Crisis in the Health Service

SIR,—Professor J. N. Walton (1 February, p. 273) has summarized much of the discontentment and hopelessness which the profession in Britain feels today. Despite the apparent length of his letter he has, in fact, accomplished this extremely succinctly, as is his wont. It is a very difficult feeling to express.

I believe that the N.H.S. as it is at present conceived is unworkable and is benefiting neither patients nor the profession. The administrative costs are huge, while that part of the limited money available which is actually spent on looking after patients appears to be diminishing. Expensive and skilled medical time is spent in committees which debate trivia and appear to be unable to take effective action on anything. An expensive and monolithic administration has been grafted on to the Service on the recommendation of a transatlantic firm of business consultants. It should be noted that several of the fundamental observations on which its report was based are questionable.

If the profession is in any way to offer health care to people in Britain I feel it is essential that we really do study health care systems; ours is debatably the second worst in the Common Market. Coupled with this study we should look at comparative medical education and pre- and postgraduate levels. In fact, what is needed is a Chair of European or Comparative Medicine. As it happens, Professor Walton's university is one of the best situated and has perhaps the best back-up facilities of the universities which could be considered for this purpose.—I am, etc.,

PAUL VICKERS

Newcastle upon Tyne

Consultant Contract

SIR,—Some time ago the whole-time consultants in the South-west Region formed themselves into an association to discuss their own particular problems of pay and conditions of service in the Health Service. Each area within the region appointed a chairman and secretary, who also acted as representatives at regional level. The views of the members of this association have been passed to official bodies from time to time.

In the lull that now exists in the negotiations over a new contract many whole-time consultants in the Cornwall Area are anxious that their views on aspects of the contract should be known, especially to those negotiating on their behalf. Because of this, a local meeting was held recently attended by a very large majority of the whole-timers in the area. Discussion was chiefly about the question of a pay differential between whole-time and part-time contracts and what form this should take. That a differential is justified was accepted by 19 of the 21 attending the meeting, on the grounds that this would produce a better pricing for the whole-time basic contract in the long term. All were convinced that the influence of private practice remuneration over the years had been to affect basic salary scales adversely. Again, the majority view (19 out of 21) was that the differential payment, whatever form it took—whole-time commitment payment or extra sessions at

premium rates—should be “additive” or additional to the basic contract.

Turning to the question of the contract itself, and what form it might take, there was now unanimous support for the following proposal:

“That consultants should be able to choose a contract of eight, nine, or 10 sessions, or, of course, a number less than eight in special circumstances. The 10-session contract would be in two forms, one which would retain the right to private practice in free time and the other, linked with a whole-time commitment payment or differential, which would not.”

It should be emphasized that everyone felt very strongly that part-timers should be paid for the number of sessions they work and that the concept of “substantially for the whole of their time” and of unpaid sessions in return for the right to private practice should be abolished. It was equally strongly felt that those engaging in private practice should be abolished. It was equally strongly felt that those engaging in private practice should not be penalized in regard to any extra payments, such as merit awards, extra sessions, or seniority payments, but number of sessions contracted.

Lastly, the meeting was very concerned that future whole-time contracts should be written in such a way that the costs of car, telephone, and other professional necessities such as journals, membership of professional bodies, etc. are allowable for tax relief.

Everyone at the meeting was well aware of the need for unity and anxious that this should be retained. At the same time they were equally anxious that their opinions should be heard.—We are, etc.,

E. W. HUGHES

Chairman

J. S. MURRELL

Secretary,

Cornwall Area Branch,
South-West Whole-time Organisation

Truro

Private Beds in N.H.S. Hospitals

SIR,—While discussion continues about consultant contracts it is timely to look again at the implications of the “phasing-out” of private beds from the N.H.S. The elimination of private beds could be just one step short of a political intention to abolish any private sector in medicine. This would lead to a disastrous black market, a decline in standards, and increased emigration of our best young doctors.

If we really believe in maintaining freedom of choice for the individual for medical care, education, or the like, surely we must try to protect the interests of our own people? More than two millions elect to subscribe to medical insurance schemes. Some may be rich, but many make considerable sacrifices for this provision. The question of privacy, of extra comfort, of the timing of admission in relation to work and domestic life may predominate. For many there is the understandable wish to choose a consultant in whom there is confidence, perhaps most of all if an operation is to be done.

Various organizations have acted on the assumption that private beds will soon be withdrawn and already a number of small private hospitals have been completed. It

is exceptional to be able to provide there the standards of care available in the average district hospital. Continuous medical cover is unlikely, full supporting pathological and radiological services are unusual, and there cannot be all the sophisticated operating theatre equipment now regarded as a reasonable requirement for safety. It is doubtful also if there are enough trained theatre nurses to staff such new hospitals. If, as seems likely, the part-time consultant survives he may well find himself working in private hospitals in an inadequate environment (and often at some distance from his N.H.S. hospitals). A proliferation of isolated private hospitals will mean that consultants are increasingly diverted from their N.H.S. duties. If they can visit and manage private patients in the major hospitals the supervision of all patients and of junior staff is increased, with great benefits to the N.H.S.

A possible solution to this problem has been advanced.¹ The organizations concerned should be permitted to finance the building and day-to-day running of private wings in those district or other hospitals lacking such facilities. The accommodation could be geared to the known local demand for private care. Where already adequate private wings exist these could be taken over. Catering and other ancillary staff could be organized separately. The tax-paying patient should be allowed the facilities necessary to this condition in the theatre and other departments at a moderate fee.

Such arrangement would have obvious economic advantages and could eliminate largely the cry of “two standards of care.” Paradoxically, if the present trend becomes established it is the private sector which will soon have the lower standards.—I am, etc.,

JOHN A. SHEPHERD

Liverpool

1 Shepherd, J., *Lancet*, 1971, 1, 903.

Junior Hospital Doctors' Contract

SIR,—At a time when a great deal of attention is being paid to the consultant contract remarkably little has been said about the new junior contract which Mrs. Barbara Castle has recently accepted and which embodies many of the principles many consultants seem to demand. This contract has implications and potential effects which have received little consideration. I believe it virtually ends the professional status of junior doctors and I suspect that remarkably few of us have given it much thought and that many know nothing of it at all. I wonder what proportion will really welcome a situation in which all will become wage earners whose earnings depend in the main on the hours of work done.

The past few years have seen a growing discontent among all hospital personnel and an increasing determination on the part of junior doctors that their excessive working hours should be rationalized and rewarded. Thanks to the skill, unanimity, and trade union approach of the junior negotiators great strides have been made and we have seen some improvements in our hours of work and career prospects. Salaries have improved in relation to those of consultants but have lagged behind those of comparable

groups in other professions and when compared to the wages of industrial workers have become a national disgrace (basic houseman salary 53p per hour for a qualified doctor).

Some of the blame for the present situation must rest with the Review Body, which has totally failed to take cognisance of deteriorating morale, the root cause of which is money. A generation ago a young doctor would accept a poor salary during higher training in the knowledge that he could look forward to a high standard of living once he became established. Today this is no longer so—progressive taxation, poor representation, and parsimonious government have reduced the buying power of the consultant salary to a level which has at last caused overworked but dedicated men to enter the market place and has precipitated the present situation with regard to the consultant contract.

I fear, however, that the new junior contract may be an over-reaction which will rebound on us in an unacceptable way. Under its terms wages in the acute specialties will rise at last to a high level, but the door will be opened for controls I am sure many of us will find distasteful. Shift work, clocking in, interspecialty cover, and administrative surveillance of actual work done will be gradually introduced and will be hard to resist in the light of the national economic and employment situation. The non-acute specialties will be in a terrible position. They already form the major shortage areas, and how many will enter in the future when an acute-unit houseman will earn more than many senior registrars at the top of the scale? Few people find it easy to drop their income—imagine the plight of a doctor on a rotation when he moves from a long-hour job to a short-hour one or anyone who decides to spend a period in an academic post. Continuity of patient care (already undermined by the reduction in the hours nurses work and the rationalization of the on-call commitment) will disappear and of course in the future "on call" will mean "at work."

Please, before it is too late, let us reconsider and ask the Review Body to price two contracts: a closed contract with an hourly wage and an open contract with a realistic salary level and adequate recognition of work load. Let us then ask all doctors (not just their representatives) to vote either for the professional salaried approach or the supervised wage-earning one. The Review Body and Government will have to offer adequate salary levels unless they want to pre-empt the vote. Given a realistic salary, I believe most doctors will choose to remain professional people.—I am, etc.,

NOEL D. L. OLSEN

London W.11

Technicians and Doctors

SIR,—The following financial figures may be of some interest, given the profession's current obsession with monetary matters. They describe a hypothetical comparison between the salaries of a medical laboratory technician and a preregistration house officer, a pairing of roles which I think may be a little more appropriate than some others which have recently been invoked, such as

the linking of consultants' salaries with those of cabinet ministers.

A newly state-registered (H.N.C. qualified) technician of average age, perhaps 21-22, after a four-year paid training now receives a salary of £2214 p.a. (this figure incorporates a threshold agreement from 1 January 1975 and is only an interim figure until 1 April). This rises to £2526 p.a. if a London weighting applies and represents payment for a contractual 38-hour working week.

Such a technician, on call cross-matching blood, may be compared with his medical houseman counterpart, transfusing this blood on the ward, though the latter will tend to be somewhat older, having had a 5-6-year unpaid training. The houseman, however, is expected to work a contracted 80-hour week (prior to overtime), so to provide an imaginary technician equivalent 42 hours of overtime would need to be worked by the latter. This would be paid for on the basis of the D.H.S.S.-agreed "two-hour call"—that is, 21 "calls," or £94.50 per week at £4.50 a call (neglecting associated standby payments at £1.50 per night). Therefore, assuming a standard 48-week working year, this amounts to overtime of £4536 p.a.

It would thus cost the N.H.S. £7062 p.a. to employ such an imaginary technician to work the standard hours of a junior doctor, currently paid £2202 p.a. Less hypothetically, an annual salary for a houseman paid at the same basic hourly rate as a technician would be £5318. (Similar calculations involving a senior chief technician and a new consultant, assuming a 60-hour week and 46-week year, would yield £7083 and £5433 respectively, or a starting salary of £7588 for a consultant at technician rates.)

I present these comparisons with little comment except to emphasize that it is in no way meant as a criticism of the salaries of laboratory technical staff. These are probably reasonable and realistic and derive from highly skilled professional wage bargaining, a resource notably scarce in the negotiating of the medical profession itself.—I am, etc.,

BRIAN PAYNE

London S.E.25

Supplementary Charges

SIR,—I would like to support the idea of Dr. L. P. Ribet (25 January, p. 214) that in the event of the Review Body or the Government not providing the necessary increment to our salary in April a scale of supplementary charges (to the patient at the time of use) be drawn up by the General Medical Services Committee. These charges could be on a sliding scale related to the various possible degrees of shortfall in our earnings and could be widely publicized in order to keep our patients fully conversant with our intended actions. This might introduce a desirable, and often canvassed, restraint to unthoughtful use of our services without disrupting the whole organization of general practice, which after all is the outcome of much patient negotiation in the past.

The N.H.S. is going to survive in some form and I think G.P.s should ponder very carefully the consequences of resignation. For if they are not prepared to contemplate the realities of resignation, they should not

make the threat. We have, as far as I know, no alternative system to offer except to revert to private practice. The real cost of each item of service to the patient could be formidable and would certainly dramatically reduce our work load and probably our income.

I noticed that our great champion, Dr. James Cameron, advised against the collection of undated resignations in the G.M.S. Committee meeting recently (18 January, p. 168), and I believe the above plan is workable, without danger to our patients, and in our long-term interests.—I am, etc.,

A. O. RUSSELL

Edenbridge, Kent

Distribution of Hospital Provision

SIR,—I congratulate Mr. M. J. Buxton and Mr. R. E. Klein on their excellent article (8 February, p. 345). They have clearly identified the disparities which exist in allocations of revenue and development funds between area health authorities within regions. I would be pleased to have them review the London Metropolitan regions, where I suspect the peripheral area health authorities of the said regions are falling far behind the central area health authorities in fund allocations. Should such a suspicion be confirmed (patients) of the heavily populated towns and country districts of the Home Counties would have reason for considerable disquiet.—I am, etc.,

DAVID BROWN

Chelmsford, Essex

Clinical Meeting in Denmark

SIR,—I have been sent a leaflet about the joint clinical meeting with the Danish Medical Association next September and I am shocked at the expense. How much of the greatly increased B.M.A. subscription will be spent on this meeting? Who are the doctors who can afford this sort of jaunt with bed and breakfast at £12.50 a night? Certainly such expenditure would be far beyond the means of an unmeritorious top-of-scale whole-time consultant like me.

Are doctors demanding more pay because of the high cost of living or is it because of the cost of high living? Does not conspicuous extravagance of the sort contemplated in Denmark seriously weaken the case for the Review Body? Nobody presents original work at a meeting of this sort and its cancellation would involve no appreciable loss to medical science. Will Council come down to earth and think again whether this clinical meeting is really necessary at this time?—I am, etc.,

MARK HUGHES

Public Health Laboratory,
Royal Hampshire County Hospital, Winchester

* * At a special meeting held on 26 November 1974 to discuss the functions, finance, and staffing of the B.M.A. the Council authorized the continuation of arrangements for this joint clinical meeting on condition that it was self-supporting—that is, that the "inclusive package" paid by members attending, together with the registration fee, covered the full costs of the meeting.—ED., B.M.J.