

Spotlight

Thought leadership and policy

Healthcare: Fixing sick Britain

Abena Oppong-Asare

Daisy Cooper

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David Nutt



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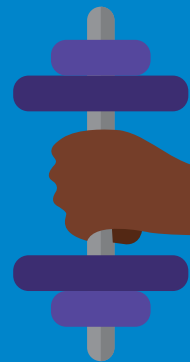


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The sick man of Europe

The UK is poorly and it's getting worse. According to the Office for National Statistics, 2.8 million people of working age are currently economically inactive because of long-term illness, a rise of 800,000 since 2019. This increase has been exacerbated by huge NHS backlogs restricting access to healthcare.

Perhaps even more alarming is the fact that people in their 20s are now more likely to be off sick than those in their early 40s, according to the Resolution Foundation. Mental health issues are the leading cause: in 2021/22, a third of people aged 18-24 reported symptoms of a mental health condition.

The shadow mental health minister Abena Opong-Asare (see page 4) writes that there are currently 1.9 million people waiting for NHS mental health treatment in England. She argues that the wider social determinants of "poverty, poor housing and financial insecurity" are also contributing to this epidemic. Indeed, a holistic approach to prevention is central to making people fit for work. Both the government and the opposition have spoken about turning the "sickness"

service into a "health" service, but neither have said how they would implement a truly cross-departmental approach.

Musculoskeletal conditions are another leading cause of long-term sickness. As the charity Versus Arthritis explains (see page 12), one million people are waiting for orthopaedic surgery such as joint replacements, causing them to be off work with pain, and therefore leading to higher poverty levels. Harry Clarke-Ezzidio explores (page 8) how dentistry is yet another area where the erosion of NHS services has caused people to live in avoidable agony, and the employee benefits provider Unum notes (page 6) that poor, inflexible workplace conditions also contribute to sickness.

Meanwhile, the Prime Minister has waged a war on "sick note" culture. A £2.5bn plan aims to help people stay in work, reduce the number signed off sick and make it harder to claim benefits. He wants to focus on "what people can do with the right support... rather than what they can't do".

But the right support isn't there – and punitive restrictions will not make Britain healthier, or more productive. Politicians need to take a whole-systems approach, to create better access to NHS services, better occupational health provision and better overall livelihoods. Whichever party wins the general election, it will inherit an ill nation – and a sticking plaster won't cure it. ●

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Spotlight

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THE NEW STATESMAN

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First published as a supplement to the New Statesman of 17 May 2024.

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Registered as a newspaper in the UK and US.

The paper in this magazine is sourced from sustainable forests, responsibly managed to strict environmental, social and economic standards. The manufacturing mills have both FSC and PEFC certification and also ISO9001 and ISO14001 accreditation.

This supplement can be downloaded from:
newstatesman.com/spotlight/reports

The view from the opposition



Abena Oppong-Asare MP
Shadow minister for women's
health and mental health

“The Conservatives have broken their promises on mental health”

As we mark Mental Health Awareness Week, we must confront the stark reality that many face. “It has never been as bad as it is today.” I hear this time and time again from family members who work in our NHS mental health services. But I hear it even louder from the patients, families and NHS front-line staff who I have been fortunate enough to meet since September last year, when I was appointed shadow minister for women's health and mental health.

Under this Conservative government, Britain has become more unwell, with millions languishing on waiting lists and far too many living in conditions of

poverty, poor housing and financial insecurity, which all worsens mental health. Currently, around 1.9 million people are waiting for NHS mental health treatment in England, and in the past 12 months nearly 40,000 children experienced a wait of more than two years, according to research from the children's commissioner, Rachel de Souza. People experiencing an acute mental health crisis spend days in A&E departments due to the limited dedicated support for them outside of hospitals.

This failure not only scars the lives of millions – it creates a huge financial burden. A recent Centre for Mental Health report estimates the cost of mental ill health on society at £300bn a year. This is nearly twice as big as NHS England's annual budget.

In the face of this crisis, what do we get from the government? We get short-sighted decisions; the scrapping of a ten-year Mental Health and Well-being Plan; the shelving of long overdue reforms to the Mental Health Act, despite explicit promises in its 2017 and 2019 manifestos. It is incomprehensible to me that legislation that would help people at their most unwell has been de-prioritised.

The Conservatives' approach to mental health is not only characterised by a lack of investment, de-prioritisation and broken promises, but increasingly by a reckless tendency to blame everyone else, including health professionals and patients themselves. This is a shameless attempt to explain away yet another policy failure by making a culture war of mental health and the so-called sick-note culture. I am gobsmacked that the government is using the final months of this parliament to erode the strides we have made as a nation on stigma.

Walking around parliament, I bump into MPs of all shades, including senior Conservatives, who are exasperated by the government's approach to mental health. Just a few weeks ago Dan Poulter MP, who is an NHS psychiatrist and a former Conservative health minister, joined the Labour Party because of what he sees every day.

We cannot go on like this. If given the opportunity to serve after the next general election, Labour will prioritise and act on mental health. We have three key ambitions: reform the Mental Health Act; improve mental health services; and take a prevention-focused cross-government approach to tackle the social determinants of mental health.

What does this mean in practice? We will reform the Mental Health Act in our first King's Speech. This will end the inappropriate detention of people with learning disabilities and autism who do not have other psychiatric disorders. It will tackle the racial inequalities in mental health, where black patients are four times more likely to be detained than white patients. It will remove prisons and police cells as places of safety under the Act, to ensure people experiencing a crisis are supported in an appropriate setting. And it will give mental health patients more of a say and greater control over their own care.

At the same time, we are realistic. We know that

reform of the Mental Health Act will not fix everything. We need to improve mental health services, especially for children and young people.

As announced by Keir Starmer, Labour will recruit 8,500 more mental health staff to cut waiting lists, introduce specialist mental health support for every school and deliver an open-access mental health hub for young people in every community.

I know from my previous role working with the shadow chancellor Rachel Reeves and the shadow Treasury team that fiscal responsibility is key. The sums must add up, and this is no different. We will deliver this plan by abolishing tax loopholes for private equity fund managers and tax breaks for private schools. We will be ambitious with the targets we set ourselves – for example, we have committed in our health mission to reverse the rising trend in the rate of lives lost to suicide.

Labour will need to address the staffing challenges overseen by this government. Thousands are leaving the NHS or planning to leave. They are burnt out, exhausted and stretched to breaking point. Mental health is the discipline with the highest vacancy rate, at a staggering 11.7 per cent. This impacts patient care, worsens staff morale and results in an ever-rising bill for hiring temporary workers (over £10bn a year across all NHS services). Staff are the jewel in the NHS's crown – we must do better by them. I am proud that Wes Streeting, the shadow health secretary, has strongly supported the NHS practitioner health programme, which provides mental health and well-being care for NHS staff.

We cannot separate physical and mental health – they do not live in isolation. The cross-government approach taken in Labour's Child Health Action Plan means that alongside the explicit commitment to end the crisis in child mental health services, other elements can contribute. For example, Bridget Phillipson, the shadow education secretary, has pledged breakfast clubs in every primary school so we have well-fed, healthy and happy children.

Critically, we must start treating mental health as a cross-service issue, involving mental health services, the ambulance service, police, schools and many others. In my constituency of Erith and Thamesmead, I see countless examples of the impact that housing and employment make on mental health. Luciana Berger is currently leading a review for Labour that will provide recommendations for cross-government working, so that we can tackle a range of determinants to improve the well-being of the nation. If elected, Labour will develop the first long-term, whole-government plan for improving mental health outcomes, making early intervention a reality, and broadening the range of services to those with severe mental health conditions.

Less talk, more action – Labour will deliver Mental Health Act reform in the first King's Speech, improve mental health services with fully costed investment and take a bold prevention-focused, cross-governmental approach. ●

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Work isn't working

Improving conditions and benefits could boost the nation's health and happiness

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Record numbers (2.8 million) of working-age people in the UK are currently economically inactive due to long-term sickness. This should be a concern to all. Sickness affects people's incomes, economic productivity and the nation's growth. Reform to working conditions that helps employees lead healthier lives and reduces long-term sickness and presenteeism could have a key role in reversing the trend.

Clare Lusted, head of product proposition at leading employee benefits provider Unum, gives her thoughts on improving workplace conditions, health and economic growth.

What do we mean when we say "working conditions"?

This encompasses a broad scope of conditions and aspects of an employee's working life. Many working conditions are prescribed by law. Employers, for example, are required to ensure the physical working environment is free from health and safety risks. Other conditions include working hours, wages and holiday entitlements, among other things. It can also mean health support in the workplace, ranging from private medical insurance to group income protection, and preventative services such as nutrition and exercise advice.

How do workplace conditions contribute to economic inactivity?

There's growing evidence that demonstrates a link between employees' health and happiness in the workplace and their productivity and rate of sickness absence; also, that healthier employees are less likely to need to leave their jobs due to long-term sickness. They're much more likely to want to stay both in their current role and more generally in work.

In research commissioned by Unum, we found a significant number of employees believe that improvements in health and well-being services provided by their employer would make them healthier. It would lead to fewer days off and people would be more productive, increasing the likelihood of them staying with their current employer. And over half of the employees surveyed – which would be the equivalent of 16 million people – said that improvements in health and well-being offerings provided by their employer would lead them to take less time off

and/or increase their productivity.

What should the government do to improve working conditions?

Unum is calling for four key policy changes that we feel can serve as a starting point for broadening the approach the government is taking. First, a collective commitment to improving workplace health and happiness. Second, to introduce a new system of statutory sickness support. Third, to look at a widened definition of occupational health, which would be part of the measures that are coming out of the government's occupational health consultations. Finally, an introduction of national employer standards.

What has Unum uncovered about health and workplace productivity?

Last year, we commissioned independent think tank WPI Economics to carry out research with over 4,000 employees. There were three key findings from the research. First, employees who are happy at work take on average nine fewer sick days per year compared to employees who report being unhappy, suggesting that health and happiness at work really does reduce sickness absence. Second, 80 per cent of employees say that they are more productive at work when they are feeling healthy and happy, indicating that health and happiness at work are key drivers of productivity. And finally, employees with good physical and mental well-being are nearly two-and-a-half times more likely to be happy at work than those with poor physical and mental health, highlighting how physical and mental well-being are central to employee happiness.

What wider societal benefits would occupational health reform have?

Our research showed that boosting access to health and well-being services at work, alongside halving the number of unhappy employees, could see companies collectively benefit by £6.4bn a year through reduced lost output from sickness absence and presenteeism. On top of this, increasing productivity as a whole could benefit companies by an additional £7.3bn per year. The new Occupational Health Taskforce is a positive development and indicates seriousness. We'd like to see some policy continuity and reforms taken forward after the upcoming general election.



Independent research links employee happiness with fewer sick days

How can the government incentivise support for employee health and happiness?

The Treasury and HMRC published a joint occupational health consultation last year looking at tax incentives. We're still waiting on the government response to that consultation. In our submission to it, we called for an explicit widening of the definition of occupational health to include provision of insurance and the associated benefits and services available. We also called for the removal of the "benefit-in-kind charge" on group critical illness policies, which limits employees' access to support if they're diagnosed with a serious illness, and for a reinterpretation of optional

remuneration arrangements for group income protection. Under the current interpretation, cover funded by salary sacrifice is subject to double taxation. This means that salary sacrificed is taxable as a benefit in kind, and the benefits are taxed as earnings for income tax and National Insurance purposes. This discourages employers from facilitating protection for their employees, when we know it would benefit businesses, employees and the state. ●

To find out more about supporting employee well-being, read Unum's "Health, Happiness and Productivity" report: unum.co.uk/docs/Health-Happiness-Productivity.pdf

A dental desert

On the front line of a rapidly decaying sector

By Harry Clarke-Ezzidio



Located one mile from Birmingham city centre, opposite a park through which a seventh-century river flows, the Edgbaston Dental Centre could hardly be described as “deserted”. Yet Edgbaston is one of many areas across the country termed “dental deserts”: places where there is either a shortage of dentistry practices to serve local people, or no more capacity in existing ones to take on new NHS patients. This leaves scores of people without access to vital dental services; some just need a simple check-up, others are suffering from tooth decay and gum disease – and many are dealing with excruciating levels of pain.

Edgbaston Dental Centre – a large, pearly-white, converted Victorian-era house, with a more modern, brown-brick extension – has practised for more than 20 years. It’s an anomaly in Birmingham: the practice is one of few in the city that is taking on new NHS patients. A 2022



One in five Britons are not registered with a dentist

BBC investigation found that 82 per cent of dental practices in Birmingham are not accepting any new adult NHS patients. The picture is worse for the whole UK: nine in ten practices aren't taking on adults, and eight in ten are not accepting new child patients.

On a chilly Wednesday morning in March, I arrive at the clinic alongside Preet Gill, the shadow primary care and public health minister and MP for Edgbaston, who I'm accompanying on a shadow ministerial visit. An array of patients arrive at the practice. One local resident travels by foot, wrapped in a black puffer jacket to shield them from the cold, while another arrives in a sparkling white Porsche, dressed in a dark grey designer tracksuit.

Around 90 per cent of dentistry services are provided by high-street practices such as this one, which are independently owned and essentially

operate as small businesses. These practices take on a combination of NHS patients, who pay subsidised costs based on the level of treatment they need, and private patients, who can pay up to three times more for the same services. Children, pregnant people and those on certain low-income benefits receive free treatment.

Inside the dental surgery, patients nervously twiddle their thumbs as they wait to be called into the treatment rooms. When I speak to them, the dentists themselves seem nervous, too. Many are worried about the level of decay (both literal and figurative) that their industry is dealing with. "Morale is very low," Dr Anoup Nandra, the owner of the Edgbaston Dental Centre, tells me, perching on his dentist's stool. "Dentists are overworked. Dental teams are overworked." The practice is "super-stretched" and is now open from 8am to

8pm. "Covid was a big problem... patients were not coming," he adds.

Despite dental care being an essential part of population health, dentists were not deemed to be key workers at the start of the pandemic. Dental practices were forced to close between March and June 2020, and appointments sharply declined, causing a significant backlog. Dental treatments peaked at a record 39.7 million in 2018-19, then dropped to a low of 12 million in 2020-21. The number has since bounced back to 32.5 million in 2022-23, but this is still below pre-Covid levels. "We are, in many ways, still catching up on the backlog of care needed," says Nandra.

One of Nandra's patients, Steven, first started coming to the Edgbaston practice in 2022 because he was unable to get registered at any of his more local practices in the nearby district of Moseley and Kings Heath. "Getting into a dentist is virtually impossible in places," he says. Treatment delays and poor oral health can cause a cascade of other health issues, beyond the well-known ailments of toothache, decay and gum disease. It can increase the risk of heart disease, stroke, diabetes and complications for pregnant people.

Steven is visiting the dentist to get "impressions" – a mouth mould – to replace two of his bottom teeth, which are rotting. "I've been in a lot of pain," he tells Gill in a treatment room, prior to his procedure. "It's ridiculous – we're supposed to be a good country."

Shortly before Gill's visit in March, NHS dentistry made headlines when the police had been called to manage a huge number of people who were queuing outside a dental practice opening in Bristol, desperately trying to register for an NHS dentist. Consequently, 1,500 patients were registered for treatments in just two days. One in five Britons (22 per cent) are not registered with a dentist, according to a survey from YouGov, with the most common reason being that they can't find an NHS dentist open to new patients. The research also revealed that one in ten people have resorted to performing "DIY dentistry" on themselves, including pulling out their own teeth or making their own dentures.

"I ain't got the bottle to pull them out myself," Steven tells Gill, half joking. She doesn't laugh.

"That is not what NHS dentistry should look like in the UK," the shadow ▶

◀ minister later tells me in a vacant treatment room.

If there is such a thing as a “utopic” dental clinic, then it is perhaps located in the affluent London districts of Marylebone and Chelsea.

Happy Kids Dental, which has two separate practices in the capital, could aptly be described as a “dental Disneyland”, rather than a dental desert. The children’s clinic could be mistaken for a playground: photos on its website of the Chelsea clinic feature hippo-shaped sinks, floor-to-ceiling sea-themed rooms with floating plastic fish, and a giant elephant-crewed toy ship, complete with a slide. The two clinics offer private treatment with a “full mouth oral health assessment” for children aged three to 16 costing £215-235 – nearly ten times the cost of an NHS check-up.

The existence of such premium clinics might add to an assumption that dental practices – and dentists by default – are all affluent. The government has leaned into this belief – perhaps to distract from the decline in service it has presided over. Earlier this year, the Health Secretary Victoria Atkins told *Good Morning Britain* that the “dental market” has “radically changed” in recent years. She suggested that dentists are increasingly choosing to perform more “cosmetic treatments”, which “tend to be rather lucrative for dentists, and a lot of dentists... are attracted to that”. But “not all” prioritise

22%

Of Britons are not registered with any dentist

10%

Claim to have carried out their own dental work, including tooth extractions

11m

People are estimated to have been unable to get an NHS dentist appointment in 2022

private work over their NHS patients, she added when challenged.

The dentistry industry wholly rejects this suggestion. Eddie Crouch, chair of the British Dental Association (BDA) and a practising dentist in Birmingham, tells *Spotlight* via video call that the opposite is true. “Colleagues are having to actually provide more private treatment... to cross-subsidise [the costs of performing] NHS treatment,” he says.

The current “NHS contract” between the government, the NHS and dental practices was first introduced by the last Labour government in 2006. Bar a few marginal improvements, it has barely changed since. This means that, rather than being paid for each piece of NHS work they do, dentists are paid per course of treatment. Dentists in England receive a “block contract” from their local integrated care board (ICB), which commits them to conduct a set number of “units of dental activity” (UDA) per year for a set fee, paid for by the NHS. If they don’t complete 96 per cent of that work, they have to pay back some money.

Treatments are categorised into three “bands” based on complexity, which are worth different numbers of UDAs and different patient charges. A check-up or examination is in band 1, accounting for one UDA; fillings and root canals are in band 2, accounting for three UDAs; and the most complex treatments such as crowns and dentures are in band 3, accounting for 12 UDAs. Patient charges range from roughly £25 to £320, and have risen by 12 per cent over the past year.

Patients are only charged a single cost per band (rather than per treatment item), and this payment also covers all treatment within lower bands, meaning dentists are doing more work for less money. For instance, one filling would cost an NHS patient the same as three fillings and an examination. Similarly, several treatments within one band only equals one UDA value, making it harder for practices to meet NHS commitments.

Crouch calls it a “broken contract”. He says that alongside poor monetary compensation, the multiple appointments and many hours of work involved in complicated cases do not accurately count towards their NHS quotas. Many practices “struggle” to fulfil these, especially as they are increasingly losing staff to other industries.

“Some of our dental team can earn far more money going to work in a

“This isn’t what NHS dentistry should look like in the UK”

supermarket,” Crouch adds. “When you can’t recruit dentists or... other ancillary staff to help you fulfil a contract, it’s really galling to hear a minister say that we are choosing to do that.”

The BDA is calling on the government to urgently prioritise reforming the NHS contract, and how dentists are paid for NHS work. The union’s other demands include building a sustainable workforce, establishing a national agenda for prevention, and giving dentistry a voice in integrated care systems. But while the sector is facing a workforce shortage (more than 2,000 dentists have left the NHS since the pandemic), contract reform needs to be the starting point for policy change, says Crouch. “Most MPs believe that this is a workforce problem,” he says. “They believe that if they train more dentists, or they import more dentists from around the world, the system will actually be better. But... if you come and work in a system that’s poor, you won’t stay.”

In February, shortly after the queues seen in Bristol, the government announced its £200m Dental Recovery Plan. The plan centres around two themes of action and prevention.

Dentists will be offered a “patient premium” of either £15 or £50 (depending on the level of treatment) to take on new NHS patients; the minimum UDA rate (the level of compensation that dentists receive) will be raised from £23 to £28 to make “NHS work more attractive and sustainable”; and a public health campaign encouraging good oral health will target those who are pregnant, as well as infants and toddlers. To help those living in “dental deserts”, the government is offering dentists “golden hellos”: a £20,000 payment to set up new practices in under-served areas.

The most striking aspect of the plan is to introduce “mobile dental vans” to provide more immediate support in dental deserts. But, in reality, this idea is not new at all. The charity Dentaaid has



The shadow public health minister Preet Gill (right) in Edgbaston Dental Centre, owned by Dr Anoup Nandra (left)

provided free emergency dental treatment to vulnerable groups since 2016, and began operating its first mobile dental vehicle – a large truck, with a rectangular unit attached where procedures are conducted – two years after. It now has nine mobile dental units and ran 422 clinics in 2023. “It’s quite devastating to think that this is what it’s come to,” Natalie Bradley, Dentaid’s clinical director, tells *Spotlight*.

Bradley says the government’s dental van plan is “not a long-term solution”, and will be expensive: buying and modifying vans for dentistry costs in excess of £250,000 per vehicle, she estimates, based on her charity’s own costs. At best, 12-15 people could be seen a day, she thinks. It’s a drop in the ocean compared with overall need: according to a survey of GPs, 11 million people were unable to get an NHS dentist appointment in 2022.

Labour has also released a plan to “rescue” NHS dentistry, which it says will cost roughly £111m per year. It was originally going to be funded by scrapping the non-domiciled tax status, but as the government has since taken this policy, the funding will need to be

generated from another source, which has not yet been confirmed.

Similar to the government’s plan for “golden hellos”, Labour would also offer a £20,000 incentive for dentists to open new practices in dental deserts, if elected. But is this enough to encourage a dentist to uproot their life? “Just to set up a dental practice will cost you many, many more thousands,” Anoup Nandra tells Preet Gill in his Edgbaston practice.

On first glance, you could be forgiven for confusing the opposition’s dentistry plan with that of the government’s. Both commit to treat those in urgent need (Labour is pledging to deliver 700,000 “urgent appointments”), reform the dental contract, and focus on prevention. Labour is also planning to introduce “supervised toothbrushing” in its new, proposed school breakfast clubs. “Our plan is absolutely different,” Gill tells me. “[The places] where parents were getting support no longer exist. That’s why the toothbrushing scheme – delivered in parts of early years and in schools – is so important, because we’ve got to make sure it’s a public health priority.”

As the shadow minister concludes her visit in Birmingham and is picked up by her driver, I speak with people on the street about their experiences of the NHS. “I had to go for private treatment in the end,” Harry, who was on his way to Birmingham New Street station, tells me. He had waited a year to register at a local dental practice that was taking NHS patients near his home, just outside of Liverpool: “I was at a point where I nearly overdosed on painkillers, because I was in pain every day.”

Harry lives with depression, which impacts his ability to brush his teeth as often as he’d like to. He ended up paying nearly £600 for private root canal treatment. He’s currently on an NHS waiting list for further treatment, and has been for two years. Unable to afford more private work, Harry believes that by the time he’s seen, his teeth may have deteriorated to the point where “it’ll have to be a full-on tooth extraction”.

“I can understand why people are doing dentistry on themselves,” he says. “I’m sure [dentists] must feel so guilty and get a lot of flak, but it’s out of their power. It’s through policy [where solutions come]. It’s through politicians.” ●

How NHS waiting times impact people with arthritis

One in six individuals in the UK are living with the condition

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Arthritis and musculoskeletal conditions are a leading cause of disability in the UK. Despite this, the conditions receive just 3.4 per cent of UK research funding. It is often left to charities like Versus Arthritis – the UK's largest arthritis charity – to provide dedicated support to those living with the condition. Deborah Alsina, chief executive of the charity, offers her thoughts on Britain's treatment of the disease.

How prevalent is arthritis in the UK?

It's a hugely prevalent condition. One in six people in the UK are affected by arthritis. And it's part of a group of musculoskeletal conditions that affect over 20 million people in total.

How does the condition manifest?

Arthritis is an umbrella term that accounts for painful, stiff and restricted joints. There are three main forms: one is osteoarthritis, which affects about ten million people. It's a condition where the cartilage at the end of the joint is unable to repair and maintain itself, so it becomes thin and uneven. Then there are autoimmune inflammatory conditions, such as rheumatoid arthritis, which affects about 450,000 people. This is where the immune system attacks the joints. The final grouping is crystalline forms of arthritis. The most common is gout, which affects about 1.6 million people and is very painful.

What is treatment provision like?

Different types of arthritis need different treatments. Autoimmune arthritis requires medicines that control and rebalance the immune system – such as anti-TNF therapies, the development of which Versus Arthritis has helped fund. Gout attacks can be agony yet are completely preventable with medicines that lower uric acid in the blood, but not enough people can access them. There has been less progress on osteoarthritis. Physical activity or maintaining a “healthy” body weight can play a huge role, but people don't get support to achieve and sustain this. Often, people find that medicines to manage pain cause side effects, or aren't helpful enough. And although many people with osteoarthritis won't go on to have joint replacement surgery, those who do find it life-changing.

How do long NHS waiting lists affect people with arthritis?

Trauma and orthopaedics, which include hip and knee replacements, have the longest waiting times of any treatment category – there are around one million active cases across the UK. I want to debunk the idea that “elective” surgery implies that people have choice. People’s conditions often deteriorate while they’re waiting for treatment. I’ve seen surgical presentations where people were put onto a waiting list needing a hip or knee replacement, then when they have arrived for an operation there’s been a huge deterioration in the joints. This results in more costly, complicated operations, and potentially worse outcomes.

How painful are these conditions?

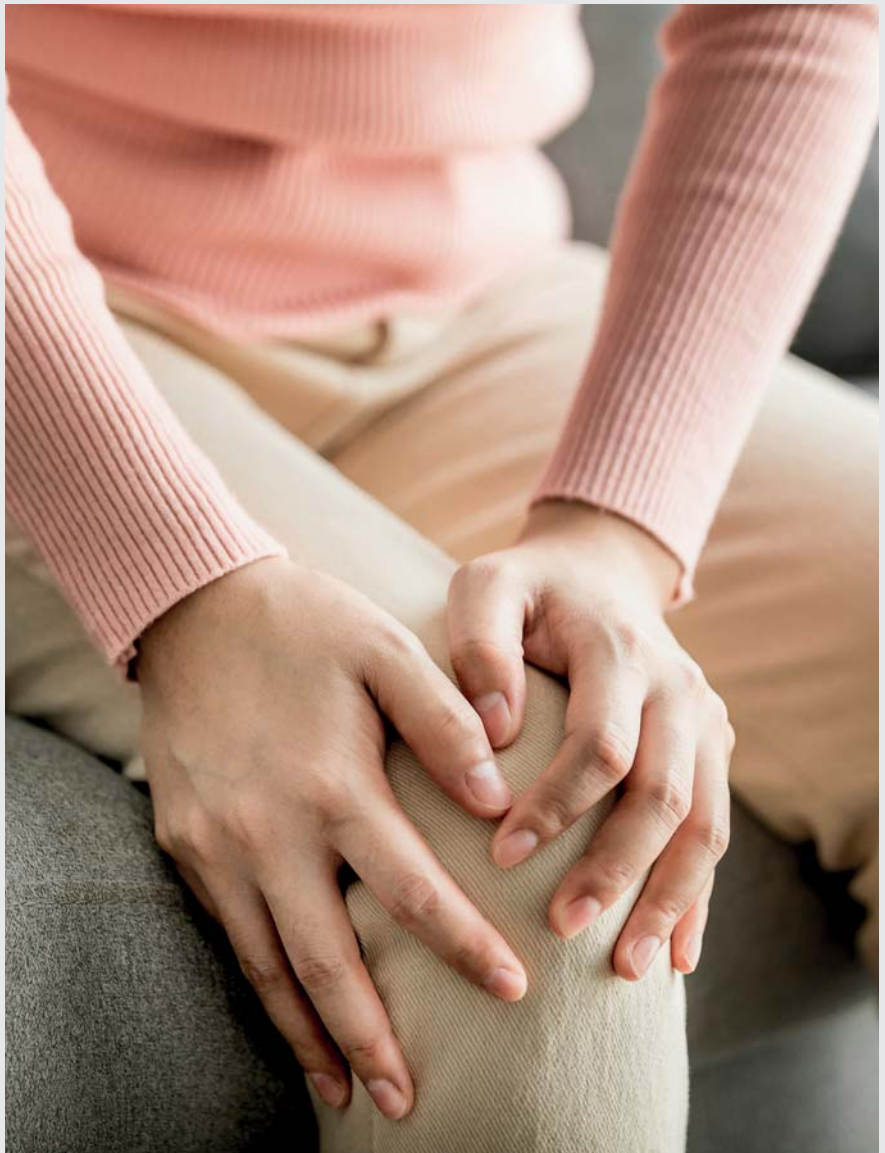
Hugely. People waiting for a hip replacement, for example, describe an everyday activity such as walking as like walking on jagged glass. People talk about feeling like being stabbed. That’s the level of pain people are dealing with.

What impact does this have on people’s livelihoods?

The current status quo is taking away people’s ability – if they’re of working age – to work. We already know that people with arthritis are 20 per cent less likely to be in work than the general population. With people stuck in these NHS backlogs, that figure has surely increased. It’s doubling down on people, so not only are they living with pain and fatigue, they’re also at risk of greater poverty as well. Some are having to retire early, and that in turn is leading to greater levels of poverty in later life.

Are there any examples that exemplify the issues at hand?

We have a free phone helpline, and lots of people get in touch to share their experiences as we support them to self-manage their condition. One person who stands out to me is a woman called Roberta, who is in her seventies. She told us that she felt that her life had been put on hold. She was barely able to walk more than a few steps while she was waiting for her hip surgery. It meant that her partner had to do everything for her. It takes away people’s independence, and those basics of dignity. Others tell us that



Rheumatoid arthritis affects two to three times as many women as men

they are feeling suicidal because of their high levels of pain. When you don’t know where you are on a waiting list, or how long you have to wait, it becomes very difficult for people to keep going.

Do you think this issue is being taken seriously enough?

About 50 per cent of people living with heart, lung, or mental health conditions will also be living with arthritis or another musculoskeletal condition. So it’s really important that we think about arthritis and musculoskeletal conditions in their own right, but also as a co-morbidity to other conditions as well. That’s why the next government has to take arthritis seriously.

What can the UK do to improve its treatment of the condition?

We need a greater prioritisation of arthritis and musculoskeletal conditions in the UK. We’re pleased that the government has recognised arthritis and musculoskeletal conditions in the Major Conditions Strategy in England. Data collection on the condition is poor – especially relative to a disease area such as cancer, which tracks how treatment relates to outcomes. Most importantly, with one million cases waiting for orthopaedic treatment, we need to see long-term protected plans to bring down orthopaedic waiting lists. This would ensure people get treatment in a timely manner so that they avoid further deterioration in their health. ●

The parliamentary view



Daisy Cooper MP
Liberal Democrat health and
social care spokesperson

“Reforming social care is one of the UK’s biggest challenges, and it cannot wait any longer”

The Conservatives promised to “fix” the crisis in social care once and for all. They promised that no one would have to sell their house to pay for care, and that they would not raise taxes to do it. They have broken all these promises, and our social care system is still on its knees.

Half a million people in England are waiting for social care: older and disabled people left with their safety, independence and dignity at risk, and many more stranded in hospital beds despite being well enough to leave, if only there was the

domiciliary care or care home beds available.

The Liberal Democrats believe that social care is vitally important in its own right. It gives individuals the freedom to live their lives as they choose, as independently as possible, for as long as possible. But there’s no way of getting away from the fact that you can’t fix the NHS without fixing social care too. For too long, the Conservatives have treated social care as nothing more than an afterthought.

Take January 2023. It was an NHS winter crisis like no other. We saw reports of people dying in the back of ambulances and suffering the indignity of corridor care. For the first time ever, some of us wondered whether an ambulance would even turn up if we called for one. The government scrambled and stumped up millions to buy care beds, to quickly remove those well enough not to be in hospital.

But this mad scramble was a false economy. By discharging patients into care homes, rather than into their own homes with domiciliary care, it was more expensive for the taxpayer. What’s more, because older people can quickly lose mobility in settings other than their own homes, experts warned that this would be bad for patient outcomes too.

This crisis should not have come as a surprise to the Conservatives. They have had years to tackle it and have done next to nothing. Reforms have been delayed again and again under Rishi Sunak, and even if he brought them forward tomorrow they would not come close to solving this crisis. The Conservatives have had their chance to reform social care – and they have failed.

Reforming social care is one of the UK’s biggest challenges, and it cannot wait any longer. Ultimately, the only way to really solve this mess is to forge a long-term cross-party consensus.

But parties also need their own plans. That’s why we Liberal Democrats have set out our bold and ambitious plans to deliver free personal care.

Under our plan no one, whether in a care home or their own home, would have to pay for day-to-day care. Needs such as help washing, taking medication and getting dressed would be covered in full. This would free everyone from the fear of catastrophic essential care costs; it would end the need to sell your home or possessions to pay for essential care; and it makes the whole system much fairer than it is today. Families would no longer be hit with care costs they cannot afford, as they are right now.

We’d also fill the thousands of vacancies by introducing a carers’ minimum wage set at £2 higher than the current minimum and by setting up a Royal College of Care Workers so their voice is heard nationally. It’s time carers were recognised and valued for their skill and hard work. A properly staffed workforce would transform social care.

These plans come with a price tag – and we’ll set out our spending plans in our manifesto – but the cost of inaction is far higher. Political parties can no longer kick the can down the road. The time to tackle this crisis is now. ●

The sector view



Richard Blakeway
Housing ombudsman

“There needs to be a renewed focus on housing as a public health intervention”

Sixteen housing ministers in 14 years exemplifies the merry-go-round nature of Whitehall, especially as the man currently holding the post, Lee Rowley, is doing so for the second time.

And while this is happening, long-term housing policy goals are not always being set or even made, with the last 30 years showing how much housing can be constrained to the political ideology of any current government or minister. But if we look back in history, the most impactful interventions have been from health ministers, Christopher Addison

MARTA SIGNORI

and Aneurin Bevan to name just two. The shock of sometimes appalling housing and health conditions inspired those interventions and led to huge changes in civil society, such as the creation of social housing and the National Health Service.

Unfortunately, many of the shocking aspects of what they saw are still present today in our housing, even if not at the same scale. How is it that in the 21st century there are families with windows boarded up or windows they have been unable to close for years? Or children living in damp and mould, with different generations sleeping on floors or confined to one room, with water cascading down the walls every time it rains? Or a disabled person unable to get through doorways in their own home for many years, while home adaptations are not progressed?

Every week, we investigate cases like this where the intimate link between housing and health is present, but absent in policymaking or on-the-ground operations. This means risk assessments are not being done, reasonable adjustments are missed and communication between health and housing bodies is ineffective.

Yet the scale of what we are seeing is unprecedented; we've completed 1,000 formal investigations over the past two months, and 22,000 remedies to put things right over the past year. But the health implications of these housing conditions go beyond the physical. In some of the most severe cases we see it is not uncommon for residents to be talking of severe stress, anxiety and even suicide.

As part of our report on attitudes, respect and rights, we called for a new royal commission – a major formal public inquiry – into health and housing. A royal commission is independent of government and not impeded by politics. It can take evidence under oath and has powers greater than a judge-led inquiry. We believe this commission could consider the role of public money, presenting a single view of welfare, health and housing spend – given the siloed approach that has existed across government for too long.

We know this would be a success because in areas where we see pockets of good practice, residents report being happier and landlords have fewer issues. For example, one social landlord has a “social prescribing” service. This enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and well-being. The landlord commissioned an independent evaluation of this, finding that, of those who were supported, more than 90 per cent showed a positive change in mental well-being.

Social housing arose from a royal commission in the 1880s which envisioned healthier lives as well as new homes. There needs to be a renewed focus on housing as a public health intervention – let's do this and give social housing the platform it needs to grow once more. ●

A smoke-free future

Is a gradual ban the only way to end tobacco use?

THE IMMORAL TOBACCO INDUSTRY MUST BE CURBED

Nicholas Hopkinson

Professor of respiratory medicine at Imperial College London and chair of Action on Smoking and Health (Ash)

Smoking is uniquely lethal and incredibly addictive. It is the leading preventable cause of premature disability and death; two out of three people who continue to smoke will die from a smoking-related disease. Bringing this avoidable harm to an end involves two tasks: supporting smokers (of whom there are more than six million in the UK) to quit, and ensuring that people don't start smoking in the first place.

Most smokers started in their teens or early twenties. Steadily raising the age of sale so that tobacco products can never legally be sold to people born on or after 1 January 2009 is a key step towards creating a smoke-free generation. We are confident that it will be effective in reducing uptake, given the clear reductions in youth smoking seen after the legal age of sale was increased from 16 to 18 in 2007. Increasing it incrementally will also prevent the tobacco industry from addicting people later in life, an inherent risk associated with limiting the increase to a particular age, such as 21.

The smoke-free generation policy has popular support across party lines, including among smokers – most would like to quit, wish they had never started and certainly don't want their own children to become addicted. It will be simple to implement, as only a single date needs to be remembered, and surveys of retailers show that they also support it. Smoking is a key driver of miscarriage and infant mortality, and the gradual ban will mean less smoking during pregnancy. Publicity is also likely to prompt many current smokers to attempt to quit.

To ensure the health, social and economic benefits of a smoke-free future are achieved as soon as possible, the government should also swiftly implement the recommendations of the 2022 Javed Khan report *Making Smoking Obsolete* in full. These include putting health warnings on cigarettes themselves, and introducing both a tobacco licence for retailers, and a “polluter pays” levy to claw back the £900m profit that the lethal and immoral tobacco industry makes on UK sales every year. ●

PROHIBITION IS RISKIER THAN IT FIRST APPEARS

David Nutt

Professor of neuropsychopharmacology at Imperial College London and chair of the charity DrugScience

A gradual smoking ban is not the only way. It is an interesting approach first conceived in New Zealand, though too recently for there to be any useful data. It looks like a victimless plan – people who currently cannot buy cigarettes will never be allowed to: where's the harm in that?

But it's perhaps riskier than it appears. Most people who are dependent on cigarettes start at an age well before they are legally allowed to purchase them, so it's hard to see how the new law will make any difference to this early onset group. History also tells us that drug prohibition usually leads to greater harms through smuggling, organised crime and the emergence of less safe counterfeit products.

Moreover, making retailers legal gatekeepers doesn't work because they want income, and underage restrictions can't be enforced. The significant underage use of cigarettes and vapes shows this, as does the total failure in stopping the illegal sale of nitrous oxide canisters. To stop such sales would incur huge policing costs that would be disproportionate to the goals.

All this just confirms that the ban is another example of gesture politics preceding an election. At least we should be thankful there is no plan to prosecute underage smokers for possession (or have I given the government another idea?)

There are better alternatives, such as allowing people to access recreational nicotine (a relatively harmless substance) without smoking cigarettes. The UK could emulate Sweden, which has largely eliminated smoking by encouraging the use of snus, a small nicotine pouch held in the cheek.

Cigarette taxes should also rise to deter young users and encourage switching to the less harmful vaping. Vape flavours should not be restricted (as the proposed legislation also stipulates), and current smokers with cigarette-related illnesses could be given snus or vapes on the NHS. And the best way to stop young people vaping would be to make it unfashionable: stop all advertising and put vapes behind the counter, alongside cigarettes. ●

WE NEED A SOCIETY WHERE NOT SMOKING IS THE NORM

Alice Wiseman

Vice-president at the Association of Directors of Public Health (ADPH)

Achieving a smoke-free future is far more complex than implementing one single measure. However, given that 83 per cent of smokers start before they turn 20, raising the age of sale will significantly reduce the number of people becoming addicted.

Simultaneously, we need to tackle industry influence by strengthening our approach to advertising and sponsorship. This will ensure that people, especially children, are not subjected to clever targeted media campaigns that encourage take-up of tobacco and products containing nicotine, and that policymakers cannot be swayed by big financial incentives. Fact-based media campaigns should show the positive impact of smoke-free environments and keep the negative impacts of smoking on health and the economy at the forefront of people's minds.

Cost is also a big motivator in helping people quit and we should reduce affordability further by increasing the tobacco tax escalator to 2 per cent above the UK's average weekly earnings. We also need a retailer licensing scheme so people are better protected from illegal products, and enforcement and regulation should be much better resourced.

There is also scope to extend smoke-free environments, reducing harm caused by passive smoking and promoting healthy spaces so that the next generation sees this as the norm.

We also need to support existing smokers to quit. Recent investment in stop smoking services is very welcome but must be sustained over the next decade to help create a society in which smoking becomes increasingly uncommon. This work should be accessible to all, and targeted; for example, pregnant women who come into contact with health services should be supported to quit.

All this takes time and resources. But with a combination of measures, and collaboration across political parties and sectors, a smoke-free future is well within our grasp, and will give everyone the freedom to live healthier lives for longer. ●

“A ‘polluter pays’ levy would claw back millions from the UK’s lethal tobacco industry”

The dementia crisis

How do we tackle the UK's leading cause of death?

In association with



This Dementia Action Week (13-19 May 2024), Hanna Svanbäck, neuroscience business unit director at the pharmaceutical company Lilly, discusses inequalities in access to dementia diagnosis and care across the UK.

This article has been paid for and developed by Lilly.

The crisis in dementia and Alzheimer's disease

One in two of us will be impacted by dementia in our lifetime, either by developing dementia ourselves, caring for someone with it, or both. By 2040, 1.6 million people are predicted to be living with dementia in the UK and the total cost of care is set to nearly triple to £94.1bn. Yet there has been limited scientific progress until recent years. It is also stigmatised in society, seen by many as an inevitable part of ageing rather than the health crisis that it is.

Alzheimer's disease, the most common type of dementia, is a debilitating and fatal neurodegenerative disease that robs people of their memories, independence, relationships and, ultimately, their futures. Despite being the leading cause of death in the UK, there is no appropriate or standardised pathway in the NHS for the diagnosis of Alzheimer's disease, and one in three people will never receive a dementia diagnosis at all.

Driving a step change in early detection and diagnosis

A timely and accurate diagnosis, using specific biomarkers, is essential for people to participate in clinical trials, provide clarity and unlock access to vital care and support. A staggering 91 per cent of people affected by dementia see clear benefits of getting a diagnosis, but too many do not have access to this.

The UK needs to rapidly increase NHS capacity for diagnostics. England lags far behind the OECD average for MRI scanner provision and just 2 per cent of people can access recommended diagnostic tests like PET scans or lumbar punctures on the NHS, compared with an estimated 85 per cent in Sweden.

Taking action now to build awareness, develop a holistic pathway for patients and support healthcare



One in two of us will be impacted by dementia in our lifetime, either as a patient or a carer

systems to adapt could help revolutionise the management of Alzheimer's disease for the benefit of people today and tomorrow. As the science continues to progress, diagnosis of Alzheimer's disease at an early stage is critical. This means we need to pivot away from the current dementia diagnosis target, which is focused on overt dementia, to new metrics that capture the importance of early-stage disease. Brain health clinics are a new and promising way of ensuring timely diagnosis by engaging people earlier in the disease course, usually with mild cognitive impairment. For these to be effective in driving diagnosis and tackling inequalities,

access must be equitable.

Blood-based biomarker tests also have the potential to diagnose patients earlier and greatly reduce the burden on the NHS of other diagnostic methods. The UK has a unique opportunity to lead the way to develop blood tests that can identify patients who either do or do not have Alzheimer's disease through the recently announced UK clinical trials.

A call for action

I'm proud to work at Lilly, a company that is relentlessly pursuing innovation in areas of huge unmet need. For more than 35 years, Lilly has been driving scientific progress to improve

outcomes for people affected by Alzheimer's disease and to embark on partnerships to drive real change.

Collectively, if we get this right, we can understand the processes that lead to dementia and Alzheimer's disease, deliver the best possible care and ensure access to clinical trials for UK patients.

Now is our once-in-a-lifetime opportunity to change the reality for every person impacted by Alzheimer's disease in the UK and make a timely and accurate diagnosis with equitable access to care the standard for all. We simply cannot afford to wait. ●

Job code: April 2024 PP-LN-GB-0077

The view from the front line



Sukhi Basra
Independent prescribing
community pharmacist

“Pharmacists are known for selling medicines, but our role is so much more than that”

When a lady I had known for 25 years was growing fragile and rapidly losing weight, I knew that she needed medical attention quickly. She dismissed the seriousness of her symptoms and didn't want to bother her busy GP. Despite her reluctance, I encouraged her daughter to take her to the doctor. She was diagnosed with colonic cancer and promptly started treatment.

Another patient came into my pharmacy concerned about a rash on her breast, which she presumed was heat rash. After a private examination,

I sent her immediately to A&E. She was later diagnosed with breast cancer and started chemotherapy. She told me that, had she not come in, she would have assumed it was nothing until it could have been too late.

In both cases, diagnosis was possible because the patients had a good relationship with their community pharmacist. I was able to spot the signs thanks to the consistency of care that community pharmacy offers. People can come in regularly, no appointments needed. But these crucial interventions will never be recorded or recognised in their medical notes.

Community pharmacies are one of the four key pillars of the primary care system in England, alongside general practice, dentistry and eyecare services. They're found on high streets, in supermarkets, in GP practices or other community spaces, and are normally within 20 minutes' walk for the local populations that use them. We're known for selling and dispensing medicines, but in reality our role is so much bigger.

We're the people who notice when your grandma is getting more forgetful and might need a memory test; the people you'll ask for advice when you weren't given the time in your GP appointment; the people who can help find someone a safe space, when they've come in asking for ANI (action needed immediately). According to the Home Office, community pharmacy has reported 186 cases to domestic abuse services since the “Ask for ANI” scheme began in 2021.

But pharmacists are not recognised for all of this work. We represent the third-largest profession in the NHS and our capacity to care for our communities is huge. We frequently develop relationships with multiple generations of families, as we often stay in the same places and may even inspire our children to follow in our footsteps.

Unfortunately, I didn't inspire my own children to do so. I often ask myself why. Is it because they watched their parents come home late every night after a 60-hour-plus working week? Or because they heard them worrying about their patients not being able to afford prescription charges? Or maybe because they watched them study until the early morning after a long working day, just to keep their qualifications up to date?

The trouble is that society has tended to see pharmacies as chemist shops, rather than a vital part of primary care. The care we provide is vast. This includes dosing out medication into containers so that people take the right pills at the right time; explaining blood test results to confused patients; checking medication safety and urging doctors to review prescriptions; organising repeat deliveries to patients' homes; and spending hours trying to source medicines from wholesalers. During the pandemic, my partner and I (both pharmacists) barely saw our children in the lockdowns, sometimes returning home from work at 2am. Our children even

helped with deliveries, walking 16km a day to deliver medication to shielding patients.

As the pressure on the NHS persists, the value of pharmacies is thankfully becoming more and more apparent. But just like GP practices, community pharmacies are set up as independent practices. We must procure our own stocks of medicines, buy or lease our pharmacies, pay our own staff and take financial risks. We don't receive paid leave, funded continuing professional development (CPD) leave or an NHS pension.

And NHS funding for pharmacy isn't sufficient. It often doesn't even cover medications, let alone staff costs or the extensive care we provide. As a result, the National Pharmacy Association estimates that three-quarters of pharmacies in England could be at risk of closure due to financial pressures.

Pharmacists are bound by an ethical code to ensure patients receive their medication with "reasonable promptness". But due to medicine shortages, we often end up searching for supplies. We witness first-hand our patients' pain and anger when they can't receive their ADHD, epilepsy, anxiety or rheumatoid arthritis medication. Constantly managing their expectations while trying to meet our ethical obligations leaves us stressed, demoralised and emotionally exhausted.

The mental toll is tremendous. Ultimately, many pharmacists have left community practice over the past few years to work in less stressful and demanding environments, such as GP practices and hospitals. Others have reduced opening hours due to financial pressures or have chosen to retire. There are now 1,000 fewer pharmacies in England compared to 2015. Pharmacists across the country are living with post-traumatic stress disorder (PTSD) after the pandemic, when we were responsible for ensuring people had access to their medication and vital advice. If no one had been able to get their medicine, the impact on the nation's public health would have been huge. We're still suffering this collective trauma, and it has not been recognised.

NHS England is rolling out a new service called Pharmacy First, which gives pharmacists more prescribing power, allowing them to prescribe treatments for common conditions such as earache, a sore throat and urinary tract infections (UTIs). This programme has already been successful in Scotland and Wales and will be the biggest expansion of pharmacy services in a decade. It's a huge step forward in making better use of our expertise.

But we need more support and recognition for the extensive work we already do – we are the front door to the NHS and ease pressure on our colleagues, especially GPs.

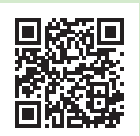
Of course, every part of our health and care system needs better funding, fairer pay and more attention. But community pharmacy is too often forgotten. Pharmacies aren't just chemist shops – they are essential to national and community well-being. It's time they were recognised as such. ●



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Habib Naqvi: “Policymakers should acknowledge that communities often know better”



The chief executive of the NHS Race and Health Observatory on tackling injustice, and why we need better representation in medical research

How do you start your working day?

Coffee and toast (I'm not much of a breakfast person). I then review news headlines and any urgent media and public affairs requests that have come in overnight, and check in with colleagues.

What has been your career high?

Becoming the first chief executive of the NHS Race and Health Observatory. Tackling injustice is a passion, and leading the observatory enables me to drive change by removing the excuses on tackling inequalities that have persisted for decades.

What has been the most challenging moment of your career?

Working in health inequalities and undertaking my doctorate research on

cardiovascular disease while my dad was suffering from the condition was one of the most challenging moments of my career. This challenge has further spurred me on to tackle inequalities in healthcare outcomes.

If you could give your younger self career advice, what would it be?

To always stay focused on doing the right thing – ensuring your moral compass is pointing in the right direction. I would remind myself to be brave and patient, and that although change takes time, perseverance does not go unrewarded.

Which political figure inspires you?

Nelson Mandela embodied passion and perseverance; he never gave up the fight for justice and freedom. There are lessons for us all on how we can adapt our strategies in ways that do not move us away from being faithful to the cause.

What UK policy or fund is the government getting right?

Investing in the potential of new technology to improve healthcare. Genomics and precision medicine offer a

fantastic opportunity to deliver targeted care in a way that reduces harm. However, it's vital that interventions are equitable – our genetic biobanks should be representative of our ethnically diverse population, and genomic medicine must be made available to all.

And what policy should the UK government scrap?

The way the NHS, and other public bodies, collect ethnicity data is outdated. In places, this data collection is based on guidance and standards that are more than 20 years old. With the NHS giving accountability to local healthcare systems, it's essential that they're making decisions based on accurate data.

What upcoming UK policy or law are you most looking forward to?

If the government follows through with its Mental Health Bill, it would be a huge moment in the history of mental health care in this country. The current Mental Health Act is over 40 years old, and we know of the disproportionate detention and poorer experiences of black and minority ethnic people. Reforming the Act is an essential step towards delivering mental health equity.

What international government policy could the UK learn from?

It's important to me that community voice is meaningfully embedded into the workings of government. I would like to see the government look towards more experimental forms of community participation – such as participatory budgeting and citizen's assemblies – which have been effective in Portugal, Spain, Japan and New Zealand. An important part of leading is acknowledging that communities often know better about what they need than policymakers.

If you could pass one law this year, what would it be?

The UK rightly prides itself as a world leader in healthcare research, but currently there is no consistent requirement that research cohorts be representative of the populations that the medical advances are designed to serve. You end up with medications and medical devices that are designed to help some people and not others. I would urge for mandating representation in publicly funded research. ●



Sarah Dawood
Senior associate editor,
New Statesman Spotlight

“The government is running before it can walk on NHS digital transformation”

In his last Budget, the Chancellor vowed to transform the NHS digitally. Jeremy Hunt pledged £3.4bn towards boosting the health service’s productivity, particularly through “harnessing new technology” such as artificial intelligence (AI) to reduce admin and speed up diagnoses.

This feels like *déjà vu* – the government has promised this grand transformation before. More than ten years ago, when he was health secretary, Hunt promised to make the NHS paperless by 2018. This target was missed, and Sajid Javid, in his tenure as health secretary, then set a new target of 2025. In July 2023 this was declared unachievable by the government’s Infrastructure and Projects Authority.

Today in 2024, nearly three quarters (71 per cent) of NHS trusts still use paper records to some degree, with patient notes and drug charts being particularly

analogue. Four per cent of trusts are completely paper-based, meaning they have no electronic patient-record system.

Technology that is deemed extinct to the rest of society still seems to be embedded in the NHS. If you thought pagers (for those under 30, an ancient form of texting through a little “bleeping” device) had been left in the 1990s, you’d be wrong. There is only one company in the world that still makes pagers, and alarmingly, the NHS is keeping it in business: 10 per cent of its global supply is used by the NHS. Despite (yet another) former health secretary, Matt Hancock, promising that this legacy tech would be phased out by 2021, four in five NHS hospital trusts still use them, costing roughly £32m a year.

Doctors and nurses have told me of the infuriating technological hurdles they face, and how these woefully inadequate systems hinder them from being able to do their jobs properly. This includes being unable to log on to a staff computer for 40 minutes; squinting to read hand-written blood sample labels because there’s no working printer; and struggling to share patient notes between teams.

Of course, this doesn’t just affect staff. As patients, many of us have experienced first-hand the disjointedness of the system: of hospital letters arriving at our door weeks after our appointment, or of constantly having to repeat our medical history because our records haven’t been passed on.

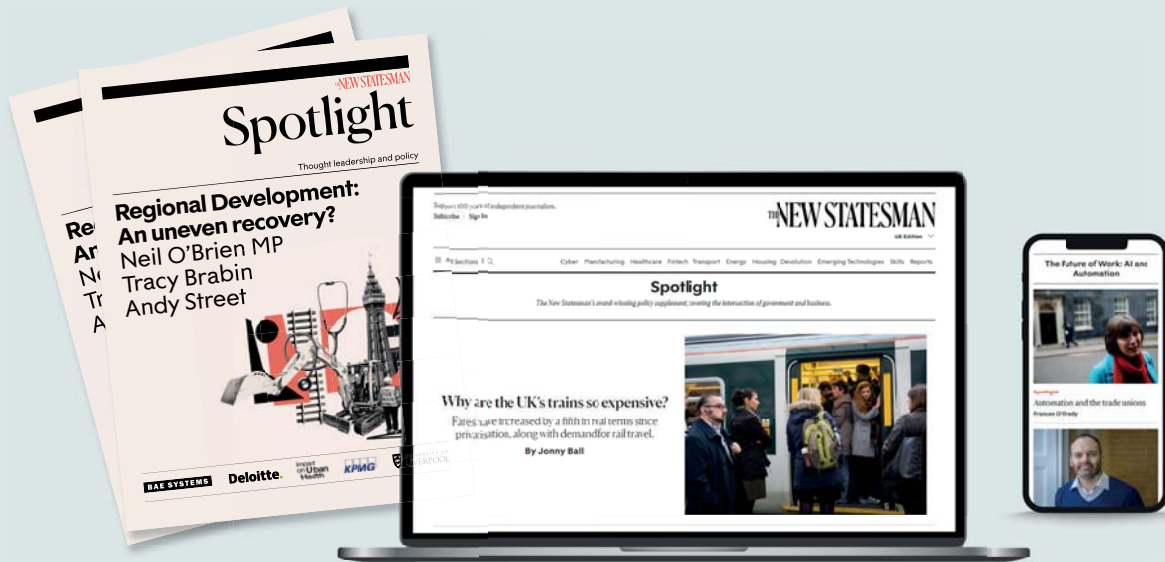
The problems facing the NHS’s digital infrastructure are so systemic that it’s going to take more than £3.4bn and a superficial adoration for “innovative” technology to fix it. There’s no doubt that new technology, including AI, will be transformative in the shift from a reactive to a preventative health service. The potential for AI to aid doctors’ decision-making in medical imaging, such as in analysing X-rays and MRI scans for cancer screening, could significantly speed up detection and diagnosis of disease, saving thousands of lives.

After years of neglecting capital funding, it’s right that the government starts investing in the NHS’s failing infrastructure. It’s a substantial block to improving productivity, and therefore patient care. But to truly shift from a “sickness” to a “health” service, we need to go back several steps.

It won’t be cheap. Indeed, a previous aborted attempt to create a patient-record system cost the taxpayer nearly £10bn. To avoid another colossal failure, it’s crucial that the government plans effectively. Politicians need to properly commit to the boring stuff: up-to-date computer software, an NHS app that actually works, and digitising every patient record into one centralised system. While it’s not perfect, the creation of www.gov.uk in 2012 shows that it can be done: it replaced nearly 2,000 government websites, saving taxpayers billions while significantly streamlining access to public services. If the government really wants to change the way the NHS operates, it should start with the basics. ●

Spotlight

Economic Growth ● AI ● Sustainability
Regional Development ● Healthcare ● Tech & Regulation



The *New Statesman's* award-winning policy supplement, providing the latest insight from government ministers, parliamentarians and business leaders