GOING PRIVATE

The case against private medicine

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The case against private medicine –
a report from Fightback and the Politics of Health Group

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The **Politics of Health Group** started in 1977 and has gradually attracted a widening membership of socialist and feminist health workers, teachers, researchers, community workers and others. We are committed to a style of politics that relates to our personal experience and tries to work towards an anti-sexist, socialist practice in the ways we organise and relate to each other. We are trying to build up a clearer picture of the relationships between who gets ill, the kind of illnesses they get and the class, sexist and racist nature of our society. We also want to understand what role the NHS plays in actively perpetuating this injustice.
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Fightback is a nationally co-ordinated, independent campaign against cuts in the NHS, and for better health for all. It aims to help existing anti-cuts struggles, to provide a forum for developing our experiences and understanding of those struggles, and to fight for better health care, preventive medicine, health and safety at work, and women's health care.
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Warning! Private medicine is bad for your health!

Two million unnecessary operations are performed every year in the US, according to a Congressional Committee report. The effects and risks of these operations outweighed any potential benefits, and the situation was blamed on private medical insurance and the "fee for item of service" system by which doctors are paid. (This means that doctors are paid a certain sum for each operation: the more people who undergo surgery, the richer the doctors become!) When a doctor knows how much richer he will be if a patient has an operation, it is likely that a balanced presentation of the risks and benefits will go out of the window.

The same could happen here, – and does happen in the NHS in particular specialties like gynaecology. It is more likely to happen if the Tories change the method of funding the health service to an insurance base. People who already go private should beware – they may be getting more than they bargained for, as in private practice, doctors are wholly paid by "fees for service". So although private patients may have a place at the top of the queue, they may not need to be in the queue at all!

Here are some true, but necessarily disguised examples of people in this country who have had private operations where the reasons for them are extremely doubtful, if non-existent. There are many, many more – which campaigners should always record if they hear of them.

A 19-year-old man has cosmetic surgery on his nose in a private hospital. Something goes wrong and he stops breathing during the operation. The hospital does not have the necessary resuscitation equipment and by the time he is admitted to the nearest NHS hospital he has suffered severe brain damage.

Private hospitals aren't always what they're cracked up to be: A middle-aged executive is admitted to a nursing home in the north west for a gall bladder operation. Everything goes smoothly until he needs painkillers after the operation. Those prescribed are not adequate, but there is no doctor available (many private nursing homes do not have any resident). So a doctor has to be called in from miles away, and the man spends several uncomfortable hours before a stronger drug can be prescribed. In an NHS unit where surgery of this nature is performed, there is always a doctor more or less on the spot.

A 56-year-old woman has a cancerous lump removed from her right breast. She then has radiotherapy treatment (on the NHS: not available privately and very expensive). Her private surgeon refers her to a plastic surgery "colleague" to have her breasts "evened up". The operation is performed, but the wound fails to heal for months because of the radiotherapy, which damages the body's healing processes. She is left with very *un*even breasts, and an ugly, painful scar on her left, previously normal side.

A 35-year-old woman is told by her consultant that the only cure for her recurrent vaginal discharge is a hysterectomy (removal of the womb). So she takes his word for it. . . .

Virtually all pregnant private patients have labour induced, or artificially started, two or three weeks before the baby is due, by the consultant on the day he is in the hospital. As a result they are more likely to have a long and painful delivery, perhaps requiring injections into the spinal column. And induced labour more often results in forceps delivery, for which the consultant earns even more cash.

A 27-year-old woman who has failed to conceive a child for nine months has a laparotomy (an opening into the stomach wall, and removal of wedges of tissue from her ovaries before having any less invasive and risky investigations, of which there are several possible sorts.

INTRODUCTION

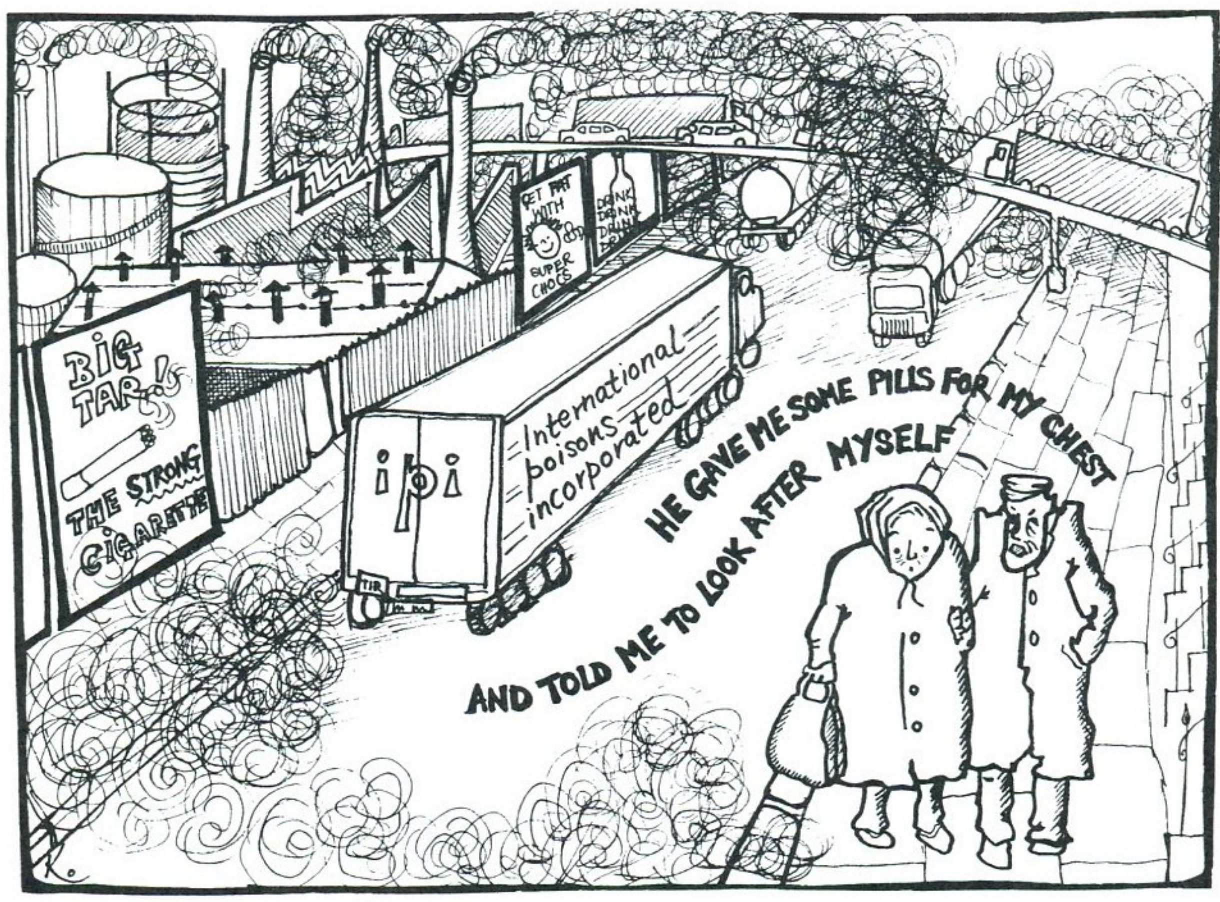
BRITAIN has seen an unprecedented boom in private medical care in the last five years. In 1980 alone there was a 27 per cent increase in the number of subscribers to health insurance, and about 3.5 million people are now covered by these policies. Many new private hospitals and clinics are being planned and built, with a projected 25 per cent increase in private beds bringing the total up to about 10,000.

More and more working class people are taking out health insurance; private screening services are now well established; and private general practice surgeries are planned for London and other cities. At a time of general economic recession "Medibusiness" has never had it so good – suddenly, after years of relative stagnation, it seems the sky is the limit.

All this, of course, is being boosted by the philosophy and policies of the Conservative party. To help its friends in big business, it is selling private medicine by telling us it will relieve the burden the NHS, leaving it free to look after those who can't afford to pay for their health care. By taking out insurance, we are told, we are doing the underprivileged a favour as well as ourselves. And payment, they say, deters the famous scroungers, who will be less likely to pester their doctors with trivial complaints.

The people responsible for this pamphlet, from the Politics of Health Group and Fightback, believe that such arguments are false, and that in the long run very few of us will gain and many will lose by the growth of private medicine. We are all socialists who work in the NHS or are active in health politics. Some of us who have worked with private patients have seen for ourselves the double standards – from which they may benefit, for example by queue-jumping, but from which they also suffer, for example, by underdoing operations and other procedures of doubtful value.

We are convinced that the growth of private medicine is undermining the very foundations of the NHS. The principle – accepted for more than 30 years – of a right to health care given purely on the



basis of need, regardless of the ability of pay, is rapidly being eroded. Many Tories would like eventually to dismantle the NHS and replace it with an insurance funded system, as in France and Germany. The state would pay out less, hence the attraction; but such a system would be less efficient, less accountable and would actually cost the individual more.

A system based on payment for each item of service, such as drugs, X-rays and nursing care, also reinforces the view that health is about what goes on between doctor and patient. The broader implications of health politics, recognition of the social causes of ill health, the potential for democratic control in the NHS – all these issues would vanish in an individualised system. The Tories would like us to see ill health and the ability to pay for health care as a personal problem. An insurance based system would take us even further away from the idea of collective responsibility and the possibility of collective solutions to health problems.

But there is no point in launching an entirely negative attack on private medicine, blindly defending the NHS as it is now. Time and again in writing this pamphlet we have been struck by the point that private medicine feeds on legitimate dissatisfaction with the NHS. Our goal of a comprehensive health service free at the point of delivery is therefore only a starting point. We also have a vision of a health care system, built on these foundations, which is democratic and sensitive to the needs of those who use it and those who work in it; which gives as high a priority to care as to cure; and which identifies and challenges the social causes of ill health.

Many of the causes of ill health, however, such as housing, pollution, unsafe working conditions and unemployment, cannot be solved by the NHS on its own.

We must not tackle the problem in isolation – just as the Conservatives' policy on private medicine forms part of an overall strategy, so must our struggle to realise our vision of a socialist health care system become an integral part of our campaign against it. As we hope to show in this pamphlet, we need to respond with a coherent alternative.

We have had long and lively discussions within our group about that vision, and about our strategy to realise it, and we still disagree on many points. But we hope that sense of debate will inform the movement against private medicine and will be seen as a strength rather than a weakness. We conclude with some preliminary thoughts about how our strategy might develop, with some suggestions for action which we hope will be considered in the light of specific circumstances – they will not be applicable everywhere – and will be extended and strengthened by other campaigners' ideas. But above all, we hope that the message will come across loud and clear: the fight against private medicine is part of the continuing struggle to improve the NHS, to make it truly *our* health service.

The cost of private health care

1. Cost of commonly required investigations

Investigation	Cost
Lung function test	£40
TB screening	£40
Liver scan	£55
Chest X-ray	£12
Full spine X-ray	£65
Skull X-ray	£25
Report of each by phone	£5

From the Harley Street Clinic Diagnostic Centre price list.

2. Cost of routine operations

Operation	Cost
Removal of appendix	£450-£850
Removal of breast lump	£400-£1750
Removal of cataracts	£700-£1000
Removal of gall bladder	£850-£1300
Hernia repair	£450-£850
Hysterectomy	£800-£1500
Hip replacement	£1700-£2500
Repair of slipped disc	£1200-£2300
Removal of tonsils	£350-£700
Varicose veins	£450-£850

From Private Patients Plan, 1979.

3. Cost per week of a private hospital bed

Hospital	Cost
Private hospital in London	£450-£1750
Nuffield Nursing Home	£415-£445
Other private hospital	£250-£650

From *Money Which?*, September 1980.

4. Cost per week of an NHS paybed (single room)

Hospital	Cost
London specialist teaching hospital	£792
London teaching hospital	£709
Provincial teaching hospital	£550
Non-teaching hospital	£440-£510
Long stay hospital	£305

From DHSS press release 80/71, 1980.

5. Cost of annual insurance premium – individual contract

Age	up to 29	30-49	50-64
Single p'son	£73-£166	£88-£222	£112-£240
Married	£144-£314	£157-£417	£221-£453
Family	£166-£411	£181-£514	£252-£549

Premiums vary according to the type of hospital where treatment is offered, and the area. All figures include a 5% discount for payment by direct debit. Adapted from *Investors' Chronicle*, July 1981.

6. Cost of annual insurance premium – group contract

Age	up to 29	30-49	50-64
Single p'son	£35-£149	£39-£198	£54-£215
Married	£70-£281	£77-£374	£108-£405
Family	£88-£367	£96-£460	£135-£492

A group is a minimum of five people, with discounts offered for numbers over 10-19, depending on the company. All figures include a 15% discount for payment by direct debit. From *Investors' Chronicle*, July 1981.

1

The Growing Threat of Private Medicine

1974 picket against private practice at BMA headquarters

THE GROWTH of private medicine poses an enormous threat to the National Health Service, and yet the private sector is parasitically dependent on the public sector. Its continued survival within the NHS has always been an anomaly and an illustration of the two standards allowed to exist in a supposedly socialised health care system. The trade union campaign against NHS paybeds in the mid-1970s, though by no means a complete victory, did achieve a compromise which effectively limited the growth of private medicine within the service. But trade union concern has since declined, while outside the service private medicine grows largely unchecked.

This growth was already well under way before the Labour government's 1976 legislation on paybeds, but the most spectacular increase has occurred since then. The irony is that the growth of private medicine *outside* the NHS poses a much greater threat to socialised health care than paybeds – yet many people who abhor paybeds see little harm in "independent" medicine, so long as it does not sponge off the NHS.

To launch a new initiative against all forms of private medicine, we need to understand the extent of the private health sector in Britain, and the causes of its recent unprecedented growth. This is not simply attributable to greedy doctors and wicked Tories! Successive governments, through continual underfunding, introducing charges to patients, and recent public spending cuts, have eroded the principle of a free and comprehensive NHS. Another factor is the inadequacies of the NHS, particularly in its choice of priorities, which favours acute and high technology medicine at the expense of primary, preventive and long term health care.

The private sector, too, is powerful, with its weighty backing of business interests; and it is selling a product – medical care, often wrongly equated with health. It makes itself attractive through effective advertising, preying on our fears and encouraging us to believe that good health can be bought. "Bupacare offers you peace of mind", "Bupacare can meet people's needs". And it is being helped on its way by Tory policy, encouraging it to grow through legislation and co-operation with the NHS.

All these factors have contributed to genuine dissatisfaction with the NHS, and to a real fear of not getting adequate treatment, which in turn fuel the private sector's growth. People who resort to private medicine are not just snobs, or queue jumpers, or misguided dupes, and to ignore this is to divert attention from the inadequacies of the present system. We need to find a way of learning from this discontent and channelling it into collective pressure for change. First, however, let us look at the historical background to the private medicine.

PRIVATE MEDICINE'S PAST

Figure 1 UK Provident population and subscribers, 1950-1979 (thousand)

Year	Total population covered by medical insurance	Subscribers
1950	120	56
1955	585	274
1960	995	476
1965	1445	680
1970	1982	930
1971	2102	986
1972	2176	1021
1973	2265	1064
1974	2334	1096
1975	2315	1087
1976	2251	1057
1977	2254	1057
1978	2388	1118
1979	2837	1328
1980(June)	**3000**	**1470**
1981(June)	**3750**	**1700**

Figure 2 UK group and individual subscribers 1965-1979 (thousand)

Year	Group	Individual	Total
1965	403	277	680
1966	443	292	735
1967	480	304	784
1968	517	314	831
1969	561	325	886
1970	602	328	930
1971	652	334	986
1972	693	328	1021
1973	740	324	1064
1974	784	312	1096
1975	793	294	1087
1976	782	275	1057
1977	800	257	1057
1978	869	249	1118
1979	940	388	1328

Source: Lee Donaldson Associates. UK Private Medical Care – Provident Schemes Statistics 1978.

Subscribers to the 3 main provident associations rose by 15.6% in 1979/80, 27% in 1980/81 and already 23% in 1981.

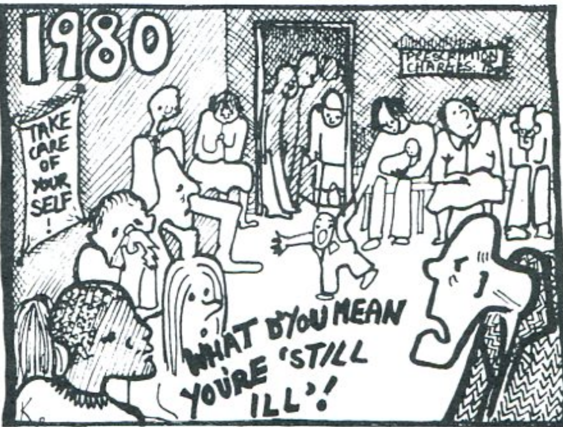
TRACING THE historical development of state and private medicine is crucial to any understanding of the recent expansion of the private sector. Some 24 million people earning £240 a year or less were covered by national insurance before 1948. Wives, children and other dependants were excluded and the benefits did not extend to hospital care. Hospitals were of two kinds: municipal hospitals inherited from the poor law, and voluntary hospitals independent of the state. By the 1930s, collections among workers to support voluntary hospitals had emerged as hospital contributory schemes, or low cost insurance.

These schemes excluded those who could afford to pay for treatment. The middle classes were by now anxious to have access to hospital care, and a second type of scheme, the provident association, emerged to cater for their needs. Pay beds were established in voluntary hospitals, and municipal hospitals increasingly found they too had to introduce pay beds to attract specialist doctors.

Primary health care (general practice and care in the community) was extended to everyone in 1948 and most hospitals were taken over by the state when the NHS came into being. Many of the contributory associations folded, and those left concentrated on providing income during sickness. Some provident associations decided to soldier on and concentrate on private hospital care within the NHS – its existence guaranteed by Bevan's deal to entice consultants into the NHS.

Since then hospital care has been the focal point of the expansion of private medicine. After 1948 there was a rapid decline in the number of people registered with their general practitioners as private patients, and attempts by the provident associations to expand in this area during the early 1960s were unsuccessful.

Private specialist care flourished, however, gradually spreading to the new managerial and professional



classes which grew rapidly after the Second World War. In 1949, the three associations which dominated the market had only 50,000 subscribers, but this had grown to 616,000 by 1959; most of this growth took place after 1954, even though the cost of pay beds and therefore of premiums was rising steeply. BUPA (the British United Provident Association) felt confident enough in the future to launch its "charitable" chain of nursing homes, the Nuffield Nursing Homes Trust, in 1957.

Group schemes, which gave premium reductions to people who joined at their place of work, were clearly established by 1960. They tended to be offered to managerial employees of large firms, attracting a younger, lower health risk category of subscriber. Sixty per cent of BUPA subscribers were in group schemes by 1965, a proportion which has grown steadily.

Into the seventies

The private sector was buoyant enough by the 1970s to attract foreign investment, and the Harley Street Clinic was taken over by American Medical International. The private sector sought for the first time to develop its own acute services, disturbing the traditional relationship whereby private nursing homes took run-of-the-mill cases to "enable the NHS to concentrate on highly specialised treatment". "In other words, pay beds enabled the private sector to provide acute surgery with a much higher element of subsidy from the NHS, while the independent nursing homes made no attempt to try to provide equivalent facilities"[1].

Nevertheless the early 1970s were not easy times for private medicine. Revenue increased, but mainly as a result of increased charges imposed by the Labour government, which also ended tax relief on provident subscriptions (now partially restored by the Conservatives). Subscriptions even fell for a while and the only real expansion was at the luxury end of the market, as Arab oil money poured into London. This flow of funds provided a basis for the expansion of private medicine in the late 1970s.

The turning point was the ancillary workers and nurses' campaign – against NHS pay beds – which have been described as a godsend to private medicine. The Health Services Board (HSB) set up in 1976 only abolished the least used pay beds, and its slow pace enabled the provident associations to raise money for expansion outside the NHS. When the Bill which set up the HSB was going through Parliament, Lord Goodman (the go-between for doctors and the Labour government) wrote to the *Times*: "If this Bill is approved I believe it provides a secure base for private medicine and a springboard for its continuation and, I hope, enlargement."

Events proved Lord Goodman right. The National Health Service Act was a tremendous boost for private practice, declared HSB member Derek Stevenson, secretary of the British Medical Association. It differed in three important respects from Labour's original proposals: no date was set for phasing out pay beds, there were no powers to restrict provident association advertising, and the controls on private hospital development were weak. But above all, the Act legitimated private medicine as long as it was "independent" of the NHS. The Labour minister, David Owen (now a leading light in the Social Democratic Party) said the deal between the government and the doctors provided a practical framework for separating private medicine and the NHS, "while guaranteeing that the process of phasing out is not a cover for any back door abolition of private practice. Through legislating the procedures for phasing out, Parliament has also guaranteed the right to private medicine"[2].

So the last Labour government, by bringing in legislation apparently fair to all parties, gave a new respectability to private medicine which undoubtedly helped it to grow. A secret report within BUPA even feared that the return of a Conservative government could "seriously undermine the independent sector"[3] by reopening the issue of pay beds in the NHS.

Independent parasites

The new independence of private medicine from the NHS is largely nominal. Apart from the continued existence of pay beds, there are three major ways in which the private sector leeches off the NHS.

- It uses staff trained at NHS expense: doctors, nurses, scientific and technical staff, and others. Premiums would have to be much higher to bear the full cost of training.
- Independent hospitals use NHS facilities they cannot afford to provide themselves, especially for the investigations and tests which take up an increasingly large proportion of the cost of "treatment". They also depend on the NHS to provide some forms of treatment, notably blood transfusions.
- The private sector does not provide a comprehensive service. It shuns high risk patients, such as the elderly, and those needing long term treatment, such as the mentally ill. It relies on NHS GPs to provide daily health care and to refer patients, and on the NHS itself to cope with its shortcomings, such as transferring patients to intensive care units.

Premiums would be much higher if the "independent" sector had to pay for all these things. Without its much vaunted partnership with the NHS, provident associations could not expand by providing cheap insurance, and so neither could private practice.

DISSATISFACTION WITH THE NHS

THIS, THEN, was the framework for growth. The cuts in public spending imposed from 1976, which caused the closure of many smaller hospitals and a general rundown of services, gave private medicine the boost it needed. The deterioration of services in the London area – with south-east England traditionally the biggest market for private medicine – encouraged more people to take out private insurance[4]. This decline was exacerbated by the redistribution of funds to provinces through the RAWP (Resource Allocation Working Party) formula, intended to overcome regional inequalities in NHS resource allocation[5]. Furthermore, the NHS's image was tarnished by constant media reports of industrial disputes in hospitals, such as those of the Winter of Discontent, 1978-9.

The 1976 upturn in private medicine's fortunes was reinforced by more aggressive marketing, much of it aimed at the middle class. They have always had the best deal from the NHS, summed up in the Inverse Care Law[6] (those with the fewest health problems receive more and better care) but long waiting lists, rundown services and the erosion of the NHS are pushing them towards private insurance to preserve their privileged access to health care.

A more unexpected feature is the growing number of working class people turning to the private sector. A 1978 survey showed that 43 per cent of BUPA subscribers came from social classes 3,4 and 5[7]. The cost of insurance can be surprisingly low and increased NHS charges, such as £1 for every item on a prescription, help to narrow the gap between the cost of public and private care. Private medicine is no longer only available to the "rich bastards": many trade unionists, despite official TUC opposition, have been involved in deals such as the EEPTU's, negotiated for 40,000 electricians.

A London fireman put many of the reasons for this in a nutshell: "I joined BUPA because I wanted to be able to have medical treatment at a time that suited me. The NHS in London has really gone down. I know of many hospitals that are closed . . . I don't mind paying extra for full security for my family. What's wrong with that?"

The rundown of the NHS, stretching resources to such an extent that waiting times for treatment of non-life-threatening but uncomfortable conditions such as hernias may run into years, is therefore contributing directly to the growth of private medicine. The private sector is also hastening to provide services which the NHS has never offered, such as occupational health care and some screening programmes.

Some people believe that the appeal of private medicine is simply a snob appeal – the lure of the single room, personal care from the specialist and so on. But the desire for more personalised treatment is also an expression of valid discontent with the kind of rough treatment or patronising attitudes many people encounter from NHS staff, themselves often acting under great stress because of overwork. NHS staff often assume that patients waste the professionals' time, expressed fairly typically here by a GP:

"Patients must realise that with the NHS they cannot have it all their own way. If the service is to work, they have got to co-operate with the doctor. If they want unnecessary visits, then I tell them straight out they have to become private patients."

But most people's experience of the NHS is that

they rarely "have it all their own way". They hope that by buying health care they are buying the right to redress the balance of power in encounters with professionals. They expect to see the consultant and not a junior, they expect to be able to ask questions, they expect to be treated courteously and humanely – expectations which the rundown NHS is increasingly unable to fulfil.

But does buying health care really give the consumer more power? The medical profession often promotes the idea that fee-paying medicine is genuinely "free" while state medicine smacks of totalitarianism[8]; there is just enough truth in this distortion to heighten private medicine's appeal, at a time when disillusion with the state as a provider of services is rife, and a key aspect of Thatcherism's appeal. But health workers still tend to keep their clients in the dark and regard their minds and bodies as professional territory over which they have dictatorial rights, whether they practise in the public or private sector.

The fight against private medicine therefore involves a desire for change in the social relations of health care – a new democratic relationship between health workers and users of the service, and between health workers themselves. This democracy would extend far beyond elected health authorities or workers' committees, right to the surgery waiting room and the bedside, an equality of relationship unacceptable to the private sector.

Can the country afford it?

The erosion of the idea that health care is a right is helping to foster private medicine, and indeed is being encouraged by those who stand to gain most from private development. It is closely linked to the idea that health is the individual person's responsibility and that illness is an individual fault, or at best bad luck. Little attention is paid to the social causes of ill health, and there is little recognition that pollution, unsafe working environments, poor housing, poverty, malnutrition and many other pressures inherent in the capitalist system are major factors in illness, mental and physical. If it is accepted that people are themselves to blame for getting sick, then it is easy to argue that it is their responsibility to pay for it, and to make provision for its possible occurence.

We are told that the country simply cannot afford to provide the kind and range of service needed, and that the demand is insatiable; in the absence of the price mechanism, it is argued, people recklessly consume as much medical care as they can. In fact the evidence suggests that state medicine in the UK is a more efficient regulator of scarce resources than free market systems. In any case, what is "the country"? It is people who pay taxes to provide services, the same taxes which are spent on weapons of destruction.

Private medicine, then, is growing primarily because the state is gradually withdrawing from the commitment embodied in the establishment of the NHS. That commitment was not open ended, it is true, because nearly everybody thought that once the cost barrier was removed, the backlog of ill health would be cleared. The increasing proportion of chronically ill and elderly people, and the NHS's inability to deal with the social causes of disease, have shown that belief to be naive.

The crisis in the health service is much deeper than the immediate problem of funding. The growth of private medicine will not be checked by repressive measures alone, nor by pumping unlimited cash into the NHS. What is needed is not only a vigorous campaign against the private sector – but also a positive campaign for a truly socialist health service.

Joyce A. Agee

TORY POLICY

"IT IS a fundamentally misconceived policy for any government to turn its back on the private sector and attempt to separate it completely from the NHS. Nothing could be better designed to create the sort of two-tier health care system that our political critics say they are anxious to avoid . . . There is a great potential for more co-operation and without it there will be waste and, in the end, both private and NHS medicine will be the losers."

Patrick Jenkin, Conservative secretary of state for health and social services, opening AMI's cardio-pulmonary diagnostic centre in Wimpole Street, 1980.

What you have just read needs translating. It should go something like this:

"It is our policy as a Conservative government gradually to relinquish the state's responsibility for the nation's health. We are no longer committed to supporting a free health service and we are concerned to promote private medicine in those fields of health care in which profit can be made. It is important, however, that we are seen to do this in the context of a deteriorating NHS increasingly incapable of providing a comprehensive service. The private sector, by taking over some of this burden, will be seen to be interdependent with the NHS and beneficial to it."

The Tory government, relinquishing its commitment to a free health service, does not intend to redistribute all the responsibility to private medicine's advantage; as cuts continue, much of it will fall on the shoulders of the ordinary citizen. People will be expected to contribute, in financial and human terms, particularly to those services regarded as unprofitable – the long-term care of the elderly, mentally ill, mentally handicapped and chronic sick.

Another Jenkin gem: "As the government sets about the tasks for which it was elected – cutting income tax, cutting public spending and curbing the burgeoning bureaucracies of the public sector – we shall be looking to the voluntary movement to take up more of the running. While the state has assumed the major responsibility for the basic provision in health, social security, and in local welfare services, it is now clear not only that it is quite impossible for the public sector to cater effectively for the entire range of human needs, but that *it is wrong and self-defeating for it to try to do so*," he said in June, 1979.

We want to show how Tory policy has developed, promoting private medicine in the guise of beneficial co-operation between the two sectors, and how it is

Patrick Jenkin speaks out.

already beginning to corrupt the principles of an NHS free at the point of need. We also want to show how the justifications offered for these policy changes undermine people's expectations (the NHS can't cope, is suffering from a cash crisis and so on); how they validate the reappearance of private medicine on a large scale; and how they quietly prepare people for the idea that health care is a commodity to be bought and sold, like any other, and ill health a catastrophe to be insured against, like any other.

You scratch our backs . . .

The incoming Tory government made plain its commitment to a dual system by announcing its intention to abolish the Health Services Board only a month after the May, 1979 election. It also showed its intention to create formal links between the two sectors, by the "increased use of contractual arrangements, in both directions . . . joint provision of services, sharing of some staff and possibly collaboration in research"[9]. Links such as these are only fostered if they favour a profit-based system, and by implication drain the NHS – by sharing staff, trained by the NHS; using research facilities, provided by the NHS; contracting to use expensive NHS equipment, or even blood, on the cheap; and charging the NHS for using private hospital beds while acute NHS hospitals are being closed.

No wonder Mr Jenkin could say, a month later: "It is, of course, the government's policy to welcome the contribution that independent medicine can make to the health care of our nation"[10].

The machinery for enacting these proposals was set in motion with the Health Services Bill, which became law in August, 1980. Much of it is taken up with encouraging the growth of private medicine.

Sections 9 and 10 abolish the HSB and end the phasing out of private practice in NHS hospitals. Sections 11 to 15 relax the controls over private hospital development and transfer the power to exercise them from the HSB to the secretary of state.

Private hospitals under 120 beds can now be provided in any health district without authorisation from the secretary of state, an increase from 100 beds in London and 75 elsewhere. Permission is needed if the building of a hospital or extension puts the number of beds over 120, or if there are already that number of beds in the district or area; but if the increase is under 20 per cent in three years, the need for authorisation is waived. The secretary of state must consider only whether the NHS would be adversely affected, and as the private sector takes over more acute work, it is hoped the authorisation of "complementary" private services will actually be seen to be beneficial to the NHS.

This licence to expand has been extended by amendments to the Land Transactions Procedures[11] concerning disposal of surplus land (April, 1980). Regional health authorities are no longer obliged to make a first offer to government departments and local authorities of their surplus land and property. In fact, the guidance on the amendment asks RHAs to consider giving priority to private medical interests "providing health services complementary to the services provided by the authority"[12, 13].

At a time when state interests have no capital for purchasing and the NHS is being strangled by cash limits, the sale of land on the open market can seem an easy way of obtaining cash for essential services. Health authorities boosted their budgets by an estimated £18 million during 1980-1981 simply by selling surplus land. But the short term gains may be outweighed by the long term disadvantages.

A typical example is the case of St Columba's Hospital in Hampstead. Hospital Corporation International, an American developer, recently proposed to buy the 27-bedded hospice, caring for the dying, which was closed in 1980 because of cuts. Its prime site is likely to become a profitable private abortion clinic, providing a service often lacking in the NHS – which performed only 30 per cent of the legal abortions in that AHA in 1979. The corporation has approached consultants from leading London teaching hospitals to ask how much they would invest in a private hospital and how many private sessions they would run, and to comment on the advantages of a unit in Hampstead[14].

Beneficial to the NHS?

Contractual arrangements between the NHS and the private sector have been operable since January 1981: the implications are far-reaching. Authorities planning NHS services are advised to take account of current and planned private facilities, "to assess the potential for contractual arrangements"[15].

The new emphasis is on a single pool of private and public resources to be planned and jointly managed on a permanent basis. Legislation which previously allowed only non-profit-making bodies to have such arrangements with the NHS (National Health Services Act, 1977) has now been extended to profit-making hospitals. Health authorities are urged to consider whether contracts are "the best way of providing an NHS service" if they avoid capital expenditure. A private institution contracted to the NHS which needs cash for expansion or upgrading "beneficial to the NHS" may even obtain cash from health authorities to carry out the work.

Who will implement these policies? Since the appearance of the "consultative" document *Patients First* in December, 1979, another NHS adminstrative reorganisation has dominated health service affairs – incidentally a useful smokescreen to veil other trends. Its proposals, which have faced heavy criticism, will be implemented in April, 1982. Area health authorities will be dissolved and their role as planning and consultative bodies devolved to 200 new district health authorities with an average population of 200,000.

Although the stated aim of the reshuffle (the second within a decade) is to cut costs and provide a more "local" service responsive to community needs – the latter a policy we support – this will not be the case. DHAs will have only four representatives nominated by the local authority, the remaining 12 being nominated by the regional health authority – a large and remote structure: 16 members in all, and none of them directly elected. RHAs' power over strategy and finance will increase, and DHA officers will find themselves unavoidably implementing cash limits – and therefore cuts – enforced by law. Some DHAs will be too small to plan and administer specialised services such as radiotherapy, a shift of emphasis away from the local health authority's commitment to provide a full range of services. This too will increase the power of RHAs and the autonomy of consultants.

The creation of new posts in unit management will strengthen the NHS's bias towards hospital care at the expense of community medicine, and also enhance the authority of hospital-based specialists. Finally, the reorganisation has been used as an excuse to curtail the activities of community health councils, set up in 1974 to express the views of the consumer in the NHS. It has been suggested by the government that their local authority membership should be reduced, and their national advisory role and statutory right to take up patients' complaints be curtailed. This, of course, would virtually silence a potential

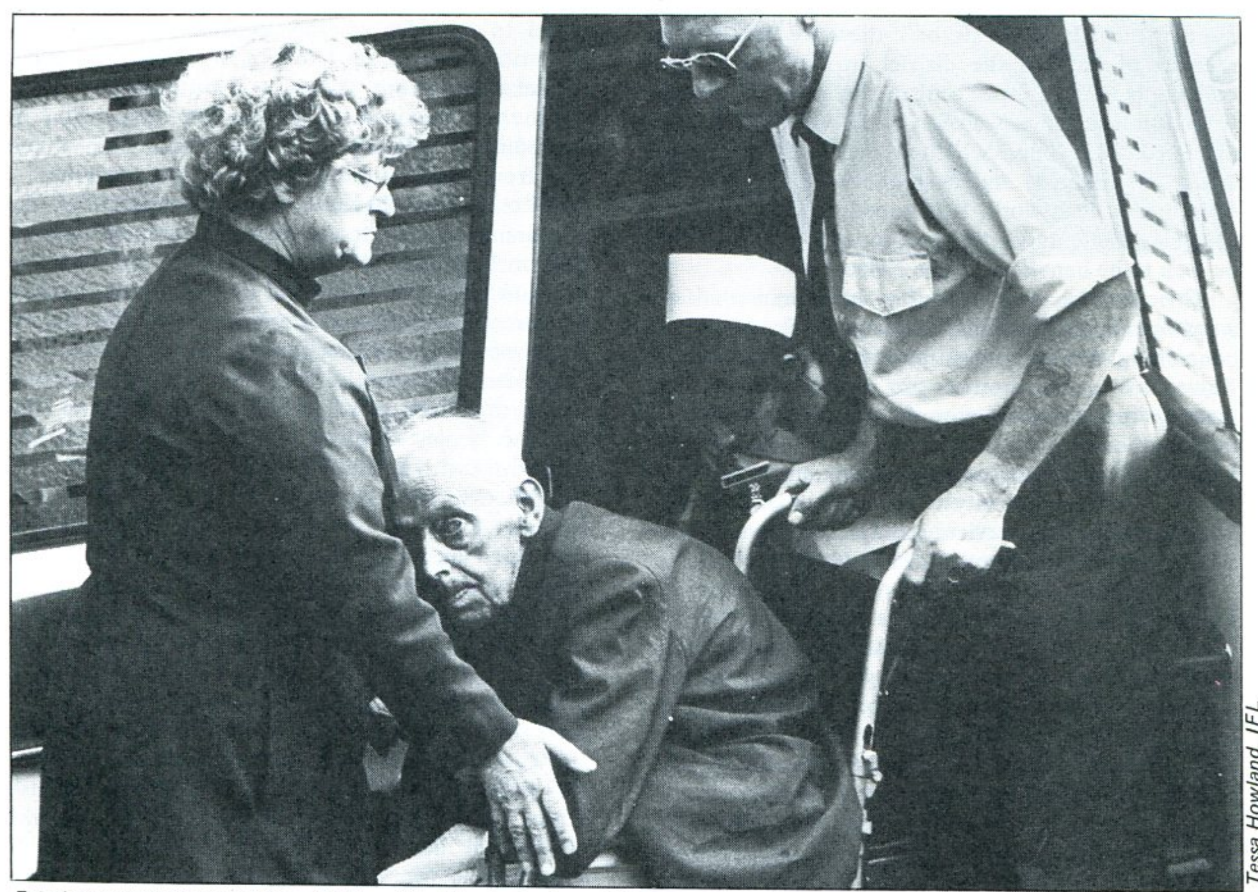
source of opposition to private development – CHCs have not been given the power to visit and monitor the growing number of private units with which the NHS might have contractual arrangements. The new plans overall demonstrate a serious lack of democracy and accountability.

A health service which lacks accountability, in which patients are treated in profit-making hospitals, money from taxes pour into the coffers of American companies and NHS administrators plan for a dual system is a long way from the concept of the NHS. Yet most people are unaware it is being undermined in this way: the government appears to be giving consumers a better service and greater choice by disguising the differing aims of big business and nationalised health care, and by talking of greater flexibility, economic advantage and a wider range of facilities.

Whose choice?

What do the Tories really mean by choice? That people should be responsible for their own health, education, housing. That everyone has "the opportunity to be unequal". That variety (different standards of care) is essential – for those who can afford it. That "free" services are always abused. That the notion of individual responsibility gives licence to cut. These ideas lie behind the measures which are quietly destroying the NHS.

Cuts in the NHS have been crucial to lowering people's expectations and alerting them to alternative services. They have been implemented largely through rigorous cash limits based on conservative estimates of inflation and wage settlements. In 1980-81, the NHS budget was adjusted to take account of an estimated inflation rate of 14 per cent, real growth being defined as money allocated over and above that percentage. But the rate of inflation in December, 1980 was 15 per cent, creating a shortfall of over £100 million between what was needed to maintain the service and what was actually given. The government admitted that only 0.5 per cent represented real growth and alternative sources estimate that the 1979-80 squeeze was as high as six per cent. The 1980 Health Services Act made cash limits legally binding, and by March, 1981, Mr Jenkin was boasting that the government had "saved" £750 million on the


Tessa Howland, IFL

Evicting an elderly patient from St Benedicts Hospital, Sept. 1980

NHS in three years.

He also had no qualms about using cash limits as a wages policy to force NHS workers into accepting minimal pay rises, saying that "if pay increases are demanded which go beyond what has been provided, the only result must be fewer services to patients", such as longer waiting lists and closures. This was a monstrous charge to lay at the door of workers whose pay has been consistently low and whose goodwill has been consistently exploited[16].

The rhetoric of individual responsibility and the reality of the cuts go hand in hand. Prescription charges have risen to £1 per item, national insurance contributions have gone up by a quarter and welfare food subsidies have been withdrawn from some large families. Mr Jenkin's moral justification, as he told the Health Visitors Association in October, 1980, was that "every individual has a duty, both to himself and to the community, to look after his own health to the best of his ability. If this is not done, then the statutory services simply could not cope with every need."

Voluntary agencies, says the government, have a responsibility to relieve statutory services of the burden of caring. It is not hard to imagine an NHS for the chronically sick and disabled which is supported by charity and in which families and volunteers play a major role. "Care in the community must mean care by the community," says Mr Jenkin. "We have stressed the importance of the voluntary sector. We have stressed the key role of the family, friends and of neighbours. We have sought to persuade social service departments to try to build partnerships with voluntary agencies, and with informal caring networks, but none of this adequately conveys what one is really trying to say."

Some idea of what the government *is* trying to say can be gleaned from its plans for fundraising by health authorities, circular HC(80)11, December, 1980. They now have legal powers to raise funds, that is to encourage people to pay twice for their health care, and "to play a far more active and positive role in advising voluntary groups where their efforts can most usefully be directed." After protests from charities and trade unions the circular was amended to assure voluntary organisations that health authorities would consult them on health planning and encourage "a closer working partnership". Its principles, however, remain unchanged.

Health authorities are enabled to appoint full time fund raisers from their budgets, so the money being sought is considerable. The avowed intention of "bringing the health service and the community closer together" will actually encourage further the two-tier system Mr Jenkin says he wants to avoid.

Eligible for treatment

The pace of implementing Tory health policy is speeding up, and its effects are directly reaching the point of need. Another circular underlines the Tory vision of the world: ridiculing the postwar Labour government for giving a lead by treating overseas visitors free, the government hopes to save £5 million by making them pay — this includes students as well as "well-heeled foreigners". Linked with fears about the pending Nationality Bill, this move may subject Britain's ethnic minorities to abuse; it seeks to give health care free only to those "ordinarily resident" (this is not defined by the DHSS) or those who have lived in the UK for at least three years. Most people will be eligible for emergency treatment but only those from countries with reciprocal arrangements will have treatment of "immediate necessity"[17].

Test questions may be asked to prove someone's eligibility for NHS follow-up or preventive care (a suggestion rejected as unworkable by the Institute of Health Service Administrators), but in practice it will probably be applied only to those who appear ineligible, i.e. coloured people. Already, black residents have been asked to produce their passports before being treated, including Lulu Banu, a Bangladeshi woman who has lived in Britain for 14 years and is a member of the Commission for Racial Equality. "I see the new system as another ploy to harass black people in this country", she wrote to Mr Jenkin[18].

These proposals amount to an extension of the private sector to new areas in the NHS, such as domiciliary support services and community health facilities. As such they are linked to the government's

Asset stripping?

Striptease dancing could not be used by health authorities to raise money for the NHS, Lord Sandys solemnly told the House of Lords during the committee stage of the Health Services Bill. But the law does allow them to raise funds by "public appeals or collections and competitions, entertainments, bazaars, sales of produce or other goods". The entrepreneurs moved in fast: in December, 1980, a one-day conference was held at a London hotel, costing £93 per person, to show NHS administrators how to raise money through lotteries and the like.

Meanwhile, back in the world of striptease: Eric Morley, boss of Miss World Ltd and Tory candidate in 1979, was nominated by doctors and appointed a member of Lambeth, Southwark and Lewisham Area Health Authority. He aims to "raise money from charitable sources for the area's health services, and to *take politics out of health*".

plans to introduce insurance funding – although many people "not ordinarily resident" who need chronic care are ineligible for private insurance even if they could afford it. But its longer term significance is to make the public aware, by means of a proposal which hardly touches their lives and is promoted as an anti-abuse measure, that a free NHS will no longer be a universal right. And the public is being encouraged to think again about alternatives: "Knowing one can never meet all expectations, and that there is a limit to what the taxpayer will pay – is it so unreasonable for the government to examine alternative methods of financing health care?" Mr Jenkin asked the Commons.

Dr Gerard Vaughan, minister of health, told the Conservative Medical Society in November, 1980, of the government's interest in changing from predominantly tax-based funding to a system in which patients would pay and have the cost reimbursed by a means test. DHSS officials visited the US, France, West Germany, Holland and Scandinavia to examine their funding systems. Six months later Dr Vaughan was telling the British Medical Association junior members' forum of a different combination: "Should the NHS be differently funded – perhaps by a state insurance scheme with opting out if you wish to insure privately?"

In fact the government has found it more difficult than expected to develop a feasible insurance scheme. It originally intended to issue a consultation paper in the summer of 1981 but instead announced that a working party would look at the issue – the trips to other countries with insurance systems having proved less fruitful than expected.

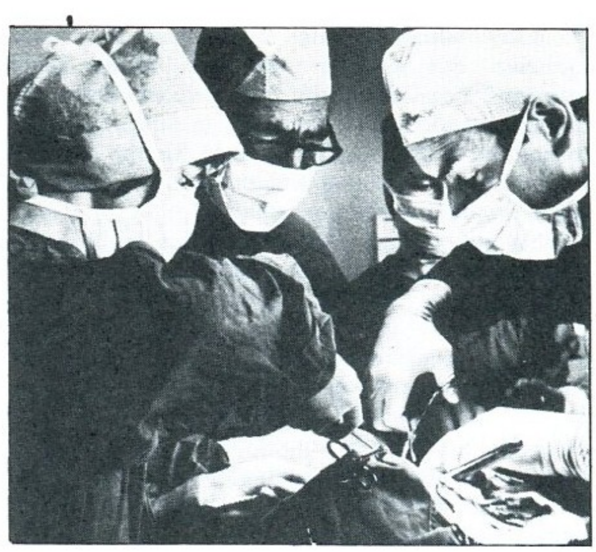
It has, however, issued a consultative paper, *Care in the Community* (July, 1981) which suggests ways of transferring the NHS's responsibility for long stay patients – the mentally ill and handicapped, the elderly, the chronic sick – to the care of local authorities, private interests and the voluntary sector. It suggests that health authorities could sell off the large institutions and transfer the capital to other agencies, through joint funding, lump sums or central government allocation, for example.

Nowhere is any blueprint for the NHS mentioned; there is no attempt to reconcile these schemes with planned reductions in local authority spending; there is no discussion of promoting NHS initiatives in small scale, locally based care for the chronic sick. One reason may be that the government aims to save money on the NHS by reducing its functions – by transferring the responsibility for long stay patients largely to local authorities, which have so far suffered much more heavily from the cuts and which have already expressed doubts about finding the money for jointly funded projects. How will they react to such a massive shift?

Ridding the NHS of the very people who are bad insurance risks also facilitates the introduction of an insurance scheme. It cannot be both commercially viable and provide lifelong care for the mentally handicapped or accommodation for the elderly. Insurance funding will raise the cost of administration and health care for the low paid; opting out will cripple the NHS even further. Measures which enmesh private medicine and the NHS are creating a secure option for private insurers – the availability of NHS backup services. But for those who will have to rely on state insurance the outlook is grim, and insecure, and is made bleaker by accompanying local government cuts – reducing the social services and standards of housing which have such vital effects on health – and cuts in social security benefits.

2

The Extent of the Problem



DOCTORS AND PRIVATE MEDICINE

THE MEDICAL PROFESSION has traditionally been a staunch and vocal ally of private medicine. When the NHS was set up in the 1940, general practitioners and hospital doctors fought for and won the right to continue to practice privately. GPs fought off attempts to bring them under the direct control of the NHS and have always remained independent, self-employed contractors with the right to do as much (or as little) private practice as they wish.

Hospital doctors fought a similar campaign. "Robbed" of "their" hospitals – 99 per cent were nationalised in 1948 – hospital consultants stuck out for the right to choose whether to work full-time or part-time for the NHS and, moreover, for the right to use some NHS hospital beds for fee-paying private patients (ie paybeds). These victories are largely responsible for the large role played by private medicine in today's NHS.

Behind this commitment lies a mixture of motives. Money certainly plays a part. For many, particularly hospital consultants, private medicine means big business: large profits from private consultation fees and medical charges, and a substantial source of income to supplement their earnings from the NHS. A morning's work in a busy and prestigious private outpatient clinic can be worth several thousand pounds to a consultant.

But the money side can be over-rated. Hospital consultants, for instance, may already earn a very comfortable living from the NHS. The basic wage of a full-time NHS consultant is between £16,440 and £21,060 a year, and on top of this there are annual merit or distinction awards worth between £3,720 and £18,110. Top paid consultants can therefore earn around £40,000 a year as NHS employees, and their part-time colleagues (over half of all consultants) earn a proportion of this relative to the hours they work.

The merit award system has come in for a certain amount of criticism. Once given, an award is held until retirement. The Royal Commission on the NHS (1979) pointed out that they do not always reflect the hard and often unsung work that also benefits the NHS. They tend to be awarded to consultants in teaching hospitals and in the glamorous specialisms: in England and Wales in 1979, over 67 per cent of all cardiothoracic sugeons held awards, compared with only 17 per cent in community medicine, 21 per cent in geriatrics and 28 per cent in mental health[1]. The scheme is deliberately veiled in secrecy and breaks a fundamental principle of the British constitution, that funds raised from public taxation shall be accounted for to Parliament. Although the total cost of the scheme is accountable, the names of recipients and the reasons for their selection are not made public.

Value of distinction awards, 1981[2]

Type of award	Value of payment
A+	£18,110
A	13,950
B	8,350
C	3,720

The continuation of this extraordinary privilege owes much to the considerable respect and awe in which doctors are held. The medical profession has been extremely successful in creating a public image of selfless devotion and unimpeachable idealism, which has obscured some of the grubbier

pecuniary details of its involvement in private medicine. But as even the BMA careers guide maintains, social class, a lot of money and the power of life and death are not the right motives for wanting to become a doctor. The "reward for the doctor's labour is an intellectual and emotional satisfaction which few other professions share."

This respect from the public has enabled the profession to defend private medicine in such high-flown terms as "clinical freedom" and "consumer sovereignty", the arrangement, it argues, guarantees the best possible doctor/patient relationship, with the former free to do what seems best and the latter free to go elsewhere if he or she doesn't like it. A number of doctors also argue that in private practice they can devote time and energy to patients, which they cannot do in the NHS because of pressure of work.

HARLEY STREET W1

CITY OF WESTMINSTER

Some of these arguments are nonsense – what does "consumer sovereignty" actually mean in the context of medicine, where most patients are almost totally ignorant of what is going on? But others contain important grains of truth. Cuts on the NHS *have* made working in the public sector less attractive. The pressure of work has increased, particularly for younger doctors, and this may foster resentment of the NHS. Most junior hospital doctors have to endure long hours of work – up to 100 hours a week, or six full working days – in conditions many others would refuse to tolerate. But these are criticisms of the way the NHS operates at the moment, not of the way it must operate in the future, a distinction which advocates of private medicine often fail to make.

Finally, it is significant that doctors are drawn predominantly from the middle and upper middle classes. In 1961 more than one third of all medical students came from professional and executive backgrounds, while only three per cent came from families of semi-skilled or unskilled workers. By 1966 the number with professional parents had risen to 40 per cent. They bring with them the values, opinions and politics of their background, which for many is profoundly conservative: along with its traditions of public service and good works, it also contains a commitment to free enterprise and individual responsibility and a hostility to state involvement.

A growing number of hospital consultants and GPs have now started to cash in on the boom in private medicine and have begun to form consortia to build and run private hospitals. There are not many of these yet in existence, but they are on the increase. And the BMA's code of ethics has no objection to this, provided a doctor first makes it clear to a patient that he or she has a financial interest in the hospital in question.

Doctors have been encouraged by a willing Conservative government to amend their contracts of employment so that there is a positive incentive to do private work. Full-time NHS consultants are now allowed to earn up to 10 per cent of their NHS salary in private practice fees, while part-timers have had a 10 per cent salary increase for no extra work and are allowed to do as much private work as they are able[3].

It would be misleading to give the impression that all doctors are convinced that, as some argue, a healthy doctor/patient relationship can only be established if cash changes hands. Some work in areas where the pickings are slender, such as geriatrics or mental handicap. Others, while unwilling to take action against private medicine, quietly oppose it, hopeful that the NHS will improve to the extent that private practice will appear less attractive to patients. Many, however, cling to the cash relationship through a mixture of motives they seldom bother to examine deeply.

HEALTH INSURANCE

INSURANCE is crucial to the development of private medicine. Put simply, private medicine is unthinkable for the vast majority of people unless they have insurance cover. A pay bed in a London teaching hospital now costs over £118 a day, and a bed in a private hospital costs anything from £600 to £1,600 a week. And this includes only the "hotel charges" – board, lodging and nursing. A consultant costs another £5.90 an hour in London, a little less elsewhere, and the use of an operating theatre works out at just under £50 for a half-hour operation. If private medical care is to be more than a luxury for the super-rich, then it must have a thriving health insurance market to back it up.

The Conservative government is receptive to this argument: it is no coincidence that the March, 1981 budget gave tax concessions to employers who offer group medical insurance schemes to their employees. It is currently looking at ways of increasing the role of insurance in health care funding. The UK is almost unique in paying for over 80 per cent of all health care out of central government funds raised through taxation.

Insurance based systems

Several criticisms can be made of insurance based health care systems in general.

• All insurance systems are expensive to operate and therefore raise the overall cost of health care. Every item of service has to be billed separately, submitted as a claim, assessed, argued over and then paid for (the fee-for-service system). In the British system doctors of each grade are paid a nationally negotiated salary and the costs of health care are automatically met by central government.

Administration absorbs only six per cent of all NHS costs, while the figure is 12 per cent in Belgium and France, 18 per cent in Australia and 21 per cent in the US. West Germany, where administration takes up about eight per cent of costs, there are 1,400 individual health insurance funds which require an army of 80,000 staff.

Talk of switching to an insurance based system is somewhat ironic at a time when the government wants to save money on health care. But the cost of health care would be transferred from the public to the private purse, and this accounting sleight of hand could be said to be cutting public spending. The fact that the country as a whole would be devoting *more* money to health care – and wastefully – is hidden.

• A system which pays doctors a fee for each test and operation encourages expensive investigations and treatments which may often be only marginally, if at all, useful to the patient. "The highest financial rewards go not to the doctor with the least professional scruples about responding to the financial incentives of the payment system. Some doctors may even claim for services which are not performed"[4].

The insurance schemes which support this method of payment encourage a curative approach to ill health which may be inappropriate and is always expensive. The average American undergoes twice as many operations as the average British citizen, at all ages. The difference is mainly accounted for by "discretionary" operations – if it pays to circumcise or remove gall bladders, then they will be removed[5].

Most countries with an insurance based system therefore face even steeper rises in health care costs than the UK. Indeed, abuses of the system in the US have for some years led to talk of switching to a publicly administered national insurance scheme, from one where the private insurance companies are dominated by hospital adminstrators and doctors. The French national insurance fund ran out of money in 1980 and had to be baled out by central government. In West Germany there have been attempts to hold down costs by imposing legal limits on charges. Inflating medical costs in Belgium have led to a Royal Commission – one of the options it is investigating is a British-style system. So, by a curious quirk of fate, while the British government is looking to other health care systems for inspiration, several are looking to Britain for solutions.

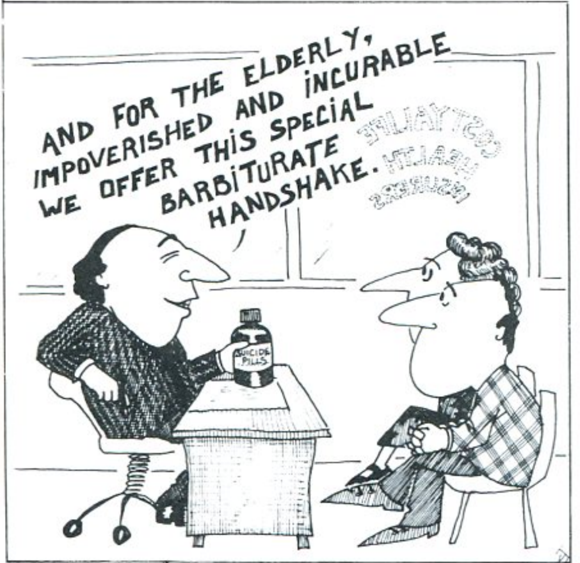
• The drive towards expensive curative medicine, integral to the survival of insurance based systems, is not only costly but reinforces the imbalance in health care which the British government has been committed to altering for over five years. It is longstanding Labour and Tory policy that there should be a relative reduction in acute medicine and a shift towards primary and preventive care, neither of which contain much financial incentive for doctors or insurance and supply companies.

"The simpler, non-technical elements, such as preventive medicine and family practice, have been pushed aside in the rush towards exciting new procedures and techniques," wrote an American academic about the US system[6]. Within the acute sector itself, care based on fees-for-service encourages doctors to specialise in the prestigious and therefore lucrative specialities like heart and brain surgery, reducing further the number of specialists in less lucrative fields such as geriatrics.

• Insurance schemes reinforce existing inequalities in health care. They always allow the better off to buy more health care than those who cannot afford the premiums. In France, 90 per cent of the population

is covered by a quasi-state administered national insurance scheme which meets only about 80 per cent of all costs. At least half the population also has private insurance to pay for what the state does not provide: and if you cannot afford private insurance, that's tough.

Well over 90 per cent of West Germans are covered by a compulsory, state supervised insurance scheme, but at least 10 per cent also have private insurance to allow them to buy, in theory, more and better health care. About 75 per cent of Americans have private insurance, and the rest are covered by state insurance, but in practice this is patchy and inadequate. Moreover, American private insurance seldom meets all medical costs. "An average family of four has the following medical needs: yearly physical examination by a doctor for all members, four visits to the doctor for illness, a yearly dental check-up and needed dental work, prescription drugs for three members and an eye examination and glasses for one. The standard insurance policy will pay for none of these services and costs the family about 350 dollars (about £175) a year.



"Private insurance companies claim that deductibles (the amount a consumer must pay before the insurance company will pay), uncovered and partially covered costs prevent the consumer from 'overusing' health facilities. In reality . . . studies show that out-of-pocket payments mainly prevent lower-income people from using needed services[7]".

Secretary of State Patrick Jenkin is not unaware of the problems. "Market forces are pretty ineffective in balancing the need for health care and the supply of services," he told an American audience in 1977. "Ten million Americans lack any private and public insurance to pay for health care and many more have inadequate cover. In 1970, ill health accounted for a third of all personal bankruptcies."

British insurance schemes closely resemble the American system, with large areas of health care not covered in the policies. "Private medical insurance is not much help if you are chronically sick. If you need a heart transplant you need the NHS. If you are badly injured in an accident, waving your BUPA policy in the casualty department will do you no good at all. And if you are old and feeble and require constant nursing, no medical insurance company will lift the tab," said a *Sunday Times* survey[8].

"Indeed the list of exclusions in medical insurance policies is long and varied: private consultations by a GP, pregnancy, abortion, chiropody, osteopathy, vasectomy, sight-testing, most dental treatment" – in short, most everyday health needs.

Growth area

About 3.5 million people in the UK are now covered by medical insurance, or about 6.4 per cent of the population. The annual average rate of growth in subscribers was 19 per cent in 1979 and around 27 per cent a year later, compared with an annual average of about 10 per cent over the previous 20 years. There has been an increase in individual subscribers.

More working class people are taking out insurance. BUPA claims 200,000 trade unionist subscribers, including 40,000 electricians; 1,000 members of the National Union of Seamen working on oil rigs whose insurance is paid by their employers; 50,000 police

(half the total), and an unspecified number of firemen. Rank Xerox and Allied Breweries offer all employees private insurance. BUPA claims that 90 of Britain's 100 biggest companies now use its group schemes and that it has 30,000 such schemes.

If this rate continues the insured population will reach 20 million by 1990, over 30 per cent, although this kind of projection is extremely uncertain. The government's plans could push the figure higher, faster, and future developments in the NHS could also make a difference. A recent BUPA survey suggested that 75 per cent of those who had taken out subscriptions in the last year had done so out of concern with the standards of care in the NHS. The state of the economy could also have an impact. Growth is almost certain, but the rate of growth is less predictable.

The way things are going, can your company stay healthy without BUPA?

Who gains? The simple answer is the 10 insurance companies which specialise in medical coverage. The long answer is the medical profession and the middle class.

Eight of the 10 companies operate behind a comfortable facade as "non-profit-making bodies", which gives them an uncontroversial and almost philanthropic air. Yet they are rooted in class privilege. BUPA's second annual report gives something of the flavour of the early days: "The governors feel. . . they are making a not unimportant contribution to the efforts of the middle class to maintain the amenities and standards to which they have become accustomed."

The history of BUPA, which dominates the medical insurance market, reveals some of the inter-

Table 1: The medical insurance industry, in descending order of size.

1. **British United Provident Association** – see text.
2. **Private Patients Plan.**
   The second largest British company, with about 20 per cent of the market. Its biggest breakthrough recently was signing up half the police force. PPP makes substantial loans to private hospitals including Nuffield, with some £4 million currently earmarked for this. Offered at discount prices to all members of the Royal College of Nursing and British Medical Association.
3. **Western Provident Association.**
   This has about two per cent of the market.
4. **Allied Medical Insurance Service.**
   This is a commercially operated insurance company, with about one per cent of the British market. It used to be owned by the Allied Medical Group but was hived off when AMG was taken over by the National Enterprise Board, and is now privately owned. Its operations are confined to the London area.
5. **The Bristol Contributory Welfare Association.**
6. **The Civil Service Medical Aid Association.**
7. **Provincial Hospital Services Association.**
8. **Private Patients (Anglia) Ltd.**
9. **Revenue Provident Association.**
10. **Crusader.**
    Britain's second commercial medical insurance company was set up in the 1980s. It is now owned by Marsh and McLannan, a huge American firm of insurance brokers, through their ownership of C. T. Bowring & Co. Ltd, the biggest insurance brokers in the UK. Crusader is unique in that it deals in all forms of insurance and makes most of its money in life and motor insurance. It is concentrated in the south of England.

ests underlying private insurance. Lord Nuffield, "the great apostle of self-help and independence", who helped bring private hospital treatment within the reach of people with modest incomes, put up £150,000 in 1941 to found the Nuffield Provincial Guarantee Fund (NPGF). This had two purposes: to shore up confidence in the provincial funds by underwriting them, and to work towards the establishment of one national fund. At this time some form of NHS was already in the wind and there were growing fears that the provident associations would disappear, and with them private medicine. Nuffield was strongly supported by the British Medical Association, which had all along been hostile to the idea of state medicine.

In 1946, with the NHS virtually on the statute book, the NPGF called an urgent meeting, attended by 89 organisations including 32 provident societies, at which Nuffield agreed the NPGF would underwrite a new national association to the tune of £50,000. The British United Provident Association was set up the following year to "safeguard the continued use and existence of private beds in NHS hospitals and private nursing homes"[9]. It was clearly understood that this continued use mattered not just to the beseiged middle class but also to the medical profession. In short, BUPA was set up as a deliberate political act to preserve private medicine in the face of the NHS.

BUPA has since remained the powerhouse of British private medicine. It has led the insurance field and has done more than any other body to ensure there is a continued supply of private facilities. In the 1950s it established the Nuffield Nursing Homes Trust as an independent non-profit-making body (though with the same board of directors) which has developed into the biggest chain of private hospitals in Britain, largely funded by BUPA from insurance income.

Today BUPA is the biggest single source of finance to British private medicine providing a third of all investment capital for new hospital projects. These include new Nuffield hospitals, other independent ones, and hospitals of its own. Without BUPA, private medicine in Britain would not be what it is today.

Savile's travels

Insurance companies are trying to exploit people's goodwill to attract more custom. Full page advertisements in the national papers in August, 1980 pushed the benefits of Hospital Plan Insurance Services, an American firm – promising that for every certificate issued it would donate £1 to Jimmy Savile's Stoke Mandeville appeal.

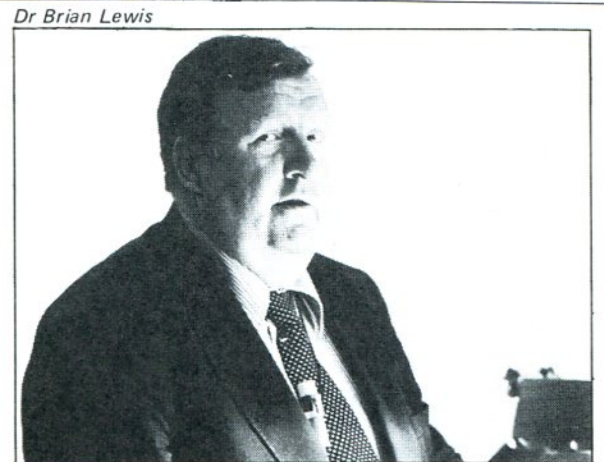
It is ironic that an insurance scheme which helps to undermine the NHS should tout for sales by offering to help finance a charity appeal. The appeal itself was only made necessary in the first place by the government's refusal to fund fully the internationally renowned rehabilitation centre.

BUPA group companies

BUPA claims to be non-profit-making. However, it is closely linked to eight subsidiary companies, all profit making organisations in private health care[10]. These are:

BUPA Consultancy Ltd
BUPA Hospital Cash Scheme
BUPA Hospitals Ltd
BUPA Manchester Medical Centre
BUPA Medical Centre
BUPA Nursing Services Ltd
BUPA Pathology Ltd
BUPA Services Ltd

Dr Brian Lewis



The unacceptable face of private medicine

BUPA plays a vital role in propping up private medicine – but it claims to make no profit. So where does the money go? Much of it goes to doctors, but it is difficult to determine the medical establishment's precise relationship with BUPA. One example of the probably informal links cementing this powerful alliance is the BMA's "frontline political heavyweight" Dr Brian Lewis ("I like power, I get a kick out of running things" –*Pulse*, February 28, 1981), fearless salesman of private medicine, consultant anaesthetist, ex-chairman of the BMA's representative body – and director of BUPA.

PRIVATE HOSPITALS

PRIVATE MEDICINE, broadly speaking, covers everything from so-called "fringe" medicine to modern hospitals; it is said to be a £1 billion business. The major area of growth and investment is private hospitals, and private acute hospitals in particular, though there is also a proliferation of "residential clinics". Behind the hospital boom lies an optimism generated by the enormous recent increase in the uptake of medical insurance, and a fear that unless something is done quickly demand will outstrip supply and waiting lists for private operations will develop – destroying one of its big selling points, speedy treatment.

Private medicine is also, of course, very profitable – the main reason for the boom (Table 2).

Table 2: Profitability of large private companies (January, 1981)[11]

	Profitability			Growth
	Return on equity		Return on total capital	Sales
	5 yr. av.	Last 12 mnths.	5 yr. av.	5 yr. av.
Humana	23.7%	33.6%	9.2%	39.8%
HCA	18.7%	18.0%	8.9%	27.6%
AMI	16.2%	20.9%	9.0%	22.1%

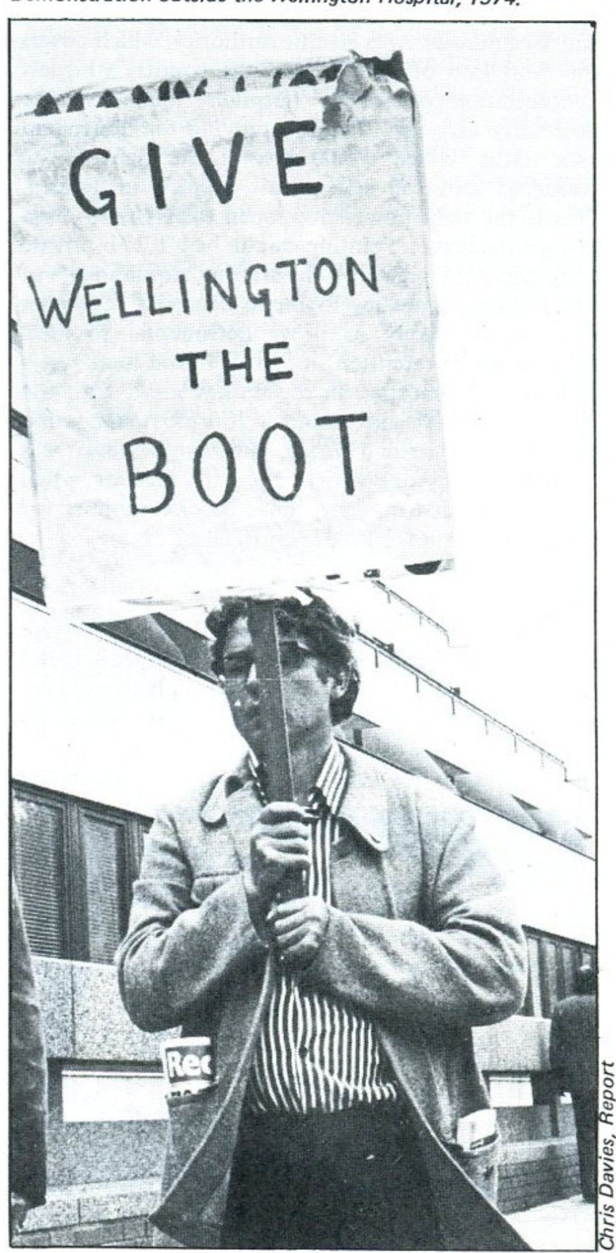
At the same time the political vulnerability of pay beds – halved by the last Labour government – has convinced private medical interests that independent hospitals are a securer and more controlled base for growth. The pay bed fracas of 1975 may have started the boom in private hospital construction, and the growth in insurance and a sympathetic government are ensuring it will continue.

Currently there are about 120 acute private hospitals in Britain (but accurate figures are hard to come by) with about 6,000 beds, plus about 2,400 private beds in NHS hospitals. Expansion will push the number of hospitals up to at least 150, and the number of private beds, including pay beds, to about 10,000. The private sector plans to invest at least £100 million, about a quarter of the entire NHS capital budget for 1979-1980.

Private hospitals vary a lot. At one end of the spectrum is the £1,600-a-week Wellington Hospital in central London, boasting £5,000 diamond and ruby necklaces in the hospital shop, G-Plan chrome and leather furniture, cardiac defibrillators and emergency trolleys on every floor, and balconies overlooking Lord's cricket ground. At the other end are the cheaper and more functional Nuffield nursing homes, with green emulsion walls and plastic and tubular steel furniture; they are institutions rather than hotels, run by matrons rather than businessmen. The former type have traditionally catered for the overseas trade (most insurance companies don't cover the costs of Wellington-type hospitals), the latter for the British middle class.

Private hospitals before the mid-1970s were usually the domain of non-profit-making charities,

Demonstration outside the Wellington Hospital, 1974.



Chris Davies, Report

local and national, religious and secular. But big business has begun to move in, finding hot investment opportunities. Unlike the charities, its first and only consideration is profit. As the managing director of an American hospital chain put it, "As long as health care generates an above average return on investment we're going to invest in it."

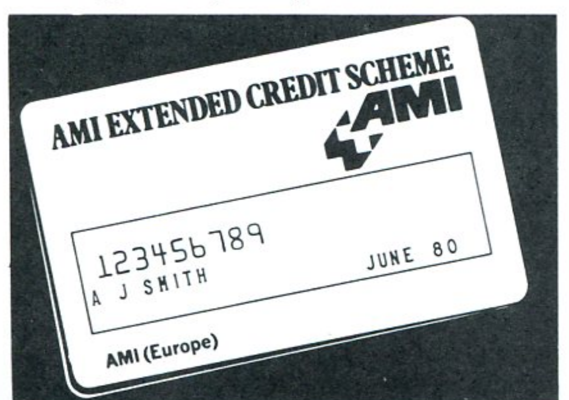
It may be argued that private hospitals only provide a tiny fraction of the country's beds – 10,000 compared with 480,000 in the NHS. But the government says it wants to increase private sector involvement to 25 per cent; moreover, the figures hide the fact that most private beds are in the acute sector, concentrated in particular parts of the country.

So what are the implications? Kensington, Chelsea and Westminster Area Health Authority, which covers the West End of London and the country's biggest concentration of private hospitals, looked at the possibility early in 1981 of applying for designated area status, which would give it the right to be consulted about all new private projects in its area. This is the only power now open to AHAs to resist private medicine. Pointing out it had 1,271 private beds, the AHA argued: "The staffing requirements of any further private developments occurring in or near the area are likely to prove detrimental to local recruitment or retention of staff." It said there was a constant staff shortage in certain key areas, with one in seven posts vacant (about 1,200 jobs), the worst shortage being trained nurses. The plan, however, was turned down by one vote at the AHA meeting, when members divided on party lines despite support for the motion from the full time officers.

The developers

Much of the money and experience in private hospital development is American: at least six hospital chains have offices in London and at least another seven are known to be actively interested in the UK market. Five have established British operations.

The biggest and probably best known here is the Los Angeles-based American Medical International, which runs hospitals in four continents, and owns four hospitals in and around London through its wholly owned subsidiary American Medical (Europe) Ltd. AMI is a flamboyant and high profile company wedded to the conviction that health is a commodity like any other; unlike some of its rivals it welcomes, indeed courts publicity. There were red faces when AMI performed 34 free heart operations on patients from Liverpool, where there are long waiting lists, in 1980, as a publicity stunt, and it recently made news with its holiday package with British Airways, which offers overseas visitors a holiday and operation in Britain thrown in.



"The AMI Extended Credit Scheme – a valuable new facility for the community"

AMI is celebrating its tenth anniversary in the UK with a £25 million investment programme including new hospitals in Manchester, Birmingham and Canterbury. It has also taken over a small American hospital group called Hyatt Medical Enterprises, which is building a medium-sized hospital outside Oxford and is considering a second in Southampton. The company reckons to have one of the most sophisticated hospital management systems in the world; every chief administrator has a daily computer printout showing the revenue, work and costs of each department. AMI is a public company, though a large chunk of stock is owned by LA businessmen Wally Wiseman and Roy Deiner.

AMI's major rival in Britain to date has been Humana, the US's fastest growing chain. Based in Kentucky, it owns London's Wellington Hospital, to which it is adding a £20 million extension doubling its size. It first had to defeat strong opposition at a Health Services Board enquiry; NHS interests were convinced it would poach scarce staff. "There was a regular restriction on the amount of open heart surgery during 1978 because of shortages of intensive care or operating staff. There is considerable evidence that there has been a loss of staff from our hospitals to the private sector," said a hospital administrator in evidence.

Humana is known in the US for its spectacular growth and hard-nosed management style, and its approach to health care has raised eyebrows even in the freewheeling States. It offers family doctors substantial subsidies in the hope that they will refer their patients to Humana hospitals, and operates a controversial "insta-care" card system which is sold to potential patients and said to ensure them one-minute emergency care by guaranteeing their credit worthiness. When it bought the loss-making Wellington in 1976, Humana cut staff by a quarter and raised fees by 50 per cent, since when the hospital has gone from strength to strength.

These two groups have now been joined by an ambitious and thrusting, if somewhat reserved, outfit called Hospital Affiliates International, which claims

to be the biggest hospital management company in the world and is owned by the massive Insurance Company of North America. HAI has just opened the "new market leader", the 120-bedded Cromwell Hospital in west London, costing about £17 million. A second wing to double its capacity is also planned. "It would be difficult to imagine a more magnificently designed and equipped hospital," wrote a slightly awed NHS administrator. HAI also hopes to open hospitals in Cardiff, Birmingham and Manchester.

Another recent American arrival is Charter Medical, a public company with 34 hospitals in the US and Puerto Rico; it specialises in residential clinics for psychiatric and alcohol problems. Charter opened its first British clinic of 41 beds in Chelsea in 1980, and says it will soon open another somewhere in metropolitan London. The clinics are aimed primarily at business executives with drink and/or personality problems.

Even more recent is the misleadingly named Community Psychiatric Centres, which bought a 140-bedded hospital in south west London in 1980 and has a second hospital in Kingston, Surrey. CPC operates from San Francisco and is owned by a conglomerate of pension funds and unit trust companies.

Finally, there is the current giant of American medicine, Hospital Corporation International, based in Nashville, Tennessee. It owns the biggest private hospital chain in the world, mainly in the US and the Middle East, but it has so far denied plans to move into the British market: its new London office is merely said to be convenient for administering its Middle Eastern operations. Few believe this will last; the company is known to have studied the British situation in detail, including a potential site in Peterborough.

The British response, in contrast, has so far been dogged by a lack of cash, with some exceptions. The Nuffield Nursing Homes Trust, Britain's biggest chain with 30 hospitals, is scheduled to open two more, although it is having financial problems. It normally raises millions of pounds through local appeals (£1.5 million in 1979 alone) but recently it launched a national appeal aimed at big business.

Similar appeals have come from a number of small companies which have sprung up to capitalise on local markets. It costs about £1 million to build a 30-bedded surgical hospital; these companies (probably several dozen), normally no more than a group of ambitious doctors and perhaps a would-be entrepreneur, have had difficulty in finding the money. One or two have opened on the cheap: a group of doctors in Sussex opened a small hospital after virtually putting it together themselves, including, it is said, some of the painting. Several others have been helped by BUPA.

City investment

The financial position could now be changing, with the City, somewhat belatedly, appearing more willing to invest in private health care. Investment bankers M. J. H. Nightingale raised £1 million for a small hospital in Bradford, joined by Barclays Bank and the ICFC, which offered long loans of another £1 million. Nightingale also expects to raise £1 million for a small hospital in London. "I'm not sure we could have raised the money for the West Yorkshire project two years ago," said a spokesman, "but we've certainly seen the writing on the wall. Probably others will too."

Others may include a number of large British conglomerates. Grand Metropolitan has tendered for contracts to manage hospitals in the Gulf but has denied similar ambitions in Britain. Cunard has discussed leasing hotels for hospital use. The Midland Bank has bought a £325,000 share in Seltahart Holdings, which plans to build 50 small hospitals in the UK by 1990; the firm's chairman is a former NHS administrator (*The Times*, June 30, 1981). But most likely is the Allied Medical Group. Rescued by the National Enterprise Board, which took a controlling share in 1977, it ditched the hospitals and nursing homes it ran in Britain to concentrate on overseas development. It now admits to studying the changed British situation but will not say whether it plans to build any hospitals. Ironically, the company has sold itself heavily abroad on its association with the NHS. "AMG has the closest links with the much admired British NHS and with many of its distinguished people who work in each of its branches," says its prospectus.

All these groups, however, could still be deterred by the speed and size of the American invasion. Even if they have the money they lack the experience, and if they have the experience they lack the money.

NORTH

Location	Project	Operator	Beds	Notes
Blackpool	Old scheme for 30 beds	Local Consultants	30	*Various groups and advisers*
	Clifton Hall N/H – extension	Existing Nursing Home	25	
Bolton	Commercial project		25/30	*I.H.M. Ltd advising*
Bradford	45 bed hospital	West Yorkshire Independent Hospital Ltd	45	*Building commenced opening July 1982*
Derby	New nursing home	N.N.H.T.	32	
Glasgow	Hospital/home	Independent Group	40	*I.H.M. advising*
Guiseley – Leeds	Hospital/home	Property Company		*House conversion*
Leeds	H.A. and H.C.A. considering sites	?	100	
Lincoln	Conversion of Nursing Home to Hospital	Consultants		
Manchester	BUPA Hospital	BUPA	88	*Building*
	American	A.M.I.	150	*Building*
	Sinclair Group	Sinclair	100+	*Rumoured*
Scunthorpe	Local Nursing Home	Consultants	30	*I.C.F.C. involvement?*
Sheffield	Extension to Beechwood Clinic	Dr. Bullas		
Teesside	New Nursing Home	N.N.H.T.	36	
Wirral	BUPA Murrayfield	BUPA	30/40	*Building*
York	Extension to Purey Cust N/H	Existing charity	10	
Newcastle	Hospital	Local Consultants	40	

MIDLANDS

Location	Project	Operator	Beds	Notes
Birmingham Central	New Hospital	A.M.I.	100	*Planning objections for over 74 beds*
Birmingham North	New Hospital	H.A.I.	80	
Birmingham South	New Hospital	A.M.I.	?	
Cambridge	Hospital	Royston Consultants	60	*Associated with Quantity Surveyors. Site is in Impington*
Ipswich	Surgical unit	Charity	30	
Leamington Spa	30 bed hospital	Local Charity	30	*Difficulty raising cash*
Leicester	Extension to London Road Clinic	Private company	20+	
Nottingham	Conversion of Nursing	Consultants		*Overseas financial backing*
	Large Hospital	Hyatt	100	
	New Hospital	G. Lighting	?	*Sinclair Group involved*
	Extension to existing N/H	Covenant charity	30+	

NORTH continued.

Location	Project	Operator	Beds	Notes
Peterborough	Hospital	BUPA/London	40	*Nightingale involved*
Solihull	New Hospital	Seltahart Clinics Ltd	35	*Local builders have contract*
Wolverhampton	Day case clinic	New company	—	*I.H.M. advising*
Worcester	Hospital	Consultants	30	*BUPA involvement?*

SOUTH

Location	Project	Operator	Beds	Notes
Ashtead	Hospital	Consultants	35	*Nightingales involvement*
Banbury	Foscote Nursing Home	Charity	35	*PPP assistance*
Bath	Hospital	Allied Medical/Grand Metropolitan Hotels?	60	
Bedford	Nursing Home	Consultants		*Biddenham Manor site*
Brentwood	Hospital	Seltaheart Clinics	32	*NHS site, Warley Road*
Bournemouth	Hospital	Independent	50?	
Bushey	Hospital	BUPA	45	
Canterbury	Hospital	A.M.I.	60	
Cardiff	Hospital	BUPA	54	
	Hospital	H.A.	75	
Harpenden	Hospital	BUPA	40	*Planning consent granted*
Hitchen	Hospital	Independent company	20	*I.H.M. advising. Now developing*
London	BUPA	BUPA	150	
London	Cromwell Road	Overseas company H.A. — managed	128	*Opening April 1981*
London	Harley Street?	Sinclair	?	
London	St. Georges Hospital	?	?	*Existing NHS hospital closing*
London	University College Project	Charity?	200?	*PPP involvement?*
London	Wanstead Hospital	Park Clinic	50	*I.H.M. advising*
Maidenhead	Hospital	?		
Margate		Consultants	30	
Plymouth	Hospital	BUPA	?	
Southend	Hospital	Consultants	50	
	Hospital, Eastern Avenue	Seltaheart	32	
	Nursing Home extension	Private company	90	*Conversion of hotel*
Swansea	Hospital	Private company	35	*Conversion of Merchant Navy Hotel*
Swindon	Hospital	Consultants	30	*Local accountants advising*
Wimbledon	Hospital	Medicure	60	*Planning permission granted in spite of opposition. Fairclough building*

PRIMARY CARE

MOST OF US when we are unwell and feel we need help go first to our general practitioner who, with health visitors, district nurses and other community health workers, provides what are called "primary care" services. The primary care team deals with most sickness and other health problems and is for many people their only direct contact with the NHS.

Little has been said about primary care in the current debate about private medicine, perhaps because the hospital services are much bigger money-spinners. However, this does not mean it should be ignored, as it is an integral part of our health care system.

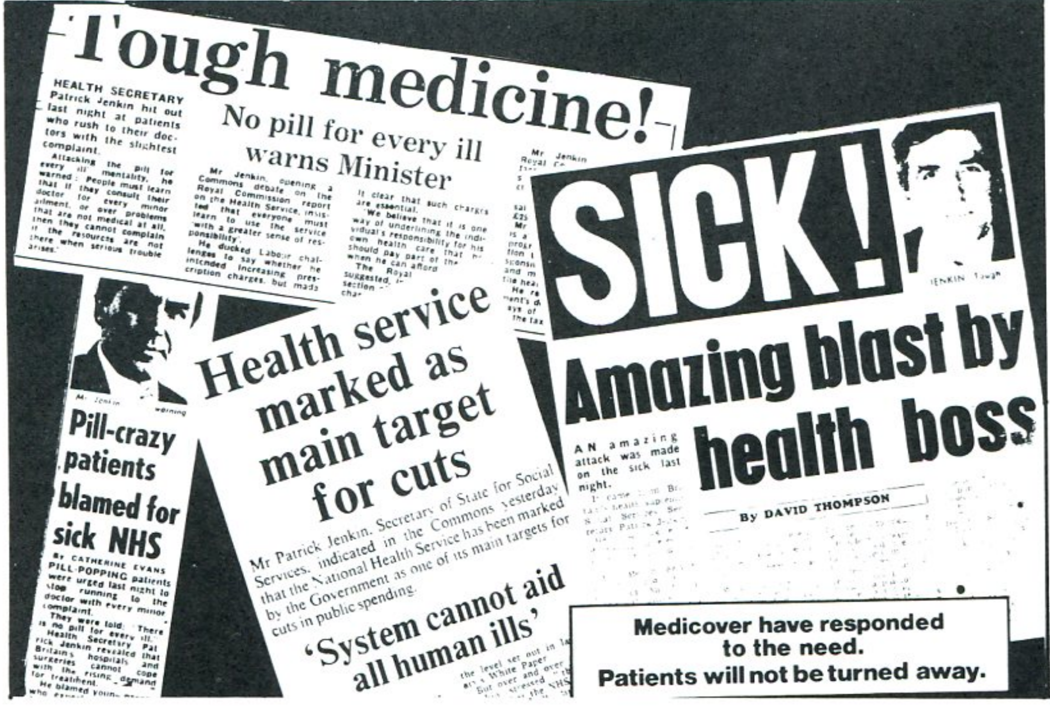
All GPs are in a sense private, in that they are self-employed and contracted to work for the NHS. They are not paid fixed salaries, and their income is made up in a complicated way from different fees and allowances. Some of the major ones are shown in Table 3. GPs can also charge the patient for certain items not covered by their contract with the NHS, such as private sickness certificates and medical reports. They are also reimbursed for 70 per cent of the salaries of their employees, such as receptionists, secretaries and practice nurses. Other primary care workers are paid directly by health authorities.

Expenses such as medical equipment, rent and rates, staff costs and travel are met from this income, and the rest is profit. The average GP's net income is around £15,000 to £20,000 a year. This system of payment, introduced to guarantee GPs' "independence", encourages them to sacrifice patient comfort and even safety for profit.

Table 3: Some major payments to GPs in 1980 (revised annually)

Payment	Amount
Basic practice allowance – paid if the GP has more than 1,000 patients and spends at least 20 hours a week on NHS work	at least £4,275 a year
Amount paid for each patient on the list	£4.15 a year, more for the over-65s
Items of service payments for certain services the GP can choose to perform – examples:	
Contraception – ordinary	£6.05
– including coil fitting	£20.15
Complete maternity services	£65.00
with care during confinement	£10.85

It is illegal for a GP to accept payment from an NHS patient except in certain specific circumstances like the ones mentioned above, but there are many reports of this happening and it may be fairly widespread. Recent immigrants who may not understand how the NHS works are particularly vulnerable and some doctors have been known to exploit their vulnerability.



Private general practice

Most recognised private general practice is done by doctors who are also NHS GPs. Their private patients, who may well be on another GP's NHS list, pay a fee set by the doctor, commonly around £20 for a first consultation. Private insurance schemes such as BUPA do not cover general practice. There is little direct information on the extent of private general practice, and doctors are under no obligation to reveal figures. A survey by Cartwright in 1967[12] estimated that 64 per cent of NHS GPs had private patients (Table 4). Some do wholly private work – an estimated 700, or three per cent of the number of NHS GPs. Eighty of these work in one London health authority, ie Kensington, Chelsea and Westminster.

Table 4: The percentage of NHS GPs with private patients

Number of private patients	GPs in England & Wales	GPs in inner London
0	36%	26%
1-19	44%	40%
20-99	16%	20%
100 or more	4%	14%

Clearly, GPs receive most of their income for treating patients on the NHS, for which they are well paid. Many make a bit of extra money by having a few private patients, but relatively few GPs are wholly or largely engaged in private practice. The situation is different, however, in inner London and probably also in other inner city areas, where it is difficult to find an NHS GP who will take new patients despite not having a full list. This puts pressure on people to see a private GP instead.

The other reasons why people decide to see a GP privately do not necessarily coincide with their reasons for choosing to see a specialist privately. A survey by Kensington, Chelsea and Westminster Community Health Council (Table 5) found that nearly a third of the sample had seen a GP privately. Most were well off but nearly a quarter came from the lower middle class and skilled working class. Nationally, however, only about four per cent of the population see a GP privately some or all of the time.

Primary care in inner London

The poor state of primary health care in inner London has been emphasised in yet another report, this time from the London Health Planning Consortium (the Acheson report, June 1981[15]). It blames the inaccessibility of many GPs, the low numbers in group practices, poor premises, and the high percentage of elderly GPs; London, like other large cities, has particular health and social problems but its inadequate primary care facilities are grossly underfinanced. The report demands urgent action.

Table 5: Reasons why people choose to see a private GP[13]

Reason	%
Better medical service than the NHS/ specific treatment wanted	40%
Convenience/no waiting	32%
More personal service/ more time spent with patient	22%
Always had one/can afford it	19%
Wanted treatment in an emergency	12%
Could not find NHS doctor	8%
Other	11%

All GPs, whether or not they see patients privately, cannot avoid being involved with the private sector in other ways. Patients with insurance subscriptions may request private referrals to a consultant, which often activates the old boy network. Some consultants whom GPs keep well supplied with patients may provide slap-up meals, Christmas bottles and other perks.

Private medicine is beginning to cast covetous eyes on primary care. Many urban GPs, especially those practising single-handed, use deputising services at night and weekends. Air Call, a deputising service sponsored by the BMA, is planning to invest £1 million in two private clinics in north London[14]. If it is successful, private surgeries will be set up in other cities. Patients will pay £50 to £60 annual subscription, covering ancillary facilities and investigations, with another £20 a year for some drugs. People with chronic illnesses will be excluded from the scheme.

London Locums is another deputising service, privately owned like all the rest, which recently started a private home visiting service in north west London, called Medicover. It says London's primary care services are inadequate and NHS GPs offer a poor standard of care. Patients are offered "instant medical aid and peace of mind" for £120 a year, with visits to subscribers guaranteed; the scheme is said to be aimed chiefly at the elderly and infirm, busy mothers and businessmen.

Medicover has been strongly criticised from many quarters, including the BMA; its advertising is offensive to NHS GPs and uses NHS cuts as a selling point (showing, for example, a newspaper headline "health service marked as main target for cuts" – "Medicover have responded to the need. Patients will not be turned away.") Its service is nothing like comprehensive and it is trying to make a fast buck out of people's real or felt sense of the inadequacies of NHS primary care.

CONTRACTORS AND SUPPLIERS IN THE NHS

THE INCREASING USE made by the NHS of private contractors and suppliers does not receive the publicity devoted to smart new hospitals and Harley Street clinics. Nevertheless, it has importance as another policy undermining the public service by encouraging the penetration of profit-orientated businesses.

It seems extraordinary for health authorities to pay outside contractors for providing essential services like laundry, catering or plant maintenance, when they could employ their own staff to provide them more cheaply. But this is what is happening. Similarly, local authorities are employing private building firms and dismantling direct labour departments. Are NHS workers lazier or the administration less efficient? There is no evidence to show that is so. Private contractors are less likely to take on dirty jobs in unsocial hours, or to provide a year-round service on call, and there is the problem of monitoring the contract to ensure the service is actually being provided. But they offer big advantages for a government which wants to be seen to be cutting public spending, and to curb the power of the unions.

The cutbacks in services and supplies hit ancillary staff harder than any other group. Hiving off catering to a private firm means NHS jobs are lost, and shows the government fearlessly pruning waste. But the real cost is simply shifted to a different account – and is inflated by the higher prices paid to outside firms. And, of course, any labour relations problems will be dealt with by the contractors, not by NHS managers; employing contract labour is an old tactic to destroy trade union solidarity and encourage blacklegging. Widespread support in pay struggles, for example, will be much more difficult to achieve if many workers, employed outside the service, continue to work when NHS unions are taking action.

So far, fewer than 40 NHS units in England use contract labour for domestic services, compared with about 2,000 hospitals using direct labour[16]. But this figure could climb rapidly with government encouragement. Unfortunately little evidence is available, and few trade union research departments keep records of contract labour involvement – they should be encouraged to monitor it.

Contractual arrangements between the NHS and the private sector are encouraged by a DHSS circular telling administrators to explore all possible co-operative schemes. Health authorities can use private facilities – goods, plant and so on – with no statutory limits: "The previous administrative bar on contractual arrangements with profit-making bodies is lifted"[17]. It is even proposed that these arrangements could be extended to planning, training and purchasing, giving private firms a large say in how the NHS operates. There is no reason to suppose that these firms will abandon their present preoccupation with making money – a motive entirely inappropriate to the provision of health care.

Interestingly, the government was recently reported to be "disappointed" at health authorities' lack of enthusiasm for this arrangement (*The Times*, September 4, 1981). "Some authorities have not responded

Hired hands

Agency nurses tend to be unpopular, with the trade unions if not with ward nurses, who are only too glad to have another pair of hands. It is said they earn more money, although a 1976 survey found they were, on average, 50p an hour worse off than their NHS counterparts[19]. Barbara Castle tried unsuccessfully to phase them out in 1975, replacing them with nurses from NHS-run banks, an idea which got off the ground in some places but not nearly enough.

What is worrying is the ease with which agency nurses seem to slide between the public and private sector. Many nurses, driven to "moonlighting" by their appalling rates of pay, turn to the private sector for quick earnings in their hours off duty from the NHS, bringing back tales of the opulence of private hospitals to their demoralised colleagues.

Others are forced to do agency work because the NHS refuses to provide flexible jobs which would enable them to combine work with child care or other responsibilities. Nor will it consider appeals to establish workplace creches, using the chicken-and-egg argument that there is no demand.

The existence of agencies, most of which are privately run, helps support the private sector by providing easily hired-and-fired, flexible, usually non-unionised labour. The majority of this work is perhaps in private houses rather than hospitals, although the latter rely heavily on agencies to provide specialist nursing, for example for patients needing intensive care nursing.

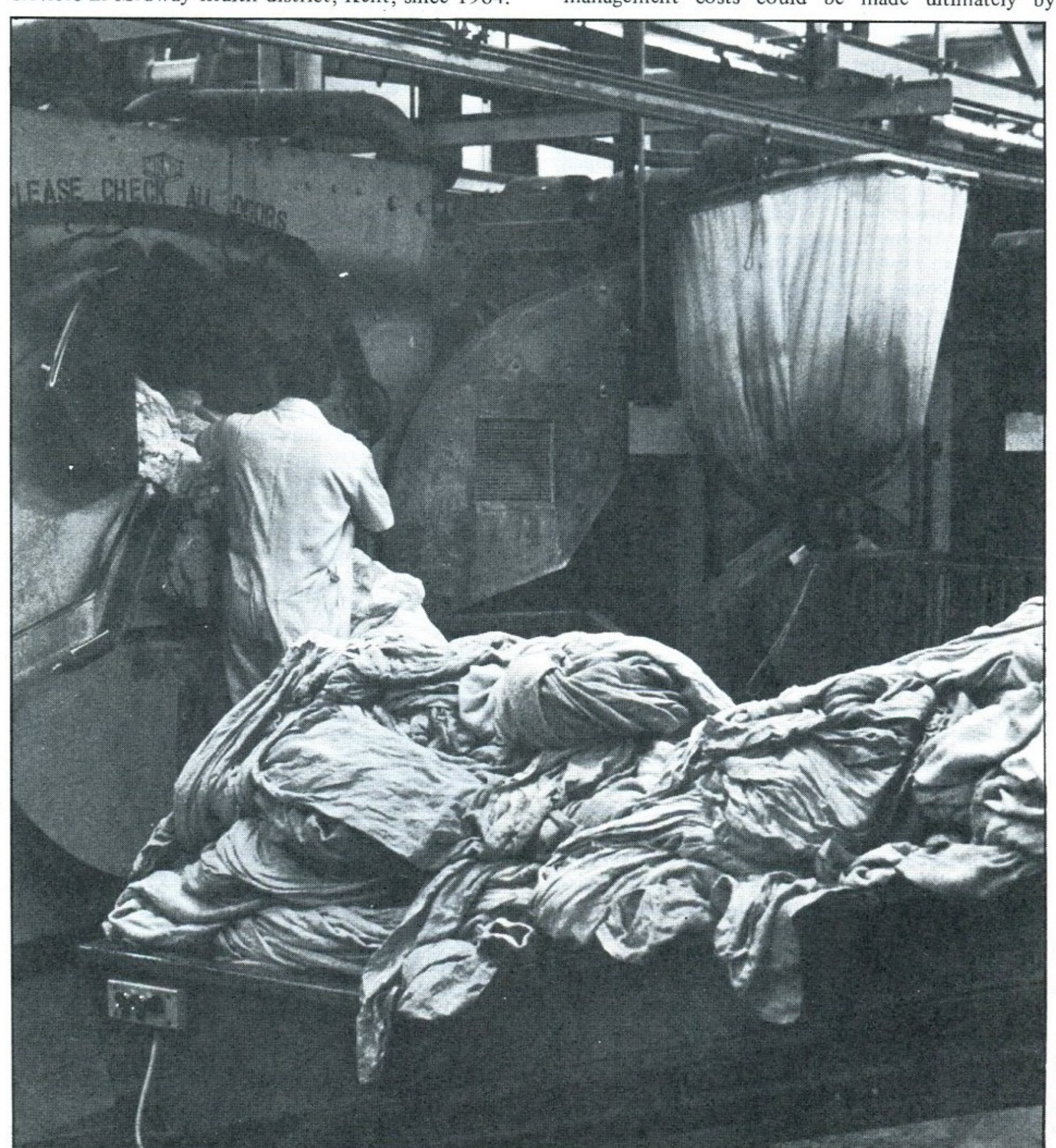
The solution to the problem is not to blame the nurses who use the agencies, often driven to it by necessity. Instead we should demand better pay, more flexible working conditions and workplace nurseries – with more NHS banks to be used genuinely as emergencies-only cover, not to bolster an inadequate staffing establishment.

constructively," complained health minister Dr Gerard Vaughan. Oxford AHA chairwoman Lady McCarthy retorted: "Direct labour is more efficient, more flexible and cheaper."

Hiring managers

NHS services in a few places have been contracted out to commercial firms for many years. Crothall's, part of a large London-based group of companies, has provided the day-to-day management of domestic services in Medway health district, Kent, since 1964. It supplies supervisors and some equipment; NHS staff, though paid by the employing authority, are managed by Crothall's personnel.

Over the years the firm has extended its operations in Medway to include all the hospitals except one, and some health centres and clinics. NUPE members have fought, so far unsuccessfully, to be managed by the NHS, and the district's own administrators calculated in September, 1979 that "a reduction in management costs could be made ultimately by



North East Photographers Coop

ending the contract with Crothall's and managing the domestic services direct."

But moves to end the contract were quashed by the DHSS, which suggested that "a direct comparison of costs did not necessarily reflect a true picture and that factors other than direct costs should be considered." The contract with Crothall's has now been extended till September, 1982. Former NUPE branch secretary Marian Bragg feels this is the thin end of the wedge, and that many other districts will adopt similar policies: "There'll be contracting companies throughout the NHS," she says.

Meanwhile other companies are hurrying to exploit the openings offered by the government. "Our business is efficiency," say Jamieson, Mackenzie and Associates, advertising in the *Financial Times*, January, 1981. It describes itself as a company specialising in all aspects of private hospital management and management consultancy. "We provide the basis for efficient management . . . provide high level management expertise on a contract basis."

Drugs, hoists, surgical appliances, medical technology – the possibilities for commercial intervention are almost endless. The supplies market is now worth an estimated £700 million a year. The government is anxious to encourage the growth of these supply industries, but it is ultimately public money which pays for their profits. Nationalisation could help ensure the products were really needed and fair prices were paid. And socially useful production – fighting redundancy by employing workers to make goods of benefit to society – could be a vital and positive alternative policy to turning over public services to commerce.

Shop stewards at Lucas Aerospace, opposing massive redundancies in the early 1970s, produced a plan proposing that the workers' expertise should be used to make socially useful products – ranging from alternative energy supplies to kidney machines and equipment for the disabled. The workers' response showed they preferred making such goods to being involved in the company's military technology production. But the bosses rejected the plan, which proposed that goods would be sold at the lowest possible price, benefiting the NHS and providing work instead of job losses. Many exciting ideas for new equipment had emerged, based on the needs of the sick and the disabled, not on the distorted perspective of a commercial firm seeking big profits.

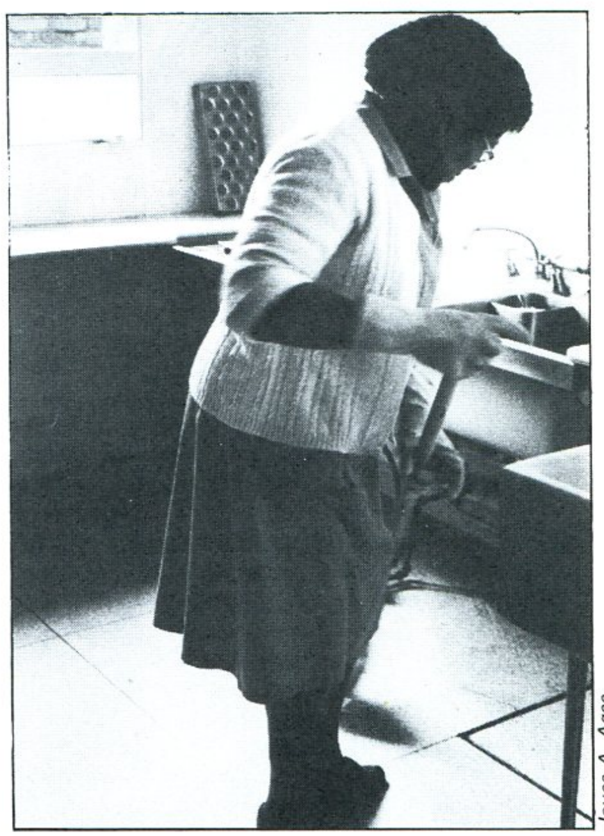
The Lucas Aerospace shop stewards' combine has shown that radical solutions are practical and possible. What we need is management and a government prepared to back them up and workers prepared to fight for them.

A pill for every ill?

The drugs industry has generally provided a notoriously glaring example of inappropriate, profit-based intervention by the private sector in the public service. "Britain's pharmaceutical industry entered 1981 on a note of flourish – with the achievement of a record-smashing £523 million surplus to round off the old year", declared the February 1981 edition of *ABPI News*, a propaganda sheet put out by the Association of the British Pharmaceutical Industry. And well might it crow, with the prospect of a nationalised drug industry receding even further into the distance than in the days of Labour governments.

The activities of the giant company Hoffman La Roche are a good example of how the NHS, which spends over 10 per cent of its budget on pharmaceuticals, contributes to those record-smashing profits. The tranquilliser diazepam (Valium) is made for £20 a kilo, then passed on through Roche's subsidiaries, preferably using tax havens. The price is raised at each transfer, but always ensuring that the final transaction shows only "reasonable profit". It is sold to the NHS at £370 per kilo, collecting a 1,850 per cent profit on the way but avoiding DHSS scrutiny for excessive profits[18].

Roche "operates and may be expected to operate against the public interest", the Monopolies Commission concluded. Nationalisation would ensure the firm did operate in the public interest: the money not paid in profits could be spent on improving services, and on disinterested research instead of advertising.


Joyce A. Agee

CHARITY FUNDING AND VOLUNTARY WORK

GIVING TIME and money to a cause you believe in is something many people do regularly – and it doesn't mean they are all do-gooders in flowery hats. After all, activity in a trade union or political group is voluntary. Many people have made substantial contributions to the mental and physical well-being of others less fortunate, particularly in hospitals, and few would condemn fundraising to buy extras for an old people's ward or spending time with handicapped children.

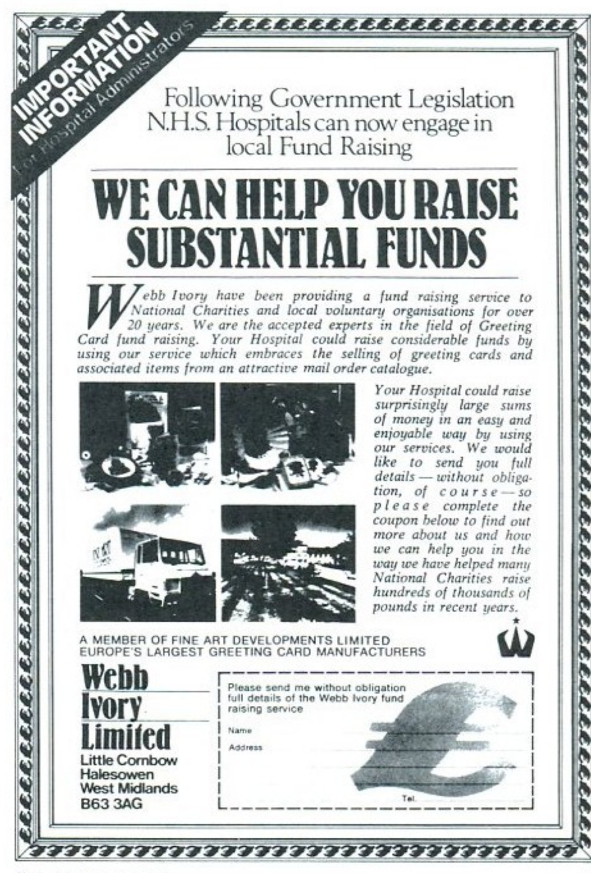
But successive governments' policies of reducing public spending have cast a shadow on these innocent activities. The Tories are now pushing for increasing reliance on voluntary services not as providers of the frills, or even as stopgaps where the state fails to provide, but as providers of essential services. "We shall be looking to the voluntary sector to take up more of the running," said Patrick Jenkin in June 1979, and his words are echoed by Cabinet ministers on every possible occasion. They indicate an attitude which has serious implications for the NHS – in funding, planning and industrial relations.

The Health Services Act, 1980, removes the secretary of state's responsibility to fund all essential services; instead he will allocate money "*towards meeting* the expenditure". The shortfall will have to be found by the authorities themselves, now empowered to raise money through raffles, jumble sales and the like. They will inevitably look to voluntary organisations and rich benefactors to help them out, with equipment, buildings or labour.

This reliance on the generosity of local people to fund services will reinforce the inequalities between classes and regions which the NHS was expected to iron out. People in working class areas with high unemployment will find it hard to give to charity – though they will do their best – but there is no guarantee this will be acknowledged when cash limits are set, and that more money will go to deprived areas.

Increased voluntary/charity involvement will affect not only the distribution and quantity of available services, but also the type of services provided – perhaps, in the long run, the most serious drawback of all. It is easy to forget that 60 per cent of NHS beds are occupied not by people having operations or sudden illnesses, but by the old, the mentally handicapped and the mentally ill. They already have a disproportionately low share of the resources, not just in medical treatment but in nursing, food, clothing, and surroundings. But few of the appeals you see in the paper or the pub are for money or goods to help them.

The Suffolk Scanner Appeal is more typical – raising money for a "very special X-ray machine",



Nursing Mirror, February 26 1981 17

Now there abideth faith, hope, and big business

Charity can be good business . . . since the new directives, fundraising companies have been advertising in health journals. "We can help you raise substantial funds," Webb Ivory Ltd told *Nursing Mirror* readers in February, 1981. "We are the accepted experts in the field of greeting card fundraising . . . your hospital could raise considerable funds by using our service, which embraces the selling of greeting cards and associated items from an attractive mail order catalogue."

How long before nurses are encouraging their patients to buy the Carmen Smoothie Ladies Shaver or children's toys advertised in the Miller Leswyn catalogue? "Quality and value like this give up to 25 per cent profit to Miller Leswyn fundraisers", says the leaflet.

"Don't delay, send the coupon away
Your fundraising profits start
today. . . ."

and so do Miller Leswyn's.

used to help differentiate certain types of cancer. What the blurb doesn't say is that doctors disagree about the value of scanners in diagnosis and choice of treatment. Some doctors find them fascinating and many appeals for similar highly technical equipment have their enthusiastic support – but others are not so sure.

Even some community health councils, set up to defend the interests of people using the NHS, have been encouraged to participate in fundraising. Maidstone CHC in April 1981 was planning to hold a lottery for a local hospital; its secretary was said to be "challenging the view that only professional companies could organise lotteries." Some members demurred, however: "I would not be prepared as a CHC member to become a fund raiser", said a member of the League of Friends of Maidstone Hospital.

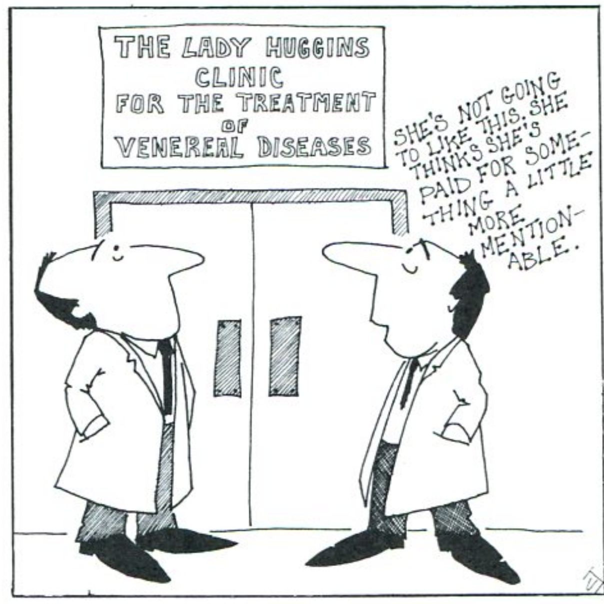
These gifts create other problems, such as the need for extra staff and new premises; they may come with strings, depending on the whims of the benefactors. Above all, they perpetrate the idea that illness can be cured by miracle doctors with miracle machines, and they divert people from thinking about the causes of ill health. If the sums spent on scanners and computers were devoted to making workplaces safe and healthy, for example, there might be an appreciable drop in sickness rates, as well as a reduction in the misery caused by illness.

The trouble with transplants

Newsmaking heart transplants are an extreme example of the kind of high-technology, doctor-oriented medical treatment which voluntary projects favour – people prefer to raise money for kidney machines or intensive care equipment than for geriatric hospitals or new boiler houses.

In 1979 the National Heart Research Fund launched a £250,000 appeal to pay for transplants at Papworth Hospital, although Papworth's transplant programme has many opponents, including some doctors at the hospital itself, who say it can no longer provide adequate routine treatment. Others claim that although the programme is supposed to be self-supporting, it relies heavily on NHS resources – which might be spent more effectively on essential services.

The appeal has done little to draw attention to the *causes* of heart disease. It is hard to imagine a health education programme encouraging people to eat more wholesome food, or a legislative programme forcing food companies to stop using inferior and refined products, arousing similar interest or raising similar funds.



Complicated co-operation

The government often talks of the need to reduce bureaucracy in the NHS. But co-ordinating activity between public, private and voluntary agencies may need more rather than fewer administrators. So far the proposals for achieving this co-operation are woolly to the point of non-existence. Knocking the administrators is a popular activity, but running even a small hospital today is complicated. Mr Jenkin wants to turn hospitals over to charities at a peppercorn rent, but it is doubtful if many can be successfully managed even if the charity is rich and has plenty of expertise. A situation can be envisaged where money and concern are devoted to acute hospitals in middle class areas, while the rest are ignored. Voluntary bodies may be able to fund small units or particular projects, but anything more ambitious demands long-term resources in money and labour, not so easily provided from the public's pocket.

Government policy is also damaging the work and reputation of existing voluntary groups. NHS workers have often welcomed the contribution made by volunteers, but the threat to their livelihoods is now so great that trade unions are forced into hostility to them. Again, it is a story of extras provided by charity becoming integral to maintaining the NHS. Hospital closures present a dramatic picture of job losses, but creeping cuts in staffing levels are just as important although more difficult to pinpoint; many workers, unsure of their futures, are choosing voluntary redundancy and others are not being replaced when they leave. This so-called "natural wastage" means those left have to do more work and it is then tempting to hand over some of the burden to voluntary workers, or to pre-nursing students or

police cadets who work on the wards for a pittance.

No-one can blame overworked nurses and domestics for letting someone else make the tea or help an old lady into bed, but it means the effects of the cuts are masked, from both workers and users of the service. If you can muddle through the day or night somehow, you are less likely to complain to managers or take action through your union, and patients remain unaware of the extent of the crisis.

Volunteers may also lack the skill to do certain tasks; even apparently simple jobs such as lifting people are dangerous if the proper procedures are not followed. Ambulance crews have complained that cutting non-emergency services will lead to ill people, or the disabled, being lifted in and out of cars by cab drivers or volunteers with no expertise. But a government which encourages untrained volunteers to perform nursing or portering duties while cutting back on training programmes may refuse to pay higher wages to skilled workers. Inappropriate voluntary intervention keeps wages down for everyone else.

A serious political threat has re-emerged with the government's plans to use voluntary labour for strike-breaking – nicknamed the *Scabs' Charter*[20]. This is one of the oldest tricks in the book: during the Winter of Discontent, 1978-9, hostile media emphasis on the harm to patients caused by trade union action encouraged many volunteers to come forward. But the Tory plans go further than Labour's; it has drawn up detailed strategies (which it tried to keep secret and failed) for dealing with industrial action – not for the good of the patients, but to destroy union opposition.

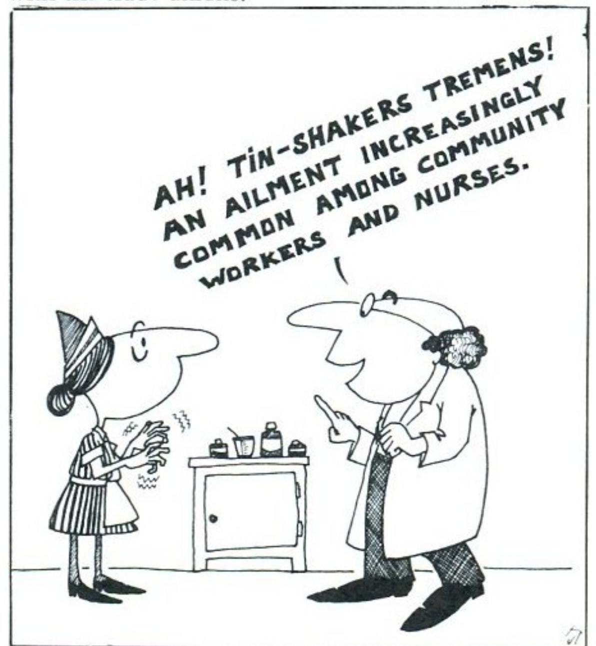
Bevan's nightmare

Aneurin Bevan, advocating a national health service which would not depend on charity but would be centrally funded, once said: "I have always felt a shudder of repulsion when I have seen nurses who ought to be at their work . . . going about the streets collecting money for the hospitals." But the scene Bevan hoped would disappear for ever may again become a familiar sight.

Each regional health authority was told to earmark at least £30,000 for such emergencies (March 1981) – spending around £1½ million on strike-breaking which could be spent on services.

Hot potato

Opposition to volunteers can sound like hard-hearted self interest, but the issue is in fact a political hot potato. People who have already paid for the NHS through their taxes feel obliged to contribute more, especially if it is for a local good cause – even if they can't really afford it. Voluntary work also diverts pressure away from the fight for better services and political solutions; instead, people are satisfied by individual acts of kindness. These may be gratifying for those who perform them and for their recipients. But apart from certain active and vociferous pressure groups, voluntary work tends to deny the importance of collective action. It does not question the power relations at the heart of the NHS's problems, but smooths over the cracks. Increased voluntary work will uphold the government and the status quo, unless the organisations work out clear demarcation lines with the trade unions.



WOMEN AND PRIVATE MEDICINE

WHAT IS the particular significance of private medicine for women? Is it an issue to which the women's movement should address itself, and if so, how?

An interesting feature of BUPA advertising is its claim that wives often pressurise their husbands into taking out private health insurance. Whether true or not, it is perhaps worth considering why this might be so, or at least why BUPA makes this kind of appeal to women in particular.

There are indeed a number of good reasons why private health care might be attractive to women. In the first place, as we have pointed out, private medical care places the recipient in the role of consumer rather than mere patient. And there are specific reasons why this role should have at least surface appeal to women. Consumption appears to offer power: the power to shop around, to make choices and decisions, to bestow patronage on this producer or that. Clearly, women experience considerable powerlessness as NHS patients. Women's complaints have low status and specialities are poorly funded. As individual patients, particularly in the fields of contraception, abortion and childbirth, women often feel they are being patronised by, dictated to, and denied information from doctors who are most likely to be men. Studies have shown that their symptoms are more likely to be dismissed as 'psycho-somatic' – but emotional problems like post-natal depression or the midlife crisis of menopause are regarded as purely physical conditions, to be treated simply by drugs.

SUMMER HEALTH CHECK REDUCTIONS

During the Summer Period we have a number of appointments available at special rates. Save £25 on a Full Health Check, £12 on a Womanscreen, and £8 on a Breast Cancer Check.

Life and work today can put extra strain on our whole body. We certainly don't want periods of sickness.

Today problems can often be detected at a very early stage. Early treatment can be so much easier and successful. Stop worrying. Come and talk to a doctor and have the tests, it may be nothing serious.

UNICORN MEDICAL CARE LTD.
29, Smallbrook Queensway, Birmingham, B5 4HE.
Tel. 021-632 6738.

The role of consumer in health care might therefore seem to offer some respite from the vulnerability which most women experience at some time in their encounters with the NHS. But in health care, as elsewhere, the power and initiative conferred by consumption is largely illusory. In their consumption of private medicine women are subject to the same pressures as in any other form.

Take cosmetic surgery, for example. Private cosmetic surgery clinics actively solicit business, by advertising in the popular press, on tube train hoardings and so on, and by sending out teams of 'consultants' to follow up enquiries. These travelling salesmen visit enquirers in their own homes to expound the benefits of the operation in question, apparently giving no information about possible problems or side-effects. Typical operations performed on women, who probably form the majority of the clinics' clientele, are breast augmentation or reduction and nasal reconstruction; painful, expensive operations often followed by long and complicated recovery periods.

The availability of such operations, which would almost certainly not be offered on the NHS, could in some sense be said to give the patient control. But this claim rings rather hollow, considering that the trade in cosmetic surgery largely depends on exploiting women's fears and anxieties about their body image, the direct product of a sexist culture that controls women by making them into objects.

In the second place, the structure of private health insurance schemes and the kind of care they offer both run counter to any notion of increased control by the consumer. Their hierarchical private ownership structure and their high technology bias are antithetical to the ideals of the women's health movement. A BUPA well women clinic would be very different from the feminist conception of a clinic staffed by women and managed by its users – with creche provided – and founded on a respect for the right of control over their own bodies.

Lastly, the availability to women of private health care is severely limited: group schemes are not normally available to the low paid or to part-time workers (women's average earnings are 37 per cent lower than men's; 75 per cent of low paid workers are women; 87 per cent of part-time workers are women). Private insurance schemes provide no cover for pregnancy or childbirth, nor for the chronically ill or elderly. Thus the growth of private medicine, and the consequent decline of the NHS, will have severe consequences for women. Moreover, they will be indirectly hit even harder, for as state services are run down, in the absence of private health care for the chronically sick, disabled and elderly, it is women in the home who will bear the additional burden of care.

Vital services

In the long term, then, the growth of private medicine will damage the health care of women. Ironically, however, it must be recognised that at present some of the most vital health care services are provided to women by the private sector. Deficiencies in the NHS

and its low valuation of women's health needs mean that if a woman wants an abortion, a cervical smear, or a sympathetic psychotherapist, she is likely to go outside the NHS.

Abortions have now been legally available on the NHS for 13 years, but the national average of women having NHS abortions is only 50 per cent, with some areas falling far short. In Coventry, for example, 83 per cent of all abortions are performed privately; in Hackney, East London, the figure is 70 per cent.

Two thousand women a year die from cervical cancer, a disease which is entirely preventable if detected early enough. Yet NHS screening facilities tend to be unpublicised and inaccessible. When a department store in Coventry stationed its occupational health scheme's BUPA screening caravan in a central public car park, so many women unconnected with the firm applied for tests that a sign had to be posted turning them away. Small wonder that women who can afford it are attracted by BUPA's £80 annual well women screening scheme.

Mental illness in women, particularly depression, is increasingly seen to be related to social conditions such as isolation and role conflict, but the standard NHS response is peremptory: a brief chat followed by a prescription from your GP, and if the problem becomes acute, ECT and more medication in a psychiatric hospital. The women's movement has developed its own alternatives, including the London Women's Therapy Centre, which charges clients on a minimum fee-paying basis. Such centres allow some of the principles of non-sexist, non-elitist health care to be explored in practice.

The growth of private medicine therefore poses an ever-increasing threat to the quality and availability of health care for women. Nevertheless, paradoxically, its existence can mitigate the failure of the NHS to meet women's needs, and in some cases can generate new ways of responding to them. The issue for feminists is therefore complex; can we simply reject private medicine and support the NHS? Certainly we must condemn the private sector for its exploitation of women's needs, and for the threat it represents to the satisfaction of those needs in future. But we must recognise its appeal, however hollow, to women's desire for control over their health care, and we must recognise that it provides some essential, even progressive services. We should use this knowledge to fight for a health service which is freely available to all, but which we control and which is genuinely responsive to our needs as women.

ALTERNATIVE MEDICINE

TREATMENT OFFERED on the NHS nearly always has its basis in the Western scientific tradition. Indeed, it often appears that this is all that medical treatment is or could be. But alternative types of treatment *are* available, based on different assumptions, and despite the medical establishment's lack of interest and derisory attitude, a steadily increasing number of people have been turning to them in recent years. The main reasons seem to be a growing dissatisfaction with Western science in general and a recognition of the limitations and dangers of the mechanistic approach – including the related, alienating attitude of many doctors.

The best known of these alternative health systems are probably homeopathy, acupuncture and osteopathy. Homeopathy, unlike the others, is to a small extent available on the NHS (from doctors trained in both homeopathy and orthodox "allopathic" medicine); but although the demand greatly outstrips supply, services like those offered at London's Royal Homeopathic Hospital are threatened with severe cuts. Adaptations of the other treatments are sometimes offered on the NHS, such as acupuncture in pain-relief clinics and manipulation by rheumatologists and GPs, but this is a long way from general acceptance of alternative forms of treatment and their usefulness in a wider range of conditions.

Nearly everyone who wants alternative treatment is therefore obliged to go outside the NHS and to pay for it, and moreover, insurance schemes will not pay for unorthodox treatment. BUPA's rules exclude "charges for services received in health hydros, nature cure clinics or similar establishments". Most alternative practitioners therefore have to charge fees to make a living, even though they may be in private practice not primarily to make money, but through commitment to their skills – many are aware of the contradictions they face.

Charges, then, vary greatly: at one extreme, a Wimpole Street osteopath charges £15 a session (15 minutes), whereas one acupuncturist charges £8 for 50 minutes, and less if the patient cannot afford it. Interestingly, the Howard de Walden Estate, which owns the entire Harley Street area, the Mecca of private practice, lets premises to registered alternative practitioners in surrounding streets including Wimpole Street, but not in Harley Street itself!

This is not the place to discuss the value and validity of alternative systems; the question whether and how they should be incorporated into the NHS needs to be fully debated. Nevertheless people's reasons for turning to alternative medicine and its obligatory presence in the private sector should be recognised as dissatisfactions with the shortcomings of the NHS and the care it offers.

Midwifery and psychotherapy services are also important indicators of that dissatisfaction; they are not strictly speaking "alternative" forms of health care but both are backed by strong movements outside the mainstream of the NHS. A growing number of pregnant women are turning to independent midwives because they feel they cannot get the kind of care they want in the NHS's male-dominated, hospital-based, high technology obstetric service. In many parts of the country it is difficult to find a GP to assist at a home delivery (the GP's fee from the NHS is minimal) and so hospital is the only option. Those women who can afford it are paying to get what they want. Insurance schemes specifically exclude childbirth.

Some psychotherapy and counselling is available on the NHS but the demand far outstrips the supply (it is very labour-intensive) and varies according to the beliefs of psychiatrists and GPs. The potential demand appears to be enormous, reflecting the extent of depression and anxiety, but only those who are well-off or lucky can find help of this kind.

More unconventional treatments and approaches should be available on the NHS. People should have the right to register with alternative practitioners, without needing to be referred from conventional doctors; straight medicine should have nothing to fear from such "healthy" competition if it really believes in itself. Furthermore, orthodox medicine should learn lessons from alternative practice, without subjecting alternative practitioners to its control.

DENTISTRY

TWENTY YEARS ago, there were only an estimated 300 fully private dentists and 9,500 NHS practitioners. Today there are about 900 private dentists, and 13,000 contracted to the NHS. An increasing number of treatments are now only available privately, and nearly all the NHS contract dentists carry out as much private work as they can; many only treat NHS patients when they have spare time not taken up by private patients.

By 1960 a few NHS dentists had stopped making full dentures on the NHS: more practitioners followed suit, and front crowns, gold teeth and metal dentures joined the list of private-only treatments. Tooth and gum care advice and knowledge became more accurate but few dentists offered it to their NHS patients. Few children leave school knowing even one tooth cleaning method, and tooth and gum care has become a saleable item. Raging toothache often can only be remedied privately – casualty departments such as London's Charing Cross Hospital refer emergency dental cases to private dentists. Many elderly patients have to do without dentures because dentists only make them for private fees.

Polly Donnison

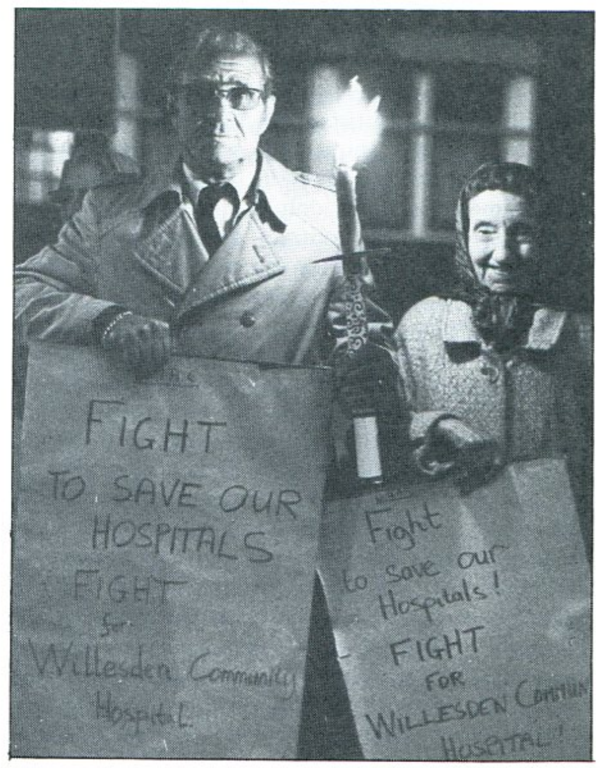
Private sector growth has slowed down slightly – people worried by the slump and unemployment do not put dental care high on their list of priorities, and the levels of dental ill health are appallingly low. But the move away from the NHS will continue: dentists have had two decades of increasing confidence in private contracts, spurred on by practice management seminars; a monopoly protected by university degrees; professional self government; and insurance protection societies.

The profession is also protected by public indifference. Most adults seem prepared to lose their teeth by the time they retire, for example, and people who accept this as the norm will do little to stop the growth of private practice.

One in 20 people who had dental treatment in the last five years was forced to go private and would have preferred NHS treatment, according to a recent survey. Half had asked their dentist why NHS treatment was not available, and of the two thirds who gave an explanation, the most common reason was that the particular treatment wanted was not available on the NHS[21].

3

Opposition and the Future



THE LABOUR MOVEMENT

THE SENSE OF unity conjured up by the phrase 'the Labour movement' is not always achieved in practice. Private medicine itself is an issue which has divided the movement: even where there has been a policy down on paper it has not been followed through in action. Both wings of the Labour movement – the trade unions and the Labour party – have been split and there have been important differences of emphasis.

Since its period in opposition in the 1930s, the Labour party has been committed to the idea of a socialised health service – but its approach has been shaped by practical considerations, such as the need to buy the consultants' support, as well as socialist idealism. The trade union movement's attitude was even more firmly based in pragmatism, with its stake in private medicine through sick clubs, friendly societies, and its even own hospital at Manor House – a necessary protection for workers at a time when little else was available.

The Labour movement, like everyone else, forgot about private medicine after the arrival of the NHS. By the 1960s the debate was going on in academic circles, and emerged into the political arena in 1972 with a House of Commons Expenditure Committee report. This assured parliament that private medicine could exist peacefully within the NHS – but Labour MPs on the committee published a minority report in which they claimed abuses were widespread. This gained considerable publicity and contributed to the appearance of an Opposition green paper, *Health Care: Report of a working party* (1973).

The paper did not demand the immediate abolition of pay beds from NHS hospitals. But it did call for charges to reflect full economic costs and the end of tax relief on group subscriptions, and for all future consultant appointments to be full time. The last was significant, for in Bevan's 1948 compromise consultants could choose to work part-time and engage in private practice.

The proposals undoubtedly implied the long-term phasing-out of pay beds, but typically, the issue of private medicine outside the NHS was virtually ignored. The subsequent history of Labour movement intervention dwells almost exclusively on NHS pay beds, and we rehearse it here to illustrate the extent of that intervention. But it should be seen in the context of an inability (as well as reluctance) to confront the wider problem of free market medicine.

Pay bed militancy

Labour's campaign document for the 1974 general election committed the subsequently elected government to phase out private practice from the NHS, abolish prescription charges and transform health

authorities into democratic bodies. But moves to put this into effect seemed as remote as ever until pressure was applied by the health service unions. Summer 1974 saw widespread industrial action against pay beds, not only in the well publicised instances of Charing Cross and Hammersmith Hospitals but all over the country. NUPE members took the initiative and were often supported by COHSE at local level.

The crucial problem of consultants' contracts was already being discussed by medical leaders and health minister David Owen, in a working party set up by Barbara Castle. Only 43 per cent of consultants were working full time for the NHS and the government hoped to increase the number by raising the differentials between part- and full-time consultants' wages. But appeals to the workers to wait till the working party reported failed to defuse the action. "As far as we are concerned the issue is cut and dried," retorted Bill Geddes, NUPE branch chairman at Hammersmith. "There is no moral defence for private patients. Leaders of NUPE have decided to wait until Barbara Castle's report on private patients comes out in October, but we're fed up with waiting and we want them out."

Local managers and senior consultants were crying out for help; pressure was coming from the TUC through its social insurance committee, and its health services committee was already urging the abolition of pay beds. So Mrs Castle had to promise action during the next parliamentary session. The Labour manifesto in the October 1974 election contained a much firmer commitment to phase out pay beds.

Legislation was promised early in the new Labour government's term of office. But in November 1974 the consultants rejected proposals for a new contract: merit awards would stay, though there was to be a "full commitment allowance" for those working full time for the NHS. The government promised to eliminate pay beds within a year, and under-used beds were to go immediately. Common waiting lists were proposed to prevent queue-jumping by private patients.

The empire strikes back

By early 1975 the consultants had begun their own industrial action, threatening mass resignations from the NHS, and common waiting lists were dropped for the time being. This led to a spate of trade union action against pay beds. NUPE leaders pressurised the prime minister and were joined by COHSE, giving a deadline after which they would call for official industrial action. Meanwhile, the doctors were awarded a 30 per cent pay rise.

Although the government agreed to phase out pay beds, it only agreed to do this through legislation (it had the power to act directly). This concession to the consultants tipped the balance of power away from the unions. The delayed introduction of legislation and its slow passage through parliament gave private medical interests a vital breathing space to establish their own facilities outside the NHS – when joint trade union and government action leading to the speedy abolition of pay beds would have left them in dire straits.

Legislation also gave the medical profession far more influence over the outcome, and the National Health Service Act of 1977 indeed showed signs of the BMA's skills in manipulating potentially threatening proposals. The 1975 plans were much diluted by the act. Government action which appeared to be dealing with private medicine had in reality dampened down the militancy of the unions and made many concessions to the consultants and the private sector.

Meanwhile, it was gradually dawning on activists that the issue of private medicine *outside* the NHS had been excluded from the agenda. The TUC had followed the health service unions' lead on pay beds, and there was a sense of unity – but private medicine was to expose deep divisions between NHS unions and the trade union movement as a whole.

COHSE moved to a wide ranging resolution on private medicine at the 1979 TUC, but debate focussed on its attack on affiliated unions which encouraged private health care for members, and on Manor House, the private trade union hospital founded in north London after the First World War.

Daily Ma

Union hits at 'rich bastards'

'WE'LL BLACK PAY BEDS'

BRITAIN'S largest Health Service union declared war on the Tory Government yesterday with an ultimatum demanding the end of pay-beds for private patients in NHS hospitals.

Otherwise the National Union of Public Employees decided its hospital members—cooks, cleaners, porters, laundry workers, even a few nurses—will withdraw all services to such patients from January 1.

By ROBERT PORTER and BRYAN CARTER

One delegate at NUPE's annual conference at Scarborough, Socialist Workers Party member Bill Geddes, a trainee carpenter from Hammersmith Hospital in West London, declared:

'Every single rich bastard who is in a pay-bed from January 1 will be blacked. That means he won't get his bed linen changed by NUPE members, won't get his meals served or his bed pan emptied. [illegible]

from the previous Labour Government's policy of phasing out pay beds. There are 2819 pay beds left, less than 1 per cent of hospital beds. The Tory Government's Queen's Speech promised a Bill to facilitate wider use of private medical care.

The flies

The deal recently negotiated between the EEPTU and the Electrical Contractors' Association, serviced by BUPA, came under fire from Bernard Dix of NUPE: "As far as our union is concerned, we do not care how you buy the privilege, whether you are an oil sheikh or a union negotiating a private agreement, we want it out." The motion was passed with an overwhelming majority.

EEPTU leader Frank Chapple was reluctant to defend the deal at the Congress and did not speak in the debate; but in the *News of the World* (September 9, 1979) he declared that private medicine would grow as NHS inefficiency worsened and waiting lists lengthened. "People, trades unionists or not, will be forced to obtain outside treatment, irrespective of principles or costs."

The EEPTU was not alone. The National Union of Seamen arranged a deal for 1000 North Sea oil riggers, and the Automobile Association of APEX is party to a group scheme. Very few national union leaderships in the TUC have actually negotiated group schemes – but in most cases they turn a blind eye to deals made at local level. Branches of the Fire Brigades Union, NALGO and ASTMS are known to have reached such arrangements, and group schemes are common in banking and insurance, though they are often introduced by management without reference to the unions. There are also signs that they are becoming more popular among manual workers – TGWU members at a fertiliser factory even took industrial action to obtain a private health scheme.

A number of non-TUC unions also offer various kinds of private insurance schemes to their members. The Police Federation has an arrangement with BUPA, and members of the Royal College of Nursing – most of them NHS employees – can have reduced price insurance with Private Patients Plan. These account for some of the 200,000 or more trade unionists claimed by BUPA, plus the unknown number insured by the other provident associations.

A few TUC unions have firm anti-private medicine policies, including ASTMS and NALGO, white collar unions with strong NHS membership. NALGO has made it clear to branches that membership of group schemes is contrary to union policy, and it has been prepared to sanction industrial action against private medicine. Local government computer staff in Gloucester, for example, have for some time been refusing to deduct contributions to group schemes from salaries.

The pressure within the trade union movement for a more principled and less pragmatic approach to private medicine has intensified since 1979. The EEPTU may now withdraw from its BUPA deal, and the TUC has told its affiliates how insurance undermines the NHS. But there is little sign of a concerted effort to educate the membership.

"The trade unionists' own hospital"

Manor House Hospital is a contentious issue in the Labour movement. Providing specialist inpatient treatment and outpatient dental and optical services, it is not formally part of the trade union movement, but is run by the Industrial Orthopaedic Society. This collects subscriptions of about 20p weekly from 440,000 members. Trade union representatives sit on its governing committees, and shop stewards committees often play a big part in recruiting members – Coventry, where the shop stewards movement is traditionally strong, has 70,000 Manor House subscribers.

But the most significant link is financial. Manor House relies for survival on donations; the TUC, TGWU, NUR and ASLEF are among the most generous, and the NUR has its own ward. Many union leaders have used its services.

Unions are involved with provident associations in two other ways. Those with a high female membership, such as the Union of Shop, Distributive and Allied Workers and the National Union of Tailors and Garment Workers, have participated with provident associations in making breast and cervical cancer screening available to their members. Second, unions have pressed for occupational health schemes – which are a profitable sideline for BUPA. Both examples show how private medicine flourishes in the gaps where NHS provision is inadequate, non-existent or even unnecessary.

Outside the NHS

The health service unions have begun to wake up to the importance of private medicine outside the NHS, and have led the campaign within the TUC and Labour party for a more aggressive policy. A COHSE resolution to the 1980 Labour party conference now commits the next Labour government to abolishing pay beds and all private medicine and charges, and the party is now studying "the methods required to take medical care out of the market place."

The question of preferential treatment for NHS employees has given rise to accusations of hypocrisy, however. Health workers do not have to buy privilege, claimed the EEPTU: "In most NHS hospitals the NHS staff in all types of jobs do enjoy priority when in need of medical advice or treatment, by custom." The unions have responded by playing down or even denying this, though such practices are widespread. They may have to take a firmer stand if they are to convince other trade unionists not to obtain special privileges by resorting to the market place.

WHAT FUTURE FOR THE NHS?

WE HAVE TRIED to show how and why private medicine is growing and the intervention of commercial interests is increasing. We hope we have demonstrated why their existence is incompatible with good, comprehensive, fairly distributed health care on practical as well as moral grounds.

We have often been told that the NHS is on the point of collapse, although the service gives rather than snaps under strain. But it does seem it has now reached a turning point. The Conservative government has already taken us down a fundamentally different path to that followed for the last 30 years. The growth in private medicine forms part of its overall strategy for health care. It has sought any and every means of reducing spending – by cuts, increased charges, charity funding and a clampdown on health workers' wages. It has aimed, through private medicine and contracting out, to provide rich pickings for its friends from the NHS's decaying carcass. It has tried to dump the care that cannot easily be turned into a profitable commodity – that of the elderly, the mentally handicapped and the chronic sick – on to the "community," encouraging "families to look after their own." The government's support for health insurance as an alternative to funding the service from central taxation is an essential prop to that strategy.

These policies, following the cutbacks imposed by the last Labour government, are already making the two-tier service a reality. The postponement of capital programmes and cuts in maintenance mean that many hospital buildings are in an advanced state of decay. All kinds of service have been reduced in quantity and quality, from the cleaning of wards and departments to the standards of hospital food. The pressure on hospital beds means that many areas have to operate virtually an emergencies-only service. Most hard pressed of all are the low status specialties mentioned above.

Savage cuts in local authority services, such as residential care, day centres, meals-on-wheels and home helps, have removed crucial supports, inevitably placing more pressure on hospitals. Only people in the most desperate straits can gain admission, while in-patients are being discharged early regardless of their home circumstances. Primary care, the cornerstone of the NHS, is decaying, particularly in the inner cities, the areas of greatest need. No wonder increasing numbers of people are deserting the service which was once the envy of the world. Those who continue to use the NHS often do so not so much

Occupation of casualty department at Bethnal Green Hospital to prevent closure, 1978.

Laurie Sparham, IFL

because they want to, but because they have no choice

We ask those who are dissatisfied or disillusioned with the NHS not to opt out by taking private health insurance, and we ask those who already have insurance to discontinue it. But these steps we can take as individuals are not enough. The battle has to be fought at all levels: to oppose the growth in private medicine generally, to change government policy, and to improve and transform the NHS.

The Left's response

When the question of what can be done about private medicine is posed, the commonest response on the Left is to reassert the need for a comprehensive service, free at the point of use and financed out of taxation, and to demand the abolition of the private sector by legislation. But this response is misplaced: first, in its view of the NHS as basically sound, needing only an injection of money (combined with phasing out charges) to restore the halcyon days of 1948. Second, in its belief that dealing with private medicine is merely a matter of wholesale nationalisation and making private practice illegal. This "solution" ignores the fundamental inadequacies of the NHS which breed dissatisfaction and the growth of private medicine, and would simply drive private medicine underground, as in the USSR. We must be more thoughtful and responsive when it comes to choosing our tactics.

The plan to nationalise all private hospitals is a case in point. It would saddle the NHS with the problem of running and financing expensive institutions providing the wrong kind of health care in the wrong part of the country – namely acute, high-technology services located in and around London. Besides, prospective investors in private hospitals will not be deterred by such threats so long as the prospect of lucrative compensation exists. Instead, we could regard nationalisation as a selective weapon. Those facilities which are suitable for incorporation into the NHS, in places where they are needed, could be brought into public ownership, perhaps under local rather than central government. (Labour controlled authorities might start working on this idea now.) Thus it might be possible to, say, reduce waiting lists by designating a currently private hospital as a district cold surgery unit, where non-emergency operations could be performed without interruption from casualties. Compensation, if appropriate, could follow the town planning precedent: paying the owner the market value of the site but not paying for the assets.

Other measures command more whole hearted political support. The charity status of some provident associations and private hospitals, and tax relief on insurance schemes, are subsidies which should be quickly ended. The ways in which private medicine is directly parasitic on the NHS, such as having access to NHS pay beds, laboratory and other facilities, and queue-jumping, should be eradicated. Such measures require accurate knowledge of precisely who is doing what, as well as executive powers to monitor standards and levy charges. But at the moment there are no published data which give a complete picture even of the size, type and location of existing and planned private facilities. We need this information, and more.

One method would be to require all health care practitioners and institutions to be licensed, just as abortion clinics are at present. They would have to provide full information, freely available to the public, on their current activities and plans for future development, and they would have to undergo checks on standards. The myth that private care is medically better would then be scrutinised, and the worst excesses of commercial exploitation could be stamped out. Licence fees could cover the cost of administering the scheme and investigating other ways in which private medicine uses up scarce resources. This fee could be set high enough to recoup the money already paid out in subsidies: anyone contemplating group insurance schemes or investment in private hospitals in the immediate future would then be aware that it might cost them dear in a few years' time. Consideration would need to be given to the nature of the licensing body – locally accountable and subject to democratic control – given that there are currently no candidates meeting these criteria.

The aim should be to bring the activities of the private sector into the open, and then to greatly restrict them by every means possible. Many more specific ideas for action are included further on in this pamphlet.

Which way for the NHS?

We have described some of the implications of Tory policy for the NHS, we have expressed disquiet at the defensive and partial response of the Labour movement and we wish to conclude by describing elements of an alternative strategy which takes seriously the growing dissatisfaction with the NHS.

In contrast to received opinion on the Left, we focus much more on changing the health service and much less on measures to suppress or eliminate the private sector. We must guard against training all our guns on private medicine, for that would play into the hands of the Conservatives – who would point to it as yet another example of socialist "levelling down". The story goes that Karl Marx was once challenged to explain why he was travelling in a first class railway carriage. "Because," he reputedly said, "under socialism everyone will travel first class." The driving force of our longer term response to the challenge of private medicine should similarly be the

goal of a health service in which everyone will travel first class.

"First class health care" is not the extension of BUPA-type care to all users. Proponents of the free market like to compare it to a democracy in which consumers (voters) exercise power by making purchases. Quite apart from the obvious problems – for example, in an unequal society some people have more "votes" than others; health care is often a very expensive commodity – the relationship between producers and consumers is not as democratic as is usually assumed. Consumers are separated individuals, while producers (in this case doctors) are well organised and powerful, and so can dictate to consumers. In health insurance schemes users are mostly the passive consumers of medical care. Joining a provident association scheme does not give you control over the standards or practice of doctors who provide care under it.

Socialised health care, on the other hand, contains the potential for collective control, diminishing the weakness of individual users. To create a health care service in which the gap in power, knowledge and accountability between consumer and producer disappears, we must fight for a democratic structure, extensive user rights, and services responsive to user influence. These are three elements essential to a socialist health service.

None of these has been realised in the NHS. The *structure* of the service has remained undemocratic for two reasons. First, without elected representation users have had no control over those in overall charge. Second, the state's broad acceptance of doctors' clinical freedom, fending off accountability to those outside the profession, has resulted in the subordination of other health workers. It is also a means of dictating to users who, in the absence of the cash nexus, have no influence to exert. Under private medicine the person paying the piper doesn't always call the tune – but there is an assumption that it should at least sound pleasing to the ear. Under nationalised medicine in the present style, users often have to put up with whatever tune the piper cares to play.

Charter of rights

One way of shifting the balance of power between users and professionals might be through a charter of user rights. This could establish a right to information, to second opinions, to privacy if desired – and many other principles which should be the subject of wide discussion. There would have to be some means of implementing this charter: one possibility is a system of tribunals, introduced as an interim measure. These would be more accessible and less formal than law courts; they would deal with everyday health service matters and not just catastrophes, and they would encourage representations from groups of users. But there are serious doubts whether a quasi-legal system would effectively further people's rights on the required scale and permanency. Experience of legislation on sex, race and employment rights in the 1970s bears this out.

Ideally the charter would become a collective rallying point, and implementation might then be monitored by an elected authority. In the context of wider socialist change these authorities would be hardly recognisable in comparison with any that exist today; they would have roots in the local community, and widespread interest and involvement.

As well as a democratic structure and a system of user rights, the *organisation* of health care ought to be more accessible and more human. Accessibility is linked to closeness, but it does not always mean that the nearer the service is to the local community, the more accountable it is: services can be remote when they are geographically near. For example, even if the GP's surgery is close by, restricted surgery hours may prevent easy accessibility. The same is true of hospitals, particularly teaching hospitals where the orientation of services and staff is towards "interesting cases" rather than general care of the surrounding community. Access hindered in these ways indicates to users that professionals, and not they, dictate the terms on which health services are delivered.

Health services should, rather, be planned and organised with user groups, to ensure that facilities are available, flexible and responsive to the community's changing needs. The organisation of health care on a more human scale is an important step towards breaking the autonomy of larger, dominant institutions, in which bureaucratic relationships and the needs of the system take priority over the needs of users, who are "guests" of the professionals, powerless and dependent on them for all their daily needs.

This is not to say we oppose all forms of institutional care. Often institutional as opposed to family-based care is more appropriate, for reasons of treatment or user preferences, or to relieve relatives and other lay carers. Institutions do not have to be isolating or dehumanising. But this demands more than a reduction in scale or a switch to location within the community, as advocated by the present government. Such moves will not lead to change unless the structure of power within the institutions is transformed. A democratic health service in which small, locally based units were accountable to all who used and worked in them could monitor and rectify dehumanising policies and the advance of bureaucracy.

These are the directions in which the NHS should go. They offer a third option which retains the best features of a socialised system of health care, while

taking seriously its many faults. There are many unanswered questions. How might the NHS intervene more effectively to prevent the social causes of ill health? How can the artificial split between health and social services be bridged? How can the rigidly stratified division of labour be broken down, and knowledge shared rather than commandeered? How can "alternative" forms of health care be provided without subordinating them to orthodox medicine? How can user and worker control be maximised to the advantage of both, rather than at the expense of one or the other?

If we are prepared to be imaginative and courageous and to focus on these more positive issues, we will win over many more people than we could by waging a purely repressive campaign against the private sector.

Our main objective here is not to spell out solutions or strategies, but to demonstrate the need for change and the broad direction it could follow. In doing this we hope to provide a springboard for a wider discussion of the creation of a socialist health service – one which builds on the most positive features of the NHS.

Andrew Wiard, Report

Organised opposition from the gallery, at an Ealing Hammersmith and Hounslow AHA meeting, 1977.

ACTION

WE WILL conclude by presenting a list of suggested action and a charter of what we're fighting for. Many of the ideas have already been tried up and down the country, and some have been successful. Obviously no single action can succeed in isolation, and the economic and social climate is making the chances of winning seem more distant. But only by continuing struggle, by refusing to give up, by repeating our case over and over again, can we win local victories, attract more people's support and link up our union activities and campaigns in a nationwide strategy to defend and extend the NHS.

What we are fighting for

- The abolition of NHS paybeds.
- An end to contracts which allow NHS doctors to practise privately.
- Stricter controls over private medicine.
- An end to profiteering in the NHS by contractors, medical suppliers and drug companies.
- A health service funded entirely through taxation, not insurance schemes, charity or charges.
- An end to cuts in health and social services.
- The development of primary care and services for the elderly, chronic sick, mentally ill and mentally handicapped.
- Radical policies to tackle the causes of ill health – to end poverty and class inequality.
- An end to discrimination in the NHS, against users and worker, on the basis of class, race, gender or sexual orientation.
- Good pay and conditions for NHS staff.
- Democratic control of the NHS, to make it responsive to people's needs.
- Campaign for a charter of people's rights in the NHS.
- Availability of alternative medicine on the NHS.
- A nationwide, long-term campaign against private medicine to counter the propaganda of the government and private companies, and to build a truly socialist health service.

1. Action checklist for NHS trade unionists

- Propose a resolution along the following lines at your next branch meeting: "This branch is opposed to all forms of private health care within and outside the NHS. We call on the union to join other unions and appropriate organisations in a joint campaign against private medicine and the harmful policies of the present government. We declare our support for the principle of a health service centrally funded and free at the point of delivery."

Use some of the information in this pamphlet to argue your case; compare public spending on health with spending on weapons of destruction. If the resolution is passed make sure your officials forward it to headquarters and the full-timers; publicise it in the local press and your union journal.

- Once the principle has been agreed, action is needed. Urge your representatives to argue it at national conference and take it to the TUC. Ask the TUC to put pressure on those unions and branches which support insurance schemes or run their own hospitals – such as the EEPTU's insurance deal, Manor House, the FBU branches' package scheme.

- Use the members' experience and work positions to collect information about local private development and the use of contracted services within the NHS. Make sure officials and HQ know about them. Publicise what is happening in the local media and in union journals. Send speakers out to other local union branches and to public meetings on health. Distribute leaflets outside health centres and hospitals.

- Link up with other unions through your local Trades Council to extend the struggle. Make sure your Trades Council has a health sub-committee which can co-ordinate activity and put out publicity, and that it uses its right to nominate representatives to the District Health Authority. Such representatives, who should attend all meetings, are a useful means of keeping the members well informed and putting their views to the policy makers.

- Demand support from your local authority. They have several members on the DHA and on community health councils, so make sure committed people are appointed, and demand their replacement if they are not (check the DHA minutes, available from CHCs, to find out whether they attend meetings and how they vote). Set up a caucus to meet before DHA meetings, including the DHA members, CHC members, branch officials and shop stewards, full-timers, Socialist Health Association members, Labour Party representatives and so on, to discuss the agenda and propose resolutions.

- Collective non-cooperation by NHS workers is not necessarily easy or straightforward, particularly in the present climate. But although risky, it can be effective, both as part of specific campaigns and as tactics

in industrial disputes. Action might include:

- blacking paybeds
- refusing to work with private patients or provide backup services such as X-rays, clerical work etc.
- refusing to co-operate with the private sector in transferring patients, using private ambulances, sharing services etc.
- refusing to collect new or increased charges, or to demand identification before giving treatment
- refusing to accept charity funding as an alternative
- blacking voluntary workers who do NHS staff's jobs.

• Fighting the cuts is part of the campaign against private medicine, so refuse to cover jobs left vacant and demand more staff; occupy threatened premises; link up with other local groups.

• Turn the defence of the NHS into a positive campaign for improvements in local services. Demand better pay and conditions to stop people being tempted to work in the private sector, and ask for NHS-run agencies for doctors, nurses and other staff which can offer part-time, flexible working hours.

• Discuss the possibility of recruiting members from private hospitals, although we recognise they will have different vested interests. Some workers in private hospitals and nursing homes are obliged to work there because of lack of NHS jobs or impossible shifts; recruitment might help enlist their support.

• Action against cuts, in support of hospital work-ins and against government policy, may have to take the form of work-to-rules, blacking and strike action; preparations will also be necessary in defence of any workers who may be threatened by the Employment Act or other legal action (e.g. pickets). This will need regular contact with other organisations, sending speakers to meetings, petitions, leaflets, involving members in the campaign. As well as the ultimate sanction of striking, consider protest pickets and demonstrations, e.g. of private hospitals; picketing private hospital sites; occupying threatened premises.

2. Action checklist for non-NHS trade unionists

• Propose a resolution at your local branch, along the lines suggested for NHS trade unionists, affirming opposition to private medicine and support for the principles of the NHS. Find out whether any branches of your union have insurance package deals and push for union policy to prohibit them – raise the issue at national conference and ensure the executive committee abides by Conference's decision.

• Campaign to stop your union pushing out insurance blurb in wage packets.

• Push for union support against private medicine at the Labour Party conference and on the Labour Party's health committee.

• Link up with NHS trades unions through the Trades Council and request speakers from local health services to address branch meetings and explain the issues. Support any action they may take by blacking, picketing, demonstrating etc.

• Fight for a greater awareness of health and the government's policy within the union. Use issues like health and safety at work to encourage discussion – e.g., if the local casualty department closes and there is an accident at work, where will people go? Use the information in this pamphlet to show how the expansion of the private sector is at the expense of the NHS.

• Join local campaigns against private medicine and for better health – link up with organisations within and outside the Labour movement for mutual understanding and support.

3. Action checklist for campaigns

• Locally based campaigns around particular issues, involving local pressure groups, tenants' associations, CHCs, political organisations and women's groups, can give strong support to trade union struggles and link different parts of the community on a broad base. Invite representatives to a meeting on a specific issue, e.g. plans to build private medical facilities, and use the groups to spread publicity.

• Use the resources of different groups to monitor local events and collect information, e.g. on the quality of private services, future plans. Press the local authority to refuse planning permission for private development; contact local people with leaflets, questionnaires, door to door visits to explain what's happening.

• Formulate positive demands for improving NHS services, based on local needs, e.g. better screening for cancer in women, bus routes to hospitals from inaccessible areas.

• Contact similar campaigns in other areas – starting within the same health authority – for co-operation and ideas, and exchange of information. Use national linking groups like Fightback to extend local action

Thwarted?

One way of frustrating plans to develop or take over property for private hospital use is to lobby your local council's planning committee, as it is in a position to hold up, and ultimately block, any planning applications which come its way.

This has happened recently in Tower Hamlets, where the development committee has refused permission to United Medical Enterprises to convert the London Jewish Hospital, closed in 1979, into a private hospital. The committee saw the decision as a tricky one: first because there were no substantial grounds for refusing planning consent, and second because local public meetings with racist overtones strongly opposed one of the other two contending bids – for an Islamic community centre – and were in favour of the UME proposal. The third proposal was for conversion to flats. The committee compromised by refusing all three proposals, on the grounds that they would cause traffic congestion! – although they could have allowed one to go through by imposing appropriate conditions.

This is, at best, a stalling procedure complicated in this case by political expediency concerning race relations in the borough, but it gives local unions, the Trades Council, and the CHC time to plan their campaign. They intend to persuade the area health authority to apply for designated status, to prevent an increase in private hospital beds in Tower Hamlets without authorisation from the secretary of state. This plan should be strengthened by reminding the AHA that, by law, they should invite representations from all relevant local organisations and take them into account when the final decision is made on whether the site is sold and to whom.

into longer term national campaigns.

- Hold public meetings; circulate petitions; write to the local papers, councillors and MPs; print leaflets for distribution in local shops, libraries, GP waiting rooms; draw up a list of speakers for trade union, party and other organisations' meetings; print bulletins putting the arguments about private medicine.

4. Action in the Labour Party

- Put pressure on the Labour Party leadership and local MPs through resolutions at ward and branch meetings, GMC meetings and conference, and through affiliated bodies such as trade unions and the SHA.

- Ensure that Labour local authorities are committed to a policy opposing private medicine in fact as well as in principle, using their nominees on bodies like DHAs and CHCs.

- Lobby the party's health committee, at present drawing up a new strategy on health, to oppose all private development and include strong commitment and concrete plans in the next manifesto.

5. Action for community health councils

CHCs are in a unique position to exert pressure on their health districts to obtain facts about the use of NHS facilities by the private sector. They are also in a good position to obtain information about plans for new private developments.

- CHCs, both individually and collectively, should set about systematic gathering of information to give a comparative and comprehensive picture of existing practices and planned developments throughout the country. They should design a questionnaire indicating the information needed to build up such a picture.

- CHCs should compile a national register of existing private sector development, with an updating facility to ensure all new plans are monitored.

- They should produce information sheets with details of specific enquiries.

- Questions CHCs should ask about their own districts:

Find out how much use the private sector makes of NHS resources.

Determine the true cost of the private sector to the NHS.

Find out how many pay beds there are, and their average occupancy.

Establish how many private beds there are in hospitals and nursing homes.

Find out how many consultants have part-time contracts.

Try to find out how hard they work.

Find out where they do their private work.

Campaign for common waiting lists in your area.

Find out how many consultants receive honorariums, and how much this costs the NHS.

Try to visit independent facilities and hospitals, and write reports on what you have seen – if you cannot gain access, publicise the fact.

Find out how many NHS staff, and how many AHA members, have private health insurance.

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Further reading

CHC News – the journal published by the Association of Community Health Councils of England and Wales – often contains up to date and informative articles on developments in the NHS. 362 Euston Road, London NW1, tel. 01-388 4943.

Chronic and Critical – the long crisis in London's everyday health care, a discussion document commissioned by London CHCs. Available from South Camden CHC, 114 Hampstead Road, London NW1, tel. 01-388 6780.

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Fightback produces regular bulletins and action sheets. Address above.

Inequalities in Health (Black Report) – report of a DHSS working party, 1980. Expensive and difficult to obtain, but essential. Try your local CHC.

Medicine in Society, a quarterly marxist journal of health studies, is starting a regular column of information on private medicine. Subscriptions from Central Books, 14 the Leathermarket, London SE1 3ER.

Politics of Health Group produces a quarterly newsletter, and has published two pamphlets, *Food and Profit* and *Cuts and the NHS*. Address above.

Quality, inequality and health care – notes on medicine, capital and the state – special edition of *Medicine in Society*, April 1977.

Radical Statistics Health Group, *Whose Priorities?*, *In defence of the NHS* and *The unofficial guide to official health statistics*. Pamphlets and details of the group from 9 Poland Street, London W1.

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CAMPAIGNS AGAINST PRIVATE MEDICINE

NHS Unlimited – A Committee to Combat Private Medicine

NHS Unlimited is a national organisation which was established after a meeting held on April 8th 1981 at the House of Commons on Private Hospitals and the NHS.
Its aims are:
- to promote the interests of the NHS by publicising its advantages and the threat posed to it by the private sector and insurance schemes;
- to collect and disseminate information on all aspects of private medicine and insurance schemes and their effect on the NHS;
- to provide a focal point for all individuals and organisations with the same aims and to assist local groups, promoting and providing resources for action by them;
- to promote research into the effects of private health insurance, hospitals and linics and to anticipate likely future trends and policies.

It believes that only a well informed defence of the NHS and attack on private medicine has a chance of succeeding in countering this very serious threat to the NHS.

For further information contact:
Chairperson, Frank Dobson MP, House of Commons, Westminster, London SW1 or
Joint Secretaries, Jacqueline Kelly, South Camden CHC, 114 Hampstead Road, London NW1 Tel 388 6789
Marcia Saunders, Islington CHC, Liverpool Road, London N1, Tel 359 5066.

Fightback Against Private Medicine

In June 1981 Fightback held a conference aimed at delegates from trade union branches and campaigns to launch an active campaign against private medicine. Convincing people of the evils of private medicine is not enough. Our aim is to coordinate on a national and a local level existing struggles against private medicine and help to build local campaigns in new areas. We have produced a 4 page broad sheet on action against private medicine (price 8p per copy).
For further information contact: Fightback at 30 Camden Road, London, N.W.1.

Useful addresses

Association of Scientific, Technical and Managerial Staffs, 10-26a Jamestown Road, London NW1.
British Society for Social Responsibility in Science, a non-aligned socialist umbrella organisation which has several health groups as affiliates: 9 Poland Street, London W1, tel. 01-437 2728.
Confederation of Health Service Employees (COHSE), Glen House, High Street, Banstead, Surrey.
Fightback, 30 Camden Road, London NW1, tel. 01-485 8610.
Hospital Worker, c/o Matthew Gregory, COHSE office, St Lawrence's Hospital, Caterham, Surrey.
National Abortion Campaign, 374 Gray's Inn Road, London WC1.
National Union of Public Employees (NUPE), Civic House, Aberdeen Terrace, London SE3.
Politics of Health Group, 9 Poland Street, London W1.
Radical Nurses Group, 20 Melrose Road, Sheffield 3, South Yorkshire.
Socialist Health Association, 9 Poland Street, London W1, tel. 01-439 3395.

GOING PRIVATE
The case against private medicine –
a report from Fightback and the Politics of Health Group

Who gains and who loses as private medicine grows?

There are already two classes of health care in Britain today. More and more better-off people are paying for their health care, while the poor, the elderly, the chronically sick and the disabled are left with a second class service.

Going Private draws together the facts about the startling growth of private medicine. It names the hospitals, the investment corporations, the insurance companies and the 'non-profit-making' charities and reveals the complex links between them.

The growth of private hospitals and private health insurance is being fuelled by widespread dissatisfaction with the increasingly impoverished and impersonal NHS. This report analyses the government's role in promoting the growth of the private sector.

It asks the crucial question: how do we want to change the health service in ways that will rekindle people's enthusiasm for a free, collectively organised service? *Going Private* suggests some practical tactics for trade unions, community groups and political organisations who want to stop the growth of private medicine.

Written and published jointly by
Fightback, 30 Camden Road, London NW1
and
The Politics of Health Group, 9 Poland Street, London W1

70 p