Health Care Services in Crisis

Consistent failure to address the fundamental causes

A DISCUSSION PAPER FROM CITIZEN NETWORK RESEARCH

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APRIL 2023

CITIZEN NETWORK
FOR A WORLD WHERE EVERYONE MATTERS

PUBLISHING INFORMATION

First published April 2023
ISBN download:978-1-912712-45-8
23 pp.

Health Care Services in Crisis is published by Citizen Network Research.
The publication is free to download from: www.citizen-network.org

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Foreword

As a long-time employee of the NHS, I have seen first-hand the many ways in which the organisation has successfully provided accessible and comprehensive care to the citizens of the UK. However, in recent years, the delivery of care has faced significant challenges, despite advances in therapies and surgical interventions. The root causes of this decline have been consistently ignored, despite numerous attempts at reorganisation and review.

This paper, written by three experienced hospital consultants, aims to identify the causes of these problems and suggest solutions. It discusses the negative effects of the ongoing reduction of hospital beds and the abolition of community hospitals, and advocates for more community hospitals and state-controlled care homes. The paper addresses the workforce crisis, which has been caused by a lack of long-term strategy and other factors that could be addressed without additional funding. It suggests methods to change the current unacceptable culture and reintroduce ward-based teams, as well as addressing specific issues related to primary care and social care.

The paper also explores the public's lack of understanding of the cost and limitations of the NHS, and the failure to effectively communicate changes and improvements to the service. It emphasises the importance of localities and true integration in care delivery, and advocates for empowering local teams rather than relying on centralised management.

The paper concludes by calling for the integration of the NHS and social care and the implementation of a comprehensive, continuous care model that addresses the needs of individuals throughout their healthcare journey.

Recent surveys have shown strong support for a National Care Service, with a willingness to pay extra tax for care. The current political climate presents an opportunity for making fundamental changes to the way care is delivered and funded, but such changes will require a cross-party decision and an honest information campaign to the public. Care services should be centred on the needs, accessibility, and expectations of patients, rather than being driven by bureaucratic or

political ideologies. The professional and union bodies have a crucial role to play in promoting the changes proposed in this paper, which include a truly integrated structure at all local levels and the ability for multidisciplinary teams to work across silos and organisational boundaries with the aid of technology.

As the NHS approaches its 75th anniversary next year, it is clear that reform is necessary in order for the organisation to continue serving the needs of the UK's citizens. This reform must address the serious structural problems outlined in this paper, including the need to reform the way doctors are trained, to allocate funding more effectively, and to address the social care system and funding for long-term care needs. With these changes, the NHS can continue to thrive and provide high-quality care for generations to come.

Professor Clare Gerada

President Royal College of General Practitioners

Summary

Over the last four decades several new therapies and surgical interventions have led to significant improvements in the outcome of many diseases and increased life expectancy. In contrast, the ineffectiveness in the delivery of health and social care has steadily been decreasing over the same period reaching a critical level that now warrants urgent attention. These things have happened despite numerous reorganisations and reviews over the same period, including the many changes made by NHS England, which was established in 2013.

This paper identifies the causes that have been consistently ignored and suggests solutions. In summary:

1. End the ideologically driven reorganisations of the NHS
2. Recognise the real points of failure in the current system
3. Focus on improving morale across the whole workforce
4. Tell people the costs of NHS care at every point
5. Reorganise the system to achieve integration and decentralisation
6. Make social care free, like NHS care
7. Introduce regular productivity reviews across all NHS services
8. Establish a new settlement for the NHS and social care

1. Introduction

Over the last few decades several new therapies and surgical interventions have led to significant improvements in the outcome of many diseases and increased life expectancy. In contrast, effectiveness in the delivery of health and social care has steadily been decreasing over the same period reaching a critical level that now warrants urgent attention. Many blame the Coronavirus pandemic, but this has merely thrown into sharp contrast the deficiencies between health systems and social care. Many blame lack of funding, but there is much evidence that draws attention to the failure of successive governments to recognise the causes that have led to the current crisis.[1,2]

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, 9 reviews and reports and other interventions since then, the problems we had in 2019 (before the pandemic) are not only the same but more severe (see the Tables below).[1,3]

HOSPITAL PROBLEMS IN 1980	HOSPITAL PROBLEMS IN 2019
Bed shortage number: 350,000	Bed shortage worse number: 141,000
Blocked beds	Blocked beds worse
Funding % of GDP 5.6% OECD 6.6%	Funding – GDP 7.1% OECD 8.8%
Waiting times - fair	Waiting times - unacceptable
A&E waiting time - fair	A&E waiting time - unacceptable
Pay - low	Pay - worse for lower grades
Care Teams - adequate	Care Teams - mostly lost
Staff morale - fair	Staff morale - low
Consensus management - failing	Professional management - worse

PRIMARY CARE IN 1980	PRIMARY CARE IN 2019
Informal integration - reasonable	Informal integration - lost
Continuity of care - fair seen by the same doctor	Continuity of care - lost seen by different doctors
Workforce shortage - fair	Workforce shortage - critical
Staff morale - fair	Staff morale - low

COMMUNITY & SOCIAL CARE IN 1980	COMMUNITY & SOCIAL CARE IN 2019
Community hospitals - present	Community hospitals - nil
Shortage of care beds - manageable	Shortage of care beds - critical
Workforce shortage - fair	Workforce shortage - critical
Staff morale - fair	Staff morale - low
Short term planning	Short term planning

The recent review on leadership requisitioned by the government was either to implicate management for the crisis or a failure to understand that no amount of leadership could make a system work which is overwhelmed with demand and lacked appropriate facilities.[4]

2. Focus on the real factors

Failure was the result of either an inability to recognise or a conscious denial of fundamental causes that collectively resulted in a worsening system of care over the years.

The delayed times to be seen in an A&E department and long queues of waiting ambulances are not new; winter crises have been a regular feature for decades. The Kings Fund reported that the total number of NHS hospital beds in England had more than halved over the past 30 years, from around 350,000 in 1980 to 141,000 in 2019/20, while the number of patients treated had increased significantly. In 2018/19 general and acute bed occupancy averaged 90.2% and regularly exceeded 95% in winter. As the overall population has increased and the proportion of people over 65 in particular, it is unsurprising that the number of beds occupied by patients, mostly over the age of 65 had increased and further exacerbated by failure to discharge patients because of lack of beds in the community.[5] Given this obvious cause, successive governments have continued to reduce the number of beds, not just in hospitals but have closed community hospitals completely. The latter, medically supervised by local general practitioners, had provided a much-needed service for the local population. This service also enabled doctors to treat patients with less serious problems locally rather than admitting them to a hospital. This practice also promoted continuity of care.

The current government's desire to increase the number of hospitals reveals yet again its failure to understand the relevance of community hospitals and the urgent need to increase care beds within the community. Community

hospitals could also function as outpatient clinics, conducted by general practitioners or specialists, thereby decreasing referrals to hospital clinics. They could, depending on the size of the population served, also be the local providers of rehabilitation services.

Care Homes run by the private sector will continue for the foreseeable future. The State should ensure that the correct unit cost of running care homes was paid. In so doing the State should establish governance rules.[6]

Directly because of bed shortage, those patients who are already in hospitals are frequently moved from one ward to another: often, more than once during a single admission. This gives rise to loss of continuity of care, patient confusion, particularly in the elderly. This practice also contributes to delayed discharge. Blocked beds, particularly in winter, frequently result in cancelled operations at short notices causing much distress and prolongation of pain for patients, and preventing expensive theatre staff from working.

3. Improve staff morale

At the risk of stating the obvious, the care services are desperately short of staff largely due to the lack of any meaningful workforce planning. This crisis has several causes, many of which could be corrected without the need for extra finance. Lord Carter of Coles in his report on productivity in hospitals commented 'the workforce is regarded as a cost to be controlled rather than a creative and productive asset to be harnessed'. [7] 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.[8] Despite the above observations, staff work in an environment of fear that prevents them from speaking up. They are subjected to bullying, harassment and discrimination. They are not valued and have lost the sense of belonging.[8,9,10.11.12] Teams have been destroyed and this has led to loss of continuity of care. The cumulative effects have led to low morale. Is it a surprise that doctors and nurses, in particular, are leaving early, and recruitment has been difficult? This level of unhappiness has contributed to the demand for more pay.

The prevalent culture must change. The fact that this has been allowed to continue for years suggests that there is need for an intervention that would have statutory powers. It is acknowledged that culture change would be difficult. The establishment of an independent and elected scrutiny panel with statutory powers, at each Trust would have an immediate effect on the behaviour of management, who would have to seek permission from this panel before subjecting a member of staff to any investigatory action.[13] The panel could also be the local guardian for Freedom to Speak Up. An alternative method of changing the culture would be to insist on members of each Board to be elected by the staff for a defined period.[14] Restoration of a sense of belonging and ensuring continuity of care could be achieved by reintroducing ward-based teams.[15]

Training more doctors and nurses takes time and is expensive; waiting for UK trained staff to resolve staff shortage fails to meet the increasing numbers of patients requiring treatment now and for some years to come. The NHS, from its inception, has relied on the valuable services of staff from abroad; it is difficult to understand why there is no emphasis on increasing this recruitment, and the deliberate policy of the Home Office to discourage it. Allowing the current waiting times to remain unresolved quickly would be unacceptable.

General practice

General practitioners have always been independent self-contracted providers to the NHS. Each practice is partner-based. Apart from the provision of care to patients, a partner has other responsibilities such as staffing, performance management, premises and accounts. Most individuals entering medical school do so to work as a doctor and not to be involved in running a business. Combining this with the increasing bureaucracy, general practice has become less attractive. The loss of continuity of care has added to this. An increasing number of doctors do not wish to be partners and are happy to be salaried and enjoy the flexibility of working.[16] There has also been a trend towards the formation of large practices with many doctors, further resulting in loss of continuity of care, and patient dissatisfaction. It should be noted that the continuation of general practice as independent contractors, combined with the market ethos have prevented an integrated care service.

A pragmatic way forward would be to allow a mixed economy in primary care enabling the continuation of partner-based practice but establishing

salaried doctor primary care services owned by the state and applying NHS contracts. This would have the added advantage of engendering integrated practice and enable a salaried GP to work in both sectors.

Formation of Primary Care Networks are large units that cover a population of 30,000 to 50,000 have yet to be tested. Suffice it to say, the belief that larger is better is highly questionable. Each unit would be further away for many patients and one wonders how continuity of care would be possible in this situation.

Community careers

Care workers report chaotic and unorganised shift patterns, many are dissatisfied, stressed, and feel undervalued. The typical independent sector care worker in 2019 earned £8.10 per hour and it is therefore not surprising that growth is almost at a standstill and vacancies are harder to fill.[17]
The sector accounts for around 6% of total employment in the UK; four in five social care workers are female with an average age of 43. Most of the workforce is British (83%) with 7% (95,000 jobs) filled by EU citizens and 9% (127,000 jobs) by non-EU citizens.[18]

A report by National Audit Office (NAO) about adult social care workers in 2018 noted that rates of pay, along with tough working conditions and a poor image, were preventing workers from joining and remaining in the sector.[19]

It is imperative that the pay and status of carers are improved as an emergency:

- Establish national standards of training for carers with recognised qualifications.
- Establish and enforce standards of staffing numbers and qualifications for each service
- Establish national pay scales, based on level of training, like those of health care assistants in the NHS.
- The formation of an association to which carers may belong will give them a sense of belonging and respectability.
- Carers from outside the UK should not be considered as unskilled labour for visa purposes – identifying this work as such is demeaning.
- Ensure that non-British carers are given settlement status.

The costs of these improvements may not be as large as it initially appears. Low and unstable incomes of care workers are already subsidised hugely by the taxpayer through the benefits system. This may reduce the poverty of the recipient but does not bring with it the self-esteem and sense of public worth that would come from a more appropriate pay packet. It does nothing to improve the attractiveness of work in social care. The social impact of such a low-pay sector is accompanied by significant public cost and lost opportunity. Wages are more likely to be spent in the local economy, boosting the prosperity of local businesses and the tax revenue that would accrue.

4. Involve the public

It is difficult for most people to comprehend the significance of how much the NHS costs; billions are unimaginable. The expectations of the public are increasing year by year, and yet NHS fails to make us understand that there are limits, it fails to draw our attention to the vast sums of money that are wasted, and it utterly fails to make us realise how much each one of us cost the NHS whenever we use its services.

We also do not quite understand how much prescriptions cost and the waste of time and money when people do not turn up for their appointments. The public is never given a clear description and explanation of the various changes made to the NHS; this results in increasing disinterest. Most people are not callous nor unthinking or deliberately careless in the way the NHS is used.

Each time we use the services of the NHS we should be informed of the cost. Each prescription dispensed should state the actual cost to the NHS for the pills, the cost of consultations should be clearly stated, including the cost of operations and hospitals stays.

The NHS collects a great deal of data; it should not be too difficult for the costs to be assessed. Once people begin to appreciate how much every item costs society would begin to question its behaviour and demands. Society is very capable of reacting appropriately to honest information

5. Localise and integrate services

The care needs of localities differ considerably depending on several factors. The local providers of care are best placed to assess the care needs and facilities of each locality. This important point has been ignored on the basis that larger is always better and central management is better informed of the larger picture. It is also relevant to record that front-line staff who deliver the service are rarely consulted. The latest changes in care services made by Parliament demonstrate the continued fallacious thinking in its creation of remote Integrated care Service (ICS) Boards and formation of Primary Care Networks (PCN) each of which would look after 30,000 to 50,000 people!

The care needs of an individual are never static nor one off; it is mostly a continuum. Thus, a patient who suffers a medical condition that results in a degree of disability requires continuing care but of a different kind. The same individual would often require referral back to the NHS for either a recurrence or the development of a new condition. On the other hand, the same individual would require continued medical supervision by primary care that remains as a separate system. It has been obvious to most clinicians and providers of care that care is a continuum and the NHS and social services have always been interdependent.

The continued separation of the NHS and Social Care combined with lack of integration between primary and secondary care, made worse following the introduction of the market system, has led to the formation of multiple agencies and a worsening disorganised care system. Perhaps one should recall that the seeds for a disorganised system were sown when the NHS was established as a system supported by general taxation while the responsibility for social care was left to Local Authorities, and general practice was allowed to remain as independent contractors. This makes no sense and failure to understand this would result in failure of any future re-organisation of care services, and yet, the new ICS system creates two separate Boards, one for the NHS and the other for social care:

- 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, to which power should be devolved by statute.

The establishment of a statutory Local Care Authority (LCA) would mean that all hospitals would be equal; there would be no Foundation Trusts and the market system would be abolished.

- This would bring together all relevant provider units, including social care, representatives of which would form the integrated Board of LCA. This Board would ensure the inclusion of front-line staff and a senior clinician.
- The Board would also include a representative of the Local Authority to represent the public.
- 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. LCA would ensure that the agreed services are delivered efficiently.
- This structure would ensure that social care would become the responsibility of all and not left to fight its own battles.
- LCA would also liaise with charitable bodies, private providers and Trade Unions.
- Each Board would be supported by a CEO and a Finance Officer, and the executive team would be elected by the Board members.
- The budget would be set according to the needs of each provider unit and agreed by all. The budget would be sent to the Regional Care Authority
- LCA would be expected to establish a confidential and independent office for Freedom to Speak Up.
- Create a Statutory Regional Care Authority (RCA) that 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. It would also liaise with other RCAs.
- RCA would be responsible for seeking resources from the government on behalf of the LCAs and capital costs.
- RCA would ensure government policies are understood and delivered throughout the region.
- 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 carried out by the Department of Health and Social Care.

6. Make social care free

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. 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.

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 be asked why we are not expected to pay extra tax for social care.

Were the public made aware of the costs involved and made to feel involved they would probably accept to pay more tax. The willingness of the public would depend very much on the transparency of the government as well as its willingness to reduce the continued waste of funds at all levels.[20] In addition, an integrated service would also save money by reducing duplication and maintaining unnecessary structures.

7. Assess productivity

It is most surprising that a large and very expensive care service does not insist on assessing productivity. It is therefore proposed that all senior clinical and managerial staff and the many departments and structures related to the care sectors are subjected to routine productivity assessments according to agreed national protocols. The sooner this is established the better would be the transparency.

8. A New Settlement

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.[21]

One of the obvious defects over the decades has been the frequency of the changes made to the care systems, most damagingly following each general election. This has given rise to short term planning and loss of continuity. If we were to establish a sustainable funding policy and make the fundamental changes that are required, and for them to be acceptable to society, it demands a cross party decision combined with an honest information campaign to the public.

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

At the risk of stating the obvious, care services are meant for patients: their needs, accessibility of services and their expectations. For far too long these have been forgotten in the interests of bureaucratic or political ideologies whenever the services have been reorganised.

The role of the professional and Union bodies in promoting the fundamental changes proposed in this paper cannot be overemphasised. An efficient, cost-effective, and sustainable model of care would be a system that would allow members of multidisciplinary teams to use their skills outside their current silos and across organisational boundaries, aided by technology. This would not happen without a truly integrated structure at all local levels, as described in this paper.

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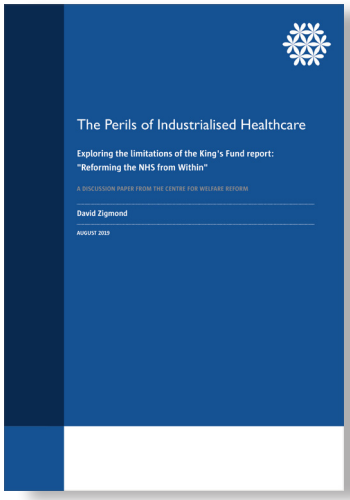

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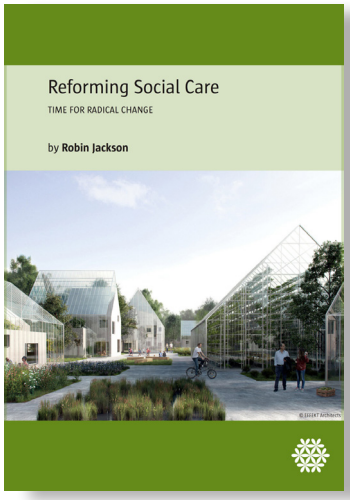
In his paper, David Zigmond argues that it's dangerous to underestimate the industrialisation of healthcare and that the National Health Service needs to be built on a human scale.



Reforming Social Care

In his paper, Robin Jackson argues that integration between health and social care is not desirable, setting out a clear vision for reforming social care in its own right.

Both publications are available to read at:
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