Annex C

Public health and healthcare delivery task and finish group
Final report
Annex C

Relevant resolutions of the representative body

*Improving the population’s health (Section three)*

That this meeting recognises that scientific public health analysis shows that austerity damages both health and economic growth and:

i) recognises that such adverse impact on health is borne out by the clinical experiences of many doctors;

ii) calls on Government to take more account of this in its economic strategy. (2014)

That this meeting notes:

i) the findings of the Marmot review on health inequalities which found that those living in poorest areas live an average seven years less than those in the richest ones;

ii) that the Marmot report believes the provision of a good start for children, free from poverty, is the single most important recommendation it can make. (2012)

This meeting believes that child poverty is unacceptable at any level in one of the world’s richest countries and resolves to ask the governments across the UK to take action on this issue to ensure that it is addressed both in terms of policy and resources by the administrations in London, Edinburgh, Belfast and Cardiff. (2012)

That this meeting applauds the Marmot review: *Fair Society, Healthy Lives* and strongly urges the BMA to lobby Government to:

(i) take forward the recommendation that expenditure on preventative services increase;

(ii) increase the proportion of overall expenditure allocated to the early years to give every child the best start in life;

(iii) set a ‘minimum income for healthy living’;

(iv) adopt fiscal policies to narrow the income gap between our poorest and richest citizens. (2010)

That this meeting believes in the principle that work is good for health and well-being and recommends that doctors work closely with all interested parties to facilitate their patients’ safe and timely return to the most suitable and meaningful employment. (2010)

That this meeting requests the minister of public health to commission a series of independent reviews focusing on the health problems of society, and that these should be commissioned by a standing royal commission on public health. (2000)

That this meeting:

(i) recognises that health is determined not only by health services, but also by political, social, environmental and personal factors; and

(ii) calls for the development and wider use of health impact assessment in all public policy areas, both national and local. (1998)

*How the English NHS should work (Section four)*

1 Introduction

That this meeting deplores the heavy expenditure by successive Governments on repeated reorganisation of the NHS. (2012)

That this meeting believes that current and proposed reforms to the NHS in England are associated with significant and wasteful costs and:

(i) condemns the diversion of resources away from patient care and into reorganisation;

(ii) condemns the recent lengthening of waiting times for non-urgent care;

(iii) mandates the BMA to publicise the high costs of restructuring the NHS, and to continue to campaign for better use of resources;

(iv) calls upon the Government to address the underlying structural financial problems of the NHS before implementing NHS reforms. (2011)
2. Competition and the market

That this meeting is dismayed that private providers have won so many tenders for clinical services in the English NHS since the Health and Social Care Act came into force, and:
(i) believes the market in healthcare has led to fragmentation and waste with adverse implications for patient safety, quality assurance and training;
(ii) calls for the repeal of competitive tendering legislation;
(iii) calls for a patient-focused healthcare system based on collaboration, cooperation, transparency and accountability. (2014)

That this meeting recognises the NHS Act confers responsibilities on CCGs to promote patient involvement and choice and:
(i) believes these responsibilities take precedence over the NHS Procurement, Patient Choice and Competition (2) Regulations 2013;
(ii) instructs the BMA to publicly and privately lobby for the requirement for competitive tendering to be withdrawn from regulations applying to the NHS. (2014)

That this meeting calls for the restoration of the statutory responsibilities of the Secretary of State for Health to secure and provide universal healthcare. (2014)

That this meeting exhorts the BMA to assert its pride in the NHS and promotes it as the preferred provider of healthcare services. (2014)

That this meeting congratulates the chair of council on his call to action on the crisis in the NHS. We look to council and all representatives to get behind the practical delivery of the chair’s message. (2014)

That this meeting believes that commercial healthcare providers have profit as an overriding aim and opposes any further moves towards privatisation of the NHS;
(i) asks that the BMA consider how best to ensure consistent quality of patient care in a market-driven system;
(ii) calls for the NHS to be the preferred provider, with proper integration and collaboration between primary and secondary care;
(iii) applauds those administrations which have chosen to avoid competition driving their healthcare systems;
(iv) calls on the BMA to work with the public and other stakeholders to defend the NHS. (2013)

That this meeting believes that, in respect of commissioning and tendering for services, the following principles must apply:
(i) quality should be at the heart of all NHS contracts;
(ii) before transfer of services to primary care, commissioners should ensure that the necessary infrastructure, governance, capacity and resources are in place;
(iii) imposed conditions of commercial confidentiality are unacceptable;
(iv) local NHS organisations should be regarded as preferred providers and alternative providers should be sought only if local organisations are unable or unwilling to improve services to the required standard;
(v) an impact assessment on local NHS services must be considered as part of any decision to tender for alternative providers;
(vi) ‘cherry picking’ must be prohibited. (2012)

That this meeting recognises that the private sector cherry picking local services will compromise the future viability of local hospital trusts. (2012)

That this meeting calls on Parliament to amend clause 1 of the Health and Social Care Bill to ensure that the health secretary remains fully accountable for the provision of services, albeit with that function delegated to the National Commissioning Board and Commissioning Consortia. (2011 special representative meeting)
That this meeting believes that the proposed prime duty of Monitor in clause 52 of the Health and Social Care Bill of promoting commercial competition in the NHS must be secondary to a duty to maintain and extend a cooperative healthcare system. (2011 special representative meeting)

That this meeting requires that the Government legislates to enable NHS providers to become preferred providers in the NHS, with the use of non-NHS providers only when a service is of inadequate quality, insufficient capacity, or not available on the NHS. (2011)

3 Commissioning
That this meeting notes with concern the proposal for commissioning support units to become separate entities in 2016 and call for any support functions for CCGs to remain in the NHS. (2014)

That this meeting recognises the NHS Act confers responsibilities on CCGs to promote patient involvement and choice and:
(i) believes these responsibilities take precedence over the NHS Procurement, Patient Choice and Competition (2) Regulations 2013;
(ii) instructs the BMA to publicly and privately lobby for the requirement for competitive tendering to be withdrawn from regulations applying to the NHS. (2014)

That this meeting believes that combining all sectors of care into health maintenance organisation-style bodies would harm patient care and should be actively resisted. (2014)

That this meeting, in respect of commissioning by CCGs believes that:-
(i) CCGs should be locally accountable not centrally directed;
(ii) CCGs should have freedom to commission services in ways that best meet the needs of their populations;
(iii) CCGs should have autonomy on the procurement of services for their patients;
(iv) CCGs should be entitled to review the commissioning decisions of their predecessor PCTs;
(v) the BMA should monitor interference with and challenges to CCG decision-making;
(vi) if CCGs are prevented from making decisions in the best interests of patients, the BMA should consider balloting GPs on withdrawal from engagement with CCGs. (2013)

That this meeting believes that doctors in practices, community organisations and local hospitals should be encouraged to work together and not be driven apart because such collaboration is deemed anticompetitive. (2013)

That this meeting notes with concern that commissioning for addictions services is moving under public health rather than CCGs. Addictions have widespread health implications and cannot be sidelined or separated away from medical services in primary and secondary care. This meeting calls on the BMA to lobby for addictions services commissioning to come under the remit of CCGs. (2013)

That this meeting, in respect of clinical commissioning support services (CSS), believes:
(i) (as reference) that the outsourcing of CSS should be halted until there is transparency about how the CSS will prioritise patient services and promote collaboration;
(ii) that safeguards are needed to protect patients from vested interests;
(iii) that CSS should be selected by commissioners without external pressure;
(iv) that CSS should not be forced to become non-NHS organisations;
(v) that commissioners should not be forced to outsource commissioning support to private companies. (2012)

That this meeting supports the principles of clinician-led commissioning with increased medical participation in the organisation and delivery of NHS care for the benefit of patients and believes that this could be achieved without the need for further legislation. (2011 special representative meeting)

That this meeting believes that successful and effective commissioning can only occur through close collaboration between GPs, hospital doctors and public health doctors. (2011 special representative meeting)
That this meeting believes that the Health and Social Care Bill should ensure that, in carrying out commissioning functions, GP commissioning consortia must:

(i) act in a transparent, fair, evidence-based manner;
(ii) take account of advice from all medical specialties, patients and the public;
(iii) take into account clinical need, equity, quality of care, cost-effectiveness and the effect of clinical pathways on research, education, training and the sustainability of the health economy;
(iv) be permitted to encourage collaboration between commissioners and current local providers to develop integrated services, without being accused of anticompetitive behaviour;
(v) commission, as a minimum, a national set of core services which ensure appropriate care for patients wherever they live. (2011 special representative meeting)

That this meeting believes that successful commissioning requires the close collaboration and support of doctors from across the profession. (2011)

That this meeting:

(i) believes that successful commissioning requires decisions to be based on population health needs and calls for public health support to be available to commissioning consortia;
(ii) is opposed to the privatisation and fragmentation of the NHS into a multitude of competing providers with the potential to destabilise pivotal hospital services and insists that commissioning bodies should be required to use local NHS services as their preferred provider, unless the local NHS services cannot provide the services or capacity required;
(iii) calls upon the BMA to ensure that there are appropriate safeguards to prevent local variations in care leading to a ‘postcode lottery’ and that patients are treated equitably. (2011)

That this meeting insists that:

(i) NHS providers should be supported and developed and have ‘preferred provider’ status in delivering NHS care to NHS patients;
(ii) the private sector should be used to treat NHS patients only in the interim where there is insufficient capacity in the NHS. (2008)

4 Funding

That this meeting:-

(i) notes the enormous burden of PFI debt that threatens to sink the NHS;
(ii) demands that Government legislates to rescind all NHS PFI debt;
(iii) demands that Government does not enter into any new PFI scheme. (2014)

That this meeting believes that PFIs continue to be a drain on the public purse and demands that:

(i) Government directly fund new NHS capital projects;
(ii) Government renegotiate PFI contracts to ensure a better deal for the taxpayer;
(iii) Government enables existing PFI schemes to be bought out by the NHS. (2013)

That this meeting maintains its opposition to the system of PbR because it:

(i) does not reflect the true relative cost of treatment, which is resulting in erroneous funding to providers;
(ii) creates inherent perverse incentives with consequent behaviours that damage patient care;
(iii) creates division between primary and secondary care, using patients as financial pawns;
(iv) is resulting in bureaucracy and transaction costs which increases expenditure on administration rather than on patient care;
(v) is in conflict with the Government vision of ‘care closer to home’;
(vi) places an unnecessary burden on primary care. (2010)

That PbR is a payments tool facilitating a health policy of fragmenting care into saleable bits on which a profit can be made. It disadvantages NHS units providing complex and comprehensive care. This meeting calls on the BMA to oppose payment by results. (2007)
That the BMA should vigorously oppose PbR as currently proposed because:
(i) low-cost private treatment centres will cherry pick uncomplicated cases and leave more complex cases to comprehensive NHS hospitals;
(ii) NHS trusts are threatened by diverting funds to the private sector;
(iii) strategic planning of health services based on need will be undermined;
(iv) it will increase bureaucracy and management costs. (2005)

5 Integration
That this meeting recognises fragmented care is not in the best interests of patients and contributes to unnecessary pressure on front line services and:
(i) believes the BMA should proactively define and develop proposals for integrated models of care and resourcing systems;
(ii) believes any definition of integrated care should include in its scope both primary and secondary care;
(iii) believes any definition of integrated care should include social care within its scope. (2014).

That this meeting:
(i) (as a reference) believes that NHS mental health services are lagging behind NHS acute services in setting standards of patient care;
(ii) is concerned by the inappropriate admission of adolescent mental health patients to adult medical wards;
(iii) recognises that patients with dual psychiatric diagnoses often receive substandard care;
(iv) demands more integration of social and NHS care in mental health services;
(v) calls on Government and commissioners to rapidly rectify these issues. (2013)

Public health services delivery (Section five)
That this meeting urges the DH to ensure that funds are ringfenced by the local authorities for public-health work. (2014)

That this meeting believes that public health is the foundation for a healthy society and implores the BMA to ensure that the work of public health professionals is valued and supported. (2014)

That this meeting notes recent criticism of PHE that as part of the DH it is insufficiently independent. This meeting calls on the BMA to:
(i) lobby for greater autonomy and independence for PHE;
(ii) specifically, PHE doctors should not be bound by the Civil Service code of conduct or any similar civil service regulations. (2014)

That this meeting urges the DH to ensure that funds are ringfenced by the local authorities for public-health work. (2014)

That this meeting urges a clarification and strengthening of the role of health authorities’ directors of public health within local authorities. (1998)

That this meeting believes that directors of public health should always be ex-officio executive members of health authorities. (1991)

That this meeting believes that public health doctors have a key role in supporting effective practice-based commissioning, and is dismayed by the lack of reference to public health doctors in Government commissioning guidance. (2009)

That the BMA should pursue a policy with regard to public health medicine that ensures that this small specialty does not become fragmented between health authorities and trusts and maintains the integrity of, and a national structure for, public health medicine. (2001).
That this meeting firmly believes that the plans for public health services should:
(i) recognise the role that public health doctors and staff play in advising on healthcare needs, service planning, commissioning, quality and effectiveness;
(ii) ensure the public health function is not split to avoid fragmentation and disruption of services and loss of valuable experienced staff;
(iii) create a single NHS public health agency in England including specialists in all three domains of public health practice – improving services (including support to commissioning) health protection, and health improvement;
(iv) ensure that public health professionals are employed on NHS terms and conditions of service;
(v) ensure that the budget will be held centrally by PHE and deployed directly to directors of public health as local leaders for health improvement;
(vi) ensure that during any changes, public health capacity is not reduced so as to maintain the existing comprehensive arrangements for health protection. (2011)

That this meeting:
(i) asks the health departments to acknowledge that public health physicians have an essential role in commissioning;
(ii) welcomes the opportunity for public health doctors to work with GPs in implementing practice-based commissioning (PBC);
(iii) urges the health departments to insist that primary care organisations include dedicated public health support within all commissioning structures to ensure that clinical interventions and services are effective, cost-effective and of high quality. (2007)

This ARM notes the decision of the Coalition Government to have a separate funding stream for public health and a new public health delivery system. It notes that the format of that system is currently under discussion. If this proposal is implemented this ARM insists:
a) NHS commissioning and public health strategies each require both public health and clinical input;
b) directors of public health should be legally recognised as advocates for the health of a defined population;
c) it should be explicit what is and what is not covered by the new public health funding stream;
d) appropriate areas of local government expenditure, such as funding for the new community organisers, should also be transferred to the public health funding stream. (2010)