



Williamson, C. (2015) 'The quiet time? Pay-beds and private practice in the National Health Service: 1948–1970.' *Social History of Medicine*. 28 (3): 576-595.

This is a pre-copyedited, author-produced PDF of an article accepted for publication in Social History of Medicine following peer review. The version of record is available online at:
<http://dx.doi.org/10.1093/shm/hkv024>

ResearchSPAcE

<http://researchspace.bathspa.ac.uk/>

This pre-published version is made available in accordance with publisher policies.

Please cite only the published version using the reference above.

Your access and use of this document is based on your acceptance of the ResearchSPAcE Metadata and Data Policies, as well as applicable law:-

<https://researchspace.bathspa.ac.uk/policies.html>

Unless you accept the terms of these Policies in full, you do not have permission to download this document.

This cover sheet may not be removed from the document.

Please scroll down to view the document.

The quiet time? Pay-beds and private practice in the National Health Service: 1948–1970

Clifford Williamson

Abstract

The study of the history of private practice in the NHS has generally been focused on either the introduction or the abolition of pay-beds. This article looks at the period characterised as the ‘Quiet Time’ when a political consensus seemingly emerged to retain some form of private provision within the service. This piece argues that rather than ‘a quiet time’ it was a period of intense activity and controversy as to the place and contribution of pay-beds when there were multiple attempts to rationalise and to make them cost effective. This article is an original study of a much-neglected subject in public policy history.

Keywords

Health policy, government, NHS, private practice, party politics

Introduction

The role of private practice in the British National Health Service (NHS) has long been a controversial issue. But as Gordon MacLauchlan and Alan Maynard have argued in most countries there has been an inevitable mix of public and

private interests in health care'. (1) Traditionally in the NHS this has generally been understood to be the mix between the state system and private medical insurance. However, in the last third of the twentieth century this has become a more complex mix with the internal market introduced by the Conservatives in 1990 and the Private Finance Initiative (PFI) championed by New Labour under the Premiership of Tony Blair. More recently, the Conservative/Liberal coalition policy for GP choice was added to heighten the complexity of provision further still. All of these instances were examples where to a certain extent, the private sector or market forces had a role within the NHS. However, these innovations have not been the preserve of administrations over the last 35 years or so as we might at first assume. From the inception of the service in 1948 through to the late 1970s, private practice existed within the NHS through the system of pay-beds.

For most of the history of pay-beds and especially in the period covered by this article (1948 to 1970), there was amongst politicians and medical authorities, generally speaking, a consensus on their continued existence; this period of consensus was referred to by Butler and Randall as 'the quiet time'. (2) Yet there is plenty of evidence that the issue was under constant scrutiny during this time. Initially we can see this from the early review of pay-beds conducted by the Ministry of Health in 1948 which affected subsequent adjustments to the rules that governed their operation. We can also see scrutiny being afforded to pay-beds through lobbying in Westminster by advocates of either an expansion or contraction of them, such as during the proceedings of the Select Committee on Estimates in 1951 and also when Labour Health minister Kenneth Robinson conducted a review into them in 1967. The third level of scrutiny was evident in the ideological battle over the future of the NHS

between the Conservative and Labour Parties where pay-beds came to be an important battleground of political debate.

The study of pay-beds during the so-called 'quiet time' offers three important insights into the workings of the NHS and the party political struggle over the issue during the period from 1948 until the start of the 1970s. First, it allows an insight into the evolving public-private mix in the NHS. This highlights, as MacLauchlan and Maynard have argued, questions of resources, value for money, optimum use of resources, equity in care and equity of access'. (3) Secondly, as John Mohan has argued in his work *Visions of Privatisation* we can identify the forces and processes...boundaries and mixes between public and private in the NHS. (4) This is particularly important if we accept Charles Webster's view that the Conservative government from 1951 to 1964 was far more active in trying to promote changes that were significant departures from the principles adopted by the early architects of the NHS'. (5) While the Labour party has been in power, the public-private mix has been more intriguing as the Wilson administration had to placate two important interest groups: first, the Labour movement which was largely hostile to pay-beds and second, the Royal College of Surgeons and the Royal College of Physicians who wanted to retain them. In addition Labour had to deliver on pledges made during the election campaigns of 1964 and 1966 especially in relation to the abolition of prescription fees, which trumped the abolition of pay-beds as a priority. Furthermore Labour had to adapt policy as a result of the financial crisis of 1967 as pay-beds inadvertently became part of the debate on public expenditure. The third insight is into the overall party political struggle over the NHS between 1948 and 1970. At each stage of the period, inevitably, there

would be a clash between the rival visions over the mix of state versus private provision in the NHS which was debated through the prism of pay-beds.

The study of pay-beds—or to be more formal in-patient care authorised under Section 5-1 of the 1946 National Health Service Act which allowed patients to pay separately for care and medical treatment by a consultant of their choice at a time most convenient to them—is very underdeveloped in the scholarship on the history of the NHS. (6) Most studies of pay-beds tend to concentrate on one of two periods: 1945–48, encompassing the struggle to establish the NHS of which private practice was a key ingredient, or 1970–79, focusing particularly on the long drawn out attempt by the Labour party to abolish pay-beds. (7) However, almost no study of the history or the politics of the NHS has analysed the contribution of pay-beds to the development of the NHS in any detail or examined the many debates within the Ministry of Health (MOH) and in Parliament about their utility and role in the state system. Even Charles Webster’s magisterial two volume official history of the NHS is light on the subject of pay-beds as are the works of Brian Abel-Smith and Richard Titmuss, despite the work done by the two latter authors for the Fabian Society and the Socialist Medical Association during the 1950s and 1960s. (8) There has been some study of private practice policy formation and choices most notably by Joan Higgins in *The Business of Medicine* published in 1988. Although this work is generally useful it makes no reference to ministerial or cabinet archives due to the restrictions on access to British official papers at the time of writing and as a result, in the main, it is focused on the Provident Associations such as BUPA. (9) The articles written by Michael Ryan in 1975 and Butcher and Randall in 1981 are both of value: in the former case on the ideological aspects of private practice and in the latter as a

study of the changing politics of the Labour Party. (10) Similarly attention on this issue has largely focused on Labour policy despite the fact that the Conservatives were in power for 13 out of the 22 years under consideration. This is especially problematic when we consider that, in the major reinterpretation of Conservative policy towards the NHS authored by Webster, which has challenged the scholarly orthodoxy expressed by Rudolf Klein, consensus was the watchword of the period while the Tories were in power. (11)

The first part of this article will examine the financial aspects of pay-beds such as revenue, costs and the budgetary aspects of private practice. The bulk of the article will consider, in a chronological manner, the evolution of the issue of pay-beds and the changing political debates around their role in public health to 1970. A significant subtext to the study will be the changing relationship between the professional and managerial staff of the health service at both local and national levels. Klein has argued in the *New Politics of the NHS* that due to the influence of consultants, during the founding of the service and their continued prominence led to all aspects of management in his words being 'medicalised'. (12) In effect this meant that consultants wielded a veto over any change in the service unless done to the direct, often financial, benefit of physicians. As will be seen, suggested changes in pay-bed provision frequently had to be accompanied by a financial package. Even Barbara Castle as Secretary of State for Health had to sweeten the phasing out of pay-beds in the late 1970s with the prospect of a new contract for consultants. Essentially, interventions by senior medical staff in relation to either national or local policy were bought off. Pay-beds were also emblematic of the autonomous status of the Royal Colleges and the British Medical Association (BMA). This

independence was not enjoyed by other employees in the NHS and by end of the process, although consultants were still an important part of the service, they had lost much of their influence. In this study we examine attempts to modify pay-beds at a time when the power of the consultants was at its zenith.

The creation of the pay-bed system

Pay-beds were something of a compromise. It was one of the means by which the Health Minister Aneurin Bevan was able to bring on board physicians and specialists to the state system, by offering a part-time contract which would allow consultants to maintain a degree of independence and retain access to lucrative private practice. Despite some backbench Labour agitation to delete the pay-bed clauses of the act it was adopted nonetheless. (13) Although Bevan would grow to hate the compromise, as we shall see in due course, it was crucial to stop a feared mass defection of senior staff from the new NHS to independent nursing homes. Unlike the trials and tribulations of the Labour Government with the BMA over the General Practitioner service which threatened to derail the whole project in early 1948, the Royal Colleges of Surgeons and Physicians were early converts to the system. This was partly due to the largesse of Labour over contracts, which Bevan would later memorably describe as 'stuffing their mouths with gold' and also due to the personal rapport between the minister and the President of the Royal College of Physicians, Lord Moran. (14) Bevan also sought to use private practice as one of the means to spread excellence across the NHS by offering pay-beds as an inducement to specialists to move out of London and into the provinces. An indication of the dominance of the capital for senior medical staff is that at the start of the NHS in 1948 nearly half of all private beds were located in the

metropolitan area with some 2,753 out of 6,090 or 45 per cent. (15) The majority were under the control of the Hospital Management Committees (HMC) of the Regional Hospital Boards (RHB) but around 1,800 were under the administration of one the 35 independent Boards of Governors (BOG) of the Teaching Hospitals either as a London undergraduate teaching hospital, a London postgraduate teaching hospital or a provincial teaching hospital. (16) The actual number of available pay-beds as a percentage of the total of all in patient beds was remarkably consistent between 1948 and 1970 with the national figure at 1.21 per cent and most RHBs also hovered around this level, with the exceptions being found in Wales with less than half the national average and in the BOG hospitals with sometimes seven times the average number of pay-beds available.

Although the Act was clear in determining the means of operation of private practice it was not quite so transparent on the types of costs for in-patient care and the cost for each procedure. These were covered in Statutory Instrument SI.1490.1948. (17) Right from the start, the Statutory Instrument was a considerable cause of friction and controversy amongst politicians and medical practitioners (see the section The Early Review of Paybeds). There were three elements of the charges for pay-bed private care. First, there was the cost of the room or bed. Second, there was the cost of care from nursing and other staff for pre-operative and post-operative treatment. Then there was the cost of the consultant and his staff for the procedure to be performed.

Accommodation was determined by the 'whole cost' of the facilities of an individual hospital and not a flat rate, so each hospital would have a different accommodation charge. (18) The second aspect regarding cost of care was less obvious in operation and no direction for how this charge ought to be

calculated was provided within the Statutory Instrument. The third part was governed by two parts of the Statutory Instrument. First a ceiling was placed on the amount a consultant could get from a single case and that was set at 75 guineas. (19) The second part of the charge for treatment consisted of the three schedules issued alongside SI.1490.1948. The first schedule was for outpatient charges for pre- and post-domiciliary treatment such as radiology and physiotherapy. The second schedule was for charges for private patients detailing the costs for surgical and non-surgical treatments. At the heart of this was the creation of three tariffs of operation— major, intermediate and minor—this schedule also fixed costs for specialists such as Obstetricians, Anaesthetists, Psychiatrists and Radiologists. Schedule three then set out the procedures by which cases were to be classed as major, intermediate or minor.

Although pay-beds were never really seen as a means to generate extra income for the NHS, revenue was nevertheless an important issue as concerns were raised about pay-beds being subsidised or pay-beds subsidising free beds. Both scenarios were potentially controversial politically and, as the NHS grew, concern over costs also became more salient. In addition, following the devaluation crisis in 1967, the income generated from pay-beds became the reason for their retention as advocates argued that the subsequent loss of revenue would be damaging for the service when the Treasury enforced tight public spending limits. From just under two million pounds in 1949 the amount contributed to hospital boards by pay-beds rose to just over eight million in 1970. (20) Despite this, in real terms the revenue generated was low at around 1 per cent of NHS income and in keeping with the number of pay-beds available throughout the period.

The early review of pay-beds

The first indicator of the potential problems relating to pay-beds came just six months after the founding of the National Health Service in December 1948 when P. H, Barber, the Chief Financial Officer of the Ministry of Health, circulated a letter to all Regional Health Boards, Hospital Management Committees and the BOGs of the 35 teaching hospitals. (21) The purpose of the letter was to review the workings of SI.1490.1948 and Barber asked for the costs of a single room, a double room and a small ward both before and since the service was established on 5 July 1948, known as 'the appointed day'. He was also asked for any additional costs to be detailed, the general running costs of a ward per week per patient and the current costs for each authority.

The results Barber received show a very wide range of costs as well as divergent procedures used to manage them. The lowest charge for a single room was in the North Western Metropolitan RHB at £2.2 s. The highest was in the University College Hospital, which charged 21 guineas. (22) There were significant variations in price within each health authority in terms of minimum and maximum charges: in Liverpool RHB for instance the difference was £16.4s. The largest variation, and overall the most expensive provision, was in the South Western Metropolitan RHB where the minimum cost of single room was £8.8 s and the maximum was £25.5 s a variation of £16.17 s. Every single hospital charged a different rate as the calculation used was based on a formula. Change over time with regard to pricing structure was also significant with the largest noted in the Royal Brompton Hospital which charged £8.8 s in July 1948 and £12.5 s afterwards, a difference of £3.17 s after the appointed day. This was a rise of nearly a third, while the nearby Samaritan Hospital

charged only 10 shillings more, going up from £9.9 s to £9.19 s, a rise of around 10 per cent. Although there were more private beds in London than elsewhere, the cost of a pay-bed was on average higher there than in the provinces.

To the Ministry, the chaotic nature of the introduction of pay-beds was problematic as it built up tensions and instigated patterns of conflict in a number of areas: between the centre and peripheries, between management and medical staff and also between the NHS and the consumers of health services. These were arguments that would persist over time and would bedevil the service. The final report, compiled by W. O. Chatterton the Accountant General of the MOH, set out a significant number of points that needed to be addressed. All areas of Statutory Instrument SI.1490.1948 came under criticism, from the apparently arbitrary nature of the charges that seemed to bear no relation to the services provided, to the inconsistency in the costing of charges (with some calculated on a RHB or HMC basis and some on a hospital-by-hospital basis within an authority). There was also a lack of direction regarding out-patient charges. Not all private patients stayed in hospital for treatment overnight and as the focus of the charge was often based on a notional rental value added to the fee of consultant, this made non-residential patient charges appear 'purely arbitrary' to the consumer. (23)

There were concerns that the smaller the hospital, the higher the cost to private patients. This appeared to be particularly the case for the cottage hospitals. The payment of full-time specialists, ancillary to treatment, who were not themselves in private practice also needed to be properly integrated into the final cost to the private patient. In sum, there was criticism of almost every area on the workings of the Statutory Instrument and the management of pay-beds. This was, no doubt, due to the fact that the focus was on the

straightforward financial aspects of Section 5 facilities rather than on the clinical provision or managerial context concerned.

Chatterton suggested three alternatives to the present arrangements. The first was for the ministry to prescribe charges either nationally or regionally for private beds. Secondly, he floated the idea of creating a series of classes of bed, different classes of hospitals and a charge for treatment based on them. The third alternative proposed by Chatterton was that the cost of a general ward bed be deducted from the charges levied. However, he then went on to dismiss each of the alternatives to the status quo in turn. First, he noted that the idea of the ministry devising charges clearly intruded upon the autonomy of the RHB, HMC and the BOGs even if they only had a regional dimension as opposed to a national scale. The second option, argued the Accountant General, was 'more realistic but would be extremely difficult to work out, and would still be unsatisfactory'. (24) The third option was regarded as unacceptable as it would have necessitated a reduction in the ministry's income. (25).

What was proposed instead was to allow for greater flexibility in the construction of charges, as well as possibly allowing for a weighting for those treated in London. As such, Chatterton proposed an amendment to Section 5 of the 1946 Act which would allow for a corresponding degree of latitude. (26) Yet, as has already been pointed out, charges for London pay-beds were generally higher on average. Consequently the greater cost did not result in the problems of under-usage experienced elsewhere and Chatterton's recommendation seemed superfluous. There was, however, no appetite for

reform of the system at this early stage so none of the proposals went any further and S1.1490.1948 remained intact.

Discussion of pay-beds moved into the public arena in the summer of 1951 with the first parliamentary discussion and investigation of the workings of the pay-bed system in the Eleventh Report of the Select Committee on Estimates, which was focused on the RHBs and HMCs. (27) Although pay-beds were only mentioned briefly in the larger report, it deserves attention as it brought together all of the protagonists in the initial debate on pay-beds: the Royal Colleges, the MOH and the BMA. Not only did they offer their perspectives on the experience of the new arrangement but they also made recommendations for changes to the system.

The first of the organisations to appear before the committee to discuss pay beds was the BMA. Prior to the appearance of their representatives led by the Secretary Dr Charles Rowland Hill, the BMA circulated a memorandum to members outlining the attitude of the BMA. They were questioned by the committee on this issue and they very much set the agenda going forward. Overall the BMA was happy with the system under the 1948 Act; Rowland Hill commented that the medical aspects were 'operating perfectly smoothly' with no indication of conflict. (28) However, when questioned about the charges for pay-beds, the BMA was far more critical and called for the 'arrangements (to) be altered,' arguing that there 'is little point trying to continue ... if the cost is prohibitively high'. (29) When giving evidence, the BMA representatives claimed that the charges were causing private nursing home numbers to 'mushroom'. (30) In addition, they called for a single national tariff to be applied rather than that set out in the formula under S1.1490.1948 with

variations from hospital to hospital and region to region (a situation already discussed at Ministerial level).

Essentially, the BMA sought a return to the pre-NHS approach when private rooms of 'reasonable' cost had been available. In the evidence given before the select Committee, there was an expansion of this idea. The BMA argued that the practice had effectively been to subsidise the overall costs pay-beds by reducing the maintenance cost which would then be recouped by increasing the numbers paying for a private bed. (31) This idea would reappear a number of times in the discussion of pay-beds, as a means to increase bed usage and maximise revenue. In their submissions the issue of subsidies or some form of tax relief would also be brought up by the Royal College of Nurses (RCN) and the Royal College of Physicians (RCP) with the RCN calling for a subsidy to 'middle class patients' (32) and the RCP advocating a form of grant in aid. (33) The BMA called for the levying of a hotel charge for board by all NHS patients who could afford to pay, arguing that the money raised was necessary to partly release the service 'from growing economic strangulation'. (34) On this point, the BMA was unsure of the logistics of the system, although it was supported in the principle by the RCN. However, in later discussion, the idea was not pursued much further. (35) This idea would be bandied about through the 1950s by various interest groups and politicians but never to such an extent that it would be enacted.

In terms of the BMA's specific concerns raised before the select committee, one issue that emerged during the session related to fixing costs for different procedures by surgeons. Although the Joint Consultants Committee (JCC) of the BMA worked closely with the MOH to devise the schedules, the practical

workings of these schedules left the consultants relatively unimpressed. The issue was also a concern for the RCP when its representatives appeared before the committee on 12 April 1951. The RCP wanted the law of supply and demand to apply with surgeons devising a price based on the nature of the procedure. However, it was also noted that the price might start to become prohibitive and result in the number of private patients drying up—or as they colourfully put it, a surgeon cutting his own throat. (36)

The final witnesses to be called in June 1951 were from the MOH led by the Chief ‘Mandarin’ of Saville Row, J. E. Pater, with a panel that included the Accountant General W. O. Chatterton. They were pressed for comments on a number of issues. The idea of using pay-beds as means of raising revenue which one of the committee members, Robin Turton, a future minister of health later in the decade, called ‘a very powerful weapon’ they declined to make any comment on the matter. (37) They did, however, challenge the assertion made by the BMA that pay-bed costs were driving private patients out of the NHS and into nursing homes. The civil servants at the MOH said that there was no evidence to back up such a claim. (38) On charges and costs for surgeons in private practice, the MOH did acknowledge that there were issues to be addressed and that the schedules for calculation required some revision, adding that the matter was in hand and discussions were being undertaken between professional bodies and the ministry. (39)

The final report issued by the Committee went out of its way not to make any specific recommendations. Rather it offered observations within which a degree of implicit recommendation can be identified. (40) On costs the Committee made the point that a private bed was ‘very expensive’. (41) The

report commented that the schedules that ruled the remuneration of physicians were a source of controversy but due to the fact that this was currently under review it did not make any recommendation. (42) It was basically left to the ministry to take on board the opinions of the committee and act accordingly.

The ongoing discussions over the future of pay-bed charges took nearly three years to bring about any changes. A new Statutory Instrument, SI.1953.420, was placed before parliament by the Health Minister, Iain McLeod, on 1 April 1953. This revised SI took into account criticism regarding the inflexible nature of the previous SI. It removed small gripes such as the practice of charging the full daily rate for the day of admission and the day of discharge. These were now to be counted as only one day.⁴³ The charge for a newly born child to a mother in a pay-bed being counted as a second person was also removed. (44)

More substantial changes were made to the calculation of costs for each part of the time a patient was in hospital as a private patient. Deductions were increased from 15 per cent to 25 per cent for those instances that required specialists to be brought in from outside as part of the package of care as opposed to utilising on-site staff. (45) There were clearer guidelines too on costs for hospital-based medical staff—nurses, dentists and radiographers—who were not employed directly by the consultant but who provided care as routine members of staff. The purpose of the SI was to increase pay-beds usage and bring down costs. There does not seem to be much evidence, if any, of a reduction of costs on a hospital-by-hospital basis. (46) What was notable was the impact on income and bed usage; although both showed some improvement, with a rise in revenue from £2.1 million to £2.3 million and pay-

bed usage up from 48 per cent to 51 per cent between 1953 and 1956, it was still a pretty modest return. (47) A further attempt was made to modify the Statutory Instrument in 1961. (48) This resulted in a similarly marginal impact. Despite the average occupancy rates reaching a peak of 52 per cent in 1962 it was still less than two-thirds that of a 'free' bed in an NHS hospital.

The new politics of pay-beds

By the mid-1950s pay-beds remerged on the political agenda and it was the Statutory Instrument in particular that would bring it back into focus. In April 1953 the Labour Party submitted a motion in the House of Commons to annul S1.1953.420 as a response to McLeod's placing of the instrument before Parliament. Moving the motion was Newcastle upon Tyne MP Arthur Blenkinsop, who attacked not just the Statutory Instrument but also the whole concept of pay-beds, something that he saw as an 'anomaly in an NHS which has always tried to ensure a single standard of treatment'. In his view, the result of the pay-bed system could only produce 'a sense of injustice' amongst those without the means to gain preferential treatment. (49) It also marked the first major contribution by Aneurin Bevan to the debate on pay-beds. He attacked the practice that some beds in hospitals were kept empty so that they could be reserved for paying patients. He described this as 'a reproach to the scheme' condemning the members of the medical profession who did this as having 'not proved themselves worthy of the responsibilities with which they have been entrusted'. (50)

Further to this, the Labour Party Conference in 1954 pledged to abolish pay beds when they returned to power. (51) Moving a resolution on behalf of the

Kingston upon Thames Constituency Labour Party, Mrs E. Leggett said 'We believe that jumping the queue in anything is wrong but jumping the queue where sickness is concerned goes against the best instincts of decent people.' (52) Shortly afterwards the Conservative Minister for Health, Iain Macleod, denounced Labour's new found opposition to pay-beds as hypocritical (they had after all introduced them) and a 'sheer blistering irrelevance to the problems of the National Health Service'. (53) Later in the decade, in a speech to the House of Commons in 1958 to celebrate the tenth anniversary of the founding of the National Health Service, Aneurin Bevan added to his 1953 contribution, by acknowledging that pay-beds had been 'at that time perfectly proper' (54) and crucial in bringing surgeons and other physicians into the fledgling NHS. However, he was now concerned about the impact of this and alleged abuses of the system—'Apparently the middle classes cannot help preying on the middle classes'—and he felt this was having a negative impact on patient care. (55) He called for a 'firm administrative foot' to be put on the practice in order to make the service 'much happier, and certainly the hospitals will be much more wholesome'. (56) The next major study of the impact of pay-beds therefore occurred with the political temperature rising around them.

Although pay-beds were not a significant part of the 1956 Committee of Enquiry into the cost of the NHS—popularly known as The Guillebaud Report—that report does have some interesting observations to make on private practice within the state system. (57) It looked not only at the financial aspects of pay-beds but also at their role in retaining senior medical staff via part-time contracts and their impact in assisting the dispersal of senior staff around the country, which was one of Bevan's major objectives in 1948. The Committee

was broadly in favour of the maintenance of pay-beds. It did acknowledge the use of them as a form of 'queue jumping' but was satisfied that 'it cannot amount to very much when account is taken of the relatively small number of pay-beds at present provided in hospitals'. (58)

However, the committee was conscious of the growing public and political concerns about waiting lists, urging that pay-beds should not be kept empty for potential private patients nor that any expansion in the numbers be carried out in such an environment. (59) In 1956, the average occupancy of set aside pay-beds was 67 per cent compared to the NHS beds which had an occupancy of 88 per cent. However, this pay-bed occupancy rate was artificially inflated as they were used by non-paying patients at times of heavy demand, roughly 32 per cent of the time. (60) This was significant. It meant that pay-beds in wards were unused by paying patients for more than 50 per cent of the time. The Committee suggested that the RHBs and HMCs put the fullest effort into increasing occupancy rates either through better promotion of the provision available or by increasing the use of these beds by non-paying patients. (61) The occupancy statistics were ultimately to provide the *raison d'être* for reductions under the Robinson Review (see the section 'The Wilson Governments and the Question of Private Practice') and undermined on-going support for pay-beds and private practice in an environment where waiting lists were growing and the NHS becoming more financially constrained.

The committee also addressed the idea of charges but could not come to a firm conclusion. There were three options. First, maintain the status quo. Second, set a nationally arbitrary charge below the actual costs to encourage uptake. Or, third, recalculate the annual cost either locally or nationally based

on the previous year's actually cost derived by the category of hospital concerned. (62) The committee rejected the second option because, although it would lead to greater usage it would need such a large reduction in the actual charges that it would result in 'a net loss to the Exchequer as compared to the present position'. (63) In effect there would be a subsidy to private patients to make the bed usage numbers look good. On the third model the committee saw 'no real advantage' of a recalculation based on either a regionally or nationally defined charge as it would still result in some paying more than others. It was also felt, in the words of the report that it would not produce 'any better relationship between the charge and the value or quality of the services provided than that produced under the present system'. (64) Not surprisingly they recommended no change. This agnostic approach was further emphasised by the Select Committee on Estimates in 1957 which was investigating the running costs of hospitals and did not even discuss pay-beds or make any recommendations. (65) The inertia of the MOH and Parliament over the future of pay-beds can be seen in the capital-spending context of the NHS of the 1950s. There was little in the way of capital spending on hospitals. Moreover, the infrastructure of the service was still based on an inherited hodgepodge of small, medium and large hospitals, most of which had been built in the nineteenth century (some of course were even older). The system was, Klein observed, one of 'care and maintenance'. (66) However, the 1960s were destined to be different, being characterised by a greater emphasis on planning for future demands.

Pay-beds and the 1962 Hospital Plan for England and Wales

The more prominent role for long-term planning in the NHS was indicated in 1962 with the publication of A Hospital Plan for England and Wales. (67) The plan was introduced by the new Conservative Health Minister Enoch Powell who, as well as being a rising star of Tory politics, was also the first Health Minister since 1951 to be a member of the cabinet. This was an indicator in itself of just how far the NHS had risen in political importance by the early 1960s. The ten-year plan to upgrade, replace and modernise the hospital service did not seem at first glance to have much relevance to the issue of pay-beds. The focus of the plan was to introduce new District General hospitals that would centralise acute and specialist services in purpose-built buildings that could take account of new developments in nursing, treatment and technology. Although the plan stressed the augmentation of the existing infrastructure, it would inevitably necessitate the closure of a significant proportion of the current building stock that was out of date for modern purposes. For example, the Charing Cross Hospital in London was earmarked for replacement with a new hospital in Fulham but it had a number of private beds that would have to be reconstituted in the replacement facilities. (68)

Such a move was potentially controversial as in 1961 the MOH had tried to introduce a capital cost element in the charge for pay-beds but had found no consensus on an acceptable formula after consultation with the RHBs, HMCs and BOGs. Consequently any new pay-beds would be built at public cost without any remuneration for capital expenditure built into the fees; in effect private practice would be publicly subsidised. (69) In addition, the new hospital building programme would mean a fresh round of discussions on the number of private beds which had the potential to reignite the dispute over the statutory provision of pay-beds and growing political concern over waiting lists.

Throughout the 1960s, as the Plan for Hospitals grew more ambitious under consecutive governments, the JCC sought a series of discussions with interested parties on pay-bed provision in new buildings and this was still a source of concern and potential division at the time of the Robinson Review. (70)

After he left office in 1963, Powell was to offer an interesting perspective on the issue of private practice in his pamphlet, *A New Look at Health and Politics*, published in 1966. (71) Although generally a strong advocate of free market solutions, he offered a pessimistic prognosis on the utility of private practice in the NHS. To Powell, pay-beds were not a viable way to increase the flow of money into the service or a means to divert affluent patients to the private sector and therefore free up resources. Powell argued that even a threefold increase in income would only contribute about 6 per cent to the funding of the service and would 'only result in a slower deterioration of the service' rather than reversing it. (72) Additionally, any moves to abolish private practice as a solution to the problems of the service would produce a 'negligible result' as it absorbed only around 1 per cent of the entire resource base of the NHS. Any changes would be lost in the bureaucracy. (73) Herein lay the conundrum of pay-beds: they were not such a substantial drain on resources that they needed to be removed to free up much needed space nor did they generate enough in the way of funds to make their extension an attractive option as an income stream.

The Wilson Governments and the question of private practice

The General Election victory of Harold Wilson in October 1964 heralded the return of Labour to power after 13 years. The main health priority for Labour in its first term was an end to prescription charges; as their manifesto said ‘to restore as rapidly as possible a completely free health service’. (74) Private practice had been mentioned in the 1964 manifesto with a pledge to ‘combat queue jumping for hospital beds’. (75) Labour policy since 1954, as previously noted, had been for abolition, a policy recapitulated in 1959 at the General Election in the policy document *Members One of Another* that promised that pay-beds would disappear. (76) However, during the early 1960s, Labour had moved away from complete abolition—especially after the death of Bevan in 1960—and away from traditional class based politics towards a more European-style social democratic politics.

Despite the strong association between Labour and the NHS between 1964 and 1968, the Health Minister was not a member of the cabinet in the Wilson administration and would only be elevated to the top table with the merger of health and social security in 1968 as part of the super-ministry, the Department of Health and Social Security (DHSS). Until that point when health matters were discussed—such as the abolition of prescription fees, which was one of the first acts of the new Government—the Chancellor of the Duchy of Lancaster acted on behalf of the ministry. The Labour Health Minister from 1964 to 1968 was Kenneth Robinson and his tenure, according to Charles Webster, was one of frustration; he frequently threatened to resign due to the weak position of the ministry in cabinet policy priorities. (77)

By 1964 pay-beds had dropped down the list of Labour priorities, with a review of the 1962 Plan for Hospitals at the top of the primary care agenda and

negotiations for a new General Practitioners contract also a priority. However, this did not stop pressure being brought to bear via the Trades Unions and former Bevanites who were prominent in the high echelons of the government, for example Jennie Lee, widow of Aneurin Bevan, and Barbara Castle (although she would have her hands full during the Wilson administration first as transport and then as employment secretary). There was also a Labour Health subgroup in Parliament led by Willesden West MP Laurie Pavitt in the Commons and Lady Shirley Summerskill in the Lords. All together there was a significant number with influence who pushed for change. (78)

The situation for Robinson was set out in an article in The Times in 1965 where pay-beds were described as 'a political fishbone wedged in the gullet of the Labour Party'. (79) Money was seen as the main problem. The pledge to abolish prescription charges meant that any further reduction in the health budget was deemed unacceptable in the context of the increasingly difficult financial situation faced by the Labour government both before and after devaluation in 1967. With pay-beds contributing £10 million per annum to the NHS, any change to the available provision had to be carefully considered. Furthermore The Times argued that direct confrontation with consultants would be a problem, as it would result in another branch of the service being at odds with the government. (80) Labour therefore had to deal with three competing elements. First, pressure from the treasury to ensure no loss of funds; second, to strike a deal which persuaded the BMA to go ahead with planned changes; and third, the desire to appease party opinion.

The Labour Government pushed two separate but related policies in relation to pay-beds. The first was a restructuring of the charging regime and the second was to make good the manifesto pledge on 'queue jumping'. The new system of charges was to centralise the costs of pay-beds and make the Minister of Health responsible for the authorisation of pay-beds in hospitals. The new charges system was to abolish the equation devised under Statutory Instrument SI.1490.1953 and replace it with a national scheme. However, initially there were to be five classes of hospital and rates were defined and altered on a year to year basis by the MOH.

The five classes of hospital were: RHB long stay medical, RHB mental, London teaching, provincial teaching and RHB acute. (81) Ultimately there were no fewer than 21 different types of hospital squeezed into the five-band charging system. The new charging regime could not be introduced without legislation as it was a significant departure from the charges sanctioned under Section 5 of the 1948 National Health Service Act and would have to wait for a suitable legislative opportunity. There is no evidence to suggest that the new charging system was deliberately devised to act as a disincentive to patients 'going private'. However, there was a fear amongst the opposition that this was the case. Opponents of private practice appeared to hope that the number of private patients would decline as a result of these plans but the attitude of the MOH was essentially to be neutral over the impact of charges.

In order to reduce the number of pay-beds, it was established that the main focus of activity needed to be on usage not cost as the chief determinant of maintenance or removal. This turned out to need a much longer time to achieve than anticipated. It took nearly four years from November 1964 until

the royal assent was given to the National Health and Public Health Act in March 1968. Much of the delay can be attributed to the fact that the Labour Government had a very small majority after the October 1964 General Election and it was July 1966 before they had the majority required to be in total command of the legislative process. The review process took a considerable time. In the initial phase there was a period of policy formulation and negotiation, most significantly with the JCC of the BMA, which was not concluded until the late summer of 1965. There was also a delay in the drafting of a satisfactory piece of legislation and the consultation process with the RHB, HMC and BOG took until the middle of 1966 to finalise. (82) Time then had to be found on the parliamentary timetable and the first available slot was not until the 1967–68 session.

The first indicator of the potential difficulties in dealing with pay-beds came on the day after the General Election of 1964. In common with all incoming Governments, chief civil servants presented the new administration with a digest of legislative options for polices contained within their manifesto. The civil service brief on pay-beds outlined a number of options to achieve the desired outcome of a reduction in pay-beds. These included prohibiting the use of acute beds in hospitals for private patients, a straightforward cut in the number of pay-beds or an option to gradually reduce the number of part-time contracts for consultants, thereby reducing opportunities for private practice. (83) The chief stumbling block outlined by the civil service was the attitude of consultants to these potential changes and civil servants warned that the plans ‘would be opposed by the leaders of the profession and by those who aspire to such positions later’. (84) There was, however, a significant opportunity to convince the JCC of the merits of a reduction by offering to abolish the upper

limit on fees chargeable for private consultations and treatment which had been set in 1948 at 50 guineas and then raised to 75 guineas later.(85)

Robinson met his chief civil servants and advisors on 25 November 1964 and immediately rejected the options contained in the paper. Instead he proposed that the methodology for reduction would be based on removing pay-beds 'where their use is substantially below the national average' with the aim of bringing 'the occupancy of paid beds in any hospital as near as possible to the overall bed occupancy'. (86) The minister specifically ruled out any changes to existing part- and whole-time consultant contracts but was 'inclined' to remove the upper limit on private charges. (87) The minister gave a further reason for his support of the removal of the upper limit for consultants. He wanted to 'curtail the growth of BUPA' which he felt was 'reaching a size as to offer a rival hospital service'. (88)

Although the offer to remove the limit on fees earned was potentially a good initial bargaining counter, the JCC was unimpressed by the potential changes in policy. In a paper circulated by consultants they argued for an increase (my italics) in the number of pay-beds. They made this suggestion in part because there had been an increase in subscriptions to BUPA and other health care companies. (89) This had shown that there was a desire for private medicine. Moreover, the consultants were convinced that this would 'do something to lessen the financial burden on the NHS'. (90) Despite these seemingly contradictory intentions for pay-beds, in a series of meetings in July 1965 between the JCC and the MOH, agreement was reached over the lifting of limits on fees thereby smoothing the process for a review of pay-beds. (91)

As had been the case in 1948, whether the process was consensual or confrontational came down to the overall attitude of the JCC and the Royal Colleges to change and the financial inducements offered by way of compensation. Robinson, like Bevan before him, was notably conciliatory over the attitude of the consultants towards change and was eager for agreement. However, there is no indication that he had to 'stuff their mouths with gold' as his predecessor had done. On the contrary, the JCC abandoned any ambition to extend private practice for the prospect of charging more to existing patients. The minister was also aware that consultants had to be cautious over charges because there was the prospect of pricing themselves out of the market, a fact that had already been acknowledged in the original memorandum compiled by the MOH civil servants in November 1964. (92) On 9 December 1966, Robinson set before Parliament a new Statutory Instrument which, amongst other things, included a clause to abolish the 75 guinea ceiling on charges made by consultants for the treatment of a single patient. (93)

Pay-beds and the health services and Public Health Act, 1968

The result of the development of pay-bed policy would culminate in the 1968 Health Services and Public Health Act. (94) Even to its supporters it was something of a mess of regulations and changes covering such disparate issues as food poisoning, notification of infectious diseases, child minding as well as pay-beds, with the clauses and issues therein numbering over 70 in total. By far the most important topic and the focus of much of the debate on the floor and in Parliamentary committees were the first two clauses regarding private practice. The new arrangements and structure of private practice were

contained in Sections 1 and 2 of the Act. (95) First, the decision making process over authorising private practice in individual hospitals was to be centralised. This is very much in line with the policy trends of both the Labour Party and health policy more widely.

Labour had come to power in 1964 on a ticket which stressed central planning as the antidote to British economic underperformance, with the national plan under the new Department of Economic Affairs at the heart of it. This technocratic process was also noticeable in health planning even before 1964 with the 1962 Hospital Plan for England and Wales being a key indicator of this trend. The Conservative members of the standing committee of the Bill attempted to put local boards into the decision making process but were rebuffed, although they would try again in 1972 with their own NHS Reorganisation Bill. (96) These clauses were the most significant to the political aspects of the 1967 Bill, as they established the centrality of the minister and his/her authority on the issue of the expansion or contraction of private practice.

By 1969, as a result of the new mechanism for approval and authorisation of pay-beds, their number decreased in England and Wales from 5,572 to 4,350, a fall of 1,222 representing a decline of 22 per cent. (97) Robinson's purpose had been to increase pay-bed usage numbers and he succeeded. In 1966 the figure was 51 per cent occupancy and by 1969 it was 60 per cent, albeit an increase of just under 20 per cent. (98) The review and new system had resulted in a roughly proportionate decrease in numbers but an increase in bed usage, although it was still some way short of the percentage occupancy of free NHS

beds at 84 per cent in 1969.⁹⁹ Income from private practice realised £8.4 million for the UK exchequer in 1969/70. (100)

Regionally the pattern was similar with all regions cutting back pay-bed numbers. The largest cuts were in the North of England with Newcastle RHB cutting 123 beds, nearly half of the 280 total, but also increasing occupancy levels from 46 per cent in 1966 to 53.5 per cent in 1969. (101) Manchester, Leeds, Liverpool and Sheffield made similarly large cuts and—with the exception of Liverpool—increased their occupancy rates to over 50 per cent. By 1969, the Merseyside RHB had cut the number of its pay-beds by 62 from 198 to 136 and increased occupancy from 40.5 per cent to 48.5 per cent, but it remained the only English authority to have a rate below Robinson's review target of a minimum of 50 per cent usage. (102) In Wales the contraction of private practice continued. There had been 130 beds in 1950 but by 1969 only 69 were left, with rationalisation allowing an increase in occupancy from 39 per cent in 1966 to 51 per cent in 1969. (103)

The area where the Robinson reforms seemed to have had least impact was on the BOGs in the teaching hospitals in England. There was a global reduction in the numbers of pay-beds from 1,454 to 1,312, a loss of 133, by 1970. (104) But this represented a fall of less than 10 per cent from the total in 1966, whereas the overall fall in pay-beds in the NHS was, as noted above, some 22 per cent. (105) The fall masked some interesting regional variations; the bulk of the reductions came from the provincial teaching hospitals accounting for 129 of the total with only four being lost by the London Teaching Hospitals. The further you went from 'Middle England' the greater the number of reductions achieved, with Newcastle

topping the proportion with a reduction of just under 50 per cent. (106) The decreases in Sheffield, Liverpool, Manchester, Leeds and Bristol were more in line with the national average for non-teaching hospitals. Only Cambridge of the provincial BOGs increased the number of pay-beds between 1966 and 1970 from 20 to 26. (107)

In the London teaching hospitals, the undergraduate institutions saw no effective reduction with four losing beds, four gaining beds and four unchanged. One hospital, St Bartholomew's, Even managed to introduce pay beds for the first time but overall the undergraduate BOGs lost seven beds.

The postgraduate BOGs fared better and gained three beds but this was mainly due to the expansion of private care at the Hammersmith Hospital as the majority of these hospitals only experienced slight reductions

In numbers. (108) Pay-bed usage results for the BOG hospitals were very mixed with 17 having reductions in usage and only 15 increases. (109) This led to an overall reduction of 1.7 per cent in bed usage across the teaching hospitals with a fall from 65.8 per cent to 64.1 per cent, although this was still higher than the non-teaching hospitals. (110) Variations were substantial with the London undergraduate BOG falling from 69.5 per cent to 67.8 per cent, the postgraduate BOG falling from 72.7 per cent to 71.2 per cent and the provincial BOG from 52.3 per cent to 48.7 per cent. (111)

The situation for the provincial teaching hospitals is interesting. Although their use of pay-beds was considerable, there was not the pressure of physically empty beds to cause concern or friction. Moreover the maintenance of pay beds as, arguably, an indulgence to consultants may have helped in the retention of senior staff at a time when numbers of medical staff emigrating

was causing a crisis in recruitment. (112) In the case of Newcastle, for instance, the fall in pay-beds was countered by a substantial increase in usage from 35 per cent in 1966 to 58.5 per cent in 1970 and was closer to the national average. Similar experiences were noted in Manchester, Leeds and Sheffield. Overall, the teaching hospitals increased their position as a bastion of private practice in the NHS even after the Robinson Review with 30 per cent of pay-beds in 1970 compared to 22 per cent four years earlier and overall there were reductions in bed usage.

The outcome of the review was potentially a satisfactory compromise. It allowed Robinson to say to Labour Party opponents of pay-beds that he had further reduced their numbers. He could also point out to the Treasury that he had increased revenue from £4.5million in 1964 to £8.3 million per annum from a smaller number of beds. He had successfully persuaded the medical profession that a reduction in pay-beds was a positive step without needing to coerce them or provoking outright insurrection. However, this appeasement demonstrated by Robinson was ultimately to be meaningless as the issue was one of principle not subtlety. To the abolitionists, selectivity in a universal health service was anathema. To those who saw the medical profession as an independent entity in the NHS, a further reliance on state salaries was one more move towards dependency. This was expressed clearly in the debate that took place over the Robinson Review in February 1967. To Conservative supporters of pay-beds, their maintenance was essential as part of an effort to:

‘encourage people to make provision for themselves, the more likely we are to raise the standards of service, to reduce pressure on the National Health Service, and prevent doctors going abroad who might otherwise stay’. (113)

For opponents such as Dr David Owen, who was an NHS physician prior to being a Member of Parliament, private medicine was 'a menace to the provision of an equal and fair health service'. (114) Furthermore, he worried about the impact of the low cost of pay-beds on the NHS. This was an argument he was to build on in his contribution to the Fabian Society pamphlet *Social Services for All* which he wrote alongside Peter Townsend and Brian Abel-Smith. (115) Owen argued that the economic difficulties of the late 1960s had forced Labour to reconsider the issue of charges and had already resulted in a U-turn on prescription charges. (116) In this work he then went to look at other areas of the NHS where there was the possibility of increasing revenue for the service such as road accident charges, hospital meal charges and enhancing the pay-bed system. On pay-beds and other charges, Owen saw a possible danger in using charges for raising revenue as it would have the potential of reducing the cost of private health insurance in comparison to state medicine and would result in more patients moving into provident schemes. This would be a drain away from the NHS and the revenue from charges would fall and would therefore fail in its objective as an alternative source of income. (117) Robinson defended the changes he had made saying 'the object...is not to withdraw facilities to private practice but to rationalise them, and to provide the more effective use of consultant manpower and hospital beds.' (118)

In 1968, following the devaluation of the pound the previous autumn, the first of a series of public expenditure cuts were introduced by the Chancellor of the Exchequer Roy Jenkins. The key impact on health as a result of these changes was the selective reintroduction of prescription charges. This constituted a major political humiliation for Harold Wilson, who had resigned when a similar

thing happened in 1951 and it was personally galling for Kenneth Robinson who had to go back to the Commons and announce a return to prescription charges only four years after having abolished them. Robinson was on his way out in any case as the creation of the 'super-department' of Health and Social Services was all but complete and he would find himself shunted off to another post. (119) For pay-beds, the changing context of economic policy meant that savings had to be found but existing income streams were to be protected, assuring that pay-beds would remain part of the public/private mix in the NHS for the time being.

Conclusion

Pay-beds were initially a pragmatic response to a potential staffing crisis within the fledgling NHS that turned out to have long-term ideological and political consequences. Pay-beds as an inducement were successful in their initial objective of convincing the RCP to support the introduction of the NHS, as they necessitated the creation of part-time contracts for some physicians to continue in private practice and also to treat their patients within NHS facilities. Moreover, in this way the pay-bed system served to preserve the elite status in the medical profession of consultants, who were thus provided with an effective veto on any changes to the working conditions and contracts considered by the state.

The experience of pay-beds highlighted the evolving character of the public/private mix within the NHS. They were the precursor of developments such as the internal market and PFI in that they introduced into the public service a characteristic that was seemingly at odds with equality of access and

provision, where some patients could gain advantages such as earlier treatment if they were to pay an extra charge. Pay-beds also sharpened the debate on resources as they were mostly underused with occupancy rarely above 50 per cent of the available beds. Repeated attempts to address underuse came via changes in the charging regime—for example as in 1953 that led to allegations, most notably by Bevan, that they were being subsidised to placate specialists. Under Robinson the charges were revised but at the same time the number of beds was cut to allow part-time consultants to protect their incomes while putting more bed space in the hands of hospital administrators in an attempt to cut waiting lists.

The study of pay-beds in this period from 1948 to 1970 also allows an insight into the forces and boundaries of private practice in the NHS. The forces behind pay-beds were primarily located within the Royal Colleges that sought to maintain a semblance of independence from state control. It only offered a modicum of autonomy, however, as most practitioners did not get actively involved in private practice. However, they were nonetheless determined to maintain the principle, at least in the short term. The opposing forces were led by elements of the Labour movement, but even here compromise was essential. The Labour governments of the 1960s had a general ideological inclination towards abolition, but ministers feared that an acute shortage of doctors could be made worse if it moved too aggressively to restrict pay-beds. In addition, the financial crisis of 1967 made it impossible to press further change as it would result in public expenditure consequences. The boundaries of private practice as represented by pay-beds were intriguing. They were never intended to offer an alternative model of priorities within the NHS. There were those who came to the conclusion that revisions to pay-bed policy

would result in a slippery slope towards further expansion of private practice, which would represent a threat to the single standard of service that was the founding principle of the NHS. Additionally, there were advocates of expansion who saw pay-beds as a means by which the NHS's insatiable demand for public spending could be alleviated. However, as Powell was to observe, this might only result in a slower deterioration of the service rather than solve the problem or reverse the trend.

It is clear that the period from 1948 to 1970 was not quite the quiet time first advocated by Butcher and Randall or a period of consensus as argued by Klein. There is significant evidence of disquiet at the implications of pay-beds, their impact on resources and on standards of care and service in the NHS. Similarly, there is evidence of shifting attitudes towards the maintenance, expansion or abolition of pay-beds with Labour—previously instrumental in their introduction—gradually moving towards an openly hostile stance. Conversely, the Conservatives tested the waters of alternative funding options for the NHS which many have seen an enhanced role for pay-beds. Limiting both political agendas was the lack of an overwhelming economic case that might have legitimated expansion and minimised anxieties about the implications for staffing, especially in relation to the further loss of senior consultants that was to restrain the urge to abolish. In the interim, there was a grudging consensus that left neither side completely satisfied nor their ambitions realised.

- 1 Gordon MacLauchlan and Alan Maynard, *The Public Private Mix for Health* (Oxford: Nuffield Provincial Hospitals Trust 1982), 1.
- 2 Tony Butcher and Ed Randall, 'The Politics of Pay-beds: Labour Party Policy and Legislation', *Policy and Politics*, 1981, 9, 274.
- 3 MacLauchlan and Maynard, *The Public Private Mix for Health*, 1–2.
- 4 John Mohan, 'Visions of Privatisation' in Jonathan Gabe and Michael Calnan, eds, *The New Sociology of the Health Service* (London: Routledge, 2009), 83.
- 5 Charles Webster, 'Conservatives and Consensus' in Ann Oakley and A. Susan Williams, eds, *The Politics of the Welfare State* (London: Routledge, 1994), 54.
- 6 National Health Service Bill. (94) [passed, cap 81] 9 & 10 Geo. 6. (London: HMSO, 1946), 3.
- 7 See for example Rudolf Klein, *The New Politics of the NHS* (London: Longman 1989), 1–30, 105–44; Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London: Harper Collins 2001), 101–26, 311–53; John Pater, *The Making of the National Health Service* (London: King Edward's Trust for London 1981), chs 5 and 6.
- 8 See Charles Webster, *Problems of Health Care: The National Health Service before 1957* (London: HMSO, 1988); Charles Webster, *Government and Health Care The British National Health Service, 1958–1979* (London: HMSO, 1996); Brian Abel-Smith and Richard Titmuss, *The Cost of the National Health Service in England and Wales* (Cambridge: Cambridge: University Press, 1956).
- 9 Joan Higgins, *The Business of Medicine: Private Health Care in Britain* (London: Palgrave, 1988).
- 10 Michael Ryan, 'Hospital Pay-beds: A Study in Ideology and Constraint', *Social and Economic Administration*, 1975, 9, 164–84 and Butcher and Randall, 'The Politics of Pay-beds', 273–93.
- 11 Webster, 'Conservatives and Consensus', 54.

- 12 Klein, *The New Politics of the NHS*, 54.
- 13 Ryan, 'Hospital Pay-beds', 168.
- 14 The quote is from Timmins, *The Five Giants*, 115.
- 15 Ministry of Health Annual Report for 1949–50. Cmd. 8243. (London, HMSO, 1950).
- 16 The Boards of Governors were integrated into Area Hospital Boards as a result of the 1975 reorganisation of the administration of the NHS.
- 17 Statutory Instrument SI.1948.1490 (London: HMSO, 1948).
- 18 *Ibid.*, clause 5 Section 1.
- 19 *Ibid.*, clause 8.
- 20 Summarised Accounts of the Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees, Executive Councils (including Joint Pricing Committees) and the Dental Estimates Board, for England and Wales (London, 1949–1974).
- 21 National Archives (NA), Ministry of Health Papers (MHP), AGD5B94150/1/117; MH99/33, 16 December 1948.
- 22 NA MHP 94150/1/117; MH99/33.
- 23 NA MHP 94150/1/117; MH99/33.
- 24 *Ibid.*
- 25 *Ibid.*
- 26 *Ibid.*
- 27 Eleventh Report of the Select Committee on Estimates on Regional Hospital Boards and Hospital Management Committees, (London: HMSO, 1951), 261.
- 28 *Ibid.*, 79.
- 29 *Ibid.*, 294.
- 30 *Ibid.*, 80.
- 31 *Ibid.*, 78.

- 32 Ibid., 299.
- 33 Ibid., 231.
- 34 Ibid., 294.
- 35 Ibid., 299.
- 36 Ibid., 231.
- 37 Ibid., 318.
- 38 Ibid., 318.
- 39 Ibid., 319.
- 40 Ibid., 22.
- 41 Ibid., 22.
- 42 Ibid., 23.
- 43 SI. 1953.420, (London: HMSO, 1953) clause 9 (1).
- 44 Ibid., clause 9 (3).
- 45 Ibid., various clauses.
- 46 If there is, it was not complied centrally by the Ministry of Health.
- 47 Collated from the summarised accounts of the Ministry of Health in its Annual Reports from 1949–70. London 48SI. 1961.184 (London: HMSO, 1961).
- 49 Parliamentary Debates (House of Commons), 29 April 1953, vol 514, col.2289.
- 50 Ibid., 2294.
- 51 The Times, 1 October 1954, 4.
- 52 Ibid., 4
- 53 The Times, 7 October 1954, 2.
- 54 Parliamentary Debates (House of Commons), 30 July 1958, vol 592, col 1396.
- 55 For the quote from Bevan, see *ibid.*, 1396 and 1396.
- 56 *Ibid.*, 1397.

- 57 Report of the Committee of Enquiry into the cost of the National Health Service, Cmd. 9663, (London: HMSO, 1956).
- 58 Ibid., 161.
- 59 Ibid., 161.
- 60 Ibid., 160.
- 61 Ibid., 161.
- 62 Ibid., 162.
- 63 Ibid., 162.
- 64 Ibid., 162.
- 65 Sixth Report from the Select Committee on Estimates, Running Costs of Hospitals, (222) (London: HMSO, 1957), 15.
- 66 Klein, *The New Politics of the NHS*, 44.
- 67 *A Hospital Plan for England and Wales*, Cmnd. 1604 (London: HMSO, 1962).
- 68 Ibid., 143.
- 69 See NA MHP, File: 'Capital costs and private practice', MH99/127.
- 70 See NA MHP, File: 'Consultants and Pay-beds 1962–63', MH99/133.
- 71 John Enoch Powell, *A New Look at Medicine and Politics* (London: Pitman Medical, 1966).
- 72 Ibid., 68.
- 73 Ibid., 69.
- 74 *The Labour Party Manifesto for the 1964 General Election* (London, 1964).
<<http://www.politicsresources.net/area/uk/man/lab64.htm>>, accessed on 4 December 2015.
- 75 Ibid.
- 76 *The Times*, 26 August 1959, 5.
- 77 Webster, *Government and Health Care*, 180.

78 For an insight into the lobbying approach of the Health sub-group see Richard Crossman, *The Diaries of a Cabinet Minister Volume 3: Secretary of State for Social Services* (London: Henry Holt and Company, 1978), 35.

79 *The Times*, 24 August 1965, 5.

80 *Ibid.*, 5.

81 For more details see NA MHP, 'The Review of National Charges in Pay Beds', MH150/143.

82 For a full indication of the drafting process see NAMHP 'National Review of Pay-beds', MH 150/145.

83 NA MHP, 'Position Paper on Pay-beds presented to the Minister of Health, 24 November 1964', MH150/144, column 11.1–11.3.

84 *Ibid.*, col. 4.

85 *Ibid.*, col. 11.4.

86 NA MHP, 'Letter from M.J Hewitt to M.J. Cashman, 25 November 1964', MH 150/144.

87 *Ibid.*

88 NA MHP, 'Letter from M.J. Cashman to M.J. Hewitt, 4 December 1964', MH 150/144.

89 With nearly 2,000,000 subscriptions according to the BMA.

90 NA MHP, 'Pay-beds Paper JC876', Joint Consultant Committee of the British Medical Association, 1965, MH 150/144.

91 NA MHP, 'Note of meeting between the Minister of Health and the Secretary of JCC of the BMA on 24 July 1965', MH 150/144.

92 NA MHP, 'Position Paper on Pay-beds', MH 150/144.

93 *The National Health Service (Pay-bed Accommodation in Hospitals, etc.) Regulations 1966*, SI 1966.1553 (London: HMSO, 1966).

94 1967 Health Services and Public Health Bill (12) Passed, Cap 46 (London, 1967).

95 Ibid., Part I, Section 1, Clause 1.

96 Proceedings of the Standing committee D on the Health Services and Public Health Bill, Parliamentary Papers (London: HMSO, 1967), (145), 4.

97 Fourth report from The Expenditure Committee of the Employment and Social Services Sub-Committee, National Health Service Facilities for Private Patients (London, 1972), (172), 48.

98 Ibid., 48.

99 Ibid., 48.

100 Ibid., 49.

101 Ibid., 417.

102 Ibid., 411.

103 Ibid., 395.

104 Ibid., 381

105 Ibid., 381.

106 I have taken this 'Middle England' to include the Oxford, Cambridge, and Birmingham United teaching hospitals. The figures for Newcastle are to be found in the fourth report from The Expenditure Committee, 381.

107 Ibid., 381.

108 Ibid., 381.

109 Ibid., 381.

110 Ibid., 381.

111 Ibid., 381.

112 In the years between 1964 and 1969 the NHS had a net outflow of doctors of 1,760 through emigration. Source: Memorandum from the Department of

- Health and Social Security to the Fourth Report from The Expenditure Committee of the Employment and Social Services Sub-Committee, 386.
- 113 Parliamentary Debates (Commons), 20 February 1967, vol 741, col 1072.
- 114 Ibid., 1079.
- 115 David Owen, Brian Abel-Smith and Peter Townsend, eds, *Social Services for All*, Fabian Tract No. 385 (London: Fabian Society, 1968).
- 116 David Owen, 'Selectivity and the Health Service' in Owen, Abel-Smith and Townsend, eds, *Social Services for All*, 91.
- 117 Ibid., 104.
- 118 Parliamentary Debates (House of Commons), 20 February 1967, vol 741, cols 1085–86.
- 119 He became Minister of Planning but that post too was abolished in late 1969.