

# Scottish Democratic Alliance

## Health Policy

Updated 10-06-2009

### Current Situation

Scotland with a population of 5,062,011 (2001 census), spends over £ 10 billion a year on its health services, (one third of the total Scottish budget). £ 6.2 billion of that budget is spent on the 14 regional Health Boards of which one, Greater Glasgow and the Clyde receives, over 30%. Each Health Board operates the hospitals in its area, plus the Primary Care services. Scotland's NHS has 145,000 staff, plus 13,000 independent contractors (GPs etc.). (Whitaker's Almanac 2008, the UK in figures, and Health, and Health Services, Scotland). Private health care is smaller in Scotland than in England but often contracts to treat NHS patients. Some private contractors may run NHS facilities through public-private partnerships.

Live birth rates per thousand are over 12 for England, Wales and Northern Ireland. Birth rates in Scotland are less, - at 10.7 per thousand. Life expectancy in Scotland based on 2004-2006 data, is 77.8 years for men, and 79.6 years for women. This is an improvement of 5.7 years for men and 5.0 years for women since the previous survey. In contrast, UK wide life expectancy is 76.2 for men and 81.3 for women.

(The Register General for Scotland commented on the improvement reflected in the data: "Our calculations show that people throughout Scotland are likely to live longer now than they did 10 years ago. But that improvement is not spread equally. Life expectancy for men in Shetland has risen by almost five years - but by only two months in Clackmannanshire. For women, life expectancy in East Dunbartonshire has increased by almost three years, but in East Ayrshire by only eight months".)

Deaths from natural causes are 53,535 per year in Scotland. The main causes are:

Cancer	15,409
Heart	10,331
Strokes	5,789
Respiratory	5,320
Dementia etc	2,454
Meningitis	1,386
Liver etc	1,152
Genital & urinary	1,063

For comparison, accidental deaths in Scotland total 2,252

In 2000 the World Health Organisation issued a ranking of the health systems of all countries. The 2000 list places the United Kingdom 14<sup>th</sup> in the global table of health care provisions and facilities for all of its population. Among the top rated countries were France (1), Italy (2), Singapore (6), Spain (7), Austria (9), Japan (10), Norway (11), Iceland (15), and Netherlands (17). The United States was ranked (37). (The World Health Report 2000 - Health systems: Improving performance.)

The average cost of a week's stay in a Scottish hospital was £ 2,930 in 2007; and the cost of primary care services in local care centres and clinics was £ 705 million, equivalent to £ 137 for every man, woman, and child, in Scotland. Total health expenditure in Scotland, in 2009 is expected to work out at £ 2,281 for every person in the country. In 2005, the number of beds available in Scottish hospitals was 28,100. Occupancy averaged 22,500.

A major step forward for Scotland's health care was the assignment of health as a devolved matter following the referendum of 1997, the Scotland Act of 1998, and the Parliament inaugurated in 1999. This gave the Scottish Assembly direct control of health expenditure and health service delivery in Scotland. A second major step was the commissioning of the Kerr Report *Building a Health Service Fit for the Future*, and its subsequent implementation. The Report written by a national framework advisory group under the chair of Professor David Kerr, was commissioned during the Labour-Lib-Dem administration, and is being implemented with minor adjustments by the SNP Government. (<http://www.scotland.gov.uk/Publications/2005/05/23141307/13135>)

In considering the future shape of the NHS in Scotland, Professor Kerr consulted the Scottish public and the healthcare professional working in the clinical front line. From these consultations he found the main concerns related to :

- Maintaining high quality services locally, and improving waiting times
- Supporting Scotland's remote and rural communities
- Empowering clinical staff to reform the health service
- Using new technology to improve the standard of care
- Reducing the health gap between rich and poor
- Ensuring value for money across the NHS

Commenting on the Report, Professor Kerr said, *"All of us (wish) to transform the NHS with a series of bold initiatives to deliver safe, quick, and sustainable health care. Rather than restructure Health Boards, I would rather build on the well of human resource, improve the culture of leadership, collectivism, and engagement with the public and the clinicians. We need to win public confidence and build bridges between the Royal Colleges, the Boards, the Health Department, and the NHS staff. A more truly Scottish model of health care would be to take a collective approach, integrating and transforming through unity of purpose. This implies investment in pathways that span primary and secondary care, networks of rural hospitals linked to and supported by major teaching hospitals; and rational distribution of services between neighbouring hospitals; with national planning of complex service frameworks like neurosurgery, and specialised children's services. Scotland's NHS, though criticised and maligned by some, is still seen as the greatest gift government can give its citizens. It is well served by a dedicated staff. So we should put aside narrow self interest and pull together to better serve our old, our infirm, our poor, and our children's children, and in doing so cast off the label of 'the sick man of Europe'.*

An element of the Kerr Report recommendations which has been strengthened by the current Scottish government is preventive, anticipatory care, rather than reactive management. This involves tackling the root causes of much ill-health, including smoking, excess alcohol consumption, obesity, lack of exercise, poor housing, and violence in the home and in society.

A target of the health policy was to reduce waiting times for referrals from GP to Hospital admission, to less than 18 weeks. As of 31 December 2008, 99.9% of new outpatients, and over 99.9% of inpatients and day cases were waiting less than the 18 week national standard. Also 97.5% of Accident and Emergency patients in Scotland were admitted, discharged, or transferred within 4 hours. The national standard is for 98% of these patients to be dealt with within 4 hours. Alcohol related discharges from general hospital in 2007/2008 numbered 42,430. That was an increase of 7% over the previous year, and represented a discharge rate of 777 per 100,000 of population. Over the five previous years alcohol related age standardised discharge rates from Scottish hospitals, increased by 17%.

Patients receiving NHS care that is on-going, non-acute care, delivered as an inpatient, and often over an extended period, in a hospital, hospice or care home, numbered 2,715 in 2008, corresponding to a rate of 36 per 100,000 of population.

The Scottish Government's current priorities for improved health and longer life expectancy, include: Reducing the harm done by misuse of alcohol

Immunisation to reduce the risk of cervical cancer

Screening for early detection of potential serious illness

Anticipatory treatment to target risks detected

Tackling obesity by improved diet and exercise

Inequalities are to be addressed by supply of good quality sustainable housing; by tackling the issue of violence against women and those of minority races; and by innovative approaches to reducing poverty and disadvantages. The Government also plans to phase out prescription charges.

## **Conclusions and Policy Statement**

The **SDA** welcomes the recommendations of the Kerr Report and broadly agrees with most of the comments made by the nurses and health profession workers through UNISON. We also support the initiatives by the current Scottish Government to place even more emphasis on anticipatory care and prevention, as well as their commitment to a holistic approach to health that tackles obesity, substance abuse, and inequalities due to poverty or disadvantage; and which supports efforts to provide sport facilities and to tackle violence against women, children and other vulnerable persons.

We have in Scotland, a largely dedicated and competent work force in the health service, who given the powers and support, can make our Scottish NHS even better and more effective. We do not believe the major problem is finance, or training, or the structure of the various elements of the service. It is our considered view after consultation with front line doctors, nurses and other clinicians, that the area in most need of improvement is that of management. We need much better administration than we are experiencing at present. Professional skilled management could reduce costs and improve the environment for both staff and patients. Clinicians are not managers but should work closely with them. This view is shared to some degree by UNISON, (<http://www.unison-scotland.org.uk/healthcare/kerrreport.html>).

The private sector hospitals in Scotland are important and have some advantages over the NHS which has to undertake added duties such as teaching and training. While private health is obviously expensive, cooperation with the NHS can be on a low cost

basis. For example, BUPA has provided some services to the NHS at a knock-down rate, and at little profit to itself. The three main private health groups are BUPA (now SPIRE Health Care), BMI Healthcare, and NUFFIELD Healthcare. Of the 3, BMI has most staff, hospitals and medical centres in Scotland, Nuffield has 2 hospitals in Scotland, and SPIRE has 1. But pre-SPIRE BUPA, had a huge national and international group's resources to draw on, as has BMI. We believe that private sector / NHS cooperation is essential and sensible, and can be improved, possibly along the lines of the German health system. Effective cooperation requires good liaison and reliable administrative from both partners. There is a need to improve efficiencies and synergies in these partnerships to e.g. reduce waste which may be caused by last minute cancellation of operations due to communication failures.

A problem is that professional managers have a business model profit driven ethos, whereas clinicians motivation is to do the right thing for patients, which may not fit with a strictly business model. Unless the clinicians see the managers are making sensible decisions for patient welfare they will obstruct attempts by managers to change (and anyway they are changes one would not want). Moreover it can make the managers frustrated and feel they are not allowed to manage. The answer has to be a partnership between management and clinicians with discussions and sharing of values, in their approach to patient care.

Privatisation of hospital services as organised under past Labour and Conservative administrations was believed to be a way to improve efficiency and reduce cost. But it was neither as we discovered in a number of ways, such as when hospital cleaning supervision was taken away from nursing staff and given to contractors. The result was some dirty hospital wards, and the spread of super-bugs (MRSA, E-Coli, and C-diff which resulted in tragic deaths, particularly in Lanark), in the very places where vulnerable patients needed protection from infection. The link between contracting cleaning services to the private sector, and the increase in super-bug infections has been recognised by UNISON and the SNP. See the Guardian report below: (<http://www.guardian.co.uk/society/2008/oct/19/mrsa-health-scotland-private-cleaners>)

Recent reviews of NHS management have examined the whole cycle of patient care from the first onset of symptoms to the contact with local doctors or health workers, and on to further treatment or hospital care, and from that to post treatment care and monitoring. The Scottish Government is working on ways to address identified flaws in the current operation, to reduce waiting times, and to work towards an improved interface between rural health services and the national hospitals. We support their efforts to improve care in the community, and to work on prevention as well as cure, while ensuring that serious illnesses are diagnosed early and each patient is seen by a specialist within the target times set.

Financing of the Scottish NHS is a huge issue and we regard the PFI arrangements supported by Labour and Conservative parties as an enormous over-charge on the public purse which future generations will have to pay for, yet not ever actually own the buildings and facilities. The situation of the Edinburgh Royal hospital leasing its building from a private firm, at great cost, is also unacceptable. The **SDA** would seek to reverse these arrangements where possible, and to ensure that future construction of NHS hospitals would be at controlled cost, and the properties would remain in government ownership. The web site below describes that and other PFI failures. (<http://home2.btconnect.com/london-health/he-issues/he59centre.pdf>)

The **SDA** agrees with the current (Kerr / SNP) view of health-related matters, including the relevance of the quality of our housing and, the need for better sports facilities for schools and for the general public. It is also our policy to introduce voluntary national service for all young people, who might spend from 3 to 24 months in community work in Scotland, or in teaching or development work in poor countries abroad. We fully agree with current efforts to tackle alcohol abuse among young people in Scotland, to control advertising and sale of cigarettes to young people, and encourage smokers to give up that habit.

The government must ensure that the higher education and training systems provide a constant supply of medical, nursing and health care staff sufficient to maintain the requisite size of skilled workforce, to the extent that it will not be necessary to bring in staff from abroad. Where foreign staff are employed, their qualifications and skills must be thoroughly scrutinised and tested to ensure they are equal to the standards laid down for Scottish health service staff.

We believe Scotland should be moving in the direction of a central computerised health register, whereby patients can take their card to any GP, specialist, clinic or hospital in the country and be assured of almost instant attention on the basis of their accessible medical records. Such systems are becoming standard throughout the EEA (not just the EU). The cards contain only the personal identification information, the records themselves being accessible by inserting the card into the computer terminal. This works well in some European country health systems. The card must be produced at each individual consultation or treatment; otherwise the GP or clinic cannot be reimbursed by the health service.

The **SDA** is in favour of reciprocal arrangements with other countries so that Scottish citizens who take ill abroad may be cared for under that country's health service, and vice versa. We favour making our health services free at the point of delivery for non-Scots working in the country and paying tax to the Scottish treasury, as well as for those immigrants who are legally accepted by the Scottish Government. Those provisions would have to follow Independence, and the reduction of unionist burdens on the country, such as the cost of Trident nuclear weapons. Receipt of revenues from North Sea oil will also put Scotland in a position to finance improvements to the health service which are not possible under the devolved arrangements.

There are a number of proven management models that might be applied to the NHS to improve effectiveness, to maintain staff morale, and to raise the quality of patient care at all levels. Since the training, motivation and focus of nurses and doctors is very different to that of professional managers, we believe as a general principle, it is not appropriate for clinicians to be expected to undertake management responsibilities. At the same time we are convinced that managers must work in close harmony with the front line nurses and doctors. At the service level in all hospitals there should be a joint arrangement with a clinician head of patient care and medical treatments; and an administrator head of budget, management, and effective staff utilisation. These two officers should hold equal rank and authority with distinct accountabilities.

As the Kerr Report noted above, Scotland has extremely competent and committed teams of health workers and front line nurses and doctors. Their morale has suffered in recent years for a number of reasons. Among these, in our view, has been poor communication between clinicians and managers, and situations like privatised hospital

cleaning, where nurses feel they have no direct input to correct deficiencies. They have also been hampered by inadequate IT systems that sometimes result in notes being lost or mislaid, or treatments not initiated in a timely manner.

We will therefore support moves towards application of proven relevant management systems that can benefit a large organisation like the National Health Service. Leeds University, Professor Oakland and others have done admirable work in this direction, as have Professors Slack, Chambers, and Johnston of Warwick University Business School. (*Total Organizational Excellence*, John S. Oakland, Butterworth, Heinemann / *Operations Management*, Nigel Slack, Stuart Chambers, Robert Johnston, Prentice Hall). We need to apply such proven models in a professional way to escape from the dismal results of amateurish approaches to NHS management.

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