DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

A safe distance? Digital medicine and the NHS – Page 5

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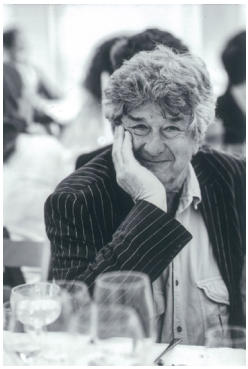
After Covid: What do we need to 'build back better'?



At the start of 2021 our NHS is shuddering with the near-catastrophic strain of a third wave of Covid pandemic.

Yet, simultaneously, with the green-light given to the Oxford AstraZeneca vaccine, we think and hope we can see an end to this modern plague.

Many, understandably frustrated, talk with weary impatience of 'returning to normal'; the United Nations with greater wisdom and foresight urges 'building back better' – now frequently troped by our government.

It is not yet clear what kind of 'better' this government might mean for the NHS, and the current signs are that what is 'better' for the government is not so for the governed: patients and practitioners.

Events since the start of this Covid-crisis indicate how and why this is so. Early on there seemed a great gulf between the ethos and competence of the government, and that of the NHS healthcare professionals. This distinction is worth defining and understanding.

At the beginning of the pandemic the NHS healthcarers were rapidly and necessarily unleashed from almost all aspects of the Internal Market and the managerial regimes of inspection and compliance. Practitioners for many years had made clear that they felt their working efficiency and spirit were substantially undermined by forests of mandatory bureaucracy that were not only frequently obstructive of intelligently humane practice, but even corrupting it. That early-pandemic unleashing coincided with the lionising ritual of the Thursday evening neighbourhoods' clap-in for NHS workers. The euphoric ritual may now have passed, but public appreciation and support for this bravely resolute NHS – which is now run more by committed clinicians' decisions than hired corporate managers' edicts – remains strong. For all their imperilling stress and exhaustion many doctors report feeling a sense of liberation, relief and proud, rediscovered motivation: this Covid-crisis has thus shown us all what can be achieved if we are unshackled from the Internal Market and its associated draconian inspection-compliance regimes.

Meanwhile the ethos and competence of the government's handling of the Covid-crisis is shown to be very different. The challenge has, of course, been severe and difficult for all nations but the UK government has been especially self-handicapped by its ideology of marketisation. Over the last three decades we can see how the governing authorities have devolved and fragmented our National Health Service to be more of a network of competitively commissioned agencies (NCCA?), franchised behind the unifying NHS logo. This is a profound abdication of governmental responsibility and inevitably incurs loss of knowledge, engagement and expertise at both local and national levels.

This has been especially evident with the government's handling of Test and Trace. Having largely lost interest in, commitment to, and working knowledge of, Local Health Authorities and community health services – the 'real' NHS – who would have the competence and commitment to fulfil these tasks if adequately resourced, the

government swiftly awards large contracts to corporate profit-seeking businesses who have the financial capacity but not the competence, cognisance or commitment to execute these complex responsibilities.

The wasteful and dangerous inefficiency involved in so swiftly contracting such tasks to Serco, Sitel et al does not address the equally serious charge of expedient chumocracy or corrupted nepotism. If this is the foundation-terrain on which we are to 'build back better', we have much to be fearful of.

The Health Secretary's repeatedly expressed views on primary care should cause us equal alarm. Because GPs have rapidly and universally adopted the digital technology necessary to continue some kind of skeletally essential service throughout this unprecedented crisis, Hancock has seen how this might fortuitously herald a Digital Revolution throughout general practice.

What does this mean? Hancock envisions all consultations relegated to videophone or other digital devices with few exceptions. Face-to-face contacts with a known and trusted person become an inconvenient rarity in a virtually tasked and streamed flexible workforce where, increasingly, no-one-knows-anyone.

Such developments can only accelerate the already parlous and perilous processes of demoralised unravelling so destabilising current general practice and mental health services. Until the first of our serial neoliberal NHS managerial reforms, 30 years ago, UK general practice – for all its inconsistencies and flaws – was a very popular profession, among both staff and patients. Morale, recruitment and staffing stability were high. As was its international reputation for high-quality, cost-effective personal continuity of care.

Personal continuity of care seems, to Hancock's mooted digital revolution, an anachronistically sentimental and disposable irrelevance to the real work: swift delivery of treatments. But the majority of NHS contacts involve far more than generic biomedical interventions: care means contextualising these within a growing knowledge and understanding of unique eco-systems: individuals, their kith and kin, their communities…

It was the possibility of this kind of personal, community-based, doctoring that largely made for the erstwhile GPs great work satisfaction and loyalty, and with that – mostly – the reciprocal experience of patients.

Admittedly, the Health Secretary's drive toward remote management and cybernation of the majority of consultations could – short-term – be popular among some: the otherwise healthy and happy with a readily 'fixable' complaint, organisational executives looking to make expedient (if specious) savings, the digital technology industry … and those commercial enterprises all-too-ready to cherry-pick from a blighted tree.

For the rest of us these changes would be much less beneficent. Doctors working throughout pastoral healthcare will be working with even less work-satisfaction – struggling to maintain colleagueial morale, identification and coherent stability. And patients, of course, will be the recipients of this attrition.

When we are most vulnerable where will be the human harbour and anchor point where the implicit and personal can be professionally tended and guided with skill and nuance?

Without satisfactory answers to such questions, 'building back better' may remain a lubricious slogan.

The articles in this journal's edition express our effort to counter that possibility.

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[More articles are available on David Zigmond's Home Page: **https://bit.ly/3ocajRn**]

Human contact: Do we need it in medical practice?

Have rapid recent advances in IT, and the necessary Covid restrictions, rendered traditional face-to-face medical consultations largely redundant? Here are the views of three doctors: one younger, publicly on television; two older, more privately

In the third week of April 2020, already deep into our long Covid maelstrom, a young woman GP, Dr YW, was briefly interviewed for *BBC Newsnight*.

She was fresh, direct, warmly personable and was introduced as, also, a newspaper journalist and thus (presumably) a part-time, 'portfolio' GP – a new and increasing breed of doctor better able to survive the otherwise unsustainable burdens of contemporary primary care. Portfolios may be rich in opportunities; they rarely commit, longer-term, to any community.

Dr YW was asked how, in her experience, was general practice coping with the current crisis? Her response was remarkably positive and optimistic: in her neck of the woods, she said, there was no crisis, in fact – paradoxically – the current challenges had improved many essential services in primary care.

How could this be so? Dr YW readily fired off her upbeat explanations: GPs had rapidly learned to increase use of digital and IT devices to almost entirely replace the need for personal or physical contact with either patients or staff. 'In a couple of weeks we have learned, changed and thus advanced more than in the previous decade.' Almost all traditional face-to-face appointments could be replaced by emails, texts and audio-visual phone calls. Consequently, at a stroke, much infrastructure and adjunctive services could be drastically reduced, if not eliminated: large, costly premises with waiting areas, numerous consulting rooms and reception staff. This unencumbered service has consequently become more manoeuvrable and (virtually) accessible. Teleworking professional staff can opt in to staggered work rotas providing vastly increased (virtual) consultation hours, often working from home: shared electronic records make personal continuity of care largely redundant and irrelevant. Likewise a shared working space.

These bouncy, confident assertions could have been mentored by a PR or advertising agency. 'Because of these rapid changes, we've never had more capacity [for core tasks]' was one of her cheerful boasts.

At the end, if she had turned directly to the camera and beamed exultantly, 'The future's bright! The NHS is virtual!' It might not have surprised the viewers.

I imagine governing politicians and NHS executives watching felt relieved, if nervously, and only for a while.

A different view

A day later an older, late-middle-aged GP, Dr MM, is talking on the phone rather differently of his working life. He had watched, and listened carefully to, Dr YW's youthful and bracing optimism. What he has to say is worth quoting at length:

'Well in some ways she's correct, and persuasively so. Yes, it's true that we GPs and our staff have

adapted remarkably quickly in adopting all the IT devices and procedures she mentioned to enable a new kind of lockdown service. So she's right to applaud the profession's efficiency and plasticity here.

'But I don't otherwise want to join her on her Bouncy Castle because I don't feel much bounce about what this job has now become: it may be charged with the adrenaline of a crisis, but it has assumed the lifeless loneliness of a call centre…

'As that young Dr YW said, we now do exceptionally few face-to-face consultations and no home visits. Our 'real' encounters with other staff are much reduced: wary, brief, sparse and usually singular. So my workstation (should I still, hopefully, call it a consulting room?) has become – I imagine – like a command post in a submarine or nuclear fall-out bunker: I am planted there to receive and process signals and data from a world beyond that I must distance myself from…

'So there I sit, often for many hours, with screen or phone. There are endless emails. The increasing number from institutions – informing and instructing about innumerable things – are so many, long and bureaucratic as to defy my sustained consciousness. Those from anxious patients are often nervously chaotic beyond ready comprehension. I often feel like an exhausted traveller trudging for survival against a driving, blinding blizzard.

'The phone calls with patients can actually be a bit of a relief: at least there's a human and individual voice there! That provides me with some personal exchange and vitality. But even that isn't what it was … you see, in earlier times, when this practice was much smaller and GPs had their own patient-lists, we used to know our patients much more…

'Why does that matter? Well previously when I saw somebody's name or heard their voice there was already, frequently, a bond of knowledge and understanding – often trust and affection, too. That didn't just help me operationally, it replenished my morale and motivation…

'All this applies just as much to the enormous traffic of signals from hospitals and investigation reports, and then requests for prescriptions, and my own medical reports. In my younger days, when I looked at each of these, an anchoring and enlivening face, or voice, or memory would often, briefly, enter my mind – I would most often know the person referred to. That wasn't only more pleasant and interesting – it was also safer, too. Now I'm looking at these things

and I usually don't have a clue who the person is – it's all become much more abstract and impersonal … my attention is then bound to drift… Yes, I can go into the electronic records, but I find that that is no substitute for what I'm talking about: personal and historical knowledge – that's mostly gone.

'In a way none of this is new, but it's certainly accelerated in these last few weeks: since I joined general practice 20 years ago all the reforms have made it less personally rewarding for me. All the automations and amalgamations have made strangers of our previous little communities. And the box-ticking way of controlling us has largely driven out my sense of judgement, skill and joy in my work…

'Yes, I think most of my peers feel the same, but they keep going… Why do I continue? Well, I really believe in the NHS: in my youth I'd always wanted it to be my life's work… I keep hoping that we'll somehow get back to some of the values that beckoned me to be a family doctor, all those years ago. I certainly never wanted to be a senior call-handler or Submarine Commander!

'Will I still be here in a couple of years? I'm increasingly doubtful.'

I am doubtful too, but also hopeful, that Dr MM might stay. He has, at least, a concerned sense of the human value of what is being lost: what is sacrificed in our acceleration into a healthcare that is rendered increasingly generic, cybernated and remote. Dr YW seemed, to me, to have, instead, cheerfully jettisoned – or been oblivious to – these considerations.

The lens of history

History can explain some of this, and my own perspective, too. I joined general practice in the early 1970s, when skilled personal encounters, often from a base of personal continuity of care, were regarded as a bedrock of our applied medical science. When Dr MM embarked 15 years later, this culture was well-rooted and respected, but already threatened by the early stirrings of neo-liberalism … yet it remains for Dr MM as a clear, strong, early memory. Dr YW, in contrast, has had no such experience: she has known only a healthcare that, de facto, is increasingly cybernated, automated, marketised and generic. Here corporations may (with difficulty) be publicly accountable, but individual vocation is driven to irrelevance. Dr MM and I reciprocally commiserate on this shared loss.

The general practice of this post-millennial era is modelled increasingly on a 'sort, fix or send' (SFS) model. This limited (if demanding) brief is well-suited to contracts, measurement, procedural management and thus commodification and commercialised industrialisation. So SFS is best suited to well-defined 'fixable' problems, usually of the surgical or acute medical kind.

But such SFS practice falls far short of adequate when dealing with anything that cannot be simply so processed, and that (surprising to some) is the larger part of our erstwhile general practice. Consider: problems of maturation and development; all chronic structural disease; functional and psychosomatic syndromes; stress-related illness; mental health; the degenerations of ageing; terminal care. Few of these can be fixed, but we are now pressured to be ingenious at circumventing or redefining them, to fit our SFS schedules.

So what may otherwise we do in this vast hinterland of SFS-incompatible problems? Well, the answer to this question tells us much about both the raison d'être and ésprit de corps of the

kind of general practice now lost to Dr MM and myself. In previous times on those occasions when we could not fix we could find the headspace and heartspace to ameliorate, comfort, guide, support, palliate, encourage and not uncommonly – that mystery that transcends any procedure – we could heal.

Yet all of these activities can anchor and thrive only alongside the growth and reliability of personal attachments, relationships and bonds – these are not in the realm of currently prevalent commercially commissioned teams and procedures, but of vocational practitioners tending known individuals in the longer term. We can call all this non-SFS activity 'pastoral healthcare' and, importantly, it is mostly synonymous with personal continuity of care.

Dr MM later talked of how moving and nourishing a particular encounter was for him when, just before Covid times, a freshly widowed nonagenarian, Nellie, came to share her lonely, frail grief with him. He found himself far away from any clever package or fix.

'I know there's nothing you can do, doctor, but you've known us both for all those years … I just want you to know what I'm going through. It makes the world of difference to me, my knowing that you know', she had said.

In his more recent phone call Dr MM reflected: 'That brief tender conversation I had with Nellie made all the difference to me, that morning, too … Such deep and fragile sharing used to be much commoner in general practice, but we've made it very rare. Since Covid lockdown, I find it now impossible…'

Dystopic frailty?

As I approach my mid-seventies I count my blessings: I currently need only repeat prescriptions to contain my common risk factors. Eventually, unless I die quickly, I will want a vocational GP committed to pastoral healthcare. I may not live longer, or even be less ill, but such personal containment and care will make my experience much more bearable.

Instead, I fear I will be Zoomed by a pixilating face with a voice I do not know. The call will be compressed and monitored amidst the many other remotely operated and cybernated clinical tasks for the doctor designated to that shift.

I wonder: would Dr YW feel vindicated or alarmed by this?

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Behind the NHS Logo: What kind of NHS will survive?

The Covid pandemic has challenged and stretched the NHS as never before. What kind of service is likely to emerge and survive?

The ubiquitous blue NHS logo does its task well: for many it continues to reassure us by symbolising an integrated and freely accessible health service that will endure beyond our individual lives.

The sign thus serves as a kind of shield or amulet saying: your socialised welfare is assured, here, to protect you. But the sign – while conjuring such unitary purpose and functioning – may also conceal many hidden conflicts of interest and agencies of control. Like a franchised commercial network, the individual units may be conducting hidden business behind the friendly-familiar sign.

This worried observation is not new to some, but is becoming clearer and greater with this government's response to the Covid-19 pandemic. This is amplified further by the Health Secretary's recently stated predictions and wishes for the future functioning of the NHS. What, together, do these indicate?

Legacy of neglect

At the time of writing (late-December 2020) there is currently a national wave of ebullient relief at the pioneering rollout of a Covid vaccine. Yet, overall, apart from the government and its tribal loyalists, few are in any doubt that the UK's response to the pandemic has been often inconsistent, incoherent and lacking in holistic intelligence. Of course this newly-emerged virus has confounded much of our previous knowledge and working assumptions, but most nations of similar economic status have performed much better. The vaunted 'Moonshot', 'world-beating' Test and Trace systems and 'cutting-edge, game-changing' Apps have proven to be more like advertising slogans or bar-room braggadocio than the considered measures of a socially-responsible, scientifically-informed government. This is all the more remarkable and tragic to be happening in a nation that was, until 30 years ago, often held to be a model of efficiently sustainable, socialised national health care.

How has this descent happened? And what now might we expect for our post-Covid NHS?

The last few months – since Covid became crisis – have been pivotal and seminal. We have seen the inherent limitations of a service that all too easily devolves to divisive, profiteering market forces, and remotely managed cybernation.

Considering the former, the government has again disregarded the long experience and expertise of established laboratory and community-based NHS staff in delivering Test and Trace. Instead, with swift stealth, they subcontracted this work out to large business corporations: Sitel, SERCO, Randox etc. Aside from the probable corruption of cronyism and nepotism there is now the even more indisputable evidence that these business conglomerates may have the financial and resource capacity for these tasks, but they do not have the competence or commitment to understand, engage or influence local communities or individuals. These crucial kinds of service used to come far better from the combination of established clinical practice and community service – from the 'real' NHS, not the expediently and expensively hired giant businesses borrowing and displaying the trust-us-we're-the-NHS blue logo.

What the last three decades of government have, cumulatively, failed to understand is that the more we commodify and commercialise our health service the less well we address the human

nuances of communities and individuals. This has been long argued by those alarmed by the erosion and displacement of personal continuity of care, particularly in primary and mental healthcare. Yet similar caveats are now clear in the mass-scale public health activity of a population threatened by a pandemic. Will the government learn from its recently exposed specious bluster and dangerously extravagant rhetoric?

This currently looks unlikely. The Health Secretary has recently broadcast notions about what, post-Covid, he hopes and predicts for the NHS: particularly a pre-eminent role for digital technology and social media. He envisions an NHS where face-to-face consultations are mostly made redundant by phone and video links, Apps, emails and the like 'wherever possible'. Such remote, even automated, contacts will function much like a giant network of call centres. In general practice these will be located in megapolyclinics, staffed largely by part-time, rotated professionals who either hot-desk or can work from home. Commercial operators will be encouraged to cherry-pick parts of this. The gains are evident: rapidity of response, ease of access, flexibility of staff deployment, and – not least – significant cost savings. All good, surely?

But our Health Secretary has opined all this despite the mass of evidence showing us how ill-suited are such hi-tech, impersonal, cybernated systems to engaging with our Covid test–trace–track. As David Heymann, Chair of Public Health England, recently explained and warned us: 'Face-to-face trust is what's important … You can't do contact tracing from a central location [and expect it] to be effective.'

So the government should be learning what many of the 'real' NHS professionals – local and public health experts – have been trying to tell them: there is no adequate (no matter how expensive) substitute for local-professional knowledge of, then engagement with, individuals within their neighbourhoods and communities. Hancock's preferred devices may be well suited to handling data, but meaningful human engagement requires much else: substituting smartphone Apps for human (personal) contact tracers is proving to be dangerous…

There is no sign – yet – that the government recognises or understands the nature and importance of the gap between the two.

The broader view

A broader view shows how this government's response to this pandemic has been faithful to its legacy of neoliberal managerialism: to commercially outsource and corporatise resources; to remotely control the population as if from a control tower. By international comparisons this approach has mostly been an expensive failure.

If this is the case with public health, what will be the fate of those more essentially personal healthcare sectors, particularly primary and mental healthcare?

The government's current trajectory and the Health Secretary's expressed inclinations will send a dispiriting chill through the heart of those practising, and those sustained by, any personal continuity of care. For that threatened subtraction is actually of the larger part of our frontline NHS activity, because it includes anything that is not a singular, clear problem that can be swiftly and completely 'fixed' with generic technology or simple advice. So it comprises problems of maturation, adjustment and development; all chronic illness (by definition); stress-related illness and mental health; degenerative conditions of ageing; palliative and terminal care…

All of these will sometimes require technical devices but they are mostly addressed by pastoral healthcare: healing or comforting consultations that skilfully guide, support and encourage. Such interactions must draw from growing personal knowledge, trust, faith and understanding. These are subtle processes of consciousness and communication that depend on relationships that are individual, local and relatively enduring. If remotely generated Apps or automated algorithms fare poorly with test-track-and-trace, how much worse will they be when consigned to contain and caretake such personally-embedded complexity as general practice or psychiatry?

These two branches of medical practice – general

practice and psychiatry – provide the NHS with most of our pastoral healthcare, so the larger, longer historical picture – beyond their increasing current blight – is worth portraying.

In the first four decades, doctors were largely motivated and sustained by vocation and a sense of community – both with colleagues and patients. For example, very commonly GPs would spend a working lifetime employed in one practice with a small team of practitioners and ancillary staff. These surgeries were much smaller than now and staffing was more stable and thus became professional communities that could more easily look after, and look out for, one another. They then saw their work as looking after and looking out for yet another community – patients – whom they got to know over the years, not just in consulting rooms, but also in their homes, neighbourhoods and families. The experience and mindsets of these professionals thus tended to be of caretaking and growth – not items-of-service procedures or contractual requirements, as later.

From the 1990s we have had three waves of neoliberal 'modernising' reforms, each of which has turned this work's culture from growth and stewardship toward industrial manufacture. They are:

1. **Marketisation planted and fertilised in the first 20 years of the Internal Market.** This largely undermined – often destroyed – colleagueial trust, understanding and cooperation. Aspirational vocation was replaced by financial incentivisation. Responsibility to and for individuals was pushed aside.
2. **The Health and Social Care Act** has empowered the earlier reforms by expanding this modus operandi to encourage an External Market. The effect has been to further alienate and distract practitioners from one another and what they see as their core work (patient care). The clearest beneficiaries seem to be those large commercial corporations skilled at winning bidding wars.
3. **The Digital Revolution.** This is the vision, the avowed mission, of the current Health Secretary. Computers have been increasingly important to all kinds of clerical, administrative and logistical work since the millennium. But Hancock's proposals go far beyond this: he does not see phone and digital media, Apps etc as augmenters or ancillaries for direct human contact in NHS consultations, he sees them as *replacements*.

Why does this matter? It relegates the skilled ethos and vocation of pastoral healthcare to generic algorithms of institutionally defined tasks. The anchorage and sanctuary of the familiar practitioner is replaced by an unknown voice or screened face probably never to be encountered again. The relationships we grew at work were, before our serial reforms, the terra firma of our more complex clinical practice – our bonding and supportive colleagueiality, the resonance by which we may best endure, comfort, understand and heal.

Marketising reforms have ruinously fragmented this NHS terra firma. Hancock's grandiose quest for a thorough and uncompromising digital cybernation of consultations would vapourise that better humanity: where could we find it? And how could we grasp it?

This is bleak modern history: each successive NHS reform, since the 1990s, has been officially vaunted to increase inclusion and responsiveness yet has lured us further into a mire of no-one-knows-anyone-but-just-do-as-you're-told.

Babylon's *GP at Hand* and similar apps will be fine for the healthy, busy young professional with early tonsillitis – an easy problem. But what about the lonely, frightened nonagenarian whose recent widowhood is exacerbating her degenerative spinal pains? The app marketeers may emblazon the comforting NHS logo, but where is its humanly sensed terra firma?

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View from the Chair: Taking care of business

You have to admire those clever people at NHS England! Not just being able to walk and chew gum at the same time, they are able to strain every sinew to meet the challenges of the third wave of the pandemic, and also set out proposals for a major restructuring of the NHS in England.

It may be that they have been working on this project for a long time. Maybe they have had friends who have been able to help them. Nevertheless, it is still an impressive performance!

As announced in the briefing papers accompanying the Queen's Speech in December 2019 [1], the Government is planning to bring forward primary legislation to support the implementation of the *Long Term Plan* for the NHS: in essence, finding a way to establish the new structures the Plan describes (Integrated Care Systems) as statutory bodies. A period of public consultation has just ended, considerately timed to coincide with what was once known as the Festive Season, and the distraction of rising activity across the NHS. DFNHS has submitted a response, which can be found on the DFNHS website [2] and our Facebook page.

The NHS was created by political giants, with a very simple vision and legislation that was clear and concise and easily understood by the whole nation. The subsequent actions of relative pygmies have succeeded in producing a structure that is so complex, defined by such turgid and impenetrable legislation, that I entirely believe those senior politicians that said that they passed the Health and Social Care Act in 2012, but didn't understand what it meant. That mammoth bill, that took over a year to be enacted and which created "a reorganisation so big that it could be seen from space", must have left a sour taste in the mouths of many of those still in the Government. But far from recognising the folly of passing legislation that they didn't understand, they seem to be outsourcing to NHSE the drafting of new legislation to replace much, not only of this Act, but also of the National Health Service Act 2006. Isn't this encouraging an abdication of political responsibility?

While many of us were appalled by the impact of those two pieces of legislation, it doesn't necessarily mean that their replacement will be an improvement. A new NHS Act will govern the operation of the NHS for a very long time, should be of great concern to most people living in this country and should be a matter of informed and broad-based debate. Right now, the nation might have a few other pressing things on its collective mind? Apart from the timing, I found the image conjured up by Andy Cowper of the *Health Service Journal* has stuck in my memory (those of a delicate disposition should look away now!):

"in the middle of a third wave of a respiratory pandemic, mixing multiple household bubbles indoors would be on a par with health secretaries structurally redisorganising the NHS, or dogs licking their own arseholes: just because you're able to, it doesn't mean that you should." [3]

DFNHS has always demanded the return to an NHS that is publicly funded through progressive taxation and driven by the public service ethos, rather than the pursuit of profit, but these proposals do nothing to remove or reduce commercialisation and financialisation of the NHS. The legislation that governs commercial competition and contracting would cease to apply to the NHS, but contracting and subcontracting would still be the basis for arranging NHS services. The National Audit

Office report into the procurement of personal protective equipment [4], during the first wave of the pandemic, gives an idea of the risks that occur when contracts do not go through an open and fair process of competitive tendering. As long as the market remains, its workings need to be as fair and transparent as possible, at whatever level these transactions are taking place, to maintain public confidence and avoid any hint of misuse of public funds.

DFNHS was a generous supporter of the 2018 Judicial Review into attempts to introduce Accountable Care Organisations into England, with many of the features of the discredited Health Maintenance Organisations operating in the USA. Quite a number of those features are still to be found, or easily enabled, in the Integrated Care Systems that are being proposed to take over the commissioning of health and care services from Clinical Commissioning Groups. These new organisations could include powerful private providers in key positions of influence within statutory bodies. The Commissioning Support Units, which currently do most of the work in the contracting of services, and which include big multinational accountancy and health insurance companies, seem destined to remain in place, possibly with even greater influence. The powers of Foundation Trusts, which can make up to 49% of their income from non-NHS work, would remain.

The professed goal of these changes is to replace a fragmented system based on competition, with a more collaborative experience of people using the service – as implied in the title "Integrated Care System", and few people would object to that outcome, but nobody has been able to explain how you can integrate a health system that is universal, comprehensive and funded from general taxation, with a social care system to which there is limited entitlement and is heavily means-tested. Nobody has explained why it is necessary to retain a system based on commercial contracts, the boundaries of which define where the responsibility of any particular provider begins and ends. Nobody has explained how a private company, whose overriding legal responsibility is to maximise the profit for its shareholders, can be changed to put the quality of the service it provides as its top priority. I have been following the hearings of the Grenfell Tower Inquiry and the testimony time and again reflects these limitations of commercial contracting. It is inappropriate to the provision of universal, comprehensive healthcare.

> "Even before the pandemic there was ample evidence that the market has not produced a flexible, cost-effective, resilient health service....Any organisation that is struggling to retain staff really does need to take a long hard look at itself"

Even before the pandemic there was ample evidence that the market has not produced a flexible, cost-effective, resilient health service. In a similar way that it has undermined public dental care and social care, the market has produced hospitals so cramped that infectious diseases can be transmitted with ease; with insufficient beds to cope with even a normal winter; or the ability to make up lost ground in the summer; and severe shortages of trained clinical staff, in numbers much lower than most comparable countries. We might have been able to fill conference centres with hospital beds, but we can't make use of them because all the staff are sick, in isolation or working their socks off already. Any organisation that is struggling to retain staff really does need to take a long hard look at itself.

These proposals do not address the key challenges facing the NHS in England – shortage of appropriately skilled staff at all levels and years of inadequate capital investment in buildings and equipment. They are likely to add further delay to addressing these issues. We suspect that they are building the foundations for an even more radical change to the NHS, as our evidence concludes:

> **"DFNHS is opposed to models of care in England that are based on the Health Maintenance Organisation. It may be unintentional, but the emphasis on patient pathways, the use of data and digital tools to confine the treatment of individual patients and stratify risk and the delegation to providers of decisions on what services to provide and in what way, would be consistent with laying the groundwork for an insurance-based health system. We are sure that this is unintentional, but it needs to be made very clear that this is not the direction of travel."**

I would urge members to read the proposals (5) and, if you share the concerns of your Executive Committee, please contact your MP and ask for their help in supporting a different vision for the NHS. Since 2012, the response has often been "The public have no appetite for another big reorganisation of the NHS", but if such a reorganisation is being planned anyway, then we need to convince the public and our lawmakers that there is a better way to improve the integration of patient care. The NHS Bill presented to Parliament in 2018 by Eleanor Smith MP describes how this could be achieved. It can be done!

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[1] Queen's Speech 2019: Background briefing notes. Available at: https://bit.ly/39jOObl
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Testing Unmasked

The Test & Trace system for England has been widely criticised for giving billions of pounds of public money to private companies who have failed to deliver. Here, a volunteer Covid tester tells her story

Sonia (not her real name), who until the pandemic worked in hospitality, responded to a 'very vague' advert, claiming to be a new opportunity in 'hospitality'. When Sonia spoke to the recruiter by phone in September, she never indicated that Sonia would be standing close to and guiding people taking Covid-19 tests. Sonia was told her work would be 'meeting and greeting' and putting people at their ease. In fact, when Sonia turned up for her first shift it was obvious she would be standing close to people taking tests. But the worst was yet to come.

'The testing centre I worked at is in a big tent with a corridor in the middle with testing cubicles either side', said Sonia, 'We would stand by the cubicles and guide them through the test. We weren't doing the test on them. There were about eight cubicles in total in the tent, plus a cleaning cubicle for the cleaners. But although we had handgel, gloves and basic disposable masks we had no visor and no uniforms (ie washable jackets), because they said they didn't know whether we would stay in the job and they didn't want to pay for uniforms.

'At first, I hadn't really put two and two together and hadn't realised I'd be working under Serco. But once I realised this I did talk to someone from Serco, and told them this was counterproductive. We had face masks, but that was it really. We were told we had to wear our own clothes and wear black. Basically we were going on the Tube in our own clothes, which could potentially have been contaminated as far as I was concerned. They said they would give us uniforms but not until about a week later. I actually never got a uniform because I left before I got one. They said there would be a place to put the PPE clothing; I never saw a place where you could leave them at the centre and change back into your own clothes.

'The people taking the test have to take their masks off to take the test and we were not given plastic visors. I had one gentleman come in, who was choking. He'd been sent a home test but he told me that the home kit he had received had no testing liquid in the tube and this is why he came into a centre. When I told the supervisor what was happening he was very good and told me the man could just do the nasal swab. But really the man should have been advised not to leave his house in the first place as it was obvious he was very sick, and there was inadequate PPE in terms of having no visor and being near someone who was clearly very ill.

'They are getting a lot of young people who want that job to earn money, and they are not really very focused on what's happening with all this. In the canteen, a lot of food was left lying around. The Serco managers took several days to point this out and stop it.

'Anyone was encouraged to step up and be a supervisor when they had hardly started the job but the supervisors were thankfully good.

'The way the whole thing was done was shoddy. I heard one young woman boasting that she had been up until 3 am that morning and she was at work at 7.30 am. This was the sort of thing that happened.

'While I was there, two people in the staff had Covid. One person came in with Covid from the

outside. Staff had the option of being tested and both of these people tested positive and had to go home. But staff who work at these centres should be prepared to be tested for Covid ahead of time. They should have done Covid tests on all the staff. It seems crazy to me that staff can bring Covid into the centre when we are supposed to be testing people and keeping people safe.

'If three people on the staff had tested positive, they would have had to close the centre down. So I wondered whether they might try to cover up Covid cases. It all felt a bit prone to subterfuge.

'We were told to keep the 2 metres distance, but when you're talking through a mask and you're trying to explain things it could have been the right sort of distance but was probably less. I still think a visor in that situation would have been advisable.

'I think the whole thing should be more transparent. They had two agencies employing staff like myself. We were told not to discuss with the other agency how you are paid and when you are paid because it might cause conflict. It was so incohesive.

'I was also surprised there wasn't a single medically trained person in some way at the centre. There was no indication of who to turn to if anyone did need medical help.

'It was almost like a jolly – they weren't taking it seriously enough: the managers just didn't have the gravity or maturity to tell people off to get them under control and say this was a serious place to work.'

Sonia stayed for one week. Her story is not an in-depth analysis, and we cannot know how typical of testing centres her experience is. But what she saw and heard is damning enough. A call-centre model with an assembly-line approach, with scant regard to health, safety – or common sense. When you are dealing with a virus never before encountered, which ticks three of the four boxes for the 'end of days' catastrophe (easily transmissible, no natural immunity, and asymptomatic transmission; mercifully it missed the fourth: high fatality), levity and targeting profit above people is, quite simply, unacceptable.

Yet that is the legacy this government has poured billions of taxpayers' money into creating.

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'If I was Minister of Health': Democratising Healthcare

This year's Essay Prize brought some stunning contributions. The winning entry, by Joseph Freer, is foremost and is printed here in full

"For 20 years successive governments have pursued a policy that the public hasn't voted for and doesn't want."

– Leys and Player, The Plot against the NHS (2011)

Sociologist Colin Crouch coined the term 'post-democracy' to describe the changing power relations in 21st century capitalist societies such as the United Kingdom, in which corporations and the "politico-economic elite" have taken greater control of the institutions of the state at the expense of popular sovereignty [1].

Within an increasingly post-democratic society, the NHS is a particularly post-democratic institution. It has been captured by corporate interests, and there is a 'revolving door' between the public and private sectors [2]. It has an unelected leadership in executive bodies with poor accountability [3], and only rhetorically involves citizens in its running [4,5].

This essay outlines a proposal for how a new, ideal Minister of Health could democratise healthcare, describing a fundamental restructuring of the institutions and systems that are currently undermining improvements in health outcomes. Part 1 considers representative democracy (that is, government by elected representatives) and proposes a major constitutional change, separating health and welfare from other functions of government. Part 2 considers deliberative democracy – citizen engagement in public decision-making – and proposes how power could be shifted from politicians and corporations into the hands of patients and the public.

Part 1: Representative democracy

1a – A unified Ministry of Health

The crises of the First World War and the 1918-19 influenza pandemic galvanised public health activism, which had been gaining pace since the beginning of the 20th century (in 1917, campaigners adopted the slogan "It is more dangerous to be a baby in England than a soldier in France" [6]), and in 1919 the first Ministry of Health (MoH) was formed. It was heavily influenced by the socialist reformer Beatrice Webb, who in a 1909 report had described the causes of poverty as structural, rather than individual, and argued for universal provision of health services by a unified, centralised ministry [7,8].

The remit of this new ministry was wide, and at different times in the following decades its responsibilities would come to include social housing, welfare, and environmental health (Figure 1). This is not so today, with the Whitehall department responsible for healthcare being entirely separate from the agencies responsible for public health and the ministries responsible for the social determinants of health.

Over the last 40 years, those ministries' responsibilities have narrowed as the welfare state has contracted. This, in addition to substantial cuts to local authorities' budgets in the last decade, has been associated with widening inequalities in health and wealth, falling life expectancy in deprived areas [9] and, by one estimate, 150,000 excess deaths since 2010 [10].

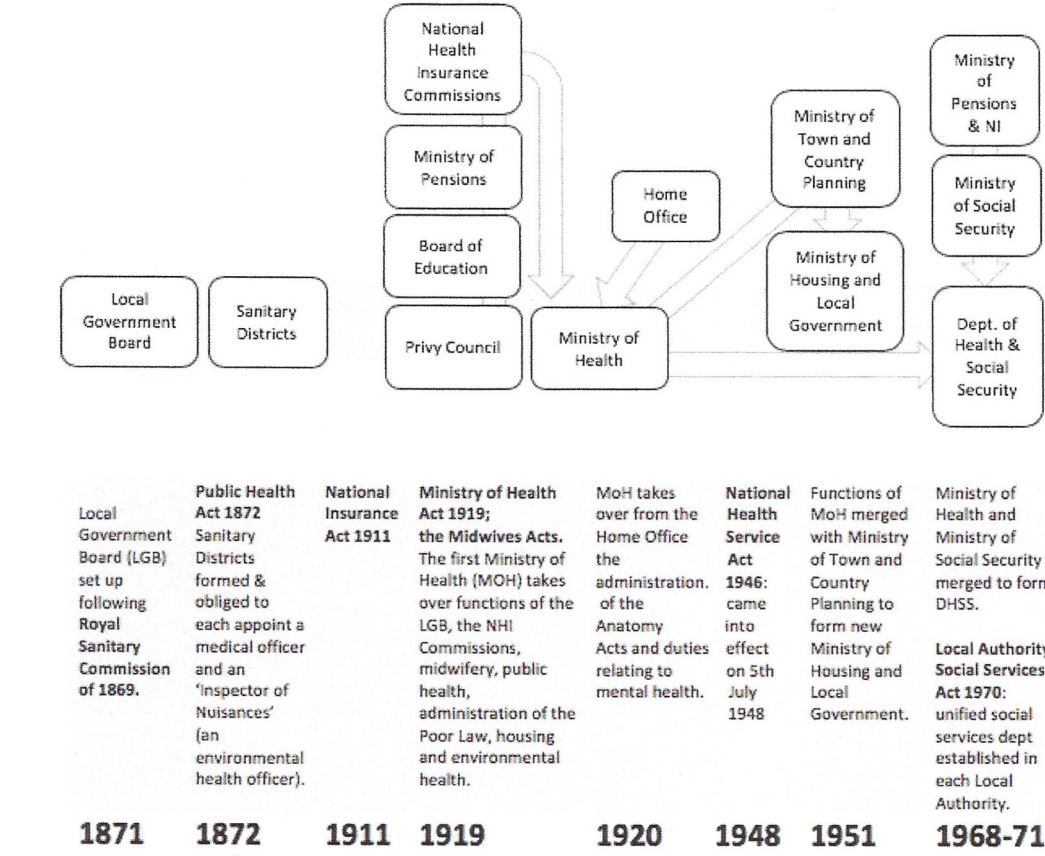
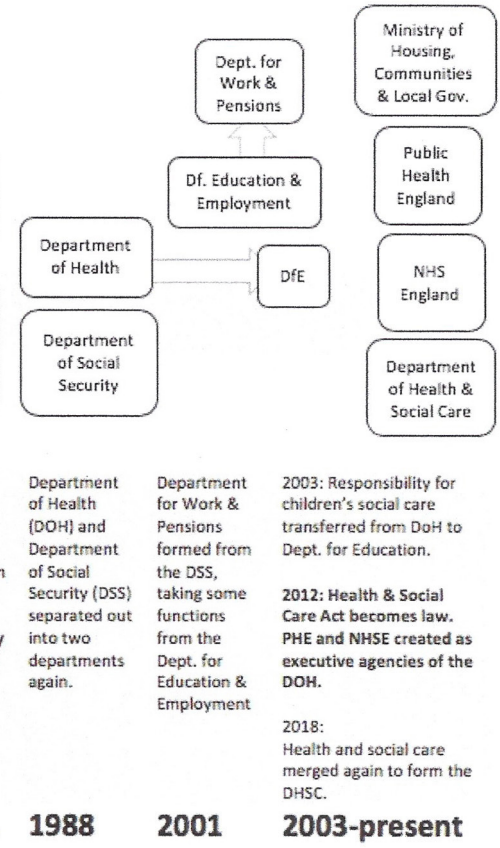


Figure 1. Government-level responsibility and accountability for health and its social determinants, 1872-2020.

To flatten this social gradient in health outcomes, government departments should be realigned to make health ministers accountable for all of health – from its determinants to its outcomes. This framing of problems of social housing, poverty and welfare as problems of health is intended to ensure that public health and the social determinants of health are properly funded, by taking advantage of the willingness of voters to provide healthcare with adequate resources.

1b - The Health Assembly

A King's Fund survey in 2017 found that 90% of people supported a version of the NHS that is comprehensive, universal and funded by taxation [11]. Further, 67% believed treatments and services should be provided only if they are available to everyone; and 70% believed that the public should be consulted or actively involved in decision-making about the availability of treatments and services [11].



This is quite different from the NHS as it has been reconfigured in recent years, with increasing out-of-pocket fees [12], variations in service provision [13], and higher barriers to access for marginalised groups [14]. In addition, the 2012 Health and Social Care Act (HSCA) has increased fragmentation and privatisation in the NHS and made its decision-making unaccountable [15]. The Act itself was profoundly undemocratic: it was widely reported to have been the co-product of a maverick minister and corporate influence [16-18].

Lord Owen's and Eleanor Smith's recent Bills to reinstate the founding principles of the NHS offer a starting point to inspire the new, ideal, Minister of Health envisaged by this essay [19]. Within an NHS Reinstatement Bill, Clause S3(1) of the 1946 NHS Act should be restored, once again bestowing upon the Minister the "duty to provide" health services. The HSCA removed this duty, thereby opening, according to Tallis and Davis (2013), a "fundamental accountability gap" in health decision-making [20]. The current reorganisation of healthcare in England into Integrated Care Systems (ICSs) clearly demonstrates that unaccountability: ICSs are not statutory bodies, and their development has not been subject to a legislative process [21].

But a Reinstatement Bill is not sufficient. The short political timescales of a parliamentary democracy combined with its vulnerability to corporate lobbying have subjected the NHS to frequent and disruptive reforms. This is harmful to patients: according to the Organisation for Economic Co-operation and Development, "each reform costs two years of improvements in quality" [22]. Lansley's removal of Clause S3(1) passed ministerial responsibilities onto NHS England (NHSE), a more politically 'stable' institution, and this might conceivably have discouraged such short-termist reorganisation. But this decision also ceded enormous power to unelected officials. For the NHS, accountability and evolutionary change seem to involve a trade-off.

To square this circle our new, ideal Minister of Health should be empowered by a constitutional change: the creation of a Health Assembly and Executive, separate from Parliament and invested with its own tax-raising powers. All current health functions of Government, including those of NHSE and Public Health England, would be transferred to this parallel health legislature and executive (Figure 2). Responsible for devolved local decision-making on health and social care, public health, housing and welfare, Assembly members would be directly accountable to voters in their local health authority area.

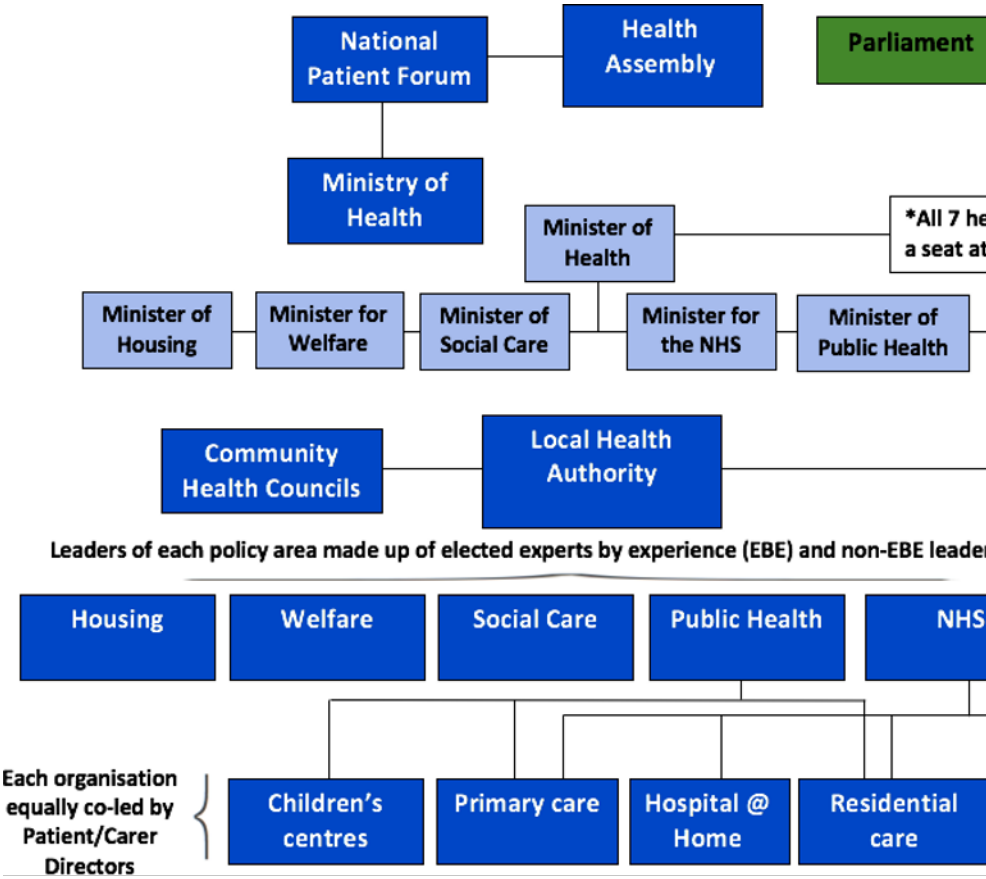
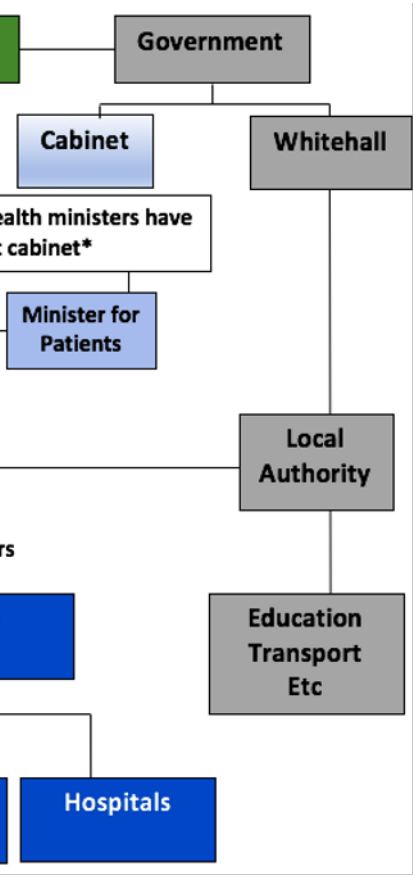


Figure 2. A proposal for enhanced representative democracy in the UK health system.

Health Assembly elections would be held at the same time as general elections, but candidates would stand on exclusively health-related platforms. Public support for a version of the NHS that is universal, comprehensive and free at the point of use is so consistent that running separate 'health elections' should reverse the current pro-market direction of healthcare. Assembly members would be elected proportionally by a Single Transferrable Vote system, resulting in a more pluralistic Assembly. This should limit policy changes to those enjoying broad democratic support and should make frequent large-scale reorganisations less likely.

Since inequalities in those contributing to decision-making results in health policy which excludes the needs of marginalised groups [23], selection of Assembly members should employ shortlisting quotas [24] of candidates based on age, gender, ethnicity and income/wealth, creating an Assembly that is representative of the population.

To close the 'revolving door' between the



public and private sectors, commercial conflicts of interest (COI) would be a barrier to Assembly membership. The same COI exclusion would apply to all civil servants, clinicians and advisors with a local or national health policy role.

Part 2: Deliberative democracy

Many modern political theorists consider a state to be only weakly democratic if it does not allow for continuous, active participation and deliberation by citizens [25].

Dalton (2017) has shown that countries with higher levels of citizen participation have better performing governments (Figure 3) [26]. If the participation involves citizens from a broad range of socioeconomic backgrounds, governance is better still [26].

In recent years, government reforms to patient and public involvement (PPI) in healthcare have not involved any significant redistribution of power. In an influential 1969 paper, Sherry Arnstein described how "participation without redistribution of power is an empty and frustrating process for the powerless. It allows the powerholders to claim that all sides were considered, but makes it possible for only some of those sides to benefit" [27]. Arnstein described a 'ladder' of increasing levels of citizen participation (Figure 4). Current levels of PPI in the NHS are generally described as being on the 'tokenistic' rungs [28,29].

Sections 13H and 14U of the 2006 NHS Act and 2012 HSCA stipulate that NHSE and Clinical Commissioning Groups (CCGs) must "promote the involvement of patients". To enact this duty the government created Healthwatch, linked-up local committees with statutory duties to represent local people's views on health.

Such 'health committees' have a strong international evidence base for improving quality of healthcare [30] but there is clear evidence that their effectiveness depends on factors such as the inclusion of marginalised groups, careful attention to power asymmetries between the community and other stakeholders, adequate funding, and clearly defined responsibilities [31-33]. Healthwatch fails these tests: its national committee is predominantly white [34], local members' roles and accountabilities often overlap with the remit of existing organisations [35] and its budget is modest [36].

PPI in the NHS has previously been more ambitious and successful. Between 1973 and 2003, Community Health Councils (CHCs) were relatively well funded, independent and

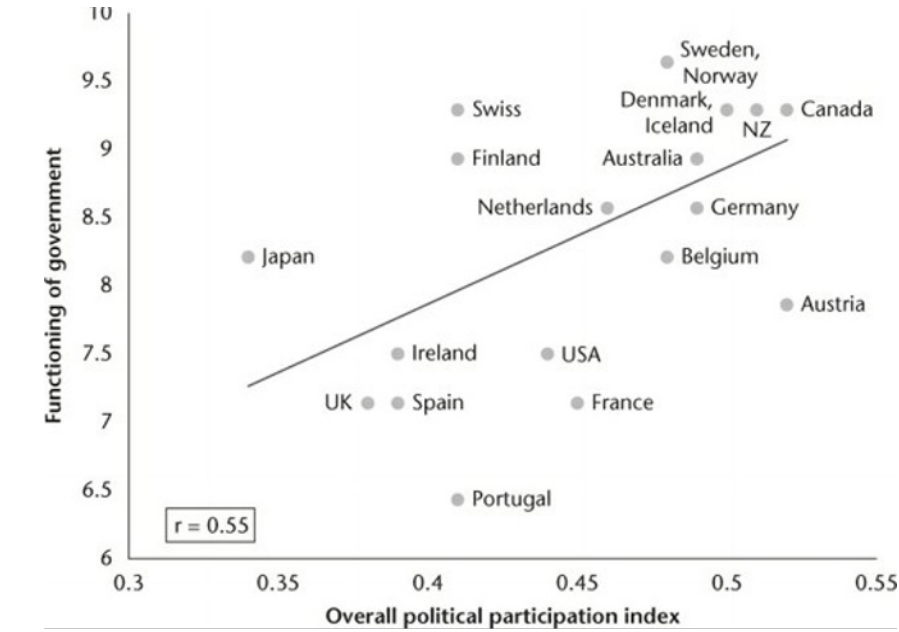


Figure 3. Political participation and quality of governance [26]

autonomous, and had the power to refer disagreements on local health service changes to the Minister of Health. Their abolition in 2003 has been linked to how "they had become very politicised and objected to almost all change" [37] – perhaps unsurprisingly so, given that during the latter part of their existence they witnessed the beginnings of the fragmentation and marketisation of the NHS. It appears that CHCs were seen by government to have too much power, and stood in the way of marketising reforms: subsequent iterations of health committees have had diluted rights and negligible impact [38,39].

To improve deliberative democracy in the health system, CHCs should be re-established, but radically reformed to operate within devolved local health systems in which they have budgetary and decision-making powers equal to those of the local health authority (Figure 2). At government level, a National Patient Forum would provide expert, deliberative scrutiny of the Health Assembly's policy-making (Figure 2).

These deliberative structures must be pluralistic. Analyses of the relationship between public preferences and government decision-making have shown that policy outcomes are biased towards the preferences of high-income citizens [40]. Further, if only affluent citizens have access to deliberative democratic processes, support for state welfare provision, on which poorer citizens depend, is often lower [41]. As such, recent Citizens' Assemblies in Ireland, which are formed so that they are representative in terms of age, gender and ethnicity, and which pay participants for their work, are a model of citizen participation on which CHCs and the National Patient Forum could be based. Van Reybrouck (2016) has praised the Irish deliberative democratic process, arguing that such an approach to democracy "flourishes precisely by allowing a diversity of voices to be heard" [42].

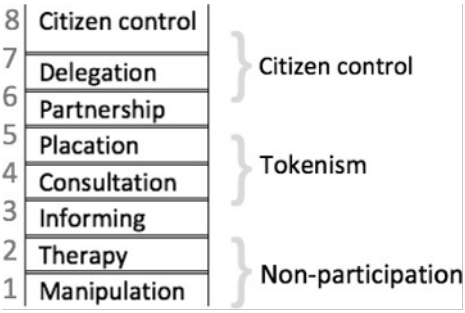


Figure 4. Arnstein's 'Ladder of Citizen Participation' [27]

CHCs allow community scrutiny from outside the health system, but their effectiveness would be enhanced if there were also powerful PPI on the inside. To achieve this, there should be an expert-by-experience director of each policy area in every local health authority and a patient/carer director in every health organisation (Figure 2), an innovation that has already been successful in Sussex and Camden [43].

Finally, effective deliberative democracy requires transparency. Many CCGs have taken advantage of the allowances in the HSCA to meet in private and not publish board papers [20], corporatisation of Foundation Trusts has allowed previously transparent bodies to claim commercial sensitivity when they have been asked to publish data, and public bodies can be bound by non-disclosure agreements [44,45]. Such barriers are good for businesses but bad for patients: they get in the way of accountability and effective governance, especially deliberative democracy, and are therefore likely to have a negative impact on quality of care. Our new Minister of Health would revoke them.

Conclusion

Current decision-making institutions concentrate power in a politico-economic elite, and the resultant unequal distribution of resources has resulted in wide health inequalities. Recent modes of citizen participation are a simulacrum of democracy, a symptom of a 'post-democracy,' created in a manner that preserves the power of elite institutions rather than redistributing that power [46].

In the system of governance envisaged in this essay, the interaction of powerful citizen groups with the Assembly, and of the Assembly with the Government, would continue to involve struggles over power. But that is the nature of healthy democracy. By considering the political system in its entirety – from a powerful and engaged citizenry to a pluralistic and socially representative legislature – this essay has shown how power, wealth and therefore health outcomes could be distributed much more evenly.

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Joseph Freer

This year's essays are also on the website:
https://www.doctorsforthenhs.org.uk/resources

Book Reviews

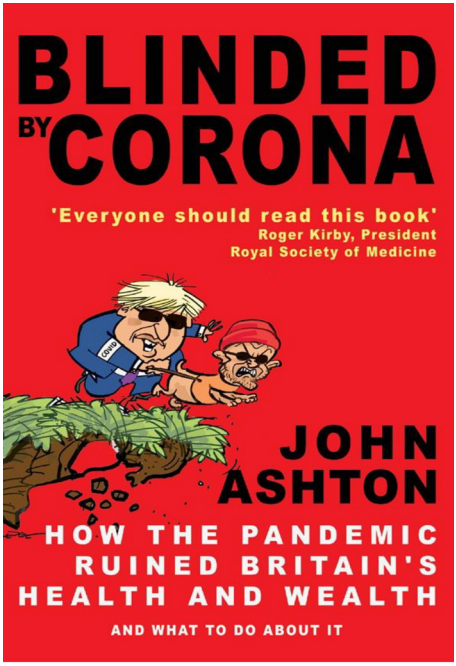
Blinded by Corona; how the pandemic ruined Britain's health and wealth
John Ashton. Gibson Square Books, London, 256pp. (£10.15, Amazon, paperback)

It seems very unlikely that Boris Johnson will read this excellent and very readable book, although he should. He would not find it comfortable reading.

After a long and very distinguished career of over 40 years in public health, including 13 years as regional director of public health for NW England, Professor Ashton certainly knows what he is talking about. As well as posts at Southampton University, the London School of Hygiene and Tropical Medicine and at Liverpool University school of Medicine, he was the president of the Faculty of Public Health for several years and has been involved with WHO. He spoke out strongly against the Health and Social Care Bill as it went through Parliament, fearing that it would 'totally demolish the NHS'.

Professor Ashton begins with a historical perspective, including Plague epidemics, and also the 1919 pandemic of 'Spanish' flu—which seems to have started not in Spain but in Texas—and which catastrophically spread worldwide because of delays caused by a poor US public health system and a President distracted by WW1. He stresses that epidemics will always occur, and their timing is unpredictable. Prompt public health measures, planned in advance, are absolutely vital to contain them when a threat arises, though expenditure and preparation for those that do not occur or are averted by the preparation will find themselves criticised as a 'waste of money'.

Britain has a proud tradition of public health and we read that the well-tried measures for dealing with infectious diseases have in the past been responsible for most of the reduction in mortality, even for those for which a vaccine later became available, so vaccines will never be the only answer. Professor Ashton is strongly critical of many policies of this and previous governments which have made the UK's response to Covid-19 far less effective than it could and should have been. He describes the effects of the very damaging Health and Social Care Act as well as the many adverse effects of austerity. Directors of Public Health, once again part of increasingly cash-strapped local authorities, found their budgets and staffing cut and their status downgraded. The 2013 Cabinet office guidance on preparation for pandemic 'flu, and the many deficiencies shown by the 2016 simulation 'Exercise Cygnus' (which among other



things predicted the problems with social care in the current pandemic) were ignored and never acted on. All this, coupled with the underlying effects of 10 years of austerity on population health, gave the UK the highest rate of excess deaths among European countries during the first five months of the pandemic.

Professor Ashton describes the development of the pandemic from its first report by China in December 2019 and the inexplicable secrecy of Public Health England (PHE) who withheld information on Covid, even, crucially, from Directors of Public Heath. 'It was as if the Battle of Britain was about to be fought with RAF pilots who were given neither information about enemy planes, nor ammunition, nor even accurate radar information where attacks were happening and weren't even allowed to go to their planes'. He writes that 'during the lockdown period, Wikipedia would have been a better source of information than PHE'. Meanwhile, Boris Johnson missed five COBRA meetings before attending his first in March. Unlike those of most other countries, UK borders were still largely open with thousands of travellers coming in without any screening or quarantine and the infection was spreading rapidly. WHO had on January 30th declared 'a public health emergency of international concern' and advised an immediate and comprehensive approach with testing, contact tracing, quarantine and social distancing; 'not just one alone, do it all', but this advice was ignored in spite of the warnings of critical situations elsewhere, particularly in north Italy.

Most other countries did so much better. Professor Ashton was contacted in early February by the Crown Prince of Bahrain to advise on the careful preparations Bahrain had already been making for the pandemic. Almost all Ashton's recommendations were carried out and the death rate per 100,000 was less that ¼ of that in the UK. Even locally there are good examples such as the Isle of Man which closed its borders promptly, arranged local testing and implemented strict quarantine, and the effective early action of Ceredigion Council in Wales. The deputy chief executive, a retired biology teacher, had seen the importance of infection control measures carried out by the local public health teams.

> "Boris Johnson was Mayor of London for 8 years, a period during which there were epidemics of TB and also HIV, so he should have been better placed than most national leaders to understand what was needed. "

As Professor Ashton points out, Boris Johnson was Mayor of London for 8 years, a period during which there were epidemics of TB and also HIV, so he should have been better placed than most national leaders to understand what was needed. Those had been successfully dealt with, under Boris's nose (or possibly while he was having IT lessons), by trained public health teams actively finding and treating infected individuals and their contacts and seeing which areas were particularly affected. Standard public health measures, carried out by trained public health officials doing their job, in fact. Unfortunately, with Covid more and more opportunities were missed. Having suggested, but later denied, that 'herd immunity' was the aim, Johnson failed to tell the current Mayor, Sadiq Kahn, that London had the highest rates of Covid-19 in the country while continuing to deny local public health teams the information and resources to deal with it.

A major theme throughout the book is the way that local public health staff were deliberately

bypassed in favour of an ineffective centralised approach and were also forbidden to speak publicly, while the extra Government spending went elsewhere. A central PHE lab was used for viral tests, rather than local facilities, and its inadequate capacity meant that community testing was dropped when numbers of infections rose. Similar centralisation, combined with an ideological obsession with outsourcing, led to the poorly-performing private-sector £10bn 'Track and Trace' service run by Dido Harding, 'a Talk-Talk chief executive, wooden spoon recipient and former amateur jockey', with no obvious qualifications for the job. It became all too apparent that local teams were far more effective in this work, in spite of their financial constraints.

A cynical lack of care for the public is another theme. 'Herd immunity' would have guaranteed the deaths of large numbers of vulnerable people, while many thousands in care homes did in fact die after infected patients were discharged among them. Mendacious claims by PHE (made because of avoidable shortages) that Covid-19's severity had been downgraded also led to use of inadequate PPE for NHS and care staff, many of whom became infected, some fatally.

There was also a sense of British exceptionalism and a failure to learn from other countries; 'the government's approach seems to have been to look around the world at what was working elsewhere in practice and dismiss it as not working in theory'.

This book is a shocking and distressing account of the mismanagement, delays, dithering, muddle, cronyism, ideology, lies and incompetence shown by this government in a major crisis where effective leadership was really needed. A wealthy country with a well-established public health system now has one of the very highest worldwide death rates from Covid (per100,00) and the worst economic damage in Europe.

As Professor Ashton says, "The key choices and errors were all political, responsibility lies with the PM……For much of the time, with a part-time, narcissistic and distracted Johnson, nobody had been at the wheel".

Eminently readable, it should be part of the historical record of this sad event. You should read it and so should those who steered their chaotic way through the last year and still lie and claim success at dealing with Covid-19.

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The Hype Machine: how social media disrupts our elections, our economy and our health
Sinan Aral. Harper Collins, London, 352pp. (£8.19, Amazon, paperback)

This book dispels with refreshing clarity any lingering doubt anyone may have about how dangerous, destabilising, influential – yet potentially beneficial – social media are and could become.

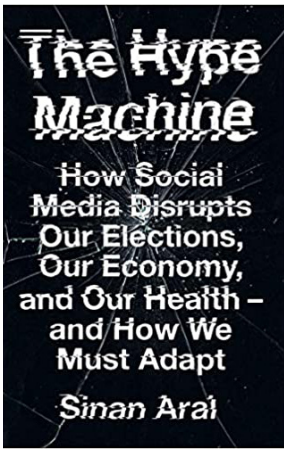
Sinan Aral takes a logical path, describing the overall anatomy of social media before going on to describe the function and economic, social and political effects.

There is, for example, a clear and disturbing description of how social media and the machines used to operate it (now the Smartphone, tomorrow....?) tap directly into our neurochemistry in a process startingly close to the pathways for addiction. How advertisers and corporations then don't just recognise this, but depend on it, for influencing far, far more than the next pair of trainers, or how we address (or even define and choose) our friends. It is no exagerration to say that outcomes of elections have been swayed by social media, a suspicion held by many but mapped with forensic clairty by the author, who also points to predatory loans targeting low-income groups and other nefarious applications. We are a world away from dancing kittens here, yet it's the same technology and the same 'mass hypersocialisation and persuasion' driving it. The fact he admits to his own limitations in drawing the alarming conclusions only adds weight to the argument.

And there is so much more, terrifyingly more. For example:

'... perhaps more astonishing (and worrying) is Facebook's development of its brain-computer interface, designed to allow users to control social technologies with their thoughts. This is not hypothetical. Today Facebook has over 60 people working on the project...It can already decode brain activity in real time and aims to allow users to "type" 100 words per minute just by thinking, without ever touching a keyboard.'

Huxley meets Orwell meets the Borg (*Star Trek*'s own 'hive mind' cyborg creation)? How wondrous abilities like that could be for medicine. Yet how dangerous, politically.



One of the most appealing parts of this book are the chapters looking at possible ways of avoiding dystopia. Veliz puts the case for fundamental privacy law reform but in a way that preserves the capacity for such things as investigative journalism while avoiding the growing nightmare of the surveillance state. He holds up the combined action of communities and platforms as a way of staving off the immensely corrosive effects of misinformation with labelling of 'fake news' by trusted actors. Ways of combating election rigging by hostile parties (the real deal, not the Trumpian fantasy) are proposed, as are ways of incentivising the most influential actors (such as Facebook) to prevent misinformation and become more transparent (at the moment, there are massive economic incentives for the companies to remain obtuse).

The solutions are of course political. But, as for climate change, they are solutions which must be found. As recent events in Washington have shown, the power of social media must not be left to the market alone.

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Obituary

David Player

2 April 1927 – 2 October 2020

David Player was a trailblazer in the field of public health decades before many of the socio-economic principles he championed were commonly accepted or widely recognised.

David qualified in medicine from Glasgow University in 1949. He served as a doctor in the British Army in Hong Kong, before returning to train in psychiatry in Dumfries. He worked in general practice in Cumbria, where he saw first hand the effects of poverty on health. He returned to Glasgow University to gain a diploma in public health in 1960. He was appointed medical officer of health for Dumfries, and then director of prison psychiatry in Scotland before becoming director of the SHEU in 1972, and a decade later director general of the Health Education Council.

As Director General of the Health Education Council in the 1970s, he worked tirelessly to overcome the then almost universal focus on the individual and the victim blaming that went with it, aiming to create health-promoting environments while exposing the commercial forces that were damaging to public health.

He fought the pervasive influence of the tobacco industry for decades, establishing the precedent that public bodies should not be associated with 'Big Tobacco' (tobacco firms were promoting the idea of 'safer cigarettes' at the time).

He commissioned an update to the *Black Report* (1980) on the social and economic determinants of health, *The Health Divide*, which was published in 1987. Despite (or perhaps because of) rumours of suppression by the Thatcher government, the report's findings into the socio-economic determinants of health and health inequality, with their undeniable links to poverty, became widely known. The ensuing political row finally sealed the fate of the HEC under the Thatcher government, which was already threatening its closure, and it was disbanded in 1987. David served as director of public health for south Birmingham (1987-91), where he continued to work to help the local population, which includes some of the most deprived communities in England.

David was an active member of DFNHS for nearly 30 years. He joined what was then the NHSCA in 1989. He returned to his native Scotland in 1991 to do similar work in Edinburgh. There he was a leading member of our numerous and effective membership in that country. He was elected to the Executive Committee in 1993 and served in that capacity until 2015 when he was obliged to stand down because of health problems. David is survived by his two sons from his marriage to Anne, who died in 2006, John and Stewart, and their four grandchildren.

A man of strong views but an excellent friend and colleague, who is sadly missed.

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Coronavirus is not the only threat...

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- Its protection is not guaranteed.
- Plans to privatise it are still being made.
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