Local Government and the National Health Service

Many people would not be alive today without the advances in medicine since 1963 when one of us qualified as a doctor. The expectation of life has risen from 68 years then, to around 80 years now. It is the measure of our NHS that this applies mostly to all, not just the few.

The Commonwealth Fund in the USA rates the UK health system as the best in the world. This ranking is achieved because we do well for equity, care process, access and efficiency.

For health care outcomes we are next to bottom. In the Eurostat Statistics Explained Survey we are 18 out of 32 European countries for amenable mortality, that is deaths that could have been avoided with optimal health care.

The European Health Consumer Index for 2107 has the UK 15th out of 34 countries, out of the top tier, again because of poor outcomes and waiting times.

The author maintains that Bismark health care systems that are based on social insurance are superior to Beveridge systems where financing is through taxation.

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Enoch Powell in his monograph A New Look at Medicine and Politics, written in 1966 but still worth reading today and available on the internet, was clear “I have made no secret of my opinion that a National Health Service is inherently unsuitable for administration by a political minister”. So what can be done?

The first response when our NHS is in trouble is to ask for more money.

Indeed as Powell pointed out when a service is funded through taxation it becomes a

positive ethical duty to bombard the government and force or shame it into providing more money.

Currently the NHS consumes 9.8% of our Gross Domestic Product. This is against an average of 9% for OECD countries and higher than, for example, Australia, Finland, Italy or Iceland.

However it is less than most G7 countries and others such as France, Germany and the Netherlands spend more. Powell also predicted that if the management of the service was vested in an independent authority that was not politically

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accountable their response to criticism would be to join the chorus asking for more money. We suspect he might now be tempted to say "I told you so"

We now know we shall have more money but will it solve the problem of poor outcomes which after all is what most people who are poorly want to know?

One answer is to start by acknowledging that we have been here before, in 2002.

What happened was… we did improve but not enough. There was one huge success which was the reduction in waiting times for elective treatments in hospitals.

Waiting times was a problem Powell thought was insoluble, "It is an activity about as hopeful as filling a sieve". But he was wrong, Alan Milburn set a standard for maximum waiting times and then invited the private sector to offer treatments on the same terms as the NHS if these times were breached.

Hospitals improved their performance and the combined increase in activity reduced waiting lists. Hopefully some of the new money will enable this improved performance to be re-established.

The next new initiative was the Health and Care 2012 Act and the creation of NHS England and other decentralised bodies, what Nick Timmins has termed the "World's Biggest Quango".

In 2002 the Kings Fund paper on the Future of the NHS recommended both decentralisation and the need to increase democratic accountability at a local level.

In a number of ways the 2012 Act by creating NHS England and other bodies was a response to the need to decentralise the massive organisation that is the NHS but as the Prime Minister in her recent speech acknowledged; "It is too bureaucratic, inhibits

joined up care, and takes money and people away from the front line".

But, you cannot get away from the political fact that, as Powell's wrote, "the plain rule is that wherever the taxpayers' money is being spent, a minister must be held accountable for how it is being spent".
We cannot move to a social insurance system. It would be a massive undertaking and the British people are clearly content with the present model.

Funding through taxation is more efficient and ensures equity, that is treatment and care free at the point of consumption and restricted only by what the service, rather than the individual, can afford.

It is local government that most touches our daily lives…

Those in most need get most service so in that sense the NHS is not rationed because rationing implies equal shares for all. But, we do need to reduce the need for central accountability and all that flows from it including excessive bureaucracy.

The other alternative, inherent in the Bevan settlement, is to recognise that some services could be better organised, controlled and accountable on a local basis.

Again Powell "The nationalised medical undertaking consists of two parts, organised on widely different principles. Medical services to hospital patients are provided in state-owned hospitals by public employees.

Medical services outside hospital, as well as dental and optical services, are provided by private individuals who have contracted with the state to do so. This essential difference of organisation produces a different relationship of Medicine and Politics in the two parts."

For many of us the role of local government is perplexing but it is the closest we come to democracy in action.

It is local government that most touches our daily lives. The roads we drive on, clean streets, the parks we take our children to, where we exercise our dogs.

The libraries, planning permission, schools, housing, police, fire services, cemeteries, transport, child care and services for our vulnerable elderly and emptying the bins. Local government employs health visitors, runs children's centres and is responsible for public health.

Most importantly in relation to our argument, they are responsible for social services and thus crucial to supporting people in the community rather than going to hospital.

Local government spends £60bn of our money, yet at elections to

decide who will spend the money and how, turnout will almost certainly be dire. Probably, if past elections is

anything to go by; 36% in the Shire Districts, 31% in the Unitary Authorities and just 26% in the Metropolitan Boroughs.

As citizens we don't take local government seriously. Well, not seriously enough. Voting in local elections is left to hobbyist democrats, older voters with a particular view of citizenship, party enthusiasts and the disaffected who want to protest about something national government has done.

It is important to understand the predicament local government finds itself in.

It is important to understand the predicament local government finds itself in. Through complex funding mechanisms and reduced budgets, local authorities preside over poorer and poorer services… that are patently obvious to residents. Bin collection reduced in some part of the country, holes in the roads and services closing.

A weekly, if not daily, reminder of dwindling services.

In fact the public manifestation of local authority failure disguises a more interesting truth.

Local government is astonishingly efficient.

They have made a success of outsourcing and externalising service delivery where other departments of government and the private sector have failed.

They are very good a managing diminishing budgets. Central services (across all types of authorities), adult social care (within single tier and county councils) and environmental and regulatory services (particularly within district councils) have all been reviewed by innovative councils and improved their efficiency.

These two facts of local authority life: Councils are for a dwindling handful of enthusiasts but they have changed to become hugely more efficient by reinventing how they go about their business, creates an interesting contrast with health services.

Health services who manage billions with no democratic interface and some councils, whose budget could be compared to an NHS operating theatre budget, with over thirty councillors and monthly public meetings to scrutinise the use of every penny.

This leads us to considering how health and social care can work more closely together and how

porous is the boundary between health and social care?

How flexible can it be without encroaching on each other's territory? The territory argument is important. In the world of local government, services for adult social care are means-tested. In the NHS' world, they are not.

Much of social care is outsourced to third party organisations. Little of NHS care is subjected to competitive tendering in spite of intentions.

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Aside from the shift in fundamental thinking and approach, there is a more sinister issue.

If the NHS and social care are to be brought closer together, or even merged, how much social care will have to be free at the point of use. The other side of the coin is how much NHS care might be means-tested. These are thorny issues.

Aside from the philosophical questions there are the practical issues of changing the law and the impact another upheaval might have, distracting service delivery.

A recent report suggested that social care should be free at the point of need and income tax increased to fund it. In the present febrile political climate, distracted by so many other issues and with the uncertainties ahead, it will be difficult to find majority support.

Fortunately, within existing structures there are ways in which these two vital services can be brought closer together, simply and effectively.

The 2012 Act established Health and Wellbeing boards as joint enterprises between councils and the NHS. These boards administer the Better Care Fund from money transferred from the NHS. The crucial points are that these boards involve local government which is politically accountable to local citizens.

They provide the means to link health and social care spending within a community. There are now a number of initiatives testing yearly personal health budgets for people with frailty and chronic illnesses.

These could be linked to similar social care budgets with the health component provided by the NHS and the social care part through the means tested local government contribution.

Indeed they could also be used to fund local community nursing

care and a capitation budget for primary care based on need. Such budgets to cover the costs of primary care for people in nursing homes are already being commissioned.

The tax-based systems that seem to work best are in the Nordic/Scandinavian countries where local government shares the funding and accountability for health care with National Government.

In the Netherlands hospitals run at occupancy levels of around 85% because of better community services. There it is difficult to get into hospital and easy to get out; the reverse is true here!

Perhaps we could adapt this model? The Department of Health and Social Care would continue to hold the overall system to account. The "World's Biggest Quango" could and should be rationalised with at least the merger of NHS England and NHS Improvement and maybe other so called arms length bodies.

We need to recognise that our poor health outcomes are because our hospitals are overcrowded.

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Local government using joint commissioning with the NHS of social care, community nursing and primary care would take responsibility for care outside hospitals and most importantly with public health, for improving health and reducing health inequalities.

Community hubs serving populations of around 50,000 or more or less depending on local needs would link general practice to specialist support.

They would provide out of hours emergency care. They would have diagnostic centres; late diagnosis is a major contributor to our high amenable mortality.

They would use using digital technology to help coordinate care, support people at home and for research and teaching to improve outcomes and safety.

We have a marvellous health care system of which we are justly proud.

We have celebrated its 70th Birthday with pride but we need to be open to ideas to make it even better.

Cyril Chantler and Roy Lilley July 2018