An Economic Analysis of Collective Behaviour:
The Case of the British Medical Association.

by

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CHAPTER 1

Purpose and Scope of the Study.

The British Medical Association is a venerable body of medical doctors whose traditions span more than one hundred and forty years. In suggesting that during this period it has been a successful body one immediately poses the difficulty of defining success. For example, is it measured in terms of the new medical ideas which the Association has helped to foster? Is it more appositely recognized within the structure of the medical profession which the B.M.A. has helped to mould? Or indeed is it more widely evident in the improved status and working conditions the B.M.A. has achieved as a pressure group for the profession? None of these lines of inquiry can prove mutually exclusive and all are inextricably inter-twined with yet another success story. This is the notable success which the Association has enjoyed in terms of its high membership. In absolute terms its membership has stood as high as 76,673, while in relative terms Association membership has represented some 80 per cent of the medical profession. Throughout every quarter of the profession the B.M.A. has enjoyed a high membership rate, and therefore it is not surprising that it has been, and still is, recognized as the spokesman for the profession as a whole. Indeed it would be no exaggeration to suggest that in the minds of many the B.M.A. is equated with the medical profession as a whole.


This success of the B.M.A. is emphasized if one makes but a brief comparison of the B.M.A. in its formative years of 1832 with its position in 1975.

1.1 The British Medical Association: Early Days.

At Worcester Infirmary in 1832 Dr. Charles Hastings proposed the inauguration of a new medical association to a small group of some fifty medical gentlemen. The purpose of such a venture was quite clearly to provide a stimulus to research into all aspects of medicine and also a vehicle for the dissemination of new information. Hope was expressed that this association might serve to maintain the honour of the profession in the provinces of England and Wales, and the doctors at Worcester chose to call their association, the Provincial Medical and Surgical Association.

There was little that was new in the establishment of a medical society in the provinces. Such medical research and education clubs may be traced to the last third of the eighteenth century. In 1770 the doctors of Warrington had established just such a society, and they had been emulated in 1774 by the medical men of Colchester. In 1794 a similar society was founded in Plymouth and again in 1800 at Leicester. By 1822 Halifax and District followed suit as did St. Helens in 1826 and Nottingham in 1828. According to J. L. Thornton the Provincial Medical and Surgical Association in 1832 took its place alongside another forty medical societies in Britain in that year.


In the tradition of many other medical societies the P.M.S.A. published an annual volume of transactions; the first appearing in 1833. However on October 3rd, 1840, a new weekly publication, The Provincial Medical and Surgical Journal appeared. This journal took upon itself the function of providing a means of communication of medical ideas as well as distributing news of medical societies and of course, in particular, news of the P.M.S.A. Yet even at this time there were seven medical periodicals published in Great Britain, of which three appeared quarterly, one fortnightly, and three weekly. The P.M.S.J. found significant problems in establishing itself as a competitor. Between 1847 and 1853, for reasons of economy, it became a fortnightly journal. By 1855, The Medical Times and Gazette published a leading article on the decay of the P.M.S.J. and recommended its discontinuance.

Indeed, reports suggest that the future of the P.M.S.A. was very much in the balance during these early years. In 1836, for example, The Lancet, referred to the "total failure" of the P.M.S.A. Whilst criticism of the young Association and its Journal may in part be due to aggressive competition from contemporaries, there is, nevertheless, evidence to collaborate some of the views expressed. In 1882 Dr. William Strange, for example, recalled to members of the Association that in the early years,

"The meetings were small; and the communications with signal exceptions were only second rate; whilst the journal which contained them was as frequently uncut and unread as not."

It appeared that two important ventures of the Association had soon met with failure. By 1859 only 174 subscribers could be found to the Medical Benevolent Fund of the society; a fact that was strongly criticised by the committee of the P.M.S.A. Yet as early as 1836 the hopes of providing library facilities were dashed when a committee reported the insurmountable difficulties involved, and recommended that this plan be shelved.

The growth of membership of the P.M.S.A. can at best be described as slow. By 1853, that is after twenty one years, it still had considerably less than two thousand members. The Medical Directory for that year showed that there were at least 11,808 qualified doctors practising throughout the country. In fact, membership of the P.M.S.A. had begun to fall slightly in 1852. By 1853 there was a movement to broaden the basis of the society. Initially the Association had been designed for provincial doctors. In London the medical world had been dominated by the two Royal Colleges, i.e. the Royal College of Physicians and the Royal College of Surgeons. These bastions of privilege and nepotism had for many years deemed provincial practitioners as beneath their notice, and to a large extent it was resentment of such treatment which had led the founders at Worcester to emphasise the provincial nature of their undertaking. However in 1853 doctors in the metropolis were formally invited to

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8. B.M.J., August 6th, 1859, p 636.
10. Association Medical Journal 1854, Report of Council 22nd Sept., p 851 declares that the P.M.S.A.'s membership in 1853 was 1,853.
join the Association. By 1855, when membership was still only 2,125 and again falling, the Association, not without some remorse on the part of older members, adopted the name of the British Medical Association. The headquarters of the Association moved from Worcester to London, and on January 3rd, 1857, the journal of the Association adopted the title of the British Medical Journal.

1.2 The British Medical Association: Today.

The B.M.A. is today a body of some 64,000 medical gentlemen, and as such it represents the second largest medical association in the world. While absolute membership is large, the density of membership is also high. The density of membership of an association may be measured in terms of

\[
\text{Actual No. of Members} \times 100 \over \text{Potential No. of Members}
\]

In order to indicate the importance of the B.M.A. in national medical political life two measures of density appear useful. First, in terms of the percentage membership of doctors in the United Kingdom the B.M.A. has had a membership density of 77 per cent in 1950.

and in 1973 this figure remained as high as 68 per cent.\textsuperscript{18}

Secondly, in terms of the percentage of the working profession in the United Kingdom the B.M.A. recorded 85 per cent in 1950,\textsuperscript{19} and in 1973 was still able to boast an impressive 70 per cent.\textsuperscript{20}

Either in terms of absolute membership or membership density the B.M.A. is today a formidable body. Similarly its success has been matched by that of the B.M.J. In 1973, this journal circulated to twenty thousand subscribers over and above the membership of the B.M.A.\textsuperscript{21} The B.M.J. is no longer the only journal published by the B.M.A. It has been joined by seventeen specialist journals as well as a widely popular Family Doctor Booklet series, and together with the B.M.J. these currently make a surplus before tax of sixty-four thousand pounds per annum.\textsuperscript{22}

The B.M.A. itself receives six and a half thousand pounds per annum in subscription fees. However, the costs of its secretariat have obviously risen and particularly so during this century. In 1904 there were only two full time officials in the B.M.A.; today there are twenty-three.\textsuperscript{23} Within the U.K. thirty-five Branches extend outwards from its headquarters; though Branches are found in all corners of the world. The Year Book of the B.M.A. testifies to

\begin{thebibliography}{99}
\bibitem{20} G. Forsythe, op. cit., p 3.
\bibitem{21} Annual Report of Council 1973-74, B.M.J (Supp) 27th April, 1974, p 43, claims that circulation of the B.M.J. was 86,000 whilst membership in that year was 65,985.
\bibitem{22} Annual Report of Council, 1973-74, op. cit., p 44.
\end{thebibliography}
the numerous specialist committees which deal with everything from the ethical problems of the profession to the narrow problems of small medical specialties. While outside the B.M.A. representatives are to be found on an inordinate number of committees, e.g. most recently they have taken seats on the Standing Committee of Doctors of the Common Market.

The B.M.A. still takes its place alongside many other medical societies but today "the B.M.A. is by far the largest and most powerful of the doctors' organizations." The medical world is inundated by an ubiquitous distribution of associations which for convenience may be classified within three groups. Firstly the prestigious Royal Colleges are still in evidence. Their main function is that of qualifying bodies and supervisors of post-graduate medical education. Their political voice is not dismissed, though it is more quietly and more infrequently exercised. Indeed when it is exercised it is generally with regard to the interests of the consultant hierarchy of the profession. Beneath the grandeur of the Royal Colleges one finds a body of associations such as the British Post-Graduate Medical Federation, the Faculty of Ophthalmologists, the Apothecaries Society, the Society of Medical Officers of Health, the Fellowship of Postgraduate Medicine. Such bodies neither attempt to exercise or indeed possess, a great deal of political influence. However, a third group which includes the B.M.A., does encompass those medical bodies who would wish to exert

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influence. This group includes such bodies as the Medical Practitioners Union, the Junior Hospital Doctors' Association, the Hospital Consultants and Specialists Association, the General Practitioners' Association and the Socialist Medical Association. These infants, all of the twentieth century, have had far less influence than the B.M.A. It would be fair to assess their activity more often in terms of a "ginger group" to the B.M.A. None of these medico-political associations could boast one-eleventh of the membership of the B.M.A., and as Forsythe insists, there is "no serious challenge to the British Medical Association as the representative of the British doctor." 

The position of the B.M.A. today, therefore stands in marked contrast to that of its humble origins. Perhaps the greatest tribute to its success, however, is inherent in the comment of Paul Vaughan: "in the minds of many people the British Medical Association has become synonymous with the medical profession in this country."

1.3 The British Medical Association: A suitable case study.

The evolution of the B.M.A. together with the influence it has exerted upon medical practice in the U.K. is a social phenomena which merits research in itself. The position of prominence which the

27. The M.P.U. "claims" 5,000 members (Guardian, Friday 10th November, 1972); the G.P.A. estimate about 3,000 members, (interview with the National Secretary, Dr. Quest); the J.H.D.A. estimate about 5,000 (The Observer, 2nd November, 1975); and the H.S.C.A. have no more than 5,000 (I am informed by the H.S.C.A. that in June 1975, their membership was 4,980).


Association holds today is one which begs some investigation of its structure, power, and purpose. Its influence on decision-taking in the National Health Service calls for examination, not least because of the large sums of public expenditure involved. These roads of inquiry however, are not the sole or even the main aims of interest; they are subsidiary to a fundamental questioning of the behaviour of individuals with respect to associations.

The behaviour of individuals which, in particular, interests this investigation is the decision to join and contribute to the costs of an association. The term association is very loose. It includes for example, trade unions, pressure groups, trade associations, professional associations, social or sports clubs, even religious fraternities. The British Medical Association has been taken as one example of such associations in order to pursue an intensive analysis of the decision of doctors to join. Yet while attention is focused on the motives behind such a decision one cannot help pass comment on the consequences of the decision.

The British Medical Association was chosen at random in order to pursue this line of inquiry; although on reflection it quickly proved suitable for at least three reasons. Firstly, membership to the B.M.A. is voluntary and hence the decision to join is left with the

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30. At 1973 prices £2,644.1 million was spent on the National Health Service and this will grow at an average annual percentage growth rate of 2.9 per cent until 1977-78. See R. Klein, J. Barnes, M. Buxton, E. Craven, Social Policy and Public Expenditure 1974, Centre for Studies in Social Policy, London, 1974.

In this context David L. Shapiro, "Pressure Groups and Public Investment Decisions: A Note", Public Choice, Vol X, 1971, pp. 103-108, notes "No model of public investment is complete without introducing the effects of the interaction between pressure groups and agency officials."
individual doctor. That is to say that doctors can legally remain in practice without joining the B.M.A.\textsuperscript{31} Secondly, the B.M.A. has been extremely successful in attracting both a high absolute and relative membership. Thirdly, the B.M.A. engages in a wide range of activities. In acting as a pressure group for doctors it frequently adopts all the characteristics of a trade union. Furthermore it offers its members social and educational facilities typical of many non-political clubs.

In a discussion of the mobilization of doctors via the B.M.A. the aim is primarily to assess what the economist can say concerning the decision of individuals to join associations. The experience of the B.M.A. is the experiment in collective action which is to be analyzed. This is the example chosen to be placed under the microscope. However, the analysis is undertaken in the hope that results that are yielded will have more widespread relevance than simply to this one association. The question that is at issue is the likelihood that individuals voluntarily engage in collective action to attain collective goals. This has important implications for such questions as whether or not individuals are likely to support collective associations, whether or not they will undertake the costs involved in voting for particular collective policies. An important test, therefore, of this research will be the degree to which it provides an analysis which will both explain and predict the possibility of voluntary individual participation in a collective venture. The lessons which are to be learned from this narrow case study will be judged by their applicability in a very much wider context.

\textsuperscript{31} The B.M.A. has recently once again looked at the prospect of making membership compulsory for some doctors, but have formally rejected the idea. See \textit{B.M.A.} 19th July, 1975, p 172.
1. 4 Collective Action and Collective Awareness.

Even the most cursory review of literature on the question of collective behaviour reflects the wide range of disciplines from which contributions have been made. Authors associated with areas of study such as sociology, psychology, politics, the study of industrial relations, and economics have looked to the question of why individuals might engage in collective activity. Nevertheless within this diverse literature it is possible to note at least two main lines of approach to the question. The first of these is one which focuses attention on the environment of individuals. It is held that factors in individuals' environment will determine whether or not they are likely to wish to join associations. If the environment changes then their demand for membership of an association will change also. Individuals' desires or wants are taken to be related to the environment in which they live. As such one asks the question what factors determine the demand for an association.

Just such a question has been asked with respect to many groups of individuals. Professor David Lockwood for example, in seeking to explain membership of clerical unions looked to changes in the work environment of clerks. He noted that membership had increased at a time when the individual relationship clerks had entertained with their work and with their employers had been transformed. It had been transformed into a bureaucratic environment of standardized functions with common rules and regulations and with no personal contact with employers. As such it was argued that clerks now recognized common interests with other clerks. They recognized common interests in terms of a common stipulated wage for particular

functions, or in terms of common working conditions to perform duties. As such he claims that bureaucratization represented a set of conditions extremely favourable to the growth of collective action among clerical workers. For he argues that concerted action "ultimately depends on the awareness of individuals that they have interest in common; and therefore that they belong together."\(^{33}\)

The existence of collective interests for a group of individuals is then an important feature in explaining collective action, and in similar vein other writers looking to other groups have concentrated on isolating in the environment the factor which has produced collective interests. Work environment has proved an important influence on the existence of collective awareness and hence on the propensity of individuals to join associations. For example, the survey for the Royal Commission on Trade Unions and Employers Associations in 1967 found 63 per cent of trade unionists in their sample worked in establishments with a 100 or more workers, and 64 per cent of the non-unionists were working in establishments with less than a 100 workers.\(^{34}\) Routh's study not only notes aspects of an individual's work environment e.g. the size of establishment where work is conducted, the degree of skill involved in the work, but also the nature of the occupation of parents, and the area of residence.\(^{35}\)

\(^{33}\) Ibid, p 140.

\(^{34}\) The results of the survey are quoted in J. Hughes, Patterns of Trade Union Growth, Trade Union Research Unit, Ruskin College, Oxford, 1973.

Indeed the influence of social background on membership of trade unions and voluntary associations is a variable which has been investigated by many authors. The rationale, of course, is based on the argument that certain backgrounds create a collective awareness, i.e. an awareness on the part of the individual that he has common interests with other members of a particular group.

Some studies specifically seek the stimulus to this collective awareness in the existence of a collective threat. Trueman for example explains the formation of associations as the reaction of some individuals to a political or economic threat which they feel collectively. Davis has similarly suggested that the relationship between rising prices and the growth of unions is based on the reaction by groups of individuals to an attack on their real incomes. Siedman, London and Karsh note the importance in stimulating union membership of a threat or unfair treatment from supervisors.

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37. "A worker's willingness to join a union varies directly with the degree to which association with and participation in the union would reinforce normal group attachments and interest", E. Wight Bakke, "Why workers join Unions", Personnel, Vol 22, No. 1, July 1945, p 37.


However, the environment can be examined not only in terms of whether or not it stimulates a demand for membership of associations, but also whether or not it is conducive to the supply of associations, F. Castles for example stresses the importance of the political climate to the emergence of associations.\(^1\) Within totalitarian regimes one finds significant barriers to their formation. In under-developed countries, where illiteracy is high, communications poor and hence political awareness dormant, the development of associations is inevitably restricted. In similar terms K. Prandy and G. S. Bain have noted the attitudes of employers to membership in trade unions.\(^2\) White-collar workers, fearing that promotion will be blocked by membership, clearly may not pursue collective aims by joining associations. The likelihood that membership of an association grows must be heavily dependent on the way in which the associations' services are sold.\(^3\) The appearance of good leadership and sound constitution in associations will be


\(^{3}\) It seems obvious that membership of an association will increase, at least in absolute terms, if it recruits from as wide a basis as possible. Nevertheless the importance of this has of late been stressed by John Hughes, *Patterns of Trade Union Growth*, op. cit., p 8:

"One thing is surely clear. A structure of narrowly conceived industrial or occupational unionism may be a dead hand on union development. This form of unionism does not use its strength and organizational capacity in sector A to build or strengthen unionism in sector B.... The main unions that have shown capacity for growth and development have been much more open in their recruitment approach ...."
vital in persuading individuals that membership will lead to the attainment of collective aims and interests.\textsuperscript{44}

This approach to analysis of collective action then suggests that given there are no barriers to establishing an association, individuals will be more likely to take up membership to the extent that factors in their environment make them aware they have collective interests. In applying this approach to the growth of membership of the B.M.A. many interesting questions are raised. What conditions in society facilitated the supply of such an association in the mid-nineteenth century? Can changes in the demand for membership of the B.M.A. be related to changes in doctors' work environment? What influence has the development of professional consciousness had on membership? To what extent might one explain membership growth in terms of the social background of doctors? How important has the intervention of the State in the medical market been to the demand for membership of the B.M.A.? Questions such as these are pursued in chapters one and two of this thesis with a view to begin an explanation of concerted action in terms of the awareness on the part of doctors of collective interests. Later some comment may be usefully made on the merits of this approach.

\textsuperscript{44} This factor has already been noted with respect to the B.M.A. A. M. Carr Saunders and P. A. Wilson, The Professions, Oxford University Press, London 1933, comment

"To what is the great success of this association which has just celebrated its centenary to be attributed? Looking back upon its history the persistently skilful leadership makes a strong impression upon any observer. There has been a long succession of unusually able permanent officials and of medical men willing to sacrifice time to the affairs of the association. Their appearance upon the scene has been facilitated if not called forth by the ingenious constitution admirably adapted to the needs of the case."
1.5 Collective Action and Collective Goods.

The second form of analysis which can be identified in the literature on collective behaviour is one which moves emphasis from the environment of the individual to the goal which the individual hopes to attain. Rather than searching for those forces in society which transmit a desire or awareness on the part of the individual that he may benefit from the attainment of a collective goal, it focuses attention on the nature of such a goal. This form of approach was pioneered by M. Olson Jr. It was his observation that "the achievement of any common goal or the satisfaction of any common interest means that a public or collective good has been provided for that group." He defined a collective or public good completely in terms of the "non-exclusion principle." That is to say that should the good be provided to any one individual, then there was no means by which its consumption could be restricted to other individuals. Thus, for example, a group of workers may have a common interest in attaining a higher wage, but, once attained, that wage rate might be received by anyone taking the job. Similarly a group of individuals might have an interest in lobbying for favourable legislation, but once exacted all might reap the benefit of the legislation. The fact that a goal or purpose is common to a group means that no one in the group is excluded from the benefit or satisfaction brought about by its attainment.


46. Ibid, p 15.

This observation of Olson has quite important implications. The question of whether or not an individual will choose to pursue common interests by subscribing to an association is exactly the same as the question of whether or not an individual will voluntarily contribute to the provision of a collective good. Given the definition of the good and given assumptions concerning the nature of individuals, certain predictions can be made with respect to this question. Assume for example it is possible to identify a group of individuals who wish to provide a collective good. Each individual is initially defined in terms of a selfish or pure economic man, i.e. he is neither malevolent nor benevolent and is concerned only with his own personal independent utility function. It may be accepted also that each wishes to maximize his utility and that he acts rationally. If an association is formed, it is assumed that this is merely a vehicle for the provision of the collective good, i.e. the analysis is individualistic and recognizes no other aims than those of the individuals involved. Each individual will only subscribe to the association and hence contribute to the provision of the collective good if the increment in utility derived from such action is greater than the opportunity cost involved. However he is aware that if the good is provided he will enjoy that increment of utility whether or not he has undertaken the opportunity cost. There is therefore an element of doubt as to whether or not he will make the contribution and join the association. His strategy may instead be to allow others to cover

48. Rational behaviour on the part of an individual may be summarily defined in terms of the following three conditions: (1) the individual evaluates alternatives on the basis of his preferences among them; (2) his preference ordering is consistent and transitive; and (3) he always chooses the preferred alternative. Such a definition will later be looked at in more detail. A discussion is to be found in A. Downs, An Economic Theory of Democracy, Harper and Row, New York, 1957 p 6.
the costs incurred by the provision of the collective goal, and to enjoy the good so produced without any personal sacrifice. As such the individual would hope to "free-ride."

This argument is not independent of the question of the size of the group. If the group is small, it has been argued that, other things being equal, the individual can expect a more "significant proportion of the total benefit from the collective good." In this case the increment in utility he enjoys from this good may more than cover the total cost of providing the good. Hence, rather than not see the good provided at all, the individual would cover these costs himself, or if possible cover them by some agreement with individuals in a similar situation. There is then the likelihood that the good may be provided, and that this may be as a result of the association of individuals. There are other arguments that support the proposition that the voluntary provision of collective goods is more likely when the group is small. For example it may be suggested here, and later proved more rigorously, that, if an individual feels that his share to the costs involved is more significant in a smaller group, then he may more readily participate. Furthermore, the case that small groups are more effective in providing collective goods may be supported by the argument that bargaining costs between individuals would be lower in smaller groups. It is not argued that small groups necessarily provide themselves with collective goods in optimal fashion, but merely that they will tend to provide some of the good. On the other hand, the large group, where no one individual would cover the total costs of provision of the good,

and where each individual feels that his contribution to the costs is of no significance, will remain latent. The irony of such a situation is that, even in the large group situation, it can be shown that the total benefit to be accrued by the individuals concerned may outweigh the total costs involved, and still the large group remains immobilized in the pursuit of its collective aim.

A more detailed analysis of this argument, and of its significance to the medical profession and to membership of the B.M.A., will be undertaken in Chapter four. It is clear however, that if we view the medical profession as a large group, one would not expect there to be any tendency on the part of an individual doctor to contribute to the costs of providing a collective goal via subscription to the B.M.A. It is no longer sufficient to show that changes in society have stimulated demand on the part of doctors for a collective good. This may be a necessary condition to begin discussion of collective action, but it is not sufficient to fully explain membership of association. In large groups individuals may possess a demand for collective goods, but because of the nature of such a good they are likely to under-reveal it, and hence do not subscribe to associations attempting to attain it. An examination of the properties of collective goods and of their effect on the choice or framework of decision-taking of the individual, leads one to argue that collective action cannot be adequately explained in terms of the existence of collective interests.

1.6 The Dilemma.

At this stage there appears inconsistency in the literature. On the one hand it is proposed that collective behaviour is a response to common aims, and on the other it is argued that common aims will not induce collective action from large groups. Something of the
flavour of this inconsistency is to be found in alternative views of society. There are those who would stress the argument that societies emerge because individuals share a consensus of opinion, a similarity in views and objectives. There are also those who would stress the reverse, i.e. that social intercourse between individuals is dependent rather on the differences between individuals. That individuals have different skills and different resources, such that trading between all can be to their mutual advantage. In this sense individuals act collectively not so much as a reflection of a desire to attain common ends, but as a result of the fact that each may individually benefit by dealing with others. 50

The dilemma with respect to the case study at hand is that even though doctors may have common interests they should not be mobilized to pursue them. However, of course, it has been shown that they are so mobilized. As such it is necessary to explain collective behaviour in terms of the existence of a mechanism by which individuals reveal their preferences for collective goods. This appears a course of study which might reconcile the two approaches to collective action, and indeed provide a more useful theory of collective behaviour. In this study an examination is to be made of potential stimulii to doctors in revealing their desire for collective action.

There are a number of lines of inquiry that immediately offer themselves but whose suitability may be in doubt. The first of these

is that the association can, to some extent, coerce potential membership. In the case of the B.M.A. it has already been suggested that the association's status is voluntary. However this does not preclude behind the scenes social coercion of doctors. The American Medical Association epitomises just how well the art of friendly persuasion can be applied. As a result of its licensing powers and its network of influence it may be highly risky for a practising doctor to neglect his subscription to the Association. In chapter five of this study questions might similarly be asked of the B.M.A. What powers does it possess in attaining its goals and how far can it control the profession? To what extent does it exert social pressure on doctors in pursuing its goals, and are pressures brought to bear over the question of membership?

It has already been noted that the B.M.A. provides services of an educational and social nature. Such goods and services can be exclusive to membership only. That is to say that individuals consume such goods only as a result of subscription. This is not necessarily to argue that such goods are purely private. Whilst possessing the characteristic of price exclusion, they may nevertheless be goods such that when consumed by one person the marginal cost of consumption by other individuals is zero, as long as the number of individuals is kept within certain limits. This is exactly the sort of good one finds provided in the private market by clubs. Given the definition of the good it is possible to determine the optimal size of the club, and it may be argued that

even when the group is large the club itself may prosper and grow. These services provided to membership, which are sometimes referred to as selective incentives, may prove the stimulus which leads individuals to join associations. The provision of collective non-exclusive goods may then be viewed as a by-product of the association. This is the argument to be questioned in chapter six. It has been suggested that, because a large number of voluntary associations employ such incentives, then the importance of their role is evident. However, in looking to the B.M.A. the question is asked whether or not individuals actually use such facilities. How useful are selective incentives to doctors and is it fair to argue that doctors largely join the B.M.A. to consume these goods and services?

The failure of a theory to provide predictions which are compatible with behaviour in the real world calls for such re-examination of the assumptions of the theory. Despite the theory of collective goods, doctors join the B.M.A., and one assumption that possibly calls for attention is the nature of the individual. There are those authors who see the pure selfish economic man as a poor representative of individuals in the real world. There are those, who would suggest that, in particular, he does not describe members of the professions. Authors such as T. Parsons, T. H. Marshall, V. Fuchs, M. Reder, P. J. Feldstein and R. M. Severson, have argued

that professional men be viewed as individuals who subsume self-interest to the best interests of their clients.55 There are few problems in relaxing the definition of the individual, though it is difficult to argue how the introduction of altruistic behaviour will solve the problem of collective goods. It is even more difficult to argue that the definition of the individual should be altered. There is a wide body of opinion, typified by the views of D. S. Lees and M. Friedman, that professional autonomy has not necessarily been employed in the client's best interest.56 Thus, whilst in chapter seven, the argument is probed that altruism leads individuals to pursue collective aims at the expense of individual interest, there is also an examination of whether or not the medical profession, via the B.M.A. has revealed such behaviour. For example, is it really the case that doctors display such philanthropic motives on behalf of patients or on behalf of other doctors?

An examination of the environment's impact on decision taking will eventually be undertaken. Research on the impact of the environment on the question of whether individuals voluntarily


provide collective goods has already been pursued. Buchanan for example makes the distinction between an economic market and a political market.\textsuperscript{57} In the former it has been argued that decision taking is determined by the individual's tastes and preferences though in a political market where decisions are of a "political nature" the individual is more inclined to be aware of the full interdependent effect of his decision. Such arguments require closer scrutiny, but one of the more important aspects of the environment will be the degree of uncertainty. An uncertain environment itself may change the decisions which individuals take. For example, an individual card player may vote out of self-interest for a much 'fairer' set of rules in a world of uncertainty, where he does not know the cards he holds, than would be the case in a world of perfect information.\textsuperscript{58} However, possibly the most important effect of an uncertain environment is that it allows the introduction of a political entrepreneur.\textsuperscript{59} This is an individual who believes that he may derive a surplus from the provision of the collective

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good. He may or may not derive any utility from the good himself, but he believes that there is a surplus in the collection of contribution towards a public good over and above the costs so incurred in the provision of the good. It is his aim to maximize this surplus, and in pursuit of this goal he is prepared to undertake the task of influencing individuals' expectations such that they accept that their contribution is necessary to bring about the provision of a collective good and will bring about such provision. The appearance of a political entrepreneur has been an exciting and stimulating innovation in the theory of collective goods. An examination of his activities will be undertaken in chapter eight with a view to illustrating how he may mobilize demand for a collective good.

It is clear that the environment has again come under consideration. In this instance concern rests not so much with how the environment stimulates a demand for a collective good but rather how it influences individual decision to reveal their demand. Already the question of what sort of environment best facilitates the exploits of a political entrepreneur has been raised.

Much more needs to be said about all the questions raised in this introduction before the possibilities of establishing a theory of collective action will become apparent. It has already been claimed that there are lessons to be learned from a successful case study. Thus, as a pre-requisite for the study, the history of the B.M.A. must be placed under the microscope. What can its history tell us in answer to the question of why individuals voluntarily contribute to the attainment of collective goals?
CHAPTER 2

The History of the B.M.A.

In analysing one hundred and forty three years it is convenient to deal with three sub-periods: 1832-1900; 1900-1950; and 1950 to the present. During each period events which may have influenced B.M.A. membership will be called to notice. Events, of course, beg some interpretation, and as such this chapter is flavoured with the author's personal view of the history of the B.M.A.

The first period 1832-1900 was one in which the prime aim of the B.M.A. was to raise the status of the practise of medicine. The association's first task was to install some organization and control over the supply of medical practitioners' services in the U.K. Reform of medical education; the institution of a code of ethics and the establishment of a controlling body; the protection by law against unqualified competitors were high on the list of priorities.¹ Success in this fashion would inevitably be important in creating a greater degree of uniformity amongst medical practitioners and perhaps in concentrating their recruitment from the middle class.

The second period, 1900-1950, saw what Rostow might describe as the 'drive to maturity' on the part of the association.² It was

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1. It is tempting to refer to this process as "professionalization" of medical practise by the B.M.A. This is consistent with the use of the word by H. Wilensky, "The Professionalization of Everyone", American Journal of Sociology, Vol LXIX, Sept. 1964, and G. Millerson, The Qualifying Associations: A study in Professionalization, Routledge and Kegan Paul, London 1964. However, what the word professionalization does or should refer to is a vexed question; see for example T. Johnson, Professions and Power, Macmillan, London, 1972. Thus we say simply that this period was one whereby greater control over medical practise was pursued.

during this period that the B.M.A. made its real imprint in political life, and many of its early experiences are accompanied by the 'growing pains' which are incurred by the acquisition of political experience. It has been suggested that the B.M.A. was not keen on entering the political arena. The impression is given that it was reluctantly called upon to take up political battles. This view will be challenged. The B.M.A. had every reason to welcome political disputes and to be thankful for the intrusion of the State in the medical market. In the first case it was proving itself a failure in dealing with institutions in the private sector. The Friendly Societies, for example, were less sympathetic than central government agencies. Secondly, at a time when it was beginning to attract criticism from the profession, it was placed in the position of a figure-head to which the profession would rally at the prospect of State control of their skills. That the B.M.A. fought to get doctors the best terms under the N.H.I. scheme, and later in the N.H.S. should not be taken as an indication of the fact that the Association was unaware that its interests were served by State terms of involvement. Clearly, if only in boosting membership, one should note the threat of the State in unifying doctors in the ranks of the B.M.A.

The third period, 1950 to the present, is one which has shown that whilst the fear of the State might unify doctors, the employment

3. H. Eckstein, Pressure Group Politics, op. cit., p 40-41 and E. M. Little, op. cit. p 327 give this impression. Little writes that the B.M.A. was "brought up against" the N.H.I. controversy. Eckstein comments that "From the time of its founding (1832) until well into the twentieth century, the British Medical Association played a part in politics only reluctantly." John Rowan Wilson, "B.M.A. Syndrome" Spectator November 4, 1966, claims that in 1911 "the days of innocence were past" as the B.M.A. was "called on" to fight Lloyd George.
of many sections of the profession by the State can also introduce divisive tendencies. The N.H.S. took control of hospital doctors as well as general practitioners. The way in which it was established represents compromises between g.p.'s, hospital doctors and local authorities. Many authors have noted how different interests within the profession, e.g. between g.p.'s and consultants, played its part in the formation of a tripartite structure for the N.H.S. What, however, has not been adequately stressed is that the fact that a government department now pays more than one distinct section of the profession, has led to a widening of conflict between doctors. Thus the influence is not solely one way. It is not only that conflicts within the profession have influenced the structure of the N.H.S., it is also that the existence of the N.H.S. has widened conflicts in the profession. One section will be jealous if other sections appear to have greater increases in remuneration. The problem of wage differentials becomes more difficult when they are set by one paymaster. It is no surprise that at some stage either g.p.'s, or consultants or junior hospital doctors have felt badly treated by comparison with the others. This is reflected by the growth of associations representing each and acting as a "ginger group" to the B.M.A. The problem of the B.M.A. of reconciling all parties has been made worse since they all have a common paymaster. Jealousy, and a feeling of being hard done by, is instilled by the

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4. R. Stevens, Medical Practice in Modern England, op. cit; G. Forsythe, Doctors and State Medicine, op. cit; and D. G. Gill, "The British National Health Service: professional determinants of administrative structure" in C. Cox & A. Mead A Sociology of Medical Practice, Collier Macmillan, London, 1975, are typical of such authors who tend to suggest a uni-directional effect, i.e. solely of the profession on the N.H.S. structure.
belief that the B.M.A. has been neglectful of one section. Thus this period has been one which has widened conflict in the profession. Reorganization of the N.H.S. in 1974 will have little effect if all sections are still paid by a common body, i.e. the Department of Health and Social Security subject to the advice of a Review Body.

In a sense the history so outlined would seem to be running almost full circle. A divided profession in the early 19th century finds reason to unify. Unity is intensified by the threat of State involvement in the medical market. Finally, conflicts that have never been fully erased are intensified by the problem of wage differentials between sections of the profession. Having thus set the scene it is possible to return to 1832 and more carefully trace those steps in the story which may have influenced membership growth of the B.M.A.

2.1 1832 - 1900

"Everything now conspires to make this present a fit time to begin our great experiment", said Charles Hastings as he proposed the establishment of the Provincial Medical and Surgical Association.5 One is left to wonder just how aware he really was of the validity of this statement. For it was no accident that this era was to mark not only the birth of the B.M.A., but also of many other nation-wide associations. The Institute of Civil Engineers (1825), the Royal Institute of British Architects (1834), the Royal Society of British Artists (1823), the Royal Geographical Society (1830) and many others were all products of this period. Unquestionably conditions in society favoured the establishment of societies.

5. Quoted in P. Vaughan, Doctors' Commons: A Short History of the British Medical Association, op. cit.
However propitious circumstances were particularly noticeable in the case of the Medical profession.

It is by no means a coincidence that the era which witnessed the birth of as many national associations was also the era which saw marked improvement in communication and transport systems. The coaching network was highly developed and the railways were about to expand, e.g. the opening of the Liverpool to Manchester line in 1830 and the Birmingham to London line in 1838. The penny post was to be introduced in 1839 and to be followed by the development of electric telegraph. Such innovations were clearly essential, and as Stern points out it was only in the 1840's that any national trade union was able to maintain its existence for longer than six years.

Political changes, as well as improvements in communications, pervade the 1830's. It was significant that it was in the year of 1832 that the first Parliamentary Reform Act was passed.

Clark notes that:

"The Reform Act of 1832 altered not the powers of Parliament or its ways of doing business, but the electoral system. For the old haphazard arrangements by which many members were chosen by municipal corporations it substituted a national, if still very imperfect, geographical division of constituencies. There was a uniform franchise in the boroughs and also, with a different set of qualifications, in the counties."


Roughly speaking this brought large sections of the middle classes into the electorate. It probably gave the vote to many medical men who had never had it before, and now, speaking again very roughly, for the first time the 'doctors', from the London physician with his carriage and pair to the country apothecary with his horse and trap, were political units. There were supposed to be about 30,000 of them. They made a substantial percentage of the 217,000 voters who now joined the former 435,000."^8

If doctors recognized their existence as a political force they did not witness any obvious appreciation of this in Parliament. The same author notes that the Reform Act "did not lead to an influx of medical men into the House of Commons. In the first reformed Parliament there was no physician and the only surgeon was the radical Joseph Hume ... He did not take an interest in medical matters ...."^9

There may then be grounds for arguing that medical men, resenting their under-representation in Parliament, hoped to exercise their political force through an association which would exert influence on Parliament. Certainly evidence suggest disillusionment with the state of representation inside Parliament.


Mapother comments

"No impartial man could deny the importance of having members of the medical profession, who could be consulted on the numerous questions relating to public health to be discussed. The other learned professions are most amply represented in both the upper and lower houses, for instance, over 100 members of Parliament are practising Barristers, and no just reason has or probably can be adduced why medicine should not enjoy similar invaluable privileges." ¹⁰

It is clear that the medical profession was particularly scantily represented in Parliament. In the Commons of 1832 there were 51 army officers, 12 naval officers, 5 higher lawyers and only 1 medical man. By 1868 the position had only slightly improved, with 41 army officers, 4 naval officers, 22 higher lawyers, and 5 doctors. By 1885, there were 12 medical men, 35 army officers, 7 naval officers and 34 higher lawyers. ¹¹ The army and the navy were both accused by the profession of exploiting medical practitioners, while the Guardians of the Poor Law which was introduced in 1834 were to be looked upon as ruthless task-masters of the profession. How important it soon would become to have influence in or on Parliament.

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The early nineteenth century not only saw an awakening of political awareness, but also throughout the country, witnessed a keener emphasis of the importance of education. Wide interest could be seen in Adult Education. In 1825 for example, Lord Brougham founded his Society for the Diffusion of Useful Knowledge and this was soon followed by the formation of local branches. Also the Annual Report for 1831 of the Yorkshire Philosophical Society contained Brewster's suggestion for a British Association for the Advancement of Science. In the medical world this period was one of great changes in education and research. New diagnostic instruments were developed, e.g. the stethoscope was invented in 1819. There was a new interest in anatomy and the advantages of dissection of corpses was realized. New fields were opened up, e.g. the study of bones, the eyes and ears. Most important was that scientific approaches were being applied to medicine and empirical research challenged old abstract ideas. Newman was to regard this period as "one of the most notable since that of Harvey to Newton." The attention paid to medical diagnosis in the early nineteenth century was to lead to the importance of clinical and laboratory diagnosis in the latter part of the century.

It is interesting that the B.M.A. began as a provincial

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12. This political awareness can be seen within the profession. It is evident towards the second half of the eighteenth century when the Fellows of the Royal College of Physicians were attacked by junior licentiates who were excluded from any say in the College's affairs. Many of the junior licentiates were barred from full membership because they lacked a degree from Oxford or Cambridge. The licentiates, although continually challenging the regulations which refused them a say in College affairs won only token concessions.

association and that the provinces were at this time experiencing an unusual expansion of medical schools. The Mount Street School in Manchester, set up in 1814, was the first school of anatomy and medicine outside London, Oxford and Cambridge. Other schools quickly followed e.g. at Liverpool, Leeds and Birmingham. These schools were to challenge the Authority of the London Colleges. For example, the Royal College of Surgeons insisted on a compulsory period of training at London. The provincial schools disputed this requirement. The ensuing battle led to a Select Committee on Medical Education in 1834, and finally in August 1839 the Royal College dropped its requirement.

The Provincial Medical and Surgical Association can be seen to typify this interest in education in the provinces. Its objectives on formation were

1. Collection of useful information, whether speculative or practical through original Essays or Reports of cases recurring in Provincial Hospitals, Infirmaries, or Dispensaries, or in Private Practice.
2. Increase of knowledge of the Medical Topography of England, through Statistical Meteorological, Geological and Botanic Inquiries.


3. Investigation of the Modifications of Endemic and Epidemic Diseases, on different situations, and at various periods, so as to trace, so far as the present imperfect state of the art will permit, their connexions with peculiarities of soil, or climate or with the localities habits, or occupations of the people.

4. Advancement of Medico-legal science, through succinct Reports of whatever cases may occur in the Provincial Courts of Judicature.

5. Maintenance of the Honour and Respectability of the Profession generally in the Provinces, by promoting friendly intercourse and free communication of its members; and by establishing the harmony and good feeling which ought to characterise a liberal profession.¹⁶

Interest in education was prominent in the profession and particularly so in the provinces. The profession itself at this time was becoming more unified. Little has argued that from the moment that the Lancet had constituted itself, i.e. 1823, it was obvious that a body of men felt they belonged to a profession.¹⁷ In fact

¹⁶. E. M. Little, History of the British Medical Association, op. cit., It was agreed by members of the Association that at every Annual Meeting a paper was to be prepared and read concerning medical ideas. This would later, together with other research be published in the Association's Journal.

Hastings in the early 1830's made frequent reference to the expression "medical profession." Although this had no legal validity as such for the following twenty-six years.

It would be wrong, however, to suggest that the profession was one solid unit at this time. The distinction between the Physician, the Surgeon and the Apothecary was still a meaningful one. In general the physician was responsible for internal medicine, the surgeon for external treatment, while the apothecary prescribed drugs. The physician stemmed from a higher social background and looked for his qualification status to the Royal College of Physicians of London. A charter during the reign of Henry VIII necessitated the possession of a licence from the College to practise physic within seven miles of London, and an extra licence to practise outside of London. The Edinburgh Royal College of Physicians and the King's and Queen's College of Physicians in Ireland had similar licensing prerogatives within their respective countries. The separation of physic and surgery stemming from the Edict of Tours (1150), for many years had left the practice of surgery to the more humble pursuits of the barbers. However, by 1800, surgeons' status had risen and indeed they had their own Royal College of Surgeons of London. The Apothecary, on the other hand, was decidedly from the lower middle, or shopkeeper class. Yet he too had a separate licensing body, i.e. the London Society of Apothecaries. In 1815 this Society attained the right to restrict the practice of pharmacy to its licentiates throughout England, as well as the right to charge

20. By this edict the Church had avowed its abhorrence of blood.
for medical advice. Holloway has summarized the situation of the profession:21

"The law; wrote J. E. Willcock in 1830, 'recognizes only three orders of the medical profession, physicians, surgeons, and apothecaries.' Between the physician, who could claim to belong to a learned profession, the surgeon, who practised a craft, and the apothecary, who followed a trade, the gap was wide and impassable. Chief Justice Best pointed out in 1828, that the distinction between the various departments of the medical art had been drawn 'with great precision.' Each practitioner is protected in his own branch and neither must interfere with the province of the other.' This system of stratification was not only ancient, it was also peculiarly rigid. In the eighteenth century no apothecary could secure the licence of the Surgeon's Company unless he first withdrew his membership of the Society of Apothecaries. Even as late as 1834 it was necessary for Members of the College of Surgeons and licentiates of the Society of Apothecaries to be disenfranchised before qualifying as licentiates of the College of Physicians. The medical profession, it was held, had its ranks and orders, each with their own function and sphere of usefulness; and each estate

had its necessary position of subordination and authority. Bishop Butler's view that the Architect of the Universe had 'distributed men into different ranks, and at the same time united them into one society was applicable to the medical profession as to society in general.'

Even so, while this summary would still be applicable at the beginning of the nineteenth century, it would be wrong to dismiss the changes which were occurring. Changes in medical education, i.e. the observation of the fact that the advancement of physic went hand in hand with that of surgery, also the demands of a growing urban middle class called forth a practitioner who was a blend of the three sections of the profession. The skills of physician, surgeon and apothecary were to be required in one individual, i.e. the general practitioner. The use of the term "general practitioner" may be traced to the 1820's and was common in the 1860's. His frock coat and top-hat were soon to symbolise the medical profession. Compare Holloway's description of the medical profession in the early 1800's with that of the preface of the London and Provincial Medical Directory of 1847:

22. The realisation that progress in physic and surgery went hand in hand can be traced, for example, to Mr. Lawrence of Richmond Hospital School, an early advocate in 1827.

23. Demands which had been restricted to the upper stratum of society filtered down. Both the physician and the apothecaries strove to meet this increased demand of the middle classes, with the result that conflict between their respective associations was to increase. The eventual compromise was the appearance of the general practitioner. See T. Johnson, "The Professions", in Human Societies, edited by G. Hurd, Routledge & Kegan Paul, London 1973, p 125.

"The Physician, the Surgeon, and the Apothecary mark its sub-divisions; and law and custom would seem distinctly to have defined the position and duties of each class. It is needless to observe, however, that practically this classification has become almost obsolete. The nomenclature alone remains in force, and its inapplicability to the existing state of things constitutes an admirable ARGUMENTUM AD ABSURDUM for the reorganization of the profession. In times past, these several practitioners, in their various grades, were no doubt equal to the sanitary requirements of the people ... At all events, in the present age, the public, advanced in knowledge and power, perceive that they are considerably benefited by a departure from the economy of the profession as ordered of old. A change, accordingly, is now in progress, which, like all transitions, is marked by a confusion of position and character among individual members, that calls for some state interference to establish order and union in a profession which has thus been disturbed, and to meet the increasing demands for excellence by a people rapidly progressing themselves. If we look around, indeed, it will be found that the Physician, the Surgeon, and the Apothecary, as distinct and separate practitioners, exist but little more than their several designations ... For whilst Physicians, Surgeons and Apothecaries, appear to be so vitally interested in the continuance of useless titles, they
really are, by the force of a public convenience they cannot withstand, being gradually classed into Consulting and General Practitioners ..."  

Clearly then the growth of the general practitioner brought a greater degree of uniformity to the profession. The development of specialties was in its earliest stage even in the late nineteenth century, although it was a feature which would grow with the developments of technology of the twentieth century. It was the case that some fields of specialism had been contemplated before the birth of the B.M.A. e.g. Moorfield's Eye Hospital in London had been set up in 1804. Yet at this time within the profession there was some suspicion of these new fields. Stevens points out that as late as 1860 a surgeon of the staff of St. Mary's Hospital, London, was forced to resign for simultaneously accepting an appointment at St. Peter's Hospital for the Stone.

"He knows", said the Medical Committee in condemning his action, "that special hospitals in general, and special hospitals for stone in particular, are not only useless but worse than useless."  

Sir Heneage Ogilvie commented in 1953 that at the end of the nineteenth century

"There was no essential separation between the doctor who looked after the patient at home and the doctor who looked after him in hospital ... Practitioners were seeing the same cases using the methods of investigation."  

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It would be fair therefore to comment that the profession enjoyed a greater degree of homogeneity than had been the case before or that would be the case later. Of rising importance in the profession were the general practitioners, and this section of the profession found itself without a direct spokesman. The attitude of the Royal Colleges may well be typified by the statement of the Royal College of Surgeons, i.e. that "The College of Surgeons is not, and never professed to be representatives of the general practitioner." A plaintiff letter to the Lancet expressed the plight of the general practitioner:

"As a general practitioner, he belongs exclusively to no one branch, and is therefore virtually excluded from all." 

It is apparent that this section of the profession called for a spokesman. The prestigious societies of London were slow to welcome the G.P., and with the growth of their numbers throughout the provinces, it is perhaps understandable that the champion of the G.P. should be an offspring of the provinces.

It would be a mistake to argue however, that the meeting on Thursday July, 19th, 1832, at Worcester was one automatically destined for success. Why, one might ask, did earlier provincial societies not develop into the voice of the profession? It would be unfair to belittle the skill of the early founders in explaining the successful establishment of the Provincial Medical and Surgical Association. Charles Hastings proved a man eminently suited for a


venture of this sort. He had a history of personal involvement in medical associations both at Edinburgh and Worcester before 1832. He did not rush into the ambitious plan of setting up an association for the provinces without careful consideration and preparation. The feelings and needs of the profession were unearthed before the attempt was made. This was done through the response he found to the journal, The Midland Medical and Surgical Reporter. It was through this journal that Hastings made many contacts and indeed advertised the inauguration of the P.M.S.A. The Reporter ran into sixteen issues before it ended in May 1832, and made way for the second stage of the experiment, the actual formation of the society.

In his venture Hastings possessed, what looking back with hindsight, appears to have been the ideal combination of ambition and caution. His ambition may be seen in the fact that while many societies were established with a view to serving localities, e.g. 1832 the York Medical Society, the P.M.S.A. would begin with a view to represent the provinces as a whole. It was no idle boast, either. For, while contemporaries may have scorned them, the P.M.S.A. began the virtually unprecedented policy of holding their Annual General Meeting in different centres throughout the Provinces. For example, in 1833 it met at Bristol, in 1834 at Birmingham, in 1835 at Oxford. The effect was clearly to advertise the association throughout the country. Soon branches were to be created. Of the

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30. One biographer of Hastings so links the fortunes of the P.M.S.A. to the vitality of Hastings that he suggests by 1865, one year before Hastings's death, there was a decline in young doctors joining the ranks. It would appear the Association was ageing with Hastings. See W. H. McMenemey, "Charles Hastings (1794-1866): Founder of the British Medical Association", in Charles Hastings and Worcester 1794-1866, B.M.A., London, 1966.

31. The Lancet, 1836-1837, Vol 1 p 232 called them "The Migratory Provincial Medical Club."
formation of the South Western Branch in 1840 Mr. Russell Coombe commented

"The attendance by Medical Men from Exeter at the inaugural meeting at Worcester showed keen interest in medical politics, and so it came to pass that in 1842 the Tenth Annual Meeting of the Association was fixed for Exeter. To prepare a fitting reception the South Western Branch was founded chiefly by the efforts of Dr. Thomas Shapter ..."32

Elsewhere the reputation of the P.M.S.A. was sufficient to entice local independent associations to disband to join the P.M.S.A. For example, the West Somerset Medical Association was originally founded at the Taunton and West Somerset Medical Association and in 1844 became a branch of the Provincial Medical Surgical Association.

There can be little doubt that the publication and distribution of the Journal also helped project the P.M.S.A.'s national image. It carried information of medical developments as well as news of the Association and by 1901 Hardy stressed its importance to members.33 Also Charles Hastings was very careful to diplomatically ensure that the P.M.S.A. did everything it could to speak on behalf of all the profession, and as little as possible to split the profession. While the Royal Colleges took up a non possumus attitude towards the plight of doctors working within the Poor Law, the P.M.S.A. began in 1835 to campaign on their behalf. By 1850 they were petitioning on behalf of doctors in the Armed Services. The effects of such petitioning may be discussed later. The point, of course, was that

32. Quoted in E. M. Little, op. cit. p 42.
the P.M.S.A. was pursuing the aims of all branches of the profession. More than this, however, there were issues which by the mid-nineteenth century were the concern of the whole profession. Reform of medical education and quackery were aggravations which united the profession and, in dealing with these, Hastings most clearly revealed his powers of diplomacy. In fact the struggle for medical reform not only displayed the political influence of the P.M.S.A., but was also of vital importance in improving the status and homogeneity of the profession. For this reason a closer examination of this reform is desirable.

(i) Reform of Medical Education: formal unification of the Profession.

The question of reform of medical education in the mid-nineteenth century was one which encompassed at least two pressing issues. The first of these was the position of the rights of unqualified practitioners to practise. In a period when there was a pronounced interest in medical education, it seems hardly surprising that interest in the competition from the uneducated should also be stimulated. In 1805 Dr. Edward Harrison reported the result of an inquiry which had been made into the state of medical practice in the county of Lincolnshire for the Lincolnshire Benevolent Medical Society. He found that quacks exceeded medical practitioners in the ratio of nine to one. The 1841 Census showed 33,339 persons practising one or more branch of medicine, but the Medical Directory of 1853 showed only 11,808 qualified. The Medical Times and Gazette in 1853 brought notice to the fact that the estimated number of

34 Though Hastings and the other founder members played an important role it is clear that at times the pace of growth of the Association outstripped their wishes. They were clearly reluctant to open membership to the Metropolis and objected in 1856 to re-naming the P.M.S.A. the British Medical Association. Nevertheless they acquiesed in the face of majority opinion.
unqualified doctors was double that of the qualified. Another
estimate in quackery in 1851 had enumerated 21,400 unqualified
practitioners. However, what was probably most alarming of all was
that in 1841 it became known that out of 1,830 candidates for
Medical Office under the Poor Law, 320 had never been examined in
medicine, while 233 had not undergone any professional examination
at all.35

The second though not unrelated issue was the question of the
standardization of education. In the 1830's and 1840's qualification
in medicine could be acquired by choosing from a large number of
quite different medical degrees and diplomas which were issued by
totally unrelated bodies. There was no consultation in the
intrinsic worth of these qualifications and their standard varied
widely. For example, examinations for the Licentiate and the
Fellowship of the Royal College of Physicians were brief, oral,
conducted in Latin and covered the classical languages and a few
fields of medicine.36 The important qualification was a degree from
Oxford or Cambridge. This was preferred to a degree from a
Continental or Scottish university, though, by the end of the
eighteenth century, these were giving vocational medical education
in the newly developed areas of medical science. Graduates of these
universities were unable to become more than licentiates of the
Royal College unless they held an English qualification. There was
little or no instruction in any subject at this time at Oxford or
Cambridge and especially none in medicine.

The large number of qualifying bodies also possessed different licensing privileges. That is to say that qualifications issued by these bodies might be recognized in some parts of the country but not in others. Charles Hastings, himself, was a practitioner with qualifications from the University of Edinburgh which were not recognized in England. Rivington described the situation of the early nineteenth century:

"Before the Medical Act of 1858 was passed by Parliament the grossest anomalies prevailed throughout the United Kingdom in the relative position of the Licensing Bodies to each other, and in the privileges of the various orders of Medical Practitioners. England, Ireland, and Scotland had different interests. The colleges waged war against the universities, and at the same time were at variance both with the Apothecaries Societies and with each other. Exclusive privileges were possessed by the Medical Corporations and special local jurisdictions in cities and provinces were assigned to them which none could invade without being exposed to a rigorous prosecution."\(^{37}\)

Such disension within the profession would be of little value to an association which was establishing itself to represent the profession as a whole. Thus as well as the value of reforming medical education in and of itself, the B.M.A. had a further reason

to act in this way. To accomplish their objectives a unified profession would be most desirable. For example, the Poor Law Committee of the P.M.S.A. had commented in 1837 that, 'Your Committee are led, by present occurances, to regret the want of some general discipline, some presiding influence over the members of our profession: an influence which is exercised in every profession except the medical. It is true that a higher standard of qualification would utlimately accomplish the desired end; ...',

The need for medical reform was apparent both for the profession and for the B.M.A. However, had the B.M.A. the means to take a leading position in this field? They had some experience of influencing Parliament. Their suggestion for the improvement of data in Parochial Registrars was accepted by the Commons in 1833. In 1839, after six years consideration they recommended to Parliament compulsory vaccination against small-pox and this was taken up in the Vaccination Act of 1840. Indeed their mounting influence in Parliament must have been considerable. Lord Ripon once claimed that the Bill he introduced for medical reform did not contain provisions desired by the P.M.S.A. and it was this body that had secured its defeat.

Hastings's Association was also to be successful in its bid for medical reform because unlike his adversaries, he was more able to meet the feelings of the profession as a whole. The P.M.S.A. became the B.M.A. in 1853 as has been explained. However, in 1836 another British Medical Association had been formed in the Metropolis and for a time this was a serious rival to the P.M.S.A.


This B.M.A. had been founded by a group of doctors from Camberwell and Southwark and was led by a Dr. George Webster of Dulwich. One of the most influential members of this association was Thomas Wakely. The association did not publish a journal, but with Wakely on its council it had no need to. Wakely was the editor of The Lancet, and after a short period of welcoming the advent of the P.M.S.A. he was to become one of its most bitter opponents. He was impatient with the P.M.S.A. in their strides for medical reform. In 1841 representatives of the P.M.S.A. and of other medical associations arrived at a conference called by Webster in London. First on the list for reform which Webster presented, was reform of the medical corporations - the Colleges, and secondly was the formation of a single Faculty of Medicine for the whole of the United Kingdom to control medical education and the activities of quacks. Representatives of the P.M.S.A. were apprehensive and withdrew. Wakely retaliated. The Lancet carried the headline: Bribe of the College Fellowship to Dr. Hastings to Extinguish Provincial reform.

Yet Wakely, and his plans for a state examining board, were too radical for the profession. The aims of the medical corporations were not exactly parallel to those of the rest of the profession. They profited by a large number of students and entrants to the profession, while the rest of the profession looked askance at these future competitors. The result would be a compromise between both sections. The P.M.S.A. was able to realise this. The metropolitan B.M.A., by 1844 was to reach the end of its ephemeral life. Their radical approach finally appealed to no one and The Medical Times

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40. Quoted in P. Vaughan, op. cit., p 16.
of 1844 commented

"The British Medical Association, suffering a
resurrection under the galvanic agency of the
New Bill met in the person of Dr. George Webster
on September 28th. The Secretary was absent,
and the resolutions appear to have been moved
by the President, seconded by the President,
put to the vote by the President, and carried
by the President. He was the whole meeting." 41

Webster was later to take an active part in the P.M.S.A. which
finally took up, more successfully, the name of British Medical
Association.

There was then the need for medical reform, and the P.M.S.A. with
its understanding of the profession and with its position of
influence would become prominent in securing this reform. Those who
feel the Association was drawn reluctantly into medical politics
would do well to note the speed and enthusiasm with which the P.M.S.A.
promoted this reform. On its first anniversary at Bristol the
problems of medical education were raised. To the Royal
Commissioners on the Medical Act the representative of the P.M.S.A.
described reform as the Association's first aim. 42 In 1837 at
Cheltenham a Medical Reform Committee of 11 members was established,
and in 1839 they presented a strongly worded memorial to Parliament.
In 1840 representatives met with the M.P.'s Wakely, Warburton and
Hawes to agree on support for Hawes Bill. By 1845 the Association's

41. Ibid, p 17.

42. Report of the Royal Commissioners on the Medical Act 1858,
para 1545, page 116.
prominence was again recognized when Sir James Graham enlisted its aid in reference to a Bill which he was introducing. In 1850 the Association presented a memorial to Sir George Grey to assist in his work for reform, and two years later George Hastings, the son of the founder of the P.M.S.A. drafted a Bill. Finally in 1858 a Bill introduced by W. F. Cowper, and drawn up with the aid of Sir Charles Hastings, finally became law. The struggle had been a long one and had been delayed as much by the fractious nature of the various constituents of the medical profession as by the laissez faire philosophy of Parliament.

The Medical Act of 1858 was a compromise in every sense of the word. The 21 medical examining and licensing bodies were left intact and practise by quacks was not prohibited. However, an over-seeing body was established, i.e. the General Medical Council. It was composed of seventeen representatives of the universities and medical corporations, six members nominated by the Crown, and a President elected from outside the Council. Its task was firstly, to establish and maintain a Register of those individuals qualified in medicine. Secondly, to fix and maintain a minimum standard of education and ethical behaviour; the achievement of which would determine qualification for admission and retention on to the Register. Finally, to compile and publish a Pharmacopoeia.

Recognition of the P.M.S.A. was made when Sir Charles Hastings was

43. The Act of 1858, 'would never have been passed but for the Association', T. Laffan, The Medical Profession, 1888, p 133, (quoted in A. M. Carr Saunders and P. Wilson, The Professions, op. cit., p 93).

appointed one of the first nominees of the Crown. 45

The Act did make a significant distinction between qualified practitioners and quacks. The latter did not have the right to refer to himself as a "doctor" of medicine or medical practitioner. He did not have the right to recover at law any charges for his services, and he was unauthorised to certify to statutory documents, e.g. death certificates. Yet most important in view of the future of medical services, he was unable to find employment in State Service.

Dissatisfaction still remained however. The profession did not approve of the lenient treatment of quacks. They felt that representation of the profession on the General Medical Council was too small. Finally they also had not achieved one portal of entry to the profession. It was the case for example, that a man might practise in medicine, surgery and midwifery after qualification in only one of these branches. He could legally become a general practitioner for example on the strength of a M.R.C.S. attained by an examination of an hour in anatomy or surgery. Steps were to be taken then to achieve an amendment to the 1858 Act. In the struggle which ensued the importance of professional representation was stressed by the B.M.A. In 1870, for example, a Bill was introduced which called for one portal of entry, but did not strive for direct representation. An offer was made to the B.M.A. that if the Bill went through, a select committee would be formed to look to the question of representation. The Bill had gone down from the Lords to the Commons, but the B.M.A. contrived and succeeded in stopping

45. The Act provided legal recognition to the Medical Profession. The Lancet rejoiced in the G.M.C., "We never before had a collective existence", (Lancet 1858, Vol 11, p 147).
this. B.M.A. action had been taken by the Council and the membership had not been informed. Later however, the importance of direct representation to the B.M.A. itself would be revealed.

The idea of State Examining Boards for entry into the profession was one which took hold at this time. A Royal Commission set up in 1881 advocated three such Boards for the nation, and 1883 a Bill was presented to Parliament. The corporations panicked and established conjoint Boards between themselves in a bid to make the action unnecessary. Finally in 1886 the corporations, now nineteen in number, survived the Amendment Act. However this Act did insist that students must qualify in medicine, surgery and midwifery. It also added direct representation for the profession on the General Medical Council. Five members were to be elected by the profession to the G.M.C. and when expedient an additional representative might also be elected by the medical profession. It proved expedient before the turn of the century.

The results of the medical Acts of 1858 and 1886 might be looked at from the viewpoint of the profession and the B.M.A. The profession, as a result of the struggle, and the outcome, would become more solidified. The struggle had been a prolonged one. Seventeen Bills had preceded the Act of 1858, and twenty-three amending Bills had been introduced before the success of 1886. Parliament had bowed to this pressure and recognition of qualified practitioners had been made; even if in practice there was, as Newman and Turner claim, little to choose between the medical skills of the qualified and the
The medical profession had then taken on some legal identity and also entry to it had been made much more difficult. In fact prior to the Act, argument had been raised in favour of a lower order of practitioners to meet the needs of the poor and rural population. The B.M.A. however took the following position:

"Every attempt to create an inferior grade of medical men of limited education and with aptitude only for the 'ordinary exigencies' of practice should be resisted. Disease affected people wherever they were and whatever class they were, and so the same degree of medical skill should be available for everyone." 47

There was therefore to be no "feldscher" level of practitioner in the U.K. 48 Also there was to be an immediate reduction in the

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Given the state of medical education in the early nineteenth century this comment is acceptable. As late as 1834 membership of the College of Physicians could be obtained (provided you were an Oxbridge graduate and, of course, Church of England) for 50 guineas and by passing three twenty-minute examinations. Sir David Barry, in 1834, remarked that the exam could be passed by a man "who is a good classical scholar but knows nothing of surgery, little or nothing of anatomy, nothing of the diseases of women in child-bed, and nothing of delivering them." See A. J. Culyer, "The Economics of Health", in R. M. Grant and G. K. Shaw, Current Issues in Economic Policy, Phillip Allan, Oxford, 1975, p 153; and B. Abel Smith, The Hospitals, op. cit.


48. A "feldscher" level practitioner is a doctor in the U.S.S.R. whose qualifications are not as high as those generally required for general practice.
numbers of qualified practitioners. The B.M.J. of 1887 reported

"From a comparison of the number of names in Churchill's Medical Directory of 1883 and 1885, it appeared that the number of qualified practitioners had increased from 19,947 at the close of 1882 to 21,381 at the close of 1884; this was stated to be equivalent to an increase of rather over 7 per cent. The new edition of the Directory gives the number of practitioners in the United Kingdom as 22,316 at the close of 1886 the increase therefore has been considerably slower and only amounts to a little over 4 per cent. In London the increase has been from 4,564 in 1884 to 4,729 in 1886, or an increase of 3\(\frac{2}{3}\) per cent, instead of 12 per cent as in the previous period of two years. The increase in the number of practitioners resident abroad is also less considerable; in the last two years the number has been increased by 297, which is equal to about 15 per cent whereas in the previous two years it was 404, which was equal to 26\(\frac{1}{2}\) per cent."\(^{49}\)

The profession was made more recognizable and its rate of growth was curtailed. With the control over entry, and the growth of prestige of the profession, the social background of entrants was later to become stereo-typed. Also over the profession as a whole a disciplining body, i.e. the G.M.C., had been constructed to generate some ethical code. The B.M.A. was to have a hand in this in that it took upon itself the task of appearing as complainant against

\(^{49}\) B.M.J., January, 1st 1887, p 34.
professional misconduct of individual doctors. Indeed the G.M.C.'s work was to become greatly dependent upon the views of officials of the B.M.A. Even before 1886 evidence shows that B.M.A. officials enjoyed seats on the G.M.C., and as can be easily shown the directly elected membership of the G.M.C. have invariably been B.M.A. nominees.

The whole exercise had been a success for the Association. Admittedly quackery had not been completely outlawed and efforts would still be expended towards this end. However a distinct identity had been given to the profession and a means of controlling its behaviour had been instituted. The Association had been successful in the face of opposition from Webster and Wakely's London doctors. Its prestige had risen and membership followed suit. It had taken the B.M.A. forty-four years to reach a membership figure as high as 7,000; it would more than double this in the next fifteen years. This, at a time when a steadying influence had been created on the growth of the profession, meant that by 1900 its membership density was as high as 50 per cent of those on the Medical Register.

2.2 1900-1950

The establishment of a unified profession was undoubtedly a factor which would help the Association in its politico-medical work. In such activities two precedents had been established before 1900. The first of these was the willingness on the part of the Association to pursue the interests of all branches of the profession. The second was the success it enjoyed in negotiation with central government authorities as compared with its discussions with private

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51. P. Vaughan, op. cit., p 47.
52. This is proved in Chapter 5.
The cause of the Poor Law doctor was one of the first to interest the P.M.S.A. The Poor Law Amendment Act of 1834 had established an unsympathetic policy towards the poor. They were not to be indulged at the expense of local rate-payers and the Guardians were appointed to ensure financial stringency. Doctors taking appointments under the Guardians were in receipt of low stipends for covering large districts. An increasing supply of qualified and unqualified doctors helped to perpetuate this situation. Appointments were eagerly sought by doctors, as a means to supplement their private income, and appointments were made, to the horror of the P.M.S.A., on the basis of a submission of tenders. A large proportion of doctors, at some time or another, took work under the Poor Law, and the association was determined to correct the evils it saw there.

As early as 1834 the P.M.S.A. established a Committee to report on conditions within the Poor Law. Memorials and petitions were brought before the Poor Law Commissions who had responsibility for the administration of the system as a whole. In 1842 the Commissioners responded by issuing the General Medical Regulations and Explanatory Circular which abolished the system of tendering and insisted that candidates for posts must be qualified in medicine and surgery. Districts of Poor Law doctors were limited in size and some hope was encouraged of an improvement in salaries. The foundations

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for the improvement of the system had been laid, and step by step
the Provincial Association and the newly formed Poor Law Medical
Officers Association (1846) would build upon it. This new
association had been instigated in part by the P.M.S.A., and its
gratitude was to be shown in the stress it laid upon Poor Law
Doctors being members of the Provincial Association.

By 1850 the P.M.S.A. had widened its net to take up the struggle
of doctors engaged in the Armed Services. Petitions again met with
success when in 1858 a new set of Army Medical Regulations materially
improved the position of medical men and the standard of medical
recruits. However, combatant officers disliked this promotion of
Medical Staff, and strove to restore the status position between
them. By 1861 pressure from the Horse Guards and from the Admiralty
led to a new set of regulations which reduced the relative ranks of
medical men. The P.M.S.A. (now the B.M.A.) rose to the challenge
and as part of their campaign canvassed medical schools in an
attempt to cut the supply of recruits to the army. A semi-official
attack on the Association was made in the Army and Navy Gazette on
the grounds that it had deprived the army of medical officers.
However, the rear-guard action of the combatant officers proved of
little effect. By 1879 the B.M.A. had again ameliorated conditions
of medical men and by 1898 it fulfilled its objectives when the
Government established the Royal Army Medical Corps and accorded its
officers military titles.

The success in negotiations over army medical staff was
reflected in discussions with the Admiralty. In 1875, after a

54. E. M. Little, op. cit., p 152.
series of memorials and deputations, the Admiralty issued a new warrant dealing with the medical department of the navy. This made a variety of concessions, but the most important of them was, perhaps, that which granted ward-room rank and ward-room privileges to all medical officers, whatever their seniority. In the 1880's the B.M.A. achieved some success with the Board of Trade which led to ship's surgeons enjoying a more favourable position for the pursuit of their services, and which forced shipping companies to exercise greater care in their selection of suitable persons.

It was, however, through the government that the B.M.A. was proving successful with its negotiations. This is probably no better illustrated than in its early activity in public health services. For example, it succeeded in its early advocacy of compulsory vaccination, and later on, besides exacting for vaccination officers a better scale of fees and other advantages, succeeded in modifying bills which would have had the effect of practically putting an end to compulsory vaccination. It also succeeded in getting metropolitan medical officers of health made whole-time officers and irremovable from their posts without the sanction of the Local Government Board. Further, by helping to obtain for local authorities the right to receive an Exchequer grant in respect of one-half of any salary they might decide to pay their medical officers of health, they did much to improve the position of officers of health. The Association achieved payment of notification of disease, not only for private practitioners but also for medical officers of health, in regard to cases seen by them privately. In 1910 it petitioned the Local Government Board to direct that a medical officer of health must receive three month's notice of the
termination of his appointment. Many other successes can be attributed to the B.M.A. in this sphere.\textsuperscript{55} Many of which were of a defensive nature, e.g. it was not improbable at one stage that public health work would be added to the duties of the Poor Law medical officers without any addition to their pay.

The B.M.A.'s work in the private sector had, on the whole, been more bitter, more prolonged and less successful.\textsuperscript{56} By the turn of the century they had made some headway against Medical Aid Institutions but had little impact on the Friendly Societies. The Medical Aid Institutions were commercial bodies who offered medical services in return for regular payments. The Association did not so violently object when such clubs were operated by doctors themselves. However, it did object to the intervention of a layman who organized the contracts with patients and employed the doctor. It was not so much the conditions under which such employed doctors worked which aggravated the Association as the very principle of such commercial activity by laymen. In 1892 a medical man in the employ of one such institution was brought before the G.M.C. on a charge of unprofessional conduct. The G.M.C. could see nothing to criticise, except the difficult working conditions he had accepted. However, reports into the system were drawn up, and more pressure brought to bear on the G.M.C. The result was, firstly, that those doctors who worked for institutions which canvassed and mass advertised were

\textsuperscript{55} See B.M.J., June 20th, 1914, pp. 1367-1369.

\textsuperscript{56} H. H. Eckstein, "The Politics of the British Medical Association", Political Quarterly, Vol 26, 1955, p 348, comments that by the early 1900's "The B.M.A. was far more suspicious of private than of public control."
regarded as guilty of professional misconduct. Secondly, those
doctors who worked for institutions which employed non-qualified
medical practitioners again were professionally mis-behaving.\textsuperscript{57}
By 1900 then some success had been achieved, but its significance
is questionable. In 1911 the Secretary of the Medical Alliance
(of Medical Aid Associations) claimed the first one had started
in 1869 at Preston and that now he could boast of upwards of 100
of these institutions in the country.\textsuperscript{58}

The other form of contract practice which the Association felt
uneasy about was work with the Friendly Societies. They differed
from Medical Aid Institutions in that they offered a number of
different services; one being medical care. It was rare at the
beginning of the century that such medical services should be offered.

However by the 1870's the provision of the services of a medical
practitioner was more commonplace.\textsuperscript{59} By this time the actual number
of members of friendly societies was estimated at 4,000,000.\textsuperscript{60} They
offered posts to doctors which were highly sought after, since, as
with Poor Law posts, doctors could use this position to subsidize
and to promote their private work. While the Association had
isolated successes in certain localities in modifying the activities

\textsuperscript{57.} B.M.J., July 4th, 1914, pp. 24-25.

\textsuperscript{58.} It is clear that by 1905 at least 12,100 doctors were employed
in some form of contract practice. See B. B. Gilbert,
The Evolution of National Insurance in Great Britain, London
1966, p 310.

\textsuperscript{59.} P.H.J.H. Gosden, The Friendly Societies in England 1815-1875,

\textsuperscript{60.} Ibid, p 14.
of friendly societies, e.g. in 1892 in South Cork, they failed to have any real impression on the policies which the societies pursued in the provision of medical benefit. Representatives of the Association met those of the friendly societies in 1898. The B.M.J. in 1914 looked back on that meeting:

"The conferences commenced in 1898, but were not followed by any material improvement, partly because the friendly societies, believing that they held the medical profession in the hollow of their hand, were totally unwilling to listen to reason - they refused, for instance, even to consider the question of adopting the principle of a wage limit ...."  

As a result of the failure to influence these societies the Association began in 1903 an inquiry into the problem of Contract Practice. The Contract Practice Report of 1905 was to lead to a plan to put the provision of medical services in the profession's hands. It was suggested that an organization, to be called a "Public Medical Service", be established in every working class area. These bodies were to be voluntary associations of medical practitioners who would settle on what terms and conditions contract practice should be offered in their locality, and would keep the whole management in their own hands. Work on the scheme was begun.

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64. Details of the plan are discussed in *B.M.J.*, 4th July, 1914, p 25.
but was discontinued as the National Health Insurance Bill of Lloyd George occupied more attention.

However, enough has been said to suggest that the B.M.A., far from being horrified at the prospect of a public medical service such as the N.H.I. would welcome it. They accepted in principle some form of contract provision of health for the lower classes provided the interests of the doctor was safeguarded. These interests could not be adequately safeguarded with the Friendly Societies providing these services, but pressure against the government had been much more successful in the past. Yet the B.M.A. had a second reason to welcome the introduction of the Bill. At a conference of more radical local medical societies in 1899 the Association had been criticised for not adequately fulfilling its role in political and ethical matters. Demands for the establishment of a new association were only averted by promises to change the constitution of the B.M.A. and hence enhance its effectiveness. The N.H.I. controversy would give the Association the opportunity

65. The report of the B.M.A. on contract practice in 1905 hoped to establish an income limit for friendly society members and hoped to provide more control for the doctor. In 1909 the Report of the Parliamentary Agents to the Annual Meeting of the National Conference of Friendly Societies said that "To accept the recommendations of the Report of the B.M.A. of 1905 would be to destroy the principle of trust now held for the Branch Surgeon, who is the officer upon whom we rely for safeguarding the funds from malingering etc." See Gilbert, op. cit., p 311.

66. A number of small medical guilds had been set up. They criticised the B.M.A. for not advancing the Medical Acts of 1886 further to the doctor's favour. It was clear that the Association must show itself more influential.

to prove itself and rally the profession to its ranks. The characteristic caution of the Association which it had displayed throughout the nineteenth century, was replaced at this juncture by a determined attitude. It was not, that the Association had been at last reluctantly drawn into medical politics, it was that now, - possibly more so than at any one time before, - the Association recognized a crucial opportunity to achieve its desires for the profession and to enhance its own position. Public intervention would be welcomed if the powers of the Friendly Societies were reduced, the position of doctors improved, and the dominance of the Association in the profession confirmed.

(a) The National Health Insurance Act 1911-1913.

Lloyd George's National Insurance Bill, which was introduced in May 1911, was clearly of the greatest importance to the medical profession.

68. The B.M.A. Report on Contract Practice concluded, "The cause of these evils is the advantage which non-medical organisations are able to take of the competition between individual medical practitioners." In February 1910 (before Lloyd George had introduced his Health Insurance Bill), the British Medical Journal wrote: "We are thus reduced to a dilemma from which most people see no escape except by some form ... of State assistance." See R. M. Titmus, "Health", in Law and Opinion in England in the Twentieth Century, edited by Morris Ginsburg, London, 1959.

69. H. Eckstein, The English Health Service, Harvard University Press Mass., 1964, p 129, has offered the following explanation for the B.M.A.'s predilection for public rather than private control: "Private organizations were far less likely to permit medical control over their affairs than public authorities and far more likely to administer medical services with an eye to economy rather than effective practice. Consequently, given the choice between private and public administration, the B.M.A., having had a long and bitter experience with private arrangements, chose to be controlled by the government."

70. R. M. Titmus, "Health", op. cit., p 307, points out that "With the withdrawal of the working classes, club and contract practice virtually collapsed after 1911."
profession. For a maximum contribution of fourpence a week, those employed could be insured against sickness, and with the exception of a few special classes, insurance was to be compulsory for those earning less than £160 a year (the income tax level at the time). The B.M.A. welcomed the Bill in principle as "one of the greatest attempts at social legislation which the present generation has known..... destined to have a profound influence on social welfare and the health of the community." The B.M.J. commented as early as June 1911 that "the medical profession starts with that kind of prejudice in favour of the idea of national insurance." However the B.M.A. disliked the conditions of the Bill as they affected the profession. They had for some time opposed, with conviction, certain working conditions within the friendly societies. They had been unsuccessful at influencing the friendly societies; they needed some success to restore the faith of the profession, and they realised that this government action provided the opportunity to make the changes. Thus while the B.M.A. welcomed the Bill they would bitterly fight to secure the best conditions upon which doctors would work under the Act.

The Bill had been initially drawn up as a result of negotiations between the government, the friendly societies, and the insurance

71. The employee paid fourpence, the employer three-pence and the State two-pence giving the famous nine-pence contribution, the "ninepence for fourpence" of which Lloyd George was so proud.

72. Quoted in J. D. Bray, The Doctors and the Insurance Act: A Statement of the Medical Man's Case against the Act, Manchester, 1912.

companies. The doctor was to be offered conditions similar to those accepted within the friendly societies. The medical benefits of the Bill were to be administered by the friendly societies, the trade unions, and the larger insurance companies, all of whom were known collectively as Approved Societies. The Societies not the patients, nor the doctors, were to decide which doctor treated which patient. The doctors were given no representation on the administrative bodies, and thus no say in the conduct of the insurance scheme. They were only to be paid six shillings a head for medical attention to insured persons. Also the profession was concerned that there was no limitation by income; anyone could join.

The doctors saw the opportunity to change such conditions. They insisted at a special meeting of May 31 - June 1, that Six Cardinal Points would represent the minimum conditions under which the profession would take service under national health insurance.

The six points were:

1. An income limit of £2 a week for the insured, no one earning more should be permitted to receive medical benefit without extra payment to the doctor.

2. Free choice of doctor by the patient, subject to the doctor's consenting to act.

74. The B.M.J. claimed that Lloyd George had seen the doctors only once 'for an hour or so', in the two years he had negotiated with the Friendly Societies. Lloyd George claimed he had only seen the doctors on four occasions. See B. B. Gilbert, op. cit., p 363.
3. Medical and maternity benefits to be administered by the local health (later insurance) committees, not the friendly societies, and all questions of medical discipline to be settled by medical committees composed entirely of doctors.

4. The method of payment in the area of each insurance committee to be decided by the local profession.

5. Payment should be "adequate"; this later was defined as a capitation fee of eight shillings and sixpence per head per year, excluding the cost of medicine.

6. The profession to have adequate representation upon the various administrative bodies of national health insurance.

Of these conditions the first and the fifth were to prove the most difficult. Through the summer free choice of doctor and the administration by insurance committees of the medical benefit, although not the maternity benefits, had been guaranteed. Local medical committees, made up entirely of doctors were instituted to handle medical discipline. Doctors might choose their method of remuneration within their locality. On the question of income limit the doctors were placated to some extent by the imposition of £160 maximum income for voluntary insurers, although it was provided that after five years on insurance a contributor might continue as a voluntary insurer, even though his income exceeded that amount. The fee doctors required however was not complied with.

Throughout the summer the B.M.A. had mobilized professional opinion against health insurance. This involved obtaining signatures
to a declaration stipulating that the undersigned agreed "that in
the event of the National Health Insurance Bill becoming law, I will
not enter into any agreement for giving medical attendance and
treatment insured under the Bill, excepting such as shall be
satisfactory to the medical profession, and in accordance with the
declared policy of the B.M.A. ..."75 By the Autumn however, the
concessions made had left medical opinion unsure and unformed. It
was at this time that Lloyd George revealed the political ineptitude
of the B.M.A.'s officials. At the very time that upwards of 27,000
doctors had signed the B.M.A. pledge, Lloyd George offered
J. Smith Whitaker an appointment to the joint insurance committee
which would administrate the scheme. Smith Whitaker placed the
decision with the B.M.A. Council and they recommended he accept.

The outcome of this action was that a large section of the
profession felt itself betrayed and came out in open revolt against
the B.M.A. Clearly now if the B.M.A. were to maintain its position
as the spokesman of the profession it would have to overtly show
firmness on the six cardinal points and show obstinacy to co-operate
with the Government on any other than its own terms. The out-cry
against Smith Whitaker's appointment had led the B.M.A. to a
position of intragence, which they felt vital if they were once
more to unite the profession with them. During the first six months
of 1912 there was no negotiation and virtually no contact between
the government and the profession. Not until June 7, did the
Chancellor of the Exchequer meet representatives of the medical
profession. With the consent of both parties a well-known chartered
accountant, Sir William Plender investigated remuneration of British

general practitioners. The books of practitioners in six towns, Darwen, Darlington, Norwich, St. Albans and Cardiff were looked into. The report suggested that the ordinary general practitioners received an average of 4s. 5d. per patient per year. Clearly this was well below the six shillings offered in Lloyd George's scheme. The B.M.A. denounced the validity of the report, but they would have done well to have taken it into deeper consideration. Their reply was to reiterate the demand for an income limit and for a basic 8s. 6d. capitation fee.

Negotiations once more broke down. Lloyd George talked of returning decisions on medical benefit to the friendly societies, and indeed of the advantages of a salaried service. While reminding the profession of such threats on the one hand, he also, on the other hand offered in October, a fee of nine shillings per patient per year inclusive of drugs and appliances. This was not equal to the 8s. 6d. demanded by the medical association, but it was never-the-less a considerable increase. The intention was to give all doctors a minimum income of seven shillings per patient per year, excluding the cost of drugs. One shilling and six-pence was set aside to meet the cost of drugs and a further six-pence was available for the doctor in so far as it was not required for drugs. Furthermore, in December the government had suggested that payment for assistants and milage payment allowances would be made.

On December 21, 1912, at a special Representative Meeting of the B.M.A. they voted by 11,219 votes to 2,408, to reject the Government's

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76. Report of Sir William Plender to the Chancellor of the Exchequer on the Result of his Investigation into Existing Conditions in Respect of Medical Attendance and Remuneration in Certain Towns. 
As Cox was later to point out, this rejection of the scheme at this stage was a catastrophe. The B.M.A. had been influenced not by the rank and file of the profession, but by the well-paid consultant and specialist. The lowly general practitioner stood to gain considerably by the National Insurance Scheme as it stood. The consultants and specialist physicians were not to be affected by the scheme, yet this was the section of the profession which created the pressure on the B.M.A. They had been the individuals who had deplored the B.M.A. for allowing Smith Whitaker to take his post in the scheme in the preceding December. In so doing they had driven the B.M.A. to a position of intransigence from which it could not easily back down. One year later they were encouraging the Association to turn up its nose to the Government's offer. Yet they were the least affected by it. Cox later pointed out that at the time the vote was taken by the special representative meeting, he had in his possession telegrams from secretaries which showed an affinity on the part of the general practitioners for the scheme.

Lloyd George had recognized this split in the profession even if the B.M.A. had not. He had also prepared for the rejection which the B.M.A. was displaying. He proposed that the four insurance commissions to be set up would hire doctors on salary where they could get them and transfer them into areas needing medical service. However, doctors would not stand fast even if the B.M.A. said they should. The general practitioners in their thousand rushed to join


79. Ibid, p 93.
the scheme. The National Insurance Gazette for January 11th, 1913, noted that 11,000 had already joined. When the local insurance committee advertised for doctors in Bradford, it got three times as many as were needed. The B.M.A. was merely recognizing the obvious when, on January 17th, it released doctors from their pledge to abstain from service under the Act. Cox remarked in 1923 that the Association had achieved much in determining the terms of doctors under the Act, but had appeared to have lost the fray. The Association had been led "into a humiliating Debacle, when we might have claimed substantial victory - and all, at the end, for the sake of sixpence."  

(b) Steps to a National Health Service: 'Once Bitten Twice Shy!'  
The medical profession proved more than happy within the National Health Insurance scheme. Financially the position of the general practitioner was much improved; Gilbert comments "Lloyd George's Act reversed decisively and permanently the trend, several decades old, towards a steadily declining economic position among general practitioners."  

The B.M.A. itself was placated by the willingness of the insurance commissioners to bring the Association as fully as possible into the administration of the scheme. By 1933, the twenty-first birthday party of National Health Insurance was celebrated at a luncheon organized by the B.M.A. with Lloyd George as the guest of honour. Wounds had healed and the B.M.A. were gradually mounting pressure for an extension of the scheme. However, at the next conflict it would determine to be more mindful of the will of the profession.  

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80. B. B. Gilbert, op. cit., p 415  
The B.M.A. had set its unequivocal seal of approval on the National Health Insurance scheme in a memorandum of evidence to the Royal Commission on National Health Insurance which reported in 1926. Both the B.M.A. and other medical and lay organizations testifying to the Royal Commission recommended a broad extension of health insurance. Coverage had increased since the 1911 Act came into effect, but wives and dependents of insured persons in Britain were still excluded, as were the self-employed and those above a set income. There was a strong case for including complete consultant and specialist advice and treatment, laboratory service, hospital and institutional care, dental care, and full supporting services to insured persons and their family dependents. In this the B.M.A. were more progressive than the Ministry of Health and the Commissioners who signed the Majority Report in 1926. The B.M.A. commented that if specialist services were to be provided for insured people at home and in hospitals, they would feel seriously concerned about the position of non-insured persons of moderate means. The only remedy would be to make a similar benefit available also to the middle classes. The Commissioners however, did not feel equal to the task, and a comprehensive medical service through the agency of the government would be delayed for twenty years.

The B.M.A. were then content within the government sector. They exhorted the American Medical Association to be encouraged by the fact that "the much greater experiences of the British Medical Association in collective negotiation and bargaining indicates that

83. R. Stevens, op. cit., p 54.
84. Ibid, p 54.
the power of the organized medical profession reasonably exercised, is very effective. In 1930 and in 1938 it issued reports calling for the establishment of a comprehensive medical service. The approach of World War II and the establishment of the new Emergency Medical Service in 1939, only served to further medical opinion towards such an end. Under the E.M.S. consultants for the first time became actively engaged in National medical policy. They advised on the development of a regional blood transfusion service and a national pathology service. Regional hospital officers were appointed to plan, co-ordinate and organize services over a geographical area. The exercise shed light on the strength of the medical profession in influencing national policy, and they introduced the Royal Colleges to negotiations with the government over conditions of service. Strength of feeling within the profession for an extension of public medical care culminated in the report of the Medical Planning Commission in 1942. The Commission, composed of representatives of the British Medical Association, the Royal Colleges, and the Scottish Medical Corporations set out the aim to render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional.

Opinion within the profession for a comprehensive medical service had reached its high tide mark. As the government strove to act upon it, once more the B.M.A. presented a desperate struggle to insure doctors' working conditions within the scheme. The

86. The British Medical Association's Proposals for a General Medical Service for the Nation, London, 1930; reissued in 1938.
parallels between the introduction of the National Health Insurance Act and the National Health Service Act were to be proved complete except for the B.M.A.'s eventual more graceful accession in 1948.

(c) The National Health Service.

The demands which the profession expressed at the advent of the National Health Service were:

(1) No full-time salaried service.
(2) Freedom to practise without State interference.
(3) Freedom for both patient and doctor to choose whether to take part in the service or not.
(4) Freedom for the doctor to choose the form and place of his work.
(5) Freedom of every registered doctor to take part in the service if he wished.
(6) A planned hospital service.
(7) Adequate representation on all administrative bodies.

At the outset proposals were being made which were clearly at variance with these aims. The Brown Plan of 1943 made some alarming suggestions with respect to general practitioner services; it proposed a free general practitioner service available to all and preserved the right of the patient to choose his own doctor. Doctors in urban areas at least, would work from health centres and be paid a full-time salary. The services would be controlled by the local health authority who, together with a Central Medical Board, would make appointments to the general practitioner

service. Also, although joint health boards were talked about as a temporary measure, it seemed likely that plans for the future held the prospect that hospitals would be unified with general practitioner services under local authorities.

The prospect of a salaried service under the administration of local authorities was more than the profession, particularly the general practitioners, could ever concede to. Gradually as one plan replaced another this was recognized. The Brown Plan was followed by the White Paper of 1944, 89 which in turn was followed by the National Health Service Bill. 90 This Bill was introduced by Aneurin Bevan in 1945, and its structure reflected many concessions made to the profession.

Within the Bill nationalization was offered as the only viable solution to the hospital reorganization problem. Consultants and hospital doctors accepted this rather than work under local authorities. They also of course were offered special concessions regarding the position of the powerful teaching hospitals. Regional Boards composed of medical and other bodies would undertake, on behalf of the Minister, the general administration and planning of the hospital services in its regions. They would appoint local hospital management committees to carry out the day to day hospital management. Yet the teaching hospitals were excluded from this scheme and not linked regionally with other smaller hospitals. They instead would have direct access to the Minister of Health. Each would be administered by a specially

89. *A National Health Service*, Cmnd 6502 (H.M.S.O. 1944).
constituted board of governors, and unlike other voluntary hospitals they were allowed to retain their endowments. In short, they were being offered a superior service.

The Bill's recommendations for general practitioner services followed the lines of the 1944 White Paper and the previous Plan. Local ad hoc bodies (Local Executive Councils) would be set up and doctors in the localities would be in contract with these bodies. A National Medical Practices Committee would regulate the appointments of doctors, and by determining the over-doctored areas attempt to improve the distribution of doctors. It was hoped that a system of health centres would be established. The sale of medical practices would cease and compensation be paid. Local government authorities would retain their existing domiciliary services, including midwifery, maternity and child welfare, home nursing and home help, ambulance service, and other preventive and after-care services. They would also have a duty to provide and to maintain the health centres, in which both specialized clinics and general practitioner clinics might be held. But since their own hospitals would be nationalized, they were to lose all control over hospitals.

The National Health Service Bill then created a tripartite organized structure. To a large extent it was the result of concessions to the groups involved. The local government associations represented by groups such as the County Council Association and the Association Municipal Corporations had lost much by comparison with the Brown Plan. The hospital groups represented by the British Hospitals Association had fallen foul of nationalization. However the medical profession, represented in the main

by the B.M.A. and the Royal Colleges had gained much—e.g. no salaried service for G.P.'s, much less local government control, the removal of hospitals from local government, special treatment for hospitals, seats on administrative bodies. In much the same way then that the strengths and gains of the profession could be compared to the losses of the Friendly Societies in 1912, once again it might be compared with those of other interested parties in the negotiations surrounding the N.H.S.

Just as Lloyd George forcefully kept the medical profession uninformed in the introduction of his Bill so also did Aneurin Bevan. He argued that the mandate the party had received should determine the introduction of the Bill, and he would not compromise this by lengthy 'negotiations' with the B.M.A. The Bill was enacted in November, 1946, and the appointed day for introduction was July 5, 1948. It was between these dates that the political skill of Bevan is most notable. As Lloyd George had split the profession in 1912, Bevan divided it in 1946. Resistance to his Bill was clearly reduced by the fact that he had "wooed the consultants." There is strong evidence to support the view that the major concessions were made to the consultants. He accorded the teaching hospitals a favourable position administratively and on their endowment, he instituted no disciplinary machinery for consultants (although he did so for general practitioners), he permitted the treatment of private patients for fees in state hospitals (despite backbench criticism from his own Party) and in some of the amendments he accepted in the Commons he was falling in with the wishes of the Royal Colleges. The result of this was of course, the support of the Royal Colleges when required. For example, after the Act was

92 A. J. Willcocks, op. cit., p 70.
passed the B.M.A. agreed to negotiate only if acceptance of the Act was subject to a plebiscite of the profession after the discussions were completed, and if the possibility of new legislation was not excluded. The Colleges agreed to negotiate unconditionally. Also, when discussions broke off between the B.M.A. and the Minister the Royal College of Physicians and the Royal College of Surgeons, interceded suggesting to the Minister the appropriate areas of concern in the profession and offering the opportunity to make overtures to the profession.

The areas of concern in the months before the "appointed day" were almost entirely those affecting general practitioners. The B.M.A. suggested that the G.P.'s disapproved of the Medical Practices Committee, the prohibition on the sale of goodwill and practices, and the disciplinary machinery for G.P.'s and the appeal mechanism. Also of concern was Bevan's statement that he favoured a basic salary (£300 a year) as part of the income of general practitioners. This talk of salary incensed the profession and step by step Bevan was made to amend his statement. It was to become the case that the Executive Councils were instructed to make such 'fixed payments' only in certain cases; when a general practitioner is starting anew or when he is disabled. Also legislation was promised to remove the possibility of a salaried service.

Beyond such concessions it was clear that the B.M.A.'s cause was hopeless. The Minister was determined to introduce the service on the appointed day and substantial numbers of specialists and hospital staff would join. It was suspected too that a large number of general practitioners would also join. The B.M.A. proceeded with a plebiscite stipulating that if at least 13,000 G.P.'s voted against the Act, then they would continue the struggle in defiance of the law. In fact only 9,588 G.P.'s were against it,
though only 8,639 were in favour. Afraid of a similar outcome to that of 1913 the B.M.A. more gracefully accepted the N.H.S. Yet, while in so doing it realized it did not have sufficient control over the profession to dictate loyalty, it must have been comforting to note that its membership at the end of this dispute contained over 80 per cent of the profession.

2.3. **The B.M.A. 1950 to the present.**

If the influence of the B.M.A. and the profession had been of importance in the establishment of a National Health Service in the first half of the 20th century, then it might be argued that more recently this institution has had an important influence on schisms and dissensions in the profession. It is clear from the negotiations of 1944-48 that there was a distinction in the interests of the general practitioners and the consultants. Negotiations of both sections with one employer had revealed if not emphasized the differences between them. To some extent the consultants might be said to have had the better of the deal in 1948. However, the rivalry of 1948 would be maintained in the following years. The inevitable consequence of the N.H.S. is then to emphasize sectional interests within the profession. The tripartite structure of the N.H.S. divided general practitioner from hospital doctor from public medical officer. Questions of remuneration have stressed the conflict between the G.P.'s and the hospital doctor, and questions of staffing have more recently

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93. R. Stevens, op. cit., p.32.

94. Authors have commented on the effect of the dissension in the medical profession on the structure of the N.H.S. but appear to ignore the reciprocal influence. Such authors are cited on page 28, footnote 4.
brought junior hospital doctors into conflict with consultants. Negotiations with one employer has revealed the willingness of certain sections of the profession to make its demands, if necessary at the expense of other sections.

(a) The General Practitioner and the Consultant.

The interests of the G.P. and the consultant has never been completely harmonious. However discussions on remuneration since 1948 have served to stress the differences. It is the negotiations of 1963-68 which reveal this most bluntly. The problem of this period arose from the anomalies of the remuneration mechanism of the G.P., but serve to show clearly the under-current of rivalry between these sections.

Competition between the G.P. and the hospital consultant can be traced to the late 19th century. Both parties found themselves in competition for the prosperous middle class, and the special hospitals established at this time served to fan the flame. "Many of the cases treated at these special hospitals are of the most ordinary nature and not in the least requiring the skill of a specialist, but could be quite well treated by a general practitioner", wrote a critic in 1900. Criticism increased with the establishment in general hospitals of special out-patient clinics, ostensibly for the destitute sick but utilized by the middle class. The eventual compromise between G.P. and consultant was the 'referral system'. By the late 19th century hospital staff who specialized were acting as consultants to other doctors on cases of particular interest. At the beginning of the 20th century almost a third of the out-patients and over a half of the

95. Ibid, op. cit., p 32.
in-patients seen in the Central London Throat and Ear Hospital were referred there by other doctors. Articles appeared on consultant etiquette in which it was suggested that g.p.'s should send their patients for a second opinion only to full-time consultants who were not also general practitioners. "The physician and surgeon had retained the hospital, but the general practitioner retained the patient." In such a way then the spread of specialisation throughout the general practitioner ranks would not be the feature of the British Medical Profession, as it would in the United States.

The National Health Insurance scheme did not affect the hospitals, but it did affect the relationship between g.p. and hospital practice. For some years the ancient rivalry between the Royal Colleges and the B.M.A. had reappeared through the development of dispensaries and out-patient departments in the voluntary hospitals, where treatment could be had on a charitable basis. Arguing that this injured the interests of their local practitioner members, a committee of the B.M.A. had been touring the country urging voluntary hospital committees to close departments to public access. They enjoyed little success since the committees were more influenced by the local surgeon who served them in an honorary capacity and were associated with the eminent Colleges, than by the g.p. trade union attempting to enforce restrictive practices and lines of demarcation. With the passing of the 1911 Insurance

96. Ibid, op. cit., p 32.
Act, however, the charitable out-patients' departments ceased to be a threat to the g.p. and instead became his ally. Patients requiring much time and attention could be off loaded to these departments, and the doctors in densely populated working class areas could take on large practice populations with a consequent increase in their income.

The National Health Insurance scheme did much then to bring peace and unification to the profession. The N.H.S. however, would have the reverse effect. By bringing the hospitals within its boundaries, the g.p. and hospital doctor found themselves paid by the same body. Implicitly at first and then bluntly explicitly the vexed question of remuneration differentials arose. However, for an Association which hoped to represent all sections of the community this would serve only to create further difficulties.

Remuneration Negotiations 1946 - to the present:

The first determination of incomes in the N.H.S. was made by the Spens Committee of 1946 and 1948, which set out suggested scales and methods of remuneration for general medical practitioners and for consultants and specialists. Each Committee was independently staffed; their conclusions appeared to have been arrived at independently, and they were based on the pre-war incomes of each branch rather than on the desirable future relativity between general and consultant practice. Figures in the Spens reports indicated that the consultant might expect to earn almost twice as much as a g.p. They recommended a median net income (after practice expenses) for a general practitioner aged 40 to 50 years of £1,300; a whole time specialist was to receive a salary
of at least £2,500 at about age 40.99

The adjustment of this remuneration from 1939 values to post-war values was to cause contention. For general practitioners, it was left to Justice Dankwerts to arbitrate. He decided that a betterment factor of 100% was appropriate. The average net income of g.p.'s was to be £2,222 and this was to include income from all sources. Also the method of remuneration was altered slightly. Instead of being established in terms of a settled capitation fee multiplied by 95% of the population it was based on an average net figure multiplied by the number of doctors. This change in the form of remuneration was the result of panic on the part of the profession in the early 1950's that the number of doctors was increasing more rapidly than the population.100

The treatment of the g.p.'s at the hands of Justice Dankwerts led the consultants to lodge a similar claim with the Minister of Health. He was, however, afraid of automatically linking rises in income to the cost of living. While consultants asked for a post-Dankwerts increase because of the 'reduced value of money', the Ministry of Health related the increase it gave to the need to safeguard consultant recruitment and to help to restore the balance between the pay of the two branches. From April 1954, the consultants' basic scale was increased to the equivalent of 40% above the Spens figure at the bottom of the age scale, and 24% at the top - the new scale being £2,100 to £3,100. Distinction awards, which provided additional income to one of three consultants, remained unchanged. Even so, in terms of the Spens reports, the


100. R. Stevens, op. cit., p 131
difference between G.P. and Consultant incomes had been considerably reduced. 101

By 1956 the profession felt that their remuneration should again be adjusted to compensate for the change in the cost of living. The Treasury at this time sought to kill this implication of Spens, i.e. that medical remuneration should never vary. Thus in response to a B.M.A. claim for an increase of 25% the government suggested the establishment of a Royal Commission to conduct an inquiry into the entire question of doctors' pay in relation to other professions. The B.M.A. realizing the delay involved were against the proposal. Here, however, the Royal College of Physicians again swayed the profession. By agreeing to give evidence to the Royal Commission it brought the B.M.A. to heel, since the B.M.A. would not relish the thought of no spokesman for the general practitioner. 102 The Commission did not decide the question of remuneration differentials. It reported in February, 1960, and recommended that average g.p. income be raised by £2,425 with hospital doctors' salaries raised accordingly. 103 The most important effects of the Pilkington Commission however were to establish permanent machinery for the review of doctors' incomes and to attempt to end the dispute over the interpretation of Spens. The medical profession was no longer to be able to automatically claim insulation from inflation. On the other hand, the Commission made it clear that doctors' incomes were not to be used as an instrument for regulating

101. R. Stevens, op. cit., p 133.
102. G. Forsythe, Doctors and State Medicine, p 36.
103. Royal Commission on Doctors' and Dentists' Remuneration 1957-60; Cmd 939, February 1960, London, H.M.S.O.
the economy. The threat of a chain reaction through which other incomes might rise as a result of doctors getting more money was not to influence the doctors' case one way or the other. The Review Body recommended by the Pilkington Report, and established under the chairmanship of Lord Kindersley, asked that the profession make a single claim on behalf of the whole profession, rather than separate cases for g.p.'s and consultants. Eventually the profession agreed to submit two memoranda's; one making out a claim for a general increase, the other looking to the question of differentials.

The Review Body made its first report in March 1963, and an across-the-board increase of 14% was to be made effective from April 1965, with the understanding that there be no further increase for three years. This 14% was slightly above the guiding line set for the government's incomes policy.

For many general practitioners the 14% increase did not materialize. Their net income did rise from £2,425 to £2,765, though not their practice expenses. The pool for doctors' remuneration was calculated in the following manner:

<table>
<thead>
<tr>
<th>£ Million</th>
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<tbody>
<tr>
<td>Net income £2,765 x 22,000 doctors</td>
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<tr>
<td>Plus agreed practice expenses</td>
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<tr>
<td>Gross collective income</td>
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before being divided for distribution to individual doctors. Also from this pool deductions were for payment to general practitioners e.g. for work as clinical assistants in hospitals. Given the fact that the availability of such work is not even, and that g.p.'s had been

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receiving a greater amount than allowed for in making the increases, any doctor restricting his work purely to family practice and dependent on the capitation fee found that his income had risen not 14% but only 5%. Yet of course the hospital doctor with no practice expenses had received the full 14%.

The annual meeting of the B.M.A. representatives in July 1963, took place at Oxford. Here the Chairman of the B.M.A. Council, a consultant, warned the majority of indignant g.p.'s of the need for unity and of the threat that consultants could be driven away to negotiate independently of the rest of the profession. Even so a motion calling for a stronger line to re-affirm the need to upgrade the financial status of family doctors led to a heated debate.105

The disillusionment of the general practitioner with the B.M.A. at this time is no better reflected than in the establishment of the General Practitioners' Association. Formed in October 1963, and advertised by the weekly newsheet Pulse, it was to grow in membership. The B.M.A. highly critical of the Association became aware that it was losing the initiative. The G.P.A. proposed to appoint a professional negotiator on a "top salary" and to call in management consultants to work out a system of remuneration in general practice. The g.p.'s saw that the Royal College of General Practitioners would not take the stand which Consultant Royal Colleges might have taken, and thought an outside body necessary.

Within the B.M.A. the General Medical Services Committee and the Central Consultants and Specialists Committee, representing g.p.'s and consultants respectively, realized the need for

105. R. Stevens, op. cit., p 291.
conciliation. The General Medical Services Committee decided to widen its scope of inquiry to the broader problems of general practice, and to prepare a draft report on remuneration. The Central Consultants and Specialists Committee stressed that consultants did not wish to be obstructive or to employ delaying tactics, and the B.M.A. Council agreed in a statement on November, 1963, to reassure the g.p.'s that everything possible was being done on their behalf.

By June 1964, the profession submitted a memoranda to the Review Body. They requested that the pool system be modified to exclude all income except capitation fees and the "loading" or weighting attached to them. They asked for a net income for the g.p. of £2,765 per year from capitation fees alone, and also that £5 million be set up as a system of awards for seniority. The Review Body in 1965, summed up the situation

"The Joint Evidence Committee have assured us that the profession's proposals to us ....are based upon the intrinsic needs of the general practitioner. Not upon envy of the consultant. It would however be ignoring the realities of the situation not to recognize that for many general practitioners their sense of discontent is sharpened by a comparison of their lot with the lot of hospital doctors, both in respect of remuneration and in respect of conditions of service. It is a fact that many general practitioners attach importance to the proposals .... as a means of bringing their
remuneration and status into a closer relationship with those of hospital doctors and specifically of consultants."\(^{106}\)

And in paragraph 46

"Though we do not question the sincerity of the conviction of general practitioners that remuneration has been seriously inadequate ever since 1948 we find no evidence to support it and no not share it."\(^{107}\)

The result was that the Review Body awarded a 9% increase adding £5.5 million to the cost of the G.P. services and the £18 million asked for. Furthermore about three-quarters of the £5.5 million would be assigned to new expense schemes; the remainder would be paid as extra capitation fees.

The G.M.S.C. demanded that the whole of the £5.5 million should be immediately and unconditionally credited to the pool in respect of capitation fees. Meanwhile the British Medical Guild of the B.M.A., goaded by the militancy of the Medical Practitioners Union and General Practitioners Association, collected 18,000 undated resignations from G.P.'s to be handed to executive councils on July 1st, unless the dispute were settled.\(^{108}\) The Review Body agreed to the request concerning the £5.5 million and once more the B.M.A. returned to the drawing board to hastily construct further proposals. The "Charter for the Family Doctor Service", was soon

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108. R. Stevens, op. cit., p 308.
It suggested firstly that the G.P.'s contractual obligation with the National Health Service be related to a specified working day, a five and a half-day week, and working year which provided six weeks vacation — (Even part-time consultants were expected as part of their N.H.S. contracts to be individually and continuously responsible for their own patients at all hours of the day and night, and to be responsible for work performed under their directions by junior medical staff). The G.P.'s also wished a return to a method of payment according to the number of patients instead of according to the number of doctors — the concept of which the pool had been based since the Dankwerts award of 1952. Since the population was now increasing faster than the number of G.P.'s the suggestion was clearly advantageous. G.P.'s were claiming the best of both worlds. Claims were made in the charter for the re-imbursement of expenses for assistants directly and in full (another parallel to salaried service) and for re-imbursement for maintenance of practice premises. The establishment of an independent corporation financed from public sources was recommended to lend money to G.P.'s for purchasing or improving premises and equipment and to acquire buildings for lease or sale. Finally, groups of G.P.'s, it was suggested should be given a choice of payment — by capitation fee, item of service, or some form of salary — although the financial basis for each type would be the same. The B.M.A. estimated that the proposals would cost between £30 and £35 million — a total revised by the Ministry to over £40 million; and that sum would be in addition to the £5.5 million granted by the

Yet the profession's new charter was for g.p.'s only: it concentrated on g.p. pay. Indeed between 1963 and 1965 all negotiations centred largely on the problems of g.p.'s Junior Hospital Doctors were demanding recognition of their claims it is true; though the g.p.'s case predominated. Their case rested on their being underpaid in relation to consultants, and overworked in relation to what they were paid; the Review Body disagreed. In terms of the differential it appeared that the g.p. had in fact gained under the National Health Service. The original Spens Committee reports on medical incomes had indicated a 2 to 1 ratio in favour of consultants. The £5.5 million award raised the average net income of the g.p. from official sources to about £3,000 while the top of the consultant basic scale was £4,445. According to these figures, the differential had narrowed from 92% to 48% by 1965.

Negotiations with the Review Body had therefore proved successful for the g.p.'s. In May 1966, the Review Body gave the g.p.'s an average net increase of over 30% in a two year period. Consultants received only 10% though the number and value of distinction awards was increased. The pool system of allocation had been altered. There would be a basic practice allowance of £1,000 per annum with a standard capitation fee of £1 (increased to £1.80

110. R. Stevens, op. cit., p 100 The Times, March 9, 1965 commented "How many other unions can boast of having gone to arbitration, been disappointed, had the arbitrators obligingly change their recommendations, and finally had expenditure suggested on a scale far more lavish than the originally rejected claim."

111. R. Stevens, op. cit., p 318.

for those over 65) up to 1,000 patients on the G.P.'s list, plus another 2s. 6d. for those above 1,000. Payment would be made for 'out-of-hours' duties, vocational and postgraduate training, seniority, and for initial practice in a designated area.

The review was to last for two years. No general award was made in 1968, but in 1969, the Review Body\(^\text{113}\) made an award back-dated to January 1st, 1969, to last until April 1970. Compared with May 1966, the new scales gave consultants and intermediate grades of hospital staffs rather more than 8% and junior doctors 13\(\frac{1}{2}\)% at the bottom and 11\(\frac{1}{2}\)% at the top. For G.P.'s the increase was about 9%. The Economist commented

"A G.P. aged about 50 and accepting round the clock responsibility will now receive in practice allowances capitation fees and two seniority payments around £4,700 a year if he has an average list of practitioners. From this sum have to be subtracted those expenses (perhaps £1,500) which are not re-imbursed directly. To this sum should be added extra earnings from, say cervical smears, vaccination and night visits and earnings from private practice and local authority and hospital work. So a G.P.'s pay can compare favourably with that of a consultant whose scale will now run from £3,470 to £5,275.\(^\text{114}\)

In 1970 the Twelfth Kindersley Report\(^\text{115}\) broadly recommended


\(^{114}\) The Economist, February, 15, 1969, p 54.

a 30% increase for all doctors and dentists. The Government argued that part of this increase should be held up, because of the inflationary impact it might have on the economy by its effect on other professions. However they accepted that young doctors in training were poorly paid for the work they did, and accordingly they were to receive the full 30 per cent. Senior hospital doctors would have 15% of the award paid promptly, and general practitioners 20% (which included an increase in their expense allowance). The remaining proportion of the Kindersley recommendation, an amount of some £28 millions was to be considered by the Prices and Incomes Board.

The Review Body had no course but to resign at this challenge by the Government to their independent status. The B.M.A. did not have the full support of the profession in order to make the threat of resignation. It realised that it was futile to expect junior doctors not to pocket the 30% increase in pay or senior doctors and general practitioners to accept theirs on account. Action such as was taken was in the form of a refusal to co-operate in N.H.S. administration and in signing National Insurance Medical Certificates. However, with a general election and the establishment of a new Conservative Government measures were taken to set up a new Review Body under the chairmanship of Lord Halsbury. In the first Halsbury report, proposals were made for overall increases ranging up to 8%, with the exception that no increase was proposed for the training grades of hospital staff who received the full award of 30% in 1970. The B.M.A. accepted this as making good the

recommendations of the previous review body though pointed out that because the new award was back-dated only to April 1, 1971, "the profession other than the training grades had lost out substantially in respect to the period April 1970 to April 1971."  

By 1972 it is possible to take a look at the movement of doctors' remuneration between 1960-61 and April, 1971. During this period there were increases of 83 and 131 per cent in the average remuneration of hospital doctors and general medical practitioners respectively. The average increase for all doctors, weighted according to the numbers in each category was 106 per cent. The comparable general increase in salaries in the U.K. was 102 per cent. Clearly then doctors have improved on their 1960-61 situation. However, the area of improvement has been largely in general practice. Hospital doctors fell behind because of the serious deterioration in the position of the consultant.

In the following table which compares the movements in doctors' earnings between 1960-61 and 1972 it is clear that general medical practitioners and hospital house officers did comparatively better than other workers who had similar incomes. Registrars and Senior Registrars did comparatively worse than other workers in their income class, but within the profession their position too improved vis-a-vis the consultant group.

119. This table is based on that presented in the Review Body on Doctors' and Dentists' Remuneration Fourth Report, Cmnd 5644, 1974, Appendix A, p 35.
Table 1—Movements in doctors' and dentists' earnings compared with corresponding percentiles of April 1972 (Indices 1960-61 = 100)

<table>
<thead>
<tr>
<th></th>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Earnings</td>
<td>Corresponding</td>
<td>Sharesfall (−) or</td>
</tr>
<tr>
<td></td>
<td>April 1972</td>
<td>percentile</td>
<td>excess (+) of earnings</td>
</tr>
<tr>
<td></td>
<td>Amount</td>
<td>Percentile</td>
<td>April 1972</td>
</tr>
<tr>
<td></td>
<td>Index</td>
<td>Index</td>
<td>Revised</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>estimate</td>
</tr>
<tr>
<td>House officer</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>1,749</td>
<td>259</td>
<td>50th</td>
</tr>
<tr>
<td>(maximum)</td>
<td>2,625</td>
<td>245</td>
<td>50th</td>
</tr>
<tr>
<td>Senior house officer</td>
<td>2,380</td>
<td>207</td>
<td>25th</td>
</tr>
<tr>
<td>Registrar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>2,634</td>
<td>211</td>
<td>25th</td>
</tr>
<tr>
<td>Senior registrar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>3,120</td>
<td>205</td>
<td>10th</td>
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<tr>
<td>(4th point)</td>
<td>3,714</td>
<td>206</td>
<td>10th</td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>4,536</td>
<td>190</td>
<td>2-5th</td>
</tr>
<tr>
<td>(maximum)</td>
<td>7,350</td>
<td>188</td>
<td>1-5th</td>
</tr>
<tr>
<td>(with C award)</td>
<td>8,742</td>
<td>188</td>
<td>1st</td>
</tr>
<tr>
<td>General medical practi-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tioner (recommended)</td>
<td>5,575</td>
<td>249</td>
<td>5th</td>
</tr>
<tr>
<td>General dental practi-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tioner (target)</td>
<td>5,070</td>
<td>210</td>
<td>5th</td>
</tr>
<tr>
<td>All doctors (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All doctors and dentists (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Inland Revenue statistics, OME Survey, NES

Notes: (1) The latest estimate of actual earnings for 1972-73 is £5,510 for GMPs and £4,772 for GPs.
(2) The figures in columns (c) for these aggregate groups, relating to a time span of over 10 years, are subject to greater error than those for individual grades and should be treated with caution. They are not comparable with figures quoted in or derived from paragraphs 36 of our 1972 Report.
(3) Column (c) = Column (a) − Column (b), as percentage of Column (a).

In the 1970's a new consultant association has emerged in an attempt to protect the interests of their colleagues. Just like the Junior Hospital Doctors Association and the General Practitioners

120. At the same time as the National Health Service was established the Regional Hospital Consultants and Specialists Association was established. Primarily it was to look after the local needs of the regional hospital consultants. By 1969 it was felt that this association had let the terms and conditions of hospital consultants fall too far, and as such the R.H.C.S.A. was revitalised on a National basis. Membership at this time grew rapidly. In 1974 the teaching hospital consultants asked to join the R.H.C.S.A. and the name was changed to Hospital Consultants and Specialists Association.
Association they too hope to act as a "ginger group". They originally took the name of the Regional Consultants and Specialists Association - for after all, the plight of consultants in the regions, who are less blessed by private practice than the "princes" of Harley Street, must have seemed the more urgent. Today however they have appeared to drop the emphasis on the regions. They have grown to some 4,500 in number, and they have had some qualified success.

The following two tables show the movement in doctors'

Table 2—Movements in doctors' and dentists' earnings compared with corresponding NES percentiles between April 1972 and April 1973 (Indices: April 1972 = 100)

<table>
<thead>
<tr>
<th></th>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Earnings</td>
<td>Corresponding NES percentiles</td>
<td>Difference in earnings relative to percentile</td>
</tr>
<tr>
<td></td>
<td>April 1973</td>
<td>April 1973</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td>Amount</td>
<td>Index</td>
<td>Percentile</td>
</tr>
<tr>
<td>House officer (minimum)</td>
<td>£1,811</td>
<td>103</td>
<td>50th</td>
</tr>
<tr>
<td>House officer (maximum)</td>
<td>£2,208</td>
<td>103</td>
<td>50th</td>
</tr>
<tr>
<td>Senior house officer (minimum)</td>
<td>£2,475</td>
<td>109</td>
<td>25th</td>
</tr>
<tr>
<td>Senior house officer (maximum)</td>
<td>£2,850</td>
<td>108</td>
<td>25th</td>
</tr>
<tr>
<td>Registrar (minimum)</td>
<td>£3,368</td>
<td>108</td>
<td>10th</td>
</tr>
<tr>
<td>Registrar (highest)</td>
<td>£3,868</td>
<td>107</td>
<td>10th</td>
</tr>
<tr>
<td>Consultant (minimum)</td>
<td>£5,085</td>
<td>105</td>
<td>2-5th</td>
</tr>
<tr>
<td>Consultant (maximum)</td>
<td>£7,859</td>
<td>103</td>
<td>0-75th</td>
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<tr>
<td>Consultant (with C award)</td>
<td>£8,591</td>
<td>103</td>
<td>0-5th</td>
</tr>
<tr>
<td>General medical practitioner</td>
<td>£5,350</td>
<td>102</td>
<td>2nd</td>
</tr>
<tr>
<td>General dental practitioner</td>
<td>£5,157</td>
<td>102</td>
<td>2-5th</td>
</tr>
<tr>
<td>All doctors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All doctors and dentists</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source of data: NES

Notes: (1) Index based on 1972-73 recommended net remuneration of £5,575. For 1973-74 the contemporary estimate of net remuneration was £5,575 (for 1972-73) plus intended increase of £200. The latest estimate of actual earnings for 1973-74 is £6,100.

(2) Index based on 1972-73 target net remuneration of £5,050. For 1973-74 the contemporary estimate of net remuneration was £6,050 (for 1972-73) plus intended increase of £200 from the cash supplement. The latest estimate of actual earnings for 1973-74 is £6,070.

(3) Column (c) = Column (a) -- Column (b), as percentage of Column (a)

121. These tables are also based on those in the Review Body Report, Cmnd 5644, pp. 36-38.
earnings between April 1972, and April 1973, and between April 1973 and April 1974. During this period the remuneration of general medical practitioners has fallen below that of other workers in their class far more than has been the case for consultants. However consultants have hardly improved their position vis-a-vis the general medical practitioner.

Table 3—Movements in doctors' and dentists' earnings compared with corresponding NES percentiles at April 1974 (Indices: April 1973 = 100)

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
<th>Index</th>
<th>Percentile</th>
<th>(b) Corresponding NES percentile April 1974</th>
<th>(c) Difference in earnings relative to percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a)</td>
<td></td>
<td></td>
<td>Earnings April 1974</td>
<td>Index (estimated)</td>
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<tr>
<td>House officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>2,202</td>
<td>115</td>
<td>50th</td>
<td>108</td>
<td>+6</td>
</tr>
<tr>
<td>(maximum)</td>
<td>2,538</td>
<td>115</td>
<td>50th</td>
<td>108</td>
<td>+6</td>
</tr>
<tr>
<td>Senior house officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>2,823</td>
<td>114</td>
<td>25th</td>
<td>108</td>
<td>+5</td>
</tr>
<tr>
<td>Registrar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>3,198</td>
<td>112</td>
<td>25th</td>
<td>108</td>
<td>+4</td>
</tr>
<tr>
<td>Senior registrar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>3,711</td>
<td>110</td>
<td>10th</td>
<td>108</td>
<td>+2</td>
</tr>
<tr>
<td>(4th point)</td>
<td>4,311</td>
<td>109</td>
<td>10th</td>
<td>108</td>
<td>+1</td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(minimum)</td>
<td>5,433</td>
<td>107</td>
<td>25th</td>
<td>106</td>
<td>+1</td>
</tr>
<tr>
<td>(maximum)</td>
<td>7,917</td>
<td>105</td>
<td>0.75th</td>
<td>105</td>
<td>0</td>
</tr>
<tr>
<td>(with C award)</td>
<td>9,453</td>
<td>105</td>
<td>0.5th</td>
<td>103</td>
<td>+2</td>
</tr>
<tr>
<td>General medical prac-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>titioner</td>
<td>6,147</td>
<td>107</td>
<td>2nd</td>
<td>106</td>
<td>+1</td>
</tr>
<tr>
<td>General dental prac-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>titioner</td>
<td>5,455</td>
<td>106</td>
<td>2.5th</td>
<td>106</td>
<td>-0</td>
</tr>
<tr>
<td>All doctors and dentists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>-1</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>-1</strong></td>
</tr>
</tbody>
</table>

Source: OME

Notes: (1) Index based on estimated net remuneration for 1973-74 of £5,510 plus £240 (see footnote to Table 2). For 1974-75 the estimate of net remuneration is £5,550 (for 1973-74) plus intended increase of £377 less adjustment for expenses of £20. This excludes income from the possible introduction of general contraceptive services to NHS during 1974-75.

(2) Index based on estimated net remuneration for 1973-74 of £4,950 plus £207 (see footnote of previous table). For 1974-75 the estimate of net remuneration is £4,772 (for 1972-73) plus £33 (adjustment for reimbursement of additional expenses) and intended increases of £600 (consolidation of 1973 and 1974 increases to the fee scale).
Negotiations within the National Health Service have failed to establish the differential between different sections of the profession which is satisfactory to all sections within the profession. In the early years problems in the settlement of remuneration were characterised by the need to safeguard against inflation and to ensure similarity between other comparable income earners. The question of differential was left to be implicitly set. However, the need to present single claims on behalf of the whole profession to the Review Body, and the anamolies of the old "pool" system certainly brought the question of differentials out into the open. It was a problem which, as pointed out by the Review Body of 1965 was supported by a general envy of the g.p. within the N.H.S. for the status of the consultant. 122

In the early years of the N.H.S. the general practitioner had felt himself to be in the front line against the unleashed demand which a system of zero-pricing created for him. The consultant on the other hand was protected within his hospital. Each consultant was assisted by two full-time hospital medical practitioners, thirty-five full-time members of the nursing and midwifery staff, together with other technical and secretarial staff. 123 The g.p. however lacked assistants. Surveys found general practitioner surgeries to grossly inadequate. J. S. Collings at this time suggested that there was a "demoralization which can only accelerate the decline of


123. R. Stevens, op. cit., p 167.
general practice." Relations between consultants and g.p.'s were also poor on a professional basis. In a survey of letters from specialists to g.p.'s less than 40 per cent informed the g.p. that an operation was proposed.

In an attempt to declare themselves equal to the consultants and specialists the g.p.'s in 1952 founded the College of General Practitioners. Yet as Stevens points out, "Structurally, financially, and educationally however, the two branches were still unequal. The primary focus of the N.H.S. between 1949 and 1961 had, not unnaturally, been on the development of hospitals ...." The result was, as has been shown, that g.p.'s became more vocal in the 1960's. Of course the turning point came in 1965 with the implementation of a new charter for the general practitioner. It gave g.p.'s higher capitation fees, re-imbursement for most of the cost of ancillary help, and additional pay for night and week-end work, for continuing post-graduate in service education, for practising in under-doctored areas, and for seniority. Importantly, it also provided financial incentives to physicians to combine into groups and build their own premises. More health centres have been established to facilitate a new pattern of general practice in which teamwork is said to be the main characteristic.


125. R. Stevens, op. cit., p 165.

126. Ibid, p 168.

now work in groups and are supported by practice managers, medical secretaries, receptionists and filing clerks and they now work in specially built premises. Notably the total number of general practitioners, which had been falling for years, rose in 1969 and again in 1970, when for the first time in twelve years the average number of patients on the lists of general practitioners fell.\textsuperscript{128}

The point is that since the introduction of the N.H.S. the g.p. became more closely aware of his situation by comparison with the consultant. Both parties were subject to the same employer and relied on the B.M.A. to present their case. It is obvious that the general practitioner has of late done notably better than the consultant. It may be claimed that there is reason to believe that the B.M.A. would favour the g.p. because of the make-up of the membership of committees in the B.M.A.\textsuperscript{129} However there is even greater reason to note the influence of "ginger groups" on the B.M.A. The success of the g.p. came three years after the foundation of the G.P.A. Notably the success of the junior hospital doctor would show signs of materializing three years after the foundation of the J.H.D.A. The envy of the g.p. for the consultant has been explained. The dissension between the junior hospital doctor and the consultant ought to be noted.

\textsuperscript{128} Table 56 of the \textit{Annual Abstract of Statistics}, London, H.M.S.O., records a drop in general practitioners in Great Britain from 25,132 in 1962 to 24,005 in 1966, in 1968, however, there was a rise to 24,107 and by 1972 this figure was 25,184.

\textsuperscript{129} In comparing the leadership of the American Medical Association with that of the B.M.A., Eckstein, \textit{Pressure Group Politics}, op. cit., found that 93 per cent of the A.M.A. office-holders were specialists, while the relative specialist/general practitioner position was almost reversed in the case of the B.M.A.
(b) **Junior Hospital Doctors and Consultants.**

Junior hospital doctors may well have been pleased at the advent of the National Health Service. Prior to the introduction of the N.H.S. hospital junior staff received their board and lodgings and £50 per annum if they were fortunate; and it automatically followed that access to specialist status involved years of financial sacrifice. With the introduction of the N.H.S. there were considerable increases in salary and a career structure was imposed on the hospital service where none had existed before. However, the demands on work-load within the hospital led to a swelling of the middle ranks. The result was that such ranks worked long hours, had shorter time for training, spent more on routine work and had less prospect of achieving the higher consultant rank.

The Spens Committee of 1946 instituted a distinct career structure in National Health Service Hospitals. It envisaged a training ladder of about seven years. This would include one year as a "pre-registration" house officer in medicine and surgery before the doctor's name was admitted to the Medical Register; one further year in a training post as a senior house officer; next a junior registrar post for about two years (at the age of 26 or 27); and eventually a senior registrar or chief assistant for about three years before attaining consultant status. The development of the grade of Senior Hospital Medical Officer as a second junior specialist grade somewhat modified this ladder; and at the same

time the further tenure grade of Junior Hospital Medical Officer was added at about the registrar level. There was thus seven established hospital grades each with its own salary level.

The training ladder structure assumed that the individual would start at the bottom as a recruit and end at the top as a fully trained professional. He learned by doing; each grade giving him extra skills and extra responsibility. The internal balance of the system was thus important for its success. If there were more than one or two juniors (for example one house officer and one registrar) to each consultant or in each "firm" headed by two consultants, the individual tuition that was the essence of apprenticeship was weakened. It was also important that the structure should be so balanced that each promising junior would have a reasonable chance of moving up to the next grade and ultimately, if he wished, to a consultant post. Yet the balance between categories of medical staff was being subjected to service demands quite different from those of the training ladder. Specialization meant that the supporting grade of junior hospital staff were to grow and to be required to fulfill new and necessary technical procedures.

It was expected by young doctors that there would be room at the top for more who chose this training ladder. Initial experience suggested this would be so. In the first full year of the service (1949-50) the number of consultants in England and Wales rose by 9 per cent and in the first three years they rose by a fifth. 132 Even so, in pre-war terms, the ranks of the middle grades were

132. R. Stevens, op. cit., p 142.
becoming excessively swollen. Figures indicate that before the war there had been more consultants and specialists than other grades; after the war the situation was reversed. The regional hospital boards and the boards of governors had filled staff posts on the basis of immediate need rather than on the basis of the Spens training ladder.

In October, 1950, the Ministry of Health, in an atmosphere of financial retrenchment, endeavoured to impose central control. The J.H.M.O. grade was made a permanent one. The recommendation was made to discontinue the appointment of existing senior registrars in their third and subsequent years, termination of second and third year registrars, and an annual review of the performance of registrars and senior registrars in post. To the relief of the redundant registrars, the B.M.A. managed to persuade the Ministry to modify these proposals. In 1951 the registrar grade was re-designated as a staffing and not a training grade, and tenure of a senior registrar post was increased from three to four years in 1952. Concessions were also made in 1954 for retaining time-expired senior registrars on a year to year basis while looking for jobs. Yet while the concessions had relieved the misery for the registrars the problem of medical staffing remained. The build up in the middle grade continued:

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133. The controversy is well documented in Eckstein, Pressure Group Politics, op. cit., pp. 113-125.
The number of consultants was limited. Consultants themselves had two built in and long held disincentives to expand their rank. First, since hospital beds were a status symbol the incumbent was loath to share his allocation of beds with new appointees. Second, they feared a loss of private practice work. S.H.M.O.'s were entitled to private practice, but g.p.'s were more likely to refer patients to specialists of consultant status.

Despite the fact that there were too many registrars for the available consultant posts and that lower ranks were also far too swollen, regional boards were still desperate for doctors of these ranks. It was the case that more and more they were filled by over-seas doctors.

By 1958 a working party, chaired by Sir Robert Platt, was established to appraise the situation. In 1961 they reported in favour of the "firm" system of hospital staffing i.e. two consultants with adequate supporting staff taking responsibility

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134. R. Stevens, op. cit., p 147.

for some sixty to eighty patients together with emergency duties. Furthermore the committee confirmed the need for greater numbers of consultants. They also re-designated the S.H.M.O. to become a Medical Assistant in the hope that the changed name might improve his status.

The Platt report failed to do enough. Abel-Smith and Gales undertook research on doctor emigration. Amongst many other estimates, they suggested that for each year of the period from January 1955, to July 1962, an average of about 390 British born and trained doctors left Britain and did not return. The interesting feature of this study was that it also gave figures for the last position held in the N.H.S. by the doctors emigrating between 1955 and 1962. More than half of them were hospital doctors in the grade of registrar and below; 74% were senior registrars; only 12% were consultants. The authors' commented,

"The commonly held view that the majority of those going abroad are ex-general practitioners is untrue both in total and for doctors resident in each separate country. But unwillingness to enter general practice, or stay in general practice as it exists under the National Health Service, was nevertheless the most common complaint mentioned by those who responded to our postal questionnaire from Canada and Australia. We could well appreciate the reluctance to enter general practice of those who had spent

several years climbing the hierarchy which leads to consultant rank and saw or found no prospects ahead of them. It seemed to us understandable that they preferred to take their specialised skills to somewhere where they could use them rather than to enter the general field several years behind their contemporaries. This was a special problem in the nineteen fifties, which has been described and analysed elsewhere. It is not clear, however, that this problem has been finally resolved as the result of the recommendations of the Platt Committee.\textsuperscript{137}

Another study pursued this research to 1968. O. Gish found that Britain had lost permanently about 7,000 doctors through overseas emigration during the years 1952-68, and that the current annual net loss was about 400 per year.\textsuperscript{138} The major reason for this emigration was the lack of desirable promotion opportunities for those in the junior hospital grades. Evidence for this conclusion was to be found not only in anecdote and survey material but in statistical analysis of the age, occupation and career structure of the emigrants. What was found to be happening was that British doctors were emigrating from the upper end of a hospital training ladder which should have brought them a consultancy but didn't, while immigrant doctors were being funnelled onto the lower end of that same ladder along with the current output from British Medical

\textsuperscript{137} Ibid, p 57.

\textsuperscript{138} O. Gish, Doctor Migration and World Health, Occasional Papers on Social Administration No. 43, G. Bell & Sons, 1971.
Schools. The hospital/training/staffing pyramid had been shown to be too narrow at its upper end to accommodate all those trying to reach that point.

Emigration then had clearly demonstrated the dissatisfaction of junior hospital doctors. They further registered disillusionment with the activities of the B.M.A. when in October 1966, the Junior Hospital Doctors Association was formed. Soon after its formation it recruited a third of the total number of junior hospital doctors, i.e. some five and half thousand members. Its first aim was to try and secure proper representation for junior hospital doctors within the B.M.A. Their leaders were continually elected to the B.M.A.'s Hospital Junior Staffs Group Council, but their proposals for greater representation were not readily accepted by other consultants committees. In 1969 at an Annual Representative Meeting of the B.M.A. such proposals were rejected, and since this time the J.H.D.A. has taken a more independent line. It has attempted to bring publicity to the complaints of junior hospital doctors and has provided evidence in written form to the Review Body and other government committees.

Since the establishment of the J.H.D.A. as a "ginger group" to the B.M.A., there has been some action to deal with the problems of junior hospital doctors. In April 1968, the B.M.A. and the Health Departments produced a document which proposed the rapid expansion of the Medical Assistant grade. This however, was to be viewed as an attempt to get consultancy work done cheaply. After the J.H.D.A.'s press campaign and a petition to the Government, the B.M.A. at its Eastbourne A.R.M. set its own policy on its head and

139. Information kindly provided for me by the Junior Hospital Doctors Association.
asked for a moratorium of the grade. 140

The non-acceptance of this line of approach meant, of course, that the problem of medical staffing remained unsolved. The only answer was an expansion of the consultants grade. In 1971 a growth rate of this grade of about four per cent was proposed by the Department of Health. Training post grades were to increase only by 2\(\frac{1}{2}\) per cent. The aim is that balance between the two might be achieved over the following years. 141

Junior hospital doctors have also received improvements in their financial position. During the period that the J.H.D.A. worked within the B.M.A. a system of overtime payments for junior hospital doctors was instated. Since 1969, the Review Body has favoured remuneration for junior hospital doctors over and above other sections of the profession. The effect of this has already been noted in the discussion of the movement of doctors incomes since 1960-61. Between 1960-61 and 1972 they did almost as well as G.P.'s and considerably better than consultants in terms of improvements of incomes within the profession. Since 1972 they have improved their situation vis-a-vis G.P.'s. 142

2.4 The Future

In a discussion of the profession since 1950 it is clear that the main influence has been divisive. Sections within the profession

140. The B.M.J., noted:
"The main problem in the hospital career structure is seen to be imbalance, particularly severe in some specialities, between the numbers in training for consultant posts in this country and the opportunities for promotion to that level. This has long been a cause of dissatisfaction and the latest figures show that the position has been continuing to get worse."

141. The Economist, September, 4th 1971, pp. 24-25.

142. See Tables 1, 2 and 3, pages 93, 94 and 95.
have become pre-occupied with their own sectional interests and have often been jealous of the situation of the others. Distinctions within the profession have then been widened. The B.M.A. has pursued the unenviable task of trying to satisfy all sections. The appearance of "ginger groups" has been the ultimate outcome. The G.P.A. established in 1963 did much to bring about through the B.M.A. the considerable improvement in general practitioners conditions in 1966. The J.H.D.A. established in 1966 has certainly been seen to have had an effect on the lot of the junior hospital doctor by 1969. It is likely then that the Regional Hospital Consultants and Specialists Association established in 1970 will have some future success. Clearly the fall in the differential between consultant and general practitioner has of late been arrested, and the consultant hopes for better things to come from their new contract which is under negotiation.

The splits in the profession then have become more important of late. There can be little doubt that the formal tripartite structure of the N.H.S. has added to this. Local government, hospitals and general practice have been the three pillars on which the N.H.S. has been built and it has been argued that it has been to the detriment of the service that intercourse of ideas and personnel has been restricted between the three.\(^{143}\) On April 1, 1974, a change in the administration of the N.H.S. took place with a view to achieving a greater degree of unification.\(^{144}\) The existing


fifteen regional hospital boards, thirty-six boards of governors of teaching hospitals, three hundred and thirty hospital management committees and one hundred and seventy-five local health authorities disappeared. These hospital boards and committees together with the local health authorities and finally the executive councils of the g.p.'s formed the tripartite foundation of Bevan's N.H.S. They were replaced by ninety Area Health Authorities which in consultation with matching local authorities will be responsible to fourteen regional health authorities for the planning development and operational control of services that were formerly administered by up to a dozen or more separate local authorities, executive councils and hospital management committees. These A.H.A.'s are expected to delegate day to day operation of the service to two hundred and five district management teams. In terms of unification the intention is that the teaching hospitals will lose their independent board of governors. The local authorities will lose their personal health services, e.g. ambulance service, school health, maternity and child health services, and they will fall directly to the N.H.S. However the g.p.'s will concede nothing. Replacing their executive councils will be family practitioner committees with its own budget to administer g.p.'s contracts. These committees are part of the new administrative hierarchy but it is important to distinguish between administrative integration and effective managerial controls. The family practitioner committees will consist half of nominated lay members and half of representatives of the profession and because of this professional representation will be more autonomous than other N.H.S. authorities. While g.p.'s remain independent contractors the family practitioner committees will have little managerial authority over
them and as they inherit control over health centres from local authorities the bargaining strength of g.p.'s may have increased. The Guardian commented in August 1972,

"The doctors remain independent contractors unlike the hospital and community health service workers who are salaried employees. Any chance of closer monitoring of the doctors seems as remote as ever. Reformers who hoped for a monitoring scheme such as proposed by Professor Colin Dollery in "Challengers of Change" last year have underrated the power of the doctors in resisting any adequate system of scrutiny."¹⁴⁵

Attempts to unify the N.H.S. are hardly complete. However would such structural unity bind the dissensions in the medical profession? The old tripartite had hardly created these dissensions. The referral system distinguishing g.p. from consultant pre-dated the N.H.S., and the distinction will survive. As all sections of the profession are paid by the same body then envy and criticism of the B.M.A. for neglect will follow. This problem is one that the B.M.A. will not lightly shake off. In a similar vein Brown comments,

"But is is arguable how far administrative restructuring will in itself bring about positive improvements in inter-professional communication and co-ordination. Administrative barriers have not necessarily been a hinderance in the past. Administrative unification may not

alter ingrained attitudes nor expand limited
frames of reference in the future."  

The B.M.A. will not easily shake off the embarrassment of the
"ginger groups" in the future.

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Chapter 3

Factors affecting the Growth of Membership of the B.M.A.

In reviewing the history of the B.M.A. attention has already been drawn to factors which may have led to a growth of membership. Conditions in the mid-nineteenth century, e.g. good communications, political awareness of the middle classes, were favourable to the establishment of a national association, and it was suggested that the ensuing growth of homogeniety in the profession, the threat of state involvement in the medical market and the ability of leadership of the B.M.A. could play a part in explaining the heights attained in B.M.A. membership. If doctors be viewed as consumers of the B.M.A. then already we can identify certain of the variables which should enter their demand function.

In this chapter it is intended to list the factors that enter the demand function of doctors, and to examine whether or not they are likely to be important. The following demand function may be offered for analysis.

\[ D_{B.M.A.} = F(Y, T, G, R, W, A, P) \]

- \( D_{B.M.A.} \) = demand for B.M.A. membership
- \( Y \) = the level of doctors' income
- \( T \) = the existence of a collective threat to the profession
- \( G \) = the growth of homogeneity in the work force
- \( R \) = recognition of the B.M.A. as the spokesman of the profession as a whole
- \( W \) = changes in work environment, e.g. the degree of bureaucratization
- \( A \) = advertising and recruiting campagins on the part of the B.M.A.
- \( P \) = the subscription rate for membership of the B.M.A.
By tentatively looking at changes in these variables against changes in B.M.A. membership it is hoped to give some impression as to their relative importance. Obviously proxies will have to be employed for certain of the variables. For example, for the growth of homogeneity in the work force one can look to the extent to which recruitment to the profession has been concentrated from the middle class. For the existence of a collective threat one can look to changes in the real incomes of doctors and/or extensions of government activity in the medical market. Though for some of the variables data may be too weak to substantiate a precise measure of their importance, it may still be possible to draw some conclusions on their relative importance.

To begin this analysis it is desirable to have some impression as to exactly how membership has changed, both in absolute and relative terms over time. The following graph presents time series data of the growth of membership of the B.M.A. It has been general to accept the total number on the Medical Register as the representative figure for the medical profession. As such, it is possible to trace since 1875 the percentage of doctors who were members of the B.M.A. In this way therefore, account can be taken of the obvious influence on growth of members of the B.M.A., i.e. the growth of the profession.

The time series data is most useful between 1875 and the late 1950's. Both B.M.A. membership figures and numbers on the Medical Register contain the names of doctors working outside the U.K.

The graph then, aggregates the proportion of members in the U.K. with

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1. This for example, was employed by Harry Eckstein, *Pressure Group Politics*, op. cit., p 45, and G. Forsythe, *Doctors and State Medicine*, op. cit., p 8.

2. Statistics for the number enrolled on the Medical Register are available from 1875.
Figure 1.
Membership of the B.M.A., 1832-1973

No. on the Medical Register

% of total doctors

Membership of B.M.A.

Thousand

1833 1850 1900 1950 1973

(Source - B.M.J.'s and General Medical Registers)
the proportion of members overseas who are on the Medical Register. Changes in the graph are generally dictated by changes in the former proportion i.e. of members in the U.K. In the 1960's however there is a sharp drop in membership, caused mainly by the establishment of independent associations in Australia and New Zealand and the subsequent disbandment of the B.M.A. branches here. During this period therefore, the proportion of membership at home would not have fallen as substantially as indicated in the graph. For this period supplementary data will be called upon, when reference is made to the way in which home membership changed.

3.1 Doctors' Incomes.

An examination of doctors' incomes and B.M.A. membership might easily lead to two lines of reasoning. Firstly, that membership of the B.M.A. may increase as income rises. The real cost of membership may be falling in such periods and also individuals may acredit the association for the prosperity of the profession. Indeed such an argument has often been part and parcel of the proposition that American trade unions grew during periods of prosperity in the business cycles of the U.S. However, there is a


4. Except when the B.M.A. publishes data it is impossible to measure with any accuracy only the proportion of members in the U.K. As such, the graph until the 1960's is the best indicator of changes in this proportion.

5. L. Wolman, Ebb and Flow in Trade Unionism, National Bureau of Economic Research, New York, 1936, links the prosperous period of business cycles with growth of unions. However, he admitted that his analysis failed to work during the 1920's as "the very prosperity of the period and the generally high standards of wages and employment acted, apparently, in most classes of industry to retard rather than to accelerate the pace of union growth."
second form of argument which describes falls in the level of real income as the stimulus to association membership. Essentially the reasoning is that it is a feeling of grievance on the part of individuals which leads them to join associations. It will be interesting to test both of these hypothesis with reference to the B.M.A.

If attention is focused on the changes in percentage membership of the B.M.A. it can be seen that they correlate quite well with the existence of threats to doctors' income and working conditions. The period 1875 to 1890 was clearly a high growth period, with percentage membership increasing from 27.53 per cent to 46.8 per cent. The rate of growth was considerably faster than in the following fifteen years when membership density rose from 46.8 per cent to 50.7 per cent. Looking back at the history of the B.M.A. it is clear that between 1875 and 1900 doctors experienced grievances as a result of their treatment under the Poor Law, in the Armed Forces, in public health, from competition by quacks, and from the Friendly Societies and medical clubs. It has been argued however that the late 1880's marked a watershed in the history of the B.M.A. In all cases, except the Friendly Societies and medical clubs, notable improvement had by this time been accomplished. Though grievances were expressed against the medical institutions the B.M.A. had done a great deal to improve the conditions of the profession.

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The growth of membership in the early 1900's slowed down and indeed in 1908 it fell. However in 1910 it grew again at a rate faster than ever before. This obviously could be interpreted as a reaction to the announcement of Lloyd George's National Health Insurance Bill. In 1912 proportionate membership stood at 64.11 per cent. It has been argued that the doctors realized that the Bill as finally implemented made them better off, not worse off as anticipated. It should therefore be no surprise that membership in the early years of the scheme declined. By 1918 45.5 per cent were members.

If one was looking for the cause of the next rise in percentage membership one might again search for a collective threat. Indeed in 1918 the B.M.A. was arguing the need for a capitation fee of thirteen shillings and six-pence. The government at this time strongly opposed and offered only eleven shillings. The arbitrators of the award in 1920 only gave eleven shillings. However, by the end of 1921 the government was proposing a reduction in remuneration to a fee of nine shillings and six-pence. The profession accepted the cut in the capitation fee in the interests of the need for national economy, but by 1924 the government proposed a further reduction of either eight shillings and six-pence for a period of three years or eight shillings for a period of five years. Agreement could not be reached and after a threat of mass withdrawal of doctors' services the matter was referred to a court of inquiry which finally fixed a fee of nine shillings. This controversy clearly reflects the profession's fears of the monopsonistic powers of the government. It explains why by 1930 the B.M.A.'s membership had risen once more to 64.5 per cent.
In the early 1930's the density of membership of the B.M.A. once again fell. This appears strange in view of the fact that in 1931 the government had cut remuneration again by 10 per cent. However it must be noted that in 1934 this cut was reduced to 5 per cent and by 1935 the full rate was restored. Furthermore doctors were beginning to enjoy the increasing value of the pound (e.g. fixed income groups were 50 per cent better off in real terms throughout the 1930's than in, for example, 1920). While most general practitioners were not well-to-do they were comfortably situated with a net average income in 1936-38 of about £1,000. Indeed the B.M.J., in 1939 suggested that conditions in the National Health Insurance scheme were such as to induce a "better class of man" to enter general practice. In the light of this evidence it would appear that the 1930's gave doctors somewhat less cause for concern and appropriately membership fell off.

The remarkable rise of percentage membership in the 1940's must obviously be related to the prospect of the introduction of the National Health Service after the War. The government was proposing to take responsibility for 95% of the medical market, and this was to effect hospital doctors as well as general practitioners. If anxiety characterised the profession in 1911 then in 1944 one could safely describe a state of panic as proposals from the Brown Plan.

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8. R. Stevens, op. cit., p 57.
were leaked. Membership reached an unprecedented 80 per cent of the profession, and interestingly it did not fall off, but continued increasing after the negotiations. Two explanations might be offered for this. Firstly, the B.M.A. did not appear humiliated at the end of the struggle, but rather bowed gracefully to the inevitable. On May 20th 1948, and before the inception of the N.H.S. in July, the B.M.A. Council led by Dr. Guy Dain took note of the 1913 collapse and resolved to accept the N.H.S. Secondly and perhaps of more importance, conditions of remuneration were not fully settled on entry into the N.H.S. The reports of the Spens Committees settled the net incomes of doctors in 1939 values. It would await the Dankwerts Adjudication of 1952 for the "betterment factor" to be settled and for incomes to be settled in post-war values.

In examining the 1950's the B.M.A. has published figures showing membership as a percentage of the total working profession in the U.K. These have been set out in the following Table (Table 4). They clearly indicate a fall in density of membership after the favourable Dankwerts Adjudication. Incidentally they also indicate that when doctors retire they feel less threatened and leave the B.M.A.

Membership density has not fallen very quickly in the 1950's and this period was one when all professions were finding it difficult to maintain their relative income position vis-a-vis salary earners. The medical profession as a whole found the Dankwert's award eroded by inflation. By 1959, for example, G.P.'s average earnings had increased by 9% but prices had risen by one-third, so reducing the real value of incomes by above 20%.

Table 4

<table>
<thead>
<tr>
<th>Year</th>
<th>Membership as a % of the total profession in the U.K.</th>
<th>Membership as a % of the working profession in the U.K.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1946</td>
<td>N.A.</td>
<td>75 (approx.)</td>
</tr>
<tr>
<td>1947</td>
<td>75</td>
<td>77.5</td>
</tr>
<tr>
<td>1948</td>
<td>76</td>
<td>78.7</td>
</tr>
<tr>
<td>1949</td>
<td>76</td>
<td>78.0</td>
</tr>
<tr>
<td>1950</td>
<td>77</td>
<td>85.0</td>
</tr>
<tr>
<td>1951</td>
<td>76.6</td>
<td>85.0</td>
</tr>
<tr>
<td>1952</td>
<td>74.0</td>
<td>84.0</td>
</tr>
<tr>
<td>1953</td>
<td>72.0</td>
<td>81.0</td>
</tr>
<tr>
<td>1954</td>
<td>71.0</td>
<td>80.0</td>
</tr>
<tr>
<td>1955</td>
<td>71.0</td>
<td>80.0</td>
</tr>
<tr>
<td>1956</td>
<td>71.0</td>
<td>80.0</td>
</tr>
<tr>
<td>1957</td>
<td>70.3</td>
<td>79.2</td>
</tr>
<tr>
<td>1958</td>
<td>70.2</td>
<td>79.0</td>
</tr>
<tr>
<td>1959</td>
<td>70.5</td>
<td>79.3</td>
</tr>
<tr>
<td>1960</td>
<td>70.9</td>
<td>n.a.</td>
</tr>
<tr>
<td>1961</td>
<td>71.2</td>
<td>n.a.</td>
</tr>
<tr>
<td>1962</td>
<td>71.0</td>
<td>n.a.</td>
</tr>
<tr>
<td>1963</td>
<td>70.8</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

Source: British Medical Journals.
During this period the community's standard of living, in terms of G.N.P. per head at constant factors cost rose by 22 per cent. Professor Lees commented, "In short, the standard of living of G.P.'s went down by a fifth while that of the community in general went up by about as much." John and Sylvia Jewkes refers to the efforts in the 1950's to keep down the costs of a virtually zero-priced service as leading to delays in increasing the remuneration of doctors as the cost of living rose. Doctors insisted that the Spens Reports promised them money incomes that would keep pace with changes in the cost of living and according to the B.M.J. in 1958, "Doctors are united in considering that the Government, by its apparent repudiation of the Spens Reports, has broken faith with the profession." Even so in 1956 general practitioners with the average number of patients (but with no other source of income) were in the highest 2.4 per cent of British income receivers. Those with the maximum of 3,500 patients were in the highest 1.4 per cent, as were also all full-time consultants of at least three years standing. Sixty seven per cent of doctors answered a Gallup Poll question in June 1956 that if they had the chance to vote again in favour of starting the N.H.S. they would vote in the affirmative. Clearly then there was discontent at the failure of remuneration to match inflation, but doctors were not bitter about the N.H.S.


Hence therefore the conclusion that B.M.A. membership would fall very slowly.

The Royal Commission's Report in 1960 did much to redress the grievances of the profession. Between 1960-61 and April 1971 it was claimed that there were increases of 83 and 131 per cent in the average remuneration of Hospital Doctors and G.P.'s respectively. The average increase for all, weighted according to the numbers in each category, was 106 per cent. As compared with an increase in salaries during the same period of 102 per cent. Nevertheless there has been a crisis during the 1960's and 1970's in terms of attaining the appropriate differentials between sections of the profession.

It would follow from the hypothesis which we are pursuing that the grievances felt by such sections would lead to the formation of sectional associations and this of course is precisely what has happened, e.g. the G.P.A., J.H.D.A. and R.H.C.S.A. have been established. Indeed many doctors are both members of the B.M.A. and also one of these sectional associations, e.g. out of 2,114 replies to a questionnaire issued by the Regional Hospitals' Consultants and Specialists Association 1,427 answered that they were also members of the B.M.A. The percentage membership of the B.M.A. in the U.K. has dropped to 68% of the total profession. This is not a violent fall. If the nature of the problem faced by the profession


during the 1960s had been different it would clearly not have been so great. That is to say that if doctors felt the grievance to the profession as a whole and not solely to a section of the profession it is quite likely that those members of the G.P.A., J.H.D.A. and R.H.C.S.A. who are not members of the B.M.A. would instead have become members of the B.M.A.

In this way then, the rises and falls in proportionate membership of the B.M.A. can be correlated respectively with periods in which the doctor had reason to fear and with those in which he need not be concerned about the monopsony power of the N.H.S.

Clearly, however, over the period as a whole proportionate membership has increased and the economic position of the doctor is markedly better. The following table shows that between 1913/14 and 1955/6 doctors have notably improved their standing as compared with barristers and solicitors.\(^\text{20}\) Figures for barristers and solicitors in 1960 are not given, but if they were granted 32 per cent which was the weighted average for the others their earnings in 1960 would be 531 and 459 per cent respectively of 1913/14. The cost of living index stood at about 425 in 1960 with 1913/14 = 100 so that clearly general practitioners had improved their standard of living.

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"At the beginning of the twentieth century the position of many general practitioners was professionally vulnerable and financially precarious. The myth of a golden age of medical practice, which contrasts the high social prestige and economic status of the doctor in his heyday as an independent professional man with his fallen state as an N.H.S. employee, tends to apply to the many what in fact was true only of the few. Certainly in economic terms, the position of the average doctor has improved - both relatively to other professions and absolutely - as the State has taken increasing responsibility for the provision of the health services."
### Table 5

Average professional earnings (occupational class 1A), 1913/14, 1922/4, 1935/7, 1955/6 and 1960.

<table>
<thead>
<tr>
<th></th>
<th>1913/14</th>
<th>1922/4</th>
<th>1935/7</th>
<th>1955/6</th>
<th>1960</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>% of 1913/14</td>
<td>£</td>
<td>% of 1922/4</td>
<td>£</td>
</tr>
<tr>
<td>Barristers</td>
<td>478</td>
<td>235</td>
<td>(1,090)</td>
<td>(97)</td>
<td>2,032</td>
</tr>
<tr>
<td>Solicitors</td>
<td>568</td>
<td>193</td>
<td>(1,238)</td>
<td>(113)</td>
<td>2,086</td>
</tr>
<tr>
<td>Dentists</td>
<td>368</td>
<td>163</td>
<td>676</td>
<td>112</td>
<td>2,273</td>
</tr>
<tr>
<td>General practitioners</td>
<td>395</td>
<td>191</td>
<td>1,094</td>
<td>145</td>
<td>2,102</td>
</tr>
<tr>
<td>Clergy</td>
<td>206</td>
<td>161</td>
<td>370</td>
<td>111</td>
<td>(582)</td>
</tr>
<tr>
<td>Army officers</td>
<td>170</td>
<td>229</td>
<td>205</td>
<td>53</td>
<td>695</td>
</tr>
<tr>
<td>Engineers</td>
<td>292</td>
<td>160</td>
<td>..</td>
<td>..</td>
<td>1,497</td>
</tr>
<tr>
<td>Chemists</td>
<td>314</td>
<td>177</td>
<td>512</td>
<td>92</td>
<td>1,373</td>
</tr>
</tbody>
</table>
Accepting the comparison of 1960 with 1970, which has already been referred to, it is evident that doctors have maintained this upward trend in their standard of living.\textsuperscript{21}

The comparison with the law profession is particularly interesting. In the U.S.A. doctors were thought to be the benefactors of the strong monopolistic position of the American Medical Association.\textsuperscript{22} However doctors' median income was below those of lawyers, certified public accountants and consulting engineering.\textsuperscript{23} In the U.K. the median income of doctors in the N.H.S. between the ages of 30 and 65 was above those of barristers, solicitors, accountants, actuaries, architects, surveyors and engineers.\textsuperscript{24}

If the standard of living of doctors has risen during the history of the B.M.A. another change is that the differential remuneration between doctors has been falling. In chapter two the differential between consultant and g.p. was seen to narrow. However this is merely a continuing episode of a rather longer process; as indicated in the following table.\textsuperscript{25}


\textsuperscript{24} Royal Commission on Doctors' and Dentists' Remuneration, Cmnd. 939, 1960, London H.M.S.O.

\textsuperscript{25} G. Routh, \textit{Occupation and Pay in Great Britain 1906-60}, op. cit., p 63.
Table 5a.

Professional earnings 1913/14, 1922/3 and 1955/6.

<table>
<thead>
<tr>
<th>Lower quartile as per cent of upper quartile</th>
<th>Median as per cent of highest decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>1913/14 1922/3 1955/6</td>
<td>1913/14 1922/3 1955/6</td>
</tr>
<tr>
<td>Doctors</td>
<td></td>
</tr>
<tr>
<td>28 38 63</td>
<td>31 41 65</td>
</tr>
</tbody>
</table>

It would be fair to argue then that during the growth of the B.M.A., doctors have improved their standard of living and doctors' earnings have become less dispersed. Both these changes may have had an effect on the doctors' propensity to join the B.M.A. However, whilst this is so, there is also no question that changes in the membership of the B.M.A. are related closely to falls in real income or to a fear of an attack on real income as a result of a growth of State monopsonistic power. Doctors' membership of the B.M.A. shows a decided upward trend during such periods. 26

26. Many scholars, e.g. B. C. Roberts, Trade Unions in a Free Society, (2nd ed., London Institute of Economic Affairs 1962) and E. M. Kassalow, "White-Collar Unionism in Western Europe", Monthly Labor Review LXXXVI, 1963, argue that a similar effect, represented by the narrowing of the White-Collar to Manual earnings differential, has been a major factor encouraging white-collar workers to join trade unions.
3. 2 Group Cohesion - The Social Background of Doctors.

The extension of state medicine may well have made doctors aware of a collective threat, and via a homeostatic mechanism, it is argued that doctors would join the B.M.A. Yet the feeling of collective solidarity may well run much deeper in the profession than just a willingness to protect their collective position. The professionalization of medicine, and the rising status it henceforth enjoyed, have drawn within the profession individuals from a quite narrow spectrum of society. If collective identity is then an important variable in and of itself, it is possible to estimate the degree to which this has taken place by using the index of the rising homogeneity in social background of recruits to the medical profession. 27

In the era prior to the medical acts of 1858 and 1886 doctors emerged from all spectrums of society. Those in the higher classes adopted the position of physician, while the "less well-bred" might entertain the prospect of becoming a surgeon. Even the members of the lower classes of the social strata might, through apprenticeship to an apothecary, have learned something of the art of medicine and later set up practice. Merskey has commented:

"The period in question was a seminal one in English, if not in British Medicine. The basic professional structure, established for more than

a century, was changed as a result of many different influences. These included economic and social upheavals, the aftermath of the French Revolution and Napoleonic wars, the rapid growth of the population increases in the size of cities, the spread of commerce and, equally with all the rest the development of scientific knowledge. Medicine was a profession in which an able youth could cross social barriers. It attracted extracts from a large range of social classes - from the respectable poor youth who went as an apothecary's apprentice, to the graduate of Oxford or Cambridge from a relatively affluent family - and in the midst a world in social and intellectual ferment, it underwent vigorous although often bitter developments."

With the success of the medical reform movement led by the B.M.A. this tendency of social integration within medicine was to end. The requirement of qualifications, dependent on success in examination, and the increasing length of the curriculum proceeding the examination, was to permit only the more affluent classes to consider medicine. The fact that the status of the medical practitioner was rising with the increasing middle class as patrons, meant that the sons of the middle classes felt the long training worthwhile. There remained in the 1880's only one practical means of entry into the profession for the poorer classes. This relied

upon the system of "covering". Qualified practitioners would build up large practices by supervising unqualified practitioners. The unqualified might then learn something of medicine at very little cost while still receiving a small income. Eventually they would attend for examination at the medical colleges of London. Yet this avenue was closed in 1891 when the General Medical Council declared all medical practitioners guilty of unprofessional conduct if they engaged in "covering." There may of course have been evils in the system to the extent that individuals might be treated by unqualified practitioners if they did not or could not choose otherwise. Yet many an eminent doctor entered the profession this way e.g. Alfred Cox, the medical Secretary of the B.M.A.29 Also one cannot help thinking that the system was more harmful for those practitioners already qualified. In the first instance it increased the supply of practitioners, and secondly it heightened the competitive spirit within the profession by the tendency for some g.p.'s to build up extensive practices.

The restriction of entry to the profession from the lower classes meant that in 1944 it was estimated that 80% of the population (the manual, lower clerical and distributive workers) were contributing only about 5% of the Nation's doctors.30 The fact that the State now heavily subsidizes the costs of a much more expensive medical training does not appear to have made a great deal of difference. In 1954 a London medical student paid at most about 19%
of the cost of medical training.\textsuperscript{31} Yet a report in 1955-6 showed that the proportion of students admitted whose fathers were manual workers was lower in medicine than any other faculty. For Oxford, this percentage in medicine was 5\%, at Cambridge 6\%, London 13\% and for all Universities 15\%.\textsuperscript{32}

If there was to be a trend towards taking slightly more recruits from the lower classes this has recently been sharply reversed. In 1961, 68.9\% per cent of final year medical students were drawn from the Registrar General's Social classes one and two while only 31.1\% per cent were drawn from combined classes three, four and five. Social classes one and two make up only 18.3\% per cent of the total while classes three, four and five make up 81.7\% per cent. In the succeeding five years 1962-1966, the balance in intake altered. Of first year medical students entering in 1966, the proportion drawn from classes one and two had risen to 74.7\% per cent, while social classes three, four and five had fallen to 24.2\% per cent of the intake.\textsuperscript{33}

\begin{thebibliography}{9}
\bibitem{31} Ibid, p 163. An opinion survey among Scottish Medical graduates undertaken in 1955, by Professor A. Mair found that the cost of Medical training 'was not considered a deterrent by the majority of Students', \textit{B.M.J.}, (1955) Vol. 1 p 532. The Joint Consultants Committee in giving evidence to the Royal Commission on Doctors and Dentists' Remuneration in December 1957, stated that nearly 70 per cent of Medical students now receive grants from public funds (\textit{B.M.J.}, 1958, Supp. 1 p 6).


\end{thebibliography}
Recruitment has therefore been selected from a particular social background even since the introduction of State subsidization to students; and any movement away from this has been sharply altered. The degree of selectivity in the medical profession is more fully appreciated when it is realized that the Robbins Committee found 59 per cent of all undergraduates in universities drawn from classes one and two in that year, and this compared with 73 per cent in medical schools. The desire to draw students from the homes of higher social classes seems to be a tradition that has survived the introduction of the grants system. The Royal College of Surgeons suggested for example, "There has always been a nucleus in medical schools of students from cultural homes ... This nucleus has been responsible for the continued high social prestige of the profession as a learned profession. Medicine would lose immeasurably if the proportion of such students in the future were to be reduced in favour of precocious children who qualify for subsidies from the local authorities and the State purely on examination results."  

In comparing successful with unsuccessful applicants, Table 1 shows that proportionately fewer applicants from social classes three, four and five are accepted and more rejected, than applicants from social classes one and two. The argument that there were academic standards for such a policy is without foundation, those

34. P. Elliot, op. cit., p 68.
35. Quoted in P. Elliot, op. cit., p 68.
from lower class backgrounds having a consistently superior academic performance at medical school in contrast to their colleagues from the upper social classes. Other explanations were sought, e.g. the nature of the school at which pre-college education was taken featured prominently in the differential policy of selection; 78.3 per cent of those applying for entry to medical school from state-financed school were rejected, while only 20.5 per cent of those applying from the various forms of privately financed schools were similarly treated. 36

Table 6. 37
Distribution by Social Class of unsuccessful and successful applicants to medical school.

<table>
<thead>
<tr>
<th>Social Classes</th>
<th>1 and 2</th>
<th>3,4 and 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Average of medical students entering in 1961 and 1965</td>
<td>72.7</td>
<td>27.3</td>
</tr>
<tr>
<td>Unsuccessful applicants</td>
<td>66.4</td>
<td>30.1</td>
</tr>
<tr>
<td>General population</td>
<td>18.3</td>
<td>81.7</td>
</tr>
</tbody>
</table>

There seems therefore, to have been a trend during the history of the B.M.A. to recruit doctors from a very similar social background. Indeed this trend has been supplemented by a significant rise in the percentage of the profession that have been self-recruited, i.e. that were themselves the sons of doctors. Kelsall has traced the growth of this phenomena and compared it with that of other profession. The following table summarizes his findings in these

36. J. Robson, op. cit., p 414
37. Ibid, p 414.
Table 7

The Percentage of all Students or Graduates having Fathers in certain Professions, who chose the same Professions as their Fathers.

| University          | Teaching Sons Children | Medicine Sons Children | Church Sons Children | Law Sons Children | All 4 professions Sons Children |
|---------------------|-------------------------|------------------------|----------------------|------------------|---------------------------------
| Cambridge 1850-99   | 20                      | 29                     | 55                   | 33               | 43                              |
| Cambridge 1937 & 1938 | 36                      | 56                     | 33                   | 48               | 44                              |
| Aberdeen 1901-25    | 34                      | 50                     | 84                   | 76               | 44 42                           |
| Glasgow 1926-35     | 37                      | 69                     | 82                   | 68               | 52 58                           |
| 'A Scottish University' 1947-8 | 30                      | 36                     | 57                   | 50               | 37 33                           |
respects, to the extent that the medical school, for which figures applied, was typical of the period, then it is fair to make certain comparisons. Firstly taking the data for Cambridge it is clear that self-recruitment in medicine accelerated sharply between the 1850's and the late 1930's. Self-recruitment in Scotland seems to have been considerably higher so that while it was reduced in the 1940's it still remained considerable. Clearly one factor which may explain the rise in self-recruitment between 1850 and the late 1930's in the case of medicine was the ability to hand on a practice to a son, or to take him into partnership.

In a survey conducted for the academic year 1955-56, it was recorded that 17 per cent of all medical students were the sons of doctors. However the decline may well be more than arrested.

Research conducted for the Royal Commission on Medical Education 1965-68 showed by 1966 that just over one-fifth of medical students had medical fathers. There was a slight trend towards an increase in the rate of self-recruitment between the first year students and those about to qualify.

The entrants to the profession have then been highly selected.

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Women it is argued have been purposely desriminated against. Quotas of women students have been employed by medical schools and they were condemned by the Todd Commission on medical Education, which found it iniquitous that a higher standard was consistently expected of women applications to medical schools. Assurances have recently been made that such quotas will be phased out at an early date, but scepticism remains.

Yet if entry is so restricted, an even greater degree of common identity is imposed on the entrants during their education. It is the view of Hill that the

"Aim and object of medical education is to educate a student to become a member of the profession of medicine rather than a mere scientist or technologist."

The comparative isolation which a medical student experiences for some six years fosters a social dependence on and identity with the dominant professional ideology. Throughout training a knowledge of

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42. Report of the Royal Commission on Medical Education, op. cit.,


the ethics and values of the profession are imbibed by the student. The profession has recommended the maintenance of the isolation of the student. The recommendations of the Royal Commission on Medical Education for closer integration of the medical schools with the mainstream of academic life in the universities were opposed by many teaching hospitals. 

The profession then does appear to possess a common identity. The B.M.A. grew up in a tradition of passing on practices from father to son. Indeed the B.M.A., and membership of it, has become a traditional part of the profession.

3.3 Recognition by the Ministry of Health.

In analysing membership increases in white collar unions G. S. Bain has ascribed great importance to the attitude of employers. Three lines of reasoning were used to relate union growth to union recognition by employers. The first of these was the belief that white collar workers identify with management and

45. J. Robson, op. cit., p 415
46. T. Johnson, "The Professions", op. cit., pp. 127-128 comments that the high development of colleagueship within the professions "leaves the layman with the feeling of a Kafkaesque hero; helpless in the face of professional silence, solidarity and ritual. George Bernard Shaw expressed this feeling well when he wrote in The Doctor's Dilemma: 'All professions are conspiris against the laity.'

Indeed the measure of solidarity within the profession in terms of similarity of class background is probably an inadequate index. There is of course some kind of espirit de corps within the profession. D. S. Lees, The Economic Consequences of the Profession, op. cit., p 31 refers to the difficulty, for example, for a plaintiff to get a doctor to testify against the defendant in cases of medical negligence.

will reject what management rejects. The second was the suggestion that membership of an unrecognized union may become a barrier to promotion. Thirdly was the argument that recognition by management of unions will make unions more able to achieve their aims vis-a-vis remuneration and job regulation. Hence the hypothesis is that without recognition, not only are a large number of employees not likely to join the union, but many of those who have already done so are likely to let their membership lapse because the return they are getting on it is insufficient.

In looking to the medical profession it seems hardly likely that the first two lines of argument are applicable. In the first instance doctors have shown in the negotiations proceeding the N.H.I. and N.H.S. a distrust of lay interference in their work. Most certainly then they do not identify with the lay administrators or managers and if anything resent their potential interference. Secondly, whilst B.M.A. members and officials do hold positions on committees within the N.H.S., there was a unanimous feeling expressed in my interviews with doctors that advancement was not dependent on membership of the B.M.A. Nevertheless the third line of reasoning suggested by Bain may have relevance to the medical profession. There is within the literature on medical politics a seminal work whose thesis is that the B.M.A. shares a unique and "intimate" partnership with the Department of Health in the administration of the National Health Service, and that, when allowed to flourish without outside interference, this relationship assists the B.M.A. in achieving its aims.

48. These interviews followed a questionnaire survey of doctors in the Leicestershire and Rutland area, the details of which are more fully described in chapter five.

49. H. Eckstein, Pressure Group Politics, op. cit.
is, it is argued, directly related to the degree to which this relationship between the B.M.A. and the Department of Health holds.

H. Eckstein surveyed the relationship between the B.M.A. and the Ministry of Health in the early years of the National Health Service. He describes such relations as strikingly close and friendly. An 'old boy network' was said to exist between the officials in the Ministry, (now the Department of Health and Social Security) and their opposite numbers in the B.M.A. The officials of the B.M.A. referred to Ministry officials as 'our colleagues', and were generally on first name terms. Indeed a breakdown of this relationship would harm both parties. The Ministry administrated the conditions of medical practice and it was vital that the association did not risk antagonizing it beyond safe limits if it was to maintain the claim to represent the profession monolithically. Furthermore the Ministry was and still is necessary to the B.M.A. as its advocate before other government departments and at the level of the Cabinet, particularly on questions of expenditure. Yet on the other hand close relations with the Association is also important to the Ministry. They are important as a source of technical information, as a channel through which to educate and reconcile practitioners, and not least, because the support of the Association is one of the few power factors which the Ministry can exert in inter-departmental disputes or under political fire.

Eckstein then emphasises this relationship as an essential one to the B.M.A. In assessing its political strength and weaknesses he comments, "On the positive side are, above all, its pre-eminent position in the corporate structure of the medical profession and
its intimate relations with the Ministry ....."50 Yet Eckstein seems unaware of the fact that this mutual dependence between the Ministry and the Association can be traced back long before the National Health Service. Referring to the introduction of the National Health Insurance Dr. Alfred Cox, a former Medical Secretary of the B.M.A. commented

"If the controllers of the National Health Insurance Commission had been small-minded people they would have treated the Association as a defeated and discredited body and would have encouraged attempts which were made to side-track it in dealing with Insurance affairs. But Morant and Whitaker were statesmen and recognized that it was in their interest to deal with an established organization which they believed had learned by experience. Morant told me later that he believed that an old-established body interested in every aspect of medicine, would carry more weight than any ad hoc body, and he thought it his duty as well as his interest to help us to restore our self-confidence, in the hope that it would lead to the Act being worked by a contented profession. Moreover, and this shows his foresight, he looked forward to the time when consultant and hospital service would become part of the benefits of the system, and he believed we were the natural body for dealing with the consultants and specialists."51

50. Ibid, p 73.
To emphasise the efficacy of this relationship between Ministry and B.M.A. Eckstein took two examples. The first was the situation where negotiations were allowed to continue between the B.M.A. and the Ministry without outside interference. This then was a successful negotiation and contrasted according to Eckstein with the other situation where the Treasury interfered in the negotiations. The successful example was that affecting Registrars in N.H.S. hospitals. It has been explained how the Spens training ladder was introduced for hospital medical staff and how as early as 1950 it appeared that the middle grades had become over subscribed. The Ministry in an atmosphere of financial retrenchment issued a memorandum instructing that Registrars could hold their posts for two years only while Senior Registrars might be incumbent for only three years. Only 600 Senior Registrars and 1,100 Registrars could hold their appointments, though to help with short-run problems temporaries could be appointed. Effectively the memorandum made over 1,000 Registrars redundant and advised them to accept less suitable posts.

The discussions which took place between the B.M.A. and the Ministry on this issue led to a step-by-step reversal of Ministry policy. By April 1952 Senior Registrar establishments would be fixed at 960 instead of 600, and the normal term would be four instead of three years. By the end of negotiations in 1954 the actual number of Registrars made redundant was 100 or so, rather than over a thousand. Eckstein's comment was that, "On the whole the situation is not very different from what it was at the beginning." To this extent then negotiations had been a success. The problem of over staffing in the middle grades had not been
solved, but the immediate difficulties of the Registrars had been considerably erased.

To contrast with this 'successful' negotiation Eckstein points to the struggle over the betterment factor applied to the Spens award. The Government had calculated a 20% increase on net incomes as a monetary "betterment" factor. Early in 1949 the G.M.S.C. felt that this should be a figure of 70%, retroactive to the first day of the N.H.S. The Ministry attempted to delay discussions. By February 1949 the Ministry had been compelled to request supplementary appropriation to pay for the N.H.S. The Ministry was accommodating on questions of the distribution of the pool, though not its size. From the beginning of 1949 the Ministry was under the shadow of the Treasury, and by the Autumn of 1949 it was clear that another supplement would be called to finance the N.H.S. In early 1950 when the Chancellor of the Exchequer put an absolute ceiling on the cost of the health service the Ministry had no option other than to pursue delaying tactics. Talks then proceeded but in reality the Ministry did not have the ability to succumb to the demands of the B.M.A.

When Aneurin Bevan was succeeded by Hilary Marquand as Minister of Health, there was no change in these tactics. The doctors were offered a modest increase of two million pounds to the Central Pool. Yet even if they had been inclined to accepting this, they would have been dissuaded by the conditional cuts in other areas of the Service, and also the fact that the new Minister seemed greatly in favour of a large salary element in the remuneration of newly established doctors. It was clear in fact that the Ministry was eager to prevent a breakdown in talks but unable to resolve
them. The doctors were kept at the negotiating table as much by the diplomacy of the Ministry as by the fact that doctors appeared too apathetic to respond to calls for strike action.

By 1952 the profession had responded to the increasing cost of living and had increased their betterment factor. It became even more obvious that the negotiations were in deadlock, and the Ministry finally agreed to resort to arbitration. In a week Mr. Justice Dankwerts and his Working Party ended the conflict that had lasted over two years. They decided on a betterment factor of 100 per cent for 1952 and 85 per cent for 1948. This, together with the betterment factor for practice expenses, was greater than the B.M.A.'s original claims. 'Initial allowances' (i.e. basic doctors salaries) were to be paid to newly established. Maximum lists were reduced from 4,000 to 3,500 and special loadings were granted for patients in the range 501 to 1,500 on doctors' lists. The question is then had this been a success for the B.M.A?

It is clear that the B.M.A. had got what it had asked for. It was not enthusiastic about initial allowances or reduction of lists, but it had certainly received a satisfactory betterment factor. Even more than this, it had vindicated the important principle that the Spens Award should be honoured regardless of the state of economic conditions. Yet it would be fair to say that in the negotiations the B.M.A. had always had an unassailable moral case. General Practitioners had entered the Service with the understanding that the Spens proposals would be implemented fairly. The Ministry on the other hand could only plead the general economic situation as its defence, but this was hardly a moral argument for inflicting a burden on nationalized doctors which was not inflicted
on unnationalized professions. Furthermore, during the negotiations the B.M.A. had been shown as unable to mobilize strike action. The profession had not responded to its leadership. As for the Ministry - B.M.A. relationship over the period, it had been destroyed and become characterized by bitter feelings. The Ministry had become visibly more intransigent as the Treasury became concerned. To this extent then Eckstein would call these negotiations unsuccessful. They are contrasted with the former incident of the 'redundant registrars' where the financial stakes as far as the Treasury was concerned were picayune. In such an occasion the profession had peacefully achieved its aims in an unpublished atmosphere of negotiations. The lesson then was when Ministry and B.M.A. relations are allowed to flourish the B.M.A. is more successful.

It would be fair to point out that Eckstein is not alone in indicating the importance of the B.M.A. - Ministry relationship for the B.M.A. Stevens has argued that the Ministry dislikes seeing the B.M.A. in trouble within the profession and prefers to keep it as the unquestioned spokesman for the profession. In the 1963-65 confusion on remuneration the B.M.A. and its leaders were under heavy criticism from the profession. The Minister of Health (Anthony Barber) intervened to establish a new working party to deal with the problems of general practice, and in an open letter to the B.M.A. expressed his concern over the discontent of general practitioners. Such a gesture might be interpreted as an attempt to pacify general practitioners who at the time were feeling somewhat betrayed by the B.M.A. Stevens commented that in the situation

52. R. Stevens, op. cit., pp. 297-300.
"the Ministry would be forced to take a stronger planning initiative both to safeguard general practice and to reinforce the professional associations whose strength was essential to running the health service."

That the institutional framework of negotiations is of importance to the B.M.A. in terms of improving the condition of the profession has been hotly disputed by Marmor and Thomas. In a review of the book they are suspect of the examples Eckstein chooses, and particularly in his interpretation of the 1949-52 remuneration negotiations as unsuccessful. They argue that in that instance he himself notes that the doctors did get what they wanted. More generally they are critical of the concentration on the British example. By an examination of medical politics in the U.K., the U.S.A. and Sweden they offer a different hypothesis to explain and also to predict the outcome of negotiations, and this hypothesis is independent of the different institutional settings. They argue that in all cases when doctors meet government representatives for discussions on remuneration they do so with the over-riding goal of preserving familiar methods of payments even at the cost of losing remuneration increases. The methods of payment preferred were of course different in the different countries they looked at, and

53. Ibid, p 294. Note also that the B.M.A. tends to respond in like manner. That is to say, when the D.H.S.S. appear to have fallen foul of strong attacks from a section of the profession, the B.M.A. attempts to restrain the profession. A case in point was the junior hospital doctors' dispute of 1975. Here as junior hospital doctors threatened militant action in response to changes in the pricing of their contract the B.M.A. appeared to do its best to restrain them. See, Sunday Times, October 19, 1975.

were dependent on the historical traditions of the profession, but
nevertheless maintenance of them was uppermost in the minds of the
profession's negotiators. The government negotiators main concern
is to restrain expenditure increases. They must of course avoid
strike action while the profession's representatives must maintain
the faith of the profession in their ability to succeed. The
outcome in all cases, is that concessions on methods of payment
are made by the government in return for concessions in the amount
of expenditure.

The example that Marmor and Thomas give in the British
context as support for their hypothesis is unfortunately the 1963-
65 negotiations. It is unfortunate in the sense that while it is
fair to argue that concessions were made on methods of payment they
were hardly visible on increases in remuneration. The authors
themselves confess that at the end of discussions "The granting of
a 35 per cent payment increase in a time of general wage squeeze
can only be interpreted as an extra-ordinary concession to medical
demands. This is doubly evident when one considers that the
profession was given a 10 per cent increase just a year earlier,
and no criteria used to establish the 10 per cent figure had changed
to promote an upward revision, ...." However, the importance of
the Ministry - B.M.A. relationship had most certainly been
questioned.

A. J. Willcock's analysis of negotiations is another which calls
into question the value of the B.M.A. - Ministry relations. In his
opinion it is the fact that the B.M.A. offers the necessary medical

55. Ibid.
skills for the N.H.S. to function that alone accounts for its success. He writes,

"Indeed subsequent development since 1946 suggests that, except on remuneration, the medical profession has, by and large, prospered in its dealings with the Ministry of Health. We have the doctors: you want the doctors', one British Medical Association Chairman publicly told the Minister at an annual Meeting of the Association. 'Crude pressure group stuff' or 'political realities', the Minister could not ignore it and sought to gain peace by compromise."\(^56\)

It seems unusual then that so much emphasis is placed on B.M.A. and Ministry relations in explaining B.M.A. success. Surely as Willcocks has pointed out, the rate of substitution of doctors for other factors of production, e.g. nurses, technicians, together with their elasticity of supply of alternative factors of production might be investigated. The elasticity of demand for the product is a factor which has not been referred to in explaining B.M.A. success, and doctors' remuneration as a proportion of total N.H.S. costs might be noted in any explanation of the relative success of the B.M.A.\(^57\)

The relationship of Ministry and B.M.A. would then be only one factor in explaining the success of the B.M.A. as a trade union. Its effect is clearly a moot point. However, to the extent that it is accepted as important and to the extent that Bain's relationship between union recognition and union membership is valid, then one

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57. G. Stigler, op. cit., p 257.
might say that from 1912 onwards the membership of the B.M.A. may have been importantly influenced by this variable. Clearly suspicion rests on how important recognition by the D.H.S.S. is, and how far doctors are influenced to join the B.M.A. because they believe this to be important to bringing success.

3.4 Work Environment.

In discussing the influence of work environment on doctors' behaviour attention focuses on the extent to which their work has become bureaucratized. To what extent has the advent of the National Health Service destroyed doctors' status as independent practitioners and bound them to a common code of behaviour? Have rules and regulations been established and standardized such that they have a greater collective awareness? If doctors are employed in hospitals, are they more ready to accept they have common interests than if they were, for example, independent general practitioners?

It will be noted that it was a standardization of working conditions in larger scale establishments that Lockwood argued was the motivating force for the growth of clerical unions. 58

The question of growing bureaucratization of medical practice has already been looked at in a different context. Firstly, there can be little doubt that the greatest unifying force that bureaucratization has engendered in the medical profession is a common revulsion of the very concept. It has already been noted that clinical freedom is a concept that doctors prize and hence standardization of their work by the imposition of rules and regulations, particularly by lay administrators, is vehemently opposed.

58. D. Lockwood, The Blackcoated Worker, op. cit.
In this sense the discussion on the threat of the N.H.S. to doctors' remuneration and working conditions has already taken note of this effect. Secondly, the largest element of bureaucratization that has been accepted by the profession was in terms of the standardization of the procedure for entry into the profession and subsequent control of professional standards. The effect of this has also already been discussed. Thus the question to be looked at at this stage is to what extent has lay intervention in the provision of medical care produced an environment which conceivably may itself influence doctors' behaviour.

The success of the profession in opposing bureaucratization in working conditions gives one little confidence that the effect of this variable will be significant. Accepting M. W. Susser and M. Watson's analysis there is little evidence to suggest that a bureaucratic atmosphere exists even in hospitals. For example, the degrees of prestige accorded to doctors through the grades of houseman, senior houseman, registrar, senior registrar and consultant constitutes a hierarchy of a kind, but it is a hierarchy of age and experience, and not as in an "ideal" bureaucracy of rank and office.

The reason for this lies in the nature of the doctor's authority and responsibilities. All fully qualified and registered doctors are expected to treat any patient in an emergency; even the most junior houseman must act in an emergency without reference to his seniors if the case is too urgent to allow for consultation. He then carries legal responsibility for his actions in exactly the same way as the consultant. The houseman is protected from his inexperience in that he cannot be penalized for an error of

judgement but only for negligence in carrying out his duty. The professional and legal responsibility of all qualified and registered doctors is identical, regardless of their status, "The profession is a company of peers in which the most junior may address the most senior as a colleague, and the professional and ethical obligations of the one to the other are fully reciprocal.\textsuperscript{60} Indeed the rules of the profession are those of a "company of equals" and they ignore gradations of personal ability and standing among qualified or "technically" competent persons. In this code doctors have a professional authority over patients but not over other doctors, except over some in the relation of master and pupil. The consultant's authority over his junior assistants is based primarily on professional maturity, and not on a formal bureaucratic authority and responsibility.

A consultant does not wield bureaucratic authority over the patients of other doctors, and the extent to which he is subject to such authority is strictly limited. One indication of the source of authority is the power to appoint or dismiss the holder of a post or office. It was the case that the Regional Hospital Board and not the Hospital Management Committee, appointed consultants and registrars, and a consultant who was dismissed had a right to appeal to the Minister. Thus, the administrators of the Hospital Management Committees had no bureaucratic control over consultants, and the more remote administrators of the Regional Board could take little part in the affairs of an individual hospital. Rather consultants themselves may well have wielded power over executive

\textsuperscript{60} M. W. Susser and M. Watson, op. cit.
officers because they have been represented on the Medical Advisory Committee of Hospital Management Committees and on Regional Hospital Boards. Although more lay people than medicals were appointed to committees and boards, the advice of professional committees could not be lightly passed over, especially when the decision might have saved or lost lives. The Guillibaud Committee recommended that medical representation on Regional Hospital Boards and Hospital Management Committees be reduced to not more than 25 per cent; lay opinion could not make itself felt against stronger representation. The dominance of medicals over administrators has been a consistent finding in studies of hospitals. For example, Forsythe commented that, "The profession would have no kind of medical direction of the kind provided by medical superintendents in the pre-war municipal hospitals and consultants have been free largely to arrange their own work pattern, exercising collective responsibility through medical and advisory and staff committees with ill-defined terms of reference." Thus, although a full-time consultant is salaried, he is subject to little executive control; his position is further strengthened because private practice is open to him.

Conflicts between doctors in the health service cannot be resolved by authority as they can be in a bureaucratic organization. Solutions are inevitable compromises. Responsibility for a patient between one consultant and another will depend on which of

them controls the bed the patient is in. Nevertheless, a physician cannot order a technical specialist such as a radiologist or clinical pathologist to carry out a procedure on a patient against the specialist's better judgement. A procedure such as fluroscopy or liver biopsy may involve risks for which the specialist is responsible. Anaesthetists decide about anaesthetics, and not the surgeons who conduct operations.

Disputes over administrative problems must also reach compromise solutions. For example, the clinical pathologist usually controls the blood bank and he is responsible for matching the blood and ensuring its safety. Obstetricians may demand that a free supply of blood be provided in the labour wards for emergency use. If blood is in short supply the pathologist may insist on a procedure that does not allow stored blood to go to waste because it has not been used before the expiry date. He might therefore oppose establishing a new bank in the labour wards, and offer only a limited supply. Although the pathologist controls the blood and the decision lies with him, his professional standing depends on the quality of the service of the pathologist for many crucial biochemical haematological and immunological investigations. Under these circumstances the solution must be a series of compromises and mutual agreements. Similar compromises are likely to develop between consultants and the heads of other administrative units. 64

The g.p. also is not an individual who is subjected to precisely

64. Ibid, p 162.
defined rules and regulations. In the competitive conditions that prevailed before the N.H.S. British general practitioners were always individualistic, with a preference for working single-handed. Within the N.H.S. the administration of the family practitioner service became the responsibility of 138 executive councils covering the same areas as those of County Councils and Boroughs. Each council had twenty-five members, eight appointed by the local authority, seven by the local doctors, three by the local dentists, two by the pharmacists and five by the Minister. The council was assisted by professional advisory committees of doctors, dentists, pharmacists and opticians, each of which appointed its own representatives to the council; Local Medical Committees were usually composed of the leaders of the local British Medical Association. The council disbursed fees from a central pool, kept files of doctors' lists, arranged transfers of patients and made recommendations to the Minister on the advisability of doctors opening new practices in the area.

The N.H.S. added very few conditions to the life of the g.p. In his contract with the council he agreed to render all services normally rendered by general practitioners, to keep adequate surgeries and medical record cards, to prescribe on health service prescription forms and to issue statutory certificates. In an emergency the doctor must treat patients not on his list and he may not remove patients from his list during a course of treatment.

The size of a practice was limited and might not exceed 3,500

65. R. Klein, op. cit., comments "But general practitioners, whether practising as small shop-keepers on their own or as members of a Health Centre, are independent contractors. They are not answerable to anyone (any more than consultants in hospitals) for what they do, provided they do not over prescribe too extravagantly. See also R. Klein, Complaints Against Doctors: A study in professional accountability. Charles Knight & Co., 1973.
patients to 4,000 for a partnership, although there is no limit to additional private practice. A check is kept on prescribing to prevent excesses. Patients have a free choice of doctor and doctors of patients, with a small exception through which an executive council fulfills its obligation to provide a service for all patients, even if no doctor wants them on his list. Through their service committees, councils have heard complaints about violations of the conditions of service by doctors and recommend disciplinary measures which ranged from reprimands to expulsion. Serious cases have been referred through the Minister to a special tribunal, with a right to appeal to the Minister, who might reverse only those decisions which go against a doctor. Certain other matters, such as the issue of unsatisfactory certificates, excessive prescribing or a failure to keep records, have all been referred to the local medical committee and heard entirely before colleagues. The direction over areas to which doctors can move has been made by the Medical Practices Bureau comprised wholly of doctors.

The medical profession has therefore successfully resisted bureaucratization. It is unlikely that the new re-organization of the health service will make much difference. For example, at both Area and Regional level there are Professional Advisory Committees,

66. Although the Medical Practices Committee was composed of medical men the profession resented its establishment in 1948. They felt it marked a step towards bureaucratic authority. However the story has an ironic twist. When the N.H.S. was accepted and the general public registered with their general practitioners, some doctors found they had very small lists of N.H.S. patients. Within the first month of the new service these doctors were rushing to the Medical Practices Committee asking it to declare their areas "over-doctored" and thus closed to all new applicants. See R. Stevens, Medical Practice in Modern England, op. cit., p 88.
while in each District Management Committee there is a general practitioner and hospital specialist with the power of veto. A Health Service Commissioner has been appointed as an ombudsman, but he acts only as a court of appeal and formal complaints in the N.H.S. have been few. The profession is then hardly bureaucratically controlled, and the very nature of the doctors' work precludes strict managerial direction.

There is some evidence to suggest that doctors' views may be influenced by their work environment. For example following the 1944 White Paper on the National Health Service a questionnaire survey was pursued to discover doctors' reaction to the issues at hand. The results are shown in the following table. The results are interesting for they made clear that the officials of the B.M.A. were more strongly opposed to the N.H.S. Bill than the rank and file of the profession. For example in response to the question proposing a free service for the entire population the profession approved by a vote of 60 to 37 per cent. However as has been pointed out, B.M.A. leaders vehemently objected to this principle.

However, what is also clear is that strength of feeling on issues differed between service doctors, consultants, salaried doctors and general practitioners. The general practitioner showed

67. Despite the limited powers of the Health Service Commissioner doctors are keenly agitated by his existence. See B.M.J. Vol. 2, 28th June 1975, p 710.


### Response to the B.M.A. questionnaire on the White Paper (in percentages)

<table>
<thead>
<tr>
<th>Questions</th>
<th>All</th>
<th>Service doctors</th>
<th>Consultants</th>
<th>GPS</th>
<th>Salaried doctors</th>
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<td>Con</td>
<td>Pro</td>
<td>Con</td>
<td>Pro</td>
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<td>53</td>
<td>53</td>
<td>41</td>
<td>36</td>
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<tr>
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<td>51</td>
<td>45</td>
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<td>Larger areas for hospital administration</td>
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<td>78</td>
<td>13</td>
<td>81</td>
<td>9</td>
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<tr>
<td>Remuneration of consultants by local authorities</td>
<td>37</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>50</td>
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<tr>
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<td>Health centres</td>
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<td>67</td>
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<td>35</td>
<td>50</td>
<td>29</td>
</tr>
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<td>Salaried service in health centres: full or part</td>
<td>62</td>
<td>29</td>
<td>74</td>
<td>20</td>
<td>73</td>
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</table>

markedly less enthusiasm on issues such as salaried service; health
centres; free and complete hospital service; larger areas for
hospital administration. One explanation offered for this was the
different work environment of these groups. It is claimed that to
a large extent familiarity of working within an organization
accounted for the fact that consultants, salaried doctors and
service doctors were more willing to accept such proposals than
general practitioners. Consultants had long survived the
organization of hospitals. Service doctors had accepted "army
medicine" and were probably heartened at the prospect of moving to
health centres rather than struggling with under-equipped private
practices. This argument is questionable. It may not simply have
been that consultants had experienced salaried service that made
them more inclined to these proposals; for it was also the case that
Bevan had deliberately made entry into the N.H.S. more favourable
for them. On the other hand it may have some significance. For
example one might advance it to explain g.p.'s movement to a
form of payment much more akin to a salary in 1965. That is to say
that familiarity in more organized medicine since 1948 had made
them less afraid of such a form of payment.  

If work environment can influence opinion on the sort of goals
which the B.M.A. should strive for, then possibly it influences
membership also. However there is little evidence on this, and
indeed what data is available would not support the proposition.

70. Ibid, p 355, "The consultant's usual habitat is the hospital;
hence he has experience with "organization" and not least with
the impact of non-medical authorities."

In 1948 it was the case that eight out of ten consultants were members of the B.M.A. They were then typical in that 80 per cent of the profession were members. Unfortunately there is little suitable aggregated data to work with in exploring this question. A questionnaire survey of some 600 doctors in the Leicestershire and Rutland area, which is described more fully in a later chapter does shed a little light onto this question. In looking to the returns of the survey it appeared that, as with member G.P.'s of the B.M.A. the larger proportion of non-member G.P.'s were in partnerships of two, three and four doctors. Also it seems clear that length of hospital experience varies over the same ranges for members and non-members. The need to make direct use of hospitals had no effect on non-members' decision to join. Also whether or not a doctor worked full-time or not in the N.H.S. had no influence on the decision to join.

What data exists would not support the proposition that work environment plays a major part in determining B.M.A. membership.

3.5 Advertising and Recruitment Campaigns.

Keith Hindell has suggested that advertising on the part of an association can be instrumental in increasing the size of its membership. Such advertising could take place informally through individual persuasion by an existing member or branch official, or

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72. R. Stevens, op. cit., p.89.
as a result of a particular co-ordinated advertisement drive. Hindell suggests that trade unions have tended to regard the first of these methods to be by far the most important. They have laid great stress upon the need for this approach to the individual and until recently have not put much effort into the other method. An indication that such persuasion might have been even more effective is presented in the research of Butler and Stokes. They found, for example, that 20 per cent of the sample of non-union members to which they looked would have joined a union if asked.\textsuperscript{75} However, the work of Bain suggests that too great an importance should not be attached to advertisement and recruitment drives, for in the growth of white collar unionism he found it an insignificant variable.\textsuperscript{76}

There is considerable difficulty in estimating the importance of advertising in the growth of the B.M.A. If figures in the balance sheet showed the expenditure of the B.M.A. on this activity, or even if the B.M.J. possessed pages of advertisement, then one might have tentatively used these proxies to correlate with membership growth. However such data is not readily available. Also assistance from the Organization Committee of the B.M.A. is of little value. This Committee made an inquiry in 1971 into a recruiting effort they were carrying out.\textsuperscript{77} The recruiting effort involved addressing letters to groups of non-members either monthly, in alternate months, every three months or every four months. I was informed by correspondence that "so far as the results


\textsuperscript{76} G. Bain, \textit{op. cit.}, pp. 88-100.

\textsuperscript{77} \textit{B.M.J.}, (Supp.) 1968, Vol. 1, p 33.
of the campaign have been assessed, it would appear that some
10 per cent of the doctors thus addressed joined the Association."
But as was stressed in correspondence "This figure has to be
treated with some reserve as there may have been other factors
which induced them to join and also it takes no account of those
who subsequently resigned." 78

From the published material it is possible to argue that
advertising and recruitment does affect membership even if its
precise significance is in doubt. It seems fair to argue that,
like the trade unions that Hindell looked to, the B.M.A. finds
personal persuasion most effective. References in the B.M.J.'s
of the mid 1960's seems to confirm their faith in this approach.
For example in April 1967 the Chairman of the Organization
Committee expressed his belief that personal contact through the
local organizations was the best approach in recruiting new members. 79
In October 1968, Dr. R. Gibson spoke of the need for more personal
contact with non members 80 and the Annual Report of 1967 claimed
that "Experience in some divisions has shown clearly that the
selective personal approach to non members is by far the most
effective means of recruiting." 81

From published material it is also possible to argue that,
during the formative years of the B.M.A., membership rose most
quickly in areas where recruiting was undertaken. Appendix B looks
to membership figures in those counties which had local branches

established. These branches appear instrumental in raising membership as compared to membership in areas where there were no branches formed. It is unlikely that the branches themselves provided anything of extra importance for members. The fact that attendance at branch meetings was so low, and that doctors paid one guinea for membership of the B.M.A., but refused to subscribe an extra 2s. 6d. for branch membership, leads one to doubt that branch activities was a particular attraction. Rather it was the recruiting activities of the local officials which would seem the important factor. The point is emphasised in the Monmouth Branch. Membership in this area fell alarmingly when the local branch leader left the area and the branch fell into abeyance.

Though the data on which the analysis is based is hardly contemporary, it nevertheless justifies the proposition that advertising and recruiting have had an effect on the growth of the B.M.A.

3.6 Subscriptions.

In looking to the effect of subscription rates on the membership of the B.M.A. it is advisable to look to resignation figures. Whilst it would be difficult to suggest how many doctors did not join because of subscription increases, it is possible to indicate how many doctors may have left because of such increases.

82. W. Gordon, "Observations on the Organization of the Branches of the British Medical Association", B.M.J. July 21, 1900, p 150, wrote of the problem of getting new members. "The difficulty was apparently due to want of personal acquaintance with those whom I wished to secure. Men whom I knew personally rarely refused to join."
Resignation figures are available in the B.M.J. from 1901 to 1966 and from 1919, the resignations withdrawn are also published. In looking to the effect of subscription rate increases it is possible to isolate seven years, 1903, 1913, 1920, 1950, 1953, 1960, and 1966. The subscription rate in nominal terms is given on the following table. It would appear that there was an "announcement effect" of the rise in subscriptions during these years. With the exception of 1903 and 1960 resignations doubled as a result of the increase. However, the fact that the resignation figure is such a small percentage of the total membership figure leads one to discount any great importance in this observation.

83 There was some small changes in the structure of the rate of subscription during these years as shown in Appendix C.

84 John H. Pencavel, "The Demand for Union Services: An exercise," Industrial and Labor Relations Review, Vol 24, 1970-71, pp. 180-190, examined changes in registered union membership in Britain between 1928 and 1966 and noted that the demand for union membership was relatively inelastic with respect to the price of union membership.
<table>
<thead>
<tr>
<th>Year</th>
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<th>Resignations Withdrawn</th>
<th>Reasons</th>
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<td>622</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>1938</td>
<td>674</td>
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</tr>
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<td></td>
</tr>
<tr>
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<td>&quot;</td>
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<td>1942</td>
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<td>&quot;</td>
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</tr>
<tr>
<td>1950</td>
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<td>99</td>
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<td>732</td>
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<td>1952</td>
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<td>1953</td>
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Subs raised
(£1. 1s. Od. -
£1. 5s. Od.)

Subs raised to
£2. 2s. Od.

Subs raised 50%
to £3. 3s. Od.
Conclusion.

Despite the limitations on data it is possible to make some intuitive estimation of the relative importance of variables which might be claimed to comprise doctors' demand function for membership of the B.M.A. It is possible to argue for example that the social factors, e.g. the collective threat to doctors, the growth of homogeneity in the profession and the establishment of the B.M.A. as a traditional cornerstone of the profession are possibly of greater significance than economic variables such as the price of membership and the level of doctors' incomes. This is an interesting conclusion for it would serve to draw a direct parallel with the work of those economists interested in analysing the determinants of the growth of collective action by the state in the national economy.

Musgrave makes an intuitive observation that political, demographic, social and technological factors, may be more important than economic variables:

"Moreover, noneconomic factors such as changes in technology and population are of great importance. Together with changes in social and political climate and the upheavals caused by war, they may well outweigh the effects of rising per capita income." 85

In the same vein the discussion of the response of B.M.A. membership to collective threats is directly parallel to the work of

85. This was a conclusion which John H. Pencavel, "The Demand for Union Services: An exercise", op. cit., arrived at having examined the growth of British Unions 1928-1966.

Peacock and Wiseman on the growth of the public sector in the U.K. They set out to examine the validity of Wagner's hypothesis that the proportionate size of the public sector grows as national income grows. It is important, however, that they stress that their research is concerned with an individualistic setting rather than an organic viewpoint of the state. That is to say that individuals' preferences count, and they will vote to have themselves taxed when they wish the public sector to grow in size. Their decision to so vote is therefore similar, though not identical, to the action of doctors' giving up contributions to the B.M.A.

Peacock and Wiseman emphasise the time trend pattern in the growth of the public sector, and in particular a "displacement effect" at times of wars or social crisis. They argued that there was a limit to "tax tolerance", and that it required a shock to society in order to raise these limits. This, together with an "inspection effect" at times of national emergency, when the country fully appreciated the worst aspects of the health, education and welfare of certain sections of the population, explained the growth of public expenditure. That is to say that during such crises the nation tolerated higher levels of taxation and also appreciated the need for greater social service expenditure of the state, so that after the crises, e.g. the First and Second World Wars, taxation and public expenditure never fell to its old levels. The important factor was, then, that a crisis or threat to the community had brought about a greater willingness to contribute to collective action. If for Peacock and Wiseman the Boer War, the First and

Second World Wars were among the stimulus to greater collective sacrifice, then for the medical profession the growth of membership at 1911-13 and 1944-48 shows the same "displacement effect" as a result of the stimulus of the threat of state monopsony in the medical market.

The whole discussion however, has been concerned with isolating those variables which over time may have influenced the demand for B.M.A. membership. An analysis of the demand for a private good may require little more. However, it will be argued that the B.M.A. provides goods and services which are not strictly 'private' and that although the variables which affect demand for membership may have been isolated, this tells us little of the reason why any one individual in a given time period makes the decision to join.
Chapter 4

The Nature of Collective Goods.

There is an obvious need to examine the good supplied by the B.M.A. An enunciation of the goals of the Association was formally made in 1874. Legally the B.M.A. is not a trade union. In 1874 it was registered as a limited company, but with a licence of the Board of Trade to omit the word "limited" from its title. Its Memorandum of Association contains only one clause of basic significance, Clause 3, and this reads as follows:

"3. The objects for which the Association is established are:

(1) To promote the medical and allied sciences, and to maintain the honour and interests of the medical profession.

(2) To hold or arrange for the holding of periodical meetings of the members of the Association and of the medical profession generally.

(3) To circulate such information as may be thought desirable by means of a periodical journal, which shall be the journal of the Association, and by the occasional publication of transactions or other papers.

(4) To grant sums of money out of the funds of the Association for the promotion of the medical and allied sciences in such manner as may from time to time be determined on.

1. It has often been described as a trade union, e.g. Professor H. Laski rather uncomplementarily, as well as somewhat unfairly, referred to it as a "tenth rate trade union." B.M.J. Supp. May 11, 1946, p 119.
(5) Subject to the provisions of Section 19 of the Companies (Consolidation) Act 1908 to purchase, take on lease exchange hire or otherwise acquire any real and personal property and any rights or privileges necessary or convenient for the purposes of the Association.

(6) To sell improve manage develop lease mortgage dispose of turn to account or otherwise deal with all or any part of the property of the Association.

(7) To borrow any monies required for the purposes of the Association upon such terms and upon such securities as may be determined.

(8) To do all such other lawful things as may be incidental or conducive to the promotion or carrying out of the foregoing objects or any of them.

Provided that the Association shall not support with its funds any object or endeavour to impose on or procure to be observed by its Members or others any regulation restriction or condition which if an object of the Association would make it a trade union."

Of the aims which are enumerated the first is said by the B.M.A. to be its "prime object." It stands, of course, as a brilliant

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3. See, for example, Statement by Dr. John Happel, Chairman of the B.M.A. ethical committee, "....The first object of the B.M.A. is to preserve the honour and independence of the profession ...." The Sunday Times, November 30, 1975, p 1.
example of brevity and comprehension. It covers in a single phrase everything from scientific, ethical, sociomedical and educational to medico-political objectives, and includes by inference the pay and conditions of doctors. Yet there is little doubt, that as the government has extended its influence into the medical market, negotiations over pay and working conditions have become the central object of the B.M.A. One of the main conclusions of an investigation into the B.M.A. by Sir Paul Chambers is precisely this. Referring to clause 3 he comments

"Plainly the Association has for decades regarded the wording as covering pay negotiations and has acted as though the "trade union" activity proviso were not there or were no legal bar to its actions."  

Thus whilst not legally a trade union, the B.M.A. by its actions would appear a trade union. Its history would most certainly place it within the context of the Webbs' famous definition of a trade union, and it might be viewed as a continuous association of doctors "for the purpose of maintaining or improving the conditions of their working lives."

It is clear that the main objective of the B.M.A. is to improve conditions for the medical profession, and in this context working conditions and remuneration for the profession would seem to be its pre-occupation. It is therefore, an association which provides a service for a well defined group of individuals, i.e. those individuals who are on the Medical Register. It will not be contended that the effect of the activity of the B.M.A. does not

extend beyond this group. Certainly those individuals who require medical care will be affected by the influence which the B.M.A. exerts on the conditions of supply of medical care. This effect however is a spillover or externality to the main aim of the B.M.A., and it can take the form of an external economy or external diseconomy. It is an activity which enters into the utility function of the community outside the medical profession. However, there is no direct way in which any individual outside the profession can modify or internalize this external effect. Membership of the Association is not open to such individuals. Attempts to internalize any external effect, e.g. by the formation of a Patients Association, is constrained if only by the costs of formation. Thus the activity of the B.M.A. for individuals outside the profession is an externality to the extent that it enters their utility functions and cannot be adequately affected through the price mechanism. Furthermore, to satisfy the definition of E. J. Mishan, it is an externality to the extent that it is unintended or incidental. This is perhaps more contentious. Certainly there may be a belief that it is the aim of the B.M.A. to improve the welfare of the consumers of medical care. In reply to this one should firstly note the declared aims of the B.M.A. which are quite explicitly laid down in terms of the medical profession. Secondly, one should note the negotiations of the B.M.A. in 1911-13 and 1944-48 which at a time of great upheaval found the B.M.A.


concerned entirely with the interests of the doctor and sparing little concern for the patient. Thirdly, and even more obviously, when there is a direct clash between the interests of the patient and the doctor it will be shown that the B.M.A. favours the doctors' interest.

The B.M.A. then, is in business to promote the interests of the profession, mainly in terms of remuneration and working conditions, and any other effect it may have on individuals outside the profession may be viewed as an externality. Just as any trade union or professional association will argue that the ends they are pursuing will promote the good of the general public so also will the B.M.A. However, this effect is a possible consequence of improving the lot of trade union or professional association membership. It is not the direct aim which is to be maximized.

Maximizing, subject to the environmental constraints in which it operates, the interests of the medical profession, is a collective service provided by the B.M.A. It is collective in the sense that if one practitioner is made better off as a result of the activity of the B.M.A. then all practitioners will be made better off. The important point is that to enjoy the collective good produced by the B.M.A. a doctor does not require to become a member. If the B.M.A. achieve an increase in the capitation fee of general practitioners who are members, then non-member general practitioners must also profit from exactly this amount of increase in their capitation fee. If the B.M.A. succeed in making entry into the profession more difficult, then any economic rent which may be earned by its membership is also open to non-members already

8. Such clashes of interest between doctors' and patients is discussed more fully in Chapter 7.
within the profession. If the B.M.A. succeed in keeping its membership free of the lay interference of local government then non-members are also protected. Membership of the B.M.A. is not a pre-requisite for consuming the primary service of the B.M.A. Given the legal and institutional frame-work, non-member doctors of the B.M.A. cannot be excluded when the B.M.A. maximizes the well-being of the profession.

The fact that the B.M.A. provides a collective service has interesting consequences. In the case of private goods, individuals who do not pay the necessary price can be excluded from consumption. It is therefore the case that such goods can be supplied via a voluntary market system. Prices can be ascribed to private goods, and in order to attain them individuals' preferences must be revealed via the actual payment of the prices. However, in order to enjoy a collective good there is no obligation to pay the cost involved. If the good has been provided, there can be no restriction on consumption by those who have not contributed to the costs of the good. In such a case preferences may not have to be revealed in order to consume a collective good. Indeed if there was a belief that charges or fees would be levied according to the benefit it gave individuals, then such individuals may recognize an incentive to under-reveal preferences. The important factor which will determine whether or not preferences will be revealed in the

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9. The B.M.A. is therefore pursuing a collective good for doctors. It is a collective good which may generate external effects (either economies or diseconomies) for patients or prospective patients. The concept of a collective good which may generate external effects has been discussed by A. W. Evans, "Private Good, Externality, Public Good", Scottish Journal of Political Economy, February 1970, pp. 79-89; and E. J. Mishan, "The Relationship between Joint Products, Collective Goods and External Effects", Journal of Political Economy, 1969, pp. 329-428.
case of a collective good is the extent to which an individual feels that his contribution is significant if any of the good at all is to be provided. In such a case the contribution may be made to the extent that the benefit from making it outweighs the opportunity cost involved. Yet as the number of individuals who consume a collective good rise, and if the total cost of provision of the good is high, then each individual must view his contribution as of small significance. Thus the problems of provision of a collective good would appear a function of the numbers involved.

David Hume's famous example all too clearly indicates the problem:

"... Two neighbours may agree to drain a meadow, which they possess in common: because it is easy for them to know each other's mind; and each must perceive, that the immediate consequence of his failing in his part, is the abandoning the whole project. But it is very difficult, and indeed impossible, that a thousand persons should agree in any such action; it being difficult for them to concert so complicated a design, and still more difficult for them to execute it; while each seeks a pretext to free himself of the trouble and expense, and would lay the whole burden on others. Political society easily remedies both these inconveniences...

Thus, bridges are built, harbours opened, ramparts raised, canals formed, fleets equipped, and armies disciplined, everywhere, by the care of government, which, though composed of men subject to all human infirmities, becomes, by one of the finest and most subtile inventions imaginable, a composition which
is in some measure exempted from all these infirmities."\(^{10}\)

There appears to be the assertion on the part of both economists and political theorists alike that collective goods will not be voluntarily provided. But to what extent is this a function of the nature of the good and to what extent is it due to the numbers involved? Is the medical profession a 'large group' and if so, why do individuals voluntarily contribute? To begin an analysis of these questions it is useful to develop the model referred to in Chapter 1. It is necessary to simplify the argument in order to isolate the effect of the properties of a collective good.

4.1 Collective Goods.

Whilst the concept of a public or collective good has been familiar in economic literature since the last century, the question of definition still poses problems.\(^{11}\) Paul Samuelson perhaps, produced a landmark in the literature by defining public goods in such a fashion that it enabled a clear exposition of the conditions required for their efficient provision. The essence of his definition was that they were goods "which all enjoy in common in the sense that each individual's consumption of such a good leads to no subtraction from any other individual's consumption of that good."\(^{12}\) They differ then from private goods "whose total can be parcelled out" among individuals with one having less as the others enjoy more. The definition was not beyond criticism. Margolis for example found

it a poor description of those goods and services provided through the State. Consumption of common public services such as education, hospitals, highways, where capacity limitations are implied means that increased consumption by one individual must be at the expense of others. Yet interestingly the aims of the British Medical Association, and indeed any such association, may be nearer to Samuelson's definition of his "polar" public good.

Most certainly one of the important contributions of Samuelson's definition has been the interest it has sparked in examining explicitly the properties of such a good. One characteristic said to be implied by the definition is that to which reference has already been made i.e. impossibility of exclusion. This characteristic is not discussed explicitly in Samuelson's early works, but it is clearly implied since equal consumption holds by definition where exclusion is impossible. If Samuelson may not have been explicit, Musgrave most certainly was in his early definition, "Social (i.e. collective) wants are those wants satisfied by services that must be consumed in equal amounts by all. People who do not pay for the services cannot be excluded from the benefits that result,..." The B.M.A.'s aims then to this extent are collective. They cannot be denied to those individuals within the profession. Indeed Olson pointed out that any such association pursuing a common aim or goal provides a collective good. His definition of a collective good was quite explicitly, if not uniquely, framed in terms

of the impossibility of exclusion: "A common, collective, or public good is defined as any good such that, if any person $x_i$ in a group $x_1, \ldots, x_i, \ldots, x_n$ consumes it, it cannot feasibly be withheld from the others in that group." 16

Yet a collective good, as defined by Samuelson implies more than non-price exclusion. It most explicitly calls attention to the attribute of non-rivalness. 17 This characteristic of "equal potential availability" has been the subject of semantic dispute. In the early continental literature it is referred to as indivisibility in consumption. Head and Buchanan have referred to this characteristic as joint supply in consumption, though objection might be raised because of the confusion this may generate with Marshallian joint supply of private goods. 18 Non-rivalness is therefore the term here adopted to refer to the characteristic that if A is provided with the good then an identical quality service unit can be made available to B at no extra cost.

The question must arise as to the relationship of these two characteristics with each other. To what extent are they separate entities? It has been forcefully argued by Head, Shoup and Peston that the characteristics might be thought of as distinct to the extent that each might hold independently of the other. 19 Thus it

has been proposed on the basis of these characteristics that a
taxonomy of goods might be constructed. At one end of the taxonomy
a purely private good might be thought of as that which is both
rival and exclusive. One might then envisage a good which if rival
and non-excludable, such as free access for individuals to roads
which are at congestion level. A good which is, on the other hand
both non-rival and excludable may be a theatrical performance where
charges to the theatre are levied despite the fact that the theatre
is almost empty. Finally, a good which is both non-rival and
non-price exclusive would be a pure public good. The taxonomy may
appear somewhat arbitrary to the extent that the same 'good' may
fall into one category in one set of circumstances and into another
category in other sets. Clearly the classification of any good is
by no means obvious. However accepting the validity of the taxonomy
it is necessary to place within it the goods and services provided
by the B.M.A.

M. Olson Jr. makes the distinction between "exclusive" groups
and "inclusive" groups and illustrates it by a comparison between
"market groups" and "non-market groups."20 The market group may be
typified by a number of firms in a cartel. Their aim is to keep
the number of firms in the market low. The reason is that the
"collective good" it tries to provide, i.e. a higher price for the
commodity being produced, is such that if one firm sells more at
that price and benefits, then the other firms must sell less. Only
so many units of a product can be sold in any given market without
driving down the price. The difference between this and a non-
market or inclusive group is that in the case of the latter any

number can join without necessarily reducing the benefits for others. Such a group would be a lobbying organization. Essentially then Olson is characterising a group with reference to the sort of collective good to be provided, i.e., to an "exclusive collective good" or an "inclusive collective good." The distinction between these two goods is essentially in terms of the rivalness of the good. The exclusive good is a non-price exclusive but rival good, and hence the rationale for keeping down the number of benefactors. The inclusive collective good is a non-price exclusive but non-rival good, and hence the encouragement to keep numbers high if only to share the costs involved.

One needs to be very careful in the use of the word "group". It would appear that when Olson describes the group as inclusive or exclusive it is the formal group or the association to which he is referring, as compared with the group that will share the benefits provided by the association. In the case of the cartel this is kept low with a view to driving non-members out of the market. As far as the inclusive group is concerned it is kept high in order to reduce the average costs of the organization. The B.M.A. then, I would propose, is first and foremost an inclusive group. The collective good being provided is hence by definition non-rival for the profession as a whole. If the B.M.A. increase the size of the capitation fee of general practitioners, or salary of consultants then all enjoy the full increase. If it improves the rules under which doctors practice then all can benefit regardless of the total number involved. It may of course be argued that the B.M.A. is exclusive in the sense that it may attempt to regulate entry to the profession. This may be so and the benefit so produced to any doctor
will be rival and dependent on the number of doctors already within the profession. Yet in the main it produces equal and settled remuneration increases and effects on legislation concerning the provision of health services. Such action as this is best described as non-rival. The declared aim of the B.M.A. is the maintenance and improvement of the honour of the profession which itself appears non-rival, and in discussion with Dr. Derek Stevenson, the Secretary of the B.M.A., the hope was clearly expressed of providing equal availability of benefit to all individual doctors. Indeed the B.M.A. is best described as an inclusive group to the extent that it would wish to embrace all established doctors within itself. One may set out on this analysis then by assuming the service provided by the B.M.A. to be as close an approximation to Samuelson's concept of a pure or polar public good as is witnessed in the real world, i.e. non-exclusive and non-rival.

It must be emphasised that this position is only that adopted for the purpose of beginning the analysis. Later it will be conceded that the B.M.A. offers an array of supplementary services also. Many of such services may be best described in terms of the exclusive and non-rival (below capacity limits) classification. They are what might best be described as "club benefits" and their importance to the B.M.A. is to be assessed at a later stage. Secondly, a close inspection of the main service or common aim of the B.M.A. may reveal some degree of rivalness. It may be naive to

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dismiss non-rivalness as all or nothing. Buchanan and Musgrave have both drawn attention to this observation. Indeed Musgrave by interpreting degree of non-rivalness in the form of the extent of the spillover from a public good amongst those for whom it is provided, has established an impressive taxonomy of goods with elements of non-rivalness. Such an analysis will also be applied to the B.M.A. in a later chapter in order to analyse doctors' behaviour.

At first however the model on which concern is focused is kept simple. The collective good provided by the B.M.A. is non-rival and non-price exclusive. It is provided for a distinct and recognizable group of individuals, i.e. those whose names appear on the General Medical Register, and if its activities directly enter the utility functions or production functions of other consumers or producers, this is an externality effect. Attention then is concentrated on the provision of a pure public good which may have spillover effects beyond the group for which it is intended.

4.2 The Voluntary Provision of a Collective Good.

Having discussed the properties of a collective good it is necessary to try and assess to what extent they are responsible for the widely held view that individuals will not voluntarily co-operate to provide themselves with such goods. Recourse is made to the simple model outlined in Chapter 1., in order that the effects of the collective good will be isolated. It will be remembered that the individual involved was defined as economic to the extent that he was neither benevolent nor malevolent. He was assumed to be

concerned with maximizing his own independent utility function and to this end he was thought of as making decisions rationally. A rational man is assumed to behave as follows: (1) he can always make a decision when confronted with a range of alternatives; (2) he ranks all the alternatives facing him in order of his preference in such a way that each is either preferred to, indifferent to, or inferior to each other; (3) his preference ranking is transitive; (4) he always chooses from among the possible alternatives that which ranks highest in his preference ordering and (5) he always makes the same decision each time he is confronted with the same alternatives.\textsuperscript{24} Within the bounds of this definition of rationality the decision with which concern rests is whether or not the individual decides to contribute to an association. An association is the instrument necessary for the provision of a collective good, and for the moment at least, has no other aim to maximize than this. The collective good is provided for a group of individuals and this group is defined as those individuals for whom the good is provided. Clearly the association is a number of individuals who are a sub-set of, or equal to, the group. In the case to which particular attention is focused the B.M.A. is the association, the medical profession the group, and the doctor the individual decision-taker.

In discussing the tendency to avoid contribution toward collective goods, Buchanan has used the term "free-rider" to characterise such an individual.\textsuperscript{25} It is necessary at the outset however, to make clear the possible interpretations of such a

\textsuperscript{24} This definition is that stipulated by K. J. Arrow, Social Choice and Individual Values, Yale University, London, 1951.

\textsuperscript{25} J. M. Buchanan, The Demand and Supply of Public Goods, op. cit.
tendency. In the first instance the refusal on the part of individuals to make their required contribution for the provision of a collective good can lead to no quantity of the good being produced at all. To describe this problem as one of free riding is then a little confusing to the extent that no one enjoys a "free ride". Here the problem of under-revealing preferences would appear most acute. In the second instance the problem of free-riding can occur when some individuals make no contribution at all, but cannot be excluded from consuming that quantity of the good which is provided by others. Yet, how might this be called a problem? It is only a problem in so far as the optimal quantity of the collective good is not being provided. Such a situation of optimality is defined as one in which it is impossible to make one person better off without first making another worse off. The optimal quantity of a collective good is one that exists when the sum of the marginal evaluation of all consumers of the good is equal to the marginal cost of the good and each individual equates his contribution to the marginal cost of the good with his own marginal evaluation of the good. Thus, it is perfectly possible that a quantity of the collective good may be provided, but the fact that the 'free rider' has a positive marginal evaluation and contributes nothing implies that the optimal amount of the good is not being provided. Within the concept of free riding there are therefore, two problems. The first is that the existence of the properties of collective goods can lead to no amount of the good being produced at all, even if


27. It is interesting at this juncture to note the possibility of a "forced-rider" i.e. an individual who contributes nothing but suffers negative marginal utility because he cannot be excluded from consuming the good - See V. Tanzi "A Note on Exclusion, Pure Public Goods and Pareto Optimality", Public Finance, 1972.
the sum of the marginal evaluations of consumers of the good exceeded the marginal cost. The second problem is that the optimal amount of the good will not be provided. The question to which attention is first addressed is the former, i.e. will any amount of a collective good be provided by a group of individuals.

4.3 Why, and under what conditions will any amount of a collective good be provided?

(i) From the outset the property of non-price exclusiveness generates a considerable disincentive to contribute to the costs of producing a collective good. Why pay if the benefits can be achieved for no charge?

If there is no sign that the good will be supplied without someone volunteering to cover its costs then provided that the individuals's marginal evaluation exceeds the marginal cost involved, the individual will pay the costs and provide the good. The situation is that depicted in the following diagram.

fig. (i)
The marginal evaluation curves of A and B are shown in the diagram, i.e. ME_A and ME_B. The marginal cost of producing extra units of the collective good X is, for simplicity, assumed constant. The good is assumed to be perfectly non-rival and hence the individual marginal evaluation curves are aggregated vertically in order to give the total demand for the good. Clearly a Pareto optimal amount of the good would be \( X_2 \) with A contributing \( p_1 \) and B contributing \( p_2 \) towards the marginal cost. However in isolation, only A would reveal his demand for the good and he would consume \( OX_1 \) of the public good free of charge. 28

Such a situation has nothing whatsoever to do with the number of individuals involved. It is the sort of action which is illustrated by an individual in a crowded room paying to hear a record on a juke box. Provided that his listening to the music is not impairs by the number of individuals in the room, then he will be unconcerned about them. He will play the record if the marginal evaluation of it to him exceeds the opportunity cost it entails. It may of course be the case that more than one individual finds that the marginal evaluation he gets exceeds the costs of the good. Within any group then there may be a sub-group in this situation. Whether these individuals bargain between themselves or employ strategic action in hoping to wait until some other person provides the good, is immaterial. The point is that over any given period each is irrational not to provide the good, and eventually there is a proposition that the good will be provided.

(ii) Difficulties in the provision of any output of collective good become more worrisome in the case shown where no one individual will be prepared to cover the full cost of the good.

In the diagram the optimal output of good X for individuals A and B would be \( X_1 \). However none of the good would be provided if the individuals were operating in isolation. In this instance the importance of large numbers comes to the fore. If numbers are small, e.g. just A and B involved then the probability of bargaining is high. Clearly if it was proposed by A that he pay \( OP_3 \) in the provision of two units of the good and B pay \( P_3^Y \), then since the marginal evaluation of a unit of X by B is equal to \( OP_4 \), and since \( OP_4 > P_3^Y \) there is a presumption that agreement may be secured. Indeed one could argue that in the case of a small group adjustments in the output of X may continue to \( OX_1 \). Why however are there problems as the size of the group gets larger?
(a) The most important effect of increasing the size of the group is that each individual in the group finds that his contribution to the costs of providing the collective good become less significant. As the size of the group increases he feels himself to be one of many, such that his personal contribution may in no significant fashion increase the likelihood that the good would be provided. In the case of the small group which has just been described, past experience will have made both A and B aware that their contribution is vital to the provision of any of the good. Yet in the case of the large group each individual may hope that the sub-set (i.e. everyone other than himself) could cover the costs, and if this does not occur he may feel that his own personal contribution, being one of many, would also be ineffective.

The small group is then characterised as one in which strategic interaction is important. That is the behaviour of one individual in the small group can effectively alter the likelihood of any of the public good being provided. The large group on the other hand is one in which the environment is taken as given and each individual does not feel that he can by his own actions effect it. The distinction is one which is readily used in economics as between the duopoly or oligopoly situation and perfect competition.

In the case of the provision of a collective good the effectiveness of strategic interaction in the small group can be clearly illustrated. Assume a small group of individuals wish to provide themselves with a good. Each individual is asked to contribute £500 in the hope that a good valued at £1000 by each will be provided. The total cost of the good however is well above £1000 and hence for its provision others must contribute.
In the matrix it is clear, that if the individual contributes and others contribute, then he stands to see a return on his contribution of £500. If he contributes and others do not, he simply loses his £500. On the other hand, if he does not contribute and others do, then he receives the full £1000 free of any charge, as the good is non-exclusive. If neither he, nor any others contributes, then he stands to gain nor lose anything. In the small group case, however, the individual realizes that his contribution is significant to the successful provision of the good. The probability 0.8 that if he contributes then others will respond by making a contribution and the good will be provided. In such a case, the net expected value of contributing is greater than that of not contributing.

In the case of the large group the individual does not feel that his contribution is significant. He takes the environment as given and assumes that the chances of others contributing if he contributes is exactly the same as others not contributing when he contributes. The result in such a situation is clearly that the expected value of not contributing is greatest.29

29. It might be noted that the same rationale as that discussed here is offered as an explanation for the behaviour of non-voting members of the public. That is to say, that each individual finds his vote so insignificant that the benefits of exercising the vote may not outweigh the costs. See A. Downs, An Economic Theory of Democracy, Harper and Row, New York. 1957.
(b) If no one individual evaluates the good at more than its cost then there is also a presumption that, as the group gets larger, bargaining costs between individuals will become formidable and again preclude the likelihood of its provision. When a collective good is to be provided by two or more individuals, costs in terms of time and effort in bargaining are incurred. These costs are taken to be an increasing function of the number of individuals in the group. While there may be economies to scale if a formal organization, or association, is employed to cope with such problems, and while therefore the average costs of bargaining may fall, it has been suggested that there are indivisibilities in such a cost function. That is to say that

"A group cannot get infinitesimally small quantities of a formal organization or even of an informal group agreement; a group with a given number of members must have a certain minimal amount of organization or agreement if it is to have any at all. Thus there are significant initial or minimal costs of organization for each group. Any group that must organize to obtain a collective good, then, will find that it has a certain minimum organization cost that must be met, however little of the collective good it obtains. The greater the number in the group, the greater these minimal costs will be."

(iii) There is another argument that draws attention to the problems of large groups providing themselves with quantities of

collective good. This argument looks at the benefits received from the collective good. Olson in looking to the comparative advantages of a smaller group notes; "in a very small group where each member gets a substantial proportion of the total gain simply because there are few others in the group, a collective good can often be provided by the voluntary self-interested action of the members of the group." The argument then would appear to be that as the group becomes larger, given that the good provided is non-exclusive, each individual member of the group will personally receive less than he did before, and hence the incentive for him to contribute has been reduced. This conclusion follows provided the benefit received from the good remains evenly distributed as the group gets larger and also provided that the total amount of the good provided remains constant as the group becomes larger.

In pursuing this argument one must be more careful than Olson in distinguishing between a rival and a non-rival non-exclusive good. Clearly when Olson talks about a 'share' or a proportion of a collective good, rather than the good in its entirety, then he is ascribing the good a degree of rivalness. In the case of a non-price exclusive, but rival collective good it is fair to argue that, if the total amount of the good to be attained is fixed, then as the group increases in size each member will stand to receive so little that they may be less inclined to contribute. In the case of a non-price exclusive and non-rival good the increase in the size of the group cannot lead to a fall in utility that each member will receive if the good is provided. All that may happen in this case is that individual costs of provision will fall if more of the larger group can be recruited to the organization. This point was

admirably taken up by John Chamberlain.

"Olson's lack of clarity regarding the relationship under consideration may stem partly from his use of the concept of "the fraction of the group gain (benefit) received by the individual. For an "exclusive" good, the fraction of the group benefit received by an individual plays an important part of the individual's decision and its consideration leads to the inverse relationship between group size and amount of the good provided that was found for an "exclusive" good in the previous section. For an "inclusive" good, however, the fraction of the total benefit received by a single individual is not so important, since there exists no rivalness." \(^{32}\)

The conclusion to be drawn from this, therefore, is that groups which desire non-exclusive rival collective goods are more likely to remain latent and immobilized as numbers grow than those groups who desire non-exclusive and non-rival goods. This clearly has implications for the B.M.A., which at least at this stage, is taken to provide a non-exclusive non-rival good.


There would appear little difficulty in reconciling the birth of the B.M.A. with the theory of collective goods. I would propose that whilst the medical profession in 1832 might be classed as a

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large group there was within this large group a sub-set of individuals with a particularly prominent demand for some quantity of the collective good that the B.M.A. or P.M.S.A. might produce. It would be difficult to enumerate the size of the profession in 1832 because of the problem of distinguishing qualified from non-qualified practitioner. However there were some practitioners who had a particular interest in both scientific research and medical education reform. Hastings himself typifies such a character. The licensing laws for example meant that his qualification from Edinburgh was not valid in parts of England so that he had much to gain by reform of medical education. Furthermore Edinburgh at the time had been one of the most prominent centres for medical advancement and Hastings had a history of deep interest in medical research. Indeed the peers of the profession such as Hastings and Professor Kidd of Oxford played an important part in the launching of the P.M.S.A. Interestingly they would clearly be individuals of considerable income. Hastings had one of the largest practices in Worcestershire. Such factors as these would suggest then that this small sub-set would have well above the average demand for the services of a professional association, i.e. their demand curves would be noticeably to the right of the remaining sub-set of the profession.

These early founders were then a small sub-section of the profession. To the extent that the services which they hoped to provide would be both non-exclusive and non-rival (i.e. they were an "inclusive group") they would not be bothered by the fact that they were a sub-set of a large group. That is to say that the personal benefit they hoped to reap from the provision of the
services of the P.M.S.A. would not be reduced because they were also open to non-members of the P.M.S.A.

Looking at the costs this sub-section must have faced, a number of observations seem in order. Firstly initial organization costs were for a small number of individuals and the indivisibility problem may not have been apparent in 1832. Notice that it was not until 1837 that membership exceeded 500. Secondly costs of organization were clearly falling during this time. The increased ease of transport and communications has already been noted, as have the organizational abilities of early founders.

With such evidence as this then one might analyse the early days in the following terms. No one individual has a marginal evaluation of the collective good desired which out-weighs the marginal costs involved. However a number of individuals together have sufficient interest to combine to produce a minimal amount of the good, i.e. some degree of intercourse of scientific work together with some amount of political lobbying. The following diagram may typify the situation.

The diagram for simplicity takes the costs of provision of the good as constant. The curve Dh is the demand curve of a representative individual in the Hastings sub-set and Dp is the demand curve for a representative individual of the remaining sub-set of the profession i.e. the total profession less the Hastings sub-set. The $\sum E_{Dh}$ curve is the aggregated demand curve for all the individuals in the Hastings sub-set. There is no problem in assuming that these demands will be revealed as this group is small. Bargaining costs are not high and each individual feels his contribution to be of the greatest significance. Because
of these factors, as well as the view that the good to be provided is non-rival, then some minimal amount is provided i.e. the P.M.S.A. is formed.\textsuperscript{33}

\[ f_q \]

\[ PM = \text{Marginal cost of providing the good.} \]

\[ DH = \text{representative demand curve for members of the sub-set typified by Hastings.} \]

\[ DP = \text{representative demand curve of individuals in the rest of the profession.} \]

\[ \sum_{i=1}^{n} DH_i = \text{aggregate demand curve of those in the Hastings sub-set.} \]

\textsuperscript{33} A similar line of reasoning has been presented by Olson and Zeckhauser, "An Economic Theory of Alliances", Review of Economics and Statistics, August 1966, pp. 266-279, to explain why larger countries carry almost all the burden of multinational organizations like the United Nations and N.A.T.O. The extension of this argument, as Olson points out, (The Logic of Collective Action) leads to "explain the popularity of neutralism among smaller countries." The larger countries then are the sub-set who provide defense treaties from which smaller countries who remain neutral and contribute nothing will benefit.
The foundation of the P.M.S.A. then need not be incompatible with the theory of collective goods. The growth of membership of the P.M.S.A. however is. It is all too tempting to argue that the variables referred to in chapter three merely push all demand curves to the right and therefore the association grows. This however is to ignore the most serious problem with collective goods. As the association grows each potential member will feel that his contribution is insignificant and that little more will be provided as a result. His logical course of action, as explained, is to contribute nothing and enjoy cost-free what is produced. If all act in this manner then the logical outcome is that, though demand curves may shift to the right somewhat, there is no incentive for any individual to join the association.34

Why then has the B.M.A. grown? In the following two chapters two possible explanations are examined. The first is that the assumption that the decision to join rests with the individual is unrealistic. That is to say the association has coercive powers, e.g. closed shop arrangements, to force individuals to join. The second is that there are other goods and services which doctors require and which are supplied only to members. Olson notes the existence of such factors in many large associations to which he briefly looks.35 But exactly how important are they?

34. Though never fully developed this problem has been recognized in literature examining trade unions. E. g. A. Rees, The Economics of Trade Unions, Cambridge University Press, 1962, p 27, "for a worker employed in an already unionized establishment, wages and hours are the same whether he is a union member or not. Thus it may require additional motives or pressures to lead him to join and to pay union dues."

CHAPTER FIVE

The British Medical Association
and the Closed Shop.

The conclusions following the effect of large numbers on the provision of collective goods may be reconciled with the fact that doctors join the B.M.A., if membership of the B.M.A. were compulsory. The choice of contribution towards a collective good is then clearly taken out of the hands of the individual. Some professional associations have adopted the status of a pre-entry closed shop e.g. as far as barristers are concerned no one who is not a member of one of the four Inns of Court, is allowed to plead a case before any one of the higher courts, while for veterinary surgeons, membership of the Royal College of Veterinary Surgeons is a condition of employment. The B.M.A. however has always resisted the adoption of either official pre-entry or post-entry closed shop status. The attitude of the B.M.A. towards a closed shop was made clear in the 1940's. In 1946, with the repeal of the Trades Disputes and Trades Union Act of 1927 it became lawful for local or other public authorities to make as a condition of employment that members of its staff should belong to unions or other such associations. The B.M.A. responded to this by issuing a letter to all local authorities dated 16th December 1946. In this it stipulated that, "The Association prefers that its membership should be voluntary ..." and that it was "opposed on principle to

a practitioner being required to join any body, British Medical Association or other ...."\(^2\)

It has been made clear that during the history of the B.M.A. there has always been a significant proportion of the medical profession who have practiced without subscribing to the Association.\(^3\) However, the absence of a formal closed shop does not preclude the possibility that at various times certain sections of the profession have not been subjected to informal pressures which may intimidate them into membership. In such a respect the American Medical Association proves an example par excellence.Whilst assuming a 'voluntary' status it nevertheless possesses a network of influence which might 'persuade' practising physicians in particular to seek membership. A review of this network appears a useful prelude to an investigation of the B.M.A.

The A.M.A. has a membership of approximately 75\% of American M.D.'s.\(^4\) However of those physicians engaged in private practice about 90\% are members of the Association.\(^5\) With the exception of southern negro physicians who have been barred because of colour, non-members are primarily physicians outside private practice - those in the armed services, medical school professors, physicians engaged in research, doctors in training and public health officers. A 1960 study indicated that only 35\% of the physicians not in

\(^2\) B.M.J. Supp., December 28, 1946, p 166. It is noteworthy that the B.M.A. were praised for such a stand, e.g. see The Economist, December 7, 1946, p 903.

\(^3\) See fig. one, Chapter Three.


\(^5\) Ibid.
private practice were A.M.A. members. The difference is clearly significant, and leads one to question whether or not the practising physician falls more easily under the powers of the A.M.A.

The powers of the A.M.A. originated with the Flexner Report of 1910. Abraham Flexner, representing the Carnegie Foundation, inspected American Medical Schools and his report, which was critical of many schools, persuaded legislators that only graduates of first class medical schools should be permitted to practice medicine. The authority to determine a first class medical school fell to the Council on Medical Education and Hospitals of the A.M.A. Should a school fail to meet the standards stipulated by the Council, then loss of approval by the Council would make it extremely difficult for that school’s graduates to obtain licenses. Friedman has therefore argued that by directly exerting pressure on schools to restrict admissions, or by requiring high quality standards, the A.M.A. can restrict the supply of physicians. This of course earns existing physicians an economic rent which has been estimated to be as high as 20% of their income.

Yet the licensing powers of the A.M.A. give even greater power. Part of nearly every American doctor’s medical education consists of hospital service known as residency. This training is administered by hospitals, but in order to undertake it the hospitals must have the approval of the A.M.A. Each approved hospital is allocated a quota of positions that can be filled by interns as part

of their training. This quota is highly prized by the hospitals as it is possible to produce medical care more cheaply with interns than without. If a hospital loses its class A rating then the loss of interns implies higher costs of production and a deterioration in the competitive position of that hospital vis-à-vis other hospitals in the medical care market. Not surprisingly, therefore, hospitals respond to "suggestions" of the A.M.A. to compose their staff solely of members of local medical societies. A practising physician is dependent on the use of hospital facilities in order to compete with his rivals. The result is that being cut off from local society membership and from hospital facilities amounts to a partial revocation of the license to practice medicine.  

The influence of the A.M.A. is therefore considerable and easily explains its high membership. It is the case for example that membership of the Association is vital in many cases in order that a doctor attain admission to specialty board examinations, success in which is a necessary condition for specialty ratings.  

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9. R. A. Kessel, Price Discrimination in Medicine, Journal of Law and Economics, October 1958, and R. A. Kessel, The A.M.A. and the Supply of Physicians, Law and Contemporary Problems, Spring 1970, No. 2, Vol. XXV. It is also of course the case that membership of the local medical society is fundamental for the American doctor to make the contacts necessary to pursue his practice. O. Garceau, The Political Life of the American Association, Mass.: Harvard University Press, 1941, p. 103 comments, "The social life of the county society is important to some doctors. Few can wholly disregard it, simply because a doctor can ill afford more than a few enemies, certainly not the hostility of an organized group in positions of local prominence. His reputation is a fragile thing, and his income and practice depend upon being called in consultation, though perhaps more vitally on being able to call his colleagues in emergencies. Ostracism becomes a terrible weapon in such a business."

10. R. A. Kessel, Price Discrimination in Medicine, op. cit.
Also of course officials of the A.M.A. are to be found on the very bodies that issue licences. In the U.S.A. there are fifty-five legally constituted medical examining boards granted authority to issue licenses to practice medicine and surgery. It is claimed that the policies of the various state bodies of medical examiners are virtually identical with those of the A.M.A.\(^1\) This is an inevitable product of the fact that in about half the states the medical society recommends appointees to the state board, in others the society nominates candidates for the office, and in one state the State Medical Society Board of Censors itself constitutes the State Board of Medical Examiners.

The A.M.A. then without question controls a web of influence which may effectively intimidate practising physicians at least into membership of the Association.\(^2\) Officially it does not enjoy the status of a closed shop but informally can attain the same ends. The question therefore to be asked of the B.M.A. are twofold. Firstly in what way does the B.M.A. pursue goals for which an official closed shop may be valued? Secondly to what extent does this intimidate doctors to join the B.M.A.?

The objectives which are attainable with closed shop status may be classified as: restriction of the supply of labour; reduction of inter-union rivalry; discipline of members, particularly during strike action.\(^3\) However there is also the possibility that benefits reaped in these areas may be achieved at the loss of

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sympathy from the public and within the profession if official closed shop status be declared. Depending on the efficiency of the B.M.A. in attaining these objectives the loss of sympathy in assuming closed shop status may well be a real cost and may help explain the Association's continued rejection of overt closed shop status. With this view in mind one can survey the history of the B.M.A. to show that it functions as well, if not better, without the formal and official use of a closed shop. 14

Any association may well court the disfavour of the general public by relying on the use of closed shop power. A Gallup Poll on the Trade Unions in 1959 found that 55% of the working population thought that members of Trade Unions are not justified to put pressure on non-members to join the union, even if this improved their negotiating power. 15 This public disfavour may be of particular importance to the B.M.A. In the first instance, the B.M.A. directly negotiate with representatives of the general public and hence may prize the approval and sympathy of the general public even more highly. Secondly, experience has shown that the provision of goods and services of a medical nature can engender quite an emotive public interest, and it may well, therefore, be more important that the B.M.A. appear to have limited coercive influence over individual doctors. For both these reasons, the B.M.A. may present itself more easily as 'the voice of medical


opinion*, if it is not a closed shop. Further to this however the B.M.A. might also suffer by use of a closed shop in so far as this brought into the Association recalcitrant members. Certainly there is evidence that doctors may not wholeheartedly approve of closed shop procedure. The incident in 1946 led to many irate letters in the columns of the British Medical Journal at the prospect of closed shop. If officials within the B.M.A. are interested in a "quiet life" they may then be reluctant to take any steps towards a closed shop. It is not surprising in this sense that McCarthy found within trade unions that the concept of closed shop was more agreeable to the militant rank and file rather than to the leadership.

There would therefore be costs to the B.M.A. in assuming official closed shop authority, while alternative means have existed to attain the ends of a closed shop arrangement.

5. 1 Restriction of the Supply of Doctors.

One of the potential 'benefits' of closed shop activity is the possibility of restricting the supply of labour. If, before being able to take up employment, an individual must be accepted by the association, then the association has a method of restricting the labour supply and possibly of influencing its remuneration. The closed shop in this way has been of particular importance to unions where the supply of labour is seasonal and non-specific e.g. seamen's and dockers' unions. In the case of doctors, however, much has been achieved by pressure on government rather than by closed shop authority.


The mid-nineteenth century stands as an obvious example of a period when alarm about the supply of practitioners was evident. The result was that the profession petitioned Parliament. An indication of the extent of this activity was the fact that between 1840 and 1858 seventeen bills calling for some form of medical reform were presented before Parliament. The result was an act which did not prevent competition to "qualified" practitioners by quacks but which did, as Professor Lees noted, provide distinct competitive advantages to the doctor who was on the Medical Register. The quack might be fined if he referred to himself as a "doctor of medicine" or took any title which might give the impression that he was qualified. He did not have the right to recover at law any charges for his activity, nor was he able to certify to statutory documents, e.g. death certificates. Possibly most important in terms of affecting the supply of medical practitioners was that only those with their names on the Medical Register could take up posts within government administered services. With the introduction of the National Health Insurance scheme in 1911 and the National Health Service Act of 1946, this privilege may have meant more than was envisaged in 1858. Honigsbaum commented on the situation after 1911,

"What they (the profession) wanted most of all was protection against the competition of unqualified practitioners. Here ... the 1858 Medical Act and the 1911 National Insurance (N.H.I.) Act satisfied much of their needs .... In America by contrast the doctors ... never

received even the numerical security granted in Great Britain in 1858. To this day, the only real safeguards American doctors have against "unregulars" like "chiropractors" are their own skills and the wonders of medical science." 20

The 1858 Medical Act was of course followed by the 1886 Amendment Act which ensured that for entry to the Medical Register doctors must qualify in surgery, physic, and midwifery and not merely in any one of these. As the General Medical Council enthusiastically raised the standard of qualification for entry the supply of qualified practitioners fell alarmingly. In 1866, for example they resolved that Greek should become a compulsory subject. By 1869, however, they were forced to accept that to insist on this requirement at that stage would mean that there would soon be no doctors to attend the poor. 21 Even so the G.M.C. retained a strict control over entry as is evident by their outlawing of the process of "covering" at the turn of the century. 22

The struggle to limit competition was to continue during the twentieth century. Offensives were launched against patent medicines as well as quack doctors; and the occasional trophy was gained. For example, the Venereal Diseases Act of 1917 prohibited practice by the unqualified in relation to these diseases wherever the Act had been put in force by the Ministry of Health. 23 Also,


22. An account of such a system was presented in Chapter Three.

in 1939 the B.M.A. contrived to have a clause inserted in the Cancer Act which forbade anyone but a registered medical practitioner from treating, or offering to treat, cancer by advertisement or any other means. In 1941 the Pharmacy and Medicines Act placed similar controls over the treatment of a long list of serious diseases, e.g. Bright's disease, cataract, diabetes, epilepsy or fits, glaucoma, locomotor ataxy, paralysis or tuberculosis.

It is probably an example of the profession's success against quacks and patent medicines that in the later part of the twentieth century panic arose about the growing supply of qualified practitioners. The profession would not be concerned for long, as a government committee, working with incorrect estimates, would take steps to restrict this supply. In 1951 the Lancet suggested that the number of doctors qualifying in England and Wales was about 200 in excess of the number of permanent posts available.

In 1953 it again drew attention to this, and by 1954 the British Medical Journal reported that the General Medical Services Committee recommended that the B.M.A. invite the Ministry of Health to set up a working party to examine the situation. It saw a great danger in what it called the "obvious risks of overcrowding to the profession."

27. B. Abel-Smith and K. Gales, op. cit., p 7.
The Willink Committee duly investigated and in 1957 recommended a reduction of student intake by a tenth from an early date as practicable. Interestingly, B. Abel-Smith and K. Gales reported that the intake of medical students had been reduced by about 10% before waiting for the recommendations of the report. As concern soon developed over the possibility of a doctor "shortage" in the 1970's, the "problem" of too many doctors appears to have been too harshly dealt with. Yet even in the late 1950's when "overcrowding" of doctors had generated great anxiety, there was no evidence of widespread substantial unemployment of doctors.

It would appear fair to comment, as a result of this history, that the medical profession is not one which needs to be over concerned about restriction of the supply of labour. Even so they have, of course, been openly criticised for practising measures which could be interpreted as supporting this end. For example, the Monopolies Commission pointed to the requirement that recognition of foreign medical qualifications was not based solely on the merit of the medical qualification, but also on whether there were reciprocal arrangements for British qualifications. The B.M.A. recognized the criticism though pointed to the fact that entry to the European Economic Community would serve to extend such arrangements.

29. Committee to Consider the Future Numbers of Medical Practitioners and the Appropriate Intake of Medical Students, H.M.S.O. 1957.
32. A. Lindsey, Socialized Medicine in England and Wales, Chapel Hill, 1962.
5. 2 Inter-Union Rivalry.

The elimination of inter-union rivalry is another goal which can be accomplished by closed shop status. This however is another area where the B.M.A. has proved successful without formally making membership compulsory. Although the challenge of alternative associations has arisen it has rarely proved particularly dangerous. That is to say that, without question the B.M.A. is, and has been, the body most able to speak for the whole profession, both in negotiation with the government and within the internal domestic decision-making of the profession. Most recently independent associations have sprung up to speak for sections of the profession. However the B.M.A. has established a position both inside and outside the profession which is difficult to threaten.

(a) The Position of the B.M.A. in negotiations with the Government.

Reference has already been made to the intimate relationship which the B.M.A. and the Department of Health and Social Security might be claimed to share. Even a Minister as hostile to the profession as Aneurin Bevan conceded that the B.M.A. should be carefully consulted on "all points of high principle involving regulations." 34

Examples have already been given to show that this partnership functions most smoothly when the informal relationship between B.M.A. officials and their "opposite numbers" at the Department are allowed to flourish. The commitment of the Department to the B.M.A.

as the sole voice of the profession has already been witnessed.\textsuperscript{35} There are, no doubt, advantages to the Department in having one recognized body to speak for the whole profession rather than a multitude of mutually incompatible demands from many practitioners' associations.

Although matters of importance are settled through informal negotiation a measure of how far the B.M.A. cherishes its relationship with the Department is seen in the efforts it takes to maintain control of its formal links.\textsuperscript{36} For example, when the profession

\textsuperscript{35} See Chapter Three, Section 4. It is worth noting that this intimate relationship has existed in wider circles than merely with the Department of Health and Social Security (formally the Ministry of Health). During the First World War, for example, the B.M.A. had a "gentleman's agreement" with the War Office that no doctor would be drafted except through the B.M.A. The B.M.A. then called up doctors, and there was no appeal from their decision except on the ground of conscientious objection. As such the B.M.A. was the only body of men entrusted with a like responsibility.

During this period, in April 1917, the War Office became dissatisfied with the number of doctors called up by the B.M.A. and issued an order calling up every doctor of military age. Pressure was brought to bear by the B.M.A., via Morant and Verrall, the Insurance Commissioners, on Lord Derby, the War Minister. The result was the prompt withdrawal by the War Office of the order.

The incident showed three things. Firstly the informal influence the B.M.A. had as representatives of the doctor with government departments. Secondly, the pressure they could exert to gain their own way. Thirdly, the authority they must have represented to the individual doctor. That is, whilst ostensibly a voluntary association the individual doctor was aware of the power the association could exert over his life.

The above account of the incident between the B.M.A. and the War Office is more fully documented in A. Cox, Among the Doctors, pp. 108-110.

\textsuperscript{36} The B.M.A. often prefers to negotiate informally rather than through formal channels. For an example of how able they are to get their way in this sense see Raymond Loveridge, Collective Bargaining by National Employees in the United Kingdom, Ann Arbor, 1971. Loveridge shows how the Whitely Councils for the profession in the N.H.S. failed because the B.M.A. preferred to negotiate directly.
negotiated the introduction of the N.H.S. the B.M.A. enjoyed a position of considerable strength within the negotiating committee. Since this time "autonomous committees", i.e. the General Medical Services Committee and Central Consultants and Specialists Committee, are able to negotiate the administration of the N.H.S., but their freedom to do so is dependent on the B.M.A. That is, while they are "autonomous", this is only in the sense that

"No action be taken by either of these committees which may prejudice the interests of another part of the profession without full prior consultation with the interests concerned, and that their autonomous powers be used so as to expedite the work of the Association."  

Despite the control the B.M.A. clings to in respect to these committees, it only accepted two representatives of the Medical Practitioners Union on the G.M.S.C. on obtaining assurances:

"that in any dispute with the Government the Union's support would be forthcoming from the moment the final decision was made, even if the Union as such had an opposite view up to that time; and that no separate approach would be made to the Minister of Health by the Union on any matter affecting the terms of service of general practitioners under the National Health Service."  

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37. The negotiating committee consisted of 31 members, 16 of whom were directly representing the B.M.A. See H. Eckstein, Pressure Group Politics, p 101.

38. Quoted in the Annual Reports of the Council of the B.M.A.

In more recent years the relationship with the Review Body on Doctors' and Dentists' Remuneration has been called into question. Associations such as the Junior Hospital Doctors Association and the Medical Practitioners Union have drawn attention to the advantage that the B.M.A. has been given in being allowed to present their case orally to this body.\(^{40}\)

As far as a threat to membership of the B.M.A. by other associations is concerned it has of course been noted that the B.M.A.'s membership is some 66,000 and the membership of each other respective association would not reach one-eleventh of this figure.\(^{41}\) Furthermore about two-thirds of the membership of other associations are also members of the B.M.A.\(^{42}\) The inter-union rivalry in the profession does not threaten B.M.A. membership significantly. The case of the Royal Colleges is a perfect example. There is no question of their influence in negotiations during and since the

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40. Interview with representatives of the J.H.D.A. and the M.P.U. The fact that the D.H.S.S. treats its relationship with the B.M.A. as more important than that with any other representative body of the doctors has more recently been revealed. After a long and well publicised break-down in negotiations between the D.H.S.S. and consultants, in which the Consultants and Specialists Association had taken a leading role, terms were agreed between the D.H.S.S. and the B.M.A., on behalf of the consultants, at a meeting to which the representatives of the Consultants and Specialists Association had not been invited. See The Economist, 26 April - 2 May, 1975, p 32.

41. See Chapter One, p 8.

42. See Chapter Three, p 120.
introduction of the N.H.S. Yet as far as membership is concerned they are primarily qualifying associations and eighty per cent of their membership also join the B.M.A. Interestingly however the importance of the Royal Colleges may be confined in the future since for tax purposes they have established the status of charities and must be careful not to undertake activity which might be construed trade-union like.

Whilst the formation of 'ginger groups' might from time to time provide some anxiety to the B.M.A., to argue that they are critically jeopardized by inter-union rivalry would be unfounded.

(b) The position of the B.M.A. in the professional world.

The B.M.A. has long enjoyed considerable influence internally within the profession. Its officials have long overlapped with the membership of the General Medical Council. Even before the

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43. The position of the B.M.A. with respect to the Department is deeply cherished. Their influence on both negotiating and advisory bodies is considerable. For example the Central Health Services Council is a statutory body whose function is to give advice to the Secretary of State on any matter which he refers to it, and also on any matter which the Council itself decides to consider, within the broad framework of actual or possible services under the N.H.S. The Council presents its own report to Parliament and the Secretary of State has to supply a preface giving reasons if he has rejected any of its advise. Its composition is laid down in great detail. R. G. S. Brown comments, "A majority of the members must be medical, including the main office-bearers of the British Medical Association and the three specialist Royal Colleges ex officis and others chosen after consultation with various medical bodies. This means in practice that they are chosen from names suggested by the B.M.A. and the Colleges, ...." See R. G. S. Brown, The Management of Welfare, Fontana, 1975, p 61.

advent of the directly elected proportion of G.M.C. members the B.M.A. had at least five of their more prominent leaders on the G.M.C. at one time. The addition of directly elected representatives gave the B.M.A. an important opportunity to add to this number.

The successfulness of the procedure of election of B.M.A. representatives to the G.M.C. is perfectly exemplified in the election of 1951, but the technique involved can be witnessed in almost every preceding election. In 1951 the B.M.A. put forward eight candidates for eight positions as direct representatives of the profession in England and Wales. As usual, these candidates were afforded the support of the B.M.A. and were given space in the B.M.J. to present their views. So effective was the support of the B.M.A. that all eight were elected, and the only candidate to fail was the one who stood without B.M.A. nomination. It is notable that the B.M.A. keep strict policy rules with regard to insuring that their nominees be elected, e.g.

"restricting the number of vacancies eventually supported on its whip card to the number of vacancies, in order to avoid the splitting of votes which would otherwise occur."

45. P. Vaughan, op. cit., p 50.

46. See B.M.J., Supp. February 17, 1951, p 49 and B.M.J., Supp. May 12, 1951, p 200. Also P Ferris, The Doctors, Penguin, 1967, p 99, who comments, "... the remaining eleven (le. members of the G.M.C.) are theoretically chosen to represent the profession at large; the British Medical Association organizes a postal ballot and more or less ensures that the eleven doctors of its choice are elected."

The dominance which the B.M.A. has enjoyed can be appreciated by examining the occasion when the B.M.A. did not involve itself in the election. In the election to the G.M.C. of 1970-71 candidates supported by the medical publications "Medical World" of the Medical Practitioners Union, and "On Call" of the Junior Hospital Doctors Association did quite well. However, the total poll within the profession was much lower than it had been in the past. Clearly then the influence the B.M.A. can bring to bear on such elections is important. This influence may become all the more important in view of the recommendations of the report of the Brynmor Jones Working Party. The proposals of this committee included an increase in the proportion of directly elected representatives from 11 out of a council of 47 to 29 out of a council of 67. While this would not put the directly elected members in the majority, it would change the balance between the directly elected and those who are representatives of the universities and the colleges.

Clearly there seems to be no evidence that the position of the B.M.A. within the profession has been seriously subject to challenge. Once again the B.M.A.'s position of influence within the profession has shown itself as capable as closed shop authority in offsetting the likely rise of rival associations.

5. 3 Discipline of Members and Strike Activity.

Another of the functions of closed shop arrangements is to provide a mechanism whereby members can be disciplined, such that

no member can harm the interests of the group without fear of retaliatory action. To a large extent for the medical profession this function is performed by the General Medical Council, though the B.M.A. has performed a police-like activity in isolating individuals and bringing them before G.M.C.\textsuperscript{50} If for example any doctor brought before the Disciplinary Committee was to be found guilty of the "unethical" practice of advertising, then the group's interests might be harmed, and he would be erased from the Register. Such "unethical" practices are attacked in that wide-spread advertising might lead to a lowering of the general standards of medical treatment. Hence the consumer is protected, while medical practitioners are also protected from their trade falling into disrepute. This argument is questionable particularly from the consumer's point of view. Indeed consumers have expressed a desire for more advertising of an informative kind, e.g. on the particular specialisms or interests of general practitioners.\textsuperscript{51}

Discipline must appear more of a problem at times of conflict, but, even though there is not the formal pressure of a closed shop, this does not mean that other social pressures cannot be mustered to keep discipline. Sir John Conybeare relates incidents that occurred during the struggle over the introduction of the National Health Insurance scheme.\textsuperscript{52} At one stage of the conflict in 1911, the B.M.A. circularised both members and non-members to sign a petition

\textsuperscript{50. B.M.J.}


\textsuperscript{52. Sir John Conybeare, "The Crisis of 1911-13, The Lancet, May 18, 1957, p 1033.}
undertaking not to give any service under the N.H.I. scheme except by permission of the B.M.A. Conybeare pointed out that, as the struggle continued,

"The British Medical Journal of June 22, 1912, warns members that they must not accept appointments on provisional insurance committees formed under the Act nor even accept medical appointments in the Sanatoria under the Act.

Attempts were made to bring pressure on consultants and practitioners. The latter were urged to employ only those consultants who had not signed. Honorary staffs of hospitals were told to limit appointments as house officers and registrars to those who had signified their adhesion to the policy of the Association ...........

One suggestion made which indicates the strength of feeling among representatives, was that the General Medical Council should be approached with a view to their dealing with "blacklegs" as guilty of infamous conduct. It was also proposed that the names of those members of honorary staffs of hospitals who had not signed the
supplementary pledge should be circulated to
secretaries of divisions."

The use of social pressure was by no means new at the time of
the introduction of the N.H.I. Bill. At the turn of the century
the B.M.A. had been engaged in solving the problem of the free
treatment provided in hospital wards and out-patient departments
to potential paying patients of general practitioners. One
specific stand against this practice was made at the Great Northern
Central Hospital. In 1894 this hospital introduced pay wards for
the treatment of patients a little above the poorest class. However,
the medical staff agreed to give such patients free services
provided that the patient had been admitted with the written consent
of their own medical attendant. This was not enough of a safeguard

53. Ibid, p. 1033. It would probably be presumptuous to argue that
the B.M.A. has used the G.M.C. to discipline the profession more
tightly at times of conflict with the government. This of course
would be the time when each doctor's responsibility to the
profession would need to be stressed. The totals erased from the
Registers do rise prior to major controversies i.e. 1906-10,
1941-45. However the totals involved are small and no importance
is attached to this.

TABLE.
The total number of practitioners erased in
each consecutive period of five years
from 1901 to 1955.

<table>
<thead>
<tr>
<th>Five Year Period</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901-05</td>
<td>15</td>
</tr>
<tr>
<td>1906-10</td>
<td>27</td>
</tr>
<tr>
<td>1911-15</td>
<td>20</td>
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<td>1916-20</td>
<td>26</td>
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<td>1921-25</td>
<td>24</td>
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<tr>
<td>1926-30</td>
<td>16</td>
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<td>1930-36</td>
<td>28</td>
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<tr>
<td>1936-40</td>
<td>30</td>
</tr>
<tr>
<td>1941-45</td>
<td>56</td>
</tr>
<tr>
<td>1946-50</td>
<td>11</td>
</tr>
<tr>
<td>1951-55</td>
<td>24</td>
</tr>
</tbody>
</table>

(Source Medical Register 1958, Appendix VIII, p 26)
as far as general practitioners and the B.M.A. were concerned. Clearly pressure was to be used in this instance for Dr. Hugh Woods, a member of the Medical Charities Committee of the B.M.A. wrote to say that he was "pleased to hear on all sides firm resolves to abstain from calling into consultation any member of the staff who gives his services gratuitously in these pay wards."54

Most certainly the threat of professional ostracism was a weapon which the profession used to discipline members in their battles with the Friendly Societies at the beginning of the twentieth century.55 No finer example of the use of the weapon by the B.M.A. exists than in the case of Dr. Burke.56 In 1906 the medical staff of the Coventry Providence Dispensary aired two grievances. In the first case they objected to the control of the affairs of the Dispensary by a committee of laymen rather than medical men. Secondly, they claimed that the wages of many of the users of the Dispensary had risen so that they should be denied membership of the Dispensary. As the management committee of the Dispensary refused to take action in sympathy with these grievances


55. B.M.J., Supp. May 4, 1946, p 711, looks back at an article in the Derbyshire Times, October 4, 1902. This discussed the fight of the profession with the Oddfellows and the Druids on the same terms, and the doctors, while willing to tend the wage-earner whose employment had ceased during his illness, were not prepared to extend this to his family while the breadwinner was in receipt of full wages. The Druids objected to paying the doctor 4 shillings at Chesterfield when their fellow members at Sheffield paid only 2 shillings and 6 pence. The Lancet at this time predicted professional ostracism for any medical man who accepted an appointment as medical officer to these benefit societies.

56. An account of this is available in Pratt v British Medical Association, (19.9), 1 K.B., 244.
the medical staff resigned. The Dispensary sought medical assistance elsewhere and Dr. Burke moved to the area to work for the Dispensary in 1907.

Between 1904 and 1907 the B.M.A. had put forward model rules which its divisions could if they wished, adopt. Three of these rules F, G, and Z, contained the basis of an effective boycott mechanism. They stipulated that no member was to hold any professional relationship with any medical practitioner whom the division had deemed to be guilty of conduct detrimental to the honour or interests of the profession. If, in an emergency, such professional relations were held with the offender, these must be reported for investigation by the ethical committee of the B.M.A. It followed then that after 1908 Dr. Burke would fall victim of the substance of these rules. He was advised by the B.M.A. that he was not expected to take the post at the Dispensary, and when he continued with this action he was expelled. The Association informed doctors in Coventry, Birmingham, Nuneaton, Tamworth, Leicester, Northampton, Nottingham, Leamington and York, which were the areas in which Dr. Burke might look for assistance. J. McCardie commented,

"I am satisfied that the notices circulated by the defendants in Coventry and the surrounding divisions were intended to and did in fact operate coercively. They were more than warnings. They were threats, and were meant to be threats. Behind these loomed the power of the defendant Association and the whole machinery of the boycott scheme. They
were emphasised by the "black list" published every week by the defendants in the B.M.J."57

Dr Burke was joined by Dr. Holmes and Dr. Pratt. However, with the exception of one practitioner, the B.M.A. achieved a total boycott of those doctors even though throughout the Midlands actual membership of the Association was only 50%.

(b) Strike Action.

If closed shop status might have made the B.M.A. more successful in its collective strike action then there was possibly an argument for the adoption of such an arrangement. Indeed the major negotiations between the B.M.A. and the government, i.e. 1911-13 and 1944-48 showed that, either because of, or in fear of, doctors breaking ranks, the B.M.A. was forced to acquiesce. However, it is also the case that in both instances the B.M.A. could hardly be described as defeated. In fact it was probably the success they had in establishing the conditions of the N.H.I. and N.H.S. schemes that led doctors to desert any exceptionally militant stand.58 It is doubtful that a closed shop would have made any difference. Doctors in 1913 did not lightly break their pledge to the B.M.A., but were nevertheless eager to acquire the good conditions negotiated. On December 13, 1912, a meeting was held in the Holborn Restaurant, London, of medical practitioners who were willing to serve under the

57. Ibid, p 252.
58. In 1913 the Westminster Gazette commented,

"We all admire people who don't know when they are beaten. The trouble with the B.M.A. is that it doesn't know when it has won."

Act. They formed the National Insurance Practitioners' Association and wrote to the Chancellor asking whether doctors who took service under the Act would receive the Government's support against boycott or intimidation. On the eighteenth of December, Lloyd George replied to the letter, assuring doctors on this matter and promising Government support by every means in its power.⁵⁹

If the absence of a closed shop arrangement has handicapped the B.M.A., it is of course noteworthy that the B.M.A. has alternative weapons in its armoury. The services of doctors are such that the mere threat of strike action in the form of refusing to work within a government scheme is potent in itself. In the discussions on remuneration in 1965 Marmor and Thomas explain the B.M.A.'s success in the following terms,

"What had changed was the mobilization of professional opinion. The threat to strike had intervened. The Ministry at no time was worried about the resignation of 17,000 doctors, and the B.M.A. was never confident that more than a third of that number would actually go out of the N.H.S. But the fear was that substantial sections of the country would be faced with a crisis of medical supply, that a government with only a bare majority would face a crisis of confidence."⁶⁰


Not only, however, has the threat of strike action been potent, but also the B.M.A. has found the policy of seeking arbitration has often more than fulfilled its needs. This is perfectly exemplified in the ruling of Sir Justice Dankwerts in March 1952, when he adjusted the Spens award by a betterment factor of 100 per cent for 1952, and used a percentage of 38.7 per cent for practice expenses; both higher than the B.M.A.'s original claims. The B.M.A. had not been opposed to arbitration in principle, and the lesson learned by those who were interviewed by Marmor and Thomas, was that it is "extraordinarily expensive to have medical payment disputes arbitrated." The Review Body set up in 1960 was accepted by the B.M.A. and the lessons of 1952 have been repeated, e.g. in the Review Body Award of 1966.

One of the most effective instruments open to the B.M.A. is the use of the B.M.J. to black-list posts which do not meet with the Association's requirements. The use of this weapon was perfectly exemplified in 1920. In March of that year the Worcestershire County Council submitted for publication in the B.M.J. an advertisement for seven school medical officers. It was known that a salary of £450 per annum was proposed, and the attention of the Clerk of the County Council was drawn to the fact that unless a salary of £500 a year was given the advertisement could not be published. The Journal also refused at this time to advertise for the Council for an assistant county medical officer and school oculist, and an "Important Notice" was put in the advertisement pages of the Journal regarding the Council. The Council advertised in the lay

61. Ibid, p 424.

press but failed to find anyone suitable. By September they had revised their salaries such that the £450 per annum originally intended for a school oculist was £550 per annum, rising by £15 a year to £600. The refusal of advertisements and the black listing of appointments which do not meet the requirements of the B.M.A. can then be effective. Indeed in 1968 as a result of an Important Notice in the British Medical Journal, and also of advice given to deans of medical schools, recruitment to the Armed Forces was "virtually brought to a standstill." 63

5. 4 An Assessment.

It is clear that the B.M.A.'s rejection of official closed shop status appears a sensible policy. It does have alternative mechanisms to achieve the objectives for which formal closed shop is valued. However, it may be noted that although coercion over the individual doctor has been employed for purposes of discipline, it has not been prominent in the history of the B.M.A. Furthermore, of importance to this study is the fact that such coercion has been rendered to make individual doctors comply with the policy of the B.M.A. rather than to take up membership of the B.M.A. The incident with Dr. Burke, for example, found virtually 100 per cent of the doctors in the Midlands area complying with the policy of the B.M.A. even though only 50 per cent were actually members of the B.M.A.

63. Dr. Derek Stevenson, Secretary of the B.M.A., B.M.J. Supplement 23rd November, 1968, p 39. This is a classic example of history repeating itself. About one hundred years prior to this incident, the Army and Navy Gazette accused the B.M.A. of similarly depriving the Army of Medical Officers; see E. M. Little, History of the British Medical Association 1832-1932, London, 1932, p 152.
In this way therefore it seems realistic to make the assumption that doctors are truly free to decide to consume membership of the B.M.A., and to look elsewhere for the explanation for their so doing. The B.M.A. achieves the ends for which closed shop arrangements are used by its influence with the government, with medical schools, and, through the B.M.J. and G.M.C., with the profession. The fact that coercion of the individual doctor has played a minor role in its history leads authors such as Forsythe to comment,

"There is no question, for example, of a B.M.A. division being able to coerce an individual recalcitrant by withdrawing his hospital admission privileges as can the American Medical Association or the Canadian Medical Association. The area of operation for the B.M.A. is, therefore, narrowly circumscribed ..."  

While it is accepted that the individual doctor is free to adopt membership of the B.M.A. or not, the previous discussion raises doubts on just how "narrowly circumscribed" the B.M.A. actually is.

64. G. Forsythe, Doctors and State Medicine, Pitman, 1966, p 12.
CHAPTER SIX

The B.M.A. and 'Selective Incentives'.

An alternative explanation for the fact that large numbers of doctors voluntarily join the B.M.A. may lie in the 'selective incentives' which are offered by the Association.¹ Selective incentives may be defined as goods and services which bear the characteristic of being price-exclusive. That is to say receipt of such goods is dependent upon becoming a member of the association. Such goods need not be pure private goods in the sense of being exclusive and rival. Indeed many such goods may be non-rival within capacity limits. The B.M.A. for example provides a whole range of goods and services over and above the pure public good of wage and working conditions improvement. Membership of the B.M.A. brings such advantages as: a free and regular copy of the B.M.J.; the right to attend local and national meetings which provide medical research, political, and social interest; availability to advisory assistance from local officials or from central committees established for that specific purpose; and also the possibility of concessions in the purchase of insurance.² Whilst some of these goods may be classed as private, e.g. the possession of a personal copy of the B.M.J., others may not be viewed as completely rival. Consumption of a local branch meeting for example may well be non-rival within capacity limits. Nevertheless all the services do share the characteristic of being excludable. Hence it can be argued that it is

¹ M. Olson Jr., The Logic of Collective Action, op. cit.
² B.M.A. advertisement hand-out.
for these goods and services that doctors join the B.M.A., and that
the pure collective good it provides is simply a 'by-product'.

If the selective incentives provided by the B.M.A. were all
purely private goods then this explanation would immediately run
into difficulties. If it was solely private goods that doctors
wanted from the B.M.A. why then would an association be required?
Why is it that these private goods could not be distributed through
the market like any other private goods? The fact, however, that
many of the goods the Association provides are 'impure collective
goods', in the sense of being excludable but to some extent
non-rival, maintains the raison d'être for the B.M.A. and indeed
shows why membership of the B.M.A. may be large.

Goods which are excludable but non-rival to a certain degree,
are those goods and services normally provided by clubs. Sports
clubs may provide such goods e.g. swimming pools, or social clubs
may provide theatrical entertainment. Consumption of a swimming pool
or theatre is non-rival up to capacity limits when congestion would
reduce the benefit each person received. In the case of the B.M.A.
many historians argue that its early days were almost completely
those of a medical research club. That is to say that the B.M.A.
provided meetings for the purpose of listening to lectures or
exchanging research or social interests. The optimal size of such
a meeting may be illustrated as in the following diagram. The curve
C, shows the declining costs to any member as more individuals share
the costs of providing the meeting. The share of these costs is

3. M. Olson Jr., The Logic of Collective Action, op. cit.,

4. The following analysis is based heavily on J. M. Buchanan,
"An Economic Theory of Clubs", Economica, 1965; and Yew Kwang Ng
"The Economic Theory of Clubs: Pareto Optimality Conditions",
taken for simplicity to be equal amongst participants, as is the share of benefits. The $B_1$ curve denotes the benefit to this person as more individuals attend the meeting. Clearly this may increase at first, e.g. possibly due to the rising standard of debate as more views are aired. However eventually the benefits per person will fall as congestion occurs. The optimal number for such a meeting would then be $S_1$

![Diagram](image)

**fig (i)**

Although this is the optimal size of the meeting it need not of course be the optimal size of the club. The problem of congestion is postponed by increasing the output of the club. More than one meeting may be held. Costs for the individual person may not rise as fast as benefits because of the non-rivalness in consumption.
Indeed there may then be an argument for quite a large club, holding many meetings. If $h$ meetings were held the benefits to members of the club may be increased by the growth of club membership to $Sh$.

Following this line of argument, not only does the excludable good provide the motive for assuming membership of the B.M.A., but the optimal size of the club itself i.e. where net benefit per person is maximized, could be large. The precise size of the club would depend jointly on the degree of non-rivalness in consumption of the output of the club and the potential availability of economies to scale in its production.

The optimal quantity of the good to be supplied is examined in the following diagram. If the size of the club were $j$ members then no amount of the good should be supplied. However when membership of the club reaches $K$ then $QK$ meetings should be held.

The following diagram shows how the establishment and growth of the B.M.A. in a locality might be explained. From fig 1 we may
draw \( N_{\text{opt}} \) which gives the value for optimal club size for each goods quantity, and \( Q_{\text{opt}} \) which plots the values for optimal goods quantity for each club size.

The position indicated by \( G \) would be a position of equilibrium for the number of meetings and also the number of the club. Assume for example that \( Q_g \) branch meetings are to be held in a particular locality. The total optimal number in the club for this number of meetings is \( N_k \). However, with \( N_k \) in the club even higher net benefit per person can be attained by the provision of \( Q_t \) meetings. With \( Q_t \) meetings \( N_l \) is the optimum club size, but such a club size calls for \( Q_b \) branch meetings in that locality. So the process continues until the equilibrium position of \( G \) is reached.

In this way therefore the club may grow and grow. The B.M.A. metropolitan branch have in just such a manner postponed the problem of rivalness by increasing the number of divisional branch meetings.
in their area. In such a way therefore there is nothing to indicate that clubs must be small. If the problem of rivalness can be so postponed and if there are economies of scale, e.g. in the administration of the club as the number of meetings increase, there is no reason that club size will not grow.5

The argument is summarized below. The diagram shows the net benefit per person as the number of meetings increase. If only one meeting were held the club size would be small i.e. $N_1$. However provision of more meetings postpones the problem of rivalness. As potential membership exceeds $N_A$ it is feasible to establish two divisions in the area and run two meetings for membership. In the diagram optimum size for membership is $N_3$

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5. J. M. Litvack and W. E. Oates, "Group Size and Output of Public Goods", Public Finance, Vol 25, 1970, pp. 42-57, argue that even when congestion costs do occur, their cost will be offset to some extent by the savings which result from spreading the costs of output over a large number of consumers.
Enough has been said to argue the case that firstly, if the
good provided by the association is exclusive then doctors will join
in order to establish property rights to the good, and secondly,
even if the good is only non-rival for small numbers the problem of
rivalness can be postponed by increasing the quantity of the good.
On the basis of this argument one should not be surprised that
doctors join the B.M.A. and also that the B.M.A. has a large member­
ship. The question that is begged, however, is how important are
the exclusive goods provided by the B.M.A. to its membership. Do
these exclusive goods provide the motive for membership by comparison
with the non-exclusive goods and services the association provides?

6.1 The Importance of 'Selective Incentives'

to B.M.A. Membership.

In an endeavour to provide data on the importance of 'club
benefits' to members of the B.M.A. and to determine whether member­
ship depended on selective incentives, a questionnaire survey of
doctors in the Leicestershire and Rutland area was undertaken in

6. It will be noted that the exclusive goods and services referred
to with respect to the B.M.A. are all tangible. There are
probably intangible "goods" received which are also exclusive.
E.g. a feeling of security, or of identity, or of integrity,
which are enjoyed by the individual as a result of personal
membership of the Association. Such psychological effects of
membership of an association have been examined, e.g. L Chaffen,
"The Psychological Effects of Unionism on the Member", The
Mark van de Vall, Labor Organizations, Cambridge University Press,
1970, Chapter 5; E. Wight Bakke, "Why Workers Join Unions",
Personnel, July 1945, Vol 22, No. 1. Here however attention is
concentrated on the tangible exclusive benefits of membership of
the B.M.A. Firstly, it would be difficult to test the full
significance of intangible selective incentives. Secondly, there
is the danger of describing too much as selective incentives and
as a result losing some of the predictive bite of this argument.
June 1972. Four questionnaire forms were distributed to each of the 665 doctors in the area. The forms were designed for hospital doctors and general practitioners, both members and non-members. Each doctor was asked to complete the relevant form. Doctors who answered these forms, but who did not fall neatly into one of the four categories, answered the relevant questions on one of the forms and indicated their particular specialty.

Of the 665 doctors who received the questionnaire forms 485, or 73 per cent, were members of the B.M.A. and 180, or 27 per cent, were non-members. The number of replies totalled 335, or 50 per cent of the total, and of these 279 were from members of the B.M.A. (i.e. 58 per cent of members) and 56 were from non-members (i.e. 31 per cent of non-members). Of the 335 that replied, 10 per cent

7. This survey was made possible by a grant financed by the University of Leicester. It was undertaken with the kind co-operation of the British Medical Association. Dr. Derek Stevenson, the Secretary of the B.M.A. was particularly helpful in granting me a personal interview. Dr. Parkes Bowen, the Secretary of the Leicestershire and Rutland Branch, also provided considerable assistance in the formation of the questionnaire forms.

8. These questionnaire forms are shown in Appendix A. They were distributed together with a covering letter from the B.M.A.

9. While this total is not large it is considerably larger than other sample surveys which have looked to the work of doctors. E.g. W. P. D. Logan and A. A. Cashion looked to a sample of 106 practices in Studies on Medical and Population Subjects, No. 14, Vol 1, 1958. Wilson et al looked to 59 doctors in the Liverpool area in their survey on the Influence of Different Sources of Therapeutic Information on prescribing by General Practitioners, B.M.J., September 7, 1963, Vol 11, pp. 599-604.
were chosen for interview in order to ask more detailed questions than appeared on the form. 10

It was particularly advantageous to pursue this survey in an area such as Leicestershire and Rutland because it included doctors engaged in work in both city and rural surroundings. Each area may provide distinct problems for doctors, e.g. the concern of mileage payments may be more relevant to the rural doctor. In this way information obtained from doctors in this survey may be more widely representative than that of surveys situated on solely city or rural surroundings.

A description of the respondents to the questionnaire survey is provided in tables one and two. Some information is clearly shed on the work environment of members and non-members. It appears tempting to break down the sample of member doctors into various categories of work environment, and compare these proportions with a similar breakdown for non-members. This of course would have a weakness to the extent that biases might occur in the sample, e.g. a greater proportion of single handed general practitioner members. The greater the response rate the less likelihood there would have been of such a bias. However, since non-members' response was not particularly strong, either in

10. These 10 per cent were not chosen at random, but were chosen systematically in order to get an even distribution of doctors of all ages. Care was also taken to make this small sample representative of doctors who worked in the city of Leicester and also those who worked in more out-lying rural areas. Both general practitioners and hospital doctors were represented within the 10 per cent. Furthermore the 10 per cent was split between members and non-members in approximately the same ratio as that which applied for the total number of doctors in Leicestershire and Rutland. Although this 10 per cent sample was too small for statistical analysis it did add further insight to certain of the replies which doctors made on the questionnaire forms.
absolute numbers, or in terms of all non-members in the area a detailed comparison would hardly be justified. The survey can provide no more than a tentative indicator in this respect. It appeared for example that general practitioner non-members and members favoured work in partnerships of two, three and four doctors. They spend part of their time in work in hospitals and they have endured similar periods of hospital experience before entering general practice. There was no indication that the extent of private practice engaged in by doctors was greater for members than for non-members. One could not say therefore that the growth of partnerships of g.p.'s, or the use of hospitals, or the extent of private practice had a noticeable effect on B.M.A. membership. 11

11. The data permitted a chi-square test on the significance of working in general practice or hospitals on membership of the B.M.A. On the basis of the test it could not readily be said that such environment had no influence. It appeared that g.p.'s were more likely to join than hospital doctors. Eckstein, (Pressure Group Politics) argues that the B.M.A. has always been primarily a g.p.'s' association, though Stevens, (Medical Practice in Modern England) suggests that in the 1950's proportionately the same number of consultants as g.p.'s were members. These results would seem to support Eckstein, though the survey was taken at a time when hospital doctors felt, with some justification, that the B.M.A. had neglected them for the g.p.

The data did not support chi-square tests on the other comparisons referred to in the text. The number of g.p. non-members replying was so small that often expected observations were less than five.
**Table I. ANALYSIS OF REPLIES OF RESPONDENTS**

<table>
<thead>
<tr>
<th></th>
<th>Total Respondents</th>
<th>Members of the B.M.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Pc. of total respondents</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>201</td>
<td>60.00</td>
</tr>
<tr>
<td>Hospital Doctors</td>
<td>118</td>
<td>35.22</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors in the Armed Forces</td>
<td>5</td>
<td>4.78</td>
</tr>
<tr>
<td>Doctors in Infant Clinic work</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Doctors in Education Dept. Employment</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Public Health Doctors</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Industrial Doctors</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>335</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**Table II. ANALYSIS OF REPLIES OF GENERAL PRACTITIONER RESPONDENTS**

<table>
<thead>
<tr>
<th>General Practitioner Total Respondents</th>
<th>General Practitioner Members of the B.M.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>Pc. of general Practitioners</td>
</tr>
<tr>
<td>Retired general practitioners</td>
<td>17</td>
</tr>
<tr>
<td>Single handed general practitioners</td>
<td>19</td>
</tr>
<tr>
<td>Assistant general practitioners</td>
<td>7</td>
</tr>
<tr>
<td>General practitioners in partnership</td>
<td>158</td>
</tr>
<tr>
<td></td>
<td>201</td>
</tr>
</tbody>
</table>
One interesting piece of information which was unearthed by the survey was the fact that doctors tended to join the B.M.A. promptly on attaining their first medical qualification and seldom leave the Association.

Table 111. THE SPEED WITH WHICH DOCTORS JOIN THE B.M.A.

<table>
<thead>
<tr>
<th>Time After Qualification</th>
<th>No.</th>
<th>Pc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the year of qualification</td>
<td>170</td>
<td>60.93</td>
</tr>
<tr>
<td>One year later</td>
<td>37</td>
<td>13.26</td>
</tr>
<tr>
<td>In the 2nd to 6th year after qualification</td>
<td>53</td>
<td>15.43</td>
</tr>
<tr>
<td>In the 6th to 10th year after qualification</td>
<td>11</td>
<td>3.95</td>
</tr>
<tr>
<td>In the 10th to 17th year after qualification</td>
<td>5</td>
<td>1.44</td>
</tr>
<tr>
<td>Before qualification</td>
<td>10</td>
<td>3.58</td>
</tr>
<tr>
<td>Did not answer the question</td>
<td>3</td>
<td>1.08</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The explanation for the almost automatic entrance to the B.M.A. may be a number of factors. Firstly, the B.M.A. has been in existence since 1832 and it may almost be described as traditional to acquire membership. Secondly, the graduation in the fees for membership of the B.M.A. discriminates in favour of those who join early after qualification. Thirdly, an important factor in the formative years of a doctor's career is access to the columns of advertisements of vacant positions in hospitals and general practice that are published in the B.M.J. This of course is available weekly to the doctor at a much reduced rate provided that he is a member of the B.M.A.

12. See Appendix C.
member of the B.M.A. The Lancet also carries such advertisements, particularly of hospital posts; and literature circulated by drug manufacturers is beginning to provide such information. However, doctors interviewed in the sample have stressed the importance of the wider scope of advertisements presented in the B.M.J. Also some indicated the ease of availability of the B.M.J. by membership of the B.M.A., rather than, for example, competing for it in hospital libraries. Although the Professional and Executive Register of the Department of Employment now places a small number of doctors and although word of mouth is a useful source of information of vacancies, the B.M.J. seems particularly useful in this respect. It would appear that its pre-eminence depends upon the scope of advertisements and the advantages of acquiring a personal copy, explains the early membership of the B.M.A. by doctors.

However, while the individual doctor is quick to join the B.M.A. he is slow, even after settling in an appointment, to leave. In the survey 82.80 per cent of members of the B.M.A. had never left. This finding would seem to suggest that there are many other individual services that are of importance to the doctor. It is then to an examination of the exclusive goods and services provided by the B.M.A. that attention is focused. The survey attempts to answer the question of their importance to the average individual doctor.

(a) Local Services.

The regular branch meetings provided by the B.M.A. may be thought of as important to doctors for the interchange of scientific, medical and political ideas. Surprisingly, however, doctors in the Leicestershire and Rutland area take little interest in such meetings. It would have been possible, during the period specified, for
doctors to have attended two local divisional branch meetings. In fact, however, almost two-thirds of members had not attended one.

Table IV. ATTENDANCE OF LOCAL BRANCH MEETINGS

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members attending one or more meetings</td>
<td>35.1</td>
</tr>
<tr>
<td>Members attending no meetings</td>
<td>62.4</td>
</tr>
<tr>
<td>Those who did not answer this question</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

It was the case also, for those who attended meetings, that the larger proportion were not regular in attendance. Clearly two-thirds of those that did attend never attended more than twice.

Table V. FREQUENCY OF ATTENDANCE OF LOCAL BRANCH MEETINGS

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members attending once only</td>
<td>32.6</td>
</tr>
<tr>
<td>Members attending twice only</td>
<td>28.6</td>
</tr>
<tr>
<td>Members attending three times or more</td>
<td>38.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The percentage of those attending local branch meetings differed little between hospital doctors and general practitioners. In the case of hospital doctors 35 per cent attended, but of these 67 per cent attended no more than twice. Similarly 36 per cent of general practitioners attended and of these 61 per cent attended no more than twice. Forty per cent of those hospital doctors who attended, attended no more than once, and in the case of general practitioners, 31 per cent
of those attending only attended once.

This lack of attendance is clearly typical of conditions throughout the country. Dr. Roberts has presented statistics to show that, whatever the size of a division, only between ten and thirty doctors attended. Indeed it would appear that the largest proportion of members attending branch meetings are those who hold office.

"Enough non-executive members to defeat an executive committee resolution attended in only 25 per cent of divisions. 'In other words', said Dr. Roberts, '75 per cent of division business meetings cannot vote down anything put up by the executive committee.'"  

Mr. John Pringle, Public Relations Officer for the B.M.A. has noted the likely apathy of members of voluntary bodies, and the likelihood that only 10 per cent of members can be expected to attend meetings.

However, one would expect attendance to vary with the political climate, that is when the B.M.A. is locked in controversy with the Department of Health one would expect members' interest and support to be keener. This it is, but even in the B.M.A.'s greatest

16. It is noteworthy that, at such times, one would not automatically assume that, if the non-member's interest was similarly awakened, he would necessarily join the B.M.A. J. L. Brand, Doctors and the State, John Hopkins, Baltimore, 1965, points out that during the controversy over Lloyd George's National Health Insurance Bill non-members both attended and voted in B.M.A. meetings.
controversies attendance at meetings does not seem a necessity for members.

"Even at the height of the controversy leading up to the acceptance by the medical profession of the National Health Service Act in 1948, it was the exception for more than half the members of a Division of the British Medical Association to attend meetings." ¹⁷

Evidence would suggest then that the infrequent attendance of members in the Leicestershire and Rutland area is typical of a nationwide problem with which the B.M.A. is faced. However, in addition to branch meetings the B.M.A. also provides purely social events. In the questionnaire doctors were asked merely had they ever attended social meetings. The question with reference to social meetings was therefore left much more open. The results show that almost half of all members make no use at all of B.M.A. social meetings. In the case of general practitioners 44 per cent never attend and in the case of hospital doctors, 56 per cent make no use of social functions. For members as a whole 49 per cent don't attend social meetings. Furthermore, in the interviews carried out it was clear that attendance of social functions was a rare pleasure. Indeed it would appear that once in every three years would be a fair average rate of attendance. The reason often expressed for non-attendance was pressure of work.

The local services then which might be thought of as exclusive to members were not felt important by the membership. The national

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activity of the B.M.A. i.e. the political lobbying and negotiating for improvement of remuneration and work conditions, was by comparison felt to be the more important activity of the B.M.A.

Table VI.

MEMBERS' PREFERENCES FOR NATIONAL OR LOCAL ACTIVITY

<table>
<thead>
<tr>
<th>Members feeling the national activity was the more important to them</th>
<th>Per cent of total members</th>
<th>Per cent of general practitioner members</th>
<th>Per cent of hospital doctor members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members feeling the national activity was the more important to them</td>
<td>85</td>
<td>83.4</td>
<td>89.4</td>
</tr>
<tr>
<td>Members feeling the local activity was the more important to them</td>
<td>3</td>
<td>3.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Members feeling they were equally important</td>
<td>4</td>
<td>5.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Members feeling that neither was important</td>
<td>1</td>
<td>1.1</td>
<td>-</td>
</tr>
<tr>
<td>Members not answering the question</td>
<td>7</td>
<td>7.2</td>
<td>4.7</td>
</tr>
</tbody>
</table>

100.0 100.0 100.0

(b) Library Services

In conjunction with the local services of the B.M.A. the member can also enjoy the library services provided. The Nuffield Library at B.M.A. House will supply either books or photo copies at a much cheaper cost to members. However, it is hardly the case that this is an important service for members in the Leicester and Rutland
area. It is arguable that it is more important for hospital doctors than general practitioners, although not a large proportion of hospital doctors used this facility.

Table VII.

MEMBERS' USE OF LIBRARY FACILITIES

<table>
<thead>
<tr>
<th></th>
<th>Per cent of total members</th>
<th>Per cent of general practitioners</th>
<th>Per cent of hospital doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members using library services</td>
<td>17.2</td>
<td>14.4</td>
<td>22.4</td>
</tr>
<tr>
<td>Members not using library services</td>
<td>80.6</td>
<td>82.8</td>
<td>76.5</td>
</tr>
<tr>
<td>Members not answering this question</td>
<td>2.2</td>
<td>2.8</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Furthermore, of those members that used the library services during the period, 27 per cent used it once only and 10 per cent used it twice only.

The figures that emerge from this survey in respect of the use of library facilities seem to concur with those experienced throughout the country.

"Figures for the past ten years indicate that between 10 per cent and 20 per cent of the total membership make use of the library annually." 18

(c) Insurance Concessions

The library facilities then appear of little significance to the average member, as do the insurance concessions offered by the B.M.A. Such concessions are represented by the B.M.A., Personal Accident Insurance Schemes which provides a wide cover and under which a B.M.A. member who takes out £10,000 of insurance is told he will save £1.25 per annum. Also there are certain concessions which B.M.A. members can claim with the Medical Insurance Agency. The results of the survey show, however, that the large majority of B.M.A. membership in the Leicestershire and Rutland area does not take advantage of any such concessions. Again there was little difference in the results as between hospital doctor and general practitioner.

Table VIII.

<table>
<thead>
<tr>
<th></th>
<th>Per cent of total members</th>
<th>Per cent of general practitioners</th>
<th>Per cent of hospital doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members taking advantage of insurance concessions</td>
<td>34.8</td>
<td>36.7</td>
<td>34.1</td>
</tr>
<tr>
<td>Members not taking advantage of insurance concessions</td>
<td>64.5</td>
<td>62.8</td>
<td>64.7</td>
</tr>
<tr>
<td>Members not answering the question</td>
<td>0.7</td>
<td>0.5</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

(d) Advisory Services

An allegedly important service provided by the B.M.A. is the advice which it can provide for doctors.

"As motorists use the Automobile Association for advice about fog and traffic jams, so doctors use the B.M.A. for advice on partnership agreements, ethics, pensions and expenses." 20

Advisory services appear of importance to doctors particularly as the increasing regulations of the National Health Service make life more complicated. The B.M.A. has three standing Advisory Bureaux. Firstly, there is the The Commonwealth and International Medical Advisory Bureau which has as its main activity that of advising overseas doctors on matters such as registration, training and employment in this country. Use of this body has increased from approximately 700 inquiries per year in 1948 to 3,200 inquiries in 1968. 21 Secondly, there is the Medical Practices Advisory Bureau which has played an important role in finding appointments for doctors. This has become all the more important for general practitioners with the complications created by the Medical Practices Committee in regulating the movement of doctors in the country. The Medical Practices Advisory Bureau also acts as a locum agency, providing temporary appointments. Together with the Medical Practices Advisory Bureau there stands the final advisory body, i.e. the British Medical Association Career Service. This third body deals with such problems as entry into medical schools, financial support for mature students, pre-registration posts for doctors.

The extent of the influence of all three bodies is not that extensive. In 1971 there were 829 total inquiries for the B.M.A. Career Service. There were 1,935 written inquiries and 3,906 personal visits of inquiries to the Commonwealth and International Bureau. The Medical Practices Advisory Bureau dealt with 106 partnership vacancies; 193 requests for copies of forms on agreements between principals and assistants; 1,159 principals in general practice who requested help in finding a locum (664 of whom were actually helped); 5,598 requests for locums which appeared from hospitals (697 of which were filled). Even assuming that all these inquiries for advice and help represent inquiries from different members of the B.M.A. this only represents 19.6 per cent of the total membership of that year.

Clearly this percentage may be an under-estimate to the extent that doctors can get advice from local officials rather than by recourse to bureaux at headquarters. The results of the survey at Leicestershire and Rutland take this factor into account by asking a general question as to whether or not recourse had been made to the B.M.A. for advice. It appeared that the majority of members had at some time sought advice from the B.M.A. This was more especially the case with general practitioner members than hospital doctor members.

Table IX.

**PERCENTAGE OF MEMBERS' USING ADVISORY SERVICES**

<table>
<thead>
<tr>
<th>Members using advisory services of the B.M.A.</th>
<th>Per cent of total members</th>
<th>Per cent of general practitioner members</th>
<th>Per cent of hospital doctors members</th>
</tr>
</thead>
<tbody>
<tr>
<td>58.4</td>
<td>72.2</td>
<td>32.9</td>
<td></td>
</tr>
<tr>
<td>41.6</td>
<td>27.78</td>
<td>67.1</td>
<td></td>
</tr>
<tr>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Although a majority of members had turned at some time or other for advice from the B.M.A. it appeared clear that almost half of those who did ask for advice, were seeking help with only one sort of problem e.g. ethical procedure, taxation problems, contract difficulties.
Table X.

PER CENT OF MEMBERS' USING ADVISORY SERVICES
FOR ONE OR MORE PROBLEMS

<table>
<thead>
<tr>
<th></th>
<th>Per cent of members</th>
<th>Per cent of general practitioner members</th>
<th>Per cent of hospital doctor members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members seeking advice on one area of difficulty only</td>
<td>44.8</td>
<td>40.8</td>
<td>67.9</td>
</tr>
<tr>
<td>Members seeking advice in two areas</td>
<td>30.7</td>
<td>22.8</td>
<td>21.4</td>
</tr>
<tr>
<td>Members seeking advice in three areas</td>
<td>14.1</td>
<td>11.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Members seeking advice in four or more areas</td>
<td>10.4</td>
<td>25.3</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It was possible, from the questionnaire forms, to provide an indication as to what form of problems provide doctors with the greatest difficulties. Doctors indicated which area of difficulty caused them need to resort to the B.M.A. The number of those ticking each particular problem on the form was taken as a percentage of the total number of doctors seeking advice. As these problems were not mutually exclusive, and as a doctor might tick more than one, there is no reason for the following percentages to sum to 100. Nevertheless the table does provide a comparison of the relative importance of each area of difficulty.
Table XI.

PER CENT OF MEMBERS' USING ADVISORY SERVICES
FOR PARTICULAR PROBLEMS

<table>
<thead>
<tr>
<th>Problem</th>
<th>Per cent of total members using B.M.A. advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members seeking advice on ethics</td>
<td>35.0</td>
</tr>
<tr>
<td>&quot; &quot; &quot; &quot; career</td>
<td>12.9</td>
</tr>
<tr>
<td>&quot; &quot; &quot; &quot; in practice</td>
<td>21.5</td>
</tr>
<tr>
<td>&quot; &quot; &quot; &quot; setting up practice</td>
<td>35.6</td>
</tr>
<tr>
<td>&quot; &quot; &quot; &quot; setting fees</td>
<td>47.2</td>
</tr>
<tr>
<td>&quot; &quot; &quot; &quot; financial matters</td>
<td>11.7</td>
</tr>
<tr>
<td>&quot; &quot; &quot; &quot; some other matter</td>
<td>30.7</td>
</tr>
</tbody>
</table>

Though, to general practitioners at least, the advisory services may be important it is difficult to argue that they are a strong incentive to join the B.M.A. It is noteworthy, for example, that it was only in December 1968, that the Council decided that the Bureaux should make charges for services to doctors who are not members of the Association, and this had little noticeable effect in increasing membership. Returns from non-members showed they had used the B.M.A. for advice as non-members, and in interviews some felt confident of being able to do this in the future without becoming members.

Before leaving the discussion of advisory services it should be noted that the B.M.A. is not particularly active in the provision of medical defense for doctors. In America, the A.M.A. are very active

in this role, but in Britain such services are performed by specialist defence associations, e.g. the Medical Defence Union and the Medical Protection Society. This is not to say that the B.M.A. has not considered extending its influence. In 1887, 1897, 1903 and 1914 proposals to extend such services were discussed by the B.M.A. In 1920 the M.D.U. and M.P.S. were unsuccessfully approached by the B.M.A. in the hope that they would provide concessions for B.M.A. members if they joined en bloc. The B.M.A., then unlike the A.M.A. has less to offer members in this respect.

The British Medical Journal

In looking to the services provided by the B.M.A. one must not neglect the provision to each member of the British Medical Journal. It has been claimed that receipt of the American Medical Journal is an important factor in accounting for membership of the A.M.A.

"The importance of this attraction is perhaps indicated by a survey conducted in Michigan which showed that 89 per cent of the doctors received the Journal of the American Medical Association and 70 per cent read a state journal but less than 20 per cent read any other type of medical literature." 

In Britain there is evidence that the B.M.J. is similarly widely read. A survey on reading rates of medical journals was carried out

24. O Garceau, The Political Life of the American Medical Association, Cambridge, Mass. Harvard University Press, 1941 comments on p 103, that this is "one formal service of the society with which the doctor can scarcely dispense."


on general practitioners by the Government Social Survey for the Sainsbury Committee. The results of this survey are shown below.

Proportion of General Practitioners saying that they regularly looked at the Specified Journals and Periodicals.

<table>
<thead>
<tr>
<th>Name of Journal or Periodical</th>
<th>Proportion of General Practitioners regularly looking at each Journal or Periodical</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Medical Journal</td>
<td>84%</td>
</tr>
<tr>
<td>The Lancet</td>
<td>13%</td>
</tr>
<tr>
<td>The Practitioner</td>
<td>60%</td>
</tr>
<tr>
<td>Journal of the College of G.P.s</td>
<td>26%</td>
</tr>
<tr>
<td>Prescribers' Journal</td>
<td>85%</td>
</tr>
<tr>
<td>Drug and Therapeutic Bulletin</td>
<td>19%</td>
</tr>
<tr>
<td>Pulse</td>
<td>73%</td>
</tr>
<tr>
<td>Modern Medicine</td>
<td>59%</td>
</tr>
<tr>
<td>Medical News</td>
<td>49%</td>
</tr>
<tr>
<td>Medical World News Letter</td>
<td>55%</td>
</tr>
<tr>
<td>World Medicine</td>
<td>51%</td>
</tr>
<tr>
<td>Medical Tribune</td>
<td>29%</td>
</tr>
<tr>
<td>Medical World</td>
<td>44%</td>
</tr>
<tr>
<td>Others specified</td>
<td>31%</td>
</tr>
</tbody>
</table>

Clearly the 84 per cent of general practitioners who 'regularly looked' at the B.M.J. is impressive by comparison with the 13 per cent that looked at the Lancet. The problem is however, of comparing like with like. That is to say that the doctors having assumed membership of the B.M.A. receive their copy of the B.M.J. 'free'. The question is therefore whether individual doctors join the B.M.A. to read their own copy of the B.M.J. or whether they look regularly at the B.M.J. because they receive it free as a result of their membership. A comparison of B.M.J. reading rates with other journals or periodicals received free of charge seems to reduce the importance of the B.M.J.

For example 73 per cent looked regularly at Pulse while 85 per cent looked regularly at Prescribers' Journal.

A survey was carried out in 1972 of some 4,541 hospital doctors for the British Journal of Hospital Medicine. The survey had a 57 per cent response rate and was followed up with personal interviews. The interesting feature was that again hospital doctors found the B.M.J. more useful than the Lancet. Yet apparently of more importance to hospital doctors is the British Journal of Hospital Medicine which is distributed free to all N.H.S. doctors.

<table>
<thead>
<tr>
<th>Statements about Journals with which doctors agree</th>
<th>Hospital Medicine</th>
<th>BMJ</th>
<th>THE LANCET</th>
</tr>
</thead>
<tbody>
<tr>
<td>For keeping up with advances in medicine</td>
<td>68</td>
<td>67</td>
<td>56</td>
</tr>
<tr>
<td>Contains useful items on my speciality</td>
<td>65</td>
<td>60</td>
<td>48</td>
</tr>
<tr>
<td>Has a balanced view of medicine</td>
<td>54</td>
<td>36</td>
<td>25</td>
</tr>
<tr>
<td>Useful for post-graduate studies</td>
<td>70</td>
<td>47</td>
<td>38</td>
</tr>
<tr>
<td>Good for light reading</td>
<td>8</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>For book reviews</td>
<td>32</td>
<td>34</td>
<td>24</td>
</tr>
<tr>
<td>News of people and events in medicine</td>
<td>7</td>
<td>51</td>
<td>19</td>
</tr>
<tr>
<td>Good for social/recreational reading</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>For job advertisements</td>
<td>3</td>
<td>70</td>
<td>33</td>
</tr>
</tbody>
</table>

(Total percentages for all statements) (310) (373) (248)

There appears alternative medical literature therefore that British doctors rank as highly and consult as frequently as the B.M.J.

It would be wrong to interpret the high reading rate of the B.M.J. in

28. The details of this survey were kindly forwarded to me by Dr. M. Ware, the Editor of the British Medical Journal.
terms of doctors depending on it. Indeed it would be misleading to base any interpretation of the respective values of the B.M.J. and the Lancet totally on these reading rates. While the findings of the Sainsbury committee show reading rates higher for the B.M.J., surveys of reading rates in medical libraries show a greater dependence on the Lancet. In a survey on the use of periodicals in British Medical Libraries, Pendrill claims that the Lancet is a more popular journal than the B.M.J. W. Mell argues that, while the Lancet is essential for small hospital libraries, the B.M.J. may be considered as a supplementary periodical. Furthermore L. M. Raising in reviewing world biomedical journals between 1957-60 would attach greater importance and significance to the Lancet than to the B.M.J.  

The over-riding importance of the B.M.J. in terms of reading rates should not be interpreted as an explanation for membership of the B.M.A. That is, reading of the B.M.J. may be a result of the receipt of a free copy rather than because of the essential nature of the contents. In interviews with doctors in the Leicestershire and Rutland area reading of the B.M.J. referred in the main to scanning the contents and very rarely ever returning to actually read a particular article. Butler and Stokes found similar difficulty in relying on the answers to the rather ambiguous term "reading".

"A remarkably large proportion of trade unionists, 65 per cent, claim to read these (union) journals and two thirds of these claim to pay "some" or a

"good deal" of attention to them. However, since these journals give substantial coverage to policies, especially at election time, it is startling to find that only 30 per cent of their readers, that is to say only 20 per cent of all union members, could recall after the 1946 election having seen any articles on political questions.\(^{30}\)

In the Leicestershire and Rutland survey some indication of the importance of the B.M.J. to the doctor is sought by assessing the need of non-members of the B.M.A. to fill the gap of the non-receipt of the B.M.J. by subscribing to some other journal. The results show that the non-members of the B.M.A. had little need, in comparison with the members of the B.M.A. to subscribe to other medical literature. This may, of course, be due to the fact that members of the B.M.A. are more avid in reading journals. However, evidence suggests that it is because receipt of the B.M.J. is in no sense essential to the doctor.

<table>
<thead>
<tr>
<th>Table XII.</th>
<th>Members</th>
<th>Non-Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per cent of G.P.'s subscribing to any other journal than the B.M.J.</td>
<td>65 p.c.</td>
<td>57 p.c.</td>
</tr>
<tr>
<td>Per cent of G.P.'s subscribing to the Practitioner</td>
<td>55 p.c.</td>
<td>38.1 p.c.</td>
</tr>
</tbody>
</table>

The results of the survey were consistent with the results of the Sainsbury Committee in finding the Practitioner an important journal to which doctors subscribe. The Sainsbury Committee found that 60 per cent of doctors "look through most issues" of the Practitioner. They found that young doctors up to the age of 39 found the Practitioner the best source of information of drugs. Also doctors in partnerships of three or more found the Practitioner a better source than the B.M.J. for information on drugs.

In a survey of the sources of information for general practitioners Wilson et al have found that the medical journals are not particularly important for the G.P. They look to the source of information on prescribing by general practitioners and found medical journals an unimportant influence in comparison with information gained from representatives and postal communications from the pharmaceutical industry. This is clearly shown in the following table where the sources of information for treating various illnesses are shown. The small importance of medical journals in providing information would then hardly suggest the B.M.J. is essential to doctors.

It is submitted then that doctors do not join the B.M.A. primarily to maintain throughout their years of practice receipt of the B.M.J. Indeed figures between 1900 and 1950 show that publication of the B.M.J. fluctuates directly with membership of the B.M.A. It is the case then that when doctors leave the B.M.A. they do not feel it necessary to subscribe independently to the B.M.J. This may suggest that this reading of the B.M.J. is dependent on their membership of the B.M.A., and not necessarily that the B.M.J. is so vital that they feel compelled in any sense to join the B.M.A.

**PERCENTAGE OF PRESCRIBING FOR SPECIFIC CLINICAL CONDITIONS DUE TO DIFFERENT THERAPEUTIC SOURCES.**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Training</th>
<th>Consultant</th>
<th>Textbooks</th>
<th>Periodical Medical Journals</th>
<th>B.M.C. Prescribers</th>
<th>E.M.N.S.</th>
<th>Drug Firms</th>
<th>Discussion with G.P. Colleagues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonsils to trachea</td>
<td>22.7</td>
<td>12.3</td>
<td>4.0</td>
<td>4.4</td>
<td>15.2</td>
<td>1.9</td>
<td>3.1</td>
<td>29.2</td>
</tr>
<tr>
<td>Otitis media</td>
<td>30.2</td>
<td>9.5</td>
<td>3.3</td>
<td>6.6</td>
<td>9.4</td>
<td>1.9</td>
<td>36.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Nasopharynx, coryza, etc.</td>
<td>35.6</td>
<td>4.0</td>
<td>0.6</td>
<td>3.1</td>
<td>28.2</td>
<td>0.4</td>
<td>5.3</td>
<td>17.7</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>38.0</td>
<td>5.4</td>
<td>4.3</td>
<td>5.1</td>
<td>17.4</td>
<td>0.1</td>
<td>2.0</td>
<td>21.8</td>
</tr>
<tr>
<td>Chronic bronchitis, emphysema</td>
<td>31.2</td>
<td>4.8</td>
<td>2.2</td>
<td>6.1</td>
<td>20.0</td>
<td>0.4</td>
<td>3.8</td>
<td>26.6</td>
</tr>
<tr>
<td>Heart disease</td>
<td>47.3</td>
<td>19.5</td>
<td>2.2</td>
<td>8.8</td>
<td>5.3</td>
<td>0.8</td>
<td>14.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Hypertension, nephritis</td>
<td>22.0</td>
<td>17.4</td>
<td>8.0</td>
<td>9.8</td>
<td>15.4</td>
<td>0.9</td>
<td>3.0</td>
<td>22.2</td>
</tr>
<tr>
<td>Alimentary infections</td>
<td>31.6</td>
<td>7.1</td>
<td>2.7</td>
<td>4.6</td>
<td>15.2</td>
<td>0.8</td>
<td>14.3</td>
<td>19.7</td>
</tr>
<tr>
<td>Peptic ulcer, dyspepsia</td>
<td>39.3</td>
<td>6.9</td>
<td>2.7</td>
<td>6.2</td>
<td>22.8</td>
<td>0.0</td>
<td>2.8</td>
<td>18.3</td>
</tr>
<tr>
<td>Anaemia</td>
<td>27.3</td>
<td>19.2</td>
<td>1.1</td>
<td>6.8</td>
<td>9.3</td>
<td>0.6</td>
<td>4.7</td>
<td>27.9</td>
</tr>
<tr>
<td>Influenza</td>
<td>31.3</td>
<td>3.0</td>
<td>3.0</td>
<td>37.1</td>
<td>0.8</td>
<td>2.2</td>
<td>17.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Skin: sepsis</td>
<td>35.6</td>
<td>5.0</td>
<td>2.3</td>
<td>12.1</td>
<td>2.6</td>
<td>0.9</td>
<td>4.0</td>
<td>29.3</td>
</tr>
<tr>
<td>Skin: other</td>
<td>24.4</td>
<td>25.8</td>
<td>2.9</td>
<td>8.8</td>
<td>7.1</td>
<td>0.4</td>
<td>2.4</td>
<td>27.1</td>
</tr>
<tr>
<td>Genito-urinary: male &amp; female</td>
<td>33.9</td>
<td>16.1</td>
<td>3.2</td>
<td>6.5</td>
<td>16.0</td>
<td>1.5</td>
<td>3.0</td>
<td>18.1</td>
</tr>
<tr>
<td>Pregnancy: natal, pre-, post-</td>
<td>41.0</td>
<td>3.8</td>
<td>2.8</td>
<td>14.3</td>
<td>23.0</td>
<td>0.7</td>
<td>0.7</td>
<td>13.2</td>
</tr>
<tr>
<td>Rheumatism, neuralea, fibrositis</td>
<td>25.1</td>
<td>3.7</td>
<td>1.8</td>
<td>6.0</td>
<td>18.3</td>
<td>1.2</td>
<td>4.7</td>
<td>36.6</td>
</tr>
<tr>
<td>Arthritis joint injury</td>
<td>39.3</td>
<td>12.4</td>
<td>2.0</td>
<td>4.0</td>
<td>9.2</td>
<td>0.7</td>
<td>5.2</td>
<td>24.0</td>
</tr>
<tr>
<td>Neuroses, functional disease</td>
<td>26.0</td>
<td>13.3</td>
<td>2.0</td>
<td>7.9</td>
<td>13.4</td>
<td>0.1</td>
<td>6.2</td>
<td>27.4</td>
</tr>
<tr>
<td>Psychoses, schizoid depression</td>
<td>16.0</td>
<td>44.7</td>
<td>8.3</td>
<td>9.5</td>
<td>0.0</td>
<td>19.0</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Injuries and sequelae</td>
<td>53.4</td>
<td>6.0</td>
<td>2.6</td>
<td>1.7</td>
<td>13.8</td>
<td>0.0</td>
<td>1.7</td>
<td>19.8</td>
</tr>
</tbody>
</table>

NUMBERS ON REGISTER

B.M.J. CIRCULATION

B.M.A. MEMBERS

6.2 An Assessment

The main exclusive goods and services provided by the B.M.A. have been outlined. They clearly do not appear in any sense essential to its membership. A certain number of other services were mentioned, but these were clearly of even less insignificance. Sixteen members, or 5.7 per cent of membership, mentioned such subsidiary services as the restaurant for members in London, the advantage of trade discounts, the satisfaction from being able to serve on B.M.A. committees. Each of these sixteen referred only to one such service.

The findings of this survey would appear to indicate the danger of assuming that membership of an association or trade union can be explained by the fact that it provides not only pure public goods but also goods which are exclusive. It has too readily been accepted that the fact that such goods and services are very often provided would explain membership. Olson in particular spends considerable time and effort in listing many examples of associations which provide such services. Yet such an observation should be reconciled with the evidence in trade union literature that members seldom participate in meetings held by unions or seldom read literature distributed by unions. It is all to easy to equate the plethora of exclusive goods produced by associations with the arguments explaining membership, but similarly it is all too suspicious.

The argument that members only join for the exclusive goods provided by the association is also highly questionable in the

32 M. Olson Jr., The Logic of Collective Action, op. cit., Chapter IV.

33 Mark van de Vall, Labor Organizations, op. cit., pp. 95-102, summarizes a number of studies showing the poor attendance at union meetings, and pp. 126-127 shows that the motive for joining trade unions for personal information and advice is not important.
light of the fact that all associations providing such goods still produce the pure public goods which are non-exclusive. It would seem a fair assumption that some of their resources in terms of time and money must be devoted to this end. If it were the sole intention of members to pay subscriptions for the exclusive goods then why is there not a rise of associations producing only such goods and by not producing the non-exclusive goods being able to offer the exclusive services at a smaller subscription?

The provision of exclusive goods by associations may play a part in the decision of individual doctors to join the B.M.A., but it is insufficient in and of itself to reconcile this behaviour with the predictions of collective good theory.
Chapter Seven

The Individual and the Decision to Subscribe

The preceding arguments have failed to reconcile the theory of collective good provision with the existence, in the real world, of large associations such as the B.M.A. Inevitably then one is obliged to call to question both the suitability, and the realism, of assumptions which led to the conclusion that individuals will not subscribe to collective goods. At this stage the character of individual is to be re-examined and the implications of any change in his nature will be pursued. It will be useful later to discuss a possible distinction between his decision taking in an environment which might be referred to as "political", and that which the economist regards as the private market.

Looking firstly to the individual, it will be noted that the central assumption that has been made is that he is completely self-interested, i.e. that he is concerned purely with his own welfare or utility. To this assumption was added the refinement that he would seek to maximize his utility, and the constraint that he would do so in a rational manner.\(^1\) The individual is then perfectly selfish in the sense that his own personal happiness is his sole concern, and he is totally indifferent to the welfare of others. Such an assumption is immediately suspect. K. Boulding

\(^1\) Rational behaviour has been characterized by the following axioms.

(i) he can always make a decision when confronted with a range of alternatives;
(ii) he marks all the alternatives facing him in order of his preference, in such a way that each is either preferred to, or inferior to, each other;
(iii) his preference ranking is transitive;
(iv) he always chooses from among the possible alternatives that which ranks highest in his preference ordering;
(v) he always makes the same decision each time he is confronted with the same alternatives.

These conditions are drawn from Chapters 1 and 2 of K.J. Arrow, Social Choice and Individual Values Yale University Press 1951.
suggests,

"Anything less descriptive of the human condition could hardly be imagined. The plain fact is that our lives are dominated by...interdependence of utility functions...Selfishness, or indifference to the welfare of others, is a knife edge between benevolence on the one side and malevolence on the other. It is something that is very rare. We may feel indifferent towards those with whom we have no relationships of any kind, but towards those with whom we have relationships of exchange, we are apt to be either benevolent or malevolent." ²

Though these traits of human nature have been overlooked, there is nothing to prevent their introduction. If, for example, individuals are to be viewed as altruists, it may be more likely that they will subscribe to a collective good rather than refuse to reveal their preferences.³ This of course begs the question of what is meant by "altruism".

7.1. Altruistic Behaviour

It would not be unusual, in the first instance, to interpret the donation of gifts or contributions to what might be thought of as "needy" causes as altruistic behaviour. Unlike normal exchange behaviour, it appears a one way transfer. However, it is not necessary to assume that the individual is doing anything other than maximizing his own individual utility when he engages in such behaviour. It is possible to offer several

³ K.E. Boulding, The Economy of Love and Fear Wadsworth, California, 1973, p.6., leads one to believe that unless some such allowance is made one cannot explain the provision of collective goods.
explanations for this behaviour, and to pursue their consequences for the
provision of collective goods. Even so, few may be considered as emanating
from what might be regarded as genuine altruism. Many explanations are
consistent with maximization simply of the individual's utility function,
which contains arguments in terms of the goods and services he personally
consumes.

Response to natural disasters is one area where individuals appear to
behave altruistically. Yet such disasters as flooding, plane crashes,
disease, are typified by the prospect that at some time or another any
individual member of society, for no fault of his own, could fall victim.
Here the existence of uncertainty causes individual behaviour to be
governed by indefinite expectations concerning the future. An individual's
response to a catastrophe will be influenced by such uncertainty, and this
may explain any resources he "gives" to the victims. The society in which
the individual makes his decisions is likely to influence his behaviour.
His environment may be considered to encompass a network of social rules
and regulations, many of which might be informalized and dependent on
consensual agreement. Such agreement may not be universal but may be
generally adhered to, and as such might influence the decision the
individual takes. He may comply with the demands that society's unform-
alized rules exert upon him, and subscribe to a needy cause or disaster
because he is completely uncertain that such a misfortune may befall him,
and that therefore he too in the future may be the beneficiary of such
socially altruistic conventions. 4

4 See Christopher M. Douty, "Disasters and Charity: Some Aspects of
Co-operative Economic Behaviour," in Readings in Applied Micro-Economics,

An interesting argument on re-distribution through the State is akin
to the one being presented. That is while majority voting can lead to
re-distribution and progressive income taxation there will be a limit to
the extent of this. Members of the majority may be uncertain as to
whether or not they will get into the higher income brackets, and thus
will not make progressive tax rates too steep. See A. Downs, An
Economic Theory of Democracy, op. cit. Ch.10.
This form of altruism is typical of the custom of gift exchanging at Christmas when an individual may feel embarrassed for either giving or receiving too little. Indeed through such traditions society establishes an emphasis on an environment in which 'altruism' of this nature is fostered. Institutions such as family relationships are said themselves to be based on such altruism. Here parental sacrifice is made for children in the expectation that during old age they will find their philanthropy being reciprocated by the children. Observers have, therefore, looked at middle aged parents as repaying a "loan" to their parents while simultaneously investing in their children.\(^5\) Families then are based on such consensual agreements and it is not difficult to imagine the individual ascribing simultaneous expectations with reference to his trade union, professional association or indeed society itself.\(^6\)

If kinship groups and society are viewed as a form of "mutual insurance club", the individual doctor may willingly accept the same responsibilities with reference to the B.M.A. In just such a "charitable" manner money may

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\(^5\) K.E. Boulding, "Notes on a Theory of Philanthropy", in *Philanthropy and Public Policy*, edited by Frank G. Dickinson, National Bureau of Economic Research, 1962. The reciprocal nature of these family gifts may be such that they are passed on through generations. A son aware of the gifts reaped from his parents, feels "obliged" to act similarly to his own children. Alvin W. Gouldner "The Norm of Reciprocity: a Preliminary Statement" *American Sociological Review*, vol.25, 1960 pp.161-178, talks of the "reciprocity multiplier".

\(^6\) The extent to which such behaviour will typify society has however been questioned. That is to say that the society so created is itself a collective good and as such the 'free-rider' is not excluded if he should fall subject to such disasters. See for example J.M. Buchanan, "Ethical rules, expected values and large numbers", *Ethics*, Volume LXXVI, No.1, October 1965.

On the other hand it might be argued that expectations can be so implanted as to overcome the problem of large numbers. Indeed the 'good deeds' performed by religious orders are sometimes explained in terms of "credits in heaven".
be donated in the belief that as a 'long standing member of integrity' the whole weight of the 'brotherhood' may be thrown to his assistance should the need arise. Here the nature of society and the environment in which the individual lives colours his expectations. As such it is not sufficient that an individual join at a time of personal need. If a doctor has been in a position to subscribe, but has neglected to do so, then he is likely to feel either, that morally he is entitled to little help, or that in practice his past record, which is known to the local branch officials, will weigh against him in terms of the quality of assistance that will be offered. His outlook which has been influenced by the traditions and 'kinship' institutions of society then lead to the doctor's altruistic gesture. As the individual doctor needs to comply with the demands of medical administrators in a nationalized health industry the fears and mistrust of the future may have grown. The subscription rate however is a small premium against such future uncertain catastrophes. Membership of the B.M.A. may be interpreted as such an expense. Certainly he will also be assured with the Medical Defence Union or the Medical Protection Society against legal action. However administrative complications may be more conveniently dealt with by recourse to B.M.A. officials who are known to have a close and influential relationship with the "administration". As

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8 It is worth noting that disciplinary procedure in the N.H.S. called for the investigation of complaints against doctors by the Medical Service Committee. The persons concerned in an investigation before the Medical or other Service Committee have been entitled to be assisted in the presentation of their case by some other person, but not allowed to employ Counsel, solicitor or other paid advocate to conduct the case for them by addressing the Committee or examining or cross-examining witnesses. Direct legal help is therefore outside the doctor's prerogatives and the help of a colleague from his professional association may be more useful. See Charles Hill and John Woodcock, The National Health Service, Christopher Johnson, London, 1949.
such the doctor cultivates the image of being a dutiful member of the profession, assured, from his observations of other such institutions in society, that by so doing he will without question be entitled to the very best of aid that the B.M.A. can muster in his 'hour of need'.

The B.M.A. to some extent fostered attempts to acquire a mutual insurance character. A committee appointed as early as 1834 recommended the creation of a benevolent fund for the relief of distress among contributors and their dependents by means of grants, annuities and temporary loans. The following year the scheme was adopted and the Benevolent Fund of the Provincial Medical and Surgical Association took form. This form of mutual insurance was however not eagerly seized upon by the profession. In 1856 when the membership of the Association was 2,000 the fund had 900 subscribers of whom only 400 were members of the Association. Eventually the Fund took on a separate identity from the Association. By 1870 the separation was complete, and it became known as the British Medical Benevolent Fund. Though the Association since this date has supported charities, e.g. the editor of the B.M.J. played an important role in the creation of the Medical Insurance Agency which distributed funds to medical charities, it has not played a dominant part in this activity. Even so it is still impossible to refute the claim that individual doctors view the B.M.A. as an insurance agency of different nature, that is, one in which regular payments, and therefore commitment to professional obligation, leads to full support from the profession, should the individual require it.

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To argue that this behaviour is altruistic may be criticised in the sense that it is unworthy of the accolade. It is one explanation for behaviour which appears altruistic. Another explanation for behaviour which seems altruistic is that contributions may be made for the prestige an individual personally assumes from such an act. That is to say that donations may be made by individuals because by so doing they believe that others esteem them more highly. Such behaviour, of course, depends on the awareness of others of the individual having performed the deed. In small more personalized groups individuals may be aware of the actions of their contemporaries, but in large groups the individual becomes more anonymous. This incentive is then reduced, though means may emerge to ameliorate the problem. For example, donators may wear a badge or flag to indicate their contribution to others. Indeed, in the early years of the B.M.A., i.e. until the turn of the century, the names of subscribers were proudly published in the Journal. If, for example, membership entitled individuals to quote letters behind their name, the same effect might have been evident. Yet this is not so. Few people, possibly beyond the circle of close friends, will be aware of membership. This form of 'altruism' is therefore unlikely to be the rationale for membership when groups are large.

Both forms of altruistic behaviour described have been quite consistent with the underlying objective of maximizing of personal utility. The third interpretation of altruistic behaviour which is offered is also consistent with this objective, except that in this instance a direct variable in the donator's utility function is the

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11 See, for example, The Association Medical Journal, 1856, Vol.4, pp 913-924.
happiness of the beneficiary. The individual donor then obtains satisfaction from the knowledge that he is making someone better off. This independence can be illustrated in the following equation

\[ U^A = U(x^A_1, x^A_2, ..., x^A_N; U^B) \]

where \( x^A_1, x^A_2, ..., x^A_N \) are goods and services consumed by A and \( U^B \) is the welfare of B. The presence of the \( U^B \) variable in A's utility function indicates that A's utility depends on the level of utility attained by B. In this way the relationship has been looked upon as an "external effect" and when it is positive, in the sense that improvements in the B's utility raises A's utility, it may be internalized by the transfer of resources from A to B. The extent of the transfer will depend of course on the marginal utility A receives for every pound spent on the improvement of B's welfare, and the marginal utility he derives from the expenditure of that money on any other combination of goods and services. When the former is greater than the latter A will engage in philanthropic behaviour.12

This idea can be generalized in the sense that many alternative outlets for charity may exist in an individual's utility function e.g. donations to the blind, the aged, mistreated animals etc. It would become unwieldy to itemize them all for any individual doctor and here a shorter more sweeping classification is suggested. For example:

\[ U^A = U(x^A_1, ..., x^A_N, U^f, U^q, U^p, U^s) \]

\( x^A_1, ..., x^A_N \) = the goods and services consumed personally by A
\( U^f \) = the utility or welfare of individual A's family

\( U^q \) = the welfare of close personal acquaintances
\( U^p \) = the well-being of individual A's professional colleagues
\( U^s \) = the happiness or welfare of the society in which A lives

Here the maximization problem is completely the same as before; income is distributed between alternatives according to the marginal utilities A receives. It may be fair to argue that those individuals with whom A has personal contact, particularly his family, may have first call on his philanthropic donations, and indeed may receive a greater share of his donations. Yet as their welfare rises to an acceptable level to A then the marginal utility A receives from expenditure on more distantly related individuals may become relatively greater.

The question now arises as to how this can affect membership of the B.M.A. As far as A is concerned subscription to the B.M.A. may affect a number of variables in his utility function. Improvements of wage and working conditions may increase the value of items \( X^A_1 \ldots X^A_n \). Moreover such action which raises the status of the profession brings returns through improvement in the value of \( U^p \). Finally, the influence of the B.M.A. may improve the administration of medical care in society and thus raise \( U^s \). The impact of this on the demand for B.M.A. membership is

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13 This is clearly a set which includes all the previously mentioned sub-sets.

14 One may also view the situation slightly differently, i.e. one may look upon the individual maximizing his utility function, \( U (X^A_1 \ldots X^A_n) \) subject to the additional constraint that \( U^p, U^q, U^s \) are viewed to have risen to a satisfactory level.

15 The B.M.A. for example played an early and prominent role in the introduction of the Vaccination Act in the 19th Century which provided for gratuitous vaccination out of public funds.
Price

\[ D_A^W \] = A's demand for quantities of B.M.A. activity that will affect his own personal well-being.

\[ D_A^W \] = A's demand for quantities of B.M.A. activity that will affect the profession's well-being.

\[ D_A^S \] = A's demand for quantities of B.M.A. activity that will affect society's welfare.

The net effect of this concept of philanthropy is therefore to move the demand curve for B.M.A. membership to the right. The demand for B.M.A. activity increases. But will this lead to a tendency to voluntarily subscribe?

There are those who would argue that such philanthropy will lead to the provision of greater quantities of a collective good. Take for example the argument of Daly and Giertz

"It is well known that in a world of private preference functions less than optimal quantities of public goods will be provided..........

Such a conclusion presupposes that the individual

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The technique used in the diagram is one which has been widely used. Altruistic behaviour has been extensively examined in this fashion, for example by A.J. Culyer, *The Economics of Social Policy*, London, 1973.
takes no account of the benefits (or in the case of public goods, costs) his actions extend to others. However, the individual subject to benevolent external effects will by definition place some value on the third party effects of his actions. While this does not imply that the benevolent individual will purchase the socially optimal quantity of a public good it does suggest that he may supply some commodities or services precisely because of their "publicness", i.e. precisely because his actions affect so many people.\textsuperscript{17}

The argument may run, therefore, that if each doctor is made happier as a result of each increment in the utility of his colleagues which the provision of a wage increase will generate, then he is more likely to contribute. Indeed, such a probability of contribution may rise as the number of colleagues who receive the wage increase rise. Thus as the profession grows in numbers there is an increasing likelihood that doctors will join. Yet to pursue this argument can be misleading. Whilst it may be suggested that, given the utility function of the doctor, and his concern for the profession, an increase in remuneration for the profession has a greater impact on the doctor's utility, it is illegitimate to directly conclude that this will increase the tendency to contribute. To take this step in the argument is to neglect the problem of large numbers, that, firstly, any doctor feels his contribution insignificant, and secondly, the same increase in the doctor's utility will arise no matter if he does or does not directly contribute to financing the B.M.A.'s successful activity yielding remuneration increases for the

profession.

Marglin has noted this very same problem. He postulates a utility function for an individual member of what is defined as the present generation. One of the variables in this utility function is the utility of future generation; such that the individual feels better if the welfare of his children and grandchildren is secured. As such, increased contributions to the capital stock by this individual would yield him net positive returns. Yet it is strongly argued that, because the benefits of such increased capital provision will make future generations better off, regardless of who contributes, the individual feels better off whether he or another member of the present generation makes the sacrifice for future generations. It is the case then that the benefits reaped from the knowledge that future generations will be better off are themselves of the nature of a collective good. Therefore the individual privately under-reveals his preference for such altruistic activity, even though if communally all individuals made the sacrifice the net aggregate benefit would be positive.

So it is then with doctors. Certainly any doctor may feel better off as a result of knowing that the status and well-being of his profession and his colleagues have risen. Yet this benefit is not contingent upon his having contributed towards it. Thus in large numbers, when this

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19 Marglin postulated a utility function for the individual member of the present generation of the form $U = AKN - B(N-1)$. In this function $A =$ the marginal value an individual places on consumption by members of the next generation and $B$ was the marginal value he placed on consumption by contemporaries. The value $K$ was the marginal rate of transformation between future and present consumption. Given the values he placed on these variables it could be shown that $\Delta U$ was positive provided the present day community was greater than seventeen and each member contributed one dollar.

20 This is of course an argument for compulsory re-distribution through the State.
altruistic benefit has not pushed any individual doctors' demand curve far enough to the right that he is prepared to pay all the costs of B.M.A. activity, the same problem exists. Olson emphasises this point:

"Even if the member of a large group were to neglect his own interests entirely he still would not rationally contribute toward the provision of any collective or public good, since his own contribution would not be perceptible. A farmer who placed the interests of other farmers above his own would not necessarily restrict his production to raise farm prices, since he would know that his sacrifice would not bring a noticeable benefit to anyone. Such a rational farmer, however unselfish, would not make such a futile and pointless sacrifice, but he would allocate his philanthropy in order to have a perceptible effect on someone."\(^{21}\)

In this way, whilst doctors may have such philanthropic intentions, it is doubtful that they will be realized via membership of the B.M.A.

This leads to yet a fourth interpretation of philanthropic behaviour. In this interpretation altruism on the part of individuals is explained in terms of the genuine desire to act in a "good" fashion. The satisfaction attained by the individual operating under this motive comes from the process of acting, and is related only indirectly to the result of the act. The reason for the connection between the two motives is that in order for an individual to be able to act in a "good" fashion, he must have some method of evaluating the act as a "good" act. It is on the basis of

\(^{21}\) M. Olson Jr., *The Logic of Collective Action*, op. cit., p.64.
the ends of good actions that the individual determines the quality and satisfaction to be derived from a particular "good" act. But the satisfaction an individual receives from the end of his action is fundamentally different from the satisfaction he receives because he is the agent who is bringing about the result. He receives the satisfaction of the result no matter who provides it. He receives the satisfaction of the act only if he performs the act.

The desire to perform a "good" act, as separate from the accomplishments of the act has been referred to by Thomas Ireland as the "Kantian" motive. Kant in seeking to define the quality of a "good" or "moral" act insisted that "goodness" in an act required that the motivation for the act must be divorced from all aspects of personal gain for the actor. In Kant's system for an individual to commit a good act, he must derive no satisfaction from the end of the act, but do the act only because he attributed the quality of goodness to the act. This means that the individual must only do that act because he is motivated by the desire to act in a good fashion. Such purity of motive may be questioned. It surely must be difficult not to derive some satisfaction from the end


23 B. Russell, A History of Western Philosophy, London 1940, p.737, distinguishes between what Kant might refer to as the hypothetical imperative and the categorical imperative the former says "You must do so-and-so if you wish to achieve such-and-such an end"; and the categorical imperative says that "a kind of action is objectively necessary without regard to any end."

See also Alastair MacIntyre, A Short History of Ethics, London, 1971, who stresses the only motive for acting in a particular fashion is because it is deemed as a good act: "Kant argues that my duty is my duty irrespective of the consequences". In this way the action is not linked to any utility which may be derived from the end of the action, though Thomas Ireland does argue that utility might be derived from performing the act itself.
result. Nevertheless it is meaningful to talk of the desire to commit a "good" act. 24

Following the precedent of referring to the Kantian motive as the act of contribution, the cost of the act is the foregone alternative uses of the funds given up. Each individual would then continue contributing to receive the satisfaction of doing a "good" act up to the point at which the act satisfaction derived from giving one more dollar is less than the satisfaction to be gained in other alternative uses, or

\[
\begin{align*}
\text{MUK} & = \text{MUQA} = \text{MUB} = \cdots = \text{MUN} \\
\text{£1} & = \text{£1} = \text{£1} = \cdots = \text{£1}
\end{align*}
\]

where (A, B, C, ..., N) is the set of all alternative uses of funds being allocated and MUK is the Kantian satisfaction from using funds for "good" acts. The Kantian motive is not really a public goods motive, but rather a desire for the private satisfaction of doing a "good" deed. Yet this private satisfaction can result in the provision of funds for public goods purposes. However, the amount of funds individuals seek to provide in this manner is not directly related to the amount they would seek to have in terms of the public goods motive. In the public goods motive, individuals seek the result of having public goods. In the Kantian motive, the individual seeks only the act utility of providing the goods. This dichotomy leads to the paradox that individuals might voluntarily contribute for the provision of a public good in excess of the amount of the public good which would be justified by non-Kantian efficiency conditions.

The extent to which doctors are selfish or Kantian individuals would be

extremely difficult to measure. Most certainly the act of contributing to the B.M.A., has been ascribed some ethical virtue in the pages of the B.M.J. For example, doctors are frequently reminded of Lord Bacon's dictum, "I hold every man a debtor to his profession."\(^{25}\)

Kantian behaviour however could lead to donations to the B.M.A. to improve the welfare of society or profession.\(^{26}\) Indeed all these interpretations of altruism may be present at the same time, i.e. they are not mutually exclusive. The question is therefore begged as to whether or not doctors, via their contributions to the B.M.A., can really be thought to display altruism to other doctors or to patients. To what extent then is the B.M.A. to be considered a vehicle of altruism?

7.2. Altruism in the History of the Medical Profession

In this discussion of altruistic activities of doctors, two points must immediately be stressed. The first is that the intention is to discuss the activity of doctors collectively. That is to say that, whilst examples may be raised of individual doctors acting in a philanthropic manner, the issue with which this investigation is concerned is the activities of doctors acting en masse. In particular the question posed is to what extent evidence exists of doctors acting collectively via the B.M.A. in an altruistic fashion.

The second point to emphasise is the problem of identifying altruism. The discussion of altruism emphasised that it might be exercised as a result


\(^{26}\) It is the act of donating that is important. There are obvious comparisons in the way in which individuals' action in turning out to vote has been ascribed to utility derived from the act rather than the outcome. J.M. Buchanan and G. Tullock, The Calculus of Consent, op. cit. p.133, note many voters may on referendum issues be led to the polls more by a sense of duty or obligation than by any real interest in the issue to be determined. Similarly W.H. Riker and P.C. Ordeshook "A Theory of the Calculus of Voting" American Political Science Review, Vol.62, 1968, pp.25-42, refer to the satisfaction from the act of voting as a factor explaining electoral turn-out.
of the medical profession pursuing its own interests. For example, an 
external effect of a different remuneration scheme for doctors may possibly 
be improvement in the medical care supplied to society. If the B.M.A. 
promote such a scheme then it is impossible to ascertain to what extent 
it did so as a result of altruistic motives. Inevitably to ascertain the 
existence of altruism one must look to those instances when doctors' self 
interest was in conflict with the best interests of society. But even then 
one cannot argue categorically that the doctor is devoid of altruistic 
feeling if he chooses to pursue his self interest. The situation may be 
one in which there is no opportunity of adjustment at the margin. He may 
choose to pursue self interest because the cost of not doing so on this 
occasion is too great. After all, the doctor must maximize over all the 
elements in his utility function, i.e.

\[ U_A = (x_1, \ldots, x_i, \ldots, x_n, U^S) \]

where:

\[ \begin{array}{l}
U_A = \text{individual A's utility} \\
\sum_{i=1}^{n} x_i = \text{goods and services consumed by A} \\
U^S = \text{society's welfare.} 
\end{array} \]

Thus the problem of proving whether A has altruistic intentions is 
considerable. Of course, if he does have such aims then \( U^S \) must be 
greater than zero. There should then be some constraint such that he will 
only pursue self interest if society's welfare is at a certain level. 
However, no information of this constraint exists. The fact that doctors 
pursue self interest merely suggests that, while this constraint may exist, 
it is satisfied on these occasions.

The identification and measurement of altruism, however, is most 
usually made when self interest is subsumed to the good of other parties.  

\[ \text{James Q. Wilson and Edward C. Banfield, "Voting behaviour on Municipal} 
\text{Expenditures" in The Public Economy of Urban Communities edited by J.} 
\text{Margolis, John Hopkins Press, Baltimore 1965, judged philanthropic} 
\text{behaviour to be present when individuals voted against self interest} \]

(cont'd)
If doctors never choose to pursue this line, we will argue that they are not without altruism, but that the B.M.A. is not important in terms of fulfilling any desire to behave altruistically. Over one hundred and forty years the B.M.A. "should" have shown some sacrifice of doctors' interests if we are to believe that doctors have joined with altruistic intentions. Thus if doctors are to be viewed as behaving in a Kantian fashion, and the B.M.A. an altruistic body, it is not unreasonable to look for such examples.

S.M. Herbert proposes that

"Neither the fact that the B.M.A. is the recognized protective Association for doctors, nor the fact that it may in the past have been backward in initiating plans of its own for medical services - or even, on occasion, very hostile to plans initiated by others - can justify under-rating the value and the importance of the views it expresses on these matters at the present day." 28

The problem is that the B.M.A. is more likely to stress the needs of society when to do so helps satisfy the desires of the profession. Take for example the controversy in 1910 over the introduction of whole-time school doctors. The medical journals refused to advertise the vacant post

27 (cont'd)
narrowly conceived. They argued that different groups which they examined had a distinctive notion of how much a citizen ought to sacrifice for the sake of the community, as well as of what the welfare of the community is constituted.

for a full-time school medical officer, "and the bold doctor who was appointed was ejected from his membership of the B.M.A."29 As far as school children were concerned the service was unquestionably a benefit, but for general practitioners it meant direct competition. It was only when it was agreed that the school medical service should be used for the discovery of defects and diseases in school-children that the profession took to the idea. Clearly general practitioners now had many more patients referred to them as a result of the inspection.30 It was this fact rather than the benefits to school-children which was crucial in the B.M.A.'s acceptance of the plan.31

This view of B.M.A. negotiations has been taken by other commentators. The same emphasis on the welfare of doctors rather than patients can be seen in both the major negotiations of 1911-13 and 1944-48. Brand's comment on the National Health Insurance negotiations was:

"the British Medical Association never attempted to introduce any fundamental changes in the Bill which might improve its public health implications. True

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30 Sir A. Newsholme, Medicine and the State, commented "On balance the practitioner has many more patients referred to him as the result of school medical inspection."

31 Sir A. Newsholme, The Last Thirty Years in Public Health, pp. 367-370, argues similarly that the B.M.A. were hesitant to accept the establishment of clinics for the treatment of venereal diseases. They were concerned that the practice of private general practitioners would be affected. However, under the National Health Insurance scheme the B.M.A. had less to fear. The g.p. received his capitation fee even if the work was undertaken by the clinic. Newsholme comments: "It is fair to recall that the willingness of British medical practitioners to abandon treatment of these diseases - so far as a third of the total adult population is concerned - was favoured by the fact that for insured patients the doctor's responsibility, but not his remuneration, is reduced when he encourages his insured patients to go for treatment to a special clinic."
one provision of the Act (Section 63) dealt with action to be taken in areas where illness among insured persons was revealed. The Association did not, however, attempt to improve the Bill in regard to larger questions of co-ordination with the public health authorities.

The Act covered only a segment of the population - almost entirely the adult male wage earner - and then only for short-term risks. Even Lloyd George viewed the legislation as a temporary expedient. The Medical benefit did not include major operations, specialist services, nurses, diagnostic X-ray, or general hospital services. The British Medical Journal took note of such weaknesses, but the Association had not seen fit to incorporate them in its "cardinal points".32

The B.M.A.'s attention is focused solely on the needs of the doctor and the patient must fend for himself. B.B. Gilbert appears to share this view. He noted the absence of strong representation of the patient during negotiation over the N.H.I. bill and commented that "the story of the growth of national health insurance is to a great extent the story of lobby influence and pressure groups."33

32 J.L. Brand, Doctors and State Medicine, op. cit. pp.229-230.

The story of the 1944-48 negotiations is much the same. The basic points the B.M.A. demanded were concerned with the well-being of doctors. A.J. Willcocks, as if to echo B.B. Gilbert's earlier sentiments, said of the 1944-48 negotiations that "Without doubt the groups with skills to offer, particularly the medical profession did best." Indeed during the 1950's the B.M.A.'s worries about over-crowding in the profession and "too many doctors" can hardly have arisen out of concern for patients. The resulting creation of the Willink Committee, as has already been shown, helped to create a doctor shortage in the 1970's.

One may accept that when the best interests of the patient coincide with the best interests of the doctor the B.M.A. is magnanimous. As such E.M. Little, in the official history of the B.M.A., commends the laudable actions of the Association:

"(the B.M.A.) has in the main been in advance of public opinion, provoking considerable opposition when first formulated, but receiving the sanction of legislation after the lapse of years." But what of the times when interests clash? Eckstein, perhaps more objectively, replies:

"the writer of the centenary history could not conceal

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34 P. Vaughan, Doctors Commons, op. cit., pp.223-224.
36 See chapter five.
the fact that the financial interests of the Association's members have always been far in the forefront of its pre-occupations. As a matter of fact a great many of the public health activities on which the B.M.A. now prides its social conscience were pursued at least partly because they promoted these interests. For example, the fight against Poor Law practices, however praiseworthy its result, centred very largely on conditions of practice and doctors' remuneration. The Association battled long and hard against arrangements forcing conscientious doctors to provide their services in effect a charity, due to the parsimony of local Guardians. It insisted on the limitation of districts to be served by District Medical Officers, on adequate qualifications on the part of such officers and on their responsibility to medical authority rather than Relieving Officers and other local bureaucrats. No doubt public benefits accrued from its stand, but that does not mean that public rather than corporate benefit was the Association's aim. The same point applies to the Association's role in improving the conditions of Medical Officers of Health. And as definitive evidence, consider the Association's position on school and maternity clinics. It was heartily in favour of the schemes, but only up to the point there the profession's corporate interests as predominantly private practitioners were likely to be affected. It favoured school inspections, but it was very much opposed to a full-time, salaried school service, which might seriously decrease private practice. It was all for maternity clinics, but it insisted that they be used simply for education because they were bound to increase the demand for private services while active treatment,
in both schools and clinics, was bound to diminish it.”

It is not only in the B.M.A.'s negotiations that one sees evidence to suggest that the profession places the doctors' interests before those of the patients. If one examines, for example, the disciplinary code of doctors, one finds a district bias in terms of insuring that the actions of any doctor do not harm the interests of the profession. Unseemly competitive action, e.g. advertising, touting, may place the profession in a bad light, and is hence of concern. But what of the patient? Prof Lees makes the point that

"A practitioner in a registered profession may be struck off the register for 'infamous conduct' but not for incompetence. Thus a doctor may be struck off for sleeping with your wife but not for prescribing her an over-dose of sleeping pills”

This question of monitoring competence in doctors is one which the profession itself, and outside inquiries, continually duck.

If the B.M.A. was thought in the past to more happily sacrifice the

39 Prof D.S. Lees, *Economic Consequences of the Professions*, op.cit., p.11.
patient rather than the doctor's interest, there is evidence that this
trend is becoming more obvious. At the end of 1975 the junior hospital
doctors were involved in a pay dispute with the D.H.S.S. and the
consultants were objecting to the Government's proposed policy to phase
out pay-beds in the N.H.S. For the first time in its history the
Association called on all its doctors in hospitals to treat emergency cases
only. It asked g.p.'s to support the action which involved a ban on
overtime and a general "go slow" or "work to rule" in hospitals. This
action clearly puts patients' lives at considerable risk. More normally in
the past the B.M.A. would have made its protest felt by threatening mass
resignation from the N.H.S. but not by restricting doctors' services to
patients. Indeed the more militant turn in its policy was hotly criticised
by some sections of the profession because of its deleterious effect on the
well-being of patients.

Enough has been said to cast doubt that collectively doctors are
altruistic to patients and that they primarily wish to show altruism
directly via the actions of the B.M.A. Yet what of the argument that the
individual doctor views the B.M.A. as a vehicle for acting charitably
towards his profession. The test for this is whether or not any individual
section of the profession can be seen to forego personal sacrifice for the
benefit of other sections of the profession. The reader will of course be
sceptical. Chapter two shows only too well how g.p., hospital doctor and
consultant have, since the nineteenth century, vied to improve their relative
position. The establishment of the General Practitioners Association, the

41 J. Rogaly, "When Doctors behave like Dockers ...", The Financial Times,
      Tuesday, December 2, 1975, p.17.

Junior Hospital Doctors Association, and the Consultants and Specialists Association is an open reflection of the refusal of these sections of the profession to accept any sacrifice and especially so when the well-being of other sections of the profession appear to rise relatively.

The outcome of this discussion is that it does not appear realistic to modify the economic model in terms of assuming that doctors act out of altruistic motives in deciding to join the B.M.A. On the other hand it becomes less useful to introduce malevolence as the motivating force. Malevolence might be introduced in terms of the following form of argument. Doctors join the B.M.A. because they wish to be members of an elite group. They join because they wish to show their discrimination against dealing with other individuals whom they regard as inferior. It is then the fact that they see the B.M.A. as an exclusive club that leads them to join. Its exclusiveness, reflected by its discriminating admissions policy, is the key quality in the service rendered by the club that attracts membership. The introduction of this line of reasoning tends to be the basis of the argument that the optimal size of clubs will be smaller than one might otherwise expect. In the case of the B.M.A. it is true that in the early days admission was vetted. Application for membership needed the nomination of existing members. It is also the case that even today, of course, as a general rule, membership of the B.M.A. is only open to qualified doctors. Yet beyond this there is little substance to the argument that doctors use the B.M.A. to discriminate against others, and

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45 Honorary or Complimentary Membership may on occasion be extended to non-qualified persons who nevertheless are distinguished in science. See *B.M.A. Calendar* 1970-71, p.104-105.
hence to feel superior to others. Membership seems equally open to some
100,000 doctors and this is hardly a small group. In America, the A.M.A.
actively discriminates in its membership policy towards both Negroes and
Jews.\textsuperscript{46} The B.M.A. do not appear to indulge directly in such an activity.

Whilst some element of social class discrimination may exist in the intake
to medical schools,\textsuperscript{47} there does not appear to be discrimination in the
membership of the B.M.A. Once qualified a doctor appears, on the contrary,
constantly encouraged to join. To this extent then membership of the
B.M.A. is not interpreted as an attempt to avoid socialising with others
and to show superiority or maintain a feeling of being better than others.
Malevolence in this sense is rejected as playing an important role in under­
taking membership. It cannot be denied that it is an exclusive club to
doctors, though it does not appear to exclude doctors of different ethnic
or social backgrounds.\textsuperscript{48}

To this extent neither the introduction of altruism or malevolence
appears a legitimate way of reconciling voluntary membership of the B.M.A.
with the economic theory of collective goods. It may however be as well to

\textsuperscript{46} See E. Rayack, Professional Power and American Medicine op.cit., and
Hyde and Wolff "The American Medical Association", op. cit.

\textsuperscript{47} See Chapter Three for evidence as to class discrimination on entry for
medical education.

\textsuperscript{48} It does not directly oppose doctors of different ethnic backgrounds. Of
course, however, by its policy it does indirectly exclude them. For
example, its recent evidence to the Merrison Committee has led to the
tightening up of qualifications for overseas doctors wishing to practice
in Britain. See, Report of the Committee of Inquiry into the Regulation
of the Medical Profession, HMSO London 1975, and The Guardian, Thursday,
April 17, 1975, pp. 8-9.

Thus whilst direct exclusion may not be practiced, one can identify
this form of indirect exclusion, i.e. doing little for a particular
group. Dr A.F.A. Sayeed, Chairman of the Overseas Doctors Association,
said there had been a feeling that the vast number of overseas doctors
in Britain were practically a nonentity as far as the B.M.A. were
concerned. See The Times, June 20, 1975, p.2.

At present, only about 2,000 out of 14,000 immigrant doctors are
members of the British Medical Association. See The Financial Times,
Thursday, March 4th, 1976.
note that the theory of collective goods was based on the assumption that the individual was acting in the economic market. The question may then be put as to whether or not it is legitimate to ascribe behaviour in such a market to the question of decision taking which may be of a directly political nature.

7.3. Behaviour in a Political Market

Resorting to the initial assumption that the individual is selfish and concerned purely with the maximization of his personal utility, it is as well to discuss whether or not the behaviour of such an individual would be modified by the kind of decision or the sort of environment with which he was confronted. Behaviour such as the decision to vote, to join a political party or to join a pressure group, might all be described as political in nature. Will the individual's response to such decisions be different to those of an economic market where he is forced to choose the best way of allocating his resources between goods and services? Are there additional constraints which are likely to influence his decisions on political matters?

One line of argument has suggested a different form of behaviour on political issues than on purely individual economic matters.49 In the economic market individuals are assumed to make their decisions on the basis of their tastes and preferences for certain goods. However, when making political decisions, it is argued that the individual will be influenced by his normative views. In the formulation of political decisions he is more aware of his sense of participation in social choice.

In his attempts to alter social policy, e.g. by voting, or by membership of a pressure group, he is directly aware of the wider implications and interdependence of his actions. In the economic market, and in his purchasing decisions, he acts as if unconscious of the secondary repercussions of his act on the allocation of economic resources. Unlike his decisions in a political environment, he is not directly confronted with the wider aspects of his choice. Thus, there may well be a dichotomy in the behaviour of the individual when he is acting with regard to his personal tastes and when he is asked to make a normative decision for society. It may not be so surprising that when an individual votes he may vote for racial integration, prohibition, national participation in a war, and similarly in his personal choice in the market may choose to live in an area inhabited solely by members of his own ethnic group, consume alcohol, and take steps to avoid enlistment.

Transferring this argument to the case of the doctor, such political behaviour may be a rationale for membership of the B.M.A. The individual may join the B.M.A. in what he regards the best interests of the profession. Indeed he may vote that the B.M.A. take a strong line in negotiation with Friendly Societies or with the government. He is clearly influenced by what he regards as "best" for the profession. However, at the same time as he votes that the B.M.A. contest the activity of the Friendly Societies or the government, he may individually take up an appointment with the Friendly Societies or under the National Health Insurance scheme at conditions which the B.M.A. are pledged to reject on the part of the profession. Such behaviour typified the 1911-13 negotiations. At the same time that doctors voted they reject the N.H.I. scheme, they were privately accepting posts under it. The 1944-48 negotiations were also jeopardized by such a possible outcome and in 1965 despite the fact that some 18,000 doctors were prepared to support B.M.A. action and lodge undated resignations with the
British Medical Guild, Forsythe comments, "One wonders how many of the 18,000 would have repudiated their resignations had the Guild presented them." 50

There is yet another reason why individuals may join the B.M.A. which, in terms of the peculiarities of decision-making of a political nature. Many writers have supported the argument that the goals the individual wishes to attain for society are distinct from those he wishes to attain personally, and that the former often assume prime importance. 51

50 G. Forsythe, Doctors and State Medicine, op. cit., p.160.

51 For example, see G. Colm's criticism of Samuelson's pure theory of public expenditure, "Comment on Samuelson's Theory of Public Finance" Review of Economics and Statistics, November 1956, pp. 408-12.

The distinction between public and personal interests, however has a much longer tradition in literature of political philosophy. In the analysis above individuals order private and public wants on the basis of the satisfaction they receive from each additional unit of the good in question. Little distinction has been made between the moral character of public as opposed to private goods. According to the idealist school of political philosophy there is a general will common to all members of society which may or may not be revealed and implemented depending on society's institutional structure. Central to the argument of the several members of this school (which includes Rousseau, Kant, T.H. Green, and others) is the existence of a general conception of what should be society's goals. This latter ordering of wants may seem in conflict with the individuall's more immediate preferences. For example, according to Kant the ordering of preferences by the individual follows from three imperatives: the pragmatic, the technical, and the moral. The pragmatic imperative is the individual's impetus to seek his happiness. The technical imperative is the necessity to know the means required to carry out given ends. These two imperatives lack the ultimate necessity characterizing moral obligation; they are contingent in nature, while the moral imperative is categorical. Moreover, the moral imperative has complete interpersonal validity. In Arrow's opinion,

"The idealist doctrine then may be summed up by saying that each individual has two orderings, one which governs him in his everyday actions and one which would be relevant under some ideal conditions, and which is in some sense truer than the first ordering. It is the latter which is considered relevant to social choice,........"

Yet Coleman argues that there is no reason to suppose that these are different. He argues that, in the same way that one firm may invest in another firm which is expected to bring high returns, investment of a psychic nature is made by each individual in entities outside himself. Some of these entities may be other individuals, groups or organizations or ideologies. The investments are made for economic reasons in the sense that they are expected to provide a psychic income as the investor shares in the well-being experienced by the entity he has invested in. This is in no sense altruistic behaviour. Indeed, such investment is much more likely to be made in the rich and successful rather than the poor and unfortunate. E.g., a girl invests part of herself in a movie star because she will experience vicariously the imagined joys of the movie star, or a man invests in the fortunes of a successful football team for similar reasons. The argument is one which can be traced to Adam Smith in his Theory of Moral Sentiments. He discussed such investments as a web of "sympathy" which holds society together. He drew attention to the fact that many people concern themselves with the fortunes of a prince and are happy when he is happy, sad when he is sad, etc., but few do so with a pauper. Clearly they choose the better risk, i.e. a man to whom more good things were likely to happen than bad.

Coleman argues that in such a way individuals may feel they have an investment in the nation and may, on occasion, be seen to pursue behaviour in the national interest despite personal sacrifice. If such an argument

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could be tested, it is clearly one which could be applied to doctors' membership of the B.M.A. An individual doctor who subscribes would by this action feel an investment had been made and would receive a psychic income from the triumphs of the B.M.A., be it against quackery or against the administrators of the N.H.S. The apparently disastrous failure of the B.M.A. and the ensuing resignations of members could be viewed in this light. That is to say that by its failure the B.M.A. had proved itself a more risky prospect for the marginal investor.

Attention has been drawn to the costs as well as the benefits of political decisions. Brian Barry has argued that economic theory may be unsuccessful in explaining political activity, such as membership of associations or voting, because they are typically activities where the costs involved are not great. It might be argued that there is a "threshold" above which costs and returns influence a person's actions and below which they do not. Thus, if a positive effort is needed to join organizations (e.g. sending off money, getting in touch with organization officials), then membership will be low. On the other hand, if effort is required to avoid membership then inertia will operate the other way.

An example which vividly illustrates this argument can be seen in the administration of the 'political levy' paid by trade unionists. When the subscription was made on the basis of 'contracting out' the levy was not compulsory, but every member was liable to pay unless he took steps to contract out. The removal of the pressure to contract out, and the introduction of a system whereby individuals who wished to pay the levy had to take steps to 'contract in' led to the dramatic fall of 42 per cent.

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54 Brian M. Barry, Sociologists, Economists and Democracy, op. cit., pp. 40-42.
of those paying the levy. This form of inertia is typical of individual behaviour with respect to trade unions. Butler and Stokes, for example, found in their surveys a substantial proportion of individuals who would have joined unions had they only been asked. More recently the debate as to whether voting in the A.U.E.W. should be postal or at branch meetings highlights the effect of such inertia. At branch meetings a poll of 12 per cent was considered a good turn-out. Whilst by postal ballot in two elections the poll varied between 37 and 38 per cent.

Membership then of the B.M.A. might be explained in terms of the low costs involved. The costs of estimating the net benefits of membership are relatively so high that the decision to join is made without consideration. When decision taking costs are high it is quite likely that an individual copies the behaviour of what might be regarded as his 'reference group'. That is an individual may follow the behaviour of other people whom he deems to share a similar circumstance. The assumption being that those 'reference individuals' have made the necessary decision costs, and that the action they take is also an inexpensive guide as to the individual's best action. In such a way an individual 'feels' that he is acting in his best interests, even though he has not personally fulfilled the necessary decision making costs to confirm this. Scitovsky has attributed this 'cost-saving' behaviour to competing firms on the economic

55 John A Lincoln, Journey to Coercion: from Tolpuddle to Rookes V Barnard, I.E.A. London, 1964. It is also worth noting that individual membership of major parties is much lower than the "affiliated" membership as pointed out by Barry, p.41.

56 D. Butler and D. Stokes, Political Change in Britain, Penguin, p.194.

57 The Times, Wednesday, November 19th, 1975.
market.

"There are always some firms, however, which respond more promptly to changing conditions than others; and if a group of competitors find at repeated occasions that one of their number is consistently ahead of them in all market actions, they gradually begin to look to him for leadership and they acquire the habit of automatically imitating his moves instead of making their own calculations for independent market actions." 58

Similarly, it may be argued that a doctor joins the B.M.A. because he sees a large number of his colleagues have joined the Association, and does not personally engage in weighting all the costs and benefits of such action. Such activity might, of course, be inter-temporal as well as intra-temporal. That is to say a doctor may look not only to the behaviour of his contemporaries, but also to the behaviour of his predecessors. As time continues the latter may become more important and in this sense a "tradition" is born. In such a fashion individuals may pursue behaviour which is currently against their "best" interests because at some time in the past it had been considered desirable. Nevertheless this explanation of inertia still begs the question of why initially doctors chose to join the B.M.A. in large numbers.

There are clearly a number of arguments which may be made to suggest that decision-taking on matters of a "political" nature differ from decision taking as usually analysed by the economist. Assumptions are relaxed in order to explain the phenomena that contributions to collective

goods are voluntarily made. However the lines of argument, i.e. of Barry, Coleman and Buchanan, herein discussed are spurious. In many instances they raise as many questions as they attempt to answer, and in all cases they prove difficult to adequately test empirically. For example, what is the threshold level above which costs are important? How does it alter over time? How useful is it to distinguish between a preference ordering based on tastes and an ordering based on norms? How far can psychic income generated by an association be measured?

There are then serious limitations to these approaches. Yet one characteristic of a political environment and of political decision making does need to be emphasized. This is the greater degree of uncertainty in the political market. In the economic market, and in the immediate choice to consume private goods, the act of choosing and the consequence of choosing stand in a one-to-one correspondance. On the other hand, the voter, even if he is fully omniscient in his foresight of the consequences of each possible collective decision can never predict with certainty which of the alternatives presented will be chosen. He has still to predict the behaviour of other voters. Similarly a subscriber to an association may have full information of the implications of the goal sought by the association, but he has still to know whether others will subscribe before he can say that his subscription will lead to him actually consuming the good. Such decisions are inherently clothed in uncertainty. In the following chapter attention is drawn to the implication of reducing such uncertainty.
CHAPTER EIGHT

THE POLITICAL ENTREPRENEUR

The conclusion that individuals will not voluntarily subscribe to associations which produce collective goods and has been arrived at without any discussion of the potential activities of the leadership of organizers of the association. Their role has implicitly been viewed as completely passive. That is to say, the association has been interpreted purely as an organization standing by ready for individuals to approach it for membership; it has been given no other goal than the maximization of the welfare of its membership. Yet it is conceivable that the organizers of an association play a much more active role. That they attempt, for example, to entice potential contributors by altering the individual's expectation as to his efficacy in provision of the good. Furthermore, it is possible that alternative aims can be attributed to the association and that these are earmarked for maximization by such organizers or entrepreneurs. If so, how are the predictions of the likelihood of individual subscription to a non-rival, non-exclusive good altered?

The concept of the political entrepreneur is one which has become familiar in economic and political literature.¹ A political entrepreneur may be defined as an individual who, for personal profit, takes upon himself a part of, or all of, the costs of supplying a collective organization and via this organization, the provision of

the collective good. He will undertake these costs provided that the total resources he can collect from the potential beneficiaries of the collective good are greater than his costs. One immediate consequence of this is that an individual may choose to occupy such a leadership role and supply a collective good to a group of individuals even if he does not value the good, or indeed even if he values the good negatively. The important consideration is that he can receive from the group resources in excess of the costs involved in his activity.² It is this political surplus which the entrepreneur will attempt to maximize, and the collective good may be provided in his pursuit of this surplus.³

In discussions of the political entrepreneur it has been suggested that there are three main sources of finance which he may receive from beneficiaries of the collective good.⁴ The first of these is referred to as extortions, in so far as the entrepreneur raises such money by his ability to threaten sanctions on his membership. The second form of payment may be that which the entrepreneur receives for private goods and services which he provides in conjunction with the collective good. The third form of contribution is the voluntary donations made by individuals for receipt of the collective good. It

². These costs would clearly include the opportunity costs of the individual, i.e. how much he might have received in his next best occupation.

³. This political surplus could of course contain non-pecuniary as well as pecuniary items. That is to say that part of the return may be the feeling of power prestige that leadership may bring. Here however the intention is to look at the potential.

⁴. N. Frohlich et al, op.cit.
is the intention to concentrate on this latter form of finance. In the case of the first two forms of subscription questions immediately rise as to why the political entrepreneur provides any of the collective good at all. If he is freely able to exert sanctions, or relies on the sale of private good, it appears strange he should lose resources in the provision of collective goods. Furthermore chapters five and six have suggested that both of these forms of contribution would not be significant in the case of the B.M.A.

The political entrepreneur is then the individual who will form the association by which a collective good will be provided. He will be financed by individuals who offer donations, or in the case of the B.M.A. voluntarily pay membership subscriptions. Clearly, two things need to be established to continue with this line of argument. The first is that individuals will voluntarily contribute to the entrepreneur even if the collective good is non-price exclusive. The second is that there actually is a surplus to be made in this form of entrepreneurship.

The first proposition, i.e. that it is in the interests of a free-rider to actually contribute to a collective good, has been argued by A.M. Sharp and D.R. Escarraz and has been taken up by J. Burkhead and J. Miner. Their argument may be illustrated in the following diagram. Here the demand curves of two individuals A and B for quantities of the collective good are shown. Individual A finds it in his interest to provide $OQ_1$ of the good himself, for his marginal evaluation of the good is greater than the marginal cost of the good up to this output. Individual B in the initial instance

free-rides, enjoying \(OQ_1\) at no personal cost.

In this instance individual B would be more than prepared to pay \(OL\) per unit towards the contribution of the good if he felt that this would serve to increase output of the good to \(OQ_2\). It is likely of course that A would agree to pay \(OM\) per unit towards increasing the output of the good. His price has dropped and yet he can consume a greater output, i.e. his consumer surplus without question will increase. Individual B is also happy to contribute. Prior to contributing he enjoyed a consumer surplus of \(DB\) \(HQ_1C\), as his contribution was zero. Having now made a contribution of \(OL\) per unit he loses \(OLKQ_1\) but gains consumer surplus of \(KHJ\). Clearly if \(KHJ\) is greater than \(OLKQ_1\) he is better off as a result of making the contribution. The net welfare, in this partial equilibrium context,
of both individuals has increased.\footnote{6}

The behaviour of individual B in the diagram ought to be examined more carefully. If he contributes it must be because the net expected value of so doing is positive. It is the argument of Frohlich et al that this is the important measurement which may lead individuals to contribute or not to contribute. For the specific example above his expected value of contributing may be expressed algebraically as

\[ U_b = U_b \, (X_2 - X_1) \cdot P_b \, (X_2 - X_1) - D_j \, (X_2) \]

Here \( U_b \) is the utility of individual B; \( X_2 - X_1 \) is the increased output he may expect provided he contributes, and \( P_b \) is the probability that this extra output will be provided if he contributes. The sum \( D_j \, (X_2) \) is the cost of his donation. Now if he were sure and felt guaranteed that this extra output would be provided as long as he contributes, then \( P_b \, (X_2 - X_1) = 1 \). The utility he will receive from the extra output, i.e. \( (X_2 - X_1) \) \( U_b \) is equal to \( Q_1 \, HJQ_2 \) in the diagram. The loss in terms of donations is the price \( OL \) he must pay for each unit of output, i.e. \( D_j \, (X_2) \) is equal to \( OLJQ_2 \). From this it is clear that if the certain benefit, i.e. \( Q_1 \, HJQ_2 \), is greater than the cost, i.e. \( OLJQ_2 \), then the net benefit is positive. This of course

\footnote{6. Sharp and Escarraz argue that individuals will reveal preferences rather than go without the good because they are better off by so doing. They directly challenge Musgrave's argument that preferences will not be revealed even in the large group. Escarraz in The Price Theory of Value in Public Finance, University of Florida Press, Gainesville, Florida, 1966, pp. 23-35, directly takes up this argument. He takes as an example of this the work of Charles M. Tiebout, "A Pure Theory of Local Expenditures", Journal of Political Economy, (October 1956), pp. 416-424. Tiebout found that individuals would move from a low rateable value area to one which had higher rates, but improved amenities. Thus they appear to be guided by the value which they got from rates rather than a straightforward desire to keep rates low. As such it appears that individuals would be prepared and would choose to pay more if the quantity of collective goods were increased.}
is merely an alternative way of expressing the earlier conclusion that if $HKJ > OLKQ_1$ the individual will contribute.

To express the individual's decision making behaviour in this way has important consequences. Frohlich et al insist that as a general rule the net expected value of activity will determine how the individual behaves:

"Consider now the behaviour of any individual, $A_j$, with respect to the donations, $D_j (X_i)$, he will be willing to make toward the supply of some collective good. If $U_j (X_i)$ is $A_j$'s utility valuation of $X_i$ and $P_j (X_i)$ is $A_j$'s estimation of the probability that $X_i$ will be supplied, then $A_j$'s expected value from $X_i$ is $U_j (X_i)P_j (X_i)$, and $A_j$ will evaluate the efficacy of any donation he may make in terms of the net increase he can expect such a donation to produce in his total expected utility."\(^7\)

If then an individual's net expected value from consuming a given output of collective good increases as a result of his donation, and if this increase is greater than the cost of the donation, then he will contribute. This of course is precisely what was illustrated in terms of the last diagram. A donation from an individual may increase his expected value from the provision of a collective good in two ways. Firstly, it may increase the probability that the good may be provided. Secondly, it may increase the quantity of the good which is provided. Here then lies the first important task for a political entrepreneur. He clearly has some lee-way to operate on the expectations of individuals. He might for example approach

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7. N. Frohlich et al, op.cit., p. 32.
individuals and persuasively suggest that should they contribute there will be a greater certainty of the provision of a collective good. He might also suggest that should they contribute there will be a greater quantity of the good provided. The result will, of course, be to increase for the individual the expected value of their donation. Obviously one's estimation of the probability of his contribution being vital is a function of the information one possesses. By such manipulation of expectations the entrepreneur may indeed make individuals' expectations mutually compatible so that they are better off after contributing, e.g. as in the example illustrated above. Furthermore, the second area in which he can operate is on the cost which each individual is encouraged to contribute. For example, those individuals with high expected value from the collective good (e.g. individual A) may be encouraged to pay a higher share than those individuals who derive less utility from units of the collective good. In this way the net expected value from contributing can be kept positive. Each individual would believe himself to be better off as a result of the donation he makes, and by making the contribution the good can be provided so that, indeed, they will be better off than in their initial situation. The entrepreneur in this way can skillfully influence expectations and provide an appropriate marginal cost sharing arrangements such that individuals do voluntarily contribute to a collective good.

8. An example of the ability of a political entrepreneur to mobilize group action by providing information which moulds the group's expectations as to the efficacy of their action is given by G. Tullock, "Information without Profit", in G. Tullock, Papers on Non-Market Decision Making, Virginia, 1966, and reprinted in Economics of Information and Knowledge, Penguin, 1971, edited by D.M. Lamberton.
The first thing that can be said then is that, accepting that individuals assess the expected value of their contribution, there is an obvious role to be played by a political entrepreneur. The second consequence of such behaviour is however even more important. It is alleged that if individuals act in this fashion then one cannot automatically say that as the group's size changes, and the number of individuals increase, there will be less likelihood that an individual will donate. Assume, for the sake of simplicity, that the collective good is 'lumpy' and cannot be easily increased at the margin. Now if an individual in a group of size M finds his net expected value from contributing is positive he will donate. Assume that the group increases, e.g. to M + R individuals. If the individual ceases to contribute it must be because of one of two reasons. In the first instance, he believes that the larger group can carry the full costs of providing the good without him. In the second instance, he believes that the larger group expects him to shoulder more of the costs of providing the collective good, so that the probability that his contribution will be efficacious in the provision of the good is reduced. Frohlich and Oppenheimer comment that the assumptions of rationality and self-interest do not indicate how subjectively assigned probabilities vary from situation to situation, and that there are no grounds for imputing such reasoning to the general member in the general case. In order to impute such reasoning one must introduce exogenous assumptions, such as increased difficulty of bargaining, transactions costs, imperfect information in the larger group. Similarly if the collective good were "non-lumpy" there is no reason for the individual to find that the net expected value of his donation is negative in the larger group. To arrive at such a conclusion he must be increasing the weight he gives to the occurrences of aggregate donations of others that are at levels such that the added
increment of utility his donation would bring at that level of pur-
chase is lower than the value of the donation. Again additional
assumptions beyond those of self-interest and rationality are neces-
sary to make this assertion.

It is contended by these authors that there is no automatic
reason to expect an individual will refuse to contribute as the size
of the group increases. In order to assert this one needs extraneous
assumptions on the difficulty of bargaining in large groups. However,
it is just this difficulty that the existence of the political entre-
preneur postpones. He acts as a necessary mechanism for co-ordinating
individuals' expectations, and also is at hand to make the necessary
adjustments to marginal cost sharing arrangements as the size of the
group increases.

The assumption then that an individual is motivated by his net
expected value in deciding on a donation has two important implica-
tions. It leads to an argument that group size need not necessarily
reduce the tendency to donate, and it opens the way to a discussion
of the political entrepreneur. Yet it still needs to be proven that
there is in fact a profit or political surplus to be reaped by such

9. Norman Frohlich and Joe A. Oppenheimer, "I Get by with a Little
Help from my Friends", World Politics, 23 (October 1970), pp.
104-120 argue that mechanisms other than a leadership-role might
suffice to co-ordinate expectations so that collective goods are
supplied. In transient-benefit groups, cultural patterns,
traditions and the like may be sufficient to handle needs for
collective goods that are not omnipresent. Such cultural mechan-
isms may have been the creation of some founding leader who
supplied the group with a binding set of ethical parameters,
which the members of the group count on. This has clear implica-
tions for medical profession with its long ethical traditions and
this is an argument which can be re-examined in the following chap-
ter which takes a closer look at the concept of the group.

10. Frohlich, Oppenheimer and Young, Political Leadership and Collective
Goods, stress the importance of this arrangement. In Appendix I
they look closely at the importance of the size of the group and
comment, "the conclusion that sub-optimality will increase with
group size only holds when arrangements for marginal-cost sharing
arrangements are possible".
an entrepreneur. He obviously requires this incentive if he is to perform the role which has just been discussed. In looking at Figure 1 a marginal-cost-sharing arrangement was implemented which meant that each individual, A and B, paid the maximum sum they were prepared to pay for the marginal unit of the good. They were charged this price per unit for the good, and in this way their consumers' surplus were larger when they both contributed to provide $OQ_2$ of the good. If this marginal cost sharing arrangement had been implemented by the political entrepreneur then he would have asked for contributions from A of $OM$ per unit and from B of $OL$ per unit of the collective good. The combined sums he would receive would be equal to $OQ_2JL + OQ_2ZM$ which is equal to $OQ_2VT$. Clearly then there is a surplus to be gained of $PYVT$ over and above the costs of providing the collective good. This surplus, of course, will not be the entrepreneur's net return. The resources he collects has to cover the costs of providing the good and also the costs of providing the collection organization which has been instrumental in influencing contributors' expectations and collecting their subscriptions. Nevertheless if $PYVT$ covers the costs of running the collection organization then there is a surplus or a form of abnormal profit for the entrepreneur. It is clearly this surplus or abnormal profit that the entrepreneur will seek to maximize.

There are a number of variables that the political entrepreneur may vary in his attempt to maximize his profit. The first of these

11. Whilst the original diagram was used to show how such a surplus may occur, the same surplus may be shown by using the alternative Marshallian geometry which Buchanan uses in The Demand and Supply of Public Goods, op.cit., and which M. Olson Jr. and R. Zeckhauser imply in "Collective Goods, Comparative Advantage and Alliance Efficiency", in Issues in Defence Economies, New York, 1967, edited by R.N. McKean.
is the quantity of the good he will produce. If, for example, he pursues the policy of enticing each individual contributor to pay as much at the margin that he is prepared to pay, then the entrepreneur must be careful in reducing output near \( Q_1 \) in Figure 1, because as a result B's net consumer surplus from contributing will decline. There is then the constraint that the entrepreneur may adjust output, but yet must maintain a level which keep individuals contributing. In this respect his behaviour seems akin to that alleged for management in large firms in the private sector. It is claimed that they may pursue goals, e.g. power, prestige, greater remuneration, which entail a faster growth of the firm than is compatible with maximizing profit of shareholder. They pursue their goals, or surpluses, subject to the constraint that shareholders are kept content with profit levels. To disappoint shareholders may lead to a drop in share prices, to a threat of take-over, and as a result to the possibility of losing their positions.\(^{12}\) Similarly the political entrepreneur must maintain an output level that satisfies contributors. If he is to continue to receive donations then contributors must be made to feel that the net expected value of their donation is positive.

The second variable which the political entrepreneur may alter is the marginal-cost-sharing arrangement. For example, in Figure 2 the entrepreneur may produce \( Q_2 \) and has B's assistance by inducing a smaller contribution \( O_1 \) from him. In this case B's net expected value from donating is still positive as \( HFJK \) is greater than \( OL_{Q_1} \),

(and the entrepreneur receipts, i.e. \( Q^K + Q^L = Q^W \) are greater than costs, \( Q^V \)).

If, for example, the marginal costs of providing the good rose sharply after output \( OP_3 \) then the entrepreneur might operate in this fashion, i.e. with this form of marginal-cost-sharing arrangement.

The entrepreneur also has flexibility on the amount of money spent on his collective organization. Clearly, for any given output, if he can persuade another person to donate, then if the good is non-rival in consumption, he will add to his income and lose none of the existing contributors whose consumption has not been impaired. By persuasive action he may lead an individual to feel that his contribution will make provision of a quantity of a good more certain in the future. Nevertheless time and effort will be involved. Thus he will constantly be weighing the costs of including a new contributor against
the marginal revenue that will accrue as a result.\textsuperscript{13}

It is very tempting to pursue in detail the alternative ways in which an individual political entrepreneur might adjust such variables under his control. Indeed one may easily add to the list of variables which he may adjust to encourage membership, e.g. as the collection organization is provided the administrative costs of providing private goods to individual members may be reduced and hence these may be offered as an extra incentive for membership. Furthermore, accepting that he earns some abnormal profit one is encouraged to say something of the possibilities of competition between political entrepreneurs, e.g. of the ease of entry of new entrepreneurs into the political market and of the possible reactions of existing entrepreneurs. However to do this would be to digress somewhat from the main purpose of this thesis.\textsuperscript{14} Rather, it is essential to question more thoroughly the argument that the existence of the political entrepreneur can overcome the main problems of the voluntary provision of collective goods by large groups. If the B.M.A. is evidence of such provision how well does the activity of entrepreneurship explain this phenomenon?

\textsuperscript{13} There is some evidence to suggest that the Organization Committee of the B.M.A. is aware that the costs in advertising and recruitment should be weighed against the benefits of new members. E.g. B.M.J., 1970, Vol. 1, p. 105 they comment that "to reduce the Committee's money for propaganda might be to cut off the one sure way in which the Association's income could be increased."

\textsuperscript{14} Frohlich et al, Political Leadership and Collective Goods, op.cit., have made important inroads in these areas. They have been followed and questioned by others including Jeffrey Richelson, "A Note on Collective Goods and the Theory of Political Entrepreneurship", Public Choice, Vol. XVI, Fall 1973, pp. 73-75 and John Chamberlain who reviews their work in Public Choice, 1973, pp. 127-129.
8.1. The Role of the Political Entrepreneur in Small and Large Groups

In order to make the net expected benefit of contribution positive, the political entrepreneur has a number of alternative strategies. If the cost to the subscriber is initially considered fixed, then there are two possibilities of increasing the potential subscriber's gross expected benefit. The first of these is to make the individual feel that the probability that his contribution will be effective is greater than he might otherwise have thought. The second is to awaken him to the "happiness" and utility that he will experience as a result of a consumption of a given amount of the good.

It is perhaps more likely that in a small group a skilful entrepreneur might make better use of the former strategy. The individual may be led to believe that he is a much more significant participant than numerically would be suggested. Indeed, he might be led to feel indispensable. One technique for so persuading a potential subscriber has been referred to by Peston as the "if-then basis for contribution." 15 A political entrepreneur may approach a potential contributor with the inducement that if he actually contributes, then it is certain that several others in the group will contribute also. The probability of that individual's subscription being effective will then appear greater. Such a technique may be more effective when the number of potential subscribers is small and are well-known to each other. In a larger group, such as the medical profession, it us unlikely that the average doctor could be persuaded that a significant

15. M. Peston, Public Goods and the Public Sector, Macmillan, 1972, p. 33. This form of approach is one which Alfred Cox employed in the formation of local medical associations. See A. Cox, Among the Doctors, op.cit.
proportion of potential subscribers will follow his example.  

An alternative technique that the political entrepreneur might employ is to suggest to an individual that there is a single effective size for the association, and that he is always only one or two members short of this size. The membership of this marginal individual hence assumes a greater significance. The larger the association however, the less easy such persuasion becomes. Can an individual really be persuaded that an association of 10,001 is effective, though that of 10,000 is not? This technique, then, again is plausible only when small numbers are involved. For example, a doctor might more readily accept that if only ten doctors work for a local Friendly Society and nine already were members of an association, then his membership would make the association much more strong to the extent that it now encompassed all.  

16. In a larger group an individual doctor with a high reputation of some charismatic qualities might believe this; though clearly as numbers increase this is less and less likely.  

17. In a large group, membership at the margin might be felt highly significant under certain assumptions. For example, assume an individual doctor recognizes that the B.M.A. is a large association comprising many small groups, e.g. rural single-handed GPs, GPs in partnership working in the city, junior hospital doctors, senior registrars, consultants. Assume also that they have common aims on certain issues (e.g. the total amount the N.H.S. spends on medicine) but that their aims are competitive, i.e. not perfectly non-rival, on other issues (e.g. the way in which the amount is distributed between these groups). If the doctor believes that the policy of the B.M.A. is responsive to the proportional make-up of the Association, then the marginal impact of his membership may be even greater in terms of causing a direction of more resources toward his particular category. In this sense, even in a large group, the significance of marginal membership may be quite high.  

The author believed that this, indeed, may be an explanation for membership of the Association. Doctors do have access to information of the proportional make-up of the B.M.A., as these are periodically published in the B.M.J., and are therefore able to perceive how responsive the B.M.A. is to this. Since exploring the idea, evidence has been unearthed to suggest that individuals, as voters in the national election, calculate that the marginal significance of their vote will be greater when the outcome of the election is closely fought. However in my interviews with doctors there was no suggestion that they engaged in the time and effort to so fully estimate their importance in these terms.
In the larger group the efforts of persuasion appear more concentrated on convincing the doctor of the value of the good, rather than persuading him that the probability that his membership is significant and anything other than minimal.

Adjustment in terms of marginal cost-sharing is also employed to keep the net expected value of subscription positive, even though the good's expected value may be low. This feature, common among large associations, can be illustrated by the fee set by the B.M.A.

To explain this marginal cost sharing arrangement of the B.M.A. it is necessary to make two assumptions. The first of these is that, generally speaking, an individual doctor makes the decision to join the B.M.A. once and once only, at an early date after qualification. The questionnaire survey of Chapter Six showed that 61 per cent of doctors joined in the first year of qualification and that 82.8 per cent never left. Also the fact that doctors tend to spend their lifetime in medicine means that since they do not change occupation they are less inclined to question relinquishing membership of their professional association. Furthermore doctors tend to pay subscriptions by standing order which may make it more automatic that they remain in the association.

The second assumption is that the gross expected benefit from membership is greater for young doctors. If the B.M.A. raise doctors' remuneration by a percentage in this year then the younger doctor reaps this reward over a longer period of time. The present discounted value of the B.M.A. activity is hence that much greater to him than it would be to a doctor who retires in a year. Thus for any given probability that subscription will be effective the younger doctor has a higher expected benefit from membership.

Having made these assumptions, it is likely that the B.M.A.,
to ensure greatest membership, will keep the net expected value of membership largest at the time the doctor will decide whether or not to subscribe. This means that the net expected benefit must be positive in the early years after qualification. Thus it is not surprising to find that on the scale of fees for members the lowest point occurs in the early years. Conveniently the gross benefit is greatest at this time, so that unquestionably net expected benefit must be greatest at this time. It is worth pointing out that it would seem that not only is the nominal price of membership lower in the early years, but the price of membership relative to doctors' earnings also appears lowest at this time. As doctors' earnings increase their contributions tend to increase at a faster rate.\!^{18}

A typical scale of fees for B.M.A. membership is shown below:–

| Scale of fees for Members of the B.M.A. in 1975$^{19}$ |
|-----------------|-----------------------------|
| Newly qualified, 1st and 2nd years | £5.00 |
| 3rd and 4th years | £10.00 |
| 5th and 6th years | £15.00 |
| 7th and 8th years | £20.00 |
| 9th and 10th years | £25.00 |
| Standard Rate | £30.00 |
| Members of 40 years | £15.00 |
| Members of 50 years | Nil |

An interesting finding that emerges out of a comparison of these scales of subscription fees over the years is that as membership of

\begin{quote}
18. See Appendix C.

\end{quote}
the association has grown, the relative fee of the newly qualified member has dropped. In 1921 a new member paid two-thirds of the standard rate; today he pays one-third. This, of course, is only to be expected. As the association grows a new member feels himself of less significance in adding to the probability of success by the association. As such the expected value of membership drops and hence the B.M.A. has reacted by reducing, as far as possible, the donation.

It is arguable then that larger associations rely more heavily on less personal measures of keeping the net expected value of subscribers appear positive. Adjustment of marginal cost sharing arrangements and advertizing the merits of the good offered may be more successful than persuading the individual that his membership is in any way indispensable. This particular examination of the marginal cost sharing arrangement of the B.M.A. may be useful in setting a precedent for analysing those of other associations. It may similarly be possible to isolate specific periods when members of other groups of individuals consider membership of their association, and it would be of interest to question whether the association responds by keeping the cost of membership low at this time. As to the problem of showing the utility of the collective good to members, it will be argued in the following chapters that there are occasions when the entrepreneur may be aided in this.

8.2. Some Reservations

The whole of the argument as to the effectiveness of the political entrepreneur has rested on the assumption that the individual feels that his contribution will have some positive significance. The probability that his contribution will lead to some provision of the
collective good, though small, must be greater than zero. If the individual believed that his contribution to the good made no difference at all then the net expected benefit of contribution could not be positive. The question is still, unhappily, unanswered as to whether the individual does not view his contribution as effectively making no difference at all, when the size of the group becomes very large.20

This, of course, was implicit earlier in Chapter Four. The individual was viewed as taking the environment as given, and as having individually no effect on the outcome. He was viewed similarly to a firm in a perfectly competitive market, which individually can do nothing to affect the price at which it sells its product.21 To restrict output would have no effect and only cause losses to the firm. The firm, as such, accepts that individual efforts pursued to increase profits by raising its price will rather only generate losses. The individual in a large group was taken to be convinced that his personal action to provide a collective good would similarly have zero effect and hence only result in losses to himself. In the theoretical case of perfect competition there are certainly an infinite number of firms, and hence the probability of success of any one firm might well be viewed as zero. In the real world there may be instances when the group of firms are so large that any one regards its own effect on price not purely as zero, but as imperceptible/numerical


definition of such a size is, however, enigmatic. One cannot make
a categorical distinction as to the number of firms required before
any one firm feels individually constrained. Obviously this will
not be a subjective measurement on the part of the firm. Yet similarly
in the case of large groups of individuals there is little possibility
of defining a specific number above which individuals feel the
probability of their contribution as imperceptible.

Attempts at estimating the extent to which individuals feel that
they have some significance over collective matters have led to very
strange results. Almond and Verba, attempting to estimate an individual's
feeling of significance in altering local or national regulation
found that quite a large proportion claimed that they individually
could exert some influence.\(^2\) Such results would suggest that
individuals are not fully aware of their numerical insignificance,
and the findings are very spurious.\(^3\) However, there is evidence to
indicate that individuals do act as if they estimate the net expected
benefit of their action, and hence by implication they would feel
that the probability of their action being effective must be greater
than zero. Trade Union literature includes studies which would

\(22\) G.A. Almond and S. Verba, *The Civic Culture*, Little and Brown,
1965, pp. 136-60.

\(23\) It is conceivable, of course, that if allowance is made for block
voting then the individual may legitimately feel that he has a
greater effect on the outcome than one would otherwise suppose.
It can be proved, for example, that 2,000 resolute voters in a
population of just over a million can almost always get their way.
They have a probability of 0.977 of getting their own way assuming
that the remaining population are indifferent and will vote in
an effectively random manner. See L.S. Penrose, "Elementary
Statistics of Majority Voting", *Journal of the Royal Statistical
interpret growth of unions in terms of individuals' response to net expected benefit of union membership. Ashenfelter and Pencavel, for example, argue

"An employee's decision to join a union will depend upon his subjective assessment of the expected benefit to be obtained from union membership as against his subjective assessment of the expected costs of membership."\(^{24}\)

They propose, on the basis of an examination of time series data of trade union growth in the U.S.A. between 1900-1960, that the potential benefits were highest and the potential costs of membership lowest in periods of rising prices, and that this was the rationale for higher membership during these periods. Similarly, a cross section study by R.B. McKersie and M. Brown interpreted behaviour as a result of individuals acting as if they measured the net expected benefit of their actions. An analysis of a trade union organizing effort of some four hundred non-professional employees revealed that membership was undertaken by those who had more to gain and least to lose.\(^{25}\)

That individuals, even in very large groups, do estimate the net expected value of their action is supported by analysis of voting turnout. It has been argued that in national elections the probability that the individual's vote will be decisive is virtually zero, so that the net expected value, if calculated, would be zero. Here is an example where the individual "should" view his individual action as making no perceptible difference. However, there is evidence to

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suggest that he does estimate, however crudely, the net expected value of his action. As argued by Barzel and Silberberg, the probability that an individual's vote will be decisive is related to how closely fought the election is likely to be. To say that a single vote is trivial is to assert that individuals make decisions on the basis of average rather than marginal quantities. The crucial element in a choice-theoretic analysis of voting behaviour is not the absolute number of votes, but rather, whether a given voter may provide the swing vote. Thus the probability that a voter will have some impact on the election depends on how close he expects the outcome to be. The closer the outcome, the greater the probability his vote counts and hence the greater the expected benefit of voting. Thus, other things being equal, voter participation in a given election will tend to be smaller the more lopsided the anticipated margin of victory. By assuming that the ex post winning majority is a proxy for the anticipated (ex-ante) outcome of the election, this hypothesis can be checked. Barzel and Silberberg found that such a variable was highly significant in explaining electoral turnout in the U.S.A.. J. Silberman and G. Durden testing the same hypothesis against voter turnout for congressional elections in the U.S.A. arrived at the same conclusion. The conclusion of these authors refutes the belief that individuals vote solely out of a sense of civic duty. Rather they add weight to the belief that even in large numbers, individuals do behave as if they were estimating the expected benefit of their


Looking at the British Medical profession there is some reason to believe that doctors involve themselves in collective action according to whether or not the net expected benefit from so doing is positive. D. Mechanic and R.G. Faich made an important survey of doctors at the time of the controversy between the Ministry of Health and the G.Ps in 1965. On the basis of replies from 1,365 of the 1,500 GPs chosen at random, they were able to show that those ready to support a strike were those who had a greater personal stake in the issues at hand. The crisis surrounded the question of doctors' remuneration and doctors were asked to submit their individual resignations to strengthen the hand of the B.M.A. Those doctors who reported that remuneration was a problem in general practice were more likely to submit resignations than those who did not. Doctors who had built up a large practice were more likely to hand in their resignations than those who had not. Older doctors, anticipating retirement, had less at stake in the controversy and were less likely to submit resignations than younger doctors with their careers ahead of them. The analysis does seem to indicate that members of the profession were more inclined to take action depending on the relative size of the expected benefit to them.

This evidence then does suggest that the net expected benefit of action to the individual is important in leading him to determine his course of action. However for the net expected benefit to be positive, the probability that his action will lead to the good being

provided will need to be positive. Quite possibly if an individual gives money to a cause, then he believes that, however impercep-
tible an effect it will have, it must be positive. That is to say, an association must, however small, be better able to attain its goals with one more subscription than without. The individual may then believe that at least the gross expected belief of his action is positive.

The question of whether individuals believe themselves to be significant is quite clearly difficult to resolve. The point at which they cease to think this is not easily computable. As such one is entitled to have misgivings that individuals measure net expected values of their personal action. In the remaining chapter reference will, therefore, be made to situations where the individual does attach some significance to his actions and hence computes, however crudely, his net expected value. Reference will also be made to the case where the individual feels helpless in the environment and that his individual actions count for nothing. Note, however, that if the individual feels that he personally creates no additional likelihood of a collective good's provision, then the only benefit he individually can feel his subscription beings is a selective incentive; either a private good or a psychological return such as a feeling of security.
CHAPTER NINE

Individual Decision Making
under a Collective Threat.

The attempts at examining individual decision taking on the assumption that there were selective incentives or that the individual was altruistic proved unsatisfactory in explaining the decision to join an association. The introduction of a political entrepreneur was more helpful, but his efficacy rested on the assumption that an individual perceived that his contribution would be to some extent effective in enabling the association to attain the common goal. Such attempts at explaining collective behaviour have, however, been constructed with neglect of the conclusions of Chapter Three. There it was shown that doctors' membership of the B.M.A. was related to the existence of a collective threat to the medical profession as a whole. This was an interesting conclusion because it showed that not only did doctors' desire for B.M.A. services increase, but that they were also prepared to reveal their demand when they felt under threat. There may then be a distinction between a collective good which is the defense against threat, as compared with a collective good which solely attempts to promote welfare. Furthermore the distinction may be instructive in the discussion of whether or not individuals in large groups are prepared to contribute voluntarily for the provision of a collective good.

The first problem is to define exactly what is meant by the term threat. For our purposes I propose to define the term threat as being a situation wherein the market does not operate efficiently. For example, in a perfectly competitive market, if consumers found that one firm rose its price this would in no sense constitute a threat to
them. They would be able to easily find perfect substitutes at the old price and hence maintain their real income. If, however, the market was subject to monopolistic elements such that there did not exist perfect substitutes and their demand for the good was inelastic, then the same rise in price would be an attack upon their real income. In the first situation there is unlikely to be any collective action on the part of the consumers. They can register their annoyance at the rise in price by buying elsewhere and hence reducing the revenue to the firm imposing the price rise. In the second non-market situation they are unable to protest so easily. Collective action, in terms of a pressure group to lobby M.P.'s to take action against the "exploiting" monopolist, may be a much more likely outcome. The point is that here the individual does not have the automatic protection or defense of the market. Rather he feels vulnerable at the hands of the monopolist.

A potential "threat" situation exists then, when the market does not operate. Perhaps the situation is found in the extreme when the State interferes in the market. Authors, notably Milton Friedman, have argued that the existence of some private market alongside a State educational system provides the service with a "safety-valve" in catering for the dissatisfaction which might be felt with State education. Yet for some services, e.g. national defense, however, market provision appears out of the question and as such one expects more collective action on the part of pressure groups when the existence of the market is removed.

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Looking at this question from the point of view of individuals selling their services, the same conclusion emerges. If an individual sells his labour in perfect market conditions, he expects to be able to sell as much as he chooses at the going wage. If employers offer less than the market wage then he simply takes his labour elsewhere. However, in a situation of a monopsonistic purchaser the individual is unable to do this. He feels rather that wages will necessarily be lower and possibly employment also. He is aware that he does not have the defense of the market to fall back on. If the labour he has to offer is not specific then he may not feel as "threatened" by a growth of monopsony in one market, for he is at liberty to sell his labour elsewhere. If he possesses distinctive skills, which indeed may have demanded some sacrifice and investment at an early age, then the growth of monopsony in the market for these particular skills is all the more worrying. It represents a fear that he will not be able to reap the return on his human capital that he had expected.

The question now remains as to whether or not in a collective threat situation, or non-market situation, individuals in large groups will be more likely to reveal their preferences for a collective good. The situation can be illustrated by the medical market. Assume that there is very little monopsonistic power in the market. Doctors are therefore able to sell their services at the going price to patients.


3. "The clearest evidence of an association between depressed wage levels and monopsony is found in markets where specialized skills are required and close alternative occupation are few." Charles R. Link and John H. Landon, "Monopsony and Union Power in the Market for Nurses", Southern Economic Journal, April 1975, pp. 649-659.
If demand and supply conditions are unlikely to change radically, the doctor will maintain an adequate return on his skills. If he is persuaded that this situation is so, then he believes that he will get a certain income from the market. Yet if he imagined that the consumers would organize as a monopsony then he would expect the certain income the market would give would be lower.

Into these different environments it is possible to imagine the intervention of a political entrepreneur, i.e. the B.M.A. In the first instance the B.M.A. offers doctors the proposition that collective action can promote their welfare. Assume that the market is working competitively then the B.M.A. offers the proposition that with everyone's support they can restrict entry to the profession and competition from quacks. The supply curve for medical services by doctors is then moved to the left and existing doctors will earn an economic rent. That is to say, that the B.M.A. offer for £1 subscription from members, may, if all joined, lead to an increase of £10 to the doctors' yearly revenue. The situation is one which can be described in the following matrix. If the doctor does not join and the B.M.A. are unsuccessful then he stands to lose nothing. If he joins and they are unsuccessful, then he loses his subscription. However, should he not join and the B.M.A. is successful then he gains the full economic rent of £10 which is non-exclusive. If he joins then his net gain is £10 less the subscription fee. The outcome of course
All join the B.M.A. and successful outcome | Membership insufficient to bring about successful outcome
---|---
Join | £9 | - £1
Not Join | £10 | 0

is that the doctor will free ride if he believes that his joining does not increase the likelihood of a successful outcome. If he has insufficient information to estimate the probabilities associated with each outcome then it is likely that, if he is a cautious individual, he will play a maximin game i.e. choose the strategy that leaves him with the best of the worst possible outcomes. This implies choosing not to join.

The individual doctor in this example can clearly remain complacent. He can always receive income that the market will provide. The increase in economic rent offered by membership of the B.M.A. is a bonus that he can sit back and hope to enjoy as a free-rider. However, if the market for his services were not perfect on the demand side, the activity of the political entrepreneur is likely to change. In this situation the B.M.A. offers itself as a means of defending the doctors income. If the doctor feels that the growth of monopsony will lead to a reduction in the rate of return on his skills, then he is likely to believe that only through membership of the B.M.A. will this be resisted and his income maintained. Assume therefore that the B.M.A. present their case in a defensive rather than promotional manner. They argue that a £1 subscription fee saves the doctor from a £10 loss of income. The situation is set out thus: If the doctor
joins and the B.M.A. is successful, he loses only his subscription. If he joins and they are unsuccessful, then he loses his subscription plus £10 income. If he does not join and the B.M.A. are successful, he loses nothing; while if they are unsuccessful he can only lose the £10. These payoffs are shown in the following matrix. The outcome

<table>
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<th>All join the B.M.A. and successful outcome</th>
<th>Membership insufficient unsuccessful outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Join</td>
<td>- £1</td>
<td>- £11</td>
</tr>
<tr>
<td>Not Join</td>
<td>0</td>
<td>- £10</td>
</tr>
</tbody>
</table>

appears no different. If the doctor believes that he has no effect on the outcome by joining, and if he continues to play a maximin strategy he will not join.

There would appear therefore no reason why the change in the environment, i.e. the threat from the monopsonist should alter the outcomes. Even so, some economists have argued that when a threat situation occurs individuals in large groups behave more like individuals in small groups and reveal their preferences for the collective good. Buchanan, for example, notes

"There is, of course, no a priori means of determining just what size a group must be in order to bring about the basic shift in any individual's behaviour pattern. This will vary from one individual to another, even for members
of the same group. The critical limit is imposed by the personal relationship that the individual feels with his fellows in negotiation. During periods of extreme stress, such as was apparently evidenced by the British during World War II, behaviour characteristic of small groups may have extended over almost the whole population. In other situations, when such cohesive forces do not exist, and when communally - shared goals are not apparent, individuals may behave as they would in large groups, even for community actions. Variations in custom, tradition, in ethical standards; all these serve to shift the critical limits between small group and large group behaviour."

There appears then a belief that the environment intrudes upon the decision-taking of individuals. More explicitly it has been contended that a collective threat leads individuals, even in what might be regarded as large groups, to contribute to collective ends. Though never formally argued, there is an intuitive belief that under a collective threat the individual will join an association even in a large group.

The initial comparison of a doctor faced with a competitive market demand and faced with a monopsonist did not pin-point any difference in his behaviour in either case. Let us therefore, at this preliminary stage, temporarily make one assumption and that is, that

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the doctor feels that if he joins the B.M.A. he must, regardless of how small, be making some contribution towards the attainment of the successful outcome. Furthermore, we will take into account that the marginal utility of income diminishes for individuals. Thus for any individual doctor the total utility he derives from income takes the following form.

\[ u = \frac{e^{-h \cdot y}}{h} \]

Having made a note of these, not unreasonable assumptions, we now return to the individual and examine his response to the political entrepreneur who asks him to join. Initially the market is such that there is competitive bidding for the doctor's services and the income that he feels certain he will get is Io. The B.M.A. confront him with the proposition that if he gives up £1 there is a chance that with him

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in the association the B.M.A. will be able to raise his income by £10. The choice may be shown on the following diagram. The individual must choose between the certainty of maintaining an income of $I_0$ and gambling £1 \( \text{outcome } (I_0 - 1) \) to gain £10 \( \text{outcome } (I_0 + 10) \). The question then hinges on how successful he expects the gamble to be.

If, for example, he feels that speculating £1 to the B.M.A. will make the chances of getting the £10 increase by 50 p.c. then he might gamble. The utility he derives from a gamble may be equal to the utility from the net expected value of the gamble. When the chances of a favourable outcome are 50/50 this net expected value is shown by $I^*$. Clearly if the odds were better than this the net expected value would be to the right of $I^*$. The utility he derives from the gamble $I^*$ is greater than that derived from the certain outcome $I_0$ and so the individual would join if he feels that his joining improves the chances of getting \( (I_0 + 10) \) by 50 per cent. However, he does not have to feel that important to take the gamble. Rather he has only to
feel effective to the extent that he makes \( I'_o \) the expected value of the gamble, in order to be indifferent about joining or not. He must feel that his contribution of £1 will improve the outcome of \([I_o + 10]\). That is the probability of his being effective must be high enough to make \( I_o \) the net expected value of his £1 gamble. Now if the probability of his being effective is determined by the size of the group then in a small group he may join in this instance, but as the group rises the net expected value of taking the gamble (i.e. membership) will fall and eventually drop below \( I_o \).

The effect of a threat to the individual can now be shown. Consider figure 1 - if the market is competitive (i.e. no monopsonistic buyer) then the individual feels that \( I_o \) is his certain income. The B.M.A. offer the chance to win an economic rent for doctors so that his new income is \([I_o + 10]\), but insists that he should pay £1 subscription. If by paying £1 the doctor feels that he improves the chances of attaining \([I + 10]\) such that \( I^* \) is the net expected value of contributing then he may join. Thus the probability of his being effective must be great enough to provide him a net expected value of \( I^* - [I_o - 1] \) as a result of joining. As the group gets larger the individual feels this is less likely and hence does not join.

Assume now, by comparison, that the B.M.A. presents the doctor with the choice of joining to protect himself from a monopsonist. In the face of the monopsonist the certain income that the doctor feels he will have is \([I_o - 10]\). He is then faced with keeping this amount and joining the B.M.A.; in which case he has the chance of retaining his old income level \( I_o \) or loosing his subscription, \([I_o - 1]\). It is clear that the net expected value in income terms does not have to be as great in order to induce him to take the
membership i.e. it has to be $I^*-I_o$. Another way of saying the same thing is that the probability that an individual will be effective does not have to be as great in the threat situation in order to induce him to join. Therefore, individuals may not join a promotional association when they are members of large groups, but they may join defensive associations even though the size of the group has not changed.

There is then an income effect. Individuals are prepared to pay more to take a chance of avoiding a fall in income than they are prepared to pay for a chance of attaining/equal increase in income.
Such an income effect would stand as a fair explanation for Buchanan's proposition that large groups act like small groups when under a collective threat. It also predicts that the B.M.A. membership will be directly related to the extent that the N.H.S. appears monopsonistic; a conclusion shown in Chapter Three.

Moreover the effect of custom and tradition can be added to this model. For example, suppose that the certain income provided in the market to the doctor is the one which he has always known. There may then be inertia or a "ratchet effect" whereby a fall from this traditional position creates considerably greater disutility than a similar rise from it. This can be illustrated in fig. IV. The B.M.A. offer the individual the chance to increase his income by £10 and clearly, to take this gamble he will have to expect that his contribution will itself create at least $I^* - (I_0 - 1)$ expected value. However, in terms of defending the income to which he has become accustomed, he requires only that he feels his subscription generate $I^*_1 - (I_0 - 11)$ expected value which is now significantly less. The probability that his contribution will be effective can thus be considerably smaller and he will still join.

By introducing such inertia or tradition, the conclusions reached previously about the effect of a defensive rather than promotional situation are amplified. Furthermore, if instead of income, one had written income relative to other sections of the profession, on the horizontal axis, this same model would predict admirably the history of the profession since 1950. That is to say, that since 1950 each section of the profession has had reason to feel that their relative position within the profession was being neglected. Each section has been sensitive to some idea of the 'just' or 'right' level of relative income they 'should' be receiving. This
has brought a response in terms of increased membership of new associations, as one would have expected on the basis of this analysis.

The model is successful in explaining the evidence of the medical profession for it takes into consideration the likely effects of the environment on the individual's choice. By making assumptions on tastes and preferences the idea of custom and tradition can be incorporated. It is not essential to add this indivisibility in the utility function, but it does help to explain the reaction of individuals to threats vis-à-vis their response to the association's goals.
The reader, however, may be dissatisfied with the analysis. It is a model in which the individual behaves quite rationally, and it predicts conclusions which appear evidenced in the real world. It rests on the assumption that individuals do respond to a measure of the net expected value of their actions. It may be alleged unlikely in the real world, when the group is large, that they invest the necessary time and effort to measure this in any precise manner. They may view their own importance as small and difficult to perceive. Yet investment decisions are often taken on criteria which only approximates the ideal because of the costs involved. For the individual a decision criteria based on a comparison of the costs to him from a collective threat with those of subscription may be crudely made.

Assume the individual does not consciously perceive his own significance in terms of providing a collective good. Instead he looks at the problem as one of decision-making under uncertainty. If he is cautious he plays a maximin strategy, i.e. he will compare the worst outcomes of playing alternative strategies, and will then choose the strategy which brings the best of the worst outcomes. In the light of this one can make some comment on the two matrices which we have been using.

6. Investment appraisal is sometimes undertaken by methods which "hopefully" approximate the ideal, in order to reduce the cost of such appraisal; e.g. the payout (or payback period approach to investment appraisal). For an analysis of such "short-cuts", See W. J. Baumol, Economic Theory and Operations Analysis, Prentice Hall, New Jersey, 1965, 2nd edition, pp. 434-475.
While it is true that in both cases a maximin strategy leads him not to join there is one argument which may have significance. This is that in Matrix A, i.e. the promotional case, the subscription assumes a large relative importance. Because he is safe from loss of income anything that he pays in subscription is infinitely greater than if he had not joined (i.e. $-\frac{1}{0} = \text{infinity}$). The fact that he is secure exaggerates the importance of subscription costs. When, however, he compares the worst outcomes to him in the "threat" situation they are both gloomy prospects. The subscription cost lose their significance and makes the worst outcome of joining only marginally greater than that of not joining. Both outcomes are
alarming but one is in relative terms only just more alarming than the other.

If we assume, once again, that the individual has a feeling that his income is right and should be maintained, we can say more. In the first situation where the subscription costs are highlighted by his security, he may feel more at ease by "free-riding"; hoping for the 'bonus' that the association's success may bring. To this extent free-riding is a more acceptable strategy. In the second case his present level of income is under attack. Can he now comfortably sit back and free-ride? The difference in the outcomes if he joins or not are relatively insignificant. His own contribution to offsetting this outcome is imperceptible (but at least to some small extent likely to be positive). Here he is made more aware of the penalties of no success. Is it not arguable, as such, that he will be more ready to join; at best to help offset the threat, at worst as a protest against it? This comparison may also then reveal an asymmetry of behaviour and attitude to threat and promotional situations. In the former case he may be more ready to join.

The argument that subscription costs assume smaller relative importance in the face of 'intimidation' may be supported. Over and above the subscription fee the individual faces certain other costs if he wishes to remain a member of an association. Foremost among these is the cost of having to follow the majority decision of the association. Clearly, the individual's preferences may not always conform to those of the majority. It may be plausible to argue that at times of common threat there is less uncertainty as to the objectives which the majority may choose. There may be some dispute as to forms of defense to be pursued, but it seems likely that
defense will dominate the efforts of the association. If there is likely to be greater consensus on objectives at such times, the costs of membership are reduced.7

The argument is that individuals discount more heavily the costs of private subscription when they are faced with the

7. There is evidence that individuals do not like the risk incurred in having to abide by 'unfavourable' majority decision. To the extent that this is reduced in times of collective threat one would imagine them more ready to join the association. A survey of workers undertaken on behalf of the Department of Employment showed that the greatest disadvantage felt of belonging to a union was the need to follow majority decisions.

* The union restrictions mentioned mainly concerned admission to skilled status and the amount of overtime allowed.


(It will be argued that the public sector often appears a monopsonistic threat to workers. It is therefore not strange to see that the problem of having to follow majority decisions is less important for union members in the public sector).
intimidating costs of a collective threat. The belief that this is so is apparent in the works of other authors. For example, A. Downs, explains the decision to turn out to vote in the following way:

"Participation in elections is one of the rules of the game in a democracy, because without it democracy cannot work. Since the consequences of universal failure to vote are both obvious and disasterous, and since the cost of voting is small, at least some men can rationally be motivated to vote even when their personal gains in the short run are out-weighed by their personal costs." 8

The argument is put forward then that in conditions of uncertainty individuals are more likely to respond to demands on the part of political entrepreneurs to join associations when they feel threatened than when they feel secure. If the association defends rather than promotes well-being then it may better attract membership even when its output is enjoyed by large groups. If the group is so large that the individual feels his contribution imperceptible he may yet join in the defensive situation. The subscription costs loose their significance and the penalties of not joining become more odious. Though the individual does not finely measure net expected value, there is still reason to believe that he responds in an asymmetric fashion in threat and promotional situations. The

environment then exerts a response in terms of the likelihood that individuals will subscribe as the group gets larger.9

The remainder of this chapter will examine why individual doctors might view the State as a threat and hence join the B.M.A. as a response.

9.1 Non-Market Conditions as an Index of Threat.

If market conditions hold it has been alleged that individuals feel to some extent that they have a defense mechanism. Consumers can counter price rises for goods by purchasing perfect substitutes. Employees can counter low bids for their labour by selling elsewhere at the going wage rate. If on the other hand monopoly or monopsony creep into this situation then individuals feel at risk. They feel that such a condition might threaten to reduce their real income, since there is nothing that they, as individuals, can do to counter any such attack. If market conditions have been eroded then there is no variable within their individual control that they may easily employ to oppose the threat. It is the contention of the author that the bureaucratization of the profession by the B.M.A., and the intervention of the government into the

9. The problem of the free-rider can be thought of in terms of the "prisoner's dilemma" in game theory. Here two individuals acting independently will be led by a maximum strategy not to co-operate. Experiments have been undertaken to show the importance of the environment on the propensity to co-operate. For example, when individuals of the same sex play each other the tendency to co-operate is greater. The number of times the game is played is important. Also the extent to which high penalties for not co-operating, rather than rewards for co-operating, are offered is important. The higher the penalty the greater co-operation. See, A. Rapport and A. M. Chammah, Prisoners' Dilemma, University of Michigan Press, 1965.
medical market, has left doctors in this dilemma.

Other authors, particularly Albert O. Hirshman, have noted the growth of collective activity when the market does not provide the individual with the defensive mechanism to which reference has been made and which Hirshman refers to as "exit". 9a He distinguishes between "exit", or individual action, and "voice", which is collective behaviour. The claim is made that with exit - competition - playing a much smaller role in the Soviet economy than in the market economies of the West, it has been necessary to provide means of giving "voice" some more prominent role. Hirshman recognizes the problems of size in the execution of voice:

"Voice is most likely to function as an important mechanism in markets with few buyers or where a few buyers account for an important proportion of total sales, both because it is easier for few buyers than for many to combine for collective action and simply because each one may have much at stake and wield considerable power even in isolation." 9b

Yet he also notes that in certain circumstances when exit is impossible the problem of large numbers may be overcome.

"Certain types of purchases may nevertheless lend themselves particularly to the voice option even

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9b. Ibid, p 41.
though many buyers are involved. When the consumer has been dissatisfied with an inexpensive non-durable good he will most probably go over to a different variety without making a fuss. But if he is stuck with an expensive durable good such as an automobile which disappoints day-in and day-out, he is much less likely to remain silent." 9c

The doctor may be viewed as an individual who "is stuck" with an expensive piece of capital. The accumulation of medical knowledge is an investment which has considerable opportunity costs involved. It is made presumably with a view to attaining some expected rate of return. Both the existence of the G.M.C. and the N.H.S. limit the doctor's ability to maintain this pecuniary return should the price under which he sells his labour move adversely. Thus the return on individual initiative will be low, and hence he is more vulnerable as a result of the State intervention.

The extension of the State has limited the area where the doctor might himself set his fees. In his private practice the practitioner has clearly had reservations about adjusting the fee for services far from the norm laid down by the B.M.A. Nevertheless some limited adjustment has always been possible. The area in which the doctor himself can individually set his fee has of course been reduced by the reduction of private practice. As a result of

9c. Ibid, p 42.
the changes in 1911, 40 per cent of the population of England and Wales were covered by the N.H.I. scheme and 90 per cent of all general practitioners were participating in it. Over a third of the income of these doctors came from capitation payments and health insurance took two thirds of their time. With the advent of the N.H.S. private practice was more reduced. One estimate was that "on the appointed day (5th July, 1948) private practice shrank from being the normal form of medicine for over fifty per cent of the population to less than four per cent. The extent of private practice has fluctuated only slightly around this figure. By 1964 it was suggested that any g.p. with as many as five per cent private patients was rare, and in 1967 it was estimated that the number of doctors entirely in private practice was probably at most between two and three per cent of the total. In the 1960's general practitioners had an average income of only £170 per annum from non-official sources. Private Medical Insurance schemes have been available for g.p. and for hospital care. The Manager of the British United Provident Associations estimated that no more than six per cent of the population were potential users of such schemes.

11. Ibid. p 53.
15. Ibid. p 16.
Today there are about two and a quarter million people covered by private medical insurance schemes and this number has been roughly constant for the past five years.  

The doctor therefore has very little area in which he might individually have any great say in the fee charged. Even so, if he wished to maintain some expected rate of return then it might be argued that he still has control over his output. He may work longer and harder to defend his pecuniary income. A payment system based largely on the form of a capitation fee provides only a tenuous link between reward and the actual amount of work carried out. Such a fixed fee per annum has little relationship, for example, with the hours of consultation and surgery undertaken by the g.p. Whether the doctor sees the patient or not he is entitled to his capitation fee. To make some allowance for the fact that some patients are more demanding than others, an allowance for treatment of individuals over the age of sixty-five has been built into the fee. However the system has long been criticised as not reflecting work done. Professor Jewkes 17 and the Porritt Committee 18 expressed such

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Between 1964 and 1974 there has been a rise in the numbers of group or company subscriptions with private health insurance associations. This rise however has been partially offset by the fall in the number of individual subscribers. Total numbers covered by private health insurance has grown by a thousand between 1964 and 1974, though of course these patients are generally making claims for once-only treatment and use the N.H.S. for "every-day" medicine. See Lee Donaldson Associates, U.K. Private Medical Care: Provident Schemes Statistics 1974, Report for the Dept. of Health and Social Security, August, 1975.

17. Royal Commission on Doctors' and Dentists' Remuneration, op. cit., Minority Report, para 74.

dissatisfaction, as did D. S. Lees and M. H. Cooper

"A major conclusion that seems to emerge from
our survey is that widely differing amounts of
work are done by individual practices for any
given amount of income."\(^19\)

Part of a doctor's income is in terms of an allowance for practice expenses, e.g. equipping and improving his surgery. It has taken the form of a constant allowance for all doctors with a list of more than 1,000 patients, but adjusted for those with a list below 1,000. Yet doctors have received this payment regardless of whether or not it was spent on their practice. The Ministry of Health often suggested the need for some check on the actual spending of the allowance, but the B.M.A. looked upon this as an infringement of professional independence.\(^20\) Here again then the remunerative system is not linked to the initiative and industry of the doctor. Enoch Powell, once Minister of Health commented

"The money he (i.e. the general practitioner) spends
on improving his premises, providing himself with
modern equipment, paying for efficient reception,
clerical and other administrative staff, will not
increase his earnings by one penny."\(^21\)

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The remuneration system is therefore not closely related to the industry or efficiency of the doctor. Attempts to improve the relationship have tended to generate from the Ministry of Health, but have been rejected by the B.M.A. For example, during the important negotiations on g.p. remuneration the Ministry suggested recognition for special merit, but the B.M.A. made the point that this last item had not been part of the doctors' charter and that they had no mandate to discuss it. Yet even where merit awards have been introduced, e.g. for consultants, there is criticism as to whether they justly reflect the ability and industry of consultants.

The doctor, in this way, is not only constrained in his ability to influence his income via the fee for his services, he is also unable to alter his income very much by varying his work effort.

The capitation fee system might however be "exploited" by an individual doctor if he were to build up large lists. The problem of course is that in so doing he defies the advice of his peers.

"Whilst a little friendly competition amongst friendly colleagues can do no harm, head hunting is to be strongly deprecated."  

However, perhaps more seriously if a doctor engaged in activity likely to win him patients from other doctors then he would risk being struck off the Medical Register. So closely are such activities

22. G. Forsythe, Doctors and State Medicine, op. cit., p 158.

23. R. J. Lavers and Malcom Rees, "The Distinction Award System in England and Wales", in Problems and Progress in Medical Care, Seventh Series, 1972, published for the Nuffield Provincial Hospital Trust, by the Oxford University Press.

policed by the G.M.C. that doctors might be found guilty of non-professional conduct for having over large type for his entry in the telephone book, or a particularly big brass plate on his door. An example of what a minefield medical ethics can be was given in 1960 when Mr. Leslie Gardiner, a senior consulting surgeon to two metropolitan hospital boards was found guilty of advertising by writing a book called Faces, Figure and Feelings and by sanctioning an article in the "Woman" weekly magazine. The profession is clearly sensitive to any action which might be construed as competing for patients. However, the additional constraints imposed by the State limit the size of lists in any case, e.g. in 1952 a loading system was introduced to favour the doctor with a medium list and to taper off rewards for the larger practices (the loading was designed to provide a higher capitation fee for every person from the 501st to the 1500th and doctors lists were restricted to 3,500). Furthermore the bureaucratic nature of the N.H.S. would be likely to limit the movement of patients between doctors.

"The one limitation to this freedom of choice in the doctor-patient relationship that has been imposed since 1948 was forced on an unwilling Ministry of Health by the profession. In October 1950 restrictions

25. P. Ferris, The Doctors, op. cit., pp. 98-117. Gardiner commented, "You can neglect patients and be a sexual pervert, you can short-change the Health Service patient to attend your private practice, but you mustn't be a financial success."

26. R. M. Titmus, Essays on the Welfare State, op. cit., p 156. Whilst today the single-handed practitioner is restricted to 3,500, a member of a partnership may have up to 4,500 people on his list provided the partnership average list size does not exceed 3,500.
were placed on the ease with which patients could change doctors. The new arrangements led to some paper work, introduced a waiting period before a change could be effective and, in most cases required the written consent of the present doctor. Some patients have naturally found this an embarrassing procedure ..... Among other patients today with little knowledge about statutory regulations, an impression has gained ground that it is impossible or almost impossible to change one's doctor."

The individual doctor is then almost totally constrained. He is unable to take individual action to alter his pricing, output or advertising policies in answer to changes which could lead to a reduction in the rate of return he enjoys on his medical skills. The individual is then made to feel impotent in terms of the actions which he can turn to in the market. This of course is unsatisfactory to the extent that he also feels that his best interests may not be compatible with the introduction of the State into the medical market. If this is so then the B.M.A. is his defense-line; the market no longer operates to protect him. Doctors since the mid-nineteenth century have been sceptical about the activities of the State. In Chapter Two note was taken of the fears of Mapother in 1868 of the small number of Parliamentary members who were from

27. Ibid. p 139.
the medical profession. \textsuperscript{28} Today of course there is an even smaller proportion. \textsuperscript{29}

It has been argued that really large groups do not mobilize simply because within the political framework they have little to fear. If the groups are large then they have a significant voting power even if they are not organized. Politicians will appeal to such groups, e.g. old-age pensioners, consumers in general, in the hope of maximizing their votes. Minority groups are more at risk and this it is argued, is the rationale for the growth of associations in small groups, but not in large.\textsuperscript{30}

There are quite specific reasons why doctors may feel threatened by the State. The very structure of the National Health Service itself is such that doctors may reasonably express concern. On the one hand the service is financed from taxation. The individual in the community is therefore made aware of the costs of the service when, as a member of a large group, he is asked to vote taxes for

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\textsuperscript{29} In the 1970 Parliament there were 116 lawyers, 65 teachers, 43 farmers, 34 trade-union officials and 10 doctors. See \textit{The Times, Guide to the House of Commons 1970}, Times Newspapers Ltd., London 1970.
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The B.M.A. of course counters any deficiency in the proportion of doctors in Parliament by amending legislation before it is presented to Parliament and its implementation after leaving Parliament. Its relationship with the D.H.S.S. enables this. However, one should not completely forget its actions in terms of favourably altering legislation whilst it is in Parliament. Its role as a lobby group has recently been highlighted with the re-structuring of the N.H.S. See for example, Frank Stacey, "The Re-organization of the National Health Service," \textit{Public Administration Bulletin}, No. 15, December 1973.
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the service. His instinct may well be to keep his costs low by under-revealing his preference for a service from which he feels that he cannot be excluded. However, since he cannot be excluded, and since he is not directly charged as he uses the service, then he reacts in his consumption of the good as though it were zero-priced. His instinct is to consume the service until the marginal utility he derives is zero. The result will be that too few resources will be allocated to the health service with respect to the demand for them. Waiting lists for treatment and financial inadequacies in the face of excess demand are therefore a likely feature of the service.\textsuperscript{31} The implications are of course quite grave for the doctor. In the first instance, an institution such as the N.H.S. implies a greater call on his services because patients are not priced according to their use of medical care facilities. On the other hand, individuals reluctance to vote taxes upon them implies that, without a defensive organization, an individual doctor will be paid less for working harder.\textsuperscript{32}

There is, of course, some evidence of the monopsonistic nature of the British National Health Service. Alan Maynard has recently compared the forms of medical care provision in the countries of the E.E.C. The original six members of the E.E.C. had much less

\textsuperscript{31} J. M. Buchanan, \textit{The Inconsistencies of the National Health Service}, Institute of Economic Affairs, London, 1965.

\textsuperscript{32} If remuneration was left strictly to the views of the public as voters, there is evidence to suggest that they would be worse off. An attitude survey in the \textit{Review Body on Top Salaries First Report}, Cmd 4836 H.M.S.O. 1971, showed that the public believed the "appropriate" salary for a g.p. was £4,100 per annum, which was less than they were earning at the time of the survey.

government intervention of the State in their medical market. The result has been that expenditure on medical care has grown faster in these countries than in the U.K. This, however, does not seem to mean that the quality and quantity of medical care is superior to that of Britain. It reflects rather the fact that there is no opposition in these countries to any monopolistic power that the organized profession may have. In the U.K. the Department of Health and Social Security acts as a counterveiling power to the monopolistic practices of the profession. As such it has reduced the economic rent that doctors have enjoyed. Evidence suggests then that the monopsonistic powers of the D.H.S.S. will have a dampening effect on doctors' incomes.

There are, therefore, many reasons for believing that a doctor feels threatened by State Medicine, and that he has no recourse to individual action in the market as a defense. The B.M.A. then is the association which might offer defense. Indeed it is typified as a defensive or "protective" association. Millerson refers to it as such and Blackburn calls it "one of the best known organizations of this type." In view of this there is reason to believe that its high membership and its pattern of growth of membership is determined by the asymmetry in the micro-examination of the individual's propensity to contribute to defensive and to promotional goods.

Chapter Ten

Conclusions.

The aim of this research has been to analyze the decisions of individuals to contribute voluntarily towards the provision of a collective good. The data to which reference has been made is the history and experience of the B.M.A. It is possible, at this stage, therefore, to offer concluding remarks both on the propensity of individuals to participate in collective action and also, on the role of the B.M.A. and its relationship with the N.H.S.

10.1 Collective Threats and Collective Action.

An initial review of the history of the B.M.A. drew attention to factors which might be considered important in explaining its membership growth. Factors such as the development of professional consciousness, the growing homogeneity of social background, state involvement in the medical market, union recognition by the Ministry of Health, and advertising and pricing policies of the B.M.A., were closely analyzed in the hope of being able to present at least an ordinal ordering of their relative importance. In general sociological factors appeared the most significant. Uniformity of class background seemed important, while changes in state involvement correlated with the growth in percentage membership of the B.M.A. In this respect the study adds weight to the suspicions that other authors have voiced. E.g., Professor Abel-Smith notes,

"Doctors the world over have formed fighting organizations not necessarily because they
were more grasping than other trades and professions, but because they had been used to dictating their terms of service and this practice had been challenged by consumers' representatives."

While Professor Eckstein, more explicitly, comments, "The development of public sanitary and medical politics made the B.M.A. more active in politics; but it had other effects on its role and power as well. First of all it has engendered a constant growth in the Association's membership since the mid-nineteenth century ...."

Studies have been made on many trade unions in order to indicate the determinants of their membership growth. This study was the first to seriously analyse the question with reference to the B.M.A. However, the conclusions bear a resemblance to those of other studies. In each case factors deemed important are those which might have made potential members more aware of the aims they share in common. The belief has been expressed that association formation and growth depend on the fact that "people recognize a like complementary or common interest sufficiently enduring and sufficiently distinct to be capable of more effective promotion through collective action." What could be more likely to arouse such an awareness than State action. V. O. Key notes, " ... government intervention, or its threat, stimulates the formation of organized groups

1. B. Abel-Smith, "Paying the Family Doctor", Medical Care, Vol 1, pp. 27-35.


by those who begin to sense a shared interest ... Almost every proposed law represents the effort of one group to do something to another. When a law or proposed law impinges on a class of individuals, they are likely to be drawn together by their common interest in political offense or defense ..." 4

The problem was that the economist feels unhappy with the view that "common interests draw individuals together." In large groups it is the fact that common interests bear the characteristics of a collective good that leads individuals to choose not to join associations. Thus attention was turned to inducements which may overcome this tendency to free-ride.

We have shown that associations need not rely on coercion to swell their ranks. Coercion is clearly a means whereby some associations and the State itself induce free-riders to take more co-operate action. In the case of the B.M.A. there was no evidence to suggest that they informally exerted pressure on doctors to join. After isolating the goals for which such closed-shop tactics are employed it was shown that alternative techniques were applied by the Association for their attainment. There was evidence to show that the B.M.A. had coerced doctors to "tow the line" when they were engaged in conflict. Yet on the data available one could not fairly accuse them of exerting heavy pressure to boost their membership. Thus it was meaningful to continue in the belief that doctors

possessed consumer sovereignty and to analyze, in micro-economic fashion, his decision to join.

To the question of whether or not membership of associations depend on the inducement of exclusive goods produced by the association, the following remarks appear in order. Firstly, goods which are not purely private, in the sense that they are non-rival below capacity limits, are likely to involve some form of association or club in their provision. Secondly, given that output could be increased, the optimal size of the club could be large. Therefore, one might be led to entertain the view that the B.M.A. existed primarily to provide such "club benefits", and produced the non-exclusive good of negotiation as a by-product. Yet this research has also shown the limitations of such a view. Empirically, there is reason to dispute the importance of the exclusive goods which are offered to members. There is no evidence to suggest that tangible 'selective incentives' are consumed to a great extent by association members. Few doctors made use of the facilities offered by the B.M.A., many did not know such facilities existed. It is generally the case, of course, that union members are seldom regular attenders of branch meetings or avid readers of union journal. Furthermore, the argument that members only joined for the club benefits leaves some uneasy questions. Why is any of the by-product, i.e. the non-exclusive good, provided? Why cannot competing associations offer the club benefits only and charge reduced prices? It is of course true that many associations offer benefits purely to members, but it is suggested that these should be looked at as a bonus to members. They are not the sole reason for membership, though may be influential in marginal cases.
After examination of the goods and services provided, a re-appraisal of the aims of the individual was undertaken. The belief was that, while membership of associations did not seem likely when the individual was maximizing pure self-interest, it might be compatible with altruistic self-sacrifice. Behaviour which appears altruistic may be undertaken for motives arising from pure self-interest. Transfers may be undertaken for personal prestige, out of a feeling of the need for mutual insurance against unpredictable catastrophe, or for the satisfaction derived from performing a "good act" and behaving in a Kantian fashion. Yet altruism might also be viewed as a genuine desire to improve the well-being of some other individual or group. If an individual felt better as a result of improving the well-being of another group, it was suggested that he may join an association. Yet the problem once more was that, if this end was attained as a result of subscription by others, the end result was itself non-exclusive. The likelihood was once again of free-riding. The B.M.A. was tested to ascertain to what extent it undertook any altruistic action of the part of doctors for society. The conclusion was that, if altruism be measured at times where doctors renounce self-interest to the good of society, the B.M.A. did not act altruistically. Also there was no suggestion that g.p.'s or hospital doctors believed that they should join the B.M.A. to help other sections of the profession. Altruistic behaviour did not typify the B.M.A. and would not easily explain membership growth.

The question was raised as to whether or not one might usefully distinguish between decision taking in an economic market and a political market. It was suggested that there was a tendency for
an inherent greater degree of uncertainty to characterise the latter. In political decisions, such as voting and association membership, the outcome of decision making is more uncertain because of the greater degree of dependence on other individuals. An attempt was then made to consider the activity of a political entrepreneur who could mobilize large groups by making expectations mutually compatible. The concept of an entrepreneur is not new, although the explanation of his activities has been presented in a somewhat different way. It established that there was an incentive or political surplus which he might seek to maximize. It also showed that the analysis rested to a large extent on the belief that the individual member of a large group could be persuaded that, even though small, the probability that the good would be provided as a result of his contribution was positive. It may be accepted that, as the group gets larger, each individual expects the probability that his contribution will be efficacious falls. The important point, which is left moot, is whether he views it as zero.

The interesting feature of this line of argument is that it turns the research full circle. Assume individuals do respond, however imprecisely, to some notion of the net expected benefit of their contribution. If one assumes that individuals feel that, although small, their contribution counts for something, it is possible to argue that not only does a collective threat stimulate collective awareness, it also acts as an inducement to reveal preferences. If individuals' marginal utility is diminishing, they will be prepared to pay more to avoid a given possibility of a fall in their income than they would to buy the same possibility of an equal increase in their income. The political entrepreneur then may either offer
himself as a means whereby, if individuals pay subscription, they will to some extent help avoid a fall in income, or as a means whereby the individual joins to increase his chances of an equal increase in income. If the probability that his contribution will be effective is fixed by the number in the group, then given the "income effect", he may refuse to join if the group is large in the promotional instance, but choose to join in the defensive instance. There is then an asymmetry in the response of individuals depending on the environment, defensive or promotional, in which he finds himself. Furthermore, by introducing the assumption of a desire to maintain his traditional income or relative income, we can postulate that his utility function has an indivisibility or kink at his present income, and that this asymmetrical response will be more intense.

The question of whether this asymmetry follows when the individual discounts his own importance completely, is more difficult. In this instance of course, as the good is non-exclusive he will not join, without extra persuasion or inducement. If, however, we argue that he is a pessimist and plays a maximin strategy, then there may still be reason to suppose that he is more easily persuaded in the defensive situation. If he is secure and not under attack then the worst outcome that can happen to him if he does not join, is that he remains in his present situation. No ill befalls him, and hence his costs in this outcome are zero. When he compares this to the worst outcome which befalls him if he joins the association then, given that the costs are positive, they are infinitely greater than the losses of not joining. The maximin strategist compares only these worst outcomes. His security has highlighted the costs of joining.
When he feels threatened the worst that befalls him if he joins is only marginally greater than the worst if he does not. If the threat materialises then he will lose whether he joins or not. Having joined, the extra subscription costs which can be lost, lose their relative significance. The situation is one where he may be less inclined to sit back hoping to avoid the costs of membership.

The maximin strategy is extremely pessimistic behaviour. Maximin decision makers never vote or join associations. Our argument, however, is that they may be more easily persuaded or induced to so do if they feel threatened and the association provides defense. Clearly it is strengthened if we also argue that the individual's prime concern is maintenance of his present income.

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Recently I have become aware of the work of John A. Ferejohn and Morris P. Fiorina. They are concerned with voting, but their work may be amended to suit the purpose of this study. They believe that individuals may pursue a minimax regret criterion rather than a simple maximin. If we postulate that a political entrepreneur can persuade individuals that in one of many outcomes they will be effective when they join, then the argument can be outlined as follows. For simplicity assume

\[ S_1 = \text{success by the B.M.A.} \]
\[ S_2 = \text{no success by the B.M.A.} \]
\[ S_3 = \text{a situation of stalemate without the individual's contribution.} \]

Further assume the individual gains 1 in \( S_1 \), 0 in \( S_2 \) and in \( S_3 \) because there is an equal chance of the outcome going either way without his participation in the gain in \( \frac{1}{2}(0) + \frac{1}{2}(1) = \frac{1}{2} \). Let \( C \) represent the costs of joining and the following payoff matrix represents the possibilities.

(Cont'd)
Thus whether or not individuals measure their net expected benefit of contribution or play a maximin strategy under uncertainty (or indeed any other suitable strategy), one can justify the argument (cont'd)

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<th>$S_1$</th>
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<tr>
<td>Join</td>
<td>1-C</td>
<td>-C</td>
<td>1-C</td>
</tr>
<tr>
<td>Not Join</td>
<td>1</td>
<td>0</td>
<td>$\frac{1}{2}$</td>
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The regret matrix is drawn up by measuring the difference between if state $S_1$ occurs between what the individual would have gained by playing one strategy rather than the other.

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<th></th>
<th>$S_1$</th>
<th>$S_2$</th>
<th>$S_3$</th>
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<tbody>
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<td>-C</td>
<td>0</td>
</tr>
<tr>
<td>Not Join</td>
<td>0</td>
<td>0</td>
<td>$\frac{1}{2}$-C</td>
</tr>
</tbody>
</table>

(assuming $\frac{1}{2} > C$)

The maximum regret of joining is $-C$ and of not $\frac{1}{2}$-C. The individual will then join if

$$C < \frac{1}{2}-C \Rightarrow C < \frac{1}{4}$$

Thus he joins if the utility gain from a successful association exceeds four-times the utility loss of the subscription.

(See, The American Political Science Review, Vol 68, 1974)

The problem with this is, of course, that the individual has to feel that the outcome in which he will determine events could exist. He does not know the probability of this, but feels it conceivable (however remote). Yet for our purposes, if this analysis truly explained behaviour, then the fact that considerably more utility is at stake when the association is successful in defensive, rather than promotional situations, means that the asymmetric behaviour is amplified. This even more than net expected benefit would show that individuals are more likely to join in defensive than in promotional situations.
that common collective threats not only create collective awareness, but induces individuals to reveal their preferences for collective defense. This asymmetry of response between collective goods which maintain welfare and those that promote welfare should be noted. Also the belief is held, that at least in the case of the B.M.A., this asymmetry of behaviour has been more important than other methods of inducements. Though other inducements have been applied, response in terms of membership varies with the extent to which the N.H.S. presents itself as a monopsonistic threat.

Whilst an analysis of the B.M.A. is a somewhat narrow basis on which to make general prescriptions, there is reason to argue that the results outlined have a wider relevance. In the first place there is an open invitation to test the conclusions of this study with reference to other workers. If large scale State involvement in a market is an index of threat to skilled or semi-skilled workers then one might note the response of teachers\(^6\) or farmers\(^7\) or self-employed workers.\(^8\) Furthermore one might be tempted to undertake an

---

6. It is interesting to note that the origins of the N.U.T. can be traced to 1870; the very year that the State took greater responsibility for primary education in the U.K. It is probably indicative of this that the N.U.T. began life as the National Union of Elementary Teachers. The growing intervention of the State clearly broadened the basis of this Union's Membership. If time series data were examined then I suspect that percentage changes in membership density would correlate with State activity. See, Norman Morris, "England", in Teachers Unions and Associations: A Comparative Study, Union of Illinois Press, Urbana, 1969.


8. The recent measures of value added tax inspection has led to a considerable growth in the National Federation of the Self-Employed.
international comparison of such response. 9 Again opportunity may present itself to compare the relative significance of collective threat with other inducements to lead individuals to join. 10

In a more general setting, the results of this study may be checked against other political behaviour. An asymmetry of behaviour of individuals has been based on a belief that they discount small private costs more in the face of large losses from a collective good. Thus one might test for example whether voting turn-out is greater when the election comprises parties of widely different political views. Supporters of each party discount the costs of voting against the large costs involved in seeing the "wrong" party in power. Interestingly, another aspect of this asymmetrical behaviour has been tested. Voters turn-out is greater during periods when they feel under threat e.g. from inflation. Their response is greater in periods of declining income than in periods of increasing income. Incumbent parties, for example, loose more votes when real incomes fall than they would gain when real incomes rose by a

9. William E. Steslicke, Doctors in Politics: The Political Life of the Japan Medical Association, Praeger, London, 1973, quote membership figures on pages 55-57 which are consistent with the view that the implementation of a National Insurance Scheme led to membership growth.

10. Associations often are ephemeral because of the liquidation of an outside threat. In such cases other inducements for membership do not work. See, for example, E. J. Dvorak, "Will Engineers Unionize", Industrial Relations, Vol 2, 1962-3.

R. Salisbury, op. cit., has given examples in America where Farmers' Associations have formed and grown because of selective incentives and also when they have not required such inducements because of the existence of a collective threat.

In this study we might argue that the A.M.A. has had to rely on other inducements if only because they have protected themselves from the threat of monopsony from the State.
similar amount. 11

The research then stresses that characteristics of the environment can be introduced into the choice-theoretic model. It is contended that this will lead to improved explanations and predictions of political behaviour.

10.2 Insights into the B.M.A.

In pursuing this research we have been able to make some comments specifically on the life of the B.M.A. and its relationship with the B.M.A.

In the first instance the analysis of the B.M.A. in the late nineteenth century casts doubts on the widely held belief that the B.M.A. objected to a public health insurance scheme in principle and was reluctantly drawn into the political arena to fight such a principle. Its history shows that it was the Friendly Societies and the Medical Aid Associations of the private market that proved the major obstacle to the B.M.A. The Association had by comparison been successful in its negotiations with government agencies. Its lobbying had here resulted in greater returns than had its petitions to associations in the private sector. Indeed the position of the B.M.A. in the profession was weakening as its failure in dealing these societies became apparent. The appearance of a Bill which sought to substitute government responsibility for the health of the working classes was exactly what was required. It was beneficial firstly in that it rallied the profession behind the B.M.A. It also

provided the opportunity to overcome the Friendly Societies and improve on the conditions which they had rigidly set for doctors. The B.M.A. as early as 1905 advocated some public health insurance scheme. One therefore has reason to believe that, whilst they would fight to get doctors the best possible terms, they were delighted at the turn of events in 1911 when the N.H.I. Bill was proposed.

The profession was always suspicious and has remained suspicious of the State involvement. The question of whether or not they really have done well or badly as a consequence of it is a moot point. Evidence has shown that in the U.K. doctors had attained quite a favourable situation in the 1970's by comparison with similar professional groups and salary earnings. The latest Government Earnings Survey confirms that this situation has not changed between 1972 and 1975. Of course, there have been periods when the incomes of doctors have fallen behind because of the reluctance of the Ministry of Health to compensate for inflation and this needs to be taken into consideration. Also one may argue that, compared with doctors in Western Europe, British doctors' earnings have declined. This suggestion from the work of Alan Maynard appears to have

13. In 1965-66 g.p.'s for example, had fallen behind. The index of their earnings had gone up by 21 per cent over the previous decade and this was considerably smaller than increases of other professional groups. In the following five years, however, g.p.'s experienced a greater increase than other professional groups. See, Report of the Review Body on Doctors and Dentists Remuneration, Cmd 5010, H.M.S.O. 1972 and R. Klein, "Policy Making in the National Health Service", Political Studies, Vol 22, 1974, pp. 1-14.
recently been confirmed by a survey undertaken by the B.M.A. The question of how well doctors have done in the N.H.S., clearly then depends on the terms of reference employed.

It has often been noted that the structure of the medical profession had a considerable influence on the structure of the N.H.S. In this study we have argued that the reciprocal line of influence should not be ignored. An important point which needs to be stressed is that the fact that different sections of the profession have fallen directly subject to the same paymaster has intensified the dissensions within the profession. Whereas in earlier periods discrepancies between the economic situations of different sections might be accepted in terms of recognition of different market circumstances, they now are more easily ascribed to the attitude of negotiators, i.e. the B.M.A. and the D.H.S.S. The tripartite structure of the N.H.S. may well have led to poor communications between sections of the profession. The dissensions however, have arisen largely out of envy of differential treatment at the hands of negotiators. The erruption of "ginger groups" is of course the obvious symptom of the growth of this professional malaise.

A study of the recent history of the medical profession has shown how effective "ginger groups" can be. Such organized pressure from outside the B.M.A. has been more effective than attempts to influence policy from inside. The history of the G.P.A., J.H.D.A. and H.C.S.A. shows that following a lag of three to four years after

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their formation, the section of the profession each represents has received some favourable award. Clearly a favourable award to one is a "threat" to another section. The G.P.A. has fallen in membership and the J.H.D.A. and H.C.S.A. grown in prominence since the favourable awards of the g.p.'s in the late 1960's. It is interesting to hazard whether or not it will be re-activated following the more recent gains of junior doctors and consultants.

The growth of ginger groups has been of concern to the B.M.A., but here we have shown that it has also been more able to protect itself as a result of its relationship with the D.H.S.S. Would-be competitors to the B.M.A. have been faced with considerable barriers to entry. Competitors have been unable to negotiate as easily as the B.M.A. with either the D.H.S.S. or the Review Body. It is ironic that the American Medical Association, having checked any possibility of widespread State intervention, has had considerable problems in keeping check of other associations within the profession. The B.M.A., at least until the present, has, by working with the State had some measure of security against competition that has arisen.

In similar vein the B.M.A. has also been able to exert considerable influence in what might be thought of as professional matters. The extent to which it has been able to order the elections


16. The J.H.D.A. has recently received an official certificate as an independent trade union under the new Employment Protection Act. This may strengthen its case for recognition by the D.H.S.S. for negotiating purposes.

It would also probably prove more of a threat to the B.M.A. if its rumoured federation with the Hospital Consultants and Specialists Association materialised. See, The Financial Times, 10th March, 1976, p 10.
to the G.M.C. and ensure the appointment of its nominees has been
made evident. As such it is surprising that the recent report of
the Merrison Committee should wish to abrogate the role of lay members
on the G.M.C. The Committee, composed of a lay Chairman, seven lay
members and seven doctors, made it clear that they took the opinion
that the only people who can control professionals were the
professionals themselves. The report argues

"It is the essence of a professional skill
that it deals with matters unfamiliar to the
layman and it follows that only those in the
profession are in a position to judge many of
the matters of standards of professional
competence and conduct that will be involved...

... That is the essential argument for a
predominantly professional regulating body and
why we recommend a predominantly professional
G.M.C." 17

To the extent that the B.M.A. are able to exert influence over
the G.M.C., as a result of ordering elections, one should be sceptical. 18
The "general duty" of the G.M.C. is "to protect the public." We have
shown that the purpose of the B.M.A. is to support the interests of
the profession and that should these conflict with public interests
then the latter are readily sacrificed.

17. Report of the Committee of Inquiry into the Regulation of the
18. Constitutions and Functions, General Medical Council, May 1971,
p 3.
APPENDIX A

Questionnaire Forms.

The four questionnaire forms used in this survey are shown on the following pages. Separate forms were used for general practitioners who were members of the B.M.A. and for those who were not. Similarly, separate forms were used for hospital doctors who were members and for those who were not. Doctors outside this classification answered forms most relevant to their circumstances and indicated their form of practice.
Department of Economics,  
University of Leicester,  
June 1972

QUESTIONNAIRE FOR GENERAL PRACTITIONERS  
WHO ARE MEMBERS OF THE B.M.A.

In what year did you first join the B.M.A.? .................... 19____
In what year did you attain your first degree in medicine? .... 19____
Has your membership of the B.M.A. ever been interrupted? ...... Yes/No
If yes, in what year(s) did you leave the B.M.A.? ............. 19____
In what year (s) did you re-join the B.M.A.? .................. 19____

Are you a member of any other professional association? ...... Yes/No
If yes, which? ..................................................

Are you a member of any of the Royal Colleges, or any other  
specialist Colleges? ............ Yes/No
If yes, which? ..................................................

Are you a member of any 'medical clubs'? ..................... Yes/No
If yes, which? ..................................................

In your general practice do you work in: (Please tick where  
appropriate)
(a) A single handed practice?
(b) A partnership? (of how many? ............)
(c) As an assistant?
(d) In a health centre?
Does your work extend to the direct use of hospitals? ....... Yes/No
Are you employed in the National Health Service full-time? ... Yes/No

Do you attend social functions of the B.M.A.? ............... Yes/No
How many times have you attended local branch meetings since  
January 1970?
Have you used the advisory services of the B.M.A.:

(a) in deciding your career?  (Please tick where appropriate)
(b) in finding an appointment and setting up practice?
(c) in practice, having found an appointment?
(d) in financial matters, e.g. taxation problems?
(e) in ethical matters?
(f) in setting fees for particular services?
(g) in some other matter?

Do you take advantage of the concessionary insurance schemes which the B.M.A. can offer you? ..................Yes/No

How many times since January 1970 have you used the Library Services of the B.M.A.? ____________________________

Were you ever a member of the British Medical Students Association? ..............Yes/No

Which is of the most importance to you  (Please tick where appropriate)

Either  (a) the national activity of the B.M.A.?
Or  (b) the local activity of the B.M.A.?

Are there any other services provided by the B.M.A. (e.g. film library) of which you make use? ................................................

Which Medical Journals do you subscribe to? ........................................

Which gratuitous journals do you read? ........................................

Assuming you agree with the National Health Service, do you agree with:

(a) salaried service?  (Please tick where appropriate)
(b) a capitation fee?
(c) fee for services rendered?
(d) medical services unified under local authorities?
(e) health centres?

Would you prefer private practice to a National Health Service? ..........Yes/No

Could you give me an idea of the length of any hospital service you may have had before coming into general practice? ......................years.
Would you be kind enough to consent to a short interview purely to further the research being carried out? A sample of those consenting will be chosen for interview and in the final thesis anonymity will be strictly observed. If you will agree to this very useful exercise would you kindly add your name and address to this form? Thank you very much.

........................................
........................................
........................................
........................................
QUESTIONNAIRE FOR GENERAL PRACTITIONERS
WHO ARE NON-MEMBERS OF THE B.M.A.

In what year did you attain your first degree in medicine? ..... 19___
Have you ever been a member of the B.M.A.? .................... Yes/No
If yes, in what year did you first join the B.M.A.? .......... 19____
In what year did you finally leave the B.M.A.? ................ 19____
If you have joined the B.M.A. more than once, please indicate? ........

Are you a member of any professional association? .......... Yes/No
If yes, which? ......................................................
Are you a member of any of the Royal Colleges, or any other specialist
Colleges? .............................................................. Yes/No
If yes, which? ......................................................
Are you a member of any 'medical clubs'? .................. Yes/No
If yes, which? ......................................................

In your general practice do you work in:
(a) A single handed practice? (Please tick where appropriate)
(b) A partnership? (of how many? .....................)
(c) As an assistant?
(d) In a health centre?

Does your work extend to the direct use of hospitals? ....... Yes/No
Are you employed in the National Health Service full-time? .. Yes/No

Do you ever make use as a non-member of the services provided by the
B.M.A.?
For example:
(a) Pay as a non-member for the use of the B.M.A. Library Services?
Yes/No
(b) If yes, how many times have you paid for use of the B.M.A. Library Services since January 1970? .................

(c) Do you attend as a non-member: (Please tick where appropriate)

   (i) the local branch meetings of the B.M.A.?
   (ii) the social meetings organised by the B.M.A.?

(d) If you attend local branch meetings of the B.M.A. as a non-member, how many times have you attended since January 1970? .............

(e) Have you ever used as a non-member the advisory services of the B.M.A.? ............................ Yes/No

(f) If yes, for what purposes, e.g.

   (i) in deciding your career?
   (ii) in finding an appointment, and setting up practice?
   (iii) in practice, having found an appointment?
   (iv) in financial matter, e.g. taxation problems?
   (v) in ethical matters?
   (vi) in setting the fee for particular services?
   (vii) in some other matter?

(g) Do you use as a non-member any other service provided by the B.M.A.? ..................................................

Were you ever a member of the British Medical Students Association? Yes/No

Which Medical Journals do you subscribe to? .....................

Which gratuitous journals do you read? ..............................

Assuming you agree with the National Health Service, do you agree with:

(a) salaried service? (Please tick where appropriate)

(b) a capitation fee?

(c) fee for services rendered?

(d) medical services unified under local authorities?

(e) health centres?
Would you be kind enough to consent to a short interview purely to further the research being carried out? A sample of those consenting will be chosen for interview and in the final thesis anonymity will be strictly observed. If you will agree to this very useful exercise would you kindly add your name and address to this form? Thank you very much.
QUESTIONNAIRE FOR HOSPITAL DOCTORS
WHO ARE MEMBERS OF THE B.M.A.

In what year did you first join the B.M.A.? .................. 19____
In what year did you attain your first degree in medicine? ... 19____
Has your membership of the B.M.A. ever been interrupted? ..... Yes/No
If yes, in what year(s) did you leave the B.M.A.? ............ 19____
In what year(s) did you re-join the B.M.A.? .................. 19____
Are you a member of any other professional association? ...... Yes/No
If yes, which? ................................................
Are you a member of any of the Royal Colleges, or any other specialist
Colleges? .................. Yes/No
If yes, which? ................................................
Are you a member of any 'medical clubs'? ..................... Yes/No
If yes, which? ................................................
Do you attend social functions of the B.M.A.? ............... Yes/No
How many times have you attended local branch meetings of the B.M.A.
since January 1970? ..................
Have you used the advisory services of the B.M.A.:
(a) in deciding a career? (Please tick where appropriate)
(b) in practice of your particular services?
(c) in financial matters, e.g. taxation problems?
(d) in ethical matters?
(e) in setting the fees for particular services?
(f) in any other matters?
Do you take advantage of the concessionary insurance schemes which the B.M.A. can offer you? ................. Yes/No

How many times since January 1970 have you used the Library Services of the B.M.A.? .........................

Were you ever a member of the British Medical Students Association? Yes/No

Which is of the most important to you (Please tick where appropriate)

Either (a) the national activity of the B.M.A.?

Or (b) the local activity of the B.M.A.?

Are there any other services provided by the B.M.A. (e.g. film library) which you make use of? .....................

Which Medical Journals do you subscribe to? .................

Which gratuitous journals do you read? ......................

Do you engage in private practice:

(a) part-time (Please tick where appropriate)

(b) not at all?

Do you agree with medical services unified under local authorities? Yes/No

Would you prefer private practice to a National Health Service? Yes/No

Would you be kind enough to consent to a short interview purely to further the research being carried out? A sample of those consenting will be chosen for interview and in the final thesis anonymity will be strictly observed. If you will agree to this very useful exercise would you kindly add your name and address to this form? Thank you very much.
QUESTIONNAIRE FOR HOSPITAL DOCTORS
WHO ARE NON-MEMBERS OF THE B.M.A.

In what year did you attain your first degree in medicine?......19____
Have you ever been a member of the B.M.A.? ...................... Yes/No
If yes, in what year did you first join the B.M.A.? ............ 19____
In what year did you finally leave the B.M.A.? .............. 19____
If you have joined the B.M.A. more than once, please indicate
Are you a member of any professional association? .......... Yes/No
If yes, which? ..................................................
Are you a member of any of the Royal Colleges, or any other specialist
Colleges? .................. Yes/No
If yes, which? ..................................................
Are you a member of any 'medical clubs'? .................. Yes/No
If yes, which? ..................................................
Do you ever make use as a non-member of services provided by the
B.M.A.? For example:
(a) Pay as a non-member for the use of the B.M.A. Library Services?
   Yes/No
(b) If yes, how many times have you paid for use of the B.M.A. Library
   Services since January 1970? ..............................
(c) Have you ever used as a non-member the advisory services of the
   B.M.A.? ............... Yes/No
(d) If yes, for what purpose, e.g.
   (i) in deciding your career?  (Please tick where appropriate)
   (ii) in practice of your particular services?
   (iii) in financial matters, e.g. taxation problems?
   (iv) in ethical matters?
   (v) in setting the fee for a particular service?
   (vi) in some other matter?
(e) Do you attend as a non-member (Please tick where appropriate)

(i) the local branch meetings of the B.M.A.?

(ii) the social meetings organised by the B.M.A.?

(f) If you attend the local branch meetings of the B.M.A. as a non-member, how many times have you attended since January 1970? ....

(g) Do you use as a non-member, any other service provided by the B.M.A.? .................................................................

Were you ever a member of the British Medical Students Association? Yes/No

Do you engage in private practice:

(a) part-time? (Please tick where appropriate)

(b) not at all?

Do you agree with medical services unified under local authorities? Yes/No

Would you prefer private practice to a National Health Service? Yes/No

Would you be kind enough to consent to a short interview purely to further the research being carried out? A sample of those consenting will be chosen for interview and in the final thesis anonymity will be strictly observed. If you will agree to this very useful exercise would you kindly add your name and address to this form? Thank you very much.
APPENDIX B


(1) The Branches of the B.M.A.

Neither branch activity nor the provision of a Journal are sufficient explanations to explain why individuals join the B.M.A. Evidence suggests that individual doctors do not use the local activities of the B.M.A. and that they read the B.M.J. as a result of joining the B.M.A. rather than vice versa. However, it is undeniable that in terms of the advertisement that both these factors give to the existence and work of the B.M.A., they are important in understanding the growth of the B.M.A.

The provision of local branches did have some effect on membership of the B.M.A. in the early years. Some of the early journals of the Association provide figures for county membership.* These clearly reveal the influence of the foundation of a local branch in a particular locality. In 1853, certain counties were included under a particular branch while others were not. The contrast between the percentage of doctors who were members in these counties is remarkable.

* Journals between 1853 and 1870 provide such data, with the exception of those for 1856 and for 1860 and 1861.
### Table 1.

Membership of the B.M.A. throughout the U.K. in 1853.

<table>
<thead>
<tr>
<th>Branch</th>
<th>Counties under Branch Organisation</th>
<th>Members (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Anglian (founded 1831)</td>
<td>Essex, Norfolk, Sussex</td>
<td>20.0, 14.0, 39.5</td>
</tr>
<tr>
<td>Huntingdon (1856)</td>
<td>Huntingdonshire</td>
<td>50.0</td>
</tr>
<tr>
<td>Lancashire (1837)</td>
<td>Lancashire, Cheshire</td>
<td>26.7, 19.6</td>
</tr>
<tr>
<td>Bath (1836)</td>
<td>Gloucestershire, Somerset, Wiltshire</td>
<td>24.4, 36.0, 17.35</td>
</tr>
<tr>
<td>West Somerset (1844)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Eastern</td>
<td>Kent, Surrey, Sussex</td>
<td>23.4, 40.8, 24.3</td>
</tr>
<tr>
<td>Midlands (1851)</td>
<td>Derbyshire, Leicestershire, Nottinghamshire</td>
<td>34.3, 38.4, 21.8</td>
</tr>
<tr>
<td>Monmouth (1852)</td>
<td>Monmouthshire</td>
<td>45.6</td>
</tr>
<tr>
<td>No Branch</td>
<td>Cumberland, Westmorland, Durham</td>
<td>8.5, 5.7, 4.2</td>
</tr>
</tbody>
</table>

During the period for which statistics of county membership is available three trends can be noted. Firstly, the Monmouth Branch depended on the entrepreneurship of Mr. W. H. Michael, and when he left Swansea it fell into abeyance. There were in fact, no meetings from 1856 to 1871. This seems to be reflected in their membership figures.
Table 2.
Membership of Monmouth Branch: 1853-1870.

<table>
<thead>
<tr>
<th>Year</th>
<th>1853</th>
<th>1854</th>
<th>1855</th>
<th>1858</th>
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<td>31</td>
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<td>9</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
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<th>1869</th>
<th>1870</th>
</tr>
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<tbody>
<tr>
<td>Membership</td>
<td>11</td>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>

Secondly, the influence of the establishment of a branch in the North of England, at Newcastle on Tyne in 1864 is evident. The membership figures for Northumberland and Durham would tend to reflect this.

Table 3.
Membership in Northumberland and Durham: 1853-1870.

<table>
<thead>
<tr>
<th></th>
<th>1853</th>
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<th>1855</th>
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<tr>
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<td>8</td>
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<td>Durham</td>
<td>8</td>
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<table>
<thead>
<tr>
<th></th>
<th>1866</th>
<th>1865</th>
<th>1866</th>
<th>1867</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumberland</td>
<td>11</td>
<td>17</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Durham</td>
<td>22</td>
<td>38</td>
<td>52</td>
<td>56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1868</th>
<th>1869</th>
<th>1870</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumberland</td>
<td>37</td>
<td>48</td>
<td>96</td>
</tr>
<tr>
<td>Durham</td>
<td>83</td>
<td>104</td>
<td>144</td>
</tr>
</tbody>
</table>
Thirdly, the Birmingham and Midland Branch established in 1854 and covering the counties of Warwick, Oxford, Stafford and Worcester Counties, also appeared to influence membership growth. The following table shows how quickly membership had grown by 1870.

Table 4.

Membership in the Midlands: 1853 and 1870.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Members</th>
<th>% 1853</th>
<th>Total</th>
<th>Members</th>
<th>% 1870</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warwick</td>
<td>258</td>
<td>45</td>
<td>17.8</td>
<td>352</td>
<td>170</td>
<td>48.0</td>
</tr>
<tr>
<td>Oxford</td>
<td>113</td>
<td>21</td>
<td>18.6</td>
<td>112</td>
<td>29</td>
<td>26.0</td>
</tr>
<tr>
<td>Stafford</td>
<td>208</td>
<td>16</td>
<td>7.7</td>
<td>269</td>
<td>84</td>
<td>31.0</td>
</tr>
<tr>
<td>Worcester</td>
<td>123</td>
<td>54</td>
<td>44.0</td>
<td>158</td>
<td>54</td>
<td>34.0</td>
</tr>
</tbody>
</table>

(Source:- S.W.F. Holloway. The British Medical Association 1832-1883. unpublished thesis)).

The formation of an active Branch therefore clearly affected membership. The leaders of the B.M.A. recognized the importance of branch organization. In 1856 the editor of the Association's Medical Journal wrote:

"Until every portion of this island is sufficiently supplied with Branches, it cannot be said that our organization is complete; they are to the parent Association what the ganglia are to the brain - sub-centres of action. It is only necessary to glance over the list of members, grouped geographically to see at once that we are powerful only where we have branches. With but two exceptions, those counties which are not included in branches scarcely show out of the entire number of medical men resident in them
20 percent of associates and often not more than 5 percent; whilst counties possessing well worked Branches can show with scarcely an exception at least 25 percent, and, in some instances, 45 and 50 percent. The fact is at once conclusive as to the great advantage of existing Branches wherever it is possible." (Associated Medical Journal, 12th January, 1856).

The success of the association in establishing branches was largely helped by the fact that potential or existing local societies were now no longer established. Those already established willingly relinquished independence to become part of the nation-wide B.M.A., e.g. in 1853, the Crewkerne and Yeovil District Medical Society disbanded to join the Association. 1

The existence of local branches drew more doctors' attention to the B.M.A. It was not necessarily that doctors joined to make use of the services of the B.M.A., but that the activity of local representatives, working on behalf of the B.M.A., recruited a larger membership. Clearly the following figures for as early as 1905 show that doctors did not have a high attendance at meetings. 2

---

1. This sort of action continued at least until 1924 when the York Medical Association followed such action (B.M.J. May 24th, 1924, p 253).

2. There is no apparent relationship between membership of a branch and attendance at meetings. Based on data in Table 5, a correlation coefficient of 0.376.3 was estimated between size of branch membership and attendance.
Table 5: BRANCH MEMBERSHIP AND ATTENDANCE FIGURES AT LOCAL MEETINGS: 1905

<table>
<thead>
<tr>
<th>BRANCH</th>
<th>MEMBERSHIP ON DEC 31ST 1904</th>
<th>MEMBERSHIP ON DEC 31ST 1905</th>
<th>AVERAGE ATTENDANCE AT LOCAL MEETINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>557</td>
<td>507</td>
<td>37½</td>
</tr>
<tr>
<td>Border Counties</td>
<td>147</td>
<td>150</td>
<td>20</td>
</tr>
<tr>
<td>Cambridge and Huntingdon</td>
<td>156</td>
<td>152</td>
<td>25</td>
</tr>
<tr>
<td>Dorset and West Hants</td>
<td>203</td>
<td>219</td>
<td>39</td>
</tr>
<tr>
<td>Dunree</td>
<td>109</td>
<td>109</td>
<td>12</td>
</tr>
<tr>
<td>East Anglian</td>
<td>420</td>
<td>415</td>
<td>60</td>
</tr>
<tr>
<td>East York and North Lincoln</td>
<td>140</td>
<td>140</td>
<td>33</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>414</td>
<td>432</td>
<td>100</td>
</tr>
<tr>
<td>Fife</td>
<td>74</td>
<td>76</td>
<td>12</td>
</tr>
<tr>
<td>Glasgow and West of Scotland</td>
<td>653</td>
<td>656</td>
<td>-</td>
</tr>
<tr>
<td>Lancashire and Cheshire</td>
<td>1,286</td>
<td>1,601</td>
<td>-</td>
</tr>
<tr>
<td>Leicester</td>
<td>338</td>
<td>340</td>
<td>33</td>
</tr>
<tr>
<td>Metropolitan Counties</td>
<td>2,539</td>
<td>2,599</td>
<td>-</td>
</tr>
<tr>
<td>Midland</td>
<td>510</td>
<td>546</td>
<td>23</td>
</tr>
<tr>
<td>Munster</td>
<td>103</td>
<td>109</td>
<td>16</td>
</tr>
<tr>
<td>North of England</td>
<td>569</td>
<td>645</td>
<td>35</td>
</tr>
<tr>
<td>Northern Counties of Scotland</td>
<td>118</td>
<td>124</td>
<td>30</td>
</tr>
<tr>
<td>North Lancashire and South</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Westmorland</td>
<td>135</td>
<td>128</td>
<td>32</td>
</tr>
<tr>
<td>North Wales</td>
<td>186</td>
<td>185</td>
<td>23</td>
</tr>
<tr>
<td>Oxford and Reading</td>
<td>284</td>
<td>285</td>
<td>-</td>
</tr>
<tr>
<td>Perth</td>
<td>60</td>
<td>63</td>
<td>8</td>
</tr>
<tr>
<td>Shropshire and Mid Wales</td>
<td>120</td>
<td>127</td>
<td>28</td>
</tr>
<tr>
<td>South Eastern</td>
<td>1,225</td>
<td>1,212</td>
<td>13</td>
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<tr>
<td>South Eastern of Ireland</td>
<td>67</td>
<td>68</td>
<td>8.1</td>
</tr>
<tr>
<td>South Midland</td>
<td>222</td>
<td>197</td>
<td>22½</td>
</tr>
<tr>
<td>South Wales and Monmouthshire</td>
<td>447</td>
<td>476</td>
<td>40</td>
</tr>
<tr>
<td>South Western</td>
<td>411</td>
<td>419</td>
<td>36</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>194</td>
<td>194</td>
<td>20</td>
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<tr>
<td>Stirling</td>
<td>64</td>
<td>67</td>
<td>5</td>
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<tr>
<td>Water</td>
<td>371</td>
<td>364</td>
<td>45</td>
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<tr>
<td>West Somerset</td>
<td>76</td>
<td>71</td>
<td>15½</td>
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<tr>
<td>Worcestershire &amp; Herefordshire</td>
<td>118</td>
<td>125</td>
<td>15</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>776</td>
<td>770</td>
<td>38</td>
</tr>
<tr>
<td>Colonial Branches</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>British Guiana</td>
<td>32</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>Burmah</td>
<td>34</td>
<td>41</td>
<td>13</td>
</tr>
<tr>
<td>Cape of Good Hope (Eastern Province)</td>
<td>65</td>
<td>89</td>
<td>9.5</td>
</tr>
<tr>
<td>Cape of Good Hope (Western Province)</td>
<td>142</td>
<td>160</td>
<td>20</td>
</tr>
<tr>
<td>Giqueland West</td>
<td>109</td>
<td>104</td>
<td>-</td>
</tr>
<tr>
<td>Hong Kong and China</td>
<td>97</td>
<td>91</td>
<td>17</td>
</tr>
<tr>
<td>Malay</td>
<td>71</td>
<td>85</td>
<td>-</td>
</tr>
<tr>
<td>Malta and Mediterranean</td>
<td>54</td>
<td>57</td>
<td>14</td>
</tr>
<tr>
<td>Melbourne and Victoria</td>
<td>209</td>
<td>187</td>
<td>12</td>
</tr>
<tr>
<td>South Australian</td>
<td>126</td>
<td>147</td>
<td>-</td>
</tr>
<tr>
<td>South Indian &amp; Andras</td>
<td>135</td>
<td>143</td>
<td>20</td>
</tr>
</tbody>
</table>

*Except in the case of Oxford and Reading, the absence of a figure for average attendance means that there were no meetings that year.
Doctors did not join then in order to attend as members of these meetings. By 1901 Hardy wrote that more than one in every three members would pay no more than the one guinea for basic membership of the National B.M.A. and for the journal. To become a branch member they were required to pay an extra 2s.6d. to 4s., but they refused this small increment. Clearly, they were not essential for doctors even at these early dates.

(2) The B.M.J.

While it is difficult to argue that doctors join the B.M.A. for the journal rather than read the journal as a result of joining the B.M.A., it is clear that the journal has served the B.M.A. In financial terms, the B.M.A. was soon to realise the gains of using a journal.

"... we may illustrate our present position by viewing the members of the Association as subscribers to a Medical Journal conducted in the ordinary manner, and thus estimate the revenue of the journal issued to its two thousand subscribers at 7d per week each .... Then, deducting, as we fairly may, from the expenditure of the next six months, the amount of expenses connected with preliminary arrangements, and hence no longer necessary, we calculate the cost of the journal at £758 9s. 7d., or 3\frac{1}{2}d. per number for each member. It will thus be found that the clear gain to the Association on the whole twelve months, provided a journal be supplied .... is not less than fifteen shillings per member."

(Association Medical Journal, Sept. 9th, 1853, No. xxxvi, p786)

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However the most important financial advantage from the journal came in revenue from advertising. Such revenue of course then enabled the B.M.A. to finance it organization. The most dramatic rise in this advertisement revenue can be seen in the late nineteenth century.

Table 6.

Source of Revenue for the B.M.A.: 1876-1900

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Revenue</th>
<th>Net Revenue from Subscriptions</th>
<th>Net Revenue from Advertisements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1876</td>
<td>£11,806</td>
<td>£6,930</td>
<td>£3,401</td>
</tr>
<tr>
<td>1880</td>
<td>£16,705</td>
<td>£8,481</td>
<td>£5,634</td>
</tr>
<tr>
<td>1885</td>
<td>£23,713</td>
<td>£11,261</td>
<td>£7,893</td>
</tr>
<tr>
<td>1890</td>
<td>£31,815</td>
<td>£14,073</td>
<td>£13,836</td>
</tr>
<tr>
<td>1895</td>
<td>£38,309</td>
<td>£16,765</td>
<td>£16,799</td>
</tr>
<tr>
<td>1900</td>
<td>£43,420</td>
<td>£18,744</td>
<td>£19,508</td>
</tr>
</tbody>
</table>

(Sources: British Medical Journals 1876-1900).

The Journal however, is also useful to the B.M.A. in terms of influencing doctors' views on political topics. To the extent that doctors do read the political content, which is likely at least at times of controversy, the Journal is able to win for the B.M.A. support on B.M.A. issues. The significance that the Journal can have was made clear by Mechanic who found that during the resignation issue of 1965, 43 percent of doctors who reported reading the Lancet
did not submit resignations while only 12 percent of those who did not see this Journal responded similarly. *4

While there is reason to question and doubt whether an individual doctor joins the B.M.A. because it provides local branch activity and a journal, one cannot dismiss the impact they have had in terms of drawing attention to the B.M.A. and financially strengthening it.

---

APPENDIX C

CHANGES IN SUBSCRIPTION RATES TO THE B.M.A.

The opposite table indicates the major changes in the scales of membership subscription that have been introduced by the B.M.A. Initially the standard fee of £1.1s.0d. was charged. However over time it is noticeable how many concessional rates have been introduced. The rates are listed in nominal terms rather than in real terms. This is not a serious drawback as they are listed primarily to show how the subscription fee for newly qualified doctors has continually decreased relative to the standard membership rate.

There is also evidence to suggest that the concessionary rates are not related solely to differences in income. For example, an examination of fees in 1962 shows that the fee rises by 50 per cent between the first and third year, whilst evidence shows that doctors' incomes would on average never grow at such a rate. Indeed, if the fee were solely related to income then a doctor should be expected to double his first year income in his fifth year: a feat which few, if any, attain! There is therefore a significant concession to attract members after qualification.

1. See, Royal Commission on Doctors' and Dentists' Remuneration 1957-1960, Cmnd 939, Table 5, p 262.
### Major Changes in Subscription rates to the B.M.A. 1921 - 1972

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Membership Rate</td>
<td>£30.00</td>
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<td>£16. 10s. 0d.</td>
<td>£12. 12s. 0d.</td>
<td>£9. 7s. 0d.</td>
<td>£6. 6s. 0d.</td>
<td>£4. 4s. 0d.</td>
<td>£3. 3s. 0d.</td>
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<tr>
<td>Newly Qualified</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>1st Year</td>
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<td>2nd &quot;</td>
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<td>£4. 0d.</td>
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<td>£3. 0d.</td>
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<tr>
<td>3rd &quot;</td>
<td>£10.00</td>
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<td>£4. 0d.</td>
<td>£4. 0d.</td>
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<tr>
<td>4th &quot;</td>
<td>£15.00</td>
<td>£7. 50</td>
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<tr>
<td>5th &quot;</td>
<td>£20.00</td>
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<td>£8. 6s. 0d.</td>
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<tr>
<td>6th &quot;</td>
<td>£25.00</td>
<td>£16.00</td>
<td>£12. 12s. 0d.</td>
<td>£12. 12s. 0d.</td>
<td>£12. 12s. 0d.</td>
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<td>£12. 12s. 0d.</td>
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<td>7th &quot;</td>
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<td>£18. 0d.</td>
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<tr>
<td>8th &quot;</td>
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<tr>
<td>9th &quot;</td>
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<td>£30. 0d.</td>
<td>£30. 0d.</td>
<td>£30. 0d.</td>
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</tr>
<tr>
<td>10th &quot;</td>
<td>£45.00</td>
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<td>£36. 0d.</td>
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<tr>
<td>11th &quot;</td>
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<td>£42. 0d.</td>
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<tr>
<td>12th &quot;</td>
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<tr>
<td>15th &quot;</td>
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<tr>
<td>18th &quot;</td>
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<td>19th &quot;</td>
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<td>20th &quot;</td>
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<td>£96. 0d.</td>
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<tr>
<td>Retired</td>
<td>£10.00</td>
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<td>Dentist</td>
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<td>Overseas</td>
<td>£15.00</td>
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<td>House of Members</td>
<td>£10.00</td>
<td>£3. 00</td>
<td>£2. 2s. 0d.</td>
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<td>Pre-clinical Teacher and non-clinical research workers</td>
<td>£15.00</td>
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<td>Armed Forces</td>
<td>£21.00</td>
<td>£10.50</td>
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<td>Compound subscription for first 10 years after qualification</td>
<td>£21.00</td>
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* Concessions in the rate of subscription were made if the doctor had an unbroken membership over the period concerned.

(A) Salary links were introduced to modify this rate.
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Abstract.

The central question with which this study is concerned is whether or not individuals voluntarily contribute to the provision of a collective good. The question is presented in terms of the likelihood that an individual member of a group will subscribe to an association which pursues aims common to all members of that group. Reference is made in particular to the experiences of the medical profession and the question why doctors join the British Medical Association.

An awareness on the part of individuals that they possess common interests is often presented as a pre-requisite for collective action. Association growth is frequently explained in terms of the factors that stimulate such an awareness. In this study the history of the B.M.A. is examined to identify such factors and an attempt is made to indicate their relative importance.

It is argued, however, that in large groups individuals may be aware that they will benefit by the attainment of common aims, but still refuse to subscribe. Given the non-exclusive nature of the good, there must exist some mechanism by which they will be induced to reveal their preferences. The aim is, therefore, to indicate how individuals have been led to subscribe towards the association. The importance of coercion is discussed. The significance of private goods made available only to members is questioned. The view that membership stems from altruism rather than self-interest is
challenged. The importance of uncertainty on the choice of individuals to subscribe is analyzed.

The British Medical Association serves mainly to illustrate the basic arguments. Nevertheless an attempt is made to make quite specific comment on the power and purpose of the Association and its role within the National Health Service.