REFLECTIONS

Shaping the future of healthcare: building back better

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Abstract

The Covid-19 pandemic has not only highlighted societal inequalities but also shown how a resilient health service is essential for protecting citizens. The NHS was founded in 1948 to provide universal healthcare but has been under sustained attack for the past thirty years. As a seven-year-old patient with osteomyelitis, the NHS almost certainly saved my life. Seventy years later I reflect on the humanising and civilising aspects of the NHS, the need for doctors to be advocates and custodians, as well as clinicians working in the best interests of their individual patients; and the requirement for the medical profession to understand the social determinants of ill health and how these can be ameliorated. The reward for engaging in this struggle: a healthier world in the widest sense and greater satisfaction for all those working in the prevention and treatment of ill health.

Keywords: *National Health Service, NHS, Covid-19, global health, privatisation*

Introduction

My views on healthcare, seen through the lens of the coronavirus pandemic, are informed by an experience from my childhood, followed by years of training and working as a doctor in the UK National Health Service (NHS). The NHS was set up in 1948 to provide universal healthcare, free at the time of need, despite a war-ravaged economy. Over the last 30 years it has been under sustained attack (1-3), and may only survive if a population coming to terms with Covid-19 insists that a government's first duty is to care for the health of its people.

The National Health Service

My experience of our National Health Service (NHS) started in 1949 when I was seven years old, and the NHS just one year old.

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I was urgently admitted to the children's ward of Sedgefield hospital with osteomyelitis of the neck of the right femur…I was given the last rites. The weeks of treatment I received with the recently available penicillin, resulted in full recovery with no sequelae. Before the NHS, my parents could never have afforded the treatment I needed and received. I probably wouldn't be here to write this 70 years later had it not been for the newly formed NHS.

Despite this, I unthinkingly took the NHS for granted for the next more than half a century. It is only in retrospect that I can see so many global and existential issues that cannot be ignored in any consideration of health and disease; individual health cannot properly be considered detached from the global health of the entire planet and all of the life it supports.

Leaping forward a decade, I met Hazel, my wife-to-be, in 1961 when we both started at the University of Leeds Medical School. We were medical students when a paternalistic medical profession was still comfortable using euphemism to impart bad news, and options with respect to treatment were not considered a matter for the patient. The lofty and arrogant consultant surgeon epitomised by 'Sir Lancelot Spratt' of the famous *Doctor in the House* film was still very much in evidence (4). It came as something of a shock to discover recently that in the 1940s the dominant group of specialists had needed "their mouths stuffed with gold" in order to accept the NHS - that "Jewel in the Crown" of the new Welfare State.

For us it was six years of a crammed curriculum. I remember all of us, after two years of the 2nd MB (Anatomy, Physiology and Biochemistry), starting clinical work for the first time and wondering about the relevance of the previous two years. Patients in the hospital across the road might well have been in another universe!

Though much of that two years undoubtedly was relevant and necessary, how much better had more of that time been spent widening our horizons; understanding how health and disease are to the greatest extent determined by societal issues; to firmly and forever fix the concept that health must be a human right. Career advice (if any was given) was more likely oriented to career as an end in itself, rather than giving consideration to how our work might fit

into a wider context. In the 2020s, medical training needs a redesigned curriculum that will sensitise young students and young doctors to their wider role as custodians of the system for healthcare delivery, as well as being responsible competent ethical practitioners for their individual patients.

Over the next many decades, I was aware of change increasingly being dictated from above, but did not appreciate its significance. That the NHS would ever be threatened would never have entered my head or those of any of my fellow students. Only now in my later years do I start to understand the damage that has been and is being done "below the radar" unseen and therefore unrecognised. Examples include outsourcing, subcontracting, incorporation of international health insurance corporations into NHS bodies concerned with procurement (5) and the revolving door for senior personnel between industry and the Department of Health. Interestingly all this whilst misleadingly and dishonestly maintaining the NHS logo, promoting its use by private companies and ensuring the general public remain unaware of the alien ongoing transformation. This also includes the introduction of the odious hostile environment through charging for asylum seekers (ending universal access to healthcare) and putting increasing areas of practice outside the scope of the NHS.

General practitioners are to this day technically outside the NHS but contracted almost in their entirety to the NHS. Using this aberration as an argument for privatisation of healthcare—oft used—is entirely spurious. However primary care is undergoing contractual change — as part of the overall fundamental change in the NHS by successive governments — opening it up to competition from private competitors such as those offering digital online consultations (6).

Despite these negative retrospectives, we students did not question but that everyone, without exception, regardless of background, status or wealth, received the best most appropriate treatment available. Yes, the private wing of the hospital was there, and we served that too. There might have been private rooms and carpets, but the treatment and respect for the patient was the same.

Remoulding doctors as champions of universal health care

Is the medical undergraduate curriculum and subsequent career structure conducive to the future of ethical medical practice? If the young medical student and young doctor are not "armed" with knowledge of the key importance of the social determinants of health (7), and the "traps" that lie ahead that may wittingly or unwittingly lead to betrayal of the patient's interest in favour of the doctor or some other agency eg "Big Pharma" (8,9,10) or the food industry (11), then the future of medical practice is not safe in the hands of such a medical profession.

This in no way detracts or is intended to detract from the unimaginable achievement of the creation of our National Health Service in 1948, to provide universal healthcare free at the point of need and equally accessible to every person in the country, rather it reminds how this creation will always be a "work in progress" (12).

Thank goodness I was lucky that for my entire career, there were no restrictions regarding eligibility to access healthcare. It was sufficient, that anyone concerned in any way about their health, had full access to the National Health Service regardless of who they were, where they were from or why they were in the UK. The all-important mutual trust with my patients was not muddied by issues of "eligibility". Everyone was eligible. I'm ashamed to say this has changed. Only a few months ago during "lockdown", Boris Johnson, our Prime Minister, was "clapping for the NHS" on the steps of 10 Downing Street one day and the next his government was announcing that an annual surcharge for immigrants and their family members to access the NHS was actually to be increased. There was an outcry and, thank goodness, a U-turn. But that such a policy should even be considered is an indictment of the direction of our ruling elite (13, 14).

For the young student and doctor, evolving awareness of and participation in developing global health as a concept will be at the same time exciting, a great privilege and a great responsibility, the downstream effects much of which they will recognise in their clinical practice.

Working at the "coalface" both obscures and facilitates a broader view

Turning to examples of my experience of working in a still rapidly developing specialty during the 1980s and 90s; there was willingness and eagerness to embrace new roles and responsibilities among healthcare staff, thus allowing me to set up a new clinical haematology service for cuttingedge treatment of haematological malignancies locally. However, I would not have been able to demand extra staff to this end.

Unfortunately, sometimes much needed change in working practice was blocked; for instance: there was an urgent need for ward nurses to be able to start the pre-agreed antibiotic regimen in severely neutropenic patients when fever developed, to avoid a fatal delay. Though the ward nurses would have been more than willing, the new breed of nurse managers would not allow it. Undoubtedly that resulted in avoidable deaths.

After two decades of struggle, our own clinical initiative enabled us to join forces with District General Hospitals (DGHs) in adjacent towns, sharing with them the quantum leap in staffing and structural alteration of a ward for protective isolation (reverse barrier nursing) of immune-compromised patients and thus ensuring continuity of a thriving unit into the future. Such initiatives from DGH front-line clinical staff in today's NHS would be unthinkable.

"New Public Management" entered the NHS under Margaret

Thatcher with The Griffiths Report (15), introducing "managerial cadres" into the health system in the name of improved efficiency. This was the harbinger of privatisation and a trajectory towards a United States (US) system of healthcare, a trajectory on which we continue still, largely unrecognised by the public (and probably most NHS staff).

Undermining of the NHS

Hospital provision in the UK was expanded in the 1960s by creation in most towns of District General Hospitals (16), adding to the existing large teaching hospitals in major cities, a development steered by Enoch Powell (infamous for his racist ideology). This made good-quality NHS hospital care available closer to home for many.

However, powerful forces wishing to centralise the more complex work in tertiary centres and devolve all else to community and primary care has increasingly threatened the DGH. Numerous campaigning groups to protect our NHS have long recognised chronic and progressive underfunding, increasing privatisation and fragmentation, increasing control by large financial corporations and alignment towards a US system of healthcare (1-3). Had it not been for their relentless efforts across the length and breadth of the country, in exposing secretive government plans, there would now be little left of our NHS.

Continuing contraction of the hospital bed base over many years, declining staff numbers, increasing workload under a system no longer trusted by huge sections of the NHS staff, with consequent falling morale, has now been exposed by the catastrophe of Covid-19. Yet the drive for increasing outsourcing and privatisation (including test track and trace) continues unabated (17, 18).

We need highly educated medics with wide vision and eyes wide open, who will work at the coalface and be motivated to evolve the system of healthcare into one inspired by a belief in promoting health as a human right, including in the UK where we still have something worth saving to build on. We need solidarity with colleagues in all countries who recognise these imperatives. Global health as we all now know, is indivisible

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Note

i Ensuring global health in a truly civilised world would leave no room for unemployment. So relevant to highlight here an initiative earlier this year by three academics that has gained thousands of signatures from academics around the world relating to the nature of work: (https://democratizingwork.org/background). One of the initial core group is Pavlina Tcherneva who has written extensively on the need for a 'Job Guarantee': (http://pavlina-tcherneva.net/job-guarantee-faq/) as an important component part of that contract between each of us with all others that ensures there are no "others". This inspirational initiative has so caught the imagination of the global academy it has already become a movement.

References

1. Pollock AM. NHS plc: The privatisation of our health care. London, UK:Verso; 2004. 336 pp. https://www.amazon.co.uk/NHS-Plc-Privatisation-Health-Care/dp/1844675394
2. Allyson Pollock in conversation with Mohan Rao. Youtube. 2012 Feb 25[cited 2020 Oct 31]. Available from: .https://www.youtube.com/watch?v=P-0UdFfQkMk
3. Puntis J. 'The Conservatives never were "the party of the NHS", and history proves it'. Keepournhspublic.com. 2019 Nov 17[cited 2020 Oct 31]. Available from: https://keepournhspublic.com/the-conservativesnever-were-the-party-of-the-nhs-and-history-proves-it/.
4. Doctor in the House: UK. Youtube. 1954[cited 2020 Oct 31].Available from: https://www.youtube.com/watch?v=oVWjAeAa52o.
5. Sasse T, Guerin B, Nickson S, O'Brien M, Pope T, Davies N. Government outsourcing; what has worked and what needs reform. London, UK: Institute for Government; 2019 Sep [cited 2020 Oct 30]. Available from: https://www.instituteforgovernment.org.uk/sites/default/files/publications/government-outsourcing-reform-WEB.pdf
6. Beech J, Baird B. GP funding and contracts explained. London, UK: The King's Fund; 2020 Jun[cited 2020 Oct 30]. Available from: https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained
7. Commission on Social Determinants of Health; Final Report: Closing the gap in a generation Health equity through action on the social determinants of health. Geneva: WHO;2008 [cited 2020 Oct 30]. Available from: https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf?sequence=1
8. Editorial Staff. Who are the players in the pharmaceutical industry (Big Pharma)? Deserthopetreatment .com. 2019 Oct 2[cited 2020 Oct 30]. Available from: https://deserthopetreatment.com/addiction-guide/drug-industry-trends/
9. Light DW, Lexchin JR. Pharmaceutical research and development: what do we get for all that money? *BMJ*. 2012 Aug 7[cited 2020 Oct 30]; 345:e4348. Available from: https://www.bmj.com/content/345/bmj.e4348
10. Krumholz HM, Hines HH, Ross JS, Presler AH, Egilman DS. What have we learned from Vioxx? Example of Rofecoxib (Vioxx): *BMJ*. 2007 Jan 18[cited 2020 Oct 30]: 334:120. Available from: https://www.bmj.com/content/334/7585/120
11. Millstone E.: The evolution of food safety policy making: Speech at Food Thinkers seminar. 2016 Sep [cited 2020 Oct 30]. Available from: https://foodresearch.org.uk/foodthinkers/food-safety-erik-millstone/
12. Delamothe T.; NHS at 60; Founding Principles *BMJ*. 2008 May 31[cited 2020 Oct 31]; 336(7655): 1216-18. Available from: https://www.ncbi.nlm. nih.gov/pmc/articles/PMC2405823/
13. Malik N. The NHS surcharge for migrant staff is gone. Why did it take such a fight? The Guardian.com: 2020 May 25[cited 2020 Oct 31]. Available from: https://www.theguardian.com/commentisfree/2020/may/25/nhs-surcharge-migrant-staff-government-campaign
14. Grant H, Gentleman A. Calls to scrap 'unfair' NHS surcharge for all migrant workers. The guardian.com. 2020 May 22[cited 2020 Oct 29]. Available from: https://www.theguardian.com/world/2020/may/22/calls-scrap-unfair-nhs-surcharge-all-migrant-workers
15. Read C. The future of NHS leadership: unpicking Griffiths' complex legacy. *HSJ*. 2014 Jul 21[cited 2020 Oct 29]. Available from: https://www. hsj.co.uk/5072855.article
16. Rivett G. A 70-year perspective. In: *The history of the NHS*. Nuffield Trust; 2019. [cited 2020 Nov 4]. Available from: https://www.nuffieldtrust.org.uk/chapter/conclusion-a-70-year-perspective
17. Pollock A. Privatised track and trace has utterly failed. *Facebook.com*. 2020 Aug 7[cited 2020 Nov 8]. Available from: https://www.facebook.com/watch/?v=594864037845433
18. Pollock A. Thanks to outsourcing, England's test and trace system is in chaos. *Guardian.com*. 2020 Jul 31[cited 2020 Nov 8]. Available from: https://www.theguardian.com/commentisfree/2020/jul/31/outsourcing-england-test-trace-nhs-private