Community Advisory Committees in Victoria’s Metropolitan Health Services

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Increasingly, governments at both the state and federal level are encouraging health services to incorporate consumer participation into their structure for planning, decision-making and evaluation. This article describes how in Victoria, Consumer Advisory Committees have been used to bring a consumer voice into the Metropolitan Health Services.

The movement towards community participation in health policy, planning and service delivery has both ethical and practical foundations. Consumer participation is a democratic right which improves our society; the quality and safety of health services and individual health outcomes.

An organisational commitment to consumer and community participation is a requirement of Australian health service accreditation programs. These programs range from the Evaluation and Quality Improvement Program (EQUIP) which requires consumer participation in care delivery, planning and quality improvement (ACHS, 1996) through to the Practice Incentives Program (PIP) where consumer feedback is required for entry under the Australian General Practice Accreditation Limited (CHF, 1999a).

The National Health Strategy (Macklin, 1992) outlined a democratic approach to participation centring on three factors:

1. Public participation at a range of levels.
2. Focus on consumers and communities, rather than providers and funder interests.
3. An open system (information, public accountability, transparent and conspicuous decision-making).

(Source: Consumer Focus Collaboration, 2000, p. 2).

Putting this theory into practice is one of the major challenges being taken up in various state health systems. In Victoria, Consumer Advisory Committees (CAC) have been established as a mechanism to achieve community participation in health policy and service provision in the Metropolitan Health Services (MHS) which manage groupings of public hospitals and other providers.

History of CACs

In 1999, a Victorian Ministerial Review of Health Care Networks investigated issues including “mechanisms to ensure coordination of health services, promotion of consumer involvement and promotion of accountability of quality care in metropolitan hospitals”. The government wanted to “enable meaningful community input to assist the deliberations of the Boards and Chief Executives of the new Metropolitan Health Services and ensure that communities play a participatory role in the Metropolitan Health Services’ planning, service delivery and development of policy” (DHS, 2000, p. 12).

In 2001, the MHS established CACs as sub-committees of their Boards. The CACS were given two critical roles:

1. To assist the Health Service to appropriately integrate consumer and community views at all levels of its operations, planning and policy development.
2. To advocate to the Health Service Board on behalf of the community.

In order to encourage responsiveness from the Health Services, the Community Advisory Committee Guidelines were promoted setting out the roles, accountability and reporting relationships of the CACs and importantly, giving the Health Service Boards the complementary responsibility of “seek[ing] informed advice in a timely manner from the
Community Advisory Committee on major strategic issues and developments” (DHS, 2000, p. 5).

Health Issues Centre and Corrs Chambers and Westgarth produced these Guidelines after a process involving a review of the relevant literature and consultations with consumers, community groups, community representatives, Health Services Executives and Boards. The Victorian Department of Human Services published these guidelines in November 2000 and subsequently a report of the project.

The CACs are expected to assist Health Services to ensure mechanisms are in place to facilitate consumer and community participation at all levels of the Service. What this means in practice is a giant learning curve for all involved, from senior managers to community representatives.

**Mandatory Requirements**

The Guidelines for the operation of the CACs recognise “that the most effective processes are those that are developed locally to suit local needs”. Nevertheless the following are mandatory:

1. Advising the Health Service Board on the appropriate structures and processes necessary to ensure effective consumer and community participation at all levels of service planning and delivery.

2. Identifying and advising the Health Service Board on priority areas and issues requiring consumer and community participation.

3. Developing a strategic Community Participation Plan for approval by the Health Service Board and monitoring the implementation and effectiveness of the approved Plan.

4. Advocating on behalf of the community, including promotion of greater attention and sensitivity to the needs of disadvantaged and marginalised consumers and communities.

5. Facilitating two-way communication between consumer and community groups and the Health Service.

6. Participating in the Health Service strategic planning process.

7. Participating in the development and ongoing monitoring of key performance indicators for Health Service quality.

(Source: DHS, 2000, pp. 5-6)

Clearly the scope of these mandatory requirements is quite enormous and needs to be broken down into manageable steps. The development of a *Community Participation Plan* has been seen by both CACs and Department of Human services (DHS) as a primary task.

**Audits**

One of the major activities that has been undertaken in each MHS to complete their Community Participation Plans, is an audit of consumer participation policy and practices in the major work areas of each organisation undertaken under the direction of the CAC. Staff may be asked to spend five to ten minutes thinking through current community participation strategies in their wards, departments, programs or units. In other cases interviews with staff have been conducted. Often there are wonderful initiatives that have been or are being done, but there is little collective knowledge of these, even within the one Service or its community. An audit tool developed by the National Resource Centre for Consumer Participation in Health has been used as the basis for these audits, with modifications based on the particular situations in each Service. The Resource Officers
appointed to assist the CACs are working to ensure that these audits are completed in ways appropriate for each organisation.

Key People

These Resource Officers, who are mostly employed between four to eight hours per week to assist the Committees, in many cases also hold positions such as Quality Managers or Patient Liaison Coordinators. They are key people in helping the CACs negotiate their way around the huge and complex organisations that are Health Services. DHS originally provided $25,000 to each MHS to assist in the establishment of the CACs, with the expectation that community participation would become core business and therefore be part of each recurrent MHS budget. The Guidelines recognise that the success of the CACS will depend on:

- The availability of experienced administrative and project officer support;
- Personal support for CAC members to facilitate their participation; and
- Visible interest and support from the Health Service senior executives and Board.

(Source: DHS, 2000, p. 11)

The work of the Resource Officers and the CACs has only just begun. It is hoped that the necessary funds can be found to continue this crucial role of investigation of and support for community participation in MHS.

Another crucial person in the effective functioning of the CACs is their Chairperson. As members of their Health Service Boards as well as Chairs of the CACs, these influential people are leading an initiative that must take into account:

- the expectation that members of the Community Advisory Committee will link the Health Service with the community;
- the need to establish long term working relationships between the Community Advisory Committee and the Health Service based on mutual trust and confidence;
- the public interest in access to information; and
- the need to protect individual confidentiality and privacy.

(Source: DHS, 2000, p. 8)

Quite a juggling act! Especially since the importance and benefits of community participation in all levels of a MHS is not yet recognised as core business by all decision-makers.

A Workshop for CAC members and Chairs, Resource Officers, senior managers, CEOs and Board members will be held in late April 2002 to consider the implementation of the Community Participation Plans and the issues of review and evaluation. The key question for this workshop will be: How well is community participation being integrated into your Health Service? CEOs and CAC Chairs will be asked to submit five key issues/concerns for their organisation to assist in planning the agenda for this workshop.

Membership

Clearly the CACs have a key role in advising the MHS Boards on both policy and operations. Members are charged with great responsibilities and have enormous demands on their time and resources.

One of the issues of concern to Health Service Boards in the establishment phase of these Committees has been the recruitment of CAC members. The Guidelines suggest that “Members of the Community Advisory Committee should have the capacity to reflect the perspectives of the communities served by the Health Service and to bring …
knowledge of the opinions and policies of relevant community groups …. members should not be appointed as representatives of specific organisations” (DHS, 2000, p. 9).

The desire to get ‘real’ consumers involved in community representation is an issue occupying the agendas of a number of Ministers and officials at various levels of the Australian Health System. The responsibilities and expectations placed on the CACs demonstrate the range of expertise required to do the job. The Committees will be stronger and more effective when members bring experience and accountability of their community to their work. This means that those with direct experience of hospital care will be invaluable but equally those who know who their community and can represent a collective point-of-view are essential. Health consumers are sometimes thought of as being only the people who actually use the particular health service. But the Chronic Illness Alliance, the Rural and Remote Consumers Network, the Centre for Culture, Ethnicity and Health and the Victorian Aboriginal Community Controlled Health Organisation are among many examples of organisations which are able to express their ideas, experience and research to assist in representing community perspectives and knowledge. The demography of a MHS catchment will guide each Service as to which organisations will be appropriate for their CAC.

In fact most CACs have sought out nominees from representative community organisations at both local and state-wide levels. The Guidelines themselves do note that “A majority of members should be linked to community or consumer networks” (DHS, 2000, p. 9).

The Consumer's Health Forum, for example, defines a consumer representative “as a committee member who voices the consumer perspective and takes part in the decision making process on behalf of consumers. This person is usually nominated by, and is accountable to, an organisation of consumers” (Consumer's Health Forum, 1999, p. 3).

It is widely recognised that the terms consumers and community represent all those people and groups who have an interest in the delivery of health care:

- patients or potential patients interested in the quality of care, effectiveness of treatment and the way in which services are delivered;
- families and carers of patients;
- members of self-help groups and community networks;
- citizens concerned about social values and priorities in health policy, services planning and delivery; and
- taxpayers interested in resource allocation and the expenditure of public money (Source: Draper, 1997).

In future editions of Health Issues, what makes a good consumer/community representative will be examined through talking with a number of representatives from CACs and other consumer reference groups.

**Evaluation and Review**

Each CAC is expected to undertake an annual review to look at a range of issues including whether the Board sought their advice in a timely and appropriate manner and whether any of the CAC’s recommendations have resulted in observable changes in practice in the MHS.

There is also a requirement that within three years, “the Department of Human Services should undertake an independent, external evaluation of their structure, operation and effectiveness. Arrangements for this review should be established early to ensure adequate recording of review parameter” (DHS, 2000, p. 14). Performance indicators are an effective way of measuring results.
At a recent CAC Chairs network meeting it was reported that the DHS saw the Quality of Care Reports as a useful ways for CACs to be involved in determining performance indicators for integrating community participation into the performance of the MHS. The Guidelines also note the benefits of “systematic information exchange between the Community Advisory Committee, the Health Service Quality Committee and the Primary Care and Population Health Advisory Committee” (DHS, 2000, p. 10).

The recently published draft review of the EQUIP accreditation standards on Evaluation and Quality Improvement could also provide a useful tool for CACs to develop performance indicators. In the new draft set of EQUIP standards there is an increased emphasis on “recognition of the customer’s needs and preferences”. The level of implementation under this section includes the requirement that “performance on meeting customer needs is measured and monitored” and that “the service has a customer focus and is adaptable to customer’s changing needs” (Australian Council of Healthcare Standards, 2001, 6.1.2). Unfortunately for many people, the word customer conjures a view that sees patients as buying a service provided by professionals who know best. However, the intent of these proposed standards is clearly to increase the awareness of staff and health services about the benefits and ways of achieving greater accountability to the local and wider communities they serve.

The connections and overlaps between these various accreditation and monitoring programs and between the various committees in each MHS will need to be taken into account and managed effectively to allow the CACs to continue to develop their oversight of community involvement in health policy and practice.

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References


Draper, M., 1997, Involving Consumers in Improving Hospital Care: Lessons from Australian Hospitals, Commonwealth of Australia, Canberra.


