THE NEED FOR COMMUNICATION BETWEEN HEALTH AUTHORITIES AND THE PUBLIC

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I was prompted to write this article by an experience I had recently in fighting to preserve one of the hospitals in my locality, Talygarn. This hospital had an unique history, having been bestowed by a local merchant for the use of mining community. Talygarn had served South Wales since 1923, as a convalescent home and, since 1943, as a rehabilitation centre for miners. It was integrated into the NHS and is advised by the Talygarn Rehabilitation Committee, consisting of representatives of the Health Authority, the NUM and British Coal.

With the run down of the mining industry, demand on Talygarn from miners declined and it was opened up to other patients, suffering from orthopaedic conditions, arthritis and rheumatism. There are beds to accommodate male and female patients and superb modern facilities, 64 acres of landscaped gardens and woodland. It was operated by experienced and committed medics, physiotherapists, occupational therapists, nurses and ancillary staff. Talygarn provides an ideal therapeutic environment.

Those who were aware of the value of Talygarn were shocked to learn, through reading a public notice, of the recommendation of Mid Glamorgan Area Health Authority (Mid Glams AHA) to change the hospital's function and purpose. The proposed changes were attributed to the decline in the number of day patients reflecting the decline of the mining industry. The AHA intended to phase out the rehabilitation function of the hospital as soon as alternative facilities were available and use it as a training base for nurses in line with Project 2000. The residential accommodation for patients would cease in December 1991 and alternative arrangements would be made for day patients in other hospitals.

The Mid Glams AHA had a statutory duty to consult all interested parties and they held joint meetings with the East Glams Community Health Council (CHC) in the local area and other CHCs in the

catchment areas. Whilst the various CHCs varied in their responses, East Glams CHC were strongly opposed to the change. They recognised the need for a centre for nursing training but felt that Talygarn had established itself as a centre of excellence and there was a danger in dispersing the work in other hospitals.

As soon as the public became aware of the plans, a campaign was organised to oppose the changes. The campaign included the staff in the hospital, the South Wales Miners, our local MP, Dr Kim Howells, and members of the public. In a matter of weeks, a petition opposing the changes had been signed by 25000 people in South Wales, many of these former patients at Talygarn. The petition was simultaneously presented to the Chief Executive of Mid Glams AHA and to David Hunt, Secretary of State for Wales.

Although the AHA fulfilled its obligation to consult with the CHCs, this consultation was not very meaningful. Essential information relevant to the changes was not made available, despite the joint meetings. There were no specific details of the structure or staffing of alternative services. All that was offered were general proposals of alternative facilities in local hospitals which might receive a boost when the new hospital in the Taff Ely District was opened. It was clear that only half the patients now treated at Talygarn would receive comparable treatment in other hospitals by 1992. The other half would have to wait at least a decade for new hospitals to open. Mid Glams AHA have applied to the Welsh Office for permission to implement their plans and they await a decision but it is clear that Talygarn, as a specialist rehabilitation centre, is doomed.

The manner in which these changes were brought about offers many lessons about the relationship between health authorities and the public. The provision of information is crucial to the role of CHCs and they are dependent on the health authority for this; the same authority whose services they are expected to monitor. When the CHCs were set up, it was intended that they would develop a closer relationship between the health authorities and the public, allowing them to be more involved in influencing the major decisions that bear upon their communal health services.

Public consultation on this issue could best be described as superficial and revealed the limitations of CHCs as watchdogs. A dialogue took

place between the AHA and the CHCs but the public were not involved. But for the efforts of a few activists and the local press, the vast majority of the public would not have been aware of what was going on. While the press picked up the issues that arose from correspondence between the AHA and the CHC, most of the publicity was engendered by a small group of activists with the support of our MP and the South Wales Miners. They drew the attention of the media to the issues involved and alerted the public to the implications of the changes.

Those of us who were on the deputation protesting against the changes were particularly disappointed at the way Mid Glams AHA handled the consultative process. Their case may have been a valid one but they failed to engage in meaningful consultation to convince people of it. There was no public meeting and details of the proposed changes were not posted in libraries, clubs and local associations. The information relating to resources that would be available after the change could not reassure the public that they would be provided with a comparable service in the whole of the community. Consultation cannot take place without all relevant information being available to all parties.

Mid Glams were reluctant to give information about their staffing structure and it was not available to the CHCs. After approaching the Welsh Office, information relating to the Authority as a whole was released but they would not give essential details of specific hospitals and sites in Mid Glams.

The CHC have only limited resources for the work they do. In my area they have one full time officer and two part time secretarial assistants. There were no resources to make an in depth investigation and despite the energy and commitment of the staff and members, they could not match the Health Authority in expertise, time and resources. Much of their work demands investigation to be carried out by professional research workers but, regrettably, their funds could not cover this. Moreover, the CHCs could not afford the data base for unpaid voluntary researchers. Neither were they able to purchase the various publications which would enable them to put local issues in a wider national perspective.

This case brings into question the rights of the patients as a collective group. In what way can they participate in the decisions that affect their healthcare? With their very limited resources, we cannot depend solely on the CHCs. Ironically, the resources are determined by the Health Authorities whose role they are supposed to monitor. The composition of the CHCs is made up of representatives of the Health Authorities, local authorities and voluntary bodies. Although this system was more representative of the community than the present one, where members of the CHCs are appointees of the government, it is evident that the workload on those representing local authorities inhibits the extent to which they can participate. The CHCs would certainly benefit from more administrative and research back-up; the type of support available to the Health Authority.

If the CHCs are to campaign vigorously on issues that affect the public and do much more to involve them, they should not be dependent on the DHAs for their funds. In Mid Glams, the CHCs are allocated a mere £136752 a year, just .09% of the Authority's revenue and less than some of the new NHS General Managers are paid. Consideration should also be given to extending the role of CHCs to cope with the current changes taking place in the health services and their powers should be extended to include the new Trusts, local authorities involved in community care, GP budget holders and also the voluntary sector.

ANNUAL REPORTS

An important, though often neglected, avenue of communication is the Annual AHA Financial Report. These provide useful, if limited, information but they have tremendous potential as providers of information for involving the public in a discussion about the problems and plans that concern their healthcare. However, a close scrutiny of these reports suggests that essential information is often omitted. My main criticism is that many reports only impart basic information which is not broken down into particular hospitals and spending units. The fact that this can be achieved is illustrated by South Glamorgan's report which provides an excellent comprehensive coverage of their activities. This is a first class document but, despite its quality, I had the impression that it was not widely circulated.

The Mid Glams Annual Financial Report was not available in many of the local libraries and I found great difficulty in getting a copy. I eventually obtained one from Head Office and found that, while it contained general information, it lacked the details which would enable one to appreciate the full range of their activities. In particular, it did not probe deeply enough into the problem areas encountered as a result of government cuts. Such reports reveal the timidity of health authority managers towards the present government.

There should be much more detailed financial information dealing with the myriad of activities in its hospitals, centres and units. It should also deal with such key items as sources of finance, cash expenditure, the general rate of inflation during the year and, in particular, NHS inflation. The public should know the full details about finance raised through cost cutting and other income generating schemes.

While information on staffing is dealt with, there is no mention of, for example, the number of vacancies related to established posts, their duration and the time taken to fill them. Also missing is information about staff wastage, redundancies and associated staffing problems. At a time when particular hospitals are contemplating going for Trust status, all the relevant data should be available.

Information on outpatient and in-patient waiting lists is given and this is related to the specialities. However, there should be a category of new patients as well as the total number of outpatients. It would also be useful to know something about the age group of patients. Some studies have shown that over 60% of hospital in-patients are over the age of 60. In view of the different cost bands for age groups, this is very relevant. It would also be useful to know how many patients are treated on more than one occasion and how many are discharged from hospitals and placed in the 'care of the community'. Further points of reference for the public should also be given and assistance provided to locate this.

Whilst I appreciate that the general public might not wish to be burdened with too much information, particular care needs to be taken over the nature of the readers. There are those who would like more detailed information and this should be provided in a more accessible form with diagrams and other illustrative techniques.

SOCIAL AND DEMOGRAPHIC FEATURES

Consideration should also be given to the relationship of the health services to the social and economic factors that prevail in the community. The public need to be able to place their area in the national context. This is particularly important in view of the fact that NHS funding is related to the Standard Mortality Rates (SMR). This information is gathered by the local authority and could easily be integrated into the Health Authority's annual report. A selection of the most important findings of the Economic and Social Research Unit of Mid Glamorgan for 1991, illustrating the problems of the locality, are given below:

	Mid Glam	Wales	GB
SOCIAL DEPRIVATION			
UNEMPLOYMENT			
Unemployed	8.4	6.6	5.6
Unemployed More than 1 year	26.7	23.7	25.5
SOCIAL ECONOMIC GROUP			
Semi Skilled	12.5	11.8	12.2
Unskilled	4.6	4.6	4.1
HOUSEHOLD AMENITIES			
No Bath or Shower	6.1	3.6	1.9
No Inside Toilet	9.2	5.2	2.7
HEALTH			
Standard Mortality Rate	112	113.2	113.6
Infant Mortality Rate	9.4	8.0	8.4
POPULATION			
Over 65 M:60 F	17.9	19.5	18.4
Average Earnings			
men	£259.7	258.6	295
Women	£189.2	180 3	201.5

CONCLUSION

The public need information during this period of change in the NHS and the CHCs need power and resources to fulfil their role of accountability. There should be a closer link between the CHCs and

other bodies concerned with patients' problems: The Heart and Stroke Association, Arthritis Society, The Association of Ileostomists, to mention but a few. Moreover, the CHCs should have access to all the relevant information. Otherwise, the activities of the NHS will be shrouded in secrecy and the mystique of the accountant. Participatory democracy can only survive with opening up the books and genuine communication with the public. All channels of communication should be used thoroughly and the views of all the separate bodies that have been consulted should be published and be easily available. While the public cannot be involved in professional decisions relating to clinical matters, they have a right to resource information which may well bear upon them. We should ensure that the representatives of the community on the CHCs have the support and resources to carry out their time consuming and exacting work.

REFERENCES

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