

Policy Note

**Coronavirus Crisis: Underfunding, Restructuring,
Privatisation and Fragmentation at the Heart of the
Crisis in Holyrood and Westminster**

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Coronavirus Crisis: Underfunding, Restructuring, Privatisation and Fragmentation at the Heart of the Crisis in Holyrood and Westminster

Allyson Pollock and Louisa Harding-Edgar say there is also an opportunity to end the neo-liberalism that got us to this point

There is no doubt that the Westminster government's delay in implementing public health measures to prevent COVID-19 has cost thousands of lives and enormous hardship for the many millions of people plunged into unemployment and debt. For nearly two months following the first two confirmed case of coronavirus in Britain on 30 January, the Westminster government allowed the virus to let rip throughout our communities with inadequate effort to control or contain it. This was despite the early warnings - via the World Health Organisation - from China in January this year and when our newspapers and televisions were covering stories of hospitals in Wuhan being erected in nine days.

Perhaps, the most surprising aspect of the British COVID crisis is that the Scottish Government has allowed its strategy and the operations to be directed by Westminster, which has taken a London-centric approach to the epidemic and with respect to the lock down. And yet the COVID pandemic is not just one big homogenous epidemic. It is made up of hundreds, if not thousands, of outbreaks, each at a different stage, on-going throughout the country. Whereas England had its first confirmed cases on 30 January and first death reported in early March, Scotland did not have its first confirmed cases until the 1st March, a traveller returning to Tayside from Northern Italy, and its first death until 17 March. Some parts of Scotland and, indeed England (like Rutland, Hartlepool and Blackpool and Isle of Wight) had no reported cases until late March or early April. So the question is: why did the Scottish Government not demand UK action to seal borders and stop travel, and why did the Scottish Government not build up capacity for contact tracing, take steps to protect those most at risk, and protect some areas so that life could continue, or at the very least that children could continue with their education in unaffected areas?

Greater Glasgow is not the Borders, Lothian is not the Western Isles or Orkney, no more than Ayrshire and Arran are the Highlands or Shetland. As we write this each of these areas and their health boards have their own multiple outbreaks, some smaller and some larger than others, and at different stages, and this means local information is vital as is local tracking and monitoring of the disease. To give Scotland its due, it was quick off the mark in making COVID-19 a notifiable disease and did so some two weeks before England did on 5 March. So at least the surveillance systems were working.

But why did Scotland, where cases were far less numerous than in England, agree to the COBRA decision on 12 March to abandon contact tracing? At that point, there were few confirmed cases in Scotland though reporting of cases does not appear to have begun until 17 March. Our public health colleagues tell us that Public Health England rapidly found it had no capacity to undertake contact tracing: it had fewer than 300 staff to do contact tracing operating out of just 9 regional hubs - there are 343 local authorities.

Structural changes to public health – loss of local capacity and fragmentation

The lack of capacity is down to budget cuts and structural changes that removed and fragmented local public services for communicable disease control in England. Lansley's *Health and Social Care Act 2012 in England* carved out public health functions from local health bodies and then further

fragmented them, splitting them between local authorities and Public Health England (PHE) – an agency of the Department of Health and Social Care.

PHE now controls the decimated workforce for communicable disease control including the 300 or so field epidemiologists who, instead of being largely based in local authorities, have been centralised in regional hubs, thereby, reducing their numbers and their effectiveness on the ground. Meanwhile, although there are over 5,000 environmental officers in local authorities, some of whom had indicated that they were ready to go and start contact tracing if called upon, no one made contact with them. However, when COBRA made the fatal decision to stop contact tracing it had only contacted 3,500 people in Britain of which just 3% were cases and had been told to self-isolate.¹

The extent to which Scotland, having also centralised its functions under Health Protection Scotland (HPS) had also reduced its capacity for local monitoring of communicable disease control and contact tracing, as well as testing and laboratory facilities, are important questions to be asked. We still don't have the figures of the number of contacts that were traced in Scotland and had actually been told to self-isolate. But they were unlikely to be more than a handful as of March 12. Nor do we have data on the staffing and numbers of field epidemiologists. The Scottish Government is yet to respond to letters sent in March about the cessation of contact tracing and the parliamentary questions posed.²

And so, for 12 days after stopping contact tracing on the 12 March until 23 March the virus was left to tear through our communities. Not only that, but the governments north and south of the border had not put in place travel restrictions and quarantine at the ports of entry for people coming from abroad - it appears Scotland had no powers. But lessons from communicable diseases and previous epidemics have shown that it is vitally important to monitor the ports of entry – harbours and airports. Scotland did not.

Contact tracing and travel restrictions not implemented

The governments had both advance warning of the epidemic and advance sight of the measures that China, Singapore, Hong Kong, and Taiwan had put in place. By 24 February, the World Health Organisation (WHO) had published a most compelling and informative WHO China mission report – but as the WHO assistant director general, Bruce Aylward, commented: 'Much of the global community is not yet ready, in mindset and materially, to implement the measures that have been employed to contain COVID-19 in China'. He went on to say: 'These are the only measures that are currently proven to interrupt or minimize transmission chains in humans. Fundamental to these measures is extremely proactive surveillance to immediately detect cases, very rapid diagnosis and immediate case isolation, rigorous tracking and quarantine of close contacts, and an exceptionally high degree of population understanding and acceptance of these measures'.³

In Wuhan, the national lockdown and travel restrictions were accompanied by local intelligence gathering and local, on-the-ground contact tracing and medical observation. Even without mass testing capacity (it appears there may only have been only 10,000 RT-pcr tests conducted in that time in Wuhan with a population of 11million) the Chinese controlled the infection, combining contact tracing with house-to-house symptom checking and quarantining and isolation, travel restrictions, and lock down. All these measures were necessary and had been ramped up. If anything, testing was of far less importance though, of course, a very useful support.

When the epidemic was spreading too fast in some areas in Britain for contact tracing capacity then the next step should have been to keep disease out of areas which had no cases and to stop all mass gatherings. The Scottish Government could have imposed a cordon sanitaire combined with social

distancing around those parts of the country that had no cases, including the Western Isles and Orkney and parts of the Highlands.

It is incomprehensible that Scotland did not argue for introducing travel restrictions internationally and nationally. One of us travelled through the airports of London and Edinburgh when the epidemic was kicking off in Italy in early March without being stopped or advised to go into quarantine, while watching with concern as flights flew in from Venice, Milan, Rome, and Bergamo. As the epidemic was raging in Italy, the government allowed the transmission of the virus across the border as plane loads of infected skiers from Austria and tourists and visitors from Italy made their way back to Britain. Indeed, Britain has still not stopped international travel (see table below) - planes are still flying in and out without the passengers being stopped and checked and warned to quarantine for 14 days. As of 15 April, plane loads of Romanians are being flown in to fruit pick, despite the millions unemployed and in furlough and despite Brexit. And yet at the same time people are being fined for making unnecessary journeys in their local areas.

Instead of designing an employment plan and an industrial strategy to enable people to have decent terms and conditions of employment and make the work attractive, the government has prioritised the interests of the food industry, which is dominated by just five multinationals. Is Scotland doing the same? Are workers coming from outside the UK also being admitted without our knowledge?

As for mass gatherings, Nicola Sturgeon did impose a ban on gatherings over 500 on 12 March but that was not enough to prevent super-spreaders and it was too little too late. Meanwhile England allowed huge spectacles and public events like the Cheltenham Gold Cup.

We failed to shield the vulnerable because social care services are fragmented, privatised and underfunded

And now the news is grim. Around 80% of the deaths are in those aged 75 years⁴ and over with the majority of deaths occurring in those aged over 80 years⁵. In the week ending 19 April, 46% of all COVID deaths in Scotland were in nursing homes⁶ where elderly people are incarcerated increasingly in solitary confinement and dying without their relatives. And yet, this is the very group government measures were supposed to shield. Somehow PPE, staffing, and nursing home guidance got lost in the equation.

There are 1.5 million care workers in Britain, of which some 148,000 people work in adult social care in Scotland – 6% of the Scottish total workforce and comparable to the numbers in our Scottish National Health Service⁷. In social care the private sector is the biggest employer, employing 59,400 people. Staff shortages in social care are a huge problem, particularly for the private sector. As of December 2018 in Scotland, well before the COVID epidemic, 9% of local authority care homes and 52% of private care homes had nursing vacancies⁸. At the beginning of April, care homes in Scotland reported absence levels of 30% of their current staff⁹.

In the UK, a quarter of care home staff are on zero hours contracts¹⁰. No sick pay means people must attend work even when sick, and carers move from home to home, often as agency workers, to fill staffing gaps.

Although the Scottish Government recently increased pay to at least £9.30/hour, this is still only equivalent to the real living wage¹¹. Care workers were going into work ill because they cannot afford to be off work on statutory sick pay¹² and now the Scottish Government is having to provide funding to third sector and independent providers specifically to ensure staff receive sick pay if they are off work ill or because they are self-isolating¹³.

And to add to this shameful situation in which hospital patients recovering from COVID-19 are being moved into nursing homes, relatives are being bombarded with DNR (Do Not Resuscitate) forms, doctors no longer need to see the body when signing the death certificate and many patients are dying in nursing homes having seen no medical practitioner in their last days.

It took until 15th April for the Scottish Government to announce that all symptomatic care home staff and residents would be tested, and longer to actually roll out a testing system for this group.

This disaster has hit a system that was already under impossible strain due to years of underfunding, Scottish Government funding to councils since 2013/14 has fallen in real terms and is forecast to fall further. This is despite an estimated increase of 18-29% in need for health and social care services in Scotland by 2030¹⁴. Audit Scotland has raised concerns about the financial sustainability of the Integrated Joint Boards (IJBs), which are responsible for planning local health and social care services in Scotland. In their 2018/19 plans there was a budget gap of £208 million. The majority of IJBs struggle to break even, with some requiring additional funding¹⁵.

For profit care homes and poor quality care

The majority of care homes in Scotland are private for profit (58.6%), with voluntary or not-for-profit providers accounting for 27.1% of the sector and local authority or Health Board provision for 14.3%¹⁶. In Scotland there are 32,691 residents in care homes for older people and 26,053 of these are in private care homes. 67,985 people received home care during January to March 2018.

The number of local authority and NHS care homes for adults in Scotland decreased by 31% between 2007 and 2017, while a 21% decrease was seen in the private sector in this time. This is despite the number of residents in private care homes increasing by 6%¹⁷.

Four Seasons is a large multinational with 15 care homes in Scotland and yet the Financial Times has reported that 'tracing the finances at Four Seasons is all but impossible; the company's sprawling structure consists of 200 companies arranged in 12 layers in at least five jurisdictions, including several offshore territories' and that £71 per bed goes towards debt repayment. Despite this, its highest paid director received £1.58 million in 2016. Four Seasons health care went into administration in April 2019¹⁸.

Data from the US has shown that those nursing homes with the highest profit margins are of the poorest quality¹⁹. This effect is seen in the UK too: 84% of care homes run by local authorities were rated good or outstanding, compared with just 77% of for profit homes, according to Lang Buisson in August 2019.

This is truly an appalling situation. On top of this has been the lack of PPE for social care workers and health care workers and residents and relatives. It raises questions about the Scottish Government procurement policy for supplies and logistics of delivery and its contracting of PPE. Above all, it raises questions about its preparedness. In summer 2015, the Scottish Government conducted an exercise called 'Silver Swan' to gauge the level of preparedness for a national flu pandemic. Its report, however, is not publicly available so we do not know what all the recommendations were.

Collateral damage from COVID

At the same time, the collateral damage from the lockdown is being felt. There are rising numbers of excess deaths from non-corona causes as people die at home instead of calling an ambulance and all routine and elective care is cancelled. Community services have been cancelled so there is no hands on chiropody, physiotherapy, mental health services, and occupational and speech therapy. These are vital services for older people and telephone calls are a poor substitute. Older people, once

again, are the users of these services currently being denied to them. Meanwhile, in many hospitals, wards are half empty and some staff under-occupied waiting for the tsunami. Bed occupancy has fallen and need is rising.

The Way Forward

With the lockdown possibly continuing until at least the beginning of June, the Scottish Government needs to develop its own local action plans around easing restrictions locally. First, it needs to put public health and communicable disease control experts in the driving seat of the Scottish Government COVID -19 advisory group.

Second, we need to have the humility to learn from our colleagues in China, Singapore, South Korea, and Taiwan. It is astonishing to hear people say 'Oh, the British people won't tolerate authoritarianism - what works there won't work here'. But look at how our country has been transformed and how we have complied. Indeed, the draconian COVID legislation caused the former judge, Jonathon Sumption, to say the way the police enforced regulations was like a police state.

And this brings us to human rights. Scotland was working to put human rights at the heart of its policies and in advancing the cause of social, economic, and cultural rights. COVID has not only set this work back, it has set back human rights. Children are being denied their human right to an education. Meanwhile, the Disability Law Service condemned the COVID legislation as regressive and punitive for older people and people with disabilities, reducing care to essential services necessary to comply with basic human rights²⁰. This legislation is resulting in untold damage for mental health and physical wellbeing, for older people and those with learning disabilities.²¹

Third, as well as tracking the epidemic nationally, we need to go local and understand the epidemic in each local area. The Welsh first Minister Mark Drakeford in his press conference on Monday 21st April, outlined that local public health surveillance measures would be needed to control the "inevitable" spread of the virus within communities once lockdown restrictions are eventually lifted. He went on to confirm that council public health teams, along with other environmental health colleagues, would be mobilised to spot, trace and isolate new cases of the virus and ... it is also likely that many more people will need to be recruited to help with the work "on the ground".

We need to use local public health teams to work with local authorities on local COVID surveillance to see where cases are and where they are continuing to spread. It is vital to stop transmission, and that means identifying the reservoirs of infection by tracking every case and quarantining contacts. We need to rebuild capacity using local volunteers, health workers, the army, teachers, students etc for tracking and tracing in each local authority and health board, and environmental health officers and public health and communicable disease consultants should be driving it in each local health board and local authority. GP practices must also be involved and given data on cases and contacts in their practices. Local laboratory facilities for testing must be restored and not outsourced.²²

All this requires data, which has to be meticulously collected and reported in real time at local level and include details on cases and contacts by ward, ethnicity, occupation, gender and age and hospitalisation. The Westminster government's own recent scientific evidence clearly demonstrates through mathematical modelling that effective contact tracing and case finding is likely to remain a highly effective approach after lockdown and that a local approach is vital and will enable restrictions to be lifted following local risk assessment.

Fourth, we need to put in place a radical plan for the NHS and social care. In effect, the capacity of the NHS and its staff is what dictated our response to the epidemic. Around the 23 March, the modellers confronted the government with the terrifying spectre of hundreds of thousands of

people dying in hospitals that were overwhelmed and could not cope, and of refrigerator trucks piled up in hospital car parks to take away the bodies of the dead who had not received the care they needed.

The Chancellor's budget announcement on 11 March that the NHS would receive £6bn over the course of five years suggested it would wipe out trust deficits but this did not go far enough. Both Westminster and the Scottish Governments should be reopening the PFI contracts²³ and renegotiating the interest rates, just as large stores have been renegotiating their rental charges down with the property owners. Interest rates are at their lowest ever (0.11%) and yet PFI debt interest payments vary from 5% to 16%.²⁴ This together with the analysis Scottish Futures Trust has been meticulously analysed has been exposed by Jim and Margaret Cuthbert in a number of important papers²⁵. The Scottish Government should now be bringing forward a radical plan to re-integrate health and social care and to renationalise nursing home services in order to rebuild capacity. Much of the problem in social care is due to the involvement of private equity investors which have resulted in quality falling with low staffing levels and poor pay and conditions. Britain has privatised more of its nursing homes than the US - 86% are private for profit. The solution is not to throw more money at them.

Much is made of the 'Dunkirk spirit' and the war time effort – but buildings have not been bombed. Neither have airports or factories, or homes. We still have the chance to take the road not yet travelled. A progressive government would see COVID-19 as an opportunity for the rebuilding of our economy and industry and ensuring the renationalisation of our essential services like water, electricity and gas, telecoms and transport and our ports - this epidemic has shown how vital access to and local control over public services is. Services that have been part privatised should be renationalised (social care, some public laboratories and testing and data facilities). Intellectual property and patent laws need to be urgently changed in favour of the public with the government issuing compulsory licenses to stop the exploitation of patents for medicines, vaccines, medical tests, and tests and reagents. And, in return for bailing out companies and businesses, the government should ensure it has a stake in them so that when the good times return the public sector sees those returns and not the shareholders which have done so well in recent years. To take the road not taken since the 2008 financial crisis is essential if we are to address and remedy the poverty, inequality, and injustices brought about by the austerity of the last ten years

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Countries implementing travel restrictions

		Countries implementing measures																					
		UK	Australia	Canada	New Zealand	USA	Austria	Belgium	Denmark	Finland	France	Germany	Greece	Ireland	Italy	Netherlands	Norway	Poland	Portugal	Spain	Sweden	Switzerland	
Travel restriction	All		●	●	●	●		●	●	●		●		●		●	●	●	●				
	Italy		●	●	●	●		●	●		●	●		●			●	●	●				●
	UK			●	●	●	●		●	●	●	●	●		●			●		●			
	Europe			●	●	●	●		●	●		●		●			●	●	●		●		●
	China		●	●	●	●	●		●	●		●		●			●		●	●	●		●
	Iran		●	●	●	●	●		●	●		●		●			●		●	●			
	Republic of Korea		●	●	●	●	●		●	●		●		●			●		●	●			
	Cruise ships		●	●	●							●			●			●		●			
	International flights suspended		●	●		●	●										●	●	●		●		●
	Quarantine/self-isolation on arrival		●	●	●	●	●		●	●	●	●	●			●	●	●	●	●		●	●
Country lockdown							●	●	●	●				●		●		●	●				
Regional lockdown					●	●			●	●													

As of 17/03/20, the Foreign & Commonwealth Office (FCO) now advises British people against all non-essential travel worldwide. This advice takes effect immediately and applies initially for a period of 30 days.

Key
● Measure implemented
● Measure partly implemented

Data sources: Official government websites and EWRS

Data as of 10:30 28/03/2020

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