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ACUTE PERSPECTIVE

David Oliver: Why polarise healthcare opinions?

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Dogma and rigid ideology are rarely helpful in public policy or pragmatic approaches to running health services. The covid-19 pandemic has highlighted a growing tendency in public discourse to polarise opinions on healthcare and policy, into warring sides with seemingly irreconcilable views. Many issues have nuance and truth on both sides, and it should be possible to hold two (or more) positions at once. But social media, populist politics, and hyperbole can make life hard for people who embrace moderation and balance.

Firstly, face masks—in shops, enclosed meeting spaces, and public transport. The government's decision in July¹ to make them compulsory in England led to acres of newsprint, hours of radio phone-ins, and endless Twitter exchanges. Surely, the “anti-maskers” are right to question rushed legislation with little consultation, a contested evidence base for effectiveness, and the timing—several months after the pandemic peak, when the measure might have made more sense.²

Meanwhile, people who favour “Just wear the mask, can't you?” can point to the World Health Organization changing its own official stance in June to qualified support for public mask wearing policies,³ the more circumstantial evidence (albeit not “gold standard”) about the properties of masks and routes of covid-19 transmission, and a cultural norm of mask wearing in South East Asian countries that have got through the pandemic with fewer cases.⁴ Both parties have a point.⁵

Secondly, the dialogue about creeping NHS privatisation and its scale and impact. It seems clear that many Conservative MPs and right wing policy think tanks dream of increasing private sector involvement in our health services. Recent outsourcing of numerous contracts during the pandemic has furthered that impression.^{6 7} Parliamentary votes not to take the NHS off the table for international trade negotiations are a further concern.⁸

That said, the proportion of NHS clinical care delivered by the private sector or paid for from private insurance or personal funds remains low.^{9 10} Public resistance to market solutions is considerable, and many system leaders and health services have a range of existential threats, not least workforce gaps, that are arguably more pressing.¹¹

Both sides of the argument contain some truth about whether we can compare the NHS, and its funding and provision model, with other systems that are better funded or staffed or use more insurance and market based delivery. As a nation the UK scores highly in some domains and poorly in others, and

claims of inefficiency or poor value for money are based on ideology, not evidence.¹² A debate shouldn't be a “for or against” shouting match.

Finally, some commentators are against hospital admission: all citizens would allegedly rather be at home, admission is inevitably harmful and risky, and we're said to admit far too many people and should keep ever more of them (especially older people) out of hospital. But we already have fewer beds per 1000 in the UK than nearly all other OECD countries,¹³ and we spend a lower proportion of our health budget on hospital care than many.⁹

Capacity and responsiveness in alternative services outside hospital are often lacking, as is consistent evidence for those services “saving” money.^{14 15} Some people want and need ward based care, and much of it is supported by evidence. Has home based or care home based care always been the best thing for patients recently infected with covid-19?¹⁶⁻¹⁸

I could pick many more examples. But we need to relearn the art of holding numerous contrasting opinions and interpretations in our head at once and accepting that the truth is nuanced.

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