TALKING POINT

Consultants' cars

JAMES APPLEYARD

The consultant's car has become an increasingly expensive necessity. The effects of the "TUC's" pay guidelines on consultants' earnings and the high inflation rate have widened the gap between car prices and consultants' salaries (see table I).

Apart from a small minority who can commute to work or who have no on-call duties, most consultants accept that they need a reliable car to carry out their day-to-day professional duties. So they have been forced to finance the purchase of their cars used on NHS business out of their own declining post-tax "disposable incomes" in the interest of their patients' care. Many executives in industry on equivalent salaries in 1975, who have not suffered the 20% fall in living standards experienced by consultants over the last two years, are provided with new, fully insured and maintained company cars for duties that do not usually have the same urgency or responsibility as those of senior hospital doctors. It is not surprising, therefore, that many consultants think that they can no longer continue to afford to subsidise the NHS by using their own cars.

The two main reasons for the present unsatisfactory position are well known: one is financial, the other political. The revenue consequences to the NHS of financing consultants' cars would run to millions of pounds (see tables II and III). The Treasury would, I am sure, credit the Department of Health and Social Security with the fact that considerable sums of money have been "saved" over the years by the current method of reimbursing consultants' expenses. But in the present climate the DHSS is unlikely to allow any further spending on cars, particularly because, in its view, it would be likely to open the gates for other health care workers to make similar demands. This is the second and political reason for the current difficulties. The DHSS does not consider that senior hospital doctors, despite their special responsibilities and duties to patients, should have any "privileges" such as cars that are not available to other workers in the NHS as non wage benefits. Unless the politicians at the DHSS recognise the special need for a reliable car to be immediately available for use while the hospital doctor is on call for his patients—a fact that is so readily understood by doctors and taken for granted by patients—no satisfactory solution will be found.

Present conditions

Senior hospital doctors are at present bound by their Terms and Conditions of Service. Paragraphs 277-9 refer to "whole timers" and paras 280-4 to "part timers," travelling expenses, and mileage allowances. Unless you are well versed in the obscurantism of bureaucratise the paragraphs are hard to understand. Indeed, some authorities have prepared

explanatory notes but these in turn need a sound knowledge of geometry and algebra. Some of the principles applied to whole-time consultants are:

Expenses are paid only when appropriate from home to headquarters up to a distance of 10 miles.

No allowances are payable for the cost of home to headquarters journeys even though the car is necessary for on-call duties during the day, unless an official journey is undertaken (apart from rarely applied special conditions).

If the practitioner has no season ticket to his headquarters, ordinary mileage less the appropriate "public transport rate" is paid for home to headquarters on those days when official journeys are carried out.

Ordinary mileage allowances are paid in full for journeys undertaken outside normal hours of duty—for example, for night and emergency calls.

Under the present system, therefore, the reimbursement of consultants' expenses is highly selective and however priced operates against consultants. By the nature of their work, which entails continuing responsibility to patients in different hospitals and the community, they are unable to use a "family" car for this purpose. If the doctor's family requires a car for geographical or social reasons the consultant is forced to run a second car exclusively for his work. The present methods of reimbursement of expenses

cannot compensate him fully for that additional expense (tables II and III).

Protracted negotiations

Negotiations have been going on with the DHSS for many years to improve this unsatisfactory position. The profession has been hampered by the fact that these negotiations have had to be conducted through the Motor Allowances Subcommittee of the General Whitley Council, on which the BMA has one seat. Eventually in 1970 a revised scheme based on the AA schedule of estimated running costs was agreed. This was some improvement, but the rates are calculated on an annual mileage of 12 500 and this is detrimental to those consultants who have to run a second car and may well do a smaller annual mileage. In 1974 when the local authority health staff were absorbed into the NHS there was great dissatisfaction about the NHS mileage allowances, especially from nurses who had been used to lump sum payments. As a result of their pressure, which included the threat to withdraw the use of their cars from the NHS, the regular user scheme was offered to the staff side of the Motor Car Allowances Subcommittee in January 1975. The BMA representative immediately expressed reserva-

TABLE I—Indices of new car prices and consultant salaries 1970-7

Year	New car prices			Consultant salary* (gross)
	Mini 1000cc	Cortina 1600L	Triumph 2000+	
1970	100	100	100	100
1971	100.6	105.2	102.6	108.1
1972	110.2	111.8	114.5	116.1
1973	115.8	120.5	121.2	120
1974	164.8	170.4	161	125.5
1975	190	190.1	183.2	168.9
1976	229	235.4	236.3	168.9
1977	256.2	273.3	274.8	172.1

Maximum of salary scale.

Used because 2500TC not produced since 1974.

TABLE II—Schedule of motoring costs—selected vehicles*

Car	Running costs	Capital loss	Pence per mile† Total	Annual motoring costs†
Mini 1000cc	3.9	3.7	7.6	£ 910
Cortina 1600L	5	5.9	10.9	1308
Triumph 2500TC	6.3	8.9	15.2	1820

*Derived from data in *Motoring Which*, October 1977.

†Based on 12 000 miles per annum.

TABLE III—Comparison of motoring costs and DHSS reimbursement*

Car	Actual cost†	Standard NHS mileage rate	Regular users allowance
Mini 1000cc	£ 738.50	£ 489	£ 474
Cortina 1600L	1038.50	619	656
Triumph 2500TC	1564.50	679	656

*Based on 5000 miles NHS mileage including 20% home to duty mileage.

†Based on AA data, adjusted to take account of replacement costs.

tions but his objections were over-ruled. A no detriment clause for the existing staff on the "standard rates" was secured. The newly appointed consultant, however, with high annual mileage—for example, 10 000 miles a year—has been considerably compromised by this revised agreement. Indeed, the DHSS has admitted that these consultants will be reimbursed at lower rates than those consultants already in post and doing the same mileage yet still able to claim at the "standard rates." This unfair anomaly, which affects the young consultant with the greatest NHS work load, who has probably already suffered a drop in salary since leaving his senior registrar post, has been dismissed by the Department as a "swings and roundabouts" condition. It is perhaps symptomatic of the attitude of the DHSS towards young consultants that it has not been seen to make any effort to correct this injustice.

Four-point plan

Devising a scheme to solve all the different requirements for consultants working in the Health Service is no easy task, particularly as the consultants' work varies with specialty and area. I would therefore suggest the following four-point plan:

A five-year interest-free loan of the sum equivalent to the middle market price of a 2000cc motor car on first appointment or transfer to the new contract, plus

An annual tax-free lump sum allowance for replacement costs, with

Mileage allowance on all journeys undertaken while on call for the National Health Service or on other official business. This will need to be calculated on a formula similar to that of the AA, including factors for maintenance, depreciation, insurance, etc, but based on 10 000 miles per annum, or

The option of the provision of a fully maintained and insured 2000cc car by the employing authority renewable every two years, with a smaller mileage allowance to take into account petrol and oil costs.

For a consultant to be eligible he would need either a contractual commitment to acute on call or have his NHS commitment at more than one hospital such that a private motor car is the only reasonable way of travelling between them. Those ineligible would be able to claim the standard mileage allowance on other NHS business.

Talks have been going on with the DHSS since February this year about a new consultant contract and the DHSS has been pressed strongly by the profession's representatives on the subject of cars. The Government guidelines on pay now permit these talks to take the form of negotiations and Mr David Bolt, chairman of the CCHMS's Negotiating Subcommittee, reported progress to a meeting of the CCHMS on 22 September. Despite the fact that other workers in the NHS are helped with car purchase by employing authorities (HSC(15)135), there has been no marked movement to adapt this facility to meet the needs of NHS consultants. Furthermore, it is becoming increasingly apparent that the Department is not going to be persuaded by the profession's arguments, which have been voiced in the *BMJ* and other medical journals.

The last important change in reimbursement of travelling expenses was forced on the DHSS only when the nurses threatened to refuse to use their cars on NHS business. The DHSS obviously believed that the nurses would carry out that threat and had to give way. It

looks as if the consultants are now becoming so disillusioned that they too will follow the recent lead of the CCHMS (8 October, p 968).

The CCHMS is preparing advice to consultants in selected regions that they should stop using their cars for NHS duties for a defined period (to demonstrate to the Health Departments just how much consultants are subsidising the NHS). Only if consultants unite and take this step will the DHSS be

forced to correct the injustices of the present arrangements.

I am grateful to Mr Jon Ford, the BMA's economic research officer, for preparing the tables.

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Closed shops in the NHS?

FROM A SPECIAL CORRESPONDENT

"Union membership agreements in the NHS" was the title of a well attended one-day national conference organised by the *Health Services Manpower Review** on 13 October. "UMA" is the statutory and officially preferred title for "closed shop," because the latter is now getting a bad reputation.

Jim Mortimer, director of the Advisory, Conciliation and Arbitration Service (ACAS), opened and tried to alleviate any doubts about the impartiality of ACAS which his presence may have aroused by giving a fair and objective account of the advantages and disadvantages of the closed shop. He did not, however, say anything which had not already been said by the Donovan Commission,¹ and his repeated references to the experience of shipbuilding and other industries gave the impression that he was barely aware that the end product in the Health Service was a sick and often anxious patient. Next, Alan Fisher of NUPE delivered a spirited account of the advantages of closed shop to the unions.

Frank Pethybridge, himself a trade unionist and administrator of the North-western RHA, tried to restore the balance. He agreed that a closed shop would strengthen the unions, but he could see nothing in it for management. He had not been impressed by the ability of union leaders to persuade their members to observe negotiated agreements and he did not see how a closed shop would help matters.

The speakers representing the unions' point of view ignored a question from the floor on why management should be more confident that negotiators backed up by compulsory membership would represent the views of their members more reliably than negotiators who relied on voluntary support. It is interesting that the leader of the largest union (Transport and General Workers), who is supported by a plethora of closed shop agreements, has recently been elected for life.

Only one union speaker was honest enough to admit that what the unions wanted was to make employment anywhere in the NHS impossible for anyone who refused to join, or who left, the recognised union. But what about those who were chucked out of a union? Reg Bird, a senior official of ASTMS, was clearly nettled by a question from one of the BMA staff present who read out a section from the ASTMS rule book. This set out the powers to expel any member who acted against the interests of ASTMS or who acted in any manner contrary to the decision of its executive. Mr Bird replied by saying that his union had an appeals procedure and he proceeded to abuse the BMA for the way in which it represented doctors.

*Published by the Department of Adult Education, University of Keele.

We were well on into the afternoon before the word "patient" was mentioned for the first time. This naturally led to issues of conscience, to the obvious embarrassment of several of those present. Why is conscientious objection to membership of a union not recognised by law when it was acceptable in this country's darkest hour as grounds for exemption from military service? The only answer given at the conference was that it would make the closed shop unenforceable. Perhaps Hugh Scanlon of the AEUW gave the real answer when asked why no objections other than religious ones (and those only to belonging to trade unions as a whole and not a particular union) were recognised by law. He replied "I do not know what others there could be."

All-out effort

It was clear from the views expressed at the conference that the TUC-affiliated unions are making an all-out effort to get closed shop agreements in the Health Service. The case put forward exudes sweet reasonableness, though some of it offends the intelligence, for example, it is the employers who will dismiss the non-member from employment, not the union. But will the moderates always remain in control of the unions operating in the Health Service? As an area nursing officer who had come hot foot from the Hounslow Hospital dispute said, "The unions are not the right people to determine what is in the best interests of the health of the patients." The applause which greeted this statement was strictly localised as it had already been announced, amid much greater applause, that some important union representatives, including one invited speaker, could not be present as they were down at Hounslow "stirring things up"—only it was not put quite like that.

Perhaps the most difficult point for doctors to grasp is the violent feelings which are said to be created if non-union members are allowed to work alongside loyal union members. Again and again we were told that this seriously disturbs the workers, destroys morale, and reduces output. The public should be grateful that teams of doctors working in the Health Service are preoccupied with the treatment of the patient, and are not noticeably affected by any non-members of the BMA who happen to be working with them. If industrial unionism succeeds in infiltrating health care teams the priorities may well be drastically altered.

Reference

- ¹ Royal Commission on Trade Unions and Employers' Associations, 1965-8, *Report*, Cmd 3623. London, HMSO, 1968.