As we wait for the next phase of the pandemic, many of us are beginning to take stock of our experiences (good and bad) over the past tumultuous months. Despite the problems, there have been positive aspects to the changes in our working lives. For example, doctors have enjoyed the freedom of being able to determine their own learning needs—as adults should—for team working, clinical supervision, and a focus on psychological wellbeing. They have welcomed new flexibilities in revalidation and appraisal. When appraisal became compulsory in 2004 it was introduced as a peer led, formative, and confidential process. It was intended to enable self-reflection and professional development. It has since morphed into a complex performance management process, instilling fear and trepidation in some and seen as a bothersome, time consuming, and largely pointless tickbox exercise by many others. Appraisal has been implicated as a major contributor to doctors’ wishes to leave practice and to high levels of burnout. One legacy of covid-19 must be to review, refresh, and even discard old ways of working. We must create a working environment that is far safer psychologically than the unhealthy one that predominated before covid. This might mean abandoning appraisal in its current form and returning it to how it was intended, as a means of peer support rather than a tool for identifying poorly performing doctors or the next Shipman. It might mean bringing in better ways of supporting doctors, such as groups for reflection that give doctors time to stop and think about their work. Reflective practice makes educational sense, especially when clinicians discuss their cases, share their experiences, bring in relevant literature, and talk about ways to improve their practice. Unlike appraisal, reflection is a dialogical activity and a process of discovery with outcomes that might be unexpected, creative, and different for each participant.

Reflective practice, especially when done as a group activity with a skilled facilitator, is invaluable when dealing with the difficulties and uncertainties of day to day practice. New insights from colleagues add depth to understanding. Group learning falls within the long and greatly respected tradition of the work of Michael Balint. A strong feature of Balint groups and other reflective practice groups is their professional cohesion and sense of shared purpose and identity. They also provide an ideal container for uncomfortable feelings or experiences.

Doctors deserve to be attended to, cared for, and treated as adults. Now is the time to think seriously about how to do this. I vote for abandoning the current system of appraisal and bringing in reflective practice groups for all doctors.

Clare Gerada is GP partner, Hurley Group, London
clare.gerada@nhs.net
Cite this as: BMJ 2020;369:m2450

I’m impressed by how many doctors have shown remarkable resilience in the face of tremendous upheaval.
PERSONAL VIEW Anonymous

NHS Test and Trace: it didn’t have to be this way

A doctor describes her experience of working in England’s service

On the afternoon of 27 May, Boris Johnson told the House of Commons Liaison Committee that it was time to “move on” from the row about whether his special adviser Dominic Cummings had broken lockdown rules. Hours later, Matt Hancock, the health secretary, announced the launch of England’s Test and Trace service.

This was news to me, a doctor and contact tracer, and, it would transpire, to many others.

I’d already been redeployed from my frontline clinical role of 15 years, to work as one of 3000 Test and Trace clinical contact caseworkers. I was meant to speak by telephone to people who had tested positive for covid-19. I had to conduct a public health risk assessment and identify potential contacts.

Around 18 000 non-clinical call handlers were hired to follow up those contacts. Johnson described it as a “world beating” system that hired to follow up those contacts. Johnson described it as a “world beating” system that

The Contact Tracing and Advisory Service (CTAS) website was inaccessible on launch day and tracers were notified of a “critical incident.” The health department denied the system had crashed, but acknowledged there had been technical difficulties, claiming problems were “rapidly being resolved.”

“Complete shambles”

During my shifts later that week, there were no cases to trace, an experience echoed by others who spoke to the media, labelling the system “chaotic” and “a complete shambles.” “I’m yet to know anybody who has made a call to a member of the public,” said one.

So, what went wrong? One thing seems clear: too many organisations spoil the broth. NHS Professionals employed clinical tracers, but we were recruited by Capita and Sitel provided access to the applications and systems, and these all required different usernames and passwords. Synergy CRM assigned cases and held scripts, CTAS captured contact tracing information, RingCentral was used for calls, and

MaxConnect stored contacts data. All of these were accessed through Amazon Workspace. Training was initially through PHE’s Learnspace, and then moved to Health Education England’s e-Learning for Health.

When systems are disconnected, cracks rapidly appear. Simply resetting a broken password required calling Sitel (wait time 45 minutes) to log the problem; an Amazon “reset password” email followed 24 hours later. Calls about basic training required holding for 45 minutes—subsequently this helpline number was withdrawn entirely. Email queries went unanswered. Everyone seemed to have been caught off guard by Hancock’s announcement.

Then there appeared, to me at least, a tacit admission that the system is not yet fit for purpose. All my shifts were cancelled. Caseworker shifts over the next two months disappeared. Previously there were up to 50 a day. NHS Professionals told me demand had been met. Internal reports suggest

BMJ OPINION Fiona Donald

Take holiday now to prepare yourself for the second wave

It seems odd to talk about holidays right now, but bear with me. We all need a break from work, even when we can’t go anywhere. At the moment, many of us are working longer hours than normal, often not in our usual area of clinical practice and in physically and mentally demanding conditions.

In addition, whether your hospital is nearly back to normal or still in the thick of pandemic related activity, I imagine you’ve given some thought to further surges and what they might mean for you and your colleagues. It’s a banality to say that this is a marathon not a sprint but it’s also true, so we need to get ourselves ready to cope.

It would be naive to think the psychological effects of the pandemic will disappear as the peaks pass. Even before all this started it
ACUTE PERSPECTIVE

David Oliver

Preventing more deaths in care homes

I hope my column last week showed that all of us had a part to play in the high number of deaths from covid-19 in care homes. In due course I expect there will be a public inquiry into our handling of covid-19, and endless research and analyses. For now, though, my main concern is what we should do differently if we have a second peak of covid-19 or a pandemic caused by another novel virus.

There are some ways in which we would be better prepared. We now have greater testing capacity in care homes, although it’s a shame it took so long, and some care homes still report difficulties getting staff and residents tested. And homes seem to have better, if still imperfect, stocks of personal protective equipment.

The medical and scientific community has a much better understanding of how the virus behaves and of the course of illness in older people, including in the care home population. Yet we still don’t know how long people remain infectious to others. Nor do we know the rate of asymptomatic carriage among healthcare and care workers.

We have a better idea of how intensive care and the acute bed base would cope in a second wave, without having to transfer patients into field hospitals.

For me, this first wave brought three main lessons we need to learn to be better prepared in case of a second one.

First is the need to include the care home and home care sectors as equal partners in escalation plans and guidelines, at both local and national levels. Infection control, testing, and transfer policies need to be signed off by all parties, who should be engaged in solutions and whose concerns should be listened to, with a public health overview. The care home sector should not be an afterthought—done unto by the NHS.

Second, there is a need to create very local capacity in step-down beds, to enable care home residents to be isolated and quarantined. Although the duration of this is still to be agreed, it would avoid endangering the acute bed base during the peak and, in turn, those patients without covid-19 who need to access hospital care.

Third, care homes need adequate support from local primary and community health services, including access to palliative care, oxygen, and medications. Such models of enhanced support are well established, backed by good practice guidance and a clear aim stated in the NHS long term plan’s “ageing well” section. But their use is highly variable. Sadly, they seem to have been put on the back burner, with the focus solely on the GP contract and with a lack of clarity over dedicated funding.

And perhaps, with care homes getting more public attention than at any point during my career, this will give us the impetus to provide some lasting and credible solutions to the funding and provision of social care, as was promised in the Queen’s speech at the start of this parliament, as well as better alignment and integration with the NHS.

David Oliver, consultant in geriatrics and acute general medicine, Berkshire
davidoliver372@googlemail.com
Twitter @mancunianmedic
Cite this as: BMJ 2020;369:m2461

Any inquiry should probe the muddled formation of Test and Trace

full functionality might only emerge in September or October.

Official figures suggest Test and Trace was unable to trace a third of those who tested positive between 28 May and 3 June. However, Independent Sage labelled Hancock’s claim that 85% of contacts had been traced as “deeply misleading”.

As I reflect on recent weeks, three thoughts come to mind:

First, before another pandemic, there is a pressing need to prioritise a well funded tracing system with improved testing capacity and supported by local authorities. In early March, PHE had just 290 contact tracers with, according to SAGE, capacity “to cope with five new cases a week.” To give a sense of the challenge, more than 300 000 people have tested positive for SARS-CoV-2 in the UK.

Second, any inquiry should probe the muddled formation of Test and Trace and interrogate the vested interests involved. Ministers used special powers to hand contracts to private companies without open competition. As a tracer, am I—an NHS worker—complicit in privatisation by stealth?

Finally, this is a call for government candour and sincerity about its failures. As the tracing system expands, I am hopeful for a more open and ready to start again.

Fiona Donald, vice president of the Royal College of Anaesthetists

or your e-portfoli. As with your emails, these will still be there when you get back and by then you may be able to manage them more effectively.

3. Give your days structure by planning activities such as exercise, socially distanced meetings with friends and family, or virtual meetings with those who are further away.

4. Think about devoting some time to a hobby—new or old.

5. Don’t feel guilty. You work hard and you deserve some time off. No one will criticise you for not working during your holiday but they will expect you to come back refreshed and ready to start again.

Bon virtual voyage.

Fiona Donald, vice president of the Royal College of Anaesthetists

Cite this as: BMJ 2020;369:m2471

5. Don’t feel guilty. You work hard and you deserve some time off. No one will criticise you for not working during your holiday but they will expect you to come back refreshed and ready to start again.

Bon virtual voyage.

Fiona Donald, vice president of the Royal College of Anaesthetists

Cite this as: BMJ 2020;369:m2471

Any inquiry should probe the muddled formation of Test and Trace

full functionality might only emerge in September or October.

Official figures suggest Test and Trace was unable to trace a third of those who tested positive between 28 May and 3 June. However, Independent Sage labelled Hancock’s claim that 85% of contacts had been traced as “deeply misleading”.

As I reflect on recent weeks, three thoughts come to mind:

First, before another pandemic, there is a pressing need to prioritise a well funded tracing system with improved testing capacity and supported by local authorities. In early March, PHE had just 290 contact tracers with, according to SAGE, capacity “to cope with five new cases a week.” To give a sense of the challenge, more than 300 000 people have tested positive for SARS-CoV-2 in the UK.

Second, any inquiry should probe the muddled formation of Test and Trace and interrogate the vested interests involved. Ministers used special powers to hand contracts to private companies without open competition. As a tracer, am I—an NHS worker—complicit in privatisation by stealth?

Finally, this is a call for government candour and sincerity about its failures. As the tracing system expands, I am hopeful for a more open and ready to start again.

Fiona Donald, vice president of the Royal College of Anaesthetists

or your e-portfoli. As with your emails, these will still be there when you get back and by then you may be able to manage them more effectively.

3. Give your days structure by planning activities such as exercise, socially distanced meetings with friends and family, or virtual meetings with those who are further away.

4. Think about devoting some time to a hobby—new or old.

5. Don’t feel guilty. You work hard and you deserve some time off. No one will criticise you for not working during your holiday but they will expect you to come back refreshed and ready to start again.

Bon virtual voyage.

Fiona Donald, vice president of the Royal College of Anaesthetists

Cite this as: BMJ 2020;369:m2471

5. Don’t feel guilty. You work hard and you deserve some time off. No one will criticise you for not working during your holiday but they will expect you to come back refreshed and ready to start again.

Bon virtual voyage.

Fiona Donald, vice president of the Royal College of Anaesthetists

Cite this as: BMJ 2020;369:m2471

Any inquiry should probe the muddled formation of Test and Trace

full functionality might only emerge in September or October.

Official figures suggest Test and Trace was unable to trace a third of those who tested positive between 28 May and 3 June. However, Independent Sage labelled Hancock’s claim that 85% of contacts had been traced as “deeply misleading”.

As I reflect on recent weeks, three thoughts come to mind:

First, before another pandemic, there is a pressing need to prioritise a well funded tracing system with improved testing capacity and supported by local authorities. In early March, PHE had just 290 contact tracers with, according to SAGE, capacity “to cope with five new cases a week.” To give a sense of the challenge, more than 300 000 people have tested positive for SARS-CoV-2 in the UK.

Second, any inquiry should probe the muddled formation of Test and Trace and interrogate the vested interests involved. Ministers used special powers to hand contracts to private companies without open competition. As a tracer, am I—an NHS worker—complicit in privatisation by stealth?

Finally, this is a call for government candour and sincerity about its failures. As the tracing system expands, I am hopeful for a more open and ready to start again.

Fiona Donald, vice president of the Royal College of Anaesthetists

or your e-portfoli. As with your emails, these will still be there when you get back and by then you may be able to manage them more effectively.

3. Give your days structure by planning activities such as exercise, socially distanced meetings with friends and family, or virtual meetings with those who are further away.

4. Think about devoting some time to a hobby—new or old.

5. Don’t feel guilty. You work hard and you deserve some time off. No one will criticise you for not working during your holiday but they will expect you to come back refreshed and ready to start again.

Bon virtual voyage.

Fiona Donald, vice president of the Royal College of Anaesthetists

Cite this as: BMJ 2020;369:m2471

5. Don’t feel guilty. You work hard and you deserve some time off. No one will criticise you for not working during your holiday but they will expect you to come back refreshed and ready to start again.

Bon virtual voyage.

Fiona Donald, vice president of the Royal College of Anaesthetists

Cite this as: BMJ 2020;369:m2471
When will we be well again?

In the heat of the pandemic, news reports focused on patients who were severely ill, in hospital, and on ventilators. Fortunately, this was a minority of patients, and most people with covid-19 remained at home—some of them horribly unwell but not in need of respiratory support. Another cohort were at risk of admission but not in need of respiratory support. Home—some of them horribly unwell—may never regain your previous health is very real.

With other illnesses I can map out the territory ahead and discuss the usual course of events I would expect to see in patients with similar conditions. Although timescales may be imprecise, we have some experience and textbooks to guide us. With covid-19 our predictions are pure guesswork, and our patients know it.

In the face of a symptomatic patient with normal investigations, doctors tend to look for psychological explanations for the patient’s experience. Although fear about the future may be making symptoms harder to bear with this new illness, it’s clear that patients’ anxiety stems from the symptoms rather than being an explanation for them.

Faced with this uncertainty, we need access to dedicated respiratory clinics where patients with persistent symptoms can have further investigations and can receive the most expert advice available. Patients also need our empathy. If we feel uncomfortable ourselves about having no explanation for their symptoms, how do you think they feel?

Our predictions are pure guesswork, and patients know it.

When will we be well again?

Helen Salisbury, GP, Oxford
helen.salisbury@phc.ox.ac.uk
Twitter @HelenRSalisbury
Cite this as: BMJ 2020;369:m2490

Pandemic in South America
South America is becoming the new epicentre of the covid-19 pandemic. In this podcast, Valerie Paz-Soldan, director of Tulane’s Health Offices for Latin America, joins us to talk about the virus’s spread in the region, and how it is overwhelming already stressed healthcare systems. Here she explains how, despite an early lockdown, Peru’s government made several miscalculations in its response:

“They did not accompany that extreme measure [of lockdown] with thinking out ways to help people who are economically disadvantaged, which is the majority of the country. For example, they shut down the country but then they said they were going to give bonuses to the people who were the poorest. But most people here don’t have bank accounts and definitely not the poorest, which means that these people had to go to a bank to get the money, exposing them to contagion. Second of all, 70% of the economy is informal and people shop at markets. Markets were open to the public, but without necessarily the proper measures to ensure that people were being protected on both ends.”

The art of the staycation
Healthcare staff are in dire need of time out, yet given the uncertainties around foreign travel, how can we recreate that holiday feeling? Simon Calder, travel correspondent for the Independent, offers his staycation tips and alternative travel advice:

“I’ve been looking back at great trips and it’s such fun digging out the old photos. It’s not just nostalgia, it’s reminding you what it is about travelling that really enthused you. It’s reminding you about the joy of travel and making you plan all the great trips that you’re going to be making once lockdown is lifted and once the immense pressure on doctors is lifted.”

Listen and subscribe to The BMJ podcast on Apple Podcasts, Spotify, and other major podcast apps

Edited by Kelly Brendel, deputy digital content editor, The BMJ
Protesting during the pandemic

Across the US, healthcare workers are marching against racism, risking exposure to one public health threat to speak out against another. This feature explores what it means for healthcare workers when two public health agendas collide.

Test and trace is far from “world beating”

Chris Ham argues in this BMJ Opinion piece that a “world beating” test and trace service for England is far from the current reality. Instead of overpromising and under delivering, ministers must be open to learning from elsewhere and have the insight to understand the limits of English exceptionalism,” he says. “They should also be prepared to acknowledge mistakes and their willingness to learn from them.”

Reality does not match the rhetoric

The prime minister, Boris Johnson, set out an ambition to establish a “world class” test and trace scheme and has said he is “very proud” of the government’s response to the pandemic. Journalist Andy Cowper looks at the gap between this ambitious rhetoric and the reality of how the government has dealt with covid-19.

Individual and population risk

GP Stephen Bradley and colleagues argue in this editorial that, despite well observed disparities in the severity of covid-19, we lack a sophisticated understanding of the risk to different population groups. “Official guidance should be clear about who is considered to be at higher risk, the specific precautionary measures recommended, and the evidence behind those judgments,” they say.

Listening to vulnerable people

Melissa McCullough, an ethicist and non-executive director of the Health and Social Care Board Northern Ireland, says that the UK government is not following its own ethical principles around adult social care.

Hospital preparedness

Hastily constructed field hospitals in the US and UK have largely gone unused during the pandemic. Yet this feature finds that empty beds might provide important lessons on improving hospital preparedness and flexibility.

Reversing falls in vaccination uptake

Professor of primary care Sonia Saxena and colleagues argue in this editorial that falls in routine vaccination uptake must be reversed quickly during the pandemic response. “Urgent action is required to maintain vaccination rates and limit preventable infections,” they say. “We need clearer government messaging that reaches all groups.”

The shieder’s dilemma

In this BMJ Opinion piece, Ceinwen Giles, a director at Shine Cancer Support, discusses the impact that shielding is having on patients and their families. “With lockdown restrictions easing for many, I desperately hope that those who develop the guidelines for the very vulnerable work hard to develop a greater understanding of who the vulnerable are, and the complexities of our lives,” she writes. “We need to have some grown up conversations about how people can live well, while also protecting their health.”

Global health under fire from politicians

When Donald Trump cut US funding to WHO, it was just one of many power plays in global health affecting pandemic and other international health efforts. A feature looks at the effects of that action on many lives.

bmj.com/coronavirus

All content from across the BMJ’s journals and learning resources that relates to covid-19 is freely available and collected on our covid-19 page at bmj.com/coronavirus
Consensus is emerging that the narrow metrics of prosperity traditionally used in economic debates, such as per capita gross domestic product (GDP), are not fit for purpose. Interest is growing in considering more holistic metrics to monitor societal progress, with several attempts at developing and using alternative indicators. Examples include the gross national happiness metrics used in Bhutan and the living standards framework developed by New Zealand’s treasury to monitor societal wellbeing and inform budgetary priorities. Within Europe, Finland prioritised the economy of wellbeing in its 2019 European Union presidency programme.

There is much interest in policy circles in the concept of wellbeing, but to what end? And what might a so-called “economy of wellbeing” mean for the health sector?

The answer to the question “How satisfied are you with your life” depends on numerous observable and unobservable influences and experiences. Country rankings based on individual assessments of life satisfaction in the 2019 World Happiness Report, for example, were heavily influenced by factors such as income, social support, and health, with a substantial residual not explained by any measured factors. Furthermore, responses are likely to be conditioned by the expectations of the respondent. Given the inherently complex and vague nature of life satisfaction as a concept, efforts have been made to develop measurement frameworks that rely on more objective factors that may contribute to wellbeing. An early example was the human development index, which incorporates health, education, and income into a single composite metric. More recently, the better life initiative of the Organisation for Economic Cooperation and Development (OECD) captures data on topics such as housing, income, jobs, work-life balance, and life satisfaction, and allows analysts to create composite measures of wellbeing by attaching their own relative weights to the metrics. This flexibility is likely to be important for securing local acceptance of the wellbeing approach. More localised approaches include the guidance on measuring the impact of social enterprises on wellbeing from the UK’s New Economics Foundation think tank.

Implications for public priority setting

The principle underlying the wellbeing approach for government is that priorities for public spending should be guided by the extent to which a programme can improve population wellbeing (given its expenditure requirements). In most countries, governments are organised into specific ministerial sectors, each with their own distinct objectives and performance metrics. The diversity across sectors makes comparison of the societal contributions made by different sectors almost impossible and the task of allocating resources between sectors...
Health, especially mental health, accounts for much of the variation in wellbeing

The health sector in most countries makes a major contribution to health. For example, analysis of the effect of health system spending on health outcomes suggests that the cost per QALY in England is about £13 000, 15 and analogous estimates are emerging from other high income countries. 16 The equivalent costs in low and middle income countries are more difficult to estimate but are likely to be much lower. 17 So, the argument goes, health system spending is money well spent. Moreover, there is good evidence that health is a key input to educational attainment, labour market participation, and productivity, strengthening the argument for more health spending to promote wellbeing. 18

Effect on health systems

The wellbeing agenda has caused a stir within the health policy community. It is argued that, since good health is a key component of wellbeing, a shift in policy attention from traditional economic metrics towards societal wellbeing should translate into increased resources for health systems. 2 13 Indeed, within a country, health—especially mental health—accounts for much of the variation in wellbeing. 14

The figure shows the distribution of public sector expenditures in OECD countries in 2017. The health sector varies as a share of public expenditure, from 9% in Latvia to 24% in the United States. With the 2019 World Happiness Report as an example, variations in health explain about 15% of the variations between countries in average happiness, with the largest contributions coming from social support (26%) and income (20%). If priorities were set strictly according to a wellbeing agenda, we might expect some alignment with these determinants.

It is unclear whether a wellbeing approach will—or should—lead to any dramatic shifts in public spending priorities. For one, numerous public expenditure items do not seem to feature in an empirical study of what drives life satisfaction but are essential to a functioning society. For example, provision of safe water is unlikely to be a strong predictor of reported wellbeing in a high income country where there is virtually no variation across the population in access to clean water, and respondents may take its existence for granted. However, this should not imply water and sanitation should receive less funding. Indeed, likely in recognition of this challenge, New Zealand’s wellbeing budget is applied to only around 4% of total public expenditure. 13

somewhat arbitrary and unsystematic. The dominant analytic approach to valuing additional spending in the health sector has taken the form of incremental cost effectiveness analysis, in which the benefits of additional health spending are assessed in terms of health outcomes, often measured in quality adjusted life years (QALYs) or their disability adjusted life years counterpart. 9 Other sectors use metrics specific to their own aims, which can rarely be compared directly with the health metric.

For example, how can a finance minister compare, say, the value of additional QALYs produced by the health sector with an improvement in results produced by the education sector in the form of improved PISA scores (the standardised metrics for international comparison of pupil attainment)? 9

We could consider creating a single measure capturing wellbeing with which to assess and compare social progress, as well as to allocate resources to sectors of the economy according to their relative contribution to wellbeing. 11 If governments could measure the contribution of each sector to an overarching common concept of wellbeing, it would, in principle, be possible to adopt a better informed and more systematic approach towards allocating resources.

The figure shows the distribution of public sector expenditures in OECD countries for a range of sectors, with education and social protection receiving the largest shares in most countries. The share of health spending varies widely, from 9% in Latvia to 24% in the United States. With the 2019 World Happiness Report as an example, variations in health explain about 15% of the variations between countries in average happiness, with the largest contributions coming from social support (26%) and income (20%). If priorities were set strictly according to a wellbeing agenda, we might expect some alignment with these determinants.

It is unclear whether a wellbeing approach will—or should—lead to any dramatic shifts in public spending priorities. For one, numerous public expenditure items do not seem to feature in an empirical study of what drives life satisfaction but are essential to a functioning society. For example, provision of safe water is unlikely to be a strong predictor of reported wellbeing in a high income country where there is virtually no variation across the population in access to clean water, and respondents may take its existence for granted. However, this should not imply water and sanitation should receive less funding. Indeed, likely in recognition of this challenge, New Zealand’s wellbeing budget is applied to only around 4% of total public expenditure. 13

The health system in most countries makes a major contribution to health. For example, analysis of the effect of health system spending on health outcomes suggests that the cost per QALY in England is about £13 000, 15 and analogous estimates are emerging from other high income countries. 16 The equivalent costs in low and middle income countries are more difficult to estimate but are likely to be much lower. 17 So, the argument goes, health system spending is money well spent. Moreover, there is good evidence that health is a key input to educational attainment, labour market participation, and productivity, strengthening the argument for more health spending to promote wellbeing. 18

How OECD countries allocate their public expenditures (OECD, 2019) 12

Percentage

Social protection
Education
Recreation, culture, and religion
Health
Housing and community amenities
Environment protection
Economic affairs
Public order and safety
Defence
General public services

Effect on health systems

The wellbeing agenda has caused a stir within the health policy community. It is argued that, since good health is a key component of wellbeing, a shift in policy attention from traditional economic metrics towards societal wellbeing should translate into increased resources for health systems. 2 13 Indeed, within a country, health—especially mental health—accounts for much of the variation in wellbeing. 14

The health system in most countries makes a major contribution to health. For example, analysis of the effect of health system spending on health outcomes suggests that the cost per QALY in England is about £13 000, 15 and analogous estimates are emerging from other high income countries. 16 The equivalent costs in low and middle income countries are more difficult to estimate but are likely to be much lower. 17 So, the argument goes, health system spending is money well spent. Moreover, there is good evidence that health is a key input to educational attainment, labour market participation, and productivity, strengthening the argument for more health spending to promote wellbeing. 18

How OECD countries allocate their public expenditures (OECD, 2019) 12
Yet, somewhat paradoxically, the wellbeing agenda could lead to reductions in budget allocations for health systems. The social determinants of health movement has underlined the importance for health of sectors such as housing, education, environment, employment, and nutrition, and given rise to a health in all policies approach to policy making. If credible health related policies can be put in place by these sectors, some health related aspects of wellbeing may be more effectively served by spending outside the health system, especially if those policies also contribute to wellbeing in dimensions additional to health.

**Is there a case for investing more in the health sector?**

Although health is an important component of wellbeing, it does not necessarily mean that the health system itself should be a priority for additional funding. The key question is whether the maximum wellbeing gains associated with additional spending are best achieved through additional spending in the health sector.

There are important outputs of the health system, in the form of financial and social protection, that often go unrecognised but are likely to contribute to wellbeing independent of improvements in health. These include the health insurance benefits deriving from the health system and the implicit wealth transfer from richer, healthier people to poorer, sicker people. The nature and magnitude of such protection depends on the form of health coverage in a country, but it is a fundamental goal of universal health coverage.

More generally, we might consider the economy of wellbeing agenda as an opportunity to draw greater attention to the multiple pathways by which the health sector contributes to societal wellbeing through furthering the objectives of other sectors. As well as being valued in their own right, health outcomes produced by the health sector contribute indirectly to other sectors, most notably, but not exclusively, education and economic productivity. For example, by preventing and alleviating the consequences of disability, health systems can help people have longer, more productive working lives and reduce the fiscal and social costs of dependency in older age.

**Opportunities and challenges**

The use of wellbeing as an organising principle for governments has many attractive features. It can be a unifying concept for assessing government spending priorities and help overcome the tendency for spending programmes to become entrenched in particular ministerial “silos.” However, it also poses practical challenges. Most notably, the complexities of measuring the contributions to wellbeing of vastly different programmes are daunting.

Furthermore, there are also philosophical challenges—for example, does an emphasis on improving wellbeing imply that low priority will be given to those who have little capacity to become happier?

There are also conceptual debates about whether personal autonomy, in the form of an ability to adapt and self-manage, may be a more appropriate underpinning concept for wellbeing than life satisfaction. The emphasis on wellbeing nevertheless offers many opportunities for the health sector. It could show that additional spending on health contributes positively to wellbeing through multiple pathways, rather than being merely a cost pressure on government finances. However, a focus on wellbeing could also indicate a departure from the reliance on traditional ministry specific budgeting, and so brings with it new challenges for health policy makers.

For policies enacted within the health sector, an important requirement will be to track the implications of those policies for objectives beyond health improvement that have an influence on wellbeing. A first step would be to routinely incorporate health system objectives such as equity and financial protection into conventional economic evaluation techniques such as cost effectiveness analysis. While health ministries should remain guardians of population health, and use health improvement as a prime performance measure, they will need to show that their spending is good use of government funds and show their broader impact on wellbeing.

The particular importance of mental health as a determinant of wellbeing may suggest the need for a shift away from traditional priorities in the health sector.

Methods such as cost effectiveness analysis (possibly enhanced as above) are likely to remain the cornerstone of assessing the health outcomes of health system spending. However, they will also have to be augmented with estimates of the impact of the health system (negative or positive) on other sectors, such as employment or social protection, which also make important contributions to wellbeing.

Consideration of the broader consequences of health systems is more than just an analytic concern and could allow an economy of wellbeing approach, in which all sectors seek to assess the impact of their policies on the objectives of other sectors.

Cross sectoral projects, such as programmes to deal with risk factors associated with non-communicable disease, are likely to become particularly important from a wellbeing perspective. These might take the form of programmes to tackle smoking, childhood obesity, or poor nutrition, for example. The benefits (and costs) of such programmes are likely to accrue across several sectors, such as education, social care, and transport. The health sector will need to find ways of working effectively across traditional boundaries to assess the influences of such programmes on wellbeing. Many such programmes are likely to require the commitment of health sector funds to collaborative programmes and the development of effective governance mechanisms to ensure that the objectives of all participating sectors are met.

The wellbeing agenda is a long way from being implemented comprehensively in any country, and given the analytic challenges some doubts about its feasibility exist. If it is adopted as a unifying principle of government, it will require new ways of thinking about the outcomes arising from health system actions.
LETTERS

Where is the scientific rigour?

Scally and colleagues’ editorial on the UK’s public health response to covid-19 is disheartening (Editorial, 23 May). The BMJ has a moral obligation to publish articles based on scientific rigour. Sadly, there has been a trend towards “tabloid journalism,” with emotive language, misleading soundbites, and cherry picked citations. Only a handful of this editorial’s references are peer reviewed research; half are newspaper articles, personal opinions, and blogs. In this era of worldwide connectivity, it is all too easy for personal opinion to be referenced, re-cited, and repeated as gospel.

International and influential journals must “challenge the status quo.” But the articles that do so need to be balanced, respectful, and accurate. The potential bias of Scally’s affiliation with Independent SAGE should be made clear, and the discreet grey box in the colourful infographic should not be the only acknowledgment that the quoted numbers are unadjusted and therefore misleading. This editorial does little to further our understanding of the complexities around the fast paced and difficult decisions being made by the UK panel of experts.

The national and global responses to the pandemic are multifaceted and challenging. Individual nations possess unique characteristics—geographically, some are isolated (New Zealand, for example), and others possess busy international travel hubs located within densely populated areas (such as London). These complexities will take time to unravel—pre-emptive judgments should not be made in the heat of the moment.

The 21st century model for journalism and science writing seems to focus on negative, conflict based stories. Global wellbeing and mental health face an unprecedented challenge. A world renowned journal like The BMJ has the capability and opportunity to encourage rigorous, relevant writing that challenges the status quo, while also presenting positive stories of “progress, possibility, and solutions.”

Mary Slingo, specialty trainee year 6 in anaesthesia, Portsmouth

Cite this as: BMJ 2020;369:m2448

UK PUBLIC HEALTH RESPONSE

A game of mortal calculus

Scally and colleagues criticise the UK government’s handling of the covid-19 pandemic. We agree the UK has been comparatively slow on testing, community contact tracing, and moving to lockdown. But the authors play a game of mortal calculus, using the total number of deaths per million to “evidence” their pandemic postmortem. These are crude, unadjusted figures that do not lend themselves to international comparisons, as noted in the grey small print of an otherwise colourful infographic.

The authors neglect to mention the many millions of pounds of government investment in therapeutic clinical trials, vaccine development, and antibody validation. There is little exploration of the potential positive effects of state economic interventions on future wellbeing and as a means of countering the health inequalities—both mental and physical—created by social lockdown and economic decline. Meaningful judgment can be passed not now but in the fullness of time.

Arnyeh L Greenberg, specialist trainee in clinical oncology, Harry Greenberg, academic foundation year 2 doctor, London

Cite this as: BMJ 2020;369:m2453

Public health expertise is being sidelined

As a former director of public health, I recognise the decimation of the public health system that Scally and colleagues describe. While “public health” is in the spotlight, actual public health expertise is being sidelined.

Spending money well takes time, needs planning, is informed by evidence, and requires the skill to mobilise and coordinate a range of organisations towards a common purpose. The bulk of the historic loss to public health funding has been people—a whole generation of the workforce has been sacrificed to misguided efficiency savings.

Meanwhile, as the government let another contract go to yet another private company to recruit suitable staff for their “test, track, trace” project, Hancock told us that this “new” function would be supported by “public health specialists” at a local level. I hope that whatever is being devolved to local directors of public health includes recognition and long term resources, not just the responsibility and blame.

Marie Armitage, former director of public health, Birkenhead

Cite this as: BMJ 2020;369:m2454

Obfuscation and misrepresentation

Where did the UK’s covid-19 plan go wrong? Politics.

The crisis has exposed how the NHS is simply not equipped to deal with this kind of challenge. It runs at or above capacity even in the best of times, relying on the goodwill of staff working overtime for free.

The government downgraded the threat status of covid-19 on 19 March, enabling it to lower the standard of personal protective equipment in hospitals. NHS colleagues have died—could some of these deaths have been avoided by a more prompt lockdown and coordinated government response? Almost certainly. This was a political decision, not one based on science. The obfuscations, misrepresentation of statistics and information, and the insistence on ignoring the World Health Organization’s advice on testing have cost hundreds, if not thousands, of lives among the UK population.

The public inquiry when it comes should be comprehensive and unstinting in its findings.

Health secretary Matt Hancock (right), with Chris Whitty, England’s chief medical officer

Cite this as: BMJ 2020;369:m2455
**OBITUARIES**

**Peter Khin Tun**
Associate postgraduate dean Oxford Deanery (b 1958; q University of Yangon, Burma/Myanmar, 1981; MRCP), died from covid-19 on 13 April 2020
In 1994 Peter Khin Tun travelled from his native Burma (now Myanmar) to Britain to work as a doctor in the NHS. After graduating, he started as a research medical officer for a project on maternal and child healthcare that was sponsored by the World Health Organization. From 1985 to 1994 he worked as a GP across the villages of the Ayeyarwady Delta. His UK career took him into the training of doctors, and eventually earned him the role of associate postgraduate dean at Oxford Deanery (2012-16). He had expertise in a wide range of areas. Peter loved gardening, cooking, barbecues, sharing recipes, the Beatles, and painting watercolours. He was a devout Buddhist and enjoyed meditation. He leaves his wife, Daw Win Mar, and two sons.

Will Tun
Cite this as: BMJ 2020;369:m2029

**Joyce Lilian Dunlop**
Consultant psychiatrist (b 1933; q Trinity College Dublin, Ireland, 1959; MRCPsych), died from a subdural haemorrhage secondary to acute monoblastic leukaemia on 12 April 2020
Joyce Lilian Dunlop was born and trained in Dublin, where she met her soulmate, Jim, who was her resident student when she was houseman. After qualifying they moved to Dumfries and started their family. Joyce initially started training as an anaesthetist. They settled in Hull, where they were both involved with the BMA. It was there, while anaesthetising patients having electroconvulsive therapy, that Joyce discovered her interest in psychiatry. She tried to preserve what is best among the older physical treatments and combine them with the newer therapies to give a “two feet on the ground” approach. She was a keen gardener, traveller, and philatelist, with a 50 year career. Predeceased by Jim in 2016, she leaves three children and six grandchildren.

Douglas Dunlop
Cite this as: BMJ 2020;369:m2027

**Haripada Adhikary**
Consultant ophthalmologist Royal Preston Hospital (b 1941; q 1967; MBE, FRCS Ed, FRCS Eng, FRCophth), died after a short illness on 4 December 2019
Haripada Adhikary came to the UK in 1972 and continued training before he was appointed as a consultant ophthalmologist at Royal Preston Hospital. He laid the foundation of a modern ophthalmic department, and from its beginnings in the early 1990s he practised excimer laser refractive surgery. He published several papers on the subject. He was particularly interested in training ophthalmologists for the future and was an honorary senior lecturer and visiting fellow at the University of Central Lancashire. Outside work his interests included gardening, travelling, writing Bengali poetry, and singing. He was awarded an MBE in 2004 for his social, cultural, and charity work in Bengal and the UK. He leaves his wife, two children, and their spouses.

Manju Adhikary, Sunila Jain
Cite this as: BMJ 2020;369:m2025

**Yehuda Shemariah Kaplan**
Senior clinical medical officer Rotherham Community Child Health Service (b 1931; q University of Cape Town, 1954, DTCO, DIH), died from frailty and old age on 8 April 2020
Yehuda Shemariah Kaplan started his career in his native South Africa. He and his wife, Ruth, were active in the anti-apartheid movement, and in 1963 this forced their urgent departure. They spent the following 10 years in Swaziland. Yehuda became Swaziland’s tuberculosis medical officer, directing and supervising tuberculosis control throughout the country and working with the World Health Organization on immunisation programmes. In 1974 the family settled in the UK. Yehuda worked at the National Coal Board Radiological Centre in south Yorkshire for seven years. In 1980 he joined the community child health service in Rotherham. Ruth predeceased him in 1999, and he leaves three sons, six grandchildren, and a brother.

Ulla Trend, Leon Kaplan
Cite this as: BMJ 2020;369:m2028

**Bernard “John” Batt**
General practitioner Wickhambrook, Suffolk (b 1924; q St Bartholomew’s Hospital 1949), died from lymphoma on 13 April 2020
Bernard “John” Batt started his medical training during the second world war. He was evacuated to Cambridge before returning to London to complete his studies after the war. After national service he did house jobs, initially as a medical officer and subsequently in ear, nose, and throat medicine. In 1955 his father (a GP in Wickhambrook) died suddenly, which necessitated a career change to general practice. This was to maintain continuity in the family practice: it was what the community expected. Much respected by his patients, he worked a one in two on-call rota until he retired in 1987. In retirement he enjoyed outdoor pursuits, including golf and his garden. He leaves his wife, Shirley; three children; and six grandchildren.

Mark E Batt
Cite this as: BMJ 2020;369:m2026

**Carlo Lorenzo Acerini**
Honorary consultant paediatric endocrinologist (b 1962; q Dundee 1988; MD, FRCPCH), died suddenly on 20 May 2019
Carlo Lorenzo Acerini was at the peak of his career as an internationally recognised expert on childhood type 1 diabetes. He supported wider paediatric research through leadership roles in the NIHR clinical research network and the Wellcome Trust clinical research facility in Cambridge, and was a highly cited clinical academic who contributed greatly to the work of professional societies. He transformed paediatric undergraduate training in Cambridge as course director and senior examiner, with a strong emphasis on clinical learning and evidence based medicine, and he coedited the Oxford Handbook of Paediatrics. Carlo also enjoyed his roles as official fellow and director of studies at Girton College, where he encouraged and supported many medical students. He leaves his wife, Pauline, and three children.

David Dunger, Fiona Cooke, Ken Ong
Cite this as: BMJ 2020;369:m2024
Pattison commented that the basic principles of microbiology and virology were “rapidly learnt and equally rapidly ignored”

John Ridley Pattison (b 1942; q Oxford/ Middlesex Hospital Medical School, 1968; DM FRCPath, FMedSci), died from cancer on 18 March 2020

In 1995 the government appointed John Pattison chair of its advisory committee on bovine spongiform encephalopathy (BSE). Dubbed “the man who couldn’t lie,” Pattison was recommended by agriculture minister Douglas Hogg as someone the public could trust when they no longer trusted politicians. His success was such that he was knighted in 1998, after only three years in office.

Pattison evolved into a model scientific expert at a critical time. BSE had become one of the biggest public health crises since the second world war. Public concern and awareness spread more rapidly than the disease itself, fuelled by the knowledge that it was incurable and that any meat eater could catch it. More than 150 people died from Creutzfeldt-Jakob disease, the human variant of BSE, starting with 19 year old Stephen Churchill in 1995. The National Audit Office reported that the cost of BSE between 1996 and 2000 was £3.4bn and included the slaughter of 2.6 million animals.

In the early 1990s the government had tried but failed to convince consumers that British beef was safe—agriculture minister John Gummer is now infamous for trying to feed his young daughter a hamburger in front of an audience of journalists.

The son of a butcher and abattoir owner, Pattison knew about the basics of meat production. He also had the essential prerequisites for his controversial part time job: finely tuned management, diplomatic, and interpersonal skills, and outstanding academic credentials. Appointed as professor of medical microbiology at the University College London Medical School in 1984, he was dean of the school between 1990 and 1998. Colleagues recall a calm and measured leader, with a door and mind always open to new ideas.

Public prominence

Pattison did not appreciate how his BSE role would thrust him into public prominence. He became perhaps as well known during his four year tenure as Chris Whitty, chief medical officer of England, is during today’s covid-19 crisis. Pattison was (perhaps, naively) furious when the Independent asked if he and his family ate meat. His first BBC Newsnight appearance was described as “stilted,” but he was a skilled communicator and became an accomplished media performer. As a university lecturer he was renowned for leaving the podium for the auditorium to close the gap between him and his audience.

Pattison was brought up in the mining town of Bedlington, County Durham. Although he studied and worked in London from 1963, he always saw himself, perhaps romantically, as a north easterner. As a boy he looked like an academic high flier as he progressed from the private Barnard Castle School in County Durham to Oxford to read medicine. But he failed his anatomy exams twice and later speculated that he should have grown up more and taken a gap year before starting university. Gap years were not then fashionable. Pattison’s son, Giles, a paediatric orthopaedic surgeon, believes that his Oxford setbacks made him more sympathetic, as a medical school dean, to the heavy demands facing medical students.

Pattison spent his entire career in academic medicine. After seven years as professor of medical microbiology at King’s College Hospital Medical School, where his work included research into the human parvovirus B19 and rubella, he took the medical microbiology chair at UCL and became increasingly involved in administration. He also became vice provost and head of biomedicine.

From 1992 to 1995 he was chairman of the Physiological Medicine and Infection Board and a member of the Medical Research Council. He was on the board of the Public Health Laboratory Service (1989-95) and editor in chief of Epidemiology and Infection (1980-94). In 1999 he left UCL to become NHS head of research and development, with a specific responsibility for genetics.

Alarming examples

His legacy includes a lecture at the Faculty of Public Health in February 1999 that resonates with our new world order. He commented that the basic principles of microbiology and virology were not intellectually demanding and were “rapidly learnt and equally rapidly ignored.” He added: “The consequence is that we are constantly reminded of them by specific and often alarming examples of transmissible diseases that are either novel or re-emerging after a period of being relatively well controlled.”

Pattison leaves his wife, Pauline, and three children.

John Illman, London
john@jicmedia.org

Cite this as: BMJ 2020;369:m1559