Private practice proposals

The Government's proposals for private practice were announced in June (30 June, p 1800). The Bill, which incorporates these proposals, was published last week (p 1595). Its main provisions were set out in the following letter (30 November) from the Secretary of State and the CCHMS discussed the letter at its meeting (p 1603).

In my letter of 3 September to the CCHMS on improvements in the consultant contract (15 September, p 685) I said that I looked for the full backing of the profession, both as a body and as individuals, to ensure that the extended right to private practice was not exercised in such a way as to damage working relationships with other NHS staff and in particular for the help of the CCHMS to meet the Government's wish that the arrangements for private practice in NHS hospitals operate—and are seen to operate—fairly. This subject was also raised in Gerry Vaughan's consultative letter of 21 June (30 June, p 1800) and since then we have held several meetings with yourself and other representatives of the profession at which you were able to tell us what the profession hoped to see in the forthcoming Health Services Bill and how you saw the arrangements working. The Bill will not be published until next week but I can tell you the main elements it will contain on this subject and I am sure you will agree that we have met most of the profession's concerns.

In summary the Bill will abolish the Health Services Board and free NHS private practice from the restrictions imposed by the previous Government's legislation. The relationship between Sections 58 and 65/66 will be clarified. The Section 59 power being unnecessary will be repealed, the "no prejudice to the NHS" provision being attached to Sections 65 and 66. There will be an "entrenching" provision preventing the Secretary of State revoking authorisations in the absence of alternative facilities for private practice.

While not appropriate for the Bill, I can tell you that in response to comments made we have also decided to retain decisions on pay-bed authorisations rather than delegate them to health authorities. So far as controls of private developments are concerned, the Bill will relax them but make more effective those remaining.

It has been my aim to provide doctors with substantially improved opportunities for private practice, and I am confident that the Bill, together with the changes in the consultant contract, will ensure this. But I am sure you will realise that, when Parliament is discussing the Bill, I shall have to be able to give assurances that the changes we propose will be to the benefit—not at the expense—of the NHS. In particular, I shall have to meet the argument that the continued presence of private beds within the NHS inevitably gives rise to "abuses" related to "queue-jumping"—the purchase of preferential treatment—and that this, as well as being wrong in itself, is directly harmful to the NHS because of the dislocation of working which can occur when other NHS staff take exception to it. I accept the impracticality of pursuing the general introduction of common waiting lists any further and I do not ask for this; but it would be of great assistance in securing broad acceptance of the new arrangements if there could be a statement from the leaders of the profession about the conduct of private practice in NHS hospitals. I should particularly welcome an assurance that the profession would enjoin consultant staffs locally to take steps to prevent misuse of NHS facilities, and to observe certain general principles, which I would also ask health authorities to adopt as the basis for the equitable operation of NHS private practice.

The principles are:

(i) The provision of accommodation and services for private patients should not significantly prejudice non-paying patients. (The statutory provision for this will be tidied up in the Bill as above.)

(ii) Subject to clinical considerations, earlier private consultation should not lead to earlier NHS admission or to earlier access to NHS diagnostic procedures.

(iii) Common waiting lists should be used for urgent and seriously ill patients as at present and for highly specialised diagnosis and treatment. The same criteria should be used for categorising paying and non-paying patients.

(iv) After admission, access by all patients to diagnostic and treatment facilities should be governed by clinical considerations. This principle does not exclude earlier access by private patients to facilities especially arranged for them if these are provided without prejudice to NHS patients and without extra expense to the NHS.

(v) Standards of clinical care and services provided by the hospital should be the same for all patients. This principle does not affect the provision on separate payment of extra amenities nor the practice of the day-to-day care of private patients usually being undertaken by the consultant engaged by them.

(vi) Single rooms should not be held vacant for potential private use longer than the usual time between NHS patient admissions.

I hope that, in endorsing these principles, the profession will be able to give an assurance that in all cases the needs of the seriously ill and others requiring urgent admission take precedence over non-urgent private work. During Second Reading of the Bill, which is likely to be soon after the House reassembles in January, it will be important for me to be able to make a statement about the conduct of NHS private practice; and I would hope to be able to say that the profession have publicly accepted that "pay-bed" privileges have associated responsibilities, and then to go on to set out the principles referred to above and to state clearly that the profession endorse them and will do their part in seeking to ensure that they are fully effective in practice.

"Patients First": Government proposals for the NHS

The Government's consultative paper on the structure and management of the NHS in England and Wales, *Patients First*, was published on 11 December (HMSO, £1). It follows the report of the Royal Commission on the NHS and proposes changes to simplify and decentralise the Service and reduce bureaucracy.

The main proposals for the Service in England are:

(*a*) In the great majority of cases, the area tier of management in multi-district area authorities will be removed, and district health authorities will be established, usually serving a population of between 200 000 and 500 000 people. They will thus be like the present single-district areas, which are themselves unlikely to be changed. With more locally based health authorities the need for separate consumer representation (community health councils) may need to be reviewed.

(*b*) As the new authorities will be responsible for smaller areas than many are now, their membership should be reduced to about 20, including four local authority members. The Government does not feel it right to have staff representatives as members of authorities, believing it better for staff to take part in consultative processes.

(*c*) Each district health authority will be served by a management team, including a consultant and general practitioner, who will, by consensus, plan and co-ordinate the health services of the district. Team membership should not derogate from the personal responsibility of individual managers to manage the services for which they are responsible.

(*d*) There must be the maximum delegation of responsibility to managers in each hospital and in local community services and this must be matched by a strengthening of management at that level. This is perhaps the most important change of all.

(*e*) The channels of professional advice will be simplified so that doctors, dentists, nurses, and other professionals have a clearer voice in both management and planning.

(*f*) The regional health authorities will be responsible, after full consultation, for making proposals for the restructuring of areas. They will also, for the longer term, retain responsibilities for financial control, co-ordinating strategic plans, and overseeing their implementation. Planning procedures should be simplified to make regional plans more sensitive to district needs. The regions will be expected to leave operational matters primarily to be settled by DHAs.

(*g*) Family practitioner committees should remain but, where appropriate, one FPC may cover more than one district.

Inviting comments on the proposals by 30 April 1980, the Government states, that it hopes that much of the change will have been effected during the two years after Government decisions expected to be finalised next summer. It recognises that in some cases it may be desirable to extend the period for implementation of structural change but the process should be complete by the end of 1983. Within those limits, regions would be expected to make progress at whatever pace was most suitable to local circumstances. District authorities—when established—would be responsible for the new management arrangements. The aim throughout would be to minimise disruption to staff and patients. It is hoped that when all changes have been implemented, and in the light of the Government's general policy on reducing costs, the cost of managing the NHS —at present about £300 million a year (or just over 5% of the total cost of the NHS)—might be reduced by 10%.