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NEWSLETTER

2024: The Critical Year

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In Defence of the NHS

Keep Our NHS's Co-chair John Puntis destroys some popular myths about the NHS

It is common for the NHS to be attacked on a variety of spurious grounds, a series of negative statements often being repeated uncritically and ad nauseam by some sections of the media until they become 'common knowledge'.

This article considers some of these and suggests counter-arguments that may be useful to campaigners, particularly in the run-up to the election when the NHS will figure among the most important concerns of the electorate and politicians will require robust challenge.

"If the NHS is so good, why has no one else copied it?"

This question is meant to imply that the NHS is outdated and that a social insurance model or other form of funding would lead to better outcomes. Nigel Edwards of the Nuffield Trust (1) pointed out that if we look at countries that have health systems funded largely out of tax, that are mostly free, comprehensive and have a provider sector that is substantially publicly owned (ie like the NHS), there are actually quite a few. Scandinavian countries have systems where the majority of the revenue is collected by tax and providers are owned by local government. The current Portuguese Health Care System (2) was created in 1979 and based on the Bevanite National Health Service model; Italy, Spain and Malta also have health systems in many ways close to the NHS.

Of course, these countries do not replicate our NHS model in every detail but nevertheless have much in common, including now being the objects of ideological attack (3), and undermining of their public aspects through the growth of financialization (4) and the promotion of the unevidenced view (5) that privatisation brings efficiency. On the contrary, recent evidence from England suggests that outsourcing clinical services is associated with increased mortality (6). Where profit-hungry private equity firms (7 have taken over hospitals in the US, there has been a 25% increase in complication rate (principally infections) observed among patients. The deficiencies of some social insurance based European and other high income country systems have been outlined (8) by John Lister and include higher overall administration costs (9) and transfer of cost of care to individuals, often disproportionately affecting those on lower incomes.

Enthusiastic introduction of market reforms in the New Zealand health service in 1993 is acknowledged to have led to neglect of both workforce and planning, and resulted in fiscal irresponsibility and excessive transaction costs. The legislation through which these reforms were imposed was eventually abolished while new laws re-established a National Health Service (10) (first founded in 1938 and providing care 'from cradle to grave'). Following this, through working together rather than in competition, patient care improved and demand on hospitals was reduced. In a recent review (5) providing an international perspective, the benefits of public versus private health care were noted to include that the former reduced overall healthcare and administrative costs, helped in standardising services and creating a healthier workforce, prevented future costs, and guided the population to make better choices.

"We have given the NHS record funding" – so everything is alright

The NHS may indeed have 'record funding' – but this does not mean it is getting what it needs. More or less everyone (except those with overall responsibility (11) for the service it seems) can see that the NHS is in crisis. The government consistently attempts to counter criticism of its appalling record with the claim it is providing record funding (12). This is, of course, a meaningless statement unless it is placed in the context of historical funding, current demand and is benchmarked against comparable countries. As Mark Thomas of the 99% Organisation pointed out (13), if his salary had increased £50 each year since starting work he would now have a record salary but would be living in poverty.

'Record funding' has in fact not taken into account increased demand from population growth over the last 13 years, the far greater numbers of the elderly and those with chronic conditions such as diabetes and obesity, together with the surge in mental health problems. After the creation of the NHS in 1948, spending increased every year by around 4% in order to help meet increasing demand. From 2010, growth in spending fell below this long-term average, meaning that by 2022 there was a £322 bn shortfall (14) between what was actually provided and what would have been provided if historical increases had been maintained.

Health spending is often looked at as percentage of gross domestic product (GDP; this varies as the strength of the economy fluctuates) but more informatively, as per capita funding. The *Financial Times* (15) published data shared from the Health Foundation (16) examining health spending in the UK and Europe in the decade before Covid. Average day-to-day health spending in the UK between 2010 and 2019 was £3,005 per person – 18% below the EU14 (17) average of £3,655. Matching spending per head to France or Germany would have meant an additional £40bn and £73bn (21% to 39% increase respectively) of total health spending each year in the UK. Similarly, analysis of Britain's capital health spending on buildings, technology and equipment between 2010 and 2019 showed that an extra £33bn (a 55% increase) in cumulative UK investment would have been needed to match the EU14 average invested over the period.

John Burn-Murdoch (18) is the Chief Data Reporter for the *Financial Times* and has produced some beautiful graphs very clearly illustrating how the so-called 'record funding' of the Conservative government has caused immense damage. Among other things, these demonstrate how waiting lists swelled under Major (19), shrunk under Labour as funding increased, then climbed again under Tory austerity. While avoidable deaths had been falling steadily, this flattened off under austerity and is now on the rise; improvement in life expectancy has also stalled. Austerity produced a fall in total government spending (19), together with falls in spending on health care as percentage of GDP, public sector investment, and investment in health care. Burn-Murdoch also shows how the current crisis in the NHS damages productivity and relates among other things to no longer having enough beds (19).

The reality that 'record funding' actually amounts to nothing more than considerable underinvestment is set out in a report by the 99% Organisation (20). While nominal spend has continued to rise over the past two decades, when taking into account inflation, population growth,

ageing and increasing burden of disease real spend per unit healthcare demand clearly shows a steady decline over the past 13 years. Among the G10 countries (21), only Italy spends a lower proportion of its GDP on health than the UK. The bottom line, therefore, is that we spend less on healthcare than other developed countries; our spending has not kept pace with the combination of inflation, population growth, population ageing and increase in chronic illness.

This underfunding (aka 'record spending') has led to the unavailability of resources (staff, hospital beds, technology, etc) and so to poorer performance. To take one example, it is lack of staff and resources that are damaging cancer survival (22) rates in the UK. As the Organization for Economic Cooperation and Development has put it (23): "The United Kingdom's health system delivers good health outcomes relative to the level of health expenditure…..", and as Anita Charlesworth (24), Director of Research for the Health Foundation observed, there is a simple choice to be made: "Either we are going to have lower quality healthcare relative to other countries or we spend more".

With 2.6 million now unable to work because of sickness (25), it is clear that an effective health service is necessary for a healthy economy, which in turn is required to tackle the social inequality that drives long-term ill health. If the NHS fails, the economy fails with it. In relation to health inequality, it is estimated that between 2011 and 2019 over a million people died earlier than they would have done (26) if they lived in areas where the richest 10% reside. This prompted Sir Michael Marmot to comment (27): "One million premature deaths, made dramatically worse by austerity, is a shocking political failure….If you needed a case study example of what not to do to reduce health inequalities, the UK provides it."

"... an effective health service is necessary for a healthy economy ... if the NHS fails, the economy fails with it."

"The NHS is unproductive and wastes money"

In responding to this point, there is an instructive analogy from the 99% Organisation report (20): 'the UK government has been continually asking the NHS to do more with less. It has been acting like the experimental philosopher (described by Dickens) entrusted with the care of a champion race-horse, and attempting to show that it can live without eating. Now that the horse can no longer run, it blames the horse, not the diet!'. Similarly, politicians persist in calling for a stricter diet, rejecting the 'magic money tree' but enthusiastically embracing the 'magic efficiency tree' (28).

Rather than examining the evidence and drawing the conclusion that lack of investment is damaging productivity, some commentators choose to point the finger at staff for being profligate with resources. It is surprising that there are so many who do not work in healthcare that are nevertheless expert on wasteful practices in the NHS! It is much easier to blame managers and staff for perceived shortcomings, and to cite reports that have often come from clinicians themselves, who in the course of their work are forced to consider both waste and best use of limited funds. Standardisation of approaches to investigation and management of patients can save money but is very much central to what staff are doing on a day-to-day basis as part of their work as professionals (29). This is why, for example, the NHS no longer endorses use of homeopathy (30) and why we have an advisory body like the National Institute for Health and Care Excellence (31).

Claims such as the NHS wastes £2bn a year (32) on unnecessary treatment and investigation therefore requires some careful scrutiny. Unfortunately, much of medical practice (33)

rests on relatively shaky scientific foundations, continually raising legitimate questions (that are far from simple to answer) about the allocation of available resources. Theoretical savings (32) through withholding treatments or tests are not always easy to realise in practice (eg reducing numbers of X-rays), and even when justified, may be persuasively challenged or require investment elsewhere such as community pharmacists to reduce medication usage. What seems beyond doubt is that in a privatised rather than public health care system, the dominating profit motive is much more likely to drive waste (34) through over-investigation and treatment. This is one of the reason we see staggeringly high costs in the US (35) health care system.

Another common criticism regarding waste is that the NHS has too many managers – get rid of these and use the salaries for patient care. Any large and complex organisation needs managers. While 10% of people in the overall economy are categorised as managers, it is only 4% in the NHS (36). A strong case has been made that the NHS is undermanaged (37). The reliance on expensive external consultants (38) also suggests the NHS does not have enough managers of its own. Whereas current lack of productivity is both a reflection of the whole system and a consequence of underfunding, we can see that with investment, NHS productivity rose 16.5% (39) from 2004/5 – 2016/17 compared to growth of only 6.7% in the economy as a whole. In 2017, Office for National Statistics data showed NHS productivity in England grew by 3% (40) versus only 0.8% in the wider economy.

> "A strong case has been made that the NHS is undermanaged...the reliance on external consultants suggests the NHS does not have enough managers of its own."

Of course there is always some waste to be found in large enterprises and this should be addressed. One area ripe for making savings is cost relating to administering the expensive artificial 'marketplace' created by successive governments to allow both NHS and private 'providers' to compete with each other to offer services to NHS and other 'purchasers'. In 2010 the Commons health select committee estimated (41) that the 'purchaser-provider split' had pushed up costs of management and administration from 5% to 14% of total budget (£15.4bn/year). The current figure is unknown (42) but with estimates falling between £4.5bn and £30bn. Although such savings are speculative (43), the cost of developing, awarding and monitoring contracts with private providers clearly represents one area of waste that receives very little attention from the 'experts'.

Benchmarking the NHS

Though never perfect, we know the NHS has worked well in the past, not least from the evidence presented in detailed international comparisons. The Commonwealth Fund (based in the US) is a highly regarded source of independent research into different healthcare systems. For nearly 20 years, it has been compiling reports on 11 high income countries. These are based on international surveys carried out in each country and on administrative data from both the Organisation for Economic Cooperation and Development and the World Health Organisation. Other sources of benchmarking information include EUROSTAT (44) and the Rand Corporation (45), but these are less comprehensive.

The reports examine 71 measures of performance (46), grouped into five domains: access, care process, administrative efficiency, equity, and healthcare outcomes. Until 2017 the NHS was overall top performer, but by 2021 had slipped to

fourth (47) because of difficulty accessing care and treatment. This was the first time since 2004 (48) that the NHS had not been ranked in the top three. Ideological critics respond to these very compelling endorsements of the NHS model with what they imagine to be a devastating argument by pointing out that the NHS is placed 10th out of 11 (the US being an outlier and very much bottom of the pack) for outcomes. However, a glance at the data (Exhibit 8 in the report for 2021 (46)) shows that the NHS is very close to New Zealand, Canada and Germany for outcomes. Top performing countries were characterised by investment in primary care and social services - both currently in a state of disarray in the UK.

Conclusions

The NHS is neither a shrine nor a religion as its right-wing detractors sneeringly like to state. In truth, the fundamental business model of the NHS is better than those in the other high income countries with which it is compared. The founding model of the NHS is a winning formula and should not be changed unless there is overwhelming evidence for a better one. Those who advocate for major reform must, like the Commonwealth Fund, set out clearly just what they are proposing: the costs involved together with the expected effect on access, care process, administrative efficiency, equity, and healthcare outcomes.

Health and care must be acknowledged as tangible benefits fundamental to human wellbeing (49) and a productive economy, maximising the ability of people to participate in society, and not seen only as a cost that is grudgingly accepted. If the NHS was now properly funded it could deliver outcomes that excel even the current best. Most people (50) from across regions, demographic lines and party political allegiances support a universal, comprehensive, free and tax-funded health system. The NHS model has not failed, rather it has been failed by politicians. In this election year – now is the time to set this right and campaign for a People's NHS (51).

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Take The Pledge!

***We Own It* (https://weownit.org.uk) is launching a campaign from February aimed at motivating people to approach candidates from all political parties to pledge to fight for our NHS if elected: *Pledge for Our NHS*.**

2024 will be a key year for NHS campaigning, with a general election possibly taking place as early as May. This presents campaign groups, such as *We Own It* and DFNHS, with an opportunity to use the election to apply pressure on all parties and candidates around a set of demands for our NHS.

We Own It has asked for our support. To be effective, many people in many constituencies will need to ask candidates of all parties to 'take the pledge'. Campaign groups will need to work together to make the biggest difference. This is where DFNHS members can make a substantial contribution in their own local area. You can support *Pledge for Our NHS* in two ways:

- Post about the pledge on social media when it launches in February, and
- E mail all the candidates in your area and ask them if they would be willing to 'take the pledge' (Alan Taman will provide you with a list of candidates as the election approaches, if you need this information – please ask, healthjournos@gmail.com).

The details of 'The Pledge' are:

- If NHS spending levelled up with French or German healthcare spending per head, we would have spent an EXTRA £40 or £73 billion (1), respectively, on our NHS in 2022. **Commit to supporting proper NHS funding of at least £40 billion extra annually to catch up with the European average.**
- Evidence shows that NHS privatisation is ineffectual (2), wasteful (3) and linked to deaths (4). **Commit to supporting an end to NHS outsourcing and bringing all outsourced healthcare and ancillary services back into the NHS.**
- Families who have lost loved ones as a result of waiting too long on NHS waiting lists should be able to hold the government accountable for their systematic underfunding and undermining of the NHS in the courts. **Commit to supporting the reinstatement of the Secretary of State's legal duty to provide healthcare to all, which was repealed in the 2012 Health and Social Care Act (5).**

***We Own It* are holding a launch rally for the campaign on Zoom on Thursday 8 February, 6-7 pm. Check their website for log-on details.**

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Physician Associates: A useful pair of hands or '10,000 fake doctors'? (1)

All of us work, or have worked, with a range of members of the clinical team who contribute much-appreciated skills to the patients under our care. This would include specialist nurses, physiotherapists, pharmacists and many others, but many of us have not yet encountered this group of clinical staff.

What are Physician Associates (PAs) and where did they spring from? For those who have not been following this issue, they are relatively recent members of the 'medical associate' professions, an idea originally coming from the USA. The first PAs started working in the NHS in 2003, but the DoH 'NHS long-term workforce plan' this year announced a huge increase in their numbers, with a workforce of 10,000 by 2036-37. Inevitably, this has prompted many questions about the role.

According to the RCP Faculty of Physician Associates:

'Physician associates are healthcare professionals who work as part of a multidisciplinary team with supervision from a named senior doctor (a General Medical Council registered consultant or general practitioner), providing care to patients in primary, secondary and community care environments. This innocuous and vague description gives us no idea of what PAs are actually supposed to be doing but a list of their intended duties (from the same source) appears much more worrying and really sounds very like the duties of a doctor.

'Physician associates work within a defined scope of practice and limits of competence. They:

- **take medical histories from patients;**
- **carry out physical examinations;**
- **see patients with undifferentiated diagnoses;**
- **see patients with chronic conditions;**
- **formulate differential diagnoses and management plans;**
- **perform diagnostic and therapeutic procedures;**
- **develop and deliver appropriate treatment and management plans;**
- **request and interpret diagnostic studies;**
- **provide health promotion and disease prevention advice for patients.'**

So, what training do PAs have? According to the Government website, a degree in 'health or life sciences' is usually needed, with most universities expecting at least a second-class degree. The term 'Life Sciences' covers numerous possibilities. Presumably most such degrees would be in a clinical field such as nursing, pharmacy or optometry, but anatomy or biochemistry are also suggested. Other 'life sciences' could include such varied fields as marine biology, botany, cell biology, anthropology or palaeontology, among many others. Not, however, medical degrees, and those who started, but never finished, a medical degree cannot apply. For most centres, some healthcare experience is considered highly desirable although usually not essential and could just be on-line. In some centres, a Master's degree, or just clinical experience, can be considered. Once the candidate has been accepted there is then a 2-year training programme including theoretical and clinical experience, which leads to full qualification as a Physician Associate. Bursaries

are available for the students.

A few universities offer a 4-year undergraduate course in Physician Associate Studies, usually needing 3 'A'-levels (including at least one science). There is also an apprenticeship scheme which 'usually' requires a first degree as mentioned above, and the apprenticeship lasts for 30-36 months with some funding available for this. The final exam for trainee PAs is an on-line 200 question paper, followed by a 14-station objective structured clinical examination (OSCE). According to the 'PA OSCE' website (2) 'the PA course is not standardised among the universities and the training provided can vary wildly', but the exam is a national one for all candidates. There are even social media reports of PAs being appointed without even doing the 2-year course. Contrast this with 5-6 years of medical school, foundation jobs, Membership or Fellowship exams, competition for specialty training, rotations to different hospitals, exit exams, and after all that, annual appraisals.

Physician Associates are encouraged to join the Physician Associate Managed Voluntary Register held by the Faculty of Physician Associates at the Royal College of Physicians (RCP). Were Fellows or Members consulted when the faculty was set up? I think not, even though the original purpose of the RCP when it was founded in the 1500s was to license practitioners and ensure that only those with formal medical training were working as doctors. A poorly publicised public consultation, only covering regulation of PAs, was held in 2017, at which time only 63 nationwide were working in GP surgeries.

PAs are currently not licensed, although the GMC plans to do so (3). This is very controversial (4) as PAs are not doctors and the plan would blur the boundaries between the two. Under the 1983 Medical Act the term 'physician' only applies to a fully registered medical practitioner, so the term 'Physician Associate' (demanded by PAs) will certainly cause confusion, particularly with associate specialists, who are, of course, senior doctors. The GMC should not take on this role, but if it does, the GMC number for a PA must be easily distinguishable from that of a doctor, eg 'PA123456'.

At present, although this may change, PAs cannot prescribe and are unable to order X-rays, so a qualified doctor must do this for them, raising very serious issues of accountability if the doctor has not personally assessed the patient – something which may be quite impossible in busy circumstances.

The working week for PAs is 37.5 hours, with pay starting at £41,662, the average being £43,718 per year (£22.42 per hour) and rising to a maximum of £53, 219. PAs can work out-of-hours or night shifts, though most will not be doing so. The basic working week for doctors is 40 hours. An FY1 doctor in England earns £32,398 (£14.09 per hour), rising to £37,303 for an FY2, although they will be paid extra for their compulsory additional hours, limited by the EWTD to a maximum average of 48 per week. The fact that a new PA is paid much more than a new doctor must surely be a factor in current dissatisfaction.

What are PAs actually doing? There is no doubt that some, particularly those with significant previous experience in a particular field, are extremely useful members of that team. Ex-paramedics, for example, appear to be working well in many A&E units, although another fully trained doctor would be better. But they are not doctors, and wherever they are working are supposed to be supervised by a qualified doctor. It is hard to see how the work those with such previous qualifications should be undertaking would differ from, for instance, that of a specialist nurse working in a particular area.

Many concerns arise, however, when PAs who have undertaken the basic 2-year training are effectively working as GPs, seeing new patients with undifferentiated conditions, making a diagnosis and advising management (even if someone else has to sign their prescriptions and be accountable for this). This is surely completely inappropriate, but their salaries can be paid under the Additional

Roles Reimbursement Scheme. This money cannot, however, be used to pay additional doctors or practice nurses, and qualified GP locums are often unable to find work as practice funding is restricted. NHS England guidance to practices states that the PA 'must have access to a named GP supervisor' and that 'monthly supervision can be provided' (5). PAs have boasted on social media that they 'only need to ask a doctor for advice every couple of months', and it seems that the training rather encourages the PAs to view themselves as 'generalists', able to work independently. Recent press reports have highlighted tragic consequences of mistaken diagnoses by PAs (6), and while all doctors can and do make mistakes, this is far more likely to happen if the person has very little training and just does not know their own limitations.

Contrast this with the support given to a GP registrar, for instance in the Bradford vocational training scheme. These doctors will, of course, have spent 5 or 6 years at medical school and two foundation years before starting 3 years of GP training. Guidance here states that 'all surgeries must be followed by a debrief of 20 minutes for a two-hour surgery or 30 minutes if longer. GP trainees must be supervised at all times and someone must be available on site for giving advice'.

Why is there such pressure to introduce and greatly expand the PA role? To cut costs, of course (7,8), and an undercover *Panorama* reporter working in a GP surgery run by Operose Health found a dangerous over-reliance on barely supervised PAs, one of whom was clearly very unhappy about this (7). If properly supervised, would they really be cheaper? This seems doubtful, as they usually have longer appointment times than qualified GPs and adequate supervision and selection of suitable patients would be time-consuming for the doctors as well as leaving them with nothing but an exhausting stream of complicated patients. I very much fear that the government's ultimate aim is that most patients should be seen by PAs, with nominal oversight by a doctor who may not even be on the premises.

There is also a clear anti-union agenda directed at the BMA, and the GMC in 2015 stated that 'there is an ambition … to make sure that maximum value is derived from them as medical role substitutes'. There are already reports of GP redundancies in favour of 'other roles' (9).

What about hospitals? Although according to the Government PA website PAs 'are not replacing doctors' (10), they are often doing exactly this. At times they are staffing the registrar rota at Birmingham Children's Hospital (11) in which role they are advising doctors from other hospitals on patients with liver problems. According to the BBC article (11), they must have worked for 3 years before working as a registrar, but they, and others in similar roles, will not, of course, have passed the college Membership exams expected of a doctor at that level or had comparable training. Junior doctors I spoke to recently at a local picket line told me that a PA would be looking after patients in one bay of the acute medical ward while they did the same work in the other.

Are PAs 'pretending to be doctors'? Many are not, but some clearly are. It is impossible for a patient to know who they are seeing if they are not told, or for other staff to know who they are speaking to. Junior doctors told me anecdotally of PAs who have apparently done 1-year doctorates and therefore call themselves 'Dr', and a PA on a local surgical unit who introduces himself as 'Mr'. PAs posting on-line boast of being 'highly skilled and highly trained generalists, who, unlike doctors (who tend to specialise) can work in any area of

medicine' (12). So many unfortunate developments in the NHS have been imported from the USA and we cannot ignore what is happening there. In four states, PAs have now been officially given the right to practise medicine 'unsupervised, with no med school, licensing exams or residency'. Surely a dreadful idea! There is no doubt that the aim of the American Academy of PAs is independence (13) and to 'dispense with the outdated concept of supervision', a policy which would create a two-tier system of medical care.

There is a worrying element inherent in PA training, encouraging overconfidence. Compare this with the traditional medical training. Whilst not exactly encouraging self-doubt, this certainly stresses the need for self-reflection, the need to seek senior advice when required and to gain further knowledge and experience. The wiser of the two courses seems obvious. The encouragement of an excess of confidence from the start generates a further risk, that of the ease with which mistakes are made, clearly exaggerated by the desire for independent working.

What is the effect on doctors? Senior doctors are busy and teaching time is limited. If PAs must be taught and supervised, there is a real risk that teaching time for medical students and junior doctors, and opportunities to learn procedures, will be reduced. We are told that units 'benefit from the continuity of a PA', since they do not rotate like junior doctors, but this can mean that teaching goes preferentially to them. A recent report (14) by the Association of Surgeons in Training found that a large majority of respondents who had worked with PAs felt that their training and theatre opportunities were reduced. For trainees, rotation to distant hospitals can really disrupt domestic life, and if PAs are given more senior roles without the need for postgraduate exams this seems most unlikely to boost morale. Completion of higher medical training is vital, however, or standards will gradually but inevitably be downgraded throughout the NHS. Training, after all, is there for a purpose.

In some medical schools, PAs are involved in teaching or examining medical students. Is this really appropriate?

There has been great concern from doctors about the Long-term Workforce Plan (15) and rather belatedly the Academy of Royal Colleges has written to the GMC about the regulation of PAs and the similar Anaesthetic Associates. The BMA has also now called for an immediate freeze on their recruitment (16) until proper regulation and supervision, and agreement about their role, are in place.

A significant workforce issue is the difficulty caused by training bottlenecks, (17) as already seriously inadequate funded training places have not kept pace with medical school expansion even though many consultant posts remain unfilled through lack of qualified applicants – for instance in anaesthetics (18). Likewise, the RCP reported in 2022 that no appointment could be made for 52% of advertised consultant posts, for the same reason, in spite of a high demand for training posts. Is there a deliberate policy to replace them with less skilled and cheaper staff? I suspect so.

Reportedly, 40% of new doctors plan to leave the NHS (19). Is the way to resolve the staffing crisis really to replace them with less-skilled and often overconfident substitutes – and eventually a two-tier NHS? Why not address instead the issues causing unhappiness? How about:

- better pay,
- fund training places to remove training bottlenecks,
- no tuition fees for those working for 5 years in the NHS,
- full funding of study leave,
- free car parking,
- good meals for all on-call staff,
- perhaps subsidised nurseries on-site
- …and somehow make people feel a valued member of the team?

We must not, of course, blame well-meaning and conscientious PAs, who have taken on the role

in good faith, for the effects of this policy on the working of the NHS or on UK medicine generally. But the current plan appears to be unfair to doctors, to PAs themselves, to the future and reputation of the NHS, and above all, to our patients.

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Physician Associates – A View from General Practice

'Verschlimmbesserung': an attempted improvement that will make things worse

There is a current plan to remedy the growing problem of shortage of doctors who are now overstressed and clearly unhappy: to delegate some of their tasks to much lesser-trained Physician Associates (PAs). Will this help overall? Or will it further fragment and alienate our already ailing healthcare?

The Government's plan to increase the role of PAs as frontline NHS Practitioners can seem, at first sight, both plausible and practical. So what do the authorities promise us? That offloading much of the doctors' work to faster-trained, so more numerous and lesser paid healthcarers (PAs) will both save money and free up doctors to concentrate better on their more skilled work. Quicker service for patients; gains in quality and safety.

But these plans will be undone by several oversights and mistaken assumptions. What are these? And what are their consequences?

1. The integrity of primary care triage?

The current trend and plan is that GP presentations will be increasingly triaged by either a PA or Care Navigator, thus deflecting initial diagnostic sorting away from doctors. Doctors would only then be engaged with cases deemed more complex or 'serious'.

The faulty assumption here is that initial patient consultations can be easily, speedily and accurately processed by staff who have much less depth and breadth of knowledge and experience than doctors. The underlying fiction here is that patients and their illnesses are almost always straightforward in identification, understanding, formulation and despatch. Yet experienced doctors know that such presentations are so often not straightforward: very serious conditions usually present, initially, in a way that seems commonplace and trivial. And serious-sounding symptoms can, paradoxically, be due to something very transient.

One of the central skills of primary care medical practice is to make rapid judgements which are very largely accurate in real-world situations amidst ambiguous or incomplete information, unclear communication, healthy variations and so forth. For example, complaints of abdominal or chest pain, backache, loss of appetite, headaches, tiredness and 'no-go' are very common in general practice: all may signify serious illness, yet most do not. How is the distinction made?

It used to be an adage that GPs protect patients from hospitals and hospitals from patients. In this way they both contained anxiety in patients and prevented overload in hospitals. There is much evidence that dual function was performed mostly very well in the era when GPs were able to provide personal continuity of care with patients who became known to them, and could thus skilfully navigate such vagaries and uncertainties. By contrast, delegation of these tasks to less skilled personnel – 111 and PAs, for example – who have far less medical knowledge and are unlikely to know the patient – are much more prone to incognisance and error.

2. Greater economies; safety assurance?

The lesser medical knowledge and lack of personal familiarity of such cost-cut, skill-pared staff therefore leads to inefficiencies of both clinical accuracy and time usage. To be 'safe' –

very understandably – they generally react by having much less tolerance of inevitable uncertainties, risks and anxiety. This accounts for the much higher rates of urgent or emergency referrals – ambulance callouts, emergency visits, A&E consultations – initiated by such algorithm-proceduralised non-doctors. A doctor who often knows a patient and can easily arrange prompt and repeated personal follow-up is then far more competent and able accurately to assess and monitor risk and contain anxiety. This prevents the otherwise runaway over-diagnosis and over-referral, with its likely unnecessary and sometimes risky treatments: these are expensive and unsustainable consequences for the NHS, all more likely when it renders its practitioners compliant to organisational protocols yet increasingly personally unfamiliar with their patients.

What is overlooked in this scheme of PA-expansion is an important truth: greater clinical knowledge combined with personal familiarity and understanding can enable the wisdom to 'cut to the chase', knowing with a high degree of accuracy what does and does not need to be pursued. From personal experience I saw repeatedly how less-knowledgeable yet highly conscientious Nurse Practitioners, for example, were often laboriously slow, being unable or forbidden to exercise this discernment and clinical editing. The results were consequently often cumbersomely and officiously pedantic: this usually reflected the nature of the system, not the practitioner.

Employing lower skilled healthcarers at the 'diagnostic front door' of general practice will not save money, resources, professional time or efficiently – it produces the opposite.

3. Saving doctors' skills for more complex problems?

For some years this axiom has justified the development of various roles: Care Navigators, Healthcare Assistants and Physician Associates … and, more traditionally, Practice Nurses and, later, Nurse Practitioners. We have seen why this often works poorly for diagnostic tasks, though for procedures often prescribed by doctors the policy is far more viable (see later).

But aside from the knotty problem of people in these roles always deciding what is and what is not a complex or serious presentation, there are other factors – rarely publicly discussed – that doom this project of radically budgeting problem-stratification.

In previous decades, when general practice was at a high-ebb of recruitment, morale, satisfaction, motivation – and thus stability – GPs mostly enjoyed the range and variety of problems brought to them, particularly when this occurred in a milieu that encouraged personal and social understanding through continuity of care. I remember greatly enjoying the almost random, unpredictable assortment of minor and major pathologies that I might encounter. 'Transient and trivial' complaints could usually be quickly identified, and patients artfully advised, clarified, reassured and sometimes prescribed for. Usually this was achieved with warmth, good humour and – importantly – a growth of familiarity, understanding and trust. These 'lesser consultations' were, importantly, good investments for future, sometimes more serious, encounters. Wholesome bonds had been established.

This is why 30 years ago GPs mostly wanted to be committed partners, not locums. And the loss of this varying work-profile is largely why few doctors now wish to commit beyond locum or 'portfolio' posts.

Even fewer GPs will want to do what is now planned for them: to be confined to dealing with 'complex problems' (as often decided by other staff) in patients whose lives, stories, families, neighbourhoods are unknown to them. Such doctoring becomes humanly and socially decontextualised and devitalised. Technical procedures increasingly replace the art, heart, soul and community of general practice, leaving a zombie force of remote, understaffed and

unhappily dissociated doctors.

This is where underpinning true family doctors with PAs leads. That is, surely, a long way from the vaunted design.

4. Confusion of roles

In earlier times the different roles of healthcarers were easier to discern and understand by patients: they could much more easily identify – say – nurses, doctors or physiotherapists. For people who are vulnerable, compromised or afraid, such clarity can be very reassuring and orientating, even more so if the practitioners become personally familiar.

Several decades of NHS reforms and initiatives have largely destroyed these comforting and anchoring features of function. Patients often now are very confused by the complex and rapidly rotating carousel of the many healthcarers attending to them: it is not just names they cannot remember, the roles are a blur, too. Doctor? Pharmacist? Nurse? Physiotherapist? Nurse Consultant?...

Already there are many reports of patients not comprehending that the PA they saw is not some kind of special doctor … or even a doctor at all.

5. The safe supervision of Physician Associates?

Official documents promise safety-assurance of PAs by designing-in readily accessed case supervision by senior doctors. How can this possibly work in general practice – probably the largest employer of PAs?

Most experienced GPs will acknowledge how, as already considered, they can perform diagnostic consultations much more accurately and rapidly than delegated non-doctors. So to set up a system where doctors spend much more of their time supervising non-doctors in their slower, less adroit consultations with patients that (probably) neither knows helps neither doctors or patients.

It is doubtful that many doctors would find this kind of managerial practice attractive: it is likely to add to the demoralised depopulation of the profession – a perverse outcome for the mooted buttressing role of PAs.

6. What, then, for PAs?

The term 'Physician Associate' is readily misleading and should be abolished: many patients think they are some kind of lesser-known doctor. If they are to be employed at all they should be designated 'Medical Assistant' (MAs) or similar and clearly badged.

Such MAs should not do primary diagnostic work for the reasons already described. They could, however, be helpful in performing procedures prescribed by the diagnosing doctors – eg vaccinations, venesections, biometric measurement and monitoring, dressings, device maintenance and advice, ear syringing, external suturing, lifestyle advice and support…

But then other questions arise: if nurses can be trained to do all this, why – at great expense – train and employ yet another cadre of health practitioners?

Why not, instead, understand and protect more fully the humanly complex work that doctors and nurses can do, and then invest in them more realistically?

Is that not a better way to a more efficient, thus economical, workforce of healthcarers who get great personal satisfaction from jobs they want to stay in?

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Many articles exploring similar themes are available on David Zigmond's Home Page:
http://tinyurl.com/bdhjjfzw

The Peter Fisher Essay Prize 2023: Winning and Runner-up Essays

This year's title, 'Is the 1948 model of access to free healthcare still appropriate today?', drew 45 entries, the highest so far. The winner and runner-up stood out for their clarity of argument and style.

Winner: Mark Tan*

1948

"Death for me would be a glorious deliverance rather than that I should be a helpless witness of the destruction of India, Hinduism, Sikhism and Islam"
– Mahatma Gandhi

1948 began with death. It began, in January, with the assassination of the Indian nationalist, pacifist and leader Mahatma Gandhi. His quote, reproduced above, may be equally applicable in 2023. Helpless witnesses, not of India, nor of major religions. Instead, we seem to be witnessing the destruction of the UK's National Health Service (NHS).

As it stands, the waiting list for NHS scans and treatments exceeds 7 million patients (1, 2). This record-breaking number is almost double of pre-pandemic figures and demonstrate a far steeper increase when compared to the period between 2008 and 2020. The median waiting time today is 14.5 weeks, with over 300,000 patients waiting over a year. Emergency care is equally impacted. More patients are waiting longer in Accident and Emergency (A&E). Ambulance handover delays are at a record high, which further impact the ability of crews to attend callouts and other emergencies. These shocking statistics raise the question about appropriateness of the NHS' model of free healthcare. But the tragedy is only just unfolding.

A privatised system?

"Surely", critics argue, "we should adopt a more privatised system". It would increase the profitability of healthcare, reduce the strain on waiting lists, and provide options for patients, thereby increasing overall satisfaction. The United States of America's (USA's) National Bureau for Economic Research published detailed analyses on the effects of hospital privatisation from 2000-2018 (3). It confirmed several of the above assumptions. There has indeed been significant increase in revenue per patient, accompanying a decline in hospital employment, and a reduction in the number of patients admitted and seen. These result in hospitals making an overall modest surplus – a more "sustainable" economic model. But the report also highlighted a worrying trend of widening health inequalities reflected in a preference towards more "lucrative" patients and a decrease in access and utilisation of Medicaid

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(USA's governmental health insurance for those with low-income and disabilities).

Across the Atlantic on our British Isles, equally alarming findings were highlighted in a British Medical Association (BMA) report from 2022 (4). While the argument about the viability of the NHS' original model continues, Independent Sector Providers already occupy a significant proportion of healthcare provision in the UK (albeit still far less than many other European countries)(5). Almost £14 billion were spent on such providers in 2020-2021, which equates to 5% of all elective NHS activity. These arrangements have been put into place in attempts to tackle the waiting lists discussed at the start of this essay. But for these, the independent providers receive NHS funds – an organisation that still pursues universal access to healthcare as its core value. Therefore, rather than the "modest surplus" experienced by the hospitals in the USA, the NHS continues to lose money from elective work to Independent Sector Providers, while further reducing its ability to recover costs from emergency healthcare provision and provide good quality care to future patients.

The rise and fall of inequalities in health

When the NHS was officially launched on 5th July 1948, at Park Hospital (also known as Trafford General Hospital today), health secretary Aneurin Bevan announced that healthcare would be available to all free at point of delivery and that it would be financed through general taxation (6). It was no mistake that the NHS was launched in the North of England. Mortality rates from this area were the highest in the country in the 1950s, ranging from 9% higher than the average population in Huddersfield, 18% higher in Manchester and Liverpool, and up to 20% in Oldham and Salford (7). But these inequalities decreased in the decades following the introduction of the NHS. The 1960s and 1970s saw a narrowing of standardised mortality rates between the areas with highest and lowest mortality (7, 8). The NHS was a hopeful intermezzo to the drama of 1948. From the melancholic death of Gandhi and on the backdrop of the tragedies of war, Bevan's tune was perhaps UK's "minor fall, major lift" (9).

One could argue that 1948 was a far simpler time than the world we are living in today. After all, health inequalities have widened since the late 1970s. By the 1990s, they had become far worse than the inequalities noticed after the war. People living in the worst areas were twice as likely to die before the age of 65 (7). Today, these inequalities continue to disproportionately affect people living in the North (10), and in rural and coastal regions (11). Exacerbated by the isolation during the COVID19 pandemic, the deterioration of living conditions, the economic crisis, the rising cost of living and the repercussions of Brexit, the UK today is an outlier amongst other high income countries and has some of the lowest life expectancy rates in Western Europe (12).

Not born at a simpler time

1948 was not "far simpler". The world had just emerged from two world wars. The UK, even though less badly damaged than some other European countries, nevertheless sustained significant destruction of buildings and cities because of numerous air raids. Between the ten towns in the UK that experienced the most air raids, over 30,000 houses were destroyed across in excess of 2000 acres of land (13). The resources poured into war forced the UK into staggering international debt, amounting to over 40% of its national income in 1945 (14) and rising to an eye-watering 200% of its Gross Domestic Product in the 1950s (15). While UK pressed on with rebuilding vital infrastructure and improving living conditions, Bevan recognised the power of healthcare to ameliorate existing socioeconomic inequalities. The NHS was not born out of a simpler time. It was part of a host of interventions

to repair the fabric of a highly complex, cash-strapped, war-torn society.

Our forerunners were acutely aware of this. In 1956, Less than 10 years after the launch of the NHS, a report by the Committee of Enquiry into the Cost of the NHS raised several issues (6). These included changing trends in health and illness, the need for General Practitioners (GPs) and hospitals to work together, concerns around elderly care, and economic constraints. That these problems, raised almost 70 years ago, are uncannily similar to those which brought about the push towards integrated care detailed in the Health and Care Act 2022 (16), suggests an environment today perhaps not too dissimilar to post-war UK.

1948 was not a simpler time, but the model of universal and/or free access to healthcare continues to be vital for reducing existing inequalities in society. Universal access has been successfully implemented across the world, with strong examples from Thailand, Brazil and Mexico (17). The international buy-in is well demonstrated by several iterative campaigns by both the World Health Organisation and the United Nations. From the Declaration of Alma Ata (18), through the Millennium and Sustainable Development Goals (19, 20), to the more recent Triple Billion Targets (21), universal healthcare sits firmly as the only viable model that reduces health inequalities. These have emerged as sequels to what can only be described as a deeply hopeful cadence to 1948.

In December 1948, the United Nations' Declaration of Human Rights was published (22). The entire statement is reproduced below for a full appreciation,

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Article 25 firmly acknowledges the social and

wider determinants of health introduced earlier (22). It recognises the intricate interplay between formal healthcare (or medical care), social care, and wider factors. We do well to remember that formal healthcare plays only a small part in the "right to…health". The Black report of 1982 on health inequalities in UK found no role for medical care in the reduction of health inequalities (23). This finding was echoed in the subsequent Acheson report in 1998, reporting only minor contributions of formal healthcare for tackling health inequalities (24). These continue to be supported by contemporary reports such as the *Marmot Review 10 Years On* (25), the *Vision for Population Health* by the King's Fund (26), and even the 2023 report on *Realistic Medicine* by NHS Scotland (27). They do not change their tune on universal access. Instead, they widen the lens of health inequalities to what the UN acknowledged in 1948. That is, while universal access to healthcare may help to ameliorate inequalities, investments must also be made elsewhere to sustain improvements. Areas include child education, women's rights, critical infrastructure, employment opportunities, and many others (27-30). Such factors were also foci of post-war UK and should take a more prominent role for societal progress today.

These issues are somewhat outside of the traditional scope of healthcare. So, what else can healthcare workers do to alleviate the immense pressure on the system? Delving further into the statistics presented at the start of the essay, up to 40-60% of lifetime health expenditure is

spent in the last year of life (31, 32), usually with little improvement to quality of life (27). Ethnic minorities continue to suffer poorer experiences at the end-of-life (33). Most people desire to die at home, but up to 60% end up dying in hospitals (34). We can begin to address these issues within our systems.

NHS Scotland's *Realistic Medicine* report reframes the way we approach healthcare. Its "value-based health and care" prioritises shared decision making, which benefits individual patients and reduces costs (27). The use of words "health" and "care" shift the focus away from disease management and widens the lens to include social care and social determinants of health. The report also highlights the need to consider the effects of modern healthcare on planetary health, something the Lancet Commission on Climate Change frames as an independent determinant of health that disproportionately affects poorer populations (35). The chair of the UK Health Alliance on Climate Change advances this by proposing a shift of power away from professionals and institutions to people and communities, and an equivalent shift of balance towards community health (36). The related Lancet Commission into the Value of Death highlighted the need for society to regain its understanding of death (37). It describes several "death systems" around the world and helps clinicians and academics reframe the unrelenting pursuit of longevity. Similarly, books such as Kathryn Mannix's With the End in Mind help general readers better understand the normal dying process and thereby fear it less (38). By coming to grips with death and dying, we can learn to care for the whole patient and reduce the overall suffering caused by excessive investigations and interventions. These are but some examples of the change in culture required to reduce futile interventions, improve quality of life, address wider determinants of health, and of course, maintain the sustainability of healthcare.

The curtain has not closed on the NHS. It is not a show for paying audiences only, and its finale has not yet been written. It has and should continue to operate a model that reduces health inequalities. The system should strengthen collaboration with non-healthcare organisations to increase its resilience and better serve our increasingly complex population (39, 40). We should continue to build on existing patient and public involvement in research, which prioritises user-centred designs. Finally, by focusing on realistic medicine and humanising the many services we offer, both healthcare workers and patients can take part in the participatory theatre that is the NHS. In the first instance though, let's stop confusing health and healthcare. Considering that, allow your imagination to paraphrase this final quote:

> **"I like your Christ, I do not like your Christians. Your Christians are so unlike your Christ."**
>
> ***– Mahatma Gandhi***

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Runner-up: Peter McManus*

As the NHS marks 75 years, its doctors are on strike, waiting lists are overrun, and burnout is at an all-time high (1).

Yet it continues to enjoy near religious levels of public support and affection. This popularity can be harnessed to argue for an NHS that works better and delivers more for the population. Currently, the NHS is seemingly unworkable, the current model of care is unaffordable, and the funding model is unsustainable. However, this essay will argue that the prescription for the NHS' current malaise is not to row back on access to care but rather to expand our understanding of what the health system can and should provide for the population. Beginning with the strong 21st century case for a Beveridge model of care, it will move on to consider current challenges and make the case to expand the offering of publicly funded care. This is an aspiration for the wider health system to become one that tackles not just disease, but the four other Giants identified by Beveridge.

The current healthcare model in the United Kingdom sees the government provide universal health coverage to all citizens through the National Health Service and pays for this by general taxation. This single payer, single provider system ensures healthcare is generally free at the point of use. In evaluating the model's effectiveness, we must judge it against Beveridge's aim for it to succeed in providing financial protection and equity of care (2).

Firstly, the current model is arguably most effective at achieving a strong breadth and depth of Universal Health Coverage. There are next to no patient charges, and it stands out from nearly any other health system in the world in terms of

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coverage with minimal requirements whilst private spending remains low (3). The depth of coverage is impressive from primary to secondary care, and from emergency care to chronic diseases.

Secondly, this system is efficient and equitable. General taxation provides an efficient means of collecting funds whereas insurance-based systems require considerably more administrative burdens with significant costs associated with collecting payment and administering them. It is generally progressive with those at the top end of the income scale paying the most in. By having universal benefits, there can be no link to employment or other social status ensuring hard to reach groups are always included in the healthcare system (4). A single payer also provides the government with collective bargaining power. Having a single payer allows negotiation of the best price with pharmaceutical companies and best value for money for patients. The National Institute of Health and Care Excellence (NICE) assesses new medicines against cost-effectiveness thresholds ensuring that expensive new treatments have a strong evidence base (3).

Therefore, the charge that the NHS is "unaffordable" is best countered by demonstrating that its public nature is what makes good value for money compared to alternatives. For example, UK health expenditure per capita in 2019 was 4,500 USD compared to the USA's 10,948 USD per capita, putting the UK around the OECD average. On the contrary, UK health outcomes including life expectancy, infant mortality and maternal mortality continue to outperform the USA (5). Finally, the unitary system ensures high quality care for all, with a national approach to evidence based guidelines developed by NICE and strict clinical governance standards that should be implemented universally (3).

Considering alternative systems provides further support for Beveridge. The US system dominated by private insurance leaves it languishing in international league tables of health outcomes: life expectancy at birth in the USA lags behind OECD competitors and is comparable to the most deprived areas of England. Furthermore, the gap is most pronounced at lower social gradients (6). Social insurance systems rely increasingly on taxation based top-ups (blurring the distinction from a taxpayer-funded model) and multiple insurers can increase administrative costs and reduce efficiency (7). Overall, there is a convincing argument that a general taxation funded free at the point of use health system creates the best healthcare system for a given number of resources.

However, just how much resources to allocate to the NHS is fundamentally a political choice. But there can be no doubt that greater investment can improve health outcomes, and as envisaged by Beveridge have positive knock-on impacts for the economy and wider society (8).

This is evidenced by the early noughties period of high investment in the NHS being associated with improved outcomes in healthcare in terms of satisfaction. NHS satisfaction peaked in 2010 at 70% before a consistent reduction correlating with reduced year on year budget increases at this time (9). A government seeking to allocate more resources to the NHS in 2023 should start with addressing key crises like waiting lists and workforce retention (10). This essential, acute, initial investment should be followed by an investment in the NHS' future. Digital and infrastructure improvements to create an NHS fit for the 21st century, rethinking models of care such as increased ambulation, home monitoring and virtual will be key to the future sustainability of the NHS. Demand side pressures faced by the NHS also go hand in hand with social care provision, arguably a victim of the NHS' success. The ageing population with multiple comorbidities is driving to a large extent the pressures on the system previously discussed (11). There is undoubtedly a link between an ineffective social care system and Emergency Departments full of frailty and chronic diseases (12). Investment in a fair, Beveridge style settlement on social care, which should be brought fully into the NHS tent, will be key to securing the current model's future.

However, social care remains the great social policy issue that has flummoxed successive governments and this essay does not pretend to offer any easy solutions. Instead, the next paragraphs will focus on how we should expand the offering of the 1948 model and its perceived purpose as simply to treat and manage illness.

The first step up the ladder is to upscale secondary prevention. The benefits of secondary prevention can be widespread and impact on multiple conditions. Initiatives to promote "Making Every Contact Count" (13) should be accelerated, cognisant of time pressures on clinicians in the current stretched environment. A call from the chief medical officers in the *BMJ* to make secondary prevention the purview of all clinicians (14) is therefore welcome but must be matched by addressing investment and workforce factors discussed above. However, an NHS future where every consultation has the time and space to address secondary prevention like good blood pressure control, weight loss and exercise promotion is a healthy aspiration.

Crucially, if we are to fulfil Beveridge's goal of making health gains more equitable, we must improve uptake for interventions like statins, anti-hypertensives and screening programmes across the social gradient. For example, people from lower socioeconomic backgrounds are more likely to smoke and less likely to quit (15) whilst the healthcare costs associated with this inequality has been estimated at £4.8 billion (16).

We should therefore draw inspiration from COVID-19 era initiatives to encourage uptake of vaccinations in hard-to-reach groups. These lessons can be adopted to ensure secondary prevention uptake is increased across the social gradient (14). The untapped potential of advances in secondary prevention to improve healthcare outcomes and make savings for the public purse highlights once again the benefits of retaining a free at the point of use health service. Preventative measures are a key opportunity to prevent costly complications and further healthcare encounters. This incentive exists because it is the public purse that will ultimately pay for downstream costs; the incentives are not necessarily the same in a different healthcare model. For example, providing financial incentives in primary care through the Quality Outcomes Framework to proactively manage chronic disease and vaccinations is best achieved in the single payer, single provider system (3).

Next, we should see Public Health as part of the health system and determinants as part of a wider health system. We should not deliver healthcare in isolation from the causes of ill health and should aspire to an NHS that sees addressing all five of Beveridge's Giants as part of its responsibility. Unfortunately, whilst great strides have been made in tackling social determinants of health all of Beveridge's Giants still contribute significantly to health inequalities today: squalor (homelessness), idleness (poor working conditions), ignorance (education) and want (poverty and current cost-of-living crisis)(8). We should therefore promote and develop initiatives addressing these Giants. For example, ensuring good quality healthcare for homeless people; "Pathway" is an integrated approach to improving healthcare for homeless people, using hospital admission as a key moment for ensuring both medical and social care is delivered (17). Other initiatives can target healthy eating or in the case of "Live Well" coaches the interplay between health and employment (18). NHS trusts can also be role models in tackling social determinants of health. One example is the East London Foundation Trust which aspires to become the first "Marmott trust", by committing itself to the 8 principles identified in the Marmott report. Initiatives include ensuring it is a living wage employer, promoting access to training and employment for young people and increasing social prescribing (19). These ideas may seem to overstretch the boundaries of what the healthcare model should provide. However, healthcare is a small contributor to population health. Beveridge himself envisaged the NHS as a service to "diminish disease by prevention and cure" (8). However,

viewing these issues through the prism of health and the putative savings for healthcare has the potential to focus minds to deliver social change. A Beveridge model health system therefore provides significant advantages to taking this public health based approach: publicly delivered healthcare ensures the needs of the population are foremost as opposed to profits.

To go one rung further would be for the NHS to tackle head on the commercial determinants of health. Four industries are now responsible for a third of global deaths (20) and integrating a response to the commercial determinants of health into the healthcare system is therefore common sense. At the government level the introduction of Pigouvian taxes and regulating advertising to tackle the harmful product industries should be promoted, but at the level of healthcare organisations action can still be taken. NHS trusts should be educating patients and staff on commercial determinants of health and at an organisational level the NHS should divest from fossil fuels and reduce links to harmful product industries (21). The "Delivering a Net Zero National Health Service" report (22) in October 2020 is a welcome start on air pollution but we must go further and faster with air pollution responsible for 36,000 UK deaths a year (23). It is crucial to highlight the distinctive advantages a single payer and provider affords to these issues. If the same conglomerates that controlled these industries also had investments in our hospitals, it would be even harder to address commercial determinants of health. Ultimately, a publicly owned health service is more accountable to the public than one with multiple private providers and can speak out with one voice against the commercial determinants of health.

Overall, the depth of services and benefits the current model can provide as well as an unrivalled breadth of coverage mean it keeps its place as a system to be rivalled. However, we need not only access to free healthcare for all, but also a health system for all, and one that sees the benefits distributed in a proportionately universal way.

Crucially, a prevention-based system which aims to improve outcomes in the long term is not as easily achieved in insurance based/ for-profit systems. There would undoubtedly be resistance in some quarters to the expansion of the health service playing field. However, the public support for the institution of the NHS and the potential gains to health outcomes and society give hope for the aspiration to a health system that comprehensively addresses Beveridge's five Giants. Ultimately the conclusion is that the 1948 model is still appropriate but there is still unfinished business.

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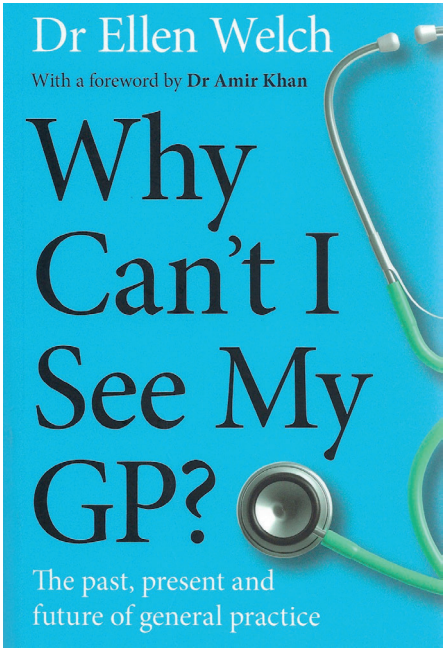
Book Review

Why Can't I see My GP? The past, present and future of general pracitce
(£16.99, Calon, hardback and eBook)
Ellen Welch, 2024, 167pp.



This book is ambitious in scope, as the sub-title indicates. It needs to be. Because the book's title must surely be one of the most pertinent and vexed questions millions of people are asking of our NHS – and time to address it is as short as current political explanation for the causes appears to be.

Ellen starts the book with an all too familiar theme: 'I tried to contact my own GP last week. I counted 19 redials and 20 minutes on hold before I was able to speak to a receptionist ... only to be told that all the appointments for the day had gone'. Telling words from someone who works as a GP herself, and has co-chaired Doctors' Association UK.

There are multiple contributors offering first-hand accounts, which lends the book added depth. Each chapter features contributions from several writers. This may have risked distraction or undermined coherence, but I found it lent the book an added credibility and appeal, with people with direct, relevant and often poignant personal experience as practising doctors and other 'experts'. A gamble perhaps, but it works. You get the overarching points all too well. They should leave you angry at the fundamental stupidity of dismantling the NHS in the name of ideology, which is what is happening.

The opening chapter starts logically enough with a brief history of general practice. Nye Bevan is featured of course, but we also read of life before the NHS, the influence of Word War II and the dawn of the service in 1948. Roy Lilley's tale of how he first experienced the then-new NHS, as a sick child, nests comfortably in the description of the early NHS. Milestones in how general practice were passed through the 1960s, seventies, eighties nineties and noughties are described in short but informative sections, bringing us up to now and the issue of commissioning and privatisation, including an account by fellow DFNHS member and GP, David Wrigley.

'How the role has changed' is covered in Chapter2, with accounts from long-serving GPs describing how things have shifted – and not for the better; 'We remain at the mercy of the state and it's high time for GPs and patients to voice their concerns together' is the end phrase, summing up the sentiment of a call for action running through the book.

Chapter 3 looks to GPs and the pandemic, with personal accounts drawing attention both to the obvious massive changes in pace and demand placed on general practice, but also less well known aspects

such as the growing difference in public perception between those working in hospitals, and those in general practice, with alarming descriptions of rising levels of abuse towards GPs and the personal toll of being a GP during the pandemic.

Chapter 4, posing the question of what a GP does, starts with some robust statistics, showing just how many GPs we are currently short of amongst other key facts, before considering the exhausting changes in working hours, and some common fears, notably of litigation and of the regulators. The personal accounts of working GPs act as a counterpoint to these broad statistics while spelling out only too clearly what they mean to a GP. I found GP Lizzie Toberty's critique of current government 'policy' refreshing in this context:

'We are human beings and we do have a limit. That is why it is disappointing to see soundbites, rather than well-thought-out policy, and targets rather than resources...it represents 'on-the-hoof' thinking by a government that does not have any idea what the actual causes of the access problems are'. Bravo.

Chapter 5 asks the question often posed, then wrongly interpreted, by opponents to the NHS: does it work better elsewhere? International comparisons are always tricky, not least because comparing like with like is nearly always burdened with confounding factors and different social circumstances, but the comparisons this chapter draws, and the extensive, detailed and convincing personal accounts of life as a GP in different countries (and back in the UK) make this argument a compelling one – general practice does remarkably well considering the resources this country spends on it, but those working the job are increasingly put under intolerable stresses and pressures to try to keep it that way, let alone make any headway. Small wonder so many colleagues are abandoning the UK and taking their highly skilled and expensively acquired expertise to other shores. Which must surely count as one of the most stupid and self-harming failures any government could have levelled at it.

This leads naturally to the last chapter, considering the future of general practice. "There is genuine discontent with primary care right now, both from patients ... and the professionals working within a failing system' opens the narrative, again with uncompromising honesty that is a characteristic of this book. The steady decline of continuity of care and the tendency for ever-larger practices are pointed to, and the growing trend to appoint allied health care professionals as a solution to the crisis in general practice (a point covered elsewhere in this newsletter) is covered sensitively and fairly, before leading into what I found to be this book's greatest attraction, a rapid-fire section covering 'solutions to the GP crisis in a nutshell', for government, for GPs and for the public. I can only hope that any incoming government heeds this. On a personal level, I found the short section on 'media messaging' one I was all too familiar with but from the viewpoint of patients and their GPs.

And that is the strength of this powerful book: there is no massive detail on performance figures, or in-depth discussion of the failings of government policy. We can find those elsewhere. But, as we take the fight for our NHS to the public over the coming months, this book's personal accounts and insights lend colour and conviction to the overwhelming case to keep general practice and our NHS while we still can.

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