Money Can't Buy You Love

The perishing of our healthcare's human heart:

a historical perspective

David Zigmond

© 2019

Can the important deficits in our NHS healthcare be adequately remedied by more money and staff? If not, why not?

A brief survey of the last hundred years may clarify.

Now is a clamorous time for those claiming they know how to fix our ailing NHS, or who will secure superior funds to ensure its more adequate staffing and infrastructure.

It is hardly disputable now that our NHS has 'poor performance' in many important areas, so the debate, for now, has shifted to a kind of contest as to who will make a better bid for the banking, training and recruitment of our service.

Even erstwhile austerity-missionaries have now implicitly recanted, to acknowledge the necessity of such increased investments. This then raises the questions of who do we believe? And how would they manage this? What and where would the compromises be?

Yet even if we can address these problems of funding and resources clearly and positively, will there still remain outstanding problems? What about the kinds of deficit and damage that we have recently incurred, yet now cannot simply 'fix' with more money, staff and equipment? What are these problems? And what is their source?

*

The blight of morale in many sectors of our NHS is one such complex problem. Many will say, correctly, that this serious malaise is aggravated, and substantially fuelled, by financial austerity: there is little doubt about this now. And it is easy for most of us to understand the stress of being expected to do too much with too little.

So then we can all-too-easily conclude that the simple and clear remedy is to increase investment.

Yet while such explanation and prescription is clearly necessary, it is in many ways not sufficient. For most experienced NHS practitioners – together with other veterans across other Welfare services – know that there have been greater yet subtle losses to their service, but of a human rather than material kind. Significantly, these losses do not receive the focused attention that disputes about money generate. So what are these deprivations? They are of professional and personal ethos, trust, fraternalism, creativity, identification … and thus any deeper work satisfaction and élan vitale.

The loss of these very human vagaries has effects far more serious than mere malcontent: the unhappiness is deep and complex, and leads ineluctably to a malfunctioning and impoverished workforce. So our staff increasingly break down, get ill, seek chemical comforts, give up, or – shockingly – dispose of themselves. And then we cannot replace them. The many tales of all these are legion, and the statistical evidence now massive.

Wider evidence is also clear that these qualitative human losses have paralleled and accumulated with our serial NHS reforms, now for thirty years. Understanding the nature and history of these processes is necessary if we are to have any success in repairing the damage, and then securing those repairs – more money and more practitioners alone will again drain away with a kind of tragic inevitability.

So what has happened, and why? Here a long view is worth taking.

A century of healthcare: a brief cultural history

1. Pre-1948: Individual capitalism and charity. *Each man for himself*

Before the NHS in 1948 most doctors worked among wealthier populations where they could be paid. The poorer and much larger majority of people therefore had very little access to medical help. There were many singular exceptions provided by charities, religious organisations and remarkable proto-socialist doctors – but the overall trend was unmistakable: most doctors worked either for themselves or for small, profitable groups, operating like small independent shopkeepers.

This guild or small-shopkeeper culture may have incorporated some vocational spirit toward individual patients but remained, mostly, protectionist at a social level. That is why most doctors (or at least their representative BMA) fought so hard against the founding of the NHS. At the time it seemed unlikely that doctors would mostly settle with, and for, this revolutionary reconfiguration of their work: many experts then were pessimistic about the viability of this new NHS.

2. 1948-c1990: Social and vocational medicine. *We're all in this together*

Yet the medical diehards so obstructive to the launching of the NHS were emphatically proved wrong. In hindsight we can now see how remarkable was this unprecedented and rapid reform: within a few years the recruitment, morale and staffing stability of this new service provided comparatively equitable care that developed a quality that drew international acclaim and research, and mostly affectionate trust and esteem amongst our own practitioners and general population.

There were failures, of course: *DSRs* (duffers, slackers and rotters), both institutionally and professionally – but these were the exception. Most worked with a high degree of colleagueial cooperation, fraternal reciprocity and interprofessional trust. Practitioners and institutions were guided and motivated by an often-unspoken sense of social vocation. There was little (if any) reference to contracts and no inspections, commercialised competition or commissioning, or metricised appraisals.

This forty-year period may, from today's perspective, seem remarkably lax, unincentivized and unmanaged. In a way this is true. It is also true that demands and expectations were then lower. Even so, most veteran practitioners would say that this pre-1990 period was one of greater work efficiency due to its better personal relationships, trust and morale. And then the more seamless and synergistic relationships that could flourish between its operational groups.

We all had a clearer sense of belonging with, and belonging for.

A good-enough system, surely? So what happened?

3. **1990-present: corporate capitalism and micromanaged medicine**. *The system will decide*

In short, this last and current period can also be denoted by healthcare via the rising culture of neoliberalism, and systems of cybernetics. Or, in more ordinary language: markets will propel and decide, and computerised systems will micromanage.

Here was a new concoction – a potent mixture of culture, ideology and new technologies that, in effect, said: '*Welfare services cannot possibly provide their best by relying mostly on the personal motivations, skills, relationships and judgements of those who work in them. That is far too capricious and unreliable. We must, rather, incentivise by introducing competitive pseudomarkets. We can further ratchet-up quality and value-for-money by computerised micromanagement. This will instruct and monitor all employees, and then, where necessary, sanction or eliminate. We can do this from outside the professions; the spectre of power will soon assure recruitment from within*.'

These reforms were first unleashed in the heyday of the Thatcher government, a regime with a quasi-religious belief in the liberation of markets, yet the astringent external governance of Welfare. Despite the increasingly evident destructive effects over these thirty years, each successive government has colluded with, elaborated or amplified these Thatcher-era initiatives.

*

So what has been the fate of this post-Thatcher, CCMM (corporate capitalism and micromanaged medicine) era? It is mixed, but mostly not good. Most independent investigations conclude that the marketisation has brought inefficient bureaucracy, perverse incentives and 'gamings' as well as mistrustful fragmentation of services. There is little evidence of greater healthcare efficiencies or better motivation.

There has been similar research indictment of the policed regulation and inspection aspects of micromanagement. While the more egregious DSRs may be identified, we

create a far greater problem among the rest by generating a mistrustful – often hostile – environment with an enormous burden and distraction of compliance tasks and bureaucracy. Most healthcarers find this not only unintelligently unhelpful but divisive, dispiriting and exhausting of their limited energies. The net effect, again, has been negative.

Such negative effects can be illustrated by a metaphor: our earlier NHS (era 2: social and vocational medicine) was handled more like a living tissue – with understanding, care, nurturance and protection it would mostly grow to produce a natural synergy and balance between its parts. In contrast, our current NHS (era 3: corporate capitalism and micromanaged medicine) is approached, rather, as an inanimate mechanical object – a motor engine, say – that must be designed, engineered and manipulated to surrender the performance we choose and command. Era 2, a time of greater work harmony and satisfaction, was *guided* by animate, organic perspectives. Era 3, our current period of commanding algorithms and policised monitoring and instruction, is, contrastingly, *driven* by considerations from the inanimate, the inorganic.

What has this led to, in human terms? Well, it has yielded us the personally 'homeless', rootless, lonely, fractious no-one-knows-anyone-but-do-as-you're-told culture. Here, now, data and metrics displace personal understandings and meanings; corporation eclipses vocation; nuanced judgement, initiative and colleagueial trust are all needlessly pushed aside by the blunt rigidity of (often commercialised) corporate contracts.

The personal warmth, spirit, élan vitale, reciprocal nourishment and mojo (choose) – the essentials to sustain our difficult work over long periods – is starved and dies. We have removed the metaphorical human heart of human warmth and inclusion, then replaced it with a mechanical heart that can only pump to order.

That is why we now have such serious problems with NHS practitioner morale and then staffing. Money may easily purchase short-term locums: it will rarely secure us veteran vocational practitioners.

*

A recent cartoon in *The Oldie* is seminal here. Depicted are manacled rows of haggard, emaciated galley-slaves in rags. They look craven and exhausted as their lives depend upon them pulling endlessly on their oars. Above them towers their galley-master: corpulent, massively muscular, menacing and wearing a Roman tunic of office. His right hand brandishes a whip.

'*Remember lads'*, he shouts above them, '*next week: staff appraisals!'*.

The cartoonist here, with profound simplicity, brilliantly captures so much of what has gone astray and awry with our NHS, and more generally in our Welfare services.

This comedified wisdom has again and again seriously eluded our serial health-reformers and their political captains (or captives?).

Money can't buy you love.

-----0-----

Note and further reading

1. Sources for this historical analysis and current description of our NHS are numerous and wide-ranging. For reasons of space I have not listed here the many audio, video or paper documents from times past, or the many more current evidence and research statistics from independent thinktanks, academics or government institutions.
2. Further and more systematic analysis of these NHS problems, together with some suggested remedies, can be found in Zigmond, D (2019) *The Perils of Industrialised Healthcare*, The Centre for Welfare Reform.

Published in *Doctors for the NHS Newsletter*, February 2020

Interested? Many articles exploring similar themes are available on David Zigmond's Home Page (http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html).