TALKING POINT

Community health councils: keeping the balance

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Rudolf Klein's comments¹ on the Government's consultative document, *Patients First*,² serve as a useful basis for drawing attention to the fundamental issues. He is right to regard the proposals as manifestations of the continuing search for an appropriate balance between central and local responsiveness and control in the Health Service. He is also right from a non-partisan and longer-term viewpoint to concentrate on the creation of the district health authorities, which will replace the areas, as the most important element in the proposals. But the paper has an important weakness. For some time Klein has argued for a form of health services inspectorate in the NHS³ and as a result his enthusiasm for this innovation encourages him to interpret the proposals as supporting a case for abolishing community health councils. His case rests primarily on what he sees as the feasible reallocation of the three primary functions of the CHCs.

Klein accepts the suggestion in *Patients First* that the first function, to represent local public interests in the Health Service, can be taken on by the new DHAs since their members will be closer to their area of responsibility. The second function, informing the public about the Health Service, could, he suggests, be transferred to the citizens' advice bureaux, especially if some of the CHCs' funds were transferred as well. And the third function, that of monitoring the Health Service, could be assigned to a new NHS inspectorate, perhaps based on a strengthened and extended Health Advisory Service.

Unfortunately, some of the arguments are not examined in depth. I believe that even after the impending reorganisation there will remain a strong case for retaining CHCs.

Klein argues that it is the great cost of the NHS—the 1978 expenditure figure was £7173m—that precludes the Government from handing over control to local authorities. Since the locally administered education service is of comparable size—£6344m—his argument is presumably based on the large incremental and transitional effects of adding health to existing local authority expenditure. Certainly, if health care were to become a local authority function and the percentage of central government contributions to local expenditure were to remain unchanged, there would need to be an appreciable increase of about half in locally raised income, though such an increase would be offset by a corresponding decrease in national taxation.

Unfortunately, without major changes in the taxation and rating systems and given the regressive effects of rates, it would be poorer households who would experience the relatively greatest increase in rates. This could be resolved when the Inland Revenue will, with improved computer facilities and if required, be able to collect varying rates of local income taxes in addition to national income tax. Placing the Health Service in the local government domain could produce benefits. Collaboration with other relevant services—for example, the personal social services, housing, and education—should become easier. It might even combat the apathy of local government electors, to which Klein refers. For the foreseeable future, however, the NHS will probably remain centrally financed and, as a consequence, centrally controlled.

It has only been relatively recently, through the introduction of RAWP, that progress has begun towards correcting the geographical imbalances of the services inherited in 1948. National standards of services can be achieved without the need for complete central control. Indeed, one of the most interesting suggestions of the 1976 Layfield Committee of Enquiry into Local Government Finance⁴ was the idea of a local government system in which, for key areas of service, minimum standards of provision would be established, financed, and monitored by central government, but administered by local authorities. For minor services and standards of provision in key areas above the minimum level, local authorities would assume full responsibility for administration and for raising finance through either local income or property taxes.

DHAs and CHCs: theoretical perspective

There is a consensus within the NHS that because services such as health need to be tailored to local needs and resources some form of local planning and administration must be devolved, even from a centrally financed and controlled service. The present three-tiered system of achieving this objective is generally recognised to be too cumbersome and the reform now being proposed in *Patients First*, that the area tier should go, is one accepted by most observers. So the DHA's functions will be crucial in the new system. Klein, however, explicitly omits this major issue from detailed consideration. This is surprising since in any organisational system the characteristics and the strengths and weaknesses of one element strongly determine which complementary institutions may need to be present to act as counterbalance.

The White Paper proposes that the new DHAs would comprise 20 members, of whom four would be local authority representatives, five would be nominated by staff and a university, leaving 11—the majority—to be appointed by the RHAs. No member would be directly elected to serve on the authority. Given that on average the areas served by DHAs will be smaller than AHAs, the paper asserts that members "will be more closely in touch with the needs of the consumers" and that "the need for separate consumer representation in these circumstances is less clear." But the counterargument, which led to the establishment of CHCs in 1974 surely remains: that so long as a DHA is not directly accountable to an electorate some accredited means of articulating the views of the community must be ensured within the local system.

Indeed, in the existing single-district AHAs, where the principal effect of the Government's proposals will be to reduce the number and the percentage of local authority members, the case for CHCs must be regarded as even stronger than at present. As one way of counteracting the lack of a fully elected representative authority Klein proposes an increased emphasis on surveys. He suggests that health authorities might be given a statutory responsibility "to show that they have collected adequate information about local opinion before they submit plans for major changes in services." Presumably this would be in recognition of the lack of direct links between members of the health authorities and the general public—few such parallel responsibilities are laid on local authorities. A difficulty with such procedures is that, given the complexity

and resource constraints of the Health Service, only for a minority of issues would it be sensible and of real value to consult the public in this way. The need is rather for an organisation such as the CHC which, though separate from the providers of the service, understands the issues. In this way the public views can be interpreted and presented by an informed independent group.

CHC members are not directly elected, though one-third are chosen by local voluntary groups, but their strength derives from their duty "to represent the interests in the Health Service of the public" and from their independence from those with managerial and clinical responsibilities. A lesser criticism, which Klein raises, is the over-representation on CHCs of the middle aged and the middle class. This is a valid criticism but it also applies to members of central and local government. Since proposals for a professional inspectorate would do nothing to solve this enduring problem, are there any suggestions for correcting such imbalances?

CHCs: experience to date

The major justification for CHCs must derive from their performance, even though some of their proponents would argue that CHCs have not existed long enough or had sufficient resources to achieve their full potential. Unfortunately, no broad-based study has yet provided a comprehensive, empirical evaluation of their work but most CHCs have shown that they can stimulate and respond to public concern for and interest in the NHS. This has probably been carried out with greater success and at lower cost than could be achieved by the administrative machinery of health authorities. Though of less interest in times of financial stringency, CHCs have played an important part in stimulating demand for improved services. Such demand is usually presented in a non-party political way by CHC members who have a prime interest in the specific topic of health services and who in this respect may be unlike members of local government, many of whom have a more diffuse range of interests. Given that one-third of the membership comes from the voluntary sector, not surprisingly a valuable feature of CHCs has been the way in which many of them have acted as a focal point for co-ordinating, in an informal but useful way, the work of voluntary societies concerned with health. In addition to the broader representative functions which CHCs possess they are also expected to act as a "patient's friend" when needed. In the absence of identifiable constituency representatives CHCs can act as the single point of call for the public with queries or complaints. Though complaints are small in comparison with the annual total of patient contacts, CHCs serve as important and necessary alternative channels to guide people through the complexity of the NHS, and, where necessary, to represent individuals at, for example, service committee hearings. Such a service is needed to prevent the Health Service Commissioner's being overburdened with matters which could more sensibly be resolved without recourse to him. Because of its confidential nature the outcome of this aspect of CHC work is relatively unpublicised and carried out for the most part by the CHCs' full-time staff, who have become valuable repositories of specialised knowledge about the operation of the NHS. This may in part account for the recent findings⁵ that 80% of district planning teams with CHC membership believe that CHC participation has helped their work and that only 59 of the 201 districts, including single-district areas, were against CHC participation.

Klein, following the Royal Commission on the NHS⁶ (to which CHCs were one of the largest groups providing evidence), also examines their work in informing the public and in monitoring local services. He puts forward an intriguing suggestion that if CHCs were to be discontinued a quarter of their collective budget could be given to citizens' advice bureaux to take over the information responsibilities. In the unlikely event that the Treasury would approve such an unprecedented

direct transfer of funds it is a moot point whether the bureaux would develop the necessary level of knowledge or cope with the volume of inquiries now dealt with by CHC staff.

There have been suggestions that the bureaux could absorb other local functions of central government or of nationalised industries' consumer protection committees—for example, gas, electricity, transport, and the Post Office. But in practice the main ability of the bureaux is to act as a first contact and signpost to specialised help. If the health regions or new districts are not to assume directly the information function the dual functions of informing and representing can best be carried out by the CHCs with their statutory responsibility and their specialist staff, independent from line management and clinical responsibilities.

Klein notes that monitoring is a responsibility with which several constituent parts of the Health Service are charged and he seems to regard the pervasive existence of monitoring functions as a deficiency of the system. An alternative view might be that, given the complexity and magnitude of the NHS as well as the diversity of the skills employed, the restriction of the monitoring function to a single point in the system would be limiting. In any case, monitoring itself is not a strictly defined single activity but may encompass the overall responsibilities of the Secretary of State for Social Services, the work of the confidential inquiries into maternal deaths, or the quality control procedures of laboratory work. Furthermore, as Klein himself notes, "The real problem of the NHS is precisely the lack of accepted and established yardsticks against which to measure performance." Since no single criterion can be used to assess a service in a uniform way by all potential groups of monitors, each group will probably approach the same position from a different perspective. Thus the type of monitoring carried out by CHCs will differ from the approach taken by managers or from the perspective of the clinician.

So there is room for several monitoring groups, each with different aims. Indeed, though CHCs are specifically barred from receiving confidential information about the diagnosis and treatment of individual patients, such matters would presumably be those to which any professional inspectorate would wish to have access. Klein's apparently polarised presentation of a choice between either a CHC or an inspectorate is unnecessary to support his case for the latter. Within the existing centrally financed and controlled NHS system there is room for DHAs, CHCs, and an inspectorate. It would be a pity if Klein's case for an inspectorate should be seen as support for the abolition of CHCs.

Cost of inspectorate

Indeed, some of the elements in the outlines so far presented suggest major problems which would have to be resolved before the inspectorate concept could be fully realised. Not the least is the cost. If each DHA were to have an inspectorate team comprising the broad range of skills suggested by Klein then the cost would be considerable. Who would be recruited from where and for how long are also questions the answers to which would be important in determining the audit team's independence. Furthermore, it would be undesirable for a health services inspectorate to comprise individuals who lack recent clinical or managerial skills.

If such an inspectorate, whatever its detailed powers, did not include the general practitioner services—at present unlikely, given the medical profession's opposition—it could not replace even the existing meagre coverage provided by CHCs. Since family practitioner committee matters are to be excluded from the remit of the DHAs there would be no local forum for the public to raise queries about FPC operations, especially those queries which do not merit formal complaint or legal action, if CHCs were to go.

The best way forward for the development and extension of monitoring is along the lines put forward by the consultative

New minimum retention periods for medical records

DHSS guidance

The DHSS has just announced recommendations for new minimum retention periods for personal health records. In circular HC (80) 7 the Department proposes keeping patients' records for a minimum of eight years after the end of treatment except for the following groups: obstetric patients' records should be kept for 25 years; the records of children and young people should be kept until the patient's 25th birthday or eight years after the last entry if longer; and records relating to mentally disordered patients (as defined by the 1959 Mental Health Act) should be kept "20 years from the date at which, in the opinion of the doctor concerned, the disorder has ceased or diminished to the point where no further care or treatment is considered necessary." The records of patients from any of these three groups who die need be held only for a minimum of eight years after death—in the case of obstetric records the death of the child but not of the mother.

Health authorities are free to keep records for a longer time than the minimum period recommended, "having regard to the wishes of individual consultants with responsibility for the case in question, the requirements of research and the implications for litigation." These suggested changes take account of the provisions of two recent Acts. The first is the Limitation Act 1975, which changed the law on time limits within which actions for personal injuries or arising from death may be brought. The other is the Congenital Disabilities (Civil Liability) Act 1976, which clarified the right of a child—as distinct from the mother—born disabled to sue for damages for that disability. The limitation period for bringing an action remains three years but this now runs from when it was first realised that a person has suffered a "significant injury" that might be attributable to third-party negligence. There is, however, no time limit on the lapse between "injury" and "knowledge" of it. For a minor the limitation period

runs from the time he reaches 18 and may be extended where material facts are not known.

Destruction of records

The circular concludes:

"As records could be required in litigation virtually without limit of time, the Department recognises that some records may be destroyed that may subsequently prove relevant to litigation. The Department's view, however,

is that the cost of indefinite retention of records would greatly exceed the liabilities likely to be incurred in the occasional case where defence to an action for damages is handicapped by the absence of records.

"If a hospital doctor involved in litigation claims that prior disposal of relevant medical records has prejudiced the outcome, this should be considered by the health authority along with all other factors when the apportionment of any liability as between the doctor and health authority is being contemplated."

Contraception for schoolchildren

BMA welcomes minister's statement

Dr Gerard Vaughan, Minister of State for Health, has decided to consult the medical profession before revising the circular (HS(IS) 32) on family planning services issued in May 1974. This gave guidance to health authorities in relation to young people. The memorandum of guidance included the words "It would always be prudent to seek the patient's consent to tell the parents." He accepts that consultations between the doctors and patients are confidential and that the decision to provide counselling and if necessary contraception without the knowledge of parents or guardians must be a matter for clinical judgment. Nevertheless, the Minister does not think that the existing guidance gives sufficient emphasis to the importance of parental responsibility. In a statement earlier this month he said that he hoped that "in any case where a doctor or other professional worker is approached by a person under the age of 16 for advice in these matters, the doctor or other adviser would always seek to persuade the child to involve the parent or guardian at the earliest stage of consultation."

The BMA has welcomed the Minister's

announcement. In a press statement the Association commented: "In guiding individual doctors and in its *Handbook of Medical Ethics* the BMA states its belief that the provision of contraception to girls under the age of 16 cannot be governed by any rigid code of practice. We advise doctors in all circumstances to attempt to involve the parents through initial counselling. If the girl agrees and the parents are involved the doctor will then make a separate clinical decision whether or not to prescribe contraceptives to the girl. If the girl is adamant in her refusal to allow her parents to become involved, the doctor must decide whether or not she has the mental maturity to understand the full implications of her request for contraception. In rare circumstances a doctor will have to face the fact that a family is unable to provide the loving support and background in which it is desirable to bring up teenage children. Such girls must not be discouraged from seeking the professional guidance they need—indeed, the involvement of a doctor may well be the family's last chance to be brought together again."

Talking point—continued from previous page

document with experimental schemes being tested in at least two regions. At the same time other methods of improving quality control in the provision of health services should also be tried. In particular, systems of peer service review could be examined further, possibly within the context of the re-examination of the NHS professional advisory machinery. But until some assessment of the experimental schemes is available there should be no structural changes in the existing monitoring systems.

While suggestions for abolishing CHCs could be seen merely as a cost-cutting exercise, their possible abolition must be interpreted more fundamentally when viewed in the light of the continuing search for balance between central control and local responsiveness. Given the proposals to have less participation of democratically elected representatives in the new DHAs, the further distancing of the FPC responsibilities from the mainstream of NHS administration, and the likely changes and cutbacks in service, the case for CHCs as the only NHS

institution charged with putting patients first is even stronger than when they were originally created.

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(Accepted 10 March 1980)