

COMMENTARY

Steady undermining of the UK National Health Service underlies industrial action by doctors and other staff

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Abstract

Erosion of standard of healthcare in the United Kingdom underlies the industrial action taken recently by staff in the publicly provided National Health Service. Underfunding and understaffing, largely as a consequence of neoliberal government "austerity" policies implemented following the 2007-08 banking crisis, together with lack of long-term planning and a drive towards outsourcing, have led to a deterioration in the quality of services. Reduction in bed numbers and neglect of community and social support have compounded problems by making it more difficult both to admit and to discharge patients in a timely fashion. Access to services has been compromised with negative consequences for the sick. Reduction of doctors' real wages together with stress at work, moral injury caused by feelings of not being able to do the best for patients, burnout from the Covid-19 pandemic and uncertainty about the future have led to the longest ever strike action by junior doctors in England.

Keywords: health care; public service; strike action; austerity

For many people around the world, tax-funded universal healthcare in the United Kingdom (UK) represents an aspirational model, that was until recently rated one of the best systems internationally [1]. Many working in the National Health Service (NHS) as well as those who depend on it for treatment, see the current situation as being one of crisis and reject the government's assessment of no more than "an extraordinarily difficult time" [2]. While the NHS is still providing 1.6 million interactions with patients each day, the damage being wrought by neoliberal policies threatens to destroy its founding model, to the detriment of both patients and staff.

Harm to staff and harm to the public

Widespread strikes in the health sector (including the first ever action by the Royal College of Nursing), are a testimony to the extreme pressure to which staff are being subjected, not only by difficult working conditions but also by the cost-of-living crisis, with inflation-adjusted wages having fallen by around 20% since 2010. The negative impact poor staffing has on patient care and outcomes is well recognised [3], and is often the first reason given by those on strike in explaining the motivation for their actions. Despite widespread public support for NHS workers, government responses have included legislation that will make it more difficult to go on strike, with the threat of sacking for those who vote to do so [4]. Delay for many years in producing a recent long-term workforce plan to address understaffing gives the lie to claims that the anti-strike ("minimum service levels") legislation is primarily concerned with patient safety. With 120,000 staff vacancies (the NHS employs 1.3 million), a recent survey indicates that things may well get even worse. For example, four in 10 doctors and dentists say they are likely to quit over "intolerable" pressures [5]. Meanwhile, record numbers of people in the wider economy are taking early retirement, most commonly because of ill health. The number of working age people claiming disability support has doubled since before the pandemic. Nine million people are now "economically inactive", with 2.5 million of those giving long term sickness as the reason [6]. There is, therefore, growing awareness among the public (if not politicians) that the UK economy cannot afford for the NHS to fail.

NHS ambulance and emergency services are failing

Ambulance chiefs have warned repeatedly that services are stretched beyond the limit. People are literally dying in the back of ambulances, while in 2021 it was estimated that up to 160,000 came to harm because they could not be transferred into crammed Accident and Emergency (A&E) departments and therefore waited outside for extended periods [7]. In the same year, the ambulance service in one region admitted that delayed transfer and the knock-on effect of reaching patients too late was causing catastrophic harm; ambulance response times across England as a whole were the worst on record. Medical Royal Colleges (the guardians of training) generally shrink from criticising government, but one College President broke ranks to state that the NHS was so pressurised it was now breaking its "basic agreement" with the public to treat the sickest in a

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timely way, adding that “the true barrier to tackling this crisis is political unwillingness; the current situation is breaking the workforce and breaking our hearts” [8].

Studies from Canada and Australia have shown that delays in transfer from emergency departments to appropriate inpatient facilities increased risk of death, while speeding up processing decreased this risk. Using Hospital Episode Statistics and Office of National Statistics data for England, the Royal College of Emergency Medicine (RCEM) estimated the number of deaths occurring across the UK associated with crowding and long waiting times in A&E from time of decision to admission to be a staggering 300-500/week [9]. There was a slow but steady rise in deaths by 30 days for patients who remained in A&E for more than five hours from their time of arrival. One extra death occurred for every 82 patients delayed for more than six to eight hours [9]. The published data was peer reviewed and the methodology clearly stated. The fact that such a study cannot prove a causal link between delay in admission and death means it is open to challenge, but other experts agree the figure is entirely plausible. It may also be an underestimate of the true numbers of deaths. These points were confirmed by the independent organisation “Full Fact” [10]. Despite this, the government’ disingenuous response was that it “did not recognise” the figures while failing to explain where it held the paper to be wrong. The study was repeated in 2023 with similar findings.

NHS workforce crisis

Jeremy Hunt, Secretary of State for Health from 2012-18, presented himself as a champion of patient safety. His legacy is contested, with campaigners pointing out that on his watch there were missed targets, lengthening waits, crumbling hospitals, missed opportunities, false solutions, funding boosts that vanished under scrutiny, and blame apportioned to everyone but himself [11]. When Chair of the authoritative parliamentary Commons Select Committee on Health and Social Care, he concluded in a 2022 report that “we now face the greatest workforce crisis in history in the NHS and in social care, with still no idea of the number of additional doctors, nurses and other professionals we actually need”, emphasising that this state of affairs was putting patients at risk of serious harm [12].

The report also acknowledged that “it is unacceptable that some NHS nurses are struggling to feed their families, pay their rent and travel to work”, suggesting they be given a pay rise to match inflationary pressures. However, once Hunt moved on to the post of Chancellor of the Exchequer such proposals were quickly abandoned, with the Treasury becoming the main block on progress in pay talks. Meanwhile, in a report from the House of Lords Public Services Committee on emergency healthcare, there was agreement that: “the state of emergency healthcare is a national emergency. The substantial delays that patients face when trying to access emergency health services create considerable emotional distress and an unprecedented clinical risk” [13].

No serious plan to address the root causes of poor performance

Funding for the NHS has not been allowed to grow sufficiently to meet increasing demand. While nominal spend has increased (allowing government to claim “record funding”), real spend per unit of healthcare demand has actually decreased. Repeated statistics over time show the service to be in a state of decline. Responding to recent data, the Health Foundation think tank commented [14]: “these figures show a gridlocked health and care system struggling to meet the needs of patients....in October 2022, hospital waiting lists hit a record high of 7.2 million, with nearly 411,000 waiting over a year. More than 1 in 10 people with a serious condition such as a stroke or chest pain waited...for an ambulance in November 2022, while nearly 38,000 people spent more than 12 hours on trolleys in A&E”. In early 2014, figures showed an increase to 7.54 million waiting for elective care [15].

The Department of Health and Social Care commissioned a report from the King’s Fund (an independent body) to help it understand how this situation had arisen. Tellingly, the report concluded that a “decade of neglect” by successive Conservative governments has weakened the NHS to the point that it cannot tackle the huge backlog of care. Specifically, years of denying funding to the health service and failing to address its growing workforce crisis have left it with too few staff, too little equipment and too many outdated buildings [16]. Government then chose to turn to the relatively small private sector for help with decreasing the backlog. Despite all this, the majority of the public still support an NHS based on its core founding principles [17], with most wanting more funding, and disagreeing with politicians in both main parties who see greater privatisation of services as the way forward.

The strike by junior doctors

Becoming a doctor in the UK requires five years at medical school. This is then followed by two years of “foundation training” before entry into core/specialty training (three years for general practice and five to seven years for a hospital specialty) [18]. Only when this lengthy period of postgraduate education has been satisfactorily completed do doctors move from the ranks of “junior doctor” (JD) into senior roles. The term JD is now considered by some to be anachronistic, since it encompasses not only newly qualified staff but others who have many years of accumulated experience [19].

JD have been one among many sections of the NHS workforce (nurses, physiotherapists, midwives, ambulance staff, radiographers, consultants) to have taken to industrial action during 2023. Their first ever strike was in 1975 [20], with the next not until 2016 [21]. This second action was over a new contract that was ultimately imposed and sharply reduced the number of working hours paid at a higher rate. For strike action to go ahead, there is a legal

requirement that at least 50% of eligible members of a union must participate in a ballot, and 40% of eligible members must then vote in favour. After a successful vote, a mandate for action lasts six months, and voting must be repeated if the dispute is to be continued beyond this. The JD dispute is ongoing, with 34 days of withdrawal of labour throughout 2023, ending with an unprecedented six days in succession in January 2024.

Of the 75,000 “whole time equivalent” JD in training roles [22], around 50,000 are members of the British Medical Association (BMA), with the Trades Union Congress-affiliated Hospital Consultants and Specialist Association and Doctors in Unite unions having a much smaller medical membership. Public support has been strong [23] but given that the BMA does not have an established strike fund (relying instead on voluntary donations) some doctors will find themselves under increasing financial pressure as the strike continues. A third ballot was completed in March 2024 with 34,000 voting. This was 10,000 fewer than in August 2023 but still constituted a 62% turnout with 98% voting in favour of continuing industrial action [24]. It is estimated that the strike so far has delayed 1.5 million outpatient appointments and cost the NHS £2 billion. Re-structuring of rotas and cover by senior staff has allowed emergency and intensive care work to be maintained.

What is the strike about?

The main demand is for real-terms pay to be restored to where it was 15 years ago. This would require a 35% increase in current salary [25] and could be done over a period of several years. The figure was derived using Retail Prices Index (RPI) to assess the impact of inflation on salaries, arguing that since 2008 there had been a 26.1% loss of earnings. While this calculation was challenged by the Office for National Statistics (advocating instead the use of the Consumer Prices Index) [26], the Royal Statistical Society backed the BMA, asserting that RPI is the better indicator of change in cost of living [23]. Government has responded by dismissing concerns of pay erosion, calling a 35% pay rise “unaffordable and unreasonable,” and offering only a sub-inflation figure of around 11%. JD have pointed out that to accept such an offer would be agreeing to a real-terms pay cut. In Scotland, where health is a matter for the devolved government, a strike was averted when doctors agreed to accept an offer of a 14.5% increase.

Additional demands by JD include that the advisory Review Body on Doctors' and Dentists' Remuneration becomes more independent of government [27] when making recommendations for annual pay awards, and that once pay has been restored, a mechanism should be established to prevent the possibility of such severe erosion in the future. The JD have been well organised, sharing a wealth of useful information to guide effective strike action [28] and gaining support from consultants (who until recently were engaged in their own parallel pay dispute). This has led to opprobrium

from right wing commentators, with the think tank Policy Exchange [29] suggesting that the BMA has been taken over by a small group of radical activists. As evidence of “revolutionary” demands, it cited calls for an NHS Staff Charter, a fund to meet postgraduate medical examination costs and improvement in representation of JD in deliberations over rota and service design across the NHS.

Dissatisfaction goes beyond pay

There are many reasons for JD being disaffected, with 40% saying they are thinking of leaving the NHS [30]. These include increased work pressure from chronic vacancies and additional short staffing on any given day from sickness, etc [22], burnout from experiencing the Covid pandemic, feeling undervalued by government, and “moral injury” [31] caused through being unable to provide the appropriate standards of care to patients. In addition, the old close-knit consultant-led hospital teams offering mutual support have long since disappeared. Doctors also see their activities increasingly circumscribed by hospital managers prioritising cost savings and budgets.

Other persistent grievances include the burden of bureaucracy [32], lack of a quiet space to write up notes and order tests, outdated and slow computer systems [33], no provision for a restorative nap [34] at night when quiet, no hot food availability [35] on night shift or weekends, nowhere to safely store personal possessions including food and drink when at work, working long shifts with anti-social hours, and no guaranteed breaks for rehydration, eating or even to use the toilet. To these may be added recent bitter memories of being denied Personal Protective Equipment by some managers [36] who refused to recognise the risk from airborne spread of Covid. Other complaints also highlight strict training structures, the pressure to make very early career decisions and a bullying and sexist culture at work [37].

A newly qualified doctor's annual salary is £37,000, rising to £44,000 at the start of specialist training. Financial burdens include hospital car parking charges that have risen to around £1000/year [38] while the cost of child care now averages £1000/month [39]. Of course, plenty of other less well-paid staff feel these pressures too, and unsurprisingly, many have come to regard the NHS as a bad employer. The average medical student debt at the start of their working life stands at £71,000 [40]. Fees for college exams and during specialty training can also add up to thousands of pounds [41]. There are then mandatory recurrent costs in the form of Royal College membership subscriptions, General Medical Council (GMC) fees and medical indemnity payments.

With nearly 9,000 vacancies [31] across the medical workforce, the planned increase in Medical Associate Professionals (MAPs) [42] from 3,500 to 12,000 has caused concern that rather than appoint more doctors, workforce

gaps will be filled by these non-medical graduates. Although medical student places are being increased, plans are proceeding more slowly than promised [43] and retention is a challenge when around a third of medical students say they will leave the NHS within two years of graduating [44]. Writing off student loan debt has been suggested as one strategy to improve retention of doctors [45], but this has not been embraced by government. The development of medical apprenticeships as an alternative entry into medicine piles on further worry [46] as do bottle necks in training [47] which see career progression to senior positions blocked.

A survey by the GMC [48] revealed an increasing number of medical trainees experiencing burnout (emotional, physical and mental exhaustion), with one in five JD at high risk in 2022, compared to one in seven in the previous year. For some specialties such as emergency medicine, this was as high as one in three. A recent survey found that 18% of doctors considered leaving the profession in 2021 — up from 12% in 2019 [49].

Conclusion

Underfunding of the NHS relative to increasing demand, together with understaffing, has resulted in a deterioration in services for patients and intolerable strains on staff including loss of earnings. Outsourcing of services to the private sector has been associated with worse outcomes for patients [50]. Despite a long-delayed workforce plan only recently put in place [51], urgently addressing problems of retention is receiving little attention. Throwing more staff into a hostile environment — while failing to look at why people leave — is both costly and untenable. MAPs must not be seen as the solution to this problem, and raises serious concerns over definition of their scope of practice, supervision requirements and patient safety [52]. Pay restoration for JD should be an immediate priority, but there are many other things the NHS needs to do to become a good employer and show proper concern for the wellbeing of staff in general. A win over pay for JD would strengthen the negotiating position of other staff groups. Ultimately, good patient care depends upon well trained staff who feel supported, valued, adequately remunerated and want to work in the service. Neglect of the workforce can only be seen as part of the plan to undermine comprehensive healthcare, which is free at the time of use and funded out of general taxation, in favour of less efficient and more costly models involving competition. Some observers have explained this succinctly in terms of wealth redistribution — from poor to rich [53].

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