Tiny Target

The separation of private practice from the N.H.S. has long been a Labour Party policy. So it was no great surprise that the new Government last year wasted little time in signalling its intentions. When the Secretary of State set up the Owen Working Party in March 1974 to look at consultants' contracts she included in its terms of reference private practice in the N.H.S.1 Presumably, a negotiated phasing out of pay beds was her hope, despite strong opposition from the doctors. Mrs. Castle's hand was strengthened in October when the Government won an overall majority in the new Parliament, but in December she mishandled a critical stage of the Owen Working Party's discussions. This brought about its breakdown2 so setting back, among other things, any expectations she might have had for an orderly transition in the immediate future.

To many consultants last week's Parliamentary statement promising legislation to phase out pay beds (10 May, p. 346) will seem surprisingly soon after their leaders' cautious re-entry into formal contract negotiations (26 April, p. 204). It also narrowly antedated some crucial union decisions on private beds. So the timing of the Government's announcement, with the profession given very short notice about it, is unlikely to make the transition any easier. The profession does, however, have the consolation that the Secretary of State has accepted the argument3 that her powers under the 1968 Health Services Act were insufficient to allow the Government to abolish pay beds without due legislation.

If the aim is to appease the militant unions it seems a hazardous game to play over a target which she herself admitted is tiny. "Of the 403 500 beds in the National Health Service hospitals . . . only 1% or 4500 are private beds," Mrs. Castle told the House of Commons. Pay beds are, in fact, unevenly spread both geographically and by specialty. For instance, in Wales in January 1973, according to Government figures, there were only 68 pay beds out of 25 500; 13 London hospitals have 15% of all pay beds. Out of nearly 51 000 beds for the mentally handicapped there is, apparently, one pay bed. Moreover, at a time when the N.H.S. is so short of money and annual Government borrowing reaches frightening heights Parliament is to be asked to approve legislation that will probably cost the Exchequer well over £30m. The bulk of this will be lost revenue, the rest will be needed to make up the salaries of those consultants who may feel obliged to go whole time.

What about the future of the consultants' contracts? Just as the Secretary of State seemed to have accepted a reasonable interpretation of the option contract and, in principle, improvements to it (26 April, p. 202) she has slammed the door on private practice. Not only does she intend to remove private beds but the Government is to tighten up its powers for controlling nursing homes. What value has an option contract in these circumstances? Unfortunately she declined to give much away in Parliament, talking vaguely of reviewing the adequacy of her powers, "given the role which the wholly private sector may take on once the phasing out programme was completed." Despite soothing words about consultation with "those interested in the very near future" the implications are that she does not intend to let market forces work unchecked in the private sector. Talk of dissipating scarce resources and preserving the integrity of the N.H.S. will not wash. If the N.H.S. offered a satisfactory working environment fewer doctors would leave Britain and many ex-nurses might return to the Service.

Indeed, in our series "Conversations with Consultants" the shortage of nurses has been a recurring criticism (p. 385). One consultant even argued that hospital planning should be done on the basis of nurse availability and not on bed numbers. Statistics on beds—empty or full—have long been suspect, and emptying 4500 private beds is unlikely to have much, if any, effect on waiting lists—that bête noire of politicians—for it will not conure up more nurses. Many private beds are in any case staffed by agency nurses, who would presumably shift across to the private sector, particularly as they are officially disapproved of by some of the health unions.

Some of the seeds of destruction of this symbiosis between private and public medicine were planted by doctors themselves. No doctor would argue that abuses of the relationship do not occur. But the evidence given by some medical organizations to the parliamentary inquiry into N.H.S. facilities for private patients4 laid over-dramatic emphasis on the failings that inevitably occur. This was eagerly seized on by the opponents of private practice. As the Fellowship for Freedom in Medicine stated in its evidence to Mrs. Renée Short's committee: "It is significant that hardly one word of the B.M.A.'s detailed and careful statements has been given press publicity, presumably because allegations about consultants pinching hospital syringes are considered more newsworthy than the hours of patient and unpaid overtime put in by the majority of N.H.S. specialists."

Much was made in the House of Commons debate of privacy, and the Government attaches such importance to this that amenity beds are to be extended and more widely advertised. It is a fine point whether paying extra for privacy snags any less of privilege for the better off patient than does his paying extra to know that the surgeon of his choice will operate on him. Indeed, choosing the specialist is just as strong a motive for patients paying for medical care as is admission at the patient's convenience. Equality of treatment within the N.H.S. is a mirage. Different parts of the country offer varying facilities. Consultants within the same hospital have a range of abilities. Furthermore, it is impossible for all patients to be treated by consultants and the quality and experience of junior staff are bound to be uneven. The standard of private care, too, cannot be the same everywhere. Otherwise why does London attract a steady flow of patients from overseas? (Patients, incidentally, whom Mrs. Castle hopes will now come into N.H.S.wards and pay.)

No. Even admitting the human failings in working the private practice compromise, even admitting that queue jumping embitters N.H.S. staff, as Mrs. Castle claims, it is hard to see how the Government's intentions will improve medical care in the N.H.S. They even worsen standards. And what does the public think of a subject that was not high on the list of election issues? Dr. David Owen winding up the adjournment debate declared: "The facts of life are that no health service in this country would be able to meet all the demands and all the requests made on it. We have, in effect, a rationed service. There can never be a health service that can meet all demands. It is in that context that we must look at how we can distribute resources fairly and evenly. This is the problem for the N.H.S."

Contrary to the Government few doctors will see this latest step as contributing to the solution of that problem. Will the public?

1 British Medical Journal Supplement, 1974, 2, 67.
2 British Medical Journal, 1975, 1, 56.
3 Health Services and Public Health Act 1968. London, H.M.S.O.
5 Fourth Report from the Expenditure Committee (Employment and Social Services Subcommittee). London, H.M.S.O., £3 95.