COMMENTARY

Money and medicine

RUDOLF KLEIN

"The unnerving discovery every Minister of Health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is money." So wrote Mr Enoch Powell in 1966, reflecting on his period in office.[1] If the medical profession's disappointed reactions to the latest Review Body report[2] are anything to go by, Mr Patrick Jenkin may soon be tempted to echo these remarks. Like all his predecessors, the new Secretary of State is likely to find himself embroiled in a never-ending argument with the medical profession about the appropriate level of pay.

Clearly no new forms of contract, providing for different methods of payment, can end the argument about the level of rewards. So long as the National Health Service is centrally financed, governments—whether Conservative or Labour—are going to insist on controlling the total wage bill and are likely to resist any move which would give the profession an open-ended cheque to determine its own earnings. Interestingly, the Review Body largely accepted the Government's view that the new consultant contract should be financed out of existing funds, though it did propose an 8% once-and-for-all increase to cover the transitional costs of change. Not unexpectedly, perhaps, consultants' representatives have rejected the pricing of the new contract.

It would not be surprising if the medical profession decided that their target should be the NHS itself—that it is the existence of a near-monopoly employer of labour, dependent on public money, which threatens its standards of living. In fact, this would be a misleadingly simple conclusion. The movement in medical earnings over the past 70 years and changes in the light of wider social changes suggest more complex, if not necessarily more comforting, conclusions. In the first place, considerable evidence suggests that the medical profession as a whole has benefited from the intervention of the State in the provision of health care. Writing in 1906, before the introduction of Lloyd George's national health insurance, Bernard Shaw drew a piteous picture of medical poverty and overwork:

"Doctors are hideously poor. Better be a railway porter than an ordinary English general practitioner. A railway porter has from eighteen to twenty-three shillings a week from the Company merely as a retainer; and his additional fees from the public, if we leave the third-class twopenny tip out of account, are equivalent to doctor's fees in the case of second-class passengers and double doctor's fees in the case of first."[3]

Narrowing the gap

This cannot be dismissed as an example of Shavian exaggeration. The history of increased State intervention is also the history of the decline and eventual disappearance of the medical proletariat. Some of the most appreciable changes have been in the internal structure of medical earnings, with a movement towards narrowing the gap between the extremes of medical poverty and medical wealth. In 1913-14, for example, the average earnings of the top 10% of doctors (£1200 a year) were more than six times those of the bottom 25% (£195). By 1955-6, the difference between the extremes had shrunk to two to one.[4] And that was before the upward leap in the pay of junior hospital doctors.

Much the same point emerges from the Bradford Hill surveys of medical earnings in the years before 1939.[5,6] Out of the 1620 specialists included in the survey, almost a quarter had an income of less than £1000 a year, while one in 20 earned more than £5000. Out of 3869 GPs in urban areas, 6·6% earned less than £400 a year while 6·1% earned more than £2000 (with income tending to fall after the age of 55). Whatever may be said of the level of earnings in the NHS, clearly the most glaring inequalities of income within the medical profession have disappeared. The golden age of medical affluence—helped by low income taxes and cheap servants—is not entirely mythical but it was based on fierce competition and excluded many members of the profession. If the opportunities for making a great deal of money have shrunk so have the risks of ending up with very little.

The changes within the medical profession mirror wider changes within society as a whole. If doctors think that they have done relatively badly over the past few decades, they are partly justified by the statistics. Medical earnings collectively have risen less fast than earnings generally since the beginning of the century. But this is true of other comparable professions —barristers, solicitors, army officers, and especially clergymen. If we take all these groups together, professional earnings in 1913-14 were 3·7 times higher than the average earnings of manual workers. By 1960, the ratio had fallen to 2·5:1.[7] And there is some evidence to suggest that the trend has continued, if more slowly. From 1960 to the mid-'70s, the share of pre-tax income going to the top 10% of all earners—which includes the majority of professional men and women—declined slightly.[8] Shrinking differentials within the medical profession thus reflect shrinking differentials within society at large. Despite all the problems of interpretation and the dangers of drawing confident conclusions from such statistics, the experience of the medical profession is not unique. General societal trends are at least as important as the specific circumstances of the NHS.

This conclusion is reinforced if account is taken of the effects of taxation. Recently doctors' discontent about pay levels has been further compounded by the fact that taxes were taking a larger bite out of earnings—a phenomenon not unique to them. In 1977 the Review Body explicitly drew attention to this factor when it pointed to the disproportionate fall in the disposable income of the medical profession compared to the average wage and salary earner.[9] This, of course, is to introduce a new, and potentially explosive, element into the debate about earnings. It will be interesting to see, for example, whether the Review Body will take account of the tax cuts introduced in the 1979 budget in its next report, since these tend to benefit relatively high earners such as doctors and other professionals more than the average wage or salary earner. At any rate, it is evident that the tax policies of governments—reflecting political attitudes about differentials—may have as large an impact on the living standards of the medical profession as explicit decisions about the level of rewards in the NHS.

What is a just wage?

All this begs the central question of what a "fair" reward is. What is the "just wage"—to use the phrase of the mediaeval

University of Bath
RUDOLF KLEIN, MA, professor of social policy

theologians—for a doctor? If resentment at what is perceived to be a relatively declining standard of living is one element in the medical profession's sense of grievance, the other element is the suspicion that the level of earnings reflects a fall in the value society puts on the contribution of the medical profession. In other words, a sense of moral injustice reinforces a feeling of material discontent. Again, doctors are not alone in this. There is a great deal of evidence to suggest that most groups of workers have a strong sense of their place in the social hierarchy of rewards: that change is resented as a form of injustice.[10 11] Witness, for example, the miners' strike in 1973 over relativities. But, in the case of the medical profession, the problem is further compounded by the difficulties of devising anything remotely resembling rational or objective criteria for deciding pay levels: mediaeval theologians would have felt thoroughly at home in the metaphysics of the debates about medical pay.

In 1960 the Royal Commission on Doctors' and Dentists' Remuneration[12] laid down the basic principles which have largely shaped the work of the Review Body since then. It suggested that three main factors should be taken into account: "changes in the cost of living, the movement of earnings in other professions, and the quality and quantity of recruitment in all professions." Of these, the simplest to interpret is the cost of living. It is a matter of simple arithmetic to index salaries to reflect price changes though the political arithmetic of incomes policy may often play havoc with such adjustments.

It is easy to establish whether enough recruits are coming forward. The Review Body did so in 1977,[9] and found that there was no lack of demand for the expanding number of places in medical schools even at a time when the earnings of doctors were in decline. Indeed, it could be argued that, a time when there is anxiety about a possible surplus of doctors in future years, the easiest (and cheapest) way of preventing an excess would be to discourage new entrants by letting earnings drift down.

This leaves the criterion of comparability. The 1960 Royal Commission examined the earnings of accountants, actuaries, barristers, solicitors, architects, surveyors, engineers, and university teachers. But is this the appropriate "reference group" to use for the medical profession? To ask this question is to underline an immediate problem in the use of the comparability principle. For example, the relative earnings of university teachers have declined in recent years, probably rightly so, as the expansion of higher education has stopped and there is no problem of recruitment. In other words, the "professions" are not necessarily a homogeneous group and there is no reason why they should be. As society changes, it would be surprising (and damaging) if all professional earnings were frozen in a rigid hierarchy and linked to each other. Only consider what would have happened if there had been a Royal Commission on pay at the beginning of this century which had linked the pay of consultants to those of Anglican bishops.

Case for changing the earnings pattern

More important still, it may be argued that the relative earnings of professions and other occupations should change over time. For instance, given Britain's current economic position, there is a strong case for strengthening the financial incentives for the most able to take jobs in industry. One of the theories invoked to explain Britain's economic decline is that the country's social structure has tended to encourage the most talented men and women to move into the well-cushioned safety of the professions or the Civil Service rather than into risk-taking industry. If Britain now needs better middle managers, engineers, and export salesmen there may be a strong case for changing the relative pattern of earnings to the disadvantage of the traditional professions.

There are further problems about applying the comparability principle. The 1960 Royal Commission rightly emphasised the importance of examining lifetime earnings, rather than salary levels at one point in time. It is not clear to what extent the Review Body has done this subsequently. Changes in the medical pay structure over the past 10 years have clearly meant that the lifetime profile of earnings has changed considerably. There are, for example, few professions whose members can expect to reach their maximum earnings quite so early in their careers as general practitioners. Lastly, there is the problem of how best to take account of income from private practice. Again, the Review Body's reports are opaque on this point. In previous reports, however, Inland Revenue figures are quoted which suggest that income from private practice tends to swell NHS earnings by about a fifth.[13] In its latest report there is no evidence on this issue. Yet quite clearly at least some sections of the medical profession have been able to protect themselves against the squeeze on NHS salaries by increasing their income from private practice. Between 1971 and 1977 payments by insured patients of surgeons' fees almost trebled: they rose from £6 650 000 to £18 310 000. In contrast, the income of other specialists from this source, barely doubled—rising from £720 000 to £1 650 000.[14] And these figures, of course, leave out the increase in income from treating foreign patients.

Yet a further issue is likely to gain prominence in the debate about pay determination—whether in the NHS or elsewhere. This is how best to balance financial rewards and work satisfaction. There is an increasing tendency to view jobs as sources not only of money but also of intrinsic satisfaction: witness the growing interest in industry in organising the manufacturing process in such a way as to create more interest for the workers. The inherited system, which paradoxically tends to give the highest rewards to those who have the most satisfying jobs and who also tend to have the lowest risk of finding themselves on the dole, is increasingly being questioned.

Advantage of autonomy

Given that this trend continues, there are obvious implications for the medical profession—among other professions. If work satisfaction is a scarce currency the professions are well rewarded. They are unique in that they allow a large degree of autonomy to their members in determining their own pattern of work: a consultant or general practitioner can largely regulate the speed with which he or she processes patients just as a university professor can largely determine how much time he or she spends with each student. Add to this the intrinsic interest of much of the work and it is perhaps no longer surprising that there is no shortage of young men and women queueing up to become members of the professions despite the relative fall in earnings. For example, one survey of work satisfaction found that 86% of doctors would choose the same occupation if they had to start their working life again: a figure equalled by only that notoriously underpaid group, the clergy, and much higher than that for stockbrokers and advertising executives.[15] In turn, this might suggest that the earnings might be allowed to drift down even further without affecting the supply of recruits—and, given the increasing restrictions on entry in the United States and elsewhere, without risking a drain of talent abroad.

All this suggests that the battle over medical pay should be seen in a wider context than that of the institutional machinery of the NHS for determining earnings. Differentials within the medical profession have changed enormously over the past decades, largely in response to the demands of doctors. In turn, the medical profession should not be surprised that differentials within society at large are changing, however much they may lament the direction of change.

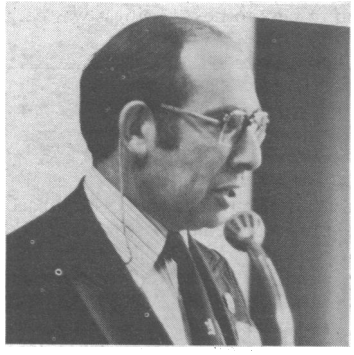
References

[1] Powell, J Enoch, *Medicine and Politics*. London, Pitman Medical, 1966.
[2] Review Body on Doctors' and Dentists' Remuneration, *Ninth Report*, Cmnd 7574. London, HMSO, 1979.

continued on page 224

Superannuation: a frustrating year, chairman tells RB

It had been a frustrating year, Dr B L Alexander told the RB. Changes in the NHS Superannuation Scheme, which applied to all or most of NHS employees, had to be raised through the General Whitley Council's subcommittee on superannuation—the Joint Superannuation Consultative Committee. It was that committee, if it agreed with the views of the constituent bodies of Whitley, which



Dr B L Alexander, chairman of the Superannuation Committee, addressing the ARM.

negotiated the proposed changes with the Health Departments. The system did not, he said, apply only to matters which affected doctors or dentists. Superannuation on DMT payments or changes in the rules which applied to general practitioners were matters which could be negotiated directly with the Health Departments. But pensions for widowers and almost all the items of the shopping list of improvements had to be negotiated through the JSCC.

But it had met only once in 1978 and then in June this year—a gap of nearly 12 months. The shopping list, which had been approved in Cardiff in 1978, had been put to the JSCC immediately afterwards but nothing had happened. So far as widowers' pensions were concerned, Dr Alexander said, his committee had drawn the attention of the JSCC to the provisions for widowers' pensions in the Parliamentary Pensions Act 1978. The matter had only just been considered by the JSCC, which had decided to take it up with the Health Departments. "This sort of delay is worse than we expect from Government departments. I think," he said, "we have seriously to consider dissociating ourselves from the JSCC and demanding a return to the right to direct negotiations with the Departments on all superannuation matters."

War service

Dr Alexander reported that the DHSS had been working hard on the time-consuming job of calculating war service pensions. It was now dealing with pensioners born in 1914. Any pensioner in England or Wales born before 1914, who had not heard the result of his application to buy war service, should write to the Fleetwood office of the DHSS. Pensioners in Scotland or Northern Ireland should write to the appropriate Government office. The Inland Revenue still insisted that income tax should be deducted from withheld moneys used to pay war service.

Pensions (Increase) Act 1971

It had been announced in the House of Commons on 13 June, the chairman said, that there would be an increase of 16% in November 1979 in the pensions of public service pensioners. That included doctors who retired from the NHS and university employment on or before 30 June 1978. Those who retired after June 1978 would get a larger or smaller increase depending on how many months had elapsed between retirement and 12 November 1979. Why was it 16% when the estimated annual rise in the cost of living to November 1979 was 17·5%? The last pensions increase, Dr Alexander explained, had been in December 1978; the standard rate of increase being paid in November would be eleven-twelfths of 17·5%—that is, 16%. [See p 225.]

NHS Injury Benefits Regulations

Drawing attention to the NHS Injury Benefits Regulations, he told the RB that they were important for those who suffered a loss of earning ability, or died, as a result of injury or disease attributable to NHS duties. "Anyone in doubt about the application of the regulations in individual cases should write to the BMA. We will do what we can to help."

Review Body awards

There had been no reply to the demand for retrospection of the superannuation aspects of the 1978 Review Body award. Doctors were not the only people concerned and the Government still had the matter under consideration.

Turning to the 1979 Review Body award, he said that he expected to see a dynamising factor of 17·6% for general practitioners for the current year. But he advised GPs not to rush out and cancel any notice they had given for retirement. The factor was almost exactly the same as the annual rate of pensions increases for the year ending November 1979. So what doctors did not get from dynamising they might get from pensions increases after retirement.

ARM and LMC Conference resolutions on pensions

That the Representative Body strongly resists any attempts to abolish the index linking of pensions. (Redbridge and Stratford)

That this meeting commends Council's efforts to obtain a two-thirds pension for retirement at 60 years of age. (Chester)

That this meeting deplores the fact that widows of doctors who retired before 25 March 1972 receive only one-third of their husband's pension, and urges Council to press for this pension to be raised to one half in line with pension rights subsequent to 1972. (East Dorset)

That this meeting regrets the failure of the Superannuation Committee to obtain equal benefits for the dependants including widowers of all doctors. (Liverpool)

At the LMC Conference on 13 and 14 June two resolutions were passed on superannuation:

That pensions of doctors retiring from the NHS during the period March 1976 to March 1978 be uprated to take into account the losses sustained by the delay in operation of the dynamising factors during that time. (North Tyneside Division)

That this conference requests the GMSC to negotiate with the DHSS to provide that payments for service on district management teams from their inception in 1974 shall rank as superannuable income. (Berkshire)

Money and Medicine—*continued from page 221*

[3] Bernard Shaw, *The Doctors' Dilemma*. London, Constable, 1911.

[4] Routh, Guy, *Occupation and Pay in Great Britain, 1906-1960*. Cambridge, Cambridge University Press, 1965.

[5] Ministry of Health, *Report of the Inter-Departmental Committee on Remuneration of General Practitioners*, Cmnd 6810. London, HMSO, 1946.

[6] Ministry of Health, *Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists*, Cmnd 7420. London, HMSO, 1948.

[7] Royal Commission on the Distribution of Income and Wealth, *Report No 3 Higher Incomes from Employment*, Cmnd 6383. London, HMSO, 1976.

[8] Royal Commission on the Distribution of Income and Wealth, *Report No 5*, Cmnd 6999. London, HMSO, 1977.

[9] Review Body on Doctors' and Dentists' Remuneration, *Seventh Report*, Cmnd 6800. London, HMSO, 1977.

[10] Moore, Barrington, *Injustice: the Social Bases of Obedience and Revolt*. New York, M E Sharpe, 1978.

[11] Runciman, W G, *Relative Deprivation and Social Justice*. London, Routledge, 1966.

[12] Royal Commission on Doctors' and Dentists' Remuneration, *Report*, Cmnd 939. London, HMSO, 1960.

[13] Klein, Rudolf, in *Journal of Health Politics, Policy and Law*. In preparation.

[14] Lee Donaldson Associates, *UK Private Medical Care, 1977*. London, 1978.

[15] *Which?*, September 1977.