Community participation and health care priorities: reflections on policy, theatre and reality in Britain

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SUMMARY
In recent years, the British government has attempted to make the finite nature of publicly funded health care explicit and to involve the ‘public’ in discussions about which treatments (or indeed patients) should be given priority over others. This article considers the nature of the new political emphasis upon local participation through an analysis of policy and illustrative reference to a system of participatory forums in the field of mental health planning developed in an area of southern England. The tendency by the health authority in question not to respond to many of the issues raised by the forums illustrates two characteristics of the health service in Britain. Firstly, there continues to exist a political, managerial and clinical hegemony within the service such that health authorities tend not to have to account for the weight they attach to local views or the manner in which such preferences are measured against other imperatives and considerations. In a second respect, the simplistic notion of the ‘purchase’ of health care by health authorities on behalf of local populations is problematic. Health authorities are faced with a panoply of political, statutory and bureaucratic requirements that preclude activity in accordance with ‘market forces’. This in turn renders the idea of local ‘advice’ to purchasers considerably more complex than the associated political rhetoric intimates.

Key words: community participation; health care priorities; local voices; priorities

INTRODUCTION
A mismatch between popular demands upon the British National Health Service (NHS) and the resources available has been evident since the 1950s. Mechanisms to regulate this demand have also always been at work. Waiting lists, general practitioner control over the rate and number of referrals for hospital treatment, and decisions by consultants upon whom to treat (usually elevated to the status of ‘clinical judgement’) have been used to obscure some of the pressures on the service. In recent years, though, the government has not only attempted to make the finite nature of publicly funded health care explicit, but also to involve the ‘public’ in discussions about which treatments (or indeed patients) should be given priority over others. Health authorities, responsible for buying health care on behalf of local populations, have been exhorted by a succession of politicians to work more closely with local people in identifying local needs and preferred options in health care. As a result, there has been an outbreak of exercises designed to gauge the views of local people—questionnaires, community meetings, citizens’ juries and focus groups are just a few of the methods employed by health authorities. This article considers the nature of the new political emphasis upon local participation through an analysis of policy and illustrative reference to new participatory structures in the field of mental health planning developed in an area of southern England.
THE NEW COMMUNITY PARTICIPATION

In recent years, the British government has portrayed local people as ‘advisors’ to the health authorities who are responsible, in the wake of the National Health Service and Community Care Act 1990, for the purchase of health care on behalf of their local populations. A number of means by which purchasers might consult local people were cited in Local Voices, an advisory document produced by the NHS Management Executive (1992). Suggestions included the use of ‘focus groups’ drawn from the local population, surveys, health forums and other interventions, but these have not been augmented by any new statutory obligations concerning local consultation. These changes and other reforms would, however, according to the government, encourage ‘those working in the service to respond to what patients want and need’ (Conservative Central Office, 1992, p. 27). This rhetoric has continued into the second half of the 1990s. The basic planning document for the whole of the health service emphasises a need ‘for giving greater voice and influence to users of NHS services and their carers in their own care, the development and definition of standards set for NHS services locally and the development of NHS policy both locally and nationally’ (NHS Executive, 1995). Concomitantly, the theme of local participation has achieved some prominence in government research and development priorities over recent years (Department of Health, 1995).

These developments appear to represent a considerable enhancement of the role played by local people. Hardly any progress had been made in this area since 1974, when Community Health Councils were established to represent the ‘public interest’ in each health authority district. This representation has, however, ranged between councils from the simple pursuit of complaints by members of the public to close co-operation with health authorities in the planning of local services (Buckland et al., 1994). The policy interventions since 1991 have, in addition, spawned a plethora of initiatives designed to gauge the ‘local voices’ that are now supposed to be active in the determination of health care priorities. The longevity and relevance of these projects vary considerably and some overlap with longer-established initiatives in community development and community involvement. In this respect, the initiative under consideration was chosen for its relatively long lifespan (over 3 years) and an apparently direct relationship to existing planning and decision-making mechanisms and procedures in the local health and social care services.

THE MENTAL HEALTH FORUMS

In 1992 Malville Health Authority and Malville Area Social Services in the south of England—encompassing a population of over 320 000—established five local forums to identify needs, preferences and priorities in mental health care provision. These groups were composed of invited or nominated ‘stakeholders’ in the receipt and provision of local mental health care services. Participants included service users, carers, local mental health social workers, representatives of the voluntary sector and community psychiatric nurses and psychologists. Each group was to be facilitated by an experienced health or social services professional and administered by a clerk funded through ‘joint finance’ —that part of health authority funding reserved for collaboration with other statutory and voluntary organisations. In terms of preparation, all initial members of the forums were invited to an induction day—this outlined in some detail the organisational structures, remits and responsible personnel in the local mental health services. Members were not given any formal training or guidance upon how to identify and consider relevant issues. Instead, the health authority and area social services decided that the forum chairpersons, agendas and procedures would be determined by the membership. The only ‘condition’ was that the forums meet every 1 or 2 months. Formal communication of group decisions, recommendations and requests to a joint health and social services mental health care planning team would be via meeting minutes, correspondence approved by the groups and delegated personal representations.

Measuring the impact of the local forums

The 93 sets of approved forum minutes over a 2-year period were obtained and analysed to identify issues raised by the groups. These minutes encompassed 645 individual attendances by 123 members. Just over half of these individuals were user-representatives, carers or belonged to local voluntary organisations—57.3% of this group
were members of the mental health forums throughout the initial 2 years. Other forum members were largely employed by local health care providers and the area social services—just over 42% were forum members for the first 2 years of the initiative. Over the same 2-year period, 16 of the 93 meetings (17.2%) were attended and annotated with the permission of forum members. In a third respect, concurrent minutes from the joint mental health care planning team were obtained. A fourth activity encompassed tape-recorded or annotated focused discussions. Nineteen executives and senior managers from the health authority and social services who were involved in establishing and overseeing the new initiative were interviewed, as were 31 (60.78%) of then current members of the mental health forums.

Each issue raised by the forums was assigned to one of four categories. The formal consultation category encompassed group suggestions and requests in relation to documents and correspondence circulated by statutory authorities for the purpose of consultation. ‘C-town’ mental health forum, for example, suggested in response to an official report that local occupational therapists devote less resources to the modification of their clients’ accommodation and more time to improving the dexterity and mobility of patients. Secondly, the funding priorities categorisation was applied to group recommendations related to the identification of local deficiencies in health, social services and voluntary sector provision, together with associated issues of policy and practice. In this respect, G-town mental health forum identified a need for greater local provision for dementia sufferers under the age of 65. A third category of issues, planning system, centred on the information-flows and decision-making procedures within the local mental health care planning system. One issue centred on the R-town forum’s request to receive the minutes of the mental health care planning team. Topics raised under the fourth theme, group management, reflected concerns about the rules and procedures under which the forums were to operate.

Each issue identified was traced to its resolution or non-resolution and given one of five outcome codes. The first code, success, indicated that a group had pursued and won to its own satisfaction a tangible objective—such as a grant to a day-centre. A second outcome code was response accepted—a group had sought a particular outcome but had, upon the basis of official answers and clarification, decided not to pursue the issue further. The third outcome code was deferred—an issue had been brought to the attention of the relevant authorities, and a corresponding decision had been expected by the appropriate individual or committee but had been deferred. Such issues were ‘current’ in that their place on the agenda was acknowledged but they were not resolved in the course of the 2-year time-frame. A fourth code, no response, was applied to those issues which had been placed before the relevant committee or meeting for a decision but had elicited no recorded answer. Issues under this heading included a failure to respond to a request for improved post-institutional care for mentally ill young people. The last code, rejected, encompassed those requests from groups that had been considered and unambiguously rejected by the local health and social services. This outcome encompassed a refusal, on the grounds of cost, to meet a request for more residential placements for sufferers of dementia.

**Results**

Overall, only 11, or under 20% of the 57 intercessions by the mental health forums could be regarded as ‘successes’, while a further 20%

<table>
<thead>
<tr>
<th>Outcome category</th>
<th>Formal consultation</th>
<th>Funding priorities</th>
<th>Planning system</th>
<th>Group management</th>
<th>Frequency of outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Success</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>11 (19.29%)</td>
<td></td>
</tr>
<tr>
<td>Response accepted</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>11 (19.29%)</td>
<td></td>
</tr>
<tr>
<td>Deferred</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5 (8.77%)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>9</td>
<td>11</td>
<td>7</td>
<td>29 (50.87%)</td>
<td></td>
</tr>
<tr>
<td>Rejected</td>
<td>1</td>
<td></td>
<td></td>
<td>1 (1.78%)</td>
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**Table 1: Summary of issues raised by mental health forums and attendant outcomes**
resulted in the acceptance by the groups of essentially placatory explanations by the health and social services (Table 1). Although only one intercession was formally rejected, over 50% of all issues raised received no response. The specific issues raised by the forums reflected a particular concern with ‘funding priorities’—this encompassed 21, or nearly 37% of all intercessions. Corresponding outcomes included three ‘successes’ (14.3% of outcomes under the ‘funding priorities’ category); 11 ‘no response’ outcomes and just one occurrence of a ‘rejected’ intercession.

A further 17 intercessions centred upon the local mental health care planning system itself. These resulted in five ‘successes’, four cases of ‘response accepted’ and—again—a preponderance of ‘no response’ outcomes. Intercessions concerned with ‘consultation’ were less prominent and, in terms of ranking, less consistent among the groups than was the case with ‘funding priorities’ and ‘planning system’ issues. Substantive concerns included the S-town forum’s comments upon the floor-plan of a proposed nursing home, and suggested amendments by G-town mental health forum to a ‘user’s charter’ produced by the county council social services department. The corresponding outcomes are marked by a complete absence of ‘success’ codes. Moreover, nine, or nearly 65% of the fourteen intercessions under the ‘consultation’ theme led to outcomes of ‘no response’.

The relative paucity of ‘group management’ intercessions—just five of the overall total of 57 issues (8.77%)—is perhaps explicable by the nature of the category itself. A rhetorical emphasis by the health and social services upon the autonomy of the groups with regard to the conduct of meetings meant that members rarely had to move beyond the participatory forums in this respect.

DISCUSSION

The mental health forums in Malville appeared to have a very limited impact upon the nature and direction of local mental health care provision. Most notably, there was a tendency by the health authority and area social services not to respond to many of the issues raised by the forums. This perhaps only confirms the continuing political, managerial and clinical hegemony with which the NHS in Britain has often been associated—a trend that has manifested itself in a lack of formal mechanisms beyond Community Health Councils for accountability to local populations. Although the recent organisational reforms have undoubtedly influenced the professional relationships within the health service, they appear not to have substantively enhanced the role of local users, carers and voluntary sector representatives in the identification of priorities. In a second respect, the limited impact of the mental health forums in Malville brings into question the degree to which the depiction of local people as ‘advisors’ to health service purchasers is realistic—an issue which centres upon the mechanics and constraints implicit in the corporate ‘purchase’ of health care in a quasi-market context.

The limits to accountability

Local initiatives around the theme of wider participation in the identification of health care priorities represent a conscious challenge to the bureaucratic, expert-based model of the NHS implicit since its inception. As early as 1946, Aneurin Bevan, the Minister for Health, argued that:

If we intend to enter into a contract with the citizens of the country, under which we collect from them a certain contribution, and in return for that contribution, we give a certain service, how are we to guarantee that service is given, and that contract is carried out, if it is carried out through the agency of independent and self-motivating bodies? (HMSO, 1946, p. 467)

By implication, central government, or perhaps the Labour political executive, were not seen to possess the independent and ‘self-motivating’ characteristics of the private sector. The interests of the democratically governed state were, on the basis of Bevan’s words, indistinguishable from those of the citizens for whom the health service would operate. No legislation since has challenged this initial implicit premise that the government, through the Secretary of State for Health, has principle responsibility and control over a ‘comprehensive health service designed to secure improvement in the health of the people’.

Clearly though, the demand for particular forms of health care will often exceed provision, a fact that has led to a number of court cases which illustrate the limited degree to which health authorities have to account for their decisions. In 1971, for example, the Department of Health approved a scheme to improve orthopaedic ser-
vices in the West Midlands Regional Health Authority. Successive expenditure cuts and budgetary constraints resulted, by 1980, in the indefinite postponement of these improvements. Consequently, a patient who had been waiting for treatment for several years sued the Secretary of State, the Regional Health Authority and Birmingham Area Health Authority. The applicant claimed that the Secretary of State had failed in his statutory duty to provide a comprehensive health service. The court ruled, however, that the Secretary of State could only be expected to provide services within the financial resources available. Indeed, one judge observed that ‘The Secretary of State says he is doing the best he can with the financial resources available to him and I do not think he can be faulted on the matter’ (Longley, 1990, p. 540).

This ruling gives some indication of the degree to which the Secretary of State and his or her agents are not required to make explicit the means and criteria by which decisions on resource allocations are made—a limited legal basis of public sector ‘accountability’ that is more clearly illustrated in another court case heard in 1988. A 5-year-old boy born with a heart defect urgently required a third operation. The child’s doctors and Central Birmingham Health Authority both accepted that this was the case. Although the boy was at the top of the waiting list a shortage of intensive care beds and specialist staff meant that the operation was cancelled three times. In response, the boy’s parents brought a court case which sought to compel the authority to perform the operation. The application was unsuccessful and the court ruled that it could only intervene if a decision was shown to be Wednesbury unreasonable (Beatson and Mathews, 1989, p.173). This test, based on case law, includes in the definition of ‘unreasonableness’ a principle that the courts can only interfere in decisions delegated to a statutory body if it is shown that the organisation in question has applied its powers contrary to the purpose of parliament or it has exceeded those powers (Puttikh, 1988, pp. 173–176). In considering issues of public sector accountability, English and Welsh law thus concerns itself with neither the allocation of resources nor, in general, details of how decisions on resource allocation are reached. This lack of emphasis upon the criteria by which decisions are made severely curtails judgements on whether a decision is reasonable (Longley, 1990, p. 541). Local people may therefore ‘advise’ health authorities but have hardly any control over the weight attached to their views or the manner in which such preferences are measured against other imperatives and considerations.

This absence of formal criteria of accountability with regard to the process of decision-making in the purchase of health care is, of course, conducive to ‘political’ interventions. The quasi-market in health care within Britain remains subject to interventions from the government and Secretary of State for Health. Moreover, the quasi-market’s primary purpose is to deliver the ‘comprehensive’ health service—the reward and punishment of those health authorities and service providers within the market does not, at the moment, encompass the equivalent of bankruptcy and liquidation. Instead, the ethos of the health service remains notionally aligned towards the idea of a post-war ‘welfare citizenship’ (Marshall, 1963). Against this background, the notion of ‘purchasing’ health care becomes highly qualified—health authorities are faced with a panoply of political, statutory and bureaucratic requirements that preclude activity solely in accordance with ‘market forces’. This in turn renders the idea of local ‘advice’ to purchasers more problematic than the associated political rhetoric intimates.

The complexity of purchasing

Dialogues, conflicts, compromise and rationing—whether overt or less explicit—have always regulated access to health care. The statutory division between health service purchasers, the health authorities, and ‘providers’ in 1990 has, however, accentuated the finite nature of available resources—a principle rationale for the ‘advice to purchasers’ role. Superficially, the trend towards dialogue between health service managers, professionals and the people for whom they are supposed to work is an overdue counter-balance to a health service divorced from any type of systematic accountability to local people. Health authorities have, indeed, been described as ‘champions of the people’ by one Secretary of State for Health, and they continue to receive occasional guidance upon how best to gauge the ‘local voices’ (Donaldson, 1995). Perhaps not surprisingly though, the reality flows less easily than the rhetoric. One obvious issue centres upon the degree to which ‘the public’ is interested in discussing health care priorities.
In this last respect, successive surveys show a high degree of support for the NHS, but interest in debates about priorities is harder to gauge. Results from British Social Attitudes surveys of between 1000 and 3000 people show, for example, that the number of respondents who claimed to be willing to pay higher taxes to finance increased expenditure upon ‘health, education and social benefits’ grew from 32% in 1983 to 63% in 1993. Over the same period, health was consistently ranked first as an area most in need of extra public expenditure (Lipsey, 1994, pp. 3–4). A considerably smaller survey suggests that 67% of respondents thought that the public should have ‘more of a say’ in purchasing and prioritising decisions (Bowling, 1993). In terms of substantive decisions on priorities, though, this figure—even if accurate—will vary considerably according to the subjects under consideration, the way in which questions are presented and the information on ‘opportunity costs’ placed before respondents. The young and healthy on a good income may, for example, be considerably less interested in the fate of local geriatric wards than the elderly people who rely upon them and who wish to stay in contact with friends and family who live locally. Even services whose threatened closure or relocation usually guarantees a voluble public response—such as specialised in-patient paediatric facilities—will, of course, have different implications for different people. When the questions become even blunter—‘Whose life is going to be saved by kidney dialysis, who’s going to be left to die and why?’—there is often not just disagreement between people, but there might also exist a reluctance to become involved in such debates. Indeed, any attempt at ‘public participation’ is premised on the implicit—often unexplored—assumptions that the individuals concerned already hold apposite opinions, that they view such opinions as legitimate and reasonable, and that they are willing to make known their true thoughts to what are usually complete strangers (Williams, 1994, p. 513).

More fundamentally—as the discussion above of traditional approaches to accountability and decision-making in the British health service infers—the presumption of ordered, rational and coherent thinking with regard to priorities is as questionable in relation to managers and professionals as it is to co-opted ‘lay’ participants. Apparently simple economic notions such as ‘opportunity costs’ belie a plethora of conscious or de facto related factors. These include the specification or absence of objectives with regard to setting priorities—these may touch on areas such as equity, efficiency and cost-containment and may, in addition, each have an explicit or opaque weight attached to them. Unless such factors are identified, made explicit to all concerned and directly related to exercises in the identification of priorities, the results obtained will either defy interpretation or fuel highly partial attempts at post hoc and concurrent rationalisation (Pollock and Pfeffer, 1993). In this last respect, the rhetoric of an internal ‘market’ in health care within Britain does not, recalling the historical association between notionally free health care and the essence of citizenship, adequately reflect the reality of the health services’ administration and management. It is thus almost inevitable that the role and impact of ‘local advisers’ within the market should be uncertain.

Accordingly, and perhaps most fundamentally, the implicit assumption that health authorities, the public and other sources of advice can simply decide what health services are to be purchased and then do so in the manner of a trip to the supermarket is often far removed from local realities. A number of strategic factors underpin the purchase of health care—factors which might have to be balanced against local public preferences. Although, hypothetically, the cheapest hip-replacements may be available in northern England, it would be impractical for a health authority to purchase them for elderly and perhaps housebound patients in the far south-west. Similarly, in the short-term, it may make sense for health authorities to avoid purchasing ‘over-priced’ or ‘poor quality’ services from local hospitals. If, however, health authorities consistently overlook their local hospitals, the latter—in keeping with ‘market-forces’—may have to dispense with certain services for which the local population has a residual or longer-term need. Unlike the supermarket, there is no reason to suppose that goods removed from the shelf will be replaced overnight by an army of shelf-stackers. Health authorities are thus often obliged to maintain or ‘develop’ relationships with providers whose short-term standing in the market would be deemed uncompetitive from a wholly economic perspective.

Public involvement in the identification of health care priorities is thus considerably more complex than the political rhetoric would indi-
Cate. Issues facing health authorities include the fundamental aim of informing the public of the statutory constraints, geographical realities and strategic factors which necessarily colour local debates upon health care priorities. There is also the question of how health authorities should engage the public with regard to different issues—detailed discussion with specific groups of patients and their families might sometimes be more appropriate than questioning people on the street about their opinions. In another respect, health authorities have received little detailed guidance on their own internal organisation with regard to engaging the public. Each authority has, for example, to decide for itself whether an overall organisational strategy would be appropriate. Similarly, it is not automatically clear whether individual directorates or individuals within each authority should have special responsibilities for this area. Perhaps even more fundamentally, there has been no guidance on what resources can reasonably be dedicated to the issue of public participation.

The highly contingent nature of health service purchasing, coupled with the maintenance of basic health care as a right of citizenship, perhaps inevitably contribute to sustained debate and uncertainty around the principles and mechanics of ‘local advice’ to purchasers.

CONCLUSION

An intensification in rhetoric surrounding the ‘new’ community participation in the identification of health care priorities within Britain has to be considered against the traditional nature of the NHS. The voice of users in the planning and provision of secondary care in particular has traditionally been marginalised in comparison to the influence of managers, clinicians and central government. The division between health service purchasers and providers in 1990 accentuated a continuing mismatch between demands upon the health service and available resources. This in itself did not, though, enhance the influence of local populations over the determination of health care priorities—a view reinforced by consideration of the impact upon local services of the five mental health forums in Malville. Recent attempts to encourage local participation are thus marked by at least some element of theatre, in addition to a possible desire to legitimise the more overt processes of service prioritisation.

The current political interest in gauging the ‘local voices’ is thus, at best, a preliminary exercise designed to raise popular awareness of the need to prioritise, rather than—as has been maintained—a means by which to actively involve people in the determination of health care priorities. Whether this presages a more substantive propagation of the ‘market’, motivated by a desire to disassociate a comprehensive health service from popular notions of citizenship, remains to be seen.

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