Socialist Health Association Scotland

NHS Scotland Reform

Discussion Paper

Introduction

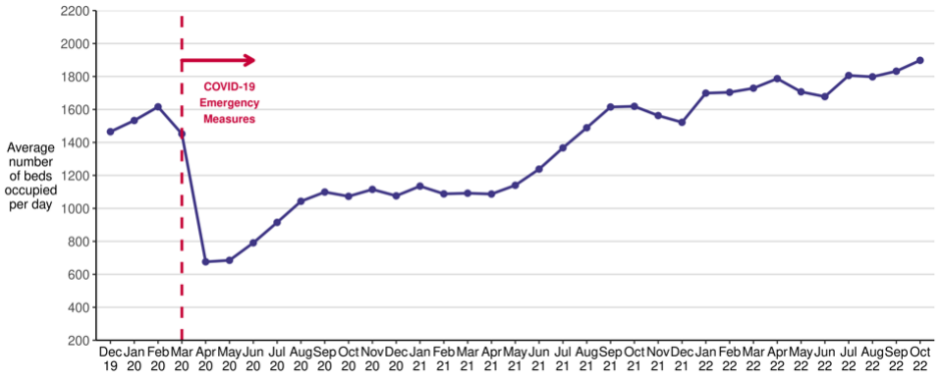
The NHS crisis in Scotland and across the UK has sparked a debate on reforms to the National Health Service. The SHA led the case for establishing the NHS, and while we are sceptical about the motives of some 'reformers', the NHS has continually been reforming itself since it was founded in 1948[i] - 75 years young this year. After devolution, Scottish Labour ended the marketisation and privatisation of many NHS services in the best interests of patients. This paper outlines some proposals and seeks views on the way forward.

Background

The NHS as an institution rightly attracts almost universal support, primarily because we all rely on it. The founding principles of an NHS free at the point of need, funded by general taxation, delivering universal, equitable, high quality, comprehensive healthcare based on needs is, in our view, the best way to organise healthcare. That doesn't mean it is sacrosanct, and it is perfectly reasonable to debate reform. Keir Starmer has said Labour is prepared to reform the NHS in England to prevent it from dying, saying, '*If we don't get real about reform, the NHS will die*.' However, we must be wary of those who use reform as a trojan horse to promote their ideological agenda.

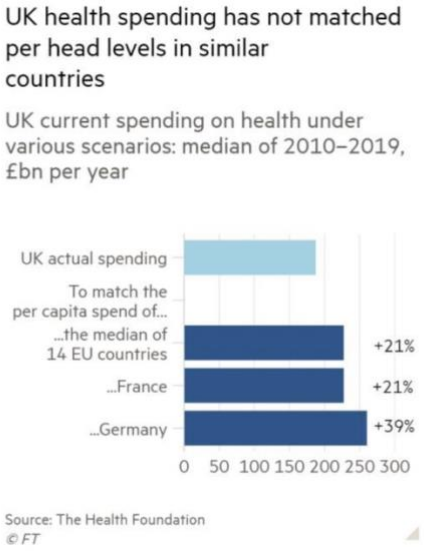
The most obvious symptom of the NHS crisis is Accident and Emergency (A&E). Less than 68% of people were assessed, treated, admitted or discharged within the Scottish Government's four-hour A&E target. More than 6,800 people spent more than 12 hours in A&E in October. Ambulances queuing outside our A&E departments is a visible sign of the NHS crisis that is difficult to ignore.

A&E issues are primarily caused by the lack of capacity in our hospitals, with far too many patients in hospital who don't need to be there. There also needs to be better links with primary care and NHS24. NHS Scotland delayed discharge statistics illustrate the need to focus on social care. In October 2022, the average number of beds occupied per day due to delayed discharges was 1,898 - the equivalent of our largest hospital and then some. The latest care inspectorate statistics showed that 60% of care services that employ nurses reported vacancies, creating a 16% vacancy rate. NHS district nurses also had a 16% vacancy rate last month. This is not unique to Scotland, with the Westminster Adult Social Committee highlighting similar concerns in England.



The NHS crisis is feeding through into public opinion, usually one of the NHS's strengths. The latest Ipsos poll found the Scottish public has a particularly negative view of the Scottish Government's efforts to improve the NHS in Scotland, with 53% saying it has done a bad job, while just 22% say it has done a good job[ii].

While there is a pandemic backlog, it has been argued that the current problems are merely a blip. The rebound effect of the pandemic will eventually end, the immunity debt will be paid by next winter with normal immunity levels returning, and a significant increase in visas issued to overseas workers will start to address the vacancy levels in the NHS and social care. Others point out that the underlying problems facing care in the UK were evident before the pandemic. Issues highlighted by the Christie Commission over ten years ago. As this chart shows, UK health spending is well behind similar countries and cuts to other public services such as local government will also have a serious impact on public health.



Increasing excess death rates, caused by austerity, highlight the underlying causes of inequality, an ageing population and the need for investment. As Gordon Brown highlights in a new report on inequalities for Our Scottish Future[iii], men in the most deprived areas of Scotland not only live 14 years less but can expect to spend 35% of their lives in poor health. Poorer women face similar problems. They live 11 years less than women from less deprived areas and spend 37% of their lives in poor health. That's why one of the most important predictors of the life chance of a newborn child is where they were born. Individuals living in the most deprived areas spend 22% longer in hospital per stay and require 72% more emergency bed days per head than individuals from the least deprived quintile, and they have 66% more A&E attendances per head.

As thousands wait for their appointments and thousands more queue to get through to GP surgeries, the NHS urgently needs more investment and fair remuneration for its staff. And this needs to be matched with a strategy to end health inequalities which disfigure our country and cut short too many lives. This strategy needs to invest in prevention through a focus on poverty, housing and other social determinants of health. Then on behaviours and secondary prevention such as screening.

So, accepting that tackling health inequalities is always the priority, what should we do about NHS Scotland?

Funding the NHS

The usual suspects are using the NHS crisis as an opportunity to privatise the NHS. Sajid Javid has proposed charging for A&E and GP appointments. It would impact Scotland because of the lost Barnett consequentials of part-funding the NHS through charges in England. Some employers are providing private health insurance to cut sickness absence, and individuals have to use lifetime savings to get past waiting times. The Tories opposed the NHS from the outset and regularly proposed social insurance and other ways to privatise the NHS. As Gordon Brown put it in the Guardian recently[iv], Conservatives *'seem to find more joy in one person joining Bupa than 60 million people using the NHS.'* It was also very disappointing to see a Green Party minister, in the Scottish Government, admitting they have private health insurance.

Charges and insurance systems would create a two-tier healthcare system in which better-off people took out private cover, undermining public support for the NHS and being very wasteful. Billing and means-testing not only mean higher administration costs but also discourage the sick from seeking treatment until too late – when more severe problems require more intensive but more costly interventions. GPs will often say that it's often the third, fourth or even fifth thing patients mention that they are apprehensive about. There is already a well-documented problem of getting men, in particular, to seek medical help. The last thing we should be doing is putting up financial barriers.

Successive governments have provided subsidies to private healthcare facilities. In addition, because for-profit companies do not employ the medical consultants who carry out the treatment, they benefit at no cost from the training and development of this expert workforce. This means that overseas investors are given access free of charge to a highly trained, expert workforce worth £8.5 billion. This has resulted in around £2 billion being invested in private health facilities since 2014, with JP Morgan betting on further outsourcing or because *'individuals are increasingly forced to dip into their own pockets to fund their care.'*[v] Patients are routinely told that long waits can be circumvented by seeing the very same NHS consultant privately. And if something goes wrong in the private hospital, it is the NHS that has to pick up the pieces.

In any case, Javid's charging plan would raise around £6 billion of the £30 billion the NHS has been underfunded since Austerity, according to the Kings Fund. There are better ways to raise this money, including halving the tax reliefs on savings for the wealthiest, bringing capital gains tax to the same rate as income tax, or tackling tax dodging. Half could be raised simply by the taxes paid by workers filling the NHS vacancies[vi]. A two-tier system is not inevitable due to market forces. Governments can reverse this trend by sustained investment in the NHS and the removal of subsidies which promote the growth of for-profit providers in the UK.

Social care

Scotland faced significant challenges in delivering social care before the pandemic. Not least, an ageing population, budget cuts and limited workforce planning. The pandemic highlighted these challenges and created some new ones[vii]. Many of these are common across Europe and certainly across the UK.

The idea that more privatisation is the solution is risible. As Prem Sikka recently highlighted[viii], social care companies are robbing the public purse, with profit margins of between 37% and 41.7%, and tax dodging is rife. This is the model that people like Karol Sikora want to expand! In addition, self-funding care home residents are now paying 40% more than publicly-funded residents, compared with 24% a decade ago. As the STUC research found, Scotland's large private social care providers are associated with lower wages, more complaints about care quality, and higher levels of rent extraction than public and third-sector care providers[ix].

Sadly, the proposed National Care Service in Scotland will do nothing to challenge this, taking even more services from the public sector. Moreover, as the Scottish Parliament Finance Committee report highlighted, the costings of this over-centralised service are largely unknown. Still, we know it will divert much-needed resources from frontline services. Creating a National Care Service remains the right approach. However, its role should be to create a national framework, with services designed and delivered locally. Implementing organisational change of this magnitude will take a significant amount of time. In the meantime, we need to support the demoralised, tired, and financially stretched frontline staff who immediately need a break, decent pay and a vote of confidence.

Primary care

Patients overwhelmingly access the NHS through GP services. However, patient surveys show this is becoming increasingly difficult despite GPs delivering more appointments (not all in person) than before the pandemic. Patient satisfaction is 12% down in the last year, with 10% saying it had become more difficult even to contact their GP practice. Some of the byzantine appointment systems don't help and put excessive pressure on reception staff, who take the brunt of patient dissatisfaction.

British GPs also have to care for more patients with complex health conditions because the population is ageing and many people have more than one chronic condition – known as 'multi-morbidity'. A large Scottish study found that more than 80% of patients over the age of 85 years had multi-morbidity, and, on average, they had more than three long-term conditions[x]. With falling GP numbers, the pressure felt by GP services will continue to increase as demand outstrips supply.

NHS Scotland, therefore, needs more GPs and other health staff in primary care. GP numbers have fallen from 3,613 in 2019 to 3,494 in 2022. Scottish Government targets focus on headcount, which ignores the growing number of part-time staff. A BMA Scotland survey indicated that 75% are more likely to quit or reduce hours in the coming year due to 'excessive workload'. Five years on, the deployment of multi-disciplinary teams has fallen short because of staffing shortages.

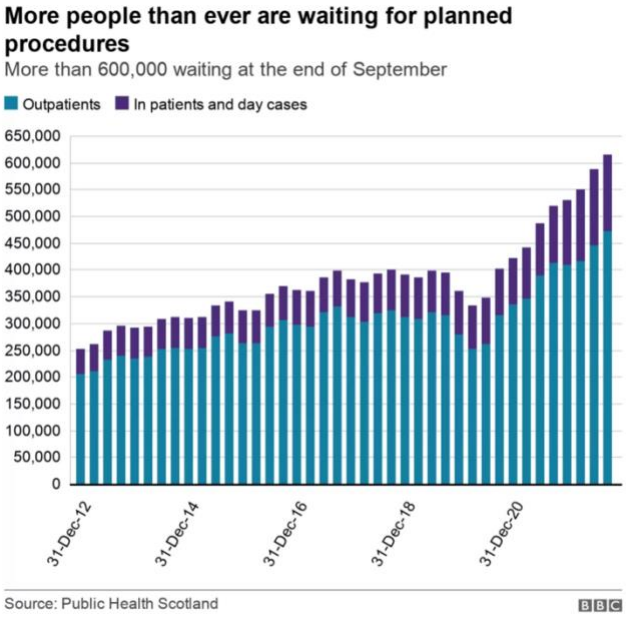
Moving away from the expensive small-business model would also help in the longer term. Many more GPs, particularly younger staff, are coming to this view. For example, GPs at the Lothian LMC have recently said that the independent contractor model 'is no longer fit for purpose.'

It is also becoming much harder to find help if you need to rely on NHS dental care. The BDA claims[xi] four out of five dentists in Scotland estimate their practices will reduce their NHS commitment. Over a third indicate they are likely to change career or seek early retirement in the next 12 months. Some 15% say they are likely to practice dentistry outside of Scotland, and 1 in 10 estimate their practice is likely to cease operations. Smaller local practices are being swallowed up by large firms driven by profit through corporate dental management service organisations (DMSOs). These are often financed offshore through private equity firms.

There is a similar case to GPs for bringing dentistry into the NHS. Even the Scottish Dental Association is proposing a system that would see dentists spend 60% of their week on a salaried basis providing NHS care[xii]. While this appears to be a progressive proposal, we should remember that before the pandemic 80% of dentist time was spent on NHS patients.

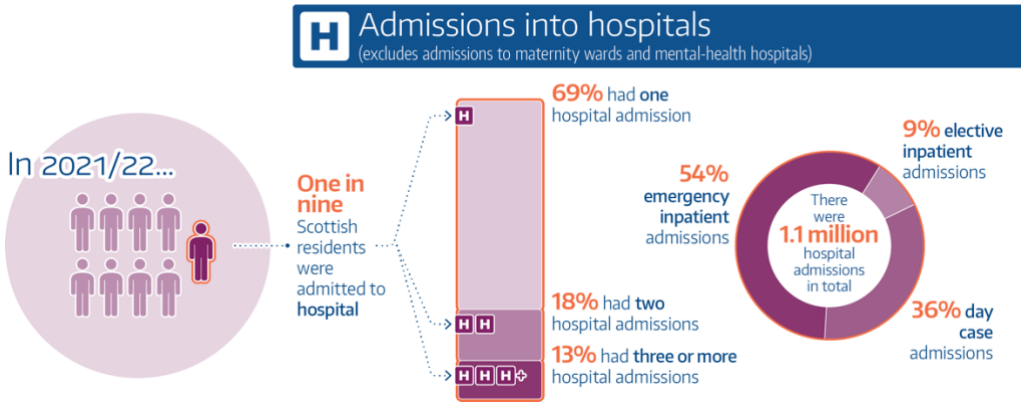
Hospital reform

One of the most significant issues the NHS faces is finding enough beds and staff to make a dent in the huge backlog of planned elective procedures it has to catch up on after Covid. As a result, more people than ever are waiting for planned procedures.



The obvious solution is to reduce demand on hospitals by addressing social and primary care issues as set out above. We also need to rebuild the capacity taken out of the system in recent years. The average number of available hospital beds in Scotland has decreased over the years. In 2021/22, the average number of available staffed beds for acute specialities was 13,323, a 2.4% decrease compared to five years ago (2016/17). The percentage occupancy for acute specialities rose from 74.8% in 2020/21 to 84.2% in 2021/22.[xiii] Compared to other nations, the UK has a very low total number of hospital beds relative to its population. The average number of beds per 1,000 people in OECD EU nations is 5, but the UK has just 2.4. Germany, by contrast, has 7.8[xiv].

In England, the government is planning to reduce demand through virtual wards. Using remote monitoring technology, the goal is to treat 50,000 people a month in their homes. Remote treatment has been used in rural areas across Scotland for many years, and its use grew during the pandemic. This has several advantages reducing the risk of infection and shortening hospital stays. However, not all patients or conditions are suitable for virtual wards. To be successful, there need to be people at home to feed, bathe, medicate and comfort the patient. So, it is back to social and primary care.



Workforce

A common theme throughout the above challenges is the workforce. Attempts a workforce planning have been patchy, particularly in the fragmented social care sector. Vacancy rates have increased, and immigration policies have reduced the supply of workers from overseas. Pay and conditions have not kept pace with inflation or even wages in the private sector.

We need proper workforce planning and fair pay and conditions to tackle recruitment and retention in health and social care. This will help end reliance on exorbitant agency costs, locums, staff banks, and the private sector.

Reform process

Some argue that it's time for a Commission on the future of the NHS to take the service away from political conflict. Simon Jenkins argues[xv] that there is no shortage of ideas for reforming public services, but there lacks a conveyor belt to turn them into policy. An explosion of partisan think tanks has, if anything, led to a decline in consensus building. A House of Lords Library Briefing makes a similar case in more detail[xvi].

On the other hand, this has traditionally been a way of kicking complex issues into the long grass. For royal commissions established after 1945, the most common timeframe taken to report was two to four years. Health is also too big and important an issue to take it out of the political area.

Discussion points:

- Is there a case for a review of the NHS and related services?
- If so, what format should that take?
- What are the key challenges and potential solutions?
- How can SHA Scotland help to take these issues forward?

Please forward any views to the Secretary: socialisthealthscotland@gmail.com

[i] Timeline: https://www.nuffieldtrust.org.uk/health-and-social-care-explained/nhs-reform-timeline
[ii] Ipsos (Feb. 20223) https://www.ipsos.com/en-uk/public-perceptions-nicola-sturgeon-dip-while-over-half-scots-are-critical-scottish-government
[iii] Closing the Gap: https://ourscottishfuture.org/wp-content/uploads/2023/01/CLOSING-THE-GAP.pdf
[iv] Gordon Brown: https://www.theguardian.com/commentisfree/2023/jan/23/nhs-tories-privately-funded-healthcare
[v] David Rowland: https://blogs.lse.ac.uk/politicsandpolicy/is-a-two-tier-healthcare-system-inevitable-in-the-uk/
[vi] The NHS Funding Crisis and How to Solve It: https://www.taxresearch.org.uk/Blog/2023/01/21/the-nhs-funding-crisis-and-how-to-solve-it/
[vii] On the Corona Frontline: https://library.fes.de/pdf-files/bueros/stockholm/17550.pdf
[viii] Privatisation has destroyed the social care sector: https://leftfootforward.org/2022/12/privatisation-has-destroyed-the-social-care-sector/
[ix] STUC: https://stuc.org.uk/media-centre/news/1659/scotland-s-social-care-rip-off-why-scotland-can-t-afford-privatised-social-care
[x] Lancet: https://www.sciencedirect.com/science/article/pii/S0140673612602402
[xi] BDA Scotland: https://bda.org/news-centre/blog/Pages/is-this-the-end-of-nhs-dentistry-in-scotland.aspx
[xii] Herald: https://www.heraldscotland.com/news/22747095.nhs-dentistry-scotland-faces-cutbacks-payments-reduced/
[xiii] Public Health Scotland: https://publichealthscotland.scot/publications/acute-hospital-activity-and-nhs-beds-information-annual/acute-hospital-activity-and-nhs-beds-information-annual-annual-year-ending-31-march-2022/
[xiv] BMA: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-hospital-beds-data-analysis
[xv] Simon Jenkins: https://www.theguardian.com/commentisfree/2023/feb/03/royal-commissions-transformed-britain-1960s-nhs-housing
[xvi] HofL Library: https://researchbriefings.files.parliament.uk/documents/LLN-2020-0094/LLN-2020-0094.pdf