The impact of ageing on the NHS

Edoardo Cervoni[1] and Francesca Cervoni[1]

[1]Affiliation not available

March 21, 2022

Abstract

The human body is, by definition, a "corpus". This Latin term emphasises the synergy and interdependence of each of its parts. There is no scientific basis for estimating the number of specialists of various types needed to meet the population's needs of the type of interventions that confer benefit. However, it is virtually certain that the proper functioning of the filter could free up more time for properly deployed specialists to provide services that would significantly improve health and, above all, equity in health. Recognition of the importance of first contact function in Primary Care as a filter and co-ordinator, should lead us to better clinical outcomes for the most part. The government should recognise, protect, and prioritise, the role of the Primary Care interface.

We are living in unprecedented times. The ongoing COVID-19 pandemic and the Russo-Ukrainian war are amongst some of the dramatic changes that are inflicting lasting damages on our fragile NHS. Currently, the NHS is at risk of being put under further pressure if cuts to healthcare budget are made in order to provide for military expenses.

I have practiced medicine in three continents, taking on different roles, for the past three decades. To me, the world and our profession have changed beyond recognition. There have been many scientific and technological advancements. Moreover, society itself has changed. Yet, what has remained unchanged is the trend in healthcare expenses. Healthcare budgets have dramatically increased.

However, when we look at both the quality of life and the life expectancy in Western countries, it is evident that there has not been considerable improvement. In fact, in some cases, the life expectancy has decreased, and the quality of life may have become poorer.

General discontent and concerns about our profession have been in the public domain. Nonetheless, disruptive measures have been taken without considering the potential consequences. For example, medical records will fully be accessible to patients in April 2022. Although, there are significant downsides to the government's decision regarding our patient's medical records.

This is the latest radical change to a 74-year-old Institution.

I am concerned about the psychological impact that this will have on practitioners.

I believe that the practice of defensive medicine will become more widespread, and the role of a filter to access the secondary care of general practitioners may be jeopardised.

The duration of the consultation will increase, potentially lasting well over 10-15 minutes.

There will be more referrals to secondary care and for further investigations.

This then leads to fewer appointments being available.

Similarly, we are more likely to see an increase in healthcare costs.

Furthermore, a plethora of potentially very serious safety and confidentiality risks compounds to all the problems I have just highlighted.

Consequently, I feel that it is vital that concerted measures are taken to avoid these apparent risks. The effect on the NHS system, which is already suffering, could be disastrous.

Before the beginning of the pandemic (February 2020), there were 4.43 million people on waiting lists for various treatments.

At the start of the pandemic, the number of people who joined waiting lists decreased. Nevertheless, this is no longer the case. In December 2021, there was a record of more than 6 million people awaiting treatment. Two million patients have waited more than 18 weeks, and over 300 patients have waited more than a year. This is 200 times the number of waits seen over a year before the pandemic (December 2019).

I believe that primary care should embrace the role of filter and coordinator of care, applying the best possible clinical evaluation skills and being strongly supported in doing so.

Doing otherwise could be catastrophic and detrimental for some patients, particularly for those who are considered to be “more patient”.

Unfortunately, the concept of “filter” has been confused with “gatekeeper”. This is a serious error of assessment. A filter is not the same as a gate. It is designed to select the features that benefit from the switch, whilst the latter does not. Also, it selects features with a high probability of being helped by the passage.

On the other hand, a gate can be opened or closed arbitrarily, frequently with pressure, and sometimes depending on factors not related to need or benefit. As well as this, gates can be opened or closed at various levels by the gatekeeper. This depends on their characteristics, the area in which they are located and the degree of entry demand.

The usefulness of specialised interventions depends on the prevalence of people with a high probability of pathology, which requires specialised care. As a result of their specialised training, specialists are exposed to people with a greater likelihood of having the specific problem. In the absence of the filter, specialists are faced with a high percentage of people with a low probability of having a problem in their area of expertise. Thus, they perform a cascade of increasingly invasive procedures and treatments, each with its own potential to cause adverse effects, or even death. The more specialists that see patients with a low likelihood of disease, the higher the chances are that more harm can be done than good. This is a phenomenon related to high mortality rates from adverse effects in hyper-specialised health systems e.g., the United States.

Over-specialisation has often overlooked the risks and leaves some of us with questions. It is unclear why doctors prefer to manage only one organ, and surgeons prefer to operate on one type of bone. Why is it

that the narrower the speciality, the greater the prestige when the average patient with multiple chronic conditions desperately needs someone to pay attention to the big picture?

The human body is, by definition, a "corpus". This Latin term emphasises the synergy and interdependence of each of its parts. There is no scientific basis for estimating the number of specialists of various types needed to meet the population's needs of the type of interventions that confer benefit. However, it is virtually certain that the proper functioning of the filter could free up more time for properly deployed specialists to provide services that would significantly improve health and, above all, equity in health.

Recognition of the importance of first contact function in primary care should lead us to better clinical outcomes for the most part. Therefore, the design of the filter should be set to maximise the effectiveness of primary care and special services, just as manufacturers position filters to achieve specific purposes.

The government should recognise, protect, and prioritise, the role of the Primary Care interface.

Perhaps, a new title should be created: that of Chief Physician, for the one in charge of putting all the pieces together and agreeing on the general plan of action with the patient.

It is time for action, and I fear that the government is following a political agenda, perhaps in bona fide, which can be detrimental to the most.