviews possible new members.

The Ontario DHCs have primarily a planning brief. In a more general paper (see attached) I outline the historical background of the establishment of the DHCs. Mustard recommended DHCs and Regional Health Services Management Boards (superseding agency boards of management!)• The latter did not proceed and, in our terms, the Ontario DHCs carry out the planning functions of what we would call our regional office. In some ways the closest Victorian analogy is the Sector Board or the Regional Health Services Council, such as the Barwon Region Health Services Council, although with considerably increased staff.

I asked Charles and Donald Walker about the relative balance as between advice and advocacy. They indicated that most Ministers, particularly one recently, have reacted strongly against DHCs taking upon themselves an advocacy role. The Minister's position has been that these are structures designed to advise him directly and it is untenable to organise and lobby against him at the same time.

DHCs are not .there to evaluate existing health services delivery. Their role relates to the future development of services. Thus, a DHC can critisise, for example, the ambulance service, but only in terms related to its need for more assets, not because of poor management.

Charles expressed the view that capital spending in Ontario has been run down in recent years. In his view there is a capital backlog of three to four billion dollars. Assets are not even being· replaced; new building has slowed down even more. In this situation DHCs get frustrated by delays; in fact, very little happens without their support.

The "consumer" on a DHC tends to be a "professional citizen". He (or she) may have served on a hospital board or as an elected official or occasionally as a trade union leader. There are not many truck drivers or welfare mothers on DHCs. The general formula is a 40-40-20 mix. The definition of the "consumer" is reasonably clear. A sitting hospital board member does not count as a "consumer".

The support of local government is important. Local government contributes both in management and in money to public health and sometimes to hospital building programs. Charles points out that DHCs are not elected and, in the events of conflict between the DHC and the local government, the latter is likely to win.

DHCs do not get involved in complaints. There is a Health Disciplines Review Board with consumer representation and separate boards for each discipline, each with citizen representation.

At this stage Bill Davies entered the room and we talked for a while about why Mustard had not been fully implemented and about municipal restructuring and the relationship between local government in Ontario, and the Ministry. of Health and DHCs.

Prior to 1965, local government in Ontario was two-tiered, with the Borough and the County. At that time some of the counties were replaced by "Regional Government", which took over many of the municlpal powers from the lower tier also.

I asked about health promotion and prevention. A unit has. been established with an outside committee, but little is being done apparently. Most DHCs have paid some attention to prevention, either setting up committees or holding occasional "health fairs" or making presentations to municipal boards. However, there has been very little central guidance or coordination.

Public health in Ontario is delivere9 through 43 independent "public health units" which are co-funded between the Ministry and local government but are independent, with their own board of management.

2.2 METRO TORONTO DHC

I had a very useful chat with Evelyn Kent at the Metro Toronto DHC.

She clarified the role of the DHCs and the area planning coordinators as being in a way the "soft option". Instead of regionalising the Ministry with planning part of the responsibility of regional health service management boards, the DHCs provide a negotiating forum for planning. Hospitals and doctors are still very powerful in the health system. Notwithstanding the large immigration programs, the Ontario establishment is still waspish and DHCs are very definitely waspish.

Evelyn estimated the "strike rate" of the Metropolitan Toronto DHC as being at about 40%. The DHC has put up around 200 recommendations since it started operations, of which 40% have been implemented. Many of the remaining 60/5 have not been rejected but are waiting to be funded.

Evelyn talked about the way a sub-committee on the Metro Toronto DHC works. They commence by reviewing their assigned area and then get permission to study in detail a particular issue. They produce a report, which is then taken through the DHC in formal terms. Members tend to identify with a project and push it through with considerable commitment.

The consumers on the DHC would be better referred to as citizen representatives, although some are real consumers. They start from behind scratch initially but with support they play an active role. The sub-committees are mostly experts.

Why do DHC members work so hard? Because they think they are having an effect.

Information. The quality of information available to DHC members is a continuing headache. There is very little leadership from the Ministry and the DHC committees have to work with what they've got.

The Ontario health planning system is still "provider driven" although DHCs have played a useful coordinating role.

2.3 OTTAWA CARLETON DHC

I started off talking with Anne Wex, the Executive Assistant to the Director.

Ottawa Carleton covers a population of half a million, a more bilingual community than in Toronto.

We started talking about mental health. The region has an acute psychiatric hospital of 272 beds (the Royal Ottawa Hospital) and a long stay facility at Bookville (60 miles away) which has recently been reduced from 900 to 500 beds. In addition, a community mental health program is being developed with increasing money each year. Proposals come each year to the DHC from the various agencies: community health centres, recovery homes, voluntary sector housing project, from the Francophone community, etc. There is considerable overlap with the work of Comsat and liaison would normally be carried out by the project proposer.

Anne indicated that there is sometimes some annoyance at the DHC owing to "under the counter" understandings arrived at between the institutional branch of the Ministry in Toronto and the psychiatric hospital management, tending to exclude DHC involvement in reviewing planning proposals.

We talked about some concrete initiatives of the DHC which have since become organisationally separate. A laboratory services coordinator which was originally a project of the DHC is now separate. Likewise a placement coordination service and group, which coordinates food services planning, was sponsored originally by the DHC.

At this stage Alan Warren, the Executive Director of the DHC, joined the discussion.

He described how the development of Regional Government in the late '60s, particularly in the metropolitan areas, stimulated local interest in the need for health planning structures. The Regional Municipal Government established to cover Ottawa Carleton in about 1969 lobbied strongly for the establishment of an Ottawa-Carleton DHC, after Mustard.

I asked Alan Warren why the provincial Government had not proceeded with the Mustard recommendation for Regional Health Services Management Boards. He indicated there had been strong opposition from the Hospital Association and the Medical Association, and despite the support of Municipal Government and the Hospital Planning Councils it did not go ahead. Mustard envisaged replacing the Hospital Boards by the Health Services Management Board and it is not surprising that there was huge opposition.

A chap who had been a member of the Mustard Committee came back after the conclusion of that inquiry and generated strong support, particularly within the Hospital Planning Council, leading to the development of a local steering committee (actually before the Minister invited the formation of steering committees). This Committee went to the Minister and offered itself as a DHC.

In passing, Alan Warren emphasises the need for DHCs to earn their influence through the credibility of their reports as well as the willingness of Ministers to act upon them.

Alan Warren commented on the role of consumer representatives within the Ontario DHC -system as being the "disinterested jury". The citizen representatives come from the same social class but are not subject to the specific vested interests of some of the professional and agency representatives.

Alan commented on the lack of leadership from the Ministry, indicating that Ottawa Carleton DHC had been something of a pathfinder. He cited as an example, the suggestion from the Ottawa Carleton DHC (in 1979) for the establishment of geriatric day hospitals. (This is a matter which Alan Warren himself has been very interested in for some time.) The Ministry established a special committee to work up the proposal and to produce policy guidance from the Ministry.

The OCDHC is presently working on psychogeriatric services and it is likely that the Ministry will in due course pick up and promulgate the results of that work.

Specific planning in relation to elderly people or mental health or acute care is embedded within a long range strategy which was published in 1979 and provides a broad basis for long range developments.

2.4 NIAGRA DHC

I met with Frank Lussing and Garry Zalot at Fanthill, which is the small town in the middle of the Niagra Region, where the DHC is based.

Niagra covers 370,000 people in 12 municipalities. There are three main centres, all 15 to 20 minutes away from Fonthill. Maximum travel time within the Region is 30 minutes.

The Niagra DHC was established in 1975. There had been a hospital planning council active in the region for many years. It served primarily to provide a communication opportunity (recall Victorian Sector Boards and Health Services Regional Councils). The Hospital Planning Council saw the DHC program as a way of continuing what they had been doing and, in addition, getting some money for staff. Accordingly there was no opposition from hospitals to the establishment of the DHC although Regional Government was concerned since it hadn't been involved. At that stage, the Public Health Service was run by a separate Board; over the last few years it has been absorbed into Regional Government.

The health unit (the public health facility) is regulated under the Health Protection Act and covers dental, inspection, sanitation, etc. It is run directly by the Regional Government, funded three quarters through the province via the Ministry of Health.

The Niagra Regional Government is made up of 12 mayors, ie, the mayor of each of the 12 municipalities, and 12 elected representatives.

During the mid-1970s DHCs were seen primarily as a means for reducing hospital expenditure, curbing the growth in hospital beds. This was clea.rly the intention of the Ministry of Health. From the municipal, public health point of **view** the DHCs were seen as being primarily hospital focused.

Only in the last two years has the Ministry insisted that public health proposals (from the health unit) also have to be approved by the DHC.

In recent years also the DHCs have moved from reacting to hospital propositions, to projecting/planning more broadly in the public health area.

The Area Planning Coordinator (Bill Davies) is welcome to attend meetings (which he occasionally does) but only as an observer. The DHC relates to the Ministry primarily through its reports.

How much leadership does it receive from the Ministry? None. The DHC has a good grasp of what's right and wrong in Niagra, thank you very much.

But what about broader system problems? For example, industrial relations or overlap with the Welfare Ministry (Comsat)? Hopefully there is someone in the Ministry who is looking at system problems? The staff of this DHC see the Ministry as a bottleneck.

Liaison between DHC staff across Ontario. There is a two-monthly meeting between executive directors of DHCs and a three-monthly meeting with

chairpersons and executive directors. There is an annual retreat of two to three days with executive directors and area planr:iing coordinators.

We then talked about the role of the Nominating Committee, which in this case includes two current members of the OHC and two ex-members, one an ex chairperson and one a local power broker. The role of the Nominating Committee is to identify possible appointees and to advertise the vacancies. A lot of people generally come on to the DHC proper having served an apprenticeship on the advisory committee. Frank (the Executive Director) then has lunch with the possible appointees telling them about the job informally and assessing their suitability for appointment.

Frank Lussing trained as a hospital administrator, worked for a while as an administrative assistant in a hospital and then for a while as an administrator within the .Ministry.

We then turned our attention to the Action Plan for the Niagra Region. The development of this Action Plan is based on a strategy involving mobilising providers of any particular area to get together and agree on a common plan.

The group which looked at computerized tomography had representatives of the interested hospitals plus a reasonable number of disinterested observers.

Another group looked at perinatal care, determining which facility should be upgraded and which should remain at a lower level. Again this group involved participants from the relevant hospitals plus disinterested observers.

Frank comments that a planning body with no implementation powers must operate through consensus.

I asked about the DHC's interest in quality assurance. This is an internal operational matter and the DHC would not choose to get involved in it. Likewise, the DHC is not involved in current budgeting, only capital/new developments .

I asked whether the DHC might have a more activist or even advocacy role. The answer was that in the local political culture the custom is to lead from behind.

The DHC always works with drafts which are ci-rculated widely for comment.

The Action Plan. The DHC used to receive proposals from agencies which it was supposed to process. Gradually the DHC has put together a coherent set of program plans for the district and most proposals (perhaps all proposals) coming to the DHC now are derived from the Action Plan. The local. health agencies are pleased to have a source of approved good ideas in drawing.up their shopping list each year.

2.5 ISSUES AND ASPECTS FROM VISITS TO ONTARID DHCs - OF RELEVANCE TO VICTORIAN DISTRICT J-EALTH COUNCILS PROGRAM

Very Different Context

DHCs in Ontario were initially conceived in the context of a regionalisation plan that also provided for regional health services management boards which were to take over management responsibilities from the existing committees of management. There was considerable opposition to this proposal, which was not proceeded with. Instead, District Health Councils were established gradually and Area Health Coordinators within the Ministry of Health were appointed.

The District Health Councils in Ontario are primarily a forum for negotiated planning. The providers bring to the forum their particular perspectives of needs. The staff provide technical planning expertise and the "lay" members of the Council provide a disinterested jury function to assist in resolving conflicts of interest on the Council.

Different Planning Role

The role of the DHC in Ontario is to produce a broad, integrated regional plan against which to evaluate specific initiatives and proposals and from which such proposals might be derived.

The DHC sets up work groups to develop program plans within each dis.trict. This is quite a technical task which requires quite some cooperation from the providers and some technical sophistication from the staff of the DHC.

The DI-IC provides considerable policy leadership both to providers and to the Ministry. Because of its close contact with providers and its broader planning brief the DHC is in a position to consider policy issues in advance of the provincial government and to provide leadership to the government through their program plans and recommendations.

The DHC does not play an activist or advocacy role. I was informed that "in the local political culture, the custom is to lead from· behind".

Tension With Institutional Branch

As in Victoria, psychiatric services traditionally have a closer relationship with the Ministry than acute hospitals. This has been a source of some conflict with the DHCs because psychiatric units have not infrequently achieved an understanding with the institutional branch at the Ministry of Health before they raise an issue with the local DHC.

Exclusions

Ontario DHCs do not consider the current operations of the health service, nor do they handle complaints.

They are not heavily involved in prevention either.

Different Membership

The Ontario DHC consists primarily of representatives of providers with a proportion of disinterested community people. This latter group tends to be successful business persons, senior academics or public figures and the function of representing relatively disadvantaged groups as has been discussed in respect of the DHC Program in Victoria is not a feature of this system.

Credibility

Notwithstanding the negotiated planning by consensus function of the Ontario DHC there was quite a lot of opposition from some quarters. The point was made to me that the credibility of planning documents produced by DHCs has been a major factor in determining the improving image and influence of DHCs within the Canadian context.

Conclusions

Ontario DHCs are not very relevant to the Victorian District Health Councils Program at any specific level of analogy. They were established in a different context and with a different purpose.

However, it would pay us to keep in mind the "disinterested jury function" and the importance of credible planning documents in establishing the reputation of the District Health Councils.

3. UNITED STATES

3.1 MONTEFIORE HOSPITAL, NEW YORK

Dan Schwartz

Dan Schwartz is a senior vice-president within the administration of the hospital and we had a wide-ranging discussion of hospital and health care matters in Montefiore, in New York and within the USA generally.

Most of the points we discussed are covered in another part of this report.

One interesting sidelight is the malpractice situation as it presently operates in New York. Dan Schwartz is responsible for malpractice at Montefiore. He comments that at any one time, they have roughly 40 cases open and they expect to pay out $1-2 million per year. They self insure for liability coverage.

Mutya San Augustin

Mutya San Augustin is physician in charge of the outpatient service of the Montefiore Hospital. She originally trained as a biochemist but became a primary care expert after having run a neighbourhood health centre· which was sponsored by Montefiore.

I was particularly interested to hear her talk about the 'doula'. A doula is an experienced breast-feeder who is used to educate new mothers. The hospital has appointed one woman full time as a doula and she works with the midwives in the Ante Natal Clinic and is available to talk to mothers at that clinic. The midwives have learned a great deal about breast-feeding since she has been in the clinic.

The general philosophy is that if you don't persuade women to commit themselves to breast-feeding in pregnancy then they are u_nlikely to do so.

Those women who have made a commitment to breast-feeding are visited by the doula after delivery and she gives them her beeper number and phone number and is always available to advise on how things are going.

Although she was initially rejected by the nursing staff she has made a big impact on the breast feeding rates (30% up to 70%) and the drop out rate at two weeks (from 50-60% down to 20%) •

Barbara Hallbridge

I spoke with Barbara Hallbridge who is the DRG expert at Montefiore.

We talked about the impact of the prospective payment system on hospital care. She mentioned the dramatic effect it has had on MRA training and status and on the education of physicians to take their clinical records more seriously. If a patient stays in hospital for an extra week because of social reasons, but there is no supporting entry in the clinical notes, the scrutineer from the PRO is likely to reject that diagnosis and the patient will accordingly be recorded only as the· medical diagnosis and hence wiH be a net loss to the hospital.

We talked a bit about the impact on quality of care and the impact on medical education.

With a dramatic fall in inpatient services it seems likely that students and interns will have to be trained in private doctors' offices to get adequate exposure to an adequate variety of clinical work.

3.2 GEORGE WASHINGTON UNIVERSITY DEPARTMENT OF HEALTH SERVICE ADMINISTRATION

Phil Reeves

Phil Reeves is Professor of Health Planning at George Washington University Department of Health Services Administration.

The Hill Burton Act was passed in 1948. It was conceived as a redistributive initiative but since it was submission driven it actually led to growth of existing facilities. Where there were no agencies to generate submissions little money flowed.

During the late '50s and early '60s, planning councils of various sorts were set up in cities and regions to coordinate applications for Hill Burton money.

In 1963 Hill Burton was amended to pay for this sort of local planning.

In 1967, as part of the Great Society (accompanying the Regional Medical Programs), Federal funding became available for state and local health planning agencies (comprehensive health planning agencies/CHCPAs). In some localities (for example, Pittsburgh), the voluntary planning agency, hitherto funded through Hill Burton, became the CHPA. In other areas there was a battle.

The RMP was heavily funded but not well led from Washington and there were flutuating guidelines.

The role of the CHPAs (1967 onwards) provided for "provider and consumer" participation at the local level. The CHPA did not have any sanctions and did not attract, in all cases, the "brightest and the best". They did not in all cases understand the technology of health care planning and their credibility was low.

With the introduction of Medicare and Medicaid in 1968 and increasing consciousness of the growth in medical costs, certificate of need provisions (CON) were introduced, initially in New York and subsequently in other states. In 1972 the Federal Government introduced the Section 1122 provisions into the Medicare legislation and mandated these CHPAs to do the requisite CONs.

The "consumer" representation on CHPAs was quite variable at this stage. In some communities the CHPAs were dominated by the power brokers. In other areas they have gone to considerable lengths to get consumer representation.

In establishing and funding CHPAs the Federal Government bypassed the States and went straight to the local government and consumer and provider groups. In 1974 with the National Health Planning Research Development Act (93-641), which established the Health Systems Agencies (HSA), there was an attempt to reduce the balance, to give the States a greater role. In addition to the HSA at the local or regional level, this legislation provided for a State Health Care Coordinating Council which would be the decision-making body in relation to any certificate of need consideration. The Act also provided for funding for technical planning within the State administration. This Act put local government off side.

The Act provided for representation of providers and consumers on the HSAs and

in several localities, activists used the courts (initially in Dallas) to prove that Congress meant quite specific representation of consumers, blacks, whites, geographical areas, disability, etc. Arising from judicial rulings the guidelines became very tight and County Governments which were asked to appoint the representatives to the HSAs were not given a great deal of scope to seek the best person. Thus if a disabled woman of South East Asian extraction living in a particular locality resigned from the HSA a great deal of trouble went into finding a person with similar characteristics to replace her.

Associated with structural problems of this sort the HSAs did not really attract competent planners.

In addition, the providers succeeded in undermining a lot of the HSA recommendations.

By the time of the Carter Presidency cost containment was the main Federal agenda item and the rhetoric of 'over-regulation' was starting to be heard widely.

In 1979 new Federal amendments were passed requiring HSAs to "promote competition".

From 1981 the Reagan Administration reduced the funding to HSAs, leading to considerable staff reductions and decreased areas of work.

However, in the early '80s, many of the provider bodies, and particularly corporate purchasers of health care realised that some planning was not all bad. Uncontrolled competition, particularly within the private sector, was threatening the viability of many of the voluntary hospitals. In other areas it produced two inadequate hospitals where there should have been one.

The concern of corporate purchasers of health care has led to the development of business coalitions on health. Although they do not have statutory sanctions, since they do represent major employers, they have considerable informal force. Some of these business groups have been able to get information that HSAs were never able to get, simply because they have the clout, which comes with being purchasers of large blocks of health cover.

In some cases the business groups have aligned themselves with existing health planning agencies. Elsewhere they have worked through consultancies.

The fundamental interest of the corporate sector in these business coalitions is clearly to keep the cost of health services down and for this reason structures such as the preferred provider organisations (PPOs) and structures which exclude cost subsidisation to the indigent have been encouraged.

There are presently certain bills before Congress which would have the effect of revitalising health planning by handing it back with more powers to the States.

Phil Reeves mentioned one Representative on the Health Subcommittee of the House Committee on Energy and Commerce who as recently as 1981 was opposed to any kind of planning. His attitude has noticeably changed and he is now supporting the reintroduction of health planning at the state level. He (a Republican) and Waxman (a Democrat from California) have drawn up a compromise proposal which was supported by the HHA and accepted by the Senate. However it was opposed by the Administration in 1982.

Phil Reeves commented that often the staff members of individual legislators have a far-reaching effect. He suggested that I read a book called "The Dance of Legislation" by Eric Redman illustrating the role of the staffers.

Dick Southby

Dick referred to the Enthoven Health Plan which recommended competitive health insurance arrangements but required a basic range of minimum services.

Stockman (whilst still a Congressman) and Gephardt introduced a bill based on the Enthoven recommendations but not requiring the same basic range of services.

The "competitive solution" has been building up since then.

Part of the competitive solution is providing better information to the public about choices. Accordingly much more vigorous marketing is encouraged. It may be that health care marketing is in the 1980s what health care planning was in the 1970s.

The introduction of DRGs and prospective payment for Medicare has encouraged intense competition between hospitals, a competition which the voluntaries are losing to the proprietaries.

The business coalitions on health are encouraging more informed purchasing by big companies. Under the influence of this more informed market, health maintenance organisations and preferred provider organisations have been growing quite rapidly.

It is important to appreciate that the tax free status of employer contributions to health insurance premiums is a critical component of what is happening. The Reagan tax reform package would provide for removal of tax-free status and could again totally change the health services environment in the US.

Some of the large companies are self insuring, carrying the costs and purchasing from a range of service providers on a contract basis, sometimes using the preferred provider organisations. Some of these large organisations are doing their own utilisation review. Dick mentioned John Deer as an example of a large company which is self insuring and Caterpillar and Motorola as companies doing their own utilisation reviews.

Employers are obliged to offer their employees a choice of health insurance plans. Many employers are including an HMO, IPA, prepaid group practice, etc.

Dick commented on the increasing use of surgicentres for particular conditions. The obligatory use of surgicentres for certain conditions is sometimes built into the insurance arrangements purchased by the informed employer.

With the growth of competitiveness, the sectors of the health care market have been identified more clearly with a view to more focused marketing. For example, the impulse/convenience market is being met by the "doc in the box". Doctors work in a clinic in a shopping centre and are immediately available at all times. However, there is no personal continuity and often no backup.

Hospitals and doctors are becoming very competitive, taking and giving courses in marketing, etc. This situation is made worse by the "physician glut". We are

seeing new physician behaviours such as advertising of after hour services and even home visits!

Dick tells a story of two hospitals in Pennsylvania which were racing to get approval for a CT. One hospital hired a mobile CT in the interim and located it three days in its own grounds and two days a week outside the competitor with a view to demonstrating that there was no additional requirement.

Robert G Shouldice

Robert G Shouldice is a member of Dick Southby's faculty. His special interest is the private sector medical half of the health care field.

He introduced me to competitive medical plans (CMP). He commented that the physician glut is generating more competition and pressure on physicians to achieve some kind of income security. He relates this to the rapid growth in group practice. The number of physicians in group practice is almost doubling per year.

Robert G Shouldice is something of an entrepreneur as well as being an academic. He commented that many group practices are "joint venturing" with HMO managements (IPAs, staff and group models).

The Federal Government has been watching these initiatives with interest and planning to try and get some of the same benefits for Medicare.

The 1972 Tax Equity Fiscal Responsibility Act (TEFRA) has been amended (1985) to authorise the Federal Government to contract with HMOs for Medicare provision.

Many of the State Health Authorities are looking to do the same thing for Medicaid.

Another innovation is the 'gate keeper', but it is not being used very much by the HMOs. The gate keeper involves the GP shouldering some of the cost risk and controlling access by the patient to specialist care. It is being used by certain HMOs in Pennsylvania, Nevada, New York, particularly where they operate under an IPA model.

TEFRA authorises the development of a CMP. An "eligible CMP" can contract with Medicare. Medicare can contract with a qualifie-d HMO or an eligible CMP. A qualified HMO is one that can legally be offered to employees, although the sanction here is being replaced by State licensure. An eligible CMP could be an HMO or a hospital or a group of physicians. It could be based on fee for service, retrospective reimbursement or include some risk such as with prospective payment per head.

It is possible in the present environment for HMOs and CMPs to achieve a return on investment of between 23 and 54% per annum.

The winners used to be Blue Cross/Blue Shield and the voluntary hospitals. The winners in today's environment are the IPAs, the HMOs and the private sector generally.

3.3 NORTH VIRGINIA HEALTH SYSTEMS AGENCY

Mark Epstein is Assistant Director of the North Virginia Health Systems Agency. He trained as a health administrator in public health.

North Virginia HSA was established in May 1976. There had been a comprehensive Health Planning Council in Northern Virginia and many of the same board members and staff moved across. Virginia with five million people has around five HSAs. Northern Virginia is the smallest geographically with the largest population.

The HSA has 30 members. They are all appointed by local government (at a county level). It is obliged to have "a consumer majority and to be broadly representative of the consumer". Members sit for a three-year term and they would have to stay off the council for one year before being reappointed. Around six positions fall vacant each year.

When vacancies are coming up, the Executive Director will write to local government and tell them that they are due to appoint replacements and gives them the guidelines. To some extent the HSA is at the mercy of whoever applies and it often has to go out and recruit "the right people". If the Executive Director hears about possible members he will refer them to the local government authorities who will nominate them.

Each local government authority in the area has at least one member and sometimes more in accordance with population. Some counties will appoint councillors ("supervisors") but generally they don't have the time to attend.

Local Government is being asked to contribute to the budget. At present the budget is 70% from the Federal Government, 15% from Blue Cross/Blue Shield (which actively support health planning), and 15% local government. The Federal subsidy used to be on a basis of 37.5¢ per head covered and this has been reduced to 22'1 per head.

At its maximum, the HSA had 22 full time staff. It is now down to six staff.

There are two distinct aspects to the planning responsibilities of the HSA. On one hand they are obligated to prepare a comprehensive and forward looking plan which scans all areas of health care and gives guidance to local agencies as to what is needed. This plan is supposed to be based on negotiation and liaison with neighbouring HSAs. This is quite a complex task for an HSA which has considerable overlap with two neighbouring states (Maryland and DC) as well as its own local structures. In fact, no one is very interested in this sort of comprehensive planning these days and most of the work of the HSA is now focused on considering applications for certificates of need.

It is uncertain as to whether the certificate of need procedures will be continued, since if capital costs are encompassed by DRGs for the purposes of prospective payment, the existing regulatory controls will be bypassed by the market. PROPAC is presently looking at capital reimbursement and DRGs.

At the State level, certificate of need is moving; but it is not clear in what direction. Maryland recently exempted major capital equipment from a requirement for certificate of need. Virginia still supports local HSA involvement

with less of a focus on state control. (The State authorities have responsibility for issuing or otherwise the CON; they are not obligated to follow the advice of the HSA.)

The HSA has some achievements in terms of actually initiating services. One survey done by this HSA focused on health education, demonstrated there are a lot of local activities which are not coordinated and stimulated the formation of a small coordinating body.

Likewise, the HSA has guided the nursing home entrepreneurs to areas of need.

The consumer members of the NVHSA have been very active. When the HSA was still involved in preparing comprehensive plans, the consumer members would ask questions about the draft as presented and would then shepherd the draft through public hearings. The advisory groups tend to be providers mainly but always chaired by a Board member. However, with decreasing emphasis on the comprehensive plan many of the present members are not so familiar with that process.

Overall the HSA has not been very effective in curbing or redirecting capital development. Perhaps it has been more effective in informing the public about policy issues and involving the public in discussion of those issues. It is also taking responsibility for educating the public about the available medical services. In 1979 the HSA published a large directory of local physicians, inciuding their billing practices, what training and qualifications they had, whether they were willing to do home visits and so forth. This document has not been republished. It is a very thick book and one wonders how many. people had access to it.

3.4 WASHINGTON BUSINESS GROUP ON HEALTH

I spoke with Willis Goldbeck, the driving force behind the Washington Business Group on Health.

The purpose of the Washington Business Group on Health is to ensure a credible business contribution to the health policy debate.

The Group focuses perhaps a third of its time on the Federal Government in respect of regulations and so forth, perhaps a third of its time on its corporate membership and perhaps a third of its time in respect of particular programs at the local and the state level.

In recent years the importance of consensus between the private sector and Government has come to be more widely accepted.

The Government's success in introducing prospective payment for Medicare was facilitated by a variety of initiatives in the private sector including utilisation review and more innovative health plans.

With the exception of care of the indigent, business and government have similar interests in respect of health care, quality, prevention and cost control.

Previously the doctors and hospitals owned all the information regarding costs efficiency quality and negotiated with Government and health planning agencies for a position of strength. However, when a business group starts to get tough and threaten to buy its health cover elsewhere the doctors and hospitals start to talk.

Recent Federal amendments have given the States the option of not having HSAs and New Hampshire for one has introduced a new planning/certificate of need system. Over the next few years a variety of planning bodies will emerge. The Washington Business Group on Health supports statutory planning bodies but other business groups don't. Many of the hospital groups which used to fight health planning now see it as at least being one step better than competition.

It is important to recognise that competition per se is not a single answer to the problems of American medicine. It must be tempered by an awareness of the problems of medical education, research and the care of indigent people. Otherwise (in Willis Goldbeck's view) there will be a backlash, followed by an explosive growth in these areas when the public/voter understands what competitiveness has produced.

There are around 150 business groups on health around the nation, most of which started between 1978 and 1983, although the Washington Business Group on Health started in 1974.

The main reason has been to take a closer look at the cost of health care particularly in terms of the cost to corporate purchasers of health insurance cover. However, it has also had an active role of utilisation review, in capital development planning and in prevention.

Willis Goldbeck expects that capital will be included in the DRGs over the next two years and that certificate of need in relation to Medicare will hence be bypassed.

Willis Goldbeck believes that overall expenditure on health is now shrinking, citing the closure of a thousand hospi_tals over the last ten years.

He agrees that the entrepreneurs are skimming but believes that they can be constrained. For example HCA is running several municipal- hospitals which provide mainly indigent care.

On the question of tax reform, Willis Goldbeck expects that a tax floor will be introduced providing for taxation of the first hundred dollars of everybody's health insurance premiums. Another option is tax exemption below a ceiling for fringe benefits and/or for health insurance premiums. This would provide that any company could provide up to x dollars (or percent of salary) in fringe benefits and anything above that would attract tax.

The trend in health insurance is clearly going to be towards prepayment, towards managed packaged programs. The trend is towards more negotiation where the buyer negotiates price and service with one or more providers either directly or through brokers (such as the Washington Business Group on Health). The consumer used to buy a health• insurance policy. Now the cost conscious employer is looking at specifying price, quality, the actual venue of some services (eg, surgicentres), precertification with respect to hospital admissions, utilisation review and many other conditions.

In addition, Willis Goldbeck believes that prevention/wellness programs will be specified.

Employee assistance programs (like the alcohol and industry program) are also likely to be encompassed.

Another trend worth noting is the practice of some corporate medical departments of providing direct care to their workers.

Willis Goldbeck is also involved in the Primary Prevention Program associated with an emerging network of PPP centres (see collected paper).

"The big issue of the 1980s will be ownership of information". A battle between the doctors and the business groups is looming.

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