Race Equality Foundation

Another missed opportunity, an analysis of the Health and Care White Paper:

Integration and Innovation: working together to improve health and social care for all

Introduction

The COVID-19 pandemic brought into sharp view the inequalities that have been allowed to persist and to grow in the UK. Just weeks before the first national lockdown, Sir Michael Marmot highlighted the decline of life expectancy in the previous ten years, calling it a "lost decade". For Black, Asian and Minority Ethnic communities, the warning signs were already clear long before evidence of the disproportionate impact of the pandemic became obvious.

In April 2019, the inquiry into maternal deaths found that black women were five times more likely to die in childbirth compared to white women. The issues highlighted included the quality and responsiveness of services as well as the wider determinants of health, such as rates of poverty and poor housing.

In cancer care, Black, Asian and Minority Ethnic people are less likely to access screening programmes, meaning they are more likely to be diagnosed late, and report poorer experiences of services. It is a similar picture for dementia, where late diagnosis means Black, Asian and Minority Ethnic people are less likely to be involved in decisions about their care. These are inequalities that have a detrimental impact on individuals, families and communities, as well as having an impact on the health and care system itself.

This paper will look at the NHS reorganisation proposals as detailed in the *Integration and Innovation: working together to improve health and social care for all* White Paper. It will summarise the key policies within the White Paper before examining some of the gaps with specific relation to race equality and broader health inequalities.

What are the key proposals?

Pressing forward with Integrated Care Systems (ICS)

The government intends to introduce ICSs across England. There will be a "duty to collaborate" placed on the NHS and Local Authorities to encourage integration, and a "Triple Aim" duty (better health for all, better quality of services, sustainable use of resources). Each area will have an ICS NHS Body and an ICS Health and Care Partnership. The intention is that the new statutory ICSs will support place-based commissioning, and there is mention of the voluntary sector as a provider. There will be some reforms to the Better Care Fund, separating it from the NHS mandate and focusing it on meeting the challenges of an ageing population, and the government will get the power to cap capital spending by NHS Foundation Trusts.

There are some other enablers mentioned, such as changes to competition law with regards NHS Trusts, reforming the tariff, and removing the requirement for Local Education and Training Boards. The Secretary of State will also get the power to create New Trusts in order

to support and align integrated systems. The emphasis of these changes is on “pragmatic” responses to need.

NHS England to merge with NHS Improvement and Central government to get more powers

This had effectively happened already, both boards had requested a merge and it’s just being put on a statutory basis. The more important element is proposed greater powers for central government over NHS England. These are described as:

“enhanced powers of direction for the government over the newly merged body which will support great collaboration, information sharing and aligned responsibility and accountability”.

Specifically, there will be flexibility within the NHS Mandate to allow the Secretary of State to set objectives. They’re also required to publish an annual report on work planning.

NHS England do get some more flexibility around transfer of powers to arms-length bodies, and Special Health Authorities (including NHSBT). This is again intended to enable NHS England to respond more robustly.

Changes to social care

The White Paper talks about introducing a new assurance framework in social care and improving data collection. Importantly, it also mentions allowing greater freedom around direct payments to providers, and “discharge to access” models.

Public health

The paper says that most of the public health policies the government intends on introducing will come through a different piece of legislation, and that this will have a focus on “population health”. That said, there are some specific measures on food advertising and labelling as part of efforts to tackle obesity, and centralising some of the powers relating to fluoridation of water.

Patient safety

There are proposals to improve patient safety by creating a statutory system of medical examiners, medicines registers and putting Health Service Safety Investigations on a statutory footing.

The government also intends to include measures to enable reciprocal health agreements, presumably as a result of Brexit.

What does the paper say about race equality?

There is only one mention of ethnicity or race in the White Paper, at the beginning as a statement of intent to improve lives, “no matter where they are from, their ethnicity or social background.” There is no specific mention either in relation to the racial disproportionality in COVID-19 infections and deaths, nor in the other health conditions

mentioned in the document that have a disproportionate impact on Black, Asian and Minority Ethnic communities such as diabetes, obesity, dementia, and mental health.

There are significant lessons to be learned from COVID-19 and its disproportionate impact on groups including Black, Asian and Minority Ethnic people and people with a learning disability who had higher death rates, with Black, Asian and Minority Ethnic people with a learning disability having an even higher death rate from COVID-19. Understanding the causes through a robust inquiry would inform the design of systems and practices that tackle health inequalities, promote equality, and help restore the trust of those communities in public services and institutions.

This is disappointing, as the White Paper specifically says it is building on the proposals in the NHS Long Term Plan. The Long Term Plan paid specific attention to race equality and racial disparities both across a number of health conditions, but also with regards the NHS workforce. For example, we welcomed the attention to the provision of GP practices in poorer areas in the Long Term Plan, as this is a key inequality in more urban and deprived areas, and is expected to widen in the coming years. While we have commented before that many of the tools to promote equality and tackle health inequalities in the NHS are present both in the 2012 Act and the Public Sector Equality Duty, the experience of COVID-19 shows that the concerted long-term action we have called for is still lacking. Without a stronger legislative framework that promotes action and accountability, these inequalities will persist alongside “warm words” from government on inequalities.

What does the paper say about health inequalities

The White Paper states that a more integrated system will be better able to address health inequalities and the wider determinants of health, as no single system can do this. It also acknowledges the inequalities revealed by the coronavirus pandemic, but says the proposals in the white paper are only one part of addressing these, highlighting the roles of data and finance. There is also specific mention of addressing health inequalities in terms of patient choice so as to make patients more aware of their rights, and with regards to the measures around obesity and water fluoridation.

What are we calling for?

The Foundation responded to the original NHS Long Term Plan in 2019, noting that while there had been real steps forwards by the NHS the evidence and testimonies of service users showed persistent inequalities, including racial inequalities in the experience of services and the outcomes from them. The experience of the COVID-19 pandemic only highlighted, in the starkest terms, issues that were known and had not been addressed by services. If the White Paper is to truly build on the Long-Term Plan, then it must address these concerns explicitly.

Greater integration of health, social care, and other providers of services is welcome. As stated in the White Paper, this creates the opportunities to address the causes of health inequalities where they are currently outside of the scope of health services. However, without a clear focus on inequalities, the ICS’s risk becoming a tool to make public services financially sustainable without delivering the promised improvements in outcomes across society.

Finance and funding need to be more aligned with health inequalities. For example, the 2016 BMA Survey found London had by far the worst figures for financial stability, with the highest level of GP practices concerned their services were unsustainable (14 per cent), the largest proportion reporting their overall financial position was weak (41 per cent) and the lowest number of GP practices reporting their situation as "strong" (2 per cent). Primary care in inner cities and urban areas is facing particular pressures around workforce, sustainability and quality. Urban areas have a smaller number of doctors relative to population, whilst often having greater levels of health inequalities.

There needs to be specific actions taken at national and local level where the evidence shows there are poorer experiences and outcomes in health services. For example, a series of recent reviews and reports generated by government, academic research and NGOs have highlighted severe racial inequalities in maternity, cancer, diabetes, mental health, and in screening programmes. While ICSs are potentially in a better position to provide local leadership, they need a clear mandate to do this, accompanied by the resources and accountability to ensure that happens.

Better collection and use of data must also be accompanied by improved accountability. The current roll out of vaccinations for COVID-19 are a case in point, where data is not being systematically collected, analysed and used to address inequalities. Such a system would enable us to understand who is being reached and who has yet to be vaccinated. This is despite the clear and known issues both around the disproportionate impact of COVID-19 and lower levels of general vaccine take up among some Black, Asian and Minority Ethnic communities.

The NHS must show leadership on addressing racial inequalities and broader health inequality. At present and throughout much of the past decades, the health and care system and its resources are focused on treating ill-health rather than preventing it. The White Paper notes the rising costs of healthcare and the need to ensure services are sustainable, a key way of addressing these issues is to address inequalities. A 2016 paper from the University of York estimated that social and economic inequality alone cost the NHS £4.8 billion a year (around one fifth of its total budget). Throughout the document, there are potential opportunities to include a focus on equality. For example, the Secretary of State's regular reporting on workforce planning could include reporting on progress against the Workforce Race Equality Standard. Direct payments in social care could better enable community-led organisations to provide specific services for specific communities – our work on this has found that black and minority ethnic-led organisations struggle to access personal budgets at present.

The reforms around patient safety could also be positive, but the evidence and our own work shows that black and minority ethnic people are less likely to lodge complaints and are often poorly served in investigations, so it would be crucial to ensure those issues are addressed when developing the medical examiners and Health Services Safety Investigations. There is a critical need for greater accountability under the new ICS arrangements, which should as a minimum consist of the Secretary of State reporting on health inequalities to Parliament, ICSs reporting both to their local communities and to the Secretary of State, and the Care Quality Commission to monitor the performance of ICSs.

Conclusion

The White Paper, and specifically the changes to promote integration, do have the potential to address health inequalities and racial inequalities. The challenges we have highlighted: higher rates of maternal mortality, late cancer and dementia diagnoses, and poor experiences of care can and need to be addressed through coordinated and systematic action across services. However, without a specific focus on these goals, the funding to support sustained action across public services, and accountability for delivering specific action, it will fail to deliver the improvements in health and care that are needed in England, particularly for those who currently experience inequalities.