Democratic Accountability in a District Health Service

(Healthy partnership - a challenge to democrats; an opportunity for the Trade Union Movement)

by
John Robb, Ballymoney

Causeway to a New Route

Francis:
Just received the revised
copy: not yet seen the light of
day to please request FEDARGO
to time being.
any ideas about place
+people for a launch.
.? Accompaniment ???
John

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ACKNOWLEDGEMENTS

In this age of computer technology the power to select the parameters by which to judge the performance of others has taken on fresh significance. It seems timely therefore to challenge the increasingly sinister exercise of such power and, at the same time, warn the 'powers that be' that personnel and people will not ignore their powerless state indefinitely.

Before apathy changes to anger it would therefore seem wise to recall that sound democratic practice was once described as "taking the people into partnership'.[1]

This pamphlet has been written with these observations in mind. I am grateful to members of the New Ireland Movement of the 1970's and the New Ireland Group of the 1980's for the development of ideas and proposals which form much of its content. The pamphlet is dedicated to those unique people, the past and present nurses of the Route and Robinson Hospitals Ballymoney and especially those who have worked with me over 20 years in the Top Flat, Casualty, Outpatients and Operating Theatres of the Route Hospital.

John Robb
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INTRODUCTION

As society becomes more and more tied up by controls and certificates, which are determined by remote forces with little or no democratic accountability, more and more doors and filing cabinets are firmly locked against the development and deployment of talent. People are thwarted by remote control in a quite unacceptable manner. Priorities are determined by administrative and academic elites; invariably such elites are closeted in the plush offices of the bureacracy or ivory towers of academia out of touch with the inter-action of consumer and service personnel at the clinical coal face. Little wonder that decisions about priorities seem so frequently wrong-headed. There is little or no democratic accountability and trust is at a premium.

Community goodwill is alienated; consumer input is minimal and because it seems unwelcome, it is often negative. Not surprisingly, it is increasingly communicated by lawyers! Personnel feel that they are there to work but not to be heard. The structures available are inadequate for open questioning by an educated workforce let alone for discussion concerning serious propositions. Apathy is indeed rapidly changing to anger.

The clocking-in, clocking-out and lining up for wage packets for certain sections of the workforce is symbolic residue of the degrading humiliation of labour in yesterday's world. Such insensitivity is outdated.

There are so many painful issues yet on-one seems to have the time, inclination or freedom to address them let alone the power to redress the balance in favour of personnel and people. There is much waste and in spite of all the concern being expressed about the ecological dimension to health there is a scandalous surrender to disposable mania throughout the health service and there is much waste. Where are the structures whereby aware members of the public and hospital personnel may raise these issues with the prospect of having them dealt with effectively?

Many of our problems could more easily be resolved if we were to encourage a more open and democratic involvement of those for whom the good running of the Health Service is central to requirement or to work purpose. Those who work in the service will hardly impart a state of well-being in the care of the sick if they do not experience it collectively among themselves.

PARTICIPATION & POWERLESSNESS

It was exciting to be alive in the summer of 1968. People who remember those long hot months will recall that Austin Currie's occupation of the house in Caledon was not the only event to disturb conventional certainties. The French students poured onto the streets of Paris and General de Gaulle, "moi je suis l'etat", felt obliged to leave for Strasbourg stricken, perhaps for the only time in his life, by indecision. All over Europe the catch-cry of youth was for 'participation' in decision-making.

More extensively educated than ever before, the youth of the late '60's felt caged-in by controls which were inhibiting individual and collective development and they rebelled. Professors suddenly found themselves sitting uneasily alongside long-haired student representatives on university council and university senate while company directors, in pin-stripe suits, struggled to come to terms with the prospect of boardroom participation by open-shirted representatives of the factory floor. Yet 1968 did not become the watershed for which so many yearned and which so many others feared.

By the middle 1970's, anti-establishment radicals had come to realise that 'participation' without the power to make it effective was little more than a sop to frustration. The professors in the universities, members of the board of directors and senior civil servants began to relax as they too perceived that the radical movement was running out of steam, its objective of **meaningful** participation unrealisable without the power to make it possible. Re-trenchment became inevitable.

Fortunately the analysis had not gone unnoticed. In Ireland, the Community Government Movement among others tried to address the problem of powerlessness. In Derry, the North-West Foundation for Human Development did something about it. In West Belfast Pauline Murphy became a driving

force behind the Northern Ireland Council for Community Education and awakened people throughout the country to its potential. In the Ulster People's College there has been much on-going debate about empowerment of people where they live and where they work; in this respect, the culmination of years of commitment was acknowledged in the appointment by the University of Ulster of Tom Lovett to a new chair in the Department of Community Education.

CITIZEN, COMMUNITY & CONTROL

The Health Service

In discussing the Health Service in the context of the local community it seems appropriate to ask who, in the **local** community, makes decisions about the function and purpose of the services and then to ask to what extent current decision-makers are accountable both to those who use the services and to those who work them? What structure exists to enable local people to engage the extended network of services existing in their own community as well as the network in the wider community of which theirs is but only one part?

In other words, what structures are available for constructive dialogue about need in the context of fair play with regard to the overall distribution of resources and talents? Do the central institutions of the State respond appropriately to need determined by the people; are they not more likely to dictate to the people as to what their needs should be? Do the central institutions of the State perceive themselves as democratic co-ordinators or autocratic controllers? Where is the balance, who is promoting it and how do we get our priorities right? In Northern Ireland, the prevailing feeling is one of powerlessness. Most people have little or no means of accessing the decision-making process and the same people feel that decision-makers are in no way accountable to them. These feelings are aggravated by the political powerlessness of the Province as a whole. In Northern Ireland there can be little gainsaying that many far-reaching decisions are being taken today behind closed doors by people who are unaccountable to those targeted by such decisions.

EFFECTIVE PARTICIPATION

Whenever complaints about working conditions or work practice come to a head those in administrative positions frequently express surprise that the staff concerned had not previously mentioned or discussed the specific issue. After all they can point out that the photocopiers have been working to

capacity to churn out the 'consultative' documents for all to read. Little do they seem to appreciate that the sheer volume of material, to which busy people are increasingly subjected, has become indigestable. In terms of the tons of fresh paper pulp utilised and incinerated daily, it is also grotesque reflection on the disdainful dismissal of the environmental impact of waste on health.

Not many nurses or junior doctors for that matter, not many hospital personnel in general or even members of the public have much confidence in the ability of the prevailing system to absorb criticism without compromise to goodwill and good feeling.

Once administration sets out on a course of action there is little expectation of meaningful discussion leading to any change in policy or direction. 'Consultation' has become little more than a charade. Trust can no longer be assured and there is no confidence whatsoever that well considered input by either personnel or people will be reflected in policy outcome by administration. Open discussion, dissenting opinion and articulate challenge are not encouraged by our institutions and hospital is no exception! Consequently, there is a strongly held opinion among hospital personnel, patients and relatives that they are neither welcome nor trusted to play an active role in health service affairs, the implication being that such must be left to the so-called experts!

Must we not therefore ask how we may incorporate better rather than isolate further all those people who presently have neither the means of accessing the system effectively nor the power to influence it?

Examples:

It is well known that secretarial, clerical and other personnel - those who hold the weakest positions in our institutions - may be pushed around in the most cavalier fashion all over the place, that experienced nurses who have given loyal and dedicated service in vulnerable units may be shifted with a suddenness that overwhelms, that patients on admission take on the equivalent of an oath of silence not to complain and relatives do their best to appear to be satisfied with the institutional rules, regulations and approaches which they do not understand and which they have little or no power to influence.

Junior hospital medical staff are, by and large, perceived as birds of passage working 1:3 rotas longing for supervised hands-on practical and clinical experience in a planned apprenticeship at the same time as market forces, public expectation and the tightening web of litigation mitigate against their hopes. As such, 'junior' staff struggle on towards the fifth decade of life preparing for examinations which have very low pass rates. In spite of the degree of anxiety associated with insecurity and uncertainty, junior staff are nevertheless expected to sustain high standards of intensive and often stressful work.

COLLECTIVE RESPONSE

Where then is the vehicle for collective response; how are the ideas to be channelled; why are we failing to express them; do we not feel free enough to do so or has the futility of our involvement led to apathy? Where spokespersons do find themselves in conflict with appointed officers they are too easily and too often labelled as troublemakers. As a result, valuable viewpoints are being lost - either trivialised, dismissed or overlooked by an administration hiding behind decisions enshrined in the paperwork that is suffocating us.

Commonsense allied to goodwill is at a premium. Rather than waiting until anger mounts, structures should be devised to enable both personnel and people to access the system and power should be given back so that participation becomes an effective means of enabling constructive change with collective responsibility.

New structures are needed to which all may relate easily. Education in the use of well tried procedures in a disciplined manner is urgently required. Decision-makers must feel accountable at all times to those who are affected by their decisions.

Much more outreach, through regular personal contact and verbal communication, is required both within Health Service institutions as well as between the institutions and the public so that questions may be asked freely, responses obtained openly, awareness raised and tensions resolved constructively. People are less likely to take recourse to law if they feel that their dignity has not been affronted, their intelligence deprecated or their goodwill taken for granted.

COMMITTEES: WORKING PERSONNEL & THE CONSUMER

THE HOSPITAL COUNCIL

In the late 1970's, in the Route Hospital, Ballymoney, we brought together an ad-hoc North Antrim Health Committee of some 36 people with a view to evolving a local health council sustained by the three planks of the service - the consumer, hospital personnel and key figures of the administration.

Some of us had hoped that as time would pass all of our institutions such as Day Centre, Health Centre and Hospital would reach the point where an annual election of a committee of users and an annual election of a committee of personnel (all of them) would take place as a matter of course and that both of these would nominate an appropriate number of members to serve alongside key figures in the administration. This would be the basis of a new form of tripartite co-operative council to which all of those working and using the

facilities on a particular campus could relate. Other persons with statutory obligations for the training and good running of the particular institution would be appointed or co-opted.

Obligations - Private as well as Public

There are sound arguments for not permitting private practice in State Financed Hospitals. Even so, private practice is permitted by present law so there are perhaps stronger arguments for retaining expensively trained consultant expertise within the system **provided contractural obligations to the state** are carefully monitored and provided a 'private' consultation is not the fast track to privileged treatments within the service and provided too that the institution as a whole has a say on what charges are made and how these are distributed.

"I have always found the cash nexus between the patient and the doctor indefensible. It cannot be a link and frequently it can be an impediment. It is little wonder than Bernard Shaw could write about it with such satirical accuracy ... From the actuarial point of view, as well as in a professional sense, there is no logical or valid reason why a national health service should not be based on a salaried system of payment".[2]

The Hospital council might consider, as is done in the Mayo Clinic, the implications for pay, resources and reserves of monies accruing from the practice of private medicine and to do so in such a manner that the potential for devisivness of such practice could be diffused. It is no longer appropriate for the consultant to take a huge fee and the theatre staff to be rewarded by boxes of Black Magic or bottles of sherry at Christmas! Furthermore, such co-operative councils would be represented on the local district health assembly (see page 12).

Independent Private Hospitals should also be obliged to convene tri-partite co-operative councils.

In spite of hopes that such an experimental development might have taken place as a result of the convening of the ad hoc Northern Antrim Health Committee, early promise was to be thwarted by a not unnatural anxiety as to where such process was leading!

When the pamphlet 'Our Health (Not Theirs): Wind of Change, North Antrim' (1981) was published, there was an immediate resignation from the ad hoc committee of one significant member who feared that the reds were getting into the beds rather than remaining under them and the whole process ran out of steam! Even so, it now seems more relevant than ever that ordinary people and the bulk of hospital personnel should feel involved rather than excluded from the debate about fair distribution of resources and talent in relation to assessment of need and determination of priorities and that there should be growing expectation of constructive response.

STATEMENT OF NEED

Doctors, nurses, social workers, administrators or anyone else for that matter should not be permitted independently to determine need let alone imagine that by themselves they can respond adequately to it. There is an inter-dependence of hospital, health centre, day centre, residential home and nursing home etc., which we ignore at considerable cost if the aim is to produce a truly integrated health service. Then there is the voluntary sector, Beacon House Clubs, Gingerbread Clubs, Multiple Sclerosis Societies and so on. Each is at best only one part of the network of support involved in the curing and preventing of disease and in the overall objective of health promotion. How then will we integrate the departments within our institutions, how will we integrate those institutions with the community network? Are we blinkered to the degree that our chief concern is merely the provision of a disease service in which the ultimate goal is a super-specialist for every pathological sub-classification - as unrealisable as it would be health defeating. Should we not instead be committing ourselves to the promotion of integration as an integral part of the search for health as a state of well-being?

SHARING RESOURCES AND DECIDING ON PRIORITIES

In the Northern Health & Social Services Board's document *'Cutting the Cake' (1988)* it is stated that:

"One of the fundamental priorities of the Health & Social Services in Northern Ireland is to share the available resources equally among the bodies who are responsible for the delivery of health care".

This laudible statement would seem to suggest two things - an equitable distribution of funds and a democratic assessment of priorities.

DISTRIBUTION OF FUNDS:

Principle of Subsidiarity - the challenge to Superspecialist Superpower

Professor James McCormick, the first General Practitioner to be appointed Dean of a Faculty of Medicine in recent times indicated that up to 90% of all 'ill-health' should fall within the compass of the first-contact family doctor.[3,4]

Also in the 1970's, Mr. Rex Lawrie, formerly a Consultant Surgeon in Guy's Hospital, writing in the prestigious Annals of the Royal College of Surgeons of England,[5] indicated that of all persons needing hospitalised care only 10-15% required highly sophisticated gadgetry or superspecialist attention. Few people would deny the importance of the highly significant section of disease and therapy which does require super-specialist attention for successful resolution; **nevertheless, should we not question a system which allocates so**

much power to super-specialists in relation to the moulding of attitudes and the arrangement of curricula at under-graduate level, the control of training and accreditation at postgraduate level as well as the lion's share of the patronage associated with job promotion, job placement and selection at consultant level.

Bearing in mind the assertion of Mr. Rex Lawrie and placing it in conjunction with the 'principle of subsidiarity'[6] - that the big and central should not be permitted to take over from the small and the peripheral what the latter can do for themselves - a relatively simple formula can be derived for the disbursement of funds (see below) in relation to population served.

The local district service could then be planned on the assumption that 15% of the hospitalised population of any district **should be the maximum proportion requiring central referral;** if this is exceeded questions should be asked about the availability and use of talent and resources in the district concerned.

In the 'region' of Northern Ireland there are four 'areas' - north, south, east and west - each with its own health and social servies board. In each 'area' there are a number of districts. If Area Hospitals such as Altnagelvin (western area) and Craigavon (southern area) are functioning as a proper filter in relation to problems requiring referral out of smaller hospitals such as Erne (in the west) and Daisy Hill (in the south) the percentage referral to Belfast should be 10% or less. In Areas without an Area Hospital percentage referral to the Regional centre should be in the order of 15%.

For those of us who hold that centralism is at the core of so much of today's dis-ease, the assertion of the principle of the subsidiarity would give impetus for a more healthy balance of power in the determination of our affairs.

Furthermore, with the introduction of computer-modem systems and the possibility of transmitting video-recorded images instanteously by telephone cable, the need to refer the patient, as distinct from the patient's problem for super-specialist attention, should if anything be diminishing.

A Formula

The challenge of meeting "the fundamental priority to share the available resources equitably among the bodies responsible for the delivery of care" may be considered by assuming,

a maximum of 15% for central referral to the regional centre from any district of an area which does not contain an area hospital

a maximum of 10% for central referral to the regional centre from those areas which do contain an area hospital

If R = Regional Population, C = Central City Population†, A = Area Population, An = Northern Area Population, As = Southern Area Population, Ae = Eastern Area Population, Aw = Western Area Population, D = District population, C.H. - population dependent on central superspecialist hospitals

then in Northern Ireland the central super-specialist hospitals, (RVH, BCH, MIH, MPH)** would be expected to serve as follows:-

their own city population = C = 100% of 320,000*	320,000
+ 15% of remainder of Eastern Area = 15% (Ae-C) that is 15% of (642,100 - 320,000) = 15% of 322,100	48,315
+ 15% An = 15% of 379,000	56,850
+ 10% Aw = 10% of 256,800	25,680
+ 10% As = 10% of 288,900	28,890
	479,735

Thus the central specialist hospitals in Northern Ireland

should expect basic funding in relation to a maximum catchment population (C.H.) of 479,735

Thus, with 1,566,800 people in the region, *(Cutting the Cake, 1988)* the central hospitals might realistically expect as absolute maximum:-

$\frac{479,735}{1,566,800}$ of the cake = approx. 30% (absolute maximum)

It would be interesting to compare expenditure per annum on Belfast's three main teaching hospitals plus a consideration for MPH, with expenditure per annum on Coleraine, Route Hospitals.

Coleraine and Ballymoney having a catchment population of around 100,000 might reasonably expect to serve at least 100,000 - 15% of 100,000 = 85,000 within their present boundaries.

General formulae can be derived as follows. For a district, where only 10% of hospitalised ill health is expected to move centrally, funding should be provided in accordance with the Formula,

$\frac{D-10\%D}{R} = \frac{9D}{10R}$ [For 15% central movement the formula would be $\frac{17D}{20R}$]

Byadding a weighting factor (W) in favour of decentralisation and a flexible factor (F) to provide for special circumstance these formulae would be qualified e.g. for districts with 10% central movement,

$\frac{9D}{10R} + W \pm F$: For districts with 15% central movement, $\frac{17D}{20R} + W \pm F$

Conversely funding of the central city specialised hospital complex would be expressed as follows: $\frac{CH}{R} - W \pm F$

***R.V.H. = Royal Victoria Hospital: B.C.H. = Belfast City Hospital: M.I.H. = Mater Infirmorum: M.P.H. = Musgrave Park Hospital*
*† In Northern Ireland the Regional City, Belfast, is situated in the Eastern 'Area': * 1981 Census figure*

People working in the central hospitals throughout these islands often respond to the type of argument outlined by suggesting that central units receive much more than 10-15% of expected hospital work from outlying districts. If this is so, it suggests a need to train consultants more appropriately for practice in outside districts or to support those in post more effectively and equitably. That there has been gross inequity is exemplified by the experience of the Route Hospital Surgical Unit. Over 19 years the unit has not had on its establishment a junior house officer or senior registrar nor has there been any on-going commitment to the posting of a registrar to it either and this in spite of around 10,000 casualty attendances per year, 1200 ward admissions per year, 1400 surgical procedures per year, 4-5,000 outpatient attendances per year and more than 500 day cases.

DETERMINATION OF PRIORITIES

Over the years, many of us have been concerned about the determination of priorities in relation to health service expenditure. For example, a surgeon looking for a resectoscope at £9,000 for which he is told there is no money is not impressed by the new tarmac being spread on the extended carpark. A sick person wishing for an extra nurse on the ward at night is not impressed by an argument for an extra gardener and the trade union movement, concerned about employment in relation to health, is unlikely to be pleased on hearing that the doctor's salary is to go up while the outside labour force in the hospital is being reduced.

With these challenges in mind pointers are suggested as to how, within overall regional and national guidelines, the user and the provider might be involved more actively in the appraisal of the service and in the determination of priorities relating to it. The structure advocated involves: (a) the creation of Institutional Co-operative Councils; (b) the creation of District Health Assemblies

(a) The Institutional Co-operative Council

1. **Users Committee**
   The setting up of a 'patient's' / 'client's' / 'user's' / committee in all health service institutions i.e. hospitals, residential homes, clinics, health centres, day centres, etc. Such committees would be elected annually. To ensure optimum attendance the date and location eg 8pm, 3rd Wednesday in September, local community hall to be printed on all headed notpaper.

2. **Providers Committee**
   The setting up of a personnel (providers) committee elected at an annual meeting to which all who work on the campus would be invited with at least one months notice by notification in salary and wage envelopes. In addition to such 'general' election, representatives also to be nominated by significant departments and sections - so that departmental and sectional interests e.g. medical staff, nursing staff, paramedical staff, non-medical non-nursing staff, chaplains and so on are represented along with overall general interests.

3. **Co-operative Councils**
   The setting up in every health service intitution - whether public or private - of a of tripartite co-operative council consisting of equal numbers of nominees from the user's committee and the provider's committee meeting on a regular basis in conjunction with key figures in the administration and key figures of the staff organisations e.g. BMA, COHSE, NUPE, RCN, etc. as well as others co-opted for particular issues by agreement.

   The objective must be to enable better access to and more accountability in decision making.

(b) The District Health Assembly

1. **Community Health Guilds**
   The development of community health guilds which would bring together in the local community, annually or bi-annually, the network of voluntary and statutory agencies dealing with all aspects of healing, health promotion, disease curing and disease prevention.

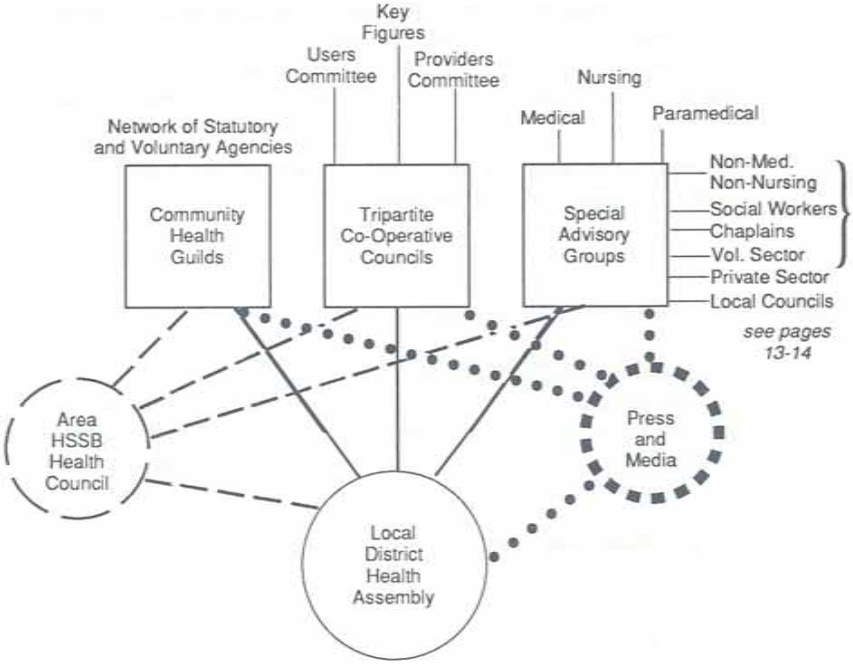
2. **Special Advisory Groups**
   The identification of special advisory groups such as the following:

   i. medical
   ii. nursing
   iii. para-medical
   iv. non-medical non-nursing
   v. social workers
   vi. chaplains
   vii. voluntary sector
   viii. private sector
   ix. local councils

   These would be convened as shown diagramatically p. 12-14

3. **District Health Assembly**

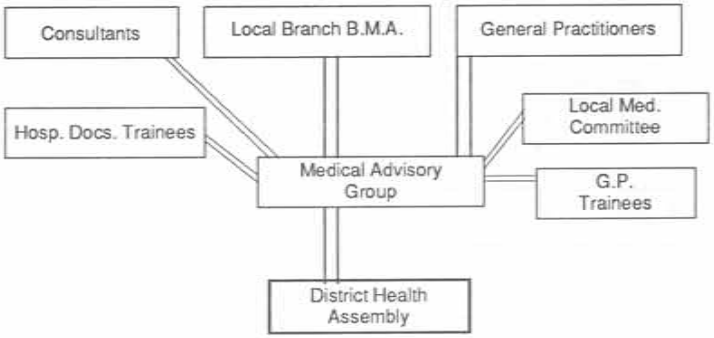
The setting up of **local District Health Assemblies** composed of delegates from the tripartite co-operative councils of the hospitals, residential homes, clinics, health centres, day centres and so on as well as a nominated delegate from each of the Community Health Guilds and at least one representative from each special advisory group (see below). These Health Assemblies would be expected to meet for a whole day at least twice per year to discuss general policy etc.



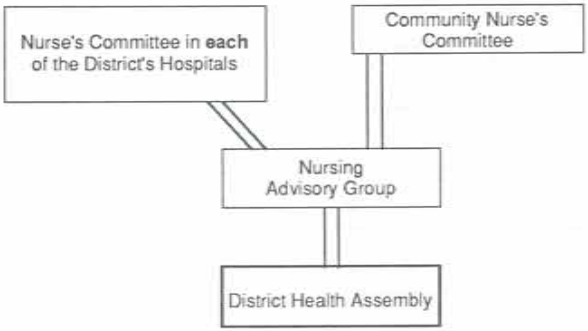
The local District Health Assemblies should contain contain, one way or another, key figures in the adminstration and key figures of staff organisations e.g. B.M.A., COHSE, NUPE, R.C.N., etc. as well as others co-opted by agreement to contribute to discussion on particular issues.

SPECIAL ADVISORY GROUPS: DIAGRAMATIC OUTLINE

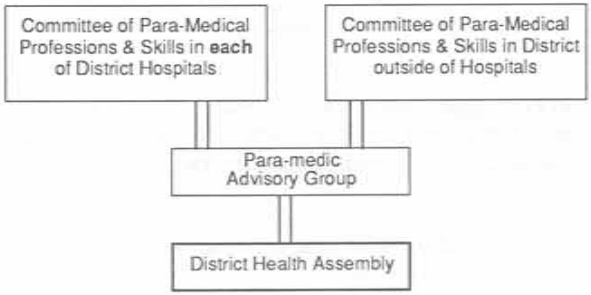
1. Medical Profession



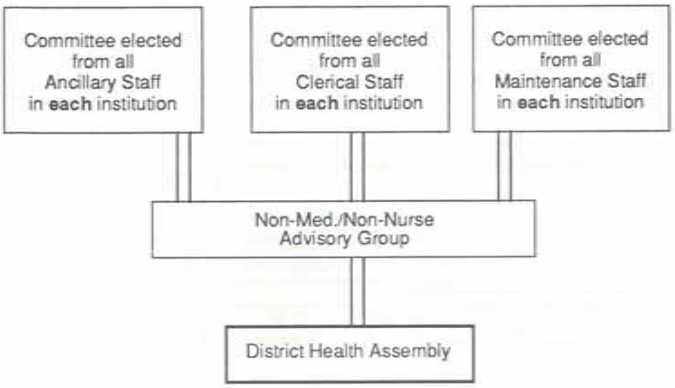
2. Nursing Profession



3. Para-Medical Profession



4. **Non-Medical/Non-Nursing Professions & Skills**



5. **Social Workers**

6. **Hospital chaplains** to be invited to form a local district hospital chaplain's group with members on the Tripartite Councils and at the local District Health Assembly.

7. **Voluntary Health Service Agencies** to be invited to form a Voluntary Health Services Agency Advisory Group in each local council community of the district and to nominate representatives from them to attend the local District Health Assembly.

8. The **local councils** to be invited to have one representative from each council on the District Health Assembly.

CITIZENS ADVICE BUREAUX

Network & Service

Throughout the Health & Social Services much greater encouragement to be given to all sections of both users and providers to access and promote development of the Citizens Advice Service.

STATUTORY HEALTH & SOCIAL SERVICES COUNCILS

Under Health & Social Services Regulations, a Health and Social Services Council has been set up in each Health Service Area - similar councils exist in Britain. In very broad terms, these area councils take the place of the former District Committees which were supposed to be the eyes and the ears of the public! At times we might have been forgiven for wondering if they had been selected because of some defect in vision or hearing.

These new councils have a number of responsibilities and it is up to all of us to ensure that they are effective:-

1. Monitoring of services which includes checking the quality of services and facilities, access to treatment and advice, waiting times, information on treatment and visiting arrangements.
2. Undertaking **consumer research.**
3. **Ensuring that Health & Social Services Boards consult the councils on all proposals for substantial development for variation in the services provided where this will affect the community.**
4. Ensuring that there is in position a proper procedure for making complaints to the Board.
5. Producing an annual report.

THE NEW PATIENT'S CHARTER

The new charter aims to raise the quality of Health & Social Services. In a sense it provides a framework to which the Health & Social Services Councils must relate as the public has a right to refer to its objectives when dealing with Health & Social Services matters. The performance of Health & Social Service institutions, whether within the N.H.S., trust funded, fund-holding, entirely private or otherwise will be scrutinised before the mirror of the standards expected by reference to the Charter.

Quality expected under Charter:

1. Courteous treatment.
2. Respect for privacy and personal dignity.
3. Respect for cultural and religious beliefs.
4. Care and treatment on the basis of need regardless of ability to pay.
5. Clear information about any treatment or care proposed **with respect for personal wishes and preferences.**
6. Freedom to withhold **without prejudice** consent to medical or other care or treatment.
7. Freedom from pressure to participate in research and student training and the right, **without prejudice,** not to take part in such research and student training.
8. Right of access to any reports made for insurance or employment purposes and any information about them held on a computer.
9. Maximum waiting time for admission to hospital to be one year by 1995!
10. Adequate notice of Outpatient appointments and date for inpatient admission.
    (a) Letter from hospital within two weeks of referral by G.P. advising of date for Outpatients.
    (b) Maximum wait for a new appointment at Outpatients, three months.
    (c) To be seen within 30 minutes of individual appointment time and be informed of reason for any delay.
    (d) To be seen by a consultant or other senior doctor on first appointment.
11. No penalties to be incurred by a patient (such as returning to the bottom of the queue) following a request - for personal reasons - to defer admission.
12. Admission to the hospital within one month in the event of an operation being cancelled on two successive occasions, either on the day of admission or following such admission.
13. After being called, emergency ambulances to arrive within 14 minutes (urban areas), 18 minutes (rural areas) or 21 minutes (remote areas).
14. The right to a named nurse or midwife in the community service.

Obligation of Management under the Charter:

In addition to obligations flowing from the 'quality' expected by the users (see page 17: 1-14), the following must be observed:

1. Appropriate monitoring of the standards which have been set.
2. Appropriate arrangements for procuring the views of patients, clients and carers in all monitoring arrangements.
3. Action taken to ensure that waiting list guarantees/arrangements are met.
4. Outright rejection of 'block' appointment systems.
5. Ensuring that patients and if necessary relatives and carers are consulted and informed at all stages before the patient is discharged and in preparation for appropriate arrangements at discharge.
6. The drafting of local charters to be published to cover all the standards set by the main Charter and to review these each year.
7. To ensure that all staff in direct contact with patients wear name badges.
8. To ensure annual publication of achievement as judged against assertions contained in the local charter.
9. Greater use of the media to raise awareness about local services.
10. Provision of information for dissemination through local groups, public meetings, exhibitions, etc.
11. In particular, provision of information about quality standards and waiting times.
12. Award of Charter Marks to be displayed prominently by those sections of the H&SS which meet the standards of a high level of service.

Information on the range of Services provided by each Board:

Information on waiting times for Outpatients, day-case inpatient treatment (and presumably A&E Department waiting times too) by hospital, by speciality, by individual consultant: such information to be clearly displayed in G.P. surgeries and Health Centres.

Information easily available to assist in the effective processing of a complaint. Information about quality of service and waiting times for each unit.

One might also make a plea for the following facts per hospital, per speciality and per consultant:-

Ratio of patients,

(a) seen initially on N.H.S. terms (as 'public' patient) who then decide to go privately because of long waiting lists, etc.

(b) seen initially by private consultation who subsequently convert to N.H.S. patient (as a 'public' patient).

(c) seen initially on N.H.S. terms who remain on N.H.S. terms

(d) seen initially as private patients and remain as private patients.

Details of waiting list times for each category.

THE PATIENTS CHARTER AND THE AREA HEALTH COUNCILS

With the record of their predecessors, the District Committees, very much in mind, it is vital that the potential of the new Health & Social Service Councils is actively encouraged and engaged. **By making ourselves aware of the individual membership of these councils and of their obligations under the Charter for Patients and under the statute which set them up, people and personnel - either individually or collectively - have a means of insisting on right of access to and limited accountability from the system as it now exists.** This will require active politicisation of the health councils by the people through:-

a. Dissemination of names, addresses and telephone numbers of health council members.

b. Communication with health council chairpersons with copies of such communications sent to the members always couched in such a way as to place the respective council under obligation in relation to its terms of reference and to the Charter for Patients.

c. **Constant vigilance to ensure that the Health & Social Service Boards do "consult the councils on all proposals for substantial development or variation in the services where this affects any significant section of the community".**

d. By dint of constant perseverance (going public as, when and however often it is necessary) to ensure that councils are pro-active rather than the passive ciphers which the powers that be might wish.

e. At all levels in the structure - such as those outlined in this pamphlet, 'Democratic Accountability in a District Health Service', to ensure that participants are aware of the purpose and function of Area Health Councils and to keep the Councils on their toes both by individual and collective pressure seeking aid, wherever necessary, of press and media. At all times personnel and people must insist that they are enabled to participate effectively in the decision making process. Those who take the decisions should be continually under pressure of accountability to those affected by such decisions.

The Area Health Councils should be perceived and used as the link between whatever structure the people now devise and the statutory arrangements already devised by government. If the Trade Union movement is thinking about re-defining its role there must be novel possibilities in the need for democratic accountability where at present there is so little.

SUMMARY OF GENERAL THRUST OF PAMPHLET THE DEMOCRATIC DEFICIT

Extract from the Cover Note of a Statement Presented to Ballymoney Borough Council 6th January 1992

This statement with regard to the Northern Health Board and Social Services (N.I.) proposals to 'rationalise' the Surgical Unit and Casualty Service which have been traditional to the town of Ballymoney out of the town of Ballymoney is the **introduction** to the detailed argument against such a proposal as presented to the Ballymoney Borough Council on 6th January 1992.

"In recent years we have been asked repeatedly to rationalise our resources. There was re-organisation of the Health Service in the early '70's, in the late '70's, in the '80's and now once more. Invariably those promoting such rationalisation couch their argument in terms of the 'need for economy' and justify their conclusions on grounds of the more intensive use of highly sophisticated and highly priced high-tech equipment involving the centralisation of talent in fewer and fewer locations. The arguments, however, are both contradictory and fallacious.

Eightyfive percent (85%) of all hospitalised ill-health does not require the attention of highly prized super-specialised talent or the attachment of the patient to the latest piece of super-technology. In any case, super-technology should be the servant of decentralists rather than the means by which centralists may hold the rest of us to ransom.

Regrettably, in a consumer-conscious society, super-technologists are frequently found hand-in-hand with those holding vested interest in the disease industry - those who would seek to control us by insisting that nothing outside of the centre is really appropriate to meet the common surgical, medical and obstetrical needs of the population. Arrogance is heaped on confusion by the addition of the tag 'of excellence' in reference to our 'centres' as though excellence cannot be found elsewhere! It was therefore encouraging to read of the findings of the House of Commons Select Committee on Health when it recently exposed much of the nonsense surrounding the colonisation of childbirth by a male-dominated gynaecological establishment.

Those who go on to use the economic argument should be reminded that the only economy worth striving for is an economy of well-being and, this being in such short supply within the National Health Service, we might ask ourselves what has gone so sadly wrong?

Health, as distinct from dis-ease could be defined as the state of well-being and health economists inevitably place themselves in an uneasy position if the economy being promoted by them undermines the well-being which should be central to their endeavour.

Ever since the mid-1970's, rationalisation has become a catch-cry of administration. Over the same period, personnel and people, as far as the health service is concerned, have become aware of less and less well-being. This state of dis-ease goes hand-in-hand with worsening personal communication leading to increasing feelings of alienation between the consumer and provider, between provider and administration and exists most lamentably among administrators and among providers themselves. Too often, we find ourselves operating in separate departments of a fragmented service in conflict with each other rather than with each other and for each other.

'Rationalisation' has become cheap-speak for 'centralisation' whereby the central, the powerful and the big are allowed to colonise the weak, the small and the peripheral. In other words, central institutions are dictating people's need rather than responding to need determined by the people.

The community's ability to realise its capacity for enterprise will depend upon the liberation of its talent on the one hand and the mobilisation of appropriate resources on the other. Such capacity is expanded or contracted according to the manner in which the particular community relates to adjacent communities and whether or not it operates within a region where central institutions lay emphasis on co-ordination or control.

Today, we know that relatively inexperienced trainees may carry out surgical operations under the Antarctic ice cap because they are monitored by satellite through radio communication and television control in the Department of Surgery in Aberdeen. In other words, our technology should more and more be used to meet need determined by people where they live and work rather than as a tool to control them. The greatest irony of the late twentieth century is to know that we have the technology which has put men on the moon and retrieve them safely to earth yet, because of the way in which our technological society is controlled, there was this year much debate on whether women should be allowed to have babies in Co. Fermanagh!

Regrettably, the present rationalising forces, responding to the cult of size and centre rather than to the needs of scale and community will continue unchecked until health service personnel and tax-paying people become more aware and more politically active with regard to the issue of control without accountability which affects us all at this time.

Whether we are dealing with on site managers of trust hospitals or fund holding health centres or managers of Area Boards or Regional Health Authorities in County Halls, accessibility to decision making and accountability of decision makers are matters which are increasingly engaging the attention of more and more people.

If this pamphlet assists in this process it will have been worth writing.

CONCLUSION

If we do not become more determined in our use of structures, more disciplined in our management of procedures and more insistent on accountability in decision-making, then health service user and health service personnel will find themselves increasingly at the mercy of remote forces over which they have less and less influence.

If it were possible to bring the proposals in this pamphlet to fruition it would be a mile-post in the promotion of local democracy at a time when people feel so powerless. Just as important it would enable a dialogue based on consensus rather than on confrontation to be established with administration and other statutory bodies - we should all therefore learn from each other and the local district benefit as a result. Who knows, if it can be done in the area of health, it might just become a prototype for a people's/professional's/administrator's dialogue in other spheres.

SIGN OF THE TIMES

In 1990 a Steering Group was constituted to co-ordinate support for the campaign for a New Hospital in the Coleraine, Ballymoney, Moyle district of Northern Ireland. This Steering Group is composed of a broad cross section of the local community including members of the three local councils, members of the people's support group of Ballycastle, Ballymoney and Coleraine and local trade union representatives.

On Wednesday 12th February 1992 the Steering group met in Ballycastle and passed a motion urging "the Northern Health and Social Services Board (N.I.) to address the need to set up a democratic structure appropriate to the involvement of representatives of personnel and people along with key figures in administration to enable better access to and more accountability of decision makers".

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