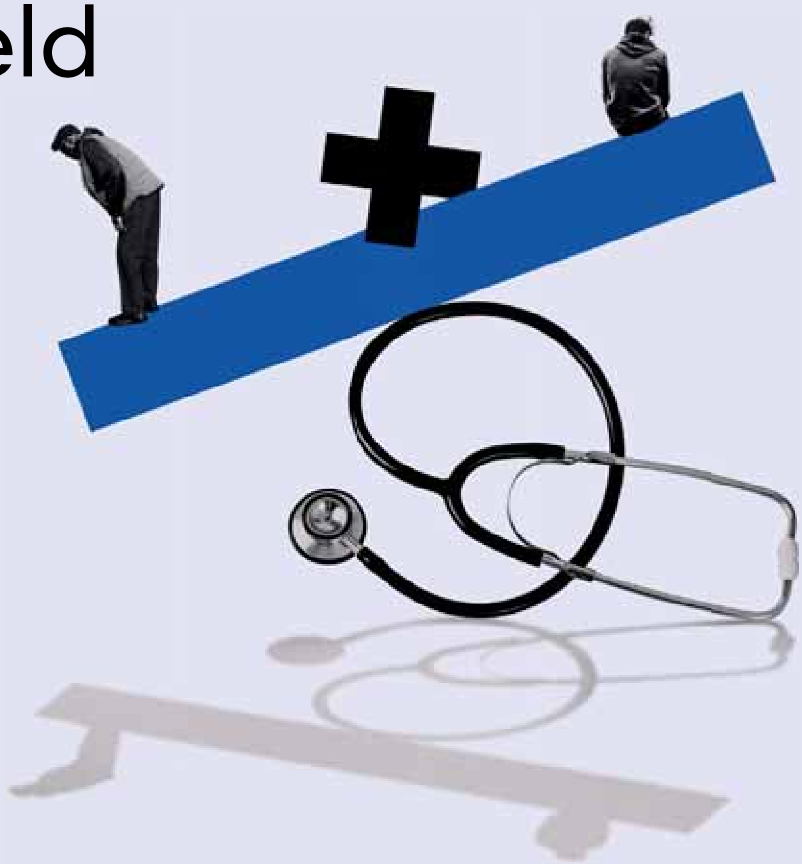
THE NEW STATESMAN

Spotlight

Thought leadership and policy

Healthcare: A crisis of equality

Wes Streeting MP
Michael Marmot
Philip Banfield



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An affront to common sense

The NHS was buckling long before the cost-of-living crisis. Now, however, continuing waves of Covid-19, staff pay rises, and the effect of inflation on the price of supplies could create a further funding shortfall.

Julian Kelly, chief financial officer at NHS England, told a recent board meeting that the health service may need to find between £6bn and 7bn to cover additional costs in 2023-24. This is on top of £14bn of efficiency savings NHS England is meant to make by 2024-25.

With long ambulance and A&E wait times, 6.7 million people in England on waiting lists for hospital treatments, and nurses voting on strike action, many parts of the health service are in acute need of attention. But the new Health Secretary, Thérèse Coffey, should take note of one of the major factors that leads people to the health service in the first place: inequality.

The link between inequality and public health was made stark during the pandemic, when people from black and ethnic minority backgrounds were dying at higher rates. But, as Harry Clarke-Ezzidio notes (see page 11), the government has reportedly scrapped the health disparities white paper, seeing it as "an affront to this government's view of what makes for health".

But this is not a matter of ideology; inequalities lead to poor health outcomes, and disparities have been exacerbated by a decade of cuts to public services. As Michael Marmot, the health inequalities expert, has warned, the effects of fuel poverty will last beyond this winter. The impacts will be seen "not just in this generation, but in the children in the next generation" (see pages 8-10).

At the time of going to press, Liz Truss said that her new chancellor, Jeremy Hunt, would deliver a "medium-term fiscal plan" at the end of October, to follow the economic chaos wrought by Kwasi Kwarteng's mini-Budget. The Prime Minister also seemed to backtrack on her campaign pledge of "not planning spending reductions", saying that "spending will grow less rapidly than previously planned". Given the links between cuts, poverty, inequality and health, let's hope she keeps her original promise. To assist the NHS, the government would do well to understand that tackling disparities is an affront to nothing except inequality. ●

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The view from the opposition

Wes Streeting
Shadow Secretary of State for Health and Social Care

"After a decade of decline, the NHS will be fit for the future under Labour"

History is repeating itself. The Conservatives have crashed the economy, causing homeowners' mortgage rates to soar, with the party paying a heavy price in public opinion. A changed Labour Party is speaking for the country again. Public services are on their knees. Patients are waiting months or even years for NHS treatment. And once again, the siren voices on the right are demanding "a hard look at how we fund the health service".

It takes some brass neck for the Conservatives, who have run down the NHS and left seven million patients waiting for treatment, to now argue that a health service funded through general taxation, free at the point of use, can never provide good levels of care. That is the miserabilist argument coming from the right today.

There is no doubt that the NHS is gripped by the biggest crisis in its history. Patients find it impossible to get a GP appointment when they need one. Stroke victims are waiting around an hour for an ambulance. Vast swaths of England are "dentistry deserts", where no NHS dentist is taking on new patients. It is no wonder that patient satisfaction is at its lowest level since 1997. Things can only get better.

The Conservatives try to blame Covid. That doesn't explain why the NHS went into the pandemic with already record-long waiting lists, why the four-hour A&E waiting-time target hasn't been met since 2015, or why the number of cancer patients not getting care on time has increased in every single year since 2010. The crisis in the NHS is a staffing crisis.

The NHS went into the pandemic with 100,000 staff shortages, while there were 112,000 vacancies in social care. Jeremy Hunt admits his "share of responsibility" for this crisis, too late. Earlier this year, Labour supported an amendment to the Health and Care Bill in parliament, to establish an independent assessment of the number of staff the NHS needs for the future. Conservative MPs voted it down, choosing instead to bury their heads in the sand.

Without a plan to give the NHS the staff it needs, the government has no plan for the NHS. Despite the 10,500 doctor positions unfilled in the NHS today, this summer the government cut the number of medical school places by 30 per cent. Straight-A students are being turned away when we need them more than ever before.

To the doctors and nurses in the NHS who are overstretched and exhausted, and the patients who are fed up with the struggle to be seen on time, my message is this: the cavalry is coming with Labour.

The next Labour government will oversee the biggest expansion of the NHS workforce in history. We will double the number of medical school places, training 15,000 new doctors a year. We will create 10,000 new nursing and midwifery placements, double the number of district nurses qualifying every year and recruit 5,000 new health visitors, all paid for by abolishing the non-dom tax status enjoyed by a privileged few. Those who make Britain their home should pay their taxes here.

This will not be a quick fix. However, we cannot continue kicking the can down the road. The Conservatives' approach to this is reminiscent of the interview with Nick Clegg from 2010 which has recently re-emerged, in which he argued against investing in new nuclear power because it wouldn't come on stream until 2022. We need to address the root cause of the crisis in the NHS. A sticking plaster won't do.

In return for more investment, we will demand higher standards for patients. Thérèse Coffey's first major announcement as Health Secretary was to set an "expectation" that patients should be able to

MARTA SIGNORI

get a GP appointment within two weeks. The previous Labour government guaranteed appointments within two days.

Labour will make better use of technology to give all patients the ability to book online, the opportunity to self-refer to specialist services where appropriate, and a wider range of choice so that we can choose whether we want to see a GP face to face, on the phone or via a video link. No more waiting on the phone at 8am to book an appointment.

There is so much evidence that continuity of care benefits patients and takes pressure off the health system. Patients with ongoing health conditions don't want to be pushed from pillar to post, having to explain their conditions over and over again. Labour will bring back the family doctor by providing new incentives for GPs.

The Labour Party has always understood that the NHS needs to change to adapt to modern challenges. Unlike the right, we understand it doesn't need to deviate from its founding principles to do so. As Nye Bevan said in 1948, "The service must always be changing, growing and improving." After a decade of stagnation and decline under the Conservatives, Labour will make the NHS fit for the future.

If you compare Britain to other major economies, we're top of the table for spending in hospitals, but at the bottom or lagging behind when it comes to primary care, mental health, public health and diagnostics. The truth is that we spend far too much money in our hospitals, because we don't focus enough on prevention, early intervention and social care. Every time a patient ends up in A&E because they couldn't get an appointment with their GP, it is worse for the patient and more expensive for the taxpayer.

Recently I spent time shadowing a district nurse in Romford in Essex with the Queen's Nursing Institute. I watched her at work, caring for a lung cancer patient in the comfort of his own home – freeing up a hospital bed for someone else – and providing palliative care to a man who was dying at home, surrounded by his family. This should be the future for healthcare.

The next Labour government will agree a ten-year plan of change and modernisation to shift healthcare out of the hospital and into the community. Along with our commitments to hire and train more district nurses and health visitors, we will recruit 8,500 mental-health workers to provide support in every school and treatment within a month for all who need it. And by ensuring full rights at work and fair pay for care workers, we will unblock the exit door to hospitals, reducing the 400,000 delayed discharges every month and providing better quality social care – the first step in our mission to build a National Care Service.

Patients are sick. And they are tired of waiting. Labour will give Britain the fresh start it needs. ●

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Advertorial

A new weapon

Innovation on the front line against infection and anti-microbial resistance

By Professor Rasmita Raval

In association with UNIVERSITY OF LIVERPOOL

A key step in fighting infection and anti-microbial resistance is understanding how bacteria interact with surfaces. New knowledge allows us to develop advanced surfaces that prevent the development of sophisticated bacterial colonies, or biofilms, offering a new approach in the war against microbes.

Within hospitals and other healthcare settings, surfaces play a crucial role in the epidemiology of healthcare-associated infections (HAIs) – infections acquired by a patient during their stay in hospital. Although some HAIs can be treated easily, others can seriously impact a patient's health, extending their stay in hospital and increasing costs for healthcare providers, as well as causing additional distress. HAIs are an issue of critical societal importance. Each year, they are estimated to cost the NHS over £2bn and cause around 37,000 deaths across Europe.

A global threat

Anti-microbial resistance (AMR) is a major 21st-century challenge. AMR arises when the organisms that cause an infection evolve in ways that allow them to survive modern medical treatments such as antibiotics. AMR occurs naturally within the biological world but has been accelerated by factors including the misuse of medicines, poor infection control, and globalisation. Warnings from the World Health Organisation and the UK's chief medical officer have underlined the serious threat of AMR.

Biofilms play a critical role in both infection and AMR, with up to 80 per cent of associated microbial infections linked to biofilms. They are sophisticated communities of microbes with defence mechanisms that have evolved over millions of years. These dense communities are able to cooperate, communicate and have a greater resistance to antibiotics and anti-microbials than individual organisms. Most chronic wounds, such as diabetic ulcers, are infected with biofilms that stop them from healing. Once a biofilm is formed and developed it is almost impossible to overcome. Therefore, it is important for surface scientists to instead focus on preventing biofilms forming in the first place.

A key weapon against AMR is knowledge and an understanding of how bacteria interact with surfaces in hospitals, such as catheters, endotracheal tubes used in ventilators, and patients' wounds. The economic health-related impact of biofilms is estimated to cost the global economy around $387bn per year, with a significant proportion of HAIs in the NHS being urinary tract infections associated with biofilms on catheters.

Surface science research provides us with new insights to enable us to engineer advanced surfaces that inhibit attack or stop micro-organisms from becoming virulent biofilms, and therefore can prevent infection. At the University of Liverpool, our work sits at the vanguard of this emerging field, seeking to translate frontier research into antimicrobial technology platforms.

The economic impact of biofilms

Biofilms can form on any surface in any environment. Biofilms have an impact across the entire economy, affecting sectors such as healthcare and medical devices, food and drink, consumer products, and marine industries. Microbial activity and biofilms on surfaces and interfaces are estimated to cost the UK economy around £45bn each year due to a range of factors including product contamination, energy losses and equipment damage.

Developing solutions to the issue of biofilms is also of critical importance for the UK reaching its 2050 net zero target. For example, creating a more effective alternative to marine paint for use on boats would reduce attachment of bacterial colonies and larger marine organisms – reducing drag, increasing fuel efficiency and therefore reducing carbon emissions.

The role of innovation

Recognising the critical importance of biofilms, the Open Innovation Hub for Antimicrobial Surfaces was founded in 2014 to address these issues. Harnessing over 20 years of research leadership in surface science at the University of Liverpool, the Hub is a multidisciplinary initiative tackling the economic burden of microbial activity on materials, surfaces and interfaces in UK industry, and addressing the urgent problem of increasing AMR.

Established through initial investment from Innovate UK and the European Regional Development Fund, the Hub has developed strong academic-industrial partnerships to address challenges and accelerate technologies. The Hub catalyses rapid knowledge exchange between academic, clinical and industrial partners who share their expertise to drive forward innovation.

AMR arises when organisms that cause infection develop resistance to treatment

SHUTTERSTOCK / JARUN ONTAKRAI

The Hub is focused on designing and engineering a new generation of smart surfaces and materials that can inhibit bacterial, viral and fungal attachment and proliferation. To stimulate economic growth, the Hub is also providing proactive resources to companies to facilitate knowledge transfer between partner organisations, link businesses to new technology and leading academic expertise, create new supply chains and boost innovation. Another area of focus for the Hub is providing cross-disciplinary skills training to innovators in industry, as well as NHS infection prevention and control practitioners.

In 2017, the Open Innovation Hub for Antimicrobial Surfaces became a co-founding partner of the £26m collaborative National Biofilms Innovation Centre (NBIC). Funded by the UK's Biotechnology and Biological Sciences Research Council, Innovate UK, and the STFC Hartree Centre, NBIC is a collaboration between the universities of Liverpool, Southampton, Nottingham and Edinburgh, with 59 associate research institutions and a growing base of more than 250 companies. NBIC was established to deliver the breakthroughs needed to prevent, detect, manage and engineer biofilms, placing the UK at the very forefront of science and innovation in this critical field. ●

Professor Rasmita Raval is director of the Open Innovation Hub for Antimicrobial Surfaces at the University of Liverpool. To learn more visit: liverpool.ac.uk/antimicrobial-surfaces

Inequalities

The third health disparities crisis

Michael Marmot on why rising prices are making us ill

By Samir Jeraj

In February 2020, Michael Marmot stood in front of a room of people (including myself) and pronounced the 2010s a "lost decade". Following the austerity cuts of the David Cameron years, life expectancy was falling for the poorest and had slowed to a crawl for all but the wealthiest, he noted in the follow-up report to his landmark 2010 review on health inequalities.

Within weeks of that new report, the UK "limped" into the Covid-19 pandemic, and now – according to Marmot – it is facing its third crisis of health inequalities, brought about, this time, by the rise in the cost of living.

The UK is headed towards a "significant humanitarian crisis with thousands of lives lost and millions of children's development blighted", he and his team at University College London (UCL) have warned in their most recent report on fuel poverty.

"That stress associated with poverty will damage children's brains, it will damage child development," he tells *Spotlight* in a call. "The impact on health inequalities will be seen, not just in this generation, but in the children in the next generation, because children's growth and development will be damaged by their parents' struggle."

Marmot, the director of the Institute for Health Equity (IHE) at UCL, is one of the UK's foremost researchers on health inequality. The 77-year-old speaks in an ordered and systematic way, outlining how, when a household cannot keep warm at a reasonable cost, the causes are poverty, the price of fuel and energy-inefficient housing – "all avoidable". Cuts to benefits and home insulation programmes under austerity and the creation of a "bonkers" energy market are all policy decisions, he notes. Marmot cites a report by the Food Foundation that the poorest 10 per cent of people would need to spend 74 per cent of their income to eat healthily.

But it is "dignity" that has increasingly preoccupied him. "If you can't afford to feed your children, you can't lead a life of dignity," he says. "If you have to beg the landlord for relief because you can't pay the rent on Friday, that's a threat to dignity." This "struggle" to make ends meet has a direct impact on people through stress and its physical and mental health effects. In a study from the late 1970s, Marmot challenged the received wisdom that heart disease ▸

KLAWE RZECZY

◂ was an illness of stressed high-flyers, finding that the lower someone's social status the higher their mortality was from heart disease.

"I've been pursuing that ever since – the gradient," he says.

Marmot began his career as a medical doctor, working in a hospital in Sydney, Australia, where he emigrated as a child with his parents. He observed patients being brought in, patched up – physically and mentally – and then discharged into the very same social conditions that had caused their health issues. "That seemed to me a bit inadequate," he says. It was this observation that led him to study epidemiology in the US and then return to the UK to pursue that research with an applied edge.

"I came at this as a public health researcher, looking at health, and then looking at the inequalities in health, and then asking, how did they come about? And then asking, 'Well, if we think we've got some understanding of what causes them, what can we do about it?'"

The latter question has proved the most challenging. Marmot gives out a long, loud sigh when asked how to get governments to reduce inequalities. While his work has largely been ignored by Westminster, it has found favour in local government, the devolved nations and other national governments. In September, Luton declared itself a "Marmot Town", pledging to act in line with Marmot's and the IHE report's recommendations.

"One way we get change is working with the people who really want to do things differently. And we find them at local government and city and regional government," he observes.

Marmot is not concerned with matters of party politics, though he asserts that "we certainly need to change government policy. And if the current government won't change policy, then we need a different government." The quality of debate during the recent Conservative leadership contest, with its focus on tax cuts, was "degraded", he says.

Nor is Marmot impressed with how the government has responded to recent strike action by railway workers, who rejected a pay offer below inflation. "I would like the other side to acknowledge it's pretty hard. If we're offering you a raise that's below inflation, we recognise the hardship that causes," he says. Marmot served as president of the British Medical Association (BMA), the trade union for doctors (an honorary role, he points out). Beyond the role that unions play in protecting the interests of members, he believes they can also advocate for a healthier population.

Michael Marmot is one of the UK's foremost researchers on health inequalities

IHE's approach has been developed to incorporate the challenges posed by climate change and systemic racism and discrimination. In 2020, his follow-up to the Marmot review noted the stark inequalities for some ethnic minority groups when it came to maternity care and mental health. Yet it concluded that the evidence base was not yet strong enough to point to discrimination as a factor. What changed?

"Covid," he says. The "astonishingly high mortality" among people of colour could not be accounted for by socioeconomic inequality. "We've got to look at racism," he says, highlighting disparities in determinants of health such as education, employment and the experience of policing and the criminal justice system.

Internationally, Marmot points out, there are examples of rich, poor and middle-income countries that have achieved progress on health inequalities. The Norwegian government commissioned his team to do some work on its low, but widening health disparities. Meanwhile Vietnam, Brazil and Sri Lanka have all taken great strides in health equity. There are theories, he says, as to why and how this has happened, but nothing conclusive. Marmot speculates that Brazil's Bolsa Família scheme of cash transfers to poor households, which are paid to women, could be key to how the country has helped reduce inequalities in the early years of a child's life. More broadly, he believes that the status of women and investment in education are important factors in health inequality in poorer countries like Sri Lanka.

Marmot's interest in disparities is reflected in one of his other great interests – literature, a subject he studied while taking his medical degree. The opening of Charles Dickens's *Great Expectations*, he says, is a poignant illustration of the desperate poverty of the young protagonist Pip. He also admires George Bernard Shaw. "We've got politicians talking about the undeserving poor, as if they just discovered it as a concept, and Shaw nailed it to the wall with his satire [in the play *Pygmalion*]," he says.

Marmot is still trying to get some of the basic points across to Westminster. "If it would take 74 per cent of household income to eat healthily, stop blaming the individual. You can give them all the advice in the world, but what are they going to do with it?" ●

Comment

Harry Clarke-Ezzidio
Policy reporter

“More cuts to public services will be devastating for vulnerable groups”

“Get Brexit done”, “Levelling up”, “Build Back Better” – the list of empty Tory slogans is long. But, after the government’s botched early response to Covid-19 – which a 2021 report by MPs declared one of the country’s worst public health failures – the government could, at the very least, still commit to its repeated pledge to “learn the lessons of the pandemic”.

And yet the Health Inequalities white paper, which would set out plans to address the various disparities highlighted by the pandemic, at the time of writing is widely reported to have been scrapped by Thérèse Coffey, the new Health Secretary.

The Health Inequalities white paper was commissioned in February 2022 by Coffey’s predecessor, Sajid Javid. It was green-lighted as a direct response to the “unacceptable disparities in health outcomes” that became apparent at the height of the pandemic, Javid told parliament. The paper aimed to address the stark differences in life expectancy between communities throughout the UK – which were seen across class, racial and regional lines.

Unsurprisingly, the reported cancellation of the paper has caused outrage. When speculation of it being nixed arose in the summer, the shadow health secretary, Wes Streeting, said that closing health disparities “ought to be a national mission”. Meanwhile William Roberts, the chief executive of the Royal Society for Public Health, said that the paper was a “clear opportunity” to tackle health inequality, and warned that disparities have “[increased] over the last two years and are only set to worsen with the cost-of-living crisis”.

These inequalities often overlap and are well known to affected groups – notably people from black and ethnic minority communities, who had significantly higher rates of death from Covid-19 than other groups, and those living on lower incomes. There are also regional health disparities, with inequalities along the north-south divide.

Under Boris Johnson, it appeared that the government was acknowledging these realities. When Javid announced the commissioning of the white paper earlier this year he promised “bold action” on reducing health disparities and to “break the link between people’s background and their prospect for a healthy life”.

Yet with the white paper’s cancellation, all that has been broken is the promise from the Conservatives – made only eight months ago – to outline and take action to end health disparities.

According to the reports, Coffey’s reasoning behind cancelling the white paper is because it’s “an affront to this government’s view of what makes for health”. Could it be that the Conservatives have reneged because they fear what the report’s conclusions might say about the government’s role in persistent inequalities? Are they hesitant because it might suggest un-Conservative solutions?

The austerity programme – brought in by David Cameron’s government in 2010 – prompted drastic cuts to public services and welfare, and pushed vulnerable groups into relative deprivation. So far, Liz Truss’ government has refused to rule out austerity 2.0. More cuts will have devastating effects on the groups the Conservatives promised to help only a few months ago. As a result, people will continue to pay with their health. ●

MARTA SIGNORI

Advertorial

The digital hospital

New technologies can improve care and tackle NHS pressures

By Bhavesh Barot

In association with Medtronic

Healthcare systems around the world are under unprecedented pressure to tackle an ever-growing patient backlog. The figures for the NHS in England from July this year show 6.84 million people are awaiting care – the highest it has ever been.

It's not possible to overcome the challenges without accelerating access to healthcare technologies that put people first. For nearly 75 years, Medtronic has made technology that transforms lives. We still do that, but today we go beyond the device.

We believe that healthcare technology must do more than just "fix" people. It needs to build resilience and sustainability into health systems, improving access to care for everyone so they can receive the care they need, when they need it.

Early detection, remote care, and more efficient systems to manage patients' journeys through their treatment are part of the solution to the current big challenges. Digital technologies are key not only to improve therapies and clinical outcomes, but also to create better patient and physician experiences.

Prioritising those who need treatment

With expanding waiting lists and stretched clinical resources, prioritising those who need urgent care is more important than ever. For so many conditions, such as bowel cancer, early detection and treatment are critical.

At the start of this year over half of those on urgent referral for bowel cancer investigation in the NHS were waiting longer than the targeted 28 days for diagnosis. Innovations are providing clinicians with the means to tackle this challenge. PillCam – a tiny camera the size of a vitamin pill – is currently being evaluated as a way to triage non-urgent patients, potentially helping the system prioritise patients at higher risk.

Colonoscopies are another critical tool in the fight against bowel cancer. Highly skilled physicians review images captured by a camera searching for polyps which may lead to cancer if left untreated. However, some of them can go undetected by the human eye. Now, artificial intelligence built into Medtronic's GI Genius system can be used to support the physician in detecting those polyps that may be missed.

The system scans every visual frame taken during a colonoscopy and alerts physicians to the presence of polyps — including hard-to-detect precancerous lesions.

With such tools, physicians have the potential to alleviate pressure from a stretched system and prevent anything from being missed.

Remote monitoring of patients

In the UK, nearly 14,000 patients receive an implantable cardiac device every year. Every patient has different needs, but all require regular follow-ups and close monitoring. This doesn't have to happen in the hospital setting. A patient can be sat in the comfort of their home while the data from their device is uploaded, via their smartphone, to Medtronic's CareLink network and remotely monitored by their clinical team. Anomalies that require the patient to come in for further investigation or treatment can be identified, and those patients are prioritised for vital face-to-face appointments. It saves time for both the patient and the healthcare professional.

More than convenience, it provides incredible peace of mind. Someone who has suffered a stroke from an unknown cause can be implanted with a Reveal LINQ II – an implantable cardiac monitor, smaller than a triple-A battery, which will listen to their heart rhythm 24 hours a day, seven days a week. Heart rhythm data is regularly uploaded and monitored over the CareLink network by their healthcare team with the aim of identifying if that patient has underlying atrial fibrillation (AF), a condition that puts them at a higher risk of having a second, more devastating stroke. Appropriate treatment and support can then be given to intervene.

Patients with diabetes can also be monitored in much the same way, enabling them to benefit from improved access to their healthcare team through virtual appointments – conversations that are filled with data-driven insights into their personal, unique needs.

SHUTTERSTOCK / SOMKID THONGDEE

Healthcare tech must do more than just "fix" people

Digitalisation to improve hospital efficiency

Delivering care is a complex process that varies by hospital, department, condition, and surgical list. For patients going through the hospital journey, it's not always easy. On top of their anxiety at feeling unwell, there is the wait for appointments, being passed around a hospital switchboard, feeling ill-prepared for procedures, and having their relief at being discharged combined with the concern of not knowing what comes next.

Experienced healthcare professionals, already managing the pressures of having to do more with the same or less resource, are managing administrative burdens that could take time from their primary goal – to care for people. With long waiting lists for surgery it is essential that every surgical slot is filled, so avoiding unnecessary cancellations or delays to a surgical list is paramount.

Get Ready – a digital, remote patient management system – is an app that is supporting both patients and healthcare professionals to manage the complexity of healthcare processes. Patients receive customised reminders, advice and information in the app during their journey. The app supports healthcare teams to monitor patients on the waiting list and prioritise those who need urgent care, prepare patients for their procedure, manage appropriate follow-up, and keep patients connected and informed throughout their journey. With this tool, healthcare professionals can deliver their services in a streamlined way that is consistent and simple – and patients experience a smoother pathway through the system.

Healthcare and technology are converging, and the boom of innovation we will experience in the next 20 years will be far greater than the past 100 years combined. Ground-breaking technology focused on each unique patient will change lives, but only if there is a shift in mindset by everyone involved. The key is to make changes to how we deliver and receive care so that we can all realise and benefit from digital innovation. ●

Bhavesh Barot is regional vice-president of Medtronic UK & Ireland

Advertorial

Changing how we treat dementia

We must focus more on prevention and early diagnosis

By Paula Head

In association with Roche

Dementia can be a devastating disease. Alongside causing memory loss, it can change the way someone speaks, thinks, feels and behaves. It impacts people's relationships with their family and friends and stops them being able to live independently. It is also the leading cause of death in Britain; dementia and Alzheimer's disease (the most common type of dementia) accounted for 12.7 per cent of deaths in England and Wales in 2018.

There are roughly 900,000 people with dementia in the UK, affecting one in every 14 people over 65, and this is expected to rise to one million by 2025. Although it mostly affects older people, it is not a "normal" or "natural" part of ageing. Despite its prevalence, it has not been prioritised in terms of health funding, and access to detection, diagnosis and care is inconsistent across the country. It is also not well known that lifestyle changes can be very successful in limiting its progression.

When people think about dementia, they tend to visualise its later stages – severe memory loss and behaviour change, and the burden it places on families and carers. Up until now, there has been little in the way of preventative treatment, so the NHS's focus has been on medication that alleviates symptoms and on providing social care for the individual. Quite rightly, people living with dementia need a strong support system to enable them to live independently for as long as possible.

But more focus now needs to be put on early diagnosis and prevention. As policy value access lead at pharmaceutical company Roche, my role involves working with the NHS and government to inform healthcare policy. One of the core parts of my job is co-creating solutions to healthcare problems that deliver better outcomes for more patients faster. This is particularly important for people living with degenerative diseases such as dementia, and this is why Roche is so focused on helping to shape patient pathways.

We need to shift from a purely social care to a more integrated medical-social care mindset, from reaction to prevention. We need to start thinking about early detection and rapid diagnosis.

We would like to see the NHS establish a clear, consistent set of standards around these two things, so that every region in the UK provides equal access to dementia services. Who you are or where you live should never be a barrier to receiving access to care and support services and appropriate treatment – there is no place for inequality in this health crisis.

These national guidelines should also provide clear definitions for terms used in dementia diagnosis, such as what constitutes "mild cognitive impairment", which is the stage between normal ageing and dementia. For those who do start experiencing symptoms such as memory loss, we'd also like to see a faster and more streamlined diagnosis pathway, where everyone in the country has access to the necessary specialist tests if deemed necessary – such as positron emission tomography (PET) scans, magnetic resonance imaging (MRI), and cerebrospinal fluid testing (CSF). Currently, despite being recommended by the National Institute for Health and Care Excellence (Nice) guidelines, some of these tests are only utilised for 2 per cent of people who attend memory assessment clinics, according to NHS England. Following diagnosis, we'd like to see psychological counselling available for all dementia patients, with one point of contact for ongoing support.

This would be no mean feat and it requires an integrated approach, with health and social care services working together. Dementia services are already delivered by dedicated and hardworking healthcare professionals, and the government should help achieve this goal through funding and resourcing the dementia workforce.

Much more can also be done in raising awareness of prevention and empowering people to make lifestyle changes themselves. The medical journal the *Lancet* outlines 12 modifiable risk factors, which could reduce dementia cases globally by a massive 40 per cent. These include: education level, hearing loss, hypertension, obesity, alcohol intake, head injury, smoking, depression, social isolation, physical inactivity, diabetes and air pollution. While the ability to make changes will be dependent on personal circumstances, proactive choices such as exercising more, reading and staying in touch with friends and family could reduce the risk of dementia for thousands of people.

We'd like to see a robust public health campaign about these risk factors, tailored to different communities and demographics across the UK. Charities including Alzheimer's Research UK already run initiatives that emphasise the benefits of exercise and diet for the brain, such as its "What's good for your heart is good for your head" campaign. Now we'd like to see the government and NHS take a leading role on this. These risk factors and their link to brain health could also be better communicated by GPs in the routine medical check-ups that people aged 40 to 64 undergo.

Given where we are with the research into potential treatments, the NHS must adapt its systems and processes around the diagnosis, treatment and care of dementia and Alzheimer's. This disease results in thousands of deaths every year, immeasurable pain and suffering for patients and their families, and a heavy toll on our NHS and social care services. We cannot afford to just focus on care any more – we must turn to prevention and early detection, to save lives and livelihoods. ●

900,000 people in the UK live with dementia

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Paula Head is policy value access lead at Roche Products Ltd and was previously a senior fellow at the King's Fund and an NHS chief executive.

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The gender health gap

A raw deal

Doctors are ill-equipped to help sufferers of extreme pre-menstrual syndromes

By Zoë Grünewald

When Sasha Baker was 11 years old, they began experiencing periods so difficult that they would make themselves vomit so they could stay home from school. Periods were “painful, heavy and messy”, they say, which will be familiar to many women, trans men, and non-binary people, like Baker, who menstruate.

Pre-menstrual syndrome (PMS) refers to various symptoms – irritability, breast tenderness, anxiety – in the weeks leading up to menstruation. There are more than 150 of these and around 75 per cent of women experience at least one during and around their period, the most commonly reported being those that impact mood. For some sufferers, PMS can be severely debilitating.

Baker suffers from a severe form of PMS called pre-menstrual dysphoric disorder (PMDD) which causes intense mood changes and exacerbates other symptoms. PMDD is little understood, but treatment often involves the use of hormonal contraceptives.

Baker was eventually prescribed a contraceptive implant. They were told it would calm their symptoms, but the effect was the opposite. “It was a terrible decision,” says the assistant podcast producer, “I sometimes wonder if my PMDD was triggered by [the implant]. It at least made it a lot worse.”

Over the following years, doctors prescribed Baker numerous hormonal contraceptives in the hope that their symptoms would lessen, but that didn't work out for Baker: “the pain, mental health symptoms and the brain fog just got worse and worse and longer and longer. I’d feel awful for probably two weeks before my period would start, and then maybe three or four days afterwards. That’s most of the month gone. It was severely debilitating; I would not leave the house.”

Nick Panay is a consultant gynaecologist at Queen Charlotte’s & Chelsea and Chelsea & Westminster Hospitals and the chairman of the National Association for Premenstrual Syndromes. He has been working on menstrual and hormonal disorders for years. He says that it has been “one of his life’s endeavours” to try and put pre-menstrual disorders “on the map”. “I think, over the years, women have had a bit of raw deal as far as this is concerned,” he says.

Baker’s story is not uncommon, says Panay. Anywhere between 5 and 8 per cent of women suffer from PMDD, and “moderate to severe PMS” is reported by around 30 per cent of women, according to the National Association for Premenstrual Syndromes.

Panay uses the term “severe PMS” interchangeably with PMDD, describing it as being a condition “where the symptoms are severe enough to interfere with a person’s ability to function personally, socially, and professionally”. He explains that there is “no magic test” for diagnosis, but practitioners look for “symptoms which occur almost exclusively pre-menstrually and then are significantly relieved by menstruation”.

The cause of severe PMS is not proven, but Panay believes it may well be genetic. There are also some non-genetic risk factors for those who may be predisposed to severe PMS. These include a history of trauma or stress within the family, he says. Incidence of severe PMS also tends to increase for women in their thirties.

Severe PMS needs to be “taken very seriously”, says Panay. Over 70 per cent of people who’ve suffered from PMDD have had suicidal thoughts, according to research by the International Association for Premenstrual Disorders,

Nearly three quarters of people with pre-menstrual dysphoric disorder have had suicidal thoughts

MARY LONG / SHUTTERSTOCK

and about 30 per cent attempt suicide. "There are some women who've been diagnosed with bipolar disorder because the cyclicity [of the period] has been missed," Panay adds.

Baker says that, in the past, they too have contemplated ending their life. "If I have to deal with this every period until I go through natural menopause, what's the point of being alive?"

Eve Muir, a domestic abuse specialist and freelance writer, has had pre-menstrual exacerbation (PME) since her periods began. PME is when menstruation worsens existing chronic mental health conditions. Muir's periods worsened her symptoms of complex post-traumatic stress disorder (CPTSD), depression and anxiety.

"I can go into deep states of depression, anxiety attacks, panic attacks, disassociation and brain fog," she explains. "I call in sick from work and I'm bed bound. I can't find any joy in life and can't motivate myself. There will be days on end of me wallowing in bed." In the worst-case scenario she can feel suicidal, she says.

"There will be days on end of me wallowing in bed"

Encounters with medical professionals have only worsened her experience. Almost as soon as she started menstruating when she was around 13 she was "pushed to get on the pill" by her school and sexual health clinic "because that was really the only advice that was given to teenagers at the time". But, as for Baker, the prescription only exacerbated her condition. When Muir came off the pill her mental health "crashed" every month. When she sought advice from her doctor, they gave her limited options, all of which involved

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◂ traditional medicine, from which she explained she felt “really disenfranchised” as a result of previous traumatic experiences she’d had with doctors. She was advised to “go on the pill, go on antidepressants, have an induced menopause or have a hysterectomy”, but felt that these were “not an option” for her.

Muir’s experience is not uncommon. Baker also wishes that they had been offered alternatives to hormonal contraception sooner, including hormonal suppression, which they now receive, and the option of a hysterectomy. “I think doctors really could be doing a lot more,” Baker says. For a long time “no one I had spoken to, including a consultant gynaecologist, had heard of PMDD”.

For people suffering from severe PMS, the lack of research and appropriate diagnosis affects their access to treatment. Though much of Panay’s work centres around hormonal treatments, he emphasises that “it takes more than one approach to achieve a good outcome”. A number of treatments are often needed, and sometimes contraceptive treatments, such as the pill, will not work. “Some pill options actually make things worse rather than better,” Panay explains. In part this is due to the “wrong types of progesterone that can have PMS-type side effects”, and also because it’s “often used with a hormone-free interval”, which doesn’t alleviate symptoms.

Panay lists a number of potential treatments for sufferers, from “hormone therapies, psychological and psychiatric approaches”, to “complementary therapies” such as agnus castus, a herbal capsule, and vitamin supplements. Panay also cites antidepressants that can be used specifically during the luteal phase of the period, or the second half of a menstrual cycle.

Periods have been historically under-researched. According to a 2020 paper from the US National Library of Medicine, a search using the PubMed engine for the term “menstrual blood” yielded “one publication during 1941–1950, followed by a steady increase over time to more than 400 publications in the last decade. For reference, PubMed searches of ‘peripheral blood’ and ‘semen’ yielded almost 100,000 and 15,000 publications, respectively, over the past decade.” A search for “menstruation” yielded about 4,000 publications in the past decade.

For many, the lack of research in this area is part of the reason many PMS sufferers aren’t able to access appropriate treatment. Camilla Rostvik, an honorary fellow at the University of Aberdeen and part of the Menstruation Research Network, explains that PMS and PMDD have been “historically under-researched and only defined in medical contexts since the 1950s”.

While the research done in the past by “pioneers” of PMS undoubtedly did some good in defining the issue, she says, it made a “vague and individual problem” generalisable across a larger population. “Some people of course were helped by having a diagnosis, but generalising PMS is not helpful. I think it’s a symptom of the wider under-funding and under-research of the entire menstrual cycle. People are hungry for answers, and the fact that things might be more complex and not generalisable does not square with the limited resources available to both happy and unhappy menstruators – nor researchers.”

In July the government published its Women’s Health Strategy. It noted that women report their experiences of periods being invalidated by medical professionals. “We heard concerns that women had not been listened to in instances where pain is the main symptom – for example, being told that heavy and painful periods are ‘normal’ or that the woman will ‘grow out of them’,” it says. “Women also told us about speaking to doctors on multiple occasions over many months or years before receiving a diagnosis.”

That matches Rostvik’s words: many experts still believe that period symptoms can be generalised across the population. As a result many women find it hard to find someone who will take seriously that their experience of symptoms may be abnormal and require additional treatment.

Every GP practice should be able to deal with this issue

Panay sees this lack of knowledge as one barrier women face in their access to care. “You can’t expect every single GP to necessarily have the tools to manage this condition, but within every practice there should be at least one or two GPs that can see women with these sorts of problems.”

He also explains that funding is a major issue: “We need investment into resources, clinics, training and research to basically provide adequate care, support and research within this area.”

For Baker and Muir, offering a variety of treatments, with full disclosure about their side effects, is vital. “I think there could be more caution with recommending [the pill]. I don’t want to say that to [stop] people who do want those interventions, I just think people need more information,” Baker explains.

Muir extolls the benefits of holistic therapies. She now treats her PME with regular acupuncture, which she describes as “supportive, positive and affirming”.

The Women’s Health Strategy does seem to take seriously the need for menstrual conditions to be better understood. It pledges to ensure that “women and girls have an awareness of the different gynaecological conditions (such as endometriosis and polycystic ovary syndrome) and less well-known conditions (such as adenomyosis), and an understanding of what a normal menstrual cycle should look like for them. Women and girls know where, when and how to seek help for menstrual or gynaecological symptoms, and what support and care they can expect.” The strategy also aims to give women and girls access to “high-quality, personalised care” to manage menstrual problems.

Panay feels positively about the strategy. “I’m hoping, hopefully not unrealistically, that the Women’s Health Strategy will make a difference,” he says. “But we do need resources behind it.” ●

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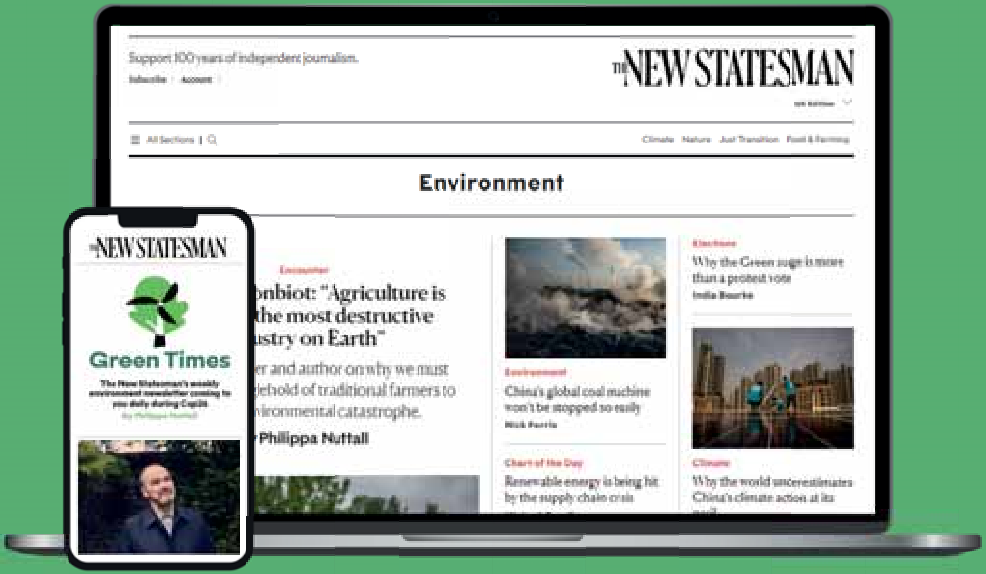

The politics, business and culture of the climate and nature crises

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Anonymous
The author is based in London

"I am a care worker – I've had enough of being mistreated and underpaid"

I didn't plan to become a care worker. My work as a designer had dried up and I needed a job. I walked into a care work agency thinking that I could give it a try and work in a sector that has real meaning – to care for others. It turned out I was right, and I loved the work from day one.

I started off working in people's homes, helping to keep them living independently and with dignity. It ranged from getting people dressed and making the bed, to sorting breakfast, to personal care. Even that hour or two can be transformative for a person, and I loved bringing my kindness and sensitivity to the work.

But care work and care workers are in crisis. My zero-hours contract guarantees me no hours; it is entirely at the discretion of my employers. Sometimes it's ten hours that week, sometimes 20, sometimes just five. At the agency, my time in between home visits was unpaid, as was the time travelling between appointments. When I called in sick, the attitude from my employers has usually been annoyance because I've caused them a problem. Sometimes it took time for my hours to return to normal after I had been off.

Almost all the in-work training I have ever done has been on an app, with no human contact or feedback for such a crucial role. I have had new colleagues start with all the right qualities and skills, but who have not been given vital information for doing the job. For example, how to feed someone on a pureed food diet or how to approach someone with dementia who could be violent or abusive. These can lead to traumatic experiences for clients and staff when something goes wrong.

A recent report found that care workers earned less than other supposedly "unskilled" workers in supermarkets. I have discussed this dilemma with colleagues, and while the satisfaction and unique experience of care work keeps me going, it is not the same for most people.

In reality, there is no real care career path unless you want to open a care agency and take up more of an office role. Care work could be a route into nursing or social work, but without the encouragement of employers it just remains a low-paid job. Everything about the conditions for care workers suggests, "We don't appreciate you at all." Nor are staff empowered to challenge those conditions for fear of having our hours cut.

Now, I work in a high-end residential care home. While the fixtures and decor may be luxury, the staff are paid the same as any other care work – despite our clients being charged a luxury rate to live there. We are sometimes so short-staffed that people have long waits for someone to change their incontinence pads, which is a humiliating and undignified experience for them. If care workers feel unvalued, are badly paid and badly treated, this affects the people we work with. It's not like a bad cup of coffee – it can have a profound impact on those in care, and could be as simple as being 30 minutes late to your appointment.

When I walked into that agency nearly three years ago, my other option had been to get work in a cafe. Even though I know how important care work is, it is sad to think that working in a cafe probably would have been better for me financially. ●

MARTA SIGNORI

Advertorial

A job for us all

Collaboration is essential to tackling health inequalities

In association with GILEAD Creating Possible

Health inequalities have been a concern for many years across the UK, but since the pandemic they have been worsening at a steady pace, with a disproportionate effect on people with lower incomes and from ethnic minority backgrounds.

So great is the issue that crucial players in the healthcare system are moving to address health inequalities through various commitments, such as NHS Core20PLUS5, the last government commitment to health disparities white paper, and recommendations from the NHS Race and Health Observatory. Yet despite this momentum, health inequalities persist.

Biopharmaceutical company Gilead Sciences is working to help minimise these differences and ensure that people have the opportunity to lead the healthiest life possible. "Our industry has a responsibility to do all it can to mitigate inequalities in health outcomes," explains Dr Véronique Walsh, the General Manager and Vice-President of Gilead Sciences UK & Ireland. "The mission that guides us is that everyone has a right to access the best healthcare they can."

Walsh explains that this is not something that can be achieved by Gilead in isolation. Collaboration across the health ecosystem is crucial, as factors that affect healthcare require the input of a myriad of stakeholders. "A combination of strong leadership, meaningful collaboration between the private sector, the state, and national and local stakeholders, and clear accountability is critical to support impactful change on the ground," says Walsh.

With an innovative portfolio for the treatment of conditions such as the hepatitis C virus (HCV), HIV and cancer, many of the communities that Gilead supports face specific challenges in treatment options and stigma, which requires nuanced and focused services. The Find Your Four campaign, funded by Gilead and developed with insights from the HIV community for the HIV community, helped people address their broader health priorities in the wake of Covid-19 and an evolving HIV care landscape. Since launch, the campaign has been endorsed by 13 patient organisations that have been consulted or engaged throughout key stages of the campaign. In 2022 Find Your Four received a Gold standard in the Patient Partnership Index, which recognises exemplary collaborations between industry and patient organisations to support patients.

Walsh explains that this cross-system collaboration allows an important combination of community-specific knowledge with the resources of other organisations. This is evident in Gilead's recent Hep C, Ki? Campaign, supported by NHS England, which involved leading British South Asian comedians and the Hepatitis C Trust. The campaign raised awareness of the risk factors for HCV among South Asian communities in England. This was achieved by working with the community groups to design an effective programme, bolstered by supporting organisations working at the grass roots, to ensure that accessible information was made available for all who needed it.

There is no one-size-fits-all solution. Distinct communities have distinct health needs, so interventions must be tailored. As Walsh explains: "In our work in HIV, for instance, our approach is very different with black African communities compared to men living with HIV." For effective programme delivery, understanding the "specific barriers that exist in each specific group" is vital, says Walsh.

One of the trickiest challenges is enabling local access to the right services – and collaboration, again, is the key to success here. One example of this is the national Hepatitis C Elimination programme, a collaboration

The national Hepatitis C Elimination programme has shown what can be achieved when the health sector works together

BLURRYME / SHUTTERSTOCK

between NHS England, drug treatment services, prisons, the Hepatitis C Trust and Gilead.

One group that Gilead supports is people who use drugs: an estimated 90 per cent of people with chronic hepatitis C either currently or formerly used injecting drugs. Treatment services for this demographic followed a traditional secondary care model that often resulted in missed appointments. To address this, in 2018 Gilead collaborated with the NHS and Change Grow Live (CGL) – a third-sector provider of addiction services – to improve HCV patient outcomes. Gilead engaged CGL to undertake elimination initiatives that drove testing and referral levels across all services.

Additionally, Gilead deployed a dedicated Patient Access to Care (PAC) team to support CGL coordinators and improve communication with the NHS.

As a result, across 65 CGL sites between May and October 2018, the partnership has so far achieved a 36 per cent increase in HCV testing, a 45 per cent increase in referrals, completed treatment for over 70 patients, and reduced phlebotomy waiting times from five months to eight weeks.

This project highlights the importance of commitment across the board. Communities are essential to Gilead's work, but action must come from the very top, too. Funding for research and resources is crucial, as is government commitment to addressing health inequalities at all levels by delivering the health disparities white paper.

"There are clear, actionable strategies that can be implemented to help address health inequalities – working with communities, lowering barriers to healthcare access, and working on informing people," says Walsh. "To create a world where health inequalities no longer exist, we need to go beyond medicine with concerted action and leadership. Only through meaningful cross-sectoral partnerships can medical innovation be delivered to all who need it." ●

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Advertorial

Prioritise mental fitness, not just illness

We can’t ignore the links between physical and mental health

By Gosia Bowling

In association with Nuffield Health

Research has consistently shown us that physical health and mental health are intrinsically linked. The most obvious example is the connection between exercise and mood, which we’ve likely all experienced first-hand. A study of 1.2 million people published in *The Lancet Psychiatry* found that those who exercised regularly reported 1.5 fewer days of poor mental health per month than those who didn’t.

Physical activity is an essential tool in the tool-box when it comes to mental well-being. According to the Harvard Medical School, exercise can sometimes be as effective as antidepressants in treating depression. And unlike drugs, exercise is low-risk, low-cost, easily accessible, has no side effects and ties in with other mood-boosting factors such as spending time in nature or with other people.

Unfortunately this interconnectedness also has its downsides; those with chronic conditions are more prone to mental health issues, and vice versa. Data from the World Health Survey indicates that people with two or more long-term health conditions are seven times more likely to have depression than people without a long-term condition. Alarmingly, people with severe mental illness have an average life expectancy of up to 15-20 years lower than the general population.

The reasons for this are complex, not least because some drugs used to treat severe mental illness can increase the risk of cardiovascular disease. But there are other factors at play. Let’s take diabetes as an example; this is a very manageable chronic health condition, and those with it can live full, active and healthy lives. But based on the evidence, a diabetic person might be more prone to depression, in which case self-care becomes more difficult. They might lose motivation and start to neglect their diet and exercise routine, forget to take medication, and miss hospital appointments.

With the link between physical and mental health so evident, why is it that the treatment of one is so often isolated from the other? A person’s diabetes and depression would likely be treated separately in a medical context, rather than in one cohesive programme.

At Nuffield Health, we take a more holistic approach by bringing physical and mental health together. Within 94 of our fitness centres across the UK, we host mental health clinics that offer a range of psychological treatments to members.

We also offer free rehabilitation programmes for those living with joint pain and long Covid. Both programmes incorporate a range of physiological and psychological treatment to target ill health in a more integrated way. Alongside reductions in pain and improved mobility, our joint pain participants report a 24 per cent improvement in their mental health. Similarly, our Covid rehabilitation programme has seen participants experience a 39 per cent reduction in breathlessness, alongside a 70 per cent improvement in emotional well-being.

Initiatives like these show the benefit of taking a holistic, "connected health" approach to supporting individuals. Such an approach is also beneficial for society as a whole. The social return on investment of these programmes is significant – this is the estimated amount of money that is put back into the economy based on factors such as reduced burden on the NHS, reduced burden on families, and reduced workplace absence. Savings come out at £3,400 per person for our joint pain programme and £5,900 for our Covid programme.

A more joined-up approach to healthcare can reduce the impact of ill health on society but unfortunately, the UK still has a long way to go in this regard. The government's upcoming ten-year Mental Health and Wellbeing Plan demonstrates a commitment to mental health and shows how the country is starting to remove perceived stigma and boost national awareness. However, mentions of physical activity are disappointingly sparse.

We need to stop viewing mental and physical health as two separate things. When the government sets out its plan, we want to see physical activity feature as a key contributor to better mental well-being, with more recognition of the interdependency of our mind and body.

This starts with thinking about mental health in terms of prevention, rather than treatment. The current system is set up so that people seek help once they're already in distress, and language tends to focus on "conditions" and "disorders". We've got a system in which we focus on trying to "fix" people, and we need to work towards one in which we don't break people in the first place.

To do this, there needs to be a greater focus on fostering healthy environments, whether that be in schools, workplaces or social settings. These are environments that enable people to thrive and reach their full potential, and find a sense of meaning and belonging. They encourage self-care, such as healthy eating and physical activity, and conversations about mental health. Workplaces are a particular issue; the Centre for Mental Health found that mental health issues at work cost UK employers nearly £35bn last year.

A healthy environment starts with the basics: access to healthy food, hydration, regular breaks and opportunities for movement such as cycle-to-work schemes. But it's also about creating psychologically safe environments that don't lead to stress and burnout. These are environments that promote well-being through manageable work demands and positive working relationships, and also empower people to talk openly. In our 2022 Healthier Nation Index survey of 8,000 people, two thirds of respondents said they wouldn't feel comfortable talking about their mental health with their employer. This needs to change; conversations about mental health at work should not only be welcomed but actively encouraged, starting with mandatory emotional literacy training for business leaders.

We'd also like the government to commission more research into the effectiveness of physical activity for enhancing mental health. We're currently working with Manchester Metropolitan University on our own research, in which we're testing the combined effectiveness of cognitive behavioural therapy (CBT) and exercise, but there needs to be more extensive work in this area.

So much preventative work has already been done in areas such as smoking, diabetes and heart disease, and now we want to see the same effort and focus given to mental health. There is a real opportunity to create cohesive, all-encompassing prevention and treatment plans that alleviate both physical and mental illness, helping individuals and society in the long term. The government, NHS, charity sector and private sector all need to work together to prioritise mental fitness and not just mental illness. ●

Gosia Bowling is national lead for emotional well-being at Nuffield Health

NUFFIELD HEALTH

Exercise can sometimes be as effective as antidepressants at treating depression

The carbon dilemma of surgery

Dr Helgi Johannsson on cutting emissions in anaesthesia

By Sarah Dawood

In 1846, the removal of a tumour from a patient's neck in a Boston, Massachusetts hospital heralded a new era in modern medicine. When a dentist named William Morton gave ether vapour to one Gilbert Abbott, the surgeon Dr John Warren was able to operate without causing Abbott any apparent distress.

Such use of anaesthesia enabled doctors to leave behind medicine's more grisly past. There are relatively few drawbacks to the option of pain-free procedures. But one problem now overshadows this mainstay of modern medicine: its carbon footprint. The emissions produced from being anaesthetised can be equivalent to those produced by a car journey from London to Leeds.

Environmental impact is not something we tend to associate with the healthcare sector, but the NHS is responsible for roughly 20 million tonnes of carbon dioxide emissions annually – 4 per cent of England's total carbon footprint, according to the NHS's 2020 net zero plan.

Anaesthetic and analgesic (pain relief) gases comprise 2 per cent of the NHS total. This might sound small but it is significant given the size of the NHS's building and transport estate, which will encompass a large proportion of its footprint. The commonly used general anaesthetic gas desflurane is particularly harmful; it has 2,500 times more global warming potential than carbon dioxide. Using a single bottle is equivalent to burning 440 kilograms of coal.

Dr Helgi Johannsson, an NHS consultant anaesthetist at the Imperial College Healthcare NHS Trust, is the sustainability lead and vice-president at the Royal College of Anaesthetists. He has campaigned for the elimination of desflurane, and believes the NHS has an obligation to become more eco-friendly.

"Healthcare has an absolutely enormous carbon footprint," he tells *Spotlight*. "Just because others are worse, it doesn't mean we shouldn't improve. Just because our neighbour drives an SUV, it doesn't give us the right to use a private jet."

There are alternative anaesthetics available; the gas sevoflurane, for example, has a warming effect that is nearly 38 times lower than desflurane. Intravenous anaesthetics such as propofol, injected as liquids, carry an even smaller footprint (though it has other drawbacks, such as harming aquatic life if not properly disposed). There are clinical implications for phasing out desflurane – it is often used when operating on patients with obesity, for instance. But the NHS's goal to reduce its anaesthetics carbon footprint by 40 per cent means that its use is dwindling.

"I think we've almost won this one now," says Johannsson. "I suspect we won't get rid of anaesthetic gases completely, but I think we'll get rid of desflurane. There's no evidence for it being better, it's just a case of adjusting your practice a little bit."

However, the use of nitrous oxide – more commonly known as "gas and air" – for managing labour pain is a more complex moral conundrum. An hour's use of the analgesic gas warms the atmosphere by an equivalent of roughly 16kg of carbon dioxide, the same as driving 106 kilometres. The process through which it is stored and delivered in hospitals – via pipes from a large central repository – also means that a lot of it is wasted. The Nitrous Oxide Project run by NHS Lothian in Scotland found that "wastage… is a far more significant problem than that of persistent clinical usage". But unlike anaesthetics, there is no directly equivalent replacement.

Johannsson believes that nitrous oxide should remain available but says major adjustments to labour care are needed. Rethinking the hospital's infrastructure, such as replacing the wasteful central pipeline system and installing technology that could capture and recycle exhaled nitrous oxide, would be a good start.

He is also calling for a national improvement plan on NHS labour wards for access to pain relief. Equipment such as transcutaneous electrical nerve stimulation (TENS) machines are currently not available on the NHS, while staffing shortages mean that anaesthetists are often delayed in delivering spinal epidurals.

"Labour is a very, very painful thing," Johannsson says. "We need good access to anaesthesia services, rather than the patient having to wait in absolute agony for an hour because the only available anaesthetist is in the operating theatre." Additionally, more holistic changes, such as training for midwives in aromatherapy and hypnotherapy treatment, as well as better patient preparation in pain management, would help to create a less stressful environment. "We need to consider labour pain in a much more forward-thinking way," he says.

Earlier intervention and a focus on prevention could result in carbon savings across the board, Johannsson believes. "Efficient and equitable medicine is actually more eco-friendly medicine," he says. "Most of the things we can do to protect the environment would also save us money and provide better patient care." Surgical backlogs, for instance, are causing millions of people to wait many months for routine operations, during which time, their condition deteriorates. This means they require longer operations that are more complicated, often with general anaesthetic rather than local, all increasing the surgery's carbon footprint.

This applies to primary care as well; inhaler emissions account for 3 per cent of the NHS carbon footprint, with propellant-based – or "puffer" – inhalers being the worst offenders. As well as steering patients towards alternatives such as dry powder inhalers, a more robust GP asthma service would empower patients to better manage their condition, resulting in less use of inhalers. "Patients protect the environment by having the disease well controlled," explains Johannsson.

SHUTTERSTOCK / SVITLANA HULKO

Anaesthetic and analgesic gases make up 2 per cent of the NHS's carbon footprint

Cutting red tape around fastidious NHS protocols would also help to reduce waste. Johannsson believes there is an over-zealousness surrounding disposable plastic products, cleanliness and waste disposal that has worsened since the pandemic. One example is the requirement to incinerate rather than recycle drapes used in surgery if there is a single drop of blood on them.

"We need to keep patient safety at the absolute centre of what we're doing," he says. "But we also need to think about the likelihood of harm to the individual, which in many cases is so small compared to the greater harm to the planet and humanity."

The government has a responsibility to ensure all NHS guidelines consider environmental impact alongside cost and patient safety, he adds.

"The NHS will always procure the cheapest thing, and that's sometimes disposable rather than reusable," he says. "But all NHS procurement needs to be done in an ecologically beneficial way. Every purchase a hospital makes should take into account the environment." ●

20m tonnes

of CO_2 is produced by the NHS each year – 4 per cent of England's total carbon footprint

1 hour

of use of the anaesthetic gas desflurane carries the same carbon footprint as driving 200-400 kilometres

110 years

is the amount of time that nitrous oxide (gas and air) remains in the atmosphere

3 per cent

of the NHS carbon footprint comes from inhaler emissions

High ambition for health outcomes

MSD's executive medical director on tackling inequalities

In association with MSD

Dr Dilruwan "Cham" Herath is the executive medical director for MSD in the UK and Ireland. With over 18 years' experience in the pharmaceutical sector, he has delivered industry-leading clinical change leadership and secured patient access to lifesaving medicines. He talks about the challenges of overcoming health inequalities and barriers to patient care.

How do you define health inequalities?

Health inequalities affect people in various ways. Historically, pharmaceutical companies focus on the uniformity of access to medicines and healthcare, but the reality is more than that.

We have to consider patient demographics – things such as ethnicity, gender and disabilities, among others. There are also factors such as geography and location, and within that, social deprivation.

While much progress has been made, the Covid-19 pandemic significantly exacerbated health inequalities and highlighted the urgent need for improvements so that everyone has access to equitable healthcare. Routine immunisations were reduced, access to testing and preventative medicines for HIV were impacted and cancer backlogs grew.

How can the pharmaceutical sector help track inequalities?

Traditionally, the pharmaceutical industry's role has been one of access and distribution. But that is changing.

We now have a really important role to play because we have access to key data in regions of inequality, and we have the resources to analyse how these inequalities are playing out.

We can also take a more active role: from designing diverse and inclusive clinical trials for our medicines, to improving health literacy and working collaboratively to overcome barriers to patient access to services and treatments. Partnerships and collaborations are key.

Our Do it For Yourself Campaign gave recognition to the prevalence of lung cancer in poorer socio-economic groups, who are also less likely to present to their doctor at an earlier stage. We deliberately used methods and channels more likely to get through to these groups (ie local press, pharmacy bags, pub beer mats, etc).

Finally, I'd just add the importance of supporting healthcare professionals in their job. Post-pandemic, the NHS is under immense pressure. We need to support healthcare professionals in their education to understand health inequalities and respond to them.

What are the biggest challenges in addressing inequalities in treatment for cancer?

There are immediate issues with our regulatory and reimbursement framework for treatments. We need better capacity and innovative approaches by leading agencies to provide early, fast and equitable access across the UK to ensure that patients are getting their treatment in a timely fashion. This is true for registering a drug, too. It can take several years to make a drug accessible for patients that may benefit, and sometimes that is too late.

There are also issues with variation in accessibility to cancer treatment centres. If you are living in an area of deprivation, there may be a number of reasons why healthcare access is trickier. It's a compounded thing that requires a much better understanding of patient pathways, as well as tailored approaches depending on the area.

MSD's recent report on cancer inequalities produced in collaboration with the Less Survivable Cancers Taskforce outlines five recommendations to reduce inequalities in cancers. These include the government making a specific pledge to

More investment is needed across regions to grow our life sciences sector

MSD

double survival rates for people with a less survivable cancer over the next decade as well as NHS England producing a national action plan. This national action plan should be paired with location action plans. The final two recommendations focus on improving the data quality and completeness for these cancers and establishing national audits for each of the cancers.

How can we overcome barriers to patient access to services and treatments?

Number one, we need to improve education. Patients should have a better awareness of their disease, treatment, and their recovery plan. We also need to get better at informing the general public about prevention, identifying diseases, and the risk factors of acquiring certain diseases.

Number two is trying to make advice for patients more consistent across the UK. It's not really the fault of healthcare professionals that patients are treated inconsistently, but a matter of data and access varying across regions. We need to work to improve this.

Number three, we need to expedite the waiting lists across the country that are making access to patient treatment plans slower and more difficult. These treatment plans need to be personalised, taking into account what else might be happening in a patient's life. We have to think about how we support the whole patient, not just treat the disease.

What would you like to see from the new government?

There needs to be a sustained commitment to levelling up. We need more investment across regions so we can grow our burgeoning life sciences sector and improve health outcomes.

We need to invest far more in generating and analysing data, which is vital for understanding which drugs to invest in and which regions and groups need more attention.

We also need to see improved NHS research and patient pathways, ensuring there is always best practice going forward. We want to see high ambition on health outcomes, even in the most challenging of economic times. We don't want to see progress being undone and we must continue to invest in health. ●

MSD has provided funding support for this activity.
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GB-NON-06515

Philip Banfield:
"Health is the responsibility of all government departments"

The chair of the British Medical Association UK council on the politics of healthcare and the virtues of Clement Attlee

How do you start your working day?
This depends on where I am, since I travel down to London from north Wales for a large chunk of the week. If I'm at home, I always make my wife a cup of coffee (she's a GP partner, and secondary care is there to serve primary care after all). At BMA House, I'm at my desk by 7.30am to get some clear "thinking time" before the plethora of meetings starts. I'm still a practising obstetrician, so my first cup of coffee may well be on the labour ward.

What has been your career high?
It is a huge privilege to be part of a family's highs when they're having a baby, but also the lows when perhaps things have gone desperately wrong, and care and compassion become the centre of the doctor-patient relationship. Without a doubt, being elected chair of BMA council is the greatest honour.

What has been the most challenging moment of your career?
The politics of healthcare in north Wales was already very messy when I was rung up one evening in 2015 by a journalist to tell me the health board was planning to announce the closure of our maternity unit the following day. There was a complete lack of transparency and we turned to the BMA in Wales for help. The local politicians worked across their party divides, the health board was found to have acted unlawfully, and we showed how the closure was unnecessary. Now the unit is thriving, and I love working with some very caring colleagues.

Which political figure inspires you?
I struggle with modern politicians because the motives for their actions have seemed more hubristic than altruistic, so I'm running with Clement Attlee. Attlee's landslide win in the 1945 general election laid the foundation of the welfare state and the NHS. I admire that he achieved so much while reputedly being modest and quiet, seeking consensus and listening to others.

What UK policy or fund is the government getting right?
The speed and scale of the procurement and rollout of the Covid-19 vaccination programme must count as one of the more successful government policies in recent history – and while a huge collective effort from NHS workers is to thank for that, credit is due to the government for acting early and ensuring the UK had sufficient stocks.

And what policy should the UK government ditch?
In the first instance, I would stop policies being scrapped. The BMA is really concerned about the government's apparent U-turn on addressing obesity, which impacts deprived families the most. It's hard for people to maintain a healthy weight when you have relentless junk food advertising, omnipresent buy-one-get-one-free offers and products filled with sugar. When almost two-thirds of adult Britons are overweight or living with obesity, it's crucial these policies are kept and built upon.

What international government policy could the UK learn from?
Use of the income taxation system to equitably fund health and social care properly as in Denmark. The Health and Social Care Levy, announced last year to deal with Covid backlogs, has already been scrapped, which just goes to show how vulnerable these "ring-fenced" funds are to changes in leadership. General taxation has the advantage of avoiding political gimmicks.

If you could pass one law this year, what would it be?
Many of the factors that impact the population's health are outside of the control of health services: quality of jobs and education, housing, access to green spaces. Health is the responsibility of all government departments; health impact assessments (HIAs) are a practical tool for assessing the impact of policy on people's health, and are already mandatory in Wales in specific circumstances. Introducing these consistently would create a more long-term approach, rather than just seeing citizens as recipients of health services. ●

MARTA SIGNORI

THE NS | EVENTS

Spotlight DEBATES

TUESDAY 1 NOVEMBER 2022 | 6PM | LONDON

Can we skill up to level up, and solve the UK's productivity gap?

Join us on the evening of Tuesday 1 November at the QEII Centre in London to hear from policymakers and industry experts as they discuss the crucial role of skills in delivering the levelling up agenda and improving productivity in underperforming areas.

Speakers include:

Toby Perkins MP, Shadow Minister for Skills and Further Education
The Rt Hon. Justine Greening, Founder of Social Mobility Pledge and former Secretary of State for Education
Eugenie Teasley, Head of Impact, Amazon UK
Chaired by Alona Ferber, Editor, New Statesman Spotlight

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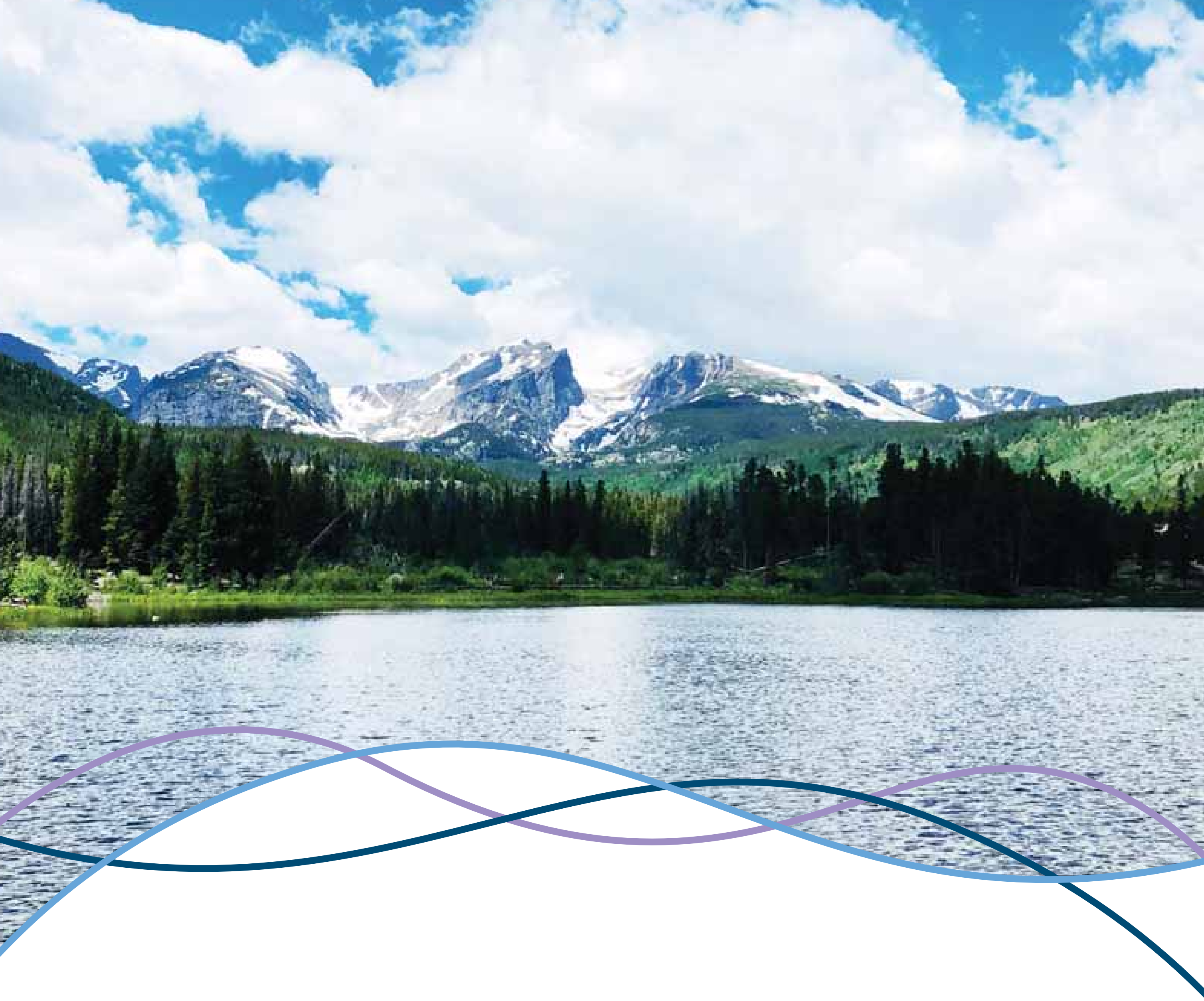

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