Where should health services go: local authorities versus the NHS?

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The Association of Metropolitan Authorities has recently proposed that responsibility for the NHS should pass from health authorities to local authorities. In these three articles, a public health physician argues against local authorities taking over the NHS; a historian provides context, and a health policy analyst looks at the opportunity that a new health policy agenda offers to local government.

The Association of Metropolitan Authorities has recently proposed that responsibility for the NHS should pass from health authorities to local authorities. One of the fiercest debates at the outset of the NHS was whether the hospitals should be run by local authorities. In the end the minister for health, Aneurin Bevan, decided against local democracy and in favour of a national health service. His arguments included the fact that equality of treatment could not be guaranteed if facilities varied with local finances and that even the largest authorities were not big enough to pool risks and expertise. All these arguments still apply today, and the recent changes in community care provide an insight into how a market model of local authority control might work. The changes have been accompanied by a shift from public to private sector provision and the introduction of charges for services that the NHS once provided free. As important, the willingness and ability of local authorities to raise extra revenue from local taxes and charges affect the service they can provide, so leading to inequalities of provision. Local authorities have yet to make the case that they can preserve the fundamental principles and benefits of the NHS, including its reliance on central taxation and unified funding formulas.

From both ends of the political spectrum the case for local authority control of health services is gathering momentum. Birmingham (Labour) and Wandsworth (Conservative) local councils are actively pursuing this policy, and in 1994, the Association of Metropolitan Authorities, the body representing the authorities responsible for running Britain's cities, published its proposals for transferring health services to local authority control.[1] Central to it and other models[2] is the retention and institutionalisation of the market.

One wonders whether the Association of Metropolitan Authorities realises the extent to which its market model replicates the 1944 white paper which Bevan abandoned in favour of a nationalised hospital service.[3] The 1944 white paper envisaged that voluntary hospitals would retain their independent and autonomous status and contract out their services to local authorities to be paid for from exchequer funds, local rates, and donations. Voluntary hospitals would be subject to some national regulation—for example, over terms and conditions of service for staff. In retrospect Bevan's decision to trade local democracy and the independence of voluntary hospitals for a national hospital service can be seen to be based on concerns about the market and the ability of local authorities to plan for equality of treatment. His five main arguments were as follows. Firstly, planning services for minority groups and conditions and diseases "when not even the largest local authorities provided a gathering ground extensive enough for certain medical specialties." Secondly, "equality of treatment could not be guaranteed if facilities varied with local finances." Thirdly, cross boundary flows and patient referrals "would be fraught with financial complexities for the authorities concerned." Fourthly, given that voluntary hospitals would rely almost entirely on public finance "we must insist on the principle of public control accompanying public financing of services." Finally, he noted that, with a few notable exceptions, local authorities had not shown their ability to run good services. Bevan argued that the democratic deficit in the NHS would not be redressed by local authority administration unless major local government reorganisation occurred at regional level.[4]

What kind of health service could local authorities provide in 1995? Would the NHS be made more democratic by local government control? Or would the transfer of health services merely accelerate the shift from public to private sector funding and provision and, by removing public services from public control, destroy accountability? Community care could be considered to be a pilot experiment in the market model of local authority control of health services; this paper reviews its operation in the light of Bevan's concerns. In doing so it illustrates the current relation between local and central government.

The shift from public to private sector provision

The 1980s saw a shift from public to private sector provision in all aspects of health care but especially in the provision of continuing care for priority groups (elderly people and people with learning difficulties, mental illness, and physical disabilities).[5] The organisational responsibility for these groups has never been clear, partly because the tripartite structure of the 1948 NHS blurred the boundaries of care. In 1948 only the hospital services were nationalised: community health services were run by local authorities until the 1974 reorganisation; and general practitioners continued to retain their independent status. The terms of the National Health Services Act 1946 and the National Assistance Act 1948 created further ambiguity: the NHS was to provide long term care for elderly people who were sick or infirm, while local authorities were to provide residential and domiciliary care for frail and old people.[6] The distinction between frailty and infirmity is important, since it means the difference between free care (from the NHS) or means tested care (from local authorities).

Closures of public sector long stay institutions accelerated throughout the 1980s: between 1982 and 1993 148 000 NHS beds were lost in the priority services (fig 1). Between 1982 and 1993 the number of places supported by local authorities fell by a third to 77 000 for elderly and physically disabled people and by 24% to 3259 for mental illness. In contrast, the number of places in the private and voluntary sector grew from 89 400 to 205 500 places for elderly and physically disabled residents and from 6540 to 12 847 for mental illness.[7] Some have commented that this expansion simply reflected unmet need as a result of local authorities applying strict criteria to their own limited supply of part III accommodation[8] and decreased provision in the NHS.

Capping public sector spending

SOCIAL SECURITY AND LOCAL AUTHORITY BUDGETS

Although the 1980s saw increasing financial stringency over public sector spending the shift from long term public to private provision was financed mainly with public money.[9] This was an unintended

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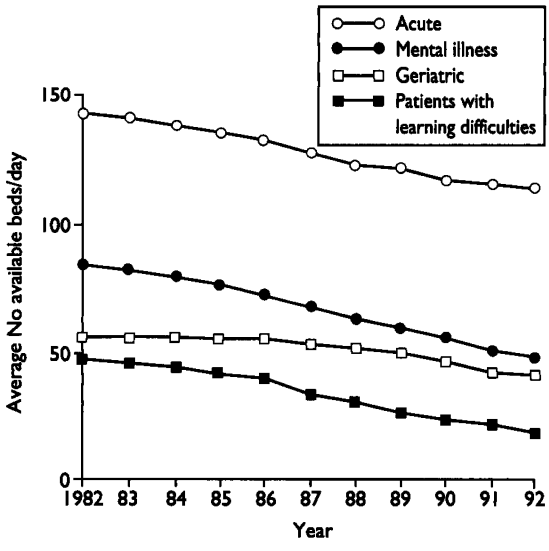

FIG 1—*Numbers of NHS beds available for different types of patients: average daily number of available beds 1982-92. (Data from Department of Health, health and personal social services statistics for England)*

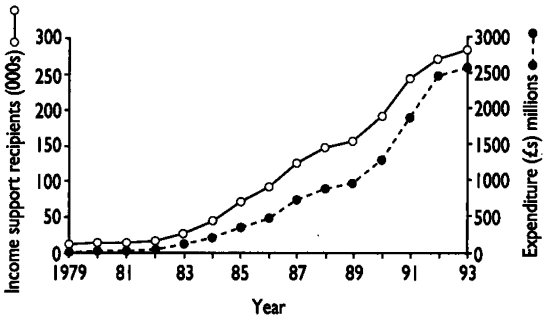

FIG 2—*Numbers of recipients of income support in private and voluntary nursing and residential homes and income support expenditure UK 1979-91. (Data from Department of Social Security)*

consequence of an amendment to the Social Security Act in 1982 which allowed residents in private nursing homes to claim social security benefits (while residents of local authority and NHS homes could not).[10] Cash strapped NHS authorities and rate capped local authorities could now encourage patients to withdraw from publicly provided services altogether: income support payments escalated (fig 2) and the number of residents supported by local authorities fell by 24% for mental illness and 39% for elderly people (fig 3).

The NHS and Community Care Act 1990 capped public sector spending on long stay care by devolving responsibilities for community care to local authorities and closing the social security loophole. Since 1993 funding for community care has come from central taxation but has been given to local authorities through their standard spending assessments, a special transitional ring fenced grant from the social security budget, local taxation, and client contributions.[11]

The special transitional grant is a four year central grant which estimates the amount that would have been spent out of the social security budget on residential care. This grant is tapered into the standard spending assessments over four years. These assessments are central allocations based on a complex formula comprising proxy measures of population need, but these differ from those used in the NHS allocation formula.

Local authorities have always had powers to raise local taxes from their community and from charges to clients who use their services. Central government has now capped the amount that local authorities can raise in local taxes so they have little option but to turn to charges. There are currently three charging options: no charge, a flat rate charge on services irrespective of ability to pay, and a means test. Authorities vary greatly in how charges are applied and for which services. The trend across all local authorities is towards an increase in charges for all services to a level above inflation and the introduction of charges where none existed.[12]

The amount local authorities can raise from charges is taken into account in the standard spending assessments: the government deducts a fixed sum of 30% of total residential care costs and 9% of domiciliary care costs for every local authority. Authorities which chose not to levy patient charges for domiciliary care therefore start each financial year with a shortfall in their total resources.

In 1970 28% of all elderly people receiving long term care outside their homes received free NHS care; by 1992 this figure had fallen to 12%.[13] Around 40 000 couples had to sell their homes to pay for nursing home care last year alone. This appears to be partly a result of the decreased availability of free NHS long term care and partly a consequence of more rigorous charging policies.[14]

CAPPING THE NHS BUDGET

The introduction of the internal market in the NHS also worked to cap spending on community health services. Since 1991 NHS purchasers have set their contracts prospectively at the start of each financial year. Providers now have a ceiling on what they can spend and how much work they can undertake in the public sector. Where providers cannot generate enough income to remain viable they may have to turn to other sources of revenue. These include private finance for capital and running costs, soliciting business from the private sector, or increasing income from NHS patients either by selecting more lucrative patients—for example, patients of fundholders and extracontractual referrals—or by mixing private and NHS care within treatment packages. Charging policies are not standardised across providers or purchasers, and thus new inequities are arising in who pays and which services are charged for.

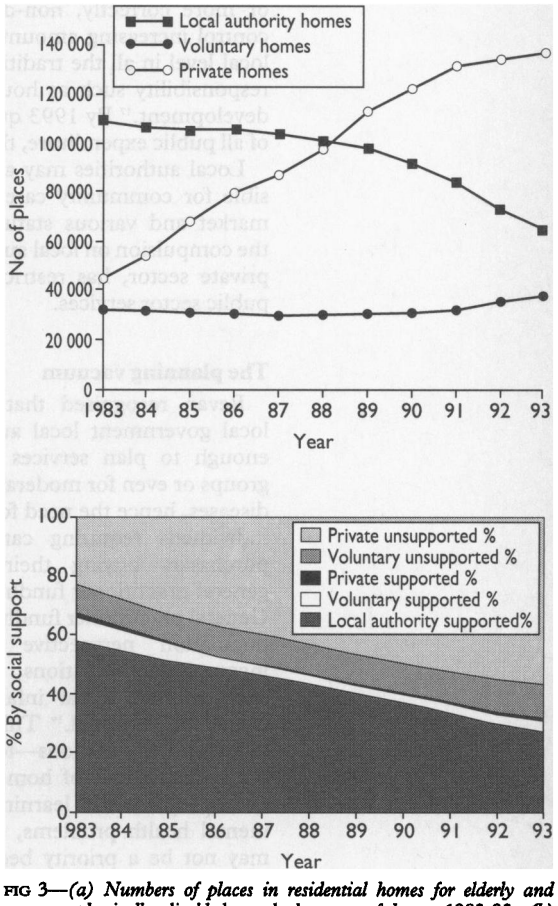

FIG 3—*(a) Numbers of places in residential homes for elderly and younger physically disabled people by type of home 1983-93. (b) Numbers of places in residential homes for elderly and younger disabled people by source of support 1983-93. (Data from Department of Health, personal social services and local authority statistics)*

Removing publicly financed services from public control

"Although it is essential to retain parliamentary accountability for the services, the appointment of members of the various administrative bodies should not involve the Minister of Health . . . election is a better principle than selection but the difficulty arises from the fact that no electoral constituency corresponds with the functional requirements of the service." Bevan, *In place of fear*, 1952.

If the 1980s signalled the end of the era of publicly financed public sector provision, the 1990s marks the end of the principle of publicly controlled and managed services. The NHS and Community Care Act 1990 changed the constitution of health boards, excluding locally elected councillors and trade union representation. Instead, members, who often had strong Conservative leanings, were selected.[15] Less obvious, but more profound was the removal of local hospitals and community services from direct health authority control, with the establishment of trusts and trust boards. The remit of trust boards is "to manage their trust effectively and to make a return on their capital stock," not, one notes, to improve patient care or give satisfaction to the community. The devolution of purchasing to general practitioner fundholders with no formal mechanisms for local accountability is part of the same trend.

In advocating local authority control of health services the Association of Metropolitan Authorities is in danger of ignoring a similar erosion of accountability in local authorities. Described by Howard Davis and John Stewart as "an impending crisis in accountability,"[16] many of the services formerly administered by central government and local authorities are now run by independent funding agencies headed by people appointed by central government. These quangos (quasi-autonomous non-governmental organisations, or more correctly, non-departmental public bodies) control increasing amounts of public sector money at local level in all the traditional areas of local authority responsibility such as housing, education, and urban development.[17] By 1993 quangos were spending a fifth of all public expenditure, three quarters at local level.[18]

Local authorities may appear to be directly responsible for community care, but the imposition of the market and various statutory instruments, including the compulsion on local authorities to spend 85% in the private sector, has restricted their ability to develop public sector services.

The planning vacuum

Bevan recognised that without reorganisation of local government local authorities would not be big enough to plan services for the needs of minority groups or even for moderately common conditions and diseases, hence the need for a regional tier. Since 1991 individuals requiring care may have up to three purchasers buying their care: health authorities, general practitioner fundholders, and local authorities. General practitioner fundholders are least able to take a population perspective since they serve small, incomplete populations, and even common events such as myocardial infarction, stroke, arthritis, or cancer are unusual.[19] This is equally true of certain vulnerable populations—for example, at practice level the special needs of homeless people, ethnic minorities, people with learning difficulties, people with mental health problems, and people with disabilities may not be a priority because of the small numbers involved.

The problem of multiple purchasers is compounded by the lack of coterminosity of the populations served by health authorities, local authorities, and fundholders, who in theory are supposed to plan and coordinate services for these overlapping populations. As purchasers increasingly set their own priorities, level of service provision will vary from area to area and from one patient to another.

The perceived strength of community care is that services should respond to the individual's needs. But eligibility and ability to pay rather than need currently determine the responsiveness of services. Before 1993 local authorities were expected to provide a certain level of service provision per head of population—for example, so many nights of respite care, so many home helps per thousand population. Although crude, normative provision was a useful indicator of inequalities in resource allocation, service provision, and access to care across local authorities.[20] Now that providers no longer serve their local populations and are expected to compete for patients and clients from other areas local authorities can no longer use normative planning as a basis for future service provision. West Midland Health Authority has recently contracted with King's College Hospital, south London, for 75 coronary artery bypass grafts for its residents. The loss of the population focus from services means that no one can determine whether local services in Lambeth or the Midlands are adequate to meet local residents' needs for services for coronary heart disease.

In the absence of data on population based service provision local authorities have recourse only to information from individual assessments of need. But the Department of Health report *Implementing Community Care* highlights weaknesses in the ability of local authorities to translate information from individual needs assessments into population needs and planning because there are no standardised datasets for community care.[21] Community care plans as yet contain no statement of the population's needs for services. Nor do they reflect the changes in NHS acute and residential care provision which are taking place. Those authorities which are monitoring unmet need are doing so only in respect to assessed needs—for example, among the tiny percentage who are eligible for services. Unmet need in the widest sense is ignored, because local authorities neither have normative service provision measures nor standardised data on needs from individual care assessments.

The NHS and local authorities risk paralysis by ignorance. Purchasing organisations have been stripped of planning functions and technical expertise.

Equality of treatment

The great strength of the NHS has been the pooling of financial risk across the whole population so that no individual authority, provider, service, or patient has to bear the risks and expense of costly treatments and care. The other advantage has been the ability to put in place mechanisms which attempt to redistribute money on the basis of need.[22] Within the NHS these advantages are disappearing. This is partly because new resource allocation mechanisms have in built inequities[23] but also because the ability to pool risks is diminished as budgets are devolved to small purchasing populations and provider units.

The transfer of responsibility for funding community care to local authorities means that the risks and costs of care must be borne by a smaller tax base; the results of this transfer will almost inevitably be regressive. Areas with the greatest need will have to find the biggest sums of money from their resident communities, and where they cannot poorer quality services will become the norm. Because money for social services is not ringfenced local authorities continue to have discretion over how much they spend on social care, who receives it, and the amount they

charge for it. This is true of all their services now that local authorities are wholly responsible for social care; the amount they spend will reflect the importance they attach to social care and their ability to raise money commensurate with that importance. This is similar to the situation before 1948, when local authorities were responsible for raising local taxes to pay for health care. As a result of delegating funding responsibilities for community care to local authorities the proportion of local taxation and patient charges to central funding has increased, thereby transferring costs to individuals and their communities (fig 3).

Local authorities and health authorities struggling with capped budgets have had to resort to various rationing measures: the NHS has continued to redraw the boundaries of care; both health and social services are now introducing eligibility criteria for their populations; and finally all authorities have complex procedures for dealing with the expensive risky individual otherwise known as the extracontractual referral.

REDRAWING THE BOUNDARIES OF CARE

The NHS is redefining health care in terms of cure and away from care.[24] In doing so it is also shifting the boundaries of care by, for example, substituting those elements of acute care it once provided free in hospital with care increasingly paid for in and by the community. Hospital at home schemes, rapid discharge, and decreased length of stay are examples of the imperatives to reduce the costs of NHS acute care.

The move towards greater joint commissioning between health and local authorities has been hailed as evidence of greater collaboration between the sectors, but it is a double edged sword. Joint commissioning may simply enable the NHS to shift services that were once free within the NHS to the local authorities, where they will be means tested and charged for.

EXTRACONTRACTUAL REFERRALS

As Bevan predicted, the extracontractual referral has become the administrative nightmare of the market. There are two types of extracontractual referral: those involving only one purchaser and those involving more than one. In the first, the purchaser has no contract with the provider for the service required. Although the services are usually expensive and complex, requiring a range of clinical inputs, it is often left to administrators with no clinical experience to decide whether payment is appropriate. The second type are usually boundary disputes involving health and social services, decisions about which authority should pay for the various elements of service needs. General practitioner fundholding will add a further dimension to these complex financial negotiations, since they may be more reluctant to fund extracontractual referrals than health authorities.

ELIGIBILITY CRITERIA FOR COMMUNITY CARE

The assessment of need is the cornerstone of the Community Care Act. In theory the individual decides which services and care he or she requires. The practice is rather different. Because social care funding is not ringfenced local authorities differ in their levels of resources and provision. The government recognised early on that one consequence of capping the social security budget and devolving funding would be rationing. It therefore recommended that local authorities should develop eligibility criteria to determine who would get services.[25] Social care needs are not to be decided by the individual after all but on the basis of these eligibility criteria. In each local authority clients now face three hurdles in having their needs assessed. They must first show that they fulfil the eligibility criteria in order to be assessed for services. If they then get through to the assessment phase they must then show that their needs fulfil local eligibility criteria for services. And, finally, they are then subject to charging or means testing for those services.

Similarly, within the NHS there are signs of a shift away from a needs based service to a service based on eligibility. In recent draft guidance to health authorities the Department of Health recommended the introduction of eligibility criteria for continuing care. This guidance is ominous because it suggests that the NHS may use the community care loophole to introduce charges for services it once provided free.[26] With fundholding general practitioners are also the rationers of care, and new inequities may arise when general practitioners find they have different budgets and priorities for care. The potential for inequities as purchasers attempt to avoid costs and define eligibility for different groups are enormous.

The balance sheet

Arguments about whether control of health services should rest with local authorities tend to ignore the realities of how the market has fragmented care, undermined the principle of equity, and destroyed planning structures. In 15 years the transition from public to private sector provision has been rapid. As a result new inequities are arising within and between some of the most vulnerable groups in society. These inequities cross health and social services boundaries and affect fundholder and non-fundholder residents alike. It is these inequities that any new strategy needs to address, and the issue of local accountability is only one component of the debate.

Fair funding strategies are essential to the pursuit of equity in the delivery and outcomes of health and social care. Local taxation and the growth of charges in health and social care are creating geographical inequities in community care, so that increasingly where you live determines what you receive and what you pay. Health and social care must be integrated under one unified authority, and funding formulas should also be unified and ringfenced. The benefits of central taxation must not be underestimated. It allows financial risks to be pooled so that risks and liabilities are borne by a wide and progressive tax base. Strategies must also examine how the market diminishes these benefits by devolving the risks and budgets to small purchasers and providers, thereby increasing the financial and administrative complexities and costs. Since 1974 regional health authorities have had an important role in planning and safeguarding national health service information. This tier has enabled expensive services and minority groups to be planned and provided for and minimised much duplication.

Local authorities have yet to make the case that they can preserve the fundamental principles and the benefits of the NHS. Back in 1946 Bevan recognised that there would be a trade off between local accountability and a national unified health service. But in 1995 those advocating local authority control, including the Association of Metropolitan Authorities, have yet to show whether their model of local authority control will increase accountability and preserve the principles and maximise the benefits of a national system. Indeed the association's model, which foresees a continuation of trust boards operating in a market, conflicts with the principle of publicly financed services being under public control. Local authorities have yet to show whether they will be able to pool financial risks for expensive and rare conditions and diseases in the way that the NHS has been able to do. How will they ensure that services will be free at the point of delivery? How will they safeguard against the growing trend towards local eligibility criteria in all

services, which currently makes the receipt of community care a lottery? How will they ensure that the principle of equal access for equal need through the fair distribution of resources and services is observed?

The Association of Metropolitan Authorities has opened a much needed debate, but the analysis is at a very rudimentary stage. This debate must consider the effect the market has had on the ability of local authorities and health authorities to deliver equitable care. It must also consider the impact of a community care policy that has transferred the costs of care from society to the individual. Public debate is also required to establish whether the collective values which drove the consensus politics of the 1940s are still those we want today.

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Local government and health care: the historical perspective

Charles Webster

Local government administration of health services is prevalent in Scandinavia, and the tradition was equally deepseated in Britain, brought to an end only in 1948. It is generally thought that the local government alternative was decisively and permanently rejected when the NHS was started, but the local government option was not so readily or completely discarded. In particular, the return of the health services to local government was a possibility at the time of the 1974 reorganisation. Both the longer term perspective and the arguments surrounding the illfated 1974 reorganisation need to be kept in mind in the course of current discussions concerning the future of the NHS.

Administrative tradition

In the course of the century from 1848 to 1948 it was increasingly accepted that public provision of health care should be the responsibility of local government rather than the poor law authorities.[1] Health care was recognised as the analogue of education; both services came to be administered predominantly by county councils and county boroughs; the various committees of these authorities concerned with health and education were the best endowed and most prestigious areas of local government administration. Over the course of a century, the suitability of local government for administrating personal and environmental health services became so widely accepted that it achieved the status of almost an unquestioned constitutional principle.

At first the departments of the medical officers of health were predominantly concerned with public health, but by the first world war local authorities also controlled a vast institutional service connected with infectious disease, destitute sick people, and longterm confinement. It was therefore entirely understandable that such advanced thinkers as the Fabian society should advocate the extension of local government activity into the acute hospital sector. As early as 1900 the Fabians declared, "We must municipalise all our hospitals".[2]

The Labour party was the most active (though not the only) advocate of a comprehensive health service adminstered by local government. Proposals for a comprehensive and free health service administered by local government were included in a Labour party planning document in 1919, one year ahead of the famous Dawson report.[3] The Labour party already coined the name "National Health Service" for its projected comprehensive municipal health service. This view of the future of health care was shared by Sir Robert Morant, the great administrator and architect of the Ministry of Health, established after the first world war, and it persisted as the official philosophy of the health departments until 1945.[4]

Despite the general atmosphere of retrenchment, expenditure on the local authority health services in England and Wales expanded from £5.6m at the turn of the century to £51m at the outbreak of war, all of this in a largely non-inflationary environment. By 1935 local authority health services accounted for about 60% of expenditure on organised health care in Britain, the remainder being split evenly between the voluntary hospitals and National Health Insurance. The trend towards local government domination of the health services continued and was accelerated by the second world war.[5]

Change within the health services was too slow for progressive opinion. Laying down guidelines that were adopted by the Labour party, the Socialist Medical Assocation ordained that the "Health Service of the future will be administered by local authorities, supervised by the Ministry of Health, which will have charge of all the Health Centres of the nation." "Health centre" was at this time the preferred term for an

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institution responsible for comprehensive health care. The planners added an important and ominous caveat relevant to Labour's eventual retreat from the local government idea: "The Ministry must, however, use to a much fuller extent than at present the powers that it possesses for compelling reactionary local authorities to carry out their statutory duties."[6]

The National Health Service

During the second world war it was increasingly evident that the voluntary sector was beyond reclaim; the obvious way forward for the postwar NHS was further acceleration of the long standing trend towards a comprehensive health service provided by local government. The strength of the argument for local government control was recognised in the draft interim report of the Medical Planning Commission, the medical profession's main contribution to thinking on postwar reconstruction of the health service. It was concluded that the "system under which local authorities administer in detail a broad policy decided by the central government is deeply embedded in the social fabric of this country." The commission echoed the usual reservations about the disadvantages of existing local government boundaries, but accepted that these difficulties were not insuperable to the creation of comprehensive and balanced health services administered by local government.[7]

Precisely the same view was expressed in the coalition government's white paper, which laid the general foundations for the postwar health service. The white paper considered but dismissed other alternatives, concluding that the well tried principles of "democratic responsibility and . . . full professional guidance" should be preserved in the future national health service. The government therefore declared that it would not "needlessly interfere with the well tested machinery of local government as it is already known; nor would the record and experience of the existing local authorities in the personal health services justify this course."[8]

Although the plan commanded wide support, there were profound obstacles to practical realisation of the white paper's scheme. The most potent objection emanated from the medical profession, which was generally opposed to full time contracts of employment, which predisposed opinion against local government administration of the new health service. Even the partisans of local government appreciated that unreformed local government areas were unsuitable for the administration of modern health services. Experiments with joint boards had failed in the past and were recognised as an unsuitable vehicle for the future. There was also the problem of "reactionary local authorities." Compared with successful local authorities like Middlesex, Surrey, Tottenham, or to some extent the London County Council, many of the public health services were an abject failure, not only because of shortage of resources but also by virtue of limitations of insight on the part of committees and their medical officers of health. The atmosphere of the hated poor law hung over municipal health services, and doctors were understandably not enthusiastic to be assimilated into such structures.

POPPERFOTO

Nye Bevan had difficulty persuading his Cabinet colleagues to abandon the local government plan for the health service

The Labour government elected in 1945 was generally committed to the white paper, but Aneurin Bevan was fully alert to the political and planning objections to local government administration. As the minister responsible for local government as well as health, Bevan realised that there was no prospect for an immediate radical reform of local government, and no indication that the medical profession would cooperate with the white paper scheme. Also Bevan was not confident that local authorities possessed the qualities necessary for presiding over the ambitious, first class health service to which he aspired. Bevan therefore rejected local government control of the health services and instead adopted a specially devised system based on regional and area units of organisation. He believed that this choice would possess the additional advantage of unlocking resources for the health service on a much greater scale than previously possible, by transferring the burden of costs from local to general taxation. It is well known that Bevan had difficulty in persuading his Cabinet colleagues to abandon the local government plan for the health service.[9,10] However, Bevan had not finally concluded that local government administration was unsound in principle or unattainable in practice.

The original region-area model for the new health service devised by Bevan proved to be unrealisable. Aspirations concerning simplicity and unity of organisation were completely frustrated. In 1944 it was hoped to unify the health services in England and Wales under some 40 units of local government; in the event Bevan's system involved some 700 separate administrative elements, in effect three parallel and administratively unrelated health services, concerned with hospitals, family practitioner services, and community services. Such compromises were the unavoidable consequence of expediency, given the importance of launching the national health service in tandem with associated Beveridge reforms in 1948. The tripartite arrangement has been defended by its planners as the "best that was possible in the context," and it satisfied immediate requirements reasonably well, but this creaking assemblage was clearly not a viable permanent basis for the organisation of a modern health service.[11]

Reorganisation

Bevan soon decided, with the arrival of the opportunity for local government reorganisation, that the health services should be unified under local government.[12] The same view was maintained by Sir John Maude, the former permanent secretary of the Ministry of Health.[13] It was not until the 1960s, however, that moves were made to unify the health service, the main thrust towards this objective emanating from the Porritt report, produced by a committee representing nine prominent medical organisations. This group bypassed the question of unification under local government, but it was also entirely vague about alternative administrative arrangements for its scheme for a single tier of health and social services authorities, which it called area health boards.[14]

By the mid-1960s it was increasingly clear that the

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Richard Crossman urged doctors to abandon their prejudice against local authorities taking over the health service

tripartite administration was unsustainable. Within the health departments and the medical profession, this realisation dawned more rapidly in Scotland and Wales than in England, where the Porritt report exercised little influence. In England the incentive for reorganisation emanated from local government. The pace was set especially by the Royal Commission on Local Government and the Seebohm committee on the personal social services.[15,16] The royal commission recommended the establishment of new unitary authorities of a type capable of administering the health services. The English royal commission was divided over many issues, but both the main report and the influential dissenting memorandum by Derek Senior[17] were united in recommending return of the health services to local government. It was argued that this was the only way to attain unification, local democratic accountability, and a close working relationship with the personal social services, which the Seebohm committee had already recommended unifying under local government.

In England, the drift towards reorganisation under Labour produced green papers in 1968 and 1970; the Conservatives issued a consultative document in 1971 and a white paper in 1972, leading to the legislation of 1973 and finally reorganisation in 1974. Although most of the objections applying in 1945 were no longer tenable in 1974, both the Labour and Conservative administrations rejected the invitation to return the health services to local government. However, there was much less confidence about this decision in 1974 than there had been in 1948. The 1968 green paper presented unification under local government as a possible option. As noted below, Richard Crosssman was increasingly convinced that the local government arrangement was the best of the alternatives, and he regretted that the second green paper had not reflected this conclusion. At first sight, the Conservatives seem to have discarded local government without much hesitation, but behind the scenes there was much disagreement, and up to the eleventh hour Edward Heath's Cabinet was split over the extent to which local government bodies should be compensated by being given a substantial slice of seats on area health authorities.[10] A further sign of regression since Bevan's time was the enormous degree of vacillation over the alternatives to local government. Every plan in turn was vigorously criticised; Keith Joseph's final scheme was adopted without enthusiasm and was regarded as a failure from the moment of its introduction. Joseph was the first of the reorganisers to place his hopes on a managerial solution, a perspective which necessitated rejection of local government involvement because the primary objective was to prevent any conflation between management and representation. This separation was not in fact achieved in the Joseph reorganisation, and the arbitrary nature of this conclusion showed in the parallel reorganisation of the personal social services, which, like education and most other personal services, continued to operate under local government, where management and representation were conflated.

Crossman's verdict

The reactions of Richard Crossman to the Joseph reorganisation are rarely mentioned, but they deserve attention on account of doubts revealed about the policy decisions in which he participated, the reservations concerning the outcome under his successor, his fears concerning the shift towards a management culture in the field of health care, and because of his insistence that a future Labour government should return the health services to administration by unitary local government.

Once Joseph's intentions were known, Crossman left no doubt about his displeasure. He objected to the new cultural shift within the health service towards domination by a "managerial philosophy," which he believed would result in a service run by "men of managerial experience," with decisions being determined by managerial rather than health care objectives.[18] He predicted that the proposed management structure would exacerbate the worst features of the existing hospital boards. The reorganised health service would become a "paradise for businessmen" who would operate through "powerful, semi-autonomous Boards," the relationship of which to the minister was "like the relations of a Persian satrap to a weak Persian Emperor."[18] Although "theoretically the personal nominees of the Minister, the boards are in fact mostly appointed by the chairmen and the chief officials and have become a self-perpetuating oligarchy responsible to no one." Insulated from accountability to staff and the community, they would display "resentful hostility to outside criticism."[19] The boards were therefore "centres of obnoxious power . . . remote from public needs, and remote from public criticism . . . aloof and remote from public opinion."[18] Crossman believed that it was impossible to transform the "satrapies of the present system into the unbiased managements" promised by Joseph.[19]

Crossman urged the medical profession to recognise that its reservations concerning local government, although well founded in 1948, were now an irrelevant anachronism. It was time to abandon the "prejudice, a very uninformed prejudice . . . that to work under a local authority would be the end of clinical freedom and the end of the doctors' standing in society."[18] Commenting on the "terrible problem of the gap between the local authority and the health service," Crossman concluded that "there is, in reason, no case for saying that the new great local authorities, with very extensive powers, should not take over the health services. That would be infinitely more logical. It would have resolved at one stroke the appalling division between the local authorities and the health service. There would have been proper democratic representation. . . . If there had been any sense in the world, the health service would come under the new local authorities and their extensive new powers and responsibilities."[18]

Conclusions

The above review reminds us that in the century before 1948 it became widely accepted that local government was the most appropriate mechanism

for administering publicly funded health services. Although this course was not followed in 1948, it is important to remember that the argument for the local government alternative resurfaced during the 1974 reorganisation. Once again the local government option was rejected, but less decisively and with much less confidence in the rival schemes. By 1974 the traditional arguments against local government control of the health services were no longer tenable. Reorganised local government was generally suitable for this responsibility; there was no longer a requirement for local services to be predominantly locally funded; and the medical profession had largely, although not entirely, forgotten its distaste for local councils. Although it would be naive to assert that local government control of the health services would have been trouble free, it might well have provided a more stable basis for the health service than was offered by its rivals. The experience of nearly fifty years suggests that all attempts to arrive at viable alternative forms of administration outside local government have resulted in failure, forcing us yet again to contemplate fundamental readjustments in the health service. It would be a serious mistake to embark on commitments to further change without taking account of the strength of the argument for a much greater degree of integration between local government and the health services.

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The case for closer cooperation between local authorities and the NHS

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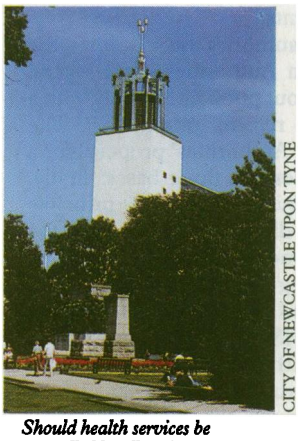
The need for the NHS to work closely with local government is not a new one. Since the first major reorganisation of the NHS in 1974, the development of effective interorganisational relationships has been a priority.[1] The principal interface between the NHS and local government has centred on social care and the development of community based alternatives to institutional care. While this remains a crucial interface, particularly in respect of the sharpening of the divide between health care and social care since the NHS and community care reforms, it is not the only one. There is a growing recognition of the importance of much of what local government does for the wider pursuit of health.[2,3] Effective purchasing (or more recently commissioning) for health gain cannot succeed without securing close collaborative links with local authorities. The key issue is whether in the longer run it makes sense to have separate agencies sharing a common health agenda or whether it might not be more appropriate to bring health and local authorities together to form single integrated agencies.


CITY OF NEWCASTLE UPON TYNE

Should health services be controlled locally—in Newcastle, for example . . .

The case for local authorities assuming this role becomes stronger when the second component of the argument for closer cooperation between the NHS and local government is examined. The NHS suffers from a "democratic deficit" that no amount of tinkering with the present arrangements for selecting and appointing members of trust boards and health authorities can overcome.[4] Various commentators and organisations have persuasively argued the case for local government assuming responsibility for health commissioning.[5-7]

Even the NHS's architect, Aneurin Bevan, wrote in 1952 that "election is a better principle than selection."[8] He was convinced that "no Minister can feel satisfied that he is making the right selection over so wide a field." Bevan claimed that the only reason for not putting the NHS into local government at the outset was that the organisation of hospitals did not correspond with electoral constituencies. He foresaw a solution if local government was reorganised, although he did not favour levying local finances to preserve the essential unity of the NHS.

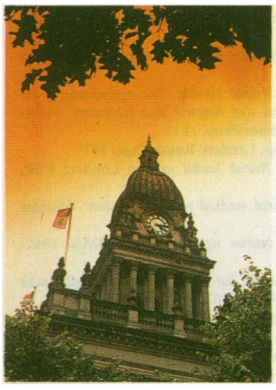
I examine these two arguments in greater detail: the case for close cooperation in recognising the wider health agenda and the need to counter the charge that the NHS is undemocratic and insufficiently accountable to local communities.

The NHS and local government: the health agenda

Much has been said and written about the links between the NHS and social care, notably as a consequence of the recent guidance for meeting continuing health care needs.[9] Though important, these links are not the subject of further attention here except insofar as the lessons from collaborative working may be transferred to other sectors. The research on joint planning and collaborative working shows the problems and constraints as well as offering stratagems for confronting them.[10-12] The case for integration of the NHS and local government is probably strongest in relation to social care. As long as separate organisations and budgets continue to exist it will always be easy to pass the buck and deny responsibility.

But the NHS is on the threshold of an even bigger, more important, more challenging agenda that will present both it and local government with great opportunities. This agenda has its origins in the notion of health gain and the health strategy in England, *The Health of the Nation,* and its counterparts elsewhere in the United Kingdom.[13] These features of health policy have been given added impetus by the purchaser-provider separation of responsibilities.

The purchaser-provider arrangement is based on the assumption that the purchaser function will allow health authorities to think more strategically about health issues other than health care delivery and that



LEEDS CITY COUNCIL

. . . and Leeds . . .

this will lead them to work collaboratively with other agencies whose activities have a bearing on the health of the population.[14] Indeed, the recent proposals for an NHS led by primary care whereby operational purchasing will progressively transfer to general practitioners, leaving the new health commissions to focus on broader strategies for the health of their populations, make it imperative that health authorities work with local authorities and other agencies.[15] The onus will be on the new commissioning authorities to look outwards beyond the NHS rather than inwards to the delivery of health care services.

A key influence necessitating a closer relationship between the NHS and local government is the health strategy. For a government sceptical of the value of local government *The Health of the Nation* emphasises the contribution of local government in unequivocal terms. The following extracts are typical.

"Local authorities have an important role in promoting public health and are key players with health authorities in taking forward the policies in this white paper" (p 23).[11] Local authorities have extensive responsibilities for environmental health, housing, education and transport as well as social services.

"Any of these responsibilities on their own would make the impact of local authorities to the strategy for health significant. Taken together the contribution of local authorities is vital" (p 24).[11] Apart from its endorsement of local government's role in, and contribution to, health policy, what is new in the history of the NHS is central government's insistence on the importance of the shared responsibility of the NHS and other agencies for improving health, in particular local government.

A key mechanism for securing collaboration with other agencies is the creation of "healthy alliances." Differences in styles of working, culture, policies, and accountability have always made for difficulty in joint working—yet the need for cooperative action and collaboration is beyond denial. In the five key areas selected as priorities (coronary heart disease, cancers, mental illness, HIV/AIDS and sexual health and accidents) the role of local government, and the implications for its services, clearly exists even if the importance of its role is contributing to the health agenda varies between them.

Nurturing and sustaining healthy alliances afford many opportunities for collaborative working. An issue like child accident prevention, for instance, touches on a range of local authority services including planning, building control, highways, housing, social services, education, police, fire, environmental health, and consumer practice. Many health authorities have picked up the issue and are addressing it collaboratively. Progress would be impossible without the cooperation of local government.

Alliance building is not easy, as the history of joint working in community care can testify. Skills in networking, influencing rather than directing, negotiating, political awareness, and so on are important. But in the area of health many local authorities are ahead of their NHS counterparts and have been for some time. Several have been in the forefront of the Healthy Cities movement, to which the WHO's *Health for All* strategy gave rise. Like *Health for All*, the Healthy Cities initiative is based on a set of key principles—equity, community participation, interagency collaboration, and the pursuit of local strategies supported by wide agreement. It is derived from a broad moral and societal view of health rather than one based on a biomedical or physical definition of illness. Its dynamic is bottom up rather than top down and therefore distinct from the way health services have been conventionally thought about, organised, and delivered.

It is in taking a broader, holistic view of health that the local authority is particularly well placed to act. Indeed, the NHS needs local government more than local government needs the NHS in terms of making progress with this agenda. The ability of the NHS to make deep inroads into this agenda is necessarily limited by its traditional focus on health care services.

The public health function is criticial in developing healthy alliances between the NHS and local government. The guidance on this function issued in late 1993 acknowledged the contribution of local government in the development of health strategies.[14] Indeed, as the public health function within the NHS becomes subject to tighter control from the centre as part of the incorporation of the former regional health authorities into the civil service a view is beginning to be heard that perhaps the location of public health within the NHS is no longer appropriate and that it should reconsider whether its pre-1974 location in local government is not more in keeping with its traditional concerns and independent stance.

The quest for accountability

There is mounting concern that the cult of managerialism and the quango culture have seriously diminished public accountability, especially at a point in the evolution of the NHS when decision making is becoming more explicit and transparent in respect of setting priorities. Public unease is focused on the lack of visibility of the growing number of appointed bodies running local services. The NHS reforms have proved to be a good demonstration of the "new politics," which is actually all about depoliticising whole tracts of public policy. Political judgments become coded in dense, complex, technical constructions in which "traditional political accountability is sacrificed for the politically useful illusion of technical precision."[15] The concept of managed care, which lies at the heart of the NHS changes, is evidence of how the professional model of health care driven by clinicians is evolving into a bureaucratic one driven by a new breed of managers. But in this process the issue of democratic accountability has been lost sight of.

Yet the critique of the "new magistracy" which now runs the NHS has struck a chord with a growing minority of NHS managers who believe that the present state of affairs is far from satisfactory.[16] The view articulated is that unelected health authorities, even linked to a democratically elected central government, do not constitute a sufficient level of legitimacy. Whatever the failings of local authorities they at least have the merit of being legitimate. This must be a critical factor in discussions about reconfiguring local services and reshaping provision away from acute hospital care to community based alternatives. The issues involved are not principally technical but political and involve judgments.

At least one of the local authority associations—the Association of Metropolitan Authorities—and several local authorities have come out publicly not only with a similar analysis but with reform proposals.[17] The Association of Metropolitan Authorities' proposal for a new role for local authorities has three bases: firstly, *democracy and accountability:* the elective principle would give citizens more direct influence over the workings of the NHS; secondly, *legitimacy:* improved accountability would bring greater legitimacy to decisions over priorities; and thirdly, *coordination and regulation:* bringing the NHS into local government would strengthen links with other public services. These arguments are important in taking the debate about the relationship between the NHS and local government beyond the case for improved cooperation. They can ultimately be satisfactorily addressed

only through a merger between the two agencies, made possible by the purchaser-provider separation, and especially the more recent distinction between commissioning and purchasing. There is no question of local authorities providing health care services. But the broader commissioning role for health, as well as responsibility for ensuring that the decisions of local purchasers (the general practitioners) are in accordance with the health strategy, could become the responsibility of local government. Such an outcome is perfectly feasible even if an incoming Labour government were to remove the purchaser-provider distinction. It is unlikely that any future government would seek to end the sharper clarification of management roles in respect of purchasing and providing.

Implications for local government

If the above thesis is accepted, then it carries major implications for local government.[3] While the NHS may suffer from a democratic vacuum, local government is also vulnerable to charges of insensitivity to local views and a tendency to operate in an outmoded, monopolistic, and bureaucratic manner. Therefore it is not a simple matter of putting forward the local government option on the assumption that local government would remain unchanged. Far from it. The emergence of a renewed commitment to local governance demands the creation of a new organisation in which the important element of strategic management through election would be complemented by a variety of other measures directed towards rendering local government more sensitive to users, including enabling the public to be more involved, if and when it wished, in helping to shape local strategies for health.

All of this will require new ways of doing business. Many local authorities would need to strengthen their corporate policy and management to make a reality of integrated services.[18] Also, many otherwise sympathetic supporters of local government assuming responsibility for health commissioning have an instinctive fear of "party politics." This will be so even where local authorities are more businesslike and efficient in their conduct. However, a more common, if unfair, perception is that local government suffers from "greater bureaucracy" than the NHS and is imprisoned and prevented from doing anything bold or innovative by "a plethora of committees and sub-committees," by the "inability of officers to make decisions without constant referral back to councillors," and by "rigid departmental barriers reinforced by the committee system."[19] Many local authorities would not recognise such criticisms, and some health authorities may be less vigorous and dynamic in their decisionmaking than the BHS reforms might imply.

NORWICH CITY COUNCIL

. . . and Norwich, and elsewhere?

It is in any case a mistake to confuse party politics with democracy rather than take a view of politics that is concerned with the values and subjectivity underlying decisions. As we have seen recently in Britain over the Child B case and Cambridge and Huntingdon Health Commission's decision, based on clinical advice, not to proceed with expensive treatment, the matter of deciding priorities, especially at a micro level, is a sensitive one as health authorities struggle to operate in defensible ways. Perhaps there can be no alternative to elected agencies providing the essential legitimacy. The courts are wholly inappropriate for such a task,[20] yet their involvement looks set to grow given the difficulty of holding managers to account through any political process.

However ingenious the attempts to engage with users or members of the public directly, it is unlikely that many of these will stand the test of time or be seen as the best use of public funds. Effective attempts at engaging the public do not come cheap. Moreover, valuable though they are, they cannot be a substitute for effective accountability at the level of strategic planning where tradeoffs between policy options are made. Citizens' juries, health panels, focus groups, and so on are all worth trying out, but they should be seen as complementing local authority control, not substituting for it.

Concluding comment

The abortive local government review in England and developments already in hand in Scotland and Wales represent a missed opportunity to look afresh at the role of local government in the context of a new local governance function. The tragedy is that the review has become a cruel irrelevance to the issues that matter. A focus on boundaries and structural issues is of little consequence when it comes to issues of policy and of deciding what local government is for.[21]

The theme of this paper is a simple one. The new health policy agenda, coupled with the commissioning role being fashioned for health authorities, offers an important opportunity to local government. Why have two separate agencies both engaged in, and committed to, the health of their local communities? Despite the rhetoric and good intentions stretching back decades, the NHS is not a *health* service. Its whole ethos and bias is towards caring for the sick. The notion that local government might, as part of its portfolio of services and policies which affect the health of local communities, take over strategic purchasing and commissioning of health care at least deserves detailed scrutiny.

For the democratic health of the nation, not to mention other facets of its health, the local government option is attractive. Closer cooperation between the NHS and local government is certainly desirable, but this must be seen as a step towards integration, with local government becoming the lead agency for the health of local communities.

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