**Rusiru Kariyawasam**

**If I was Minister of Health…**

Even before the coronavirus pandemic, other than being Prime Minister, the role of Minister of Health was probably the most daunting in Government. Considering the NHS regularly tops lists of most treasured British institutions, expectations of the Health Secretary may even be higher. Given the problems in the healthcare system over the last decade, it is an unenviable position to inherit, but vast improvement can occur, we need only look at the revolutionary 1948 foundation of the NHS itself.

Improvement is usually best identified and implemented by those in the system, thus, it makes sense to have a Health Minister with field experience. Having worked as a NHS doctor for the past eight years and as an occasional patient for two decades before that, I offer qualified insights into developing the health service.

First off, let’s deal with the barrier to productive discussion: money. There *is* money to spend. The UK has one of the strongest economies in the world, if that doesn’t equate to public spending power then I don’t know what use there is for a high GDP. Even if the piggy bank runs short following rainy day expenditures like the coronavirus furlough scheme then the solution lies in making large multinational companies pay adequate taxes by reforming corporation tax law [(for example, Amazon paid just 220m in tax on UK sales of 10.9bn in 2018)](https://www.theguardian.com/technology/2019/sep/03/amazon-accused-of-handing-over-diddly-squat-in-corporation-tax-despite-tripling-payment). The point is, money is available, let’s not use that as an excuse to limit progress.

Now we’ve redressed our outlook, we can approach issues in the healthcare service uninhibited by a fiscal fallacy. So where to start? How do you begin trying to improve such a gargantuan system? For ease of discussion I have focused on three key areas. Handily titled ‘People, Places and Public Health’ (forgive the alliteration but it’s the hallmark of any fledgling manifesto) I shall address these sequentially but consider all three to be of profound importance in improving the health service.

**PEOPLE**

When asked to consider the biggest limitation of the health service, a plethora of headlines crowd for attention. Are the [longer wait times in A&E](https://improvement.nhs.uk/documents/1069/AE_delay_main_report.pdf) more pressing or are the [notoriously large waiting lists for elective operations](https://www.hsj.co.uk/free-for-non-subscribers/the-state-of-elective-waiting-times-before-covid-19/7027377.article) the biggest issue? In actual fact, these are all facets of the same problem, namely that of insufficiency. There are not enough resources to meet demand and that translates to longer waits, compromised care and poorer health outcomes. And out of all the resources needed for a functional healthcare system, the most important is staff.

When we talk of a “lack of beds,” we actually mean a “lack of staff.” A hospital can bulk buy beds enough to fill every empty room in the building, but without a concomitant reinforcement of staffing (and that means *all* healthcare professionals, from cleaner to consultant) expanding numbers of medical equipment is essentially futile. Patients need CT scans and antibiotics, yes, but all these interventions are facilitated by staff, for example, the porter to transfer a patient to radiology and the nurse to set up an IV.

Unfortunately for the NHS, staff are leaving in droves. From Brexit to burnout, the causes for people leaving are myriad. Each reason should be addressed individually, however, an easier way to summarise the problem is that on balance, for many the pros of the job no longer outweigh the cons.

Over the past few years austerity-driven cutbacks have made conditions in the NHS extremely difficult. Experiencing insufficiency as a daily reality wears people down. Not only that but healthcare workers are regularly denigrated in the press and undermined by the Government with both entities scapegoating healthcare workers (or [Moet Medics](https://www.thesun.co.uk/archives/news/82497/moet-medics-high-life-of-docs-leaders-who-are-heading-up-nhs-strike/) as some of us are known) for deficiencies in the system.

But let bygones be bygones. How do we stop the attrition of the workforce? No, let’s go one better – how do actively recruit people to the health service? Coronavirus has shown that by increasing the standing of the healthcare worker more people are attracted to the field. Since the pandemic hit [applications to study nursing at university have increased by 15%,](https://www.independent.co.uk/news/health/student-nursing-applications-ucas-coronavirus-nhs-a9608556.html) which is no doubt fuelled by the heroic portrayal of nurses in the news. However, it is not just through the media that standing improves, the whole healthcare profession must be made more attractive.

For this we look at Google. Why do so many people want to work there? The lucrative salary plays a part but NHS workers would likely settle for more conservative wages. An inflation-matching pay rise is a good starting point but if the Department of Health were to go one better and make salaried positions handsomely paid it might draw workers away from more costly locum work. Recruiting a regular workforce would make for reliable staffing levels and thus, safer care.

We can aspire to even more than that. The NHS could become a truly tempting employer by rewarding its employees benefits like free meals, free parking and free gym membership as swanky private companies do. And why not provide heavily subsidised childcare at Trusts for all employees? A large clientele already exists, the only thing needed now is to develop the infrastructure. The NHS could then truly practice what it preaches by improving the well-being of staff as well as patients.

Finally the system should place great emphasis on nurturing staff potential. Study budget and study days should be easier to access and professional development should be encouraged and facilitated. This ties in with the second prong of my plan as Health Secretary: structural organisational change in the places we work in.

**PLACES**

Healthcare is demanding. It is labour intensive and can be emotionally draining but it needn’t be hard. By that, I mean the essence of healthcare can be deconstructed to a fairly simple model (Fig. 1).

Resolution and discharge from services

Management (+/- diagnosis) Management strategies include medication, surgery, therapies etc.

Medical Issue

Chronic Care potential for further medical issues arising

Represents interaction involving healthcare professionals e.g. investigation, examination, referral

**Fig. 1:** Flow diagram showing simplified healthcare process.

But as many of us working in the system know, it can feel incredibly hard. The Fig. 1 process is sludged up by lack of flow through the system, which is down to the aforementioned insufficiencies. These insufficiencies are partly due to Trusts trying to reduce budget deficits by cutting costs and in so doing, reducing services, where they can. The other tactic employed is to erect boundaries (often prodigious bureaucracy) to stall people when applying for services. Paperwork also burdens clinical staff, who often have to produce exhaustive written evidence of the work they have done.

So what I propose is an overhaul in the approach. Firstly, we stop penalising Trusts. Anyone who has been in debt knows that you cannot make good decisions when you are financially stressed and this is backed up by psychological research. The “scarcity mentality” has been well documented in Mullainathan & Shafir’s key psychological experiments, which show poverty can lead to a drop in IQ, ergo poorer decision making skills (1). To ameliorate this effect in healthcare we must eradicate deficits (remember, Amazon could make up the shortfall) and instead of fining poorly performing Trusts, provide *more* money to tackle problems.

Improvement initiatives should heavily involve care workers themselves as their intimate knowledge of the system means they often know how best to solve a problem. Hands off management has been shown to provide better services, for example, in the Netherlands the Buurtzog care initiative allows individual teams to decide how deliver care rather than by having far-removed managers dictate the approach. Analysis reveals that Buurtzog boasts higher quality social care for less cost than the average (2).

Also important in the approach is eliminating redundant layers of bureaucracy. Do Trusts really need a stratum of admin staff to double check every worker has done their e-learning? If that is necessary, could these staff not be redeployed to offer on-the-job training, thereby increasing administrators’ experience of the system they are managing and minimising the paperwork burden on healthcare workers. Caregivers should spend as many hours actually caregiving rather than completing documentation to “prove” themselves. We must trust that healthcare workers, who for the large part went into this profession to *help people,* are doing their job*.* An errant employee usually becomes apparent in a team and can bereformed individually.

With more effective internal processes Trusts can broaden their vision to upgrading their physical places of work as well. That means bringing healthcare facilities into the 21st century by switching to renewable energy, rejigging waste disposal schemes to incorporate as much recycling as possible and buying local foods for the canteen. A healthcare system should embody the best values and always be on the right side of history.

**PUBLIC HEALTH**

The final part of my plan involves public health. The current health system has mastered the Fig. 1 process with a tiered approach (primary, secondary care etc.), albeit hindered by the problems listed above. The NHS knows exactly how to investigate chest pain, however, processes for keeping people well enough to stay out of the healthcare system are less refined. Public health is a relatively virgin field and has great potential.

First off, we need all hands on deck and that means incorporating with social services. So much of healthcare is determined by effective social care and vice versa, the two organisations are really two heads of the same Hydra. That means the social workers and healthcare professionals should be working in the same team as par for the course rather than by occasional referral to each other.

A key limiting factor in hospital discharge of the ageing population is community care provision. We need a wholescale expansion of care, multiplying the number of facilities from nursing homes to rehab/respite centres to hospices. Concomitantly more care staff should be employed and similar to NHS workers, the profile of carers should be raised. As the coronavirus pandemic shows, this is truly essential work and should be esteemed as such.

With robust care infrastructure in place we can concentrate on promoting public health. This starts with adequate provision of the known basics e.g. addiction and [smoking services, which over recent years have actually been reduced by a third amongst councils.](http://www.pulsetoday.co.uk/clinical/clinical-specialties/smoking-cessation/third-of-local-councils-axing-stop-smoking-services-amid-funding-cuts-warn-charities/20039980.article) Of course, keep existing programs in place, we should keep promoting good diabetic control and immunising babies, but I also propose a stronger focus on wellbeing.

Hear me out, I know the idea of wellbeing has become a cliché but I am talking about more than superfood smoothies. Wellbeing [forms the first tenet in the WHO’s Constitution](https://www.who.int/about/who-we-are/constitution) and is pivotal to the concept of health. It informs personal perspectives and can be the deciding factor on whether a disease becomes an illness. Thus, we should be doing all we can to promote wellbeing in every citizen.

This starts with combatting impediments to wellbeing e.g. loneliness, inactivity, mental health and of course, poverty. These are huge topics and would need specific targeting, however, key strategies for the former rely on strengthening communities. Alongside housing the homeless, multigenerational initiatives e.g. beautiful community centres and providing free NHS gyms would improve our communities immensely. I also propose heavily subsidised health holidays for all families, thereby fostering an interest in outdoor exercise in the next generation.

Mental health is a huge topic and in addition to its improvement through the “People” and “Places” part of this plan, additional attention should be given to psychology services. In my opinion, counselling centres should become as commonplace as the high street optician, recognising the fact that a lot of health issues are worsened by past trauma and underdeveloped coping mechanisms.

As to poverty, I need another 2000 words for that.

**Summary**

So there you have it, my proto-vision as Minister of Health. The ideas may sound simplistic, especially when condensed into a three point plan, but sometimes problems haveto be simplified in order to deal with them. The health service is undoubtedly complex but the aspirations are easy enough to visualise and strive for: to optimise the health of every citizen in the most effective way possible. We must not let imagined impediments limit our vision. We can do better so let’s begin.

**References**

1. Sendhil Mullainathan and Eldar Shafir, *Scarcity: Why Having Too Little Means So Much* (2013).
2. David Ikkersheim, ‘Buurtzorg: hoe zat het ook alweer?’ *Skipr* (9 May 2016)