SHA Scotland
Submission to the Scottish Policy Forum First Stage Consultation

Introduction

The Socialist Health Scotland was founded in 1930 to campaign for a National Health Service.
SHA Scotland is a campaigning organisation which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action. We campaign for an integrated healthcare system which reduces inequalities in health and is accountable to the communities it serves.

We welcome the opportunity to respond to the SPF First Stage Consultation. We have described the challenges facing health and care in Scotland in our 70th Anniversary paper. In this response, we will focus on the solutions to some of the most challenging issues.

While our response will focus on the health and care paper, we believe that the overarching focus should be on health inequalities. As set out in the Scottish Labour Health Inequalities Commission report and this is a cross-cutting issue that requires action in all four commission areas.

NHS Scotland

There is a need for a long term look at NHS Scotland and the challenges it faces. Experience of a similar approach in England was that it did lead to a significant increase in funding. However, a review could be viewed as merely another process of which the SNP government is prone to adopt to avoid making difficult decisions. Many of the problems facing the NHS are well understood, and any review needs to have a tight timetable.

We should also be aware of the risk from UK trade deals and lobby links to traditional consultancy firms who should be excluded from any review.

Progress on health and care integration has been slow, following on from many attempts since devolution to address this issue. Governance of integration authorities is weak, with few of the stakeholders satisfied. The latest Audit Scotland review highlights many of the problems. There are some examples of successful integration, which shows the model can work. Wales has had similar experiences.

None of the structural solutions is straightforward. In several European countries, community health is part of unitary local authorities, and this creates unified governance and management. However, it can also create barriers to the transfer of resources from acute to community services, undermining preventative action. It will also be unpopular with NHS staff who identify with the NHS ethos and a stable industrial relations model.

Some have argued that social care should be unified under the NHS. The problem with this approach is poor local accountability in the NHS with its quango appointment model. Removing even more services from local democratic control would not be consistent with Labour's policy approach.

This could be addressed by a different local governance model with an integrated organisation accountable to councillors, possibly with an element of directly elected members. The current advisory board structure for stakeholders could be retained. The number of health boards would be reduced and would focus on acute and other regional services. The risk is that these organisations would become detached from the NHS and the broader local authority services that are essential to addressing health inequalities.

SHA Scotland does believe that local government has an important role to play in health. We set out the case for a council health strategy in our report *'Reducing Health Inequalities Locally'*.

Any new attempt to integrate local services has to address the place of General Practitioners. The new GP contract (we comment on it here) is an essential step in the right direction away from the small business model. However, we believe the time has come to agree on a process that will fully integrate General Practice into the NHS, and then any new local integration structure. This would create a fully integrated primary care team, with GPs at the core. There is a case to extend this approach to other local health services, including dentistry and pharmacy, but probably by considering these as future steps.

The Burns review considered reform of national waiting time targets. There is little doubt that targets are extensively gamed in the NHS and should not be the main focus of managerial or clinician time. They should be regarded as indicators, not as a political blood sport, and focus more on outcomes. The public is understandably more concerned about accessing GP services and 10-minute appointments, which should be reformed.

The allocation of NHS resources is not always focused on the areas that most need them. This requires a fundamental review of the allocation formula, with targeted interventions in areas of disadvantage. Equity of access is something highlighted by the Deep End group of GPs as well as the inverse care law described by the SHA's Julian Tudor Hart.

Mental Health

There needs to be a renewed focus on prevention and early intervention. This includes the workplace and education. There should be a transformational boost in resources and priorities as the New Zealand government has started to do. Again, there should be a focus on the most disadvantaged areas. Within the NHS, there should be parity of esteem with physical health.

Social care

We believe many of the recommendations of Scottish Labour's Quality Care Commission are still relevant to these services. In particular, the workforce challenges will only get more difficult post-Brexit, but they existed long before this became an issue.

There does need to be a discussion around funding, as the recent IPPR report on social care in England has done.

While we support the principle of personalisation, it should not be conflated, as the private care sector does, with marketisation. Self-directed support works better for some groups than others, and there are capacity challenges for some families. A range of care options are

possible without the extensive outsourcing and commissioning approach of recent years. This should be delivered within integrated local care teams (see above), which can include the best of innovative voluntary sector provision.

Health Improvement

The focus of health improvement should be on reducing poverty. The JRF has highlighted four actions to cut child poverty, which provide a good starting point. The priority should be to end destitution, homelessness, provide Fair Work and raise the incomes of families through a family income supplement.

There are different views on Basic Income and/or Basic Services within SHA Scotland. However, as even pilot schemes in Scotland are some way off, a decision is unlikely to be required within the time frame of the policy programme.

We agree that there is a drugs crisis, and the 'war on drugs' has predictably failed as a policy approach. Addiction should not be treated as a crime, and therefore, we see the merits in giving serious consideration to decriminalisation. That is not to say that there are not regulatory and addiction concerns, which need legal, health and education responses.

Wider policy

We will leave it to other socialist societies to comment on the detail of other policy areas. Tackling health inequalities requires cross-cutting action in most of the policy commission remits. In particular:

- Social infrastructure to build communities and combat isolation.
- A radical expansion of social housing and reform of the private rental sector.
- Long term action on climate change and immediate action on air quality.
- Anti-discrimination, human rights and a broader equality strategy
- Education – with a focus on the early years.

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