1

Consideration of history
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Topics covered:

- Introduction
- Why is this relevant?
- Brief history of the National Health Service (NHS)
- Historical development of the ambulance service in the United Kingdom
- Modernization of ambulance services
- Professional registration and regulation
- Conclusion
- Chapter key points
- References, suggested reading and useful websites

Introduction

The NHS has distinct differences from any other health service anywhere in the world. It is important for any healthcare professional to have an understanding of how the NHS developed and the circumstances surrounding its emergence. An appreciation of the planning, main figures and the battles fought to achieve the service that we are part of today is important to provide us all with a sense of history and to uphold the intended principles of the NHS. Today, the NHS cares for over one million patients every 36 hours (NHS Confederation 2007a). The sheer scale of the NHS is remarkable and has a fascinating historical development. As with any organization of this magnitude, it does not always get everything right; the consequences of mistakes in the NHS can be catastrophic and sometimes the difference between life and death.
Why is this relevant?

The development of ambulance services is one aspect of NHS provision today; the emergence of ambulance services as a main provider of care to the population is interesting. The NHS is an expanding organization: since 2000 the number of frontline staff has risen by 21 per cent. This rise includes a 21 per cent increase in doctors, 25 per cent increase in nurses and 17 per cent increase in ambulance staff (NHS Confederation 2007b). An understanding of developments in education, role development and professionalization are important to any student or qualified practitioner, in order that they can impact on the future of their profession.

Brief history of the National Health Service (NHS)

On 5 July 1948, a date of significant importance to all residents of the United Kingdom (UK), the National Health Service was launched. Its aim was to provide people in need with a range of health services. The history of the inception of the NHS is an interesting mix of legislation, power, negotiation and collaboration. In order to trace a brief overview of events leading to 1948, it is perhaps wise to discuss events up to one hundred years before.

Hospitals date back to medieval times: St Bartholomew’s and St Thomas’s in London were formed in 1123 and 1215 respectively, by religious foundations. It was not until the thirteenth century that further building of hospitals occurred. Records show that even this early, three distinct types of doctor emerged:

- physicians – elite doctors with university-based training;
- barber-surgeons – a guild-organized apprenticeship;
- apothecaries – developed from shopkeepers who provided basic medical care and administered drugs. The original ‘general practitioner’ (GP).

Most hospitals at this time had religious connections, so the dissolution of the monasteries by Henry VIII in the sixteenth century had a huge impact on their survival. Within London, only St Bartholomew’s, St Thomas’s and the Bethlem survived this period of history. Further hospital building did not occur until the eighteenth century.

It is also interesting to note that until the eighteenth century childbirth remained the domain of midwives and women only. Edwin Chadwick championed the public health movement and campaigned for the improvement in adequate water supplies and sewerage systems (Ham 2004). In 1848 the Public Health Act led to further Acts and eventual appointment of a medical officer for health in 1872. The Medical Act of 1858 aimed to regulate medicine and at this time a national register of qualified medical practitioners was established.

Once hospitals had been built, the nineteenth century saw more radical specialization of doctors and with them developed specialist hospitals, many of which are still evident today. Prior to the second half of the nineteenth century, workhouses had provided relief and care for the poor, as the voluntary hospitals were more concerned
with the acutely ill (perhaps as a result of doctors specializing) and refused admission to the more chronically ill and those with infectious disease. Consequently, workhouses were often overcrowded and were the source of many outbreaks of illness.

Stop and think – What are the specialist hospitals in your region? Do you know the history of them?

| 1123 | St Bart’s formed created |
| 1215 | St Thomas’s formed |
| 1300s and 1800s | Building of hospitals |
| 1848 | Public Health Act |
| 1858 | National register of Medical practitioners |
| 1867 | Metropolitan Poor Act passed |
| 1868 | Poor Law Amendment Act |
| 1929 | Local Government Act |
| 1942 | Beveridge Report |
| 1944 | White Paper for NHS proposals |
| 1946 | NHS Act |
| 1948 | NHS |

Figure 1.1 Timeline demonstrating the development of the National Health Service

In 1867 the Metropolitan Poor Act was passed and public infirmaries were created, separate to the existing workhouses. This was made law first in London and then across the country through the 1868 Poor Law Amendment Act. This is a key moment in English social history, as it was the first time the state had accepted its duty to provide hospitals for the poor (Ham 2004). Further steps towards today’s NHS were made with the passing of the 1929 Local Government Act. This Act superseded the Poor Law and made local authorities responsible for workhouses and infirmaries, as with other public services, all under the control of medical officers of health. The latter end of the nineteenth century also saw a more marked separation of community services, led by GPs and hospital-based specialists.

The outbreak of the Second World War led to public hospitals with a wide range of general and specialist services joining the voluntary hospitals in the Emergency
Medical Service (EMS). This enabled coordination of services and resources to support the war effort. The framework for administration of hospitals after the war was taken from the regional organization of the EMS. At this time the government announced plans to develop a National *Hospital* Service. In 1942 the Beveridge Report on Social Insurance and Allied Services recommended extension of the social security system and other reforms. In addition, proposals for a National *Health* Service were included, adding weight to the government’s proposals.

A White Paper in 1944 outlining NHS proposals was made, with the NHS Act following in 1946 and the creation of the service in 1948. The name Aneurin Bevan (Labour government Minister for Health after election victory in 1945) is synonymous with the creation of the NHS and he was involved in prolonged negotiations with the medical profession prior to 1948. Ham (2004: 14) states that the medical profession fought strongly for its own objectives, namely:

- retention of the independent contractor system for GPs;
- the option of private practice and access to pay beds in NHS hospitals for hospital consultants;
- a system of distinction awards for consultants, carrying with it large increases in salary for those receiving awards;
- a major role in the administration of the Service at all levels;
- success in resisting local government control.

Bevan had in fact divided hospital doctors (by providing financial incentives) from their GP colleagues (he reduced their power and isolated them), and in doing so reduced the total power wielded by the medical profession. The GPs did eventually achieve many of their aims, though. Had Bevan not chosen to adopt this approach, maybe the process of establishing the NHS would have taken even longer. Many doctors wanted the NHS to provide for only 90 per cent of the population. Bevan personally persuaded the profession that the service should be totally inclusive: we can see that he succeeded. Since its inception, the NHS has undergone many changes, but the way it is funded, mainly out of general taxation with insurance contributions only making up a small part of the total money required, is the same today as Bevan and other influential colleagues had planned prior to 1948. Many of the proposed keystones of the NHS still remain today.

Knowing the background to the processes involved in the creation of the NHS should enable ambulance clinicians to have more understanding of the history of the service within which they work. Exploring history very often provides explanations...
of the way things are today, so it is also important to explore the history of the ambulance service.

**Historical development of the ambulance service in the United Kingdom**

**Worldwide**

As an emergency service, the ambulance service is relatively young, being pre-dated by fire and police services by many years. The use of dedicated ambulance transport as a means of providing some clinical care in the field and transporting the injured to a place for further treatment can be traced back to the Napoleonic era when in 1793 Dominique-Jean Larrey (1766–1842), a bright young surgeon in Bonaparte’s army, first utilized light horse-drawn carts as ‘mobile field hospitals’, to move and treat the injured on the battlefield. The corps of nurses and surgeons who operated this early system became known as ‘ambulance volante’, meaning flying ambulance (Robertson-Steel 2005). This and other developments earned Larrey favour with the Emperor Napoleon who promoted him to Surgeon-in-Chief of his armies and later made him a baron. Since then the development of ambulance services worldwide has been considerable and varied, with different systems under the direction of different authorities.

**United Kingdom (UK)**

In the UK, ambulance service provision developed from early police-operated hand litters and the Metropolitan Asylums Board horse-drawn fever ambulances of the 1860s, through the two World Wars and motorization of vehicles, with relatively little change in the level of care provided by its operatives. Though gaining importance during this time, ambulance work was regarded as little more than manual labour, with minimal clinical control and regulation. About one hundred years on from those 1860s horse-drawn vehicles came the first real attempt at providing guidelines for the regulation of ambulance service provision in the UK. The Millar report (Ministry of Health 1966) laid down recommendations for equipment and minimum acceptable levels of training and equipment for the, then, County Council-run ambulance services. Prior to this, the training consisted of no more than a civil defence corps first aid course.

**1970s to present day**

It was only comparatively recently that the medicalization process began and in 1974 responsibility for the UK ambulance service was transferred to the National Health Service. From then to the present day there has been an unprecedented expansion in ‘out-of-hospital’ care delivery, with the advent of limited advanced training (intubation and infusion) in the early 1970s, through the initial vestiges and development of advanced cardiac life support with defibrillators, trauma care and paramedics of the 1980s. The 1990s brought “Trust” status to ambulance services and saw the continued development of paramedic practice. As a result of clinical audit and research, the devolution of some of the previously ‘reserved skills’ to be practised by ambulance technicians was enabled.
Such interventions as cardiac defibrillation, nebulization therapy and the parenteral administration of certain prescription-only medicines entered the domain of the technician. This represented a significant step in the development of evidence-based clinical practice and may be perceived as a major landmark in the professionalization of the UK ambulance service. The latter part of the 1990s bore several government publications aimed at developing the Health Service in general and ambulance services in particular.

Modernization of ambulance services

The health service circular entitled *Modernisation of Ambulance Services* (NHS Executive 1999) clearly sets out the government’s view that ‘quality care should be at the heart of the National Health Service’. It places ambulance services at the forefront of ‘the new NHS modernization programme’ (UK Parliament 1997), aiming to ensure that they perform a key role in the development of quality systems encompassing many areas of healthcare delivery. It emphasizes the importance of national standards to ensure consistent, high-quality care as specified in ‘a first class service’ (NHS Executive 1998).

An example of the influence of national standards

Major emphasis was placed on the National Service Framework (NSF) for Coronary Heart Disease (NHS Executive 2000) and many ambulance services have responded as directed by undertaking pre-hospital thrombolysis for those patients suitably diagnosed. Others, notably London, have embarked on a programme of alliance with hospitals offering primary angioplasty as the gold standard intervention for con-
firmed myocardial infarction (MI). In either system, the ambulance crew are able to make the diagnosis of MI using a 12-lead electrocardiogram (ECG) and other key factors. With this system, instead of giving a thrombolytic drug, the crew can rapidly transport the patient to one of the cardiac catheterization laboratories in the capital. This practice has produced impressive results in terms of patient outcome and reduced aftercare and carries less risk than that of primary thrombolysis.

Training

UK ambulance services currently conform to training standards as laid down by the Institute of Health Care Development (IHCD). This means that both paramedic and ambulance technician training follow an agreed strategy which is supported by a paramedic steering group composed of local clinicians. For many years the national ambulance service has fulfilled its basic role of ‘treat and transport’; it has now become appropriate to consider modifications in thinking and extend the role of the paramedic to that of a ‘practitioner’.

Education and the future

A report published in January 2000 by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the Ambulance Service Association (ASA) examined the future role and education of paramedic ambulance service personnel. The opening sentence in the report stated that ‘Emergency pre-hospital care can have a profound influence on morbidity and mortality of those critically ill or injured’ (JRCALC 2000: 3). It supports the concept of developing the role of the paramedic and envisages ‘a health care professional with a degree, and commitment to long term development of skills and education’ (JRCALC 2000: 7). The committee suggested an appropriate generic title for this professional as ‘Practitioner in Emergency Care’ (PEC). This concept has already been pursued by many ambulance Trusts throughout the country, resulting in partnerships with universities, facilitating degree courses for paramedics. This is widely regarded as a considerable step towards fulfilling this role, though the more widely used title seems to be emergency care practitioner or ECP, which also embraces nurses and other generic healthcare workers.

Professional registration and regulation

This, coupled with the advent of professional paramedic registration with the Council for Professions Supplementary to Medicine and latterly the Health Professions Council (HPC), has the effect of placing paramedics in the forefront of emergency care, with the ability to practise flexibly in a variety of primary care areas and have an even greater influence on the morbidity and mortality of the critically ill or injured. It was required that the HPC should liaise with a professional body for each of the practitioner groups on the register; all except the ambulance service had such a body. As a result of this, in 2001 the British Paramedic Association (BPA) was formed, as the representative professional body for paramedics.
Conclusion

In its publication *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* (DoH 2005: 50 point E8), the Department of Health recommends that ‘Ambulance clinicians should be equipped with a greater range of competencies that enable them to assess, treat, refer, or discharge an increasing number of patients and meet quality requirements for urgent care’. This supports the inevitable movement of ambulance education towards partnerships with higher education institutes. Such partnerships have begun the development of the role of the emergency care practitioner and have resulted in attractive alternative pathways to paramedic practice. No longer is it the sole domain of the ambulance service under the verification of the IHCD to train paramedics. Ambulance NHS Trusts are developing numerous programmes, at varying academic levels, with higher education institutes, in response to their individual service requirements for their regions. Thus ambulance service education has progressed into the twenty-first century with greater integration into university schemes across a wide spectrum of related subjects.

Link to Chapter 13 to read about policy that is shaping future practice.

Chapter key points

- In order to appreciate health care within twenty-first-century Britain an understanding of health care in Britain prior to the NHS is important.
- The development of ambulance services within the UK is of interest to ambulance clinicians and may help explain some of the practice unique to the service today.
- The chapter discusses the future developments of the ambulance service and provides the reader with a clear idea of future developments.

References and suggested reading


**Useful websites**

- NHS History: www.nhshistory.net
- NHS Confederation: www.nhsconfed.org
- NHS Connecting for Health: www.nhs.uk