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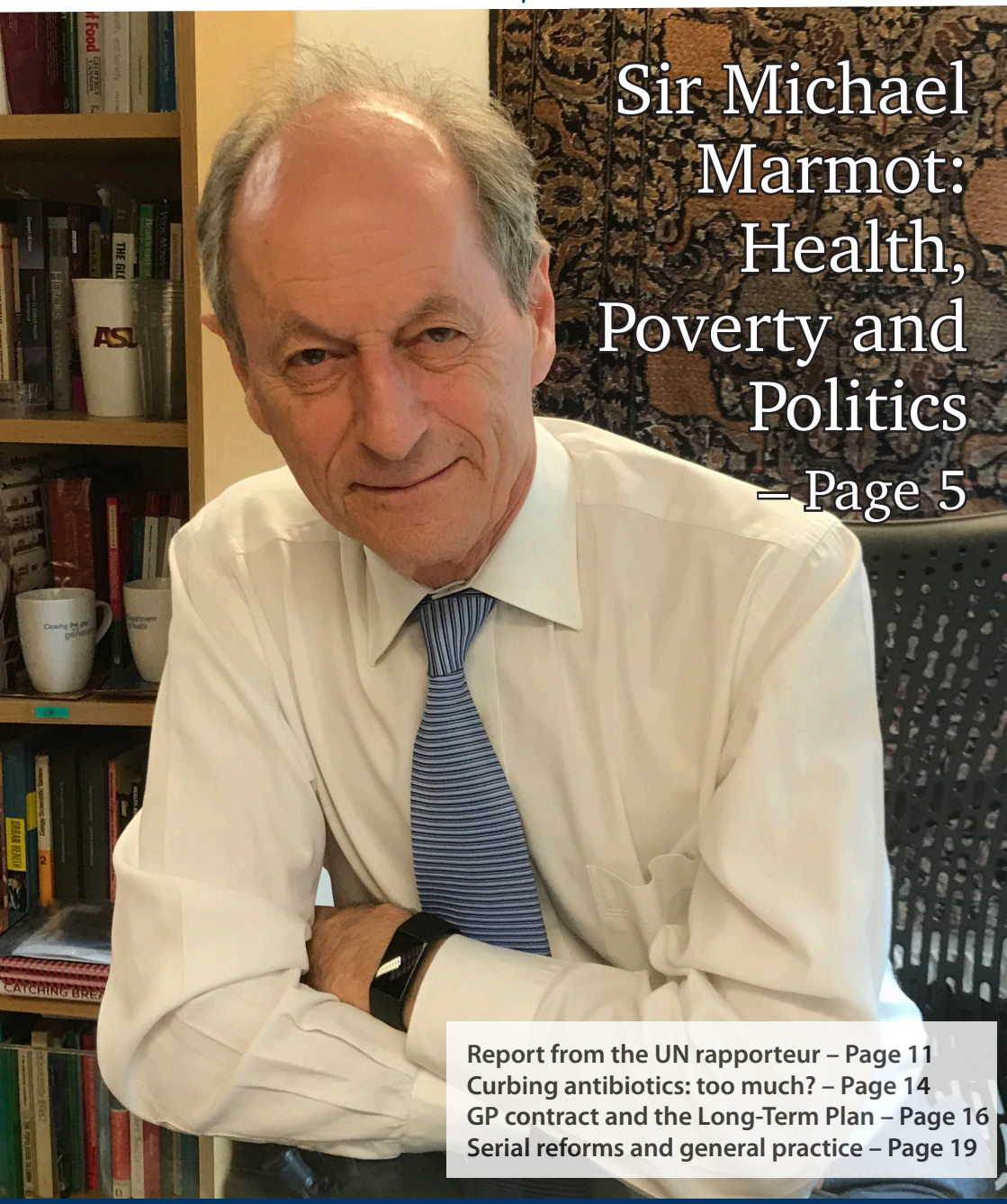

Sir Michael Marmot: Health, Poverty and Politics – Page 5

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Production notice: the newsletter will now be printed in October, January, April and July. This is to allow AGM reports (printed in the October edition) to reach members much sooner than at present.

Austerity – very bad indeed for the health and wellbeing of the UK

The austerity package announced by George Osborne in 2010 was unquestionably a disastrous decision, at least according to the academic economists.

Unfortunately they have long been sidelined because they are mostly unsympathetic to the neoliberal macroeconomics now hard-wired into the UK for four decades or more, and supported and promulgated by all the major political parties, including the Liberal Democrats in coalition while austerity measures were at their most vigorous. Osborne's economically illiterate attempt to eliminate the government's current deficit by no later than 2015 dragged with it, quite unnecessarily, public investment, which by definition isn't included in the current deficit, but of course was annexed surreptitiously by the persistent small-government tendency embedded in modern conservatism. Clever contemporary use of language encouraged support from the small number of vacillating politicians and the public. 'Austerity nostalgia' is also locked into the whole political spectrum, whether through wartime ('Keep Calm and Carry on') and the postwar period or – very importantly for the Tory spin doctors – the distant monochrome memories of the three-day week. (If you're unconvinced by this deep use of language, recall that the 4 hour A&E 'target' was eventually replaced by the 4 hour 'standard'; then more recently, and just like 'austerity', was magically waved away.)

Economic austerity was objectively a failure too, as the deficit wasn't reduced as much as anticipated. Even so, the government continued a long tradition of ensuring a headline (3 years of sterile Brexit dogmas) prevented other, more damaging, matters to dominate the headlines, in particular an unstoppable drip of measures designed to restrict access to benefits (the best-known, though quantitatively the least significant, being the 'bedroom tax', but in total amounting to nearly £19 bn per year; *Health in Hard Times*, 2019, ed Clare Bambra). The overall programme of fiscal austerity was widely adopted by many European countries under the watchful gaze of the authoritarian European Central Bank, but the UK, in spite of universally being considered to have the 5th highest GDP in the world, was assessed as imposing one of the three most austere packages. Simon Wren-Lewis, an Oxford economist, quoted Paul Krugman's 'confidence fairy' as the fantasy version of economic common-sense underlying the austerity myth.

The impact of a decade of austerity has been terrible, but using the relatively simple statistics we rely on these days, it is difficult to put numbers on the population effects, especially concerning health. Estimates converge that around 5% of GPD has been lost permanently by delaying the recovery through austerity, somewhere between £1500 and £3500 for every individual. Writing late last year, Wren-Lewis considered that in practice the austerity agenda still continues, and may free up only £20 bn, which even if it were entirely allocated to the NHS would have almost no meaningful impact on improving healthcare delivery.

In this issue, Michael Marmot, suitably cautious, believes that the complex but cumulative effects of multiple factors resulting from austerity has caused a steep and consistent decline in life expectancy, starting surprisingly shortly after imposition of austerity (see page 5). The life expectancy of those in lower socioeconomic groups has separated even further from more affluent groups. Several reports, including data from Stockton, which

includes one of the most deprived populations in the country, highlight a large, and probably growing gap in life expectancy, almost 15 years. The carry-forward effect of a decade of deprivation will probably continue to widen this gap. And we must remember that under nearly all likely governments, austerity will continue: Labour, even after its successful Keynsian expansion in the early years of the millennium, remains burdened by its decades-long reputation, perpetuated by the media, of economic untrustworthiness. Wren-Lewis writes convincingly about the 'mediamacro' view of economics which has embedded the idea, first mooted, wrongly, and many years ago, by Margaret Thatcher, that the economics of a nation must replicate the morally mandatory budgetry of a well-run household.

Austerity in the NHS is unlikely to end either. It has had a miserable decade of funding and its position in many health outcomes compared with similar healthcare systems has remained mediocre, and may fall back even further. The annual OECD report (*Health at a Glance*, 2018), confirms that while many countries cut back on health funding after the crash, the UK was particularly draconian, with zero growth in healthcare spending in the 5 years between 2009 and 2013, and a pitifully small increase, 1.3% in the subsequent 5 years up to 2017. It's hard to believe that, in spite of the view that the techno revolution in medicine will compensate for this simple headline figure, key indicators will not continue to lie well behind those of other European nations, and, as Anna Athow relates (see page 16), the welter of jargon and acronyms/abbreviations in the new *Five Year NHS Plan* (also nicely downplayed while we have been consumed by Brexit) barely conceals significant cost-cutting measures in primary care and in hospital medicine. Most importantly, in spite of torrents of position papers and warm Tweets, the integration of healthcare, social services and community provision, especially for mental health, remains another myth.

Recently the IPPR quoted a wide range of meaningful measures that place the UK at the lower end of European healthcare performance (e.g. poverty rate 9th out of 11 comparable countries, child poverty 8th – and shockingly ridiculed recently in the government's response to a UN report confirming the dreadful poverty situation; life expectancy 9th; self-reported good health 8th). They conclude that much of this is due to our total tax revenue, which at 33% of GDP is way below the 42% European average. Rapidly making up that difference might do much to mitigate the effects of the unnecessary imposition of austerity on the UK. However, ensuring this percentage does not rise, and could even fall through another embedded myth, trickle-down wealth stimulated by a low-tax strategy, is strongly supported by the candidates to be our next Prime Minister, and not sufficiently strongly opposed by the other parties. Bad times behind us, not much better ahead.

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An interview with Sir Michael Marmot

Alan Taman interviewed Sir Michael Marmot for DFNHS. Sir Michael is Professor of Epidemiology at University College London and Director of the UCL Institute of Health Equity

Q: How would you describe the state of health equity in the UK?

A: If we look at the constituent countries of the UK, in England the rise in life expectancy has pretty well stopped. Life expectancy is going down for men and women in Scotland. It's going down for men and women in Wales and it's going down for men in Northern Ireland. The regional differences of the constituent countries of the UK is widening, and then if you look by levels of deprivation of areas, what we see is the more affluent the area the bigger the increase. So the inequalities are getting bigger, and for women in the bottom five deciles of deprivation life expectancy's actually going down.

Q: Is health service provision at risk of becoming so fragmented that it is not only incapable of achieving the aspirations you mentioned in the Marmot Review but may also directly contribute to inequality?

A: I'm not the best person to ask! But in theory, yes it could. And in practice, yes it could. Because my view about the NHS is, it's not lack of healthcare that causes the problem in the first place, but when people get sick they do need access to high-quality healthcare. And if they don't get it, that adds insult to injury. If the likelihood of getting it is related to individuals' socioeconomic position, that could contribute to increased inequality.

> "I am concerned with poverty not just because I think poverty is a bad thing but because it damages health... it's important the population understands the argument."

Q: Inequities in health isn't something that occurs to most people. It's clear you believe this should be more apparent to them. There seems to be a perceived need to enable campaigning groups and others to be more aware. Why is that important?

A: To the extent that we live in a democracy, we want politicians to listen and be responsive to what people think they need. If they think that good health is about getting an appointment to see the GP – well, it is important, that's miserable if you ring your GP and you're told 2 weeks and you worry, I'm not downplaying the importance of that – but I argue that I am concerned with poverty not just because I think poverty is a bad thing but because it damages health. If somebody says 'the poor today, there's no comparison, they've all got televisions and they're clothed and they've got decent housing, what's the issue?', the issue is the social gradient in health. The fact is, the lower you are down the social hierarchy the worse your health.

So understanding how these conditions through the life course, my six domains in the *Marmot Review* (early childhood development, education, employment and working conditions, having enough money to live on, sustainable and healthy places to live and work, and taking a social determinants approach to prevention) in my view gives extra fuel to the argument for changing them. These are health issues. When politicians say 'we have to take the difficult choices', yes – having children grow up in poverty and condemning them to worse health, that is a difficult choice, I agree. But let's make clear that you understand what the choice really is. It's not 'we're going to change the tax rate', we're talking about the conditions that affect children's lives that will impact on their health. I think the health argument is important. If it's important then it's important that the population understands the health argument as well as the politicians.

Q: How important do you think the media are to that?

A: The media are vital.

Q: Is public engagement the antidote to blame, stigma and denial associated with health inequality

largely directed at those suffering the worst?

A: I think that my response to people who want to blame individuals for their poor health is to show the evidence. I think it was Jonathan Swift who said 'If a man reached his view other than through rational thought, it's unlikely that rational thought is going to change his view'. If somebody reaches their view through means other than evidence and rationality it's unlikely that my evidence will change their view.

On the other hand, I can't engage in the non-rational debate. So if somebody says 'poor people have only got themselves to blame if they don't feed their children properly', I can show you the evidence that if people in the bottom 10 per cent of household income followed Public Health England's healthy eating advice, they would spend 74 per cent of household income on food. Don't blame those people for not eating healthily. Or if they're eating healthily, don't blame them for not paying the rent. Or if they're paying the rent don't blame them for having their children grow up in cold houses because they couldn't afford to heat them. If people are irresponsible, why is that smoking rates have come down but obesity has gone up? How did we get an outbreak of responsibility in relation to smoking and an outbreak of irresponsibility in relation to eating?

> "The evidence is against the blame narrative. Personal responsibility is important but let's deal with the social conditions then we can worry about personal responsibility."

The evidence is against the blame narrative. That's why I argue from the evidence against the blame narrative because I don't know any other way to do it! The evidence is, it's the conditions that are leading to these issues. Deal with the conditions, and some people will be to blame for their choices that lead to bad health. This footballer who died in his Mercedes at 120 mph or something: a very rich person, a very expensive car, he was going at 120 mph or whatever it was. So get people out of poverty and some will be to blame for their bad choices. So blame is important and personal responsibility is important but let's deal with the social conditions then we can worry about the personal responsibility.

Q: A sceptical view is that we have had a long and dismal history of policy in the UK about addressing health inequalities where excellent reports have sounded warnings which have foundered on ineffective political action. You're going to do a follow-up to the Marmot Review next year, the Marmot Review 10 Years On. Why is there a need for this?

A: Firstly, I'm not depressed – and that may be a good sign of a secure childhood but I'd say it's the evidence! There is some research looking at New Labour's strategy to reduce health inequalities which looked at life expectancy in the poorest 20 per cent of neighbourhoods and compared it with the rest. They looked at that gap from 1983 to 2002 (New Labour came in 1997 and took a few years to develop a strategy and implement it), 2003 to 2012 and 2013 onwards. During the period when New labour was in power the gap between the poorest 20 per cent and the rest got narrower. From 2012 on, it increased again. So to say that we've still got health inequalities and they're increasing, nobody's paying attention, the fact is when they did pay attention it looked like health inequalities got smaller. Well, that's encouraging. It's not proof of causation but it's a correlation in a very interesting direction.

You get a government, and I'm not holding a candle for any particular government, I'm not being partisan, but the fact is they did have a strategy to reduce health inequalities, health inequalities did get smaller during the period that strategy was in operation and got bigger again when it got ditched. Inequalities in infant mortality got smaller during

that period and got bigger again afterwards. That's consistent with, at the very least, the magnitude of health inequalities going down as well as up, without making any causal attribution. If it can go down as well as up we shouldn't accept the current pattern as being inevitable. It happened that inequalities went down at a time when there was a government that had a policy to try and make them go down. That doesn't prove causation but it is interesting.

Q: Do you see 'downstream drift' [the focus of health policy on lifestyle choices, at the expense of social determinants] as a continuing problem?

A: Yes it is a continuing problem because people of good intention say 'what can we do? We can't reduce poverty so we'll try and get people to give up smoking and take statins'.

They're probably good interventions but it's not addressing the fundamental issues of inequality and social determinants of health. I can understand why people drift that way because it's something they can cling on to and say 'we've got an anti-smoking policy and we're trying to deal with it', which is very important, I'm not against it. A smoking expert here [UCL] was concerned that by my emphasising social determinants and fundamental drivers I was downplaying the importance of smoking. Not at all.

If you can improve health by taking some short-term action that would reduce smoking that's worth having. Even if it was taken up by the higher income people and not the lower. It's still worth having to improve health but to go home and say we've done the job now is not acceptable at all. We've got say if we've got a social mission to reduce inequalities then simply going on that downstream intervention is not enough.

Q: Do you think there's a danger that interventions like this over-play the influence of lifestyle factors and feed into the blame narrative?

A: Of course. I talk about the causes of the causes. We know that obesity, unhealthy eating, smoking, inactivity and the like are causes of ill health but we need to look at the causes of the causes. The other side of the blame narrative is personal responsibility. I am all for people taking personal responsibility. Let's create the conditions where they can exercise that responsibility.

Looking at road safety, we know that the more deprived the area, the more likely children are to be killed by a motor vehicle incident. We know that traffic calming reduces that likelihood. If a child runs out into a busy road, you could say the parent is being irresponsible. You could say the child's being irresponsible. I am not excusing parents' inexcusable behaviour in somehow allowing the child to do that.

My guess is in many situations like that the parent has another child, or was distracted – it is the whole situation.

> "If you can improve health by taking short-term action that's worth having ... but if we've got a social mission to reduce inequalities them simply going on that is not enough. "

Simply to say 'don't let your child run across the road', of course parents have to exercise that responsibility. But why is it more likely to happen in poor areas than in rich areas? How does it happen that irresponsibility follows the social gradient? That's not individuals being irresponsible. When you get a social pattern like that, it means that there are social determinants. If it were individuals it probably would be random. But when you see a clear social pattern we look for social causes.

It's the same with smoking. The fact that smoking follows the social gradient, why is it that person A and person B and Person C all made the irresponsible choice to smoke and they all happen to be at the bottom of the social pile? Well let's

look at the condition of being at the bottom of the social pile rather than just the individual decision about smoking.

Q: You advocate taking an integrated approach to tackling health inequalities.

A: Health tends to be the responsibility of the healthcare system and Ministry of Health but the kind of things that I've talked about, my six domains – take childhood development. One way to improve this is to reduce poverty. That's the responsibility of the Minister of Finance, the Chancellor of the Exchequer. Local services, housing, those are all impacts on children's early child development so we need to be dealing with housing, we need to be dealing with nutrition, with income, with services, we need all of those.

If you're a doctor dealing with a sick child, you need to have regard to who else ought to be involved. What's going on? It's pretty obvious if the child has got an injury and you suspect foul play, you know that you've got to get involved somehow, and you as a GP may feel that you yourself don't have the resources to handle this but you know that others have got to get involved. There's got to be joined-up services. When the firefighters in Liverpool told me that if a firefighter goes in to a house and suspects domestic abuse, the firefighter doesn't say 'not my problem', what they say is 'I'm not equipped to handle this but I know who is' and makes the right phone call. If we can get the firefighters involved in doing this kind of thing then we need to get doctors, nurses, and other services joined up. Joined up at government level.

The whole move to social prescribing is a way of dealing with that for GPs but more generally, we're working with Coventry and now Manchester and they've gone right across the patch looking at my six domains, trying to work together to address them.

Q: You mention the importance of 'A culture of research and evaluation involving the public' – Involve how and why?

A: When I was doing the *Marmot Review* and I went to Liverpool, I gave a lecture to some community groups. From what they said, I gathered they did not want an outside expert telling them what to do. They were talking about me! They said our values should determine our priorities and that the journey is important as well as the destination. They recognised that it was not just programmes and services but the nature of society that's got to change.

I asked them if it was more important to you that it be yours than that it be effective? You'd rather do something that's yours and doesn't work than something that's mine that's effective but not yours? They said, tell us the principle of what works but let us do it our way. That seemed to me a good principle. That is engaging the population in their values, their goals. It's using expertise in the right way so this is not being anti-expert. I work at an elite university; I'm all in favour of experts! But it's using the experts and expertise in the right way.

Over the last few years I've spent a lot of time advocating for health in indigenous Australians. Going up to the top Northern Territory of Australia. They gave me a very clear message, the indigenous groups. How would you imagine that a policy designed in Canberra or Sydney would be appropriate for what we're doing? Who would ever imagine that that would work? Down south, they say nothing seems to work. Then you go up north and they say 'of course it doesn't work, they haven't got a clue what our lives are like, and they

come in and they throw these programmes at us and we don't like them'.

You can't make progress without engaging the community. That doesn't mean they are interested in me telling them what to do or how to do it. They're very interested in knowing about evidence and understanding what works and what doesn't.

That seems to me a good model. The principles of that could be applied in Merseyside or they could be in Western Sydney.

Q: How would you counter the criticism that this risks skewing solutions to suit a particular prevailing bias politically – disregarding the evidence, in other words?

A: That's the outstanding problem of trying to get people to take seriously what the evidence shows. People have told me you need more than evidence to get political change. That may well be the case. but I know the bit of it that I can do, which is presenting the evidence in the clearest way I know how. I know there's a real thirst for it. which is one of the reasons I'm not depressed! People want to heart the evidence. Now they may not all be in Westminster and while evidence may not be sufficient to get political change, once we say 'we don't need evidence to get political change' then we're in Trump land and Brexit land. You can't make up facts to suit your purpose.

Q: You've described yourself as an optimistic researcher. Given all that we've discussed and the grave risks to health, why do you remain hopeful?

A: I can show you my inbox! E mails from Westminster, Manchester, Wales, Japan, the USA, Brazil, European groups, the BMJ, Hong Kong, the WHO, and I'm still on yesterday and today. So why wouldn't I be optimistic? There's all this interest in what we're doing and people wanting to hear about it and act on it. There's no doubt there's the evidence that there's huge thirst for knowledge about all of this. People are really interested. They may not be the politicians, and that's who we need to talk to, but this is talking to the WHO, the World Medical Association, I've been aske to speak to a meeting on universal health coverage before the next G20 meeting, on social determinants of health. Why would I not be optimistic?

Q: That suggests the political will to try to overcome the social determinants of ill health is still there?

A: It's all over the place. It means there's a huge amount of interest. A lot of people want to get engaged in this topic. In the USA, at city level and in their universities, people are talking the language of social determinants of health. They're not talking it in the White House but they are are in cities, in the USA, in Europe and elsewhere. Is that enough evidence to account for my optimism?

Q: Yes, I think that explains it very well, thank you! Finally, digital health, use of digital devices. How do you think that could be used or applied?

A: Yes, everybody's talking about digital health. I must get my head around it. I don't know, I'm talking about child poverty and people are asking me about the digital revolution...well, give families enough money to raise their children in decent conditions. I'm just struck that I've been asked that question so often recently, as if somehow this is the future. It may be part of the future but if we can improve the conditions in which children grow up, that's also part of the future. It's common that innovations in the early stages increase inequalities.

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Poverty in the UK: Unfair Society, Shorter Lives

Report from the United Nations special rapporteur* to be presented to the UN in June/July 2019

On 10 December 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights. Article 25 reads:

> **"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 his control."**

Philip Alston is a professor of law at New York University School of Law and was the UN special rapporteur on extreme poverty and human rights on a 12 day visit to the UK*. He received more than 300 submissions before issuing his preliminary report in November 2018. In the December newsletter my article Hammering the sick poor used his preliminary report to comment on the deleterious effects of two benefits related to medical illness, employment and support allowance (ESA) and personal independence payments (PIP). Alston's final report [1] (posted online on 23 May) will be presented to the UN Human Rights Council in June–July 2019 and I report on it here in a wider context than ESA and PIP.

Alston writes that the philosophy underpinning the British welfare system has changed radically since 2010. The initial reasons for reform were to reduce overall expenditures and to promote employment as the principal "cure" for poverty. But when large-scale poverty persisted despite a booming economy and very high levels of employment, the Government chose not to adjust course. Instead, it doubled down on an agenda to reduce benefits by every means available, including constant reductions in benefit levels, ever more demanding conditions, harsher penalties, stigmatization, and virtually eliminating the option of using the legal system to vindicate rights.

The driving force has been a commitment to fundamental social re-engineering and there has been a restructuring of the relationship between people and the state. The message is delivered in the language of managerial efficiency and automation. This is a far cry from any notion of a social contract, Beveridge or otherwise. Thomas Hobbes observed long ago that the poor are condemned to lives that are "solitary, poor, nasty, brutish, and short", conditions which are becoming the new reality.

**The UN Human Rights Council set up in 2006 appoints experts whose mandate is to "examine, monitor, advise, and publicly report" on human rights problems. It oversees 43 themes and has mandates for 14 specific countries. Currently there are at least 38 special rapporteurs (i.e. investigators), special representatives and independent experts.*

The UK is the world's fifth largest economy, yet 14 million people, about a fifth of the population, live in poverty. Poverty is defined relative to the standards of living in a society at a specific time. People live in poverty when they are denied an income sufficient for their material needs and when these circumstances exclude them from taking part in activities which are an accepted part of daily life in that society. In the UK context, poverty means choosing between eating and heating homes, parents not eating in order to feed their children, children going to school ill-clad and hungry, food bank usage (up four fold since 2012) and homelessness (up 60% since 2010). In-work poverty associated with low wages, insecure jobs and zero hours contracts is increasingly common and almost 60% of those in poverty in the UK are in families where someone works. Nearly half of those in poverty, 6.9 million people, are from families in which someone has a disability. Four million are more than 50% below the poverty line and 1.5 million experienced destitution in 2017, unable to afford basic essentials.

"The UK is the world's fifth largest economy yet 14 million people live in poverty...Those in crisis are pushed towards services that cannot turn them away, but cost far more."

Sure Start children's centres, first introduced in 1999, targeted highly disadvantaged neighbourhoods and dealt with the time span from pregnancy to age 5. They played an important part in organising and providing services for families, so that every child would have "the best start in life". In 2004, a 10-Year Strategy for Childcare called for a children's centres in every community, which transformed the initiative into a universal service. At its peak in 2009–10, Sure Start had 3,600 centres and a budget of £1.8 billion (in 2018–19 prices). The Institute for Fiscal Studies showed major health benefits for children in the most deprived areas with a substantial reduction in hospital visits, £millions saved for the NHS and a reduction in health inequalities [2]. Austerity has cut the number of centres by about 1,000 with funding falling by two-thirds to £600 million in 2017–18. Child benefit will have lost 23% of its value between 2010 and 2020. In 2018 almost a third of children in the UK live in poverty and this is scheduled to rise to 41% in 2021-22.

The National Audit Office estimates that funding to local authorities in England has seen a 49% real-term reduction from 2010-11 to 2017-18, this at the same time as demand for key social services has risen. The current trajectory for local government is towards narrow core services increasingly centred on social care [3].

For those living in poverty, libraries constitute the means of access to a computer which is necessary for digitised benefit claims. However 340 libraries have closed and 8,000 library jobs have been lost. Local Welfare Assistance Schemes have closed leaving vulnerable people and those facing emergencies with nowhere to turn. In 2013 the government abolished its centralised Social Fund which helped people with expenses that were difficult to meet e.g. funeral expenses.

These reforms have cost far more than their proponents admit. The many billions extracted from the benefits system since 2010 have been offset by additional resources required elsewhere. £78 billion per year has had to be spent to repair what poverty has done to people's lives. Cuts to preventative services means that needs are unmet and there is an increasing use of emergency services. Those in crisis are pushed towards services that cannot

turn them away, but cost far more, such as A&E, expensive temporary housing and the ever-shrinking, overworked and underfunded police force.

In 2014-16, males living in the least deprived 10 per cent of areas in England and Wales could expect to live almost a decade (9.3 years) longer than males living in the 10 per cent most deprived areas, and for females the gap was 7.4 years [4]. The gap in healthy life expectancy at birth is even greater – about 19 years for both males and females; those living in the most deprived areas spend nearly a third of their lives in poor health, compared with about a sixth for those in the least deprived areas. 2010 marked a turning point in long-term mortality trends, with improvements tailing off after decades of steady decline of mortality – in both males and females, and at younger and older ages. In the 100 years to 2010–12, life expectancy increased by nearly three years every decade [4], but between 2011 and 2016 it increased by only 0.4 years for males and 0.2 years for females. 2015 was an exceptional year when life expectancy fell across virtually all of Europe. The age-standardised mortality rate in England and Wales in 2015 increased by 3 per cent for males and 5 per cent for females over 2014, leading to a fall in life expectancy*. Although life expectancy picked up in 2016 and 2017, the Office for National Statistics announced that the mortality rate in the first quarter of 2018 was higher than in any quarter since 2009.

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*[*See also page 6.]*

Curbing Antibiotic Use: Has it Gone Too Far?

The emergence of antimicrobial resistance (AMR) is a regular subject of headline news reports in the UK. Media reports echo statements from the government and Public Health England blaming us: as patients we demand antibiotics and as clinicians we overprescribe.

Glover, Dangoor and Mays1 in "Antibiotic resistance: don't blame patients" [1] rightly disagree with broad condemnation of the public. They maintain that GPs deal with patients who are justifiably concerned about sepsis but rarely "demand" antibiotics. The suggestion that over-prescribing by GPs is to blame for AMR is also misguided as antibiotic resistance does not emerge in the community but in hospitals with later spill-over into the community. An early example is the emergence of penicillin resistance in *Staph aureus*. In the 1950s microbiologists would identify a penicillin resistant *Staph aureus* infection as being one that was likely to have been acquired in hospital but for several decades community acquired *Staph aureus* remained penicillin sensitive until resistant strains spilled over from the community. Penicillin was widely used but selective pressure is less intense in the community as long as antibiotics are not available over the counter.

The emergence of AMR is inevitable in intensive care and other hospital settings where immunocompromised patients receive repeated courses of several different antibiotics. Antibiotic selective pressure is more intense in this setting and results in the selection of the more antibiotic-resistant strains of bacteria: multidrug-resistant (MDR), extensively drug-resistant (XDR) and even pan-drug-resistant (PDR). Unless tightly controlled, these pathogens will spread within the hospital and out into the community.

Methicillin resistant *Staph aureus* (MRSA) is the AMR pathogen most frequently reported by the media. MRSA – first reported in the UK – emerged as a serious pathogen in hospitals by the late 1970s. In the UK, the epidemic occurred because initially, in some quarters, it was not thought to be a serious invasive pathogen so its spread was not controlled. Measures implemented to control the epidemic focussed on hand hygiene and basic control of infection measures and then a 'search and destroy' policy. Other measures, like 'bare below the elbows' were of dubious and unproven value but were enforced to convey the message that doctors were to blame. Cross infection in hospitals has been clearly shown to be related to bed occupancy and adequate numbers of staff especially nurses. Busy understaffed units will find themselves unable to fully comply with recommended infection control measures. This may explain why infection control measures have not been uniformly effective in the UK. Environmental hygiene is also recognised as being important as MRSA and other pathogens can persist in the environment but cleaners cannot be fully optimised by hospital staff when services are outsourced. These are the issues which should be highlighted in the media.

Although GPs and patients cannot be held responsible for the current AMR problem, antimicrobial stewardship is rational because antibiotics can have unwanted effects on the patient and the environment. Feedback of data on antibiotic use to individual prescribers may well improve practice but targets and league tables are likely to have negative consequences and are probably a waste of effort as AMR sepsis is increasing despite a drop in antibiotic use.

Antibiotic use should be appropriate and prescriptions should be evidence based. Glover et al [1] cogently examine the factors which may

influence antibiotic prescribing in general practise and draw attention to the uncertainty surrounding the diagnosis of infection. Inexact diagnosis will certainly lead to over- or under-prescribing. When a clinical diagnosis of infection is made, the evidence base is provided by microbiological confirmation of infection. But is this being thwarted by the pressure to reduce laboratory costs? A recent report on antibiotic resistance [2] described the case of a patient who was given 'the usual treatment' for a urinary tract infection and then again for a relapse but on both occasions without the benefit of urine culture. The infection with a multidrug resistant organism was diagnosed only after her hospital admission with sepsis. Microbiology tests are expensive compared with the ever-popular biochemistry profile but urine culture is relatively cheap and a report is often available within 24 hrs. A symptomatic patient should be able to self-refer and request a culture through the clinic receptionist. This is acceptable as long as adequate clinical data are recorded on the request form.

The two children Marcie Tadman and Jack Adcock, whose deaths from sepsis have been publicised, were both said to have succumbed to Group A Streptococcal (GAS) pneumonia and there have been several recent outbreaks of scarlet fever. Are GAS infections being missed because microbiology tests are being avoided? Sore throat is commonly due to a viral infection but streptococcal infection cannot be excluded on clinical criteria. Most laboratories can ensure that culture results from throat swabs are available within 24 hrs. Centralisation of laboratories may make this difficult.

In hospitals too antimicrobial stewardship should not merely centre on targets for reducing the cost and volume of antibiotics used. Early treatment of sepsis remains the priority. Sepsis is currently defined as 'life threatening organ dysfunction caused by a dysregulated host response to infection'. It is crucial to grasp that window of opportunity before organ dysfunction progresses to a stage which is difficult to treat. As a hospital microbiologist I supported the administration of antibiotics as soon as infection was considered a possibility but immediately after obtaining blood cultures. This preceded the pursuit of markers for sepsis staging and other diagnoses. The antibiotic prescription was stopped when an alternative diagnosis was made and ward pharmacists became adept at pursuing doctors for a diagnosis if antibiotic prescriptions were continued. Blood cultures were not obtained from Marcie Tadman nor from Jack Adcock

Scare campaigns should be replaced by sound information. AMR emerges in hospitals and resistant bacteria are prevalent in hospital settings. Patients should be made aware that they may become colonised with resistant bacteria if they are hospitalised or are regular visitors to hospital clinics or wards. Hand washing should be promoted. Hand sanitisers have a place in a healthcare setting but the widespread use of sanitisers and anti-bacterial soaps in the community should be discouraged. Patients should not be discouraged from seeking healthcare if concerned about an infection. Laboratory support for the diagnosis of infection should be adequate and readily available.

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Hidden Plans?

The sinister links between the new GP contract and the NHS Long-Term Plan

The title of the new GP contract is "Investment and evolution; A five- year framework for GP contract reform to implement the NHS Long Term Plan." 31.1.19 (Framework).

The main aim of the NHS Long Term Plan 7.1.19 (LTPlan) is to establish Integrated Care Systems (ICSs) throughout England by 2021. And for these to evolve into Integrated Care Providers (ICPs) (Ps 29 - 31 LTPlan).

ICSs and ICPs were previously called Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs). It was against the latter that Judicial Reviews were fought by NHS campaigners from 2017.

In January Allyson Pollock and Peter Roderick exposed the potential for single contract organization ACOs to be run by private companies to make profit out of commissioning and providing NHS health and social care for large populations of NHS registered patients, on huge long term contracts [1].

The purpose of ICSs and ICPs it to totally transform the payment systems and the delivery systems of health and social care in England, along the lines developed of US Accountable Care [2,3].

In the latter, providers of healthcare are incentivised to work together, to commission and provide the vast majority of healthcare for a whole population, on a capitated budget. The commissioner and provider align objectives to make a surplus on the budget, whilst pledged to achieve quality standards. The basic principle is that of American Health Maintenance Organisations (HMOs) "the less care you provide, the more money you make".

Methods used to commission and provide care below budget are the following:

- develop keen leaders
- risk segment the population
- sophisticated digital systems to promote virtual consultations
- share patient data and collect data on health service use and cost
- 'integrated Multidisciplinary teams" of mainly non-doctors adherent to managed care pathways providing 24 hour continuity of care to keep patients out of hospital substituting for doctors as often as possible.

Ruthless imperatives are to:

- reduce 'skill mix'
- continually redesign care to cheapen and cut it and
- **stop patients accessing hospital care**

The favoured payment systems are:

- capitated budgets (whole population budgets)
- performance related rewards eg QOF and CQUINs in England
- 'Shared Savings Schemes'

All of the above characterise the "new Service Model for the 21st Century" promoted in the LTPlan Chapters 1 and 7) and the Framework.

But the confusing way they are written disguises the US style Accountable Care being smuggled in.

The reference to ICS boards on P30 LTPlan actually refers to the STP boards(Sustainability and Transformation Partnership boards) already imposed in 44 areas of England in 2016.

Their remit, known from STP plans, is to make huge cuts, reconfigure care out of DGHs, develop a local system workforce with 'new roles', and get GPs into 'scale' integrated primary care systems.

The barrier to the latter, despite all the Vanguards, super practices and federations that have been created in the last 5 years by NHSE, is the fear amongst GP principals that they would lose their independent NHS contractor status and their life long General Medical Services contracts, which they would in ICPs.

The Framework is being hailed as the solution. NHSE is happy that GPs are being herded into new **Primary Care Networks** (PCNs) enabling the establishment of ICSs, all over England by 2021. The BMA applauds the Framework as a victory for saving GPs' core primary medical services contracts for now.

But the title gives the game away: "five -year GP contract reform to implement the *NHS Long Term Plan*". GPs are being told to sign up to a Network Contract DES (Directed Enhanced Services) as an "extension" to their core practice contract and a Network Agreement, which is a legal integration agreement.

"**The PCN is a foundation of all integrated care systems**…" (P 30 p4.28 Framework)

The practices in agreeing to the Network Contract DES, and the Network Agreement are bound to work together, share patient and other data, carry out network specifications, share network funding for new non-doctor network staff (over 22,000 of them over 5 years) and deliver other urgent care and extended hours services. The network agreement allows providers of other medical and social services to join the new PCN, e.g community providers such as dentists, podiatrists, Virgin provided nursing providers, voluntary organisations, and acute and mental health trusts, Local Authority social care over time.

In signing the Network Contract and Network Agreement (and agreeing a population area covering 30-50,000 or more population, giving their patient list numbers, choosing a Clinical Director to sit on the Sustainability and Transformation STP board, and deciding which NHS contracted body will receive central network funds), the member practices would form a new PCN.

Practices are being jumped into joining PCNs by the end of June. Although this is supposed to be voluntary, pressure is being applied for 100% coverage. The PCNs would work under the direction of the STP via the Clinical Director and must deliver LTPlan and STP directives and protocols or network funding stops.

In this way the STP in the area (1-2 million population) would become real – in the sense of running GPs and patient lists as their delivery arm. ICSs = STP boards + PCNs.

ICSs cannot function without NHS registered patient lists.

Astonishingly, whether practices join the new PCN or not, their patients will belong to the Network anyway (P28. p 4.19) and network services would still be provided to those patients.

Two critical consequences flow from this Framework:

1. Patient lists will in future belong to the practice and to the network. **The ownership of NHS patient lists will in this way be acquired by the ICSs.**

2. GPs will be working to their original practice contracts and to the Network contracts. The two contracts would be double running.

GPs are being assured that as they still retain their core practice contracts – albeit overlayed by the Network Contract DES, and the network integration agreement – that they are safe and their original GP primary medical services duties would remain the same.

But for those with eyes to see – with the augmentation of network funds over 5 years, (£1.8 billion nationally compared to £1 billion for the core practices) the flooding-in of new non-doctor network staff to do GP work, requirements to perform new ways of working, and redesign care, and diktats to reduce hospital referrals and cut hospital care **to achieve shared savings for the ICS** – that GPs would lose their autonomous leadership role of patient advocate, prioritising optimal care for their patients. GPs would find themselves having to endorse the constant cheapening of care and denial of hospital treatments.

GP practices would become entangled in the Networks physically and financially and find it difficult to get out again. They would be better to not sign up. Over half of GPs are now salaried sessional or locums and the BMA GP memberships has not had a vote.

This Framework is a thousand times worse than the GP contract change in 2004. It aims to herd GP practices into networks which form the basis of giant ICSs throughout England.

Through multiyear contract changes devised between the BMA and NHSE, these ICSs would evolve and open the way for fully integrated ICPs on single long-term NHS contracts, tailor made for international corporate takeover.

The American model has been pursued in England by successive governments since Enthoven recommended HMO Kaiser Permanente to Mrs Thatcher in 1990. Simon Stevens (Blair's health advisor 1997-2004; vice president of UnitedHealth, the biggest US health insurance company, 2004-14) was appointed CE of NHSE in 2014 by David Cameron, and then advocated ACO style 'new models of care' in the *Five Year Forward View*.

American accountable care methods are now being imposed in England from within by NHSE, well before President Trump even opened his mouth about more US trade deals.

These proposals should be exposed and opposed by all who treasure the NHS publicly provided according to clinical need, comprehensive and free at the point of use.

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Disintegration of General Practice: The Compound Cost of Serial Reforms

A personal view on why general practice reached its parlous state

Recently both the BBC and several newspapers ran features and news items on the hazardous disintegration of NHS General Practice.

The interviews and analysis, bolstered by a recent Nuffield Trust report, composed an unmistakable picture. This comprised not just inaccessible appointments and almost vanished personal continuity of care. It also portrayed an alarmingly depleted and dispirited workforce: career abandonment, early retirement, sickness and burnout are all reliable indicators.

Why is this? Practitioners and pundits reiterated the usual, now familiar reasons: mostly how funding for our NHS has not matched the increasing demands made of it. Those burgeoning demands come from our increasing longevity with its incurred chronic conditions, the increased expectations that come with advancing technology in our consumerist society, and the mushrooming of mental health problems amidst all this.

Is any of this disputable? Well partly: the Prime Minister claimed (again) that primary care funding and training has recently received unprecedented investment and funding. Yet even if this statement is true, it rapidly dissolves in the face of a more important truth: we are losing GPs far faster than we can securely replace them.

Why is this? Why do doctors no longer wish to do this work?

Industrialised medicine and managerialism

When I first started work as a GP in the early 1970s the hours were certainly as long, the clinical work similarly demanding, and the pay no better. Yet professional morale throughout careers was mostly positive: practitioners wanted to sign up at the beginning, and were reluctant to leave at the end. There were stresses aplenty, but they were different in kind. What is that difference?

The answer is that the profession has lost its personal relationships and satisfactions: its heart, soul and *élan-vitale*. Paradoxically and perversely it has lost them to the successive reforms that theoretically would improve services by yielding greater standardised efficiency and fail-safety. Yet in practice the results have been very different from those intended. Why?

What has happened is that the reforms have almost always led to increasing size, automation, regulation, standardisation and centralisation of control. Superficially this may seem like undeniable progress, but the losses incurred are subtle and much larger than the planning authorities had understood. The losses are those of human scale and responsiveness; thus personal access, relationship and understanding; and the satisfactions and identifications that come from personal continuity – in short, we lose personal rather than technical advantages.

Each successive reform has tended to eliminate these very human rewards. So a factory-like work milieu has replaced an erstwhile family-like colleagueiality, corporation replaces vocation, and impersonal data and procedures displace personal understanding and care.

All these transitions make much more sense to planners and managers in the control-tower of the NHS than the doctors who have

to conform to what may be described as the 'policed industrialisation' of their profession. They feel alienated, afraid, lonely, deskilled and discounted. That is why they leave or get ill.

Meanwhile, patients struggle for appointments with GPs who are likely to be, first personally unfamiliar, and then fatigued and distracted by the many instructions and demands they have from the control-tower.

Few are happy with such an outcome.

Happier times?

So what motivated the happier generation of GPs?

I would say a kind of personal stewardship: tending and growing a sense of people and community. While good medical science is the overt aim and conduit, the coincidental rewards for the practitioner – of personal connection, comfort, guidance and healing – have been, for me and most of my colleagues, the enduring and deeper satisfactions.

"The (then) much smaller practices offered a kind of easier familiarity... increasingly known to the patients, with all the richness and reassurance that can come from respectful familiarity."

Clearly the personal rewards for the GP never had the drama, charisma or technical skill of some specialists – say cardiac or neurosurgeons. GPs rarely seem, or feel, like gods, heroes or magicians. Their satisfactions were (until recently extinguished) more humble, slow and nuanced – again, akin to our better family relationships and achievements.

Indeed these erstwhile doctors were aptly named 'family doctors' as they would often know individuals, and their homes and families, over many years. Not only that, but the (then) much smaller practices offered a kind of easier familiarity much like a kind of extended family, albeit professionally attired, tasked and boundaried. Receptionists, staff and practitioners would be faces, names and natures increasingly known to the patients, and to one another, with all the richness and reassurance that can come from respectful familiarity. *The more you see of someone, the more of someone you see.*

This was the ethos and terrain of the better family doctor until our serial and depersonalising reforms. As a young recruit in the early 1970s I had long discussions with a trainer about the nature and significance of relationships and meaning in medicine. He drew my attention to the thoughts of William Osler, a philosophical physician at the turn of the twentieth century, who said: 'It is as important to know what sort of a person has an illness as what sort of an illness a person has'. In many ways that also parallels the art and science of practice, its humanity and technology.

So for several decades, until the modernist management revolution, GPs could enrich their consultations with the initial question of: what sort of person am I now encountering who is encountering this problem? And then to other considerations of context and narrative: the story and nature of their significant relationships, their network, what gets them up in the morning, what they fear when darkness comes, what do they hope for, what brings them laughter? Anger? Intolerance? Delight?... These are hardly medical considerations, yet they are key to personal contact, comfort and healing – the art and heart of practice.

The threat of modernity

But modernising management has attempted

to largely expel such crucial human knowledge and vagaries as if they are irrelevant impediments to the 'real work' of commodifying and distributing healthcare. Such commodification is now largely modelled on competitive manufacturing industries and nervously policed by governmental watchdogs. Such a mixture of neoliberal economics, industrialisation and policing is what is meant to motivate your current primary care service provider (née family doctor). These motivating forces have three main forms:

1. **The 4Cs:** competition, commissioning, commodification and computerisation.
2. **REMIC:** remote management, inspection and compliance. (The regulation and policing of healthcare as if from a control-tower.)
3. **Gigantism:** the economically mandated scaling-up for 'efficiency'.

The forced convergence of these sticks and carrots – this civic engineering – has yielded us what we have now – a crumbling, so unviable, workforce of sullen, craven, anxiously dispirited GPs who started their careers hoping to accrue the kind of skills and satisfactions they would have enjoyed a few decades ago.

There is one remarkably creative and instructive aspect to this do-as-you're-told, no-one-knows-anyone modernised NHS: we have managed to combine the driven, bullying, venal qualities of our worst capitalism with the stupefying, officious, persecutory centralism of Soviet Communism. In our care of others that is quite an achievement.

No wonder few GPs now want to do this job.

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Threat at hand

GP at Hand, the digital service offered by Babylon which has been running in London, is now extending to Birmingham.

Patients of Birmingham GPs will be able to register with the digital service, which is run from one GP surgery in East London. Patients can access a GP remotely via their digital devices and be referred for further consultation or for treatment. In London, the service has been taken up largely by people who are relatively young, fit, and do not have multiple morbidities or serious chronic conditions.

As things stand, GP at Hand has been criticised for destabilising the funding basis for general practice, as 'analogue' practices (ie, those still using face-to-face consultation and physical presence) lose the funding for the younger, fitter, less demanding patients to GP at Hand – and are left with those with greater demands, but reduced funding overall. Also, the funding stream for the digital service currently runs through one CCG in London, which thereby accrues the cost of all the patients using GP at Hand – wherever they live. Imagine routing the M25 through a single A road...

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