Behind the NHS Logo:

What kind of NHS will survive?

David Zigmond

The Covid pandemic has challenged and stretched the NHS as never before. What kind of service is likely to emerge and survive?

The ubiquitous blue NHS logo does its PR task well: for many it continues to reassure us by symbolising an integrated and freely accessible health service that will endure beyond our individual lives. The sign thus serves as a kind of shield or amulet saying: *your socialised welfare is assured, here, to care for you, to protect you*. But we can see, increasingly, how the sign – while conjuring such unitary purpose and functioning – may also conceal many hidden conflicts of interest and agencies of control. Like a franchised commercial network, the individual units may be conducting other, hidden, business behind the friendly-familiar sign.

This worried observation is not new to some, but is becoming clearer and greater with this government's response to the Covid-19 pandemic. This is amplified further by the Health Secretary's recently stated predictions and wishes for the future functioning of the NHS.

What, together, do these indicate?

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At the time of writing (late-December 2020) there is currently a national wave of ebullient relief at the pioneering rollout of a Covid vaccine. Yet, overall, apart from the government and its tribal loyalists, few are in any doubt that the UK's response to the pandemic has been often inconsistent, incoherent and lacking in holistic intelligence. Of course this newly-emerged virus has confounded much of our previous knowledge and working assumptions, but most nations of similar economic status have performed much better. The vaunted 'Moonshot', 'world-beating' Test and Trace systems and 'cutting-edge, game-changing' Apps have

proven to be more like advertising slogans or bar-room braggadocio than the considered measures of a socially-responsible, scientifically-informed government. This is all the more remarkable and tragic to be happening in a nation that was, until thirty years ago, often held to be a model of efficiently sustainable, socialised national health care.

How has this descent happened? And what now might we expect for our post-Covid NHS?

The last few months – since Covid became crisis – have been pivotal and seminal. We have seen the inherent limitations of a service that all too easily devolves to divisive, profiteering market forces, and remotely managed cybernation.

Considering the former, the government has again disregarded the long experience and expertise of established laboratory and community-based NHS staff in delivering Test and Trace. Instead, with swift stealth, they subcontracted this work out to large business corporations: Sitel, SERCO, Randox etc. Aside from the probable corruption of cronyism and nepotism there is now the even more indisputable evidence that these business conglomerates may have the financial and resource *capacity* for these tasks, but they do not have the *competence* or *commitment* to understand, engage or influence local communities or individuals. These crucial kinds of service used to come far better from the combination of established clinical practice and community service – from the 'real' NHS, not the expediently and expensively hired giant businesses borrowing and displaying the trust-us-we're-the-NHS blue logo.

What the last three decades of government have, cumulatively, failed to understand is that the more we commodify and commercialise our health service the less well we address the human nuances of communities and individuals. This has been long-argued by those alarmed by the erosion and displacement of personal continuity of care, particularly in primary and mental healthcare. Yet similar caveats are now clear in the mass-scale public health activity of a population threatened by a pandemic. Will the government learn from its recently exposed specious bluster and dangerously extravagant rhetoric?

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This currently looks unlikely.

The Health Secretary has recently broadcast personal notions about what, post-Covid, he hopes and predicts for the NHS: particularly a pre-eminent role for digital technology and social media. He envisions an NHS where face-to-face consultations are mostly made redundant by phone and video links, Apps, emails and the like 'wherever possible'. Such remote, even automated, contacts will function much like a giant network of call centres. In general practice these will be located in megapolyclinics, staffed largely by part-time, rotated professionals who either hot-desk or – even more expedient and inexpensive – can work from home. Commercial operators will be encouraged to cherry-pick parts of this. The gains are evident: rapidity of response, ease of access, flexibility of staff deployment, and – not least – significant cost savings. All good, surely?

But our Health Secretary has opined all this, with apparent oblivion, despite the mass of evidence showing us how ill-suited are such hi-tech, impersonal, cybernated systems to engaging with our Covid test–trace–track. As David Heymann, Chair of Public Health England, recently explained and warned us: 'Face-to-face trust is what's important … You can't do contact tracing from a central location [and expect it] to be effective.'

So the government should be learning what many of the 'real' NHS professionals – local and public health experts – have been trying to tell them: there is no adequate (no matter how expensive) substitute for local-professional knowledge of, then engagement with, individuals within their neighbourhoods and communities. Hancock's preferred devices may be well suited to handling data, but meaningful human engagement requires much else: substituting smartphone Apps for human (personal) contact tracers is proving to be dangerous…

There is no sign – yet – that the government recognises or understands the nature and importance of the gap between the two.

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A broader view shows us how this government's response to this pandemic has been faithful to its legacy of neoliberal managerialism: to commercially outsource and corporatise required resources; to remotely control the population (practitioners and patients) as if from a control tower.

By international comparisons this approach has mostly been an expensive failure.

If this is the case with public health, what will be the fate of those more essentially *personal* healthcare sectors, particularly primary and mental healthcare?

The government's current trajectory and the Health Secretary's expressed inclinations will send a dispiriting chill through the heart of those practising, and those sustained by, any personal continuity of care. For that threatened subtraction is actually of the larger part of our frontline NHS activity, because it includes anything that is not a singular, clear problem that can be swiftly and completely 'fixed' with generic technology or simple advice. So it comprises problems of maturation, adjustment and development; all chronic illness (by definition); stress-related illness and mental health; degenerative conditions of ageing; palliative and terminal care…

All of these will sometimes require technical devices but they are mostly addressed by *pastoral* healthcare: healing or comforting consultations that skilfully guide, support and encourage. Such interactions must draw from growing personal knowledge, trust, faith and understanding. These are subtle processes of consciousness and communication that depend on relationships that are individual, local and relatively enduring. If remotely generated Apps or automated algorithms fare poorly with test-track-and-trace, how much worse will they be in their humanly-blind proceduralism when consigned to contain and caretake such personally-embedded complexity as general practice or psychiatry?

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These two branches of medical practice – general practice and psychiatry – provide the NHS with most of our pastoral healthcare, so the larger, longer historical picture – beyond their increasing current blight – is worth portraying.

In the first four decades, doctors – and their clinical colleagues – were largely motivated and sustained by vocation and a sense of community – both with colleagues and patients. For example, very commonly GPs would spend a working-lifetime employed in one practice with a small team of practitioners and ancillary staff. These surgeries were much smaller than now and staffing was more stable and thus became professional *communities* that could more easily look after, and look out for, one another. They then saw their work as looking after and looking out for yet another community of individuals – patients – whom they got to know over the years, not just in consulting rooms, but also in their homes, neighbourhoods and families. The experience and mindsets of these professionals thus tended to be of caretaking and growth – not items-of-service procedures or contractual requirements, as later.

From the 1990s we have had three waves of neoliberal 'modernising' reforms, each of which has further turned this work's culture from growth and stewardship toward one of industrial manufacture. They are:

1. **Marketisation** planted and fertilised in the first twenty years of the Internal Market. This largely undermined – often destroyed – colleagueial trust, understanding and cooperation. Aspirational vocation was replaced by financial incentivisation. Responsibility to and for individuals was pushed aside by institutional statutory requirements.

2. **The Health and Social Care Act** for the next ten years has empowered the earlier reforms by expanding this modus operandi to encourage an External Market. The effect has been to further alienate and distract practitioners from one another and what they see as their core work (patient care). The clearest beneficiaries seem to be those large commercial corporations skilled at winning bidding wars.

3. **The Digital Revolution**. This is the vision, the avowed mission, of the current Health Secretary. Computers have, of course, been increasingly important to all kinds of clerical, administrative and logistical work through the NHS since the millennium. But Hancock's proposals go far beyond this: he does not see phone and digital media, Apps etc as augmenters or ancillaries for direct human contact in NHS consultations, he sees them as *replacements*. This is a crucial difference.

Why does this matter so much? Well, it relegates the skilled ethos and vocation of pastoral healthcare to generic algorithms of institutionally defined tasks. The anchorage and sanctuary of the familiar practitioner who knows and understands you is replaced by an unknown voice or screened face probably never to be encountered again. The relationships we grew at work were, before our serial reforms, the terra firma of our more complex clinical practice – our bonding and supportive colleagueiality, the resonance by which we may best endure, comfort, understand and heal.

Our marketising reforms have ruinously fragmented this NHS terra firma. Hancock's grandiose quest for a thorough and uncompromising digital cybernation

of consultations would vapourise that better humanity: where could we find it? And how could we grasp it?

This is bleak modern history: each successive NHS reform, since the 1990s, has been officially vaunted to increase inclusion and responsiveness yet has lured us further into a mire of no-one-knows-anyone-but-just-do-as-you're-told.

Babylon's *GP at hand* will be fine for the healthy, busy young professional with early tonsillitis – an easy problem. But what about the lonely, frightened nonagenarian whose recent widowhood is exacerbating her degenerative spinal pains?

Yes, Babylon may emblazon the comforting NHS logo, but where is its humanly sensed terra firma?

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