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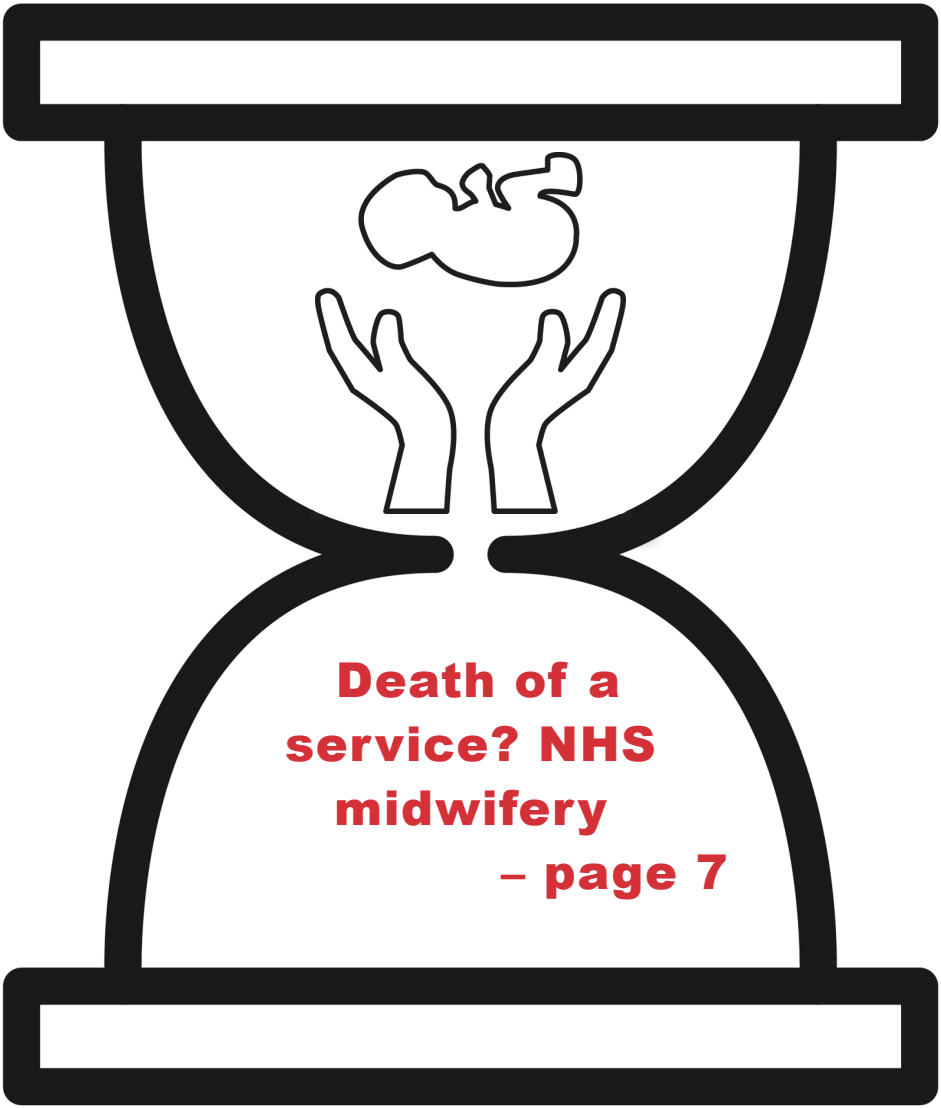

Death of a service? NHS midwifery – page 7

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Postponement of AGM & Conference

The AGM and Conference, due to be held in London on Saturday 1 October, will now be held on Saturday 14 January 2023. The speakers will remain the same.

The decision was taken to move the date because rail travel would have been severely disrupted for members this month owing to the days of action by the rail unions. Anyone who has purchased tickets for the October meeting can transfer this to the January event for no extra charge, or they may be refunded.

Apologies for any inconvenience this may have caused. However, members now have more notice in which to consider attending in January, and the speaker line-up promises to make this a good one! It will also give members the opportunity to meet and discusss ideas to help save the NHS, as it faces its most brutal winter. We hope to see you there, online if not in person.

Managing Editor – Alan Taman
healthjournos@gmail.com
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Social Injustice in a Time of Turmoil

Social injustice is killing people on a grand scale.

So concludes the 2008 report of the WHO Commission on the Social Determinants of Health [1]. Within the UK, supposedly the 5th largest economy in the world, although in terms of GDP per head of population we apparently rank 34th, Professor Sir Michael Marmot's work has provided the evidence to show that killing is taking place, and life-chances are being blighted at an increasing rate, even though we have the knowledge and the power to reduce the inequality and other factors driving this destruction. His landmark report from 2010 provided a clear pathway to address these issues [2], but that path was not followed and *The Marmot Review – 10 Years On* showed the stark consequences:

> **"Life expectancy in England has stalled, years in ill health have increased and inequalities in health have widened. Among women, particularly, life expectancy declined in the more depressed areas of the country. Some areas, especially in the North, have been ignored, left behind, as health has improved elsewhere." [3]**

The NHS and local authorities should have a significant role to play in reducing social injustice. Some would point out that the newly created Integrated Care Systems provide for just the kind of collaboration that could tackle many of the social determinants of health, including access to housing and public transport, air quality, provision of support in the early years of life and safe communities. Perhaps they could, if local authorities had not seen their budgets halved since 2010 and their powers in many of these areas severely curtailed since the 1980s, through privatisation of bus services, the Right to Buy rules for social housing and centralised control of much of education. Perhaps they could if Integrated Care Boards (ICBs) can push back against the command and control structure that has been the hallmark of NHS England. But the omens are not good, when the new ICBs have already been ordered to make cuts of 4-5 % in their planned spending in their first year of operation: remember, NHS bodies have previously struggled to find savings of 1-2% and, like local authorities, ICBs are compelled by law to operate within their budget.

The result is that central government will have to play the major part in restoration of social justice. A false narrative is being set out, that this might be a nice thing to do, but will need to wait until the economy is fixed; 'fixed' as in repaired, I hope, not 'fixed' as in a pathological specimen. The OECD has contributed to the strong evidence that lower levels of inequality boost national economic growth [4]. Major companies do not simply choose to base their headquarters in countries that offer low levels of corporation tax, but are attracted to stable, safe locations in which to live and do business, and with strong legal systems and vibrant cultural scenery. Our new Prime Minister does not accept the evidence that lower levels of inequality benefit the whole of society and insists that we must stop looking at the economy through the "lens of redistribution" [5]. This might not actually be such a complete break from the thinking of some of her erstwhile colleagues, when we hear Rishi Sunak tell members of the Conservative Party that he had been working to divert funding from "deprived urban areas" to give more prosperous towns "the funding they deserve." [6]

So how is our new government making progress in reducing social injustice?

Dear oh dear!

Dr Thérèse Coffey, who has been Secretary of State for Health and Social Care since 6th September 2022, seems to have a similarly novel approach to improving public health as Captain Redbeard Rum had on sailing a ship [7]. (*Blackadder* Series 2 'Potatoe') Not only has the seriousness of increasing resistance to our arsenal of antibiotics seemingly passed her by, but she also seems oblivious to the role of clinical examination and bacteriology in keeping people alive [8].

No reasoned explanation has been given for the ditching of the promised White Paper on Health Disparities, leading to the suspicion that its disappearance is because it diverges from the view that the diseases of poverty are all due to bad lifestyle choices [9]. Similar thinking could be behind the failure to progress the Smoking Action Plan [10] and the Anti-obesity Strategy [11]: it would be difficult to imagine that lobbying on behalf of vested interests could have had any part to play. Would it be too much to hope that the Data Protection and Digital Information Bill could also be consigned to oblivion [12]?

> "Theresa Coffey... seems to have a similarly novel approach to improving public health as Captain Redbeard Rum had on sailing a ship (in Blackadder)."

Return of a familiar face

The appointment of Jeremy Hunt to the position of Chancellor of the Exchequer on 14th October raises some interesting possibilities for the NHS at a critical point in its history. Appointed as Secretary of State for Health in 2012, to deal with the fallout from Andrew Lansley's Health and Social Care Act, he went on to become the longest serving Health Secretary, with the addition of Social Care to his portfolio in 2017, until he was called upon to deal with the fallout from Boris Johnson's tenure as Foreign Secretary in July 2018. Does his performance at the Department of Health give us any clues as to how his control of the purse strings might play out for the NHS and social care?

The combination of the austerity policies imposing the biggest ever squeeze on NHS spending and the reorganisation so big it could be seen from space, could not have made for an easy life and his time was marked by worsening shortages of clinical staff and savage reduction of bed numbers, leading to progressive increases in waiting lists for elective treatment and deterioration of the efficiency of accident and emergency departments.

The public inquiry into the breakdown of care at Mid-Staffordshire Hospitals Trust, many years earlier, led to the publication of the Francis Report in 2013 and it is not surprising that concerns for patient safety should have been a major focus during Jeremy Hunt's tenure as Health Secretary, however he was severely criticised for his selective use of patient safety data to support his unnecessary confrontation with junior doctors, exacerbated by his imposition of a new contract of employment. This led to persistent resentment amongst a generation of young doctors at a time when workforce shortages were becoming acute.

Jeremy Hunt was also in the driving seat during Exercise Alice, the modelling exercise into the UK's ability to respond to a pandemic arising from a Coronavirus, which reported in 2016. The failure to plan for a non-influenza pandemic surely contributed to poor preparedness of

supplies of personal protective equipment, testing facilities and contact tracing at scale, amongst other missed opportunities to reduce the death toll due to Covid 19 in this country.

He was also behind the attempt to introduce Accountable Care Organisations into the English NHS through secondary legislation, bypassing parliamentary scrutiny, which led to a challenge by judicial review which was supported by DFNHS. Cunningly renamed as Integrated Care Systems, they were ultimately brought into being this year, but at least the opportunity was gained for proper consideration of the proposals by Parliament, even if the Government were then able to use their majority to see off any significant amendments to their proposals.

Jeremy Hunt has given a couple of interviews to the *BMJ*, in which he reflects on his performance as Secretary of State [13,14]. He admits that he has serious regrets that he did not recognise the seriousness of worsening shortages of clinical staff soon enough. If he had, would he have still gone ahead and scrapped the bursary for students of nursing and other professions allied to medicine? He was aware of the shortage of general practitioners, and, in 2015, made his pledge to increase the number of full-time equivalent GPs by 5,000, a pledge that was repeated and enhanced in subsequent Conservative election manifestos. The actions required to deliver on this promise were however lacking: we have seen a fall in trained full-time equivalent GPs every year since 2015, so the total stands at 1,444 fewer in 2022 [15].

He did, however, expand the number of places for medical students from 6,000 to 7,500 from 2018 onwards. Unfortunately, the current government's cap on medical student numbers means that the medical schools are having to allocate a large proportion of the new places to overseas students [16]. There was also a failure to fund an expansion of postgraduate clinical posts to allow the training of sufficient doctors to fill the vacant posts in radiology, clinical oncology, psychiatry, dermatology and so many other areas of practice.

His other major regret was that he did not manage to secure a funding settlement for social care once it came within his portfolio. He seems to appreciate that this is not just essential for the NHS to be able to cope with the reduction in hospital beds, much of which occurred on his watch, but also to allow people to lead as full a life as possible, with dignity and contributing to wider society.

Since his return to the backbenches, Jeremy Hunt has used the knowledge and understanding that he has acquired as Secretary of State to be a highly effective Chair of the Commons Health Committee and continuing to press for a workforce plan for the NHS and social care, that looks at both medium and long-term requirements and, crucially, brings with it the necessary funding, so that we can make a start at rebuilding our services. Let us hope that he continues that enthusiasm, now that he can take the financial decisions that could turn a workforce plan into a reality. He can't pretend that he doesn't know the consequences of failing to do so.

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Colin Hutchinson
Chair, DFNHS
colinh759@gmail.com

Midwifery: The Death of a Service?

Midwifery is in crisis. Dr Rebecca Smyth is a recently retired midwife of 35 years and a member of The Save the Liverpool Women's Hospital Campaign Group and Socialist Health Association. Here she provides an overview of the current situation in maternity care

So where are we at the moment with maternity?

We all know of the present crisis maternity is in and I am sure we will have heard and read about heart-breaking, tragic accounts from pregnant women and their families about their childbirth experiences [1]. With this in mind I would like to cover the shortage of midwives, what impact this has on the midwives themselves and the devastating impact this has on women and their babies.

Shortage of Midwives

At present, we are more than 2,000 midwives short in England [2], this means that there is not one maternity unit in the country that is staffed adequately. Hospitals will be short of midwives on every single shift and not a day goes by when we do not hear about a maternity unit closing its doors for admissions and therefore women being sent elsewhere [3]. Did you ever imagine you would hear that a hospital closed its doors? That is what shops do, that is how businesses are run. But this is the consequence of the formalisation of the Integrated Care Systems brought about by the Health and Care Act of April 2022.

Worse too, the latest numbers of midwives show that in April this year England had 677 fewer midwives than at the same time last year, with numbers plummeting by the month [4].This drastic shortage of midwives brings unsafe practice, how can you provide optimum care for women and their families if there are not enough of you, it is

just impossible. We know that sometimes it is so unsafe that babies and women are dying, and these deaths are unavoidable, they should not happen.

A recent Confidential Enquiry found that the deaths of 8 out of 10 babies might have been prevented with better care. In at least 1 in 4 cases inadequate staffing or resources was a factor; busy workloads were most common on the delivery suite. So when we hear of tragedies on the news it is because there are not enough midwives. And not being enough is a political decision. But it is the clinicians that get the blame, it is the clinicians who end up in court.

When do we see the health correspondents in most national media lay into the government about these tragedies? We do not. Government have no accountability, they take no responsibility, and it is the midwife, the obstetrician, the paediatrician that takes all the blame. They end up being singled out, they are the people the women and public blame, but as we know it is the clinicians that are casualties just as the women and the public are, but we blame each other. Meanwhile the government is literally getting away with murder.

I talk with clinical midwives and they tell me they are frightened, imagine working and being frightened, frightened that you are going to cause a baby's death, frightened that you are going to harm a baby so they never reach their true potential, perhaps never have the life they should have. And women too, the thought of harming a women you are looking after. How can people work in those conditions?

To add to this problem, the proportion of midwives in their fifties and sixties (with a handful in their seventies) has risen, from just over a quarter (28 per cent) to almost a third (32 per cent). In headcount terms, that was an extra 1,573 midwives aged 50 or above. The NHS is lucky to have these midwives. They bring a great deal of experience, but inevitably they will all be retiring soon [6]. We need to act now, we need to find a way of keeping these midwives. Because thinking the solution is to train more does not solve the shortage problem. Data from 2018 confirms that in order to increase the size of the workforce by one full-time midwife, we need around 30 student midwives graduating [6]. This is because a consequence of poor staffing leads to midwives being overworked, which then results in midwives going from full time to part time or leaving the profession completely, either mid-career or retiring early. So when the government says we have increased midwife numbers, that is what they are talking about, that is the reality. Plus if you keep on increasing the student numbers, as we stand there are not enough lecturers to provide the teaching, not enough classrooms in universities, not enough practice assessors or supervisors and not enough clinical placements. So increasing the number of students being trained on its own will not solve the problem, it is a great party political headline, but that is where it ends. There is no quick fix.

Midwifery was always a job for life, a vocation. However, so many midwives are at breaking point, I see my colleagues leaving the profession much earlier than they previously had and the reason they give is plain and simple; they are overworked, exhausted and feel dissatisfied with the quality of care they give. It is both sad and worrying; this was never the case in the NHS.

If you lose five midwives all with 30 years' experience each, you are losing 150 years of experience. It cannot be replaced like for like with five newly qualified midwives, but that is the reality of what is happening. How can things not go wrong when that is happening, and we must not blame these newer qualified midwives, they are the casualties, they are on their knees.

Impact on the midwives themselves

There has been a recent work survey of midwives by the Royal College of Midwives (Aug 2021) [3]. The survey reported over half of midwives surveyed said they were considering leaving their job as a midwife with 57% saying they would leave the NHS in the next year. Of those midwives

'Mother and Child'. Statue outside Liverpool Women's Hospital, unveiled in 1999

who either have left or were considering leaving, more than eight out of 10 were concerned about staffing levels and two-thirds were not satisfied with the quality of care they are currently able to deliver. Alarmingly, the highest level of dissatisfaction among those surveyed came from midwives who had only worked for 5 years or less in the NHS [3].

Speaking with midwives who have recently retired, all with around 35 years' experience each, they say to me 'I'm leaving before my PIN is taken off me', in other words leaving before being removed from the register for poor practice. They say 'I'm getting out, I don't want to finish my career in court.' Nobody should be working with that fear, nobody.

This shortage is costly too. In 2016 the NHS spent a total of £97 million on expensive temporary staff, including overtime, agency and NHS bank [7]. The RCM argues this is enough money to pay for at least 2,000 full-time midwives with 10 years of experience, or 3,318 full-time newly-qualified midwives [7].

Impact on women and their babies

The impact is heart-breaking and devastating. Recently you may have read and perhaps watched the tragic account by a woman from Surrey, a mother whose baby died following an undiagnosed breech birth. This is what is happening, this is the reality of not having enough midwives [8].

That is one case, however, there have been a number of other very high-profile large investigations which have included many women and their babies. To date the largest independent review of maternity services was at The Shrewsbury and Telford Hospital NHS Trust (SaTH), the review led by Donna Ockenden, which was published in March 2022 [9]. It reviewed 1,592 families care. The Review revealed 201 babies could have survived had SaTH provided better care (70 neonatal deaths and 131 stillborn and 9 mothers died).

The Review found that mistakes where not investigated properly and the Trusts failed to learn from them, so repeated the mistakes. Where cases were explored they lacked 'transparency and honesty', parents were not listened to, there was culture of bullying in the workforce, a fear of staff to speak out and sometimes caesarean sections discouraged leading to poor outcomes. What was prominent about the Review was the catastrophic shortage of midwives as well as obstetricians, lack of support for junior staff (midwives and obstetricians) and delays in appropriate review of care.

The Independent Review heavily criticised the new model of care that had been introduced, called Midwifery Continuity of Care (MCoC). The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy. Better Births, the report of the National Maternity Review, set out

a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives [10].

However, The Independent Review importantly recognised the terrible and harmful consequences of the MCoC model. The review stated, with such poor staffing, such a programme not only cannot but should not have been implemented. The Review acknowledges the unprecedented pressures that the model places on services, services already under significant strain and impact which compromised the safety of pregnant women and their babies. The Review asked for the immediate suspension of this provision unless Trusts can demonstrate safe staffing levels on all shifts [9]. This was requested as an Immediate Action by Ockenden in March 2022, yet it was not until mid-September 2022 that NHS England finally sent an instruction to all Trusts instructing them to stop MCoC immediately if they cannot meet safe minimum staffing levels. This was some 6 months later. The Review also stated the need for robust evidence to assess if it is a model fit for future maternity care, acknowledging current evidence does not exist.

Donna Ockenden is about to embark on another maternity review, this is at Nottingham University Hospitals where more than 100 families have experienced the same type of failures [11].

Additionally, we are waiting to hear the findings from a Review by Dr Bill Kirkup into East Kent Maternity Services. The Report of the Independent Investigation will be disclosed first to families and then published on Wednesday 19 October 2022. The Report looked at up to 200 incidences [12].

There are other problems in maternity, we must

Save Liverpool Women's Hospital Campaign

Liverpool Women's Hospital Foundation Trust is a 27-year-old world-class hospital specialising in the health of women and their babies both within hospital and out in the community. The hospital is a modern, low-rise building situated in one of the poorest areas of the city. It is the largest women's hospital of its kind and cares for more than 50,000 patients a year. Last year it provided antenatal care for up to 9,000 women, delivered around 8,500 babies, cared for over a 1,000 babies in the neonatal unit, supported fertility treatment for over 2,000 couples and gave abortion care for the city and beyond. It is the only such specialist Trust in the UK.

However, since 2015 its future has been under threat because of inadequate maternity funding, lack of investment and privatisation and market forces in the NHS. It was decided that the hospital should move to the new Royal Liverpool University Hospital campus. However, there is no "capital" available, so there will be no new building but all other options are on the table, from the dispersal of services to other hospitals to a merger with existing. Recently the hospital's Medical Director asked staff to consider which hospital their service could be dispersed to.

The campaign aim is clear. No closure. No privatisation. No cuts. No merger. Fully fund our hospital. Keep it on its Crown Street Site as a hospital dedicated to Women and Babies. Contact: https://bit.ly/3Vn50Q2

always remind ourselves and keep discussing; which women in our society suffer the most by our maternity system. Black women are four times more likely to die in childbirth in comparison with their white counterparts. Asian women are twice as likely [13]. It is important for me to state that not all reasons for these deaths are attributed to health problems – structural racism has been acknowledged. This is the fight that we must not lose sight of, because by improving the midwifery numbers it is hoped these deaths will be avoided.

In conclusion, we must never let conversation go by with members of the public criticising staff acting in the delivery of children: midwives, obstetricians, paediatricians, GPs, GP receptionists. These professionals have not all of a sudden stopped caring, they have not all of a sudden become incompetent, they have not all of a sudden become unkind, and they have not all of a sudden stopped listening. It is the system that has not allowed them to care, to be competent, to be kind, and to listen. It is the system at fault. not the clinicians.

We have to take out our criticism, our anger, our disgust, our fight with this government and its complicit opposition.

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Rebecca Smyth
Retired Senior Lecturer in Midwifery
University of Manchester
rmdsmyth1@gmail.com

Back to Before the NHS

The right wing is trying to drag the NHS back to a pre-war system. That is what Dr John Lister, one of the speakers at this year's Conference, argues here. Reproduced, with permission, from the *Lowdown* (https://bitly/3VjZMES)

As the Tory conference gathered, one-time Brexit secretary David Davis became the latest mouthpiece [1] for the hoary old argument for scrapping the NHS as a tax-funded system and opting instead for so-called "social insurance".

The predictable platform for this latest outpouring of hackneyed and false assertions was the *Daily Telegraph*, but similar arguments have been retailed time and again in the last few years in *The Times* [2], the *Daily Mail*[3],the *Spectator* [4], and sadly, taken too seriously by BBC correspondents [5].

Liz Truss herself [6] is one of an 8-strong Parliamentary Board of the '1828 Committee'[7], whose 'Neoliberal Manifesto'[8], published jointly with the Adam Smith Institute in 2019, condemns the NHS record as "deplorable" and states:

> "We believe that the UK should emulate the social health insurance systems as exist in countries such as Switzerland, Belgium, the Netherlands, Germany and Israel, among others. Under these systems, individuals pay regular contributions — as they currently do for the NHS through taxation — to their chosen insurer. They are then free to seek treatment from a medical provider of their choice and their insurance company subsequently reimburses the provider for the expenses incurred."

Of course some of the information used to argue for change is correct, and we can all agree that the NHS – especially after a decade of real terms cuts in funding and the extraordinary problems posed by the pandemic – is far from perfect.

But it's consistently people who supported the decade of declining real terms funding, ignored the growing shortages of NHS and social care staff, and who have endorsed the policies that have undermined public health and widened the gap in healthy life expectancy [9] between the richest and poorest in society, who delightedly point to statistics [10] showing the NHS performing less well on measures such as cancer and heart attack survival than other European health systems.

They are delighted because they feel they can use the NHS's worsening problems to argue for changes that would otherwise be dismissed out of hand, and propose changing to health care systems that offer more openings for the private sector to cash in.

Winding back the clock

Indeed they feel they can exploit widespread ignorance of the systems they are advocating to make ridiculous arguments that the NHS as launched in 1948 is 'out of date' [11], that it should be replaced by a social health insurance system … dating back to 1883. Indeed Davis is trying to make a case for winding back the clock to reinstate the failed system that was in place in Britain before the NHS.

Social health insurance began in Germany as workplace health insurance [12], covering only the elite workers in the initial schemes, and only while they were working: it did not cover their

families, retired workers or of course the millions of people, working or unemployed, who were left outside the scheme. By 1885, just 10% of the German population was insured – by a total of 18,776 sickness funds.

This is similar to the system that prevailed in Britain prior to the establishment of the NHS in 1948, and left more than half the population [13] without adequate access even to primary health care. The German and other social health insurance systems have only developed towards universal health systems as they have been extended to cover the other groups through increased levels of tax [14] funding (i.e. become more like the NHS).

Davis claims "successive Conservative governments have shied away from large-scale reform of this most fundamental public service" – completely disregarding the succession of massive, costly and disruptive "reforms" to the NHS rammed through by Margaret Thatcher in 1989-90, David Cameron's coalition (Lansley reforms) 2010-13 and the latest ramshackle Health and Care Act pushed through under Johnson and implemented in July.

He argues with no evidence that "The NHS is plagued by ineffective bureaucracy … the ramshackle nature of the organisation is clear for all to see."

But he is apparently blissfully unaware of the much larger and more complex bureaucracy [15] that would be required to run a social insurance system. Germany's health insurance system consists of 110 sickness funds [16] – meaning that health spending also funds an extraordinary and complex bureaucracy.

Davis also ignores the additional fragmentation and complexity that have been the result of decades of outsourcing and privatisation under Tory (and New Labour) governments.

"... he is blissfully unaware of the much larger and more complex bureaucracy that would be required to run a social insurance system."

Why social health insurance?

For many years the more savvy advocates of more privatised systems have recognised the folly of suggesting any kind of US-style system based on private insurance [17] – which is notorious for its extravagant waste, inflated costs, and the numbers of people left uninsured or under-insured, facing huge and unpayable bills for health care. Hundreds of thousands of Americans each year are bankrupted by hospital bills.

The favoured models are therefore systems that can be portrayed as relatively close to the NHS – apparently offering universal coverage, free at point of use. David Davis names no specific model, but a recent article by BBC health correspondent Hugh Pym takes the example of Germany, where the first 'social insurance' system for health care was set up under authoritarian Chancellor Bismarck in 1883 [18].

Pym quotes Dr Kristian Niemietz [5], of the Institute of Economic Affairs, who argues it could be a blueprint for reform in the UK, and claims: "Social health insurance systems tend to have better healthcare outcomes."

Of course outcomes are related to inputs, and the figures show Germany spends a lot more than the UK on health – and has done for a very long time. Misleadingly, Pym asserts: "Funding of the two systems is similar. Germany spent just under 13% of its gross domestic product on health in 2021, … The equivalent figure for the UK was around 12%."

There are several problems with this. The first is that German GDP [19] is much (34%) larger than the UK, and Germany spending an additional 1% of GDP means that its total health spending in 2021 was 45% higher than the UK.

The second problem is that the comparison of

spending is based on 2021, a year in which health spending – especially in Britain, even though much of it was wasted – was heavily distorted (inflated) by the Covid pandemic.

And the third problem is that what really matters in terms of resources on the ground is not the share of GDP spent on health (which has been recalculated several times since 2009, to include more social care) but the amount spent per head of population. On this measure, UK spending is much lower than many of the countries that appear to be delivering better health outcomes. OECD figures show [20] that Germany for example spent 46% more per head on health than the UK in 2019, and 38% more in 2020 when the NHS budget was apparently inflated by Covid spending.

So it's no real surprise to find that after several decades of much higher spending on health, Germany is much better equipped to deliver good outcomes, as Hugh Pym notes [5]:

> **"The German system is better staffed and stocked than the UK, relative to the population. Analysis by Nuffield Trust shows in 2019 the UK had around nine nurses per 1,000 people, while in Germany there were about 14. The disparity in bed numbers was wider – with Germany's eight beds per 1,000 patients more than three times higher than the UK figure."**

Spending: comparing like with like

It's also important to remember that the overall spending figures include ALL spending, whether by public sector, on private care and out of pocket payments by individuals. As the Health Foundation points out [21] the significant difference if we compare only public spending on health care:

> **"Using another common measure, public spending on health care was equivalent to 8% of GDP in the UK in 2019. This is more than the OECD (6.4%) and the EU14 (7.2%), but less than the G7 (9.4%). It is notable that the UK spent more as a share of GDP on health care than the EU14, and yet had a lower spend per person. This is explained by the UK's relatively low GDP per person, which in turn illustrates how spending is determined both by the relative priority afforded to health care and by wider economic prosperity."**

Other issues are also often glossed over in discussing the German system. Pym notes that "around 86% of the population there are enrolled in schemes run by not-for-profit insurance organisations known as sickness funds." What he doesn't say is that German self-employed and employees who exceed a certain income threshold may choose to stay with the main system or opt for private health insurance (PHI) [16], which is provided by 41 insurance companies. PHI covers around 10% of the population, including civil servants; the remainder (e.g. military) are covered through special schemes. So the German system is a two-tier health care system, not universal health care.

Another important difference is that social health insurance schemes are largely funded by payroll taxes levied on the employed workforce (and their employers) – so those, including very wealthy people, who live off unearned income (shares, rents, or inherited wealth) or are not on company payrolls make no contribution to the wider pool of health insurance. This is much less equitable than a system funded through general taxation levied on the whole population.

Nor is health care free to access in Germany. It is one of the systems that levies a fee for hospital care [22]: adults have to pay €10-15 per day, up to a maximum of 28 days in a year.

Other social insurance systems

In case anyone thinks we are picking a select example here, or believes other social health insurance schemes are more akin to the NHS, it's worth noting that Switzerland, Belgium, and

the Netherlands (the other countries cited as preferable models by the IEA and by Truss and her '1828 committee' colleagues) all spend significantly more per head [20] on health than the UK.

Switzerland is the highest spending country after the US, and spent 58% more per head on health than the UK in 2019 and 43% more in 2020; Belgium spent 22% more than UK in 2019, but bizarrely CUT health spending in 2020, remaining 5% higher; and Netherlands spent 29% more per head in 2019 and 23% more in 2020.

It's also important to note that not only do these countries spend more, they also leave patients stuck with more of the cost of care.

Switzerland is one of the wealthiest countries in Europe, yet the proportion of private 'out of pocket' spending on health is exceptionally high at 26% [23] of total health spending. This means that low and middle income households pay a higher proportion of their income for health care than the richest. Swiss patients wanting health care have to pay a "deductible" (fixed amount to be paid before insurance cover begins to reimburse costs) as well as a copayment (a percentage of the cost of treatment) which cannot by law be covered by insurance. There is a £12 per day fee for hospital inpatient treatment.

Belgium, with slightly higher population than London, levies higher user charges [24] for mental health and dental care, again limiting accessibility especially for the poorest.

The Netherlands has a complex combination of mandatory and voluntary health insurance in which costs [25] fall disproportionately on poorer people. Even the right-wing US Heritage Foundation points out that low and lower-middle income individuals end up paying between 20-25% of their income in healthcare costs [26]: this is far less equitable than the UK system. Competition has increased the bureaucratization of the Dutch healthcare system, with over 1400 different insurance packages, making choice for consumers extremely complicated.

A health service, not insurance

It seems the right wing's ideal models aren't so ideal after all if we look more closely. But David Davis and others also try to reinforce their case with a lie. They insist, against all of the evidence ,that our own NHS is an insurance system. Davis argues:

"Insurance-based system" is considered a dirty phrase by some. But the truth is that we already use a principle of insurance to fund our health service: National Insurance."

But the argument for this is flimsy in the extreme: "Indeed, NHS England's budget is of a similar scale to the total National Insurance take. The recent arguments about raising NICs show that people understand healthcare has to be paid for."

This is as downright dishonest as the recent claim by new health Secretary Therese Coffey [27] that the Tories were the Party that conceived the NHS in 1944.

Davis knows full well that only in exceptional circumstances have governments turned to use National Insurance money to fund the NHS, which has always mainly been funded from general taxation – effectively sharing the risk and the costs of ill-health across the whole tax-paying population, the widest possible pool. Liz Truss and co have just reversed the most recent plan [28] to use NI funds for the NHS.

Aneurin Bevan, the Labour minister who pushed through the legislation to establish the NHS in the teeth of opposition from the Tories, who voted

21 times against it, clearly rejected any notion [29] that the NHS was an insurance scheme and any confusion with National Insurance. It seems the right-wing 'think tanks' and their allies prefer to recreate the confusion.

But why is David Davis so keen to suggest that the NHS is an insurance scheme? He wants to argue for a greater private sector slice of the action. He says so in so many words: "Involving private firms in the provision of health insurance … would simply mean sharing the burden (and the opportunity) between the state and the private sector."

Of course there is no "sharing" involved, other than allowing the private insurers to carve out a profitable niche for themselves. The private insurance industry has no interest in chipping in to the cost of running the NHS – or indeed in paying out for patient care if they can possibly avoid it, which is why they are so reluctant to insure older people and those with pre-existing conditions who are more likely to be making a claim.

So how would private insurance become an issue under Davis's view of social insurance? Only if it's linked with preferential access to hospitals, mental health and GPs, all of which would presumably be levying fees. So it's no so much changing the mechanism of funding that's at stake, but privatising and commercialising the provision of health care, again to the benefit of the rich, and disadvantage of the poor.

It's clear that once the myths and falsehoods are discarded social health insurance is not the answer to any of the big questions facing the NHS today. As Roy Lilley* recently argued [30]:

> **"There are huge waiting lists, an exodus of staff, wages are poor, working in health and care is unattractive.**
>
> **"Would a social insurance system, fix it? No.**
>
> **"We don't have enough health professionals nor enough beds.**
>
> **"Would a social insurance system fix it? No.**
>
> **"There are some outcomes [31] that are better elsewhere… but it depends on what comparator you pick.**
>
> **"Would a social insurance system fix it? No…"**

We could add that there are long queues of ambulances outside A&E, long delays in emergency admissions, long delays accessing mental health care.

And social insurance and private provision are absolutely no use in dealing with these problems, either.

In 1948 The NHS moved decisively beyond the social insurance system that had prevailed from 1911, and established a system that was universal and more forward looking, allowing services to be planned on the basis of need, patients to access services regardless of ability to pay, and national training systems to be put in place for doctors and professional staff.

Nobody but the crackpot right wing of the Conservative Party and neoliberal lobby groups now wants the discredited old system back.

***Roy is giving the Paul Noone Memorial lecture at this year's Conference.**

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John Lister
johnlister@healthemergency.org.uk

Why Dentistry Must be Brought Back into the NHS

Dental health is deteriorating and millions of people cannot find an NHS dental practice to take them on as a patient.

Together with top-up charges for NHS dental treatment and the high cost of private care, many are being prevented from accessing services. This is reflected by frequent reports of 'do it yourself' dentistry [1] - from fillings and abscess lancing, to tooth extraction. The preventative aspect of dentistry was undermined as a consequence of an NHS dental contract that has driven thousands of dentists to quit. Despite its huge importance to wellbeing and population health, dentistry has been allowed to slip slowly away from the NHS in a process that provides a clear warning of what could happen to services as a whole now 'public-private' partnership [2] has become the new government mantra. Only a commitment to provide a tax funded and comprehensive dental service free at the time of use, supportive of professionals and aiming to improve people's health and reduce inequalities, will reverse this appalling situation.

Dentistry – a founding pillar of the NHS in 1948

Dentistry was one of the founding pillars of the NHS [3] at its inception, and NHS dental services made a significant contribution to the improvement in the nation's oral health. Many of us born soon after the NHS began remember our parents, aunts and uncles as relatively young adults but having full dentures (as did 75% of the adult population in 1948 [4]). As well as a crucial preventive role, dentists also have medical expertise and at check-ups are able to pick up early signs of mouth cancer and type 2 diabetes among other conditions. Most of us can agree that tooth ache is a miserable condition that severely affects quality of life. We don't want our children or grandchildren to suffer tooth decay and we recognise the importance of dental education, oral hygiene and regular dental health checks. We would also agree that dental services should be available to all, with inability to pay not being a barrier to treatment. Some might draw the line at purely cosmetic interventions but should bear in mind these can bring important psychological benefits. In those limited parts of the country where the public health intervention of correcting fluoride deficiency [5] in drinking water was implemented (covering only about 10% of the population), there was a massive reduction in dental caries. Fluoridation schemes must be extended.

Prior to 1990, virtually all UK dental care was NHS, with only about 500 purely private dentists [6],mostly working within central London. In the 1980s and early 1990s, a combination of factors effectively pushed the dental profession into the mixed NHS/private economy that we see today. The last 25 years has seen continuous growth in UK's private dentistry sector [6] and this trend continues to accelerate. Since 2017, more money is spent on private than NHS dentistry.

Holes in services – who suffers?

The impacts of poor oral health disproportionally affect the most vulnerable and socially disadvantaged individuals and groups in society. These differences in oral health across population groups do not occur by chance, nor are they inevitable. Oral diseases are largely preventable and therefore are avoidable. Reducing these oral health inequalities is a matter of social justice and ethical imperative [7]. Despite modelling indicating that oral health improvement programmes for young

children are very cost-effective [8], the Faculty of Dental Surgery at the Royal College of Surgeons is seriously concerned about the state of children's oral health in England [9]. Almost a third of 5-year-olds are suffering from tooth decay and there are significant regional inequalities. Dental caries is the most common reason for 5–9 year olds in England to be in hospital, with over 60,000 children aged 0-19yr admitted to have teeth removed under general anaesthesia in 2015/2016. The estimated cost to the NHS of all tooth extractions in children is £50 million per year [5]; most of these were carried out due to avoidable tooth decay.

A shocking recent report [10] from the Association of Dental Groups documents that

eight million people in England are now waiting for an NHS dentist. Only a third of the population has seen one in the last 2 years, and the overall number of dentists is the lowest for a decade. Public satisfaction with NHS dental services [11] fell from 60% in 2019 to 33% in 2021. Currently, three million people suffer from oral pain [12] and two million have undertaken a round trip of 40 miles just to find treatment.

'Toothless' campaign groups around England are highlighting a dental crisis brought about by successive years of government neglect and underfunding. 'Toothless in England' [13] acts as a network hub and demands 'an NHS dentist for everyone'. Many vulnerable people aren't registered with a dentist and live with long-term pain and infection. Among the homeless, 70% have dental problems and 15% have tried to extract their own teeth. Dentaid [14], an organisation that was set up to send refurbished donated dental equipment to poor countries, is now providing mobile dental units to England. These offer emergency treatment for people suffering from dental pain in areas including Kirklees and Dewsbury in West Yorkshire, and Bury St Edmunds in Suffolk.

Problems with access

While the Covid pandemic has had a negative impact [15] on oral health, long before this, finding an NHS dentist had become increasingly difficult. A range of dental treatments were either unavailable on the NHS or required payment of top-up charges. Recent newspaper articles [16] have sounded warnings about acute shortages of dentists in counties including Lincolnshire and Norfolk. In Thurrock, Essex, just 26.1% of adults and 30.7% of children have seen a dentist in the past 2 years. There are stories across the UK of distressed people taking out their own teeth, lancing abscesses and inserting temporary fillings. Nine out of ten NHS dental practices are now closed to routine new patients, and in Somerset, it is almost impossible to register. Hundreds of thousands of people with severe toothache consult their GP only to be referred to A&E or back to dental services in an expensive merry-go-round. Overall, what has happened to dentistry represents a serious reduction in NHS services and significant erosion of the social wage (i.e. amenities provided within a society from public funds).

Charges are a major barrier to care

Charges for treatment were first introduced in the 1950s as a means of reducing demand. The 2011 Adult Dental Health Survey [17] showed that cost influenced choice of treatment for a quarter of patients and almost a fifth stated that they had delayed treatment for the same reason. Healthwatch (which has a statutory duty to find out what communities want from health and social care) says many people regard dental charges as unfair [18], and has warned decision-makers that NHS dentistry is in desperate need of reform.

The dental contract – crying out for reform

A controversial contract [19] based on the number of units of dental activity achieved by dentists was imposed by the Labour government in 2006. Dental practices were limited in the

amount of NHS care they provided, and could be forced to turn away patients for fear of breaching their contract, while facing financial penalties if targets were not hit. Different dentists were also paid widely varying sums for delivering the same treatments. NHS dentists were forced to chase targets for remedial treatment, rather than provide vital preventive care. All this has demoralised the profession and driven many dentists out of the NHS altogether.

The public sector pay cap has hit NHS staff hard across the board, but for dentists it can make the difference between balancing the books or going bust. Unlike general practitioners, general dental practitioners don't receive any capital investment from central government. Associates and practice owners in England and Wales saw taxable income fall by 35% in real terms over 10 years from 2006. Across the UK, there were 1,038 fewer dentists working in NHS primary care in 2020/21 than there were in 2019/20. Smaller practices are being priced out and taken over by large dental corporations. This government has ensured many dentists cannot see a future in the service. Without urgent reform and adequate funding there is little hope this exodus can be ended [20], with inevitable further erosion of the amount of NHS care that can be delivered.

What must be done

Nearly two thirds of practices needed to recruit a dental nurse between April-December 2021 and 80% experienced difficulty doing so; 76% of dental associates surveyed said they would not recommend a career in dentistry. Staffing shortages require a workforce plan and an increase in the number of dentists, dental nurses and hygienists being trained; meanwhile, European Union dental qualifications must continue to be recognised (due to cease at the end of 2022). The profession has argued that dentistry should be based on a capitation model with a contract that is patient-focused and preventive. Contract reforms should aim to encourage and support dentists to provide a full range of treatments on the NHS. In the future, dentists could be co-located with General Practitioners [21] in neighbourhood health centres. A robust primary care system where the staff, including dentists, work as public servants for a public service, is the foundation around which NHS dentistry should be structured. This is in keeping with the Astana Declaration [22] of 2018 (Global Conference on Primary Health Care) setting out goals for achieving universal healthcare.

NHS dental treatments need to be free at the point of use; people should be prioritised before shareholder dividend (no more privatisation); hygienists, routine check-ups and preventative treatments (including water fluoridation) must be core NHS functions. As Aneurin Bevan said of the NHS [23]: "not only is it available to the whole population freely, but it is intended . . . to generalise the best health advice and treatment." The intention was to make the same, high level of service available to all, according to need. This is what we must have for dentistry, with a contract that promotes both quality and equity. Dental services have been allowed to decay [24] by successive governments with reliance on a market for those who can afford to pay and with disastrous consequence for those who cannot. This is a national disgrace and must be reversed.

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John Puntis
Co-Chair, KONP
john.puntis@yahoo.co.uk

Book Reviews

Who Cared? Conflicts of interest
(£10, Amazon, paperback;)
Mark Aitken. 2022, 296 pp.

A comprehensive history of how the NHS came into being, how it has fared and how it is now being managed. Packed with fascinating historical details particularly in respect of the parliamentary process and political manoeuvring.

There is a fascinating account of the procedures involved in developing the district general hospital in Colchester which could well be representative of many other areas. The historical commentary is embellished with insightful commentary about progress, setbacks and missed opportunities.

It is a personal account from an experienced physician who graduated in the 60s and chronicles hospital life in the days when the ward sister ruled the ward with an iron fist, consultants swept in and out and junior doctors were mostly self-taught.

He describes the powerful learning experiences that entailed, learning with and from nurses and being seen as playing God.

Written from a socialist perspective it includes much fascinating history about pre-NHS days and how NHS policy has been determined by political agendas over the decades.

The cover is an excellent summary of the key message with the diagram showing the inverse relationship between compassion and commerce. The first page of the preface describes the birth of the NHS as a personification of Nye. The narrative then traces his infancy, growing pains and the ups and downs of progress through adulthood.

The author displays encyclopaedic knowledge of NHS policy, the (usually) good intentions and how they have fared on contact with the reality of an underfunded and understaffed service facing increasing demand.

He works through the list from medical dinosaurs, the social revolution and then describes working in the NHS up until 1975. The significant change then was general management in hospitals and a series of initiatives including outsourcing and PFI.

He describes the rhetoric and grim reality of public and patient involvement including his experience as a governor demonstrating how limited the role of representing the public can be in practice.

He describes current problems with communication, IT, pay and conditions and the duty of care. It comes right up to date with farsighted comments about the management of

the pandemic with all its failings.

Chapter headings usefully describe the content such as Competition Coercion and Clinical Outcome and Public or Private Healthcare.

Having described where we have come from and where we are, he takes 10 pages to describe the way ahead including new contracts for consultants GPs and dentists. He recommends returning nurse training to the system where major hospitals have their own individual schools of nursing which could include graduate entry.

For professions allied to medicine he sees a greater role for paramedics in general practice and hospital emergency services and recommends rebirth of the public health service with the remit of disease prevention. This could free the GP of that responsibility.

Many of the recommendations are a distillation of the knowledge that has been gained from projects to date are the not novel, such as the need to build community centres at the centre of gravity of the local population. However the previous 200 pages have demonstrated that many decisions on where to provide healthcare have not been evidence-based so it is sometimes necessary to repeat what we have learned from experience.

A very useful book showing that there is a great deal but we can learn from our past to help us with our decisions today and into the future.

Eric Watts
eric.watts4@btinternet.com

Change in printing schedule

The DFNHS newsletter is changing back to quarterly. This is being done to save on distribution costs to members following a review by EC. However, pagination will increase, from its bi-monthly range of 16-28 pages to 24-36 pages per issue quarterly. Printing costs are only marginally increased whereas postage is fixed, up to the 100 g weight limit for the newsletter. The newsletter will also feature more articles from external authors.

Members can see all issues of the newsletter online at www.doctorsforthenhs.org.uk/newsletters . Several members have asked to stop receiving the printed version of the newsletter, preferring the online PDF. If you would like to stop receiving printed copies, please let Alan Taman know (healthjournos@gmail.com). There are no plans to cease printing the newsletter and move to online only, as many members prefer the printed version.

EXECUTIVE COMMITTEE : Elected at AGM 2021

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

Mrs Anna Athow
General Surgery, London
0207 739 1908
07715028216
annaathow@btinternet.com

Dr Arun Baksi
General Medicine/Diabetes,
Isle of Wight
01983 883 853
07786 374886
baksi@baksi.demon.co.uk

Dr Morris Bernadt
General Adult Psychiatry,
London
020 8670 7305
07510 317 039
mbernadt@hotmail.com

Dr Chris Birt
Public Health
07768 267863
christopher.birt75@gmail.com

Dr Matthew Dunnigan
General Medicine,
Glasgow
0141 339 6479
matthewdunnigan@aol.com

Miss Helen Fernandes
Neurosurgery, Cambridge
haatchy1966@gmail.com

Dr Andrea Franks
Dermatology, Chester
0151 728 7303 (H)
Roger.Franks@btinternet.com

Dr Alison Hallett
Trainee, Leeds
alisonelizabeth@live.co.uk

Mr Colin Hutchinson(Chair)
Ophthalmology, Halifax
07963 323082.
colinh759@gmail.com

Dr D.A. Lee
Paediatrics, Whitehaven
01946 820268
Lee535877@aol.com

Dr Malila Noone
(Secretary)
Microbiology, Darlington
01325 483453
malilanoone@gmail.com

Dr Maureen O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

Dr Hans Pieper
General Practice, Ayr
hansandphil@icloud.com

Dr Peter Trewby (Treasurer)
General Medicine/
Gastroenterology
Richmond, North Yorkshire
01748 824468
trewbyp@gmail.com

Dr Eric Watts
Haematology,
Brentwood, Essex
01277 211128
eric.watts4@btinternet.com

Dr C.P.White
Paediatric Neurology,
Swansea (Morriston Hospital)
CPWhite@phonecoop.coop

Dr David Zigmond
General Practice/Psychiatry,
London
0208 340 8952
davidzigmond@icloud.com

Dr Pam Zinkin
Paediatrics, London
02076091005
pamzinkin@gmail.com

Communications Manager
(paid staff, non-voting)
Mr Alan Taman
07870 757309
healthjournos@gmail.com

Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.