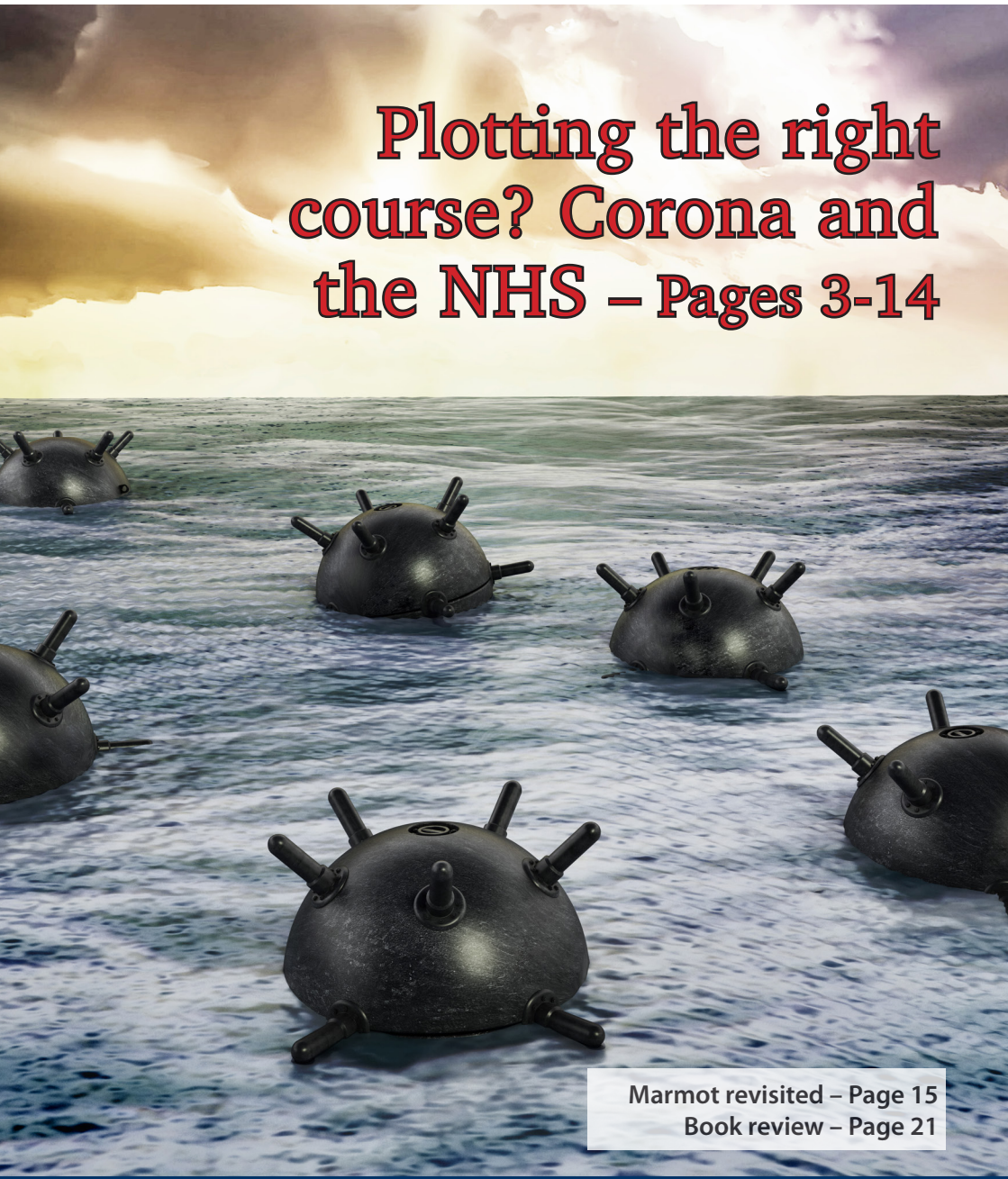
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Plotting the right course? Corona and the NHS – Pages 3-14



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APRIL 2020

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Fall-out

In a search for distraction from plagues and pestilence, I have been cheering myself up by watching the powerful HBO drama, "Chernobyl".

If you haven't already seen it, I can recommend it highly. It explores a crisis situation, when people in power are unwilling to admit that the system within which they work might not be perfect, largely as a result of previous political and economic decisions; when the response to concerns is to deny them, and threaten those people brave enough to raise alarm, rather than addressing the underlying problem head on; when every little decision has to be taken at the top of the organisation, but the top is too remote from the front line to understand the decisions that need to be taken. It describes the paralysing effect on initiative, when everybody is looking over their shoulder and seeking authorisation for every action.

It also tells the story of the enormous power and resource that can be harnessed by a unified system, once somebody accepts responsibility for solving the problem and is given the resources and authority to achieve that resolution.

Maybe not quite such a distraction from The Virus…

It is also sobering to reflect that the fall-out from the Chernobyl disaster, literally and politically, probably played a significant role in the subsequent collapse of the Soviet Union.

One of the most powerful scenes involves a group of miners being asked to tunnel under the melting core of the nuclear reactor to prevent contamination of the water supply to the whole region. When they were told the truth about the risks they faced, and were asked for their help as professionals, rather than being ordered to do it, they volunteered willingly and with pride. Although this was a dramatization, much of it rings true to human nature.

Speak to people as adult to adult, and don't pretend that everything is hunky-dory, when it quite patently isn't, and you will gain their respect and support, as long as you are also doing your utmost to put right the problems that confront them.

If you waste time denying that there is a problem, when trustworthy people are experiencing it first-hand, they are more likely to conclude that you are either too stupid to ask the right questions, that you are being economical with the truth, or that you have another agenda. Take ownership of the problem and sort it out!

Although this is not the right time for the essential and extensive retrospective inquiry as to how we came to be in this predicament, there are several serious issues of such concern that we have needed to raise, because they demanded an immediate response.

DFNHS brings together doctors with a huge breadth and depth of professional knowledge and experience. This has given us the authority to speak out against the incoherent communicable disease strategy pursued in the UK over the past 3 months: https://bit.ly/3epaYdZ and https://bit.ly/2XCB6fa. Although this has moved up the political agenda over the last couple of weeks, and more of the right questions are now being asked by responsible journalists, progress has been slow. The answers extracted have been incomplete and often contradictory, giving little sense that a coherent and deliverable plan is coming together.

There still seems to be a reluctance to accept that the 'exit strategy' will require a well-structured and locally organised system for the identification of cases, tracing of contacts and selective quarantine, with continuing support and supervision through that period. This will require a very large number of real, living, people, working in teams, within each community. It cannot all be done by an 'app' (which attracts its own concerns about privacy and confidentiality of personal data on people's phones). We have also been quoted by both the *Daily Mirror* (https://bit.ly/2wGb1AV) and the *Daily Mail* (http://dailym.ai/2RDBDts) on the parlous state of testing

Now eerily familiar – elderly former residents with protective facemasks stand near the Chernobyl reactor site.

in the UK.

The outrageous risks faced by frontline staff unable to access sufficient personal protective equipment in the NHS, social care and other settings, and the price that too many of them are paying for our unpreparedness, are now well documented in the media. We have supported The Doctors Association of the UK in their campaign for adequate personal protective equipment for NHS staff, being amongst the signatories to a letter published in *The Sunday Times* on 22nd March (https://bit.ly/2K6NsnX).

The inability to source sufficient supplies of gowns, masks, gloves and eye protection and transport them to the hospitals, local authorities, health centres, nursing and care homes suggests a lack of grip and imagination at the highest level. The necessary level of manufacture and supply has not been achieved by ministerial fiat, or even by the army, although loud concerns were voiced more than a month ago. The role, in this mess, of the NHS Supply Chain and the contracting out of the logistics services for the NHS to Unipart in 2018 is one of many questions that will need to be subject to rigorous scrutiny, once the worst of the crisis is over, but the immediate priority is for the Government to follow its own oft-repeated advice to "Protect the NHS" – by equipping all staff in line with Public Health England's own guidance.

There is a sense of impatience, in some circles, after only 3 weeks of partial lockdown of the country, that this has all gone on quite long enough. "We are bored of this disease and its impact on our daily routine and anyway, the economy is more important than a bit of winnowing of the population." They need to recognise the likely duration of this emergency. It is not all going to be over by Christmas. The Coronavirus Act 2020, which was enacted on 25th March, can remain in force for 2 years and can be extended further, by periods of 6 months, by Ministers using Regulations, which do not have to be voted through by Parliament. Certainly, the Act could

be revoked earlier, but the implication is that we need to adjust to this new normal. In this respect, we need to understand the scope of the changes covered by this new law as they affect medical practice.

The Coronavirus Act has been presented as a pragmatic piece of legislation to help society to keep going in the face of possible shortages of key members of the workforce, by introducing flexibility to previously rigidly defined processes. It permits the emergency entry onto the professional register of students of medicine, nursing, pharmacy, other health professions and social work before the normal date of completion of training.

It changes the requirements for certification of death. As long as the patient was seen by a medical practitioner within the 28 days before death, even if that was by video-consultation, then a different medical practitioner is able to complete the death certificate. A similar arrangement covers cremation certificates, and there is no longer the need for a confirmatory certification by a second medical practitioner.

Significant changes have been made to the workings of the Mental Health Act and it would be interesting to know the views of members who are psychiatrists on the necessity and the implications of these changes*. It is now possible for a single registered medical practitioner to detain a patient under some sections of the Mental Health Act, when previously it required the recommendation of two psychiatrists. There have been some changes to the length of time during which a patient might be so detained. The application of these reduced safeguards of liberty are only meant to take place if it is felt that a second opinion would be impractical or cause unreasonable delay, but it remains to be seen how often they are used and the impact of their use.

Other changes have been put in place to hasten the transfer of patients from hospital to a social care setting, presumably to free up hospital beds for acutely ill patients. It removes the requirement for an assessment to be made by the local authority of the need for care and support of the patient being transferred. It also removes the need for an assessment to be made of the patient's financial resources, which means that the local authority can put in the funds for the care package without delay, and the Government has given local authorities an additional £1.6 billion, partly to facilitate this. However, if a subsequent financial assessment shows that the patient would have had to contribute to those costs, then the money already spent would have to be reclaimed from the patient, which could lead to problems. Again, local authorities are not obliged to make use of the easing of these responsibilities, but the Local Government Association has welcomed the changes, which they feel will allow them to prioritise support for those with the greatest needs. It will be interesting to hear the views and experiences of members working in Primary and Community Care as to whether the changes help or hinder continuing care.*

The reverberations of this pandemic will continue to be felt for a very long time and have the capacity to change our society in quite profound ways. We need to ensure that those changes are for the better, for our patients, our profession, our society and our world. Will we be up to that task?

*Please let Colin know if you have any views on this. All replies will be treated in confidence.

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The Other Side of the Hill

The pattern of daily life has changed dramatically for so many people in just a few weeks. Many families are being plunged into increasing levels of debt and poverty. Domestic abuse and despair are becoming more commonplace. Many people will see businesses that they have built up through hard work and sacrifice turn to dust. Many people will be living in fear for their lives and those of their loved ones, and for quite a number, those fears will be realised.

At such a time, public morale and social cohesion are at risk. It is important that support and assistance is offered to those responsible for taking the difficult policy decisions that could affect so many lives. We should expect any advice to be welcomed and considered, free from any vested interests or long-term political game-plan. At the same time, we must not distract attention from solving immediate and pressing problems. For that reason, analysis of the factors that brought us to our current predicament needs to wait until the pandemic has been brought under control, but while the appetite and public pressure is still strong to unpick the rationale for decisions that have been taken in past years and implement any recommendations from any Public Inquiry, or Royal Commission.

That does not mean that we should be afraid to question decisions that are being taken today, particularly if they seem illogical or have potentially grave implications that could be averted by a change in policy. DFNHS will work alongside other campaigning organisations to try and bring those concerns to wider notice. It is important that we strengthen links with organisations with which we have strong and longstanding connections, such as Keep Our NHS Public, the NHS Support Federation, the Doctors Association of the UK, Health Campaigns Together and the Centre for Health and the Public Interest, to name but a few (see the summary of the beginnings of this on page 20). The breadth and depth of experience within the membership of DFNHS gives us the opportunity to add the voice of senior and independently-minded clinicians to these arguments.

In the meantime it is important that we make thorough preparations to contribute to whatever inquiry does eventually take place, to insist that it has the scope to look back at least 30 years, to gather evidence and to hone our arguments. It would be appropriate to put down markers now, to indicate the key subjects which we feel should be considered, to try and make sure they are not overlooked. These could include: the impact of the fragmentation of the NHS in England into multiple, financially autonomous, organisations; the centralisation of decision-making without regional executive bodies to coordinate action at a local level; the impact of the Carter Review on pathology services, the NHS Supply Chain and NHS Logistics, through outsourcing and centralisation; the establishment of Public Health England as a persistently underfunded quango, and its focus on diseases of 'lifestyle', or as we might call them, diseases of deprivation, with little attention given to communicable diseases; the gross reduction of funding of local authorities when much more is being expected of them, leading to massive reductions in local public health teams.

It will be important to consider whether the refashioning of the NHS to bring it into alignment with the private health system has played a part in reducing its ability to respond to a national emergency. Denigrating the National Health Service as a National Sickness Service, and prioritising disease prevention might have undermined our ability to treat patients who are acutely ill, when the main thrust of disease prevention should

come through tackling problems of deprivation, as repeatedly emphasised by Marmot and others (see report on page 15) and involves action on housing, education, employment conditions, air quality, nutrition, which lie firmly within the remit of other arms of national and local government (https://bit.ly/2VblnSE).

The pandemic has provoked seismic changes in the NHS, in government policies and in wider society, but which of these changes, if any, will persist once we emerge on the other side of this dark forest?

During the period that we have just entered, it is likely that more doctors will have had to work outside their comfort zone, learning or rediscovering a wider range of skills and, hopefully, rising to that challenge. Might it be possible to build on that foundation to reinstil the confidence of specialists to deal with a wider range of general clinical problems, improving the ability to staff on-call rotas, reverse the downgrading of smaller hospitals and offer more holistic care to their patients?

There will have been a need to work more flexibly and work in different ways, and probably more scope for using initiative. Might this encourage, in the longer-term, more decisions to be taken by clinicians at the front-line, rather than permission having to be sought from a higher authority? Might that improve job satisfaction and morale?

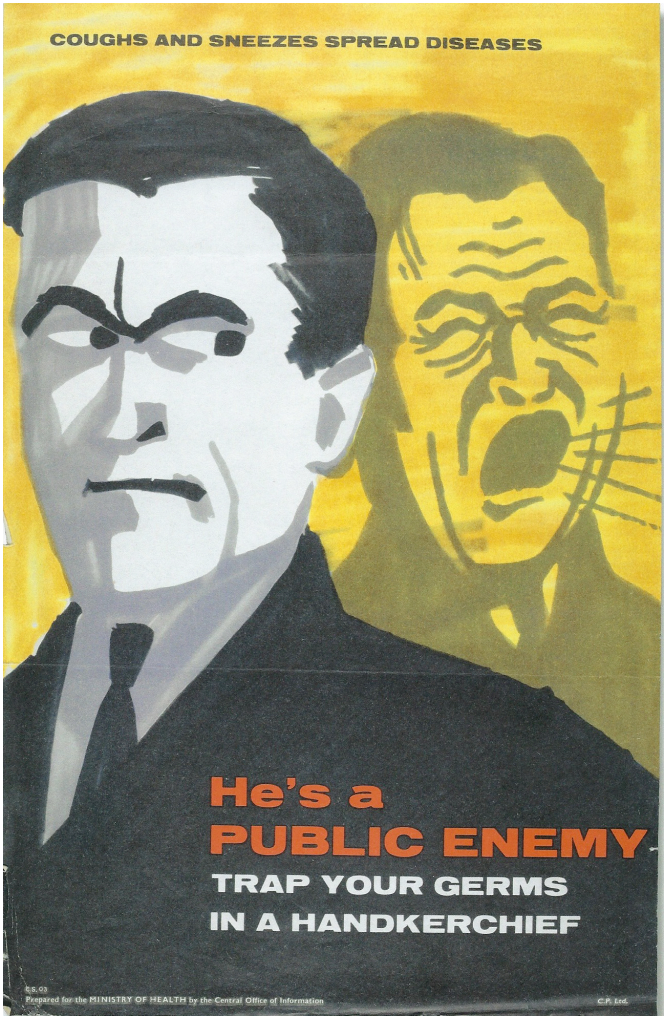
There will have been much greater use made of video or online consultation, breaking down some of the reluctance of clinicians to make use of it. There will be a greater awareness of the possibilities of remote consultation, but at the same time, an understanding of its limitations, so that it can find its appropriate place in clinical practice, rather than being regarded as a panacea.

There will be a huge challenge in resuming care for all the many thousands of patients whose treatment has been interrupted by the clinical emergency, making sure that nobody has been lost from the system.

At the moment there is an outpouring of love and respect for frontline workers in the NHS and social care, and a growing appreciation of the large numbers of underpaid, undervalued workers who keep the country running, whether it be in transport, food supply, cleansing or many other lines of work, but the gratitude of the state cannot be relied upon. Government priorities change and the national media have the attention span of a kitten. For example, once a war has been won, servicemen become superfluous, as was seen from the sailors unpaid and abandoned after defeating the Spanish Armada; the introduction of the (current) Vagrancy Act after the Napoleonic Wars; the illusory 'homes fit for heroes' after World War One; and the high proportions of ex-servicemen currently found among the homeless, the prison population and the mentally ill.

> "For it's Tommy this an' Tommy that, and 'Chuck 'im out, the brute.' But it's 'Savior of 'is country', when the guns begin to shoot."
>
> *– Rudyard Kipling*

The economic impact on the country will be massive, but we must resist by all means at our disposal the siren calls that are already being heard for a redoubling of austerity policies after the crisis – the policies that have so weakened our public services that we have been severely handicapped in our response to the pandemic – the policies which have deepened the levels of inequality in the UK, with impacts felt at almost every level of society – the policies of economic illiteracy that have strangled communities and blighted so many lives. We need to remember that severe economic challenge and shortages did not prevent the birth of the NHS and the welfare state and should not delay their rebirth.



Public health poster from the 1940s – principles rarely change. Note the use of martial language for anti-social behaviour during a time of war.

The ability of the NHS to rise to one of its greatest challenges to date, by working as a unified service, driven and strengthened by an ethos of public duty, will hopefully be clear for all to see. Many of us will be demanding an end to the use of the NHS as a means of siphoning off public money into private pockets through the 'market' and its web of commercial contracts. We needed a health strategy with the primary aim of supporting the ill and disabled: what we have been given is an industrial strategy with a health service tacked onto it. This is likely to be the reason that Public Health England have turned to big multinational companies like Thermo Fisher Scientific (US), AstraZeneca (Swedish/UK) and Glaxo Smith Kline to provide the testing for Coronavirus, rather than investing in our public health laboratories, with the long-term benefits that would bring.

There will be a natural tendency for people to want things to 'get back to normal'; for some, a sense of nostalgia; for others, because their interests lie in a return to 'business as usual.' Others will have been imagining the possibilities of taking the opportunity of this dislocation of normality to try and set out on a different course: possibly with greater resolve to address climate change and the devastation we are reeking on the natural world; possibly to ensure a more even distribution of wealth and opportunity in this country and even further afield. We must not waste this moment, when it eventually arrives.

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Corona – Not a Black Swan but a Black Elephant (And why England is so poorly prepared for this)

In 2017 Peter Ho, the former Head of the Singapore Civil Service, gave a speech entitled: "The Black Elephant Challenge for Governments". Ho, who unlike some senior policy advisors in the UK has a good basic grasp of the implications of Complexity Theory, began by identifying the relationship between the Black Swan and emergence:

> 'There are many definitions of complexity, but all of them agree that complex systems are characterised by the property of emergence. The connections and interactions among the many agents in a complex system lead to outcomes that are inherently unpredictable ex ante, and that are revealed only when they actually occur. So, when something happens, we are surprised. Nicholas Nassim Taleb famously described one class of such surprises – rare and hard-to- predict events – as black swans. In Taleb's view, black swans are not just surprising, but also have another important characteristic: their impact is large and game-changing.' [1]

However, the original and very useful idea in his lecture was his identification of another administrative zoological entity – the Black Elephant:

> 'The black elephant is the evil spawn of our cognitive biases. It is a cross between a black swan and the proverbial elephant in the room. The black elephant is a problem that is actually visible to everyone, but no one wants to deal with it, and so they pretend it is not there. When it blows up as a problem, we all feign surprise and shock, behaving as if it were a black swan.' [1]

If ever there was a Black Elephant it is the impact of the Corona Virus. Trans-specific infection is a fact of human life and a particularly acute one in an urbanized world. Now most people live in urban areas and those that don't live in densely populated rural areas with high levels of social interaction. We have been here before – with a dry run from SARS in 2003 – another Corona virus – and with the experience of the Global Pandemic of the Spanish Flu in 1918-19 which caused deaths on a greater scale (so far) than COVID-19 (but look in terror at what happened in the second wave then). When I used to teach a Social Science of Health Module 30 years ago I drew on McNeill's great book *Plagues and Peoples* [2] to point out to them that in the event of a repeat of Spanish Flu all that could be done better than was done then in terms of health care was improved nursing and intensive care because it would take too long to work up a vaccine. I said it will happen again. And it has.

Peter Ho in his lecture correctly argued for Scenario planning as essential to deal with these emergent wicked problems. The English NHS did this. In a report presented to the Board of NHS England in March 2017 it was noted that:

> 'Our preparations for pandemic influenza were exercised in October 2016 with NHS England participating in Exercise Cygnus. The exercise was set 7 weeks into a severe pandemic outbreak and challenged the NHS to review its response to an overwhelmed service with reduced staff availability. Plans are currently being revised to incorporate the learning from this exercise and ensure our continued preparedness for future pandemic influenza outbreaks. We are also continuing the challenging work around the management of surge and escalation decision making processes.' [3]

But planning for a scenario is not the same as actually putting in place the real systems which could actually do something to cope with it. The absolute emphasis in the English NHS has been on setting the system up for the engagement of private providers in order to facilitate the profits of corporate health capital. The fragmentation of management to 191 Clinical Commissioning Groups (CCGs) with a market orientation and a primarily purchasing role has fragmented a system whose origins lie in the Emergency Hospital System established in 1939 in order to have an integrated approach to impending catastrophe – then massive potential casualties from air raids. English Public Health but not Scottish or Welsh (public health remains integrated in their health services) has been handed to local authorities and massively underfunded.

There is no real system in place to cope with a crisis on this scale. In my view – expressed at greater length in a recent blog [4] – England needs to revert to a coordinated and regionally based level of governance, including not only Health Provision and Public Health but all governance functions, not for direct administration but for coordination. The abolition of the English Regional Government Offices was at best a stupid mistake and at worst an ideologically motivated assault on any level of governance which could not be controlled by neoliberals in power at Westminster. Wales and Scotland are governance entities at the right level for this kind of coordination and seem to be getting on with it. This is a national emergency on the scale of a World War – and of course it precedes the even more terrifying potential impact of global warming and climate crisis, not so much a black elephant as a herd of black Mammoths in terms of the ineffectiveness of real response to that.

Neoliberal post-industrial capitalism cannot cope with crises on this scale. Crisis: the state of a system which cannot continue but which has to lead to a system transformation, originally of course referring to the course of an acute infection in the human body and the outcomes being either recovery or death. There is an alternative. Pat Devine's outstanding *Democracy and Economic Planning* (1988) [5] outlines how the UK went far along the road of 'democratic planning through systematic coordination' during World War II and that is what we need now. Otherwise we need to ignore Lance Corporal Jones' injunction not to panic and agree with Private Frazer that we are all doomed.

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COVID-19 and Public Health in the UK: What Went Wrong?

In October 2016 the then UK government carried out a simulation exercise (called "Cygnus") on coping with a serious virus pandemic, causing considerable mortality.

The report on this exercise has never been published, although there have been various leaks from parts of it [1]. Many lessons should have been learnt at that time, such as the need to prepare on a short timescale for mass population testing for virus, provision of adequate numbers of ventilators and protective clothing for NHS (and other) staff to wear, as well as additional mortuary facilities. Clearly this did not happen, maybe because the then government was obsessed with austerity, and they were not prepared to sanction the necessary expenditure at that time.

The outbreak of what became known as COVID-19 was reported in Wuhan, China in December 2019, well before Christmas. The Chinese did not take long to establish the genetic RNA sequence of the virus, which they made known to WHO and to the rest of the world. Joseph Wu and colleagues wrote in the *Lancet* of 31st January 2020: "On the present trajectory, 2019 nCOV could be about to become a global epidemic .... internationally …. preparedness plans should be readied for deployment at short notice …." [2]. As the *Lancet* stated, the warning should have accepted and acted upon by the UK's Chief Medical Officers (CMOs), etc., from early February; in fact they did little until mid-March. Both WHO advice to "test, test, test,…" and basic public health practice relating infectious disease control were simply ignored! Why? – what went wrong?

Ordinary public health expertise seems to have got lost at the top of government. In days past, CMOs were usually drawn from those at the very top of the public health profession. Liam Donaldson was the last of such in England; until 2010 he was a really excellent CMO, having been previously the Regional Director of Public Health in North East England; Sir Henry (Harry) Burns was similarly an excellent CMO in Scotland until 2015, having been previously Director of Public Health in Greater Glasgow. Both have been replaced by non-public health personnel, with no doubt supreme expertise in their own fields, but not in public health. The current English CMO was, many years ago, a professor of epidemiology (since then a civil servant in two different departments for several years), but seems never to have undergone a proper public health training; the (recently departed) Scottish CMO had a background in obstetrics and gynaecology.

Had they fully appreciated public health priorities, they should have insisted on preparing for mass testing, following the Cygnus exercise, and started this when the very first case of COVID-19 was identified in UK, being prepared to spend massively to follow up thoroughly and obsessively, and to test, all possible contacts of these first, and later cases. This, followed by appropriate subsequent measures, is how the disease has been brought under control in China itself, in Taiwan, Korea, Singapore, and Hong Kong, and this seems to be how Germany is also now combatting the disease.

In England another major error has been to try to manage control of the endemic from the centre; how much better matters in England might have been, if this surveillance, and advice to the NHS, had been carried out, on a timely basis, by regional directors of public health and their teams, supported by local NHS departments of public health and matching local authorities, planning and supervising systems effective in their own regions. The fault here goes back to the disastrous Health and Social Care Act 2012 – disastrous in many

ways, but especially for public health. This abolished regional health authorities, and moved local public health departments out of the NHS and into local authorities; it also resulted in the establishment of a national body called Public Health England (PHE); this replaced the previous Health Protection Agency, but with a wider brief. Years ago, control of infectious diseases was first and foremost the responsibility of Medical Officers for Environmental Health, situated within local NHS public health departments, but also with strong local authority links as well. Nowadays, local public health departments have been virtually stripped of responsibility for infectious diseases control, and PHE (with a non-medical chief executive) has not proved able to carry out this function, either adequately, or in a manner sensitive to local needs.

Moreover, the establishment of a powerful PHE has divided the staff of the previously effective and adequately staffed NHS public health departments into either PHE or the now much smaller local authority-based departments, which, since their move into local authorities, have been subjected to repeated cuts to their budgets. Although this was never planned nor intended, the positioning of responsibility for infectious diseases control in PHE has sucked medically qualified public health staff out of local departments into PHE; this has left local authority public health departments with only rather weak and diminished clinical links, being staffed certainly by fully trained consultants, but whose previous backgrounds were mainly in nursing, statistics, social sciences, etc., which are essential backgrounds and skills for effective public health departments – but medical background skills are needed too!

Moreover, the lines of accountability of current directors of public health (in some cases, rather absurdly, to directors of adult social care!) have eroded the autonomy previously enjoyed by their predecessors, and their departments contain fewer and fewer staff, who, owing to budget cuts, have less and less chance to operate effectively to improve health in their local communities.

Consequently these local authority public health departments now suffer from generally rather low morale. It is noteworthy that none of the other UK countries, Scotland, Wales and Northern England, have sought to copy this adverse English experience: in those countries public health departments remain in the NHS, have not suffered cuts, and retain considerable responsibility for infectious diseases control locally.

Before 2010 public health, both nationally, regionally and locally, would have been much better positioned and prepared to address the COVID-19 challenge. Had Liam Donaldson still been English CMO after 2016, maybe we would have been ready, from early February 2020 at the latest, for mass testing of all contacts, as well as for the provision by then of adequate numbers of ventilators and of personnel protective equipment (PPE), as well as effective systems for its regular distribution. Unfortunately we shall never know.

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Failing the Test: An inevitable legacy?

As we went to press, the beginnings of mass testing for NHS workers and those in care homes were being rolled out, with the promise of more as part of the solution to end lockdown. But the government response to date warrants fair criticism

On 31 December 2019 China reported a cluster of cases of pneumonia of unknown origin linked to the seafood market in Wuhan, declaring that there was 'no obvious evidence of human to human transmission'.

It was mid-January before investigations verified that case-to-case transmission had occurred and the WHO confirmed this on the 14 January 2020. By then, a novel SARS-like virus had already been identified as the causative agent and by 12 January the genome sequence had become publicly available. On 23 January Wuhan was in lockdown and on the same day CEPI (the Coalition for Epidemic Preparedness Innovations) announced the initiation of three programmes to develop vaccines against the novel virus (now named SARS-CoV-2). The scientific world was alert to the trouble brewing.

Reassuringly Public Health England (PHE) declared: "With the publication of the genome sequence of a 2019 novel coronavirus, PHE was able to rapidly develop further specific tests for this virus working with WHO and a global network of laboratories." On 29 January the first UK cases (in two Chinese nationals) in York were identified promptly and isolated. On 5 February every hospital in England was asked to create 'priority assessment pods' and patients who suspected they had the virus were to phone 111 to make arrangements to have samples taken for PCR testing. Shipping containers, Portakabins and tents were hastily set up in hospital car parks to facilitate this. The PHE PCR test was then rolled out to 12 labs testing 1,000 people a day in England. By 26 February PHE further extended its surveillance strategy by testing all patients with severe respiratory infections who did not meet the case definition for COVID-19. There was no evidence of circulation in the community until 28 February when the first locally transmitted case in the UK was reported.

PHE had set up a testing strategy responsive to the imminent threat but the government took a laid back approach with Boris Johnson declaring on 5 March that he had shaken hands with everyone at a hospital where infected patients were being treated. Unexpectedly on or around the 10 March, when about 1,500 tests were being carried out daily, in a strategy unique to the UK, the government rejected lockdown **and cut back on testing.** Testing would be prioritised 'to those most at risk of severe illness' i.e. to those needing hospital admission and in a residential care facility if there was an outbreak. It was termed a 'reasonable and proportional response' but this strategy alarmed the WHO and on 16 March, the director general's pointed advice was 'test test test'

It is not clear why our testing strategy changed. Was it a ploy to withhold alarming data from the public? Testing would have made it plain that, in the absence of any control measures, the number affected was rising exponentially. By the 4 March the PHE information site had been persuaded to stop providing daily updates on the location of

new infections on its information site (although the numbers became available elsewhere) and it was not until the 15 March that the PM was persuaded to hold daily televised press conferences.

Was it a money saving tactic? PCR tests are expensive. Cheaper antibody tests were expected 'soon' and saving money on healthcare has been a long-term driving force.

Or was there a more sinister motive? That motive was enthusiastically revealed by David Halpern on the BBC on 11 March: If the 'epidemic flows and grows' those at risk could be 'cocooned' until 'herd immunity has been achieved in the rest of the population'. It would appear that behavioural psychologists and modellers have a dominating influence within SAGE (the Scientific Advisory Group for Emergencies) advising the government. If there were to be no control measures there was no need to test. This motive was quickly denied when the obvious flaws in strategy were aired and public outrage followed.

The public see an obvious need for more testing but their demands have been met with excuses such as lack of laboratory capacity. Of course this was to be expected as the world renowned PHLS (Public Health Laboratory Service) has been dismantled and enforced centralisation of NHS laboratories has lead to a significant reduction in capacity and resilience. Despite this, the IBMS (Institute of Biomedical Scientists) declared that the UK had a sufficient number of accredited laboratories with suitable equipment set up and ready to undertake 100,000 tests per day. Laboratory staff were running a 24-hour service, re-training was undertaken where necessary, workload prioritised and the number of available staff had been increased through temporary registration. Staffing wasn't an issue but there was a huge gap between capacity and materials available. Out of step with the rest of Europe and, it would seem, out of touch or unwilling to join any EU schemes, we are indeed short of test kits and reagents for PCR testing. Private and University accredited laboratories and other institutes such as the Francis Crick Institute in London have offered to help with PCR testing but these offers were rejected. Instead the government asked for equipment to help launch 'superlabs' which have been set up in Milton Keynes (National Biosample Centre) and Alderney Park (Medicines Discovery Catapult). The rationale for this is not clear. These institutes are outwith the NHS and the government. Are they being bailed out at a time when their own workstream has dried up? The lack of transparency continues.

The government is placing great reliance on antibody tests but there are issues with these. Sensitivity and specificity values are difficult to establish in relation to a new infective agent. Reference values have to be established and standardised controls are required and tests have to be validated in the population to be tested. In fact it takes much longer to develop an antibody test than a PCR test. In order to expedite production, the US FDA has allowed companies to market tests without submitting validation data (which are minimal at the best of times) so the market will be flooded by unreliable tests. The finger-prick home tests which have been ordered by the government are likely to be particularly unreliable. The first 15 kits tested here were found to be inaccurate but antibody testing is being pursued. Perhaps the government does believe in the herd immunity theory after all and wishes to be proved right – the virus may well have circulated widely during the months before lockdown. Pressure from the business sector to ease the lockdown also drives this policy.

Sero-prevalence will help with formulation of future public policy and will help support the introduction of vaccines but antibody testing should not be implemented as a sole strategy. Control of COVID-19 cannot be achieved without increasing the more reliable PCR tests and by clinical diagnosis and contact tracing.

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Marmot Revisited

The Marmot Review, published in 2010 [1], drew some damning conclusions about the state of health inequality in the UK, and went a long way to establishing the 'life course' perspective on health inequalities as the most promising emerging broad avenue for research, explanation and policy in the UK as they apply to our health – and the growing inequalities in health which over 30 years of continuing failure of health policy has allowed.

And that's the thing about health inequality, as defined by Marmot. A measurable difference in health outcomes between defined social groups, explained by accepted bio-psycho-social mechanisms, which is not only avoidable but is also unjust and possible to mitigate through policy. A political beast. With political solutions.

The 'life course' model is as simple in its construction as it is profound in its implications [2]. The different conditions, factors and circumstances someone is exposed to over their lifetime has a profound effect on their health, their life expectancy, and indeed their ongoing life chances because of the state of their health. Environment, employment, housing, education; how much stress, stigma, guilt and blame someone is afflicted with; and lifestyle behavious such as diet and exercise ALL interact, over the course of someone's life, to shape and determine their health, the choices they make (or indeed can make), and influence the consequences of those decisions on their future health and ultimately how long someone lives – barring accidents, violence or pandemics. More on the last later.

This March, the promised 10-year follow-on, *The Marmot Review 10 Years On* [3] was released. It covered the same ground. And found it worse. Then the pandemic hit...

Principal findings

Health Equity in England: The Marmot Review 10 Years On [3] opens with what now seems a highly prophetic introductory summary:

> 'Health is repeatedly shown to be the Nation's top priority. And so it should be – it is quite simply a matter of life or death of wellbeing or sickness. Good health is an indication that society is thriving and that economic and social and cultural features of society are working in the best interests of the population.'

Sir Michael could not have begun this rigorous and important document with a more timely and ironic two sentences if he had known about Covid-19. The fact that the Review does start this way is almost fateful, given subsequent events. It goes on:

> 'The last decade has been marked by deteriorating health and widening health inequalities. People living in more deprived areas outside London have seen their life expectancy stalling, even declining for some, while it has increased in more advantaged areas. ...This damage to health has been largely unnecessary. There is no biological reason for stalling life expectancy and widening health inequalities.
>
> 'Other countries are doing better, even those with longer life expectancy than England. The slowdown in life expectancy is not down to exceptionally cold winters or virulent flu, and cannot be attributed solely to problems with the NHS or social care....The increase in health inequalities in England points to social

and economic conditions, many of which have shown increased inequalities, or deterioration since 2010.'

Socio-economic drivers, then, can be pointed to with matching confidence and clarity as what is behind the bleak picture for health inequality over the past 10 years. Not diet. Not exercise. Not 'personal bad choice', it isn't the fact of being poor and making poor choices which affects health. The social, environmental and economic conditions many find themselves in through no fault of their own offer reduced choices and greater risks, which then compound over life to make matters worse. But all is not bleak. The Review offers hope. This can be gleaned from the key messages, built on the same principal areas of the original review, which are uncompromising in their tone and offer damning judgement of the failure to address the socioeconomic causes for worsening health inequality – but also describe how some communities have found a way to turn this around, despite the odds stacked against them:

"Since 2010 life expectancy in England has stalled, this has not happened since at least 1900. If health has stopped improving, it is a sign that society has stopped improving."

'• Since 2010 life expectancy in England has stalled; this has not happened since at least 1900. If health has stopped improving it is a sign that society has stopped improving. When a society is flourishing health tends to flourish.

• The health of the population is not just a matter of how well the health service is funded and functions.... Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.

• The slowdown in the increase in life expectancy cannot for the most part be attributed to severe winters.

• Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18.

• There are marked regional differences in life expectancy, particularly among people living in more deprived areas. Differences both within and between regions have tended to increase. For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in the North East and the largest increases in the least deprived 10 percent of neighbourhoods in London.

• There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.

• The gradient in healthy life expectancy is steeper than that of life expectancy. It means that people in more deprived areas spend more of their shorter lives in ill-health than those in less deprived areas.

• The amount of time people spend in health has increased across England since 2010. Inequalities in poor health harm individuals, families, communities and are expensive to the public purse. They are also unnecessary and can be reduced with the right policies.

• Large cuts to public spending have affected the social determinants across the whole of England, but deprived areas and areas outside London and the South East experienced larger cuts; their capacity to improve social determinants of health

has been undermined.

• As in 2010 reducing health inequalities requires action on six policy objectives. In this report we review significant changes since 2010 in five of them:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities

• For each objective we outline areas of progress and decline since 2010 and make clear the links with health and health inequalities.

• Despite the cuts and deteriorating outcomes in many social determinants some local authorities and communities have established effective approaches to tackling health inequalities.

• The national government has not prioritised health inequalities, despite the concerning trends and there has been no national health inequalities strategy since 2010.

• We set out a clear agenda for national government to tackle health inequalities, building on evidence of experience in other countries and local areas since 2010. We establish how the Government must take action in England as a matter of urgency.

• The goal should be to bring the level of health of deprived areas in the North up to the level of good health enjoyed by people living in affluent areas in London and the South..'

Which is clear enough. The findings, though reflecting worsening health for many, also indicate where and how people can be offered better chances, better choices, and some hope. Again, the political nature of this is implicit. This is not down to 'natural selection', 'poor choices', or 'bad behaviour'. This is happening because political choices have made matters worse. Political choices can make them better.

The inherent ethical nature of addressing health inequality runs through the Report, as it does in Marmot's work generally (eg [4,5]). This in turn is underpinned by assumptions about social justice: how should inequality be overcome? Giving just enough to the worse off to see them out of abject poverty (a 'prioritarian' approach)? Ensuring everyone is treated the same and offered the same resources and opportunities (the egalitarian approach)? Or distributing resources and ensuring opportunities in such a way that people receive 'enough' (however that is defined – a 'sufficientarian' approach). Marmot takes the last stance, in advocating 'proportionate universalism' in solutions to health inequality: everyone gets the help and opportunities they need to maximise their chances of avoiding poor health outcomes. A sliding-scale approach, matching the nature of the inequalities themselves, which affect all of us to differing degrees.

The Review is clear in its recommendations and cites projects adopting the principles it expounds which have proven successful. The key lies in offering people the resources they need at a local level.

This includes information which makes sense to them, and which they can apply in their particular circumstances to good effect. Top down? Yes – but only in the sense of allowing people to make decisions which improve their lives. This is in marked contrast to the prevailing and lamentable history of health policy in the UK for the past 40 years. This has focused principally

on 'downstream' determinants, such as diet and exercise, stressing the responsibility and 'power' of the individual to change these. Whereas, as the Review and a mountain of research findings make plain, solutions which work have to address the 'upstream' determinants, such as the physical environment, employment, housing, and social amenities. Ignoring these means so much of the individual 'choice' is in fact a lack of choice, and the damage caused over the life course will continue if the upstream determinants remain poor.

What the Review cannot show is the anger Marmot himself clearly feels at the way lives are now being blighted through political choices in the UK. This came through in his opening speech at the launch of the Review, in London to a packed hall, in what now seems a different world:

> **'It's particularly bad for women in deprived areas in the North of the country. Not just increasing inequalities but actual decline in life expectancy. That's not supposed to happen! [*This was shouted, angrily*] We've got used to the fact that life expectancy and health improves year on year. That's what we've come to expect, and it's not happening any more. This is a health crisis. And if you accept the argument that health is telling us something fundamental about the nature of society, it's a social crisis.**
>
> **'We need to create the conditions for people to make healthy choices. The evidence is, if you try to encourage people to behave healthily, you increase inequalities, because people down at the bottom are not in a position to act on that advice. And there have been some important policy changes. In 2010, public sector expenditure as a percentage of GDP was 42%. The UK looked like other advanced European countries in spending around 40-42% of GDP publicly. And that's gone down to 35%. That's a political choice.'**

In his closing speech, there was a note of optimism, a calling to action:

> **'I think this is our moment. Whether we're talking about empowered communities – in Coventry, in Gateshead, elsewhere – whether we're talking about the great and the good…. We take the action, that we don't sit back and say how will it come out? We convince politicians, the policy makers, as well as our communities, that we are serving in the cause of social justice and health equity. And what greater cause could there be than that?'**

At any other time, that would have marked, perhaps, a growing movement to bring about change and not just halt but reverse the worsening trend in death and disease in the UK. But as he spoke those words, a new virus was beginning to make its way through the UK population. And, as we were all about to discover, the legacy of Covid-19 could well make the findings of the Review seem almost utopian – unless political choices are taken to prevent that dystopian reality.

And then there was Covid…

The first pandemic in a century is killing people on a scale few could have imagined even a few months ago. It has heralded the ending our normal daily life, our personal liberty, in many cases livelihoods, and in some the loss of life. The steps taken have undoubtedly prevented an even higher toll. But this does not come without a price.

The UK eventually opted for the longest and most sweeping period of social isolation in its history to achieve the reduction in peak mortality (at least, for hospitals – the true figure including non-hospital deaths reflects a political storm over care-home policy and provision). This is still in force as this newsletter went to press. Many have commented on the effects this might be having on health (eg [6]):

- Increased incidence of domestic violence.

- Increased stress contingent on threat to livelihoods, social isolation, and loss of liberty.
- Social isolation itself as a factor predisposing to increased illness, especially worsening mental health.
- Increased poverty, which in itself is known to increase the risk of suffering from a wide range of factors causing inequality, eg sense of stigma or poor housing.

But interpreting lockdown in terms of the known drivers for health inequality adds even more concern:

- Longer exposure to poor housing conditions for some.
- Less ability to take exercise in a good physical environment, for some.
- Less ability to work from home in those jobs that are the most poorly paid, meaning greater risk of exposure.
- Rising food prices affects those with the least income more.
- Those in deprived circumstances are more likely to have co-morbidities, be carers, or delay seeking medical help, if data from influenza pandemics is any guide [7].

Taken together, these point unflinchingly to an inescapable fact: the pandemic is not 'the great leveller' some have claimed. On the contrary, it is almost certain to affect those worse off to a greater degree, either because their personal circumstances put them at greater risk or because the determinants of health inequality they were already exposed to are being made worse.

The answer to this lies in political determination. If people are given the right resources and information they can avoid the worst effect – Marmot's findings are still true for that, in fact more so. Whether this comes to pass is largely down to government. Which path will they choose? There is a clear role on the part of groups like

DFNHS to call out the light. Because the darkness, if chosen, will be deep and dawn could be a long time coming.

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What are the other groups up to?

The pandemic and lockdown measures took the campaigning groups by surprise. But a sense of direction is becoming clear.

If you found yourself wondering which rabbit-hole you had fallen down, don't pinch yourself. You are not alone.

The government, run by a party which for years has systematically starved the NHS of what it needs while laying the blame for its 'failures' at its feet, transformed the NHS to be the very emblem of hope and resolve, funding it in a way no government – let alone a Conservative one – had dared come close to doing. This left many groups with a rude choice. Risk being damned as 'anti-patriotic' by being too critical, or risk doing what no campaigning group should ever do: stay silent on the matters it campaigns on as massive change happens.

Keep Our NHS Public (https://bit.ly/2XENwDk) quickly resolved to make six demands of the government during the crisis which press home the point that the NHS is not the nation's treasure only during this grave threat but needs protecting to ensure it stays that way, and set up a petition based on those demands, which DFNHS has signed. They are also offering front-line stories from NHS staff. DFNHS has added its support to all these initiatives.

We Own It has chosen to look into starting a new campaign for an NHS Restoration Bill, on the assumption that as we come out of this the chances of gaining public attention for one will never be higher. DFNHS is in dialogue with them about this.

Doctors Association UK (DAUK), which DFNHS supports and is in close contact with, quickly gained a lot of media attention over the shameful state of PPE provision and lack of testing for Covid-19 in NHS staff, based on their extensive front-line experience as Juniors 'in the thick of it'.

The NHS Support Federation continues to develop new materials on the way the NHS is being treated, and to publish *The Lowdown* online, offering extensive insights into the political realities and threats to the NHS despite the Coronavirus 'hype'. The Centre for Health and the Public Interest (CHPI), not to be outdone, have released their own insights into the Coronavirus pandemic, including a critique of government strategy (or lack of, https://bit.ly/3evkyf6). Open Democracy offer new comment and interpretation weekly.

Health Campaigns Together has started to coordinate its various constituent groups (including DFNHS) to form a plan of action over the coming months, in the knowledge that as we come out of the crisis the government will seek to turn the current 'pro-NHS' stance into one that continues to allow privatisation, albeit possibly on a reduced scale or at a slower rate.

There is a strong shared conviction that the current lionising of the NHS is little more than a strategy to get over the immediate threat from the pandemic. There is a further consensus emerging that the values driving the government's agenda have not fundamentally changed, and that an existential threat to the NHS still remains despite the gathering of public support.

This is of course not to underplay that: the groups realise that public attention and support for the NHS has never been higher, and are determined to press home their message that yes, it must indeed 'be protected'. So it can continue to save lives, and not just from a new virus. We are not going to stay meekly at home while someone gives the NHS away in the wake of all the loss and suffering.

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Book Review

The Perils of Industrialised Healthcare
David Zigmond. Centre for Welfare Reform. Free download: www.centreforwelfarereform.org

In 2014, The Kings Fund published a report, *Reforming the NHS from Within: Beyond hierarchy, inspection and markets*, written by Chris Ham, the Fund's longstanding Chief Executive [1].

The report considered the success and, more often, failure of the many politically-driven reforms of the NHS since the 1980s and proffered the opinion that the role of elected politicians should be restricted to determination of the level of funding of the NHS and setting the priorities for the service through the Annual Mandate from the Secretary of State. It discussed many of the themes that have featured so prominently in the *Long Term Plan* for the NHS, published last year, stating that there was a consensus that we should be moving towards general practice at scale, reduction of hospital care and centralisation of more specialised services, and a much greater role for information technology. There might be room for debate as to how much of a consensus actually exists around those themes, but they have certainly been prominent in the restructuring of the NHS that has seen the introduction of Primary Care Networks and the downgrading of the District General Hospital in many communities.

David Zigmond is a retired General Practitioner and Psychiatrist with 50 years' experience of working in the NHS and is a member of the Executive Committee of DFNHS. In his paper, *The Perils of Industrialised Heathcare,* he analyses the limitations of the approach taken by Chris Ham, which is based on data and statistics, but largely ignores the importance of human nature, to both the clinician and the patient, and their interaction. Failure to recognise the importance of these relationships could account for the lack of value attributed to addressing the psychological component of disease, particularly of long-term conditions, and also contribute to the reduction of job satisfaction in clinicians, evidenced by poor morale, sickness rates, 'burn-out' and early retirement.

David draws a distinction between two kinds of healthcare: curative treatments and pastoral healthcare. Curative treatments tend to be short-term interventions that will eliminate the problem they are trying to address. Examples include polio vaccination, hip replacement, cataract surgery. Pastoral healthcare covers extensive areas of medicine in which curative treatment does not exist, but in which care can ameliorate the condition, provide comfort and relief of distress and may, with time, result in a form of healing. It applies to many chronic and ageing conditions and stress related illness – a large part of many fields of medical practice. The prevalent management model imposed on the NHS largely ignores pastoral healthcare and imposes structures and pathways more appropriate to curative treatments, and places barriers in the way of effective treatment of a very large number of patients and stifles the professional satisfaction that can come from the long-term doctor-patient relationship that is crucial to this kind of care.

He reflects on the impact of advances in medical science that have made it possible to cure so many diseases and disabling conditions and suggests that this has led to a rise to prominence of disorders of behaviour, attitude and mood, along with stress-related physical symptoms, which are less amenable to curative treatments.

He discusses the impact of what he terms 'Gigantism'; the scaling-up or merging of organisations in the interest of economic savings and pooling of expertise, although in the reviewer's

opinion, an increasingly powerful driving force towards Gigantism in today's NHS is the shortage of suitably trained staff in many disciplines and our current model of training which overvalues specialised skills rather than a broad range of competencies.

Gigantism leads to patients being admitted to large hospitals, at a distance form the community in which the patient and their family might live, and being cared for by multiple teams of specialists with the scope for miscommunication and poor coordination of treatment that can easily result.

The introduction of Primary Care Networks opens the door to similar risks of anonymity and loss of the resilience that can come from strong, long-term human relationships within General Practice.

While acknowledging the benefits of information technology in producing legible records, that can be shared with other clinicians with a couple of mouse-clicks, David considers that the adverse impact of inappropriately applied or poorly designed information technology has been given too little attention. Automated answerphones, online appointment booking systems and automated check-in at health centres and hospitals reduce the opportunity to reassure anxious patients, correct errors and gather additional relevant personal information. Consultations that are driven by computer algorithms can constrain the line of thought of the clinician and their interaction with the person in front of them.

He also explores the impact of diverting apparently simple patient problems to other 'services' so that the expensively trained doctor can concentrate on more complicated conditions. The success of such an approach depends on accurately identifying the nature of the problem that is afflicting the patient, but we all know that patients do not come bar-coded: their presenting complaint may well hide more deep-seated issues that can only be teased out by an astute and engaged clinician, or be a symptom of a completely unsuspected disease. The presenting symptom may often be a manifestation of psychological distress or social turmoil. How many early cases of cancer are missed because of a fixation on excluding red flag symptoms, rather than listening to everything the patient tells us? David rightly draws attention to the work of Michael Balint, author of *The Doctor, His Patient and the Illness*, and many other books, whose ideas used to have a much greater influence on medical practice, particularly General Practice, than they seem to nowadays, unfortunately.

The pursuit of 'efficiency' through large-scale reform of the NHS has proved elusive and, even worse, has often been destructive to the doctor-patient relationship, contributing to the serious problems we are experiencing in recruiting, retaining and motivating doctors. We ignore the *Perils of Industrialised Healthcare* at our cost. It is not all about lack of money.

Reference

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Available at: https://bit.ly/2VaJ3GX

The Perils of Industrialised Healthcare **is available as a free download at www.centreforwelfarereform.org.uk, where a number of other papers can be found that may be of interest.**

Colin Hutchinson

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