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ACUTE PERSPECTIVE

David Oliver: How much influence can doctors have over health policy?

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I sometimes see doctors complaining that we're ignored and marginalised by politicians, government departments, and national agencies in health policy decisions. I think that we have more influence than we realise.

That doesn't mean getting all of our wishes granted—even when we can agree among ourselves what our priorities are. And our influence will wax and wane depending on how sympathetic the current government is and how conducive the wider economic and political climate.

Not winning every argument doesn't mean that we haven't won any. Some of the biggest wins are policies we stop or modify before they're enacted. Sometimes, just getting some of what we do push for is a result. That's just the nature of public policy.

In a heavily centralised and politically accountable state healthcare system, such as that in the UK, medical professionals need to work hard to campaign on public health policy and the way healthcare services are funded, designed, and delivered. We have four key strengths in influencing.

Firstly, professional credibility. Doctors and nurses consistently top the league tables of public trust in professions (with politicians near the bottom), and the NHS remains the institution that makes people most proud of the UK. Our daily conversations with patients and their families influence public perceptions and hence politicians.

Secondly, position. Doctors have senior roles in government departments and national agencies. Their power is partly positional, but they're also credible professional experts and advisers. This extends to doctors on standing advisory committees, which provide regular advice to ministers.

Thirdly, collective power. Medical membership organisations and health charities campaigning for particular patient groups have tremendous influence. Sometimes they do this by campaigning around particular causes. Sometimes they respond to policy consultations, resulting in the modification, improvement, or dropping of policy initiatives.

Fourthly, expertise and evidence. Doctors produce compelling resources such as new research, evidence summaries and data, evaluation of service models, and audits that can affect policy thinking. These may involve public health interventions for preventable ill health and inequalities, for NHS workforce or care quality gaps, or for better treatment access and capacity.

Across all four, much policy influencing is iterative, developed over years through constant repetition and development of the same key messages and positions.

Although medical membership organisations do employ policy professionals to help them lobby, doctors are rarely expert in policy, communications, or campaigns. We need skills and training and a greater focus on measuring our impact—no matter how compellingly we make our case. We can also form campaigning coalitions with other professions, charities, sympathetic politicians, or media around a common cause.

Finally, although speaking truth to power is important, and while swathes of public policy such as healthcare funding, immigration policy, or economic inequalities are not in our gift, service leadership and delivering best practice are central to medical professionalism. Accordingly, we must always be seen to be offering constructive solutions and not just looking for government help or reflexively criticising every policy decision—even those we contributed to.

We are stronger than we think. Even if it doesn't always feel like it.

Competing interests: See bmj.com/about-bmj/freelance-contributors. David Oliver is an unpaid trustee of the Nuffield Trust, an unpaid visiting professor at City University, London, and an unpaid visiting fellow at the King's Fund. He writes both as a professional freelancer and unpaid for several publications but has never been told what he should or should not write about. He has never taken fees from pharmaceutical companies or consultancies and has never practised private medicine.

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