elements, cost them carefully, find ways of cheapening production costs without cheapening the quality of the product (shoddy goods don't sell), and get on with it with a minimum of fuss. In the most efficient cases, private hospitals run as interlocking directorates of committees of one. Also, specialisation lowers costs by eliminating learning curves and minimising waste. The NHS already accepts this principle in the provision of goods, equipment, and peripheral services, or else it would not find it economical to purchase pharmaceuticals, X-ray equipment, printing, pest control, etc from others. If there is a valid intellectual or economic argument against contracting clinical services in the same way, then the NHS should apply the theory consistently: we would then have the NHS manufacturing its own pills, extruding plastic for its syringes, and perhaps weaving its own sheets and growing its own potatoes.

To conclude, having worked on psychiatric hospital development projects in countries over the last 18 years, I have learned that there is only one constant, a single universal principle which applies in our field: our collective egos insure that the cookbook for each new service gets written in a vacuum by a local committee, when we could often more easily solve health delivery problems by copying other peoples' successes and avoiding their failures. Health technology translates well everywhere in the world, perhaps because it is effectively sold by the fellows who make hardware, but inexplicably knowledge about what wins and loses in the low-tech end of our business does not translate well. Our collective record in innovative plagiarism on both sides of the Atlantic is appalling in such areas as administrative management, cost control techniques, social service provision, state-run insurance schemes, and design-construction systems. Patients suffer needlessly as the result of our conceit. European and North American systems live in straightjackets of professional pride and xenophobia, altogether obsolete in an era of a global market for ideas.

JOHN C. HUGHES
Chairman

Community Psychiatric Centers
The Priory, London SW15

DEAR SIRS

Surely Professor Sydney Brandon is right (*Bulletin*, January 1987, **11**, 23–24) in stating we must begin to address the many questions and issues arising from the explosive growth of private practice in health care, and in private practice in psychiatry in particular, and where better and more appropriate than within our own College?

I would be pleased to receive declarations of interest and support from colleagues, and with this support I will undertake to seek to establish a group for Private Practice in Psychiatry within the College structure.

J. H. HENDERSON
Medical Director

St Andrew's Hospital
Northampton NN1 5DG

DEAR SIRS

As a Brit abroad may I comment on the amusing article by Professor Sydney Brandon entitled 'A Subversive Foray into Private Practice' (*Bulletin*, January 1987, **11**, 23–24). He reflects on the need to study this issue in the UK but, in fact, he might look elsewhere.

Canada, like Australia and some European countries, went for prepaid insurance plans rather than state medicine, totally funded from taxation. Nevertheless, the medical and social services have become largely paid for by government. So the UK and Canada are now alike in that government pays for services. There the similarity stops. There is now virtually no private practice in Canada, since extra billing over the fee schedule was recently prohibited, although physicians have a spurious sense of doing private practice since they do fee-for-service medicine. The limitation is that patients must wait their turn to be seen and private practice presumably means jumping the queue by paying cash. As for the doctors, the academics have ceilings imposed by the Dean of Medicine's office while the nonacademics are constrained solely by time and the fee schedule. All doctors, even academics, make good salaries. The price is that Canada spends about 8.5% of the Gross National Product on health and the UK about 5%, with similar mortality and morbidity rates.

Most doctors in Canada see patients regardless of status and job description. This keeps them in touch with the real world of doctor/patient relationships. (This obligation, however, prevents the academics from having many of those extensive lecture tours apparently available to their British counterparts.) Nevertheless, the British split into professors who cannot do private practice, permutations of salaries and capitation fees and private practice for the rich (or at least well insured) is seen as bewildering.

Modes of payment for medical services are different in advanced societies but it behoves us to ask why. Unfortunately (or fortunately), nothing is static and we see the British, buried in bureaucracy for 40 years, pursuing privatisation; while the Canadian doctors struggle with a system which controls the fee schedule, and therefore their income, while the public sees no need for private practice; whereas in the United States Diagnostic Related Groups and Health Maintenance Organisations, private hospitals and insurers and tough business-minded administrators have all contributed to a move from fee-for-service medicine to salaried practice.

So Professor Brandon should have a look at what is happening elsewhere. What he will find is a raucous debate about doctors' incomes, public expectations, government policy and business guidelines. All of which have little to do with the efficacy and efficiency of medical services.

Good luck!

M. R. EASTWOOD

University of Toronto; and
Clarke Institute of Psychiatry
250 College Street, Toronto
Ontario, Canada