TALKING POINT

Whole time consultants' views on private practice

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In January 1980 whole time contract holders in the National Health Service were allowed to undertake a limited amount of private practice after the Central Committee for Hospital Medical Services had negotiated improvements to the consultant contract.¹ This changed the position that had existed for 32 years from the beginning of the NHS. Divisive letters were published in the *British Medical Journal*²⁻⁴ and the *Lancet*⁵⁻⁷; most of them expressed antagonism to the proposal. Two years later we decided that it would be interesting to obtain the opinions and reactions by questionnaire of the 11 session contract holders in one regional health authority.

Method and results

At the time of the survey (December 1981 to March 1982) 702 consultants were employed in the South East Thames Regional Health Authority. Of these, 316 (45%) in 41

specialties holding 11 session contracts were invited to complete an 18 question questionnaire. Of 310 consultants who could be contacted, 253 (81.6%) replied, 39 (12.6%) did not, and 18 (5.8%) returned blank forms. The response rate from the 13 health districts varied from 58% to 100%.

The specialties of the consultants who responded were: medical 85 (33.6%); surgical and anaesthetic 50 (19.8%); geriatric medicine and psychiatry 67 (26.5%); and diagnostic and pathology 51 (20.2%).

The first two groups were broadly labelled "acute" and the second two "mainly non-acute" for the purpose of further analysis of the replies. The median length of consultant service was 7.3 years (that for all consultants in the region was 11.2 years). One hundred and ninety one (75.5%) were in their first 15 years as a consultant and 62 (24.5%) in their second; 48 (19%) held substantive or honorary sessions in teaching hospitals.

The results are given below.

How satisfied are you with the negotiated agreement allowing private practice earnings up to 10% of gross NHS salary for holders of whole time contracts?

Very satisfied	13 (5.1%)
Satisfied	103 (40.7%)
Neutral	62 (24.5%)
Dissatisfied	57 (22.5%)
Very dissatisfied	13 (5.1%)
Do not know	5 (2.0%)

Do you think the 10% rule should apply to total earnings?

Yes	80 (31.6%)
No	74 (29.2%)
No preference	60 (23.7%)
Do not know	33 (13.0%)
No answer	6 (2.4%)

Do you think the 10% limit should be raised?

Yes	104 (41.0%)
No	85 (33.6%)
No preference	52 (20.6%)
Do not know	11 (4.3%)
No answer	1 (0.4%)

Do you think the new provisions have produced tax benefits?

Yes	79 (31.2%)
No	79 (31.2%)
Do not know	94 (37.2%)

Do you feel that this agreement is in your personal best interests in the long term?

Yes	104 (41.1%)
No	76 (30.0%)
Do not know	69 (27.3%)

How do you rate the possibility for private practice in your locality (irrespective of specialty)?

Very poor	11 (4.3%)
Poor	29 (11.5%)
Fair	90 (35.6%)
Good	75 (29.6%)
Very good	37 (14.6%)
Do not know	10 (4.0%)
Not answered	1 (0.4%)

Do you think there is a demand for private treatment in your specialty in your locality?

Yes	189 (74.7%)
No	46 (18.2%)
Do not know	16 (6.3%)
Not answered	2 (0.8%)

What is your attitude to private practice in NHS hospitals?

Should be encouraged	103 (40.7%)
Should be discouraged	99 (39.1%)
No particular view	37 (14.6%)
Do not know	7 (2.8%)
Not answered	7 (2.8%)

It has been suggested that there should be a special financial allowance for whole time consultants who opt not to engage in private practice. What is your attitude to this suggestion?

Strongly disagree	21 (8.3%)
Disagree	61 (24.1%)
Neither agree nor disagree	34 (13.4%)
Agree	71 (28.1%)
Strongly agree	56 (22.1%)
Do not know	8 (3.2%)
Not answered	2 (0.8%)

If there is an increase in the total number of consultant posts what do you think will be the effect on the demand for private treatment?

Demand will increase	27 (10.7%)
Demand will lessen	72 (28.5%)
No effect	100 (39.5%)
Do not know	52 (20.6%)
Not answered	2 (0.8%)

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Discussion

The high rate of response to the survey suggests that private practice is still of great interest to consultants holding whole time contracts. There are good opportunities for private practice in the region surveyed.

Most of the respondents (45.8%) seemed satisfied with the 10% private practice now allowed, but a substantial minority (27.6%) remained opposed to it. "Extra income" (25.4%) and "more personal freedom" (16.4%) were the most common

responses given by those satisfied. Less tangible positive reasons were "it is a step forward," "removal of restrictions," and "a reasonable compromise." Of the satisfied respondents, 16.2% gave a negative response stating that they could not earn more than, or as much as, 10% from private practice. Ten and a half per cent did not provide reasons for satisfaction. Inability to do private practice was the main reason given by the equivocal group.

More clearcut reasons were given for dissatisfaction: "10% limit too low" (28.7%), and "inability to practise privately" (20.0%). Some thought that the concession would erode future salary levels and that the proposals had brought more benefit to 10 session holders, or discriminated against those unable, or not wishing, to do private practice.

There was less certainty about possible long term benefits: 41.1% supported the scheme, 30% opposed it, and 27.3% were unable to express an opinion. There were equal proportions of respondents in their first and second 15 years of service in the answers to this question. When divided by specialty more in the "non-acute" specialties (58.9%) were not able to agree that the change was beneficial compared to "acute" specialists (59.6%) who thought that it was.

An equal division of opinion was found regarding the value of tax benefits. The fact that more than a third of respondents were unable to answer the question showed that many consultants were not aware what these benefits were. Clearly some doctors do not realise that general taxation advice is available to members from the British Medical Association or, presumably, that the British United Provident Association runs occasional two day courses on entry into private practice for senior registrars and young consultants. Of those consultants who said that the new provisions had produced tax benefits, 21 (8.3%) thought these were very slight, 37 (14.6%) slight, 22 (8.7%) fair, and three (1.2%) substantial.

Most respondents (73.8%) thought that there were fair to very good opportunities for private practice in their area, with a similar figure for opportunity in respect of specialty. A good view was more common in the "acute" specialties, and those areas with little demand showed a higher than average proportion of whole time consultants.

The responses showed that in certain areas if there is a demand for private treatment it is in most specialties (or at any rate in those in which private practice is possible); otherwise the demand is not there at all.

A similar polarisation of view was apparent on the principle of private practice in NHS hospitals. More "non-acute" specialists (47.3%) were against, while one in two of the "acute" specialists (36.3%) thought that it should be encouraged. The reasons were listed under 29 headings, the most common being: reducing travel, improving NHS income, possible abuse, the value of separation, better facilities for the very ill. Some consultants who were not opposed nevertheless judged that there was now an irreconcilable gulf between the two sectors.

Half the sample agreed with the concept of the whole time commitment allowance and one third disagreed, with no differences by length of service or specialty. Those who opposed such an allowance supported private practice and those in favour were against it in NHS hospitals. Many saw the principle as fair, some opposing it as a payment not related to work done.

The CCHMS, which argued forcefully in the recent re-organisation to keep consultant contracts at regional level (with the exception of teaching hospitals), will be encouraged that the most unanimous view—211 (87.2%)—on any one subject supported contracts being held by regional health authorities. Only 10 (4%) thought that this was wrong.

Many different attitudes and views were seen in the comments that these questions produced. Two fifths of the sample said that they did not undertake private practice or had no opportunity to do so. Some strongly supported fees from patients professionally (or on professional grounds), others feeling disquiet about payment. Although some were opposed to

Revised consultant contract

Modifications to the consultant contract were agreed in principle in September 1979, the DHSS circular (PM(79)11) was issued in November, and the modifications set out below were implemented on 1 January 1980.

- Whole time consultants are allowed a limited right to private practice to the extent of 10% of their NHS salary (including distinction awards, if applicable).
- Whole time consultants and those with nine session contracts are allowed an additional paid session, where needs of the service require.
- Consultants with maximum part time contracts are to be paid 10/11ths of the whole time salary.
- Maximum part time consultants who want to limit their NHS commitments will, exceptionally, be offered a nine session contract.
- Those consultants who have retained a nine session contract may opt for a maximum part time contract within three months of the date of implementation.

this on professional and political grounds, the survey showed some support, or toleration, for private practice for whole time consultants.

Support for a whole time commitment payment from two thirds of consultants suggested that many consultants thought that this was fair. Some wished to see closer links between private practice and the NHS but others thought that this would be unwise in view of the opposition of ancillary workers.

Those who believe that consultants have been tardy in supporting a policy to increase their numbers because of fears that it would reduce the demand for private practice might be surprised that half the respondents forecast no fall in demand if consultant numbers were increased.

Conclusion

After two years the new contract still stimulates controversy, with views diverging sharply on the basic issues. Consultants' attitudes seem to be determined by a combination of professional, political, and practical factors, illustrating how difficult it is to formulate a single contract that is satisfactory for everyone. Clearly, the ideal contract should not be coercive and should take into account the different circumstances of the individual. The varying opportunities in the different disciplines mean that flexibility and fairness are required to provide sufficient options and alternatives.

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References

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