of 1.25%. When income tax has been deducted . . . ? Let us face further facts. The Minister seems to envisage a time when no N.H.S. practice will cater for more than 1,500 insured patients. At present rates a practice of 1,500 units brings in about £2,000 a year gross. With the mooted "inducement" it would be £2,037 10s. To me this is a Treasury pipe-dream. Sir, is it or is it not a fact that there is already a shortage of G.P.s, and is it not also a fact that the shortage is likely to become worse ? I suggest that the Minister's advisers have slipped up badly.

Already the idea of differential payments (merit awards) for general practitioners has met with much opposition. Who are to be the assessors, and how and why chosen ? Will they be general practitioners (unlikely) or other doctors distinguished in other branches of the medical profession (likely) ? What are the criteria of merit in general medical practice ? Surely not the mere accumulation of degrees and diplomas (although these must be taken into account), nor the membership of learned or professional societies, nor yet contributions to the medical press. Nor is the size of a practice a satisfactory guide. There remains character. But how does one fathom a person's integrity or diligence or devotion to duty and all his other intrinsic attributes ? Finally there is length of service. There should in justice be rewards based on length of service without regard of other "merits"—as there are in all the other branches of the Civil Service (and except in acknowledgment we are civil servants, if, for cheapness, without their privileges).

Only if those of us in general practice continue to be apathetic to and incoherent about our interests—and, by extension, to those of our patients—will the profession accept the Working Party's proposals. It is certain the scheme will not lead to any noticeable improvement in the N.H.S. The projected "betterments" are paltry. If the Minister earnestly wants a better N.H.S. and to prevent its further deterioration and disintegration he will have to pay for it. It is a well-established economic law that you get what you pay for. The doctor is devoted to his chosen profession, but need such devotion mean exploitation ?

Lest it be wondered who this brash writer is and what axe he has to grind, I have been in medical practice, mainly as a general practitioner, nearly 40 years and am on the point of retiring. Whatever eventuates from the Minister's latest proposals will not affect me.—I am, etc.,

London W.C.1. GERALD RALSTON.

Distribution of Rural Practices Fund

SIR,—In paragraph 27 of the comment of the General Medical Services Committee on the recommendations of the Joint Working Party on General Medical Practitioners' Remuneration (*Supplement*, August 27, 1960, p. 82), after setting out how increases in pay were to be distributed, it was stated: "The problems of the really small lists can be dealt with by . . . the proper application of the Rural Practitioners' Fund. . . ." In the Annual Report of the G.M.S. Committee, 1961–2, paragraph 34, there is the statement that "The problem of the small list resulting from geographical factors can best be solved by proper application of the Rural Practices Fund. . . ." For those who, unlike the members of the G.M.S. Committee, do not understand how the Rural Practices Fund is to be distributed, this may sound fair enough, but the G.M.S. Committee knows, or ought to know, what balderdash this is.

The scheme of distribution for the Rural Practices Fund being that set out in the Annual Report of the G.M.S. Committee, 1959–60, pages 17 and 18, it is certain that most truly rural practitioners with small lists will suffer a great reduction in mileage payments, having already been denied all but a minimal increase in their capitation payments under the Royal Commission award and only receiving an additional maximum of £37 10s. (1s. 6d. a head on 500 patients) under the latest recommendations for distribution of the reserved £1m. It was shown by the Royal Commission that rural practitioners made on average higher incomes than urban practitioners, and suggested, I think rightly, that some modification should be applied. The rural practitioner with the small list should know that the reduction will be applied to him, while the doctor with the large list but who is lucky enough to practise in an area designated "rural" will have an even larger income.

The fault, as every member of the G.M.S. Committee should know, lies in the definition of what is a rural practice. In my opinion a doctor cannot possibly attend 2,500 patients in a truly rural area, and will have to work very hard indeed to attend 2,000, yet doctors with lists of this size or more will receive a very large proportion of the money available in the Rural Practices Fund. Small-list practitioners should take action at once or they will be faced with a *fait accompli*.—I am, etc.,

Richmond, Yorks. A. F. T. ORD.

Public Health Service Salaries

SIR,—There has been much airing of views recently about the salaries of professional classes, one way or another, and now even our colleagues the nurses are pressing for a long overdue adjustment of their remuneration. More power to their elbows. I wonder if any readers of the *B.M.J.* could possibly explain why the salary scales of medical officers in the public health service are so low, particularly in the so-called junior grades. An additional qualification is usually required for such posts and most officers have experience in other fields—hospital, general practice, etc. The duties they perform must be necessary and valuable to the community, otherwise there would be no such posts at all.

In general, doctors seeking posts as assistant medical officers of health have, in addition to hospital and/or general practice experience, taken the Diploma of Public Health after a wageless year's full-time study at a university, unless they were lucky enough to obtain a post with an extended part-time D.P.H. course available. The period between graduation and obtaining the D.P.H. is usually around five years if two years' national service in the armed Forces is considered. If after this a doctor is successful in obtaining a post with a local authority he will be offered a starting salary of £1,295 per annum. Some enlightened authorities will offer two or three annual increments right way, or soon after, but in general I believe the figure is £1,295. This figure, in my opinion, in no way reflects his worth or experience. Presumably he will stay at this "junior" grade for a few years before he will be considered ready for a "senior" post, and during these years his annual increments minus tax will only keep pace with the yearly rise in the cost of living. This salary scale, to my mind, is not designed to encourage men and women of talent to this very worth-while branch of our great profession in this country. It is interesting to note that certain Commonwealth countries are offering upwards of £3,000 per annum as a starting salary for doctors in their public health services.—I am, etc.,

Milngavie, Dunbartonshire. H. MACANESPIE.

POINTS FROM LETTERS

Central Locum Bureau

DR. L. BOTROS (Sheffield) writes: I agree with Dr. J. M. Fennerty (April 28, p. 203) that group practice is not the answer to locum difficulty. . . . It is time that the Government realized that the G.P.'s health is as important as the health of his patients and if he does not get an adequate holiday his work will suffer in the long run. . . . The Government should appreciate this and take the responsibility of establishing a central locum bureau, and should also pay the locum fees. I suggest that the newly qualified doctors should do six months in general practice after they finish their hospital appointments of one year.

Correction.—The subject of the 1963 Conference of Advisory Councils on Occupational Health will be "The Immigrant in Industry" and not "The Emigrant in Industry," as stated in the *Supplement* of May 5 (p. 212).