bodies represented include the Joint Consultants Committee, Royal College of General Practitioners, and Medical Women's Federation. There are also observers from the GMC, DHSS, Scottish Home and Health Department, Royal College of Nursing, British Dental Association, Irish Medical Association, and councils for postgraduate medical education.

Initially the committee was chaired by Mr Walpole Lewin and the feeling of common endeavour and mutual trust which quickly developed, especially between the Government's representatives and those of the profession at large, and the sense of close contact with the negotiating bodies in Brussels have fully vindicated the original conception. The same good relations have continued (since 1974) under the subsequent chairmanship of Dr Alan Rowe.

In addition, there is a smaller BMA/EEC Working Group without representatives and observers from outside organisations, whose function is "To consider, in conjunction with the standing committees of the Association, the medicopolitical implications of EEC membership with a view to the formulation and correlation of BMA policy, and to report to the Council."

Lastly, to keep the main committees informed and advised on EEC affairs, small working groups have been set up by the CCHMS, General Medical Services Committee, and Hospital Junior Staffs Committee.

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TALKING POINT

Realities of private medical care*

J C SMITH

Private medical care is often depicted by its political opponents as available only to the rich and damaging to the NHS. This is totally out of keeping with the truth and the practical realities of private medical care are worth stating.

Aneurin Bevan once said that if everyone could afford private medical care then there would be no need for a National Health Service—and this self-apparent truth seems to have been forgotten recently by those who are keen to "finish his work." The crux of his statement rests in what "could afford" means, for it clearly means different things to different people.

Classifying disease

If we classify diseases on this basis there are three broad categories (see table). Everyone can afford to treat the conditions in category 1 and few people would wish to see the State system concerned with self-medication, for which doctors are rarely consulted. At the other end of the scale few people can afford the expensive treatment and care of the category 3 disorders.

Category of diseases

Category	Definition	Examples
1	Diseases that everyone can afford to treat themselves	Headaches, colds, simple constipation
2	Intermediate diseases	Most medical and surgical conditions
3	Diseases that no one can afford to treat themselves	Renal failure, haemophilia, long-term care for mental incapacity

Controversy rages, however, in the intermediate category, which accounts for a large volume of the work of the NHS and is an area where the NHS fails to give a uniformly satisfactory service, witnessed by waiting times and waiting lists.

If a finite amount of capital is available from Government sources then the greater the proportion of the intermediate category that is financed from individuals the more will be available for the category 3 diseases and the category 2 diseases for those unable or unwilling to provide for themselves. The

recent consultative document¹ makes it clear that there will be little Government money available in the next few years for category 2 and standards will decline unless alternative provision is sought.

Financial provision for private medical care

Statistical evidence in the private sector is difficult to obtain but most people who seek private care do so through one of the provident associations. Figure 1 sets out the cost of such provision and compares the cost with other non-essential items of life today. The insurance cover quoted is on the highest

FIG 1—Comparison of annual cost of private care provision with some non-essential items.

*This paper is based on a talk given to an IPC conference on 29 April under the auspices of the Campaign for Independence in Medicine.

current scales and would be more than adequate for most diseases in most parts of the country. Possibly London (as in so many other instances) is an exception to the general rule.

So often the private medical sector is portrayed by its political opponents as predatory or parasitic on the NHS despite the fact that all British private patients have already paid their contributions in full and receive little if any benefit in return. Figure 2 shows the benefits of the private sector to the community and to the Health Service.

FIG 2—Benefits of the private sector to the NHS and the community.

Discussion

With all the evident advantages to the community, what are the snags? I used to believe that the only valid argument against the private sector was that it took out of the NHS a group of intelligent, demanding people who if forced into the NHS would, by creating a fuss and stirring political action, improve the standard of care for those less demanding or less voluble.

Experience, however, has shown that these people simply use their political muscle to obtain preferential care for themselves or their families and leave the NHS exactly as it was before.² These patients often have left-wing views and ideals and boast of receiving "ordinary" NHS care.

The only really valid argument against the private sector is in the abuse of the mixed system, and the balance is admittedly delicate. It is a credit to the medical profession in Britain that abuse has been minimal but we must continue to guard against it and if necessary take action. Provided a consultant gives an honest week's work to the NHS, he should be entitled to spend the rest of his time as he wishes.

I have tried to avoid those areas difficult to quantify such as the probability that those in private practice are most cost conscious, work harder (count the cars in the hospital car park at weekends), or are more easily available for *all* their patients (you get little private emergency practice with an ex-directory telephone number). But most people in hospitals realise that the NHS gets excellent value for money from its part-time or full-

time consultants. They are the only people in the Health Service (except singlehanded GPs) who still provide continuity of clinical care on a personal basis.

References

- ¹ *Priorities for Health and Personal Social Service in England*. DHSS, London, HMSO, 1976.
- ² Smith, J C, *The Times*, 15 October 1973.

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Executive Committee of Council

This report was prepared by the BMA Secretariat

Government's incomes policy

The regular monthly meeting of the Executive Committee of Council was held at BMA House on 26 May. The committee discussed the implications for the profession of the Government's decisions so far announced on the second round of its anti-inflationary measures, to begin in August. Representatives of the Council had met the Secretary of State for Social Services, Mr David Ennals, on 30 April to stress the particular position of doctors and special aspects of the matter affecting general practitioners and hospital medical staffs in the NHS. The committee had particularly in mind the need to remove any restriction on the payment of annual increments and distinction awards for senior hospital medical staffs and seniority payments in general practice for those with incomes in excess of £8500. It was decided to advise the Council that if adequate assurances were not received from the Secretary of State as a result of this meeting with him, the profession's representatives should seek a meeting with the Chancellor of the Exchequer.

Royal Commission on the NHS

On a progress report concerning the preparation of evidence to the Royal Commission on the NHS, the committee discussed the membership of the Royal Commission as announced on 5 May (15 May, p 1221). It noted that the membership includes neither a NHS consultant nor a junior doctor and that this omission was being raised in appropriate quarters.

Remuneration of doctors in training posts

The committee endorsed a proposal for a meeting of representatives of the committees concerned with a view to resolving the complexities of establishing comparability of earnings in varying training posts in the different fields of medical practice.

Violence in the family

Arrangements were made for a small group to give evidence on behalf of the Association to the Select Committee on Violence in the Family.

The Executive Committee of Council also received and approved reports from the General Medical Services Committee and the Central Committee for Hospital Medical Services on matters within their respective spheres on which they had recently taken action.