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Education and debate

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. 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 models² 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 specialities." 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 148000 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 77000 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 89400 to 205500 places for elderly and physically disabled residents and from 6540 to 12847 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 accommodation⁸ and decreased provision in the NHS.

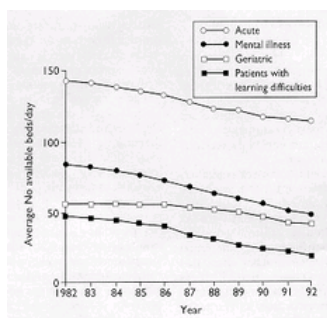


FIG 1--Numbers of NHS beds available for different types of patients: average daily number of available beds 1982-92. (Data from Department of Health, health and personal social services statistics for England)

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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 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).

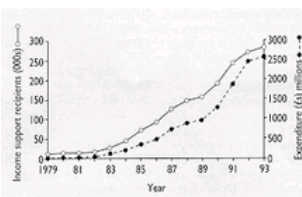


FIG 2--Numbers of recipients of income support in private and voluntary nursing and residential homes and income support expenditure UK 1979-91. (Data from Department of Social Security)

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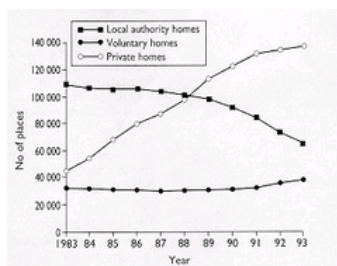


FIG 3--(a) Numbers of places in residential homes for elderly and younger physically disabled people by type of home 1983-93. (b) Numbers of places in residential homes for elderly and younger disabled people by source of support 1983-93. (Data from Department of Health, personal social services and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

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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 40000 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.

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 inequities²³ 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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