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

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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 administering 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 administered 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 Association 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

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.

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 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

POPPER/PHOTO

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

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

POPPER/PHOTO

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 Seeborn 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 Senior¹⁷ 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 Seeborn 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 Crossman 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.

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

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