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The Big Society in a Time of Crisis – the Impact on Public Health

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Abstract

At the time of writing the UK is in a 'double-dip' recession with the economy flatlining. The Government is set for a new round of benefit cuts. The cuts introduced to the public sector when the coalition government came to power in May 2010 are already beginning to bite. This 'age of austerity' and general gloom was lifted briefly in summer 2012 by the undoubted success of the London Olympics and Paralympics, however the sense of crisis within the nation runs deep. This paper explores the extent to which the concept of the 'Big Society' can alleviate the impact of the crisis on public health. The authors explore the thinking behind the concept of 'Big Society' tracing related ideas back to Victorian times. We further examine this issue, citing evidence about the impact of cuts on the National Health Service's ambulance service and how social capital offers a way forward. While acknowledging that there is merit in the Big Society's call for voluntary sector support, beyond the support provided by the State, the authors argue that the reality of the Big Society is nonetheless flawed. If anything the call should be for a 'Little Society' of voluntarism at a local level, where meaningful voluntary action can help ameliorate the inevitable forecast decline in state support.

Keywords: Age of Austerity, Big Society, Third Way, Mutual Aid, Public Health, Ambulance Service

1. Introduction

In 2012 many countries in the world face economic hardships. The International Monetary Fund announced on 9th October new forecasts for minimal, or even negative growth in many countries, including the UK, at -0.4% for 2012. The UK is thus stuck firmly in a 'double-dip recession' in which the economy is flatlining. Cuts are the order of the day within the public sector whether already made, or forecast, and there is a palpable air of crisis lifted only by the summer successes of events such as the London Olympics and Paralympics. As regards Public Health, the cuts are already beginning to bite and there are fears that a semi-privatised National Health Service (NHS) will be unable to care for the most vulnerable in society as the demands of shareholders for profit override the principle of free healthcare for all (Farmer, 2012). Within this context of crisis, Prime Minister David Cameron and others have presented the concept of the 'Big Society' as a means of involving communities across the country in helping to provide care support at a local level, via unleashing of voluntary endeavours in lieu of state provision. This paper is divided into four parts. The first section traces some of the roots of the Big Society, primarily via the work of the academic Anthony Giddens, and the social anarchist Peter Kropotkin. The following section summarises the key features of the Big Society. Then paper assesses the usefulness of the impact of the changes that the Big Society proposes to bring to the area of Public Health. Finally, the paper examines the theoretical challenges of social capital within the current economic situation.

2. The Third Way and the Roots of the Big Society

Firstly, Giddens developed the concept of the 'Third Way' as a means of helping tackle the growth of social exclusion that results from globalisation:

'There is a real parallel between exclusion between nations and regions and exclusion on a global scale. Increased prosperity for many leaves others stranded and marginalized' (Giddens, 1998, p. 152).

The neoliberal agenda that underpins globalisation is difficult for States to regulate and control (Held et al, 2002; Munck, 2002), while the values of 'Old Labour' cannot keep up with the pace and scale of global change. Giddens therefore sought an alternative, a third way:

'I shall take it a 'third way' refers to a framework of thinking and policy-making that seeks to adapt social democracy to a world which has changed fundamentally over the past two or three decades. It is a third way in the sense that it is an attempt to transcend both old-style social democracy and neoliberalism' (ibid: 26).

Giddens had the ear of such leaders as Tony Blair and Bill Clinton who embraced the concept enthusiastically. The key values of the Third Way' were summarised as:

- Equality
- Protection of the Vulnerable
- Freedom as autonomy
- No rights without responsibilities
- No authority without democracy
- Cosmopolitan pluralism
- Philosophic conservatism (ibid: p. 66)

And its associated programme is:

- The radical centre
- The new democratic state (the state without enemies)
- Active civil society
- The democratic family
- The new mixed economy
- Equality as inclusion
- Positive welfare
- The social investment state
- The cosmopolitan nation
- Cosmopolitan democracy (ibid: p. 70)

As Cook (1999) noted, the project was modernising, based on maximisation of the citizen's involvement, reduction of bureaucracy and red tape, more transparent government, greater local involvement and improvement of inter-family relations. The welfare 'safety net' idea would be replaced by a concept of 'positive welfare', investment in human capital rather than provide direct economic maintenance (similar to the Aid Agency concept of providing a fishing rod and teach people to fish rather than providing the fish). With regards to the increasing proportion of elderly population, the whole concept of 'retirement' should be revisited, and it may be that resources need to be targeted at the 'frail elderly', but Giddens admits that 'There are issues to be confronted here, including questions of a quite fundamental sort, that go well beyond the scope of this discussion' (ibid: 121). The sum total of these and other measures, including a possible 'Economic Security Council' at the UN, is to reduce exclusion, thus increase inclusion and limit the negative elements of unfettered and under-regulated globalisation that we have seen in recent years. Environmental issues too

would also be tackled via global ecological management involving ‘collective action involving many countries and groups’ (ibid: p. 152)

As Cook noted (1999, p. 12):

“It is difficult to know what to make of these ideas. In part, they seem super-optimistic and unrealistic; but at the same time they are refreshing alternatives to more of the same at the global level, whether at the scale of the global financial markets or the nation-state. There is definitely a need to have more meaningful and cooperative partnerships between different interest groups at all levels, from the local to the global... On the positive side, for example, a Social Exclusion Unit has been set up by the British government to explore ways to reduce exclusion...On the negative side, changes to the welfare system have upset lone parents and the disabled who feel that they are being discriminated against, a charge that the government denies, and there is often the feeling that business interests dominate all others, just as they did under the previous Conservative government, albeit in the shape of ‘stakeholder capitalism’ rather than shareholder capitalism.”

As we shall see below, there are echoes within these concerns of the impact of the Big Society ideas. But what of the intellectual precursors of Third Way concepts? To us we can trace these ideas back to the 19th Century, and in particular to Peter Kropotkin’s ideas of *Mutual Aid* and *sociability*, ideas that were brought together in the book *Mutual Aid*, published in 1902. Kropotkin believed that ‘Sociability is as much a law of nature as mutual struggle’ (ibid: 5), and that in higher animals including humans, mutual support, mutual aid and mutual defence were key elements in evolution. He thus combated the prevailing social Darwinist ideas that competition dominated human society. Cook and Norcup (2012) provide an update on the legacy of Kropotkin plus along with his follower Colin Ward who also made a major impact on studies of community and urban space, while the recent contributions of Myrna Breitbart and Linda Peake are also discussed.

3. The Big Society

1. It offers to the right and centre of the Conservative party considerable continuity with the touchstone ideology of Thatcherism, in being against Big Government and the tax-hungry state; and in favour of the heroic, autonomous individual and their liberty to act economically and socially as they see fit.
2. It diverts attention away from government and towards the responsibilities of others during a programme of deep cuts to the public sector, which the coalition adopted as its preferred policy choice.
3. In positively evoking ‘society’ it helps to keep the Liberal Democrats on board, creating the impression that the Conservative party has truly changed, to the extent that it now discusses the mythic banned entity of Mrs Thatcher, for whom ‘society’ was a term too close to the great enemy, social-ism.

Source: Adapted from: Ishakanian and Szreter, 2012, p. 10

Figure 1: The Big Society as a rhetoric service.

An alternative to the nanny state is the ‘Big Society’ which has become one of the key concepts in British Politics today. This policy idea was launched in the 2010 Conservative

Manifesto. The Times Newspaper on 14th April described the concept of the Big Society idea as ‘...an impressive attempt to reframe the role of government and unleash entrepreneurial spirit.’ It has been agreed by many political commentators that the reason why the Conservative Party and the Liberal Democrats formed a coalition in May 2010 was due to the policy ideas of the ‘Big Society.’ The Big Society initiative forms a substantial part of the legislative programme of the Conservative-Liberal Coalition Agreement (see Figure 1).

The thinking behind the Big Society is nothing new in British Politics. When New Labour came to power in 1997 the country saw a series of politicised policies launched with the specific aim of tackling social divide across Britain. In the last decade there has been much debate on how communities function at a local level (Flint and Robinson, 2008; Atkinson and Helms, 2007; Boody and Parkinson, 2004; Imrie and Thomas, 1999). Tony Blair in 1997 declared that New Labour was the party for middle Britain but at the same time Labour was warned that if ‘we raise the standard of living of the poorest people in Britain we will fail as a Government’ (Lister, 1998, p. 216). New Labour perceived solving deprivation in Britain was through the concept of community governance and wanted to encourage a stronger and cohesive relationship between central and local government. Governance in the broadest sense:

“...involves venturing into broad debates about policy and administration, about politics and policy, about levels of government, about the states and citizens, about authority and legitimacy, and about what shapes cultures and processes of governance.” (Healy, 2007, p. 15)

The terminology of the ‘Big Society’ has caused much criticism in the media and academic circles (Birchall, 2012; Pharoah, 2011; Evans, 2010). One of the biggest problems with the idea of the Big Society is that the general public as a whole do not understand what it means. This is evidenced when we see that the idea of the ‘Big Society’ has been launched 4 times, firstly at the Manifesto launch in April 2010, secondly at the coalition launch in July 2010, then in February 2011 and finally May 2011. Furthermore this persistence by David Cameron of continually pushing the idea of the Big Society was admitted by a Whitehall source when they reported that ‘It won’t be branded as a re-launch because that would be an admission of failure, but it cannot be allowed to fail because it was central to Cameron’s manifesto’ (Maddox, 2011, p. 2). Moreover, there is a general agreement that the Big Society’s two main principles are: (1) the state should be smaller and (2) the general public should be more involved in the decision-making (Taylor *et al*, 2011).

The vision behind the concept of the Big Society was first discussed in November 2009 at the Hugo Young Memorial Lecture, when David Cameron used this terminology as a platform which offered a solution to tackling Britain’s economic and social problems (Evans, 2011). At the 2010 General Election the Conservatives used this concept as a policy initiative and as the Conservative Manifesto (2010, p. 37) states ‘The Big Society runs consistently through our policy programme. Our plans to reform public services, mend our broken society, and rebuild trust in politics are all part of our Big Society Agenda.’ Currently there is an accusation from the opposition that the Big Society concept is simply an attempt to hide Government spending cuts. According to Brindle (2011) the Big Society has developed ‘...a growing sense that the brand is damaged goods, a vessel fatally holed below the waterline.’ This is also confirmed by the introduction of the Localism Bill the main aim of which is to decentralise power from the centralised state to local communities.

The ideology of the Big Society originates from Phillip Blond, a political scholar, who is currently a director of the think tank *ResPublica*. Phillip Blond gained eminence back in November 2009 when he gave a speech on the Future of Conservatism. In that speech he argued for an advanced acceptance of the worthiness of ‘Civic Conservatism’ in relation to the state and an appreciation of the potential transformative impact of this on society. As Kisby (2010, p. 486) notes David Cameron perceived the Big Society as:

“the implicit ideas that ‘responsibility’ ought not to be defined by individual citizens - through the payment of taxes to the state-ensuring that all citizens’ basic needs are provided for. Rather, it is principally about citizens having a moral obligation to undertake voluntary activity in the community and to take responsibility for their own individual welfare needs.”

The big society has different agendas within the public and the private sector. The new concept termed the big society has placed brought a contemporary emphasis on how the health care system works and is integrated into the welfare state. Politicians advocate that the big society encourages patients to take greater control of their own health care. However, using this style of approach in the National Health Service has the danger of dividing different social groups. There is the added complication of economic factors whereby particular services will be priced out and as a consequence withdrawn, as Hunter (2012, p. 13) argues:

“...the place of the Big Society and government in the post-bureaucratic state then it gives grounds for optimism that there remains a powerful role for public health and that it should not be bypassed or marginalised by Big Society bravado.”

4. Reducing the Welfare State

The coalition government’s spending review (October 2010) set broad limits of public spending to 2014-15. With total cuts amounting to £67 billion and spreading across all government departments, the impact of these cuts on service delivery have been far reaching. For the ambulance service, the Coalition proposals marked radical structural reforms including changes into the commissioning structures from the PCTs (abolition during 2012 but currently put on hold) and transferring those responsibilities to the GPs along with the abolition of the NHS Direct, putting more pressure on 999 calls (Wankhade, 2011). The focus on reducing the welfare state set the tone for huge changes for the ambulance service, both structurally and financially. The Department of Health (DH) also published a structural plan announcing timescales for delivering the legislative measures for implementation of the reforms set out in the coalition agreement. One of the key priorities in the reform process was to encourage more evidence based outcome measures as against the currently used response time based targets which were centrally managed and have reported unintended consequences (Wankhade, 2011a).

Three clear strands of policy shifts became evident. The first was to aim and spend for a ‘patient led NHS’. To achieve this departmental priority, a new three-digit-telephone number (111) for urgent health situations in being piloted in the north-east of England using various NHS providers that include the Out-Of-Hour Service, NHS Direct and the ambulance services suggesting a joint-up approach. Questions remained unanswered however around accountability in terms of shared resources. Disagreement occurred between the ambulance service bosses on the Chief Fire officers Association’s call for merging the 999 service with the Fire and Rescue Service (CLG, 2010). There is some merit in this argument since there is

some evidence internationally that emergency medical response is provided by the FRS across North America and many parts of Europe including some rural areas in England (Dixon and Alakeson, 2010)

The second rationale behind these welfare cuts was to promote better health outcomes for the users of the ambulance service. Response time targets are commonly used as performance indicators in most part of the world. There is a growing policy debate (Snook *et al*, 2009; Heath and Radcliffe, 2010; Bevan and Hamblin, 2009) that these simplistic indicators of performance only measure the time taken to reach the scene of emergency and are being incapable of capturing the clinical outcomes and other provisions of service delivery. Recent published evidence (Wankhade, 2011; Radcliffe and Heath, 2010; Cooke, 2011) has argued that the current ambulance performance targets are centrally driven and centrally directed, lack flexibility to deal with local differences, put pressure on the staff to perform, and can lead to serious unintended consequences.

There is also a perceptible change in the way 999 calls are made. For instance, in 2009-10, total number of emergency and urgent calls in England was 7.87 million, which was a 5.2% increase (391,000) over the previous year. Out of these calls, 6.42 million calls resulted in an emergency response arriving at the scene, a 4.3% (265,000) increase over 2008-09 (NHS, 2010). Further scrutiny of ambulance call data reveals an annual rise in the demand for ambulance services but significant shifts in the nature of the calls with only 10% of calls relating to life threatening emergencies (many of the residual 90% having primary care or social needs (DH,2005). This leads to more pressure on current resources to attend the 999 emergency calls. Development of clinical performance measures other than response times has been identified as the top-most priority for research in emergency pre-hospital care settings (Siriwardena *et al*, 2010). The quest for moving from time-based targets to evidence based outcome measures whilst maintaining the gains made over the past few years, remains one of the key priorities for the ambulance services (NHS, 2010a).

The third rationale which has proved the most controversial of the NHS reforms package has been the 'GP commissioning' which is seen by many commentators as the centrepiece of the reforms. Since 2005, the PCTs and the GPs have been involved in commissioning in the form of practice-based-commissioning (PBC) but the evidence of a widespread transformational shift in health service delivery is lacking (King's Fund, 2008; Smith *et al*. 2010; House of Commons, 2010). In the new scheme of things, all GP practices are being prepared to be a part of commissioning consortia. But due to highly polarised arguments on both sides of the divide, an objective analysis of how this new system will impact the ambulance services (being commissioned currently by the PCTs) has been missing raising a number of design and implementation issues.

Since their reorganisation in 2006, ambulance trusts have invested significant organisational resources in developing their relationship with the PCTs. This new commissioning framework could further exacerbate 'postcode lottery' by way of distribution of ambulance resources. Not much debate seems to have taken place as to how patients would respond to their GPs if and when they know the GP is responsible for deciding the level of service delivery (Nuffield Trust, 2010). Media coverage has been quite critical about this issue. Clare Gerada, Chairman of the Royal College of GPs has been quoted saying that making doctors "the new rationers" of the NHS care could diminish patient trust and turn them into "customers" who shop around trying to get the best treatment for their ailment (Health Service Journal, 2010). Concerns still remain unanswered about the skills of the GP consortia

in their early years, in handling about £ 70 bn of public funds and subject to similar pressures as the PCTs but with much less management resource and experience. Recent evidence on the integrated care commissioning has highlighted the difficulties of the PCT commissioners to put providers sufficiently at risk in relation to developing better integrated and more efficient care (Ham *et al*, 2010).

Linked to this is the role of the NHS Commissioning Board (NHSCB) in relation to the economic regulator (Monitor) and the Care Quality Commission (CQC). Being an overall funder of the NHS Commissioners, the NHSCB will be undertaking resource allocation and holding the GP Commissioners accountable for their performance but it is still unclear to what extent it will remain truly independent of the Secretary of the State and Department of Health (Nuffield Trust, 2010a). Looking into the history of commissioning by the primary-care trusts, one realises that the PCT's have struggled to control expenditure on hospital care (Audit Commission, 2009). The ability of the underdeveloped GP consortia to take decisions to prevent costly hospital care and allocation of resources to ambulance service through commissioning negotiations for acute and emergency care is critical to the success of these reforms. The recent expose on the poor quality of care in care homes has exposed the lack of 'teeth' with the CQC and the resignation of the first chair didn't do much to recuse some of the prestige of the oversight body.

5. Plugging the Gap

In outlining our main argument about the big society, we also argue that massive welfare budget cuts necessitate a bigger role by the society or social networks in the co-production of the services. The concept of social capital has been around for some time and in the past the term was seen to be ambiguous. Robert Putnam, an American political scientist, has championed social capital (Putnam, 1993; 1995a; 1995b; 2000; 2007) and has brought the concept to the forefront in public debate, as Field (2003), notes Putnam has rescued the term from social and economic theory. We turn to Putnam in suggesting that the concept of social capital could provide us some lead. Furthermore, social capital is now seen to be clear-cut because Field (2003, p.1) argues that social capital can be summed up in two words: 'relationships matter.' For social capital to work effectively it must first of all be practiced efficiently within Governance as the ideas around social capital are strongly linked to governance. Skidmore *et al* (2006, p.8) have noted that there are strong connections 'between the properties of social capital and effectiveness of governance.' Hence the promotion and practice of social capital means better governance (Putnam, 1993). The success of social capital is the development of institutions and opportunities for public engagement and involvement.

Social capital has been defined by many scholars (Baron *et al*, 2000; Zetteret *al*, 2006; MacGillivray, 2002) but the most significant definition on social capital is by Robert Putnam (1995, p.67) he defines social capital as:

“...features of social life - networks, norms, and trust - that enable participants to act together more effectively to pursue shared objectives....Social capital, in short, refers to social connections and the attendant norms and trust.”

It thus might be helpful to think about the regional variations in performance of the emergency services can be on account of the variations in the co-production or social networks within a region. We agree that the concept of social capital (Navarro, 2002; Fine,

2010) remains controversial, but provides a practical tool to explore the significance of social relationships in the field of public policy (Woolock, 2010).

6. Conclusion

This paper has examined the theoretical debates surrounding the big society and how these impact on the UK's public health service. At the start of the paper a definition of the third way is provided and how this is theoretical linked with the big society. As it was suggested the big society is seen as being a rhetoric service for government cuts, in essence the rolling back of the state. This conclusion was drawn from the analysis of the coalition government's spending review since 2010 and how this has impacted in the NHS. It was found that these government cut backs have, and will, lead to further pressures in the NHS. Furthermore, the new NHS reform package and the possible measures contained within it will not alleviate the situation but only serve to further exacerbate a service approaching crisis level in several areas. These findings question and challenge the coalition government's social capital theory and the ideology which forms the basis of this theory.

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