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Consumer involvement in health care purchasing: the role and influence of the community health councils

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Abstract
Recent reforms in the National Health Service (NHS) place great emphasis on the importance of the 'voice of the consumer' in the provision of health care. Health purchasers are now required to adopt the role of 'champion of the people', traditionally that of the Community Health Councils (CHCs). In turn the CHCs have been encouraged to become more closely involved in the purchasing process. This paper draws on a national investigation of the operation of CHCs in order to examine the response of both the Councils and local purchasers to these developments. For many CHCs pressures for greater involvement may clash with their concern to retain an independent stance. This paper examines how closely CHCs are currently working with local purchasers and explores the central question of whether those prepared to work more collaboratively with their Health Authorities (HAs) are likely to have greater impact on purchasing decisions. The paper concludes that, while some CHCs are more closely involved than others, few perceive that they exert much real influence over the decision-making process. Councils share a general view that major purchasing decisions are increasingly being made without the opportunity for scrutiny by them or the wider public.

Keywords: community health councils, consumerism, health care purchasing

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Introduction

Recent health policy shifts, most notably the NHS and Community Care Act (Department of Health 1990) and the Patient's Charter (Department of Health 1991), have resulted in a higher profile for the rights of patients or consumers in the provision of their health care. The Government's concern to introduce more market-oriented public sector provision has resulted in a growing emphasis at both central and local policy levels on identifying and responding to the 'voice' of the consumer. This task has particularly been linked to the developing role of health care purchasers, who purchase health care in line with locally identified needs. This element of the internal market introduced in the 1990 Act has increasingly resulted in the identification of consumer's views by means of direct consultation as well as by more reactive approaches.

This new concern with consumerism has implications for pre-existing mechanisms within the NHS, in particular for the CHCs. These statutory bodies, established as part of the NHS reforms of 1974, have a remit to channel public views to Health Authorities (HAs) and Family Health Services Authorities (FHSAs). However, in 1992, the NHS Management Executive (NHSME) suggested that HAs should themselves cultivate the role of 'champion of the people' and seek new ways of consulting or involving service users:

> The aim (of Health Authorities) should be to involve local people at appropriate stages throughout the purchasing cycle: a combination of information giving, dialogue, consul-

tation and participation in decision making and feedback rather than a one-off consultation exercise (NHSME 1992, pp. 3–4).

In turn, central government has suggested that CHCs should focus more on the work of purchasers than on their traditional role of monitoring the service providers (Dorrell 1992). The official expectation is that the Councils will take up 'the new opportunities' so provided and '... contribute in a major way' to the evolution and monitoring of the purchasing function (NHSME 1994, p. 2).

This paper explores the response of both CHCs and health care purchasers to these developments. It examines the degree to which HAs have begun to develop the role of champion of the people and considers the implications of this move for the role of the CHCs. The range of ways in which the Councils are currently working with local purchasers is explored and attention given to the extent and nature of their influence over the purchasing process. We focus on how the CHCs experience and manage any tension between the encouragement to work more closely with their HAs and their desire to retain a degree of independence and objectivity. In considering these issues the paper draws on a national study of the operation and impact of the CHCs in England and Wales, funded by the Economic and Social Research Council. After considering the literature on public involvement in health services and the political history of the CHCs the paper examines, from the perspectives of both purchasers and Councils, the ways in which the different types of CHC have responded to the new opportunities for greater involvement in the health care purchasing process.

Public involvement in the NHS

There is a considerable literature on the meaning of concepts such as consumer involvement, patient empowerment and community participation (Klein 1975, Berry 1988, Midwinter 1988, Potter 1988, Croft & Beresford 1990). Most commentators see public involvement comprising a range of types or levels of activity. Klein (1975) for example, talks of a continuum from professional dominance to consumer dominance, moving from information provision or consultation, through negotiation and participation to the power of veto. Papadakis & Taylor-Gooby (1987) distinguish three different types of participation: choice, voice and control and Potter (1988) identifies six dimensions: access, choice, information, grievance, redress and representation. Many emphasize the different agendas underpinning the drive for public involvement. Croft & Beresford (1990), for example, argue that a central distinction must be maintained between a consumerist approach to public involvement, led by agencies concerned to improve their efficiency or effectiveness, and a self-advocacy approach in which service users attempt to gain greater control over their lives. Hambleton (1988) distiguishes the objectives of the consumerist approach which is concerned with managerial change from the participatory democratic approach which is concerned with political control and reform. These different approaches involve different conceptualizations of the public with different rights and responsibilities being attached to the roles of 'consumer', 'citizens' and 'community'.

Evidence suggests that, to date, public involvement in the health service has not typically spanned the full range of these different types of public participation, and has developed a broadly consumerist rather than an empowerment or democratic agenda. Pollitt (1989) and Klein (1975), for example, argue that initiatives have typically involved consultation rather than participation and have tended to focus on the domestic aspects of health care, such as the quality of hospital food or the cleanliness of the wards. The emphasis on patient comfort, they argue, has served to divert public attention from more central aspects of the health service. Winkler (1987) argues that this concentration on customer relations rather than on patients' rights has resulted in a harmless version of consumerism which focuses on the way that services are provided rather than on wider issues concerning the planning and development of services. Although commanding much public visibility, she contends, this approach has delivered little in the way of real change. Peckham (1992) suggests that this restricted form of public involvement is reflected in recent government documents and guidance where emphasis is placed on informing and consulting consumers rather than on developing partnerships with local communities.

Many have argued that such an approach is inevitable, given the policy objectives driving the reorganization of the NHS. Reflecting key changes in health and social welfare policy more generally, the White Paper *Working for Patients* (Department of Health 1989) focused on the market power of the health service consumer rather than on the rights and responsibilities of the citizen (Wilding 1992). Yet, as Jones (1989) and Pollitt (1989) point out, the notion of consumer sovereignty has limited applicability in a quasi-market health service, driven by supply-led rather than demand-led forces (Hudson 1990). Hudson (1992) argues that the proposals in *Working for Patients* are primarily concerned with strengthening the mechanisms of central government control, rather than

encouraging local participation in decision-making by patients or their representatives. Furthermore, Green (1990) contends that the objective of empowering HAs and GPs to purchase health care on behalf of the public is likely, via the mechanism of the block contract, to shift decision-making power further from service consumers.

There is evidence, moreover, that there is resistance to increasing the scope of public involvement within the NHS. A national survey of health purchasers undertaken by Harrison & Wistow (1992) revealed a perception that the public is not well-educated enough to make choices about health care provision. This is particularly seen to be the case where clinical practice is concerned. A report by the Greater London Association of CHCs (GLACHC 1992) found wariness and hostility amongst medical audit groups when CHCs tried to get involved and the view that their involvement in this area of work was inappropriate. In particular, it appears that there may be a preference on the part of some HAs to work with health professionals as proxy consumers, rather than to consult consumers and their representatives directly. A national survey of District Health Authority (DHA) managers (Appleby 1992) found that the majority of HAs had consulted GPs whereas the involvement of the general public was considerably less although it is increasing. In addition the study found that the views of local residents, whether expressed through the CHC or via public surveys, were considered to be a relatively minor influence on decisions about where to place contracts. GPs expressed proxy preferences and by contrast were seen to have a major influence. This approach is given tacit support by the Department of Health's advice to HAs to secure the purchasing preferences of GPs, 'unless there are compelling reasons for not doing so' (Department of Health 1989, p. 11). Further advice allows for the possibility that the responsibility to incorporate local views in the purchasing process may be over-ridden by epidemiological, resource or other considerations (NHSME 1991). As North (1993) argues, against the official encouragement given for public consultation throughout the purchasing process, must be placed the fact that '... power remains emphatically with DHAs'.

Nevertheless, it is clear that there are also factors encouraging the process of public consultation and involvement. Sabin (1992) has observed that purchasers are currently worried about their lack of legitimacy in the eyes of the public and that many attempts to consult consumers are part of a more general desire to 'cultivate legitimacy'. This is particularly likely to be the case in a context of continued financial constraints, as purchasers face growing pressures to ration the provision of health services. Redmayne (1992) argues that this may not actually take the form of the denial of services but rather occur through the development of more explicit criteria for prioritization. However, she contends, the ability of purchasers to tackle these issues at present may be inhibited by a perception of their democratic deficit. Heginbotham *et al.* (1992) argues that, although health care has always been rationed, the challenge for the new NHS purchasers is whether they will be willing or able to justify their decisions openly. To the extent that the new 'managerialism' is part of a wider strategy to control the power of professionals (Harrison & Pollitt 1994) there are clear political imperatives for involving, or at least consulting, the public or its representatives in key strategic decisions.

The role of the CHCs

To understand changes in the current position of the CHCs in respect of consumerism in the NHS it is necessary to examine their history in the context of the major policy shifts that have characterized the development of the NHS over the last two decades. The Councils were originally established as part of the 1974 reorganization of the health service. There was concern about the potential conflict of interests involved in the combination of managerial and representative functions which characterized the old hospital management committees. The 1972 *NHS Reorganization Act* emphasized that members of the new area health authorities (AHAs), which in any case were too large to perform a representational function effectively, should have a more explicitly managerial role. They were to be chosen for '... their capacity to judge ... between the competing health needs of the services' (Joseph 1972). In the face of a more explicitly managerial role for the Area Health Authorities, the CHCs were created to represent of the consumer view and provide for '... the expression of local opinion' (Department of Health 1972).

In fact, it is argued by Klein (1990), that health authority members never quite took to their more strictly managerial role and a considerable degree of overlap existed between these two sides of the NHS. This tendency was exacerbated in the 1982 reforms as the newly instituted District Health Authorities were explicitly designed to be more representative of their local communities. At the same time, it should be noted, they were also subject to greater government scrutiny over the appointment of chairpersons (Strong & Robinson 1990). Partly as a result of this growing tension between local and central accountability, noth-

ing very much changed as a result of these reforms. As Harrison *et al.* (1992) argue:

> ... the context in which general management was implemented militated against an imaginative and purposeful consumer orientation emerging in the NHS (p. 95).

In the new managerialist model of the NHS outlined in the 1990 NHS and Community Care Act, HAs have been shorn of any representative function. The new executive-style boards are subject to more explicit central political control and the notion of local accountability is effectively abandoned. In this context, public consultation is recast as a managerial rather than a democratic responsibility:

> Consultation with potential users of services should be an integral part of the management process (Department of Health 1990).

Such a move could correspondingly reinvigorate the role of the CHCs as a means of ensuring a degree of public accountability. Moreover, in the light of the changes in the organization and delivery of social and health care services brought about by the 1990 Act, the CHCs could have anticipated an extended remit: to represent the views of users to both purchasers and providers of health care and to social services departments as well as health authorities. However, far from extending the remit of the CHCs, a series of government circulars and guidance papers has effectively served to constrain their role in the new NHS marketplace. In particular, in addition to having no responsibility towards users of personal social services, the CHCs are to have no formal role in monitoring contracts for services or rights to visit non-NHS premises. It is to be left to the HAs themselves whether they secure visiting rights for the CHCs as part of their negotiated contracts with the private sector. While HAs are obliged to consult CHCs on applications for Trust status, and the Councils have continued rights to visit hospitals that become Trusts, they have no right to be invited to Trust board meetings. The rights of the CHCs in respect of GP fund holders are even more tenuous. While the latter are encouraged to provide information anonymously about major contracts to the CHCs either directly or indirectly via the HA, the CHCs have no right to visit these practices and their request that fund holders be required to establish effective liaison arrangements with the CHCs has been rejected by the government. The Association of CHCs (ACHCEW) argues that the combined effect of the new regulations is effectively to constrain the potential of the CHCs in the new NHS:

> ... CHCs are to be left in a 1970s timewarp unaffected by the contracts game which is to be played with vigour by the health service managers of the 1990s (MacLachlan 1990, p. 1053).

One of the main issues for the CHCs is the extent to which many of their activities are now subject to the discretion of their local HAs. Hunt (1990) has remarked on the cautious use of language contained in government discussions of the role of the Councils. It is up to purchasers to *invite* the CHCs to participate in the purchasing process and to *encourage* them to participate in the development and monitoring of Charter standards and goals. The CHCs have no formal rights in respect of HA decision-making processes. Council members are able to attend HA and FHSA meetings as observers only, without voting rights, at the discretion of the Authorities. In a national membership survey, ACHCEW (1991) found

> ... a significant number of CHCs relegated to the status of member of the public,

at these meetings. Revealingly, the CHC's call for independence from the NHS structure was ignored by government: Councils will continue to be funded by the regional outposts of the NHSME whose role is primarily to ensure that they offer value for money.

There is evidence to suggest that resistance to a more extended role for the CHCs has come as much from the Regional General Managers as from ministers or civil servants. Leaked documents from the Department of Health reveal that many RGMs are extremely hostile to any extension of the CHCs' role and have applied considerable political pressure on this issue:

> RGMs have made it plain that any impression that ministers wished to extend the role of the CHCs would meet with hostility from both managers and clinicians (Jobling 1990, p. 278).

Concern has been expressed by both managers and the government about the potentially political nature of the CHCs. In Harrison & Wistow's (1992) survey purchasers expressed reservations about the role of the CHCs which were seen as being:

> too political [*or*] ... still obsessed with provider issues (p. 128).

The leaked discussion document complains about the variability of the CHCs and the fact that, in some, the legitimate activity of critical comment

> ... shades into direct political action against the government of the day (Jobling 1990, p. 278).

Whilst appearing to confirm the right of the CHCs to maintain an independent view, the document warned

warned that the flexibility that CHCs have to determine their role can result in:

> ... an occasionally hostile attitude to health authorities, and national policies.

To counter this possibility the government argued that HA and FHSA managers should develop good relationships with their local CHCs and encourage them to concentrate on activities which are potentially of most use:

> If CHCs are to be a help rather than a hindrance this will require good working relationships between HAs and FHSAs and CHCs (Jobling 1990, p. 278).

For many CHCs however the requirement to develop 'good working relationships' with their HA may present something of a dilemma. On the one hand, while it is possible for the councils to rely on indirect forms of influence, a certain amount of direct involvement with the HA may be necessary if CHCs are to influence the formative stages of decision-making. Without some degree of cooperation, CHCs may not hear about issues until they become formal complaints or major problems, and it is harder to reverse decisions once they have been made than to influence them as they are evolving. Moreover, involvement at the later stages of decision-making is more likely to lead to confrontation as the debate will more often be held in public, and occasion greater resistance. On the other hand, CHCs may feel they have to balance the potential benefits of closer involvement against the need to maintain an independence stance. Closer involvement in the decision-making process may be seen to compromise the CHC's ability to appraise outcomes dispassionately or to represent effectively the views of its local community. Councils have to tread a fine line between being too confrontational and risk being excluded from HA processes, or working so closely with their HA that their objectivity is compromised.

Involvement, moreover, is a two-way process. Whether or not the councils themselves are keen to be involved, much will now depend on the willingness of their HAs to facilitate involvement. Winkler (1987) has argued that the effect of recent government guidelines has been to make the CHCs dependent on the grace and favour of their local HAs. The ACHCEW (1991) survey revealed that such a perception is confirmed by the councils themselves, with the majority expressing the view that their work is increasingly dependent on the goodwill of local managers. In this context it is possible that overtly confrontational CHCs will not be encouraged to be as closely involved in HA decision-making as those that are willing to work more collaboratively. The government at least is very explicit on this issue:

> The CHC would have to demonstrate that it was prepared to work with and not against management (Jobling 1990, p. 278).

The encouragement being given to HAs to consult directly with consumers may also serve to increase the pressures towards CHC compliance. If the CHCs are perceived as a useful means of involving consumers then there may be less incentive for HAs to consult the public more directly. If, however, they are perceived as difficult or confrontational, then HAs may be more inclined to bypass them and develop ways of consulting local people themselves.

CHCs and purchasing

In the light of this wider political context, it is interesting to examine the extent to which and ways in which the CHCs have begun to work more closely with their HAs. Community Health Councils are characterized by considerable diversity, both in the specific work that they do and in their general approach. This has resulted from the lack of any clear guidelines for their operation and the absence of any agreed criteria for assessing their effectiveness (Ham 1986, Hogg 1993, Martin 1990). An earlier national survey conducted by the authors (Lupton *et al.* 1994) identified major differences between the Councils in terms of their relationship with local health care purchasers and providers. On the basis of this survey, five case study HAs were selected for more in-depth investigation. The case study CHCs were identified as being representative of the range of CHCs nationally, defined in terms of the extent of their involvement with HA decision-making and whether they perceived their role as broadly oppositional or collaborative. The Councils were selected using a cluster analysis of Likert-type attitudinal statements. In each case the selected council represented the central cluster. The five Councils selected for case studies can be taken to represent a range of points on each of the two continua of independence or involvement, and opposition or collaboration (see Table 1). One aim of the research, which is beyond the scope of this paper, was to assess the validity of this classification scheme. In each case study, interviews were undertaken with the chief officer, chairperson and all members of each CHC (150 in all) and with relevant senior managers in each HA or Commission, provider Trust, FHSA and Council for Voluntary Services (45 in all).

On the continuum of involvement, the *HA Partner* Councils can be seen to be at one end, working most closely with their HAs, with the *Independent Challengers*

Table 1 Case study types

- *HA Partners*
  CHCs working closely with their local HA and involved in formal and informal decision-making processes; concerned with individual consumer complaints, but not always taking the side of the consumer;
- *Consumer Advocates*
  CHCs actively working for consumer rights and on the consumers' side; working informally with their HA, although limited involvement in formal decision-making processes;
- *Patient's Friends*
  CHCs representing consumers on an individual rather than collective level; limited involvement in formal decision-making processes;
- *Independent Arbiters*
  CHCs acting as a referee between the consumer and the HA, taking the side of neither; limited involvement in formal HA decision-making processes;
- *Independent Challengers*
  CHCs actively working for collective consumer rights; not working closely with HA and largely excluded from formal or informal decision-making processes.

at the other end, largely excluded from HA decision-making. These two types are also at either end of the oppositional continuum. In the middle of these extremes are Councils which combine a degree of involvement with an overtly oppositional stance, the *Consumer Advocates*, or little real involvement with a neutral stance in respect of the opposition and collaboration issue, the *Patient's Friends*. Finally, there is a group of CHCs that appears to adopt a mid-way position on both the involvement to independence and opposition to collaboration continua: the *Independent Arbiters*.

As we have indicated, the government has urged the Councils to develop their activities beyond hospital management issues and contribute to the evolution and monitoring of the purchasing function (Dorrell 1992). The current level of CHC involvement in this area is hard to quantify, but information obtained from both HAs and CHCs about the nature and extent of their contact over the previous year gives some indication. Each of the case study CHCs had a degree of formal involvement via its attendance at HA board meetings with members being accorded speaking rights. In addition all had, or were planning to have, informal regular meetings with either the District General Manager or the Director of Purchasing. These meetings were mainly used as a means of sharing any issues or concerns on the part of either the CHC or the HA, but they also provided some CHCs with an avenue for more active involvement. Although a large proportion of CHC involvement was, at least initially, led by the HA, with Councils being invited to working groups and committees or reacting to HA proposals or decisions, a number of issues had been raised by the CHCs themselves. Not all the case study CHCs, however, were equally involved in the decision-making process. Generally the *HA Partner*, *Patient's Friend* and *Consumer Advocate* CHCs appeared to have been given greater opportunities for participation than either the *Independent Arbiter* or the *Independent Challenger*. The *Advocate* CHC, for example, had been fairly heavily involved in various discussions on future plans for acute services in the District, had commented on the HA's mid-year review and had been asked to comment on service specification drafts. Similarly the *Patient's Friend* Council had been included in discussions on purchasing plans and sent draft copies of service contrasts. Both the *Advocate* and the *Patient's Friend* Councils had been involved in discussions about the running of local mental health units, in one case obtaining a review of service provision. The *HA Partner* Council had been the most extensively involved, attending service specification meetings and commenting on draft versions of contracts. This Council had been involved in discussions about the reorganization of the HA and the proposed Trust hospitals, as well as in more strategic issues. It had also taken the initiative by requesting that a service was moved from one provider to another.

The two *Independent* CHCs, in contrast, had been much less involved with their HA purchasers and their involvement had mainly, although not exclusively, focused on health promotion and quality assurance issues. These two councils had had to press for meetings to discuss purchasing plans and the issue of contracts, had experienced delays in being shown the contracts, and had largely been restricted to commenting on the general terms and conditions of contracts after they had been finalized. The relative lack of involvement of the two *Independent* CHCs appears to have been partly due to their reluctance, or inability because of time constraints, to become too closely involved, and partly a result of the HAs' disinclination to include them. It is unclear whether these CHCs were failing to respond to invitations for involvement or whether the HAs were trying to involve them in ways that the Councils found inappropriate. There was evidence of considerable disagreement between these CHCs and their DHAs on this issue. For example, in the case of the *Independent Arbiter*, the HA perceived it had asked for comments on its purchasing plan but had not received a response, as a result the HA indicated that it was less keen to consult the Council again:

> I must confess that I don't contact them quite as much as I did at the beginning because I've not had a particularly good

response, and I don't mean that they've been hostile, it's just that the offers there haven't been taken up, so you eventually start forgetting to make the offer (HA respondent: *Independent Arbiter* case study).

The CHC on the other hand felt it was being excluded from various activities and had made several unsuccessful requests to become more involved in the purchasing process:

We just don't know anything about what they are thinking about, until they have thought about it and have done it. I do feel that we are left out in the cold on that a lot of the time (CHC respondent: *Independent Arbiter* case study).

Interestingly, in these latter two case study districts, there was evidence that the HAs were developing more direct means of consulting with consumers, often bypassing the Councils. For example both HAs had involved voluntary organizations in joint consultative planning groups, but had not included their local CHCs in these forums. In the other three case study areas the CHCs were involved in such work alongside the voluntary organizations.

Confrontation and collaboration

As we have seen, the government has argued that if CHCs are to be involved in HA decision-making they will have to demonstrate that they are prepared to work constructively with their HAs. The case study HAs confirmed that they are more likely to value Councils which are prepared to work with them over difficult issues, rather than stand outside and criticize. Although overall it was felt that CHCs had changed and relationships were less confrontational and unproducive then they had been in the past, some CHCs maintained a more explicitly oppositional stance towards their HA than did others. To a degree this appears to have affected the extent to which these Councils were involved in HA decision-making. The collaborative *HA Partner*, for example, was explicitly valued because of its non-confrontational approach:

They're realistic. They rarely, if ever, go down the dogma line. They look at the services, and they're prepared to work with us. If they don't agree with something, they're prepared to compromise (HA respondent: *HA Partner* case study).

The relationship between opposition and involvement however does not appear to be a simple or straightforward one. Thus the actively oppositional *Consumer Advocate* worked quite closely with its HA, albeit in a largely informal and ad hoc manner, while the more neutral *Independent Arbiter* was largely excluded from HA decision-making. Purchasers were keen to explain that the issue was not simply one of co-operation or confrontation. All insisted that they welcomed CHCs as an independent source of advice and criticism:

Essentially, it is very useful to go and have an outside group and have an immediate response, reactions and views to feed back. If we are getting something horribly wrong in their view that really is important (HA respondent: *Patient's Friend* case study).

One problem with the two *Independent* Councils, their HAs argued, was that they were not critical enough. In some ways this made their work easier, but at the same time the purchasers felt they lacked consumer input as a result. These CHCs were not seen to be very active in raising concerns with the HA. Managers complained that it was only if they wrote and asked for comments from the CHC that they were able to establish its view. Otherwise it was not clear where the Council stood on issues:

It would actually be helpful to have some written documents from them as to their policy position, what they are trying to achieve, what are their priorities, what they would like to see from us or other players in the health arena (HA respondent: *Independent Arbiter* case study).

From the HA perspective, the question was not whether the CHCs were oppositional or not, but rather how adequately they performed this function. Councils were more likely to be consulted and involved, HA officers argued, if they were seen to represent an informed source of criticism and comment. Those CHCs which did not appear to be very well informed about current issues and debates were seen to lack credibility. The *HA Partner* and *Patient's Friend* Councils were valued because of their high level of awareness and their useful contribution to meetings. Although not always appreciated by its HA, the approach of the outspoken and critical *Consumer Advocate* was tolerated because of the respect held for its knowledge of consumer issues and its contacts with the local community. By contrast the two *Independent* CHCs were not seen to be fully informed about the changes that were taking place in the NHS:

I think they need more teachings on what purchasing is all about ... they recognised that they had a huge training need on purchasing, on contracting, but I don't think it's actually moved on (HA respondent: *Independent Arbiter* case study).

It was clear from the case study discussions that the role of the CHCs as a source of information about the views and concerns of the public was only one reason for HAs seeking greater collaboration. The other main motive was a desire to minimize public criticism of HA decisions. As such, it appears that the HAs' willingness to accept opposition depended greatly on the

ways in which that opposition was made. In general, criticism was more likely to be valued if it was channelled via what were seen to be the proper, that is, internal, means. An important feature of the *HA Partner* case study, for example, was the level of trust between the HA and the Council. The HA felt it could provide the CHC with confidential information and allowed Council members to stay for all parts of its meetings. Although not unwilling to criticize its HA, the *HA Partner* CHC tended to do so from within rather than going public on the issue. This level of trust was largely absent in the other four case studies. One CHC, for example, was told it would not be involved in certain discussions unless it agreed to their proceedings being secret. All four reported instances where the CHC had gone to the press over issues. In the two *Independent* case studies this had led to direct confrontation between the CHC and the HA.

The desire to cultivate legitimacy and minimize public criticism may be particularly keen as purchasers face growing pressures to ration resources. All but one of the five case study HAs indicated that they were increasingly facing decisions on the prioritization of services and were looking to the CHCs to assist with this process:

> We would value as a HA a stronger consumer input on how to angle our purchasing plans for the future, but that basically comes down to what services we should buy less of (HA respondent: *Consumer Advocate* case study).

This issue may be a particularly sensitive one for Councils, and may highlight more than any other the tension between involvement and independence. CHCs may be torn between a desire to get involved in order that such decisions are taken publicly, and a reluctance to be seen to be colluding with HAs in the management of reduced resources (ACHCEW 1991). In both the *Independent* case studies, for example, the desire by HAs to involve the CHC in such discussions, and the CHC's reluctance to be drawn in, appears to have been one reason for the poor relationship between the two. As a purchaser in the *Independent Challenger* case study expressed it:

> ... the CHC I think took the view that they did not want to be asked those sort of questions. I think there is a reluctance to become involved in the rationing debate, or in the priorities debate (HA respondent: *Independent Challenger* case study).

Involvement and influence

It is important to distinguish between involvement and influence; just as it is possible for the public to influence decision-making without individuals being directly involved in the process, it is possible for the public to be involved or consulted without its views in the end having any actual influence on the decisions made. Similarly, the CHCs' influence on purchasing decision-making can be both direct and indirect, and may not be related to the degree of their involvement. By providing advice and assisting with complaints, for example, the work of the CHCs may indirectly influence HAs by encouraging individual service users to assert their rights and raise issues with the Authority. The use of the media and public forums to increase the public's awareness of the activities of its HA and stimulate debate can encourage individuals or groups themselves to put pressure on their HAs for change. More direct mechanisms may include informal discussions with key people, representation on meetings and working groups as well as feeding back the results of research and monitoring work.

The views of the case study purchasers about the specific influence of the CHCs varied, although none felt it was very considerable. Generally they ranged from the view that the Councils were not as influential as they could be to the perception that currently they were fairly peripheral to major policy decisions. Two HAs (*Patient's Friend* and *HA Partner*) claimed that the influence of the CHCs was significant but partly hidden because the values of HAs had in recent years moved closer to those of the Councils:

> We think in the same way as the CHC much more, we have the same agenda. Without any doubt, it is our views that have moved towards theirs. So they have actually done the influencing (HA respondent: *Patient's Friend* case study).

As we might expect, the CHCs least formally involved with the purchasing process, the *Independent Arbiter* and the *Independent Challenger*, were felt by purchasers to be the least influential. Such influence as they exerted was seen to be largely passive, stemming from the simple fact that they were there. HA respondents in these case studies commented that the knowledge that their actions were being scrutinized was important and, on occasions, may have made them move more quickly on an issue:

> I wouldn't say it influenced the policy making, but it probably made those who were responsible act possibly a bit quicker, it didn't change the decision, but it made us get the problem resolved (HA respondent: *Independent Arbiter* case study).

However, in none of the case studies, of whatever type, was the influence of the CHCs seen to be very considerable. The more closely involved Councils, the *Consumer Advocate*, the *HA Partner* and the *Patient's Friend* appear to have been listened to more than the

others, but generally the degree of these Councils' influence also seems limited. The *HA Partner* had the most extensive level of contact with its HA but, even this Council was not felt by purchasers to have much influence over actual decisions. Generally across all the case studies, purchasers tended to view CHC influence as restricted largely to matters of detail rather than strategic direction. As one HA officer in the *Partner* case study explained: 'They're a useful mechanism for fine-tuning the service'.

From the perspectives of the case study CHCs, the potential for influence was felt to be greater through informal means than through the formal mechanisms of HA meetings, responding to HA document or proposals for changes in services. The *Consumer Advocate* in particular felt that the informal consultative process afforded it a significant influence:

> ... in the planning bit, and general discussions with people ... the informal 'phone calls saying, 'what's going on?, what's your views about this?', the influence must be considerable (CHC respondent: *Consumer Advocate* case study).

In contrast the two *Independent* CHCs reported that they were rarely included in the earlier stages of decision-making and that their main opportunity to influence the HAs was restricted to more formal mechanisms. By this stage however, it was felt, major decisions had largely already been taken, and the only leverage for these Councils was their statutory right to be consulted:

> ... decisions are being taken on a day by day basis at the health authority that we know nothing about. They could be quite important decisions that we have views on, and we are not privy to the discussions, and it's just presented to us as a fait accompli (CHC respondent: *Independent Arbiter* case study).

The main source of influence for these two Councils had thus derived from opposing formal proposals to close services. This had met with varied success, but the *Independent Arbiter* CHC had succeeded in getting the HA to reconsider two proposals to close services. One had involved the Council holding a public meeting to discuss the issue, where over 100 people had attended. The *Independent Challenger* CHC was awaiting a decision from the Secretary of State on a proposed closure of a service.

The concern about the relatively limited nature of their influence however was not confined to the *Independent* CHCs; the *HA Partner* also expressed doubts that, despite being more closely involved in purchasing processes, its views were often taken into account. Both this CHC, and the *Patient's Friend* Council felt that their influence was over more marginal aspects and issues such as the quality of service provision. These CHCs gave different reasons for their limited impact despite apparently being valued by their HAs. *The Partner* CHC felt that the cash limits being placed on HAs and the introduction of Trust hospitals had severely weakened the strength of the HAs themselves. The *Patient's Friend* Council, on the other hand, offered a more cynical explanation for its limited influence. To some extent, it believed, CHC involvement was used to legitimize decisions that had already been taken:

> They tend to say to us that we are very important to them but I sometimes get the impression that they use us as a means of kind of legitimizing what they have been doing (CHC respondent: *Patient's Friend* case study).

This view that CHCs are being used to legitimize HA decisions was part of a wider and more general perception on the part of the case study CHCs that there has been an overall reduction in the degree of public accountability of health service managers. All Councils were of the view that, once the HA reached the stage of formal consultation, key decisions had already been made and were much harder to change:

> Once you get to consultation about something — formal consultation — the cards are so stacked against anything other than minor change, that it's best to use it as a public information exercise as much as anything (CHC respondent: *Consumer Advocate* case study).

There was also a general perception that HAs were reducing the number of formal Board meetings, and that most important decisions were being taken outside these meetings, without CHC, or any other public, involvement:

> ... the set piece of the HA meeting has always been a focal point of our work and an opportunity for us to raise our concerns and find out what was going on, and that really isn't the case any more (CHC respondent: *Consumer Advocate* case study).

These concerns about the reduced public accountability of HAs are echoed in a national survey of CHCs undertaken by ACHCEW (1991). This found that the number of public HA meetings is decreasing and that nearly three-quarters of the CHCs believe that their HAs are now making important decisions in private.

Conclusion

Central government encouragement to health care purchasers to develop the role of champion of the people has implications for the work of the CHCs which have traditionally performed this function. In turn, the CHCs have been encouraged to shift their focus from

their traditional concern with provider issues and become more involved in the purchasing process. Yet the Councils have not been accorded any formal rights in respect of this new role; their involvement in the evolution and monitoring of the purchasing function remains essentially dependent on the goodwill of local HA managers. The government has indicated that much will depend on the extent to which the Councils demonstrate a willingness to work with and not against their HAs.

The nature and extent of CHC involvement in the purchasing process varied between the different case studies. Each of the CHCs had some degree of formal involvement with their HAs, mainly via their attendance at HA board meetings, and all HA managers were considering how or whether to involve the Councils more in the future. Some CHCs however were working more closely with their HAs than others. Generally the *HA Partner*, *Consumer Advocate* and *Patient's Friend* Councils were more actively involved with their HAs than was either the *Independent Arbiter* or the *Independent Challenger* CHC. While achieving an appropriate balance between independence and involvement is clearly an issue for CHCs, it is not possible to see these two attributes as a simple 'trade off'. Closer involvement does not necessarily result in a reduced level of independence. Although the most closely involved CHC, the *HA Partner*, did appear to have sacrificed a degree of independence, and the independence of the *Challenger* and *Arbiter* stances seems to have resulted in, or possibly resulted from, lower levels of involvement, the *Patient's Friend* CHC and, to a lesser extent, the *Consumer Advocate* Council did not conform to this rule. Although the *Patient's Friend*, for example, had a more distant and formal relationship with its HA and clearly saw itself as being on the side of the consumer, it nevertheless had a significant degree of involvement in the HA decision-making process. It appeared to be the case that where CHCs were not working very closely with their HAs, there was a greater tendency for the HA to bypass them and consult directly with the public, particularly with representatives from voluntary organizations.

A more interesting question perhaps is whether the increased dependency on HA goodwill has meant that those Councils adopting a more explicitly oppositional stance are more likely to be excluded from HA decision-making. There is some evidence from the case studies that this may indeed be the case. Thus, the most explicitly compliant and co-operative Council, the *HA Partner*, seems to have enjoyed the most extensive involvement. The relationship between opposition and involvement however does not appear to be straightforward. The *Independent Arbiter* CHC, for example, assumed a relatively neutral position on the oppositional continuum, yet was largely excluded from the decision-making process, whereas the actively oppositional *Consumer Advocate* Council worked quite closely, albeit informally, with its local HA. The issue appears to be not whether the CHC is critical of the HA but, in part at least, the extent to which its criticism is seen to be well-informed. Councils with little knowledge or understanding of the changes taking place within the NHS were seen by their HAs to lack credibility. Oppositional Councils on the other hand were nevertheless valued if they had a good knowledge of issues and developments. In particular HA managers appeared more likely to involve CHCs if they were seen as a source of good information about public views and concerns or about local community networks.

Access to information about consumer views and local contacts however is only one motive for greater public involvement and collaboration. The other equally important objective indicated by the case study HAs is the desire to minimize public criticism. To an extent at least public involvement seems to be part of a more general legitimation strategy on the part of HA managers. Strong preference was given, for example, to those CHCs which were prepared to work internally and if necessary confidentially with the HA over contentious issues and those Councils which the HA felt could not be trusted were likely to be excluded from key meetings. In particular all but one of the case study HAs indicated that they were looking to CHCs for assistance with decisions about the prioritization of services. This had created difficulties for many of the case study Councils and the reluctance of two CHCs to be involved in this process was clearly an important factor in the poor relationship which existed between them and their HAs.

Whatever the extent of the CHCs' involvement in HA decision-making, however, few Councils appeared to be having much influence on the outcome of those decisions. The general view of all CHCs was that the opportunities for influence were at the informal stages of the decision-making process rather than at the formal consultative stage. Although some Councils were involved more than others in informal consultative processes, only one of the case study CHCs felt that it had been afforded significant opportunities for informal influence. There was a widespread view that CHC influence was mainly limited to fairly marginal issues, such as quality assurance, and that key strategic issues were increasingly being taken outside the formal consultative mechanisms. Most felt that their role was ultimately to legitimize decisions that had already been taken. This per-

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spective was confirmed by HA managers who felt that CHC influence was largely confined to peripheral rather than major policy decisions: a useful mechanism for fine-tuning the service.

Despite the rhetoric surrounding the role of the consumer in the NHS, therefore, and despite the particular encouragement being given to the CHCs to co-operate closely with purchasers in their role of champion of the people, the window of opportunity for public involvement in the NHS appears to be barely open. The experience of the case study CHCs would seem to indicate that the vogue for public involvement is largely driven by a managerialist rather than a democratic agenda. In this context, CHCs will be involved to the extent that they underpin and inform rather than undermine the centrally driven management function. Even here it appears that they may not be included at the real heart of the purchasing process where, the case studies suggest, the tendency may be for less rather than more public visibility and accountability.

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