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Ideology, Class and the National Health Service

Rudolf Klein

Based on working papers of the Royal Commission on the NHS

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IDEOLOGY, CLASS AND THE NATIONAL HEALTH SERVICE

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EDITORS' INTRODUCTION

Although the terms of reference of the Royal Commission on the NHS referred specifically to the financial and manpower resources of the NHS, the Commissioners felt that they should consider the way in which private practice affected NHS resources. The Commission therefore set up a small working group to consider this topic in 1977. Chapter 18 of their report presents a summary of the more important facts about private medicine, considers the arguments for its benefiting or harming the NHS and finally looks at pay beds in the NHS.

Professor Klein's paper was submitted to the Commission in 1977, amongst a wide variety of material on this subject made available to the Commission through written and oral evidence, background papers prepared by individual members and members of the full-time secretariat, research papers, discussion with experts and visits to private sector institutions.

Ideology, class and the National Health Service presents an analysis of the factors underlying the conflict over the pay beds issue which erupted during the period 1974–76; a conflict which some consider to have been one of the precipitating reasons for the appointment of the Royal Commission. Professor Klein examines the roles of all the protagonists in this 'battle': the Labour Government, the trade unions, the medical profession and the Conservative party. In presenting this case-study, he highlights the susceptibility of health care systems to political developments outside them. His paper brings together much new information about the period and presents a cogent analysis of the factors contributing to a major and continuing debate in the NHS. The views expressed are his and do not necessarily reflect the views either of the Royal Commission or the King's Fund.

This paper is the fourth in a series of project papers based on the working papers of the Royal Commission on the NHS, published by the King's Fund Centre. We are grateful to King Edward's Hospital Fund for London for giving us a grant to enable this series to be produced, and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

INTRODUCTION *

For most of the thirty-odd years of its existence, the history of Britain's National Health Service (NHS) has been one of conflict within consensus[1]. There have been a number of issues which have provoked sharp differences either between the Labour and Conservative Parties or, more usually, between the medical profession and the government of the day. But, despite party clashes on such issues as prescription charges and despite periodic threats of mass resignations by the doctors over pay claims, the consensus about the basic structure and principles of the NHS has constrained and limited conflict.

There has, however, been one notable exception. This is the conflict, between 1974 and 1976, over the issue of pay beds in the NHS: i.e. the beds set aside in NHS hospitals for the treatment of the private, fee-paying patients of consultants. For this was a conflict which called into question—and indeed revolved around—the nature of the consensus: the basic concordat on which the NHS was built. It was ideological in character, in that much of the argument reflected clashing perceptions about the moral and social basis of the health service. It brought into opposition, furthermore, the Labour Party and the trade unions, on the one hand, as against the Conservative Party and the medical profession, on the other: a seemingly neat and symmetrical illustration of a conflict where disagreement about a specific health issue reflected a clash of class interests.

The two-year political battle over the pay beds issue is therefore of greater interest than the intrinsic importance of private practice within the NHS might suggest. Indeed, as this paper will seek to show, the pay beds issue became important not because it could be shown to have much impact on the day to day effectiveness, efficiency or even fairness of the service, but because it was linked to—and symbolic of—a number of more fundamental concerns involving the principles on which the NHS is built. The reason for analysing the battle in detail is, therefore, that it is an opportunity to test theories about the nature of policy change in health services: the relative

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importance of exogenous, socio-structural factors and of factors endogenous to health care systems[2]. Further, the episode illustrates—in the British context—the emergence of a new set of policy actors, the trade unions, in the health arena[3]. Lastly, the question of private practice and the NHS draws attention to some of the political problems created by the existence of a near-State monopoly of health care in a pluralistic, liberal democracy.

For ease of presentation, the first section of this paper will set out the basic facts about private practice and the NHS and the second section will give a brief account of the events in 1974 and 1976. Following sections will then examine the conceptual problems of analysis, the roles of the Labour Party, of the trade unions and of the medical profession, while the conclusion will discuss the implications for the study of the politics of health.

PRIVATE PRACTICE IN THE NATIONAL HEALTH SERVICE

Private practice in British health care takes a number of forms. There are some doctors, insignificant in numbers, who are totally outside the NHS. There are other doctors, however, who have the right to engage in private practice once they have fulfilled their contractual obligations to the NHS: this category includes virtually all general practitioners and about half the hospital consultants. In turn, these may treat their private patients either in their own offices or in privately-owned hospitals or use the facilities specifically set aside in NHS hospitals: the so-called pay beds, established by the 1946 Act setting up the NHS[4].

Determining the scale, and nature, of private practice is far from easy. There are no routinely collected statistics and hardly any special studies[5], a fact which, in itself, suggests both low salience and small scale. But there are a number of sources from which it is possible to stitch together a general, and somewhat rough and ready, impression. Taking, first of all, the number of people covered by private insurance schemes, there was a fourfold increase in the 20 years between 1955 and 1975 largely because of the rise in group schemes organised by employers for their white-collar workers: from 585,000 to 2,315,000[6], most of it in the period before 1970. In other words, one out of every 25 people in the population is covered by such a scheme. Between them, they paid out £52 million for private medical care in 1975: the equivalent of just over one per cent of the national expenditure on the NHS. Additionally, of course, patients outside these schemes may have paid for private care out of their own pockets, but no satisfactory information is available about the extent of such transactions. The only available source, the Family Expenditure Survey [7], suggests that the scale of such private spending on health care is insignificant in total (though, of course, it may be quite large in particular cases).

Turning to the other side of this equation, information about medical incomes from private practice is equally scarce and unsatisfactory—although crucially relevant when trying to assess the economic importance of this issue to the medical profession. Twenty years ago, in 1955/6, the Royal

Commission on Doctors' and Dentists' Remuneration [8] carried out what still remains the most comprehensive survey of medical earnings. This showed that the average net income of part-time consultants with private practice was 20% higher than that of full-time consultants without this additional source of income—an excess which, however, rose to 43% for the highest decile. This differential does not appear to have changed greatly over time. In 1969/70, the average income of part-timers was 23% higher than of full-timers[9], while in 1971/2 the difference was 18%[10]. Given the problems involved in collecting and interpreting such data, it would be a mistake to try to make anything of the fluctuations over time: the safest conclusion would seem to be that, taking all consultants and ignoring differences between specialties, private practice adds roughly a fifth to the incomes of those engaged in it. For general practitioners, earnings from private practice and other fee-earning activities outside the NHS is more marginal still: in the early 'seventies, it added less than 10% to their average income[11]. Even allowing for the possibility that some fees may not be declared—and the advantage of being able to offset earnings against tax-exempt expenses—the picture is consistent with the figures of fee payments from patients. The sums involved are clearly only a very small proportion of all spending on health care in Britain.

Similarly, the pay beds themselves form only a small proportion of all NHS resources. In 1949, there were 6,647 pay beds in England (the numbers in Wales and Scotland are, relative to population served, smaller still, and can therefore be ignored). Thereafter, the numbers declined steadily, if slowly, and in 1974—at the beginning of the pay bed crisis—there were 4,500 [12]. However, the number of patients treated in these beds moved in the opposite direction. As a result of the general acceleration of throughput, it increased from 86,064 to 111,400, having reached a peak of 118,000 in 1972. Thus in 1974, pay beds represented just over one per cent of all NHS beds, and the private patients treated in them represented two per cent of all non-psychiatric cases handled in the NHS. No analysis is available of the patients by diagnosis or form of treatment but the fact that the average length of stay in pay beds is shorter than that in either general medical or general surgical beds—7.4 days, as against 13.1 and 8.8 days respectively in 1974 [13]—confirms the accepted view that private patients tend to use these facilities for routine procedures, rather than for

long-stay conditions or major operations.

In all this, one of the most significant facts—in view of the political crisis which broke in 1974 and which is described in the following section—is precisely the paucity of information. This suggests that private practice was not only marginal to the NHS in its scale of operations and finance—as indicated by the available data—but was also marginal administratively and politically. And while it may be argued that it was in the interests of those who benefit from private practice (the doctors) or from not stirring up the issue (the administrators) to avoid collection of information, the same cannot be said about the opponents of private practice. In other words, lack of information would seem to suggest lack of political salience in the years before 1974: a point which will be analysed further when the reasons for the sudden eruption of this issue are discussed.

The Political Battle, 1974–1976

In February 1974 the Labour Party fought and won, albeit on a minority vote, a national election. Its manifesto[14] included the following short paragraph: 'A Labour Government will revise and expand the National Health Service; abolish prescription charges; introduce free family planning; phase out private practice from the hospital service and transform the area health authorities into democratic bodies'. In the subsequent October election of the same year, which confirmed Labour in office, the commitment became more specific still: the Labour Government, the manifesto declared, 'has started its attack on queue-jumping by increasing the charge for private pay beds in National Health Service hospitals and is now working out a scheme for phasing private beds out of these hospitals[15]'.

In between these two manifestos, the political climate within the NHS had changed dramatically. Starting at one of the London Teaching Hospitals, Charing Cross, rank and file members of the National Union of Public Employees (representing mainly the semi-skilled and unskilled workers in the NHS) took industrial action against pay beds. NUPE members refused to serve meals for, or otherwise help in the care of, private patients. Other unions, notably the Confederation of Health Service Employees and staff at other hospitals followed suit. Although it was never quite clear just how

much indutrial action was being taken at how many different hospitals, the issue of private beds was overnight put on the front pages of the newspapers and onto the television bulletins—helped by the fact, perhaps, that Charing Cross Hospital happened to be conveniently accessible to Fleet Street and the television company headquarters. In reply the Central Committee for Hospital Medical Services—representing the consultants—threatened a work-to-rule unless the Secretary of State for Social Services, Mrs.Barbara Castle, took immediate action to restore normal working and to rescind the union ban on admission to private beds[16].

So, in the summer of 1974, the battle lines were drawn up. And perhaps the most important outcome was to force the Secretary of State, Mrs. Castle, to take a public stand and to declare her position on the issue. After long negotiations between the Secretary of State and the representatives of the medical profession and of the unions (probably the first occasion when all three had met around the negotiating table) an agreement of sorts was worked out. The unions agreed to call off their industrial action and the consultants withdrew their threat. The question of pay beds was referred to a working party already appointed to negotiate the details of a new contract for hospital consultants. The Secretary of State condemned the use of industrial action to compel policy change in the NHS but endorsed the aims being pursued by the trade unions. Indeed in doing so, she explicitly stressed the ideological aspects of the debate: 'The issue before us is whether the facilities of the NHS, which are supposed to be available only on the principle of medical priority should contain facilities that are available on the different principle of ability to pay. We say that those two principles are incompatible in the NHS[17]'. So, in effect, the trade union protesters had asserted their right to take part in the policy debate, raised the emotional temperature of the dispute and persuaded the Secretary of State to define the issue in terms which made it central to the Labour Party's vision of itself as a crusade for social justice. The religious metaphor is apt: as Mrs. Castle was to point out on a subsequent occasion, 'Intrinsically the National Health Service is a church. It is the nearest thing to the embodiment of the Good Samaritan that we have in any aspect of our public policy. What would we say of a person who argued that he could only serve God properly if he had pay pews in his church?[18]'.

The next major step in the battle came with the publication, in August 1975, of a consultative document by the Government outlining proposals for the separation of private practice from NHS hospitals[19]. This proposed a dual strategy. First, legislation was to be introduced to revoke the authorisation of pay bed facilities in the NHS and set a specific date for completing the process of separation. Second, legislation was to be introduced to establish a licensing system for the private sector designed to ensure 'that the total provision for private medical care after pay beds are phased out shall not materially exceed...that which obtained within and outside the NHS in March 1974'. In short, the total size of the private hospital sector was to be permanently frozen.

The consultative paper appeared at a time when the medical profession were already in conflict with the government over other issues: in particular, the negotiations over a new contract for consultants (see below). But the threat to pay beds also produced a specific reaction from the medical profession. By the beginning of December 1975 the Secretary of State faced a militant profession. The Council of the British Medical Association had recommended that senior hospital doctors should limit their work by caring for emergencies and existing patients only, and was collecting undated resignations[20]. This coincided with an on-going pay dispute with the junior hospital doctors, who had already introduced an emergencies-only rule, and produced a counter-threat from NUPE to blockade pay beds in retaliation against any consultants who obeyed the BMA call. On the assumption that all those involved in the battle actually meant what they said, the NHS appeared to be on the point of total collapse. So, not surprisingly, there followed an intervention by the Prime Minister — Mr.Harold Wilson — and a series of meetings at No.10 Downing Street with the medical profession. Lord Goodman—who had previously acted both as the Prime Minister's solicitor and as legal adviser to the medical profession—was called in as a mediator, reputedly to the dismay of Mrs. Castle, and produced an acceptable compromise formula which became the basis of the subsequent legislation embodying the new concordat between the government and the medical profession on private practice.

The Goodman compromise[21] —like the subsequent legislation—was based

on the explicit recognition of two principles. First, there was the introduction of the principle that private beds and facilities should be separated from the NHS. Second, there was the formal commitment by the government to the principle that private practice should be maintained in Britain, and that doctors should be entitled to work both privately and in NHS establishments. The second principle was no more than a reiteration of the Government's acceptance of private practice as a fact of life. The Secretary of State had, indeed, maintained throughout the crisis that it was no part of her intentions to try to abolish private practice, as distinct from separating it from the NHS. However, as we shall see, the medical profession was sceptical on this point and its doubts had been further reinforced by the Labour Party conference in the autumn of 1975: this had carried a NUPE resolution calling for the eventual abolition of all private practice and the prohibition of all private insurance schemes, against the advice of Mrs. Barbara Castle[22].

More specifically, the Goodman compromise showed a number of important changes in the proposals put forward in Mrs. Castle's consultative document, all designed to provide concessions and reassurance to the medical profession. Only 1,000—or under a quarter—of the private beds were to be phased out immediately. Decisions about phasing out the rest were to be taken not by the Secretary of State but by an independent Board—with half its four members drawn from the medical profession and the other half appointed after consultations with the trade unions and other interested parties, and the casting vote held by an independent chairman. The Board, to quote the Secretary of State, would be guided by the following criteria in phasing out the pay beds: 'that there should be a reasonable demand for private medicine in the area of the country served by a particular hospital; that sufficient accommodation or facilities existed in the area for the reasonable operation of private medicine, and that all reasonable steps had been, or were being taken to provide those alternative beds and facilities'. No limit was set on the future size of the private sector. No date was set for the completion of the phasing out operation.

In the event, the Government's legislative proposals followed the Goodman concordat almost to the letter. The Parliamentary Bill, published in April 1976, filled out some of the details left open by the Goodman agreement

but did not touch any of the principles: for example, it gave the Board power to licence the construction of all new private hospitals with more than 100 beds in London and more than 75 beds in the rest of the country, but did not specify any maximum. The medical profession took the view that, while it was still opposed to the principle of the Bill and felt itself free to campaign against it, the legislation represented the most acceptable form of rape. The Government took the view that, while it would have preferred the more radical approach of its consultative document, it was committed to the Goodman compromise and was not prepared to make any further concessions—whether to the doctors or to the trade unions.

The final Act of Parliament showed few changes from the initial Bill, and none affecting the main architecture of its provisions. This was despite the prolonged and well-orchestrated rearguard action fought by the Conservative Party on behalf of the medical interests. The Conservatives opposed the Bill both in principle and in detail, both in the Commons and in the Lords. No sooner had it been introduced than a body of advisers, representing the BMA and other professional organisations, was set up to brief the Conservative spokesmen, who tabled 400 amendments and a number of new clauses during its passage through Parliament. A rota of advisers—organised by a member of the BMA Secretariat—was 'in constant attendance at all the Parliamentary sittings[23]'. But only a few, minor concessions were wrung out of Mr. David Ennals who, by this time, had succeeded Mrs. Castle as Secretary of State, following the change of Prime Ministers from Mr. Harold Wilson to Mr. James Callaghan. At one stage it seemed possible that the Conservatives might succeed in killing the measure by exhausting the available parliamentary time. However, Ministers—their backs stiffened by threats of industrial action from the trade unions, should the Bill be abandoned[24]—insisted on pushing their measure through, cutting short the parliamentary discussion by means of the guillotine (a procedural measure for time-tabling the debate).

The Government's insistence on sticking to the Goodman compromise was reflected also in its attitude towards its own supporters. Ministers resisted the repeated attempts of the Labour Left—backed by the unions—to give the measure more bite: in particular, to fix a date by which all pay beds would have had to be phased out. So, in the end, the Government could

rightly claim to have stuck to the Goodman compromise and to have been totally faithful to the concordat reached with the medical profession. And the medical profession—though frustrated in its desire to defeat the principle embodied in the Government's legislation—could reflect that, in practice, it could look forward to the continuance of private practice within the NHS for the indefinite future, if on a reduced and perhaps slowly contracting scale.

The Problems of Analysis

The above account of the 1974 to 1976 crisis is by no means a comprehensive history of events: it simply presents the context of analysis in order to define the questions which require further investigation. Some of these are general in kind, and applicable to all fields of policy study. How, for example, do we identify the precipitating factors which convert a dormant political issue into an active one? Others are more specific to the study of health services. How, for instance, do we account for the emergent influence of the trade unions during the crisis, and does this mark a shift in the balance of power within the health care system to the disadvantage of the medical profession? In turn, does such a shift (assuming that there was one) reflect a more general structural shift in society?

In addition to such **political process** questions Britain's 1974 to 1976 crisis also raises some puzzles about **policy substance**. So far little attention has been paid to the arguments used in the debate about private practice and pay beds. But, as we shall see when we turn to them in detail in the following sections, the debate was not exclusively ideological in character: i.e. it cannot be reduced to the simple symmetry of a clash between those who were opposed to private practice out of a general dislike of the market economy (reinforced by a specific dislike of the commercial element in medicine) and those who saw private enterprise as positively desirable, whether in health care or elsewhere. That, of course, was an important element in the conflict and certainly helps to explain the vocabulary of the consequent rhetorical babble. But, equally, some more practical policy considerations were also involved: in particular, the question of the extent to which comprehensive health care planning is feasible while there is a private sector outside governmental control.

To analyse these questions further, it is perhaps useful to think of the policy drama in terms of the inter-action between three groups of actors: the Labour Government, the trade unions and the medical profession. Each of these groups has its own stage or arena, where its internal differences are acted out. But there is also a larger stage where the three groups confront each other, and act out their differences: a dialogue which, however, can only be interpreted in the knowledge both of the strains and tensions within each group and of the audience for whose sympathy they are competing.

The Labour Government

In the 1974 to 1976 debates, Labour Ministers tended to take it for granted that opposition to private practice within the NHS had always been an article of faith for the party. The 1946 decision of Aneurin Bevan to permit pay beds and part-time private practice was seen as a tactical concession, a necessary sacrifice of principle to expediency without which it might not have been possible to launch the NHS[25]. It was this which had helped Bevan to split the medical profession, by buying the support of the hospital specialists and thus isolating the general practitioners[26]. But Bevan's tactics should not be confused with Bevan's aims, it was argued in the 'seventies, and therefore Labour Ministers were only carrying out the original intentions of the architect of the NHS. The 1976 legislation, seen in this light, simply represented the delayed implementation of what had always been the Labour Party's aims. Immanent policy had simply become explicit action.

In fact, the history of the emergence of private practice as an active political commitment by the Labour Party is more complex and more puzzling. Effectively, it submerged for more than 20 years after 1946. Bevan's compromise was criticised by a number of Labour backbench MPs during the 1946 debates, and the issue was subsequently kept alive (if only symbolically) by the Socialist Medical Association. The SMA periodically moved motions at the annual Labour Party conference directed against private practice. But these produced little more than vague pledges, on behalf of the leadership, to take 'steps to combat queue jumping for hospital beds', in the words of the 1964 Manifesto[27]. In 1967 the Labour

Minister of Health, Mr.Kenneth Robinson, reduced the number of pay beds —which had been much under-utilised—in agreement with the medical profession, in return for lifting the limit on the fees charged by consultants. Even this, however, was not seen as an ideological move—either by the Labour Party or by the medical profession—and only produced mild dissenting noises from some Conservative MPs[28].

The puzzle of the emergence of private practice as an issue is compounded when the history of pay beds is compared with that of prescription charges. Ideologically, the latter was far more highly charged. It was undoubtedly one of the Labour Party's articles of faith that health services should be free at the point of delivery: this, after all, was one of the issues over which Aneurin Bevan had resigned from the Labour Government of 1951. Prescription charges were thus anathema, and the 1964 Labour Government duly abolished them soon after taking office. Two years later, however, they were reintroduced in the wake of an economic crisis. This, in turn, provoked a strong reaction from the Party activists. Of the 30 resolutions submitted about the NHS to the 1969 Labour Party Conference, 20 called for the abolition of prescription charges. Only six called for the abolition of private practice or beds in the NHS[29]. Moreover, this pattern was by no means exceptional[30]. Throughout the 'fifties and 'sixties, prescription charges were a much more salient—and emotive—issue for the Labour Party's rank and file activists than private practice and pay beds. Yet when another Labour Government was returned to office in 1974, it was the phasing out of private beds—not the abolition of prescription charges—which was put on the political agenda and carried into execution, although both commitments had appeared in the election manifesto.

So why was priority given to the issue of private practice? One answer might be that, in the 'seventies, private practice within the NHS had grown in scale and therefore importance. But, to judge from the evidence already presented about the growth of private practice, this does not appear to have been the case: if there was any increase, it was incremental and marginal. Alternatively, of course, the explanation might be that although private practice had not increased to any extent, knowledge about its impact had—thus transforming perceptions of the problem, if

not the configuration of the problem itself.

There is at least some evidence in support of this latter interpretation. In 1971/2, the Employment and Social Services Sub-Committee of the Parliamentary Expenditure Committee carried out an inquiry into NHS facilities for private patients[31]. And the Labour majority on this Sub-Committee used the opportunity to direct attention onto the abuses (as they saw it) of private practice within the NHS—although their conclusions were, in the event, overturned by the Conservative majority on the main Public Expenditure Committee. The findings of the Sub-Committee are interesting in that they both encapsulated past criticisms of private practice and anticipated the main themes of Labour spokesmen during the 1974 to 1976 debates.

Private practice in the NHS was indicted on a number of counts. In the Sub-Committee's view, it permitted 'queue-jumping for non-medical reasons, allowing patients to by-pass the waiting-lists for reasons that have nothing to do with their medical condition'. It was unfair on junior hospital doctors, nurses and technicians 'used for private practice purposes and without willing consent'. It lead to 'dual standards of service' within the NHS. It encouraged the most highly skilled consultants to congregate in those parts of the country—notably London—with the greatest scope for building up a private practice rather than with the most urgent medical needs.

In all this, there was general agreement among the witnesses appearing before the Sub-Committee that there might be **some** abuse. Even the Department of Health officials and the representatives of the medical profession, who resolutely defended the **status quo**, conceded that some consultants might exploit both patients and staff. The real question, therefore, was whether the scale of such abuses was such as to balance the advantages of private practice and to justify the political costs of change. The advantages, it was argued in evidence to the Committee, were that private pay beds ensured that consultants were on duty in NHS hospitals—instead of dashing off to private clinics—and that private patients introduced a more exigent type of consumer into the NHS, so creating pressure to improve standards.

In practice, the Sub-Committee was never able to draw up a balance sheet. It received a variety of anecdotal evidence about abuse from junior doctors, nurses and trade unions, but no firm evidence about the scale of the problem. A questionnaire sent out by the Royal College of Nursing—designed to elicit whether consultants deliberately built up their NHS waiting lists in order to persuade their patients to pay for private treatment—produced only five examples of 'queue-jumping'[32]. Yet, interestingly, this lack of evidence—and the subsequent decision by the Conservative-majority of the Expenditure Committee to repudiate the Sub-Committee's critical comments—did not prevent the report from gaining wide currency: its authority was, for example, frequently invoked by Labour speakers in the 1974 to 1976 debates. Even though there had been no change in the actual situation within the NHS, and even though no extra information had become available, the private practice issue had acquired a new political salience in the context of the Labour Party at any rate[33].

But salience does not explain action, though it may help to account for the appearance of the issue on the agenda. Once again, there is the already-noted contrast between private practice and prescription charges to point up the puzzle. And indeed the puzzle can only be resolved by placing the issue of private practice in the larger context of the political and economic situation in which the in-coming Labour Government found itself in 1974. It is when policy-making is seen as the product of political pushes and economic constraints that the actions taken by Labour Ministers fall into a coherent pattern. On the one hand, there was the inevitable pressure on any in-coming Government—particularly strong in the case of an activists Administration of the Left—to do something: to satisfy the expectations of its supporters. On the other hand, there was the fact that the Government had inherited a distressing economic situation, where both unemployment and inflation were rising against the background of a rapidly increasing balance of payments deficit.

The Secretary of State for Social Services, Mrs. Barbara Castle, and her Minister of State, Dr.David Owen, were therefore in something of a dilemma. Their ability to improve the NHS, in terms of increasing the available resources, was severely constrained by economic circumstan-

ces and by their own decision to give priority to raising the wages and salaries of employees, as distinct from improving the scope or scale of service provision[34]. Yet they somehow had to satisfy the expectations of their own followers and, in particular, of the trade unions: for the foundations of the Labour Government's policies, in the period 1974 to 1976, was the understanding that the unions would accept wage restraint in return for priority being given to spending on the social services—the so-called Social Contract[35]. The tactical problem for Ministers was therefore how best to make the maximum political impact at the minimum expense.

Given this context, the decision to press ahead with the issue of pay beds rather than prescription charges followed logically—if not inevitably. Abolishing prescription charges would have been expensive, and immediately and unmistakably so. Phasing out pay beds had no visible cost consequences: there was much argument in the parliamentary debates about the spending implications of the government's policies, but no conclusion since the income foregone from private patients had to be offset against the expenditures generated by them, and it was far from clear what the net impact on the NHS's budget would be[36]. In short, the decision to phase out pay beds can be interpreted as an attempt to satisfy the ideological demands on Labour Ministers at the cheapest price (although it must be stressed that a price which may be low in terms of one unit of analysis may be very high when the currency is changed: thus the pay beds was a 'cheap' issue in public expenditure terms, but 'expensive' in terms of its impact on the government's relations with the medical profession).

Other factors were also involved, some endogenous to the NHS and others exogenous to it. In the former category comes the emphasis placed by Labour Ministers on the need to redistribute resources—both of manpower and of plant—within the NHS[37], both geographically and as between different sectors of health care. The system of part-time consultants with private practice was seen as an obstacle to policy implementation. It tended to encourage doctors to choose those areas and specialties with the best prospects of private practice. Neither the Government's tactics, nor the medical profession's reaction, therefore, make sense unless both are seen in the context of the simultaneous negotiations that were going on between them to devise a new consultant contract. In these

negotiations—more fully discussed in the section (below) dealing with the attitudes and role of the medical profession—the Government's concern was mainly to change the incentive so as to encourage full-time commitment to the NHS and thus discourage private practice. So the concern about pay beds in particular, and private practice in general, can be seen as reflecting both political and managerial considerations: in particular, the concern to secure the rational allocation of resources within the NHS which had already provided the intellectual justification for the administrative reorganisation scheme introduced by the Conservative Government in 1974[38]. In other words, to the egalitarian ideology of the Labour Party was married the planning ideology of DHSS administrators.

Exogenous to the NHS, there were also a number of further factors. First, there was the personal history of the Secretary of State, Mrs. Castle. In the 'fifties she, like Harold Wilson, had been one of the 'Bevanites', both a personal and political disciple of Aneurin Bevan. Like her Cabinet colleague, Michael Foot, she owed her influence partly to the personal backing of the Prime Minister[39] and partly to the massive support given to her by the party activists in the elections to the Labour Party's National Executive. Moreover, she had a past to live down. In the last days of the 1964 to 1970 Labour Government, she had been responsible for introducing a bill to regulate industrial relations which had antagonised the trade unions and split the Labour Party[40]. Politically it was therefore particularly important for her to avoid another such confrontation if she was to maintain her reputation as a radical.

The history of Mrs. Castle's lost battle with the trade unions in 1969 is the key to another—more crucial—factor. This is the role of the trade unions in influencing government policy generally and shaping the decisions of the 1974 to 1976 Labour Administration specifically. It was the trade unions, as we have seen, whose rank and file membership started industrial action against pay beds in 1974 and thus precipitated Mrs. Castle's decision to translate the manifesto commitment into immediate policy action. No account of the 1974 to 1976 crisis can thus make sense without considering the transformed role—no less a phrase will do—of the trade unions in the 'seventies.

The Trade Unions

The 1974 Labour Government took office after an election largely fought over the issue of a national strike by the miners' union[41]. It had been called by the previous Conservative Government in an attempt to assert its own authority: to invoke the popular mandate as against union power. The failure of the Conservatives thus opened the way for the Labour Government to design its overall strategy on the principle that government could effectively only be carried out with the co-operation of the trade unions. The industrial relations strategy introduced by the Conservatives, and bitterly opposed by the unions, was repealed. The Labour Government's economic programme hinged on the support of the unions. All in all, therefore, the period 1974 to 1976 was characterised by the increasing incorporation of the unions into the government decision-making process: an explicit acknowledgment of a shift in the balance of social power.

Within the NHS, too, the unions—as distinct from the traditional pro-pressional organisations like the BMA or the Royal College of Nursing—were growing in both numbers and influence. In line with trends in the United States and other countries[42] the proportion of unionised workers in the health industry had increased. The overall proportion rose from two-fifths in 1948 to three-fifths in 1974 it has been estimated[43]: thus by the latter year the NHS was more highly unionised than the British labour force as a whole—only 50% of whose members belong to unions. But this estimate conceals the real significance of the rise: its concentration in the late 'sixties and early 'seventies. This comes out dramatically in Figure 1, which shows the membership trend of the Confederation of Health Service Employees (COHSE). This is the only union whose membership—partly nurses, partly ancillary workers—is concentrated exclusively in the NHS, and is therefore the only reliable source of figures about the union-isation of the service[44]. Between 1956 and 1966, the membership of COHSE rose by a mere 16,000 members: a rise of 32%. Between 1966 and 1976, the rise was 147%. There was a similar explosion in the membership of the National Union of Public Employees (NUPE) over the same period, thus confirming the trend—although it is impossible to put a precise figure on what happened in the NHS since a high but uncertain proportion of NUPE's membership is in the local government sector[45].

So here there would appear to be striking evidence of growing militancy in the NHS, particularly among the least skilled workers: the nurses recruited by COHSE, for example, tended to be concentrated among those with the least prestigious professional qualifications and in the least popular sectors of the NHS such as mental care and long-stay hospitals. It is tempting, therefore to push the point one step further and to talk about growing self-awareness and militancy among what might be called (somewhat imprecisely) the working-class of the NHS—in contrast to the long-established and organised professionals.

But what might be called the radicalisation of the labour force thesis—though it fits in snugly with the rank and file action about pay beds in 1974—requires qualification. If there was any radicalisation, the evidence suggests that it was instrumental rather than ideological: that NHS workers were getting more assertive about pay. In 1967 the National Board for Prices and Incomes published a report[46] which suggested that, in order to improve the traditionally very low rates of pay in the NHS, local productivity schemes should be introduced. Thus the national pay bargaining system was supplemented by a local system of negotiation. One result, therefore, was to give local union officials and shop stewards a direct incentive to recruit more members, while the members themselves could see direct results from adopting a more assertive stance towards management[47]. A further result was that rates of pay in the NHS, relative to other occupations, began to improve particularly among manual workers[48]. The process of growing militancy over pay culminated in the 1973 strike of ancillary workers against the then Government's incomes policy: a national demonstration of industrial power, as against the more sporadic and largely verbal protests that had marked earlier disputes. Militancy paid dividends for both union members and union leaders. It brought better pay for the former and more members for the latter. Thus growing union assertiveness was also associated with growing competition between the unions involved in the NHS. The NHS even now is much less highly unionised than the rest of the public sector: its 60% unionisation rate compares with figures of 90% in central and 86% in local government. It thus offers an attractive recruiting ground. In particular there was no clear demarcation line between COHSE and NUPE, and these unions competed not only against each other but also against bodies like

the Royal College of Nursing—since one of the aims of the union movement was to exclude professional organisations from wage negotiations[49]. Militancy could thus be seen by the union leaders as a form of advertising: a recruiting campaign, in effect.

The situation in 1974 can therefore be best described as one in which there was scope for action by radical elements in the NHS labour force, rather than one which the labour force as such had been radicalised in any ideological sense. Indeed, given the composition of that labour force with its high proportion of women and part-timers[50], this is not surprising. Consistent with this interpretation, the lead in directing attention to the pay beds issue was taken by the National and Local Government Officers' Association—with a relatively small number of members (about 80,000) in the NHS—representing chiefly white-collar administrators. It was NALGO which moved a resolution calling for the 'abolition of all part-time posts and the abolition of private pay beds' at the 1973 meeting of the Trades Union Congress[51]. This was the first time that the pay beds issue had been given prominence at a TUC conference—which, like the Labour Party, had previously always concentrated its ideological fire on prescription charges. Subsequently, the extrusion of private practice from the NHS became official TUC policy[52].

There is a further piece of evidence to support the interpretation that the industrial action taken in 1974 should be seen as reflecting the views of self-selected activists rather than a general groundswell among the union rank and file. Later, in April 1976, the British United Provident Association—representing independent hospitals—commissioned a public opinion survey[53] as part of its campaign against the Government's bill. This indicated that rather more trade unionists (42%) were in favour of keeping pay beds than were in favour of their removal (25%). Again, it is clear that the industrial action was concentrated in those hospitals—particularly London teaching hospitals—where the provision of pay beds was particularly visible: where there was, in one way or another, some tangible evidence of private patients being treated differently (if only in terms of accommodation and food) from NHS patients. In short, action may have sprung from a down to earth sense of unfairness—combined perhaps with resentment towards consultants—rather than ideological considerations.

So, in effect, a spontaneous but limited rank and file protest forced the trade union leaders to activate what had been a long-standing, but dormant, attitude: an implicit policy bias became an explicit policy commitment. Given the competition for members, it was clearly not in the interests of any one leader to resist the growing militancy—but rather each had an incentive to put himself at the head of it. Once again, however, the puzzle remains why the trade unions pursued this issue rather than that of prescription charges. One explanation could be that the perceived 'unfairness' of pay beds was less their effect on patients than their impact on staff: that the system allowed consultants to increase their incomes at the expense of the supporting staff, who contributed their work but did not receive any rewards. In contrast, the deterrent effect of prescription charges—to the extent that it exists—is less visible because limited to precisely those patients who (by definition) are kept outside the NHS system as a result. Another explanation, of course, may be that symbolic actions are not the monopoly of governments: to the extent that the trade unions realised that there was little chance of securing the abolition of prescription charges, so there may have been a displacement effect, and the need for a symbolic ideological victory may have been satisfied by taking up the issue of pay beds.

The Medical Profession

So far the recurring theme of this inquiry has been why an issue so marginal in its impact on the operations of the NHS as that of pay beds should have become the cause of so prolonged and so bitter a political conflict. But, once granted that the Labour Government and the trade unions had determined to act, it would seem redundant to seek any elaborate explanations for the resistance of the medical profession. Straightforward economic self-interest would appear to be the answer: the medical profession was defending its income in defending pay beds.

But this explanation requires qualification and elaboration. Taking the medical profession as a whole, the evidence already discussed indicates that the income from private practice is marginal (though allowance must be made for the possibility that the official figures under-state the cash flow to doctors). Further, the proportion, though not the numbers of

hospital consultants with part-time contracts entitling them to undertake private practice has been declining: by 1973 it had fallen below the 50% mark[54]. For most of the profession, therefore, private practice would seem to be a source of pocket-money, at best, with only a small minority making large incomes.

To understand the battle over pay beds it is therefore once again necessary to put this particular dispute in a wider context. In the first place, it came at a time when the medical profession already felt its standards of living to be threatened, both relatively and absolutely. Rapid inflation was eating away the value of earnings, while the incomes and tax policies of the 1974 Labour Government deliberately discriminated against all higher-income groups. At the same time, the militant tactics of other health service employees was improving their relative position: soon after coming into office in 1974 the Labour Government made generous pay awards to both nurses and ancillary workers. So, as Table 1 shows, medical practitioners—and in particular the top 25% of them—were slipping down the earnings hierarchy between 1970 and 1975: an example of relative deprivation in terms of their own expectations. Moreover, absolute incomes were also falling: according to the 1977 report of the Review Body on Doctors' and Dentists' Remuneration[55], the living standards of general practitioners and consultants fell by 20% between April 1975 and April 1977.

Second, the battle over pay beds coincided—as already indicated—with the negotiations over a new contract for consultants. These negotiations had been initiated in 1974 by the profession itself. The aim was to create a system of rewards which would relate earnings more closely to effort, either by fee for service payments or by basing salaries on a specified working week, with extra payments in return for extra duties performed. The fee for service approach was ruled out of court by the Secretary of State from the start of the negotiations. But talks about a 'closed contract', with extra payments for extra duties, continued. The Labour Government also saw this as an opportunity to change the bias of the payments system in favour of full-time consultants, and so to create added incentives for them to move into the shortage specialties and deprived parts of the country. It therefore proposed to offer a new form

of incentive payments—'career structure supplements'—for which only full-timers would be eligible[56]. These supplements, it was proposed, would replace distinction awards, criticised on the grounds that they reinforced and preserved the traditional values, structure and distribution of specialists[57].

In the outcome, these negotiations dragged on for more than a year before being abandoned in the face of the medical profession's opposition; confirmation of the thesis that while the medical profession may not be powerful enough to insist on its favoured system of payments, it possesses veto power over what it regards as threatening changes[58]. But as long as the negotiations continued, they reinforced the medical profession's suspicion that the Government's policy over pay beds was only the beginning of a campaign to make it impossible for NHS consultants to engage in private practice of any kind. And while Labour Ministers denied that they were trying to compel consultants to withdraw from private practice, the contract proposals were self-evidently an attempt to devise a new system of rewards designed to encourage full-time commitment to the NHS. This strengthened the conviction of the medical profession that the Labour Government was repudiating the basis of the 1946 NHS agreement: that it was moving from a mixed economy towards a State monopoly.

The third element in the situation—mirroring the position among the trade unions—was competition between different bodies claiming to represent the interests of the NHS consultants. The British Medical Association was throughout the period under increasing attack from the Regional Hospital Consultants and Specialists Association, which argued that the BMA had concentrated on promoting the interests of general practitioners at the expense of hospital doctors. Already at the beginning of 1974, long before the pay bed crisis broke, some 900 consultants had resigned from the BMA to join the RHCSA[59]. So the rival spokesmen for the consultants had a direct interest in competitive militancy: to show their zeal in defence of the medical profession's interests.

Given all these considerations, it is not surprising that the medical profession's reactions to the Government's pay beds policy appears dis-

proportionate to the immediate financial interests involved. The policy was seen as the first step towards turning the medical profession into full-time State employees: precisely the fear which had inspired resistance to Aneurin Bevan's proposals in 1946[60]. As it was, the dependence of doctors on the NHS for most of their income appeared to be leading to a progressive decline in their incomes; moreover, they were clearly doing much worse than their peers in the Common Market countries like Germany or France[61]. But there was also the fear that total dependence on a State monopoly employer, through the gradual elimination of private practice, would lead to a further deterioration in the financial position of the medical profession. In reality, private practice in Britain may be economically insignificant, and certainly does not offer the medical profession an alternative form of financial support; in the profession's mythology, however, it embodied the doctor's traditional image of himself as an independent entrepreneur, rather than a salaried civil servant[62].

So far all the factors analysed would seem to be consistent with the mobilisation of the medical profession against the Government's pay beds policy, culminating in threats of sanctions. The Government, it would thus seem, had to retreat in the face of a united profession and to make the concessions embodied in the Goodman compromise. But, as in the case of the trade unions, the picture of ideological commitment and single-mindedness is over-simple. In practice, the Government did not face a homogeneous or united medical profession, as became clear in the wake of the Goodman concordat.

Following the concordat, the BMA's Central Committee for Hospital Medical Services organised a ballot of all consultants[63], to take their views about the agreement and about the profession's future tactics. This confirmed the results of an earlier ballot, held in 1974[64], in that it showed a 73% majority of consultants to be opposed to the principle of separation. But only a minority of consultants were willing to fight for the maintenance of this principle to the point of being prepared to resign from the NHS. Over three-fifths (63%) declared themselves ready to accept the Goodman compromise. The replies to the questionnaire showed some interesting differences, as between the various specialties and parts of the country, indicative of the heterogeneity of views within the medical

profession. The proportion of consultants in favour of the Goodman compromise ranged from 60% in England to 88% in Scotland (where the number of pay beds is negligible), from 83% for full-time consultants to less than half for part-timers, from 81% for specialists in pathology (where there is virtually no scope for private practice) to 49% for surgeons (where there are the greatest opportunities). Altogether only 54% of eligible consultants took part in the ballot: a figure which suggests that the issue was less salient for most doctors than the rhetoric of the official leadership might have suggested.

The militants among the consultants saw the results of the ballot as a disaster. In any negotiations with the Government, one of them argued bleakly, doctors 'would be like inmates of a concentration camp meeting to discuss their future'. This was, another declared, 'a black day for the whole of hospital medicine'[65]. But although the verbal campaign against the principle of the Government's measure continued, both in and outside Parliament, the threat of sanctions or mass resignations was withdrawn. The Government had won its symbolic victory; the profession had won its practical safeguards. The real battle was over, despite the oratorical fireworks that were to follow in parliament.

One clear conclusion to emerge from this analysis of the 1974 to 1976 crisis over pay beds in Britain is that to study the politics of health care issues in isolation is to risk mystification or misinterpretation. It is to support the conclusion that 'We have political struggles in the arena termed health, but not a politics of health'[66]. There are no factors endogenous to the health care system which can explain the sudden emergence of this issue. Nothing in the situation affecting pay beds—and private practice—had changed in 1974, except for the political environment in which decisions about the NHS were taken. The crisis is therefore an example of the importance of politics, in the most old-fashioned and traditional sense of party politics, as against organisational routines or pressure group bargaining.

This, in turn, would suggest that the usefulness of different theoretical perspectives depends on the nature of the puzzle or problem being tackled. In trying to account for the evolution of Welfare State Systems over time, and in trying to explain their growth in terms of expenditure, it has been found that ideological factors are largely irrelevant[67]. But ideology may not be irrelevant when it comes to trying to explain **how** different systems operate: their operational assumptions and policy priorities. The fact that the Labour Government had an egalitarian ideology, and a moral commitment to the proposition that health care should be provided irrespective of the ability to pay, was a necessary condition for its actions in the period 1974 to 1976—although it was by no means a sufficient condition.

But the ideological commitment of the Labour Party only represents what may be called a predisposing factor. The Labour Party has a variety of ideological commitments on a great many subjects which, in practice, never get translated into policy, or only partially so. And this, of course, is true of all political movements. What, then, activated this latent commitment? In trying to answer this question, the Alford thesis[68] of the importance of societal and structural factors is particularly relevant. The emergence of the pay beds issue depended not just on the election of a Labour Government: previous Labour Administrations had, after all, quite

happily ignored the whole question of the scope for private practice. It depended quite crucially on the fact that this particular Labour Government was dependent on the support of the trade unions. In short, there had been a shift in the societal balance of power towards organised labour (which is not to assert that this change must be necessarily permanent).

It was precisely because of this change in the environment of the NHS that the trade unions within the service were able to exert political pressure on the Secretary of State. One way of viewing the Government's commitment to act on pay beds is therefore to see it as the price paid for collective trade union support on national, as distinct from NHS, issues. In turn, this is to underline a more general point of political analysis. Ideological commitments, like all policy commitments, carry a price-tag. Hence an implicit cost-benefit analysis takes place in choosing which ones to carry into execution: an exercise complicated by the fact that different actors in the policy arena use different currencies of accountancy. For Labour Ministers, the pay beds issue appeared to be a cheap way of obtaining union support: the opportunity costs, as measured in terms of expenditure, appeared to be low. For civil servants in the DHSS, however, the opportunity costs were extremely high, as measured by the effects on long-term relations with the medical profession: which is why Labour Ministers received little support from DHSS officials.

So far the emphasis has been on analysing the **political** influence of the trade unions in the NHS. This method of analysis inevitably draws attention to the importance of structural factors: on the role played by organised labour in a particular society. But this is to neglect the possibility that the influence of the trade unions may also be based on their industrial strength. In other words, the unions in the NHS may derive their power as much from their increasing ability, reflecting on increasing membership, to disrupt the work of the NHS as from any political leverage that they may be able to exercise. In practice, this conceptual distinction may be blurred: one source of power clearly feeds on the other. But to make this point is to draw attention to the fact that health services are complex organisations. They require the co-operation of a large variety of organised groups not because they are delivering a commodity called 'health' but because they are dependent on a complicated mix of special-

ised skills. In short, we are dealing not with the politics of health but with the politics of complex public services when discussing the role of organised labour.

This perspective is also helpful in analysing the role of the medical profession in the 1974 to 1976 crisis. If the medical profession is seen as one example, among many, of organised labour—distinguished mainly by the fact that it organised itself earlier and better than other groups of health workers—then much of what is otherwise puzzling about the whole episode falls neatly into place. For the pay beds battle is destructive of most of the accepted theories for explaining the political role of the medical profession. Elite theory does not help: the fact that the medical profession shared both much of its social background and values with the leadership of the Conservative Party—and, come to that, civil servants—did not prevent the emergence of the pay beds issue. Nor does this approach account for the compromise that ended the confrontation: the political battle fought by the Conservatives on behalf of the doctors did not, as we have seen, effectively make any difference. Again, political culture theories[69] are inadequate. They do not help to explain what is really interesting about the pay beds issue—that it represented a political challenge to the existing order, a discontinuity in the incremental process and organisational style of policy-making in the NHS.

But if the situation is analysed in terms of industrial power within complex organisations, then both the failure of the medical profession to prevent the Labour Government from taking up the pay beds issue and its ultimate success in compelling a compromise become comprehensible. Moreover, the relationship between factors exogenous and endogenous to the NHS is also clarified. The NHS trade unions were able to force pay beds onto the political agenda because of structural factors extrinsic to the NHS. So much is grist for the mill of those who argue that change within health services is possible only if the societal environment is also altered. But the medical profession was able to prevent the Government from pushing through its programme of change because of industrial factors intrinsic to the NHS, qua complex organisation. It was because the Government needed the co-operation of the medical profession (in exactly the same way as it needed the co-operation of nurses, technicians

and laundry workers) that it had to compromise. To sum up, then, while structural factors may be a necessary precondition for change, organisational factors may explain the problems involved in carrying out new policies.

The events of 1974 to 1976 show that a new set of actors are now involved in the policy arena of the NHS: the trade unions. This is not to say that the arguments about policy will in future be carried out on class lines. Although on the face of it, the dispute over pay beds would seem to fall neatly into such a category, this view is not supported by detailed analysis of what actually happened: there is as much difference in the social class composition within the trade unions (representing as they do both unskilled workers and highly skilled technicians and administrators) as there is between the medical profession and the unions. Indeed our analysis would seem to underline the need for micro-analysis in seeking political explanations, since otherwise it is all too tempting to reify heterogeneous social categories like 'the medical profession' and the 'trade unions' as though these have a collective, homogeneous and indivisible identity—which is far from being the case, as we have seen.

It would therefore be premature to conclude that the emergence of this new set of actors will lead to a radicalisation of health politics, although it may give greater scope to a radical elite: the pattern in 1974 to 1976. But structural change, by promoting the growth of organised labour, has created a situation where there may be more pluralistic bargaining. But in future it will no longer be possible to analyse pressure groups politics in terms exclusively of the relationship between governments and the medical profession: the problem, rather, will be to analyse the inter-action of a whole complex of organised interests. In other words, the paradoxical conclusion would be that structural and pluralistic theories of policy making are mutually supportive rather than exclusive. It is structure which shapes the universe and provides the value-language of pluralistic bargaining. But it is the dialectic of the various interests involved, not the structure, which determines the outcome of any particular policy dispute.

The case of the pay beds issue is, however, interesting not only because of the insights it provides into the problems of explaining political processes

but also because it raises a fundamental question about the political limits to health care systems engineering. The logic of comprehensive health care planning is total State control over the resources required, just as the logic of rationing health care exclusively according to need is the elimination of all payments by patients. In a sense, therefore, the battle over pay beds—and indeed over private practice within the NHS—was a 'phoney' war. To exclude private practice from the NHS might, even if successful, encourage the growth of the independent sector and thus increase the problems of resource allocation within the public service. To make it impossible for patients to get quicker treatment or more comfortable surroundings within the NHS may simply persuade them to take their custom elsewhere. Thus preserving the ideological purity of the NHS—as it were—may, in practice, do nothing to improve the distribution of services or to prevent money buying preferential medical care.

Yet to move beyond this point would mean changing not just the health system but society's entire value system. In other words, the ideal health service may only be achievable at the cost of sacrificing other deeply entrenched values: of strengthening the power of the State bureaucracy by giving it a monopoly control over health services, of limiting the rights of individual citizens either to buy or provide particular services. Thus when we talk about structural factors limiting the possibilities of change within health services, it would often be more accurate to talk about the social values which constrain State hegemony, and embody a concept of freedom opposed to the abuses of both market and bureaucratic power.

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TABLE 1 Movements in Earnings, 1970-1975 (full-time men only)

Occupation	Lower quartile			Median			Upper quartile		
	1970	1975	% increase 1970–5	1970	1975	% increase 1970–5	1970	1975	% increase 1970–5
Medical practitioners	100 (£34.2)	100 (£66.8)	95.3	100 (£50.0)	100 (£92.0)	84.0	100 (£82.3)	100 (£146.9)	78.5
Nurses	50.6	58.2	124.9	42.4	56.0	142.9	29.2	43.5	166.3
Ancillary staff (NHS)	51.5	60.6	130.1	41.2	52.4	134.0	30.7	40.0	132.4
All manual workers	60.8	66.0	112.0	51.2	57.8	107.8	38.0	43.9	106.1

The index is based on the gross weekly earnings (= 100) of medical practitioners; their actual earnings are shown in brackets.

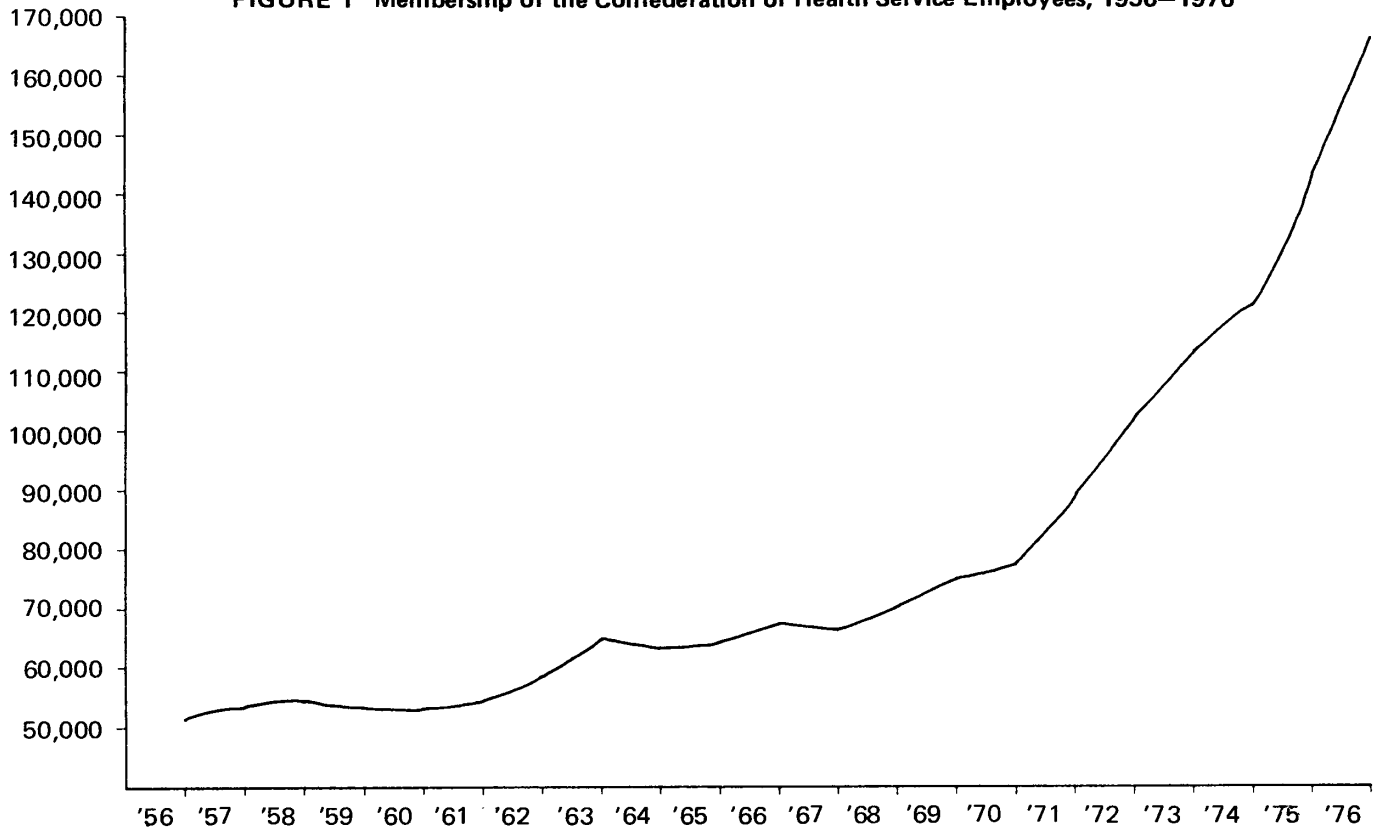
Source: New Earnings Survey for 1970 and 1975 (Adapted from R. Klein, *Incomes: vive la différence* British Medical Journal, 10 July 1976)

FIGURE 1 Membership of the Confederation of Health Service Employees, 1956–1976

1956	51,379	1963	64,713	1970	77,808
1957	53,841	1964	63,443	1971	89,550
1958	54,219	1965	64,035	1972	102,554
1959	53,365	1966	67,588	1973	113,401
1960	53,352	1967	66,240	1974	121,150
1961	54,195	1968	70,290	1975	143,479
1962	58,248	1969	75,183	1976	167,200

Source: Trades Union Congress Annual Reports, 1956–1976

FIGURE 1 Membership of the Confederation of Health Service Employees, 1956–1976



Source: Trade Union Congress Annual Reports, 1956–1976

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