Reforming Social Care

and the case against Integrated Care

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Preface

An earlier version of this paper was discussed at the inaugural meeting of the Yorkshire branch of the Socialist Health Association (SHA) on 1st November 2018. The central ideas were also explored in a speech at the Reclaim Social Care Conference, organised by members of Keep Our NHS Public, Health Campaigns Together, the Socialist Health Association, the National Pensioners Convention and the Green Party. I hope this paper honours the intentions of this important alliance and offers some food for thought as it develops its strategy further.

I would also like to thank the *Journal of Integrated Care*. I have been lucky enough to sit on the editorial of the *Journal* for many years, and during that time I have read many interesting papers. However I have read none that suggest that integrated care is the solution to the pressing problems faced by social care today.
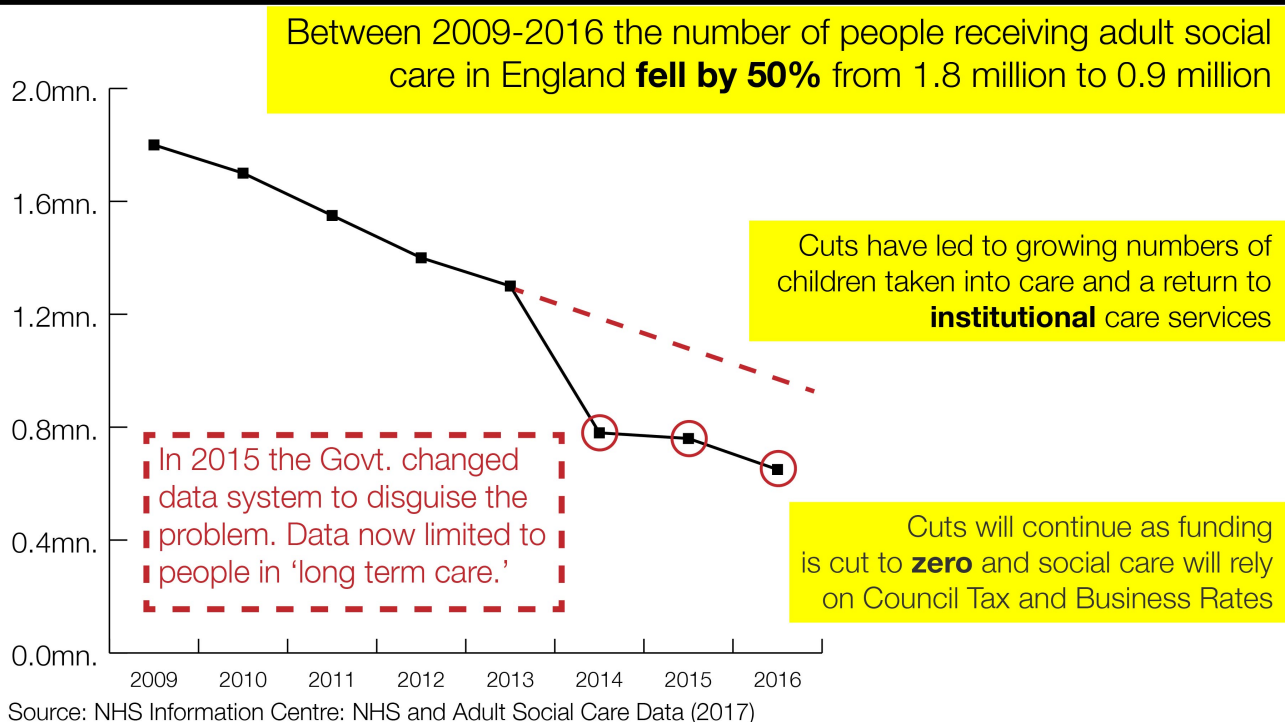
Summary

1. Social care is in a deep crisis created by severe cuts enforced on local government by central government and the failure of the system to defend itself from these attacks.

2. Integrated care is now proposed as a solution to the social care crisis, but not only is it not the answer, but it will harm, both social care and the NHS itself.

3. Social care is a distinct public good state and it needs to be organised in ways that recognise its strengths and its role as an agent of citizenship for all.

4. The problems facing social care today are the result of decades of poor policy-making and the refusal to put social care on a level footing with the NHS and other services.

5. The resources necessary to transform social care into a universal public service are modest and can easily be achieved with the necessary political will.

6. Universal social care should be implemented alongside a range of other reforms, including the reintegration of social care for children and adults.

7. Creating the case for a decent social care system also demands the creation of a wider alliance for change and systems that can protect the system in the future.

8. Better coordination of health and social care services will only occur if the NHS itself begins to work more effectively with citizens, families and communities.

1. Defenceless social care savaged by austerity

Social care is a public policy disaster: growing numbers of children are going into care, families have been brought to the point of crisis, people are living without adequate care and support, excluded from a meaningful community life in community people. People are now dying, before their time, in our homes, on our streets, in our hospitals or in care homes. Social care has always been an under-valued and under-funded element of the welfare state; but since 2010 it has faced a severe and unprecedented by a Government that is either heartless, clueless or both.

In 2010 the Coalition Government began to reduce funding to local government by about 10% each year. Its aim is to completely eliminate central government support for local government. Cuts to social care were inevitable. Social care is the main responsibility of

Cuts to social care are far WORSE than is presented

Between 2009-2016 the number of people receiving adult social care in England **fell by 50%** from 1.8 million to 0.9 million

Cuts have led to growing numbers of children taken into care and a return to **institutional** care services

In 2015 the Govt. changed data system to disguise the problem. Data now limited to people in 'long term care.'

Cuts will continue as funding is cut to **zero** and social care will rely on Council Tax and Business Rates

Source: NHS Information Centre: NHS and Adult Social Care Data (2017)

✻ Reforming social care - integrated care is not the answer

local government, accounting for about 60% of local government spending in 2010, and this percentage continues to increase as local government vainly endeavours to protect social care from the worst impact of central government cuts.

Essential systems of support have been stretched beyond breaking point. Social care has seen: severe cuts in service, escalating eligibility thresholds, and extreme means-testing. As the cuts bite deeper local services have responded with institutionalised and undignified services - in direct breach of human rights and our international obligations.

The Government's immoral austerity programme has redistributed resources away from social care, away from disabled people and away from other disadvantage groups. This

has led to a 50% cut to the number of people receiving Adult Social Care, and similar cuts in children's services. The United Nations, in a series of reports, has severely criticised the UK Government for targeting its cuts to services and benefits on the most disadvantaged. Social care has been just one area under attack; although a strong case can be made that the cuts to social care have been deeper than in the case of any other statutory service.

This policy is wrong and unjustified, but to date, the government has rejected the reports from the United Nations and rejected the claims made by social care experts, campaigners, charities and disability groups. Partially this reflect a new post-truth era where governments feel increasingly at liberty to reject ethical standards or the demands of evidence or logic. But the 'success' of these attacks reflects the fact today's extreme policy builds on at least two decades of under-investment and privatisation in social care. Many of the organisations that the public might expect to stand up to these cuts (e.g. large charities like Age UK, Mencap or Mind) have become so reliant on central government funding and patronage that they have lost the ability to stand up to government. At the same time most of the services in this sector are privatised and lack effective trade union representation. The defence system for social care is in tatters and the ability of any in social care to hold the government to account appears to be minimal.

2. The dangerous dream of integrated care

It is perhaps natural, given the financial pressure faced by local government, that some now seek to protect social care under the sheltering wings of the NHS. Some may even truly believe that health and social care integration is a sensible model for the organisation of the NHS and Adult Social Care. However, I know nobody, no disabled people, no families and no social care leaders who believe that integration will solve the real problems faced in social care. Instead those I talk to fear that integrated care will be a distraction or even worse.

The idea that any kind of merger between social care and the NHS will improve matters faces several serious objections. In fact integrated care is unlikely even to improve the integration of frontline services. As we will see, if we really wanted to improve the coordination of health and social care services, then we should approach the relationship between health and social care from a very different direction altogether.

The most important and obvious problem with integrated care is that about a third of social care - social care for children - is already been 'integrated' into something other that the NHS - **the education system**. Like all such structural policies, the integration of children's social care and education has achieved little, but did at the time consume a vast amount of time and money. The appalling outcomes for children who go into care and the inadequate support for families with children with disabilities has not been remotely improved by any of these structural changes.

If there is any case for integrated care it is for the **reintegration** of social care for children with social care for adults. There is no reason to integrate care with education when you are under 18 and then integrate it with with health care when you are an adult. The real impact of these policies has simply been to divide and weaken the social work professional and the wider social care community, leaving it confused and leaderless, unable to advocate for its real needs or defend itself from attack.

But in the current policy drive to integrated care no one seems to remember that children need social care. Today's integrated care policy seems driven by a mixture of panic and a

strange kind of amnesia. Social care is being confused with Adult Social Care, and Adult Social Care is being confused with 'care for older people who could be at home instead of in hospital.' That is, it is assumed that social care primarily exists to increase the speed of people in and out of expensive acute hospital beds. In fact for some policy-makers, social care seems merely to be code for cheap care.

Of course there is an important relationship between Adult Social Care and the NHS. This is why the Department of Health, once it had woken up to the reality of the cuts facing Adult Social Care, created the *Better Care Fund* in order to fund integrated care. However this policy is just trickery and there is no evidence it has led to significant innovations or improvements in practice. Primarily it is a stunt to enable central government to dip into the NHS in order to cross-subsidise the savage funding cuts to local government:

Robbing Peter then
Giving him the comfort of
Robbing Paul as well

If we stand back from these short-term policies we will remember that there is nothing new about this talk of integrated care. Policy-makers have been proposing integration for decades; yet no effective system has been created, and a great deal of energy has been wasted. In England the integration of health and social care has been a policy objective since 1962 - and the idea of integration has been extolled by every government and minister since - to no good end. For instance, the community care reforms of the 1990s were supposedly intended to introduce a new era of health and social care integration - they didn't.

Integrated care has been in place in Northern Ireland for decades; yet the people of Northern Ireland still face care taxes, inadequate support and institutionalised care. Organisational integration does not actually integrate distinct services, nor solve the actual problems faced in social care. Similarly the recent initiatives to integrate services in Scotland has drawn energy away from the kinds of real reform required in social care. My colleagues in Scotland lament the waste of energy and the dominance of the NHS agenda; they do not celebrate any systemic transformation or useful policy developments. Wales may be an exception, but if so it reflects the fact that local government in Wales is much stronger than in England and that the pain of cuts has been spread more equally between the NHS and social care.

The fact that no successful integration policy has been achieved should tells us something important - but we just don't appear to be listening.

Not only is there no evidence to support a policy of health and social care integration, it is often no more than a vague rhetorical trope. At best, it reflects a rather forlorn hope that social care - which has always been a weak element of the welfare state - will somehow be protected or strengthened by its integration into a more powerful and successful NHS. At worst, it reflects the desire of a more powerful and centralised NHS to suck up the limited resources of local government, away from citizens and local communities, towards priorities set by its centralised bureaucratic administration.

In particular, at this time, we need to be particularly careful not to allow the idea of integrated care to provide cover to the latest threat to the principles of the NHS. The current NHS leadership are currently dismantling the phoney internal market and are proposing to replace it with: *Accountable Care Organisations*, *Integrated Care Systems*, *Sustainability or Transformation Partnerships* et al. This array of jargon is a smokescreen. What is really going on within the NHS is the creation of a new kind of NHS organisation -

divorced from direct democratic control - one that can be sold-off or managed by Whitehall using funding mechanisms that will shift policy decisions into the hands of anonymous bureaucracies. These kinds of organisations are known, in the USA, as *Managed Care Organisations* and they have the become dominant model within the dysfunctional US health system. They are particularly attractive to right-wing politicians, because they reduce political accountability for rationing and move important public decisions into the hands of private businesses.

In the context of the UK the threat created by these *Integrated Care Services* is double. By integrating Adult Social Care into their control these agencies will become more attractive to US health insurance companies that run *Managed Care Organisations*. Furthermore, because Adult Social Care is severely means-tested, these new *Integrated Care Services* will be forced to institutionalise means-testing and co-payments within the NHS itself. This will create the perfect environment for ending free healthcare, piece by piece. Anyone committed to the principles of the NHS should resist integrated care - at least until Adult Social Care has been made a universal service, free at the point of use.

3. The essential nature of social care

Of course the plausibility of integration starts with a truth: for many older people the journey from primary care, to secondary care and then onto social care (and the multiple entwined journeys henceforth) is a basic reality which dominates a large part of the work of the NHS. It is certainly in the interest of the whole community to create systems which improve responsiveness, rationalise leadership and improve the coordination of care.

Social care is NOT just a cheap way to reduce 'bed blocking'

Social care exists to help all of us lead a life of citizenship

children · disabled children · older people · people with learning disabilities · asylum seekers · families · people with chronic illness · disabled adults · people in crisis · people with mental illness

Reforming social care - integrated care is not the answer

However, once you take your eyes away from the case of older people (where frailty and illness can quickly lead to the kind of impairments that then require assistance and care) then the case for integration starts to look much weaker.

People with disabilities, including people with learning difficulties, mental health problems and chronic illnesses, use social care to help them live free and independent lives. Rightly, they do not see their support needs as being anything to do with healthcare. In fact many people have worked hard to reduce the power of healthcare professionals in their lives. Everyone needs good healthcare, when they need it, but none of us want to live lives that are defined on a daily basis by healthcare professionals.

Another important element of social care is to support families who are struggling with poverty, or where families have fragmented, or where someone is becoming abusive and dangerous. Social workers work to keep people (adults and children) safe and ideally to support families to avoid such damaging and dangerous behaviour. In extreme cases - and sadly at an increasing rate, as austerity damages the social fabric - social workers are forced to remove vulnerable children and adults to find new places where they can be safe. This work is not an attenuated form of health care; moreover, the persistent lesson of history and empirical research is that formal and professionalised 'care' environments tend to be less safe than loving family homes or welcoming and inclusive communities. If the healthcare systems are put in charge of family and community life there is a severe risk that their responses will reflect their own services and systems - rather than building on the gifts and capacities of local people and communities.

The need for care is not just a function of illness or physical impairment. People need extra care and assistance because of their mental illness, their immigration status, the state of their housing, poverty, communication difficulties, social problems, relationships or many other circumstances that can create the risk of harm, loss of status or inadequate personal development. It is not at all clear that the NHS or its systems are well attuned to providing the right kind of support in these areas. Historically the NHS has tended to redistribute resources away from community resources and towards professional and institutional solutions, whose advocates within the medical system tend to be much more powerful than social or community workers.

It is certainly true that today the NHS is paying increasing attention (particularly as austerity has bitten deeper into the fabric of the welfare state) to:

• Social prescribing, i.e the value of community life in reducing the risk of harm

• Social determinants of ill health, i.e. the negative impacts of poverty and justice

• Community anchoring, i.e. the need to act as a source of support to local communities

These are good initiatives which suggest the NHS is beginning to understand the value of wider factors in creating demand for health care services. However it makes no sense to see the NHS as the final prop for the welfare state, upon which everything else must lean. Poverty can only be reduced by just economic redistribution of taxes through the benefit system and flatter salary systems. Local communities must be able to use their local democratic structures, not just rely on handouts from the NHS. Just because the NHS is a good system for organising health care services does not mean it's a good structure for organising the whole of society.

Healthcare might be said to have three parts:

1. **Pastoral** - A good doctor, nurse or psychiatrist can offer a relationship which enables them to provide support, guidance and a listening ear at a time of crisis. Often this also provides the basis of better health care, because there is true understanding of the person's needs and the person is supported to move forward in ways that make more sense to them. Of course, this also describes good social work. This kind of healthcare flourishes where the scale of things is made more human. Increased professional complexity and centralisation inevitably weaken interpersonal relationships.

2. **Technological** - Much of health care, especially secondary care, is about the delivery of drugs, the application of therapies or the use of surgery to solve identifiable problems in the body. In some respects we may be willing to accept a degree of industrialisation in these kinds of healthcare, because of the benefits of specialisation, automation and economies of scale. However, even here there are real dangers in weakening the link between communities and services. The UK has a large population and it does not need services to be centralised via London. Cities like Sheffield or towns like Barnsley are quite large enough to justify sophisticated and local services; there is no need to shift power away to obscure regional bodies.

3. **Supportive** - There is also the kind of caring which becomes essential as people experience illness and as they return to help or even when they prepare to die. This nursing function can be protective, therapeutic or enabling, but in the context of the NHS, it is usually considered to be part of the temporary process by which one moves back from illness to health.

This model of health care is coherent, but it is quite distinct from social care. Although there is much more to healthcare than its technological component the technological side of health care often dominates the system. The high costs and specialist knowledge

Reform of social care requires a commitment to human rights
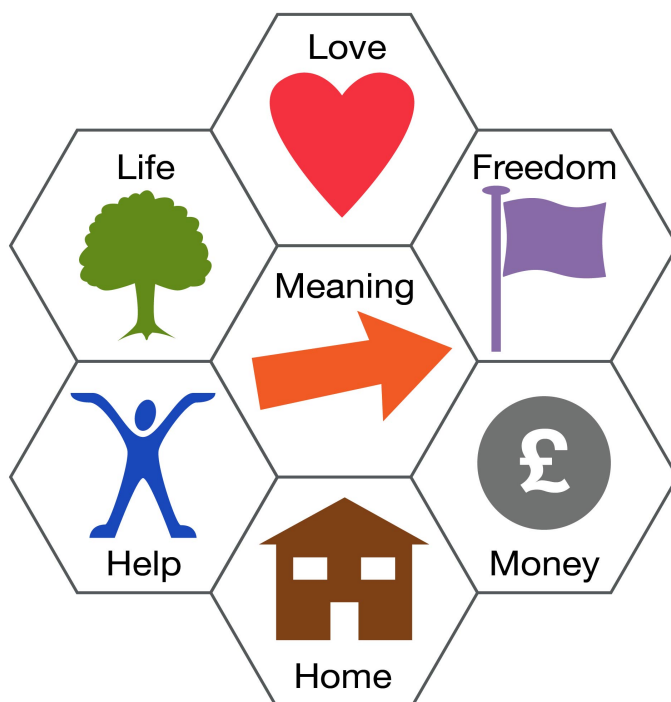
Assistance and other support needs to be **individualised** and directed by the person or a suitable alternative.

Social work and systems of community support need to be rooted in **neighbourhoods**.

Social care must be **universal** with no means-testing and fully funded by national taxation under local control.

Reforming social care - integrated care is not the answer

associated with the technological dimension of healthcare often distorts the pastoral and supportive aspects of healthcare into gatekeeping functions - guiding people into and out of hospital, surgery or therapy. It is important that the NHS combats the gravitational tendency built into its own systems. However, adding social care into the NHS will much more likely distort and damage social care than it will rebalance or humanise health care.

For the fundamental logical of social care is very different to health care. Social care is fundamentally about supporting human development and full citizenship. Its purpose is to help people overcome obstacles that they experience on the way to citizenship and - at its best - it operates at four levels:

1. **Personal** - People are helped to identify what is not working for them, how to overcome the problems they face and - where appropriate - offered support to help them achieve their goals. Helping people and families access peer support should be an essential role of a good social care system.

2. **Family** - Families are helped to work together to solve their problems and to ensure that everyone's well being is advanced. Help is offered to think things through and help the family practical problems that are holding them back.

3. **Community** - Social workers or community development workers have a critical role in working with local neighbourhoods to make them more welcoming places and to reduce the risk of crisis by linking people together and encouraging inclusion.

4. **Political and system** - Social care provides a way of understanding how the impact of government, public services and systems of entitlement are functioning to support or undermine citizenship and community development. Social care operates at the interface of these different services and should stand alongside those most at risk of marginalisation or institutionalisation.

Fundamentally this means that social care is not some cheap version of health care - it is not just low-cost nursing - which can simply be organised in the same way as the NHS. Social care is a **different kind of public good**. Just as we distinguish housing, education and income from health care - so should we distinguish social care from health care.

Social care has a distinct logic which is quite unlike health care:

• The purpose of health care is defined by the avoidance of death or by the reduction of illness symptoms. The right treatment is defined by an expert and - if you consent - delivery is managed by a professional (a surgeon or therapist) or by the patient taking engineered drugs (prescribed by a physician). Management of these processes involves the coordinated use of highly constrained professionalised resources and often best practice involves creating higher standards by repetition and standardisation. This means a large part (although not all) of health care is capable of being industrialised.

• The purpose of social care is to enable people to live an independent life of citizenship, with their own distinct and personal goals. Social care is not a treatment, instead it involves building on gifts and needs, and a mixture of practical assistance, access to community life and possibly additional resources. Management of social care should be creative and empowering, with decisions and partnerships primarily driven by the person themselves. Social care, at its best, is not standardised, not professional, but is entwined with the capacities of individuals, families and communities.

Integrating health care and social care is like integrating metal and wood. Not entirely impossible - but essentially artificial.

4. Real reform of social care

The failure to get to grips with social care has been one of the problems that has bedevilled the UK welfare state since its birth. This failure is not accidental: it reflects the dark history of prejudice and institutionalisation faced by disabled people, the UK's hyper-centralised (almost colonial) style of government and the era of total-marketisation in which we now live. It's not hard to be clear amidst so much darkness.

The social care system has not escaped by the demeaning assumptions of the Poor Law and the regimes of social control established in the nineteenth century.

This is not to be complacent. The current social care system does not work well and it is far worse than the current health care system. But the cure of integration could easily be worse than the disease of a poorly founded social care system. The weaknesses of social care will only be exacerbated by tacking it into the edge of the medically dominated health care system.

Crisis in social care is caused by long-term policy failures
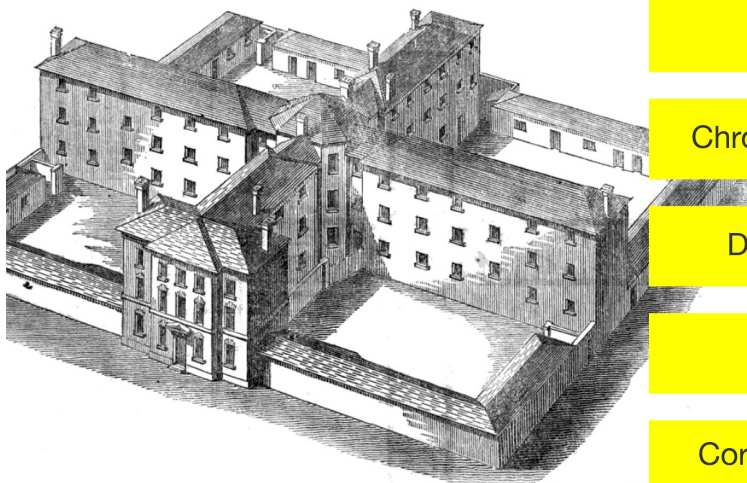
Vicious care taxes, i.e. 'charges'

Chronic underfunding and wrong tax base

Damaging division of adult and children

Fragmented professional structures

Corrosive tendering & procurement policy

Despite decades of worthy social policy, social care remains locked in a 'Poor Law' paradigm - treating impairment as a reason for exclusion and inadequate, mean-spirited care.

Inadequate system of rights and advocacy

No collective and organised social pressure

❋ Reforming social care - integrated care is not the answer

The fundamental problem of social care is that it is - for no good reason - highly means-tested and very poorly funded: free social care should be a basic human right and should be organised to make this right real.

Social care is certainly as fundamental as health care, and just because fewer people use it, there is no reason to downgrade it, means-test it or make it extremely difficult to obtain. The Socialist Health Association (SHA) should continue to support the principle that social care is a universal entitlement, funded from taxation and not subject to means-testing.

Moreover that social care is a human right does not mean it needs to be integrated within the NHS. Education is a basic human right - this does not mean we should integrate health and education.

It should also be noted that social care is highly gendered. This means:

• Women make up 80% of the professional workforce

• Women make up 58% of carers

• System injustices against women are reflected in salaries and status

Attention to these issues will only be addressed if social care become stronger in its own right, but is also true to itself, focuses on its own role and builds alliances from a position of strength.

5. We have the money, but not the will

There has always been enough money in the economy to properly fund social care, to remove means-testing and reduce all the dangerous eligibility thresholds. Social care is not, and has never been, expensive. At the end of the New Labour Government Adult Social Care cost about 2% GDP and now, after 8 years of Conservative control it costs about 1% of GDP. The figures for Children's services are similar. This is in public expenditure terms, peanuts. If we can halve the resources available to social care then we can certainly double or triple them.

What is lacking is not the money, but the political will.

Over the past few decades long and detailed reports have offered descriptions of complex ways to shift responsibility for the funding social care between central government, the NHS, local government and private citizens. Typically these reports merely try to frighten policy-makers into some modest increase in spending by presenting a negative picture of escalating demands and rising costs. But this strategy has never worked. Previous governments have always been able to ignore such expert advice. It has seemed that radical change was impossible.

But the current Conservative government has proven that radical change is quite possible; although it has created radical change in entirely the wrong direction. In 2010 its plans for public expenditure cuts targeted local government, whose primary responsibility is social care (for adults and children). The Conservative model for social care funding is that it should be funded from Council Tax and Business Rates. This makes no sense, it means that funding is inversely correlated with need, benefiting places like City of London and crucifying the poorest parts of the country. When it comes to social care the current government's policy seems to be:

To take more from those with the greatest their needs; to give more to those with the greatest means.

We can no longer assume that government will do what is right or reasonable. In the face of severe criticism from the United Nations the current Government has demonstrated that it is quite happy to see people go without having their needs met, even if this leads to indignity, early death or creates costs and further difficulties for other public services.

The recent announcement by the Conservative Government that it will further increase spending on the NHS was combined with no effort to fix the failed funding settlement for

social care, which continues to be inadequately propped up by the Better Care Fund. It would take only a fraction of the extra funding recently committed to the NHS to end the care tax built into the current social care system and to create a better universal system.

Funding for social care has almost always lagged far behind funding for healthcare, and this creates dramatic effects on our society and on our economy - in particular it reinforces severe gender inequalities. This is the current data for England:

- The NHS budget is about £125 billion

- There are 1.4 million NHS employees, most are women

- Adult Social Care is about £15 billion

- Adult Social Care employs about 1.6 million people, 80% are women

- The budget for Children's Services is about £8 billion

- About 6 million people are proving unpaid care, more than 60% are women

Not only does the NHS receive far more funding than social care, but also:

Social care is a distinct 'public good' not a part of anything else

| Healthcare | Adult Social Care | Children's Services | Education |
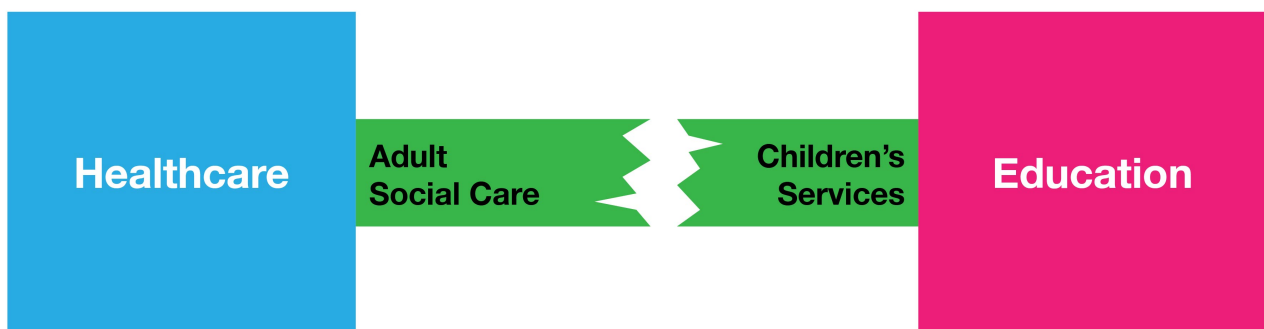
The empty dream of 'integration' has been around since 1962. Despite constant policy imperatives nothing meaningful has been acheived. Integration in Scotland and Northern Ireland has led to no significant improvements. Integration is a dangerous distraction.

The real challenge is to **integrate** children and adult services...

and increase **accountability** of public services to local people

✳ Reforming social care - integrated care is not the answer

1. In the NHS we spend £90,000 per employee; in Adult Social Care we spend just over £9,000 per employee. It seems we value NHS employees far more than social care employees.

2. We take women for granted in our workforce and in our community, women do most of the work of providing people with paid and unpaid assistance, yet often gain little or no reward.

3. It is Government that distributes resources for care, in its different forms, not just through differential funding public services, but also by setting salaries and benefit levels (like the Carer's Allowance).

It is not the market that shapes this unbalanced distribution of resources. It is government that determines some people will get more than others and it currently distributes the available resources in a way which demonstrates a deep disrespect for:

• Women and the work of women

• Disabled people and their needs

• Children and families in need

• Older people at the end of life

Social care is the help that a decent society offers to enable citizenship, strengthen family life and enrich our local communities. If we truly valued the lives of ordinary citizens then we would make the investment necessary to ensure everyone lived lives of dignity, that everyone was enabled to make their full contribution to society. our failure to do so is a sign, not of poverty, but of an impoverished understanding. We don't see our true potential, we don't understand the true meaning of life.

6. How to reform social care

Instead, if we really care about social care, we should start by clarifying the positive changes we want to achieve and start to work towards those ends: none of these will be achieved by integrated care. If we wanted to genuinely reform social care then there are some obvious improvements which could be made, including the following:

1. The moral rationing principles that underpin the NHS should be applied to social care: social care should be free, universal and funded from general taxation. The vicious means-testing, which is nothing more than a *Care Tax*, which bedevils Adult Social Care should be ended. Citizens should understand that their right to social care is **universal** and just as important an element of the welfare state as health, housing, education and income security.

2. Public services are part of the **commons** and they belong to the people: we need appropriate democratic decision-making systems to ensure the accountability of public officials to local people. Our sense of ownership of communities services needs to be made real by ensuring that support is embedded in the community itself. This will require appropriate modes of control at the level of the citizen, the neighbourhood and within local government.

3. We need to recognise that most care and support is provided by family and friends and that the purpose of social care is to enhance **citizenship** and to strengthen family and community life. Effective social work and other professional roles are best carried out in a spirit of partnership with people, enabling the innovation and community change necessary to build the kind of good society we seek. Rights to control, information, advocacy and peer support will be an essential element of good social care system.

4. Decision-making in all public services should follow the principle of **subsidiarity** - decisions should be made as locally as possible and power should only become more centralised when the nature of that decision really requires it. Much of social care, and important elements of health care (e.g. domiciliary, nursing, mental health care and palliative care) are best organised at an individual level. Other parts need to be organised at a neighbourhood level (e.g. local area coordination, social work or community development), at a local level (e.g. regulation) or at a national level (e.g. funding and constitutional protection).

5. The best structure to encourage greater effective cooperation at a local level is a much more local democratic framework for health, social care and other public services: **not** the merger of (adult) social care into a highly centralised NHS. There is no reason why we could not have a National Health Service or a *National Care Service* which is accountable locally to relevant local bodies. England is a hyper-centralised country - we need **greater democratic control** at every level.

6. Adequate funding for social care should be based on principles of social justice, funded from **general taxation** and distributed according to need. The current policy direction is insane - local government is being expected to fund social care from Council Tax and Business Rates - despite the fact that these are likely to be negatively correlated to need. In a country as economically divided as England it is an essential role of central government to divide available resources on the basis of need, not income.

7. Fundamental principles and structures for public services, and other parts of the commons, should be subject to constitutional constraints and protections, rather than being subject to superficial changes in political power. Public services should support the achievement of **human rights** (UDHR) and for social care these are the rights of the child (UNCRC) and the rights for disabled people (UNCRPD). Establishing and protecting critical social rights - like the right to independent living - should be critical to the reform of social care and this requires not just legal changes but the inclusion of disabled people and families within national policy-making and advocacy structures.

8. reintegrate

In summary, social care is a distinct public good. There are good reasons why people, in particular disabled people and others, have persistently argued for maintaining a strong distinction between social care and health care. We do need a much better social care system - but an organisational merger of social care and health care is both regressive and a distraction from the real challenges we face.

Most care is provided by families - five times more than is provided by the state. Are families simply to be integrated into the NHS? Of course not.


7. Building an alliance for change

The critical question then becomes how do you organise social care well?

Let us begin by asking whether there is really any logic to organising social care for children in a completely different way to social care for adults? Certainly legal authority shifts at 18, but in the case of social care, where protecting the autonomy of the person -

at any age - is a first principe, of good care, this is not a reason to treat children's social care and Adult Social Care as fundamentally different.

In fact, given that social care for children and adults is fundamentally linked to family and community life and that the split of social care causes serious disruption for younger disabled people as they enter on adult life, then the best organising principle is that social care should be treated as one public good where differences of age are not fundamental to how it is organised. That means our first priority should be to **re-integrate social care** with itself: the split between adult and children's social care should end.

If we then ask where decisions about social care should be made it is clear that this question cannot be answered once, because it depends on what type of decisions we are talking about. Reflecting on this question in practice suggests that there are at least 4 levels of decision-making for social care:
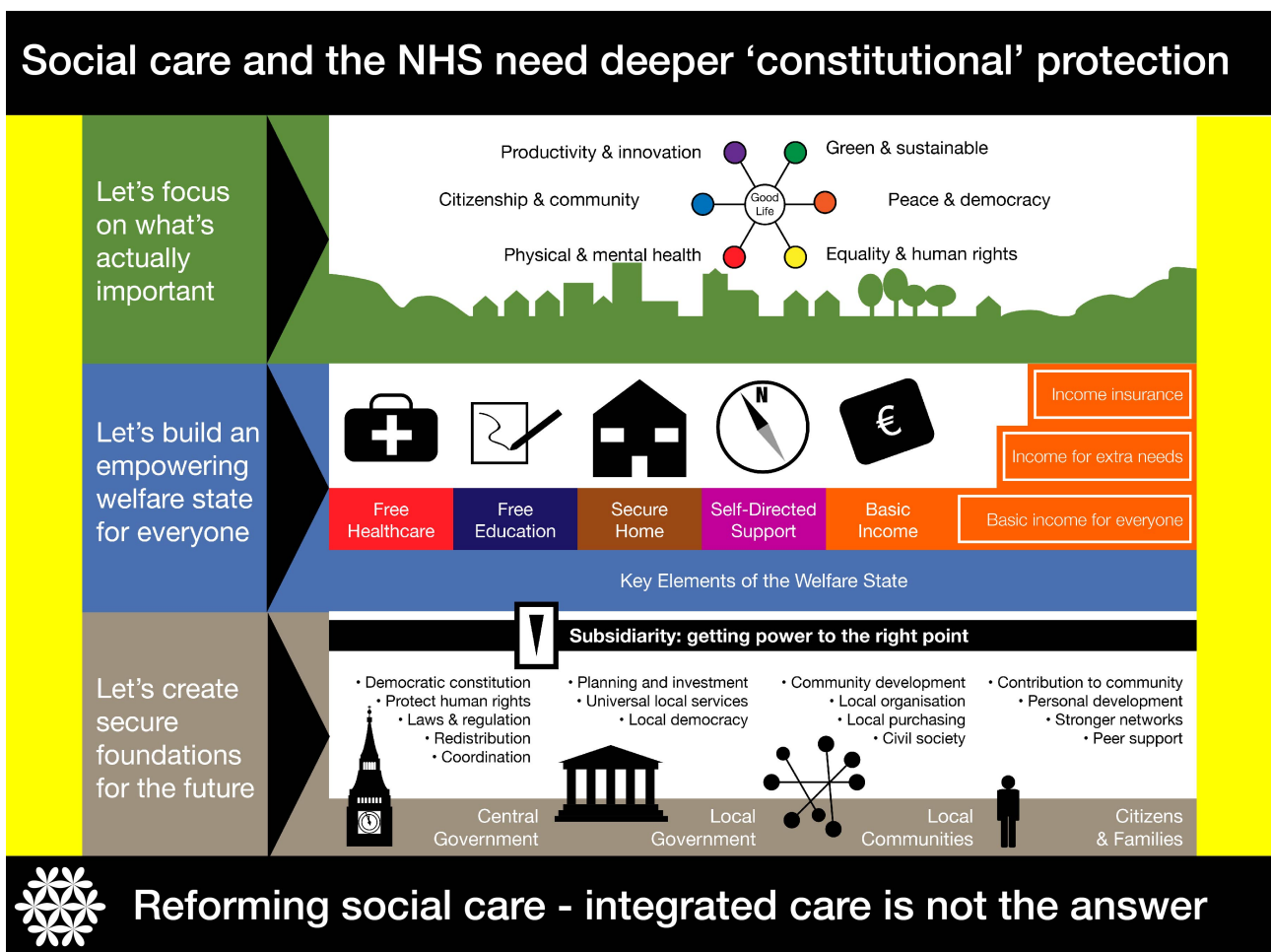
1. **Individual or family** - An effective system of social care will allow people and families to make many decisions about care and support themselves, although with access to good advice from peers and professionals. Systems of individualised funding, allowing for personal control and freedom may be important, alongside highly local supports which are closely connected to the community. Arguably some

forms of NHS funding do serve more individualised ends (e.g. mental health expenditure) and as such these could be transferred into the social care funding system.

2. **Neighbourhood or community** - An effective system of social will develop local community resources and habits which are generated, owned and controlled at a local level. Good social care will be reflected in inclusive and caring communities where problems are identified and solutions created by local people. Good community social work or local area coordination will work to strengthen local community strengths.

3. **Local system level** - Social care will need to be linked to decisions made by education, housing and health care systems - ideally at one coordinated level. There is no reasons for the NHS to be organised in conflict with local authorities - which are already large by international standards. Management coordination and mutual responsibility would rely on team work, standardised boundaries and shared democratic accountabilities.

4. **National level** - social care needs to be funded from national taxation, like health care, because there is no link between local resources and local need. Only a national system of funding can provide for a fair system.

Conclusion

The most effective integration will arise by abandoning the idea of organisational integration and instead ensuring that social care is well-founded and aligned with health and other public systems.

Social care reform will not happen without social pressure

Universal - no means-test

United - no division

Self-directed - no patronage

Positive - no pity

Funded - no misery & no crisis

Australian civil society - people, families and professionals combined to successfully campaign for a national, fully funded, non means-tested, self-directed, social care system for children and working age adults.

Reforming social care - integrated care is not the answer

Somethings - like the funding formula for social care - should certainly be centralised. But most things should be decentralised to the person, family or local neighbourhood. NHS leaders should seek, above all else, to end the ambiguity that is created by an NHS which is not accountable at the level of local government.

In fact the most important reforms in public services will not be created by organisational reform - which is often merely destructive folly. Instead we need stable structures and strong ethical principles - rooted in constitutional reform.

Reference

Axel Kaehne, (2018) "The tacit assumptions of care integration", Journal of Integrated Care, Vol. 26 Issue: 4, pp.254-256, https://doi.org/10.1108/JICA-10-2018-057

Insa Koch The labour of care: why we need an alternative political economy of social care

Need to review of 'health care' model

Need to strengthen references to privatisation/tendering/personalisation

More breakdown re subsidiarity

Quality Checker

In essence, I'm suspicious that the whole 'Westminster Bubble' is fiscally obsessed to the exclusion of all other considerations. I see 'social services' as being about achieving a good society – not just serried ranks of affordable services and a structure for seemingly fair resource management. Hence I think that we need to be highlighting the range of challenges that need to be addressed in order the bring about that radical 'cultural' change.

Similarly, day to day experience tells me that the delivery of our espoused goals will demand the reinvention of truly professional leaders and practitioners – professionals who are clear about the purpose of social care and apply themselves to being enabling and resourceful forces for good, primarily accountable to those they serve and their peers. The consequence of decades of centralised control and systematization is a dearth of such talent. So I would insist that a competent local social care system requires true professionals – of the collegiate variety.

I'm especially grateful for the bullet point at the top of page 6 in which you encapsulate the purpose of social care. (I'll no doubt quote it often!)

With the purpose clear, the next task is to define the non-negotiable, underpinning principles/conditions. For me, these will include:

·   Universal – nationally funded

·   Cradle to grave – lifelong journey

- ·   Person, Family and Community centred

- ·   Set in a vision of a sustainable, caring and interdependent society (and a governmental culture focused upon securing and sustaining this)

- ·   Local – neighbourhood focus

- ·   Supplementary and complementary – enriching the core/relational system rather than attenuating or replacing it

- ·   Facilitating, enabling, coordinating, supplementing…

- ·   Delivered by largely self-managing, skilled and resourceful collegiate professionals (who are the core resource, not intermediaries)

- ·   Who are actively engaged in and accountable to a local participative democracy – including devolved participative budgeting

- ·   Resistant to institutional options

- ·   Questioning of Standardisation and Economies of Scale

- ·   Attentive to the cancerous consequences of generalised and unbridled consumerism

If we can agree our purposes and principles it is much easier to think about designing a social care framework that is fit for purpose.

I think it is dangerous to accord any credit to the NHS for taking, of late, some peripheral interest in communities, 'social determinants', and the core economy. The criteria underpinning such initiatives (I'm engaged in a quite a few) are never social and invariably evaluated in terms of their immediate impact on health budgets. Most initiatives are short term and rarely renewed or incorporated into mainstream provision. They are formulated in order to co-opt citizens to deliver institutional goals and invariably resistant to design proposals based upon what matters to target participants. NHS Commissioners tend to get sniffy and progress quickly to 'Trump–like' when this is pointed out.

Even if you do not accept the seriousness of these threats then history shows us that integration is, at the very least, an energy trap. Time and money are wasted on organisational change while all the real policy challenges facing social care are avoided. Given all of these dangers, it is sad to find that some in the Labour Party, one of the few beacons of hope in these difficult time, have been persuaded that integrating Adult Social Care into the NHS might be some kind of solution to our problems. It simply isn't.

For decades we have followed the temptation to avoid hard decisions; instead we have latched onto the empty dream of integrated care. The paradox is that, if we actually began to solves some of the real problems in social care then we would discover new opportunities for meaningful and positive integration will open up for us. For various services can be integrated, both at the level of the person and at the level of the neighbourhood. However these models of real world integration are completely opposed to the current models of integration being deployed by policy-makers and to work effectively they require positive reform of social care.

Meaningful integration at the right level often requires purposeful and careful separation at other levels.

Barnsley

LAC

Regulation

Social Work