

**Our ailing NHS:
the follies beyond our financial struggles**

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Have our successive healthcare reforms provided, as promised, better efficiency and value for money? Or have they, rather more, created both psychological and social damage to healthcarers and thus the care they provide?

In 2014 the King's Fund published a report, *Reforming the NHS from within. Beyond hierarchy, inspection and markets*. This had the familiar hallmarks of that organisation's work: thorough research, sharp analysis and clear writing. Certainly the analysis and conclusions remain as essential now to any more sustainable and humanly responsive service as they were in 2014. In brief, the messages are:

- (1) The NHS is chronically underfunded compared with similar (ie European) nations.
- (2) Serial efficiency-seeking and money-saving reforms over the last two decades have mostly achieved neither.
- (3) There needs now to be discriminating decentralisation; we need more areas of intelligent devolution and local accountability.

This report was written four years ago, but I had not seen it before it was recently given to me by its author, Professor Chris Ham, the Fund's CEO, shortly before his retirement. He offered it to me, I think, as a kind of valedictory personal summation of what he thinks most ails our NHS. Certainly, it remains a probing and cogent account of wider and enduring fiscal and systems failures. As such the report has qualities typical of the King's Fund's dependable staple and reputation: non-partisan and solidly objective analysis of finances, systems and outcomes. The robustness of all of these has been well-demonstrated by the clear pattern of events of the last few years.

So this report remains formidably valid: solid arguments, thorough research, competently collated data, clear exposition, accurate prediction... So far, so good. Yet, to my mind, there are important dimensions missing: seminal questions of a

social and psychological kind. Why have we adopted these systems in the way we have? And what are these systems now doing to us?

For some years I have followed this other line of enquiry – to understand how and why we have adopted the often misconceived systems we have, why they are so difficult to undo, and the personal and relational damage that follows – both individually and *en masse*.

My answers to these questions make up my response to the King's Fund report: *Industrialised healthcare: how do we replant our human sense?*¹, a kind of compensatory critique that attempts to add those missing dimensions to their report. This abridged version here outlines its main points.

1. A personal formulation

I was asked recently about my overall view of the changes the NHS had undergone during my long frontline employment as a doctor (since 1969). I replied: 'Everything to do with technology is better; almost all that is dependent on human understanding, relationships, or meaning is much worse.'

What does this mean? Well, broadly that divergence can be seen in a number of ways. For example, it equates with what I term 'curative treatments' (flourishing), as distinct from 'pastoral healthcare' (perishing). We can see it in the dehiscence of the *science* of medicine from the *art* of its practice. This schism is reflected, too, in our different kinds of knowledge: how, for example, generic notations of quantifiable data are increasingly displacing other kinds of personal and experiential language and knowledge.

In practice this divergence is manifest in how technical *treatments* for the curable have generally become much better, but personal *care* for the less-than-curable is likely to be worse. So if, say, you need surgery for cataracts or coronary artery disease the outcome is likely to be far better than thirty years ago.

But what if, instead, you need comfort, support and guidance to help you endure and heal what cannot be decisively fixed by technology? These are the commoner and myriad ailments of mind and body from life's losses, disconsolations and inevitabilities – our misfortunes, our stresses, our lost anchorage, our ageing declines, our often mysterious predispositions – then, with all these, it is very different. You are unlikely now to receive the kind of personal continuity and understanding that underpinned our erstwhile better pastoral healthcare, especially in General Practice and Psychiatry, thirty years ago – before our successive waves of depersonalising reforms.

These divisive reforms have arisen in an unprecedented culture: one increasingly in thrall to quantitative data and evidence. This bias toward the systematised and standardised leads to a specious, if undeliberate judgement: that curative treatments are evidence-based and effective; the less quantifiable pastoral healthcare struggles to produce this kind of evidence or resolution. Therefore it has seemed to make organisational and financial sense to preferentially concentrate thought and money on treatment rather than care.

The result? A systematic neglect, demolition and fragmentation of those services whose functional 'spine' is personal continuity of care² – General Practice and

mental health services, again, are especially vulnerable examples here and yet, crucially, provide most NHS consultations. Both currently struggle to keep intact their functional spine – as a very simple indicator of this consider how few patients can name the clinician they last saw. What kind of care is that? Clearly, we have depersonalised these services. The result? Patients feel uncontained and adrift; practitioners are deprived of the deeper meaning and gratifications that grow with personal bonds. The health consequence of all this far exceeds mere comfort or niceties.² In the meantime staff recruitment drops, burn-out and drop-out rises, the little human connection that still exists struggles to survive, the spine disintegrates further³...

This is the legacy of a healthcare system that designs-out, or even destroys, personal bonds, relationships and understandings.

Increasingly, inevitably, nobody-knows-anybody.

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Of course, technology-prevalent services – say Orthopaedics or Intensive Care – have their struggles: for example, for finances or resources. But they are not deracinated of human connections, opportunities and understandings in the same way or with the same impact as pastoral healthcare.

So what is it about our efficiency-seeking, money-saving reforms that seem not only to fail their primary task but, in addition, add this kind of human collateral damage?

2. Dehumanising systems

My understanding is that we are now governed by three major and growing forces. These three have converged to produce such human depersonalisation, dispiritedness and alienation. This convergence has had a compound, sometimes exponential, effect. The combined administrative power is synergistic: each part interlocking with, then boosting, the others.

The first of these receives fuller description and analysis, as much is also common to the other two.

- i **The 4Cs** stands for competitive commissioning, commodification, commercialisation and computerisation. The first three of these comprise models derived from manufacturing and distribution industries. The last – computerisation – is, of course, now a ubiquitous and seminal force throughout our post-millennial world. It is included here as it is crucial to the functioning of the other three – like the last leg on a four-legged chair.

We now have growing awareness of the wasteful bureaucratic inefficiencies, even nefarious corruptions, of commercialisation in healthcare.⁴ Competitive commissioning and commodification – when serving a commercialised system – all too often serve a commissar-like function overtly for the ‘service user’ (patient), though covertly – but more in reality – for the commercial interest of the ‘provider’ (increasingly big business). Hardly ever does such business-determined proceduralism nourish the better spirit of our care.

Computerisation has now become not only the 'glue' that holds the other three together, but also provides the 'data-fuel' from which they can operate. This 4Cs organisational quadruped can then, with increasing coherence and efficiency, function apparently more and more like a precision-engineered machine. Such is the intended power and promise of our ever-more cybernated systems.

And what is this marketised machine like, to work in or be cared for by? Well, the pattern is becoming increasingly clear: satisfaction is highest among the system's designers, commanders and nest-featherers – elsewhere, particularly in pastoral healthcare, we see increasing malaise: confusion, anomie and signs of absent or disrupted attachments.³

In General Practice and mental health this malaise is evidently and equally true of both staff and patients. There is much data to show how healthcare workers are buckling and leaving. The resulting problems for patients – of declining access, of increasingly depersonalised and discontinuous care – becomes inevitable. A nobody-knows-anybody service is proving bad for all our health and welfare. The evidence for this is massive.⁵

- ii. **REMIC** (remote management inspection and compliance) is another manifestation of Welfare governance that has been accelerated and anchored by computerisation. Modern IT systems can now monitor and instruct innumerable practitioners in a way that was impossible two decades ago. Such capacity has led to ever-increasing command-and-control systems and then mindsets. The generating idea is to be like an air-traffic control-tower,

but for the management of healthcarers. Precise protocols and routes are designated to all practitioners, who are then instructed, monitored and inspected according to standardised templates. *Compliance* is essential to REMIC, so deviation is rarely tolerated. This has led to a health-culture aptly termed *Technototalitarian*.⁶

The results of REMIC?

These are probably more harmful than helpful. While some (very few) egregiously and irredeemably bad practitioners may be stopped by our REMIC system, for the vast majority the situation is far more complicated. Most practitioners, at least initially, want to do a safe and caring job. With intelligently vigilant and supportive management they will – with few exceptions – continue to deliver this, so long as the work conditions and expected tasks are viable.

But REMIC has largely undone this erstwhile sustainable culture of trust and intelligent support, and replaced this with something very different: mistrustful regimes of didactic and hierarchical power that drive strict compliance to generic specifications. We have seen how often this then leads to increasingly demanding, yet shallow, box-ticking: ‘we’ve all got to play the game’.

So what is going on? Well, firstly, as NHS commentator Roy Lilley⁷ often points out, regimes based on inspection and micromanagement simply do not work. But it is worse than that, because REMIC – as all technototalitarian

systems – inevitably becomes inimical and destructive of vocational spirit, trusting relationships, intellectual autonomy and intelligent creativity.

So the result of REMIC is all too often such psychological and social damage as to yield us a hollowed-out, miserable, resentful and anxious workforce that now has existential problems with staff health, recruitment and retention.⁵

Patient care is a tragically unavoidable casualty.

So, operating together with the 4Cs, REMIC then offers us an ingeniously perverse hybrid: the mendacious opportunism of capitalism, merged with the oppression, stupidity and paranoid unviability of Soviet-style managerialism.

- iii. **Gigantism** is a cornerstone of manufacturing and distribution industries: these will always *scale-up* as much as they can, wherever and whenever they can. 'Bigger is better' is a pragmatic principle for efficiency-savings in logistics, standardisation, monitoring and personnel management etc.

This approach may make good sense with, say, the manufacture of washing machines. What about healthcare?

Problematically, the results are much more mixed in healthcare. Scaling-up to larger and fewer units can make much sense in very hi-tech and specialised activity, for example coronary care or most forms of surgery. Large units, even if physically distant, are then the best compromise.

But this may not apply to most hospital admissions: the elderly frail who need competent, kindly medical and nursing care, but not of the hi-tech variety (eg ICU, CT or MRI scans). These people cannot be managed at home, yet their care may be most humanely and effectively delivered if it is homely. Smaller size, proximity and familiarity of staff and surroundings are here paramount. Our erstwhile many smaller hospitals used to provide these things well; our remote, giant conurbations mostly cannot.

The mandate of Gigantism in General Practice is causing increasing damage to pastoral healthcare. Generally, the larger a practice the less well people know one another – patients, doctors, colleagues, receptionists... Larger then, paradoxically, often means lonelier.

Does it matter if we don't get to know these others? Well, *the more you see of someone, the more of someone you see*. So to understand experience, meaning and subtext in other people we have to develop relationships. And this can only develop from personal continuity of care.² Of course this cannot be provided everywhere, for everyone, under all circumstances, yet it remains an anchoring principle for our best human (as opposed to procedural) mental and primary healthcare.

Yet Gigantism with its ever-larger centres and rapidly rotated teams is barren soil in which to plant our endeavours of personal continuity of care.

Procedures become clearer; people become hazier. Fulfilled vocation becomes replaced by sharp but corporatised job descriptions.

The cost of this? Consider the morale, recruitment crisis and the public's growing disconsolation with our GP and mental health services.

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3. What can be done? How may we best de-industrialise, so rehumanise, our NHS?

The following is a preliminary list of measures that would help free up and re-establish our better human sense and connection. Many of these would require the demolition of recent reforms, so would find obdurate resistance from established authorities. For reasons of relative brevity I have not added explanatory commentary here, though have done so elsewhere.⁸

- (a) Abolish the entire marketisation of healthcare and its apparatus: of purchaser-provider splits, autarkic Trusts, financially-based commissioning, payment by results, financial penalties for underperformance etc.
- (b) REMIC (remote management, inspection and compliance) needs substantial disarmament and reduction.
- (c) Stop the hunting and closure of small, popular General Practices.
- (d) Restore personal lists to General Practice: patients to register with a person, not a place.
- (e) Abolish Geriatrics; bring back General Physicians.
- (f) Bring back Consultant-led firms with dedicated wards and support staff.
- (g) Bring back smaller, more local, lower-tech hospitals.
- (h) Bring back Nursing Schools and hospital Matrons.

(i) Break up Medical Schools into more but smaller units.

Interested to see more? You can read the original, more detailed article *Industrialised healthcare: how do we replant our human sense?* in Article 109 on my Home Page.

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References and notes. Referenced articles are most easily found on my Home Page.

1. *Industrialised healthcare: how do we replant our human sense? A response to a King's Fund report.* 2018. Article 109
2. Pereira-Gray DJ et al (2018) in his BMJ open article *Continuity of Care with doctors – a matter of life and death*, showed statistically and clearly how personal continuity of care contributes, for example, significantly to longevity. My own research is not quantitative, but more exploratory of social and psychological factors. See, for example, Letters 7, 26, 47, 59 and 83.
3. Kay, Adam (2017) *This is going to hurt. Diaries of a junior doctor.* Picador
This is one of q several recently published books graphically describing, in personal detail, the increasing human disconnection experienced by NHS doctors.
4. Wrigley, D, Davis, J and Lister J (2015) *NHS for Sale: Myths, Lies and Deception.* The Merlin Press
This, again, is one of several recent books documenting current tangles of folly and malfeasance brought about by recent NHS reforms.
5. The evidence for this is vast and wide and here space-prohibitive. In particular, I have drawn from NHS Digital, Office for National Statistics, Social Care Information Centre, British Medical Association and the King's Fund. Also newspapers: *The Guardian* and *The Daily Telegraph*.
6. *Edward: shot in his own interest. Technototalitarianism and the fragility of the therapeutic dance.* 2005. Article 19.
7. Roy Lilley. ihm.org.uk/roy-lilley-nhsmanagers/
8. See, for example *Plummeting morale of junior doctors: one branch of our blighted tree of Welfare*, 2016, Letter 47.

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