Saul Miller

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Change and progress

We're beings with finite existence. In that limited time, few ever make a lasting difference to our world. But those few cumulatively raise the collective game. There is much to appreciate from this for those of us who would prefer to leave behind the hunter-gatherer life. And yet my youthful belief in the march of human progress still wanes.

Take obesity. We know it is a major cause of illness and disability. We know there is a relationship between access to fast-food outlets and rates of obesity. We know that deprivation and obesity rates are significantly linked from childhood on. During the COVID-19 pandemic, it turned out that obesity was also a major risk factor for death from that novel coronavirus. And yet as much as a coherent national policy on the topic might seem obvious, a whole-system approach even within the NHS does not yet exist.

In the surgery, patients still express the hopelessness of their lived reality: lives built around sitting; exercise options that are difficult to access geographically and financially; and the cheapest food options too often the 'wrong' choices. Exercise support options come and go but are always limited. Dietary support is simply not available unless you are already diabetic.

We could of course take other topics and detail similar patterns: alcohol and drug abuse; physical activity levels; smoking; cancer; and so on. All patterns linked to the level of socioeconomic disadvantage of those involved. And all involving disjointed policy, not the least of which is policy around public health medicine. But the point is this: that the underlying inconsistency is driven by controversy around how much of individual behaviour should be in scope for policy at all, and how much is simply an issue of liberty and free will.

I have left out of that analysis the question of how much influence does big business have on government policy. Insofar as the emphasis repeatedly comes back to liberty and free will, this would seem to support concerns that the answer may be 'too much'.

After all the popular support during the COVID-19 pandemic, the NHS is in turmoil. The pandemic is one factor but added to it are the twin pressures of inflation and industrial action. In the midst of this is another major reorganisation, with the shift to integrated care systems. At primary care level, we are facing the end of the 5 year Primary Care Network (PCN) contract in a year's time and no one yet knows what follows.

The idea promoted by Claire Fuller, of Integrated Neighbourhood Teams (INTs), seems to have political currency. As usual though, the top-line idea is not so important as the absent detail of how it will be implemented. Although population health management was made a responsibility of PCNs, regulation and targets (never mind the small matter of a pandemic) have given little space for this. Will even that flicker survive reorganisation?

I recently found out about a problem facing medical students recruited as part of the 'widening participation in medicine' agenda. It turns out that the NHS generously pays their final year tuition fees but they have no access to a student loan for the rest, only a £1000 grant and a means-tested bursary of up to £2643 to cover a year's living and accommodation costs.

This reminded me of an article about the inverse relationship between the distribution of English GPs and socioeconomic inequalities in health. Encouragingly, it concluded things had improved substantially in the decade up to 2014. I wonder what's happened since?

Much changes in the world but progress is not inevitable.

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This article (with references) was first posted on *BJGP Life* on 24 March 2023; https://bjgplife.com/change

DOI: https://doi.org/10.3399/bjgp23X732501

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