

VIEWS & REVIEWS

PERSONAL VIEW

Think about the care in healthcare

Thinking about care separately from health may help raise its standing and ensure individuals get what they need, says **Jonathan Benger**

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You can find the word “healthcare” everywhere. It is often used to describe the broad range of health related services provided to patients in the developed world. On the face of it, the word seems intuitive. We wish the services that we offer to combine both “health” (an improvement in physical, mental, and social wellbeing as a result of specific interventions) and “care” (the provision of support, compassion, and personal assistance). Recent events in the United Kingdom—exemplified by the problems in Mid Staffordshire¹—suggest that although we may be skilled in providing health interventions, we sometimes fail to provide the care that people need.

To examine this further it may be instructive to divide health from care, and consider them as separate entities rather than one unified package. Health is traditionally the domain of doctors, who are accorded high status in society and substantial salaries as a result. Health is a highly valued commodity, enshrined in the National Health Service (interestingly, not the National Healthcare Service), and is of such importance to the public that its budget has been protected by politicians in a time of national austerity.

Care, on the other hand, is accorded no such privileges. Care may be provided by skilled nurses, but they are still seen as having a lower standing than doctors (making care subservient to health). All too often care is delegated to the lowest status and lowest paid workers, who may not even be recompensed for travel time between domiciliary visits. As a result between 160 000 and 220 000 direct care workers in the United Kingdom are estimated to be paid less than the legal minimum wage.² Care services are afforded no special protection during times of austerity, with recent budget cuts of at least 15%.³

It seems that we are willing to value and protect health, but not the care that inevitably follows—for patients whose life has been preserved by cutting edge health interventions, for example, or for those with long term conditions, or advancing years. Perhaps the promise of something better makes health more attractive than care, yet from my conversations with patients it is clear that when health declines and age increases it is care that we want, and good quality care that we actually need.

Working in emergency medicine, I often encounter patients who need care but find themselves in an emergency department because this care does not exist, or cannot be accessed in a timely way. I have no care (outside hospital) to offer, unfortunately, and so I offer health (hospital admission) instead. Trying to provide health instead of care, however, is not a good substitution for either the patient or the system.

Modern hospitals are designed principally to deliver health not care, and are an expensive way of supporting somebody who needs a little extra care while they recover from an infection or a fall. Hospitals are not without risk and, aside from causing further infections and falls, patients admitted to them needing care may find themselves burdened by unnecessary tests, additional diagnoses, new drugs, and “too much medicine.” Many of the health interventions being delivered in acute hospitals could be readily achieved in community settings (supported at home or in nursing homes or community hospitals) where they are convenient to the patient, and where an emphasis can be placed on care.

We should ask why healthcare can’t be delivered as a whole package, and we should certainly strive to ensure that hospitals provide both excellent health outcomes and excellent patient care. Skilled care for high dependency patients is essential to recovery from major health interventions such as surgery. In seeking to reform and improve the system, however, it may be helpful to consider each patient’s needs and wishes under the two separate headings—to determine whether health or care dominates and therefore the best approach for that individual.

The ongoing Urgent and Emergency Care Review, led by Professor Sir Bruce Keogh, places an emphasis on management outside hospitals for patients wherever possible.⁴ Such patients will have care needs that predominate, with simple health interventions (such as antibiotics) delivered at home, and transfer to a hospital only for a defined purpose (such as computed tomography), with a return to a community based facility as soon as this has been completed. Such an approach, and shift in thinking, has the potential to achieve the goals of the Keogh

review but requires radical changes in system behaviour and approach.

Current initiatives to integrate health and social care may go some way to tackle the current imbalance. However, because better care is clearly required, and total budgets are fixed, this may inevitably result in less health and more care. Such a change will be challenging to achieve in terms of organisational culture, professional status, and service provision, but it may well prove to be the right choice for all our futures, come the time when health can no longer be improved, and what we really need is care.

Competing interests: I have read and understood the BMJ Group policy on declaration of interests, and have no relevant interests to declare.

Provenance and peer review: Not commissioned; not externally peer reviewed.

- 1 Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. HMSO; London, 2013. <http://www.midstaffpublicinquiry.com/report>.
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- 4 NHS England. High quality care for all, now and for future generations: Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report. NHS England; Leeds, 2013.

Cite this as: *BMJ* 2014;348:g4210

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