Annex B

Public health and healthcare delivery task and finish group

Final report
Annex B

The BMA and the NHS: principles and professionalism

1 History
1.1 The BMA first produced proposals for a national health service in its document *Proposals for a General Medical Service for the Nation* in 1930. A further set of proposals, developing many of the themes from the 1930 publication, were put forward by the association in 1938 in a revised document, *A general medical service for the nation*. The BMA’s key principles were that:
   - The medical system should be directed to positive health and the prevention of disease
   - Every individual should be provided with a GP or family doctor of their choice
   - Consultant and specialist care should be available through the agency of the family doctor
   - The medical service should be closely coordinated and developed through a planned national health policy.

1.2 In 1948, with a national debt exceeding twice GDP, the British people pursued the health of the people as a social goal. The NHS deployed committed health professionals and health workers to support socially owned, publicly accountable organisations. Health would be improved by addressing the determinants of health and providing health care free at the time of use, provided according to need not ability to pay, planned to optimise resources, and financed by general taxation.

1.3 Thus was created an NHS universally admired as one of the best and most cost-effective health services in the world.

1.4 It is a just institution: none of us has to face the financial burdens of illness alone.

1.5 Each of those principles set out by the BMA in 1938 and implemented by Aneurin Bevan in 1948 is important:
   - A service which pursues health as a social goal rather than just providing health care
   - Leadership by professionals
   - Accountability to the people
   - Social ownership to avoid commercial influences
   - The planned optimisation of resources
   - Healthcare free at the time of use, provided according to need not ability to pay and financed out of general taxation.

1.6 Many politicians quote the last of these principles as if it were the whole of the principle of the NHS. This is a serious misunderstanding of the breadth and scope of the original vision and it does not capture anything like the full essence of an NHS.

1.7 The introduction of the NHS carried a wide consensus.

1.8 There was debate about nationalisation of the hospitals, a dispute about the mode of employment of doctors and deep disappointment at the failure to include workplace health in the NHS, but fundamentally Government, opposition, public and profession were united behind the principles the BMA had set in its proposals for an NHS in 1930.

1.9 The Conservative Party opposed the nationalisation of the hospitals. This was the main point of difference between the Conservatives and the Government at the time. A Conservative spokesman later admitted that Bevan had been right on this point.

1.10 There were disputes between the BMA and Bevan about the mode of employment of doctors. The BMA was anxious to maintain the clinical independence of doctors and not turn them into salaried civil servants bound to the instructions of Government. The independent contractor status of GPs and guarantees of freedom of speech, academic research and clinical judgment for consultants resolved that dispute.
1.11 It is sometimes said that in fighting for independent contractor status for GPs the BMA accepted a commercial model. This is wholly untrue. The businesses of general practice were nationalised in 1948 and the sale of goodwill in them remains illegal. The reason for the particular contractual model in general practice was to do with the maintenance of professional independence not any commitment to the commercial principle, which the NHS abolished.

1.12 Because of the dispute between the BMA and Government about the terms of employment of doctors in the NHS, it is often said that the BMA opposed the NHS. This is wholly wrong – the BMA had been advocating it for 18 years before its introduction, as set out in its 1930 document *Proposals for a general medical service for the nation* and its 1938 document, *A general medical service for the nation*.

1.13 The BMA proposals for an NHS had included workplace health and Bevan supported this but Ernest Bevin opposed it and it did not come to pass.

1.14 The principles laid down by the BMA in 1930 and implemented by Bevan in 1948 remain valid. The BMA and the British people still believe in a healthy society and a professionally led, patient-centred democratic health service.

1.15 Departures from that vision have damaged the NHS.

2 The health of the people as a social goal

2.1 In order to save the healthcare system from a rising burden of preventable ill health it is important to be able to address the causes of ill health.

2.2 This is one of the reasons the BMA was so disappointed that Bevan was unable to win the argument for workplace health to be part of the NHS. Had this battle been won it is possible that health and safety may have taken a less bureaucratic direction and that employment re-enablement may have been more focused and effective, thereby creating economic growth.

2.3 The NHS as established by Bevan did however have considerable potential to live up to his vision of a service that would improve the health of the people. The original NHS was tripartite, with three wings – the hospital service, general practice and the health departments of the local authorities. The local authority wing was responsible for public health and community health services.

2.4 In the first quarter of a century of the NHS the local authority health departments cleared the slums, cleaned the air and eradicated polio and diphtheria. The widespread statement that the NHS has never been geared towards prevention simply is not true.

2.5 In 1974 local government, one of three wings of the original structure, was separated from the NHS. This fragmentation of the health service made it difficult to address social and environmental determinants of health. Environmental health remained with local authorities but was no longer seen as part of the NHS. The rest of public health transferred into health authorities along with community health services and lost much of its potential to influence areas important to health and for the NHS comprehensively to pursue the health of the people as a social goal. This is where the idea that the NHS has never prioritised prevention has arisen – it has been true since 1974 as a direct result of the structural changes that were made then.

2.6 Although the changes in 2013 appeared to reverse the 1974 reorganisation, the creation of PHE alongside the transfer of former PCT functions to local authorities actually risks increasing the fragmentation of public health delivery.
2.7 Government terminology has arisen that no longer describes local government public health as part of the NHS, but of something called the ‘comprehensive health service’.

2.8 Until 2013 the term ‘the comprehensive health service’ was simply the legal term for the NHS. The two terms meant the same. When local government was part of the comprehensive health service from 1948 to 1974 it was part of the NHS. When it was removed from the NHS in 1974 it was removed from the comprehensive health service as well. The adoption of a terminology that distinguishes the meaning of the two terms was new in 2013. Had this terminology not been adopted, public health in local government and in PHE would still be regarded as part of the NHS.

2.9 This is not just a question of confusing terminology. It also has practical implications and affects the way we think about health.

2.10 The confusion caused is bad enough – few people will understand that public health in local government is not part of the NHS but is part of the comprehensive health service provided under the NHS Acts. But the public would be amazed to hear that when Government refers to ‘the NHS’ it no longer includes drug and alcohol treatment services, GUM clinics, school nurses or NHS health checks in that term and, from 2015, that it will not include health visitors either.

2.11 This also affects funding. In 2015/16 spending on PHE has been cut and spending on local government public health frozen in cash terms despite _The NHS five year plan_ emphasising the importance of prevention and the prime minister having stated that more money needs to be spent on prevention in a reply to a PMQ.

2.12 It also affects access to information. Public health departments can no longer obtain access to the NHS information systems, which are necessary for them to monitor the health of the people and discharge their statutory duty to give public health advice to NHS commissioning bodies.

2.13 It also affects access to a wide range of NHS support systems.

2.14 The impact on the way we think about health is just as important. If the NHS is just about treatment then that is where attention will be focused. To have a coherent health strategy we must once again start to think of the health of the people as a social goal not just as a commodity.

3 Medical professionalism at heart of the NHS

3.1 The year 1948 saw the creation of a health service based upon a collectively owned vision of which the BMA was a key driver. This was a service run by health professionals but accountable to local bodies — executive councils (overseeing family health services), hospital management committees and local councils running public health and community health services. These local bodies operated in a framework set by Parliament to whom the minister was accountable.

3.2 The recent history of the NHS has seen developments that have put the concept of a health service based upon and led by medical professionals under threat.

3.3 Medicine is a vocation. Doctors put their knowledge, skills, technical excellence and professional judgment at the service of human health and well-being. This involves considering patients’ needs holistically, preserving patients’ dignity at all times, developing a relationship of mutual respect with patients, actively involving patients in decisions about their care, and considering actions and options from a patient’s perspective.
For the health system to be most effective, doctors must be able to use their expertise to help shape that system for the benefit of their patients. In particular, if a system change is proposed, medical input to the development of options and decision-making is required to ensure the outcome is in patients’ best interests. System incentives that are perverse to patients’ best interests must be challenged. Medicine is an applied science related to the art of healing by diagnosis, treatment and prevention. To continue the growth of the science and improvement of its application on patients, doctors must be able to engage in and support clinical trials and medical research. Clinical input is vital to ensure safe, well-led and well-run health systems.

The promotion of inflexible target-setting can undermine the development and exercise of good clinical judgement, while the introduction of market-based reforms can undermine professionalism through the proliferation of conflicts of interest that can undermine the ability of doctors to focus on the best interests of patients.

From the 1990s onwards the NHS has progressively been subjected to market reforms that impose a commercial ethos even on those parts of the system which are socially owned. NHS foundation trusts, social enterprises and charities still have to act commercially to exist in this market.

The Health and Social Care Act 2012, building on previous market reforms that the BMA opposed, finally removed the idea of a service socially owned and planned to optimise resources, changing the NHS beyond all recognition.

Planning the allocation of resources according to need, rather than ability to pay, is a guiding principle of the NHS. Where this principle has not been followed, access to the service has been damaged. For example, although more than 90 per cent of all prescriptions are dispensed free of charge, the level of the charge can act as a barrier for those required to pay prescription charges. In particular, for those whose incomes are just above the levels required to trigger exemptions on the grounds of low income, the application of a prescription charge is disproportionate as under the current system patients are either exempt or must pay the full charge.

However, this is not the only threat to access. It is said that the NHS is safe if health care is financed out of general taxation and provided according to need. On that argument it would be safe even if not a single NHS hospital or general practice remained and commissioning had been passed to insurance companies. This redefines ‘the NHS’ to prepare the grounds for its dissolution.

Services need pulling together around the needs of patients but have been further fragmented by markets. Commissioners seek to contain costs but providers actively generate income. Commercial provision erodes the ability to co-ordinate services and plan patient pathways. We cannot afford further ideologically driven experiments in a free market.

Although the BMA supports the role played by commissioning, this should be based upon a holistic approach ensuring that service design places primacy on an assessment of need, defined as that which scientific evidence shows will improve health, and proceeding to design the services that best meet the needs of the people. Commissioners and providers should not be separate. There should be a network of professionals and support functions, with decisions taken by health professionals held to account by local people within overall frameworks set by Parliament.