WHY WE NEED A FUNDAMENTAL CHANGE
IN
HOW CARE SERVICES ARE DELIVERED AND FUNDED

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Association of Pakistani Physicians and Surgeons UK, British Association of Holistic Medicine & Health Care, British International Doctors Association, Bangladesh Medical Association, British Association of Physicians of Indian Origin, Centre for Welfare Reform, Doctors Association UK, Ghanaian Doctors and Dentists Association UK, Medical Association of Nigerians Across Great Britain, Muslim Doctors Association, Nepalese Doctors Association UK, Our NHS Our Concern, Portsmouth Asian Socio-Cultural Organisation, United Iraqi Medical Association UK and Ireland, Whistle-blowers UK

Introduction

It would be relevant to consider what were the problems affecting the care sectors in the 1980s Despite a Royal Commission, 15 organisational and legislative changes, nine reviews and reports and other interventions (1) since then the problems we had in 2019 (before the pandemic) were not only the same but worse (Table 1).

	Problems 1980s	2019
1	Shortage of beds	Worse
2	Blocked Beds	increasing
3	Social services - inadequate	Not fit for purpose
4	Funding - inadequate	inadequate
5	Waiting times increasing	No change
6	A&E waiting times increasing	No change
7	Winter bed crisis each year	No change
8	Workforce shortage	Worse
9	Low pay	Some improvement worse in social care
10	Health inequalities	No change
11	Consensus management changed	Worse – inefficient, unaccountable, wasteful
12		Different doctors each time
13		Loss of continuity of care
14		Informal integration destroyed
15		Low staff morale
16		Loss of Teams
17		A&E Closures

Table 1 Change in problems over 40 years

Why did the interventions fail?

Failure was the result of a failure to recognise the relevance of several factors which were collectively ignored.

The care needs of localities differ considerably depending on several factors. The local providers of care are best placed to assess the care needs of each locality. This important point has been ignored on the basis that larger is always better and central management were better informed of the larger picture.

The care needs of an individual is never static nor is it one off; it is mostly a continuum. Thus, a patient who suffers a medical condition that results is a degree of disability requires continuing care but of a different kind. The progressive closure of hospital beds has been based on an erroneous judgment that modern therapy and investigation would shorten the period of hospital stay and could be manged within the community thereafter. Yet, little effort was made to ensure adequate preventive and rehabilitation facilities. The lack of continuity of care was also responsible for the failure to provide adequate and appropriate therapeutic interventions within the community.

It has been obvious to most clinicians and providers of care that the NHS and social services have always been a continuum of care and each have been interdependent. The continued separation of the NHS and Social Care makes no sense and failure to understand this would result in failure of any future re-organisation of care services.

The introduction of the purchaser and provider system and the introduction of the market ethos have resulted in the destruction of what was voluntary integration between primary and secondary care, in addition to creating multiple agencies and a disorganised care system. This ethos should have no place in the care system.

Lord Carter of Coles in his report on productivity in hospitals published in 2016 commented ‘the workforce is regarded as a cost to be controlled rather than a creative and productive asset to be harnessed’ (2). As Lord Willis of Knaresborough put it in a debate in the House of Lords in 2018: ‘All too often, those who deliver the services, the workforce, are treated as a commodity rather than as a precious resource (3). Front-line staff are rarely consulted; the increasing use of management consultants is a symptom of this practice.

True integrated service would be difficult to establish without a unified budget at each local level

What is the alternative? Establish a National Care Service

1. Establish a statutory Local Care Authority (LCA)

1.1. All hospitals to be equal; there would be no Foundation Trusts).

1.2. The market ethos to be abolished.

1.3. This would replace the local CCG.

1.4. This would bring together all relevant provider units (hospital care, primary care. community care, social service, mental health and ambulance service) within the influence of the LCA.

1.5. Each provider would be expected to provide a set of agreed services according to the needs of the local community and avoiding duplication of services.

1.6. LCA would ensure that the agreed services are delivered efficiently.

1.7.1. The Board would consist of representatives of each provider, a representative of the elected Local Authority would represent the public view. It would be a requirement that representatives of providers include a senior clinician and a member from front-line staff.

It would also liaise with charitable bodies, private providers and Trade Unions.

Each provider unit would keep its own administrative structures unless they wish certain aspects to be given to the LCA.

1.7.2. Each Board would be supported by a CEO and a Finance Officer

1.7.3. The executive Body would be elected by the above team.

1.8. LCA would establish agreed governance structures and annual audits readily available to the public.

1.9. Budget – This would be set according to the needs of each provider unit and agreed by all. However, consideration should be given to ring-fenced allocation for social care. The budget would be sent to the Regional Care Authority

1.10. LCA would be expected to establish a confidential and independent office for Freedom to Speak Up.

2. Create a Statutory Regional Care Authority (RCA)

2.1. RCA would replace current structure at a regional level and would include representatives from each LCA within the region in addition to those from large providers across the region, tertiary centres, universities, government agents and the Colleges.

2.2. RCA would be responsible for seeking resources from the government on behalf of the LCAs and capital costs.

2.3. RCA would liaise with other relevant RCAs.

2.4. RCA would ensure government policies are understood and delivered throughout the region.

2.5. RCA would receive annual reports from LCAs.

3. Establish pragmatic commissioning services

Commissioning services should be within the NHS and external providers would be considered only if a particular service is not available within the NHS. This would be carries out by the Department of Health and Social Care.

4. Funding

4.1. The public consent to pay tax for NHS services free at the point of need irrespective of whether they might not ever require the services of the NHS. In contrast, only those with assets below £ 14,250 are entitled to receive free social care. Those with assets of £ 23,250 must pay from their savings till assets are consumed.

4.2. It can be argued that those with assets of over £ 23,250 had already paid tax during their working life and therefore the use of their assets to pay for social care was tantamount to paying extra tax retrospectively.

4.3. The cost of the NHS is vastly higher than social care and yet we pay tax for it. As in the case of the NHS, not everybody would require social care. The question has to asked why we are not asked to pay extra tax to pay for social care.

4.4. The care sectors, NHS and Social Care, have been underfunded for many years. Having stated that, it must be a priority to stop the continuing wastage of money at all levels. In addition, an integrated service would also save money by reducing duplication and maintaining unnecessary structures.

Conclusions

We therefore request the government to remove all organisational and legislative obstacles to establish a National Care Service as described in this paper.

At the conclusion of a recent webinar on Health and Care for All, the vote for a National; Care Service was 100% (from 85%), willingness to pay extra tax for care was 83% (78%) and was 57% for unified funding.

An Ipsos survey before Brexit revealed that people rated care for older and disabled people as third after Brexit and NHS and higher than economy, education, and housing (4).

Given the significant strength of the present government, the time is right for establishing this fundamental change in how care is delivered and funded.

Finally, we should be prepared to carry on the campaign for all long as it takes.

References

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