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NEWSLETTER

A Fork in The Road? What will Darzi mean?

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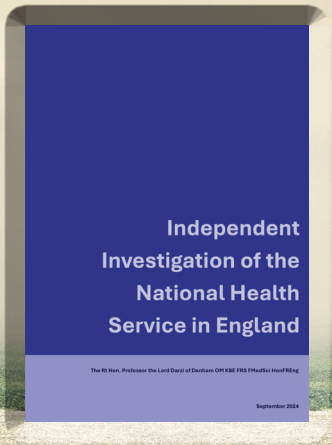

JULY – SEPTEMBER 2024

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A Fork in the Road?

Whether you're a plumber, a motor mechanic, or a physician, an accurate diagnosis is essential before you embark on a course of treatment.

The remit given by the government to Lord Ara Darzi was pretty daunting in its scope – to assess the state of the NHS in England, including patients' access to services, the quality of care they eventually receive and the overall performance of the health system. He also needed to express his findings in a report that was both concise, and understandable enough for people who are not experts in the healthcare system – to allow the public to understand why their experience of care in the NHS too often fails to meet their expectation, and to allow policy makers to develop a strategy to restore the people's confidence in the service, as recently as 2012. His terms of reference were explicitly to provide a diagnosis of the current situation, and not to prescribe the treatment, which is the responsibility of the elected government, which needs to balance the competing demands for resources across all their areas of responsibility, many of which also have a bearing on the health of the population.

Many of the findings in this report will come as little surprise to members of DFNHS, but it is refreshing to read an authoritative report so obviously written by somebody who has had extensive experience in clinical medicine in the NHS, but who also has a deep knowledge of the political environment.

His terms of reference did not extend to public health or social care, but the report inevitably makes reference to both, as they have such an impact on the health of the nation, the demands placed on the NHS and the efficiency with which the NHS can use its reduced and internationally low hospital bed capacity. When are we going to see an attempt made to analyse the state of social care, which is even more 'broken' than the NHS, with a view to establishing some form of the promised National Care Service? We can't afford to wait another 10 years.

We need health in all policies

The report begins with a stark reminder that the health of the nation has deteriorated since 2010 with a fall in healthy life expectancy, leading to a greater proportion of life being spent in ill health, and the consequential increase in demand for NHS services. As has been emphasised so many times before, "The underlying causes are based on income, education, work, housing, relationships, families and our natural and physical environment" and the increasing impact of socio-economic inequalities is stark. Most of these factors lie outside the control of the NHS: as Lord Nigel Crisp, former Chief Executive of the NHS titled his book, "Health is made at home, hospitals are for repairs", but their impact is felt acutely by the NHS.

Chapter 7 does state that "there is extraordinary power in getting public health right," but also that "It takes the political will and the willingness to invest to achieve it." It points out that the responsibility for public health was devolved to local authorities as part of the massive reorganisation under the Conservative-Liberal Democrat Coalition Government, and has been followed by a cut to the public health grant that funds this work by more than a quarter between 2015/16 and 2023/24 and it is not targeted towards the most deprived communities in the country (1). It contrasts the effective impact of legislation on reducing harm from smoking, and the compulsory wearing of car seatbelts, with the lack of action on regulation of the food and alcohol industries. Inequalities in the access to and delivery of healthcare to particular

groups in society are discussed, including those who live in poverty, the homeless, people with learning disabilities and disparities by ethnicity, but there is no mention of the barriers to healthcare experienced by migrants as an intentional result of government policies to create a 'hostile environment' for people seeking refuge from war and persecution, while they are caught up in another 'broken' system of public administration.

The underlying business model of the NHS is still sound

Lord Darzi states that, "Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay." Most members of DFNHS would probably add, "Funded by a progressive system of taxation, publicly provided and publicly accountable", but hopefully he will have done enough to silence the calls for an insurance-based system of some other model, at least for a while. The NHS has proved a resilient model, which has shown itself able to adapt to meet changes in demand over more than 75 years, with varying success, but has overall served this nation well for much of that time. Systematic international comparisons, such as those of The Commonwealth Fund, have consistently ranked it as the best performing in the world over many years, in terms of care process and healthcare outcomes; access and equity; and administrative efficiency and spending – at least until 2014. The most recent report shows that it still performs relatively well in some respects, but that delays to specialist care and the quality of care received in primary care have led to overall deterioration in our rating (2). There is no good evidence that switching to any of the systems used in another country would reduce the overall cost of healthcare to the nation, or be 'more affordable'.

Why has the NHS been so badly damaged?

So if the basic business model is still sound, and has been capable of delivering high-quality, accessible and equitable care until relatively recently, at a cost that is less than that of comparable countries, what does Lord Darzi believe has gone wrong? He makes no bones about the damage caused by prolonged underfunding as a result of austerity policies pursued by successive governments since the global financial crisis of 2008/9. Any business that fails to invest in up-to-date facilities, equipment and the skills of its workforce soon pays the price in falling productivity, which is being seen nationally, across our wider economy. This has been very pertinent in the NHS, with very low capital investment and capital budgets repeatedly raided to fill gaps in the unrealistically low budgets allocated for maintaining day-to-day services. This has been compounded by the organisational chaos resulting from the Health and Social Care Act 2012. COVID-19 made a bad situation worse, causing more profound and lasting disruption to core healthcare, at least in part due to official policies delaying routine care more than in any comparable country.

What are the main priorities?

Out of hospital care

As a local authority Councillor, in my role of scrutinising the performance of health and social care services across the West Yorkshire Integrated Care System, I am acutely aware of the problems that so many residents experience in accessing primary care, of the experience once they have received an appointment, the difficulties in navigating their way between different elements of the local health service and the absence of continuity of care. In Chapter 5, the report explores some of the reasons that primary care is deteriorating both in meeting the expectations

of patients, but also as an attractive career, with unsustainable workloads; working from inadequate and over-priced buildings that are not fit for their current purpose; persistent recruitment problems for medical and nursing colleagues; a contract that does not support or reward the delivery of good care and a decreasing budget to support the needs of an ageing and less healthy population.

Few of us would deny that primary care, community care and mental health services need to be prioritised to allow them to rebuild the capacity needed to fulfil their potential for responsive and personalised care, in particular the care of people with long-term conditions, of families with young children and end-of-life care. The Conclusion section of the report suggests that this needs to be accompanied by the hardwiring of financial flows, linked to a better flow of data describing the work that is carried out and its impact.The case is made that revitalised community and primary health services would reduce demand on acute hospitals and is more cost-effective, but it has not been clearly stated that the benefit would not be felt immediately and there would need to be a significant period of funding dual running of continuing hospital work until the capacity has built up in the community. Simply transferring money from hospital care to community care in one go will cause chaos for patients. The same is true of the strengthening of public health services: that should be seen as a long-term investment, with the benefits in reduction of future demand on health services over a matter of decades. Funding for current treatments cannot be withdrawn until the benefits of stronger public health services and policies have begun to work their way through.

The strengthening of neighbourhood teams, bringing together primary, community and mental health workers, within the NHS, to deliver holistic care in, or as close as possible to people's homes would also seem to make sense, particularly if it can be linked up with social care services, where there are overlapping needs. The point has been made strongly that there needs to be a particular

emphasis on building up the depleted workforce of Health Visitors, District Nurses and Learning Disability Nurses. Surely there is also scope for considerable strengthening of school nursing services, to support the mental and physical needs at this crucial time of life and encourage healthy patterns of behaviour which can deliver happy, healthy adults in due course.

Give us the tools for the job

A significant section of the report, Chapter 5, is devoted to exploring areas in which improvements in productivity might be achieved in different healthcare settings. It does not suggest that increased productivity simply requires the hamsters to run faster round the wheel, but neither does it suggest that simply increasing the number of staff will automatically help the flow of patients through emergency departments and acute hospitals. Of course, there are likely to be specific situations where the lack of a key member of staff might be hampering the work of a whole team, such as insufficient radiographers to operate expensive MRI scanners to their full capacity. I certainly noticed a massive impact from the reduction in Consultants' Secretaries when they were replaced by typing pools, in terms of patient administrative tasks and clerical tasks that then had to be carried out by the Consultant, when they could be using that time far more productively. More importantly, Secretaries embedded in a department performed an invaluable, knowledgeable point of contact for

patients who were experiencing problems, or who just needed help in navigating arcane NHS services. It is also possible that financial strictures or the lack of ability to recruit skilled staff might be leading to employment of staff who lack the skills to perform all the duties required of their role: it is difficult to know from the data provided.

Darzi does suggest that lack of capital expenditure in the facilities and equipment with which staff are working means that they cannot work to their full potential. The excessive reductions that have taken place in the number of hospital beds and inadequate numbers of intensive care beds has led to wasted time in managing those beds, the cancellation of scheduled operating sessions, with valuable surgical teams left to twiddle their thumbs and distressed patients left with the uncertainty of when they will actually receive the treatment they need. And too many of that reduced bed base, around 1 in 8 beds, are occupied by people whose care would be more appropriate in a different setting, such as their own home or a nursing or residential home, but those places do not exist, or there is insufficient capacity in community health or social care teams to deliver the care they need.

He makes the point that "Failing productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work." There is little that is more dispiriting than contributing to the managed decline of a service. Lord Darzi emphasises the need to re-engage staff in building up the service, in harnessing their passion for their work and, particularly dealing with the organisational culture that has been too prevalent in the NHS of covering up problems and pursuing retaliatory action against clinicians who dare to raise concerns. Clinicians are required to abide by a duty of candour – that should be required of all managerial staff at all levels of the NHS organisation. Patients, as well, can struggle to have their voices heard, their experiences acknowledged and complaints dealt with promptly and thoroughly. There has been some discussion amongst members of DFNHS of the profound benefits that could be unlocked by a focus on increasing democracy in the workplace within the NHS, and including the public that we should be serving as partners in the democratic workplace. That would seem to chime with Lord Darzi's suggestion. Is it an idea whose time has come?

What Darzi doesn't say

There are several factors that have contributed to the financial and productivity woes of today's NHS which have received little mention in the report. What significance, if any, should we attribute to this silence?

Private sector: help or hindrance?

The first is the systematic opening up of the NHS to private providers, initially through the introduction of Independent Sector Treatment Centres (ISTCs), beginning in 2003, under Health Secretary Alan Milburn, who is still on the scene, acting in an advisory capacity to the current Secretary of State. Originally these were set up to provide increased capacity for routine elective surgery for NHS patients, ostensibly to avoid the compromises that most hospitals had to make in balancing the provision of emergency and elective care, with its fluctuating demand; to increase the quality of care in the NHS through competition; and to offer 'choice' of provider to patients, which was becoming a key tenet of various public services, particularly education, health and social care (3).

From their early days it became apparent that this model did not significantly increase NHS capacity and was not cost-effective. It sucked public money away from the long-term expansion of much-needed capacity in NHS facilities, but it did throw a lifeline to an 'independent' sector which was beginning to experience the reduction of demand as the NHS started to benefit from increasing public investment. We saw a similar level of life-support extended to private hospitals during the pandemic, at great cost to the public purse, to

keep them afloat until they could reap the benefits of the huge backlog that had developed in elective care (4). ISTCs blurred the boundaries between private and public service in the perception of the public: "people don't care which organisation is actually providing their care, as long as it is free at the point of use and it is of high quality" ran the argument, with the NHS potentially reduced to a funding stream and a logo. Many DFNHS members will recognise the huge differences in ethos, in terms of conflicts of interest between what is good for the patient, what is good for the nation, and what is good for the business, that the introduction of the profit motive can drive. It also provided a stepping stone to the much greater involvement of the for-profit sector facilitated by the hugely disruptive Health and Social Care Act of 2012, developed by the Conservative – Liberal Democrat coalition, which has been roundly and rightly condemned by Lord Darzi as one of the principal factors in reducing the efficiency of the NHS.

The concept of the ISTC persists, currently fuelled by the post-pandemic Elective Recovery Plan, a renewed interest in 'surgical hubs' and community diagnostic facilities and in the outsourcing of more than half of cataract surgery to high volume, for-profit providers which are undermining the ability of NHS ophthalmology services to provide care for everything that isn't a cataract, including many potentially blinding conditions, as described in a recent report from the Centre for Health and the Public Interest (5).

Should it seem strange that Lord Darzi has not explored the continuing, and potentially expanding, role of the involvement of the for-profit sector in clinical service provision in his analysis of the state of the NHS today? Although Chapter 10 of the report condemns Lansley's Folly, it does so mainly from the point of view of the huge disruption to NHS managerial, regulatory and administrative structures, with the wasted costs, time and distraction. There is little reference to the disruption to clinical services and the care delivered

to patients in the turmoil of being required to put every service out to tender. The break-up of established clinical teams as whole groups of staff and patients were transferred between provider organisations. The further disruption when contractors found they could not make enough profit and handed back their contracts to the NHS at short notice.

I have been around long enough to remember that the NHS worked best as a seamless service, in which patients could be referred between hospitals, between departments and between clinicians with minimal administrative or financial barriers, dependent only on their emerging clinical needs. By contrast, a service that is based on a complex web of contracts, defining where a particular provider's responsibilities begin and end, rather than by the professional capabilities of the staff, is always going to lead to increased administrative burdens and cracks through which patients too often can fall. This seems to be a particular problem in many psychiatric services, with many patients being denied care, because they don't meet the admission criteria for a particular service.

There is some discussion of the benefits of linking funding to the volume of activity delivered, as persists with elective care, and which is felt to be a valuable incentive to improving performance, as well as being more attractive to the 'independent' sector. The distinction is drawn in Chapter 5 between the 'reward for activity' that governs the finances of the hospital sector (public and private) and the 'reward of effort' that is applied to most

of the rest of the health service, particularly primary and community care and mental health services. This is felt to be one of the reasons that an increasing proportion of the limited healthcare budget has been directed to the acute hospital sector, where activity is easier to measure and is directly linked to income flows. In contrast, there has been little attempt to measure primary, community and mental health services, to link that activity to funding streams. This has been compounded by the exclusion of these services from the constitutional standards, such as waiting times, that have been applied to care in acute hospitals. If we are going to achieve the oft-promised shift towards out of hospital care, these systemic distortions need to be addressed.

Training is integral to the NHS

One of the most serious casualties of the fragmentation of the NHS that has arisen as a result of legislative upheavals to try and create a market in public healthcare is the training of the future workforce and this seems to have received little attention in Lord Darzi's analysis. Through most of my working life, the various elements of the NHS accepted that they all had a part to play in ensuring a sustainable workforce. Doctors and nurses in training made an important contribution to service provision and their professional development was supported in the full acknowledgment that they would probably end up working in a completely different part of the NHS. Organisations which focus on fulfilling their contractual obligations have very little interest in training the next generation; they want to be able to pluck fully-trained staff off the shelf, rather than investing time and expense in training people who may then take their skills to a different employer. This is again demonstrated clearly by the outsourcing of cataract surgery to for-profit organisations, which are only lately being 'encouraged' to make any contribution at all to training the microsurgeons of the future (5). The 'independent' sector as a whole is still almost entirely dependent on clinical staff trained at the public expense.

Health Education England, created under the Lansley reforms, but now reincorporated into NHS England, never seemed to be able to get to grips with its purported role, was excluded from the 'protection' of the core NHS budget during austerity, and suffered from the lack of government willingness to publish or fund any long-term workforce plan. And the chaos continues, with increasing numbers of places in new medical schools, but with serious bottlenecks all the way along the post-graduate training pathways that are essential to turn the products of medical schools into the General Practitioners and Consultants that are in such short supply now. This in turn is driving the provision of so much care to be 'reconfigured' into fewer and fewer 'centres of excellence', increasingly remote from so many of the patients that require these services. And now NHS England is consulting on plans to greatly restrict access to patient transport services, which were often put in place to mitigate the impact of these reconfigurations, with the detriment most likely, as usual, to be felt most strongly by the most disadvantaged in society, who are often those most at need of these services, as described in Chapter 1 of the report.

Have we heard the last of PFI?

There is no mention in the report of the impact, for better or worse, of the Private Finance Initiative (PFI) policy pursued so enthusiastically by the New Labour government, but which has left a continuing financial legacy, distorting the finances of so many NHS organisations and their scope for action to meet current challenges, including the trust for which I worked for many years, which could illustrate some of the flaws in such partnerships with the private sector.

At that trust, Calderdale and Huddersfield NHS Foundation Trust, which benefitted from the second PFI hospital to be completed in England,

the period of agreement with the consortium that funded the building of the new Calderdale Royal Hospital, which was originally for 30 years, had to be extended to 60 years after a few years, when reduced levels of NHS funding rendered the level of repayments unmanageable. The maintenance arrangements for the PFI hospital were set out in the original agreement, and locked in a specific provider for the duration of the agreement and took precedence over other spending decisions of the trust, so repainting had to take place, for example, rather than the purchase of new anaesthetic machines, no matter which was a higher priority at the time.

When it became obvious that reconfiguration of services between the two district general hospitals run by the trust was required, to allow safe working within the affordable and available levels of staffing, and a decision was needed as to which of the two hospitals would be developed, the inflexibility imposed by the PFI agreement governing one of the hospitals was the deciding factor in the financial case for the project. There then followed very protracted and confidential negotiations as to how the necessary expansion of wards and other new buildings, as a publicly financed project, could take place on the site which was now in the ownership of the PFI, which has considerably delayed the start of the project.

Lord Darzi's report rightly emphasises the severe lack of capital investment in the buildings, equipment and information technology with which the NHS is working and the way in which this is having a daily impact on the productivity of NHS staff and their ability to take pride in doing the best they can for their patients. He points to this lack of capital investment being as great, if not a greater problem, in primary and community care and that, if we are to unlock the productive capability of our workforce, and retain a fully trained and motivated workforce, we need to give them the right tools and the right buildings for the jobs we expect them to do.

Perfectly reasonably, the report does not offer any opinion on where that capital funding might come from, which can inevitably lead to speculation that some version of PFI might return, when recent statements from the Treasury are considered and there is an increasing expectation that large pension funds, such as the Local Government Pension Scheme, should invest in national infrastructure, rather than it be funded by government borrowing. I would point out that one of the major stakeholders in the Calderdale and Huddersfield NHS Foundation Trust PFI is PGGM, a large Dutch not-for-profit cooperative pension fund. Is it possible to strike long-term deals with what are essentially private investors that allow the flexibility to respond to the future requirements of essential public services? Hopefully any move towards PFI Mark 2 would be subject to very intense scrutiny (6).

What happens next?

The Secretary of State for Health has stated that Lord Darzi's role was to provide a diagnosis of the problems afflicting the NHS in England and that it is the job of the government to prescribe their preferred course of treatment. The Prime Minister has been very clear that the NHS will only receive additional funding, if it is tied to reform of the service, but has refused to be drawn on what he means by 'Reform'. There are plenty of good ideas within Lord Darzi's report, but also significant gaps which could fuel concerns that powerful interest groups might continue to exploit the NHS

as a reliable source of financial gain, rather than a service to safeguard the wellbeing of both the people and the wider economy of this country. There will be plenty of influential individuals and lobbying organisations well placed to lobby their cause. We need to make sure they are not the only ones to have their voices heard. We have the opportunity to restore the NHS to its former pre-eminence amongst world health systems. We can't afford to blow it!

References

1. Patel, N., et al. (2024) 'Options for restoring the public health grant' Health Foundation, 30 August [Available at: https://tinyurl.com/38c44swh]
2. Mendedlsohn, E., et al. (2024) 'Feeling the pressure: what the 2023 Commonwealth Fund survey reveals about the state of the UK health system' Health Foundation, 22 August [Available at: https://tinyurl.com/4humh7u7]
3. Gregory, S. and Naylor, C. (2009) 'Independent sector treatment centres' The King's Fund, 1 October [Available at: https://tinyurl.com/2z23j9az]
4. Ryan, S., et al. (2021) 'For whose benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' CHPI [Available at: https://tinyurl.com/4d2kb82b]
5. Rowland, D. and Ryan, S. (2024) 'Out of Sight – understanding the hidden impact of cataract outsourcing on NHS finances' CHPI [Available at: https://tinyurl.com/4d2kb82b]
6. Hellowell, M. (2014) 'The return of PFI – will the NHS pay a higher price for new hospitals?' CHPI [Available at: https://tinyurl.com/v7rszvv3]

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Much more needs to be done if Labour really wants to fix the NHS

Wes Streeting, Secretary of State for Health and Social Care in Keir Starmer's new Labour government, has declared the NHS to be broken (1).

He explained that he meant the quality of service now being provided to patients was unacceptably poor. After 14 years of Conservative managed decline, few would disagree. However, a more complete explanation might have referenced underfunding, understaffing and the breaking up of the NHS into 42 Integrated Care Systems (many now struggling financially(2)). The implications of the NHS being 'broken' are not yet clear in terms of health policy other than what has appeared in the manifesto and the King's speech, while the promised 10 year plan (4) has yet to materialise.

Is it true that the NHS is broken?

While targets are routinely missed and service failures evident, the NHS is currently providing 1.7 million interactions with patients every day. The National Audit Office (4) says that the NHS is not broken, but could well break from the intense pressure to which it is being subjected. It concluded that either future demand for healthcare must be curtailed or more funding be provided. Failure to invest in the estate, inflationary pressures and the costs of pandemic recovery were all making the financial situation worse. With political will, there is no doubt that more money could be found (5), for example by taxing wealth. Richard Murphy has also suggested discontinuing payment of interest (6) on all the central bank reserve account balances that are held by our commercial banks with the Bank of England, worth £40bn a year. Labour peer Prem Sikka has pointed out (7) that the government severely reduced its policy options by promising not to create money, borrow or increase taxes on the rich. Such self-imposed constraints are likely in time to become extremely problematical.

The Labour manifesto: glimmers of hope but many reservations

Those who support the restoration of the NHS based on its founding principles would have wanted much more from Labour's manifesto (8). Major concerns include the lack of any commitment to much needed investment after 14 years of austerity. There is also every possibility that finances will be squeezed even further, with funding lower than in the recent past (9). Reform' (unspecified) is being prioritised over additional funding, and nothing is said about ending the wasteful and damaging investment in the private sector. Conversely, there is a worrying and unevidenced claim that private sector 'spare capacity' (10) can benefit the NHS and reduce waiting lists. This indicates a willingness to repeat failed experiments (11) of the past such as the Independent Sector Treatment Centres (ISTC) (12). There is no mention of ending 'Overseas Visitor' (13)charges for undocumented people, despite these effectively ending universal access to free care.

Whereas some manifesto commitments are objectives that have been trumpeted for years by various governments (shift to community care, focus on prevention, benefits of technology) and now comprise Streeting's three 'major shifts' (14), some specific aspirations are to be welcomed. These include an extra two million NHS operations, scans, and appointments every year; doubling the number of CT and MRI scanners; delivering on the NHS long-term workforce plan; taking pressure

off GP surgeries; rebuilding dentistry; ensuring that failing maternity services are robustly supported into rapid improvement; training thousands more midwives; closing the Black and Asian maternal mortality gap; reducing waiting times for mental health and appointing 8,500 more staff; prioritising women's health. However, it is crucial that these commitments are funded and implemented with urgency as there are important patient safety issues at stake across the whole of the NHS. On the public health front there are also promises to ban advertising junk food to children; addressing the social determinants of health; halving the gap in healthy life expectancy between the richest and poorest regions in England; raising the age of sale for tobacco by one year every year.

In a welcome early move, the government has engaged with junior doctors (15)over their pay claim and come up with an improved offer. Despite this, there is no general commitment to pay restoration for NHS staff as a way of urgently improving retention and promoting safe patient care. Instead, there is a reliance on overworked and stressed staff agreeing to work overtime to reduce the NHS waiting lists.

General Practice – in need of major funding uplift to keep it viable

Although Labour is committed to training more GPs and 'bringing back the family doctor', GP workload continues to increase (16) and GP numbers have fallen by nearly 1800 since 2015.The paltry below inflation 1.9% uplift in practice funding for 2024/5 (recently raised to a still inadequate 7.4%) is making some surgeries unviable. GPs have now balloted to take industrial action (17) for the first time since 1964. Cost pressures on GPs include a 400% increase in service charges (18) levied by NHS Property Services over the past 9 years. Many practices have had to stop using locum GPs because of lack of money.While unable to employ GPs through the Additional Roles and Reimbursement Scheme (ARRS), fully qualified GPs remained unemployed (19). The ARRS has now been extended (20) for one year to include paying GP salaries; this should be made a long-term arrangement to get more GPs into the workforce. While 84% of locum GPs cannot find work, a third of GPs are considering changing work or career plans.Two thirds of practices report concern about short- and long-term viability and 1,000 have closed over the past 9 years at an astonishing rate of two per week. When it comes to government finding the necessary funding, for each £1 invested in community or primary care, there is up to a £14 return into the economy (21). Clearly a new funding settlement is needed, but this must not be at the expense of hospital care (22).

Deteriorating NHS estate

In a recent parliamentary discussion (23),Streeting warned: "I want to see the New Hospital Programme (NHP) completed, but I am not prepared to offer people false hope about how soon they will benefit from the facilities they deserve. That is why I have asked officials as a matter of urgency to report to me on the degree to which the programme is funded along with a realistic timetable for delivery". In addition, the maintenance backlog now stands at £11.6bn (24) and poses significant risk to staff and patients. Having recognised that NHS estates are in a state of disrepair after years of neglect, the welcome manifesto commitment to the much-needed NHP now appears to be an early casualty of Labour's

arbitrary and self-imposed tax and spend limits.

Use of the private sector to reduce waiting lists

According to the Nuffield Trust, the overall amount of NHS England budget spent on non-NHS owned care provision was 20.8% for 2022/23. The independent sector delivered 9.6% of all NHS-funded elective care, up from 7.8% in 2019. NHS commissioners are being encouraged through the Elective Recovery Fund (25) to make more use of private providers. The Independent Health Providers Network claim there has been an increase of more than 30,000 patients treated each week since 2021. While the private sector has done well out of the NHS over recent years, there are major questions about both its ability to expand further and its impact on NHS provision (26).

It is hugely concerning that a main plank in Labour's strategy is use of the private sector (27) to reduce waiting lists. The private sector has limited capacity (around 8,000 beds) and even the CEO of Spire Health (28), the largest chain of UK private hospitals, considered there was very little leeway to take more NHS work. There is also the key issue of staff being taken from the NHS (29) and NHS work since the private sector by and large does not train its own workers. Whereas upscaling activities may be relatively simple for some high-volume low-risk procedures such as cataracts, this is not the case for orthopaedic surgery. The huge increase in cataract surgery has come at a cost to NHS departments (30) as well as having damaging effects on patients at serious risk of losing their sight (31). A serious approach to waiting lists would be to learn from past experience and invest in expansion of NHS services and staff.

"It is hugely concerning that a main plank in Labour's strategy is use of the private sector to reduce waiting lists. The private sector has limited capacity."

Pushing back on privatisation

Although not in the section of the manifesto dealing with the NHS, Labour's 'Delivering a New Deal for Working People' (32) indicates a possible route for rolling back privatisation (33). This document states that "Labour will end the presumption in favour of outsourcing and oversee the biggest wave of insourcing of public services for a generation .... The next Labour government will also examine public services that have been outsourced as part of our drive to improve quality .... Before any service is contracted out, public bodies must carry out a quick and proportionate public interest test, to understand whether that work could not be more effectively done in-house. The test will evaluate value for money, impact on service quality and economic and social value goals…. We will also reinstate and strengthen the last Labour government's two-tier code to end unfair two-tiered workforces". Health service trade unions should be pressing government to turn these words into action. For example, this should signal the end to disputes such as at East Suffolk and North Essex Foundation Trust (34) where there are plans to outsource hundreds of jobs in cleaning, catering and portering.

Who is advising government on the way forward for the NHS?

Rather than consulting with health trade unions, professional bodies, campaigners and members of the public, Streeting has chosen to seek advice from those who promoted failed initiatives in the past and advocated for greater involvement of the private sector in health care. Influential voices from

the Blair years are now having their say. Patricia Hewitt, for example (Secretary of State for Health 2005-7; advisor to the Conservative Government (35) on NHS administration; current chair of NHS Norfolk and Waveney) lost no time in giving her interpretation (36) of Streeting's 'broken' NHS. She claimed that what he meant was that "the model of care is broken," and therefore it followed that "If we want to change the model of care we have to change the model of funding as well". Volunteering her ICS as a test bed, she also identified the need for financial incentives to drive a more preventative health system.

Another powerful voice is that of Alan Milburn (37), also a former Secretary of State for Health in the Blair government, and now tipped to return to advise on NHS reform. In his past NHS role he was seen as a champion of outsourcing and the disastrous Private Finance Initiative, which for just £13bn of investment has cost the NHS £80bn. (38). Milburn is reported to have made more than £8m from his private healthcare (39) consulting company. He chairs PricewaterhouseCooper's 'health industries oversight' board, which was set up to expand the accountancy firm's business interests in public and private healthcare. He is also a senior advisor to private equity group Bridgepoint Capital, which owns one of England's largest external providers of NHS services and a care home chain, and was also chair of US private healthcare giant Centene's former Spanish subsidiary, Ribera Salud.

A further powerful player is Lord Ara Darzi, who became health minister in 2007 under Gordon Brown. His previous recommendations included the creation of polyclinics (40) to improve access to primary care. These turned out to be expensive and faced criticism for destabilising primary care, being introduced without regard to local need, and duplicating primary and urgent walk-in care. After 9 weeks of extensively reviewing NHS data he has recently published an investigation of the service (41) with a particular focus on access to and quality of healthcare, and the overall performance of the health system. Darzi paints a sorry picture (41) of the NHS but says little which health campaigners, staff and think tanks will find new. He is, however, clear that austerity has caused huge damage and significant capital investment will be essential (42) to improve matters.

No doubt the report provides Labour with a short breathing space and is adding to the performative narrative of new and shocking insights (43) into the Conservative's legacy. Streeting says (44) the review was aimed at 'diagnosing the problem' so 'ministers could write the prescription'. Let us hope that when deciding on treatment, ministers understand we are now in a world of evidence-based medicine which requires combining the best available scientific evidence with healthcare professionals' experience and patients' values and preferences.

Finally, we have Paul Corrigan, former senior health advisor to Tony Blair (45)and now appointed to the DH&SC (46) to help shape health plans. In his earlier incarnation he was involved in developing policy as costs of PFI hospitals soared, and as more and more expensive new deals were done with the private sector. By 2012 Corrigan was urging the Cameron coalition government to make 'reforms' even more radical than Lansley's Health and Social Care Act and advocated for the private sector to take over failing hospitals (47). He is now warning against giving more money to the NHS while it fails to improve productivity but so far has not explained the underlying causes of poor productivity or how things can be improved without investment.

Conclusions

The scale of the crisis in both health and social care merits the calling of a national health emergency. Striking examples include the deaths of over 250 people each week (48) from delays in Emergency Departments and 39,000 people in England dying prematurely (49) from cardiovascular conditions in just one year. While welcoming the limited commitments so far made

to the NHS by Labour, much more needs to be done. Wes Streeting and Keir Starmer have repeatedly said that the NHS will not get funding without reform (50). However, there has also been talk of delivering both investment and reform (9) in order to put the service back on its feet. Darzi did not address policy but has certainly produced a challenge to government. Now it has to come up with some credible plan to improve services for patients and there really has to be action and not just words (51).

The current insistence that 'reform' trumps more funding is unsustainable in the longer term, and expectations among the electorate are high. It is important that health policy is firmly evidence based and not simply a reflection of the ideology of prominent advisors. We know that the NHS was once one of the best health systems in the world until damaged by underfunding and understaffing. With proper investment and planning based around the founding principles, it could once again provide excellent care to all. If 'three shifts' are needed they should be to fund the NHS to succeed and not for it to fail, to roll back privatisation and build back a publicly provided service, and reversal of the structural fragmentation that has taken place, to restore a national NHS. A vital fourth shift should be establishing a national care, support and independent living service (52).

Prospects for economic growth will be severely undermined (53) should the health service continue to fail. The Treasury imposing another round of austerity (54) would also have additional dire consequences including further erosion of trust in politicians and fuelling the growth of the far right (55). Similarly, any reliance on the private finance sector (56) for developing public infrastructure is fraught with dangers. We do not need a return to policy pursued by the Blair government, centred on competition between providers and promoting privatisation. We neither require a new model of care nor one of funding. If ministers are to diagnose the NHS's problems and prescribe accordingly, this should only be after a dialogue and agreement with the public, health workers and their trade unions. For health campaigners who support a revitalised NHS based on its founding principles, there is much to fight for even after the return of a Labour government.

References

1. *Guardian* (2024) 'Wes Streeting says NHS is broken as he announces pay talks with junior doctors', *Guardian*, 6 July
[Available at: https://tinyurl.com/3hbd6k99]
2. Medical Buyer (2024) 'UK hospitals cutting jobs, beds to plug a £3B NHS black hole', Medical Buyer, 24 July [Available at: https://tinyurl.com/5n75enam]
3. Smout, A. (2024) 'Reform or die: UK PM Starmer promises 10-year plan to fix health service', Reuters, 12 September
[Available at: https://tinyurl.com/4fzwj62e]
4. National Audit Office (2024) 'NHS Financial Management and Sustainability', National Audit Office [Available at: https://tinyurl.com/3ep23x7h]
5. Toynbee, P. (2024) 'The billions Britain needs are at Rachel Reeves's fingertips, and no fiscal promises need be broken', *Guardian*, 30 July
[Available at: https://tinyurl.com/26kurmcz]
6. Murphy, R. (2024) 'Is Labour really short of money?', Funding the Future, 28 July
[Available at: https://tinyurl.com/mt3shske]
7. Sikka, P. (2024) 'The Labour Party needs to take on neo-liberalism and the rich', Left Foot Forward, 18 July [Available at: https://tinyurl.com/2nn4buaz]
8. Keep Our NHS Public (2024) 'Labour's NHS manifesto not 'Fit for the Future', KONP, 28 June [Available at: https://tinyurl.com/zxhxzkfx]
9. Helm, T., Ungoed-Thomas, J. and Savage, M. (2024) 'Labour and Tories would "both leave NHS worse off than under austerity"', *Observer*, 15 June [Available at: https://tinyurl.com/3tr6fs5w]
10. Puntis, J. (2024) 'Myth of spare capacity in private health care sector straining to help the NHS', KONP, 5 June
[Available at: https://tinyurl.com/3p9j6vet]
11. Squires, M. (2007) 'Independent Sector

Treatment Centres: a leap in the dark', *Br J Gen Pract,* Mar 1; 57(536): 250–252
[Available at: https://tinyurl.com/33y3c6tp]
12. Keep Our NHS Public (2024) 'Using the private sector to help the NHS? – is Labour intent on repeating the mistakes of the past'
[Available at: https://tinyurl.com/mrk3rfbx]
13. Bruce, G. (2018) 'Healthcare charging – unethical practice, unacceptable outcomes', Medact, 28 February
[Available at: https://tinyurl.com/3af8dpm4]
14. Invezz (2024) 'Wes Streeting outlines three key shifts for the future of NHS care delivery', Invezz, 8 September
[Available at: https://tinyurl.com/3bzcr2tf]
15. Gregory, A. (2024) 'Junior doctors' leaders agree 22.3% pay deal over two years', *Guardian*, 29 July [Available at: https://tinyurl.com/2s4hma4d]
16. Lister, J. (2024) 'Doctors give Darzi hard facts on primary care', *The Lowdown*, 21 July
[Available at: https://tinyurl.com/bdpwj4e2]
17. Gregory, A. (2024) 'English GPs to stage industrial action over 1.9% budget increase', *Guardian*, 1 August
[Available at: https://tinyurl.com/4yrdjay4]
18. Shepka, P. (2024) 'GPs give up contract amid 400% service charge hike', BBC News, 17 July [Available at: https://tinyurl.com/yvb9xjx6]
19. RCGP (2024) 'GPs struggling to find jobs while patients are 'crying out' for appointments, says College', RCGP, 19 June
[Available at: https://tinyurl.com/43wf6zkk]
20. Bostock, N. (2024) 'Contract uplift and £82m ARRS plan 'first steps' to sustainable general practice, Streeting tells GPs', *GP Magazine,* 1 August
[Available at: https://tinyurl.com/mryap3ra]
21. NHS Confederation (2023) 'Extra investment in out-of-hospital care can reap billions for the wider economy', NHS Confederation, 23 August
[Available at: https://tinyurl.com/mvysyv92]
22. Gregory, A. and Mason, R. (2024) 'Wes Streeting pledges billions to GPs in order to 'fix front door' of NHS', *Guardian*, 8 July
[Available at: https://tinyurl.com/mvsj49ut]
23. Hansard (2024) 'New Hospital Programme Volume 752: debated on Tuesday 23 July 2024'
[Available at: https://tinyurl.com/nhhv6nzj]
24. NHS Providers (2023) 'Billions to prop up creaking NHS estate and plug mounting repairs backlog', NHS Providers, 14 December
[Available at: https://tinyurl.com/2vdjv3pu]
25. NHS England (2024) Elective Recovery Fund technical guidance 2024/25. NHSE.
[Available at: https://tinyurl.com/mr275mdr]
26. Puntis, J. (2024) 'Myth of spare capacity in private health care sector straining to help the NHS', Keep Our NHS Public, 5 June
[Available at: https://tinyurl.com/3p9j6vet]
27. Lister, J. (2024) 'Can the private sector help shrink waiting lists?, *The Lowdown*, 22 July
[Available at: https://tinyurl.com/8j2c3rte]
28. Lintern, S. (2024) 'Private hospitals boss says they're not the answer to NHS crisis', *The Sunday Times,* 26 May
[Available at: https://tinyurl.com/47yb486p] [Paywall]
29. Rowland, D. (2022) 'Private hospitals coming to the NHS's rescue? Labour should know better', *Guardian*, 12 December
[Available at: https://tinyurl.com/5bdd5zkp]
30. Rowland, D. and Ryan, S. (2024) Out of Sight – understanding the hidden impact of cataract outsourcing on NHS finances. CHPI
[Available at: https://tinyurl.com/56ebwacb]
31. Hall, R. (2023) 'Hundreds left with lost or damaged eyesight after NHS delays – research', Guardian, 21 March
[Available at: https://tinyurl.com/kzhxmnts]
32. Labour Party (2024) Labour's Plan to Make Work Pay
[Available at: https://tinyurl.com/yk7547fd]
33. Lister, J. (2024) 'NHS privatisation: will Colchester be the last time?', *The Lowdown*, 21 July
[Available at: https://tinyurl.com/bddmncsd]
34. UNISON (2024) 'ESNEFT: In-house is best', UNISON
[Available at: https://tinyurl.com/22me79rx]
35. *Guardian* (2024) 'Wes Streeting says NHS is broken as he announces pay talks with junior

doctors', *Guardian*, 6 July
[Available at: https://tinyurl.com/3hbd6k99]
36. Calkin, S. (2024) 'Hewitt: 'We need to change care funding model' Local Government 11 July [Available at: https://tinyurl.com/yfhnn4n4]
37. Dropkin, G. (2024) 'Alan Milburn and the Labour agenda for the NHS', Keep Our NHS Public [Available at: https://tinyurl.com/3rmkzyr7]
38. IPPR (2019) 'NHS hospitals under strain over £80bn PFI bill for just £13bn of actual investment, finds IPPR', IPPR, 18 September
[Available at: https://tinyurl.com/27kv8ejk]
39. Geoghegan, P. (2024) 'Starmer's NHS 'fixer' has made £8m+ from private health consultancy', Democracy for Sale, 16 July
[Available at: https://tinyurl.com/tjuxt9hs]
40. Monbiot, G. (2008) 'Labour's perverse polyclinic scheme is the next step in privatising the NHS', *Guardian*, 29 April
[Available at: https://tinyurl.com/bdfuvukr]
41. Darzi, Lord (2024) Independent investigation of the National Health Service in England, September
[Available at: https://tinyurl.com/yc4vtkkt]
42. Campbell, D. (2024) 'Darzi review says the NHS is in a critical condition but sets out a treatment plan', *Guardian*, 11 September
[Available at: https://tinyurl.com/2p5hhdnk]
43. Reeves, R. (2024) 'Rachel Reeves expected to reveal £20bn shortfall in public finances', *Guardian*, 25 July [Available at: https://tinyurl.com/ymvh6ur2]
44. Gregory, A. (2024) ' ''A proper diagnosis'': Prof Lord Darzi, keyhole pioneer asked to unpick NHS', *Guardian*, 11 July
[Available at: https://tinyurl.com/yc6jy8dz]
45. Lister, J. (2024) 'Wes Streeting turns to the ''usual suspects'': why no involvement of trade unions and patients', *The Lowdown,* 21 July
[Available at: https://tinyurl.com/457kx32s]
46. DHSC (2024) 'Paulk Corrigan appointed by the government to help shape health plans', DHSC, 6 September
[Available at: https://tinyurl.com/5n936vrk]
47. Corrigan, P. (2012) 'Let the private sector help save failing hospitals', *Guardian*, 28 September
[Available at: https://tinyurl.com/bde9vdb6]
48. Hughes, D. (2024) 'Long A&E wait times lead to more than 250 needless deaths a week – analysis', BBC News, 1 April
[Available at: https://tinyurl.com/2yzydp32]
49. British Heart Foundation (2024) 'Early heart disease deaths rise to 14-year high', BHF, 22 January
[Available at: https://tinyurl.com/2tv6rwau]
50. Grunewald, Z. and Thomas, R. (2024) 'Wes Streeting: NHS won't get any extra cash from Labour without major surgery', *Independent*, 8 April
[Available at: https://tinyurl.com/3a7ywc7m]
51. BBC News (2024) ' ''Work of change begins' - Keir Starmer's No 10 speech in full', BBC News, 5 July [Available at: https://tinyurl.com/28k2w6n5]
52. End Social Care Disgrace (2024) 'Our Seven Demands'
[Available at: https://tinyurl.com/yytd4au6]
53. The 99% Organisation (2023) *The Rational Policy-Maker's Guide to the NHS,* The 99% Organisation
[Available at: https://tinyurl.com/2pj8zmjz]
54. Portes, J. (2024) 'Rachel Reeves is pulling off a transparent political manoeuvre. But she's not entirely wrong', *Guardian*, 29 July
[Available at: https://tinyurl.com/3ahk9zpz]
55. McDonnell, J. (2024) 'Quick, tangible change will see off the hard right – these are the things Labour must do now', *Guardian*, 16 July
[Available at: https://tinyurl.com/5xcrwup6]
56. Gabor, D. (2024) 'Labour is putting its plans for Britain in the hands of private finance. It could end badly', *Guardian*, 2 July
[Available at: https://tinyurl.com/3fp3f3wt]

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The Peter Fisher Essay Prize 2024: Winning Essay

This year's title, 'Non-medical practitioners on the front line – a help or hindrance to good practice?', drew 31 entries. Vanessa Kocia's winning entry drew on personal experience and well-supported argument to answer the question in a clear style.

Before I began to answer the question posed in the topic of this essay, I felt the need to define who exactly is a non-medical practitioner.

Perhaps the most fitting definition I found was this one: "traditional health workforce roles are changing, with existing roles being extended and advanced, while new roles are being created, often undertaking duties previously completed by doctors, sometimes referred to as non-medical practitioners (NMPs)" (1).

The non-medical practitioners – a concept once entirely foreign to me, having studied medicine in a country where the above job description simply does not exist. It allowed me to somewhat appraise the idea of NMPs with an open mind and thus share my thoughts in writing.

First of all, an important distinction must be made between the different types of non-medical practitioners and for brevity's sake this essay will focus on two of them. The first group are the Advanced Nurse/Care Practitioners, many of whom have proven invaluable in my internal medicine trainee's journey so far. The ANPs and ACPs I have had the pleasure of working with have all had plenty of experience in different healthcare roles, before deciding to train further and acquire new skills. I view them as an essential bridge between the junior doctors who change posts frequently (due to the training programmes' requirements), and the senior decision-makers who may be too busy to supervise the juniors in a way they may have wished to, had there been an option to be in two places at once.

If I was to name a downside, it would be that the seasoned ACPs can sometimes look down on the junior doctors due to their inexperience and varying skills at the point of commencing a new post. It can certainly be frustrating to receive a new "batch" of doctors every few months, each of them completely unaware of the ward's modus operandi, existing team structures or differences in the local guidelines (2). Personal feelings aside, this is exactly why the Advanced Care Practitioners are so essential in forming well-balanced teams. Side by side with doctors they help treat acutely deteriorating patients (Critical Care Outreach), manage patients with specific long-term conditions (specialty ANPs) and brave the out-of-hours shifts together (the OOH coordinators), just to name a few.

I consider myself fortunate to have met and worked with many wonderful professionals from varying original career backgrounds, who now work as the Advanced Care/Nursing Practitioners.

A different case entirely is the intrinsically inflammatory issue of the Physician Associates (3). Hard, as I might try to understand why many of the NHS's governing bodies are so enamored with the idea of PAs, the rationale behind it eludes me. Despite a plethora of arguments and voices against further implementation of Physician Associates, the

decidents seem adamant in pursuing the idea.

The arguments for the introduction of Physician Associates are as follows: severe doctor shortages and long training times resulting in no quick solution for the shortages, combined with long primary, secondary and tertiary care services waiting times resulting in service users' dissatisfaction and possible adverse outcomes. I imagine it is very tempting to cut a corner or two and come up with a quick and easy solution, especially when the "long and complicated but safe" doesn't look as good on a newspaper headline.

Allow me to share a story from my ongoing house renovation, I believe there is an important lesson there. During a detailed inspection of the walls of my new home, I have discovered that the decorative swirls and whorls covering most of the interior were in fact made with Artex – an asbestos-containing material, which was extremely popular in the 70s.

Artex was cheap, available and its application required no plastering skills, so it appealed to whoever was eager for a quick and cost-effective solution. Alas, with the wisdom of retrospect we now know the dangers of asbestos and so any wall decor made with Artex decades ago is now dangerous and costly to remove, but also dangerous to leave in place. Although it may seem a very unkind comparison, I hope the readers will appreciate the alegoric message and a deep personal worry I am trying to convey – one generation's "easy solution" implemented without sufficient analysis and foresight can easily become a problem for the future generations to inherit.

Being Polish and having grown up in a country struggling with its post-communist and post-world wars heritage, I am no stranger to kafkesque situations which would be amusing, ridiculous even, if they weren't a part of our then reality. It is my personal feeling that the very institution of Physician Associates is an idea that could well have been dreamed up in times of communism, dressed up in pretty words so as to appear for the benefit of the Working People, but in reality creating damage beyond what it aimed to repair. There's a reason why medical studies last 5, or even 6 years as was my case. There's a reason why Pilot Associates do not fly planes and Nuclear Engineer Associates do not ensure the nuclear reactors' safety. These jobs, just like ours, are simply too important and too dangerous to be performed imperfectly, thus the education and training of the people performing them must be kept to the highest of standards.

Becoming a doctor is by far the hardest, yet the most important thing I have done in my life, and practising medicine is in equal parts a noble burden and an honour. I have spent my entire youth studying and working harder than my peers, a characteristic I share with all doctors regardless of where they trained. I have passed the A-levels well, but not well enough the first time around.

I have then worked as a waitress to support myself after high school, and studied even more to pass the A-levels resit with near-perfect marks, as that's what is required to prove one can study medicine successfully. Six challenging years later, each of them comprising 9-10 months of studying and at least one further month of electives and practicals, I have finally graduated with a Dr in front of my name. Sure, I was as green as a spring leaf when I started the Foundation Programme but the theoretical knowledge was already there – all it needed to flourish was time, experience and careful nurturing by the senior colleagues. I am a product of my youth's hard work and my seniors' time and wisdom that they willingly share with me.

For there to be a safe, high-quality healthcare there is no other way and there is no shortcut. Both these essential components are in my opinion endangered by the introduction and persistent promotion of the Physician Associates.

I worry how will the senior doctors support and nurture their well-educated, yet inexperienced juniors, if they are pushed to train the PAs to enable them to perform acceptably in their limited roles. Permit me again to use the "Pilot Associates" as an example, because what purpose would there be to have an associate trained only

in critical engine failures, and another trained only in environmental control systems, and another two trained in standard take-off and landing procedures respectively? How do you pick the two to pilot your plane, if all these skills (and many more) are needed, yet the seats in the cockpit are only two? And if you agree that at least one of them, the captain, needs to be a pilot – not a pilot associate – then why would you push for an associate to be their first officer? Why "unseat" a junior pilot capable of becoming the captain in the future, in order to train an associate for a role they will never be able to perform independently? A staggering short-sightedness in full display, made worse by the fact than in medical field it is no longer anecdotal but has been made a saddening reality.

Subsequently, why should today's youth go through the uphill path of hard work and effort, only to inherit a great responsibility with many more years of learning and exams ahead, if the alternative is a much shorter course with a much better starting pay and being hailed as the salvation of the NHS? Frankly, if the government, the GMC, the Royal Colleges and other decidents believe so firmly in the idea of Physician Associates as being safe and needed, I would encourage them to permit the final year medical students to take the Physician Associate exams. After all, what better way to supplement a modest Foundation Year 1 pay when one is considered too inexperienced to work in a community setting, than to work part-time as a Physician Associate in a local GP surgery. Truly, if this did not serve as an ultimate punchline to my essay, nothing else could.

References

1. Abraham, J., Bailey, L., Coad, J., et al. (2019) "Non-medical practitioner roles in the UK: who, where, and what factors influence their development?". *British Journal of Nursing*, 28(14), 930-39.
2. Griffin, M., and Vidar M. (2006) "Developing an advanced nurse practitioner service in emergency care: attitudes of nurses and doctors." *Journal of Advanced Nursing* 56.3, 292-301.
3. Malone, R. (2022) "The role of the physician associate: an overview." *Irish Journal of Medical Science* 191.3, 1277-83.

Physician Assistants: An Inside View

Adam Skeen is in his fourth year of a graduate-entry medical student course at the University of Birmingham. He has worked as a PA in an acute medical unit after he trained to be a PA for 2 years. He spoke to Alan Taman about the PA role and medicine.

Why did you become a PA and not a doctor at first?

I had applied for medical school after 'A' levels but missed out on the grades. At the end of my pharmacology degree I still very much wanted to study medicine further, wanting to work with patients, wanting to apply my skills in a clinical setting. The limitations for me were that graduate-entry courses are few and far between. Funding for non-graduate courses is very poor. I was also limited to my local university, which offered 26 places for graduate-entry students and I was unsuccessful in getting this.

Around that time, the PA role was starting to become more common and it started to look a lot more appealing than being a doctor. There had been a shift from 'assistant' to 'associate' , and it started to look like a way that you could work in clinical medicine doing many of the tasks of a doctor but without the downsides of all those years of training – the 2 years before earning became much more attractive. Being able to choose where I could live and work was much more appealing, as was the ability to directly apply for a specialty I was interested in. Given all those things that were very unattractive about medicine – you could be sent anywhere else in the country, you had to go through numerous rotations before getting to where you wanted to be – it was much more appealing to become a PA.

What was your impression of other PAs during your training and practice as a PA?

I do think the PA role is very attractive to people who have previously considered becoming a doctor and for whatever reason have had to take a different path, whether for academic reasons or finance or personal circumstance. I'd say 50 per cent of my colleagues on the PA course were people who had previously applied to medical school or had considered it and for whatever reason had ended up in PA school. Most commonly there had been some sort of barrier to entry.

There was definitely a cohort of students who had actually never wanted to be a doctor and very much were attracted to the idea of doing an assisting role. Speaking to some of those people now you find that actually they are uncomfortable with where the scope of practice is going in comparison with the training they received. So these were people who applied with the intention of doing something to assist doctors who are now finding themselves being asked by their employer to do a role that looks almost identical with that of a doctor.

Has the change of title from 'assistant' to 'associate' changed the role, or vice versa?

I think this is a bit of a chicken and egg situation.

The rationale from changing from 'assistant' to 'associate' was partly that those driving forward the PA role and seeking regulation found that the government and key stakeholders were telling them that assistants don't require statutory regulation, therefore having that as their title would be a barrier to seeking regulation and therefore would be a barrier to extending scope to things like requesting X-ray imaging and prescribing, which are things that those key PA stakeholders wanted and for years had found not being able to do very frustrating.

The title changed partly in response to wanting regulation and the added benefit that would come with that. But equally I think the change from assistant to associate has precipitated a more rapid development in scope but has attracted people who wouldn't want to be an assistant, like myself, who find the role appealing when they otherwise wouldn't have.

How important is omission of underpinning principles and knowledge during training as a PA?

This is really a critical point. I think it's something that's very hard to appreciate until you've gone to medical school and started to learn those first principles and realised how much more sense everything makes with that context and added information. I don't think I appreciated back when I was a PA student, and I started to realise that I still didn't really 'get it' in the way that I do now. The problem is that there is very good evidence that those first principles are essential for getting that key foundational knowledge and understanding of why and how, which forms a really important party of then being able to develop clinical reasoning skills and is integral to being able to realise your blind spots. That becomes a real problem for PAs, because they don't cover a lot of that stuff, therefore their clinical reasoning will be deficient in seeing undifferentiated patients.

How was the role PAs have in diagnosis reflected in training? Were PAs expected to diagnose?

Absolutely. If you read any description of what a PA does, they all talk about the key things PAs do as history taking, examination, investigation, diagnosis and management plans so diagnosis is a key part of that.

> "PAs may have the ability to diagnose that conforms to those very simple algorithmic patterns but we know that patients don't present in those ways."

At PA school on my course there was no focus on first principles as part of developing that diagnostic reasoning and skill. The focus was more on learning about conditions in discrete chunks, so you'd learn about heart attacks as a discrete chunk, chest infections as a discrete chunk, and you'd learn about it as a set of patterns: symptoms that a patient would report, and things that you might find on examination and investigations. We do that at medical school as well, but what is lacking as a PA is that they haven't got that understanding of why a condition presents in that way, why an investigation may show a certain result in this condition. So that means PAs may have the ability to diagnose that conforms to those very simple algorithmic patterns – but we know that patients don't present in those ways and you don't know which patient it is that 's going to trick you! So you do need that broad, deep understanding to make a diagnosis safely. It's something that you get a foundation on and build on with many years of experience.

So why the 'red line' in seeing undifferentiated patients?

That red line for me is that PAs don't have medical degrees, they haven't covered the same depth of content. They don't have that same level of understanding that a doctor has. Therefore it's not safe to see undifferentiated patients, because you don't know what you don't know. That's where the real risk of harm to patents is, with misdiagnosis. If you look at legal claims for medical negligence, the biggest cause is diagnostic error. That diagnostic error is going to be much more common in people who have less experience and less training. Giving a lack of experiential learning but also a lack of foundational knowledge.

How do you think PAs cope with the dangers?

What should happen is that they are very well supported and well supervised, and have very stringent senior oversight, really from a consultant. Really the key to this is a strict scope of practice. So that what we're allowing PAs to do is very much tailored as to what we know their skill set is based on the training. That is how we should be making it safe. On an individual level it's quite difficult to say how the PA will cope with this on a day-to-day basis. There's a concept of medicine as being 'unconsciously incompetent', and that's not to say someone is foolish or lacks intelligence, it's to say that if you've never heard of something before and you don't know the breadth of knowledge you will need, it's very easy to not realise that you don't know something. If you don't know a concept exists and it's not on your radar, you can't really appreciate your knowledge is deficient in any area. That's why it's so dangerous for us to not have a very clear, well-defined scope of practice and appropriately senior supervision of PAs.

"It's so dangerous for us to not have a very clear, well-defined scope of practice and appropriately senior supervsion of PAs."

How do you think the role is likely to affect doctors?

I can speak to the data that is out there and my personal experience. When I was working as a PA, there were certain things I couldn't do. If I was allowed to see a patient who was presenting with chest pain, I would be able to arrange for them to have the chest X-ray that they need, or the pain relief that they would need, which is an essential part of looking after a patient well, and I'd have to delegate that task to a doctor colleague, who would already have their list of jobs from a ward round and their own patients. I would often find that there was this growing list of things that I would be giving them to do, whilst I was doing what might be considered the 'fun parts' of working with patients, the interesting parts of taking the history and examining patients.

So I certainly felt that I was adding to the workload of my colleagues, particularly on days when we were short staffed. That comes with safety issues. Also the BMA have the data from the survey they carried out, in which 55 per cent of doctors felt that PAs increased their workload.

When you were training and working as a PA was your professional identity clear to you? How does this compare with the identity you are now acquiring as a doctor during your training?

I think my feeling is that doctors are a very well established profession. There are rites of passage. Medical school is a very well standardised process, starting with your first year in medical school and going through your pre-clinical years to then finally to be set free as a clinical student. You go through this rite of passage and socialisation process that's been done by all of the doctors who came before you. With that comes this development of a

professional identity, everyone shared that process. With PAs being such a young role, they don't really have those traditions. Also the course isn't sufficiently long that you go through that process of socialisation where you mature into a role in the same way through re-visiting things, through making mistakes across your 5 years. So I think there's a time component and a well-established role to the professional identity that is lacking for PAs. But I also think that the lack of definition and the fact that what PAs are doing is practising a very defined sub-set within the medical world, their identity is so clearly linked.

But I'm not sure a PA develops their own professional identity. One thing I very commonly saw as a PA student was they probably struggled to say what their role was. I think if you can't describe your role without saying what you're not, so 'we're not doctors but we work like doctors', then it's very difficult to have your own professional identity when it's very dependent on another profession.

How great is the danger of conflation – might a PA be tempted to think 'oh well I'll just get along with people thinking I'm a kind of doctor'?

The majority of people who are going to be looking after patients are all very well intentioned, usually well-aligned individuals who aren't seeking to deceive or do anything harmful to anyone. I'd hope that it's rare that this happens, where you have someone who actively seeks to mislead a patient about what their role or their training is. Although there have been examples shared on social media where people are blurring those lines, whether intentionally or by accident. I think the real danger is in the government, the GMC, or the Royal Colleges not defining the role. Because I think the title 'physician associate', is very confusing. The job description of a doctors sounds very similar to that for a PA. The dangers are more in what we do around the role rather than individuals seeking to mislead. I think reverting to a title of 'physician assistant' would help clear that up, because I think there is no doubt in the public's mind that if someone's an assistant they are probably not a doctor. I do think the regulation by the GMC and the use of language that has 'medical professional' by the GMC is a real risk to patients by not appreciating that PAs are not doctors.

Are there any other key ethical issues that you see differing between the PA and medical roles?

The PA course can be accurately described as a condensed 2-years. Unfortunately that means a lot of stuff will be missed. On my course what was missed was teaching on law, teaching on ethics, having lengthy ethical discussions, learning about case law that underpins a lot of the stuff we do in medicine, about why we consent patients in certain ways, things that govern confidentiality, a lot of that stuff was lacking on my PA course. Then we're allowing PAs to do things in their roles that really require that underpinning, that understanding of ethics and law. I think those blind spots will cause problems and risk harm to patients, and to hospitals and organisations, and the reputation of the profession.

How important is it to remedy medical student funding and improve retention to minimise the problems you are currently seeing?

Medical student funding underpins so many of the problems that we're seeing now. So many people who do a PA course are people who have

come out of a first degree, looked to be a doctor, would make an excellent doctor, but simply can't afford to fund 4 or 5 years of training because they don't get full student finance, there are very few grants and scholarships. So they are left with other options, PA training being one of them. Funding and access to medicine is a key part of dealing with the PA issue, because what we really need to deal with the NHS crisis is more doctors. If we can get these people who are driven and motivated, and bright enough to look after patients and do an excellent job then we should be encouraging and supporting that, rather than funnelling money into a parallel role that doesn't train people to the same standard that people expect and deserve.

Improving medical student funding would also solve numerous problems outside of the PA issue. There are lot of students who struggle with career planning and progression, because unlike their wealthy colleagues they have to work many part-time jobs to fund their training, and therefore can't get involved in research and qualifications improvement with those extra-curricular activities that make them more well-rounded and experienced doctors who are competitive for the assisted training programme, and who contribute a lot to our health services by becoming leaders.

That means that people who are from under-represented backgrounds in medicine have a much higher mountain to climb to become those leaders. Actually we need those people who look like the patients we look after leading our health service really. A lot of patients with complex conditions are from deprived backgrounds because of the nature of the conditions. It would be really great if we could have doctors who really understand where those patients are coming from, and can provide really excellent care for them. With the current funding that's really not possible.

Any other way that medicine can be made more appealing?

I think some geographical stability – being able to have some say over where you live and for how long is really important for people. Flexibility around training pathways. Access to training numbers. There are huge bottlenecks for a number of specialties now. The competition rations for specialty training are astounding for some specialties that were previously under-subscribed, which are now hugely over-subscribed. That's very unappealing for someone who wants a stable career pathway. There's the full pay restoration campaign, which I wholeheartedly support. I also think we need to look at how we deliver in medical education as well. I think some of the problems come from the workforce crisis. We don't have enough doctors to look after the patients, so it's then very hard to have enough doctors to then educate the next generation of doctors. Medical students are having quite a hard time on clinical placements, because they are often ignored, often not getting that quality contact with consultants. The solution to that is to solve the other problems to get to a position where we've got a strong workforce but good recruitment, good retention, and enough doctors to look after the patients and train the next generation of doctors.

> "I have great respect for my former colleagues but they need to be in the role that is appropriate for their training, or supported in training to be doctors."

Should the GMC be responsible for governing PAs?

I previously would have said 'yes', because I though PAs ought to be supervised by doctors and doctors are regulated by the GMC. If there were

to be a fitness to practise this would involve both so it would have made sense. But I think the way this has progressed, with scope expanding rapidly without any checks in place, it's now very difficult to distinguish what a PA does from what a doctor does in a number of places and the GMC regulating PAs adds an extra layer of confusion to that for the public and other healthcare professionals who are working with PAs. I also think that the GMC have failed to deliver an acceptable plan for how they will regulate PAs. That's why there are two legal cases ongoing against the GMC, one by the BMA for the use of 'medical professionals' by the GMC to describe both PAs and doctors, and one by Anaesthetists United around the lack of defining scope of practice which is seen as a failure by the GMC to carry out its duty.

Because the GMC have failed to give a clear indication of how they will regulate scope for PAs, I don't think they can make sure PAs are practising safely.

Is there anything else you would like to add?

I would like DFNHS members to strongly consider what scope of practice is appropriate. As a PA who is now training to be a doctor who recognises the shortcomings of my training. I have seen the lack of standardisation of PA training across the country by talking to PA colleagues.

I wholeheartedly support the idea of having a national scope of practice framework rather than a 'pick n' mix' elective scope of practice, because there is this huge spectrum of competence within PAs. There are 220 years' of courses now, completely unregulated, a 4,000 strong workforce with very different experience and training. The only way to ensure that is at all safe is a national scope of practice. I would strongly urge DFNHS members to think about the BMA scope of practice document [**https://tinyurl.com/2rukcpcj**], to engage with their Royal Colleges on developing a national scope for their specialties, ensuring that this is appropriate to the level of training a PA has.

I have great respect for my former colleagues, but they need to be in the role that is appropriate for their training, or supported in training to be doctors – because I think all of them would make really good doctors!

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(Adam's first degree is in pharmacology. He is a member of the Medical Students' Committee on the BMA as a representative of his university (Birmingham) and also a member of the UK Council.)

Jettisoned Communities: The Broken Heart of NHS Healthcare

The discourse about our current NHS problems often reduces these to notions and language better suited to manufacturing, commodities and utilities than to complex human bonds and interactions. What has happened? And what can we do about it? EC member David Zigmond offers a personal perspective.

> **'Technology made large populations possible; large populations make technology indispensable.'**
>
> *– Joseph Wood Krutch (1958), Human Nature and the Human Condition*

August 2024

Several weeks after a landslide General Election result. For a while the combative sectarian rhetoric is quietened, as the vanquished – abject and bewildered – tend their wounds. Yet at the starting point of this staged battle there was always an anchoring agreement – some shared assumptions of what is and what should be. All parties agree, for example, that our NHS is floundering and in urgent need of bolstering; all similarly promised, for example, a rejuvenating increase in both staffing and its operational efficiency.

Of course, there had to be disagreements. The outgoing, now disarrayed, governing party said it has done these things and would continue to do so: it justified the evidently poor results on uncontrollable factors – the pandemic, subsequent healthcarers' strikes and the world economy, for example. The opposition – now governing – party denied this: our problems are due, rather, to neglectful and nepotistic incompetence. They promise that their putative extra resources will be managed with more caring conviction, competence and probity.

The new government, so decisively victorious, now has its chance …

Despite this political sea change there remains another kind of agreement, but it is expediently befogged and stealthily dissembled by all: it is about funding. Where will the money come from? 'Economic growth' seems a capricious promise. Yet all major parties avoid saying: 'We are all now expecting lives to be enhanced, largely ensured, and often usefully lengthened, by our continually advancing technology. Yet such technological growth depends on more funding. If we want such blessings we must be prepared to pay for them – all but the poorest should be willing to pay more taxes…'

Many politicians may believe this but dare not say it: they think, or sense, that the electorate would (mostly) reject any such self-compromise that prioritises, instead, our communal predicaments and thus any longer-term realism. It is likely that a politician of greater candour or integrity would lose their seat and (limited) influence to those who expediently sidestep or deny such inconvenient truths.

It seems we are not yet ready to welcome increasing our progressive taxes to ensure and honour any expanding communal welfare.

Current limitations

There is yet another healthcare no-man's land

where we stumble, purblind, amidst our perceived problems and juggling solutions – and it is quite as misguided and serious. It is signified by how, generally, we restrict our description, analysis and debate about our NHS healthcare. We confine ourselves to particular language, concepts and data – these are, almost always, about distribution of funding and resources, and then how these are 'managed'. We talk of our healthcare as a commodity, a service industry, a utility – much less do we hear notions of relationship, motivation, resonance, belonging or community … the kind of complex humanity that motivates people to want to do these difficult jobs well, and to stay in them happily over a working lifetime.

Instead, almost all politicians, analysts, pundits and media-commentators confine their formulations to a necessary-but-not-sufficient service industry perspective. So almost all the public hears are charges or laments about current shortcomings of resources, or promises about what extra, in future, will be provided: GPs, specialists, nurses, scanners, drastically upgraded and integrated IT systems, new hospitals … Manna from a New Order!

Many of us detect a manic nervousness in such promises: unanswered questions of funding continue to rankle. But that is not the only, or even the major, area of neglected oversight. Even if we could rapidly provide all these professionals, facilities and commodities, we would still be left with some recently evolved yet fundamental deficits – the displacement and destruction of our vocational spirit and communities; the abandonment of those subtle and fragile personal meanings and connections that can make this work so worthwhile and endurable.

These are complex losses with enormous consequences. They have accrued incrementally largely amidst, and because of, the serial reforms that are – paradoxically – meant to bring us all benefits through industrial efficiency and commercial acumen. The technical and legal details of those reforms have escaped most people's interest and understanding, but the resulting

dissatisfactions from 'Service Users' and 'Service Providers' (sic) are frequently heard:

- 'I never see the same doctor twice…'
- 'They don't know my story so have to spend their time looking on the computer instead of seeing me.'
- 'I'm no longer looking after, or looking out for, patients I get to know well, nor do I do this with familiar colleagues who become like family … I may be called 'Doctor', but I feel like a factory worker in the service of a remote corporate employer.'
- 'In the past I felt it was a private matter when and how I saw my doctor (GP); it was like an ongoing personal conversation that I largely decided – that now all seems managed by people I don't know, or even computers…'
- 'Yes, we're now in this shiny new building, with automated and electronic-everything but somehow, with all that, the heart and joy have gone out of the work…'

Such refrains, from both patients and healthcarers, have become increasingly common and now, surely, tell us much about the more unspoken predicament of our healthcare.

It is this predicament – the advance of micromanaged systems at the expense of personally meaningful and gratifying relationships – thence some kind of experience of 'community' – that is so little recognised, understood or discussed

in our public discourse.

The demise of continuity of care

The absence of these considerations – of personal relationships, meanings and communities – in our thinking, planning, management and then practice of healthcare now has insidiously destructive effects. These are certainly equal to the substantial damage from the much-discussed inadequacy of funding and physical resources.

The historical evidence for the importance of this is compelling. Prior to the 1990s (the beginning of neoliberal, then digital-mediated, systems reforms) the NHS was of very variable quality, (relatively) technologically primitive and often cumbersomely slow. But in many ways it functioned excellently. For example, staff morale and esprit de corps were generally much better than now: recruitment, retention, team-stability, delayed retirement … all indicated that practitioners liked their work. This was because they experienced what they did as people-work: they worked in smaller stable teams with patients and colleagues they could get to know increasingly well. Rarely, if ever, did anyone talk about 'contracts'.

> "Recognising the importance of people does not just help them feel better about one another and themselves: it saves money and resources."

This pre-serially-reformed NHS often provided personal continuity of care far more readily, particularly in primary and mental health sectors. Such personal continuity far exceeds mere niceties and comforts: wiser practitioners and managers recognised this (informally) as a *sine qua non* of their work. We have now massive evidence to show that its beneficial influence reaches far beyond well-documented staff morale, work satisfaction and stability, and patient trust and positive experience. Such personal investments and understandings are related to significantly better outcomes in chronic disease management, fewer specialist and emergency service referrals, less psychiatric breakdown and self-harm, and significantly increased longevity.

So recognising the importance of people – having a personal understanding and sense of community with individuals – does not just help them feel better about one another and themselves: it saves money and resources. How come, then, that such recognitions have been allowed – even enjoined – to perish?

Those who choose a more political and sectarian political analysis often, and very plausibly, argue that these losses are primarily due to deliberate inadequate funding; and that, they say, is due to the regressive economic consequences of neoliberalism and its characteristic austerity policy; even worse is the nepotism (for the few) and the marketising dehumanisation (for the many) that such policies lead to. This, they say, is an inevitability of our unbalanced and unfettered capitalism.

Yet however cogent this view, it does not adequately account for why so many of us in the more industrialised ('advanced') countries are facing similar and wider problems of human-ecological imbalance – our ability to live together, and with other species, in ways that are humanly fulfilled, synergistic and sustainable.

This raises all sorts of other questions. What kinds of increased economic growth, technological cybernation, mass production and consumerism are compatible with our viability and broader welfare? Which tasks are best depersonalised and delegated to machines and which not? Why, in this country, over several decades, have we increasingly modelled our healthcare (and other welfare services) on competitive and corporate manufacturing industries? Why do we think we

can better our welfare services by everywhere ratcheting-up commissioning, regulation, standardisation, compliance and inspection? Such questions may include, yet far exceed, party politics – rather they signify symptoms and predicaments of our industrialised culture, our era: zeitgeist.

Taking the longer view

As always, history may help us understand what has happened, what is happening now, and even what we might best do.

Here is a very wide and long-spanned view.

Recent human evolution has seen an astonishing acceleration of human power – our abilities to manipulate one another, other life forms and our physical environment. *Homo sapiens* has become *Homo instrumentulans*; conscious humankind has become, very emphatically, 'Man the Manipulator' – increasingly we engineer our world. We command it according to our designs and desires. This is massively true of our physical environment; it is increasingly true, too, of our bodies … such control of our minds is proving more refractory.

Generally, though, we have privileged ourselves to treat the world as a gigantic, almost infinitely intricate machine that lies prostrate before us, merely awaiting our 'understanding' and control.

But this species' self-empowerment comes with very great costs and responsibilities: our powerful engineering is almost always at the expense of other life-forms. Almost always, others are destroyed, displaced or mutated. Such collateral damage often becomes more unconscious with our increasing efficiency. It is, therefore, very hard indeed for engineering to exist without some form of near or distant ecocide. That is the cataclysmic dilemma, the 'inconvenient truth', the incomparably important lesson we are having to learn from in the twenty-first century.

It is as if we have built a diorama of this in our NHS: more and more we are treating this enormously complex network of human experiences and needs as if it is merely a machine that can be reductively designed and managed to perform better. So like, say, an internal combustion engine: can we improve the fuel flow or air intake? Increase the compression ratio? Optimise complete combustion? Have more sensors and electronic controls? Increase the octane rating? Etc. The system is there to be driven to perform better for us.

Hence the talk of improving our services is so often analogous: ensure more funding (fuel); shorten the training (increase the compression ratio); tighten surveillance, regulation and compliance (engine management systems and sensors); recruit more staff from other (poorer) countries (subcontract cheaper essential components), and so forth. All are there to drive up performance.

This is largely how we talk and what we do. Increasingly we see our health service as an inanimate machine: its management a task of civic engineering.

And before this …?

A better past?

In the post-war decade, the era of the birth of the NHS, our powers of technology and cybernation were significantly less. Engineering had not yet so utterly displaced and then deracinated ecology. This enabled our services to function more akin to more complex living organisms, say mammals: it was tacitly recognised that they needed nourishment, protected space, relationships that

stroked, groomed and recognised, and – in humans – provided meaning.

Because we did not then have the power to directly manipulate and engineer as we do now, we had, instead, to grow our working communities and institutions – much as a gardener tends plants, or parents raise families. Whatever the technological inefficiency of this pre-industrialised era, these were – in human and community terms – halcyon days. Older practitioners and patients felt they belonged, they mattered, and their individual stories, meanings and natures were more likely to be recognised. Such things are essential for any kind of effective and sustainable people-work. Affectional bonds are not an irrelevant epiphenomenon of such work – they are essential elements, a generating force.

All of this has been largely displaced, extinguished or eclipsed by our drive towards industrialised packing, coding and cybernation – the tools and systems that are so indispensable to our successful manufacturing industries are often subtly yet deeply inimical to our people-work.

This is, increasingly, what we cannot or will not see.

Technology rich, humanity poor

A recent example of this came from Wes Streeting in his first public statement as Secretary of State for Health in the new government. His demeanour and voice were stern, bullish and uncompromising. He said:

> **'From today, the policy of this department is that the NHS is broken. That is the experience of patients who are not receiving the care they deserve, and of the staff working in the NHS who can see that – despite giving their best – this is not good enough … [*We have*] received a mandate from millions of voters for change and reform of the NHS.'**

The rhetoric here far exceeds any useful meaning. Saying the NHS is 'broken' does not help us understand or remedy its malfunction. For example, if we have a substantial problem with our car, say, and a motor mechanic deems it merely as 'broken', that cannot help us. All acknowledge now that the NHS is functioning poorly. Repeating this as a 'policy' makes for little sense or help. We have, instead, to accurately identify the 'what' and 'how' of the malfunction.

Similarly, to assert that the solution to the obscurely-defined 'broken' mandates 'reform' raises far more questions than answers. As we have seen, the serial reforms of the last 30 years – however well-intended – have generally rendered far more administrative than human sense. They have resembled elegant and impressive architects' models of buildings that subsequent inhabitants do not want to live in. So it is, for example, that our radically reformed general practice has morphed from a stable and happy 'family' network of colleagues into an unhappy and fractious network of siloed factory employees in which few wish to work. The erstwhile family doctors mostly enjoyed their people-work and often were reluctant to retire; the current GPs – Primary Care Service Providers – do not like their de-peopled work. They consequently work part-time and are unlikely to work until retirement age. Most pre-reformed GPs invested their lives and skills in communities that had sentience and meaning for them; the current thoroughly-reformed GP is, by contrast, contracted, controlled and regulated – the commitment to investment in communities, with their shared growth of meaning and sentience, is now all but impossible.

Increasingly our doctors work in milieux that are technology-rich yet humanity-impoverished; scanner-sighted but humankind-blind.

A price too high?

Perhaps this predicament – this zeitgeist-folly – is currently reflected in the evident and increasing disturbance and unhappiness in so many

of our children and young people. They are now surrounded and infused by technologies that conjure unprecedented instant and remote contact, virtual networks and screen-imaged presence … yet so many young people now, simultaneously, show alarming signs of unattachment, non-belonging and estrangement from self and others. They seem to be adrift from real communities that provide meaning and motivation.

We – the supervising adults – the parents, the teachers, the healthcarers, the police, the coroners – are witness to the casualties of all this in its many forms. We have categories, of course: severe dysthymia with self-harm, eating disorders, autism, drug abuse, gender dysphoria, ADHD, dangerous violence (even homicide) … the list is growing.

From our initial enthusiasm – a couple of decades ago – and welcoming of providing our children with this wondrous techno-cornucopia we have slowly become sceptical … and now confused and alarmed.

As so often in our contemporary world, our cleverness so easily outruns our wisdom. We lose the discipline, the restraint, the discriminating judgement to ensure that impatient expedience does not become unmanageable excess. How do we steer appetite away from obesity, palliation from addiction?

And in healthcare how do we best garner the considerable power and efficiencies that our ever-advancing technologies bring us, while also retaining and nourishing our only-human and all-too-human bonds, understandings and communities?

There are no complete and final answers to this question. But avoiding it has a very high cost, in terms of both our health economy and our human experience.

We are paying that cost now…

'Men reform a thing by removing a reality from it, then do not know what to do with the unreality that is left.'

– GK Chesterton (1928), Generally Speaking

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Book Review

The Invisible Doctrine: The secret history of neoliberalism
George Monbiot and Peter Hutchison
(£10.99, 220pp., hardback/paperback)

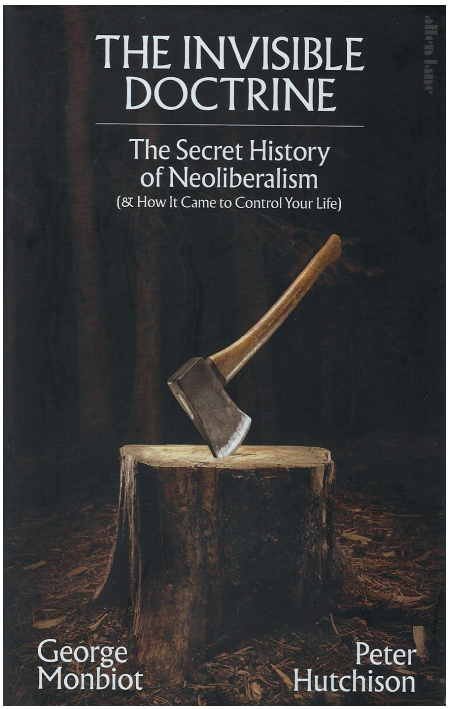
- **Everyone is responsible for their own destiny, and if you fall through the cracks, the fault is yours and yours alone.**
- **The state has no responsibility for those in economic distress, even those without a home.**
- **There is no legitimate form of social organisation beyond the individual and the family.**

This paraphrase of one of Mrs Thatcher's best known interviews suggests a type of society few would wish to live in. In the words of US politician Steve Bannon, the aim is "the deconstruction of the administrative State". Governments must cut taxes, shed regulations, privatise all public services and curtail protest and the power of trade unions so that wages can be suppressed. This will allow entrepreneurs to generate more and more wealth which will, in theory (though not in practice), trickle down to the rest of us.

These are, in the words of the authors "the snake oil remedies of neoliberalism", an ideology which dominates our politics but does not speak its name.

Everyone should understand this short and readable book which shows how these policies arose, how we are persuaded to accept them and how they affect us all.

Neoliberalism is described as "capitalism on steroids" – but what is capitalism? It has been with us for hundreds of years and is described here as being "founded on colonial looting". The essential feature is always the motive to make a profit, and in the process powerful state and private interests exploit land, natural resources and labour, particularly of poorer countries, to create private wealth. When an area becomes less profitable and resources are exhausted, it is just abandoned and attention moves elsewhere, a pattern described as "Boom, Bust, Quit". Constant growth is essential.



Social democracy is a gentler variety of capitalism. Policies such as the Welfare State involve increased government spending to create public services and a safety net and also redistribution of wealth so that many more people share the available resources, although other, often poorer, areas are still exploited.

Two exiles from Nazi-occupied Austria, Hayek and von Mises, were concerned about the growth of post-war social democracy. They felt that anything which put the interests of society before

those of the individual would limit individual actions and eventually lead to totalitarianism such as Nazism or Communism. Their books championing neoliberalism – a term which had arisen in the late 1930s – became extremely popular, particularly among the very rich who could therefore consider their financial self-interest to be a stand against tyranny and could delude themselves and others that even the poor might ultimately benefit from their extreme wealth.

How could neoliberal ideas be spread? Think tanks, well-financed by rich individuals and by damaging and polluting corporations such as oil and tobacco companies, and working on behalf of their funders, would spread the ideology. Invariably and mendaciously described as 'independent', organisations like the Institute of Economic Affairs, the Centre for Policy Studies and many others, became increasingly influential via academic and political lobbying and via the mainstream media. US economist Milton Friedman was a particularly well-known advocate and political advisor.

Neoliberalism was originally in the authors' words "an honest, if extreme philosophy" but in the 1960s became "a sophisticated con". The aim was to make Hayek's ideas seem sensible and even inevitable.

Redistributive Keynesian ideas predominated in the post-war Welfare State and the US New Deal, and neoliberalism was then considered morally reprehensible, so its proponents stopped using the term. But economic crises in the 1970s led to the elections of Ronald Regan in the US and Mrs Thatcher in the UK, both enthusiastic followers of Hayek. The think tanks essentially wrote their policies, so privatisation of most public assets and services soon followed. Council houses, state-owned industries and utilities were sold off and internal markets started in health and education. If really understood, the aims and strategies of neoliberalism would be immensely unpopular, so stealthy ways have had to be found to make them seem acceptable – the myth that the services would be more efficient or competitive, or just (as Mrs Thatcher often said) that there was no alternative. The real triumph of the international neoliberal network came when the Labour Party and the US Democrats were persuaded to abandon most of their founding principles, so neoliberalism became the norm.

The NHS has remained extremely popular and no government has overtly dared to privatise or destroy it, so this has had to be done carefully and gradually. Systemic underfunding for many years has left a huge funding gap and large waiting lists, and nearly 9000 general and acute beds have been lost in the last decade. The authors point out that neoliberal governments have found this process frustratingly slow so an accelerant has been "the disempowerment, frustration and elimination of the staff providing the service". Doctors and nurses leaving in droves is part of the plan. The template for the rest of the service, they feel, is NHS dentistry, a service which has been made so unattractive that the only dentists providing it are those who feel morally obliged to do so.

What happens if neoliberals get everything they want? "Economic life falls off a cliff" as in the brief premiership of Liz Truss, beside whom Mrs Thatcher looked moderate.

And what about democracy? As corporations asset-strip other businesses, corporate power becomes oligarchic power and nothing must stand in the way of profit-making. Natural disasters, and manufactured ones like Brexit, are ruthlessly used as in Naomi Klein's "The Shock Doctrine", to remove environmental, human rights and consumer protections. The resulting insecurity and confusion must be blamed on others, such as "elites" or immigrants and a strong or authoritarian ruler seen as a saviour, but many voters will just become disengaged and hopeless.

To neoliberals, the environment does not seem to matter and they may dream of escape to a spaceship or another planet, where they will be free from taxation and regulation. Funding by polluter interests ensures that environmental protections are completely inadequate, even

though we are already seeing the terrifying consequences. If large parts of the world become uninhabitable wastelands, so what? The ideology cannot be contested.

The final chapters offer us hope, in terms of a participatory democracy, with a new narrative based on belonging, community involvement and respect for the planet. The aim should be "private sufficiency and public luxury" and the rejection of both poverty and excessive wealth. Neoliberalism can and must be challenged so that this damaging ideology is seen to be unacceptable. Previously unimaginable sweeping changes in public attitudes have occurred in the past and can happen again, because once a threshold of 25% of the population is reached the rest soon follow.

The cloak of invisibility around this ideology must be exposed.

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Jenny Vaughan Memorial Conference

The *Doctors' Association UK* (DAUK) is holding a day-long conference in memory of their founder member and former chair Dr Jenny Vaughan, who was also a DFNHS member for many years.

Saturday, 17th May 2025
The Wellcome Collection
183 Euston Road London NW1 2BE (opposite Euston station)

Inspirational speakers such as Edinburgh Fringe Comedian & Psychiatrist Dr Benji Waterhouse.

Engaging panel discussions on:

- **The Role of Medics in the Media**
- **Debating the Role of Physician Associates**
- **Climate Change & Healthcare**

For more information:
https://tinyurl.com/48b9ft8a
(Free to attend but please indicate you are a DFNHS member if asked.)

EXECUTIVE COMMITTEE : Elected at AGM 2023

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

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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.

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