Covid-19: are there lessons from history?

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Currently we are caught in a maelstrom of the very alien and all-too-human. What are we to make of our diligent and bravely steadfast healthcarers having to face a dangerous pandemic while so dangerously ill-equipped?

Some historical snapshots may explain.

In the third week of April we are approaching – we hope – the national peak-danger of this Covid-19 pandemic. And now we are facing a particular organisational hazard: our lack of preparedness to provide either timely individual diagnostic tests or PPE (personal protection equipment) on a suitably massed scale. These lacks, almost certainly, themselves derive from the institutional lack of coordinated administrations and planning for such an eventuality. The consequences are then inevitable: the absence of dedicated staff to implement clear plans, inchoate distribution methods drawing from inadequate, unreliable stocks. These failures, of course, have egregious human and economic costs and our government's current tone – simultaneously contrite and defensive – reflects tacit acknowledgement of this.

That acknowledgement – that we are caught in a dangerous game of catch-up – is humbled by the additional knowledge that certain countries – for example Germany and South Korea – have responded to the challenges very much more effectively.

So what sense do we make of this organisational lacuna? No doubt in the coming years there will be many kinds of investigations attempting to understand this, and to prevent the repeat of any similar failure. Meanwhile, can some snapshots from history help us?

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In 1858 the Houses of Parliament were abandoned due to The Great Stink – an overwhelmingly noxious miasma arising from the adjacent Thames, running through a city fearfully plagued by Cholera. This was the culmination of a rapidly

increasing and densely packed population living amidst a mixture of open sewers and newly-invented piped flushing toilets, which all flowed into the river.

The economic and political background here is very significant. The 1850s was a period of unprecedented economic growth and international trade made possible by newly-invented internal combustion steam engines and then electrical telegraphy. To service these burgeoning possibilities the British governments championed a kind of laissez-faire liberalism and economics – non-intervention in the realms of public health, education, labour relations and factory conditions, for example.[1]

This was grotesquely expressed in a parliamentary exchange. Lord John Manners, the Commissioner of Works, was asked by an MP what should be done about the fatally toxic river. Manners replied, 'Her Majesty's government have nothing whatever to do with the state of the Thames. [1, 2]

Eleven days later the *Illustrated London News* published this seminal rebuke: 'We can colonise the remotest ends of the earth; we can pay the interest of the most enormous debt ever contracted; we can spread our name, and our fame, and our fructifying wealth to every part of the world; but we cannot clean the River Thames. [1, 3]

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Are there instructive parallels between this story and our current predicament and travails, a hundred and sixty-two years later, where we, a relatively prosperous nation, now cannot readily respond to, or adeptly resource, this public health challenge?

Certainly our neo-liberal fuelled growth economy of the last few decades has some fascinating similarities to 1850s Britain, where new technologies – then the steam engine and telegraphy; now based on IT, robotics and synthetics – have accelerated all kinds of activity, manufacture, exchange … and then the essential mass production and marketisation of these: commodification. Such commodification has undeniably alluring benefits and efficiencies, but the hidden hazards can make these specious. For example, in the realm of inanimate manufacture it has led to a desired growth-economy … and then we find that the inevitable consumerism leads to ecological damage that ends in the horrifically unsustainable. In our animate or human exchanges and activities – in particular our welfare services – such commodification has additional dimensions of damage: for example, the loss of the kind of living identifications and relationships that suffuse our individual and social lives with meaning. These usually perish when caught between the ratcheted teeth of profit and mass production. Commodification, again, can lure us to the unsustainable.

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At the height of her power in the 1980s the veteran prime minister, Margaret Thatcher, attempted to dismiss such complexly human caveats. 'There is no such thing as society', she chided with Olympian sternness.

In 2020 a newly-appointed prime minister, Boris Johnson, now ailing from Covid-19 addresses the nation from his self-isolated flat in Downing Street. 'I want to assure you … there *is* such a thing as society', he says, with emphatic slowness. He is looking ill and tired, but nevertheless wishes to convey warmth and optimism.

Beneath tribal (party) loyalties is he recanting the received long legacy that now seems so ill-equipped to deal with our communal – our societal – current crisis?

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A little over forty years ago, at the height of Thatcher-era hegemony, the government decided that healthcare largely run by professional vocation, good faith and judgement was no longer fit for purpose. There was, they alleged, too much variation, slack, indolence and incompetence. The NHS needed slicker, sharper manufacturing industry-type management and organisation. It needed, too, the commercial devices to incentivise a keener, leaner, more muscular, motivated and anxiously alert workforce. Hence, first, the purchaser-provider split, thence competitive tendering and commissioning, and thereafter to the fiefdom-like, autarkic NHS Foundation Trusts.

The Internal Market thus fragmented a time-tested cooperative confederacy and replaced it with a marketplace of competing silos.

This commodified, trading model of healthcare could only really deal (literally and metaphorically) with actional 'items' of healthcare that can be easily identified, proceduralised and measured – suitably packaged for contractual commercial purposes. Yet even in this limited arena the marketised NHS has been found to be largely ineffective and often counterproductive.[4]

In the remainder of healthcare, our commercially fragmented services fare even worse. Commercial determinants are usually inimical to personal continuity of care

(PCC). This is important because PCC is often crucial to anything that cannot be quickly and completely cured by technology – that (surprising to many) is the bulk of NHS work: almost all mental health, most of elderly care, general practice, stress-related illness, chronic and congenital disease…[5]

With public health – the main focus of this article – our marketised and fragmented NHS fares equally badly. That is what we are witnessing now.

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In 2011 the then new Secretary of State for Health, Andrew Lansley, proposed an even larger step towards a laissez-faired and commercialised health service, with the Health and Social Care Act (HSCA 2012). Parliament was mostly confused by the bureaucratic complexity of the plans and prolix supporting documents but Lansley explained, at length, how good this initiative to shrink the centralising state would be. Healthcare decisions would be devolved to localities who would commission and purchase items of healthcare from competing – therefore cheaper and better – providers. GPs would take largely commanding and navigating roles in being purchasing agents for their patients and communities. The rhetoric was that of increasing democratic participation and local responsiveness. The people will decide the best; the market will manipulate the cheapest. This state-shrinking service will become largely auto-regulating: the Health Secretary, for all the best reasons, will have much less to do amidst the flourishing of excellence…

We now know how badly this worked out, how mistaken were Lansley's assumptions. The economic and human damage caused by the HSCA has been

investigated and documented by many agencies in numerous reports.[4,5] Several common themes emerge: one is how our serial marketising reforms have impoverished our wider sense of community, commonality and fraternalism. We have lost our benign sense of being part of a larger whole, much of which we may have little or no direct contact with. Yet this made it so much easier to achieve consonance and agreement when we *did* encounter unknown and remote (to us) parts of the service.

Instead the marketised service fostered languages, conduits and protocols around competitive tariffs for items of service, conditions for inclusion and exact boundaries for responsibilities. Fences proliferated defensively, bridges fell into disrepair and sometimes collapsed under unanticipated light traffic. Bit by bit we lost the spirit and culture of the 'larger than us', the common-bonds that can help us quickly adapt in common purpose when the unscheduled and untariffed may strike us.

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Come April 2020 it should not surprise us, therefore, that our overall coordination is so tardy and clumsy. Having concentrated most of our administrative energies and ideas into getting our NHS to emulate just-in-time manufacturing from parts provided by numerous competitive suppliers shepherded by short-term contracts, it is then very difficult for this fragmented and intra-competitive giant to react with holistic intelligence to the dramatically unforeseen.

Thank goodness (literally) our NHS healthcarers have managed, for now, to transcend their stymieing and divisive system to provide devoted service venturing into the heroic. But the system itself is currently shown to be massively ill-equipped

for this kind of unmarketisable, uncommodifiable public health challenge. Without adequate stock-reserves or distribution pathways this just-in-time, austerity-derived service now imperils healthcare staff in their acts of devotion.

The USA – the highest health-spending nation on earth – is, daily, revealing to us how socially irresponsible and hazardous an intensely marketised healthcare system can be.

Maybe even Lord John Manners would balk at such tragic inconsistency.

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Notes and References

1. Wilson, B (2016) *Heyday: The 1850s and the Dawn of the Global Age*. Weidenfeld and Nicolson
   This engaging narrative history gives an excellent account of the 1850s and is well worth reading for the insights it can give us about our present era. Wilson's account of The Great Stink inform this article.
2. House of Commons, 15/6/1858, col. 2113
3. *Illustrated London News*, 26/6/58
4. Ham C (2014) *Reforming the NHS from within. Beyond hierarchy, inspection and markets*. The King's Fund
   This stand-alone report also draws widely and thoroughly from other research.
5. Zigmond D (2019) *The Perils of Industrialised Healthcare*. Centre for Welfare Reform

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).