DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

The Only Fair Game in Town: The NHS at 75

- View from the Chair – Page 3
- Human right to healthcare – Page 7
- The Patients' Association – Page 13

JULY – SEPTEMBER 2023

CONTENTS

Editorial –
Colin Hutchinson
View From The Chair 3

The human right to healthcare 7
John Puntis

Looking at the Patients' Association 13
Alan Taman

The Peter Fisher Essay Prize 2023 16

Bevan's founding principles for the NHS have stood the test of time 18
John Lister

Our neglected impoverishment 22
David Zigmond

Book reviews

What is a Doctor? 24
Alan Taman

Lost in work: Escaping capitalism 26
Mike Galvin

Executive Committee 2022-23 28

If you would prefer to download your newsletter from the website (https://www.doctorsforthenhs.org.uk/newsletters) and stop receiving printed copies, or if we do not have your e mail address and you want to receive e mails from DFNHS, please let Alan Taman know.

Contributions welcome: original articles, opinion, book reviews. If you have an idea for a contribution please ask Alan Taman.

Managing Editor – Alan Taman
healthjournos@gmail.com
Published quarterly. Next issue: October 2023

View From The Chair: The NHS at 75

As the NHS turns 75, the birthday tributes flood in.

Many from well-wishers; from people grateful for care they and their family have received, or from those of us that are aware we might need to call on its services sooner or later. Others from the equivalent of greedy relatives, keen to be seen at the bedside, in the hope of getting a favourable mention when the will is eventually read; asking why they don't just hurry up and die, and make way for the next generation; doing the minimum to keep the old dear comfortable, but not return them to rude health, and not wishing to be accused of murder. It's vital to keep up appearances, especially with an election approaching.

Health check at 75

In this newsletter, John Puntis gives a stark analysis of the impact of the 'do the minimum' approach. In the decade up to 2021the population of England increased by 6.5% with a disproportionate increase in the proportion over 65 and particularly those over 85. Spending on health has been at historically low levels, with the result that the average level of annual spending on health per head of population in the UK between 2010 and 2019 has been £3005, compared with £3655 across the EU14 countries – 18% less, year on year. And crucially over this period, 55% less capital investment into our buildings, equipment and IT [1]. Any budget increases for NHS England spending have been at the expense of shrinking budgets for Health Education England and the Public Health Grant. So much for prioritising preventative healthcare.

As the 40 (or is it 48?) new hospitals inconveniently fail to be anything other than a slogan, and the reluctance to resolve the current industrial unrest undermines the spirit of the new long-term workforce plan, the folly of short-term thinking that puts the needs of 'the economy', or a sector of the economy, so far ahead of investment in the health and education of the people who live in this country, is becoming terrifyingly clear. Is the need to be more reliant on our key national resource, our people, post-Brexit, going to be a wake-up call, as it was when the poor health of recruits for both the Boer War and the Great War was blamed for under-performance on the battlefield and stimulated public health reforms? [2]

The persistence of the false notion that the health of the nation is dependent on the economy, rather than the economic health of the nation being dependent on the health of its people, is clear as the long-awaited national Covid Inquiry gets underway. We are beginning to hear questions being raised about the priorities of recent governments, along with feigned incomprehension from leading political figures at the head of those governments, that they could have taken any course of action other than the one that saw our public services enter the pandemic in such a weakened state, with inadequate stockpiles of essential kit, with near total dependence on supply chains stretching hallway round the world, to a country already in the grip of the pandemic.

I have been refreshing my memory of those days with the accounts of two Sunday Times journalists in their book, *Failures of State*, which documents the course of events during 2020 [3]. Decisions on measures to be taken were delayed time and again because of their perceived impact

on 'the economy', with disastrous consequences for people, families, businesses and, surprise, surprise – the economy.

Bevan was right

Anniversaries are a useful time to reflect, and John Lister charts the key events during the lifetime of the NHS clearly and concisely. He reminds us of the founding principles set out by the author of the NHS, Aneurin Bevan, and the problems that have arisen when 'reforms' have been imposed, most often as a result of faith in the power of 'the market'. Other examples may spring to mind, such as the privatisation of water, railways, the National Grid, public transport, social housing, universities, the Bradford and Bingley Building Society.

John restates the case for centralised control, ownership of political responsibility and funding from general taxation in providing the most secure and stable base for our national health. And the importance of that taxation system being fair and redistributive. He highlights the key decision taken by Bevan to bring all hospitals into national ownership, rather than leaving them as a mixture of local authority, charity and private ownership. We can see the problems that have arisen in social care from relinquishing the responsibility and financial muscle of central government; or public health following Lansley's madness. In each case, devolution has been followed, very rapidly, by budget cuts, in large part due to our over-centralised taxation system: central government devolves the duty to deliver services, but not the means to pay for them. Local authorities are left to take the blame as services to the public deteriorate. There are fears that integrated care systems have a very rocky road ahead of them. Recently the West Yorkshire Integrated Care Board, for example, has been instructed to cut its budget by 30% for planning and arranging health and care services (not the budget for providing services) to a very large, diverse population with massive levels of deprivation, before it has had a chance to fully establish itself. Set up to fail?

Shared concerns

Like 'the economy', the NHS is just a means to an end: it is there for the benefit of its current and future patients, and their families. Alan Taman's interview with Rachel Power, Chief Executive of The Patients' Association, should remind us that our patients should be our most powerful allies in our struggle for a stable and healthy NHS, staffed with happy, fulfilled, well-trained clinicians, with access to the supplies and equipment that enable them to work to the best of their ability. Collectively, patients have a much louder voice and political influence than any professional organisation. It is an alliance that DFNHS should seek to strengthen, in my opinion, in the fight to re-establish an NHS that holds true to Bevan's principles.

Patients are concerned that they are not seeing sufficient benefit from IT: the expectation that it should bring together the right information about an individual patient, no matter which NHS setting they find themselves in, while still being sure that their confidentiality will be secure. Rachel makes reference to the difficulties that many people experience in seeing their personal health records. I have always felt that shared records have a huge part to play in helping people understand their health and can improve compliance with treatment. The amount of information retained during a brief encounter in a clinic room is limited and incomplete. Transparency also allows patients to identify where their record is factually incorrect, or attaches too much, or too little, emphasis to particular symptoms. For many years, I used to address my consultation letters to the patient, with a copy to the referring GP, as a logical sequel to the consultation. It encourages the use of plain language and respectful attitudes.

Rachel points to the importance of reducing waiting times for treatment in restoring confidence in the NHS. Having worked through the 1980s and '90s, when waiting times were even worse, and being able to compare that period

with the noughties, I know how much easier and more satisfying it is to work as a clinician running a service with a large element of elective care. If you are operating on somebody you have only seen a few weeks ago, there is less likelihood the clinical picture will have changed significantly, or they have moved house, or died. Patient flow through the system is much smoother and more efficient. And for the patient, they will have less time to endure the pain or disability while waiting; the feeling of putting their life on hold; the uncertainty of whether the summons to attend hospital might come tomorrow, next month, next year; can I book that holiday? Or worse: "Have I been forgotten, or lost in the system?" We should be actively managing the patients on our waiting lists and keeping in communication with them so they know they haven't been forgotten or lost in cyberspace. And that should be a continuing responsibility of the clinicians in hospital, not in primary care.

A plan – at last!

I am certain that the timing of the publication of NHS England's Long Term Workforce Plan, together with £2.4 billion in support from the Treasury, has been timed partly as a birthday present, but also to leave the responsibility, and cost, for delivery of the plan largely in the hands of the next government or three [4]. On initial reading, there are welcome aspirations. Expansion of domestic education and training of clinicians by 50-65% over the next 15 years has to be a better solution than stripping much-needed staff from developing countries. The reality of global shortages of clinicians means that international recruitment will become harder and harder in coming years: we have to 'grow our own.'

At last there are firm figures placed on the deficit of main groups of staff, with estimates of numbers of training places required, including not only lifting the cap on domestic entrants to existing medical schools, but an intention to establish additional schools in areas such as Cumbria, in the hope that

this will encourage more graduates to join the local workforce. The plan importantly commits to adequate numbers of foundation placements and specialty training places, particularly GP specialty training places, without which this expansion would be pointless.

What is less clear is how clinical training capacity is going to be expanded without further reducing capacity for treating today's patients. It is the right thing to do in the medium to long term, but poses a difficulty right now. The Doctors Association of the UK (DAUK) report survey results showing 9 in 10 medical students being turned away from placements, because there was no one to treat them; three-quarters of students finding doctors have no time to teach them on placement; half of medical students reporting 5 or more students per ward and a third reporting 5 or more students per GP practice. For the plan to be delivered, the whole NHS will need to become focused on training the next generation of staff, but the time (and space) to do this needs to be recognised.

There is limited analysis of the need to increase specialty training places in individual specialties, but a commitment to work on this with royal colleges. There needs to be a fairer means to fund these places if we are going to make the most of training opportunities across all NHS organisations. There also needs to be a commitment to fund substantive posts at the end of the training period, to capitalise on the investment that is being made.

Measures such as apprenticeships in medicine and reducing undergraduate training by a year are

bound to attract comment. Cambridge University School of Clinical Medicine was set up in the 1970s, partly on the back of piloting a reduction of clinical training from 3 years to 2. It was pretty intensive, with no holidays apart from bank holidays and part-time electives at the same time as teaching in 'minor specialties', but there were only 50 of us, with the run of large hospitals across East Anglia, allowing masses of clinical exposure. Nevertheless, feedback from trainers and students led to the course being extended by 6 months for subsequent intakes. I hope experience from such pilots is considered in designing any new courses, particularly given the poor experiences noted by DAUK.

Pilots of medical apprenticeships could be valuable in removing the huge cost of training, and supporting oneself, from the shoulders of students coming from less affluent backgrounds. It could also allow apprentices to find out whether they actually enjoy the working environment, and whether being a doctor is what they imagined: whether they actually like people and can communicate with them, before they have invested too many years of their young lives, and too much treasure, to be able to change to a different career. As ever, the devil will be in the detail of such schemes.

For years, DFNHS has been clear about the need to rebalance training to allow the continuing development of generalist medical skills in the great majority of trainees, throughout their training, alongside more specialised interests. My early experiences in what were then called geriatric wards brought home the challenges of looking after patients with more than one condition. It is essential to have the confidence to recognise and treat most common conditions, while still recognising when you need to call on advice from a colleague. Sub-specialisation has been a major factor driving the proliferation of consultant posts and some of the resulting shortages. It also causes no end of problems in staffing safe on-call rotas and providing outreach services. It is heartening to see the emphasis on developing and maintaining general medical skills expressed repeatedly in the plan.

There are aspects of the plan that could fuel the excessive division of labour that David Zigmond describes, particularly in what is termed 'Personalised Care' and multidisciplinary teams. I hope the need for these to be specific roles is critically reviewed. There is also an apparent naivety in the scope of artificial intelligence to replace the complex interactions involved in teasing out a diagnosis, understanding the patient's circumstances, fears and aspirations, how to help them understand what is happening to them and to gain their trust and cooperation. I do not expect to see doctors being superseded by computer terminals any time soon. Doctoring is not simply a matter of intelligence.

References

[1] Rebolledo, I. and Charlesworth, A. (2022) 'How does UK health spending compare across Europe over the past decade?' The Health Foundation [online] Available at: https://bit.ly/3NYlPiL
[2] UK Parliament (1917) '1917 UK Health Problems Pamphlet' [online]
Available at: https://bit.ly/3NZRccy
[3] Calvert, J. and Arbuthnot, G. (2021) *Failures of State.* London: Harper Collins.
[4] NHS England (2023) 'NHS Long-Term Workforce Plan' [online]
Available at: https://bit.ly/438eilD

Colin Hutchinson
Chair, DFNHS
colinh759@gmail.com

The Human Right to Healthcare

John Puntis is Co-Chair of Keep Our NHS Public (KONP) and a long-standing member of DFNS. Here he presents an overview of the situation of the NHS and the fundamental threats it now faces. This is a summary of his address to the United Nations House Scotland's Roundtable on the Human Right to Healthcare in April

The founding principles of the NHS

The founding principles of the NHS were that it should be universal, equitable, comprehensive, high quality, free at the point of delivery, and centrally funded from taxation.

Note that at a time when the economy had been wrecked by 6 years of war, this demonstrated huge ambition and remarkable political leadership. The philosophy was that in order to have a strong economy, you needed to have a strong health service. This is the opposite of the current mantra of those in power – that you can't spend money to improve public services until you have a strong economy.

The founding principles are reiterated in the NHS constitution, which while recognising that funding is finite asserts that public funds for healthcare should be devoted solely to the benefit of the people that the NHS serves.

The World Health Organization's (WHO) aims accord with those founding principles, and are aligned with the Sustainable Development Goals, focusing on achieving universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. I am going to explore how universal health care in England has been undermined

The NHS is now in crisis, but this is a recent phenomenon.

The US Commonwealth Fund periodically examines health care systems in the world's richest countries and looks at what lessons might be learned for the US system – the most expensive, yet the one with the worst outcomes (proving of course that it is not just how much money you spend on health care but also how you spend it that is important). The NHS ranked first in these assessments from 2007 to 2017, but fell to fourth in 2021. The reasons for this decline relate in large part to delays in being able to access care and treatment, and lack of investment.

The government in England thinks the NHS is going through an "extraordinarily difficult patch", blaming variously the covid pandemic, strep A infection, flu, staff sickness, and delayed discharges. Most who work in the service believe it is experiencing the worst crisis in its history due largely to lack of workforce planning and chronic underfunding. This was also the assessment of the Commons Select Committee on Health and Social Care, and indeed an independent review from the King's Fund commissioned by the Department of Health and Social Care!

There are around 150,000 staff vacancies out of a total workforce of 1.3 million (1 in 9).

150,000 beds have been lost over the last 30 years, including 20,000 in the past decade, and 5,000 because of covid infection control requirements. Waiting lists have risen to an astonishing record of 7.2 million. The number of working age people claiming disability support has doubled post-pandemic. Record numbers of people are taking early retirement, most commonly because of ill health. Nine million people are now 'economically inactive', with 27% giving long-term sickness as the reason. All of this shows that the UK simply cannot afford for the NHS to fail.

There are some stark figures on how patients are being affected. For example, according to peer reviewed research, delays within emergency care are leading to 500 deaths every week. The Chief Ambulance Officers report estimated 160,000 incidents of patient harm from ambulance delays in one year, and there were 500 deaths last year from late ambulance responses. For non-urgent care, since 2019, over 500 people have lost sight because of not being able to access treatment in a timely fashion.

Commenting on all this, the president of the Royal College of Emergency Medicine observed that pressure on the NHS is now so severe that it is breaking its 'basic agreement' with the public to treat the sickest in a timely way, identifying the true barrier to tackling this crisis as political unwillingness.

Underfunding is a real issue

Despite the government insistence that the NHS has never had so much money, a convincing case can be made that it remains underfunded. Annual budget rises up to the banking crisis were always around 4%, but fell to 1% as part of the Conservative government's austerity programme. Incidentally, it is estimated there were 335,000 excess deaths related to austerity from 2012-2019. The NHS may have had more money overall, but it has not been allowed to grow as the population has increased in number and age, and new treatments come along. The British

Medical Association estimates that if funding had continued on the same trajectory as during 2001-2010, the NHS would now be getting £60bn more each year. Bear in mind that the UK has the sixth largest economy in the world; some comparable EU countries are spending around 25% more per capita on health care, going a long way to explain their better outcomes; the Health Foundation estimated that we spent £40bn less each year for 10 years up to the covid pandemic.

The NHS is not profligate with its funding, although administration costs increased from 5% of budget to 14% with introduction of the market reforms, and is probably now even higher. This could be a key focus for reducing costs. Far from being inefficient, the NHS increased productivity from 2004-16 by 16.5% compared with only 6.7% in the economy as a whole. Neither is it overmanaged with only about 3% of its workforce being managers, compared with the industry average of around 12%.

I would agree with the very incisive comment made recently by Anita Charlesworth of the Health Foundation when discussing the crisis in emergency care: there is no route to a better NHS that is not an adequately funded NHS.

Government response to managing the NHS

The government approach to the problems of the NHS has been structural reorganisation (usually termed 'reform') rather than investment in staff and infrastructure, for example the 2012

Health and Care Act which put competition at the centre of its strategy. We now don't have enough capacity particularly to deal with the backlog of care from covid, for example there are 2.2 beds/1000 population in the UK versus 8/1000 in Germany and an average of 5/1000 in the members of the Organisation for Economic Cooperation and Development; only Sweden has a lower number of beds, a country where there has been significant investment in community services.

There is still much NHS estate that is old and no longer fit for purpose, yet capital funding is not forthcoming and lags £33bn behind other European countries. There is an estimated maintenance backlog of £10 billion. None of the promised 48 new hospitals have been built or even approved and funded for that matter, and there are 34 hospital buildings in imminent danger of collapse, including King's Lynn Queen Elizabeth Hospital being held up by thousands of building props.

> "Dentistry is a good example of what may happen to the NHS as a whole ... smaller practices are being priced out and taken over by private companies ."

The parlous state of NHS dentistry

Dentistry is a good example of what may happen to the NHS as a whole. Top up charges for most adult patients were introduced in 1951 and increased every year; it is clear that these charges have become a barrier to care for many. Driven by changes to the dental contract under the last Labour government, preventive dental care was given little priority and dentists could only perform an amount of work agreed in advance even if demand increased. Smaller practices are being priced out and taken over by private companies, so that most dentistry is now performed in the private sector. There are 8 million people in England who are not registered with a dentist, and only 1 in 10 practices are accepting NHS patients. There is clear evidence that oral health is deteriorating, particularly in children. The impacts of poor oral health disproportionally affect the most vulnerable and socially disadvantaged individuals and groups in society.

The end of universal access

Universal access to health care effectively ended with the introduction of the euphemistically named overseas charging legislation, part of the hostile environment. The Immigration Act of 2014 meant the definition of 'ordinarily resident' (a qualification for NHS treatment) was modified to mean you had to have indefinite leave to stay. This meant that undocumented people (thought to number between 800,000 to 1.2 million) were liable to pay for many NHS services. The charging system contradicts a global commitment to Universal Healthcare Coverage defined by the WHO as ensuring access to needed health services while also ensuring that the use of these services does not expose the user to financial hardship. This is included in Sustainable Development Goal 370. The UK is also a signatory to the International Convention on Economic, Social and Cultural Rights in which Article 12 explicitly lays out a human right to the highest attainable standard of physical and mental health. This right is not dependent on migration status, but rather applies equally to all people.

Rationing

A number of treatments have been withdrawn from the NHS on the basis of lack of evidence for

effectiveness and some medications such as simple pain killers are no longer available on prescription and neither are gluten free foods for patients with coeliac disease; often these treatments are still available in NHS hospitals to self-funding patients, and through private clinics. One example is removal of benign skin lesions such as moles on the face or cysts on the scalp, which can be very distressing to patients. NHS England's rationale was partly to prevent unnecessary harm. Ironically, reports followed of increasing numbers of people being burnt and scarred after taking themselves for treatment to high street beauticians who were not qualified to provide this service and were also oblivious to potential signs of skin cancer. The huge waiting lists are also a very obvious form of rationing. The new Integrated Care Systems in England are currently being asked to find savings of £12bn and also threatened with strict financial controls, expected to result in denial of care and cuts to services.

Privatisation

How much the NHS has been privatised is contested. The WHO defines privatisation as "a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services". If we take this broad definition, the government's attempt to deny privatisation of the NHS by claiming that services remain publicly funded and free at the point of delivery does not escape the WHO definition, even when services are delivered by non-governmental actors, such as third sector voluntary and community organisations.

David Rowland of The Centre for Health and the Public Interest (CHPI) found that about 18% of the NHS budget made its way to private companies. CHPI estimated that there were around 53,000 individual contracts which underpin flow of money between the NHS and the independent sector, worth £29 billion each year. Over 50% of hip and knee operations are now done for the NHS in the private sector, and nearly 50% of cataract surgery. Increasing numbers of people are opting to pay for private care mainly because of long delays in the NHS. Private companies are profit maximisers and not cost minimisers; private contracts take money away from the NHS. Outsourcing is associated with poorer quality of care, worse patient outcomes and worse terms and conditions for the workforce.

> "Eighteen per cent of the NHS budget made its way to private companies... around 53,000 individual contracts which underpin flow of money... ."

Are we moving towards a two-tier system?

Since 2014, the private sector has invested £2bn in newly opened acute health care facilities; the NHS has spent only £761 million on large hospital developments. Over the past two decades government has actively grown the private health care sector in the UK through a series of policy initiatives. Recent history shows that when the government invests substantially in the NHS, private healthcare spending drops and public satisfaction increases. A two-tier healthcare system in the UK is not an inevitability. Its likelihood depends on political decisions about funding for the NHS, investment in new healthcare facilities and an expansion of the healthcare workforce. According to Rowland, if a two-tier system does emerge over the next decade, it will be to the detriment of the health of the population and is likely to exacerbate the high levels of health inequalities in the UK. He argues that re-affirming the founding principles of an NHS which provides

care based on need rather than ability to pay is critical to maintaining and improving population health.

What does the public think about the NHS?

The recent British Social Attitudes survey on health and social care findings makes grim reading. Overall satisfaction with health has fallen to its lowest point in 40 years, to 29% down from 36% the previous year. 40% are 'very' or 'quite' dissatisfied with emergency departments, but there were drops in satisfaction across all areas of care. Staff surveys also show increasing levels of stress and dissatisfaction, and a 70% rise since 2017 in number of staff days lost through mental health issues. However, like in Health Foundation and Ipsos Mori surveys, public support for NHS founding principles was found to remain high across the political spectrum. The Ipsos poll found that only 8% of people in England think the government has the right policies for the NHS, while 90% wanted care free at the time of delivery, 80% comprehensive services, 84% funding to be through taxation, and 82% more funding (63% Con voters, 94% Lab).

So what should the future look like?

In the 2018 Astana Declaration on primary healthcare, the WHO envisioned governments and societies that prioritise, promote and protect people's health and well-being, at both population and individual levels, through strong health systems; primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed. In the UK as a whole we should not be complacent about where we are now, and current policies from the major political parties give little cause for optimism.

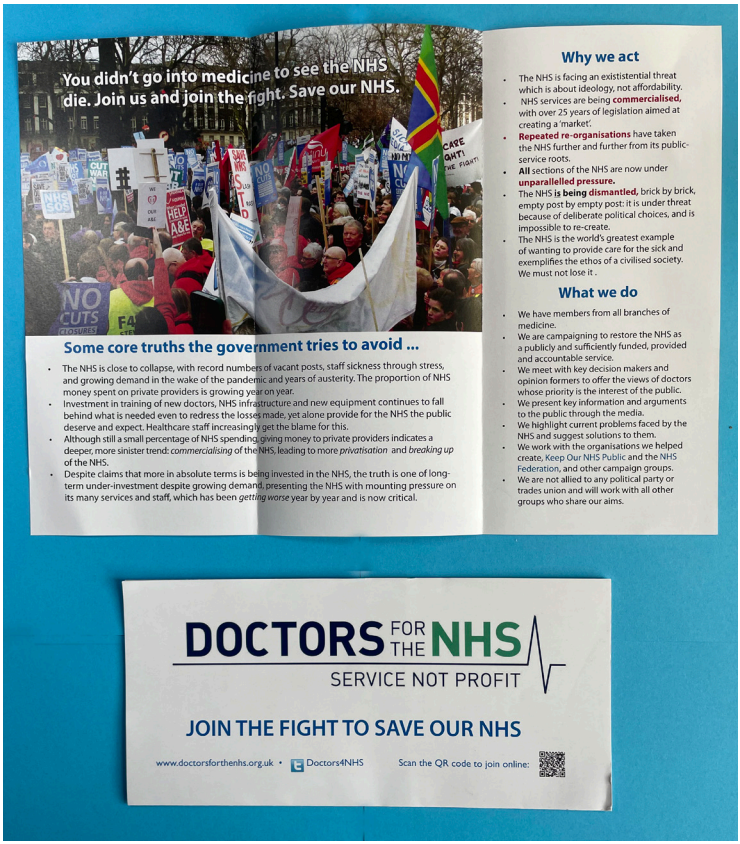
Working with the Independent Scientific Advisory Group for Emergencies, KONP developed an outline of what lessons might be learned from the covid pandemic. In a nutshell, we need effective, equitable and resilient health and care services. This is not unaffordable, and it must be regarded positively as an asset, and not negatively as a cost. Privatisation does not bring efficiency, and public health cannot simply be about personal choice.

Politicians are clearly out of step with what the public want for the NHS. KONP is working to build a broad-based campaign that will harness public outrage and build effective political pressure that will result in a health care system once again based on the founding principles of 1948.

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

New Recruitment Leaflet

- 'Tri-fold' design allows easy portability for face-to-face use
- Ideal for workplace or public-campaign settings
- QRS codes allow smartphone access to website
- Up to 10 copies sent to members on request – one enclosed



- To request copies please ask Alan Taman: healthjournos@gmail.com

Looking at the Patients' Association

The Patients' Association (www.patients-association.org.uk) lobbies on behalf of patients and it does so in line with the NHS's founding principles – as DFNHS does. Here their Chief Executive, Rachel Power, talks to Alan Taman. Rachel has over 20 years' experience of working in health and social care within the voluntary sector and joined the Patients' Association as its Chief Executive in June 2017

My role title is a very grand one for a small charity! It's about supporting and leading in developing our strategy and achieving it.

The Patients' Association is the only national health charity that's non-disease or condition defined. We are unique in that we cover all health and care issues and work with patients directly. Patients are our members and also the people who benefit from our services. We work with a wider cohort of patients as well, in very different ways – thousands – via our helpline and online information and guidance. This is not medical. It is there to help signpost patients, and to give patients power where they want to do shared decision making, and be actively involved in their care.

We get a range of calls on the helpline. Helpline colleagues regularly share with the wider team what they're hearing. We bring what we're hearing to our partners in the NHS and to government. We run numerous surveys with patients to understand what's happening to them, and we are commissioned by NHS trusts and other organisations to hold different focus groups on specific subjects. We pull together focus groups with patients from an array of backgrounds. We work with patients at risk of health inequalities so we can ensure that their voice is heard through the work we do. We use everything we hear from patients to influence policy makers for better outcomes for patients. My role as Chief Executive is to take all of that and bring it to the NHS' door. Our vision for the Patients' Association is that everyone can access and benefit from the health and care that they need to live their lives well.

We believe that has to be done in partnership. If the NHS is to be successful it has to design and deliver services in partnership with patients. That is our strategy. Our theory of change looks very much at the individual relationship between clinicians and their patients and what happens around that relationship. One of the things we've been focusing on recently is that once patients get to see a healthcare professional the relationship is actually quite good, it's everything else around that which is causing patients a pretty torrid time: communications and access. So they are what we are focusing on at the moment. We welcomed a lot in the Primary Care Recovery Plan. Patients have had a really tough time over the past few years and we've seen growing waiting lists. What patients say to us quite often is that in a way they understand having to wait longer for treatment, but what they want to know is when treatment might happen and get good communication about what is happening while they are waiting for treatment. This access and communication issue is something that needs to be addressed.

I think every day is a challenge for patients at the moment. We are concerned about patient safety. We are concerned about the waits patients are having. We absolutely acknowledge how hard healthcare staff are working. But the recent NHS

Survey showed staff are demoralised and the staff are leaving. Because of that, it's going to have an impact on patients. So I think the lack of a workforce plan is a big issue for the NHS at the moment. Recruitment and retention of staff are really important because as this goes on, patients are waiting longer and longer for treatment.

Shared decision making

This is something the Patients' Association advocates. We did a couple of surveys, with health professionals and with patients, and we examined a lot of the barriers for healthcare professionals. They talked about time, resourcing, and IT systems being barriers. Patients want to have a conversation about what matters to them. Every healthcare professional interacting with a patient should be starting the conversation with 'what matters to you? What's important to you?' – and from there coming up with a treatment plan. The most important thing for a healthcare professional in reaching a diagnosis is understanding what matters to the patient. The NHS App, for example, should contain more details about what matters to that person, what is important. We did a webinar a few weeks ago about accessing medical records. Patients said if you don't have continuity of care then having all the information on an app would mean they didn't have to repeat themselves if they were talking to a healthcare professional.

For patient partnership, there's a raft of evidence that says if patient partnership and shared decision making is done well, there will be better outcomes for the patient, which will be more motivational for the healthcare professional and it will make the system safer. It will also make sure services work for patients, and that's what the NHS is about.

Patient information

With regard to patient information, patients have to have confidence about how their data are going to be used and patients want to be involved in how their data are being used. There needs to be more communication. The NHS needs to be much clearer about how data are stored and where data are stored and how they are going to be used. But at the end of the day they're my data. Not anyone else's. One of the biggest downloads from our website is to the template letter asking for access to your own medical records. My focus on this is not to dwell on possible dystopias but on how you work in partnership to make sure people understand how their data are used: the data pact. So important questions are what is it that concerns you about data, and how can we (the NHS) assure you that your data are safe? Trust is a really important thing. I think there have been examples where data haven't been used correctly in the past. Now, if we are going to move towards data capture and using all that data, patients need to be really assured about how it is going to be used and how safe their data are.

Health inequalities

On health inequalities, another recent piece of work we did included talking to patients in refugee hotels, patients with English as a second language, patients in poverty and rural settings. The key to understanding health inequalities is understanding the impact of services and how we get to hear from those voices. Because if we get feedback in partnership with people who historically haven't been able to access the services that they need, then we're going to get it right for everybody else. So I think the whole role of care navigation lies in pointing people with accessing and signposting. The NHS is a massive beast in a way. We've heard of patients who tell us letters are not written in accessible language, and they don't understand – we're regularly shown letters to patients where I think 'yeah I've actually no clue what that letter means'. From an inequalities point of view we need to write in accessible language to patients so that people can understand it.

Inequalities are wider than the NHS. We are a rich nation and we should have a health and wellbeing strategy that looks at the health of

the nation which looks at education, housing, and poverty. Poverty creates ill health. Ill health ends up at the NHS's door. So there is a big issue where we need to think about how we can all work together to look at the prevention agenda as well – for that, we need a strategy that looks across all government departments. If you go back to shared decision making, and that individual consultation, if the doctor is really passionate about what matters to the patient that will help inequalities.

The best way forwards

The NHS is an amazing institution and we have to work together for it. The public have a great love for the NHS. But from our recent survey and the Public Attitudes Surveys we know they are losing confidence. The only way we can regain that confidence in the NHS is to get the waiting lists down. We can do that by working in partnership. If you go back to shared decision making and you look at some of the models of shared decision making and the 'BRAN model' which is the benefits, the risks, the alternatives, and the question of doing nothing, having those conversations with patients is instrumental in showing clearly that they do have the decisions and they can make their treatment plans. The priorities for the NHS are workforce, communication and social care.

The communication needs to be active and positive, where the NHS is listening to patients and acting on what patients are telling them, on what they are hearing.

We really need to focus on social care. We need a seamless health and care system for patients, so you need to look at the front door of primary care, A and E, through to social care, and make sure the system works in partnership and works for patients.

How can doctors help?

Doctors can help the Patients' Association more by working in partnership with patients. For example, we've just done a project with an NHS Trust in which they wanted to design a Centre of Excellence. They brought together healthcare professionals and patients and we facilitated the meeting, about what was needed in this new centre. Through the development of this new centre, patients realised 'I never knew that's how you need to develop things, that's really frustrating for you'. Healthcare professionals were hearing remarks like 'If you had designed the service like this, I wouldn't have had to give up work to make my appointments'. So I do think that designing and delivering services should be showing a passion for that shared decision making – there are doctors who do shared decision making amazingly well. I think doctors can do more around primary care, where it's about GP practices working in partnership with their PPGs to design and deliver those services. If you look to secondary care and the referral optimisation pathway through primary care into secondary, it's how the patient should be at the centre and involved in the consultation. A recent piece of work we did on referral optimisation had some really good examples of how it can be done in partnership with patients.

I'd also like to see more done on patient choice. A recent survey we did said that patients weren't sure they had been given a choice. There is a choice about where to receive your treatment, how to receive it, and what's going to work best for you.

Alan Taman
healthjournos@gmail.com

DOCTORS FOR THE NHS
SERVICE NOT PROFIT

with

JOURNAL OF THE ROYAL SOCIETY OF MEDICINE
JRSM

The Peter Fish

- Open to all doctors in training
- Essays should be under **2000** words (excluding refer
- Closing date for submission 31st July 2023
- Winning and runners-up essays will be published in for publication in the *Journal of the Royal Society of M*
- Essays should be submitted by email to: **doctors4th**
- Any questions about the competition can be sent to

Doctors for the NHS was founded in 1976, by Dr Peter Fisher (whom this prize i delivering healthcare to all who needed it freely. Our sole p Membership is open to all doctors w

doctorsforthenhs.org.uk

@Doctors4NHS

ner Essay Prize 2023

- £500 first prize
- £200 second prize

rences) and use the title shown above

this newsletter and website and be considered
Medicine.

henhs@gmail.com
this address

s named after) and others who believed in a universal, accountable NHS
urpose is to fight for the NHS and the public it serves.
ho share these commitments.

Bevan's founding principles for the NHS have stood the test of time

John Lister gives an overview of why the NHS's principles, which we campaign to protect, are as critical, cherished and threatened now as they were right at the beginning. Reproduced with permission from *HCT News*.

When it was launched by then Minister of Health, Aneurin Bevan, on July 5 1948, the NHS was based on three core principles:

- that it should be comprehensive – meet the needs of everyone;
- that it should be universal – free to all at the point of delivery to access GP consultations or hospital treatment;
- and that it be based on clinical need, not ability to pay.

And although Bevan did not make a further explicit principle out of public ownership, the nationalisation of the hospitals was also central to the 1946 Act which established the NHS.

Bevan was convinced it would have been impossible to ensure that the chaotic mix of under-resourced and in many cases near- bankrupt voluntary, private and municipal hospitals would work together if they remained in separate hands.

Some Tories (not least Jeremy Hunt) have tried to argue that the NHS would have been set up whichever party had been in power. But the 1944 White Paper from Tory minister Henry Willink would have left the responsibility for the NHS in the hands of local government, and the scattered network of voluntary hospitals largely unchanged, with fees still in place.

Bevan insisted he had not felt any consensus behind him as he fought to get the Act passed and implemented: only Labour's landslide 1945 majority ensured repeated Tory attempts to defeat the Act (and – as late as spring 1948 – block the launch of the NHS) were beaten back.

Public ownership and control, with public funding raised by central government through general taxation, rather than dependent on local council decisions or local taxes, was essential to ensure services would be equitably funded and available to all.

So most hospitals were nationalised, brought into a single system for the first time, and administered on a regional basis, although some public health, community health and ambulance services remained initially with local government.

Insurance model rejected

And with the call for hypothecated taxes or insurance based systems still doing the rounds in the right-wing news media, it's useful to note Bevan's argument that by raising the necessary funding through taxation rather than insurance, the NHS also worked as a mechanism for redistribution of wealth and addressing inequalities:

> **"… we rejected the principle of insurance and decided that the best way to finance the scheme, the fairest and most equitable way, would be to obtain the finance from the Exchequer funds by general taxation, and those who had the most would pay the most.**

"It is a very good principle. What more pleasure can a millionaire have than to know that his taxes will help the sick? … The redistributive aspect of the scheme was one which attracted me almost as much as the therapeutical."

The principles of the new NHS immediately proved so popular with voters that for almost four decades it enjoyed consensus support from both Conservative and Labour parties.

However subsequent 'reforms' imposed by governments have served to fragment, disorganise and demoralise the NHS, undermining its principles to make room for private profits in place of the focus on patient care.

Contracting out

This began in the mid-1980s with the Thatcher government contracting out hospital support services (cleaning, catering, laundry, porters, security) to profit-seeking and generally poor quality private contractors, which broke up NHS ward teams and effectively casualised vital jobs.

Then 1990 legislation implemented by John Major's Tories established an "internal market", which separated NHS 'purchasers' from providers. It set providers in competition and rivalry with each other, making collaboration and cooperation difficult or impossible.

These changes, which emerged from Margaret Thatcher's secretive "review" of the NHS in 1988 and the 1989 White Paper "Working for Patients," brought the alien notions of neoliberalism and "new public management" into the NHS, supplanting Bevan's 1948 values of public service and social solidarity.

The same 1990 Act included similar plans for what we now call social care, implementing proposals from Sainsbury boss Sir Roy Griffithss in 1988. The new policies, implemented from 1993, transferred responsibility for "community care" – most notably for long-term care of older people – to local government social services.

This made these services subject for the first time to means tested charges. It deepened the divide between care for vulnerable people inside and outside hospital.

Specialist beds axed

As a result, most NHS specialist beds for older people were closed down, while government restrictions on councils' use of funding for community care forced a growing level of privatisation of domiciliary services and long-term care.

To make matters worse, tightening 'eligibility criteria' imposed by councils from the mid-1990s, driven by growing constraints on local government budgets, ended any possibility of proactive and preventive care that might keep potentially vulnerable patients out of hospital.

Despite Tony Blair's repeated empty promises up to 1997 to end the 'costly and wasteful' internal market, the fragmentation of the NHS was deepened from 2000 by even more far-reaching competitive market measures which included for the first time tendering out contracts for clinical care under New Labour's NHS Plan, as well as the use of private capital to finance new hospitals and other projects under the Private Finance Initiative. [1]

Unlike Bevan, who had been forced to compromise and permit private beds for consultants and independent contractor status for GPs in order to establish a new publicly owned system, New Labour actively pursued policies to privatise what had been core NHS services.

They signed a Concordat for NHS patients to be treated in private hospitals, and established Independent Sector Treatment Centres to treat elective cases funded by the NHS, as well as for-profit 'Diagnostic and Treatment Centres' – all at higher cost than NHS provision.

Even primary care was opened up for private corporations. Meanwhile substantial annual real terms increases in spending in the 2000s ensured that NHS performance increased and waiting times were drastically reduced.

Austerity since 2010

But in 2010 David Cameron's Tory-led coalition slammed on the financial brakes, ending a decade of NHS funding increases. Within weeks of that election Health Secretary Andrew Lansley also unveiled wide-ranging and complex proposals – none of which had been put to the electorate – to further entrench the competitive market within the NHS and create new opportunities for the private sector. [2]

Lansley's hugely controversial 2012 Health & Social Care Act brought a wholesale top-down reorganisation of the NHS and compelled commissioners to put an ever-widening range of clinical services out to tender, while encouraging foundation trusts to expand their income from private medicine to as much as 49 percent of turnover. [3]

For almost 40 years various so-called 'reforms' have served, piece by piece, to undermine the initial values of the NHS as established in 1948.

NHS managers have been diverted down costly cul-de-sacs of 'new public management', 'business-style' organisation, competition and privatisation, often urged on by unhelpful advice from expensive management consultants.

The huge historic achievement of the NHS in 1948 was always more than as simply the first universal health care system to be funded from taxation and free from charges.

It was a decisive modernisation, which made it possible to supersede the previous "mixed economy" of health care, in which voluntary, private and municipal hospitals and GP services had functioned in parallel, with no coordination between them, while patchy insurance cover left a majority of the population unable to afford to access a full range of services.

Although it began with old and inadequate building stock, with an ad-hoc and undemocratic regional management structure, and even though it inevitably took time to develop, the seeds were sown in 1948 for the development of a qualitatively new service.

It was as fair in raising its funding as the taxation system, and could be shaped around the needs of the population rather than the charitable whims of the wealthy or the quest for profit.

The creation of the NHS as a national organisation also meant systems for training doctors and nurses could be put in place, and more specialisms were encouraged. Consultant numbers since 1949 have increased more than ten-fold from 5,000 to almost 55,000 in 2023. The Nurses Act 1949 established a modern framework for the role of nursing increasing nurse numbers almost three-fold, to 333.000 in 2023.

As a national system, the NHS created – for the first time – the possibility of planning the allocation of resources according to need.

This was especially important for establishing hospitals in post-war new towns and other previously under-served areas, and rectifying inequalities between regions and within regions. [4]

A new role for primary care

A specific arrangement was eventually agreed with General Practitioners, who had remained diehard opponents until the very eve of the launch of the NHS on July 5 1948.

They would not accept Bevan's plan to make them salaried employees, and were only eventually drawn to work with the NHS as independent contractors.

None the less the rapid enrolment of so many families in the new NHS meant almost all GPs immediately found themselves dependent on NHS contracts.

From the mid-1960s as more, younger GPs embraced this link with the NHS, new policies increasingly focused on the development of a specific role for primary care as the first point of engagement and gatekeeper controlling referrals to specialist services and elective treatment.

Universal

The early NHS, funded almost entirely from general taxation, but launched in a period of generalised rationing and austerity, nevertheless provided all services free of charge at point of use – including prescriptions, eye-tests and spectacles, and dental checks and treatment.

Even overseas visitors living in Britain were covered. This removed any of the deterrents that might prevent poorer families from accessing the full range of treatment.

However this principle came under attack from the beginning, and there were soon discussions about imposing charges for prescriptions and for dental treatment, which have persisted.

This has been revived by post-Brexit racism and chauvinism, with new requirements on front-line NHS staff to enforce mean-spirited charges on overseas visitors (also as a result requiring some British residents to produce ID or face punitive costs).

Charges have only ever been marginal to the total NHS budget. Almost 9 of every 10 prescriptions are dispensed free of charge in England; and they have been abolished in Wales, Scotland and Northern Ireland.

Prescription charges in England, now £9.65 per item – are a problem for the working poor, but raise less than 0.5% of NHS England spending.

Charges mainly deter people from accessing the full treatment they require – regardless of their level of need for treatment. Like so many of the counter 'reforms' that have disfigured and distorted the NHS since 1980, charges have made the service less effective, less efficient and less focused on patient care.

Having superseded the limitations of the market in 1948, every reversion to competition and market-style methods has been a step backwards: even plans claiming to aim for "integration" threaten loss of accountability and potential privatisation. There is no evidence of any benefits to compensate for the extra costs, bureaucracy and complex reorganisation.

Bevan was right.

And the NHS founding principles are still valid and essential.

75 years on from its launch the task of restoring the core values of the NHS and reinstating it as a public service is a vital one for staff, patients and the wider public.

References

(1) Lister J. (2008) *The NHS at 60: For Patients or Profits*, Chapters 6 and 9. London: Libri.
(2) Tallis, R. (ed) (2013) *NHS SOS*. London: Oneworld.
(3) Davis, J., Lister, J. and Wrigley, D. (2015) *NHS For Sale*. London: Merlin.
(4) Timmins, N. (1995) *The Five Giants: A Biography of the Welfare State*. London: HarperCollins.

John Lister
johnlister@healthemergency.org.uk

Our neglected impoverishment: The destruction of our healthcare communities

Can we arrest the haemorrhage of morale and staffing of our NHS general practice by fragmenting and devolving more of its traditional work? Probably not Here is why.

Early in May 2023 came yet another government initiative to stem the ever-growing overwhelmed disintegration of our general practice. Apart from the perennial mantra-like promises of expanded funding and training, the beleaguered frontline doctors will now be relieved even sooner by new regulations: pharmacists will now be licensed to treat common infections and pain conditions; patients will be able to self-refer directly to physiotherapists.

Such plans may seem to make quick and easy sense and would add to our already established GP-deflector roles: healthcare assistants, nurse practitioners, care navigators, associate physicians… All of these have been introduced in recent years to devolve and reduce doctors' work as quickly, cheaply and safely as possible. 'Just-as-good', we are promised, but cheaper, more efficient and so more sustainable.

A worthy quest, surely?

Well, it would be if it turned out as planned, but the evidence is that, generally, it does not.

Why and how such increasing managed division of labour so often backfires can largely be understood by considering a mistaken founding assumption: that medical practice – particularly general practice – is essentially a system of scientifically formulated separate diagnostic and therapeutic interventions. Our healthcare can then be executively designed and delivered, like any industrialised utility, commodity or manufactured object.

Yet this working assumption is only effectively true in certain situations; in other healthcare situations it works badly, even hazardously. For example, it works well with vaccinations or anaesthetics; it fares poorly with all conditions that cannot be swiftly and decisively eliminated by prescribed procedures. And that terrain is vast. Paradoxically (for some) it comprises the greater bulk of primary and mental healthcare – that is disturbances/disorders of maturation and ageing; stress-related/psychosomatic reactions; distressed patterns of BAMI (behaviour, appetite, mood and impulse); chronic physical illnesses; palliative/terminal care… Rarely are any of these easily eliminated by impersonal procedures of medical science alone. They need also the skilled, bespoke engagement of a professional whose knowledge of science is threaded through a growing fabric of personal knowledge of each individual patient.

Clearly this modus operandi is not a perfectible or completable task. It is an aspiration, and adopted as such it was responsible for the previous comparatively excellent professional morale, recruitment, stable retention and work satisfaction of erstwhile GPs and their staff … and in reciprocated trusting and affectionate satisfaction among patients.

Of course there were exceptions to, and failures of, this ethos of better practices – but it was sufficiently true to make British general practice for about three decades an internationally reputed and studied exemplar of equitable, sustainable, safe and economical primary care. Time and again its personal continuity of care was identified as an essential anchoring and motivating principle. By

getting to know their patients – their stories, their predicaments, their families, their neighbourhoods – they could better comfort, contain, guide, advise, witness, encourage … all those human aspects of relationship that help us endure and heal. It also enabled quicker and more accurate diagnoses and treatments of those conditions that are readily treatable.

It was this facility, to weave the art of the personal with the science of the procedural, that made general practice such a stable and popular profession … until the serial reforms intruded to destroy this subtle balance, a little over 30 years ago.

The cumulative error of our 'modernising' reforms has been the destruction of relationships in pursuit of standardised, measurable, manageable procedures. Practitioners are now less motivated by vocation, yet more driven by corporation. Increasingly, consultations have become remote, tick-boxed and compliant to a no-one-knows-anyone-but-just-do-as-you're-told-and-follow-the-algorithm culture.

In our government's quest to model our healthcare, first, on competitive manufacturing industries – and then to adopt some expedients from the gig economy – we have sacrificed the deeper satisfactions of the job for practitioners, together with its consequent beneficence for patients.

To remedy this reform-inflicted damage GPs do not need to have their work further fragmented and subcontracted by management design and decree. That merely adds to our system's malady: a bit-part relay-culture where more and more professionals must know prescribed procedures and protocols, but not patients.

Our more sanguine, happy and stable general practice traditionally had four cornerstones: relationships, personal continuity of care, generalism and holism.

If we wish to invest in our own health – as well as those of our communities – we must carefully replace and secure these sunken foundations.

- **Many articles exploring similar themes are available on David Zigmond's Home Page (https://bit.ly/3JTMOdp)**

David Zigmond
EC member
jdavidzigmond@icloud.com

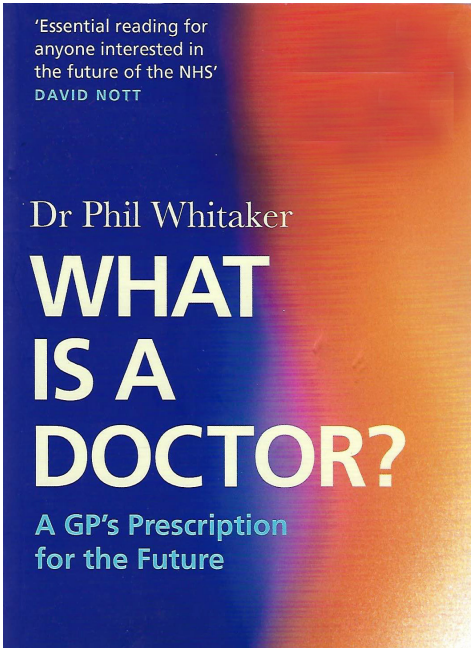
Book Reviews

What is a Doctor? A GP's prescription for the future
(£16.99, Canongate Publishing, hardback and eBook)
Phil Whitaker, 2023, 308pp.

You would expect a writer of Phil's calibre (he is *New Statesman's* Medical Editor) to render a text on something as important as the future of general practice and the NHS coherent and persuasive. He does not disappoint. I found this book, as someone who knows very little about the realities of general practice but a great deal about the threats to the NHS, both of those, and entertaining besides.

A strong key to the success of this book's narrative lies in Phil's playing to his obvious strength, and one that anyone who has practised would instantly recognise: he refers extensively to his own clinical (and personal) experience both to punctuate his arguments and to lend them what I found to be a compelling humanity. You just know, when he develops ideas about the NHS on a wider scale, that the patients he draws his experience from and whose own experiences and illnesses are described are real (names changed of course) and were known to him personally – the very heart of clinical practice, set amdist a deepening picture of unworkable pressures, ill-conceived top-down diktats and services not just on the brink but teetering over, creaking, and swaying ominously. When it very much need not and should not be so. This is done to draw out the larger, usually grimmer picture, of politics and sweeping changes (mostly not good).

Each chapter addresses a current area of concern for general practice, and the NHS, illustrated with detailed case description, to give an impressive overall range. So the second chapter chronicles the shift from evidence-based medicine (EBM) to evidence-dictated medicine (EDM) because of fears about litigation or just appearing 'out of step' with the prevailing sets of beliefs



governing the use of evidence. The next looks at the emergence of what is termed the 'national risk service', and the unfair loading on to the NHS to look for solutions to problems like type 2 diabetes as a medical condition when its root causes are grounded in social and economic factors. The next provides a highly effective demonstration of the trend to deal with the problem of not enough GPs with the handing out of what was their 'brief' to para-professionals and NHS 111, with all the attendant shortcomings and innate unfairness that creates, instead of dealing with the root problem – not enough GPs.

'Doctor Google and the AI revolution' covers the growing trend to turn to apps and what

appears to be increasingly sophisticated machine-based medicine, with all the glowing praises and fanfares from various government sources and Ministers, while ignoring the underlying flaws and what should be painfully obivous but to many isn't: AI is a tool which should be used to inform decisions based on clinical experience, not supplant them with so much algorhythmic jiggery-pokery (a point we have covered before in these pages, and eloquently explained recently in the *Guardian* [1]).

The relatively new phenomenon of multimorbidity and how this confounds the current system is poignantly illustrated with one case. You might think that is a weakness. But to me, that is its strength: it makes it all the more human. The numbers are already there – what makes them real, to me, isn't the multitude, it's what this means to this one person, and his or her GP.

The crucial concept of patient-centred care and how this takes in what the patient themselves believes, with a backdrop of increasing consultations carried out remotely, is given the priority it should command:

> 'What is needed is time to practise medicine properly. If the government fails to invest adequately, and fails to direct recources where they are needed, then patient-centred consultations may never become the norm. They will be in the private sector, where adequate time will be funded by those who can afford it. The NHS may be reduced to a transactional safety-net service for those without the resources to exercise choice [***the 'two-tier health service' we and groups like ours have been voicing concerns over for some time now.***]
>
> 'This matters. Patient-centred consulting is much more efficient for the health service ... and I am certain it would also be shown to be associated with lower activity levels both in general practice and in hospitals. Beyond that, though, it results in far greater patient satisfaction. People feel listened to and understood, and properly involved in their own care. That is healthcare that is genuinely worth having.'

Each chapter of this critically important book, which I would recommend to anyone, makes its own point with similar appeal. Phil makes no sweeping assertions about 'fixes' to put right was is now so desperately wrong with general practice, and the NHS. But, steeped as he so obviously is in clinical experience, in dealing with real people as well as the many processes, protocols and at-times conflicting policies which now form the medical landscape, he offers hope. This is from the final chapter:

> 'Continuity with a good general practitioner is vital if we want to experience holistic care. A system, a protocol, a guideline – they are by definition impersonal. The GP, steeped in the medical world, intimately acquainted with the ways in which the NHS works and sometimes lets us down, and equally conversant with the myriad interplay between biology and emotions, psychology and life circumstances in the experience of illness – the GP is our expert ally.'

Reference

[1] Van de Schaar, M. (2023) 'AI powered personalised medicine could revolutionise healthcare', *Guardian*, 26 June.
Available at: https://bit.ly/44n4hIT

Alan Taman
Managing Editor
healthjournos@gmail.com

Lost in Work: Escaping Capitalism
(£9.99 Pluto Press)
Amelia Horgan 2021 166pp

A little background to the reason for highly recommending this book.

Amelia is prominent as one of a growing number of scholars around the world casting light on why and how work is now central and at the root of our profoundly dystopic world.

If the founding principles of the NHS, for which this organisation campaigns, are not to be further diminished, corrupted and abandoned, 'Work' must cease to be the problem and become the solution.

Restoration and development of those founding principles are more than essential, as Amelia describes. An environment where the nature of work is re-imagined and people are valued must replace the capitalist focus of profit; for the NHS this could be existential.

We will all have stories that expose the reality of what has happened and continues to happen. For example, setting up a clinical haematology service in Wakefield in 1978 as a single-handed consultant with minimal junior support (a situation that took a decade to 'breakthrough'), meant I could develop the service only with the goodwill and hard work of all members of staff from the nurses on the ward to the biomedical laboratory scientists in haematology.

The burgeoning anticoagulant clinic was only possible due to the willing cooperation of the team of phlebotomists, they became the only direct interface with the patient demanding a whole new role for them in collecting vital data; lab staff adopted algorithmic computerised support for warfarin; lab staff learned to harvest peripheral stem cells to allow us to develop autologous stem cell transplant; the secretaries came to know the patients and their GPs as well as (in many ways better than) I did.

In retrospect I worry I did not make moves to ensure those greater responsibilities by so many so willingly and enthusiastically were appropriately financially rewarded. I can only hope the chief scientist in managerial charge of pathology looked after all that; but it should not have been like that.

None of us wish to 'go back', though I suspect all of us recognise good things that have been all but lost.

To recover and progress our NHS for the future will require a workforce at all levels to gain 'ownership' and control of their own 'work lives' – and this is where the underpinning philosophy of Amelia's book becomes critical. I have chosen to use a few quotes from Amelia's book to give a sense of how it is so relevant to the task before us.

'There's a comforting narrative of progress about work: the bad old days of horrible jobs – of children working in mines, of cotton mills, of workplace injuries, of cruel bosses – are gone.';

in the words that follow this opening, she blows apart that 'comforting narrative'.

'…this is not a book about people's subjective preferences [about work] so much as the conditions in which those preferences are formed, and the background of possibilities against which they exist, such as the lack of other sources of fulfilment and sociability. It is a consideration of the ways in which capitalist work curtails people's freedom, how even while it might provide some satisfaction, even some pleasure, it does so at the expense of cultivation of other kinds of pleasures, of other ways of living and producing, together.'

These words nearing the end of the introduction anticipate how she then deeply explores the issues around work in the chapters that follow:

'X,Y or Z happens because of capitalism. This might be true, but it's banal. As those interested in changing the world, seriously changing it,

not just curbing its worst effects, we need to actually figure out what capitalism is like. This might seem like a pointless, academic exercise: we already know it's bad! Why do we need to work out exactly what it is or consider the ways in which it's bad? But without knowing the internal dynamics of capitalism, how it works and how it affects us, as individuals and at the level of the social whole, we can neither make sense of it nor change it. It's not enough to say that capitalism is bad, we have to explain why and how, and imagine and fight for alternatives.'

After focusing our minds on the general 'banality' of the critique-of-capitalism-discourse, she goes on to illuminate using the history of making garments from pre-history until now; this may sound obtuse to an argument about saving our NHS, but the illustration she draws has deep relevance for the principles she puts forward. The last paragraph from Chapter 1:

'Rather than accept the circular logic of the mock critique of capitalism offered by mainstream political commentators – one that says that things are capitalist but there's not much we can do – this book hopes to make sense of the violence that might be said to characterise capitalist work: and to put that violence in the context of political relationships, of human agency and of human action. In short, how and in which sorts of ways things could be different.'

The rallying call of the last paragraph:

'This conclusion's severe weather metaphors are not intended to make change seem impossible, but rather to allow us to look at the situation in which we find ourselves with clear eyes. We face deepening crises along with significant practical and theoretical challenges for the left as a movement, but what is at stake is not only control over our own lives, but over

our collective destiny, our shared freedom and our shared joy. A future without the indignities, petty cruelties, exploitation and misery of capitalist work is possible, and it is one worth fighting for.'

The picture of 'Work' Amelia paints is reminiscent of the writings of Michael Marmot in *The Status Syndrome* and *The Health Gap*, and she does cite his work in support of her arguments.

Many people now believe that capitalism has had its day. What I believe we all recognise is that change is urgently needed in how we regard work.

Amelia's insight in *Lost in Work* is bleak and chilling; it needs telling and understanding. Michael Marmot's life's work demonstrated the impact of 'bad work' in ill-health and shorter lives. Isabelle Ferreras provided a route map for enfranchisement at work in *Firms as Political Entities* (reviewed in the last newsletter).

Lost in Work makes (and vividly illustrates) coherent arguments for overturning the current way we regard work with its disempowerment of people in the NHS as elsewhere. If true democracy in and around work is to take root, the cogency of Amelia's insights in *Lost in Work* must be recognised.

Mike Galvin
EC member
drmcgalvin@hotmail.com

EXECUTIVE COMMITTEE : Elected at AGM 2022

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 Mike Galvin
Haematology, Wakefield
01784616649
drmcgalvin@hotmail.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.