The high price of commodified healthcare

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Commerce, industrial manufacture and monetarism are seriously flawed bases for Welfare provision. This brief letter presents another snapshot of what is happening.

On one evening in the last week there were two separately channelled TV programmes addressing yet more apparent incompetence in NHS Healthcare. Each of the two programmes focused at opposite ends of a spectrum: the 111 Service for acute and short-term directive contact and then psychiatric services for the complexly distressed, for longer-term care. From this wide span of missed and miscommunications what common themes emerge?

The programmes' portrayals were consistent with my many decades' experience as an NHS doctor. What we are witnessing is the loss of a healthcare culture of personally invested connections and understandings. This has happened through attempts to emulate industrial manufacture and commercial trade. Before twenty years ago there was much good practice that was free of the current errors. For example, I was part of a GP out-of-hours rota which – together with our telephonists – provided a much more skilled, competent and personable service with little administrative clutter or expense. Likewise, when I worked as a psychiatrist I was able to offer personal continuity of care over many years with the commensurate containing, and healing effects: this was humanly rich yet financially economical. These lost patterns of healthcare extended beyond sensitive and sensible care for patients, they were – indirectly though substantially – sources of human nourishment and enlivenment for healthcarers too: the doctors I know may now be paid more, but they have less personal work satisfaction.

In complex human Welfare if employees do not really like their work they are unlikely to ever do it well, whatever the strictures and structures. A commercially or industrially modelled system becomes – perversely – humanly disconnected, then harmful and economically wasteful. The evidence for the failure of this approach is now ineluctable: it is a doomed project. We now need to largely dismantle these well intended but corrupting devices: autarkic and competing Trusts; commercial subcontracting; payment by results; hegemonic Goals and Targets, algorithms, Care Pathways and statistics-before-sense. We need to understand and reclaim the underlying motivational and vocational psychology of our work: why and how should we care for one another?

Our complex human bonds may then be better honoured.

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