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**The United Nations Association**

**Bexhill & Hastings Branch**

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**UN Culture of Peace**



**With the Release of a Discussion Paper**

***Entitled***

**Celebrates the 75th Annuiversary**

**of the United Nations**

**on UN Day the**

**24th October**

**2020**

***Global Capitalism versus***

***Human Health & Welfare***

**In a Post-Covid 19 Crisis World**

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**24th October, 2020**

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**FOREWORD**

I begin by making one thing clear. I have the approval from the UNA-Bexhill & Hastings Branch to launch this Discussion Paper as part of our celebration of the UN’s 75th Anniversary on UN Day, 24th October, 2020. I do not yet have the Branch’s approval for its content. The thesis statement, the background information and the points of discussion, are all entirely my own. However, they are not the outcome of my imagination or opinion. I have used my professional qualifications & experience and research in health & social care and economic & social development. Also, during my 25 years as a member of the UNA, I studied how civil society might interact with the UN System to solve global problems concerned with health and human security. This has led to my organising (either as lead or associate) numerous public events.

**WHY WE CELEBRATE UN DAY, 24th OCTOBER**

The Charter of the United Nations was signed by 51 nations**[[1]](#footnote-1)** on 26th June, 1945 at the UN Conference in San Francisco, USA. After a majority had ratified the Charter, the UN came into force on 24th October, 1945. In 1947, the UN General Assembly declared the 24th October as ‘United Nations Day’……

“…..*that* *shall be devoted to making known to the peoples of the world the aims and achievements of the United Nations and to gaining their support for the work of the United Nations; invites Member Governments to cooperate with the United Nations in securing observance of this anniversary*.”**[[2]](#endnote-1)**

The United Nations Association (UNA) aims to enable people to critically support the Government to responsibly execute Britain’s role as one of 5 permanent members of the UN Security Council. This obliges the United Kingdom to address global problems according to the terms of the UN Charter and to ensure that all sequential decisions and actions do not contravene the purposes & principles of the United Nations.

**HOW THE UNA-BEXHILL & HASTINGS BRANCH (UNA-B&H) CELEBRATES UN DAY**

The Branch’s annual programme covers the Environment, Climate & Oceans, Health & Human Development and Peace & Human Security. On UN Day, we focus on the UN System itself and on its weakest point, which is the UN Security Council’s (UNSC) failure to maintain peace & security. Two years ago, in collaboration with the Bexhill Quakers, we began a series of annual UN Day Peace Events.

At the first one, *UN Peacekeeping Revisited* on 17th November, 2018, we mainly concluded that the deterrence theory applies only to the right of self-defence under Article 51 in the UN Charter. Aggressive defence systems (especially those with nuclear weapons) are not a deterrent because they are more likely to provoke the wars they claim to be preventing. Therefore, fully resourced UN peacekeeping/building missions deployed by the UNSC is the most effective way to maintain peace & security.

At the second one, *Think Global, Act Local for Peace, but what Peace?* On 26th October, 2019, our main conclusion was that as most wars were illegal, ineffective and inhumane, the term ‘security’ should be replaced with ‘Human Security’. This means protecting people from all threats such as crime, drugs, poor health & malnutrition, poverty, intolerance & social exclusion, as well as from terrorism & warfare. But most nations (especially the rich ones) concentrate on building threatening military strategies whilst pursuing economic growth at all costs. In taking precedence over human health & welfare, this course of action violates Human Security and causes extreme environmental degradation.

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Our third UN peace event, entitled, *Legality and the Ethics of War,* was to be held on 24th October 2020. But in the face of the Coronavirus (COVID-19) Pandemic, we decided to replace our usual reality event with a virtual launch of this Discussion Paper. It now has the more topical title of *Global Capitalism versus Human Health & Welfare* and will serve as UNA-B&H celebration of the UN’s 75th Anniversary.

We invite our UNA colleagues and groups, government and non-government organisations, and the public to take part in the discussion as set out in this Paper. (If you need it, there is more supporting information in the appendices.) I would welcome, by 30th April 2021, critical constructive comments, ideas and suggestions to be sent to me via any of my contact details given below. We will present the outcome of this discussion at our next UN Day Event provisionally planned for 23rd October 2021 in Bexhill.

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24th October, 2020

**GLOBALISED CAPITALISM versus HUMAN HEALTH & WELFARE**

**CELEBRATING THE 75th ANNIVERSARY OF THE UNITED NATIONS**

Many would use the occasion of its 75th Anniversary to call for the reform of the United Nations to enable it to better deal with the problems of today’s world such as the Coronavirus (COVID-19) Pandemic. Let me explain why such thinking is neither just nor accurate. The UN has four key constituents, which are …

* The 193 Member States
* The Secretariat (headed by the Secretary-General)
* The collective administrative units of its 5 main organs (e.g General Assembly, the Security Council) and those of its 43 agencies (e.g WHO, UNESCO, UN Refugee Agency)
* Civil Society.

All four of these constituents rarely work together. More often, the Secretariat and the administrative units work with various non-government organisations (NGOs) and civil society organisations, to investigate and keep track of global problems as they emerged from the new world order in the wake of the Second World War. From the 1950s, they gave fair warning with strategies for solving the problems to the Member States as per UN protocol. In such cases as environmental or healthcare issues, the Member States responded by attending international conferences and signing & ratifying the outcome treaties & conventions designed to resolve the issues. But this is undermined by the Member States (especially the 5 permanent members of the Security Council**[[3]](#footnote-2)**) failing to act in a similar way to resolve war & peace issues. The UN was further stymied by post-war economic policies that are driven by the pursuit of economic growth at any cost. Such policies have culminated in globalised capitalism where money and profit take precedence over the environment, health & social care and peace.

Post-war policies have not created a world as envisaged in the Charter of the United Nations. Instead, they re-created a world in which all kinds of problems, including pandemics, can take root and flourish. It is almost as if the UN does not exist. The UN has been side-lined, misunderstood, misused and maligned. It is not, however, the UN that needs to be reformed, it is the Member States. Specifically, they need to reform their foreign policies and diplomatic departments to enable them to operate in international affairs according the UN Charter that they all signed – as an international treaty – when they joined the UN.

As the prime civil society organisation founded to support the UN in its entirety, the UNA’s role and responsibility is to inform, enlighten and reassure people about the true nature of the UN**[[4]](#footnote-3)**. Such knowledge and understanding would then empower them to support and use the UN System to devise and campaign for sustainable solutions that do not simply lead to the next global problem.

So let us, on the occasion of its 75th Anniversary, turn back to the United Nations, revisit its neglected treaties, conventions & policies find integrated sustainable solutions to today’s global problems. And let us begin with the most topical global problem today - the Coronavirus (COVID-19) Pandemic.

**THESIS STATEMENT**

The Coronavirus (COVID-19) Pandemic has exposed and highlighted the tragic humanitarian and environmental costs of 74 years of ever intensifying Globalised Capitalism. The Pandemic is an effect rather than a cause of global problems. Democratic and autocratic governments, in their single-minded pursuit of Globalised Capitalism, have dis-invested and neglected their national public health/epidemiology and personal health & social care services. Therefore, this, and other existing or future pandemics, can only be permanently dealt with by re-investing in and re-developing those services according to the international ‘Health for All through Primary Health Care’ policies as established, developed and regularly renewed by the World Health Organisation in accordance with its 1948 Constitution.

**SUMMARY BACKGROUND INFORMATION OF THE THESIS[[5]](#footnote-4)**

While the British Government and the English were pre-occupied with Brexit, Britain and the World were facing a range of catastrophic and interconnected global problems from environmental degradation and climate change to warfare, terrorism and the resurgence of nuclear weapons, from ever increasing wealth in the hands of the few and ever-increasing poverty in the lives of the many, from the rise of populism to the decline of democracy, from increasing poor health and malnutrition to the decline of national public/epidemiology health systems, national health & social services and the neglect of human and animal welfare. This conglomerate of global problems arise from the same underlying complex causality of which, the Coronavirus (COVID-19) Pandemic is an effect. While the discrete anti-infectious disease measures may solve the Covid-19 problem, the way would still be left wide open for the next pandemic. Therefore, we should also be addressing the underlying complex causality of the conglomerate of global problems.

**Globalised Capitalism ‘Sets the Scene’ for the Coronavirus (COVID-19) Pandemic**

I find it noteworthy that according the Worldometers**[[6]](#footnote-5)** the richest countries and the emerging economies have suffered the highest numbers of Covid-19 cases and deaths rates**[[7]](#endnote-2)**. Perhaps, in addition to having better record systems, this is because they are the biggest drivers and users of Globalised Capitalism, which they have engineered to prosper at the expense of human health & welfare. Globalisation has had a two-fold impact on the Pandemic. First it has facilitated the production and spread of the Coronavirus. And second, it has contributed to lowering people’s resistance to the disease by increasing poverty and by polluting the environment. Both impacts nurtures ill-health and mal-nutrition, including obesity and type-2 diabetes. This actually makes Covid-19 both a cause and an effect of the global economic, environmental and healthcare problems.

**Globalised Capitalism**

During the 17th Century, capitalism began to emerge as an economic system based on the private ownership of the means of production in order to operate them for the maximization of private profit. As it developed and matured, the capitalist economy was organised, regulated and protected within its home nation. It is difficult to pin down the date when capitalism began to globalise, but for the purposes of my thesis, the most likely time was during the second half of 1945. At that time, there was a sharp stimulus to not only rebuild war-torn Europe but also, to rush through the development of poor countries beginning with their de-colonisation under the terms of the then newly formed United Nations.

In the early post-war years, development was governed by the ‘trickle-down’ theory that promoted economic change at the ‘top of a nation’ in the belief that it would trickle down to reach and benefit the rest of the country. Social development was expected to follow in the wake of economic development. Healthcare in particular was perceived to be an optional add-on extra that a nation could choose to adopt after it had industrialised and its continuous economic growth was assured**[[8]](#endnote-3)**.

Despite early signs and warnings against it, the ‘trickle-down’ theory both dominated and distorted post-war development. The accumulating wealth was not converted into welfare that in this context, is more than the provision of benefits and free public services. Welfare also means the provision of opportunities for people to own at least some of the means of production so as to enable them to fulfil their own basic needs. One of the most important needs is nutrition that requires control over localised food supplies. But as this brand of post-war development globalised it distorted local economic transactions. The demands of capitalism – for labour and for consumers – caused populations, especially in developing countries, not only to rapidly increase, but also to become more dependent on national and international support systems to fulfil their basic needs. This created the alarming new problem of ‘how to feed the world’.

***The Global Food System***

The model of Globalisation has been applied to the problem of how to feed an ever growing number of people. In February, 2020, ‘Yale Global Online’ reported that the world population now stands at 7.8 billion people, which indicates a slightly faster growth than the projections of a few years ago**[[9]](#endnote-4)**.Through the global supply chains, endless numbers of lorries and fleets of ships connect tens of millions of farms to hundreds of millions of shops and kitchens. Given their nature, farms are local, but their means of production – seeds, fertilisers, herbicides & pesticides, (all mostly patented) and machinery & fuel – have to be purchased from the giant international companies such as Bunge & Cargill and Louis Dreyfus that also supply equally giant food processing companies such as Kraft or Unilever. In fact, over the course of the last twenty years, ownership of the agro-industry has become concentrated in a few firms that operate on a global scale. Food has now become like cars meaning that while it is ‘assembled’ close to consumer markets, its various parts or ingredients are sourced in several different countries around the world. The production of food therefore has been globalised along with most other industries. The world’s huge agro-industry feeds four fifths of world’s population**[[10]](#endnote-5)**, which means the majority of people have lost localised food security.

Alarm bells about the downside of the post-war economic development were sounded before the ‘take-off’ of globalised capitalism in what is now called the ‘age of disillusionment’.

**The Age of Disillusionment**

Towards the end of the 1960s, the UN agencies, various NGOs and civil society organisations warned that the ‘trickle-down’ theory would not work in practice. The wealth accumulated by economic development was not re-distributed either between nations or within nations. The result was gross inequality and social exclusion. At the same time, the emphasis on economic growth had caused severe environmental degradation, and a marked and unsustainable increase in population in the developing countries. People everywhere, but especially the poor, had lost the means and opportunities to look after themselves, their families and their local communities. Such a state of helplessness left them under-nourished and under-educated in eco-damaged communities, lacking in public services that left people as prey to acute & chronic ill-health and disease.

Therefore, while 1970 heralded a more sober decade than the ‘swinging sixties’, it also marked the beginning of a new conceptual thinking based on the idea of the ‘development of people’ rather than the development of the state and its economic and financial institutions.

**The Development of People**

In 1977, under the chairmanship of Willy Brandt**[[11]](#footnote-6)**, the Independent Commission on International Development was set up to recommend how global issues arising from economic and social inequalities might be resolved. When it reported in 1980**[[12]](#endnote-6)**, the Commission recommended a new international order based on the ‘Development of People’. By this, it meant improving the health, nutrition and education of people so as to abolish poverty and change the economic system to enable developing countries to help themselves to achieve sustainable development. The Commission advised that the UN be strengthened so as to allow it to lead in putting this new world order in place.

**The WORLD HEALTH ORGANISATION (WHO) and the ‘HEALTH FOR ALL’ POLICIES[[13]](#footnote-7)**

Also, in 1977, the 30th World Health Assembly decided that the main social goal of WHO and governments should be the attainment by all people in the World by the year 2000 of a level of health that would permit them to lead a socially and economically productive life**[[14]](#endnote-7).** The ‘level of health’ that governments should aim for was consistent with the WHO definition of good health, which is:

***“Health is a state of complete physical, mental and social***

***Well-being and not merely the absence of disease or infirmity.”***

This gave birth to the global goal of **Health for All by the Year 2000**(HFA/2000). In the following year, WHO and UNICEF organised an international conference in Alma Ata, in the then Union of Soviet Socialist Republics (USSR) to discuss how the new global goal might be reached. The Conference was attended by 134 countries (including the UK) and concluded with the conviction that Primary Health Care (PHC) was the best way forward. The conference defined PHC as follows:

***The Definition of Primary Health Care*[[15]](#endnote-8)**

“*Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process*.” (Source: Ref. 8 page 3)

The final outcome of the Conference was the Alma Ata Declaration, which stated:

***“Health for All by the Year 2000 through Primary Health Care”* (HFA-PHC/2000)**

Primary Health Care means more than the first port of call when someone is sick. It is primary in the sense that health begins with our interaction with ourselves, with our families and neighbours, and with our local environment. PHC is the provision of the personal and environmental services essential to enable people to take an active and knowledgeable role in the promotion and control of their own health & wellbeing and that of their families and neighbourhoods. It includes services like safe & adequate food and water supplies, immunisation and health education, and facilitates access to general medical, nursing & therapy services provided in hospitals, health centres, dispensaries and in peoples own homes.

Sustainable development and social stability depend on having enough healthy people able to take up education and job opportunities arising from development. Therefore, as WHO and others have always said, healthcare, as a necessary *precondition*, should be placed at the heart of the development agenda.

Therefore, with the Alma-Ata Declaration in 1978, a new era in healthcare was born. At the time, it appeared the new era would grow and assume its place at the centre of social & economic development.

The Declaration was widely endorsed by governments and NGOs throughout the world. HFA-PHC/2000 became a topic of global debate. Numerous conferences, seminars and workshops were run by governments and NGOs at the international, regional and national levels to discuss how each country might re-interpret PHC to make it applicable to their own national healthcare system (NHcS). Many countries made plans to reorient their NHcS towards PHC in readiness to adopt and implement WHO’s ‘Health-for-All’ policies. Due to the wide range of types and stage of maturity among the world’s national healthcare systems, interpretation and progress of PHC varied greatly, especially between what was termed at the time as the countries of the ‘First’, ‘Second’ and ‘Third World’**[[16]](#footnote-8)**.

**THE RELATIONSHIP BETWEEN ECONOMIC GROWTH AND HUMAN HEALTH & WELFARE**

Britain and some other ‘First World’ countries in post-industrialised Europe, installed publically funded national health & welfare systems in the immediate post-war period. But despite the Alma Ata Declaration, such systems were not central to their post-war policies for developing the countries of the ‘Third World’ for which they were responsible**3**. Instead, rich countries tended to promote PHC as part of their foreign aid programme that was separate from that for economic development. As a result, PHC programmes were often introduced to run alongside of, but not integrated with, the existing healthcare system**3**. Some of the ‘Second World’ countries, such as China, managed to develop a public healthcare system albeit less sophisticated than those in the mature industrialised countries. But then, in the latter years of the 20th Century, the autocratic nations, again such as China, adopted capitalist ways in order to join the globalised road to wealth and power.

A road so dedicated to economic growth that it restricts funding to, or removes funding from, health and social welfare systems. It also inhibits the re-distribution of wealth according to need. In 2016**[[17]](#endnote-9)**, it was reportedthat about 734 million people were living in extreme poverty**[[18]](#footnote-9).** Although that equates to roughly 1 in 10 people, more than 85% of poor people are living in 20 of the world’s official list of 197 countries**[[19]](#footnote-10)**, and nearly half of them live in India and China**4**.

Despite this, and global economic recessions every 8 to 10 years**[[20]](#endnote-10)**, nations have, with the support of large sections of their populations, retained faith in Globalised Capitalism. The [International Monetary Fund](https://en.wikipedia.org/wiki/International_Monetary_Fund) (IMF) defines a global recession as a decline in annual per‑capita real world GDP that features a decline of at least one of the seven global macroeconomic indicators such as, industrial production, trade, capital flows, oil consumption, unemployment rate, per‑capita investment, and per‑capita consumption. According to this definition, there were four global recessions since the Second [World War -](https://en.wikipedia.org/wiki/World_War_II) in 1975, 1982, 1991 and 2009. Of these, the 2009, was by far the worst both in terms of the number of countries affected and the decline in real world GDP per capita.

In 2007,**[[21]](#endnote-11)** a depreciation in the subprime mortgage market**[[22]](#footnote-11)** in the United States triggered an international banking crisis. This escalated into a Financial Crisis following the collapse of the investment bank, Lehman Brothers, on 15th September, 2008. One month later, WHO revisited the Alma Ata Declaration.

**30th Anniversary of the 1978 Alma Ata Declaration**

On 14 October 2008, WHO returned to Alma Ata - now called Almaty in Kazakhstan – to launch its World Health Report in commemoration the 30th Anniversary of the 1978 Alma Ata Declaration. The Report, entitled ***Primary Health Care: Now more than Ever,*** set the case for revitalising the Primary Health Care approach as a means of strengthening healthcare systems to achieve **Health for All[[23]](#endnote-12)** as an on-going process in the 21st Century. In other words, they removed ‘by the year 2000’ bit. In order to meet the challenges of today’s world while staying true to its original values, WHO set out four main reforms to the PHC Concept as follows:

1. Universal Coverage to improve Health Equity
2. Service Delivery to make Health Systems People Centred
3. Public Policy to promote & protect the Health of Communities
4. Leadership to make Health Authorities more Reliable (Source Ref. 12, page xvi)

However, the event and the hope of re-invigorating the Alma Ata Declaration went by quite unnoticed by a world obsessed, at the time, with the Financial Crisis. The Great Recession that followed it in 2009 was destined to become the biggest since the Great Depression of the 1930s. Asian markets including China, Hong Kong, Japan, and India were the first to be destabilised. The collapse of Iceland's banking system came next. This triggered the [European Debt Crisis](https://en.wikipedia.org/wiki/European_debt_crisis) that spread to Portugal, Italy, Ireland, Greece and Spain causing an overall loss of confidence in all European businesses and economies.

The governments of most of these countries, including Britain’s, responded to 2009 as they had done in the previous economic recessions. They introduced austerity programmes to reduce spending on public services in order to shore up their financial system and economic institutions. This meant they cut jobs in public services at the same time they were cutting back on welfare benefits. Given its adverse effects, it is not clear why governments think austerity will restore their country to financial security.

During economic recessions the level of ill-health increases among the whole population, but especially among vulnerable people. This is because the austerity measures causes job loss and rising prices in essentials like food and rents. The resultant reduction in household income increases poverty, which then threatens people’s health status by forcing them to eat cheaper junk food and/or to turn to alcohol to relieve their despair, or to gambling in an attempt to ease a chronic debt situation**[[24]](#endnote-13)**. Given their immediate post-war investment in public services, it is a mystery as to why, since the 1970s, rich countries believe they are forced to choose between the health of their economies and the health of their people. Especially as the health of both is inter-dependent.

The Coronavirus (COVID-19) Pandemic has shown yet again, that most governments respond to such problems by applying what could be termed as the ‘Sacrifice Solution’.

**THE SACRIFICE SOLUTION**

When the 2008/09 Financial Crisis caused the Great Recession, most rich country governments dealt with this by adopting severe austerity policies. In other words, human health & welfare was sacrificed to save the economy. Ten years later, most of the same governments dealt with the Covid-19 crisis by imposing a social and economic lockdown. In other words, the economy was sacrificed to save human health & welfare. In the event, neither austerity nor lockdown have resolved their respective crisis.

The Sacrifice Solution is a panic response to an unexpected critical event. And as such, it can only serve the short term. In the medium to long term, it will lead to more problems that will be even more difficult to resolve. The whole World is now facing - even as the disease continues to run riot – the Covid-19 (Economic) Recession. According to the International Monetary Fund (IMF) this is likely to be the biggest since the Great Depression in the 1930s**[[25]](#endnote-14)**. Also, it could be bigger than that caused by the Financial Crisis 2007/8. Since the IMF predicted this in March 2020, many countries including Britain, are now facing the seemingly intractable problem of getting out of lockdown and while having to re-impose local lockdowns to deal with the second wave of Covid-19 disease. It appears that lockdown damages everything except the Coronavirus. Further, all countries will have to deal with the complexity of problems caused by Covid-19 and the lockdowns, from a position of national and international disadvantage.

On the national level, the heavy costs of Covid-19 and the lockdown have greatly reduced GDP whilst increasing the demand for welfare benefits and for non-Covid-19 health & social care. On the international level, because the member states (especially the UN Security Council) have so undermined and misused the UN in the past, they are now either unwilling or unable to take a multilateral cooperative approach to solving the global problems that Covid-19 has exposed. Solutions to global problems can only be found and sustained through the UN. It is not a question of re-inventing the UN. It is a question of re-inventing its member states so as to enable them to use the UN System as intended and clearly set out in its Charter – an international treaty – and in the resolutions, conventions and treaties that the UN has passed into international law since its foundation in 1945.

**THE ‘SACRIFICE SOLUTION’ IN BRITAIN**

The Government’s lockdown slogan: ***Stay Home, Save the NHS, Save Lives***, raised the question of,

“Why should we save the NHS when we thought it was there to save us?”

A pertinent question, when we remember we all pay throughout our adult lives for the NHS to do just that**[[26]](#footnote-12).**

Another pertinent question is not how best to manage the lockdown, but to ask why nations such as Britain, with long established public epidemiology and healthcare services, have had to resort to lockdown as seemingly the best and only way to deal with the Coronavirus (COVID-19) Pandemic?

Long before Covid-19, the media had repeatedly reported that the NHS itself, was at near crisis point. Years of dis-investment, cuts and fragmentation had rendered the NHS unable to cope with normal healthcare demand. For example, it was already a common experience for patients (after being on a waiting list) to have their elective surgery cancelled two or three times before NHS England announced – on the 17th March - the cancellation of all non-urgent operations, treatments and investigations. It was forced to do this in order to free up beds for the expected rush of patients with Covid-19 infections.

How did our NHS get into such a dismal state?**[[27]](#footnote-13)**

**THE DECADE OF HEALTHCARE DECLINE: 2010-2019[[28]](#footnote-14)**

In 2010, the newly elected Tory-led Coalition Government responded to the 2008/9 Great Recession with the severest Austerity Programme in Europe**[[29]](#footnote-15)**. The Programme had two main goals as follows:

1. The first was to eliminate the current budget deficit, which had skyrocketed from £19.13 billion in 2006 to £103 billion in 2010**[[30]](#endnote-15)**
2. The second was to secure a continuous fall in the [national debt](https://en.wikipedia.org/wiki/Government_debt), which is measured as a percentage of annual Gross Domestic Product ([GDP](https://en.wikipedia.org/wiki/Gross_domestic_product)). From 1986/87 to 2006/7, the average national debt was around 40% of GDP. It then rose to 56.8% of GDP in 2009**[[31]](#endnote-16)**.

Both these goals were to be achieved through sustained reductions in public spending and tax rises, thus reducing the Government’s role in the [Welfare State](https://en.wikipedia.org/wiki/Welfare_state_in_the_United_Kingdom) with one exception – the NHS.

In times of recessions, British governments, while cutting back on public service expenditure, set about ‘saving the NHS’ by re-organising it to increase its economic efficiency. The response to 2009 Recession was no exception. The Government’s claim to ‘ring-fence’ the NHS from spending cuts, turned out to using – or misusing – the ‘ring-fenced’ money to implement the Health and Social Care Act 2012**xiii** that launched yet another controversial and probably unnecessary, re-organisation of the NHS.

In practical terms, the Government did not except NHS from its Austerity Progamme, because its cuts in most of the other public services had an adverse effect the NHS. From 2010 to 2019, funding to local authorities (LAs) – that provide all public services with the exception of healthcare – was reduced by 49 per cent**[[32]](#endnote-17)**. As a result, the LAs were forced to cut social care, which forced people to inappropriately turn to the NHS thus increasing healthcare demand. As a result, ‘bed-blocking’ discharge failures, cancelled surgical procedures and increased waiting times have all made a ‘come-back’ from their heyday in the wake of the 1990 NHS and Community Care Act**xiii**. So in effect, the Government has not protected the NHS from the spending cuts as it promised to do.

**Antecedent to the Decade of Healthcare Decline: the NHS and Community Care Act 1990xiii**

The World Health Organisation has 195 member states and all these nations, regardless of wealth and power, are subject to WHO policies. Therefore, subsequent to the Alma Ata Declaration**[[33]](#footnote-16)**, the WHO European Region published guidance for how European countries should achieve Health-for-All (HFA) by reorienting their National Healthcare Systems towards PHC according to the Alma Ata definition. This should not be confused with primary care (PC) or general medical practice (GPs) in the United Kingdom.

Throughout the 1980s, the Thatcher Government reviewed the NHS and planned for extensive reform of the NHS and social services. The primary aim was to improve efficiency and efficacy, which would have been fine if this was to be done within the original tenets of the NHS and in-keeping of the WHO HFA/PHC guidelines. But the overall approach to the reforms were in total disregard of both. Efficiency and efficacy boiled down to cutting costs, while cost effectiveness was confused with the cheapest. Margaret Thatcher accepted and followed the advice of Milton Friedman (the American economist) and like-minded health economists in the UK, while largely rejecting advice from the British healthcare professions.

The result was the NHS and Community Care Act of 1990. This was remarkable for placing health and social care within the same Act and then for creating more divisions between the two than ever before. One of the most damaging was the legalised division between district nursing and social care. The actual division – now known simply as divided care – occurred with the introduction of ‘Care in the Community’ in 1993, which was the belated implementation of the Community Care side of the 1990 Act**xiii**.

**‘Care in the Community’ Today**

Today, ‘Care in the Community’ is big business and looking at the TV adverts for home care agencies such as Home Instead, Helping Hands and Care at Home, it all looks wonderful. A great advance since 1993. Older and vulnerable people can now have daily – or round the clock if necessary - support from personal carers who will do anything to enable them to live in their own home instead of having to sell it to pay to live in a care home. During the same time period, the NHS has replaced its convalescent homes with intermediate care designed to re-enable people to live at home again after a stay in hospital. The NHS still provides district nursing – albeit as a reduced service – and it has enhanced, in some areas, its community provision of occupational therapy, physio-therapy and psychotherapy & counselling.

The rosy picture ‘as seen on TV’ is only available to those who can afford it. Although cheaper than a care home, home care is still costly. For example, in one case, an agency home care package designed to meet the client’s full need cost £26,000 a year, which was the equivalent of the client’s full pension income**[[34]](#footnote-17)**. For those people who cannot pay, the picture is far from rosy. The Government’s financial cuts to the local authorities has forced them to severely reduce all local public services including adult social care. Community healthcare, including the vital intermediate care, is good where it exists, but it is not available everywhere in the capacity and flexibility required to fully meet demand. And so the unmet needs that ‘Care in the Community’ was supposed to have eliminated, is still there, which translates into a great deal of silent human suffering and a grave infringement of Human Security**[[35]](#footnote-18)**.

Britain is not alone here. The dedication to Globalised Capitalism has caused most rich and emerging economies to not only neglect investment in human health and welfare in their own countries, but also to omit such investment in their aid to poorer countries. However, WHO has retained an enduring faith and activity in its ‘Health-for-All through Primary Health Care’ Programme.

**40th Anniversary of the 1978 Alma Ata Declaration**

On 25–26 October 2018, WHO, UNICEF and the Ministry of Health of Kazakhstan jointly hosted the Global Conference on Primary Health Care. This was to mark the occasion of 40 years after the adoption of the historic Alma-Ata Declaration in 1978. Ministers, health workers, academics, partners and civil society came together to review and revive Primary Health Care as the cornerstone to the promotion of Universal Health Care (UHC) coverage.**[[36]](#footnote-19)** The Conference passed the bold new [Declaration of Astana](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf) that aims to encourage governments, non-governmental organisations, professional organisations, academia and global health and development organisations to renew their commitment to Primary Health Care**[[37]](#endnote-18)**.

The WHO brand of Primary Health Care is the most efficient & cost effective way to achieve around the world, human health and welfare systems based on a considerate, compassionate, cooperative and caring ethos that used to underpin the NHS and the Welfare State in the United Kingdom.

**UN Human Rights Commission (UNHRC) Report on the United Kingdom 2019[[38]](#endnote-19)**

The Special Rapporteur on extreme poverty and human rights visited the UK from 5th to 16th November 2018. The purpose of the visit was to report to the UNHRC on the extent to which the Government’s policies and programmes relating to extreme poverty are consistent with its human rights obligations. The following year on 23rd April, the Special Rapporteur reported on his visit to the UK to the UN General Assembly. In summary, he said that although the United Kingdom is the world’s fifth largest economy, one fifth of its population – that’s 14 million people - live in poverty. The cause was attributed to the fact that the policies of austerity introduced in 2010, had continued largely unabated, despite the tragic social consequences. Food banks have proliferated; homelessness and rough sleeping have increased greatly. In addition, the social safety net has been badly damaged by drastic cuts to local authorities’ budgets. The Special Rapporteur concluded that …

***“The bottom line is that much of the ‘glue’ that has held British society together since the Second World War has been deliberately removed and replaced with a harsh and uncaring ethos.”***

Britain has therefore, regressed from being, in the early post-war years, a world leader in establishing publically funded comprehensive national healthcare systems, to being a nation that has failed in providing adequate healthcare and social security for its population. And it has done this by an intentional shift away from the considerate, compassionate, caring and cooperative ethos that underpinned the NHS and the Welfare State at the time of its foundation in 1948.

**THE DISCUSSION: Globalised Capitalism vs. Human Health & Welfare**

In 1945, the newly elected a Labour Government initiated the post-war reconstruction of Britain to become a country based the tenets of the UN Concept of Human Security. This means protecting people from all kinds of threats such as crime, drugs, poor health & malnutrition, poverty, intolerance & social exclusion, as well as from terrorism & warfare. The new Government began with the NHS Act of 1946, which gave Britain the honour of establishing the first universal health care system anywhere in the world. In preparation of its implementation on 5th July 1948, the Government, in the preceding June, sent a leaflet to every household to explain what the NHS was all about, which is summarised in the quote below:

“It will provide you with all medical, dental and nursing care. Everyone — rich or poor, man, woman or child — can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a “charity”. You are all paying for it, mainly as tax payers, and it will relieve your money worries in time of illness.”

— Central Office of Information, for the Ministry of Health

Seventy one years later, in November 2019 (before Covid-19) the *Guardian* reported that the NHS was now in a “perpetual state of crisis” and so was heading for its worst winter on record. This was due to steady underfunding and dis-investment of the NHS since 2010 and increasing staff shortages since 2016.

Seventy two years later, the Government had to enforce a social and economic lockdown because the NHS lacked the capacity to deal with both the Coronavirus (COVID-19) Pandemic and with the provision of normal healthcare services.

As it happened, the ‘Sacrifice Solution’ not only failed to deal with the Covid-19 crisis, but also it created a whole lot more non-Covid illnesses and health problems. The NHS is now facing a higher demand than ever before as well as the second wave of the Covid-19 disease. The primary and community health & social services, and their supporting voluntary agencies, are all still under Covid-19 restrictions. Furthermore, on 12th August last, it was widely reported in the news media that Covid-19 has caused Britain’s GDP (gross domestic product) to fall by 20.4%. The country is now in the deepest recession since records began and it is the worst of any of the nations in Europe or North America**[[39]](#endnote-20)**.

**We are where we are now …..**

It would appear that Britain is now completely stuck in a deep, deep crisis. And regardless of what we might have done to avoid – or at least mitigate - such a crisis, we are where we are now and must all buckle down to get ourselves out of it. However, while we are doing that, some of us must look to the future and heed the lessons over and above pandemics, and learn how to resolve the global problems that the Coronavirus (COVID-19) Pandemic has painfully exposed and of which, the Pandemic is now an effect.

**…… But we must never be where we are now, ever again**

This Discussion Paper is not about getting out of the current situation it is about how not to ever get into this situation ever again.

**The Argument**

Therefore, the argument is not whether lockdown is a good way to deal with pandemics. Instead, the argument rests on the question of why nations with established public epidemiology and healthcare services, have had to enforce a near complete social & economic lockdown in order to deal with the Coronavirus (COVID-19) Pandemic? And the answer in short, is that no rich nation, especially supposed leaders in national healthcare systems like Britain, should have to resort to lockdown in order to deal with any pandemic.

**The Discussion Question**

I would like to put forward the idea that if the post-war considerate, compassionate, cooperative and caring ethos had endured, the NHS would have been developed throughout the subsequent 72 years to be in a perpetual state of fitness for the purpose. Further, such development would render its continuous compliance with 2004 Civil Contingencies Act**[[40]](#footnote-20)**, especially in regard to dealing with such a contingency as the Coronavirus (COVID-19) Pandemic.

The question to be discussed therefore, is how to remake the NHS to get it out of a perpetual state of crisis and into a state of being continuously able to fulfil its purpose, which is to provide universal, equitable, comprehensive, appropriate and timely healthcare according to need, free at the point of use.

**‘Setting the Scene’ for the Discussion**

We need a different kind of solution to crises that benefits everyone according to need and does not create more health problems than existed before the crisis in question. But we have to avoid, ‘hand-to-mouth’ decision making based on a cursory superficial view on what has gone wrong. For example, deciding that Britain should have locked down sooner would only be tinkering with the ‘Sacrifice Solution’. This type of ‘hand-to-mouth’ decision making simply results in building mistakes on mistakes.

***“To go back to put right what once went wrong”***

It is been said many times, that you cannot go back to the past because things are different in the present and problems have to be solved in the modern context. And anyway, if there were ever any ‘Golden Ages’ they are long gone now.

But I believe, with reference to the Thesis Statement (on page 3) the only way forward in this instance is to take a ‘quantum leap’ backwards to find – and then put right, what once went wrong.

I have borrowed this idea from [Donald P. Bellisario](https://en.wikipedia.org/wiki/Donald_P._Bellisario), the American who created the [science-fiction](https://en.wikipedia.org/wiki/Science-fiction) television series called *Quantum Leap*. The show was originally aired on [NBC](https://en.wikipedia.org/wiki/NBC) for five seasons, from 25th March 1989 to 5th May 1993. The actor [Scott Bakula](https://en.wikipedia.org/wiki/Scott_Bakula) played Dr. [Sam Beckett](https://en.wikipedia.org/wiki/Sam_Beckett), a physicist who leaps through [space & time](https://en.wikipedia.org/wiki/Spacetime) during an experiment in [time travel](https://en.wikipedia.org/wiki/Time_travel). After making a quantum leap back to the past, he temporarily takes the place of another person in order to correct historical mistakes. And thus, his mission, according to the show’s introductory slogan, is:

“To go back to put right what once went wrong”

**In Preparation for the Discussion: How to Right the Wrongs**

The calls for more funding for, and re-investment in, the NHS are on the right track, but it should not be done in the style of ‘just throwing money at it’. And nor should it be in the style of ‘bits & pieces’ or ‘quick-fix’ such as just building more hospitals with the same design faults and without comparable development of the primary and community services. This calls for a review of the NHS - within the context of the whole welfare state – to where and how it needed to be reformed ***before*** the Coronavirus (COVID-19) Pandemic.

The review, however, should not lead to yet another costly re-organisation of the NHS. Instead, the review could take the form of going back to previous re-organisations and putting right the parts of them that went wrong. This does not mean doing a ‘bits & pieces’ job or indulging in ‘quick fixes’. It means searching the recent past for ‘key faults’ that if corrected would lead to the correction of several other faults. In this respect, the two most important re-organisations are those set in motion by the NHS and Community Care Act 1990 and the Health and Social Care Act 2012**[[41]](#footnote-21)**. Both these Acts were based on the commercial & competitive ethos and driven by the principles of health economics. However, neither of these two Acts were so completely bad that they deserve to be repealed wholesale, but they do contain a number of ‘key faults’ that could be put right without total re-organisation or too much new legislation.

Under the heading of ‘Points for Discussion’ below, I have attempted to stimulate the discussion by listing the things I think have gone wrong with the NHS during the last 40 years. Also, I have identified what I think are the ‘key faults’ in the 1990 Act and the 2012 Act. The list is by no means an exhaustive one. It is simply meant to offer you a guide on how to handle the discussion question if you would like to use it.

**POINTS FOR DISCUSSION**

**Maintaining the integrity of the Human Health & Welfare Ethos of the original NHS Act 1946**

To re-iterate, the ‘glue’ that the UN Human Rights Commission (UNHRC) described as holding the British Society together since 1945 translates into a considerate, compassionate, caring and cooperative ethos that promoted and underpinned the foundation of the NHS and Welfare State in 1948

During the build up to, and the implementation of, the 1990 NHS and Community Care Act, the 1948 human health & welfare ethos lost out to the principles of health economics, which are efficiency, efficacy and cost-effectiveness. While it is understood that these principles are important managing the NHS, in the 1990 Act, they boiled down to cutting costs and confusing cost-effectiveness with the cheapest option.

The first thing to do therefore, in the remaking of our NHS is to restore its considerate, compassionate, caring and cooperative ethos to underpin not only the application of the principles of health economics, but also the correction of all the other faults and failures.

**Reconnecting with the World Health Organisation and Human Rights[[42]](#footnote-22)**

The WHO Constitution includes a declaration that health is a fundamental human right. Therefore, WHO and all its member states**[[43]](#footnote-23)** are committed to ensuring the highest attainable level of health for all, which is defined as:

*“Health is a state of complete physical, mental and social*

*well-being and not merely the absence of disease or infirmity.”*

The creation of a national healthcare system that is consistent with human rights, is dependent on the ‘Development of People’ as described in the 1980 Brandt Report above. This will do three things. First, it will produce a smaller but healthier population that is assured and maintained by locally available nutritious food so as to be able to take up the opportunities offered by health services, education and social security, to earn a living and take care of themselves. Second, healthier people will be better able to withstand epidemics & pandemics and deal with their social & economic impacts. Third, people will be enabled to come together as a stronger and better informed civil society to influence how their national governments deal with domestic problems and supports the UN to deal with global problems, including ‘war and peace’.

**‘Key Faults’ in the 1990 NHS and Community Care Act and the 2012Health and Social Care Act**

1. Bed Occupancy Rate and Speed of Patient Throughput

In an effort to cut the costs of acute hospital care (under the terms of the 1990 Act) the bed occupancy rate was increased from 85% to 95-100%. In addition, the length of patient stay was reduced, while the number of day cases increased, which greatly increased the speed of patient throughput from admission to discharge. These changes turned out to be a ‘key fault’ because they created more costly problems – both in terms of money and patient welfare – elsewhere in the system some of which are listed below.

* A bed occupancy rate of 95-100% leaves no spare capacity for dealing with emergencies and unforeseen events without cancelling elective treatments and increasing waiting times and lists.
* The new speed of patient throughput did not give enough time for nursing and social care staff to arrange an appropriate and sustainable discharge, especially for vulnerable patients with complex needs and/or who live alone. As a result, patients were either discharged too soon only to be re-admitted as an ‘emergency’ – the revolving door of re-admission – or they were kept in hospital and labelled as bed-blockers while they lost all their independent living skills.
* Part of the cost-cutting exercise (which predates both the 1990 Act and the 2012 Act) was to increase the number of beds be decreasing the space between them. This amounted to over-crowding and so increased the rate of hospital acquired infections and made infection control very much more difficult.

1. Promote ‘Care in the Community’ not as the Cheapest Option but as the most Cost-Effective

Theoretically, the ‘Care in the Community’ (introduced in 1993 under the terms of the 1990 Act) was designed to counter balance the reforms in NHS hospitals by arranging timely discharges or avoiding admissions by providing re-enabling and/or rehabilitation care programmes in people’s own homes, or in community settings such as cottage hospitals. But in practice the community health and social services have never received enough and sustained funding & investment to provide appropriate, adequate and universal ‘Care in the Community’ as envisaged in the 1990 Act.

And so, although good in some areas, overall ‘Care in the Community’ is another ‘key fault’ because the successive governments perceived it to be the cheapest option. It’s not. But it could be the most cost-effective is properly funded and resourced, especially the services provided or commission by the local authorities (LAs). But in reality, the LAs have always been subjected to more drastic cuts than the NHS.

Increased funding & resources are required for developing – equally around the country - NHS intermediate care. This will enable timely hospital discharge, ensure a patient’s recovery to their full potential, and prevent ‘revolving door’ admissions. Also, the community nursing and therapy services need re-investment and re-design to enable nurses and therapists to respond quickly to patients with holistic care programmes. District nurses should resume supervision & oversight of the social care services and undertake home visiting before a patient develops such things as pressure sores or becomes bed-ridden.

1. Preserve and Improve the Integrity of the Commissioner/Provider Split

The main reform of the NHS side of the 1990 Act was the division between the health commissioners (purchasers) and the providers. This created the intended internal market that introduced competition and commercialism into a hitherto cooperative and not-for-profit NHS. Both commissioners and providers could be organisations in or outside of the NHS, which opened up the field of public healthcare provision to the private sector.

In the beginning, the existing district health authorities became the commissioning authorities that purchased the healthcare, according to assessments of need, from the providers who were the hospital and community NHS trusts. But later developments by successive governments distorted the commissioner/provider split by allowing GPs to become the main commissioners while still remaining as essential providers as independent businesses outside of the NHS. This was cemented with the establishment of GP-led Clinical Commissioning Groups (CCGs) under the terms of the 2012 Act.

The distortion of the commissioner/provider split is a ‘key fault’ that could be righted by the following steps:

* Restoring the integrity of the split by allowing on NHS non-provider bodies to undertake the commissioning role, which means re-instating the district health authorities matching in size and area of jurisdiction, the local authorities at county level. This would also help to mend the division between health and social care created by the 1990 Act.
* Ensure that the commissioning authorities are NHS non-provider organisations that may commission services from inside and outside of the NHS, according to the rules embodied in the point below
* The commercial & competitive ethos of the1990 Act permitted for-profit organisations to bid for NHS contracts, which meant that public money could be used to pay dividends to shareholders. In order to restore the considerate, compassionate, cooperative and caring ethos to the NHS, its commissioning authorities must be so regulated as to be only able to contract with private sector providers that are not-for-profit, voluntary or charitable organisations. After all, the NHS has contracted with such charities as Hospice UK for years and GPs – a main provider - have never been part of the NHS.

1. Renewal of General Medical Practice (GPs)

It should be remembered that with some notable and worthy exceptions, GPs have for some years provided a limited and inadequate service while still being paid for every patient on their lists regardless whether they see them or not. And for the most part, GPs don’t see their patients. Anecdotal evidence indicates that it is very difficult to get a face to face appointment with a GP and most of them do not carry out home visits, not even for very sick patients and those who are discharged from hospital still very ill after major surgery or other treatments. And nor do GPs personally manage patients with a complexity of long-term conditions. This adds pressure to the A & E departments as these patients have nowhere else to go when they cannot see a GP. And this was the state of the GP service before the Covid-19 crisis.

They are sufficient grounds for a complete make-over of the GP service, but exactly how this should take shape is a matter for research and debate. Meanwhile, we might consider the following suggestions:

* Relieve GPs of all commissioning services and let them return to be pure providers
* Consider and consult if and how GPs should or could be brought into the NHS
* Enrich and improve the opportunities for GPs to practice more medicine over and above serving as the gateway to secondary care and community health services. There are plenty of pilots and established localised schemes in the recent past that could be adapted and adopted to become universal GP practice, as well as the greater medical role that GPs had before the NHS, especially in relation to community hospitals. In some places, this has survived the advent of the NHS.

1. Resolving the Problems with ‘Divided Care’

‘Divided Care’ means the marked divisions between NHS community health and social services and between personal and nursing care. The latter has had the effect of divided nursing practice from nursing care within the nursing service, which has reduced – if not abolished – the case management role of community nurses for acutely ill patients or those with a chronic long-term conditions. Research and anecdotal evidence demonstrates that Divided Care has caused a myriad of problems and resolving them is going to be a long and complicated job. Meanwhile, we might consider the following points:

* As with GPs, the role and opportunities for community nurses to care and practice should be enriched and extended, and also integrated more closely with the social home care services.
* Revisit the creation and establishment of health centres (as permissive under the terms of the NHS Act 1946), which are often attached to community hospitals and that house representatives from all the community health and social services including GPs, therapists, social workers and the voluntary sector. They are also closely attached to, NHS intermediate care for newly discharged hospital patients and to the various joint community health and social care teams. There are such well working health centres – or the equivalent – already in existence, but they are not universal and they need to be.

1. Strengthen National Public Health and Epidemiology Services

The current Government’s handling of the Covid-19 crisis through its hastily passed Coronavirus Act on the 23rd March 2020, is still under review. One of the many controversies concerns the use and involvement of Britain’s existing National Public Health and Epidemiology Services that until recently, each of the four nations of the United Kingdom had their own Public Health Department to match their own NHS.

According to some news media reports the Government has out-sourced all or parts of the public functions in dealing with an outbreak of an infectious disease in England to private companies such as Serco. If this is true, the Government is not informing Parliament of the public of how it is using the 2020 Coronavirus Act to contract with private companies to carry out public health functions using public money. Also, there have been conflicting reports about the Government’s handling the ‘test & trace’ service it set up last May, which should have re-placed lockdown as a means of controlling the spread of the Covid-19 disease.

On 18 August 2020, the Government added more confusion about public health is supposed to run, when it announce that Public Health England (PHE) was to be replaced by the [National Institute for Health Protection](https://en.wikipedia.org/wiki/National_Institute_for_Health_Protection). This is a new agency that combines PHE with the [NHS Test and Trace](https://en.wikipedia.org/wiki/NHS_Test_and_Trace) operation to deal with infectious diseases. There was little mention of the other public health functions of which there are many.

Although all this confusion makes it difficult to see how our public health and epidemiology services should be strengthened, I would suggest that we reinstate a national multi-function Public Health Authority with a national headquarters that is integrated with the county level local authority public health departments.

**CONCLUSION**

Long before the Coronavirus (COVID-19) Pandemic, the single-minded pursuit of Globalised Capitalism had resulted in a time of great global wealth while millions of people are suffering severe inequality, poverty, poor health and the lack of the means and opportunity to assume responsibility and management of their own livelihoods. Both the autocratic and democratic states have focused on the economic development of their nation to the detriment of the social development of their people, and conservation of the natural environment, on which all economies depend. And now the Coronavirus (COVID-19) Pandemic has caused a great deal more human suffering while leaving nations with even less resources to deal with it. The Pandemic and its after effects will drag up much longer that they might have done had people had been less poor and unhealthy and if their national healthcare systems had been ‘fit for purpose’.

Further, the neglect and dis-investment in human health & welfare amounts to a breach of human rights.

The 1948 UN Universal Declaration of Human Rights (UDHR) states in Article 25: *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond their control.*

In addition to being subject to the UDHR, Britain passed the Human Rights Act in 1998. The Act gives effect to the human rights set out in the European Convention on Human Rights and obliges all public authorities, including the NHS, to respect the human rights as stated in the Convention and the 1998 Act.

The way in which the Coronavirus (COVID-19) Pandemic has been handled also amounts to a breach of human rights. The measures taken to control Covid-19 under the terms of the 2020 Coronavirus Act have provided healthcare to some people while denying it to others. This makes the NHS non-compliant with the UDHR and the 1998 Human Rights Act because it has only met rights of some people, while compromising the rights of others.

Although MPs passed the Coronavirus Act in record time and without a vote or waiting for Royal Assent, they did so with grave misgivings. One MP, Steve Baker, went as far as accusing the Government of imposing a “dystopian society.**"[[44]](#footnote-24)**

**Is this the kind of country we want the United Kingdom to be?**

**APPENDIX ONE: ABOUT THE UN AND THE UNA**

[](https://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=2ahUKEwiUk-WQu4faAhXJ0RQKHebPDfoQjRx6BAgAEAU&url=http://translatorthoughts.com/2014/05/working-as-a-translator-for-the-united-nations/&psig=AOvVaw3R0i_kBTJ-ze6pDc2s8bEN&ust=1521993200889423)

**THE UNITED NATIONS**

During the last summer of the Second World War, 51 nations**[[45]](#footnote-25)** signed and ratified an international treaty that founded the United Nations on **24 October 1945**. The treaty – known as the UN Charter – sets out the principles to govern international relations as follows:

* To maintain international peace and security
* To develop friendly relations among nations based on respect for the principles of equal rights and self-determination of peoples
* To cooperate in solving international economic, social, cultural and humanitarian problems and in promoting respect for human rights and fundamental freedoms**[[46]](#endnote-21)**.

There are two important things to understand about the United Nations.

**The UN System**

The first is that it is not a single organisation but a large family of organisations that together make up the UN System**[[47]](#endnote-22)**. It consists of 6 principle organs – the General Assembly, the Security Council, the Economic & Security Council (ECOSOC) the Trusteeship Council, the International Court of Justice and the Secretariat - and 43 specialised agencies, funds and programmes such as WHO, UNESCO, the World Food Programme and UNICEF**[[48]](#footnote-26).**

**UN Millennium Declaration 2000 and the Concept of Human Security**

The second important thing is that the UN’s current driving force is the UN Millennium Declaration 2000.Over the course of time, a government’s ‘first duty’ to protect the state from military invasion has broadened to include the protection of its people from all threats such as crime, drugs, poor health & malnutrition, poverty, intolerance & social exclusion, as well as from terrorism & warfare. This was the basis of the debate that took place at the UN World Summit in 2000. Its outcome was the Millennium Declaration that seeks to coordinate peace, development, human rights and fundamental freedoms as a *single* way forward. Therefore, the Concept of Human Security – as opposed to state security - was formally recognised and adopted by all the UN’s Member States.

To continue with the Declaration’s implementation, the 8 Millennium Development Goals (MDGs) 2000-15 were replaced by 17 Sustainable Development Goals (SDGs) 2015-30. They require all countries to strengthen their partnership working with other member states, non-government organisations (NGOs) and with civil society. Overall, the comprehensive nature of the SDGs calls for us to take a deeper look at why some things are working and others are not**[[49]](#endnote-23)**. The ‘us’ here refers to how civil society has organised itself to work together on their chosen part of the comprehensive UN Millennium Programme. There is however, one day a year that is devoted to promoting the UN itself. The aim is to strengthen its ability to effectively carry out its many functions as laid down in its Charter and subsequent international treaties, conventions and resolutions.

Despite its frequent bad and inaccurate press, and persistent marginalisation on the part of some member states, the UN remains popular with nations and with civil society. Of the approximate 206 nations**[[50]](#footnote-27)** in the world 193 have joined the UN. And a total of 4,045 NGOs have gained consultative status with the UN. However, when it comes to supporting the UN itself, this required the creation of a ‘United Nations Associations’ (UNA).

[](https://en.wikipedia.org/wiki/File:WFUNA_logo_pos_2c_RGB.jpg)

**WORLD FEDERATION OF UNITED NATIONS ASSOCIATIONS (WFUNA)**

Of the approximate 206 nationsin the world 193 have joined the UN. In just over half (100) of them a UNA has formed to support the UN and to educate the public as to how – as the only international system of its type – it is supposed to work. In addition to supporting their own nation to act appropriately as a member state of the UN, UNAs may join WFUNA in order to work together as an international force to influence all member states.

#### **WFUNA's Mission Statement[[51]](#endnote-24)**:

“The World Federation of United Nations Associations (WFUNA) is the largest global network of people supporting and engaging with the United Nations. As a global non-profit organization established in 1946, we represent and coordinate a membership of some 100 national United Nations Associations and their thousands of constituents.

Guided by our vision of a United Nations that is a powerful force in meeting common global challenges and opportunities, WFUNA works to strengthen and improve the UN. We achieve this through the engagement of people who share a global mind-set and support international cooperation– global citizens.”

[](https://www.google.co.uk/url?sa=i&url=https://www.una.org.uk/magazine/special-issue-2015/united-nations-working-us-all&psig=AOvVaw37ZWyuFWU687KyGiXsnjHG&ust=1597326829131000&source=images&cd=vfe&ved=0CAIQjRxqFwoTCMC1s7nolesCFQAAAAAdAAAAABAD)

**THE UNITED NATIONS ASSOCIATION-UK**

The outbreak of the Great War in 1914 did not deter people from their peace movements. The League of Nations Society, set up in England in 1915, merged with the League of Free Nations Association to form the League of Nations Union (LNU) in 1918. Therefore, the LNU was well established as a civil society organisationa whole year before the League of Nations (LoN) was founded as part of the 1919Treaty of Versailles**[[52]](#endnote-25).** The LoN came into force on 20th January, 2020.

Although dismayed by the outbreak of the Second World War in 1939, the LNU did not give up. Lord Cecil, a founder member of the League, said the “*first great experiment is over, we must work for the second.*” And so they did. The United Nations Association of the United Kingdom wasformed as a successor to the LNU on 7th June in 1945 and thus preceded the foundation of the UN by four months**25**. This history, together with how the Charter opens with “***We the Peoples.….*”** and not “*We the Member States…..*” indicates the strength and foresight of civil society as the inspired leader of the most endurable international peace movement to date.

In the present day, UNA-UK remains true to its conviction that the UN is indispensable for building a safer, fairer and more sustainable world; and is therefore, the foremost advocate for the UN in the UK. In an era of growing instability and interdependence, the need for collective action is greater than at any time since the UN was founded. However, the UN’s ability to operate according to its Charter is dependent on its member states’ willingness to work together. The increasingly fractious geopolitical environment has led time and again, to failure in addressing pressing challenges, from mass displacement to climate change. This has increased the pressures on the UN, which is experiencing a serious financial crisis, as well as frequent deadlock in the Security Council**[[53]](#endnote-26)**.

The UK is a permanent member of the Security Council and a large multilateral aid donor, which makes it an important global player with a strong track record in providing leadership at the UN. However, in recent years, there is frequently a gap between UK rhetoric and policy, which puts it at odds with international norms and obligations. The 2016 referendum on membership of the European Union and its aftermath have also raised questions, within and outside the country, on the future direction of British foreign policy**26**.

Overall, the UNA aims to enable people to give constructive critical support to the Government to more responsibly execute Britain’s role as one of 5 permanent members of the UN Security Council. This obliges it to address global problems according to the terms of the UN Charter and to ensure that all sequential decisions and actions do not contravene the purposes & principles of the United Nations.

UNA-UK adopts a strategic plan every three to five years. The current one is very briefly described below.

**UNA-UK Strategic Plan 2019-21 the three Main Programmes are quoted below**

* Global governance transformed: making multilateralism fit for the 21st century – through Together First, we will inspire and support a global people’s movement for greater global cooperation and more effective, inclusive global institutions
* Global Britain in practice: campaigning for a principled, multilateral British foreign policy – we will advocate for greater priority, ambition, action and creativity by the UK in tackling global challenges and strengthening global institutions
* Global citizens inspired: boosting public engagement with global issues – we will use outreach and communications to increase understanding and involvement in these activities, with a particular focus on the UN’s 75th anniversary in 2020 (Source: reference No. 26)



**THE UNITED NATIONS ASSOCIATION:**

**BEXHILL & HASTINGS BRANCH (UNA-B&H)**

In 2012, UNA-UK became a charitable company limited by guanrantee. (Registered number is 1146016.) Its ‘Articles of Association’ state that the UNAs of Wales, Scotland and Northern Ireland, and the England regions and branches should function as legally and financially autonomous entities. However, they must in their structure and activities, reflect the mission & values and realise the aims & objects of UNA-UK within their own areas. This presented new opportunities for branches to play a more direct and active role in promoting the cause of the UN. But not by each working alone in their ‘own small corner’. After several years of re-adjustment, UNA-B&H is now a constiuted unincorporated association in its own right. However, the Branch remains closely attached to, and is formally recognised by, the Board of Trustees of UNA-UK.

Although welcoming members from anywhere, UNA-B&H matches the same geographical and judicial areas of Rother District Council (RDC) and Hastings Borough Council (HBC). The Branch is currently strenthening relations with the two councils in keeping with its Mission Statement.

**UNA-B&H Mission Statement**

In recognising that the UN works on a wide varity of interconnected global issues - none of which can be resolved in isolation - UNA-B&H strives to work in collaboration with other groups and organisations to assist and empower people in our local area to support the work of the UN and all its agencies. At the same time, we recognise and support the need for reform of the UN in order to strengthen its credibility and effectiveness.

In other words, we exist to help turn the ideals of the United Nations into reality.

How infinitesimal is anything we can do!

How infinitely important that we should do it!

**UNA-B&H Current Aims and Objectives from February 2020**

The current overall aim is to assist government and non-government organisations to implement in the local area the UN Agenda 2030. This 15-year comprehensive programme for a global transformation, aims to coordinate the inter-linked Sustainable Development Goals (SDGs) with the campaigns for peace, sustainable development and environmental protection**[[54]](#endnote-27)**.

Therefore, UNA-B&H’s current objectives are divided between three categories as follows:

The Environment, Climate & Oceans

To enable local action on the accumulated outcomes of the UN’s Series of Earth Summits e.g. Agenda 21, that are now incorporated in UN Agenda 2030. (Please see Appendix Two.)

Peace & Human Security

To enable local participation in implementing on all levels the ‘*Swords into Ploughshares’* Peace Policy. This aims to transform the culture of war into a culture of peace by transfering the resources from war-making to peace-making.

Health & Human Development

To enable local action to promote the ‘Development of People’ (health, nutrition, education and rights & obligations) as a means of achieving fair and equitable social and economic development.

**APPENDIX TWO: UN AGENDA 2030**

The International Governance System has been enhanced by the Millennium Declaration. This was the main outcome of the two UN World Summits 2000 & 2005, which aims to coordinate peace, development, human rights and fundamental freedoms as a single way forward. The Declaration included 8 Millenniuim Development Goals (MDGs) that have now been replaced by 17 Sustainable Development Goals (SDGs) 2015-2030. This has given rise to a new UN Programme - Agenda 2030. This should not be confused with Agenda 21 where the ‘21’ refers to the 21st Century and is therefore, still active. It is suggested that planning for Agenda 2030 should take place within the existing framework for Agenda 21. The UN’s official document on Agenda 2030 is summarised below.

**TRANSFORMING OUR WORLD: THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT**

**Resolution A/RES/70/1: Adopted by the UN General Assembly on 25 september 2015**

**PREAMBLE** (to a 35 page document)

“This Agenda is a plan of action for people, planet and prosperity. It also seeks to strengthen universal peace in larger freedom. We recognize that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development.

All countries and all stakeholders, acting in collaborative partnership, will implement this plan. We are resolved to free the human race from the tyranny of poverty and want and to heal and secure our planet. We are determined to take the bold and transformative steps which are urgently needed to shift the world on to a sustainable and resilient path. As we embark on this collective journey, we pledge no one will be left behind.

The 17 Sustainable Development Goals and 169 targets which we are announcing today demonstrate the scale and ambition of this new universal Agenda. They seek to build on the Millennium Development Goals and complete what they did not achieve. They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated and indivisible and balance the three dimensions of sustainable development: the economic, social and environmental.

The Goals and targets will stimulate action over the next 15 years in areas of critical importance for humanity and the planet.

**People**

We are determined to end poverty and hunger, in all their forms and dimensions, and to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment.

**Planet**

We are determined to protect the planet from degradation, including through sustainable consumption and production, sustainably managing its natural resources and taking urgent action on climate change, so that it can support the needs of the present and future generations.

**Prosperity**

We are determined to ensure that all human beings can enjoy prosperous and fulfilling lives and that economic, social and technological progress occurs in harmony with nature.

**Peace**

We are determined to foster peaceful, just and inclusive societies which are free from fear and violence. There can be no sustainable development without peace and no peace without sustainable development.

**Partnership**

We are determined to mobilize the means required to implement this Agenda through a revitalized Global Partnership for Sustainable Development, based on a spirit of strengthened global solidarity, focused in particular on the needs of the poorest and most vulnerable and with the participation of all countries, all stakeholders and all people.

The interlinkages and integrated nature of the Sustainable Development Goals are of crucial importance in ensuring that the purpose of the new Agenda is realized. If we realize our ambitions across the full extent of the Agenda, the lives of all will be profoundly improved and our world will be transformed for the better.”

**APPENDIX THREE: The WORLD HEALTH ORGANISATION (WHO)[[55]](#endnote-28)**

The United Nations exists not as a single organisation but as large family of agencies that together make up the UN System. The World Health Organisation (WHO) was established in 1948 as one of the UN’s earliest specialist agencies. Its first task was to maintain continuity by taking control of communicable disease that had previously been done by several international organisations. WHO then coordinated this function with the promotion of health governance and the development of comprehensive and universal healthcare systems. Since its inception, WHO with its many different partners, has supported countries to develop their national healthcare systems.

From its headquarters in Geneva, Switzerland, WHO works through six regional and 147 country offices. WHO has 193 member states and 2 associate member states that are not members of the UN. Its governing body, the World Health Assembly (WHA) meets annually. Its decisions and policies are then acted upon by the Executive Board composed of 32 government appointed health experts. The WHO objectives and strategic direction are as follows:

**Objectives**

To improve the quality of life

The attainment by all people of the highest possible level of health by:

Promoting technical cooperation for health among nations

Carrying out programmes to control and eradicate disease

**Strategic Direction**

Reducing excess mortality, morbidity and disability, especially in poor and marginalised populations

Promoting healthy lifestyles and reducing health risks that arise from environmental, economic, social and behavioural causes

Developing health systems that are more equitable and effective, respond to people’s legitimate demands, and are financially fair

Developing appropriate health policies and institutional environments, and promoting the health dimension of social, economic, environmental and development policies.

**The WHO Constitution (very briefly)**

The Constitution includes a declaration that health is a fundamental human right and therefore, commits WHO to ensuring the highest attainable level of health for all, which is defined as:

***“Health is a state of complete physical, mental and social***

***well-being and not merely the absence of disease or infirmity.”***

This implies an overall objective to improve the health and the quality of life of all people. Since 1948, WHO has striven to achieve this though Universal Health Care, which it describes as follows:

***Universal Health Care (UHC)***

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. This enables everyone to access to good quality services that address the most significant causes of disease and death. In addition to personal healthcare, UHC includes population-based services such as public health campaigns, safe drinking water, controlling communicable diseases. Achieving UHC is rightly one of the targets the Sustainable Development Goals (2015-2030) because good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

The cornerstone of achieving UHC is investments in quality Primary Health Care, which is the most cost-effective way to ensure access to essential health care.

**WHO in Practice**

Global health policy is formulated by the World Health Assembly and is applicable to all its member states. However, in regard to implementation, WHO concentrates its practical assistance to developing countries that have urgent health problems but few means by which to deal with them.

As with all UN specialist agencies, WHO has to balance its long-term work as indicated by its objectives and strategic direction with the short-term demands of its member states or a health crisis in part or all of the World. Its member states are also facing demands from inpatient electorates that want to see an immediate return for the dues their government pays to WHO. More pressure therefore, was directed to WHO to focus on its fourth objective – to carry out programmes to control and eradicate disease – before the establishment of national healthcare systems.

At first, in the 1950s, WHO tried to resist such pressures by saying that there would be little point in their using targeted interventions to eradicate or control specific diseases if the national healthcare systems were too weak to keep the diseases eradicated or under control. While the member states who control the purse strings, expected WHO to do both, they sought early proof of the worth of WHO by calling for the eradication of smallpox. This was after all a widespread and devastating disease. WHO complied and carried out an historic global campaign of surveillance and vaccination. Finally, in 1980, the World Health Assembly declared that smallpox had been eradicated.

To this day, smallpox is still the only infectious disease for which WHO has achieved this distinction. This has not, however, affected how the member states demand that WHO should work. The pressures to pursue ‘quick fix’ interventions to deal with specific diseases and health problems have continued, which has created a marked tension between vertical and horizontal healthcare provision.

**Vertical versus Horizontal Healthcare Provision**

The post-war development economics demanded a postponement or complete by-pass of investment in establishing national healthcare services the developing countries. Government aid departments and non-government organisations (NGOs) often made their award of international aid conditional on not using it to set up basic healthcare services or for the provision of social security. Instead, they favoured supporting ‘vertical’ interventions that address a particular disease or health problem that had a beginning and an end and also a price tag. These interventions were generally designed, funded, managed and delivered as low cost programmes by governments and NGOs in the developed nations. For the most part, vertical interventions were neither coordinated with each other, nor integrated with the recipient country’s horizontal planned or actual healthcare system. This made vertical interventions ineffective, unsustainable and unaffordable in the long-term. Examples include immunisation programmes against specific diseases, the distribution of vitamin A capsules, the attempt to deal with the alarming increase in population by regulating fertility with a limited range of contraceptives**[[56]](#endnote-29)**,and the delivery of packages of discrete interventions aimed at reducing maternal and/or child illnesses and deaths without addressing the social and environmental determinants of the conditions that caused the high levels of morbidity and mortality.

**‘Health-for-All’ through Primary Health Care: the WHO Alma Ata Declaration 1978**

However, despite the pressures and distractions from its objectives and strategic direction, WHO managed during that later part of the 20th Century to obtain widespread approval and endorsement of its ‘Health-for-All’ and ‘Primary Health Care’ policies.

***40th Anniversary of the 1978 Alma Ata Declaration***

On 25–26 October 2018, WHO, UNICEF and the Ministry of Health of Kazakhstan jointly hosted the Global Conference on Primary Health Care. This was to mark the occasion of 40 years after the adoption of the historic Alma-Ata Declaration in 1978. Ministers, health workers, academics, partners and civil society came together to review and revive Primary Health Care as the cornerstone to the promotion of Universal Health Care (UHC) coverage.**[[57]](#footnote-28)** The Conference passed the bold new [Declaration of Astana](https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf) that aims to encourage governments, non-governmental organisations, professional organisations, academia and global health and development organisations to renew their commitment to Primary Health Care**[[58]](#endnote-30)**.

**Primary Health Care (updating but also reinforcing previous descriptions)38**

Primary health care is an approach to health and wellbeing centred on the needs and circumstances of individuals, families and communities.  It addresses comprehensive and interrelated physical, mental and social health and wellbeing. It has three main components as follows:

1. Ensuring people’s health problems are addressed through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key system functions aimed at individuals and families and the population as the central elements of integrated service delivery across all levels of care;
2. Systematically addressing the broader determinants of health (including social, economic, environmental, as well as people’s characteristics and behaviours) through evidence-informed public policies and actions across all sectors; and
3. Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and wellbeing, as co-developers of health and social services through their participation, and as self-carers and care-givers to others.

The WHO Primary Health Care (PHC) is the most efficient & cost effective way to achieve around the world, human health and welfare systems based on a considerate, compassionate, cooperative and caring ethos. Therefore, PHC offers a more comprehensive and integrated approach to healthcare service development. But so much of this good work is being undone by globalisation and the turbulent events of the first two decades of the 21st Century.

**THE CURRENT STATE OF HUMAN HEALTH & WELFARE IN THE WORLD**

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One year before the beginning of the Coronavirus (COVID-19) Pandemic, the World Health Organisation issued a news statement reiterating its earlier reports about the grave situation resulting from years of dis-investment in human health & welfare**[[59]](#endnote-31)**. The news statement began with four key facts as follows:

**Key Facts**

1. At least half of the world’s population still do not have full coverage of essential health services.
2. About 100 million people are still being pushed into extreme poverty (defined as living on 1.90 USD or less a day) because they have to pay out-of-pocket for health care.
3. Over 930 million people (around 12% of the world’s population) spend at least 10% of their household budgets to pay for health care.
4. All UN Member States have agreed to try to achieve universal health coverage (UHC) by 2030, as part of the Sustainable Development Goals – UN Agenda 2030**[[60]](#footnote-29)**.

One year later, on 13th January 2020, just as the Covid-19 Pandemic was about to begin, Dr Tedros Adhanom Ghebreyesus, the WHO Director-General, issued a second news statement about the urgent health challenges that the World will face in the coming decade**[[61]](#endnote-32)**.

The challenges, listed in no particular order, had been developed with input from WHO experts around the world. They reflects a deep concern that leaders are failing to invest enough resources in core health priorities and systems. This puts lives, livelihoods and economies in jeopardy. While none of these issues are simple to address, it must be realised that health is an investment in the future. Countries are already investing heavily in protecting their people from attacks by terrorists, but they fail to protect them against attacks of viruses; even though this could be far more deadly to peoples’ health and cause far more damage to their economic and social systems. A pandemic could bring economies and nations to their knees, which is why health security cannot be a matter for ministries of health alone.

**APPENDIX FOUR**

**THE CURRENT STATE OF HUMAN HEALTH & WELFARE IN BRITAIN**

The brand name ‘[National Health Service](https://en.wikipedia.org/wiki/National_Health_Service)’ (NHS) refers to the provision of free public health services of [England](https://en.wikipedia.org/wiki/England), [Scotland](https://en.wikipedia.org/wiki/Scotland) and [Wales](https://en.wikipedia.org/wiki/Wales), individually or collectively. In Northern Ireland [the](https://en.wikipedia.org/wiki/Northern_Ireland) NHS is known as 'Health and Social Care' to indicate the good sense in promoting a dual integration of health and social services**[[62]](#endnote-33)**.

**The National Health Service in 1948**

The NHS in Britain was the first universal health care system to be established anywhere in the world. In preparation of its foundation on 5th July 1948**[[63]](#footnote-30)**, the Government, in the preceding June, sent a leaflet to every household to explain what the NHS was all about, which is summarised in the quote below:

“It will provide you with all medical, dental and nursing care. Everyone — rich or poor, man, woman or child — can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a “charity”. You are all paying for it, mainly as tax payers, and it will relieve your money worries in time of illness.”

— Central Office of Information, for the Ministry of Health

**The National Health Service in 2020**

In November 2019, the *Guardian* reported the NHS to be a “perpetual state of crisis” and was heading for its worst winter on record. This was due to chronic underfunding from 2010 and increasing staff shortages since 2016. The next month, December, Britain was busy with its general election when the Covid-19 outbreak was officially reported in China. Covid-19 arrived in Britain in January 2020. By 11th March 2020, it had spread worldwide and WHO declared it as the Coronavirus (COVID-19) Pandemic.

On the 19th March, the Coronavirus Bill 2020**[[64]](#footnote-31)** was introduced to Parliament and passed through the House of Commons without a vote on 23rd March. On that same day, without waiting for the Bill to pass through the [House of Lords](https://en.wikipedia.org/wiki/House_of_Lords) or gain Royal Assent (which was not achieved until 25th March) the Prime Minister, Boris Johnson, publically announced an extensive and near complete lockdown under the slogan:

***‘Stay Home, Save the NHS, Save Lives’***

I slogan was a thinly disguised statement of the fact that years of dis-investment, cuts and fragmentation had rendered the NHS quite unable to cope with normal healthcare demand let alone such a crisis as the Coronavirus (COVID-19) Pandemic.

The slogan also indicated that as a whole, the NHS was in a state of non-compliance with the 2004 Civil Contingencies Act**[[65]](#footnote-32)**. There is a section in that Act that requires all NHS organisations to plan for, and respond to, a wide range of incidents and emergencies that could affect health and patient care. The range of emergencies includes outbreaks of infectious disease and pandemics and all have to be dealt with while maintaining critical services. For purposes of the legislation, ‘critical services’ does not appear to be defined, but for practical purposes what is ‘critical’ can change with time and circumstance. We are now making the painful discovery that conditions that started out as non-critical at the time of the lockdown, quickly became critical through delay and neglect of routine and elective healthcare.

Under the terms of the 2020 Coronavirus Act, the Government made provision to shield and protect extreme clinically vulnerable patients from Covid-19 while still providing them with their essential services. This was necessary and good, but there were others equally vulnerable that were not especially protected such as people living in care homes and those living anywhere with underlying conditions. Further, these people and all NHS patients not in the Government’s designated groups, were subjected to the Government’s orders for the cancellation of all elective surgery and routine non-essential treatments – for both physical and mental illnesses - in NHS and private healthcare settings. Dental practices and opticians were also ordered to close while severe restrictions were made to the already restricted GP and community healthcare services. In addition, various charities and voluntary groups that support the NHS and Social Services, such as the British Red Cross, were also ordered to close.

People were told to stay away from GP surgeries and hospitals except those in need of urgent or emergency healthcare. The authorities then became concerned because too many people with non-Covid-19 but still serious conditions were staying away from the NHS. The Government released a press statement strongly advising people not neglect non-Covid-19 healthcare, but the damage was already done. So that now as Britain faces a second wave of Coronavirus (COVID-19) infection, the NHS, is having to deal an upsurge of Covid-19 patients when it was already struggling to deal with the vast backlog of patients that were once categorised as elective or non-urgent cases. Furthermore, due to the delay and neglect of their treatment and care, the conditions of many of these patients has worsened so much, which is turning them into emergency or urgent cases.

How did our NHS get into such a dismal state?

**THE DECADE OF HEALTHCARE DECLINE: 2010-2019**

In 2010, the newly elected Tory-led Coalition Government responded to the 2008/9 Great Recession with the severest Austerity Programme in Europe**[[66]](#footnote-33)**. The Programme had two main goals as follows:

1. The first was to eliminate the current budget deficit, which had skyrocketed from £19.13 billion in 2006 to £103 billion in 2010**[[67]](#endnote-34)**
2. The second was to secure a continuous fall in the [national debt](https://en.wikipedia.org/wiki/Government_debt), which is measured as a percentage of annual Gross Domestic Product ([GDP](https://en.wikipedia.org/wiki/Gross_domestic_product)). From 1986/87 to 2006/7, the average national debt was around 40% of GDP. It then rose to 56.8% of GDP in 2009**[[68]](#endnote-35)**.

Both these goals were to be achieved through sustained reductions in public spending and tax rises, thus reducing the Government’s role in the [Welfare State](https://en.wikipedia.org/wiki/Welfare_state_in_the_United_Kingdom) with one exception – the NHS.

**The Health and Social Care Act 2012**

In times of recessions, British governments, in addition to cutting back on public service expenditure, appear to ‘save the NHS’ by re-organising it to increase its economic efficiency. The response to 2009 Recession was no exception. The Government’s claim to ‘ring-fence’ the NHS from spending cuts, turned out to be the use – or misuse – of the ‘ring-fenced’ money to pay for the Health and Social Care Act 2012 that launched yet another controversial and probably unnecessary re-organisation of the NHS.

In regard to this Discussion Paper, there are just three things I would like to note about the 2012 Act.

1. The first is the creation of Public Health England as a new executive agency of the Department of Health. It took on the roles of the Health Protection Agency, the National Treatment Agency for Substance Misuse as well as a number of other health bodies. The Act also returned public health to the local authorities, from which it had been removed by a former Tory Government under the terms of the NHS Re-organisation Act of 1973.
2. The second is that the GP-led Primary Care Trusts (PCT) were abolished and replaced with similar GP-led Clinical Commissioning Groups (CHG). CHGs are responsible for commissioning healthcare on behalf of patients and public in their local area. They are over-seen and coordinated by the NHS Commissioning Board Authority. At the same time as being heavily involved in commissioning, GPs continue to provide their own services, while they control access to a range of community services such as intermediate care, district nursing and health visiting. Also, CHGs are the major point of access for private service providers to operate within the NHS.
3. The third thing is that the responsibility for the health of the people was removed from the remit of the Secretary of State for Health. This responsibility had been enshrined as a foundation principle in the original NHS Act of 1946 and had remained as such until it was transferred to the newly created NHS Executive under the terms of the 2012 Act.

In the event, the Government did not actually except NHS from its Austerity Programme, nor did it actually give up its responsibility for the ‘health of the people’ or reduce its role in the Welfare State. This is because the Government retained control of the public sector purse strings, which ensures its continued de facto power and control over the both NHS and the Welfare State. Cuts in financial and other resources to any public service will inevitably adversely affect the NHS to the detriment of the ‘health of the people’.

**Reduced Funding for Health and Social Care**

During the years between 2010 and 2019, the cuts in expenditure for welfare payments, housing subsidies and social services added up to more than £30 billion**[[69]](#endnote-36)**. At the same time, funding to local authorities – that provide all public services with the exception of healthcare – was reduced by 49 per cent**[[70]](#endnote-37)**. As a result, the local authorities were forced to cut social care, which forced people to inappropriately turn to the NHS thus increasing healthcare demand. As a result, ‘bed-blocking’ discharge failures, cancelled surgical procedures and increased waiting times have all made a ‘come-back’ from their heyday in the wake of the 1990 NHS and Community Care Act. So in effect, the Government has not protected the NHS from the spending cuts as it promised to do.

**Declining Hospital Capacity**

In March 2020, King’s Fund published an update of its *NHS Hospital Bed Numbers - Past, Present and Future* in which, the key messages included:

* The total number of NHS all types of hospital beds in England has more than halved over the past 30 years - from around 299,000 in 1987/88 to 141,000 in 2018/9.
* The number of hospital beds for general and acute care has fallen by 34 per cent since 1987/88, the bulk of this fall due to closures of beds for the long-term care of older people.
* Research shows that initiatives to moderate demand for hospital care often struggle to succeed. This is because a) the intermediate care capacity is currently only enough to meet half of demand from patients who on discharge from hospital, need further rehabilitative care in the community and b) cuts in funding have led to significant reductions in publicly funded social care that could support early discharge from hospital or prevent the admission in the first place.

**Rising Demand for Emergency and Planned Hospital Care**

Two years before the Covid-19 crisis, in February 2018, Rocco Friebel of the Health Foundation reported that “… the NHS is experiencing a period of unprecedented pressures on resources”. During the 10 years 2006 to 2018, there was a 28% rise in the total annual number of hospital admissions. Patients aged above 65 had increased by 46% and the proportion with long-term conditions has doubled. Patient complexity increases the pressures on hospitals beyond the simple rise in the number of admissions**[[71]](#endnote-38)**.

Exactly two years later, in February 2020, Carl Baker in a House of Commons Briefing Paper, reported that “… demand for NHS hospital services in England has continued to rise. At the same time, performance on many of the main waiting times measures has fallen.”**[[72]](#endnote-39)**

The offset rising demand for a decreasing number of hospital beds, the bed occupancy rate was increased from 85.6% to 95%. During the winter months, it regularly exceeds 95 per cent reaching 100% on occasions**[[73]](#endnote-40)**. Hospitals cannot operate at 95-100% occupancy rate because spare beds are required to accommodate variations in demand so that patients can, at all times, continue to flow through the system that ends with a safe and sustained discharge care plan**[[74]](#endnote-41)**. When the patient throughput becomes clogged with delayed discharges, planned admissions are subjected to multiple cancellations causing illnesses to worsen through lack of timely treatment and thus, are likely to present at A & E as emergencies (!)

In addition, many emergency admissions are inappropriate. Apart from over-loading A &\* E departments, this adversely affects a patient’s chances of recovery because they are admitted to the wrong healthcare setting for their conditions and complexity of needs. Such patients are not best treated and cared for in acute hospitals, where their condition worsens rendering them more unable to cope with living at home.

So why aren’t they living and being cared for in their own home, or at least in a local community setting?

Whatever happened to ‘Care in the Community’?

**Antecedent to the Decade of Healthcare Decline: the NHS and Community Care Act 1990[[75]](#footnote-34)**

The World Health Organisation has 195 member states and all these nations, regardless of wealth and power, are subject to WHO policies. Therefore, subsequent to the Alma Ata Declaration**[[76]](#footnote-35)**, the WHO European Region published guidance for how European countries should reorient their National Healthcare Systems towards PHC according to the Alma Ata definition. This should not be confused with primary care (PC) or general medical practice (GPs) in the United Kingdom.

Throughout the 1980s, the Thatcher Government reviewed the NHS and planned for extensive reform of the NHS and social services. The primary aim was to improve efficiency and efficacy, which would have been fine if this was to be done within the original tenets of the NHS and in-keeping of the WHO PHC guidelines. But the overall approach to the reforms were in total disregard of both. Efficiency and efficacy boiled down to cutting costs, while cost effectiveness was confused with the cheapest. Margaret Thatcher accepted the advice of Milton Friedman (the American economist) and like-minded health economists in the UK, while largely rejecting advice from the British healthcare professions.

The result was the NHS and Community Care Act of 1990. This was remarkable for placing health and social care within the same Act and then for creating more divisions between the two than ever before.

The NHS side was implemented in 1991. The key reform was the division between the health commissioners (purchasers) and the providers, which created the internal market and thus introduced competition into a hitherto cooperative NHS. Both commissioners and providers could be organisations in or outside of the NHS, which opened up the field of public healthcare provision to the private sector. This would have been alright if private sector providers had been restricted to not-for-profit, voluntary or charitable organisations. After all, the NHS has contracted with such charities as Hospice UK for years and GPs have never been part of the NHS. But the 1990 Act permitted for-profit organisations to bid for NHS contracts, which meant that public money could be used to pay dividends to shareholders.

The overall upshot of the 1991 NHS reforms was that they demanded the creation of many more managerial and administrative roles than the previous system. This was contrary to the Government’s primary aim, which was to cut costs by reducing management and administration (!).

The Community Care side of the Act was not implemented until April, 1993.

**‘Care in the Community’ and District Nursing**

Under the terms of the 1990 Act, the local authorities’ social services departments (SSD) took over from the NHS the responsibility for all chronically ill and disabled people in need of continuing social and nursing care. The SSDs planned and implemented care packages for these vulnerable people in the own home, or they funded and placed them in care homes in the public and private sector. This had a profound effect on district nursing. At the time, the service had just completed its evolvement from providing the lone patch-based district nurse to providing a multi-skilled team of community nurses for the total care of people in a specified geographical area or the patients of a GP group practice to which the team was attached**[[77]](#endnote-42)**.

***The Division between Nursing and Social Care – Divided Care***

Under the terms of the 1990 Act, it was decreed that basic nursing care – that is washing and toileting, general patient observation and monitoring of bodily functions, nutritional status, the integrity of the skin and prevention of pressure sores, simple wound dressings, ‘non-medical’ eye drops, prompting for medication and providing emotional support and exercise to avoid deterioration in mind and body – all this was decreed to be not nursing but personal care and so was legally transferred to social services to become part of their extended responsibilities. This led to a division of care where only bits and pieces of nursing practice remained under nursing supervision and is provided free on the NHS. While what was once basic nursing care became part of the social services remit and as such, was subjected to their means-tested charging policies, which amounted to the privatisation of a vital piece of healthcare.

**‘Care in the Community’ Today**

Today, ‘Care in the Community’ is big business and looking at the TV adverts for home care agencies such as Home Instead, Helping Hands and Care at Home, it all looks wonderful. A great advance since 1993. Older and vulnerable people can now have daily – or round the clock if necessary - support from personal carers who will do anything to enable them to live in their own home instead of having to sell it to pay to live in a care home. During the same time period, the NHS has replaced its convalescent homes with intermediate care designed to re-enable them to live at home again after a stay in hospital. The NHS still provides district nursing – albeit as a reduced service – and it has enhanced its community provision of occupational therapy, physio-therapy and psychotherapy & counselling.

The rosy picture ‘as seen on TV’ is only available to those who can afford it. Although cheaper than a care home, home care is still costly. For example, in one case, an agency home care package designed to meet the client’s full need cost £26,000 a year, which was the equivalent of the client’s full pension income**[[78]](#footnote-36)**. For those people who cannot pay, the picture is far from rosy. The cuts in government expenditure on local authorities has forced them to severely cut back on all local public services including adult social care. Community healthcare, including the vital intermediate care, is good where it exists, but it is not available everywhere in the capacity and flexibility required to meet demand. And so the unmet need that ‘Care in the Community’ was supposed to have eliminated is still there, which translates into a deal of silent human suffering.

**Decline in the Social Care System**

Given the emphasis that the consecutive governments have placed on ‘Care in the Community’ the intermittent periods of cuts to the social care system do not make sense, and certainly not during the last decade when the Tory Governments were intent on protecting the NHS.

In September 2016, the King’s Fund and the Nuffield Trust published a report entitled, *Social care for Older People: Home truths***[[79]](#endnote-43)**. The most relevant messages to this paper are given below:

* The most visible manifestation of pressures on health and social care budgets is the rapid growth in delayed discharges from hospital, which is undoubtedly driven by funding pressures on both services.
* The funding outlook for the next five years looks bleak. The measures announced by the government will not meet a widening gap between needs and resources set to reach at least £2.8 billion by 2019. Public spending on adult social care is set to fall to less than 1 per cent of GDP.

***King’s Fund Up-date***

Three years after the publication of *Social care for Older People: Home truths*, King’s Fund posted an update on its website about howthe social care system is still not fit for purpose. It is failing the people who rely on it, while providers are struggling to deliver the required quality of care. The resultant [high levels of unmet need](https://www.kingsfund.org.uk/publications/social-care-older-people) place great pressures on families and carers. The underlying cause is that most of the social care reforms have not been matched with adequate extra funding. This situation is worsened by the under-investment in primary and community NHS services, which is undermining the policy objective of keeping people independent and out of residential care.

Britain is not alone here. The dedication to Globalised Capitalism has caused most rich and emerging economies to not only neglect investment in human health and welfare in their own countries, but also to omit such investment in their aid to poorer countries. However, WHO has retained an enduring faith and activity in its ‘Health-for-All through Primary Health Care’ (HFA/PHC) Programme. The WHO member states should recognise worthiness of this Programme and pick up again on their original faith and commitment to HFA/PHC. In addition to achieving sustainable development, HFA/PHC will improve the capability of dealing more effectively with infectious diseases in their three forms - sporadic outbreaks, endemics and pandemics.

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