increased income. Though they are a definite financial liability they are also a financial demonstration that the doctors care for the health of their patients.

Several local practitioners have been performing minor surgery regularly for many years. One practice's recent records showed over a score of procedures carried out, ranging from one patient whose accessory nipple was excised through 43 operated on for epidermal cysts to 106 on whom vasectomy had been performed. Individual doctors have their own special interests, and as a result there are many practices with well woman clinics, well baby and child assessment clinics, antenatal clinics, special investigation and surgery sessions, with some practices offering psychotherapy, hypnotherapy, acupuncture, and homoeopathy.

Practice nurses have played an increasing part, and one nurse has set up a walk in health check and screening clinic for her practice's patients. Such a service can be provided only with the support of other professionals such as community sisters and practice nurses, and some of the work they do generates extra income, but part of the salaries of practice nurses comes from doctors' own pockets.

The government talks about support in the future for computerisation. Many of our practices have systems "up and running," and others are planning to introduce them. With well organised practices the computer gives a massive improvement in patient care and saves the Department of Health money—for example, from more efficient prescribing—but it provides doctors little in the way of extra earnings.

The profession's aim has been an average list size of 1700 patients—to allow time for doctors to look after their patients properly—rewarded with proper remuneration. The government is now proposing that a much greater proportion of doctors' remuneration should be based on the number of patients on their lists. Already one local practice that was about to take on an extra partner—not to attract more patients but to permit the development of a more comprehensive service with more screening and special illness group clinics—is having second thoughts.

Will it be last decade's medicine next decade?

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SIR,—The government's white paper suggests that health authorities will be encouraged to purchase services both across area boundaries and in the private sector for an agreed fee.

The ear, nose, and throat unit at St Bartholomew's Hospital, London, cannot readily handle the demand for tonsillectomy in the catchment areas of the City and Hackney and Newham Health Authorities. After the allocation of central Department of Health and Social Security funding in 1987 and 1988 to reduce waiting lists the unit had two "tonsillectomy blitzes," whereby at an all in unit cost per patient we hired private facilities. In 1987 an arrangement was negotiated with the Princess Grace Hospital, London, in which a fee of £180 per patient was paid to cover all inpatient costs including fees for theatre, drugs, pathology and blood transfusion services, and overnight stay.

After the success of the first blitz a second sum was allocated from central funding in 1988. Tenders were invited from various local private hospitals and those shortlisted were required to arrange sufficient nursing staff to make available two operating theatres for our exclusive use, provide recovery facilities, and permit access to intensive care in an emergency. It was agreed that any patient requiring inpatient care after the weekend would be transferred to St Bartholomew's. The London Independent Hospital offered the most attractive terms of £150 unit cost per patient.

Consultants at the unit and consultant anaesthetists from St Bartholomew's provided free senior cover, and a contribution to their respective departmental funds was negotiated. Extra duty payments were made to the junior medical staff concerned. These costs were subtracted from the total sum available and divided by the unit cost per patient to give the maximum number of patients who could be included in each project, which was 128 in 1987 and 152 in 1988.

Preadmission screening clinics and an efficient reserve list were organised to ensure that the target of 280 cases was achieved, a measure of success which contrasts with the high non-attendance rate for NHS elective operations. We think that this reflects in part the fact that we were confined to a specific limited budget so that any failure to operate on the specified number of patients would entail a waste of money. Clearly, the interaction of the NHS and the private sector was mutually beneficial in this instance.

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SIR,—An important factor in initiating the NHS review was the successful campaign highlighting shortfalls in NHS funding. In the debate about the white paper[1] the level of funding is being neglected. Yet this is the acid test of the government's commitment to the NHS.

In a well funded system, and with some modifications to the white paper's proposals, district health authorities and general practitioner budget holders can be envisaged acting as true advocates for the people they serve. Services would not simply be bought on the basis of cost but on that of assessed local needs, user friendliness, convenience, quality, and so on. In a poorly funded system, however, cost will inevitably be the overriding factor in determining which services are purchased where. Flexibility and choice will be reduced.

In addition, the doctor-patient relationship stands to be severely damaged, not least because the natural tendency will be to blame the decreased choice on those buying the services—for example, general practitioner budget holders—rather than the government providing the budget.

The government's spending plans for the next three years[2] give little cause for optimism. The cash increase for hospital and community services in 1991-2 over 1990-1 is only 3·5%; for family practitioner services it is 7·3%. Not only are these increases likely to be below the level of general inflation but they fail to recognise that the white paper's proposals are likely to be more expensive to run than the current system. There will, for example, be an increased need for information technology and managerial and accounting services. So at the time when the proposals are coming into full effect NHS finances will be appreciably squeezed. Such considerations support the view that in the long run the government will be happy to see the demand side of the proposed internal market fail, thus providing the opportunity to introduce an insurance based system.

Whether or not the existence of such a hidden agenda is accepted, I believe that it is crucial that in the current debate the need for adequate funding is persistently emphasised. This is one way to illuminate the government's true intentions for the future of the NHS.

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1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmnd 555.)
2 Treasury. *The government's expenditure plans 1989-90 to 1991-92*. London:HMSO, 1989. (Cmnd 614.)

SIR,—Traditionally, the British Medical Association seems to oppose change of almost any kind. The present generation must be perplexed when they learn that the National Health Service was vigorously attacked at the time of its inception—and tonsils were still being removed on kitchen tables at the time.

To those like myself, a former soldier but then a student, the NHS was a godsend for it removed the dread of having to cost services by appraising the quality of a carpet, the pictures, and the furnishings of an abode.

Now, 40 years later, there is the prospect of belonging to a hospital or practice that can become a citadel of excellence in which the members or partners have the incentive to pursue the highest standards of medicine with the greatest control and to generate revenues to further their endeavours.

The realists in the profession, surely, appreciate that the service cannot be open ended and that some degree of selective constraint and common sense is imperative if we are to perpetuate a universal health service as good as the NHS.

Another group of realists are the housemen and final year students, who, almost to a man (or woman), are heading for general practice in droves, whereas less worldly beings sequestered in the colleges plot exit examinations, further discouraging specialisation and confounding the sensible. No wonder the public are coming to realise that we really are a trades union.

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SIR,—The new white paper describes a service that puts patients first, but these will be mainly private patients.

We all welcome shorter waiting lists, better hospital services, and the freedom to choose our general practitioner. Is this, however, what is really being offered? Based on information from higher management this document, in fact, lays down the foundations for a two tier service.

The fundamental facts regarding the money to be made available for the new health service have not been made public; this information is crucial in determining the extent of the proposed changes.

If implemented two key proposals will make a two tier service inevitable: the establishment of general practices with their own NHS budgets and the creation of self governing hospitals or trusts. These proposals are closely linked, and they provide the foundations for an alternative service funded by private insurance.

It is clear to many of our managers that there will be no appreciable increase in government funding to the NHS. For example, the Riverside district in London now receives £150m a year. In future if the white paper is implemented it will receive only £75m a year plus a possible 5% to account for the special needs of the population (according to calculations by the district's management based on its population figures) to finance already severely cut hospital services, general practitioners whose practices do not hold their own NHS budgets, and the community services, which are thoroughly neglected in the white paper. Such a reduction leaves little room for real improvements in the government funded health services.

Failure to increase the funding of the NHS, the main area of savings for this district and its regional health authority as well as for others, will result in as many people as possible being encouraged to take out private insurance schemes to free money for poorer patients. The main effect of the white paper will be to produce more private patients by the implementation of the two key proposals.

Self governing hospitals will have no public funding and will have to make their money by selling their services on the free market. Profitable