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...

CITY OF NEWCASTLE UPON TYNE

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, inter-agency 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 critical 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.

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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