THE URBAN AND LOCAL HISTORY OF SOCIAL POLICY SINCE THE SECOND WORLD WAR

The Forgotten 'Cradle to Grave' Welfare State: a comparison of local and national health care

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Introduction

It has been claimed that the British welfare state is 'perhaps the most thoroughly nationalised of all welfare states' (Ashford, 1986: 298) with its most obvious core can be found in the *National* Health Service (NHS) founded in 1948. However, before 1948 local or municipal health care was regarded by most commentators as the goal of progressive policy. This was part of a larger view about local government. Using a phrase generally linked with the post-1945 welfare state, Mr Marshall, Labour MP and a former Lord Mayor of Sheffield stated that 'In one way or another, local government touches our lives at all stages from the cradle to the grave' (in Powell, 1995: 361).

This paper focuses on the moves between local and national health care in Britain, examining the main contours of conceptual and empirical debate. It first examines the conceptual literature on local versus national welfare; and then presents three

perspectives - political, contemporary and historical- on the moves from local to national health care.

Models of Local and National Health Care

There has been little conceptual discussion of a local as opposed to national welfare systems. Victorian Britain attempted to devise schemes for delineating national from local services. This argument was developed by Cannan, Marshall and Goschen, the 1901 Royal Commission on Local taxation and the Kempe Commission of 1914 into ideas of oenerous/ national and beneficial/ local expenditure.

Similar central/ local frameworks has been presented by fiscal federalism writers (eg Oates 1972; Bennett 1980) and in the Layfield Report (1976) Layfield recognised the continuing drift towards centralisation, and considered that a decision now needed to be taken to place responsibility firmly either with the government or with the local authorities. Greater local responsibility requires two elements: less dependence on national taxation, and bouyant local tax. The Report suggested something nearer equality in central and local contribution.

One of the few detailed discussions on localism is Page (1991: 1; cf Page and Goldsmith 1987) who states that 'local' implies some control over decisions by the community. He differentiates legal and political localism. The legal scale is concerned with measuring functions and discretion.

Powell (1998) suggests three main criteria that distinguish national from local services. First, a national service should be little autonomy and no democratic input at local levels.

Second, there should be national as opposed to local funding. Third, central control and funding should lead to provision which is equitable according to centrally determined standards. In short, a national service should be based on national as opposed to local citizenship, funded 'from each according to their ability', delivered 'to each according to their need' at the national level. The aim of a truly national service would be to make geography irrelevant.

From Local to National Health Care

Political Perspectives

Labour's 1943 policy document, 'National Service for Health' insisted that 'wide powers must be left into local authorities.' Initial plans for the NHS from 1938 were based on various forms of municipalism. Local authorities played a major role in the 'Brown' Plan of 1941 and Willink's White Paper, 'A National Health Service' of 1944.

The nationalisation of the hospitals, Bevan's main innovation, came very late in the day (Webster 1995). One of the main stated reasons for nationalising the hospitals was to reduce inequality, which was one of the main criticisms of health care before the NHS (eg Powell 1992). Conservative spokesman, and former Minister of Health, Willink pointed out that 'every word he said about the uneveness of finance in different counties and county boroughs would defeat the whole of the Education Act' (1946, c 234).

Bevan argued for national (Parliamentary) rather than local accountability: boards 'will be and they must be the instruments of the Ministry'. He stated that 'When a bedpan is dropped on a hospital floor its noise should resound in the Palace of Westminster' (Jenkins 1996: 65).

On the other hand, the two main arguments in favour of a local government service were of democracy and integration. The Conservatives saw their chance to become the defenders of localism: to support the man in the Town Hall as opposed to Labour's gentleman in Whitehall. Sir Harold Webbe claimed that the NHS Act signed the 'death warrant of local government' (col 274). After the demise of the Brown plan, neither the 1944 White Paper nor the NHS Act planned to secure a unified service. Sir Harold Webbe (1946) considered that the NHS would re-open the gap between preventive and curative public health, and take health back to a position which would be worse than before the 1930s (col 367).

The period of reorganisation in the 1960s and 1970s (Klein 1995) saw a number of discussions on the administration of the NHS. Labour's 'First Green Paper' of 1968 put forward a vague option for local authority control. By January 1969 Crossman 'ruled out the Green Paper in one stroke.' In the Second Green Paper the Government accepted the force of the Maud Commission's arguments about bringing health under local government, but in one paragraph this option was found to be unacceptable due to the opposition of the profession and the insufficient financial resources of local government. In Parliament Crossman produced four 'compelling reasons' against the transfer: first, that local authorities lack the necessary financial resources; second, some vital parts of the health service require planning and organisation on a scale much larger than even the proposed new local authorities; third, it is difficult for patients to cross administrative boundaries under local government; last, and 'most important', there is the issue of clinical freedom, upon which the medical profession have strong feelings. As Crossman confided to his diary, we are not handing over the NHS to local government 'even though there is an overwhelming case for doing it.' Another problem was that the Treasury was insisting that only tight centralized control was compatible with the necessary financial

discipline of the Service. However, the main problem is clearly the medical veto. Crossman candidly admitted that vested interests and constraints forced planning 'into a miserable middle way.' The incoming Conservative of 1970 proposed 'managerialist' rather than representative bodies, making great play of the fact that Labour had not seen fit to hand over the health service to local government. Secretary of State, Sir Keith Joseph, stated ' No doubt in a perfect world...the answer would be to unify the health services within local government....' A number of other MPs across the political divide argued that, at least in theory, the local government option was best, but as Joseph continued, 'but we do live in a perfect world, and that [the local government option] is not practicable.'

The 1979 Consultation document issued by the new Conservative Government, 'Patients First', stressed the local dimension. In contrast to the 1974 reorganisation decisions were to be taken at local level rather than being passed down the chain of command. The Conservative Secretary of State for Health, Patrick Jenkin, saw the health service 'not as a single national organisation, but...as a series of local services run by local management.' (quoted in Klein 1995: 126). Note, however, that this did not incorporate a commitment to local democratic control. However, despite a rhetorical commitment to localism, most commentators argue that the White Paper, 'Working for Patients' (DH, 1989) led to a centralisation of the NHS, with Health authorities viewed by many as an example of the 'new magistracy': a result of patronage by Ministers leading to a 'one party state' of bodies with strong Government leanings and connections (eg Jenkins 1995).

It its first term, New Labour stressed both centralisation and localism. On the one hand, Labour stressed localism, an emphasis on diversity rather than national uniformity. However, on the other hand, the White Paper, 'The New NHS' (DH, 1997) aimed 'to renew the NHS as a genuinely national service.' New central institutions such as the

Commission for Health Improvement (CHIMP) and the National Institute for Clinical Excellence (NICE) are to be set up. National Service Frameworks and sets of central performance indicators are emphasised. The NHS Plan (DH 2000) introduced the concept of 'earned autonomy': well performing hospitals will be allowed more finance and freedom. The concept of 'Foundation Hospitals' (FH) was also introduced, which would have a large degree of autonomy, and by controlled by a locally elected board. Secretaries of State for Health, Alan Milburn and John Reid have both argued for FH in terms of the new localism. Milburn (2003) presented the case for 'real localism'. We have been moving- in health care and local government- from a centralised command and control model to new localism. NHS Foundation Hospitals are not about relinquishing a little central control, but relocating ownership out of the hands of a state bureaucracy and into the hands of the local community, modelled on co-operative societies and mutual organisations. With greater local control, there will inevitably be greater diversity.

John Reid's (2003) 'Localising the NHS' speech argued against a 'national uniform approach' and advocated 'new localism. It is 'new' because it consciously sets out to bypass the old local government. Reid's model is the London School Board, with the flagship of new localism, Foundation Hospitals, seen as a special-purpose local body along the lines of the LSB (cf Milburn 2004). .

Political discourses show clear moves away from local to central, although the initial change- and reversal of party policy- took place quickly and quietly. The debates on NHS reorganisation in the 1960s and 1970s indicated a theoretical advocacy of localism, but also for Labour an 'inverse radicalism law': in opposition radical politics were advocated that were not practical a few years earlier in government. The Conservatives of 1979 rhetorically stressed localism, while increasing centralism, while New Labour in its first

term stressed both at the same time. In its second term, there are some moves towards localism.

Contemporary Perspectives

While academics, politicians and civil servants identified many problems with local government and municipal health care such as size and financial capacity, these were balanced by the advantages of local democracy and integration of services (eg Chester 1951; Mackintosh 1953; Wilson 1938, 1946). Moreover, no serious alternative model was ever advanced.

Many assertions were based on the traditional arguments in favour of local government (see Stoker 1996). Localists tended to regard inequality either as a positive dimension of diversity or as an inevitable trade-off in a responsiveness system of local government (eg Robson (1953; Wilson 1938, 1946). Between 1929 and 1948 the Medical Officer of Health could- in theory- integrate curative and preventive services (McKintosh 1953: 154).

Localists and centralists tended to favour different criteria of evaluation, with the former pointing to the advantages of participation, responsiveness, integration and diversity, while the latter stressed the problems of inequality. However, neither side produced convincing evidence to back up their assertions.

Historical Perspectives

Many historians have tended to favour centralist over localist arguments, arguing that a local government system was either undesirable or impracticable (eg Dupree 2000; Davis 2000). The most common argument is associated with inequality. There are three main problems with these arguments (Powell 1998; Powell and Boyne 2001). First, with some exceptions (eg Powell 1992; Mohan 2002), little detailed empirical evidence is produced for the level of inequalities before the NHS. It is even less clear whether these inequalities were changing over time (but see Levene et al 2004). Second, the geographical aims of the NHS are unclear due to confused policy pronouncements: we do not know what type of geographical equity the NHS is attempting to achieve: equality of provision, access or outcome. Third, it is clear that a national uniform standard of service has not been achieved. Klein (1995: 225-6) concluded that 'more than 40 years after its birth, the NHS had yet to offer everyone with the same level of service'. There is a tendency to contrast the actual inequalities of localism with the theoretical- rather than the actual- inequalities of national services.

Moreover, some writers have suggested that Morrison versus Bevan debate should be reassessed (eg Foster et al 1980: 58; Fraser 2003: 256; White 2004). As Campbell (1987: 177) sums up: ' all the fundamental criticisms of the NHS can be traced back to the decision not to base services on local authorities. The various medical services were fragmented instead of unified; the gulf between the GPs and the hospitals widened instead of closed; there was no provision for preventive medicine; there was inadequate financial discipline and no democratic control at local level. In retrospect the case for the local authorities can be made to look formidable, the decision to dispossess them a fateful mistake by a Minister ideologically disposed to centralisation and seduced by the claims of professional expertise.'

With some exceptions, historical perspectives have tended to view events through centralist lenses (cf Walker 2002, but unlike the political science perspective eg Wilson and Game 2002). Most commentators see inequality as a problem rather than diversity as a virtue. In contrast to inequality, the problems of the loss of functions and democratic deficit are not given a large amount of attention. Earlier political and contemporary perspectives are not given a great deal of attention, while empirical evidence tends to be scarce.

Conclusions

A large proportion of the historical perspective appears to be implicitly based on the central point of view, and seems not to place much emphasis on the conceptual literature, or on earlier political or contemporary perspectives.

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