How public service reform can address inequalities in the age of coronavirus

The stark inequalities that have been exposed by Covid-19 are not new. As a social worker in the 1970s, I witnessed first-hand the difficulties and challenges that face the most deprived communities in our country. I saw how the erosion of communal institutions, public services that had become distant and unresponsive to local needs, and precarious and poorly paid work had left many families unprotected and isolated. I also learnt that if deprived communities are empowered to take decisions, whilst given the right help and support, then the lives of the most disadvantaged in our society can be transformed, for the common good of all.

I was proud to be part of a Government that between 1997 and 2010, empowered disadvantaged communities across the country to transform the lives of some their poorest members and disadvantaged families. The introduction of a minimum wage and tax credits saw 800,000 children and 1 million pensioners lifted out of poverty. Also central to our achievements was the reform of public services, programmes such as Sure Start with its focus on health and family support, outreach and community empowerment, ensured that many children got a decent start in life.

Despite our achievements, there remained individuals and families who saw little benefit from these policies and who were too often deemed "hard to reach" by public services.

In 2006, when I was Minister for the Cabinet Office and Social Exclusion, the Social Exclusion Unit –which was abolished by the Coalition Government in 2010 – estimated that around 2.5% of the population were facing such multiple, entrenched disadvantages that the Government's reform agenda had done little to improve their lives. This was why in September 2006, I launched an Action Plan on Social Exclusion.

The Plan which sought to improve the lives of this 2.5%, identified five principal issues that needed to be addressed: deprived communities required better preventative services; a system of identifying what works needed to be put in place; better co-ordination of separate agencies was needed; the right balance had to be struck between personal rights and responsibilities – we found that people were often best supported by local voluntary and community groups which helped them to help themselves and to gain control of their lives; and finally, we needed to instil an intolerance of poor public service performance.

Fourteen years later, the Lords Public Services Committee, of which I am Chair, is currently conducting an inquiry on what coronavirus can teach us about public service reform. We have found that many of these same structural weaknesses in models of public service delivery, remain.

Covid-19 has tragically demonstrated the consequences of leaving these issues unaddressed.

Witnesses have told us how the funding of preventative services was not a priority in the years preceding Covid-19. Richard Sloggett, of the Policy Exchange, warned us that even in

the midst of this crisis, we are still talking about short term fixes such as hospital capacity, rather than services that would prevent people ending up in hospital in the first place.

Obesity was a significant public health problem before the coronavirus outbreak and a symptom of our underinvestment in preventative services; in England around 27% of adult men and 30% of adult women are obese. Obesity – and associated diseases such as diabetes – is concentrated in our most deprived communities.

The fallacy of the idea that coronavirus is a great equaliser, was demonstrated by a recent Public Health England report which found that diabetes was mentioned on a significant number of coronavirus death certificates, particularly for BAME people. Diabetes was mentioned on 21% of death certificates where Covid-19 was also mentioned. This proportion was 43% in the Asian group, 45% in the Black group and higher in all BAME groups than for the white British population. Unsurprisingly, diabetes was also more likely to be mentioned on coronavirus death certificates in our country's most deprived areas.

This same underinvestment is seen in adult social care – James Bullion, who kindly invited me to speak today, told the Committee that the severe budget restraints placed on adult social care in recent years has meant a reduction in preventative spending. Shamefully, this reduction in preventative social care spending has fallen disproportionately in the most deprived areas.

We have also been told by witnesses to our inquiry, that going into the crisis, national government too often did not take local expertise seriously. This lack of coordination between national and local agencies has played out with disastrous consequences during the crisis.

Jessica Studdert, Deputy Director of the New Local Government Network, told the Committee that during the early stages of the pandemic local authorities did not receive information from the NHS about shielded groups, even though they were responsible for delivering food and essential supplies.

So, whilst many of the problems identified back in 2006 remain the same, some things have also changed, and sadly not for the better. The 2.5% per cent of the population identified by the Social Exclusion Unit as locked in a cycle of disadvantage and harm has grown exponentially in the last decade.

The Marmot Review published earlier this year found that ten years of austerity meant that:

- people can expect to spend more of their lives in poor health;
- improvements to life expectancy had stalled, and declined for the poorest 10% of women;
- the health gap had grown between wealthy and deprived areas;
- places matters – living in a deprived area of the North East was worse for your health than living in a deprived area in London, to the extent that life expectancy was nearly five years less.

Sir Michael Marmot when giving evidence to the Committee, told us that the stripping back of local government expenditure in the most deprived areas is likely to have made a huge difference – in the nine years since 2010-11, spending by local authorities went down by 16% in the least deprived 20% of areas and went down by 32% in the most deprived 20% of areas. He also described to us how the Covid-19 mortality rates in the most deprived areas is almost twice as high than those in least deprived.

We have also seen other inequalities deepen during the pandemic.

A recent Public Health England report found that the mortality risk from Covid-19 was higher among black, Asian and minority ethnic people. The Committee heard from the Angelou Centre – which works with BAME women in the North East – as well as Sir Marmot, that the fact that Black British people and Bangladeshis have about twice the mortality from COVID-19 can largely be attributed to the deprivation caused by structural racism and deep-seated inequalities in health.

We have also seen in recent years, the structural problems in adult social care develop into a full-blown humanitarian crisis. This crisis has deep roots. Indeed, as Professor Nick Pearce – previously Head of No10 Policy Unit under Gordon Brown – articulately set out to the Committee: the lack of integration and equality between health and care – which during the crisis was seen in the failure to have a proper testing infrastructure in place in community social care settings and for care homes, the discharge of patients from hospitals into care homes without testing, and the lack of PPE, which ultimately resulted in thousands of unnecessary deaths – has its origins in 1948 and the foundation of the NHS, when medical care was made free but social care was means-tested.

However, the Committee has heard, that going into this crisis, social care was facing unprecedented funding pressures and workforce challenges – with a vacancy rate of around 8%. There was a huge number of people living with unmet social care needs, including 1.5 million older people according to Age UK.

Worryingly, as James explained to the Committee a couple of weeks ago, unmet needs have risen further during the pandemic, particularly amongst the working aged disabled. The social care bill has also rocketed during lockdown, threatening to cripple local authority budgets. The Health Foundation estimates that demographic pressures and rises in the national living wage alone will add £4bn a year by the end of this Parliament and will require significantly more to address the sector's long-term needs.

This crisis therefore represents both a risk and an opportunity, it has both deepened existing disadvantages but also forced into focus, inequalities that have been with us for some time.

Covid-19 has removed any possible excuse for a delay in confronting these inequalities – and a radical reform of our public services, particularly social care, will be vital in achieving the levelling-up of influence, power and opportunity which this crisis demands.

As the experience of 1945 and the construction of the welfare state teaches us, times of national trauma can also give way to national renewal.

What gives me particular cause for hope is the incredible innovation and civic action that we have seen, often at the local level and on the frontline, in response to the unprecedented demands that have been placed on public services and communities during the crisis.

The Committee has heard how local authorities, the voluntary sector and mental health services have collaborated in new ways during lockdown to support people with mental ill health, at risk of homelessness and substance misuse, to get themselves out of their difficulties and to gain control of their lives.

Revolving Doors – an organisation that works with a variety of agencies to break the cycle of people facing multiple disadvantages, ending up in the criminal justice system – told the Committee that Covid-19 has resulted in unforeseen, sudden, and large-scale changes to the services supporting people traditionally described as hard to reach.

We heard how people facing multiple disadvantage have benefitted from services becoming increasingly flexible during lockdown. The use of technology, fast tracking and simplifying referral processes, increased collaboration between agencies under crisis conditions and a reduction in bureaucracy had come together to transform people's lives.

As one service user told Revolving Doors, more flexible ways of working during lockdown has given them responsibility and empowerment, which has been key to getting them on the path to recovery.

Whilst the Committee has received much evidence on the overly centralised response to Covid-19, we have also heard how the crisis has resulted in local areas being empowered to support their most vulnerable members, by taking a place-based approach to delivering integrated services.

The NCVO and the Lloyd's Bank Foundation told us how increased flexibility in Cabinet Office commissioning guidance during lockdown, with a greater emphasis on social value rather than cost, has allowed local authorities to tap into the voluntary and community sectors in new and innovative ways, when delivering social care and other services to meet local needs.

During the course of our inquiry, we have learnt that if local areas are given respect and autonomy by national government; and health, social care and other services treated as equal partners in a local system, then rapid integration and innovation for the benefit of local communities is possible.

Eamonn Boylan, Chief Executive of the Greater Manchester Combined Authority told us how for years, Greater Manchester had been attempting to have a single digital patient record to be shared across local health and care services. However, within six weeks of the

pandemic lockdown, it was done – because the crisis demanded that local services were given the space to do it.

However, this inspirational innovation – whether in commissioning, collaboration between health and care, digital transformation and data sharing, the development of placed-based approaches or the new role for local voluntary organisations – is not sufficient on its own. A new funding settlement is essential.

Eamonn also told us that Greater Manchester is facing a cliff-edge in central Government funding later this year. He set out the need for a frank discussion between national and local government about how services can be funded sustainability in the long-term.

Nowhere is this more necessary than in adult social care – the public desire and political will, brought about by this crisis, to finally put in place a long-term funding settlement for social care should not, and cannot be wasted by this Government.

Another funding priority must be preventative services, particularly for our most deprived areas and disadvantaged groups – to stop people arriving at crisis point in the first place.

Sarah Pickup, Deputy Chief Executive of the LGA told the Committee how cuts to preventative services in the last ten years meant that going into this pandemic, our public services were fragile, struggling to cope with rising demand and health inequalities were rising. This left our most deprived committees particularly vulnerable to the virus.

This Government, even as it responds to immediate the needs of people pushed deeper into crisis during lockdown, can no longer afford to ignore prevention and early intervention.

As Professor Marmot convincingly set out to the Committee: any long-term strategy for systematically reducing health inequalities, and ensuring our public services and communities are resilient in the face of future pandemics, will require significant investment in preventative health and care services, and a joined-up approach with housing, education, transport, early years and employment services.

I hope the Committee's report, which will likely publish in October – when we could potentially be facing a second wave of the virus – will contribute to this new debate on public service reform. The innovations we have seen during lockdown cannot be lost; services need to be given the political and financial support to be truly preventative and integrated to meet people's needs, and local areas the means and autonomy to develop place-based approaches to support their most vulnerable. Just as in the years following the second world war, this crisis is an opportunity to reinvent our public services, to ensure they are fit to meet the challenges of our times.