Funding the Future

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Wes Streeting’s plans for the NHS all have one purpose, and that is to increase the role of the private sector and big pharmaceutical companies within it, at cost to us, the patients. He should not be trusted.

https://www.youtube.com/watch?v=tMFFVuhgcBU?si=xd13dqjIuuhCTXE8

The audio version of this post is available here:

https://www.podbean.com/player-v2/?i=bvtcg-16eca2a-pb&from=pb6admin&share=1&download=1&rtl=0&fonts=Arial&skin=c73a3a&font-color=auto&logo_link=episode_page&btn-skin=ff6d00

This is the transcript:

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Wes Streeting has committed to three strategic shifts in the NHS and I suggest we should all be worried.

The three strategic, the three strategic shifts that Wes Streeting has committed to are to move from hospital to community and then, he said, the NHS will move from analogue to digital. And finally, it's going to move from treatment to prevention.

Now, as slogans go, all of these sound entirely reasonable. But I listened to a video recently put out by Crispin Flintoff, and he had a chap called Dr Bob Gill on there, who I don't really know of, but he came up with some extremely worrying points, and I've discussed them since with people who know about the NHS, and it seems to me that

West Streeting is, in fact - you can guess it- lining the NHS up for privatisation.

So, what do these three strategic shifts really mean? Let's start with the first one - moving from hospital to community.

Privatised medical providers do not like hospital care. They know that those people who end up in hospital - and all of us do at some point in our lives - will require complex medical treatment.

Those who are in A&E will never get private medical care.

Those who get through that process because they have heart attacks or strokes, or they've got cancer, or they've had a road traffic accident, or they require a major surgery for whatever that reason might be, will never, in most cases, ever have private medical treatment.

These acute cases all involve complexity, and private medicine really does not want to go anywhere near acute cases and complexity if it can avoid them. So, the whole basis of the transfer of medicine from hospital to community is to outsource from hospitals all those things that can be run by medical algorithms.

Like what? Things like diabetes control, things like the control of cholesterol through statins, everything to do with hypertension and heart disease, and maybe even the control of what I call the diseases of despair, which are things like depression. Those all run, to a very large degree, on the basis of an algorithm that says, if you see this, do that. And those are the conditions. that private medicine loves.

They are largely consistent with this whole idea of moving from treatment to prevention as well, because treatment to prevention doesn't mean we're going to stop actually treating people at all. In the way that Wes Streeting thinks about this, the move from treatment to prevention is about prescribing a great deal of drugs in anticipation that somebody might be ill. So, I've just mentioned them, all those things for statins and cholesterol and high blood pressure, low blood pressure, and everything else that many people, by the time they reach my age, are taking on a very regular basis. It is apparently quite common for a man, once they've reached retirement age, to be on at least ten regular drugs a day. That's what prevention means. And you can understand why privatised medicine loves this idea.

First of all, these algorithms can be run by relatively lowly trained people. There is now a massive move inside the NHS and amongst some of the Royal Colleges of Medicine, rather surprisingly, to replace the role of the doctor inside UK medicine with the role of the physician associate.

What does the physician associate do? Well, they're a person who's got a couple of years of post-graduate medical training - the equivalent of a glorified master's degree if

you like - but really have none of the skills that are provided to a doctor as a result of them doing five years of a medical degree and a year in hospital post qualification and then usually a significant number of postgraduate qualifications as well.

The physician associate is there to simply deliver the algorithm, to prescribe the routine medicine, to make sure that when they put all the routine medicines that have been prescribed to a person back into the algorithm, that AI says there are no conflicts between them.

Now that is, by the way, important, because one in eight admissions of older people to hospital are because of conflicts within the prescribed medical regimes that they have been given to deal with the complexity that they apparently suffer from. But that can all be managed by these relatively low-grade staff who are cheaper, of course, to employ and who will, of course, deliver vast profits to private medical companies because the drugs bill will go through the roof.

So, treatment to prevention means more prescriptions, and that means more profit.

Just the same as moving people out of hospital to community does the same, because the community will not employ full-scale GPs, but will instead employ people like physician associates or the paramedic who I saw the last time I went to see what I thought was a GP, but was not.

So, two of these three shifts already look like they are about putting private medicine in charge.

So, let's look at that third shift in the NHS that Wes Streeting wants. That's the one from analogue to digital. This sounds very logical, and to a certain degree it is.

There are major problems in the digital systems of the NHS. It is crazy that it still uses pagers and fax machines. It's madness, you might say, that there are different systems in use in different GP practices around the country, so they can't all communicate with each other, and inside many hospitals there are inadequate systems of recording digitally the progress of a patient so that people do not know what is going on even inside the same unit by looking at the digital medical record, and it's very hard to then communicate outcomes to GPs. That obviously needs to be addressed.

But I do not think that this is what analogue to digital means, because let's be candid, there is not now a single GP practice in the whole of the UK that does not use digital methods for storing the data on patients.

Those days of paper records in GP practices have gone and that's over 90 percent of all NHS appointments.

In the vast majority of hospitals, everything is also recorded digitally too.

In other words, the practitioner, whoever they might be, will record the outcome of a consultation on a medical system of some sort, on a computer of some sort, which will usually be available to produce a summary for transmission to anybody who needs it.

In other words, the analog to digital transition of the NHS has really already largely taken place, a few exceptions apart.

Therefore, Wes Streeting must be talking about something else, and he is. What is he talking about? He's talking about two things.

One is the use of AI, and I really do doubt whether AI has a major part in most of the medical consultations that take place in the UK. Why is that? Because most medical consultations that take place in the UK are about the management of a patient's uncertainty. In other words, the patient turns up with a range of symptoms and conditions which they probably incompletely relay to the medical practitioner, out of which uncertainty the medical practitioner has to decide on a course of action. That course of action is not based upon an assessment of risk. It is based upon an intuition of what is required. Because in a situation of uncertainty, there are no probabilities. There is only guesswork. And you might say, surely medicine has gone beyond that, but given the complexity of the human being, our own inability to communicate what we are suffering from, and to relay our own history of our illnesses, uncertainty is what has to be faced.

Now, computers are great at dealing with risk. Risk is all about probabilities. If X has happened, what is the probability that Y will follow? AI might well be able to deal with that, and AI will of course be able to deal with some algorithmic style management of cases, maybe things like diabetes. But, when we face the complexity of most people, particularly the elderly, who have what are called in medical terms multiple comorbidities, or those who have anxiety and depression, which are illnesses which are not necessarily, in any sense, easy to comprehend for anyone, then we are dealing with situations where AI is unlikely to provide the answers.

But that is what, I think, Wes Streeting wants to deliver. He wants to produce a digital NHS because, as is the belief of the Tony Blair Institute, which appears to be putting this idea right across the whole of government, AI is now the answer to everything. And Wes Streeting is, no doubt, listening.

But there's another dimension to this as well. What does he really mean about analogue to digital? What he means is that he wants every record of every person in the NHS to be available to sell to medical companies so that they can, therefore, take the data on a patient and come back and say, “Do you realise that you should prescribe this or you should be offering that, or you should be doing this blood test, or you should be having this checkup or whatever.” All of those services will, of course, be provided by - you've guessed it - private medical operators or by pharmaceutical companies who will be making the drugs in question. In other words, this movement from analogue to digital is

not about putting the patient at the heart of this idea of transition to a better service, but is about the idea that the medical industry knows best for you, and you are going to be subject to its consideration as to what you require to be done to you.

I believe that is wrong.

I believe that all these moves are deeply dangerous.

Hospital to community, no thank you. Because what we know we've got in the UK is an acute shortage of hospital beds compared to every other country in Europe. We cannot already meet the demand for inpatient care in this country. Now I know all the problems with social care and bed blocking, but that would still not, even if it was solved, provide the number of hospital beds that we need. So that is the wrong direction of travel. And community does in any case mean downgrading.

I don't believe in moving from treatment to prevention if prevention means the prescribing of more drugs because that is simply a way to boost pharmaceutical company profits.

And I don't believe in this analogue to digital approach to medicine which takes the human out of care and puts the AI algorithm into it.

Therefore, and in conclusion, let me suggest one thing. Wes Streeting is not to be taken at his word.

He has not said he is against the privatisation of the NHS.

He has in fact said he believes there is ample scope for improved relationships between the NHS and the private sector.

I believe his whole programme for the NHS is about delivery of those.

The presence of Alan Milburn, a former NHS Health Secretary, as an unpaid advisor at the Department of Health, who has since 2010 spent most of his time working for US health companies promoting the idea of private medicine, is clear indication of that direction of travel.

Where Streeting's own rhetoric is indication of that. And if we unpack these three directions of travel, these shifts that Wes Streeting talks about, they too are all about increasing the role of private medicine in the NHS and downgrading the role of those people who we really need to rely on - those people of enormous experience called doctors and senior nurses.

This is not what we need. Wes Streeting is all about profit, not care for you. And that is not where Labour should be going.