Jennifer Crane and Jane Hand (eds), *Posters, protests and prescriptions: Cultural histories of the National Health Service in Britain*

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**Epilogue: ‘I’m afraid [,] there’s no NHS’**

Commas are such useful nuancing devices. The careful positioning of a comma between ‘I’m afraid’ and ‘there’s no NHS’ changes the intent from a very English expression of disappointment into a personal statement of fear. Both seem appropriate when considering the history and current state of the English National Health Service.

Technically, the ‘NHS’ is on shaky ground as a legal entity. The institution created in 1948 was the ‘National Health Service’. That was the title of the 1946 Act of Parliament, and the name used by Bevan in his speeches during that period of uncertainty when members of the medical profession were yet to be convinced of their status, value and autonomy within a potentially dictatorial system. The leaflet posted to all households on the eve of 5 July 1948 referred to ‘Your new National Health Service’. But it’s a bit of a mouthful, and frequency of use naturally inclined it to the abbreviation ‘NHS’.

The change from ‘National Health Service’ to ‘NHS’ provokes the issue of periodisation in the service’s history, and the benefits of an explicitly cultural lens through which to view such transitions. Analysing the shift in name demonstrates the value of approaching the institution from different viewpoints – the employer, employee, patient – and more recently, the management consultant, the contracted staff (often from external agencies) and the consumer. There is useful rhetoric to explore around its name: *Your* National Health Service; *my* NHS; *our* NHS; *the* NHS. The current UK Prime Minister, Boris Johnson, never fails to say ‘***our*** NHS’. We haven’t (yet) got *their* NHS – but maybe that is coming. It’s certainly true for certain aspects such as dentistry, which dropped the pretence of a universal, free at the point of delivery service soon after 1948.

Cultural histories of the NHS can be attuned to noise that doesn’t feature on the radar of social or policy historians. It consciously seeks out language, values, interpretations. Its preferred sources include imagery, which have provided rich territory for exploring the evolution from ‘national health service’ to NHS. The globally recognised blue logo emerged at the start of the 1990s, a nationally imposed veneer to replace local permutations. The blue lettering had been there before, but it became standardised in that larger march towards ‘quality’: now specifically Blue Pantone 300, with letters 2.4 times as wide as high in Frutiger Italic font. It must have been an institutionally challenging process to produce. How were the public and the staff consulted? Did the logo designers consider including an image, such as a stethoscope, or maybe the rod of Aesculapius? What’s the logic of the colour (and has the NHS always been ‘blue’?). The logo has evolved since the early 1990s: it’s lost its stiff upright posture through italicisation introducing an impression of movement, progression. It has been ‘refreshed’ with increasing frequency – mirroring the changes to the organisation, but always within carefully curated parameters. According to the official NHS website, it ‘evokes positive, rational and emotional associations of trust, confidence, security and a sense of dependability’ as one of the UK’s ‘most cherished and recognised brands’.[[1]](#footnote-1) It’s protected by a UK trademark owned by the Secretary of State for Health and Social Care. There are strict rules for its use: the amount of blank space to be left around it, the permitted colour of backgrounds (never red, orange, green, black or dark grey). It cannot be placed ‘so close to the edge of materials that it looks like an afterthought’.[[2]](#footnote-2) No – the NHS is bold, in our face, at the centre of our British lives.

If you type ‘NHS’ into Wikipedia (the English language version) it automatically redirects to ‘National Health Service’. Those seeking the National Honor Society of the United States are directed onward. There are also links to separate pages for the individual national healthcare services of England, Scotland, Wales and Northern Ireland. Wikipedia clarifies that National Health Service (NHS) is the umbrella term for the systems in the UK. The logos displayed alongside the description of the components belie the public understanding of a ‘national’ service. The official NHS website notes that recently ‘the NHS colour palette has been expanded to give NHS organisations the flexibility to visually differentiate their communications from each other, but not from the NHS’. NHS England uses one blue, in italics; NHS Scotland proclaims its semi-independence with two shades of blue, non-italicised.

These permitted deviances are important – both in their chronology and process. Studying their negotiated emergence and implicit impact on their audience is a rich and useful approach to understanding how the NHS has evolved, and the challenges it has faced. It ties the present to the past and the future, by illuminating the NHS as an evolving, living organism, that because of its very function cannot be allowed to atrophy.

Yet behind this ‘front’ there are many NHSs. There are other aspects of standardised ‘representation’ to be usefully explored, such as dress codes. The peak of the white coat and stethoscope combination as shorthand for ‘doctor’ was reached in the 1980s – directly observed by hospital patients; indirectly observed by millions of British viewers through TV drama series such as Casualty. The decline of this visual mnemonic coincided with the arrival of both MRSA and ER – and the public were re-educated to expect doctors to have arms bare below the elbows, whether in scrubs or shirts. Some doctors have literally hung on or onto stethoscopes as an indicator of role (and implied continuation of an NHS staff hierarchy) in the increasingly porous clinical working environment. Nurses have also been re-presented to the public through changes to their uniforms. Hats and belts symbolised military precision and efficiency, essential in a complex hierarchy where quickly identifying who was in charge was critical to patient care. Nurses’ hats are worthy of an academic study in their own right: the evolution from starched to non-starched ‘frillies’; the higher the hat, the more senior the wearer, from trainee to matron. The transition from blue (again) nurses’ dresses to trousers, and sometimes scrubs (now with stethoscopes) completes the confluence of clinical practitioners into an MDT: a ‘Multi-disciplinary Team’.

If logos, uniforms and personal signifiers such as stethoscopes have been so central to defining the NHS to itself and to the public, perhaps this explains the relative invisibility of public health and primary care? This is not to conflate two very different parts of the NHS, and indeed public health hasn’t always been a part. It was retained by local government when the NHS was created in 1948, and its inclusion via the 1974 reforms was clumsy. Its return to local government in 2012, and the creation of Public Health England (with its national counterparts), was equally uninformed by historical review of its function and points of engagement with the larger system. Applying the ‘blue logo’ did little for public health staff sense of identity.

Primary care has, however, perhaps suffered from over-familiar patient identity. Its role as the gatekeeper has ensured regular, and sometimes frequent, contact to the extent that patients have strong visual memories of its spaces: the collections of old magazines (in the BC era: before COVID-19) in pseudo-domestic settings complete with the occasional house plant, or fish-tank. Most of the early NHS primary care spaces – invariably called surgeries despite the fact minimal surgery happened there – were real domestic settings, located within the general practitioner’s home, with the delimitation of work and life spaces further blurred by the common practice of employing one’s wife as a secretary/assistant.

Understanding the NHS as not a monolith but as a composite of hundreds of diverse parts is critical to the survival of the ethos and practice of universal (national) health care. More specifically, illuminating *how* the parts work together becomes a vital task, and one that historians are well-equipped to undertake. If the materials in this book are foundation stones, they need careful placement to meet specific purposes. This has risks: historians can become complicit in the co-production of activist narratives that have deliberate if unspoken objectives around *preserving* the status quo. Viewing the NHS as a composite system is not new. In the 1950s, NHS management drew on the expertise of Operational Research (OR) practitioners in the quest for effectiveness and efficiency. From the 1970s the vogue was for guidance from external management consultants, many of whom were OR practitioners in a new guise and paid inflated fees rather than civil service salaries. These were the experts who went looking for the dropped bedpans in provincial hospitals at the demand of Bevan’s ministerial successors – insistent on surveillance of the NHS *as a whole*. These were the experts who could identify the faults in ‘the system’ – that over demand from primary care could lead to waiting lists in secondary care, but who rarely lifted their gaze to observe the causes of bed blocking in the dislocated, external, social care system.[[3]](#footnote-3)

There are clear opportunities for cultural approaches to analysing the NHS as a system. Using metaphors of tensions, demands, pressures, streamlining, standardising, inputs and outputs open up new perspectives. Setting the laundry workers disputes alongside the GPs frustrations with sick notes, for example, or the Boots pharmacists’ sales targets, exposes the often-submerged pressure points. We can usefully think of the NHS through comparisons with family systems (with tensions between established wisdom and young upstarts) and surveillance systems (monitoring consumption – of licit and illicit drugs; establishing and patrolling standards such as weekly recommended alcohol units; family planning guidance for adolescents).

Perhaps the ultimate system metaphor is that of the human body – a trope that in recent years has been in danger of over-use when applied to the NHS. Significant birthdays have invited predictable journalistic discussion on whether it will exceed the biblical human lifespan of three score years and ten, and what signs should be monitored for evidence of senility and terminal decline. A human body metaphor can also be useful in understanding the shift observed in how we respond to the NHS – from being passive external patients, to being collaborative consumers who are encouraged to see ourselves as part of the NHS, part of the body. This clever enabling device has permitted stronger directives, drawing on the parallels between individual and collective behaviour: ‘don’t abuse your/the body’; manage your appetites (food, NHS services); play your required part. We can be as critical of the NHS as we can of our own bodies because it is *self*-criticism.

The living organism metaphor works well with the human body – its an easy translation – but another living organism might be better – the octopus. Its complex, distributed intelligence, ability to lose and regrow parts, and capacity for changing appearance are all visible the NHS system. Its three hearts more closely reflect the culture of the NHS than the single human heart does. Three hearts speak to Whitehall, Westminster and the frontline – a ménage à trois – in perpetual states of falling in and out of love with the concept of universal health care, (almost) free at the point of delivery. It is impossible to separate out the politics from the operational side of the NHS: like a body, it can only function as a whole.

How then do we understand the behemoth that is the NHS? What methodologies do we need to properly see and interpret its fluidity over more than seventy years? This enormous organisation, which now is the largest employer in the UK, is probably beyond the scope of the lone historian. It is a feat of Sisyphus to keep up with its constantly changing parts. The first generation of NHS historians were indeed ‘sole practitioners’. They approached the NHS from the foothills of Whitehall files, with occasional forays into studies of professional organisations and major clinical developments. This produced a specific type of history, relatively impermeable to either public understanding or engagement (that may be unfair: most academic historians before REF did not actively seek a wider reach of their work). Technological advances – digitisation of archives, the internet – have transformed opportunities for large-scale analysis, and opened up the possibility of co-production, both between historians, and between historians and the public. As patients have become informed consumers there has been a parallel surge in interest in understanding the whats, whys and whens of healthcare. This resonates with the emergence of an ‘interview society’; in which surveys proliferate, and ‘navel-gazing’ is increasingly accepted and sometimes encouraged. Oral history now reigns supreme and is adaptable to just about every aspect of the NHS – its workers and patients, births, deaths, innovations, scandals. Skilling up the public to not only *give* their histories, but also to *make* their histories, should result in better history – more accurate, more relatable. But it comes with risks when it is put to the service of supporting the NHS widely seen to be under threat. Our views may become coloured. What was it Bevan said? "I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one".[[4]](#footnote-4) Yet it is usually the smaller scale, local, aspects of NHS history that the public recall and value: the kindness of the individual nurse, the taste of the post-tonsillectomy jelly and ice cream. Yet these are subjective accounts; how do we value them in the bigger analysis of the NHS against the cold objective facts such as the size of waiting lists, QALYs, DALYs? Alongside biomedical authority on what makes for an efficient NHS organisation, what counts as credible historical evidence, and how should it be included within the policymaking process?

The very success of this new type of NHS history has created pitfalls. Many people feel they now ‘know’ the story of its creation. There is an easy familiarity with key names such as Beveridge and Bevan. In the conflation of campaigning and documentary-making in the service of ‘Keep our NHS Public’ or ‘Save Our NHS’, corners are cut and sound bites become sloppy. Trafford Hospital was not the first hospital in the NHS, it just happened to be the one chosen of the hundreds that were nationalised overnight on 5 July 1948 for Bevan to use for his photoshoot. Bevan did not say ‘The NHS will last as long as there's folk with faith left to fight for it’, but many people wish he had.

If one had asked in January 2019 ‘what’s the biggest threat to the continuation of the NHS’, few would have said a pandemic of a novel infection. Fears for the NHS in the ‘BC’ era were related to the under-the-counter deals with commercial contractors, the widening gap between resources and needs, the resilience of the workforce and looming impact of Brexit. The NHS’s COVID-19 experience has amplified these pre-existing concerns. NHS history during the pandemic has been both implicit and explicit: in comparisons with how previous pandemics were managed (usually better), and in projects to capture testimony – from staff, patients, relatives – of how the service has coped. If, as Susan Sontag so eloquently put it, we have dual citizenship in the kingdom of the well and the kingdom of the sick, thousands have spent more time in the latter since February 2020.[[5]](#footnote-5) COVID-19 has permanently shifted our perceptions of what the NHS is. It is no longer so clearly defined by its architectural fabric now that we are increasingly comfortable with receiving advice and care through our computer screens or mobiles. The easing of that long-held convention that clinician and patient need to be in the same physical space at the same time shakes fundamental cultural assumptions. It has enormous potential to improve the NHS’s efficiency, yet may also diminish its security, if we lose contact with those sights, sounds and smells – the waiting room, the chat, the whiff of anti-bacterial cleaning fluid. Some of these signifiers will remain, but in pseudo-NHS settings, as seen in large pharmacists who provide vaccination services. They have adopted, quite correctly, the reception desk procedures, the socially distanced chairs, the clinical uniforms. But it worries me that the blue NHS logo is placed so tightly alongside another well-known blue logo (different shade different font, but trading on the same public recognition and ‘trust’). Of course, this collaboration has been there from the start of the NHS, but COVID-19 has made it feel somehow more permanent; it would be hard to go back to the BC era. Do digital consultations and the creation of new NHS spaces outside the traditional hospital and GP practices also enable ‘divide and conquer’ of the NHS workforce? Will it diminish the sense of collective identity, or stimulate alternative ways to promote it?

COVID-19 has disrupted the foundations of the NHS, exposing ruptures between the core and the periphery, the workers and the commercial contractors, the state and the people. Our expectations have been shaken, and explicit historical comparisons have played a critical part in this. If clinical care continues to be given virtually (36% of NHS staff have worked from home), and the ‘temporary’ Nightingale hospitals with their private management become a permanent solution to crises, perhaps we should re-consider the NHS’s 72 years as an aberration in the longer history of a mixed economy of healthcare. As historians we should revisit our frameworks and methodologies, consider our collaborations, stand up our teams. I’m afraid, there is no NHS.

1. <https://www.england.nhs.uk/nhsidentity/identity-guidelines/nhs-logo/>. Accessed 25.10.21 [↑](#footnote-ref-1)
2. Ibid. [↑](#footnote-ref-2)
3. A “bed blocker” is shorthand for someone who is unable to leave hospital and return to their own home, even though they do not need medical treatment or care.’ See ‘What are Bed Blockers – and are they Signs of a Failing NHS?’, *OpenLearn*, 12 January 2017, <https://www.open.edu/> openlearn/health-sports-psychology/health/health-studies/what-are-bedblockers- and-are-they-signs-failing-nhs (accessed 28 October 2021). [↑](#footnote-ref-3)
4. Aneurin Bevan, speech in the House of Commons, Hansard, House of Commons, vol. 422, cols 43–142 (30 April 1946). [↑](#footnote-ref-4)
5. Susan Sontag, ‘Illness as a Metaphor’, *New York Review*, 26 January 1978. [↑](#footnote-ref-5)