After Covid: what do we need to 'build back better'?

At the start of 2021 our NHS is shuddering with the near-catastrophic strain of a third wave of Covid pandemic. Yet, simultaneously, with the green-light given to the Oxford-AstraZeneca vaccine, we think and hope we can see an end to this modern plague. Many, understandably frustrated, talk with weary impatience of 'returning to normal'; the United Nations with greater wisdom and foresight urges 'building back better' – now frequently troped by our government.

It is not yet clear what kind of 'better' this government might mean for the NHS, and the current signs are that what is 'better' for the government is not so for the governed: patients and practitioners.

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Events since the start of this Covid-crisis indicate how and why this is so. Early on there seemed a great gulf between the ethos and competence of the government, and that of the NHS healthcare professionals. This distinction is worth defining and understanding.

At the beginning of the pandemic the NHS healthcarers were rapidly and necessarily unleashed from almost all aspects of the Internal Market and the managerial regimes of inspection and compliance. Practitioners for many years had made clear that they felt their working efficiency and spirit were substantially undermined by forests of mandatory bureaucracy that were not only frequently obstructive of intelligently humane practice, but even corrupting it. That early-pandemic unleashing coincided

with the lionising ritual of the Thursday evening neighbourhoods' clap-in for NHS workers. The euphoric ritual may now have passed, but public appreciation and support for this bravely resolute NHS – which is now run more by committed clinicians' decisions than hired corporate managers' edicts – remains strong. For all their imperilling stress and exhaustion many doctors report feeling a sense of liberation, relief and proud, rediscovered motivation: this Covid-crisis has thus shown us all what can be achieved if we are unshackled from the Internal Market and its associated draconian inspection-compliance regimes.

Meanwhile the ethos and competence of the government's handling of the Covid-crisis is shown to be very different. The challenge has, of course, been severe and difficult for all nations but the UK government has been especially self-handicapped by its ideology of marketisation. Over the last three decades we can see how the governing authorities have devolved and fragmented our *National* Health Service to be more of a network of competitively commissioned agencies (NCCA?), franchised behind the unifying NHS logo. This is a profound abdication of governmental responsibility and inevitably incurs loss of knowledge, engagement and expertise at both local and national levels.

This has been especially evident with the government's handling of Test and Trace. Having largely lost interest in, commitment to, and working knowledge of, Local Health Authorities and community health services – the 'real' NHS – who would have the competence and commitment to fulfil these tasks if adequately resourced, the government swiftly awards large contracts to corporate profit-seeking businesses who have the financial capacity but not the competence, cognisance or commitment to execute these complex responsibilities.

The wasteful and dangerous inefficiency involved in so swiftly contracting such tasks to Serco, Sitel et al does not address the equally serious charge of expedient chumocracy or corrupted nepotism. If this is the foundation-terrain on which we are to 'build back better', we have much to be fearful of.

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The Health Secretary's repeatedly expressed views on primary care should cause us equal alarm. Because GPs have rapidly and universally adopted the digital technology necessary to continue some kind of skeletally essential service throughout this unprecedented crisis, Hancock has seen how this might fortuitously herald a Digital Revolution throughout general practice.

What does this mean? Hancock envisions all consultations relegated to videophone or other digital devices with few exceptions. Face-to-face contacts with a known and trusted person become an inconvenient rarity in a virtually tasked and streamed flexible workforce where, increasingly, no-one-knows-anyone.

Such developments can only accelerate the already parlous and perilous processes of demoralised unravelling so destabilising current general practice and mental health services. Until the first of our serial neoliberal NHS managerial reforms, thirty years ago, UK general practice – for all its inconsistencies and flaws – was a very popular profession, among both staff and patients. Morale, recruitment and staffing stability were high. As was its international reputation for high quality, cost-effective *personal continuity of care*.

Personal continuity of care seems, to Hancock's mooted digital revolution, an anachronistically sentimental and disposable irrelevance to the real work: swift delivery of *treatments*. But the majority of NHS contacts involve far more than generic biomedical interventions: *care* means contextualising these within a growing knowledge and understanding of unique eco-systems: individuals, their kith and kin, their communities…

It was the possibility of this kind of personal, community-based, doctoring that largely made for the erstwhile GPs great work satisfaction and loyalty, and with that – mostly – the reciprocal experience of patients.

Admittedly, the Health Secretary's drive toward remote management and cybernation of the majority of consultations could – short-term – be popular among some: the otherwise healthy and happy with a readily 'fixable' complaint, organisational executives looking to make expedient (if specious) savings, the digital technology industry … and those commercial enterprises all-too-ready to cherry-pick from a blighted tree.

For the rest of us these changes would be much less beneficent. Doctors working throughout pastoral healthcare will be working with even less work-satisfaction – struggling to maintain colleagueial morale, identification and coherent stability. And patients, of course, will be the recipients of this attrition.

When we are most vulnerable where will be the human harbour and anchor point where the implicit and personal can be professionally tended and guided with skill and nuance?

Without satisfactory answers to such questions, 'building back better' may remain a lubricious slogan.

The articles in this journal's edition express our effort to counter that possibility.

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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).