TALKING POINT

Another look at consultant mileage allowances

R T MARCUS

As consultants view their neighbour's new company car and compare it with their increasingly shabby vehicle, the nagging thought that consultant mileage allowances are seriously wrong wells up yet again. But how is this possible if the reimbursements are in line with those recommended by no less an authority than the Automobile Association?

Do consultants need a car for their work? Present contracts do not require consultants to have cars. The need for emergency transport or transport between places of work is the accepted responsibility of an employer, who can choose to provide such transport. So running a car is the choice of the consultant. Most consultants still care about their patients. They know that a taxi may be too late to save a life and that the time lost in using public or hospital transport routinely between places of work would paralyse the service. They have been uncritically content with an inflation-proofed mileage allowance and have failed to equate themselves with others on similar incomes, many of whom have cars supplied by their employers or whose motoring costs are wholly offset against taxation.

What cars do consultants use? A recent limited survey by the Welsh Committee for Hospital Medical Services (1977) showed the breakdown given in table I, a pattern confirmed by inquiries at the West Midlands Regional Health Authority.

TABLE I—Size of car used by consultants

Welsh Region		West Midlands Region	
Less than 1000 cc	1	501–1000 cc	33
1000–1500 cc	6	1001–1750 cc	287
1500–2000 cc	11	Over 1750 cc	300
Over 2000 cc	14		
	32		620

The maximum NHS reimbursement rate relates to cars of over 1750 cc (1501–2000 cc AA grouping), yet 14 out of 32 consultants in Wales have been prepared to accept inadequate motoring expenses; a similar proportion in the West Midlands would be 271 out of 620. There were also another 81 consultants in the West Midlands who had not claimed mileage at all in 1977.

What is the average annual mileage driven by consultants on NHS duties? The West Midlands regional computer shows that the total mileage claimed for in the year 1977–8 by the 620 consultants was 3 757 756 miles—namely, an average of 6061 miles (the author's approximate annual NHS mileage). The Welsh Region's figures confirm the pattern:

0–5000 miles	..	..	..	14
5000–10 000 miles	..	..	..	13
Over 10 000 miles	..	..	..	4

What does it cost to run a car for 6000 miles a year? The AA allowances are based on an

TABLE II—Annual cost of running a car

	Engine capacity (cc)		
	1501–2000	2001–3000	3001–4500
Standing charges per annum (£):			
Car licence	50.00	50.00	50.00
Insurance	160.70	210.70	323.40
Depreciation	468.28	696.55	1288.75
Interest on capital	206.04	306.48	567.05
Garage/parking	104.00	104.00	104.00
Subscription	11.50	11.50	11.50
	1000.52	1379.23	2344.70
Running cost per mile (pence):			
Petrol	2.762	3.504	4.478
Oil	0.158	0.183	0.272
Tyres	0.379	0.465	0.846
Servicing	0.514	0.581	0.840
Repairs and replacements	2.123	3.192	4.401
	5.936	7.925	10.837
Cost per mile based on 10 000 miles (pence):			
Standing charges	10.005	13.792	23.447
Running costs	5.936	7.925	10.837
	15.941	21.717	34.284
Cost per mile based on 6000 miles (pence):			
Standing charges (annual ÷ 6000)	16.675	22.987	39.078
Running costs	5.936	7.925	10.837
	22.611	30.912	49.915
Annual cost based on 6000 miles (£):			
Gross cost 6000 × cost per mile	1356.66	1854.72	2994.90
Reimbursement 6000 × 15.94p*	956.40	956.40	956.40
Net cost to consultant	400.26	898.32	2038.50

*Maximum NHS reimbursement 1978 for cars over 1750 cc is 14.7p per mile.

assumed 10 000 miles per year for eight years. To work out the cost of 6000 miles a year the 1978 figures supplied by the AA have been used as shown in table II.

These figures show that large subsidies are being paid by consultants to provide a good NHS service, the respective AA costs being 22.6p, 30.9p, and 49.9p per mile against a maximum 1978 NHS refund of only 14.7p (over 1750 cc), but no doubt it will be argued that the consultant also has the use of the car for personal motoring. Is this a great advantage?

Family motoring is assumed by the AA to be 10 000 miles per annum. The Welsh Region found that 23 out of 32 consultants studied had second cars and of the nine who had not, six had hired or borrowed a car during the period. If it is assumed that the family car is a modest 1501 to 2000 cc saloon like the first car then there is no saving as miles done in the first car are deducted from those done in the second (table III).

Unless the use of both cars combines to a

TABLE III—Cost of family motoring

	1st car	2nd car	Total cost (£)
NHS Personal	6000	10000	1356.66 1594.10
			2950.76
NHS Personal	6000 4000	6000	1356.66 1594.10
			2950.76

Cost per mile £2950.76 ÷ 16 000 = 18.44p.

total of 20 000 miles per annum the costs will remain over 15.94p per mile; over 21 600 miles need to be driven to bring the cost down to 14.7p.

Most part-time consultants will use their first car for private practice as well but it will still usually mean a subsidy towards the 6000 miles of NHS use, albeit small. Or is it so small? Most successful part-timers will have a car of more than 2000 cc, so if we assume an NHS mileage of 6000 and another 6000 miles for private practice the consultant is subsidising the NHS to the tune of £283.12 annually (table IV).

TABLE IV—Annual subsidy by consultant to NHS

	Annual costs (£)
Standing charge	1379.23
Running costs 12 000 × 7.925p	951.00
	2330.23
Cost against tax	less 1165.12
Cost against NHS	1165.12
Reimbursement 6000 × 14.7p	less 882.00
Subsidy to NHS	283.12

What should be done?

To the question do consultants need a car for their work? consultants must firmly reply that they are a special case. Reliable cars are essential if lives are to be saved. There has been and will be government resistance to this idea and there can never be a solution to the argument without a trial of strength. But it

may be avoided by adopting the following proposals.

A personal investigation of the cars provided by a small number of large companies for their executives shows that those on salaries of £8000 to £11 000 per annum would have company cars costing up to £8000—say, a Rover 3500. The consultants' negotiators should tell the DHSS that consultants have been downgraded in respect of a major social status symbol, their cars, and they should press on with negotiations for improved allowances. A recent survey by the British Institute of Management studied 400 major UK companies and found that the general policy was to replace company cars at three years or 45 000 miles.¹ The AA should be asked to provide the appropriate costs for using cars for less than eight years, as depreciation is a major factor.

Consultants should be reimbursed by submitting mileage claims as at present, paid at the proper rates mentioned above—related to the capacity and age of the car and based on annual mileage derived from the total mileage of the previous year. At the end of the year the consultant would be required to state the reading of the speedometer and an adjustment would be made (table V). This is similar to the present taxation system.

the employer must provide a taxi or a car or pay the full motoring costs. If the consultant thinks it essential to use his own car then a rate applicable to his annual mileage must apply, with an arbitration mechanism to decide on the mode of transport. Alternatively, the consultant could be offered a properly negotiated regular user type of arrangement.

Conclusion

Repeated plundering of consultants' real incomes has left them unable to replace their aging cars and forced them to trade down when eventually they find replacement inescapable. This must be put right and the evidence from industry cannot easily be ignored. Our employers must pay their fair share for a respectable car but a consultant must have the right to have a car of his own choice and to use it as he wishes.

If the new consultant contract goes through almost all journeys from home to work as well as those at work will be eligible for

payment. Thus it will become possible for a consultant's car to be used solely for work and so become the entire responsibility of his employer. If the consultant then reduces the cost to his employer by doing a personal mileage with that car why should the employer object? Now that the Central Committee for Hospital Medical Services has wisely removed motoring negotiations from the Whitley Council arena to their own negotiating committee let battle commence.

References

- ¹ Automobile Association, personal communication, 1978.
- ² Appleby, J, *British Medical Journal*, 1977, **2**, 1169.

Stratford-upon-Avon, Warwickshire

R T MARCUS, CHM, FRCS, consultant surgeon

TABLE V—Claim for mileage reimbursement for car of 2001-3000 cc

Running claim based on previous year's total mileage costs:			
Age of vehicle	2 years		
Speedometer reading	24 000 miles		
Previous year's motoring	12 000 miles		
Cost per mile	19.42p		
NHS mileage	6000 miles		
Reimbursement (6000 × 19.42p)			£1165.12
Cost per mile based on actual mileage in current year:			
Age of vehicle	3 years		
Speedometer reading	35 000 miles		
Previous year's motoring	11 000 miles		
Cost per mile (based on 11 000 miles):			
Standing charges (£1379.23 ÷ 11 000)	12.538p		
Running costs	7.925p		
Total			20.46p
Year-end adjustment to running claim:			
Cost to consultant (6000 × 20.46p)			£1227.60
Reimbursement			£1165.12
Refund			£62.48

A mileage in excess of 12 000 miles would result in an adjustment the other way, which could be deducted from the next travel claim.

Are any constraints required in the above scheme? If the consultant is honest with his mileage claims the additional annual requirement to state the speedometer reading would be minimal and capable of easy verification. Computerised accounting should make calculations easy.

At present only those few consultants doing over 10 000 miles a year with their first car for eight years as well as over 10 000 miles a year with their second car are going to make any profit. This small band will have to accept a loss of profit so that the majority on lower mileages can be properly paid. The regular user rates, which have not been mentioned so far as the break even point is around 6000 miles per annum,² attempt to do this but are unrealistic at present.

The main problem would be for the employer faced with a high cost per mile for the consultant who does low mileages. If the employer requires the consultant to be mobile,

NHS will cost £8000 million in 1978

The annual average growth in the family practitioner services will grow faster than both the hospital and community health services, according to a recent Office of Health Economics briefing (No 7, October 1978). The overall spending on the Health Service will rise by 2% in the present financial year but less for the two subsequent years. Because of the DHSS policy of "people before buildings" the capital investment has been less than planned 10 years ago. But in the long run, the OHE says, "if medical care is to improve more new buildings are necessary to replace many of the present ill-sited or underequipped old ones."

The estimated cost of the NHS in 1978 will be £8000m—three times more than in 1949, though similar increases have occurred in other spheres such as education. Even so, other richer nations have increased their expenditure on health more quickly—North America and Western Europe spending more than 7% of their GNP compared with the UK's 5.7%.

The last year for which detailed figures are available is 1976, when, of the £6309m spent on the NHS, £127m was paid directly in the form of prescription charges, dental treatment, and the cost of spectacles. Direct patient treatment costs in the hospital service (salaries and equipment) absorbed 55% of the £3972m spent in 1976; administration and general services (catering and laundry) took 37%. Increased expenditure in the hospital services are the result of increases in manpower, increases in wages—particularly in 1974-5—and expanding work load. Between 1967 and 1976 the number of inpatients treated (measured by discharges and deaths) rose from 5.9m to 6.5m.

Primary health care services—general medical, dental, ophthalmic, and pharmaceutical services—accounted for 20% of NHS expenditure, but spending on general medical services has declined as a proportion. In 1953, for instance, they accounted for nearly 11% of NHS expenditure as compared to 6% in

1976. Even so, the number of prescriptions handled has gone up from 310m in 1967 to 361m in 1976. The increase and the introduction of new medicines has led to a DHSS projection of a 5% increase in pharmaceutical costs to 1980. Since NHS reorganisation in 1974 the most notable increase in expenditure, the briefing points out, has been in "other" services—£686m in 1976: for example, headquarters administration (RHAs, AHAs, boards of governors, and health boards) took 35%, and the ambulance services (inherited from the local health authorities) 17%.

Looking to the future OHE concludes: "Current expenditure by volume on all services is projected to increase at an average of 1.7% per year. This level of growth is considerably less than that enjoyed in past years. Within this, expenditure on hospital and community health services, now regulated by 'cash limits,' will be limited (and is cut in relation to past projections) although even by 1981-2 these services will still be consuming well over three times the revenue resources available to the family practitioner services. Although there is no clear indication as to which of the services will be actually affected by the restraints DHSS guidelines indicate that community based services should be protected. . . . The annual average growth in [family practitioner services] is projected to rise faster than both hospital and community health services. It is forecast that, in the current financial year, the volume outlay on general medical and pharmaceutical services will rise by 2.4% and 4.5% respectively, but that general dental and ophthalmic services will both drop by between 4% and 5%. With the exception of the latter, growth in all services is projected to increase proportionately less in 1978-9 with general dental services showing a continued negative growth. This indicates that any extension of these services will mainly come from financial charges paid by patients."