Written evidence submitted by Dr Michael Lambert (FGP0269)

Profile and Reason for Submission

I am an academic historical sociologist of the welfare state and social policy in twentieth century Britain specialising in governance and policy processes. My approach has been to develop multi-layered complex small-scale local or regional case studies to understand these dynamics at both comparative and national levels.

In 2017 I completed my doctoral thesis on decision-making in local authority social services (primarily children and families) in the North West of England from 1943 to 1974, funded by the Economic and Social Research Council (ESRC) at Lancaster University.[1] This research has informed several associated publications.[2] Based on this expertise, I was subsequently commissioned to undertake research for The Prince's Trust concerning the child migration policies and practice of the Fairbridge Society as part of the Scottish Child Abuse Inquiry.[3]

From 2017 to 2019 I was a Research Associate on the Governance of Health project at the University of Liverpool funded by the Wellcome Trust. Here, with colleagues, I was involved in producing several elite witness seminars on different policy issues within the NHS (National Health Service) over time.[4] My strand of the project examined decision-making in the NHS in Liverpool and the city region from 1948 to the present, and as part of this I have a forthcoming book with Liverpool University Press examining governance and policy issues – encompassing primary, secondary and tertiary care – in the NHS on Merseyside from 1978 to 1996.[5]

Since 2019 I have been a Postdoctoral Fellow in Social Inequalities at Lancaster University, with a research focus on the centrality of care to global understandings of, and developments of alternatives to, social and economic inequalities. Here, I have consolidated my existing research interests through a series of applied case studies on 'learning' from history in health and social care services. This has covered general practice, inequalities, and change over time for practitioner audiences,[6] and broader political and national governance dilemmas for general audiences.[7]

Across each of these appointments I have regularly submitted evidence to a range of Parliamentary Committees and external inquiries relating to 'learning' from history in the organisation and delivery of health and social care services. These include the Public Accounts Committee,[8] Health and Social Care Select Committee,[9] the Housing, Communities and Local Government Select Committee,[10] and the Joint Committee on Human Rights.[11]

This submission builds on this experience of using robust archival and oral history research to 'learn' from history in order to think about the constraints imposed by the past on the future of general practice.

1. Executive Summary

1.1. The past does not determine the future of general practice, but its future cannot be free from its influence. These cumulative histories have opened, or in other cases closed, the horizons available to the future of the landscape of British general practice. There are three thematic areas to which this applies: vocational; organisational and relational.

1.2. **General practice has traditionally been imagined as a vocation rather than a profession**, with its own distinct identity rooted in the places it is practiced, the people it served, and the relationships forged which give meaning to family medicine and primary care. Changes in working practices from a cottage industry practiced by artisans, through collections of small businesses,[12] to an industrial concern staffed by proletarians, what Steve Iliffe terms the 'industrialisation of family medicine',[13] have altered not only what general practice is, but also its vocational image.

1.3. The political attention given to general practice and primary care at key junctures of change in the NHS over time has been significant, not least because of the influence of the British Medical Association (BMA)[14], but this has been more limited in mundane organisational administration. **It is only with rising costs that significant political intervention into the organisation of general practice was undertaken**. The speed, scale and pace of these changes leaves general practitioners (GPs) as independent contractors caught between both commissioning and providing roles, cast adrift from wider structural changes.

1.4. The work of GPs as the frontline of primary care cannot be understood in isolation from the wider NHS system. Changes in working practices, policies, processes or populations among one impacts upon the other. This applies at national, regional, and local levels. **The future of general practice is inseparable from that of the wider NHS system, and its associated partners including community and mental health services, and social work and care**.

1.5. History does not repeat but it rhymes. We cannot derive decontextualised lessons from the past which can be readily applied to the present. Instead, it offers learning opportunities, showing how and why issues have emerged, embedded, or been eclipsed over time. These experiences continue to shape the NHS through to the present.

2. General Practice as Vocational

2.1. The distinction between general practice as a vocation, rather than a profession, can still be seen in the route into primary care through medical education. The GP Vocational Training Scheme (VTS) is the label given to the post-qualification pathway for doctors seeking to become GPs upon completion of their Foundation Year. Doctors moving into the hospital sector, and eventually consultants, embark upon a range of specialty pathways. This represents a deep division within British medicine, even with the growing specialisation found in general practice, and the community orientation of many specialisms. This division existed prior to 1948 and is immediately recognisable in how services are organised today.

2.2. The historical division in British medicine between GPs and hospital consultants is one based on class. Following medical registration in 1858, qualified doctors unable to live without other means were compelled to survive by their trade, working on a fee basis. Those who could rely on other support could obtain appointments to prestigious voluntary hospitals where they could subsequently develop a private practice amongst the middle and upper classes. This division in British medicine has remained entrenched in subsequent policy changes opening access to services for patients in 1911 with NHI (National Health Insurance) and the establishment of panel doctors, and 1948 with the creation of the NHS.[15]

2.3. Despite subordination to hospital medicine, general practice has developed a distinct vocational identity based on service to place, its people, and their primary care needs. The enduring image of general practice under the NHS can be found in John Berger's *A fortunate man*, painting a portrait of a medical man singularly committed to his community, working day and night and knowing his community inside out.[16] Whilst not capturing the realities of general practice at the time– overwork, lack of resources, poor clinical facilities, limited ancillary or support staff, and often acrimonious relations with other colleagues[17] – the idealised image of a general practice as the beating heart of his community persists. Indeed, it could – and was – reinvented for the deprived urban inner cities of deindustrialising Britain through the entrepreneurial spirit of its practitioners.[18]

2.4. Changing working practices and practitioners since Berger's *A fortunate man* was published in 1967 have altered the vocational character of general practice. Practitioners have joined in partnership, serving larger geographic areas and patient populations, work in health centres rather than splendid isolation from their living rooms, and often serve larger communities than the village idyll of Berger.[19] Moreover, given the professional subordination to hospital medicine, general practice has also been shaped over time by doctors from South Asia and latterly, by growing numbers of women practising part-time around families.[20] Enduring workforce shortages, particularly in certain places and spaces,[21] coupled with a reduction in overwork through working time regulations,[22] have all eroded the potential to maintain – if it ever existed – the vocational character of general practice.

2.5. The transformation has been likened to the experience of industrialisation in the health economy. GP Steve Iliffe likens the experience to moving from a cottage industry practiced by artisans, recognisable in the portrait offered by Berger, to working in an industrial concern as a proletarian, whose utility was measured by time and output framed around mass production rather than bespoke crafts.[23] This has been echoed by an intellectual luminary in general practice, John Fry, who – writing at the cusp of these changes – noted that during his career there had been a move away from cottage industry into small business within the sector.[24] Ultimately, the industrialisation of family medicine – shaped both by working practices and the environment in which they operate –

has rendered the vocational vision of general practice depicted from the inception of the NHS beyond reach.

3. General Practice as Organisational

3.1. The changing vocational of general practice has not occurred in a vacuum but has been shaped by its organisation within the NHS and the health economy. Despite reforms, the organisation and administration of general practice in Britain by 1990 would be recognisable to those practicing in 1911. The structure was threefold. Firstly, that general practitioners were independent contractors rendering certain services to the patient on behalf of a payment or insurance organisation. Secondly, that the payment organisation remained an actuarial body largely unchanged from 1911 with Local Insurance Committees (LICs) accountable to the NHI Commission; through Executive Councils (ECs) with the inception of the NHS in 1948; to Family Practitioner Committees (FPCs) created in 1974 until they were replaced in 1990 by Family Health Services Authorities (FHSAs) which took a more active role in managing GPs and creating primary care. Thirdly, these entities – LICs, ECs, and FPCs – were firmly corporate in character with senior local GPs and other leaders taking the primary role for contracting and arranging services alongside local NHS officials. This image is widespread among the established literature: one of the marginalised position of general practice, subordinated financially and organisationally to acute hospital medicine.[25]

3.2. The marginalised position of general practice in terms of mundane organisational administration, leaving it unchanged throughout most of the twentieth century, must be contrasted with the prominent political attention given to general practice and primary care within the NHS at key junctures of change. The endurance of organisational arrangements is a testament to the mobilisation of the professional interests of GPs within the NHS at a national level, namely through the BMA. [26] It was only with rising costs of services, largely through therapeutic medicines and pharmaceutical products which constituted the bulk of prescriptions, that general practice obtained political interest.[27]

3.3. With the institution of an internal market within the NHS in 1991, between providers and purchasers of health services, GPs increasingly occupied an uneasy position between the two roles which has never been transcended. FHSAs began the shift from the administration of services to their management, instituting performance measurements, targets, quality outcomes and medical audit.[28] This, combined with GPs becoming fundholders served to blur and complicate the boundary,[29] which had historically preserved through the division in British medicine, which was reified in its organisational distinction between structures managing primary and secondary care.

3.4. This ambiguous position has never been resolved across a series of organisational reforms. The creation of Primary Care Groups (PCGs) in 1998 alongside Health Authorities (HAs), and their replacements with Primary Care Trusts (PCTs) from 2003 solidified this uncertainty. This entity sought proximity to population as the best means of informing purchasing decisions whilst also centralising and rationalising the organised delivery of family medicine as a consequence.[30] This was part of a push towards a primary-care led and managed NHS[31] which was overturned in 2013 with the abolition of PCTs and their replacement with Clinical Commissioning Groups as an effort towards more GP-led purchasing decisions as an explicit policy orientation.[32] These have been, in turned, replaced by smaller Primary Care Network (PCN) footprints of practice mergers and patient coverage subsumed within Integrated Care Systems (ICSs) in the latest ongoing reforms where place is primary, rather than primary care leading health services.[33]

3.5. Each of the above mentioned approaches – fundholding, practice or partnership, purchasing, organisational management as a primary care authority, population commissioning, GP-led commissioning and primary care networks in conjunction with other actors – were all posited as

alternative futures for general practice in an edited collection published in 1996.[34] The introduction to the series of which the book forms a part by Pat Gordon of the King's Fund, opens:

> From a position of neglect and invisibility, primary care has shot to the top of the NHS policy agenda. This has much to do with the NHS reforms and the drive to control public spending. Like all industrialised nations faced with ever-increasing costs in health care, we are experimenting with reorganisation.[35]

This process of 'experimenting with reorganisation' has never ceased since the time of writing, with recurrent organisational changes impacting primary care far more than secondary. It also speaks to the same set of challenges at a political level about general practice which have re-emerged as a consequence of the Covid-19 pandemic.

3.6. The speed, scale and pace of organisational changes at the cusp of this inquiry leaves GPs still as independent contractors in a recognisable form stretching back more than a century. However, this form has never had a certain position within the new NHS created by an internal market of one form or another. Caught between commission and providing roles, and remaining adrift from wider structural changes in the NHS which have occurred concurrently with those in primary care, the reorganisational churn in general practice continues owing to enduring political uncertainty over how to position *general* practice in a *specialised* system.

4. General Practice as Relational

4.1. The view of GPs as the 'gatekeeper' to the rest of the health system,[36] as 'a screen and protector of expensive hospital services',[37] or occupying the 'key position' in the health economy,[38] is remarkably persistent across the history of NHS from 1948 to the present. General practice is the frontline of primary care services which shapes access or demands on other areas, provides the first and ongoing point of contact, and services as a significant point of contact for wider advice and support on health beyond services. The work of GPs as an integral part of this wider system cannot be understood in isolation from the rest of the NHS and other individuals and agencies involved in the organisation and delivery of other primary, secondary, tertiary, community, and mental health services.

4.2. Changes in working practices in any area of the NHS have the potential to impact on the work of general practice, and the reverse is also the case. Although its exact relationship is contested, there is a clear connection between timely and accessible forms of primary care provided by general practice and demands upon accident and emergency hospital services.[39] Equally, although again contested, general practice provides the primary point of contact for individuals experiencing mental health issues and serves to shape demands on associated services.[40] Both of these relations – with acute hospital and mental health services – have been heightened during the course of the ongoing Covid-19 pandemic.[41] Yet they are historically embedded in the relational organisation and practice structures of the NHS and modern medicine in Britain.

4.3. Changes in policies, processes of constituent patient populations across different areas of the health and social care system also impact others. For instance, beyond links with the NHS, general practice has also provided a principal point of contact for concerns about children at risk of harm or neglect, and in turn as a source of referral to other agencies working with children and families.[42] Recent and historic serious case reviews attest to this significance.[43] These experiences also point to changes in services and practice organisation with access to third sector and other support and advice for patients, the development of social work teams operating from and with general practice, and engagement with case conferences as a means to identify and tackle these attendant problems.[44] These have also been impacted by the ongoing Covid-19 pandemic,[45] point to the exacerbation of underlying relational processes under almost unprecedented strain.

4.4. The relational dimensions of general practice outlined in 4.3 also vary by place, and there are significant inequalities between access to primary care, its form and quality of delivery, relationships with other elements of the health and social care system, and the outcome for patients.[46] Although tempting to see these as emergent, immediate and new crises brought by the experience of working and managing a pandemic, they are deeply rooted in historic relationships in the organisation and delivery of care which are as recognisable in 1911 as 2021.[47] Areas with few GPs still have few GPs. Areas with deprivation still live in significant disadvantages compared to more affluent locations. Certain populations, especially those in the greatest need, remained under-served. Indeed, Julian Tudor-Hart's inverse care law – that is, areas with the greatest need have the fewest resources to meet such demands – remains as recognisable in 2021 as 1971.[48]

4.5. The future of general practice cannot be disentangled from its relationship to the wider health and social care system, but especially with other facets of the NHS health economy. These relationships are historically rooted, with changes in working practices or resourcing in one area impacting those of another, shifting the burden of care or costs. These exist across practices, policies, processes and patient populations. In short, the future of the NHS is inseparable from wider

changes, and should not be treated in isolation from the wave of significant reorganisations in service structures through ICSs, and review of leadership with the forthcoming Messenger Report.

5. Conclusion

5.1. The past shapes, but does not determine, the futures open to general practice under review by this Health and Social Care Committee. The horizons open have been formed by the previous landscapes determined by decision-makers, practitioners, and patients. These enduring issues can be seen as vocational, organisational, and relational.

5.2. General practice has traditionally been idealised as a **vocational** calling distinct from the rest of medicine, which has been formed as a more hierarchical profession. GPs have their own distinct identity rooted in the places they practice, the people they serve, and the relationships formed with patients. The industrialisation of family medicine has eroded this vocational ideal in theory and practice, with GPs largely dispensing a range of pathways to care rather than caring for patients. This historic ideal never wholly existed, and cannot be recaptured or rediscovered, but exerts a continuing appeal on the general practitioner imagination.

5.3. General practice has historically been subordinated at an **organisational** level to the delivery of acute secondary and tertiary hospital services. This is because of their greater prestige, higher costs, and domination of the national political and administrative agenda of organising health services. The organisation of primary care remained largely unchanged throughout the twentieth century from 1911 to 1990, leaving GPs as independent contractors. The creation of an internal market and a purchaser-provider split brought primary care rapidly onto the centre of the political agenda, but their ambiguous position between both commissioning and delivering care in a bifurcated system remains unresolved.

5.4. General practice has often been undertaken in splendid isolation by single-handed practitioners working from repurposed houses, but it is fundamentally a **relational** facet of the health and social care system. Changes in working practices, policies, processes or populations in one area of the health and social care system impact upon the other. This applies at the granular practice and local levels, but also regionally and nationally. These changes are not new or emergent but deeply rooted, historical, and have accumulated over time. The future of general practice is inseparable from the wider NHS system and its associated stakeholders in social work, care and population health. Wider systemic upheavals can and will impact on primary care, and a more holistic approach is necessary to overcome historic separation.

5.5. History rarely repeats first as tragedy then as farce, usually it rhymes. Simple off-the-shelf lessons detached from context and the circumstances which gave rise to them cannot be drawn from the past. Instead, history offers the ability to take learning opportunities in decision-making, showing how and why issues have emerged, become embedded, or been eclipsed over time. These underlying historical themes of general practice as vocational, organisational, and relational, should be at the forefront of any concerted effect to determine the future of general practice which is fit for purpose in the twenty-first century.

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[9] Michael Lambert, 'Written evidence submitted to the Health and Social Care Committee Inquiry into Delivering Core NHS and Care Services during the Pandemic and Beyond', May 2020. Available from: https://committees.parliament.uk/writtenevidence/2721/pdf/.

[10] Michael Lambert, 'Written evidence submitted to the Housing, Communities and Local Government Committee of Inquiry into the Funding and Provision of Local Authorities' Children's Services', March 2019. Available from: https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/housing-communities-and-local-government-committee/local-authorities-childrens-services/written/93900.pdf.

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