DOCTORS FOR THE NHS NEWSLETTER
SERVICE NOT PROFIT

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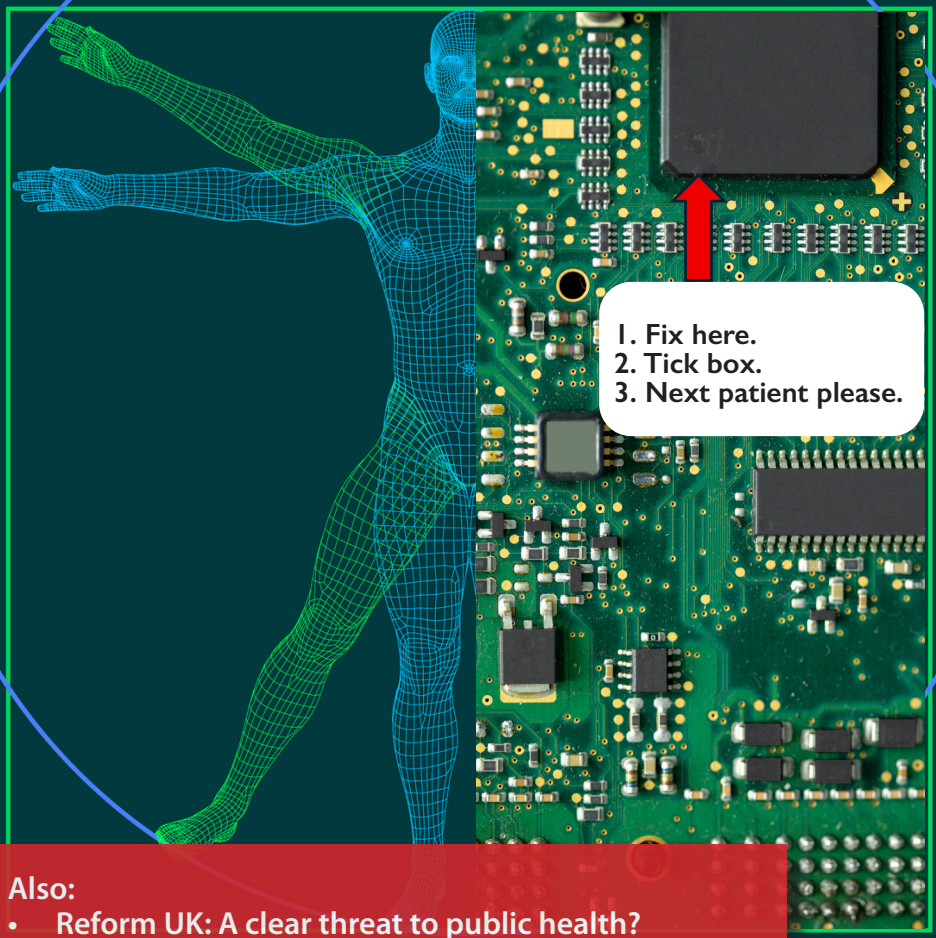

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A View From the Chair: Eric Watts

The Chinese curse, may you live in interesting times, is upon us again as we enter another phase of increased political turbulence.

Forty eight people have served as ministers at the Department of Health and Social Care since the 2015 general election, with an average tenure of 487 days.

We have a new Health Secretary and it is relief that Wes Streeting, who has been unnecessarily critical of and confrontational with loyal NHS staff as well as advancing privatisation, is no longer in post. There are opportunities to review the *Ten Year Plan* and to reconsider wasteful policies including the appointment of non-medical staff into roles requiring appropriate medical qualifications.

We welcome James Murray to his first substantial post noting that he has a good record in housing and is a Starmer loyalist who has kept a low profile so far. He made his maiden speech in March 2020 on the NHS, praising its role in treating his myasthenia gravis.

The founding father of the NHS and the first Secretary of State knew what he wanted because it was the culmination of years of careful planning based on the experience of operating the Tredegar Medical Aid Society which evolved from the vast network of friendly societies and mutual aid organisations in the area. In short, they developed a system that worked and was shown to work through several years.

Since then we have seen a succession of people bringing ideas without sufficient scrutiny, trialling or evaluation. Whilst much has changed since 1948 the key fact remains that the Medical Aid Society model went on to transform the health of the nation.

Fast forwarding to 2024 we had the Darzi report, produced by a man with long experience in developing health services and new models of care, and then the *Ten Year Plan*. The plan was extensively reviewed in last year's newsletters and the Health Reform Bill – which risks reducing the patient voice and undermining partnership work between the NHS, social care and public health at a local level with the removal of mandatory local authority representatives within ICBs – passed its first reading on 1 June.

My particular concern has been in respect of democratic input which has been shown to improve performance. The Medical Aid and Friendly Societies had a cooperative or democratic structure but democratic input now is reduced to general elections where health is an important, but not the only issue.

This means that health secretaries can implement their ideas if they can get them to Parliament and experience shows that few parliamentarians understand the issue sufficiently well to make good decisions. Despite the claims of certain 'reforming' health ministers repeated surveys have shown a clear majority of the UK public favour the NHS as publicly owned, publicly provided and publicly accountable.

In a previous issue of this newsletter, EC member Mike Galvin wrote on the value of citizens' senates or juries as a way of finding the authentic view of the public on matters which need to transcend party politics (1) and this would be better than health secretaries' claims that they know what the public want because their party has been elected.

The Darzi review stated that patients should have a greater say (2). This view is well supported by evidence compiled by NICE in their guidance on shared decision making (3). This is a more complex area than deciding the better of two medical treatments and in their guidance they

state that hospital and health authority board should consider appointing a Lived Experience Director to their boards.

The *Ten Year Plan* turns away from these expert recommendations and aims to abolish HealthWatch England and Hospital governors.

My experience with working with HealthWatch in Sheffield and in Essex is that they have both gone out to engage with the public and champion the authentic patient voice. The proposals in the *Ten Year Plan* will make that voice more distant and will go through too many filters to be truly representative.

Most of our hospitals are now foundation trusts and have governors to provide a link with the communities. I have served as a governor and attended national meetings, organised by NHS Providers ,which provided a useful dialogue with governors up and down the country.

Most of the governors fell into two categories, ones where they were welcomed by the hospital chair and boards and where they had useful input into the boards machinery ie committees, subcommittees etc. Unfortunately most fell into the other category where governors were tolerated but not expected to do their job ie to be critical friends.

If the government wishes real engagement of patient and public it would set up a suitable democratic structure so that patient representatives would be elected from the communities and would be on hospital boards with the same powers as any NED.

The problems with the existing boards have been well documented leading to the creation the policy of Problem Sensing Boards. Briefly, too many board members have seen loyalty to their board as a greater priority than listening to 'outsiders' who, in speaking up for patients and public, may criticise the board.

Directly elected NEDs may be a step too far but at least one trust, Midlands Partnership Foundation Trust, has appointed a Lived Experience Director and is demonstrating the value of that appointment.

I have advocated better patient engagement and often received the reply that boards are made up of experts and do not need input from patients. A quick response would be to look at the hospital league tables, imperfect but a quick and dirty guide, using data from the NHS Oversight Framework. Trusts are scored across key metrics — such as A&E waits, waiting lists for routine operations, cancer treatment, ambulance response times, and financial management.

They show that the trusts who have invested in good public and patient partnership – such as Guy's, UCLH and Northumbria – to be in the top 10%.

The situation is healthier with respect to preserving local HealthWatch as HealthWatch England faces abolition.

In Sheffield the local HealthWatch has won support not only from health organisations but from councils and voluntary organisations. They state their role is most effective when operating outside of statutory bodies, enabling it to challenge, convene and reflect system-wide perspectives rather than organisational ones.

The local consensus is that this independent voice should continue the major challenge, being funding locally should central support be withdrawn.

We have seen governments abolish patient

> "A cherished principle in health for over 2000 years is that the contents of a medical consultation are private but health data is seen by some, particularly insurance and IT companies, as valuable data."

centred organisations and then later realise their value and re-establish them. In particular I well recall the good work of the national Cancer Survivorship Initiative, a joint venture started by the Department of Health and Macmillan in 2008. It was wound up by the government in 2013 but soon after they realised the need for better care for cancer survivors and their established the Living With and Beyond Cancer project.

The major problem was that having closed the initiative, they lost the organisational memory which could have informed the start of the new agency, a dreadful waste of resources. The future of the local HealthWatch is assured until 2027, time for a rethink or an orderly transition to a new system.

Ownership of patient information

A cherished principle in health for over 2000 years is that the contents of a medical consultation are private but health data is seen by some, particularly insurance and IT companies, as valuable data. Palantir are one of those organisations and we know that they have used data collected in the USA that has been passed to ICE (the USA Immigration, Customs and Enforcement Agency) to identify areas where high dependency patients live as these are seen to be likely areas to house illegal immigrants.

There is sufficient evidence that ICE has done great harm to vulnerable communities to say that no health organisation should cooperate with them. Palantir are using health data against the patient's interests

There has been outrage that the NHS has placed contracts with the company and there have been nationwide protests including one at Sheffield when the local Health and Wellbeing Board (HWB) met. DFNHS was there and I spoke to the fact that we should not do business with a company that does not respect the privacy of confidential data.

The HWB agreed with the point but is not responsible for placing contracts and it asked all the NHS groups involved to review their policy and consider alternative providers.

Medical Staffing

It is a long-standing policy of DFNHS that we should have sufficient qualified doctors and nurses. The career pathways are well established and the best care is delivered by fully qualified consultants and GPs with sufficient numbers of doctors in training to meet the needs of the service.

We have lived through decades where most care was delivered in hospitals by staff in training who are cheaper than qualified consultants and now we see a new approach in the appointment of non-medical staff.

This is to be one of the topics in the forthcoming Doctors for the NHS and DAUK conference in October (Saturday 10 October at Bedern Hall, York; save the date!).

We have seen non-medical assistants being introduced and if they were simply to assist busy clinicians they could be a real asset but the evidence does not support this.

The Leng Revue (4) demonstrated serious problems with the status quo and in particular confusion caused to patients when the assistants or associates did not identify themselves as such. This point was also made by the Patient's Association who reported the public awareness was low and patients would expect to be told

who was treating them.

The BMA response has been to highlight leadership failures resulting in a postcode lottery in the quality of care (5). Other reports have identified a 'creep' of other professionals taking clinical responsibilities, with poor outcomes (6).

Despite these problems we continue to see appointments being made including doctor substitution in medical rotas. This raises real quality and safety concerns. Although theoretically possible that non-medical staff can be under the supervision of a medically qualified consultant the reality is that most decisions are determined by the man or woman on the spot and it is essential that they have the necessary knowledge and experience. Bizarrely this is happening at a time when recently qualified doctors are having difficulty in finding work and non-medical substitutes reduce the training experience.

The Role of AI

Another challenge is the role of AI and we can't fail to be impressed by the speed with which these systems can survey vast amounts of data and process them much faster than any living person. The challenge comes in the form of judgement, and experience to date shows this to be lacking.

Given a symptom or symptoms AI systems can produce a list of diagnoses but work is still required by clinicians and diagnostic departments to confirm it. Some work can be robot assisted and robotic surgery can be marvellous to behold but, like all innovations, it needs to be carefully evaluated.

The lay and some medical press see AI as a major step forward but there is a huge amount of work to do in testing, refining and monitoring the systems.

Asking Google about AI in healthcare produced this report from NIH:

'In conclusion, while AI presents the opportunity for a health care revolution, it is imperative to address the ethical, regulatory, and safety challenges linked to its integration. Proactive measures are required to ensure that AI technologies are developed and deployed responsibly, striking a balance between innovation and the safeguarding of patient well-being'. (7)

The important point is to recognise what it can do well, ie store and process data, but the experience to date shows that like any tool, we must learn how to use it and use it safely.

These are interesting times. We see change and experimentation but we have yet to see any evidence that the NHS needs to change from its founding principles. To the contrary, the harder we look, the more we see the need to preserve them.

References

1. Galvin, M. (2026) 'NHS bottom-up workplace democracy' DFNHS Newsletter, Jan-Mar, p.20 [Available at: https://tinyurl.com/2er5wcdc]
2. Darzi, Lord (2024) *Independent Investigation of the NHS in England (the Darzi Review)* [Available at: https://tinyurl.com/ycyc9754]
3. NICE (2021) 'Shared decision making' 17 June [Available at: https://tinyurl.com/mpppxypn]
4. Leng, G. (2025) 'Independent review of the physician associate and anaesthesia associate roles: final report' 16 July [Available at: https://tinyurl.com/2sak3vtz]
5. BMA (2025) 'The Leng Review exposes "catastrophic failures in NHS leadership" but fails to fully protect patients, says BMA' Press release, 16 July [Available at: https://tinyurl.com/49eyzenf]
6. Ireland, B. (2026) 'Doctors raise alarm on "unsafe and distressing" substitution' The Doctor, 11 May [Available at: https://tinyurl.com/4xa9d7j6]
7. Chustek, M. (2024) 'Benefits and Risks of AI in Health Care: Narrative Review' *Interact J Med Res,* Nov 18;13:e53616. [Available at doi: 10.2196/53616]

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Reform UK: A clear threat both to the NHS and public health?

How do the stated poliicy of Reform Uk and public comments of its prominent members stand up to scrutiny when it comes to the NHS? John Puntis analyses the evidence.

Executive summary

Reform UK has risen in the polls (1) and some suggest that the party could be in government after the next election. It is clearly important to know what this might mean for all of us in terms of access to health services. Reform's policy on healthcare is insubstantial, lacking in detail andcontradictory. However, if statements coming from the Reform UK leadership about the urgent need to change the NHS were put into practice it is clear that there would be:

- No new additional cash for an NHS struggling because of chronic underfunding.
- Public money steadily diverted to support growth of the independent health sector (£17bn per year (2)), inevitably leading to a two-tier system with second-class service for those who cannot afford private care.
- Unnecessary increased spending on administering a more expensive funding model than the one we have at present.
- A shift so that more of the cost of care comes out of the pockets of patients (should we became more like France as advocated by Nigel Frage, for example – top-up insurance costs, 'hotel' charges in hospital, and payment to see a GP).
- An undermining of public health through the promotion of conspiracy theories, vaccine scepticism, attacks on the World Health Organization and a rejection of climate science.
- Abandonment of attempts to understand and reduce health inequalities.
- Subservience to US business interests that would damage the NHS.
- A kicking into the long grass of the grave issues in social care (calling for a Royal Commission of Inquiry into Social Care System).

Background: overwhelming public support for the NHS

The vast majority of the population see the NHS as a vital public service and want it to continue to be publicly provided and funded; 89% want care to be free at the time of use (3), and 81% favour funding from general taxation. The NHS is an important element in the (slowly eroding) social wage – benefits we enjoy paid for through taxation. While Labour is currently doing its best to persuade people (4) that its policies on the NHS are really making a positive difference, objective facts suggest that promised targets will not be met (5). As a consequence, deteriorating performance driven by chronic underfunding has been fuelling demand in the right-wing press (6) for a change in funding model.

What do Reform UK leaders say about the NHS?

Reform UK has pledged to keep health care 'free at the time of use' but at the same time advanced proposals that would undermine and weaken the NHS. Party leader Nigel Farage (former public

school pupil, former banker, millionaire businessman and ex-member of the Conservative Party) has said in the past (7) that we are going to have to move to an insurance-based system for funding the NHS, and has held up the French system (8) as an ideal model. Despite some equivocation, Farage has clearly stated 'Everyone knows we are not getting value, let's re-examine the whole funding model and find a way that's more efficient' (9). He is also the chair and a co-founder of Action on World Health (10), which campaigns to reform or replace the World Health Organization (WHO), arguing against its global role in promoting and defending public health.

Richard Tice (11), deputy leader of Reform UK (former public school pupil, millionaire businessman and ex-member of the Conservative party) has argued for major 'reform' of the NHS (12), saying that the increasing numbers on waiting lists despite a boost to funding proves this is needed. In other words, he argues that current funding is adequate (13) to meet need, but funds are being mis-spent. Tice has said in the past that Reform UK would bring NHS waiting lists (currently 7.3 million) down to zero in 2 years. He provided little detail as to how this extraordinary feat could be accomplished but suggested it would be done by making more use of the private sector and funded through 'efficiency savings'.

> "There are big questions about how funding of public services would fare in general under Reform UK stewardship."

Mr Tice also claims that abandoning net zero targets could save money that would then be used for the NHS. This would seem to be an acknowledgement that more funding for health is needed, but clearly fails to recognise the huge health care costs (14) that will be driven by climate change. The Sunday Times reported that Mr Tice's company avoided paying £600,000 in corporation tax, consistent with Tice's view that people should aspire to pay as little tax as possible (15). He has also argued that there is a crisis of overdiagnosis (16) of children with neurodiverse conditions, adding for good measure that the sight of children wearing ear defenders is 'insane'.

Rupert Lowe MP (former public school pupil, former banker, ex-member of the Conservative Party and millionaire businessman (17)) has set up his own hard-right party 'Restore Britain' (18) since being ejected from Reform UK. Lowe was initially suspended (19) over claims that he had made threats towards the chairman, Zia Yusuf. Subsequently, he verbally attacked Nigel Farage, calling him 'a coward and a viper', and describing Reform UK as 'a protest party led by the Messiah'. Lowe became the chosen favourite of Elon Musk (20) who described Farage as 'not having what it takes'. The feuding continues, and Mr Lowe considers himself to be banned from GB News (21) on Farage's direction while a number of Reform UK councillors have defected to Restore Britain.

When still a Reform MP, Lowe declared that 'The NHS is a fraud.... We should be allowed to opt out of the NHS and have some form of...scheme where we buy our own healthcare' (22). Note that even less ambitious reorganisations of the NHS are very expensive, with Andrew Lansley's 2012 Health and Care Act estimated at costing around £3bn (23). This massive change to care would in itself involve huge costs while buying health care would be beyond the means of many people (current per capita spending in England is £4,336) (24). Lowe seems to harbour a visceral dislike for the NHS, saying that he wants it to be 'dismantled and reassembled'. It is likely that his views on health are representative of others in Reform UK. For example, James Bembridge, a Reform UK candidate for the 2026 local elections in London, has stated that 'hate is too weak a word for what I feel towards the NHS. I'd tear it down and salt the earth upon which it stood' (25). He also has a record of abusing NHS nurses on line. The whole idea of the NHS as a service that looks after

everyone irrespective of colour, creed or financial status probably makes it anathema to many in the party.

There are big questions about how funding of public services would fare in general under Reform UK stewardship. In January 2025 Lowe brought in a 'ten minute rule' bill as a prelude to a private member's bill to ban quantitative easing. He was supported by Farage and the other Reform UK MPs, his speech highlighting the dangers of excessive state intervention, debt, and moral decline. Richard Murphy of the 'Tax Justice Network' pointed out that such legislation would completely crash the UK economy (26) and allow the Bank of England to fail. He suggested that Reform UK must want to destroy government as we know it by removing its ultimate power of being able to create money.

In addition, Reform UK says that if in government it would expect to dismiss the top civil servant (27) in every government department and replace them with people seen as more likely to implement the party's priorities. This plan has prompted warnings that a shift towards a less stable and more politicised civil service could result in the loss of significant expertise and of institutional memory making government less effective. It is not difficult to imagine that if this were to happen, the NHS would be thrown into even more chaos than at present. Reform UK has also pledged to abolish the NHS Race and Health Observatory (28) which works to identify and tackle ethnic inequalities in health and care by facilitating research, making policy recommendations and enabling long-term transformational change.

"Reform UK has also pledged to abolish the NHS Race and Health Observatory which works to identify and tackle ethnic inequalities in health and care."

How does Reform UK plan to 'reform' the NHS and what would this mean?

Reform UK's 2024 manifesto, 'Our Contract With You' (29), was described by critics as 'Liz Truss economics on steroids' (30) after it promised £140bn in tax cuts including raising the threshold of income tax to £20,000, and claimed that £156bn could be found through making spending cuts. However, 2 months after the 2024 general election, Reform UK announced that its 'contract' should no longer be taken as specific policy but rather 'more as the philosophy of what the party wants to achieve'. Addressing the crucially important social determinants of health (31), like much else, seems missing from the Reform UK health agenda. Currently policy detail has still not emerged, but the 2024 'contract' together with the statements by Reform UK leaders give a good idea of what might lie in store for the NHS were they to gain power. The 'contract' contained these proposals:

- Use independent healthcare capacity; harness independent and not-for-profit health provision in the UK and overseas.
- Tax relief of 20% on all private healthcare and insurance; this will improve care for all by relieving pressure on the NHS; those who rely on the NHS will enjoy faster, better care; independent healthcare capacity will grow rapidly, providing competition and reducing costs.
- Put patients in charge with a new NHS Voucher Scheme; NHS Patients will receive a voucher for private treatment if they can't see a GP within 3 days; for a consultant it would be 3 weeks; for an operation, 9

weeks; services will always be free at the point of use.
- Improve efficiency; cut waste and unnecessary managers; operating theatres must be open on weekends; rotas must be planned further in advance; nail down better prices using economies of scale.
- Charge those who fail to attend medical appointments without notice. Abolish the NHS Race and Health Observatory.

This amounts to a plan to use taxpayers' money to expand private healthcare services without providing additional resources directly to the NHS and was criticised by Daniel Goyal (32) writing in the *Byline Times*:

- The pledge by Reform UK to keep the NHS 'free at the point of use' is not the same as ensuring it is a tax-funded, publicly owned, universal healthcare system. A depleted public healthcare service can still be free to use while providing substandard care. The important question is whether patients can access the right medical treatment at the right time and without facing financial hardship.
- Redirecting public finances to private healthcare providers is continuing a trajectory that successive governments have followed, while Reform UK's plans go much further. Expanding private healthcare capacity while redirecting NHS funds to private providers directly via the patient will have the effect of replacement of publicly owned health services with private providers.
- The Voucher Scheme would mean that private providers can access money directly from NHS budgets in the absence of any NHS contract. This would mean less money for the NHS – worsening services - more vouchers – more tax payer money flowing to the private sector.
- Tax relief on payments towards private healthcare insurance or services is intended to promote the growth of the independent sector.

It is clear that implementation of these proposals would progressively replace public ownership of healthcare with private provision funded by taxpayers, and lead to a two-tier system with inferior services for those without the means to pay for better. It could not deliver the promised 'faster and better care' in an increasingly under-resourced NHS. There is also no evidence to suggest that competition (33) among independent providers would drive down costs.

> "Implementation of these proposals would progressively replace public ownership of healthcare with private provision funded by taxpayers."

Is moving to an insurance-based system a sensible suggestion?

Firstly, it is important to note that European countries with insurance-based systems spend much more on healthcare per head than the UK (France 26%, Netherlands 28%, Germany 32% and Switzerland 89%) including on higher administrative costs (34). Switzerland has mandatory health insurance, but the proportion of private 'out of pocket' spending on health is also exceptionally high at 26% of total spend. This means that despite an insurance-based system households with lower earnings pay a higher proportion of their income for healthcare than the richest.

Arguments against a social insurance model of the type advocated by Farage have been summarised by the King's Fund (34):

- It is based on payroll taxes paid by employees and employers, meaning that it cannot provide universal coverage and the state and/or the taxpayer has to fund services for the unemployed and others unable to pay the payroll tax.
- As costs rise due to growing need, some countries have chosen to increase tax-funded contributions rather than increase employer contributions for fear that this could harm economic growth and employment.
- In general, there are higher administration costs as earmarked contributions cost more to raise than general taxation, and sickness funds incur their own administration costs.

A recent analysis by the IPPR (Institute for Public Policy Research) (35) across 22 high-income countries reinforced these observations. It concluded that switching the NHS to a European-style insurance system would not improve performance across measures of capacity, access, quality, efficiency and equity. A key advantages of a tax-funded system is that it is cheaper for patients: people in the UK spend 2.6% of household income on out-of-pocket health costs, compared with 3.5% for those in insurance systems, and there are also lower administration costs. Overall costs would rise and people would pay more if the NHS were to become like the French system.

What would we get if we did transition to a French-type system?

In the French social insurance delivered healthcare system, overall costs are higher than the NHS, and not only do people pay to see a GP (€30 each visit, about £25) and for time spent in hospital, many have to pay for health insurance as well as contributing to the costs of care. Masses of evidence indicates that there are no positive health gains (36) linked with moving to a social health insurance system, and that no one type of funding model is systematically better (36) when it comes to delivering value for money. It should be noted that if the UK had matched funding per head on health in France over the 10 years before the Covid pandemic, the NHS wold have received an additional £40bn to spend each year (37).

In France (38), the social security system covers many costs but some have to be paid by patients from their own pocket or by taking out private insurance cover – social security payments alone are not enough. For those in work, the employer may contribute to a collective private health insurance, while self-employed people have to arrange their own insurance. Average costs of top-up insurance were €979 (£845) in 2024, but there is wide variation. Some on low earnings are eligible for top-up insurance provided by the state. For patients in hospital, there is a daily €20 (£17) charge for accommodation, meals and laundry, which is not reimbursed by the state although covered by most insurance policies.

The state reimburses 80% of the costs for services of the hospital's medical staff, medicine and equipment. Service charges vary but can be as much as €3,000 (£2,590) a day for intensive care. There is a bill of €600 (£518) per day for those who don't have supplementary medical insurance. Certain groups qualify for free hospital treatment (eg pregnant women during the last 4 months of pregnancy, at birth and for 12 days afterwards; infants under 30 days old; some people on low incomes; those hospitalised after an accident at work or an occupational illness; patients receiving hospital care at home; disabled children in specialist care; and those with military pensions).

Lord Darzi pointed out in his report on the state of the NHS for the Labour government (39): 'Every advanced country has universal health coverage (except USA) but other health system models – those where user charges, social or private insurance play a bigger role – are more expensive.' Reform UK MPs are well enough off to choose the private sector rather than the NHS for their care. They should reflect on the fact that the independent sector does not want to take over areas like A&E, acute surgical services and intensive care. Policies that grow the private sector inevitably undermine these services rooted in the NHS and supported by its expert multi-disciplinary teams and on which we all depend, for example after major injury in an accident (40). Those like Farage who advocate moving to an insurance-based model are either unaware of the wealth of evidence that this would increase costs without delivering benefits, or are not troubled by this fact given that as long as you are wealthy, good healthcare will remain within your reach.

Could money be saved through efficiencies as Reform UK argues?

The NHS is constantly making efficiency savings, forced upon it by reducing levels of investment in relation to rising overall demand. While nominal spending continues to increase, spending related to health needs has decreased. It is this underspending (41) that has led to poorer services and now poses a threat to the economy. While there may be examples of waste in the NHS, as in any big organisation, it is very unlikely that this explains poor services. The comprehensive international comparisons in the Commonwealth Fund reports (42) rated the NHS very highly on 'administrative efficiency' (low billing, less bureaucracy, simpler paper work). As recently as its 2014 report (43) the NHS was rated best overall. Research by the King's Fund (44) also found that the UK health service is amongst the most efficiently run healthcare systems, for example, spending relatively little budget on administration and keeping medicines costs low. The Organisation of Economic Cooperation and Development noted that the NHS shows high efficiency in administration (45), spending significantly less on overheads (roughly 1.9% of health spending) compared with peers like the US (8.9%) and France (5.5%).

An important message for policy makers is that one important cause of inefficiency is lack of investment, resulting in poor hospital buildings, outdated equipment and lack of staff. Lord Darzi concluded (39) that the NHS is not just short of money but has been systematically underinvested in capital (in fact a £37bn funding gap), leaving it with outdated infrastructure that limits productivity, capacity, and quality of care. While patient outcomes in the UK are worse than some comparable countries, the King's Fund explains this as driven by underinvestment in equipment and staffing, leading to fewer hospital beds and scanners per capita. This causes long waiting times, delayed diagnoses for cancer and other chronic illnesses, and higher rates of treatable mortality, coupled with higher population inequality and wider health inequalities.

"An important message for policy makers is that one important cause of inefficiency is lack of investment, resulting in poor hospital buildings, outdated equipment and lack of staff."

Before the 2025 local elections Reform UK claimed it would 'reduce waste and cut your taxes' (46). For Reform UK led councils, council tax was then increased on average by 3.94%, and just lower than the overall average rise of 4.86% (46). However, some Labour led councils (Hartlepool, Westminster) had the lowest rises and Reform UK minority-led Worcester the

highest at 8.98%. Reform's failure to reduce taxes was spun by Richard Tice who announced that a £45m 'reduction' (47) had been delivered. This figure seems to have been derived by subtracting the value of the Reform UK council tax rises from the notional value should a theoretical maximum allowed rise of £4.99% have been imposed. In fact, no Reform UK council delivered a cut in council tax in cash terms. Just as with the NHS, there might be ways of making local government more efficient, but this would require investment rather than cuts. From all the above it seems that Reform UK would do better to focus on additional investment rather than looking for savings, just as its dream of making savings in local government (48) through its Department of Government Efficiency unit (49) evaporated when it collided with the reality of running a council.

Things that Reform UK would do that would certainly make the NHS less efficient is to cut off the supply of staff who have been trained abroad (those training costs having saved the UK an estimated £14bn (50)). One in five NHS staff have come from other countries and without them the NHS would collapse. The figure in care services is more like 1 in 4, yet unlike in health, Reform UK is not advocating that essential care workers be allowed to come to the UK for employment. Reform UK argues its Acute Skills Shortage Visa will be able to maintain essential staffing temporarily while training more UK nationals. A health union described this approach as 'morally repugnant' (51) and 'completely unworkable'. Even more extreme is Rupert Lowe's Restore Britain party which estimates 1.8-2.0 million 'foreigners living in Britain' should be deported (52). It also demands that the only priority for the NHS should be serving the 'British people' (53).

Vaccine and climate scepticism

Wilful disregard of science means that Reform UK is simply not equipped to protect our health

Before the end of the Covid pandemic, Farage and Tice (then leading the Brexit party) argued it was 'time to redirect our energies', insisting Britain should 'learn to live with the virus, not hide in fear of it' (54). Public health was reframed as a matter of individual choice rather than collective necessity (55). Looking back, this was clearly a huge misjudgement. Research by Imperial College London estimated that the first national lockdown saved more than 470,000 lives (56). The Hallett inquiry later concluded that introducing restrictions just one week earlier could have prevented an additional 23,000 deaths in England during the first wave (57). Members of Reform UK remain keen to propagate bizarre and unevidenced theories about Covid, for example that the pandemic was actually a conspiracy led by the US-military and global elites (58) or that the Covid vaccine caused King Charles to develop cancer (59). Rupert Lowe when a Reform UK MP also called on the Foreign Office, demanding reparations from China over 'man-made Covid-19' (60). A third of Reform UK's council leaders across the country have expressed vaccine-sceptic views, openly questioning public health measures that keep millions safe (61). Of course all of this would be risible, except this is a party possibly within grasp of power and could soon find itself responsible for protecting us all against the next pandemic (62).

Objecting to a recent public health initiative, when government announced moves towards healthy eating in schools, Reform UK declared that this was 'another example of the government trying to micromanage people's lives' and obesity was a matter of personal responsibility (63). In fact, obesity is a chronic disease that has important

social and commercial determinants. Obesity costs the economy £126bn a year (64) and understanding its origins is crucial to its prevention and treatment, making it a key public health issue as acknowledged even in the United States (65). So much for Reform's promise to ensure that tax payer's money is never wasted!

The biggest blind spot in terms of science, public health, and our future survival is Reform UK's climate change denial. It has pledged to scrap net zero policies and argues that CO_2 targets are unaffordable and unachievable. Across England, councils led by Reform UK have been scaling back climate commitments (49) at the very moment climate risks and the costs of fossil fuel dependence are intensifying. The claim is frequently made that 'the anthropogenic climate change narrative is overblown' and that 'the world's climate has always changed.' The denial of climate change and its potentially devastating consequences, as in the USA and elsewhere, is supported by misinformation and by those who stand to gain financially from continued exploitation of fossil fuels.

"Reform UK poses a major threat to our health service and is likely to shift more costs to patients should it ever form a government. In addition, it clearly poses a major threat to public health."

Globally, across most authoritative scientific institutions there is agreement that the climate is warming (66), human activities are the dominant cause and the risks increase as warming increases. The health costs of climate change (67) include heat exhaustion and heatstroke, cardiovascular and respiratory strain, worsening air quality, more wild fires, increased spread of infectious diseases, food and water insecurity, extreme weather and injuries, adverse effect on mental health, displacement and forced migration, and increased strain on healthcare services. As with the pandemic, it is ludicrous that the public health implications of climate change are not acknowledged by Reform UK. In the short term, local authorities should be focusing on reducing emissions, cleaner air, more active travel and access to green spaces since these are good for physical and mental health and would reduce demand on the NHS and save money.

Conclusions

Reform UK poses a major threat to our health service and is likely to shift more costs to patients should it ever form a government. In addition, it clearly poses a major threat to public health and keeping us all safe. It is likely that the affluent public school background of Reform UK leaders breeds complacency and a feeling of entitlement that is at odds with valuing the NHS as a universal service (68). Not surprisingly there are some divisions in Reform over the future of the NHS. For example, despite Nigel Farage favouring funding through insurance, the party leader in Wales (Dan Thomas) has said he would not consider 'any kind of insurance-based system or privatisation' (69).

This debate is taking place because national populist parties like Reform UK have to some extent abandoned laissez-faire economics, allowing a space for state intervention and the welfare state while being against social and cultural liberalism (for a detailed discussion see (70)). Farage for example (71) was happy to back the nationalisation of British steel and the party has recently committed to the triple lock in a pitch towards pensioners, albeit prior to an announcement of 'the biggest cuts to the benefits bill ever seen in the history of this country' (72). He is trying not to alienate Reform UK supporters when to many, the NHS

remains extremely important (73). However, the divisive issue of benefit funding means that this is seen as pot of money there for the taking (74). Farage says the financial model for the NHS will be a national decision made ahead of the next general election (75).

While it is incorrect to say that Reform UK would 'scrap' the NHS (76), it would certainly like to drive it towards a two-tier system, directing public money to investment in the growth of the private sector and neglecting the social determinants of health which most disadvantage the poor. It has no convincing answer to current waiting lists, GP access difficulties and the crisis in corridor care. Reform UK policy, such as it is, is likely informed by the understanding that healthcare offers rich pickings to the private sector (77), although currently Labour is the standout beneficiary of donations coming from healthcare companies (78).

Labour needs to distinguish itself from Reform UK by committing to the founding model of the NHS, and pointing out that this is proven to be more efficient and cheaper than a social insurance system. It should also commit to getting private providers out of the NHS, an increase in overall funding to levels more like those in comparable European countries, and the recruitment and retention of well-trained staff in order to be able meet the health needs of the population. Public health and the social determinants of health must be placed high on the agenda and funding aligned with meeting need. Failure to deliver on its promises to improve the NHS will only risk furthering the support for the rich business people in Reform UK intent on selling their particular brand of snake oil.

References

1. Politico (2026) 'United Kingdom – Parliament voting intention'
[Available at: https://tinyurl.com/mfam895f]
2. Elliott, F. (2025) 'NHS doesn't need more money – it will be wasted on bureaucracy, says Reform UK' *The iPaper*, 3 August
[Available at: https://tinyurl.com/837sdkzu]
3. Taylor, B., et al. (2026) 'Public satisfaction with the NHS and social care in 2025 (BSA)' King's Fund, 25 March [Available at: https://tinyurl.com/5cbrvk9d]
4. Streeting, W. (2026) 'NHS reform and the future of the health service' Gov.uk, 25 March
[Available at: https://tinyurl.com/mzwr574h]
5. Campbell, D., et al. (2026) 'NHS to miss targets for cutting A&E wait times and performance in England' *Guardian*, 29 March
[Available at: https://tinyurl.com/jc2spxzv]
6. Lister, J. (2022) 'Gathering storm as critics press for "reforms" to NHS' The Lowdown, 3 August
[Available at: https://tinyurl.com/43m5y9td]
7. Farage, N. (2025) Facebook posting, Facebook, 8 April
[Available at: https://tinyurl.com/y4bsycxt]
8. Reed, S. (2024) 'Is French-style health care the answer? Why we should stop idealising other health systems' Nuffield Trust, 12 June
[Available at: https://tinyurl.com/2n2nj9xn]
9. Full Fact (2025) Cited in 'Is Labour right to claim Reform UK would "scrap the NHS"?' Full Fact, 30 April [Available at: https://tinyurl.com/mrxnbkbc]
10. Mason, R. (2024) 'Nigel Farage's anti-WHO campaign has link to nicotine products industry' *Guardian*, 21 November
[Available at: https://tinyurl.com/x5pkbb5u]
11. Wikipedia (2026) 'Richard Tice'
[Available at: https://tinyurl.com/279rw6t7]
12. Tice, R. (2024) Facebook post, 4 June

[Available at: https://tinyurl.com/547daea7]
13. Elliott, F. (2025) 'NHS doesn't need more money – it will be wasted on bureaucracy, says Reform UK' *The iPaper,* 3 August
[Available at: https://tinyurl.com/43ey43u3]
14. UK Alliance on Climate Change (2025) Building a Climate-Resilient Health System in the UK, June
[Available at: https://tinyurl.com/3wdnkahn]
15. Grunewald, Z. (2026) 'Reform's patriots don't want to pay for their country', The Lead, 17 March
[Available at: https://tinyurl.com/mt5s2e4f]
16. PA News Agency (2025) 'Sight of children wearing ear defenders in school is 'insane', Richard Tice says' Guardian Series, 17 November
[Available at: https://tinyurl.com/umuvvumy]
17. Wikipedia (2026) 'Rupert Lowe'
[Available at: https://tinyurl.com/2s4y6fzj]
18. Restore Britain (2026) Home page
[Available at: https://www.restorebritain.org.uk]
19. BBC News (2025) 'Ex-Reform MP Lowe will not face charges over alleged threats', 14 May
[Available at: https://tinyurl.com/mryxzah3]
20. Hutchinson, E. (2025) 'Who is Rupert Lowe, the MP Elon Musk thinks could replace Nigel Farage as Reform UK leader?' ITVX, 6 January
[Available at: https://tinyurl.com/57469tfk]
21. Mahmood, B. (2026) 'Right-wing spat: Rupert Lowe says Nigel Farage has "banned him from GB News"' Left Foot Forward, April
[Available at: https://tinyurl.com/5bt4mp9z]
22. Sennitt, O. (2025) 'Norfolk MP Rupert Lowe criticised for NHS "opt out" comments' Rayo, 17 January [Available at: https://tinyurl.com/449vv3fy]
23. MacFadyen, J. (2026) 'The Cost of NHS Reorganisation and Why it Matters' Evington Echo, 15 March
[Available at: https://tinyurl.com/3necnvdv]
24. World Bank Group (2025) 'Current health expenditure per capita (current US$)' World Bank Group, 12 December
[Available at: https://tinyurl.com/39am3k7d]
25. Clarke, R. (2023) Facebook post, 16 April
[Available at: https://tinyurl.com/5eakyj32]
26. Funding the Future (2026) 'Reform want to destroy government and the economy as we know it' 13 January
[Available at: https://tinyurl.com/57aerndh]
27. Walker, P. (2026) 'Reform UK government would replace top civil servants with those "more likely to implement party's priorities"' *Guardian*, 14 March [Available at: https://tinyurl.com/5yrzsvdt]
28. NHS Health & Race Observatory (2026) Home page, 8 June
[Available at: https://tinyurl.com/37ybbtpv]
29. Reform UK (2026) 'Our contract with you', 8 June [Available at: https://tinyurl.com/zkc6vhyw]
30. Mahmood, B. (2024) 'Nigel Farage ditches Reform UK's "contract with the people" just 2 months after election' Left Foot Forward
[Available at: https://tinyurl.com/5hxz3bw5]
31. World Health Organization (2025) 'Social determinants of health' 6 May
[Available at: https://tinyurl.com/2r2p5bnb]
32. Goyal, D. (2026) 'Reform UK Promised "17 Billion in New Healthcare Spending" but None of It Is for the NHS' *Byline Times,* 30 March
[Available at: https://tinyurl.com/ym6fr3s3]
33. Goddard, M. (2015) 'Competition in Healthcare: Good, Bad or Ugly?' *International Journal of Health Policy and Management,* Aug 1;4(9):567–69
[Available at: https://tinyurl.com/yckyex56]
34. Wickens, C. and Brown, T. (2023) 'The NHS in crisis – evaluating the radical alternatives ' The King's Fund, 31 July
[Available at: https://tinyurl.com/bdd9uaw2]
35. IPPR (2026) 'Changing NHS funding model would be a "pointless distraction", finds IPPR' IPPR, 13 April
[Available at: https://tinyurl.com/8nufbhjr]
36. Wagstaff, A. (2009) Social Health Insurance vs. Tax-Financed Health Systems — Evidence from the OECD, Policy research working paper 4821, World Bank
[Available at: https://tinyurl.com/35jybm5m]
37. Rebolledo, I. and Charlesworth, A. (2022) 'How does UK health spending compare across Europe over the past decade?' Health Foundation, 16 November

[Available at: https://tinyurl.com/msf8rtz3]
38. Hamilton, J. (2025) 'Reform's plans for the NHS: what would a French healthcare model look like?' NorthEast Bylines, 24 September
[Available at: https://tinyurl.com/35p2b848]
39. Darzi, Lord (2024) 'Independent Investigation of the NHS in England' (The Darzi Report)
[Available at: https://tinyurl.com/ycyc9754]
40. BBC News (2015) 'UKIP leader Nigel Farage: "NHS almost killed me"' 14 March
[Available at: https://tinyurl.com/4vhrrhbw]
41. The 99% Organisation (2023) The Rational Policy-Maker's Guide to the NHS
[Available at: https://tinyurl.com/6s53ymdh]
42. The Commonwealth Fund (2021) 'Mirror, mirror 2021 – Reflecting poorly' 4 August
[Available at: https://tinyurl.com/yckxcrtu]
43. Evenstad, L. (2014) 'Commonwealth fund says NHS world "best"' 18 June
[Available at: https://tinyurl.com/4dbfxfv4]
44. King's Fund (2023) 'New report from The King's Fund: "How does the NHS compare to the health care systems of other countries?"' 27 June
[Available at: https://tinyurl.com/y29ajcmm]
45. King's Fund (2023) 'Comparing the NHS to the health care systems of other countries: five charts' 26 June
[Available at: https://tinyurl.com/fp8t3wd5]
46. Full Fact (2026) 'Did Reform UK break its promises on council tax' 9 April
[Available at: https://tinyurl.com/n69cyt89]
47. Tice, R. (2026) Post on 'X', 16 March 15:10
[Available at: https://tinyurl.com/2uu4w7h8]
48. Quinn, B. and Walker, P. (2025) 'Reform UK claim to have saved £331m at English councils – but do the numbers stack up?' *Guardian*, 24 November
[Available at: https://tinyurl.com/3fpk9wdy]
49. Hope Not Hate (2026) Reform in Power, p.26
[Available at: https://tinyurl.com/2rp8tffr]
50. Crawfurd, L. (2026) 'How Foreign-Trained Health Workers Saved the NHS £14 Billion' Center for Global Development, 16 March
[Available at: https://tinyurl.com/ysbx2jbx]
51. Cowburn, A. and Buchan, L. (2025) 'Nigel Farage indefinite leave to remain plan torn apart as NHS would "collapse"' *Daily Mirror,* 22 September
[Available at: https://tinyurl.com/t6dthk7u]
52. Restore Britain (2026) Mass Deportations: Legitimacy, legality, and logistics
[Available at: https://tinyurl.com/bhj6a5sj]
53. Restore Britain (2026) 'Restore the National Health Service' 13 February
[Available at: https://tinyurl.com/2uyjn6xw]
54. BBC News (2020) 'Nigel Farage: Brexit Party to focus on fighting lockdown' 2 November
[Available at: https://tinyurl.com/wyzdkxtp]
55. Pickard-Whitehead, G. (2026) 'Right wing watch' 28 March
[Available at: https://tinyurl.com/mrxxk2d3]
56. Gallagher, J. (2020) 'Coronavirus: Lockdowns in Europe saved millions of lives' BBC News, 8 June
[Available at: https://tinyurl.com/5n743x3d]
57. Ireland, B. (2025) 'Government response to COVID-19 was "too little too late", inquiry concludes' The Doctor, 20 November
[Available at: https://tinyurl.com/4937rb54]
58. Mortimer, J. (2026) 'Reform UK Candidate Claimed COVID Was "Pentagon-Led Plot" in Conspiracy Theory Journal' *Byline Times,* 15 April
[Available at: https://tinyurl.com/4et5uayp]
59. Warburton, D. (2026) 'Doctor who claimed Covid jab probably caused royal cancers standing for Reform' *Daily Mirror,* 17 April
[Available at: https://tinyurl.com/rc36kyz2]
60. ITV News (2024) 'Reform MP writes to Foreign Office demanding reparations from China over "man-made Covid-19"' 12 November

[Available at: https://tinyurl.com/np4hhz9k]
61. Crerar, P. (2025) 'Third of Reform UK's council leaders have expressed vaccine-sceptic views' *Guardian*, 29 December
[Available at: https://tinyurl.com/3kkzbu53]
62. Rogers, J. (2025) 'The "Big One" is coming: How can we prepare for a future coronavirus pandemic?' CEPI, 31 October
[Available at: https://tinyurl.com/2n4ds7mj]
63. Clarke, H. (2026) 'Deep-fried food banned in new plans for school dinners' BBC News, 12 April
[Available at: https://tinyurl.com/4bzfm6mr]
64. Campbell, D. (2025) 'UK's obesity and overweight epidemic costs £126bn a year, study suggests' *Guardian*, 2 July
[Available at: https://tinyurl.com/yc8k8cea]
65. Novak, N.L. and Brownell, K.D. (2012) 'Role of Policy and Government in the Obesity Epidemic' *Circulation* 126
[Available at: https://tinyurl.com/54nuzy6v]
66. IPPC (2025) Press release, 5 December
[Available at: https://www.ipcc.ch/2025/]
67. WHO (2023) Climate change, Fact sheet, 12 October
[Available at: https://tinyurl.com/47774wnu]
68. Campbell, D. (2026) 'Private firms providing services to NHS made £1.6bn profit in two years, research finds' Guardian, 13 April [Available at: https://tinyurl.com/*mu3musx*]
69. Barber, O. (2026) 'Reform accused of fighting like "rats in a sack" over its NHS policy' Left Foot Forward
[Available at: https://tinyurl.com/3c6ddy2h]
70. Bloomfield, J. and Edgar, D. (2024) *The Little Black Book of the Populist Right*. London: Byline Books.
71. Farage, N. (2025) Facebook post, 8 April
[Available at: https://tinyurl.com/yran7dey]
72. Nevett, J. (2026) 'Reform UK pledges to cut welfare to keep pensions triple lock' BBC News, 2 April
[Available at: https://tinyurl.com/yznnct7e]
73. Gill, M. (2026) 'As Farage sacks an acolyte for his "shameful" words, how far is too far for the high priest of toxic politics?' *Guardian*, 7 April
[Available at: https://tinyurl.com/5apxa84e]
74. Toynbee, P. (2026) 'A question for those desperate to cut benefits to fund defence: who exactly are you willing to impoverish?' *Guardian*, 17 April [Available at: https://tinyurl.com/bvw37f45]
75. Bloom, D. (2026) 'Nigel Farage breaks with his Welsh leader over insurance system for the NHS' Politico, 12 March
[Available at: https://tinyurl.com/2afkpvfu]
76. Full Fact (2025) 'Is Labour right to claim Reform UK would "scrap the NHS"?' 30 April
[Available at: https://tinyurl.com/mrxnbkbc]
77. Campbell, D. (2026) 'Private firms providing services to NHS made £1.6bn profit in two years, research finds' *Guardian*, 13 April
[Available at: https://tinyurl.com/mu3musx]
78. EveryDoctor (2025) 'Which MPs have received donations from people and companies linked to the private healthcare sector?' April
[Available at: https://tinyurl.com/aud8zsma]

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Happiness and Wellbeing in the NHS

Malila Noone on the importancce of staff wellbing for the NHS, often undervalued but on which the NHS depends every minute. Isn't it time this was given the political value it deserves?

Wes Streeting and others before him believed that they were facing several different NHS problems: long waiting times, cost and inadequate staff numbers.

NHS workers were blamed for poor productivity. Piecemeal solutions are proposed, each throwing up a different set of problems or worse, they add to current inadequacies. On our part we fight against each folly as best we can. We have appraised each proposal and find they are of no value or, more often, adversely affect patient safety. It all seems futile and is like fighting Hydra with no Hercules in sight. I wonder whether, in addition to the critical analysis and protest, we could formulate a more positive proposal aimed at increasing productivity When Wes Streeting called doctors 'moaning Minnies' I felt the following was an edict we could present:

> **'If you engage with your staff, support them, treat them well and refrain from calling them names, problems of productivity and cost will fade.'**

Is there a scientific basis for such a statement? Many businesses declare that 'staff wellbeing is important to us'. Do they really mean this? Is there a business case for it?

The history of staff wellbeing goes back to the 1930s. The Western Electric Companies 'Hawthorn' test room studies were experiments into what variables in a workplace environment might affect worker fatigue (1). They showed that improving working conditions, such as better lighting, increased productivity. The idea of linking employee wellbeing and good business was taken on by Henry Ford and other business magnates and the concept of 'Welfare Capitalism' was born. These improvements mainly related to basic physical working conditions, many now enshrined in law. Human factors were overlooked (2).

Later reviews analysed the relationship between job satisfaction and job performance. Reports of 'best places to work' linked wellbeing to outcomes such as productivity and profitability as well as reduced staff turnover and customer satisfaction. These were retrospective studies, relating to a small number of individual companies mainly in finance, manufacturing, services, and retail. More recently, employee wellbeing has been measured using a Work Wellbeing Score from the jobs website 'Indeed' and linked to company performance using 1million self-reported job satisfaction data covering 1,782 publicly listed companies in the United States (including healthcare companies) (3). This was a well-researched Oxford/Harvard study. Wellbeing related to three distinct dimensions of wellbeing:

(1) Affect –positive and negative, (2) evaluation, and (3) eudaimonia: (OECD guidelines 2013) The Work Wellbeing Score combines responses scored by levels of agreement with four statements:

- I am happy at work most of the time: positive affect.
- Overall, I am completely satisfied with my job: evaluation.
- My work has a clear sense of purpose: eudaimonia.
- I feel stressed at work most of the time: negative affect.

Democracy or employee participation is not mentioned directly but may be incorporated within 'eudaimonia'. The Wellbeing Index proved to be strongly related to current firm performance, firm profitability and firm value but also of future firm performance.

Companies with happier workers before COVID-19 performed better afterward in all three performance indicators (valuation, return on assets, and gross profits). Happiness scores proved to be especially predictive of firm performance for service sector firms which are the most closely allied to healthcare and the NHS. Of particular interest in relation to the NHS was that stress was less significantly related to performance than happiness, satisfaction, or purpose.

There is independent evidence that high levels of responsibility, challenging work, and even time pressure may be positively related to job satisfaction and job performance. This is generally true for doctors although it may lead to burn-out if excessive or prolonged.

Perusal of the 'Indeed' jobs website shows that wellbeing Index scores are included in adverts thus equating them with good reviews. It suggests that good scores are expected to have a positive effect on recruitment. The reverse effect of poor scores is well known. Experience in the NHS has shown repeatedly that a 'failing' department fails to attract job applicants leading to a downward spiral and an increasing vacancy rate. The reported high vacancy rates in the NHS are rarely drilled down to the true reasons behind the reports.

These studies do not establish a causal relationship and it may be argued that there is a reverse effect: successful companies may be able to provide a better working environment leading to staff satisfaction. However meta-analysis supports the predictive value of the original observations (4).

In addition, there have been more 'scientific' laboratory studies, using control groups. Happiness-inducing treatments (including watching 10-minute comedy videos or receiving free food) lead to a 12% increase in productivity measured by dealing with complex numeric tests. Participants who were made to feel happier were subsequently more creative on various problem-solving tasks, including word associations and grouping exercises. Experimental studies have also revealed that positive moods were more likely to promote cooperative behaviour and help reaching compromises.

"There is independent evidence that high levels of responsibility, challenging work, and even time pressure may be positively related to job satisfaction and job performance."

At an individual level, it would appear that happier workers are higher performers but will happiness and wellbeing increase NHS productivity – this being a pre-election promise ? In the *Ten Year Plan*, improving productivity is a central goal and the spending review 2025 sets a target of 2% year-on-year productivity. Improving productivity is not just about staff working harder – they work hard already and are exhausted. Better performance may mean:

- Fewer strikes: major saving and a direct impact on productivity.
- Better team working and co-operation: poor relationships are often mentioned in reports into scandals and at Employment Tribunal hearings. It was a key issue in the Martha Mills case (5).
- Fewer mistakes: minor errors probably occur quite frequently when working under pressure or when exhausted. Only major errors hit the headlines.
- More creativity in relation to problem

solving: essential in healthcare with its constantly changing challenges.
- More likely to take on extra shifts: understaffing is an issue during outbreaks of 'flu etc.

Better performance may not be recognised as relevant to increased productivity. The NHS adheres to the industrial model of productivity which is based on inputs vs outputs. In the NHS, this equates to resources used (staff, consumables, buildings etc.) vs the amount of activity (scans, appointments etc.). Arguably, reducing the cost of inputs by employing cheaper grades of staff (PAs, Pharmacy First) will increase productivity. The government is fixated on this measure which has been widely condemned. There are several other ill thought out schemes such as the novel 'Further Fast 20' (6). The Public Accounts Committee has been critical about the lack of effect of these and other actions such as abolition of NHSE and the introduction of Diagnostic Centers.

The perceived economic benefits of prioritizing employee wellbeing has resulted in many organisations set up to advise companies on establishing a 'wellbeing strategy' backed by a Deloitte Report which suggested that for every £1 invested by employers in mental health support, they can expect a return of £5 (7). Despite the persuasive evidence, there is no indication that companies embrace this ideal of prioritising staff wellbeing in an effective way. John Lewis is a well-known example. Less well known are Dishoom and Octopus Energy.

You may be surprised to learn that the NHS too has a wellbeing strategy. 'The NHS People Plan' (8) refers to a number of 'key programmes that are in place to assist organisations to develop culture of wellbeing, in which their workforce feel supported and well at work'. The NHS People Promise (9) does not mention happiness but comprises the following 'promises':

- *We are recognised and rewarded:* A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.
- *We each have a voice that counts:* We all feel safe and confident to speak up.
- *We are safe and healthy:* We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.
- *We are always learning.*
- *We work flexibly.*
- *We are a team.*
- *We are compassionate and inclusive.*

Will the current (and future) Health Ministers be committed to the promise of 'A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution'? Do the CEO and the Board see these as personal responsibilities? Are there lines of accountability and identified funding?

A Staff Survey will measure progress but results only 'enable teams and departments, as well as whole organisations, to see their progress and take action to improve'. Responsibility appears to lie with the workers themselves and *The Promise* (9) goes on to say: 'This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone'.

Lastly, it is proclaimed that: 'If we don't look after ourselves and our colleagues, we cannot deliver safe, high-quality patient care'. This would appear to support democratic action or at least employee participation which is a key factor in job satisfaction. Perhaps it is a call for staff to set up

their own elected Panels within Trusts. An elected Scrutiny Panel has been advocated in the proposal 'Hospital investigatory proceedings against doctors in England: A case for a change' which has been presented in a previous Newsletter (10).

Considering the snail's pace of changes in the NHS, perhaps we need an evangelist to drive this with pronouncements such as:

> **'The job of healthcare executives isn't taking care of patients. That is the job of doctors, nurses and other frontline staff. The job of healthcare leaders is taking care of the people who work in their organization.'**

This is from a speech attributed to Simon Sinek (11), a motivational speaker at the Medical Group Management Association (MGMA) annual conference in Boston. He is a TED speaker and travels the world (at least Australia).

He has also said: 'Every single organization must have a just cause that drives your decisions'. Since we already have a just cause in the NHS, and since the NHS takes readily to ideas from the USA, perhaps an invitation would be appropriate!

References

1. Roethlisberger, F.J. and Dickson, W.J. (1939) *Management & the Worker.* Google Scholar [Available at: https://tinyurl.com/4xfwynfy]
2. Hassard, J.S. (2012) 'Rethinking the Hawthorne Studies: The Western Electric research in its social, political and historical context' *Human Relations,* 65(11) [Available at: https://tinyurl.com/5vzss85d]
3. De Neve, J.-E., et al. (2024) 'Workplace Wellbeing and Firm Performance'. University of Oxford Wellbeing Research Centre Working Paper 2304 [Available at: doi.org/10.5287/ora-bpkbjayvk]
4. Schneider, B., et al. (2003) 'Which comes first: employee attitudes or organizational financial and market performance?' *J Appl Psychol* Oct;88(5):836-51 [Available at: doi: 10.1037/0021-9010.88.5.836]
5. Roxby, P. (2025) 'Martha doctor's failings "particularly grave"' BBC News, 9 June [Available at: https://tinyurl.com/5n85ansy]
6. Opie-Martin, S. (2025) 'Are 'crack teams' reducing NHS waiting lists?' The Health Foundation, 15 April [Available at: https://tinyurl.com/ycxznh5f]
7. Deloitte UK (2020) 'Mental health and employers: Refreshing the case for investment' 6 January [Available at: https://tinyurl.com/2mzabc5f]
8. NHS England (2021) 'Online version of the People Plan for 2020/2021' [Available at: https://tinyurl.com/ytyemmej]
9. NHS England (20260 'The Promise' [Available at: https://tinyurl.com/3k39ra25]
10. DFNHS (2022) 'Hospital investigatory proceedings against doctors in England: A case for a change' 26 April [Available at: https://tinyurl.com/3xndfpku]
11. Schein, M. (2018) 'Author Simon Sinek Is Full Of Hot Air (And Other Reasons You Should Follow His Lead)' *Forbes*, 13 June [Available at: https://tinyurl.com/25jy36jm]

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GPs in Primary Healthcare: What Has Gone and What Is Coming?

A dialogue from a restive and bewildered profession

GP to GP: Steve Taylor and David Zigmond in conversation.

David Zigmond served for 40 years as a principal GP in south east London until 2016. He is on the Executive Committee of DFNHS.
Steve Taylor has been a GP and trainer for 30 years and is co-lead for General Practice at the Doctors' Association UK (DAUK). He works in Manchester as a locum and sits on DAUK's Executive Committee.

The Lost Bedrock

DZ: Reading *Your GP, Here for You* (1), I was struck by how much it describes the world we once knew – small teams, personal lists, relationships that mattered. The document could almost be a recipe for rediscovering the essence of general practice.

ST: That was exactly our aim. It's about rebuilding what originally made general practice work: continuity, good care, and a humane workplace. The challenge is persuading ministers that these things aren't nostalgic luxuries but prerequisites.

DZ: I keep asking how we let them vanish. My conclusion is that we imported the wrong ideology – a kind of corporate neoliberal thinking that tried to remodel human care on industrial manufacturing. Targets, outputs, throughput … those things deliver efficiency where the product is repetitive, but they're hopeless where meaning lies in relationship. Machines can be standardised; people cannot. We've mistaken control for quality.

ST: And that mindset has turned general practice into a target-driven service. Reform was supposed to eliminate poor performance, but most practices were already doing good work. We applied industrial standardisation to a craft profession.

DZ: That's the key distinction – craft. You can't mass produce craft. The best consultations I ever had weren't about perfect policy; they were two human beings navigating uncertainty together. We've bureaucratised that out of existence.

The Costs of Losing Continuity

ST: Continuity is the heart of it. When I left partnership, my list had 9,000 patients. On my final day I saw 50 people – a blur of face-to-face and phone calls. It's impossible to think deeply with those numbers.

DZ: And the irony is it's sold as efficiency. But it's not. When you know someone, you practise more safely and cheaply. You avoid duplicate tests, unnecessary referrals. You can explore the human background – the rows, the worries, the disappointments – that lie behind symptoms. I had a patient once with dizzy spells; because I knew the turbulence in her marriage, I didn't request another MRI. Healing grew from context, not technology.

ST: That's almost impossible now. Patients rarely see the same doctor twice. The named GP system was a good idea, but you can't have person-based care without person-based teams. Massive practices and carouselled rotas have

dissolved commitment and belonging.

DZ: In the 1970s, most of us worked for decades in one patch. We became part of the landscape. You grew old together with your community. That's what people mean when they recall 'my family doctor.' The smaller the unit, the more possible that intimacy.

ST: We could recreate some of that even in larger partnerships by dividing into semi autonomous 'firms' – small groups of GPs covering 4–5 thousand patients. Micro-continuity within macro-structures.

DZ: I'd embrace that, provided it includes dedicated space and a stable core team. Hot desking and rotating locums destroy emotional ownership. Patients can tell instantly when no one truly knows them. And doctors lose the sense of stewardship that keeps vocation alive.

The Pressure Cooker

ST: It's also a practical crisis. One in nine people are waiting for hospital treatment – seven million across England – and many chase their GPs for updates, interim support, or reassurance. Add in complexity: hospital stays are shorter, but convalescence hasn't shortened, so we pick up half-recovered patients. Preventive medicine expands our long-term medication lists. Twenty years ago only a fifth of my population were on regular prescriptions; now it's half. Workload multiplies by stealth: new forms, new tasks, new screening targets – none removed when another is added. It's incremental drowning.

DZ: And that cumulative overload leads to burn-out. When I started, older colleagues often retired tired but fulfilled. They'd say, 'I've had a good run'. Now we see early retirement, cynicism, moral injury. People who once loved the work now talk about escaping it. That's a cultural tragedy.

ST: We've become data clerks as much as doctors. A GP's day can feel like ticking boxes for unseen auditors rather than engaging with the patient in front of you.

DZ: We've built a surveillance state around good intentions. Of course we must prevent harm and weed out incompetence, but over-regulation sucks life from the majority who don't need it. Families thrive on trust, not constant external inspection; so did general practice.

The Partnership Paradox

ST: The irony is that the traditional partnership system handled that balance beautifully. It combined NHS commitment with local autonomy. Yet funding cuts and political disbelief have undermined it. We now get about £169 per patient per year – 20 per cent less, in real terms, than a decade ago. Some politicians think direct state employment would work better.

DZ: The partnership model was unique: state funded but self-directed. It created a sense of ownership that bred care. When you run 'your practice', you tend the soil as well as the crops. Salaried employees rarely feel that. I couldn't have been as committed if I were merely executing top-down orders.

ST: And yet many see partners as privileged. They don't grasp the complexity – we're clinicians, employers, HR managers, property supervisors, strategists. It's part vocation, part enterprise, part public service. The risk and responsibility balance each other.

DZ: Once, people stayed in those partnerships for life. Staff loyalty, nurses, receptionists – everyone had longevity. They cared because they belonged. You can't replace that with central management from an integrated care board.

ST: If partnership dies, the likely successors will be corporate providers. That's what happened to dentistry: small local surgeries replaced by multinationals. We may be 2 or 3 years from that tipping point if policy doesn't change.

DZ: Then we'll see GPs employed by BUPA or Tesco Health, incentivised by shareholder returns. Very different from vocational medicine.

Generalists and the Fractured NHS

ST: And it ties into a deeper loss – the loss of generalism. Hospitals once had general physicians who followed complex patients through multiple systems. They've vanished. So GPs are now the last true generalists.

DZ: When medicine fractures into silos, coordination costs explode. One case stays vivid for me: a man with Lewy body dementia, COPD, atrial fibrillation, diabetes. Each admission meant eight specialist teams, each running their own tests. The most junior ordered yet another brain scan primarily to shield himself from future blame. No one owned the whole person. That's not good medicine; it's bureaucratic panic.

ST: A general physician could have managed that intelligently, saving distress and thousands of pounds. But we design systems for accountability, not wisdom.

DZ: Precisely. The more we know a person, the less we need to investigate them. Relationship replaces duplication.

ST: And those relationships extended beyond the consulting room. Receptionists, district nurses, health visitors – they all noticed subtleties. In my smaller practice, a receptionist once spotted early dementia before any clinician did, simply through familiarity. Larger systems lose that texture.

The Industrial Mindset

DZ: Our main cultural error is assuming that bigger means better. In manufacturing, yes – scale brings efficiency. In human care, scale strips meaning. Yet we keep merging, centralising, outsourcing. Healthcare planners seem unable to distinguish between mass production and relationship work. They think duplication of premises is wastefulness, when in fact it represents accessibility and connection.

ST: It's the managerial illusion of control. We've seen it before – new hierarchies rebadged as 'integrated systems'. The lessons of failed reorganisations are never remembered, because institutional memory itself has no metric.

DZ: As a young doctor, I learned from Balint groups – those meetings where we explored the emotional undercurrents of consultation. They taught us to listen to what wasn't said. That skill depends entirely on continuity. Today, I doubt many trainees even experience it. We've replaced curiosity with coding.

> "The more you see of somebody, the more of somebody you see. Medicine is not just about blood results; it's about stories shared over time."

ST: Training now mirrors bureaucracy. Every competence must be ticked, every reflection documented. But what matters most – empathy, discretion, human judgement – resists quantification. Those are learned through apprenticeship and continuity, not through audit.

DZ: The more you see of somebody, the more of somebody you see. Medicine is not just about blood results; it's about stories shared over time.

Guidelines or Guidance?

ST: One of our biggest mis-steps is turning guidelines into rules. NICE intended them as frameworks, to be applied with judgement. But younger doctors fear deviating because governance systems punish divergence, not negligence of humanity.

DZ: I've experienced that personally. I take the occasional diclofenac for arthritis. My GP insists on adding a proton pump inhibitor because 'the system' requires it, even after I tell him I don't want or need it. He admits he'd get flagged if he didn't. The absurdity is obvious: we're treating not the patient, but the algorithm.

ST: That's manufactured medicine – civic engineering applied to health. Risk management becomes ritual compliance. Real professionalism is using discernment to balance benefit and burden. Yet that art is being crowded out.

DZ: And civic engineering assumes that human beings are inert materials. It says: 'We'll remodel you by protocol'. But medicine's essence is engagement: helping people mobilise their own internal resources. You cannot engineer the soul.

ST: That's why our *Your GP Here for You* (1) proposals argue for relational reform – space, time, and trust instead of endless targets. Rational care, not industrial output.

Reclaiming Vocation

DZ: So where does hope lie? I think we must re-sow the soil – bring back small relational cells within larger organisations, restore pride and craft, reward commitment rather than compliance. Vocation cannot be mandated, but it can be cultivated by the right ecology.

ST: Agreed. We need to prove that continuity isn't indulgence; it's efficiency through trust. The public understands that intuitively: patients miss 'their doctor'. If we don't repair that bond soon, we'll wake up to an NHS run by branding consultants rather than clinicians.

DZ: The essence of the NHS, at its birth, was solidarity: care based on relationship rather than transaction. That is precisely what industrialisation has forgotten. We still have time to remember.

ST: Continuity and conversation – they sound soft, but they're our hardest infrastructure. Without them, the rest collapses.

DZ: Then our challenge is to protect that humanity in an inhuman system, to keep medicine an art as well as a science.

ST: Yes. Because to save the NHS, we must first save what was best in general practice.

Reference

1. Taylor, S. (2026) 'Your GP, here for you' DAUK [Available at: https://tinyurl.com/ty4rbk5y]

SAVE THE DATE!

David and Steven will be speaking further about the plight of general practice at this year's Conference, which is to be held in York (Bedern Hall, a long-time favourite venue) on Saturday 10 October. This year, DFNHS will be holding the Conference jointly with Doctors' Association UK (DAUK). Online access will also be possible.

Speakers: Dr Louella Vaughan; and surgeon, author, and equality advocate Dr David Sellu, who will deliver the Paul Noone Lecture. DAUK's Dr David Nicholls will discuss the role of Palantir in the NHS, while lawyer and crisis manager Radd Seiger will address patient safety within the NHS.

Full booking details will be sent with the next newsletter as well as a separate mailing, nearer the date.

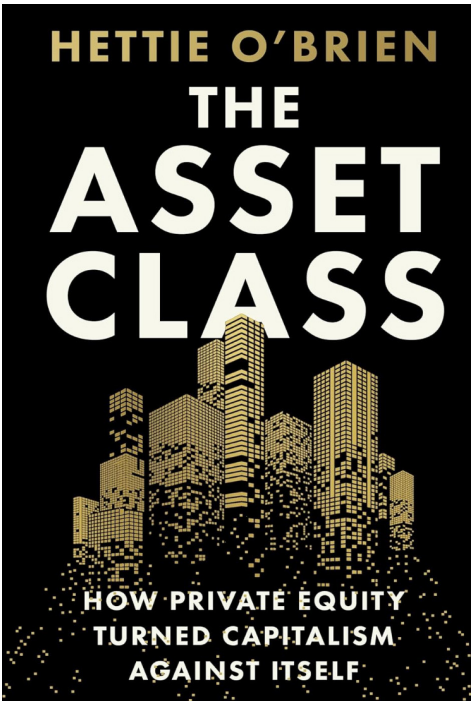
Book Reviews

The Asset Class: How Private Equity Turned Capitalism Against Itself
(£20 hardback, £10.99 paperback)
Hettie O'Brien, 2026, W & N, 320pp.

Most Brits still take for granted that we have access to good healthcare, regardless of our ability to pay for it.

For those working in the NHS, our prime concern should be to provide our patients with the best and most appropriate care they require, without having to consider whether they can afford to pay and to practise free from commercial considerations such as attracting business, satisfying investors and maximising profitable activity. As we are well aware, no health system is perfect, but as recently as 2014, the NHS was ranked number one overall in the developed world by the Commonwealth Fund (1), and it has proved sufficiently adaptable to serve this country well for nearly 80 years. However, when arguing for the merits of a health system that puts service before profit, we repeatedly come up against the argument that comprehensive, universal healthcare might have been (almost) affordable in its early years, but that advances in the treatments that are available and the changing age-structure of society compels us to consider alternative models. We can back up our case using clinical and moral argument, but it is vital to be able to also understand the economic system within which the NHS is embedded and the forces at play inside Alan Milburn's 'ecosystem' of healthcare (2). It is also incumbent on us to ensure that the national budget for healthcare is used to its greatest effect, and not frittered away on unproductive activities.

One important player within this ecosystem is the private equity fund, a vehicle for investment that has only been around for 40 years or so, and which operates with a high degree of secrecy, but has been associated with major changes in the increase of inequality and the rise of the super-rich and the political influence they are able to wield,



while contributing to the reduced quality of life and increasing precarity of the majority.

This opaque world of private equity is unmasked by Hettie O'Brien, a journalist at the *Guardian* and formerly at the *New Statesman* in *The Asset Class*, and she achieves this in a clear and readable account, but I warn you: be prepared to become very angry.

It is illustrated by a series of stories of the key characters that were responsible for developing and applying this model of finance and the impact this has made on the lives of ordinary people. If you have a tendency to glaze over at the mention of the world of financial institutions, I would

encourage you to persist, because it underlies so much of what is going wrong today, whether in terms of access to housing that is truly affordable, social care for our most vulnerable children and adults, access to clean drinking water and unpolluted rivers and diversion of international aid away from healthcare for the most disadvantaged in the global south and towards profit-making from an emerging middle class. Reports from the Centre for Health and the Public Interest have revealed the role of private equity in the diversion of more than half of cataract surgery away from NHS hospitals, with the resulting destabilisation of NHS ophthalmology (3,4), as well as its contribution to the cost of residential social care and the instability of the care home sector (5).

The Theory

Private equity is distinct from venture capitalism, which tends to invest in small, emerging businesses that are just getting off the ground, assisting their growth before selling them on at a profit, similar to the activities portrayed in the TV show, 'Dragons' Den'. Private equity instead targets established businesses and assets such as housing, commercial property and infrastructure and extracts as much profit as possible from them. The theory was that this served a wider purpose by increasing the efficiency of these businesses, but the book goes on to show that the evidence of benefit is thin, while the harm caused has already been considerable and is potentially catastrophic.

The basic operating model of private equity funds is clearly explained:

- Fund managers invest money on behalf of 'limited partners', typically pension funds, university endowments, sovereign wealth funds, family offices and high net-worth individuals. The commitment of partners is usually long-term.
- These funds are often used in 'leveraged buyouts' of assets, such as a publicly listed company, either by taking a controlling stake of more than half the shares, or, if the plan is to 'take it private' and delist it from the stock market, nearer 90% of shares would need to be bought before the remaining shareholders can be forced to sell up. This would require access to a lot of money.
- 'Leveraged' means that at least some of this money is borrowed, from banks or other sources. Often the fund will put up 20% of the cost and borrow the remainder. Once ownership of the target company has been achieved, the loan is repaid from the profits that have come from making the business more successful or efficient (or by other more rapacious activities).
- Of course, the fund would be at risk if the expected increase in profitability doesn't materialise, but private equity managers can reduce that risk by executing a 'debt pushdown', by which they transfer liability for the loan to the company they have just acquired. If it does well, the fund reaps the reward: if it doesn't, the company is responsible for the debt, not the private equity fund. The interest payments on that debt can often be offset against tax liabilities.
- The partners who invest in the private equity fund are charged fees of 2% of the value of the assets under management, plus 20% of any profits generated. This is a phenomenally lucrative arrangement for the managers of a fund, but not always for their investors. The bigger the fund, the bigger the fees exacted, so there is a strong incentive for fund managers to expand the assets under management.

The Practice

The book begins with the impact of the sell-off of the arches under railway viaducts that were part of the estate of Network Rail and housed thousands of small workshops and other

businesses. In 2015 George Osborne sold them all to two private equity funds which became one of the largest landlords of small businesses overnight. Rents began to rise substantially and services such as cleaning and security deteriorated as profit-taking was maximised, rendering many of those small businesses unviable (6).

It goes on to describe the buying up of huge amounts of cheap residential property in the centres of Copenhagen and Stockholm, which were then put back on the rental market at greatly increased rents, unaffordable to previous tenants.

Other examples are given including ophthalmologists at private equity-owned practices in Germany being pressured to recruit as many people as possible for cataract surgery; private equity-owned education colleges in the USA racking up tuition fees while graduation rates tanked; private equity-owned dental practices in the USA allegedly performing unnecessary root canal treatment on children and drilling perfectly healthy teeth.

Private equity was quick to spot the potential arising from the UK government's decision to pass responsibility for adult social care from the NHS to local authorities in the late eighties. Local authorities' statutory obligations, coupled with self-funding of residential care through the proceeds from the sale of residents' homes against a backdrop of rapidly increasing property prices made this an appealing investment proposition; however, many private equity funds used a 'sale and leaseback' model in which the care home would be split into an operating company, which managed the business of looking after residents, and a property company which owned the actual building. The property company could then be sold off, which would release cash to fund further acquisitions, or be distributed to keep investors happy.

The drawback was that, if the new landlord decided to increase the rent, the care business could come under pressure, as led to the collapse of the Southern Cross chain of 752 care homes in 2011, leaving 31,000 vulnerable

people effectively homeless. In other cases, it has contributed to reductions in staffing levels and ratios of experienced staff, reduced quality of food and increased fees putting pressure on self-funding residents as well as local authorities whose budgets were already strained by reduced funding from central government. A review of private equity ownership of healthcare, including nursing homes, in the *BMJ*, describes its rapid increase and its association with increasing costs to payers and deteriorating quality of the service provided (7, 8).

Out of Sight

One of the reforms that took place in the aftermath of the Wall Street Crash of 1929 was the requirement for companies that were issuing shares on the stock market to be compelled to publish information on the activities and performance of the business that would allow potential investors to make an informed choice as to whether to buy a share in the company. This was seen as particularly important in offering some protection to smaller 'retail' investors, who might be putting their life-savings at risk. One of the first Executive Orders signed by Donald Trump at the start of his second term made investment in private equity funds open to the general public, without any requirement for such disclosure.

A key features of private equity funds is that they are private – they do not have to disclose the identity of the owners of a business, how it operates or how well it is performing. As an

example, when private equity fund Terra Firma acquired the Four Seasons chain of care homes and ran into serious financial difficulties, it was found to have a corporate structure of 185 companies, mainly off-shore holding companies, organised across 15 different layers. What might be the benefit of creating such an opaque structure? Possibilities might include:

- The owners are protected, because if they were ever sued they could push liability down the chain.
- It can obscure how much money the business is making. This could allow a care home to more easily pressure the government into providing more funding and push back against improving the terms and conditions of staff and the quality of service to residents.
- It can obscure forms of profiteering such as unspecified 'monitoring' and 'transaction' fees paid to another of the companies in the same ownership, or borrowing against that company to pay dividends to fund managers or their investors.

Who Benefits?

There is a stark contradiction in a financial system that regards public debt as a serious moral failure while lauding business models based on loading companies with debt. It has been driving governments to find ways to pay for public services and infrastructure without taking on government debt, even though, in a country with a sovereign currency, government debt is always cheaper than other means of borrowing. The current fiscal rules that are being slavishly adhered to suggest that this trend is only going to continue, undermining the capacity of the country for future growth and the wellbeing of its people. It has led to increasing influence of private equity funds on political decision-making, possibly enhanced by the prospect of a later career for politicians and other public servants. There are probably many examples. David Cameron joined Jeb Bush's firm, Carlyle in 2025. John Major is also employed by Carlyle. Alan Milburn is a longstanding advisor and shareholder with another firm, Bridgepoint Capital, and Andrew Lansley held a similar appointment with Bain Capital.

Could such influence have contributed to the 1986 decision to issue guidelines, highly favourable to fund managers and which weren't subject to parliamentary scrutiny, that meant that the fees extracted by fund managers would be treated as capital gains, rather than income under the tax regime?

This arrangement persists. It might partially explain the kid gloves with which the privatised water industry is being treated. It might go partway to explaining why British foreign aid delivery through the Commonwealth Development Fund would fund projects designed to make a profit, rather than directly benefit the welfare of the impoverished, partnering with private equity to fund luxury hotels in Lagos and beach resorts in Mauritius, as well as private hospitals in Nairobi, where, resembling Dickensian debtors' prisons, patients were detained for many months until they could pay their bills, including paying for their own detention (9).

Might it explain why the UK was one of the only countries to actively oppose EU regulation of leveraged funds to try and reduce the dangerous financial risk taking that had fuelled the Global Financial Crisis of 2008? Is it a coincidence that hedge fund and private equity managers donated £7.4 million to the Brexit campaign and only £1.25 million to Remain? Or that a new type of limited partnership was designed specifically to benefit private equity funds in 2017, shrugging off warnings that it would also be attractive to money launderers, organised crime and kleptocrats? Or that the Treasury is currently considering lightening the rules under which private equity and hedge funds operate, on the premise that it could promote economic growth. And, as the availability and cost of housing and other essentials puts them beyond reach, the resulting discontent is directed

at any target apart from one of the major culprits, private equity and the system that promotes it?

Instead, evidence is available that once the financial sector becomes too large, it becomes a drag on growth and productivity and contributes to wage stagnation, which itself reduces domestic demand for goods and services. One study found that Britain lost 3 years of average GDP growth between 1995 and 2015 due to the size of the City of London (10). As political economist Robert Reich commented, his best students were being drawn to the 'pie-dividing professions of law and finance' rather than the 'pie-enlarging professions like engineering and science'.

Have the size, reach and operating practices of private markets reached a point that could undermine enough of the financial system to trigger another crash? Concern has been heightened particularly by private equity firms creating private credit funds – shadow banks – issuing loans, outside the regulatory framework that requires declaration of the size of these loans or their performance. Last year, Moody's published a report warning that private credit could act as a 'locus of contagion' and 'disproportionately amplify a future crisis' (11).

Are We Powerless?

Hettie O'Brien suggests that the helplessness of our lawmakers to rebalance the economy is feigned and that the stranglehold of private equity could be broken, although there is no single action that would be sufficient:

- Our government could cap the prices on services such as children's and adults' social care and make capital available to local authorities to build their own regulated children's homes and care homes for disabled adults.
- It could remove the tax incentives that allow fund managers to load public infrastructure companies with debt while issuing massive payouts to managers and investors.
- It could, at a stroke, change the guidelines that determine that fund managers' payouts are taxed as capital gains rather than income.
- It could legislate to require disclosure of information about funds and the companies they own, which would reveal where funds are sucking value from a company and the fees they are charging while doing so.
- Our government could establish a state investment bank, with the power to issue its own bonds, which could be sold to pension funds as the long-term, low-risk investments they require, to raise money for transport and infrastructure projects, removing the need entirely to partner with private equity fund managers.
- In the USA, Senator Elizabeth Warren of Massachusetts has been a key figure in raising awareness of the impact of private equity on many aspects of life in America (12). She produced an eight-part proposal, in which the first recommendation was that any private equity firm taking control of a company would have to retain responsibility for its debts, giving greater incentive to make that business flourish. She has recently piloted legislation through Congress with bipartisan support that prohibits private equity firms from buying up single-family homes and has drawn attention to the role of private equity in the demise of retail chains like 'Toys R Us' from US shopping malls (our high streets) which is often blamed entirely on Amazon and online shopping.

In this instance, it would appear that USA legislators are showing us a way forward. We need to make sure our political representatives understand that we expect much, much more from them. They need to get educated and recognise that the economy needs to serve the British people, rather than the nation being subservient to the economy.

The Asset Class has opened my eyes to a world that I had only partially glimpsed, but has helped me to make sense of much that seemed inexplicable, but more importantly, it offers a pathway to set the country on a better course, if we only have the courage and determination to follow it.

References

1. Davis, K., et al. (2014) *Mirror, Mirror on the Wall.* Commonwealth Fund
[Available at: https://tinyurl.com/3ptds8zc]
2. Dixon, J. (2025) Alan Milburn on the 10-year health plan. Health Foundation
[Available at: https://tinyurl.com/yey5vmk9]
3. Rowland, D. (2025) Briefing note: The local and national impact of profit leakage in the outsourcing of NHS eye care services to the private sector. CHPI
[Available at: https://tinyurl.com/5ahzfazs]
4. Rowland, D. (2025) Out of Sight – the hidden profits and conflicts of interest behind the outsourcing of NHS cataract care. CHPI
[Available at: https://tinyurl.com/xbzb8cjj]
5. Kotecha, V. (2025) Plugging the leaks in the UK care home industry – Strategies for resolving the financial crisis in the residential and nursing home sector. CHPI
[Available at: https://tinyurl.com/y3tuawcm]
6. House of Commons Committee of Public Accounts (2019) Network Rail's Sale of Railway Arches. Report
[Available at: https://tinyurl.com/yc54c6vs]
7. Borsa, A. (2023) Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ* 382:e075244
[Available at: https://doi.org/10.1136/bmj-2023-075244]
8. Corlet Walker, C., et al. (2022) Held to Ransom. What happens when investment firms take over UK care homes. CUSP
[Available at: https://tinyurl.com/5crkj7th]
9. Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm and should be stopped. Oxfam
[Available at: https://tinyurl.com/cyc89f95]
10. Cecchetti, S.G. and Kharroubi, E. (2015) Why does financial sector growth crowd out real economic growth? Bank for International Settlements
[Available at: https://tinyurl.com/33zt37ec]
11. Ghamami, S. (2025) Private Credit & Systemic Risk. Moody's
[Available at: https://tinyurl.com/yrpw73fy]
12. Eva, S. (2026) Private Equity in Selected Industries: Policy Background. Library of Congress
[Available at: https://tinyurl.com/3ce3h5k5]

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Health at a Glance. OECD Indicators
(A comparison of health systems in OECD countries)
OECD, 2025, 240pp. [Available at https://tinyurl.com/mrt8s57u]

This is a monumental public health document comparing key indicators for population health and health system performance across the 38 OECD members.

They comprise Australia, Austria, Belgium, Canada, Chile, Colombia, Costa Rica, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, UK, and the USA. Some indicators are included from other countries – Argentina, Brazil, Bulgaria, People's Republic of China, Croatia, India, Indonesia, Peru, Romania, South Africa and Thailand.

Data presented in the publication come from official national statistics, unless otherwise stated. What about the quality of the data? 'OECD Health Statistics 2025. Definitions, Sources and Methods' (1) is a five-page listing of the areas covered. Just one of the items on the five-page list is life expectancy which is 12 pages long. It starts (alphabetically) with Australia which describes, in detail, the methodology of the Australian Bureau of Statistics by year with various caveats and a URL for further information. Next in Austria …. In addition each chapter has a definition of terms used in the chapter.

The main document presents so much material that I have simply chosen items that seem particularly interesting. There is no space here for the numerous tables and bar charts. The numbered headings below are the 10 chapter headings.

1. Overview and major trends

This chapter compares how countries compare across five dimensions: health status, non-medical determinants and risk factors, access, quality, and health system capacity and resources.

Switzerland, Japan, Spain and Israel lead a large group of 27 OECD countries in which life expectancy at birth exceeded 80 years in 2023. Mexico and Latvia had the lowest life expectancy, at less than 76 years. While life expectancy often fell during the pandemic, the latest data show signs of a subsequent recovery. However, life expectancy in 2023 was still below pre-pandemic levels in 13 OECD countries. Avoidable mortality rates (from preventable and treatable causes) were lowest in Switzerland and Luxembourg, where fewer than 130 per 100,000 people died prematurely. Colombia, Mexico and Latvia had the highest avoidable mortality rates, at over 400 premature deaths per 100 000 people. The avoidable mortality rate for men (303 deaths per 100,000) was double that of women (149 per 100,000), on average across OECD counties.

Non-medical determinants and risk factors for health

Smoking, alcohol consumption and obesity are the three major individual risk factors for non-communicable diseases, contributing to a large share of worldwide deaths. Air pollution is also a critical environmental determinant of health.

Air pollution is not only a major environmental threat but also causes a wide range of adverse health outcomes. OECD projections estimate that ambient (outdoor) air pollution may cause 6-9 million premature deaths a year worldwide by 2060. On average across OECD countries, populations were exposed to 11.2 µg of fine particulate matter (PM2.5) per cubic metre in 2020. The WHO Air Quality Guidelines of 5µg per m^3 was met by only one country, Finland which had lower levels. Exposure to ambient air pollution has declined over time in most countries.

Overall, countries with higher health spending and higher numbers of health workers and other

resources have better health outcomes, access and quality of care. However, the absolute quantity of resources invested is not a perfect predictor of better outcomes – risk factors for health and the wider social determinants of health are also critical, as is the efficient use of healthcare resources. The USA spent considerably more than any other country (USD 14,885 per person in 20240, and also spent the most when measured as a share of gross domestic product (GDP). Health spending per capita was also relatively high in Switzerland, Norway, Germany, the Netherlands and Austria. Mexico, Colombia, Costa Rica and Turkey spent the least, at less than USD 2 500 per capita.

2. Which diseases affect men and women differently – and why this matters

Women live longer than men in all OECD countries, but the gap varies from 3 to 10 years across countries.

Over the past decade, most OECD countries have narrowed the gap between women and men in life expectancy at birth.

Differences in death rates by disease reveal distinct drivers of premature mortality for men and women. Among men, external causes – including suicide, accidents and violence – are the leading contributor of potential years of life lost, accounting for 31% of the top 10 causes of premature deaths across OECD countries. This points to urgent prevention needs, as many of these deaths are avoidable and linked to mental health issues, risk-taking behaviour and occupational hazards. Suicide rates remain between two and eight times higher among men than women, despite declines in recent decades. In contrast, cancer is the leading cause of potential years of life lost among women across OECD countries.

The morbidity – mortality disparity: women spend a larger share of their life in poor health, despite living longer. Across OECD countries, women report more years with activity limitations after age 60 than men (6.3 vs. 5.0 years), resulting in a smaller share of life in good health (74% vs. 76%).

Gender gaps in disease susceptibility are largely driven by differences in behaviour and risk exposure. Men consistently smoke more, are twice as likely to engage in heavy episodic drinking, consume fewer vegetables (except in Mexico and Korea), and are more likely to be overweight or obese across all OECD countries. They also face higher risks from illicit drug use. In contrast, women report lower physical activity in all OECD countries except Denmark, Finland and Sweden.

Social inequalities in health underpin some differences.

3. Health status

In 2023, close to 13 million people died across OECD countries, with an average rate of 861 deaths per 100 000 population.

Diseases of the circulatory system and cancer are the two leading causes of death, accounting for almost half of all deaths in OECD countries.

Across 36 OECD countries in 2023, over 3 million deaths among people aged under 75 years could have been avoided. For example, circulatory conditions caused almost one in three deaths in the population, mainly due to heart attacks and strokes. Cancer accounted for one in five deaths across OECD countries – particularly cancer of the lungs, colon and rectum, pancreas, breast, and prostate.

Across 36 OECD countries, in 2023, over 3 million premature deaths among people aged under 75 could have been avoided through better prevention and healthcare interventions, an average rate of 222 deaths per 100,000 population. The avoidable mortality rate for men (303 deaths per 100,000 population) was double that for women (149 deaths per 100,000) on average. The age-standardised avoidable mortality rate ranged from fewer than 140 deaths per 100,000 population in Japan, Israel, Sweden, Luxembourg and Switzerland to higher than 400 deaths per 100,000 in Latvia, Mexico, Colombia, Romania, Brazil and South Africa.

Gender differences in mortality from suicide

are significant. In 2023, the suicide rate among men was more than 3.4 times higher than the rate among women, at 17.2 deaths per 100,000 men compared to 5 deaths per 100,000 women on average across OECD countries. In Latvia and Poland this difference was even larger, with the suicide mortality rate among men 7.6 times higher than the rate among women in Latvia, and 6.1 times higher among men than among women in Poland. Thanks in part to significant investment in suicide prevention policies, deaths by suicide have been falling in OECD countries in recent years, from 15.1 per 100,000 in 2003 to 10.7 per 100,000 in 2023.

While men are far more likely than women to die by suicide, the gender gap in suicidal intent and behaviour is far smaller – and in some instances is even reversed, with higher rates among women. The number of women hospitalised due to self-harm is significantly higher than for men in all countries with available data. In 2023, women were hospitalised 1.7 times more than men on average due to self-harm for 16 OECD countries, at a rate of 66 per 100,000 women compared to 39 per 100,000 men. The biggest gender differences were observed in Finland and the Netherlands, where women were hospitalised for self-harm almost 2.5 times more than men.

Around 8% of adults considered themselves to be in poor health on average across OECD countries in 2024. This ranged from over 13% in Japan and Latvia, followed by 12% in Estonia and Portugal, to under 3% in Colombia and New Zealand. Korea, Japan and Portugal stand out as countries with high life expectancy but relatively poor self-rated health. In general, women tend to self-report worse health than men, reflecting differences in health perception, access to care and prevalence of certain chronic conditions.

4. Non-medical determinants and risk factors

Illicit drug use, smoking, vaping and cannabis use among adolescents, alcohol consumption, alcohol consumption among adolescents, nutrition and physical activity, nutrition and physical activity among adolescents, overweight and obesity, overweight and obesity among adolescents are considered.

Smoking and vaping

Over the past decade, smoking rates have declined in most OECD countries with available data reflecting an average decrease of a quarter since 2013. At the same time, adult vaping has increased in most OECD countries. Many efforts have been made globally to reduce smoking rates and prevent smoking initiation.

Illicit drug use

This is a major cause of preventable mortality and is associated with many acute and long-term conditions – including cardiovascular and respiratory diseases, neurological and mental health disorders, infectious diseases such as hepatitis C and HIV – as well as heightened risk of overdose. In 2021, drug use was responsible for 5.1% of deaths caused by non-communicable diseases before the age of 70 across OECD countries. Cannabis, opioids and cocaine are among the most used drugs. Over the past decade, notable increases in cocaine use have been observed, largely driven by trends in North America, South America and Europe.

In 2023, around 9% of people aged 15-64 years

had used an illicit drug in the last year, mainly driven by cannabis use. The highest rates were found in Australia, where nearly 18% of people aged 15-64 had used an illicit drug in the last year, and the USA, where the rate was 25%. In nearly all countries, illicit drug use is higher among men than women.

Air pollution

This represents a major cause of death and disability. Projections have estimated that outdoor air pollution may cause between 6 million and 9 million premature deaths a year worldwide by 2060, and may cost 1% of global GDP as a result of sick days, medical bills and reduced agricultural output.

On average across OECD countries, populations were exposed to 11.2 µg of fine particulate matter (PM2.5) per cubic metre in 2020. Only one country – Finland – had average levels of PM2.5 pollution below the WHO air quality guidelines target of 5 µg/m^3 in 2020. Exposure to ambient outdoor particulate matter pollution declined between 2010 and 2020 in most OECD countries, by an average of 24%, although it increased in three OECD countries over this period (Australia, Chile and Japan). While policies to reduce pollution have led to some important reductions in deaths caused by air pollution in many OECD countries, exposure to ambient particulate matter remains a major environmental and public health concern: it was responsible for an estimated 4.1 million premature deaths in 2019, globally (GBD, 2019 (1)).

5. Access and coverage

Following the pandemic unmet needs for medical care and dental care have increased in many OECD countries. In OECD countries analysed, unmet medical care needs across the entire population rose from 2.7% in 2019 to 3.4% in 2024. For dental care, unmet needs increased from 3.8% in 2019 to 4.1% in 2024. The main reason for the increase in unmet needs for medical and dental care were long waiting times. This is especially notable in Finland, Lithuania, Ireland, Greece, Spain and France.

In 2023, the average number of annual in-person doctor consultations per person among OECD countries ranged from fewer than 3 in Mexico, Costa Rica, Sweden and Greece to 18 in Korea . The OECD average was 6.5 consultations per person per year. In Canada, Finland, Sweden, the UK and the USA, the relatively low number of consultations can be explained in part by the enhanced role that nurses and other health professionals play in primary care – notably in management of patients with chronic diseases and in dealing with patients with minor health issues.

Hospital beds and activity

Across OECD countries, there were on average 4.2 hospital beds per 1,000 population in 2023. Since 2013, the number of beds per capita has decreased in nearly all OECD countries, due in part to greater use of day care and reductions in the average length of stay. Hospital bed numbers of some of the 38 countries per 1,000 population: Germany 7.7, Austria 6.6, France 5.4, Switzerland 4.4, Australia 3.8, Italy, 3.0, USA 2.8, Finland 2.6, Canada 2.5, New Zealand 2.5, UK 2.4, Denmark 2.3, Sweden 1.9. In 2023, the average length of stay in hospital for acute care was 6.5 days across 36 OECD countries with comparable data . Turkey and Mexico had the shortest hospital stays (4.7 days); Japan the longest (15.7 days). Since 2019, the average length of stay has decreased in most countries; the most significant declines occurred in Denmark and Belgium. However, average length of stay increased by over half a day on average in the UK and the USA. Inadequate access to high-quality primary care for conditions such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes can lead to hospital admissions that could have been avoided. Common to all four conditions is that the evidence base for effective treatment is well established, and much of it can be delivered by

primary care. A high-performing primary care system, where accessible and high-quality services are provided, can reduce acute deterioration in people living with asthma, COPD, CHF and diabetes.

6. Quality and outcomes of care

This chapter covers vaccinations; screening for breast, cervical and colorectal cancers; safe prescribing in general practice; avoidable admissions for asthma and chronic obstructive airways disease, congestive cardiac failure and diabetes; person-centred care in general practice; and mortality following acute myocardial infarction and ischaemic stroke.

Care for people with mental health disorders

The burden of mental illness is substantial, affecting one-in-two people at some point in their lives. The economic costs of mental health disorders are estimated to be over 4.2% of gross domestic product, covering direct treatment costs and indirect costs from lower employment and reduced productivity. High-quality, timely care can improve outcomes and reduce suicide and excess mortality for people with mental health disorders.

Across OECD countries, suicide rates among patients who had been hospitalised in the previous year ranged from 1.4 per 1 000 patients in the UK to 6.9 per 1 000 patients in Korea in 2023 Across OECD countries, mortality rates are over four times higher for people with schizophrenia and over twice as high for people with bipolar disorder, compared to the general population.

7. Health expenditure

In 2024, OECD countries are estimated to have allocated around 9.3% of their GDP to health on average. In that year, the USA spent by far the most on health, equivalent to 17.2% of its GDP – and well above Germany, the next highest spender (at 12.3%). These are followed by a group of around 15 countries that all allocated 10-12% of their GDP to healthcare. In many of the Central and Eastern European OECD countries, as well as in the newer OECD member countries in Latin America, spending on health represented between 6% and 9% of their GDP. Finally, Mexico and Turkey spent less than 6% of their GDP on health.

Compulsory or automatic coverage, through government schemes or health insurance, forms the bulk of healthcare financing in OECD countries. Taken together, three-quarters of all healthcare spending in 2023 was covered through these types of mandatory financing schemes. Central, regional or local government schemes in Sweden, Norway, Iceland, Denmark and the UK accounted for 80% or more of national health spending. In France, Germany, Luxembourg and Japan, more than three-quarters of spending was covered through a type of compulsory health insurance scheme. In the USA, federal and state programmes covered around 28% of total health spending in 2023, while another 55% of expenditure was classified under compulsory insurance schemes, covering a mix of public arrangements and private health insurance considered compulsory under the Affordable Care Act. Out-of-pocket payments financed just under one-fifth of all health spending in 2023 in OECD countries, with this share broadly increasing as GDP decreases. Households had to bear more than one-third of all healthcare costs directly in Mexico, Chile, Latvia and Greece. In India, nearly half of all health spending is made out-of-pocket.

By contrast, in France and Luxembourg, out-of-pocket spending accounted for less than 10% of total health expenditure.

8. Health workforce

In most OECD countries, over 75% of workers in the health and social care sector are women. While women's jobs tend to be concentrated more in lower-skilled and lower-paid occupations, slightly more than half of all doctors on average across OECD countries in 2023 were female.In 2023, Greece, Portugal, Austria, Italy and Norway had the highest number of doctors among OECD countries, with 5.0 or more doctors per 1,000 population. The UK has 3.4. By contrast, the number of doctors was the lowest in Turkey and Colombia, with 2.5 or fewer doctors per 1,000 population. The ageing of the medical workforce is a growing concern in many OECD countries. In 2023, nearly one-third (32%) of doctors across OECD countries were aged over 55.

Overall, the number of medical graduates across OECD countries increased by 75% between 2000 and 2023, rising from 93,000 in 2000 to 163,000 in 2023.Many OECD countries turn to foreign-trained doctors to expand their medical workforce quickly and at relatively low cost. Although these recruits relieve immediate staffing pressures, they introduce greater uncertainty into workforce planning and can deepen shortages in countries of origin. In 2023, OECD Members employed more than 600,000 foreign-trained physicians, a rise of just over 50% since 2010. Their distribution is uneven: nearly three-fifths practise in only three destinations – the USA, the UK and Germany.

Statistics on nurses and other healthcare workers are considered.

9. Pharmaceuticals, technologies, and digital health

In 2023, retail pharmaceuticals – defined as those dispensed outside hospitals and other care facilities – accounted for around one-sixth of total health spending across OECD countries. This represented the third largest area of expenditure after spending on inpatient and outpatient services. Growth in retail pharmaceutical spending over the past decade has generally fallen behind spending in other health services, reflecting continued efforts to manage costs. However medicines used in hospital and other non-retail settings are a growing component of overall pharmaceutical costs, driven in part by the introduction of high-cost therapies in areas such as oncology, immunology, and rare diseases.

The role of the community pharmacist has expanded in recent years. In addition to dispensing medications, pharmacists are increasingly providing a range of other healthcare services (such as vaccinations, medicine adherence and chronic disease management support, and home medication review), both in community pharmacies and as part of integrated healthcare provider teams. For example, in several Canadian provinces, the UK, many parts of the USA and in Australia, community pharmacists (with the required qualifications) are permitted to assess patients with certain minor conditions and independently prescribe them medications. The expansion of the authorised scope of practice of community pharmacists was accelerated in many countries in response to COVID-19, and in some cases, it has been maintained.

Pharmaceutical consumption has been increasing for decades, driven by a growing need for medicines to treat age-related and chronic diseases, and by changes in clinical practice. Between 2013 and 2023 antihypertensive drug prescribing increased by 6%, lipid-modifying agents by 65%, antidiabetics by 50% and antidepressants by 40%.

10. Ageing and long-term care

Over the past 50 years, the share of the population aged 65 and over has doubled on average across OECD countries, increasing from

less than 9% in 1960 to 18.5% in 2023. All OECD countries have experienced considerable gains in life expectancy at age 65 in recent decades. On average across OECD countries, people at age 65 in 2023 could expect to live a further 20 years. but the pace of improvement has slowed. Most countries saw gains of less than one year between 2013 and 2023. This overall deceleration partly reflects the lingering impact of the COVID-19 pandemic, which temporarily disrupted upward trends in many countries, but it also reflects slowing advances in cutting heart disease and stroke.

More older people in the lowest income quintile rate their health as poor than those in the highest quintile. Overall, Japan, Portugal, Lithuania and Spain account for the highest levels of self-reported limitations in activities of daily living and instrumental activities of daily living (ADL and IADL), approaching or surpassing 30% for adults aged 65 and over. The figures for Hungary, Portugal, Belgium and England (UK) are more than 24%. Korea, Ireland, and Luxembourg, have reported less than 13%.

It is hugely impressive that the OECD has compiled and funded this spectacular public health record.

Reference

1. OECD (2025) OECD Health Statistics 2025. Definitions, Sources and Methods. Table of Content and Metadata for OECD Health Statistics 2025 [Available at: https://tinyurl.com/td9dv8vh]

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Pam Zinkin

Pam Zinkin, EC member for many years and tireless campaigner for DFNHS and in her local community, died just after the last issue of this newsletter went to print. She was 94. The tributes to Pam in the *Guardian* (written by her son, Martin) and in her local paper, *The Islington Tribune*, describe her life and work: 'A remarkable woman who led an extraordinary life' (*Islington Tribune*) puts it perfectly. We shall miss her.

The *Guardian* piece can be read at https://tinyurl.com/34rdxmzh
The *Islington Tribune* tribute can be read at https://tinyurl.com/eeub6zkj

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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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