DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Martin McKee on the state of the NHS and the UK

Also:

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- David Rowland and the CHPI
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JANUARY – MARCH 2025

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- Save the date
- DFNHS AGM and Annual Conference
- Thursday 16th October 2025
- Bedern Hall, York

A View From the Chair

Shortly after last year's General Election, the new Health Secretary commissioned Lord Darzi to carry out an investigation of the performance of the NHS in England (1).

This report was reviewed in our July-September Newsletter (2) and has formed a backdrop to decisions taken in the autumn Budget and the scope of a very wide consultation exercise that will supposedly shape a forthcoming 10 Year Plan for the NHS, which should be published in the early summer.

Submissions to this consultation were invited from organisations, with a closing date in December 2024, but contributions from the general public have continued into 2025. A response from DFNHS was duly submitted (3) and will be discussed later. In West Yorkshire there have also been forums set up by the Integrated Care Board and also by Members of Parliament through which members of the public and health and care workers have been able to express their views, and presumably these have taken place in other parts of the country.

When faced with the question, "How can we build a health service fit for the future?" there is the potential for a bewildering array of responses, so maybe inevitably the scope of the submissions was limited to 5,000 words and focused on three main themes which will have been familiar from *The NHS Long Term Plan* (2019) (4): how to move more care from hospitals to communities; how to make better use of technology in health and care; and how to tackle the causes of ill health and recognise illness at an earlier stage. There was still scope to raise other issues that we felt were important.

What are our priorities?

Five thousand words is not enough to explore comprehensively all of our concerns and aspirations. It was decided to concentrate on more detailed proposals reflecting the main priorities expressed by our members, including topics that might not be mentioned by other organisations, but derived from the experience that exists within our ranks.

DFNHS was set up to promote the founding principles of the NHS as a public service. Those principles have shown themselves to be resilient and adaptable through good times and bad, for more than 75 years, with the NHS consistently ranked by the Commonwealth Fund as the best performing in the world in terms of care process and healthcare outcomes; access and equity; and administrative efficiency and spending – as recently as 2012. We seek a clear commitment to that original operational model of a service funded from a progressive taxation system, publicly provided, and publicly accountable.

We felt it important that the NHS should be excluded from any trade negotiations, with a formal declaration that the NHS is a "non-economic service of general interest" and "a service supplied in the exercise of governmental authority" so asserting the full competence of Parliament and the devolved bodies to legislate for the NHS without being trumped by EU competition law and the World Trade Organization's General Agreement on Trade in Services.

We welcomed the emphasis within the NHS Workforce Plan on developing and maintaining general medical skills throughout medical training and subsequent practice (5), which we see as entirely compatible with the development of specialist skills. We would hope to see improved continuity of care and a reversal of the drift towards ever greater centralisation of hospital services, with the consequent problems of access for patients, affecting some of the communities most dependent on those services.

We drew attention to the wastefulness of

bottlenecks in postgraduate training arising from inadequate training places compared with the need for General Practitioners and Consultants. Why increase the output from medical schools without ensuring the capacity to make the most of all that potential talent?

We also felt it appropriate to point out the way in which disciplinary procedures are applied in many NHS organisations, in contravention of the processes described in 'Maintaining High Professional Standards in the Modern NHS', and the detriment both to patient safety and staff morale, as described in our Newsletter of January 2023 (6).

Moving more care into the community demands stronger primary care

Reflecting concerns raised previously within these pages and elsewhere, we disagree with the expansion of the Medical Associate Professional workforce in the absence of a clearly defined role and our particular objection to their use in assessing undifferentiated patients in primary care settings. This requires excellent skills and detailed knowledge of how the human body functions in health and disease, the wide range of patterns of disease, the accompanying signs and symptoms, and the ability to assess whether these are the beginning of something serious, possibly life-threatening, or not. Wes Streeting has pledged to "Bring back the family doctor": we agree that the General Practitioner needs to remain the foundation of primary care.

We also stressed the need to strike the right balance between timely access and continuity of care, especially in primary care, and particularly when various models of Same Day Access Hubs are being rolled out in parts of the country. The benefits of continuity of care have been well documented, including increased productivity, with a 5.2% reduction in total consultation demand (7), improved job satisfaction and better staff retention. It reduces mortality, morbidity, A&E attendances and hospitalisations. (8) Both over-treatment and under treatment are reduced, and compliance with treatment improved.

We discussed the reduction that has taken place in primary care practices, particularly in rural areas and areas of greater deprivation, with amalgamation of practices into larger units. The positive and negative impacts of these changes, including the challenge to provide continuity of care, were explored by Dr Rita Santos in her presentation to our annual conference last year (9). Although the Inverse Care Law was described by Dr Julian Hart in 1971, it is still very much in evidence.

Not only is there a need to review the resourcing of primary care towards areas of greatest medical need through a reweighting of the funding formulae to general practices, but other forms of support should be provided to practices serving deprived communities, to meet their particular challenges, and make them attractive settings in which to work.

We emphasised the Deep End Movement, which originated in 2009 among GPs serving some of the most deprived communities in Scotland, providing mutual support, sharing good practice and developing research links with universities (10, 11) and the Born in Bradford project, which has brought together research, training and treatment, including strong evidence to support public health measures, such as the introduction of Bradford's Low Emission Zone to control pollution from road traffic, which was disproportionately affecting children in the most deprived parts of the city (12).

Tackling the causes of ill health

Investment in child health, lays the foundation for good health for the rest of our lives and is the most effective way of reducing future demands on the NHS. The decline in physical and mental health of young children that was identified by the Academy of Medical Sciences showed that current trends are heading in the wrong direction (13).

Increasing socioeconomic inequality underlies much of this decline, as emphasised by the BMJ Commission of the Future of the NHS (14). Currently more than a third of all children are growing up in poverty, so measures targeted at improving the financial circumstances of families bringing up young children, improving access to secure, warm, dry housing and healthy diets would be a worthwhile investment in the future prosperity of this nation.

The NHS is the largest employer in the country, so action to improve the health of its workforce and their families could have a huge impact on the nation's health, as well as making significant inroads into the financial and organisational impact of sickness and early retirement. As an employer, the NHS needs to take a more proactive approach to occupational health.

Technology should support care, not distort it

There need to be realistic expectations of the benefits of information technology in healthcare, which is essentially dependent on person-to-person interaction and likely to remain so. It is conceivable that there could be a thinking machine at some point, but a caring machine is highly improbable, so technology needs to be designed to enhance our ability to care safely for our patients. Artificial intelligence is not a panacea and the NHS is stuck with humans for the foreseeable future. Clinicians have not been slow to embrace technology when it has made our working lives easier, or clearly improved the care we can deliver to our patients, but too often we have had to adapt the way we practice medicine to cope with the limitations of poorly designed and inflexible computer systems. Tasks that were formerly quick could frequently become frustratingly time consuming – taking valuable time away from attending to the patient. Clinicians need to be closely involved in developing systems so they can be better designed to meet our needs and those of our patients.

In another presentation to our annual conference in 2023, Martin Blanchard described the unequal relationship between the NHS and Big Tech (9). We need a more equitable sharing of the benefits of research based on our health data to ensure a continuing funding stream to our public services and to reduce the risk that the publicly-funded NHS ends up having to pay through the nose, in perpetuity, to use the tools that could only have been developed with the co-operation of the NHS. We should be exploring the possibility of a UK Tech model, developing data and other IT services in a collaboration between UK universities and companies; retaining the jobs, expertise and intellectual property benefitting the UK and its public services.

Bringing it all together

The challenge of bringing together all the contributions from such a wide-ranging consultation and translating them into a coherent, practical and affordable plan is not to be underestimated. It would appear that a number of groups of the great and the good have been set up with this in mind (15). They are probably aware of the saying that a camel is a horse designed by a committee. It will be very interesting to see the *Ten Year Health Plan* when it is eventually revealed and whether any of our ideas make it through to the finished product and whether the plan itself lasts for 10 years.

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Martin McKee: The NHS, AI and the UK

Professor Martin McKee is Professor of European Public Health at the London School of Hygiene and Tropical Medicine, where he developed a major research programme on health and health care in Europe, and he leads one of the School's largest Research Units. He is Director of Research Policy at the European Observatory on Health Systems and Policies, and is a former President of the BMA. During Covid he served on the UK's Independent Scientific Advisory Group on Emergencies (Independent SAGE). He has commented extensively on UK and European health policy, and on the state of the NHS and social care. He spoke with Alan Taman

What are your chief concerns for the NHS at the moment?

'My concerns are wider, because the NHS is s sub-set of the government or of the country more generally. There is a sense that in these extremely uncertain times, where the international order is being torn apart and where even the ideas of the rule of law are being challenged domestically within the USA and internationally, there is a concern that the current UK government has failed to communicate a vision for where it wants to be. Frankly, any British government that says that it is prioritising growth and is leading no stone unturned but is unwilling to overturn the biggest rock in the corner – Brexit – cannot be taken seriously. That is a real issue because that is the one area where they could do something about growth and they are unwilling to do it. So how committed are they?

Linked to that my particular concern is that one of the reasons that the UK is not doing as well as it should be is the poor health of the population. None of the discussions about growth and prosperity talk about health or the health of the workforce, or the health of the retired workforce because a lot of people are unable to work as they are caring for elderly relatives, or young people with mental health issues. So how can you say your main priority is growth if first of all you are not prepared to address the factor which is causing our small and medium enterprises to suffer: the inability to trade with our nearest neighbour? And second, the drag on the workforce because we have so many unhealthy people? I'm looking for some sort of coherent vision that I could sign up to and I'm not seeing it.

How well do you think the public see the connection between those social inequalities and health?

I think some of the public do see this. What we know from our work and from others is that health is a marker of a society that is in trouble. I did a lot of work in the former Soviet Union, and way before the economic markers were going awry it was health that was getting worse, and the regime covered that up. You get into what Angus Deaton (1) called 'deaths of despair'. You see that

in places like Blackpool, you see it in other coastal towns, and in some of the de-industrialising areas. That tells you that there is a warning that society is not well, not just the individuals. But the real problem with that is that ill health creates fertile ground for populist politicians selling superficially attractive solutions that will actually make things worse for those people. With my colleague Jacob Bor and others, we showed that with voting for Trump in the 2016 election (2). We showed it in voting for Brexit. We did historical research showing the link between austerity and mortality in the Weimar Republic (3,4), and we showed the link between influenza deaths in 1918 and the vote for Mussolini in 1924 (5). There is other work showing deteriorating health creates fertile ground. You then need a populist politician who can exploit that. But it does make the case that health is part of national security. There's no seeming recognition of that. There's no discussion of wellbeing, as there has been in previous Finnish and New Zealand governments for example. No real question of what is the government for.

How do you think UK health policy could best address these problems?

First of all, I think the government needs to say it has some sort of goal in improving healthy life expectancy and they are going to do something about that. That's the most obvious, both in terms of the level and distribution. But then the policy would be in some way directed at that. I'm not suggesting you take money away from anything – I'm not one of those people who say 'you should take money away from the hospitals and put it into the community': you need both. Particularly with increasing complexity and scientific advances; we cannot leave people behind whenever they can get treatment in other countries. We are still the sixth biggest economy in the world. I need to keep checking that, we were the fifth! But we should be able to do these things and we're not. I just feel a sense of drift, a sense of not really being clear about what the government is trying

to achieve. If it's not clear about what it's trying to achieve then it follows we don't know what it's doing will actually move towards whatever those goals should be.

How might the NHS in particular be improved?

I think we need to recognise that there is a problem with maths! Many politicians are not good with maths, I think we saw that demonstrated in the pandemic, and the concept of exponential growth. We've tried this in our summer school, with senior people from governments across Europe. We say there is a lily pond with a lilies in one corner, and after 10 days the lilies have covered the pond completely, and ask at what day would it be 50 per cent full, with the lilies doubling in area every day. The answer is on day nine. They answer day 3, day 5, day 6. People don't get exponential growth.

In terms of the NHS the big issue is, people look at the gap between what we should be spending and what we are spending and they measure that gap [parallel with the 'y' axis]: they are very good with a ruler but not with integral calculus! Because what they need to do is to look at the area between the two curves going back to 2010. They need to look at all of that solid bit between the line of spending what we have been spending and the steeper line of spending what we should have been spending. It's the area in between that describes the backlog of investment, there's been virtually no capital investment. The first thing we

need to be saying is not that we have a £2 billion under-spend, we need to be saying there is a legacy of an awful lot more than that. That is obviously in capital, it's in equipment and buildings (we know they are falling apart), it's in staff, it's in training. We need to have a degree of coherence. All of this takes us to the fact that I don't see a clear vision for where we are trying to be.

Any thoughts on the reliance on private healthcare providers?

The private healthcare providers are only ever going to enter the market if it's worth their while. So therefore they are going to cream skim in terms of the services they go for, we know that. The things that are easy, elective surgery and so on. The markets hate uncertainty and private providers hate uncertainty, so they want a guaranteed return and that's going to be at low cost. Within that, having selected the easy, low-risk services, they will do everything possible to select the easy, low-risk patients, and that's logical. So therefore if you do have private competition you're always going to have that selection bias. You're also going to have information asymmetry. This goes back to Ken Arrow and his paper on the American health system in 1963 (6). The people providing the service will always know more about what they are providing than you do as a purchaser. If you do manage to recruit skilled people with lots of intelligence you can be sure that they will immediately pinch them for three times the salary. So it's uneven; you're setting yourself up to fail from the very beginning. That doesn't mean you can't find things that they do: we don't expect that the NHS will go and make its own tables and chairs. But whenever the NHS is competing directly in a competitive market, the competitors have the advantages.

"Private providers hate uncertainty, so they want a guaranteed return and that's going to be at low cost... they will do everything possible to select the easy, low-risk patients."

What worries me with the private sector is less the American big corporations coming in. The challenge for them is they're getting massive profit margins in the US because everybody pays so much for their healthcare. They're not going to get those margins here. They're only going to be cream skimming in niche areas. I am less concerned about that type of privatisation. What I am more concerned about is the informal privatisation with more and more people self-paying. That's a big issue in Northern Ireland, for example, where primary care is just falling apart. I think that's the privatisation threat, that the NHS is no longer there when you need it. That's the issue I would focus on. I think you will have the big private companies coming in for the market, the Cleveland Clinic and people like that. But I think there's a limit. They can carve out areas like Adolescent Mental Health and make an absolute fortune, and in that time all the NHS stuff has gone and it can't compete. What I would like to see in those cases would be much stricter application of competition law. If you look historically at competition law, often it's been right-wing governments that have used it, such as when Reagan broke up the telecoms monopoly, or Standard Oil under Teddy Roosevelt. I think anti-Trust legislation, anti-competition legislation are important.

Do you agree with the view that if you introduce market norms into a non-market space like the NHS, inequality will follow?

I think you get market failure anyway for all sorts of reasons. You get asset specificity, they capture the market. Once they're in there, there isn't a public-sector competitor the next time you tender.

How do you see the role of campaigning groups in addressing these problems?

I think the real difficulty in the UK is the power of the media. It's not just the fact that you've got an oligarchy running the media – you've got Murdoch, and so on – you've also got the fact that if you listen to the public broadcasting system, the BBC and the Today programme has its agenda set for it by what's in the headlines of the newspapers.

More than that, it now has its agenda set by what Elon Musk has tweeted the day before. The fact is the concentrated power of the media goes far beyond the readership of the newspapers themselves, and sets the agenda for particularly the BBC, which I think is problematic. So to be heard as a campaign group is really difficult. We know that there are lots of demonstrations that take place in London that are never reported. On the other hand, we know there are some that are reported all over the place – by the Reform Party, for example. So you have BBC Question Time, with the almost constant presence of Nigel Farage. During the Brexit debate, there were no pro-EU MEPs on Question Time at all.

How important is it for researchers such as yourself to seek political solutions to health and social problems?

I've written a lot, I'm a member of Independent Sage. We've published a paper in Health Policy (7) and another one in Nature (Protocols) (8) where we argue very strongly that science cannot be divorced from policy. First of all, we are doing science to inform policy, so we need to understand what the policy options being considered are. Otherwise we will do research that is of no interest to anybody because it's not relevant. We need to have that dialogue so we can refine our questions.

Second, we need to know whether what we are doing is of any value and what kind of use it

is. Pielke and others have talked about this (eg 9). A lot of it goes back to the Philips Enquiry into BSE (see (10)) which made many sensible recommendations but was ignored. I would argue that this idea that science is detached from policy and should be separate, scientists advise and ministers decide, is actually not the way the world goes or should work. I'm not saying the scientists should make all the decisions but there should be a discussion, there should be a dialogue, so that each can understand what the other can do. Scientists need to understand the constraints on policy as well.

How does the European Observatory on Health Systems and Policies help the NHS?

It provides information and rapid responses for the Department of Health when they want international comparisons. My sense is that we're probably less well known in the UK than we are in other countries. We have a very visible presence, we're very widely drawn upon, cited and used by people in other European countries. But there's always been a problem in the UK with not looking to evidence from elsewhere. Partly it's the language of course, because people don't speak the other European languages, though with Google Translate it's not that difficult now. They don't know what's going on in other countries. You hear this all the time, when people say "the NHS is unique". Well, no it isn't. The Spanish or Italian or Portuguese systems are all based on the NHS;

the Nordic systems are broadly similar except they are more decentralised – they are all funded with tax money. No system is the same anywhere else: the English and the Scottish and the Welsh and the Northern Irish systems are all different. But they are quite similar too. The Italian system underwent management reforms in the 1990s taken from the NHS. Other countries learn from what we're doing but we don't learn from what other countries are doing.

So we provide the information if anyone else is prepared to use it but you know the old saying about horses and taking to water and drinking!

How might artificial intelligence best be used by the NHS?

I have a lot of thoughts on this because I'm leading on a policy brief on it and we've been writing quite a bit. We're trying to figure that out ourselves. I think that people are just terrified of it and don't want anything to do with it and say "It hallucinates and it's rubbish" and all the rest. There are other people who say it's going to solve all our problems. I think we're somewhere in the middle. I use it quite a bit and it is vastly improving my productivity. We're really wondering now whether with some of the new tools that are available there will be any need for young researchers to do literature reviews any more. Because some of the paid-for models are really good ones. Chat GPT will hallucinate and produce imaginary references, so don't use that! But some of the others actually are good and they are improving by the month. In terms of writing discharge summaries, for example.

But I think with the diagnostics for radiology and so on it's been used along with imaging processing and there are problems. In complex situations it can actually be worse than having humans. Particularly something like cervical cytology is an easy one for AI for image recognition, but then cervical cytology is giving way to HPV testing, virology. So the technology is changing there anyway. With things like radiographs, X-rays and things like that, we're not there yet. We've been doing work on what's called "explainable AI", where we get the algorithms to explain their decision-making process. Does that help? Sort of but not entirely!

A recent demonstration of AI by a colleague just left me gobsmacked: the ability to do a really good literature review in minutes. I think what everybody needs to learn is which tools for which job. For example, if you've been writing a paper, and you've got 1500 words and it has to be 900 just shove it in Chat GPT, frankly. It will do it for you. Read over it, make sure it's got it right, but it will take you a fraction of the time. If you want to find references that might be difficult to get in an area that you are unfamiliar with and you are not doing a systematic review but just want to know basically what the answers are and need to have the key references, Sci Space (11) is very good. But don't ask it to critically review a paper because it will just regurgitate the limitations the authors have put in. Other ones like Deep Research (Chat GPT 4.0) (12) do it really well. I think we're all feeling our way but it will definitely change the way we do things.

> "Nothing I've seen so far has suggested to me that the Cabinet Ministers who are looking at AI really grasp it. This is very hard stuff."

What do you think of the reported enthusiasm of the Health Minister for AI?

I'm worried. I don't think Cabinet Ministers understand this. There's the big issue of energy and water. That's just one level. Nothing I've seen so far has suggested to me that the Cabinet Ministers who are looking at this really grasp it. This is very hard stuff, very complicated. I'm really struggling

with it and I'm spending quite a lot of time trying to understand it. It is difficult.'

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Keir Starmer is wrong to think that privatisation is the best prescription for an ailing NHS

John Puntis (Co-chair of Keep Our NHS Public) on the dangers of looking to the private sector

The current crisis in the NHS is all too evident, with 6.4 million people waiting for 7.5 million procedures and around 1 in 8 beds taken up by those fit enough to go home if only community services and social care were available.

The government has pledged to bring waiting times down for non-urgent treatment to 18 weeks for 92% of patients by March 2029 (1) (65% by March 2026). This is an ambitious target and entails getting three million people off the waiting list. It would be an improvement in NHS performance comparable to that achieved by New Labour in the 2000s, but then investment in the NHS was the single biggest factor in the improvements (2). The context now is a very different being one of a service in a far more parlous state – understaffed, starved of capital funds, and with no promise of new money.

What about the crisis in acute care?

The crisis in acute care has been brought home by the predictable rise in winter viruses, including influenza, norovirus, covid and respiratory syncytial virus. Inability to discharge patients and free up beds means that around 14,000 people are dying (3) each year because they cannot be moved quickly from A&E to appropriate wards for treatment. Overfull emergency departments cannot accommodate patients arriving by ambulance and they wait outside, cared for by ambulance crews. Paramedics stuck outside hospitals are failing to answer 100,000 999 calls each month (4). Only 1 in 6 Emergency Departments consider they could cope with a major incident (5).

Figures recently released by NHS England showed that 2024 was the busiest year on record (6) for A&E and ambulance services. Shocking stories have arisen of patients waiting 91 hours (7) to be seem, and a pensioner being told by desperate staff that if they did not agree to give up their bed for another patient, a charge of £582 would be (8) levied for each night. Care in corridors and car parks (9) ('temporary escalation spaces' in official jargon) has become normal in many hospitals. This is terrible for patients but also putting huge strain on staff (10).

Starmer's speech

On the 6th January 2025, Prime Minister Keir Starmer launched the Elective Care Recovery Plan in a speech (11) at the South West London Elective Orthopaedic Centre in Epsom. This plan is framed as a partnership with the Independent Sector (12) (aka 'NHS dependent private sector'). He stated that rebuilding the NHS was the cornerstone of a plan to rebuild Britain, mentioning 'free at the point of use' as a key principle but as usual omitting 'publicly provided'. Warning that the NHS could not go on to become 'the national money pit', he then disingenuously misrepresented NHS productivity as 11% lower than pre-pandemic. In fact, before the pandemic, NHS productivity growth was faster in the NHS (13) than both the rest of the public sector and the economy as a whole. Now, after a post-pandemic fall-off, NHS

hospital productivity has increased (14) over the last year, with hospital activity growing faster than staffing.

Starmer went on to explain that 'this is the year we roll up our sleeves and reform the NHS.

A new era of convenience in care. Faster treatment – at your fingertips. Patients in control. An NHS fit for the future'. Pausing to give a plug for an AI enhanced stethoscope, he enthusiastically if incorrectly suggested such a device could 'save a patient in an instant'. Labour of course has high hopes of AI and intends to 'unleash' it on the nation (15). This includes unlocking public data (16) to help fuel the growth of AI businesses, with emphasis on potential benefits but little focus on the many inherent risks (17).

In a plan that we were assured is totally 'unburdened by dogma', key elements were set out for a new agreement between the NHS and the private healthcare sector which will allegedly make the spaces, facilities and resources of private hospitals more readily available to the NHS. The problem here of course is that the small private sector (around 9,000 beds versus 140,000 in the NHS) does not have spare capacity (18) and can only develop this at the expense of the NHS, including taking staff away from NHS work. One example of the negative consequences of using the private sector to bring down waiting lists can be seen in ophthalmology and cataract surgery (19). NHS departments have been deprived of staff and funding but left with the care of complex conditions where delays in treatment may mean that patients lose their sight. This is prioritising the short-term goal of reducing waiting numbers without due regard to ramifications and unwanted negative consequences.

Elective Care Recovery Plan – embracing privatisation

It is claimed that this plan will deliver the waiting list targets through two million extra appointments a year; 440,000 appointments in community diagnostic hubs working longer hours (12hr/day, 7 days a week) with same day tests and consultations; 14 new surgical hubs in hospitals, and three expanded hubs. It is hoped that by enhancing the NHS App one million appointments might be obviated, with the onus on patients to request follow-up. There will be the reintroduction of financial incentives to providers, with GPs expected to reduce referrals and hospitals to cut waiting times. The private sector estimates it can provide 1 million more appointments annually (20), for which it will be paid £2.5bn (£2,500 each!) with a focus on reducing waits in gynaecology and orthopaedics. This amounts to an overall 20% increase (21) in private sector activity.

Entrenching and boosting the role of private sector

The plan incorporates three strategies (20) for further boosting the role of the private sector. Firstly, for digital integration, with NHS and private sector digital systems being aligned around national standards, allowing patients access to appointments and results via the NHS App. Note that the private sector is far from transparent in terms of activity, capacity, staffing and costs - in fact it is currently a black hole when it comes to data (22). Secondly, long-term contracts will be encouraged in order to attract private sector investment in NHS capacity (demolishing any argument that private sector 'help' is only short term until list sizes come down). Thirdly, it is proposed that both sectors will collaborate to grow and develop the elective workforce, ensuring consistent training in the independent sector. This makes the huge assumption that relevant quality training is even possible in small (average 50 bed) private hospitals dealing with a limited range of non-acute work, and that the sector has suddenly become willing to invest in training. It is most likely included to forestall the valid criticism repeatedly levelled that the private sector does not train staff but takes them from the NHS pool; this is not likely to change.

So much is the private sector to be embraced that it is now the government's wish for it to

be planning services together with Integrated Care Board's (23). This goes even further than the Conservatives dared to suggest. Once again 'patient choice' is being used as a driver towards the private sector, with the risible suggestion that the latter will commit 'to reviewing their clinical exclusion criteria to ensure these allow choice of an independent provider for as broad a cohort of patients as possible, subject to the ongoing provision of safe services'. We know that not only are private services located in the most affluent areas (their use by the NHS being likely therefore to exacerbate health inequalities), but that they have to cherry pick simple cases (24) yet still have significant safety issues (25) with 6,600 patients a year being transferred into NHS hospitals (26).

Critical responses to the plan

Many are sceptical that the waiting list targets can be achieved without investment in supporting and growing the NHS workforce (there are now 108,000 vacancies (27) in secondary care). Community diagnostic hubs take staff from hospitals where the majority of work is done, thereby fragmenting services and undermining multi-disciplinary teams while increasing costs. NHS Surgical hubs may have a role but are concerned with high volume low complexity operations to the possible detriment of patients with severe problems. The recovery plan's sole emphasis on elective care misses out major pressing concerns over waits for GP appointments, ambulances, mental healthcare, and other services. The overall state of the service cannot simply be assessed on the basis of waiting lists.

Upgrades to the NHS App disregard large numbers of people who for various reasons are digitally excluded and misses the point that priority for treatment must be given to those most in need. Emphasis on digital is very likely to prove the accuracy of the 'Inverse Care Law' (28) (i.e. those most in need are most likely to lose out, and even more so when care is subjected to market forces). Financial rewards for better performing hospitals introduce perverse incentives with potential negative impact on quality, as well as being detrimental to those hospitals often struggling through no fault of their own. Existing financial pressures are being ignored, with ICBs having to find an implausible £8bn in 'efficiency savings' (29) and 39/42 ICS failing behind in their financial plans.

Chocolate fireguards

Those involved in management and governance of the NHS would do well to understand that the private sector is a competitor and not a helper and that the world of business is ruthless. It has been pointed out that reliance on the private sector to deliver core NHS services is 'incompatible with the sustainable delivery of first-class healthcare, across the entire population, at reasonable cost to the public purse' (2). Sensitivity to criticism that the private sector is more of a parasite (30) than a helper has led to various statements suggesting that contracts wont be allowed to negatively impact the NHS. This has of course already happened in ophthalmology (19) without any due notice or concern from the Department of Health.

The following might therefore be rightly regarded as being in the realm of 'chocolate fireguards':

'Independent providers should ensure that capacity offered to the NHS provides additionality to system capacity and is capable of being staffed without having a material impact on the existing local NHS workforce.'

'Independent providers commit to providing support in the most challenged specialties when enabled to do so'.

'One of the barriers to effective patient choice is the conflict of interest that arises when referrers deliver part of the patient pathway (including follow up care) – think high street opticians incentivised to refer patients with cataracts.

'All providers commit to ensure that they do not provide incentives that distort patient choice'.

'NHS and independent healthcare employers should work together to identify existing and future local staffing requirements to support

workforce planning and professional training.'

If these were to be rigorously applied, it is difficult to see that there would be any private contracts.

Evidence shows that when the NHS was funded to succeed it offered the best health care (31). New Labour's investment in NHS staff and facilities was the key to bringing down waiting lists in the 2000s and increasing public satisfaction, and not deals with private sector. Diverting public funding to the private sector (so that it can create 'spare capacity') undermines the funding and staff available to the NHS and provides a worse service. Public money will be used to expand private capacity, guaranteeing private profits and minimising risk. This approach is consistent with reported discussions around a giant Private Finance Initiative (32) arrangement with asset management companies and will prove more expensive than the Government directly investing in the NHS. Long-term contracts and guaranteed profits (33) from the public purse may even mean that extra capacity is never even owned by the NHS.

Aligning the private sector with digital integration, workforce development and training, joint planning of services and long-term contracts gives it a more powerful foothold in the NHS for no evidence-based reason. Low paid workers' terms and conditions are worse in the private sector and contribute to worse care for patients. NHS team working is undermined and corners cut. So, far from those who oppose private contracts in the NHS being ideological, it is a misguided and ideological choice of Government to invest in the private sector at the expense of rebuilding the NHS.

Major omissions from the plan

Labour's recent announcements show that there is really no coherent plan for the NHS. The Government is wrongly prioritising expansion of the private sector and failing to address the national emergency in acute care. The most glaring omission is surely social care (34) given the enormous strain this is putting on the NHS. Lack of access to dental

services (35) is causing misery for millions, yet there is no progress with a much needed new dental contract and a promised increase in dental appointments does not seem to have materialised (36). General Practitioners remain in dispute over funding of their new contract. They are doubtless bemused at the shift from being 'the front door to the health service… the key to earlier diagnosis…. We will bring back the family doctor… so ongoing or complex conditions are dealt with effectively' in the Labour manifesto (37), to 'not formally part of the NHS'. This last comment from Wes Streeting related to alarm calls from GPs that employer National Insurance increases would lead to the closure of some practices.

Many GPs are understandably wary about their assigned role in the plan, including a measly £20 for each patient they discuss with, rather than refer to, a specialist. This, plus expecting them to access more tests for diagnosis, is a further way of transferring hospital work to a group already beset by overwork and financial uncertainty. Finally, we should note that delay seems to be the name of the game, with the Ten Year Plan for the NHS put back to the summer, the social care commission taking three years, important pay talks with unions delayed, and decisions about the future of Physician and Anaesthetic Associates postponed subject to a review.

KONP's Vision for a People's NHS

KONP's 'Vision for a People's NHS' (38) sets out

what needs to be done to restore the NHS; it calls on politicians for a commitment to public provision and ending outsourcing. The founding model of the NHS is the best basis for providing comprehensive and universal care while also being essential to the economy: this is convincingly set out in 'The Rational Policy Maker's Guide to the NHS' (39). Emergency funding is needed now to strengthen community teams, provide more beds (40) to reduce pressure on emergency departments, and address the huge and growing maintenance backlog (41).

KONP agrees with Lord Darzi (42) that we cannot afford not to invest in the NHS. There is an urgent need to address staff retention as well as recruitment, based on a new workforce plan that realistically assesses current and future workload. No new PFI deals of any kind should be contemplated and existing ones that are draining NHS resources could be nationalised or renegotiated (43) in the public interest. Where private sector facilities exist and are not being used, these could be acquired for the NHS (44). Reform of social care can no longer be delayed and should be focused on building a National Care, Support and Independent Living Service (45), ending the misery of many needing care and support, together with that experienced by their families and carers.

The Elective Care Recovery Plan takes us to a pie in the sky world where fierce private sector competitors (who would never dream of divulging their own business plans and long term profit-driven aspirations) will 'affirm their commitment to working as part of the tax-funded free at the point of use NHS in support of that goal and to work with the NHS to strengthen the overall healthcare system in England' (46). The plan is focused on the controversial, costly and counterproductive (47) increase in the use of the private sector rather than investing in expanding NHS capacity. The acute care crisis is ignored (so much for the promise of ensuring that 'staff are able to give the standard of care they desperately want to'(48)). This is a continuation of successive government policy that has actively grown the private sector (49) over the last two decades. Many expected better of Labour, voted in on the promise of change and gaining a massive parliamentary majority. Bevan must be spinning in his grave.

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David Rowland: Centre for Health and the Public Interest

David is the Director of CHPI. He has been involved with the Centre since its foundation in 2011 and took over as its Director in 2019. He was interviewed for DFNHS by Alan Taman

'Our focus is on ensuring that the founding principles of the NHS are upheld in all of the various different areas of health and social care policy: healthcare should be provided on the basis of need rather than on the ability to pay.

'One of our chief objectives is to ensure that those who are engaged in delivering health and social care are properly held to account. This means, because of the fact that private companies are used increasingly to deliver services, we are looking a lot at the companies that are involved in delivering those services. This includes looking at things like conflicts of interest and patient safety issues, as well as looking at whether taxpayers' money is being used appropriately.

'The fact is you've got growing amounts of healthcare and social care which are being provided on a for-profit basis, happening at the same time that we are shifting - quite substantially - away from the ideas behind the NHS as it was first conceived, namely that healthcare should be available on the basis of need and that it should be publicly provided.

'We have tried to show over the past few years how the growth of for-profit healthcare actually leads to a two-tier system – you can't have people paying for private care or being forced down the private route if the private sector doesn't exist. And the private sector has only grown in this country because government has outsourced services to it, providing it with billions of pounds of funding as well as lots of subsidies.

'Because many of these issues are controversial and politicians like to dismiss them as "ideological" we use research and evidence data, lots of data, to ensure that any of our analyses are backed up by robust evidence.

'We also set out recommendations for government and seek to communicate what we do in accessible and easy ways as well, so that it can get picked up in the media and can be used

by campaigners and those working in health and social care.

How big is your team?

'We produce a lot of research but we have a very small team: myself, someone who helps with our organisation, and we use different researchers as and when we need them. So we're a tiny organisation compared with other big think-tanks but we punch above our weight. We don't accept any money from the government or the corporate sector, which is a limitation, but it's a rule we've introduced to ensure we can speak authoritatively without people asking questions about where we've got our money from. We've got a 5-star transparency rating from Open Democracy [www.opendemocracy.net] reflecting the fact that we are fully transparent in our funding. We receive individual donations as well as from organisations like Joseph Rowntree. We also have contracts with universities as part of the grants they have.

> "To date there's been almost zero scrutiny of that arrangement, which seems to have delivered very much less care than ... before the pandemic."

How does CHPI choose its research projects?

'Some of what we do is based on an iterative principle. We've recently looked at how the NHS has contracted out eye services or relied on the private sector to deliver eyecare services*. That really comes out of work we've done previously looking at how the NHS is using the private sector more generally to deliver elective operations. The issues are similar to the ones we've seen previously: issues relating to conflicts of interest for NHS consultants, issues relating to the amount of money which is being taken out of the NHS through the companies that are providing these services, as well as patient safety issues. So in a sense we've tried to focus on core issues around accountability and transparency and to seek to apply those to different areas as they become more obvious and more relevant to focus on.

'We did a lot of work during the pandemic around issues relating to the care home sector, looking at the financial impact of covid on the care home sector, and we also looked at the arrangements between the NHS and the private hospital sector during the pandemic, where we identified similar issues around patient safety, use of public money, accountability and transparency.

What are your plans for this year?

'We still have further work to publish relating to the outsourcing of NHS eyecare services*. [So that's something that will hopefully be out in the next few weeks]. That's looking at issues of where money goes. We're also looking at how contracting in the NHS market is very much not like how people think it is, where a lot of people assume the local NHS ICB (Integrated Care Board) goes out to various providers and says it wants a certain number of hip or cataract operations. It's very much driven in the eyecare sector by patient choice regulations, which means that in many instances the ICB doesn't have much control over the amount of healthcare which is provided within its local area. That's a big issue, a big risk, if you're talking about when you prioritise population need according to the people who are most in need, as opposed to those who are able to get referred for surgery.

'We're also continuing to work with the Covid-19 Inquiry. We're just in the process of writing up our views on how the Inquiry handled its investigation into use of the private sector. We're still trying to ensure that deal between the

NHS and the private sector and how the private hospital sector was used during the pandemic are properly interrogated. To date there's been almost zero scrutiny of that arrangement, which seems to have delivered very much less care than the private sector was providing before the pandemic, and there was a very strong incentive within the arrangements with the private hospital sector to encourage it to keep treating fee-paying private patients. Our argument is that that has contributed not only to very long waiting lists for NHS patients who could have just received care during the pandemic but beds in the private sector were allocated to patients who could afford to pay, as well as contributing to a growing two-tier healthcare system, which is something we're continuing to try to raise awareness of.

Please tell us a little about the series of public meetings you have been holding on the risks of a two-tier health service

'We've had a couple of hundred people attending the meetings in Birmingham and Manchester, with lots of engagement from people with the issues we've been raising, so we've discussed the disastrous cuts to public healthcare sector in the UK, and how we're moving away from the idea that healthcare should be provided by the NHS directly, and this is being seen as an area for profit generation by companies which are registered overseas. We've tried to talk to people about what that means for healthcare as patients but also as doctors as well, I think that's a very important shift which is happening. We've also talked to people about the growing two-tier healthcare system and the idea that healthcare increasingly becomes available to those people who are able to pay or have private health insurance, and that the NHS increasingly becomes less able to treat those people who are poorer and sicker. This is because the NHS itself has fewer resources to be able to care for those people effectively.

'These have been the two main themes we've been trying to engage people with. It's been a very interesting, useful experience. We've been very keen to get out of London where many of us are based. It obviously takes a lot to organise but its worth our while to meet people directly and also provide a space where people can come together for a chat as well, because one of the things we're concerned about in addition to what's happening to healthcare is the fact that people are becoming increasingly isolated and sat behind computers and don't get an opportunity to physically meet any more. I don't think that's a particularly healthy way of discussing health policy and I don't think it's a healthy way of doing lots of community organising and working with people. We found the meetings very rewarding and helpful. Quite stressful at times but I suppose that goes with the territory!

Looking forward, how hopeful do you feel?

'I always remain very hopeful because it's self-defeating if you take the opposite view. I think you just have to work on the assumption that the vast majority of people in this country want to see the NHS properly funded, properly staffed. They want to see it continue to provide healthcare free at the point of use. There is a very strong challenge to that which is coming from the government, it's coming from the type of companies we've got operating in this country, but I have a lot of faith in the fact that there are millions of people who work in health

and social care who are committing large parts of their lives to working in those services because they genuinely care about the people they are looking after, but also the ideals that have brought them into the service in the first place. Despite the various attempts over the years to seek to undermine the NHS I think the commitment to the NHS remains very strong. That's not to say it's not hugely challenged at the moment because I think it really, really is, and I think there's a very big risk that the types of care and the quality of care which people have been used to in the past are not going to be there going forward into the future. But that doesn't mean that everything is lost just because we are going through a very challenging period, I think you have to remember that.

'There is no inevitability that the NHS is heading towards a point of no return – that is absolutely possible. Introduce new funding, it will take time to bring the staffing levels back up to where they should be, it will take time to get the physical structure of the NHS back up to where it should be. But it has been done in the past, and it's been done in the past in more challenging circumstances than we find ourselves now. So it's very much about political will.

'From our perspective we need to do two things. First, to highlight areas which can be changed, particularly in relation to the growth in the for-profit sector, so for example introducing caps on all profit s that these companies make if they want to be involved in delivering NHS services, and introducing requirements around patient safety, introducing greater transparency around how these companies operate, and to make recommendations to the government which can be easily implemented. We have some evidence that the government is listening in the children's social care sector and is now actively considering introducing a profit cap on the provision of care to children and young people in residential homes. Our argument is if you make a decision around children in social care why not also cap the profits of companies who provide care to people who are 65 and over and in care homes or people who are in mental health facilities, or even for companies that are providing cataract services for the NHS as well*. This is a very straightforward way of reducing the costs to the NHS in providing those services. If the companies aren't prepared to provide those services without making 25-30 per cent profits then there is no good reason for them to continue to provide those services.

'Our focus this year is to continue to raise those questions about the proper use of public money within the NHS, particularly in relation to the use of the private sector, and to be making recommendations around ensuring that there is greater transparency over where that money goes, and seeking to bring attention to the fact that the growth of the for-profit sector in the UK does over time lead to the growth of the two-tier healthcare system. The two things are inextricably linked, and I think sometimes the government believes that it can use the private sector to support the NHS without the private sector then turning around and saying "Ok thanks very much NHS, if you're giving us all this money, we've got all these staff, we've got all these facilities, now we're just going to focus on those people who have private health insurance or have the ability to pay" – which is exactly what's happened in dentistry, exactly what's happened in relation to fertility services such as IVF. It's increasingly happening as well when you look at the provision of orthopaedic care such as hip replacement or knee surgery. So it's a big risk for government to go down that road if what it wants to do is protect the founding principles of the NHS.'

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Streamlining the NHS: No-brainer or nest of trip-wires?

New initiatives to streamline our NHS have become so frequently mooted or implemented as to be an almost-constant backcloth to our national news.
Yet the vaunted benefits mostly bring disappointment. Why is that? A current example shows how we are disregarding some crucial underlying problems, writes EC member David Zigmond

'Seek simplicity, then always distrust it'
– Alfred North Whitehead (1861-1947)

Our NHS healthcare traffic jams seem now ubiquitous: to speak to a GP receptionist, to see a specialist, to get a scan, receive hospital treatment, await an ambulance to get to hospital, to leave hospital with safe support … we can easily add to this elementary list.

This problem is not new but is accelerating and becoming ever more critical. That something must be done! has many different expressions from different sources. There is no shortage of suggestions, yet, most often, their early and apparent plausibility far exceeds their later purchase.

A recent initiative announced in the media at the start of this new year, 2025, seems eminently sensible and practical. It has been agreed that GPs will now be able to refer patients for CT and MRI scans directly, rather than these only being available to hospital specialists. This empowerment of GPs thus cuts out the expense, delay and bureaucracy of often unnecessary/premature referrals to specialists. Patients will get their test quicker, GPs' to-and-fro bureaucracy is lessened, hospital doctors will not see 'unnecessary' patients.

Everybody wins … surely?

On first-pass analysis all this seems very clear, but further considerations disperse this surety.

For example, generally the more easily available something is, the more casually and indiscriminately it will be used – the more we will relegate our human effort, engagement or attention. This drift to profligacy is true with almost all our inventions. Our currently personally depleted general practice is probably prone to this expedient default. CT and MRI scanners are extremely complex and expensive machines with high-skill and high-cost operating and maintenance requirements. How will the likely inevitable increase in demand be met? Where will the extra money and expert staffing come from? Other welfare services? Increased taxes?...

Some might argue that, apart from such resource and financial considerations, it must surely be a good thing for more people to have more investigations more easily – isn't that how we better detect and treat serious conditions earlier?

There is important truth in this, but it is partial and conditional. Low threshold investigation becomes more like screening, and then we must deal increasingly with 'false-positive' results: deviations from the normal which are ambiguous in nature and prognosis, and would not otherwise have been

found – 'coincidentanomas'. The increased use of sophisticated scanners has already vastly expanded this whole confusing area of putative medicine – whether, when or how to go on investigating or intervening with anomalies that may, in any case, be stable (non-progressive) and dormant. Over-investigation can lead to over-diagnosis – slippery phantoms of real problems.

Amidst this new tide of high tech uncertainty some lives and health are certainly saved, but also much extra work and resources are required, and then, often, much fear and anxiety is generated in the patients so burdened with shadowy ambiguous portents. Iatrogenesis easily becomes a burgeoning risk in such territory…

Such complex predicaments and pluripotential knowledge need to be matched by equivalently sophisticated practitioners. The current proposals assume that GPs can take on this responsibility unproblematically. Really? Well, 'General Practitioners protect patients from hospitals, and hospitals from patients' used to be an accurate aphorism of better practices, but struggles for any truth today.

The loss of this traditional capacity is responsible for many of our current NHS difficulties and avoidable inordinate expenses: it needs our fuller understanding.

Before the serial 'modernising' NHS reforms of the last few decades it was a sine qua non of better general practice that any science of medical practice would, whenever possible, be embedded in, and delivered with, the art of personal understanding. This was largely achieved through the provision of personal continuity of care whenever this was a patient's preference and possible – personal knowledge and understanding were regarded as seminal.

There is much evidence to demonstrate that this erstwhile ethos of practice brings far more than reassuring comfort for patients and occupational satisfaction for doctors. Therapeutic benefits and diagnostic accuracy are both markedly (though not always) increased. The former are due to the complexly healing and motivating possibilities of relationships. The latter is due to vagaries and irregularities in how human distress both presents and progresses … and thus how appositely we may apply our diagnoses.

This requires our deliberation on how variously we present our health problems and distress to others.

Very often we ask for help with descriptions of very open-ended possibilities: 'I'm just not myself'; 'I've got no go in me'; 'I get these headaches/abdominal cramps/feelings of unsteadiness'; 'I just keep wanting to wee'; 'I've never felt so hopeless, doctor';'I feel sick all the time','My vision comes over all funny'… these are typical opening descriptions by patients: 'undifferentiated pathology'. Most of these will not be heralding serious or significant disease – they will, instead, be 'transient and trivial', or expressing some personal struggle or stress. But a few will be early portents of something far more serious. The distinction is often not easy. Who decides which is which? And how?

Until recent times it was usually a GP who made these discriminations. The reason they were especially enabled to do so lay not just in the breadth and depth of their medical knowledge, and the length of their experience, but also how they were likely to have personal knowledge and understanding of the individual they were dealing with. This rich weave of various kinds of knowledge could more accurately and speedily make the necessary decision. Their substantial medical knowledge could better identify atypical presentations and rare serious illnesses; their personal knowledge led to a readier recognition of what was, or was not, characteristic of this person, or what the illness symptom might be expressing of their disequilibration, their life-predicament.

All the benefits of this have been clearly and repeatedly demonstrated by many years' research. Greater personal continuity of care is related not just to greater patient satisfaction, but to reductions in emergency referrals and admissions to hospital, routine referral for specialist assessment, urgent requests for ambulances, hazardous exacerbation of neglected chronic diseases, severe mental health breakdown and self-harm… Very strikingly,

longevity is statistically related positively to such primacy given to personal continuity.

Such are the diagnostic and therapeutic advantages bestowed by personally invested and longer-term healthcare bonds that erstwhile GPs could provide. Those doctors, working in smaller units with patients and staff they knew well, could more readily distinguish the serious from the trivial, the personal from the organic, the watch-and-waitable from the emergency-referred. For example, if Dr X knows a patient and their current predicament well they might, after examination, say, 'I don't think your headaches/stomach cramps/muscle twitching/dizzy spells are due to anything serious. It's most likely due to an overspilling of the stress from your divorce/redundancy/son's criminal charges etc… Come and see me again next week, but sooner if anything gets worse.'

Such skilled and accurately attuned containment used to be much easier when a stably anchored and anchoring GP could, and did, offer this kind of flexible and easy access. Any subsequent errors of assessment could be promptly identified and corrected. Knowing this, both doctors and patients could be less anxious; any inevitable initial uncertainty and ambiguity of undifferentiated pathology could be tolerated with (relative) safety – follow-up was clear, accessible, certain and soon. Expensive scans and hospital investigations could wait…

But this is now not the modus operandi of most current GPs. Doctors working in ever-larger practices, usually very part-time, on short-term contracts, often from several sites, will have very meagre personal familiarity or knowledge of either patients or colleagues. They are most unlikely to be able to offer the kind of vigilant flexible containment, support and guidance – the safety net – portrayed above by Dr X. What, instead, can such a transiently engaged current doctor do? Well, even though they will probably not see the patient again they can, at least, reduce culpability and risk: they can arrange extensive investigations and/or referrals.

This is a common consequence of a system whose unmanageable pressure of work is both a symptom and cause of the breakdown of continuity of care. Yet the argument is often made that such GP personal continuity is an expensive and unnecessary luxury that is a distraction from the 'real work', which can be expeditiously distilled to a relay of mass-managed practitioners and procedures.

But this depersonalised procedural relay is much more expensive than what Dr X could do so readily. And it also adds greatly to the demands, cost and strain of hospital services. And then patients' uncontained illness-anxiety is often ignited and unleashed…

Facilitating sophisticated investigations without a firm bedrock of personal and pastoral healthcare confers very mixed blessings…

The folly of this oversight has been amplified by several related initiatives in recent years to 'relieve' GPs of their cardinal frontline role. Like much populist politics these have easy appeal by apparently offering simple solutions to complex problems. So, if GPs are too few and too busy to do their work properly then why not relieve them of much of their broadly-based primary diagnostic functions and instead get them to concentrate on complex cases and managerial/supervisory tasks?

Hence the idea of First Contact Practitioners (FCPs), who would substitute for doctors in making initial assessments and diagnoses. The FCP Unterdoctors can be pharmacists, physiotherapists, occupational therapists, dieticians … all of whom have some working background in healthcare.

Physician Associates (PAs) – more worryingly – may have had only a two-year university crammer course. All, though, can be more quickly trained and cheaply paid than doctors. This bargain-package funding is called the Additional Roles Reimbursement Scheme (ARRS).

To the unwary this may seem like an Occam's Razor, but such a 'solution' will prove more of a populist folly and myth. The myth is that medical practice is merely a system of atomised facts that can be precisely itemised, navigated by algorithms, and managed by procedures. While this has some useful, yet always partial, truth in hospital medicine, it is far less apposite in the far-more chimeric and humanly vagaried world of primary and mental healthcare.

The follies come and accumulate from this reductionism. FCPs, and especially PAs, will be guided by prescribed algorithms rather than any deep knowledge, long experience or familiarity with the patient. Knowing this, they will practise defensively – adhering rigidly to management-defined pro forma, then being unable to cut to the chase. So this inventive discrimination – so essential to sustainable medical practice – becomes fearfully distanced, denied or passed on.

Very little of this will help the GPs who are meant to supervise all this and will now have even less contact and familiarity with the patients concerned. Increasingly those siloed doctors will be referred only those patients who the non-doctor FCPs deem more complex or serious. But, as we have seen, this discrimination itself often requires significant knowledge and skill: most serious conditions start off seeming trivial or commonplace. How to cannily identify the often-camouflaged dangerous, yet also not over-investigate or over-react to the vastly greater flow of minor and self-limiting complaints … that is something erstwhile family doctors were pre-eminently well-suited for. All this was respected and secured in the NHS until the serial reforms began in the 1990s. In many international studies the NHS was then regarded as the most efficient, safe, equitable and best-value-for-money health system worldwide. This was largely due to a nexus of family doctors who, by often knowing as much about their patients as they did about illnesses, could manage and deliver their personally accessible first-contact service 'protecting patients from hospitals, and hospitals from patients'.

Yes, there was then also some enormous variation in standards, and some egregiously bad practice. But despite these, the old system – based on personal continuity with a familiar practitioner – yielded a much more stable workforce with excellent morale and motivation: that was why it was able to perform so well.

There is a paradox here that is often missed: to be expert at identifying and dealing with the serious, practitioners also need immense experience, too, with the 'transient and trivial': that is how we best learn about not only the natural histories and masquerades of many complaints, but the many layers and presentations of the always-somehow-unique people who come to us. To deprive GPs of their 'front-door' function deprives them of the experience, wisdom and gratification that come from this more vernacular medical practice.

Seeing mostly patients that they don't know, who are priorly designated and referred by some form of First Contact Practitioner, will turn GPs' work increasingly depersonalised, dull and bureaucratic.

Patients are hardly likely to be safer or happier.

GP recruitment will continue to fall. Doctors will increasingly leave. Those that remain will be even more scanner-sighted, but humankind-blind.

Ah, but then we can replace them with more Physician Associates…

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

– GL Chesterton, Generally Speaking (1928)

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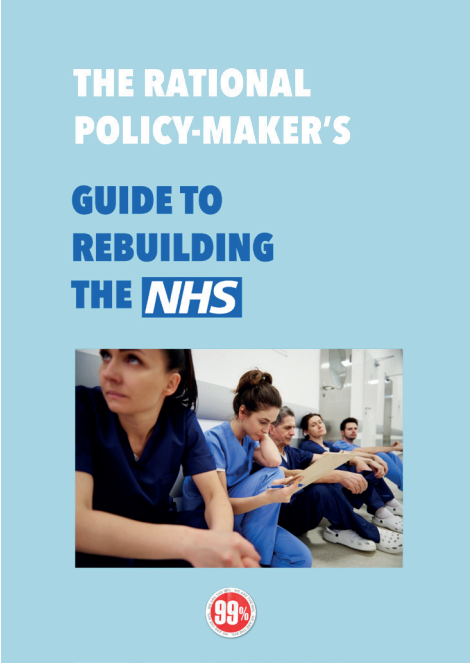
99%'s Next 'Guide' is a persuasive sequel



99%'s *The Rational Policymaker's Guide to the NHS* was well received. Its key points were described at the last AGM (see the previous issue of this newsletter for a summary).

Now, 99% is launching what promises to be an equally persuasive 'sequel', *The Rational Policymaker's Guide to Rebuilding the NHS.*

It was recently presented to MPs at Westminster at a parliamentary event organised by 99% and Labour MP Richard Burgon.

This guide takes the argument of giving us the NHS the public want further by pointing to what the last Labour government got right, as well as where it wasn't so successful. Its executive summary says:

'The government has pledged a decade of national renewal. When citizens are asked for their most pressing concerns, the answers they give are consistent: the top issue is the cost-of-living crisis, and the second is the crisis in the National Health Service. Tackling the NHS crisis is a critical part of national renewal.

'The 1997-2010 Labour government also inherited an NHS in crisis and succeeded in turning it around. This time the job is more difficult because the UK faces many simultaneous crises – not least a chronically weak economy – and there are many other pressing areas in which renewal is also needed.

'The government has set out three important shifts it intends to drive in rebuilding the NHS: from analogue to digital; from hospital to community; and from sickness to prevention. Most experts agree with the direction of these three shifts, but they do not constitute a complete strategy for rebuilding the NHS.

'This report argues that, despite the additional challenges, the government can rebuild the NHS but that, as it has very little room for error, it will have to learn from the experiences of its last term, act systemically and avoid some tempting pitfalls along the way:

- The 1997-2010 Labour government delivered a huge improvement in NHS performance – this government must learn from that experience and replicate that success;
- The 1997-2010 government also instigated some questionable initiatives which need scrutiny;

- The reason the last Labour government was successful is that it succeeded in getting right many of the most important factors, in particular, funding, prevention and tackling the social determinants of ill health – this government must do the same.

'Since the new government faces a tougher challenge than the 1997-2010 government, it can and must also learn from Attlee's government about how to deliver in times of great stress.

'As the Health Secretary said last year, "We have done this before. When we were last in office, we worked hand in hand with NHS staff to deliver the shortest waits and highest patient satisfaction in history. We did it before, and together we will do it again." This report explains how to make that aspiration a reality.'

The report then 'explores the success of the last Labour government in turning around the performance of the NHS: it covers what we mean by healthcare system performance, what outputs and outcomes Labour managed to deliver from 1997-2010, how citizens reacted, how that stacked up against other leading healthcare systems and – perhaps most importantly – what caused the improvement.'

As with *The Rational Policymaker's Guide to the NHS,* the report builds its arguments carefully, framing them by posing simple, key questions such as 'what can citizens expect from a healthcare system, and what outcomes do they want to see', then examining these using robust and comprehensive evidence, including international comparisons where appropriate, which it depicts with graphs and illustrations to good effect. .

The next section examines what the last Labour government didn't get right, or at least could with hindsight have best avoided:

'The 1997-2010 government instigated some initiatives which need scrutiny

'The overall picture from 1997-2010 is one of a successful turnaround of the NHS from a low base, but ... it is likely that some of the individual initiatives introduced by the last Labour government were unhelpful. While it is not 100% clear which initiatives were successful and which were not, there are good reasons to suspect that the following initiatives were counter-productive:

- The Private Finance Initiative;
- Lack of rigour in target-setting, leading to distortions of priorities;
- Use of public funds to build private sector capacity.

'There were also major issues which the 1997-2010 government did not tackle – notably Social Care.

'To succeed this time, the government must skilfully avoid the pitfalls of the past.'

The sections outlining in more detail how these shortcomings were flawed are all the more persuasive because they are relatively short but again supported by good, non-partisan evidence – a strength of the report which will hopefully add to its effectiveness. It concludes this section with a cautionary note:

'It is to its credit that this government is taking NHS funding more seriously than any since 2010. It is vital, however, that it learns all the lessons of the past, as the room for error is far less now.'

'While there is no comprehensive assessment of all the initiatives undertaken under the 1997-2010 government, it is clear ... that in aggregate they had a negligible impact and likely that some, including PFI, insufficiently careful use of targets and performance measures and using public money

to increase private capacity may well have been significantly negative in impact.

'The government should therefore encourage rigorous investigation by Britain's leading universities of which reforms produced improvements, and which were counter-productive, the National Institute for Clinical Excellence (NICE) should be asked to assess new initiatives before launch and the NAO should be responsible for assessing which initiatives have lived up to their promises so that policy errors can be quickly rectified.

'Lord Darzi's report concluded that, "the NHS is in critical condition, but its vital signs are strong." A patient in critical condition needs very careful handling; the same is true for an organisation. We must avoid the pitfalls.'

The next section focuses on how the last Labour government 'did get the most important things right:

- They recognised and acted on the need to address previous under-funding;
- They made significant progress in addressing the social determinants of ill-health; and
- They had a sound approach to prevention and public health.

Exploring each of these points in turn in some detail, before looking at 'why the turnaround from 1997-2010 worked', which relates back to 99%'s analysis of cause and effect loops (referred to in the last issue of this newsletter).

The final section is arguably the most compelling, leading from its title 'How this government can succeed', after explaining starkly why it must do so:

'Imagine if what has happened to NHS dentistry were to happen to the rest of the NHS.

'Regional health inequalities would worsen, many people would be unable to get treatment for non-emergency procedures and A&E demand would rise correspondingly , medical bankruptcies would become more common , and many people would postpone getting medical attention or resort to do-it-yourself treatments which can lead to life-threatening conditions and ill-health and avoidable mortality would rise.

'The health consequences are obvious, and morally unacceptable. The economic consequences would also be dramatic.... The former Deputy Governor of the Bank of England, Andy Haldane estimated that the cost to the UK economy is already £150 billion per annum. But that is nothing compared with the cost of such an NHS failure: as our previous report showed, if the NHS were allowed to fail in such a way, the UK economy would fail with it.

'The long-term political consequences for the UK of such a double failure would be unthinkable.

The UK cannot afford the government to fail on the NHS. It is not an option to be considered.

The report concludes with:

'This government faces huge challenges in rebuilding the NHS. They are challenges it must not duck. To succeed, it will need to challenge its own orthodoxy, it will need to build a genuine capability for joined-up government, and it will have to learn from what works.

'All of this is possible. The alternative is failure: for the government and for the country.

The main text concludes with:

'This government faces huge challenges in rebuilding the NHS. They are challenges it must not duck. To succeed, it will need to challenge its own orthodoxy, it will need to build a genuine capability for joined-up government, and it will have to learn from what works.

'All of this is possible. The alternative is failure: for the government and for the country.'

Appendices examine the arcane and ultimately damaging workings of the PFI scheme, and a case study in privatisation (ophthalmological services) which DFNHS directly contributed towards.

The Rational Policymaker's Guide to Rebuilding the NHS was written with advice and assistance from a wide range of individuals and campaign groups, including DFNHS and KONP.

You can download it from 99%'s website (https://99-percent.org)

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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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To find the will to fight for our NHS, people first have to see what threatens it ...

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