

## Letter from Glasgow

### ADULT HEALTH AND SOCIAL CARE INTEGRATION (AND INDYREF)

Changes are happening in health and social care in Scotland. But first a little about Indyref, the Scottish Independence Referendum, which took place on 18 September 2014 because it is relevant to the adult health and social care agenda. Readers in India may have followed the cut and thrust of the Indyref debate because there was intense interest in it internationally. Of course there is something romantic about ‘fighting for freedom’ and ‘escaping from Westminster (UK Parliament) rule’. The debate was both robust and wide-ranging. Some even compared it to freedom struggles of countries such as India or China.

What did I think of the independence debate? For me this is not about colonial rule but a post-industrial country coming to terms with how political power is used and shared. So with my heart and head—and love of Scotland—I voted to remain part of the UK family of nations. On a broader perspective of identity I regard myself in many ways—as Glaswegian, Scottish, British and European but also Punjabi, Indian, and South Asian and amalgamations of all of these. Remaining part of the UK does not diminish any of that.

For me, the argument for staying within the UK was summed up by Des Spence, a general practitioner writing in the *BMJ*.<sup>1</sup> He said that ‘Scottish national and cultural identity is undimmed because of, and despite, 300 years of union, and Scotland can gain more political autonomy without breaking that union. Travel afar and look back at Britain, and you value what we have.’

I believe that autonomy encapsulated by the Scottish Parliament, combined with being part of the UK, has served the National Health Service (NHS) in Scotland, and Scotland more generally, well. The NHS exists UK-wide but each of the four ‘home nations’ of the UK (England, Northern Ireland, Scotland and Wales) administers the NHS locally and there are differences between them. These differences are not in the NHS’s core mission of providing healthcare based on need, free at the point of use and funded mainly by taxation. Rather it is in the operational aspects; so, for example, in Scotland there is less involvement of private companies providing NHS healthcare, under contract to the NHS, than in England. In Scotland the Scottish Parliament has responsibility for the NHS and, even before the establishment of the Scottish Parliament in 1999, Scotland had control of the NHS through the Scottish Office.

Local councils (municipalities) in Scotland control the strategic and operational aspects of social care. In many ways integration of health and social care for adults exemplifies the autonomy Scotland has. The need for adult health and social care integration is important because of the overlap between the two and an ageing population. For example, locally in Lanarkshire over the next 20 years we will see an increase in 32% of our 60–74-year-old population and a 72% increase in our population aged over 75 years.<sup>2</sup>

But care for older people needs to be better coordinated and managed, so it dovetails together rather than appearing disparate as it sometimes can be. For those who think this is a route to reducing costs, I say, forget it! This is about the quality of care provided, which includes effectiveness and efficiency of services, and better use of our existing resources. This may result in an increase in the capacity and capability of health and social care to deal with other issues but it will not save money.

There is political consensus in Scotland for integration and the Scottish government has set out its perspective.<sup>3</sup> The annual report of the NHS Scotland Chief Executive<sup>4</sup> highlights the importance attached to it within the NHS at present. The aim is simple in that we: plan health and social care strategically; assess the needs of our population; commission services to meet those needs; prioritize prevention and encourage self-management of care; encourage people to participate in services development and delivery (with patients and carers as the focus of care); ensure that people stay at home if possible to receive the social and healthcare they need; and monitor what we do. The idea is to ensure patients remain outside institutions such as hospitals and care homes unless such care is essential. However, to achieve integration means a major service change which politicians may not have envisaged when they set out on this road.

Integration requires the creation of health and social care partnerships between local councils (responsible for social care for adults) and health boards (responsible for healthcare). Of course, there are many differences between councils and health boards (below) and these will need to be dealt with.

1. *Cultures*: A nebulous term admittedly but, for example, working in councils has a more ‘party political’ edge than working in health boards.
2. *Democratic mandate*: Councillors are locally elected and the Scottish government appoints health board members.
3. *Decision-making*: Councillors alone make decisions in councils and in health boards it is executive (senior manager) and non-executive board members who make decisions.
4. *Numbers*: There are 32 councils and 14 health boards, i.e. most health boards cover more than one council.
5. *Different pay and conditions*: Although for the vast majority of partnerships staff will continue to be employed separately by councils and health boards, they will be working alongside one another with, for example different working hours and holiday entitlements.

In Lanarkshire, the health board covers two council areas: we have North Lanarkshire and South Lanarkshire transition integration boards (TIBs). Full Integration Joint Boards are planned to be in place by 1 April 2016.

The two TIBs will submit integration schemes to the Scottish Government by the end of March 2015 which details how their health and social care partnership will function. As expected, health services which will be included in the partnerships in Lanarkshire include our existing community health partnership (CHP) services. These CHP services are mainly community and primary care health services. They will also include the adult and older people’s social care services from the council side. In addition the Scottish government also wishes ‘unplanned care services’ to be part of the strategic planning within partnerships. These services are those where the predominance of activity is unplanned and includes accident and emergency, old age medicine, general (internal) medicine, palliative care, general practitioner beds, general psychiatry, psychiatry of old age, learning disability, rehabilitation services and respiratory medicine. However, separating ‘planned’ from ‘unplanned’ healthcare will require financial and other analytical work to be undertaken. This is because in the NHS, for example, staff, resources and time in most

hospital services are not allocated separately to 'planned' and 'unplanned' healthcare.

Finally, partnerships will be monitored on how they perform, based on the nine national health and wellbeing outcomes below.<sup>5</sup>

- Outcome 1.* People are able to look after and improve their own health and wellbeing and live in good health for longer.
- Outcome 2.* People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- Outcome 3.* People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Outcome 4.* Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Outcome 5.* Health and social care services contribute to reducing health inequalities.
- Outcome 6.* People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
- Outcome 7.* People using health and social care services are safe from harm.
- Outcome 8.* People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Outcome 9.* Resources are used effectively and efficiently in the provision of health and social care services.

Despite the important challenges ahead, we know what we need to do—provide effective, efficient, equitable, person-centred, seamless health and social care to our adult, and in particular, to our older patients and population. We must get it right for the people we serve but also because we may just need to use these very services in the future.

#### REFERENCES

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- 3 Scottish Government. Integration of Health and Social Care. Available at <http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration> (accessed on 29 Dec 2014).
- 4 Scottish Government. The NHSScotland Chief Executive's Annual Report 2013/14. Scottish Government, Edinburgh, December 2014. Available at <http://www.scotland.gov.uk/Publications/2014/12/1954> (accessed on 30 Dec 2014).
- 5 Scottish Government. Integration of Health and Social Care—National Health and Wellbeing Outcomes. Available at <http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes> (accessed on 30 Dec 2014).

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## Letter from Chennai

### RESIGNATION EN MASSE

Everyone wants more, and so do the doctors of the Government of Karnataka. For 6 years, the doctors kept pressing the government to increase their salaries. Their demand was that they should be paid on a par with the doctors of the Medical Education department, who got higher salaries. What was worse, they had not been paid for 4 months. All my life, the unfailing advantage doctors in government service had was that they received their salaries on time. These days, governments spend so much on election promises and sops to potential voters that they have no money for even essential services, and salaries of their employees are not so important. As for doctors, they rate the lowest priority. The doctors had other demands that to my mind seemed unexceptionable, among them the supply of medicines of good quality to their hospitals, and timely recruitment to prevent posts lying vacant. They also said that Karnataka fell far behind Tamil Nadu which had periodic and timely recruitment drives so that vacancies were filled promptly, and gave preference for postgraduate seats to doctors in service. On 27 October 2014,

3500 medical officers declared they would give a month's notice to the government, and quit service on 27 November 2014 if their demands were not met.

How is mass resignation any different from a strike? It is clear that, irrespective of the outcome of their threat, the entire lot of doctors will not resign. Many may not have the wherewithal to sustain themselves and their families without the salary. It is unlikely that the government will accept their resignations and proceed to hire new recruits, though there are probably quite a few doctors ready to join.

I wondered what the Medical Council of India had to say about doctors going on strike. The code of medical ethics of 2002, amended up to December 2009, is displayed on its website. There is no mention of strikes. The closest it comes to this situation is Article 1.8, which deals with 'Payment of professional services' and says, 'The personal financial interests of a physician should not conflict with the medical interests of patients.' However, I believe Article 2.4 entitled 'The patient must not be neglected' expressly forbids strike action, though not in so many words. It