Private Medicine

A bright future?

BY A SPECIAL CORRESPONDENT

For a while at least, despite the economic recession, the wind seems set fair for private practice: subscriptions to insurance schemes are rising rapidly, a sympathetic Government is in power, and the present consultant contract has potentially allowed many more doctors to have private patients. But a Labour Government will probably be returned to power sooner or later, and it might be considerably more left wing than the last Labour Government. It might attempt to stop all private practice. Most people in private practice, however, are not greatly worried by the prospect of a radical Labour Government trying to stamp out private practice. They think that many people within the Labour Party are susceptible to the argument that being free to choose to spend money on private medicine is a fundamental right and that the strong public feeling (reflected in opinion polls) that this is a fundamental right would make any change politically impossible. They also have confidence in the political muscle of doctors to resist. And, they point out, even if private medicine was squeezed out in Britain it would not be impossible for it to continue with British doctors and patients in Ireland or on the Continent. A British surgeon might fly over in the morning, do his operations, and fly back in the evening.

At the opposite extreme some have envisaged a disintegration of the NHS and a move to an American kind of system. But the NHS is held too sacred (almost as much as the Royal Family) and the American system too awful for this to be likely—barring some total collapse of the economy. These speculations are all rather extreme, and it seems that at least in the short term an expansion of the private sector is likely—but in what way and by how much?

Grand expansion?

Some of those in the private sector, like those at AMI (American Medical International), think that a considerable expansion of the private sector could occur and might take the load off the NHS. But would such an expansion—to perhaps 25% of the size of the NHS—"take the load off the NHS" or would it lead to the much talked of "two-tier system," where the young and wealthy have quick, comfortable treatment and the poor, old, and chronically sick are cared for in an impoverished national service? Most commentators seem to think that any large expansion would be deleterious to the health services, but AMI have been studying the Irish system, where about 40% of the population receive free medical care, 45% pay a small weekly contribution towards free hospital care, and 15% pay for everything.[1] The wealthy are encouraged to insure with the statutory, non-profit-making Voluntary Health Insurance Board, and even those entitled to free care can take out insurance (at reduced premium) and then opt for private care in the hospital and from the consultant of their choice. AMI think (and, they say, the Conservative Government has sympathy with this idea) that in this way more money could be raised for health care and the private sector could expand and do much more—including work contracted out by the NHS. This is something which already occurs on a bigger scale than is generally realised—mostly with old people supported in private nursing homes by State funds.

The irony of this is that some countries that have such systems—including France, Belgium, the United States, and Ireland—are considering plans to introduce some kind of national health service in order to limit costs. In 1975 Ireland, for instance, spent 6·2% of its gross domestic product (compared with 5·2% in the United Kingdom) for a service that is far from comprehensive and also very complicated. The advantages (to set against the disadvantages) of a virtual State monopoly of health care are the possibility of controlling costs and quality, eliminating waste, supervising change, and spending wisely (for instance, how can private medicine encourage a move towards preventive medicine? Where is the profit in that?). Also collecting money by taxation and providing free service to all is an efficient way of organising services; collecting money through insurance and reimbursing fees is much less efficient.[2,3]

For the private sector to grow considerably, given that this is to happen outside the NHS, would require a considerable capital investment and a radical change in the way private practice has worked in Britain. Some doctors, including consultants and juniors, would presumably have to work full-time in the private sector, hospitals would have to be larger, equipment for specialties such as radiotherapy would have to be provided, and administrative demands would greatly increase; indeed, waiting lists might even appear and grow. If the private sector were to expand to that size it would have to start training its own doctors, nurses, radiologists, laboratory technicians, and all other grades of staff. The Royal Commission was against such a large increase in the private sector, and it is hard to imagine that it will come to pass.

Modest increase?

The likely future pattern seems a more modest increase and collaboration between the private sector and the NHS. But what does this collaboration mean? Certainly at the moment the private sector needs the pay-beds; without them private practice would be impossible in many parts of the country. But my impression is that not only trade unionists and left wingers, but also many people working in private medicine, would like to see the end of the pay-beds and all private work being done outside the NHS. Such a system would be much neater, and many of the criticisms of private practice—such as that junior doctors, nurses, porters, and other ancillary staff have to work for private patients without remuneration—would disappear. But, as Lord Goodman observed, when he talked of the "Collumpton principle," if less than 10% of the population wants private medicine inevitably in many parts of the country a readily accessible private hospital will never be economically viable. But there are still many areas in Britain where a private hospital might well be

viable and yet one does not exist. BUPA Hospitals Limited, AMI, other similar companies, and consortiums of local consultants are enthusiastically trying to build in such places. But there is strong competition in richer areas and less enthusiasm for the many less wealthy parts of the country.

Might more collaboration between "a strong public sector and a strong private sector" mean contracting out by the NHS to the private sector? Might hip operations, hernia repairs, and computed tomography be done on NHS patients in private hospitals? This happens to a small extent already, but as few doctors are working full-time in the private sector, it would mean a general surgeon doing acute and major surgery in an NHS hospital and then travelling up the road to do hernia repairs on NHS patients in a private hospital. Such an arrangement seems absurd and uneconomic, yet no surgeon is likely to be willing to do only the routine operations for which there are long waiting lists. So collaboration probably means only that people who choose and can afford private medicine do not add to the load on the NHS yet still, through taxation, help pay for the NHS. Ironically, collaboration between the two sectors might be more meaningful if pay-beds continue; then the NHS would receive an additional infusion of funds, rather than just a trivial lightening of its load.

One problem that might arise in a quiet expansion of private practice—with more people insured and every consultant able to do a little private practice if he chooses—is one of control. Might small nursing homes, without good facilities and without adequate staff cover, be encouraged to allow more major operations than they can properly cope with? Some people in private practice (mostly, not surprisingly, from lavishly equipped private hospitals) have expressed this worry to me, and the Independent Hospital Group has been discussing the problem, but others are confident that increasingly strict Government regulations will prevent such excesses.

Private practice and the general practitioner

Some enthusiasts for private practice think that there is room for an increase in private practice by general practitioners. They refer to the appearance of Medicover—a London deputising service that provides house calls for patients at an annual fee of £50 and a charge of £5 per call—and say that this is evidence of the failure of general practitioners to provide the service that people want. Most supporters of the NHS dispute this hotly, however, and suggest that the standard of general practice is higher now than it has ever been. Problems exist (particularly in inner-city areas, where the deputising services flourish) but all the signs are that things are getting better not worse, and most patients would gain nothing from private general practitioner care. Nevertheless, the insurance companies have been interested in offering insurance cover for general practitioner services, but have always found it impossible. Apart from any political and professional objections there are considerable practical difficulties in such a plan.

Some general practitioners offer only private care, but they are few and restricted to certain parts of the country. General practitioners are allowed to have private as well as NHS patients, but there are few things for which, under their contracts, they are allowed to charge NHS patients. The main problem for the insurance companies in covering general practitioner care is that the main expenditure is not on professional fees, but on drugs, and this makes it expensive. And it is unlikely, for both political and financial reasons, that any Government would allow a patient to see a private doctor and receive an NHS prescription. Another problem for the insurers is "selection against them": those patients who know they need regular care from their general practitioner are much more likely to take out insurance than those who do not. For those practical reasons and for professional and ethical reasons (when a GP has private and NHS patients within one list, and when an NHS patient of one GP sees another GP privately) it is hard to imagine much growth in private general practitioner care.

But for hospital medicine private practice in Britain seems to be set for a small, quiet expansion. The international trend is away from large-scale private medicine, where costs, distribution, type, and quality of care cannot be easily controlled, and Britain is unlikely to go strongly against this trend. So private medicine will probably continue to be concerned mostly with cold surgery, and this will probably take place increasingly outside NHS hospitals in small private hospitals.

References

1 Anonymous. Health services in the Irish Republic. *Br Med J* 1978;ii: 1310-1.
2 Royal Commission on the National Health Service. *Report*. London: HMSO, 1979.
3 Klein R. Health care: private charges and public pressure. *Br Med J* 1977;i:1170-1.

This is the second in a series of three articles.

The "ideal" oral solution recommended for use in gastroenteritis contains 110 mmol/l of glucose in addition to electrolytes. This concentration can be roughly provided by 20 g/l of glucose but parents often do not have glucose available and so use commercial sugar. Eight level teaspoonfuls of glucose provide 111 mmol of glucose. What would be the equivalent quantity of sugar to provide a similar energy and osmotic content?

The question is important, as sucrose, rather than dextrose, is so widely available in the home throughout the world. Each 100 g dextrose monohydrate powder for oral use provides 340 kcal (1425 kJ): a 5·51% solution in water is iso-osmotic with serum[1]: ten level 5 ml spoonfuls of the dextrose monohydrate powder weigh about 29 g. A 4% concentration of dextrose is suitable for use in an oral electrolyte solution to be used for simple rehydration—that is, dextrose monohydrate 40 g (200 mmol)/l.[2] Each 100 g granulated sucrose provides 394 kcal (1680 kJ)[3]: a 9·25% solution in water is iso-osmotic with serum[1]: ten level 5 ml spoonfuls of the granulated sucrose weigh about 38 g. Oral sucrose-electrolyte solution has also been used with success by some workers, the concentration of the sucrose ranging between 2% and 5%. If one compares two similar oral electrolyte mixtures containing glucose in one and an identical percentage of sucrose in the other, the sucrose-electrolyte mixture will have a considerably lower osmolality.[4]

1 Martindale. The Extra Pharmacopoeia. 27th ed. London: Pharmaceutical Press, 1977.
2 British Pharmaceutical Codex Supplement 1976. London: Pharmaceutical Press, 1975.
3 Buss D, Robertson J, comps. Manual of Nutrition. 8th ed. London: HMSO, 1978.
4 Rahilly PM, Shepherd R, Challis D, Walker-Smith JA, Manly J. Clinical comparison between glucose and sucrose additions to a basic electrolyte mixture in the outpatient management of acute gastroenteritis in children. *Arch Dis Childh* 1976;**51**:152-4.

Can lymphoedema in one leg be a complication of sarcoidosis?

Diseases that distort the structure of lymph nodes can interfere with lymph flow and thereby cause lymphoedema. On lymphography of the legs patients with sarcoidosis may show abnormal nodes in the para-aortic or ilioinguinal areas. Abnormal nodes can be shown in up to half of cases, yet lymphoedema is unusual. The lymph nodes are enlarged with a fine structured opacification and may show marginal filling defects caused by deposits of granuloma. The changes are not pronounced enough to cause a severe restriction of lymph flow and lymphoedema if it occurs is usually mild and bilateral.

1 Taensen VA. Lymphographic findings in cases of sarcoidosis and lymph node tuberculosis. In: *Progress in lymphology: international symposium on lymphology 1966*. Stuttgart: Georg Thieme Verlag, 1967.