# The Review Body. . .

● refers to NHS reorganisation and will "consider in future reviews the implication for remuneration of any significant changes in work load and responsibility as a result of reorganisation."

● does not think it appropriate to give external remuneration comparisons the same emphasis judged necessary during the 1978-80 updating process.

● admits that its 1981-2 recommendations were about 6% below the average level of increases elsewhere in the year to April 1981.

● has taken account of several "indicators and forecasts of earnings movements over the year to April 1982, including the trend in earnings movements and pay settlements during the current 'pay round.' "

● has concluded "that the overall levels of remuneration in recent years have not acted as a deterrent to the recruitment and retention of an adequate supply of good quality doctors and dentists to the NHS; and that present manpower forecasts do not suggest any need for a marked change in our current approach."

● comments that "available evidence on work load is less helpful [than recruitment trends] as a basis for drawing conclusions [on] remuneration. . . . Work load and productivity in health services remain extremely difficult matters on which to obtain satisfactory evidence."

● believes that "on balance, there may have been a slight decrease in overall work load, at least in terms of the volume of work carried out" but has not "attached great significance to it" in judging remuneration.

● sees no evidence of any present surplus in the overall supply of doctors relevant to demand in the NHS.

● has taken into account the further deterioration in the country's general employment position and concluded that there has been some further deterioration—not generally reflected in the medical profession—in the overall job security of those at similar incomes levels to NHS doctors, particularly of those in the private sector.

● do not think it necessary to give further detailed consideration to pensions and other fringe benefits this year.

## Senior hospital doctors

● refers to a "helpful memorandum" on consultants' work load prepared by the BMA (p 1494).

● reports the profession's observation that there is no evidence to suggest that the freedom to undertake a limited amount of private practice has interfered with the commitment of whole-time consultants to their basic contract.

● notes the increase of 300 whole-time consultants in England and Wales in the year to September 1981, no increase in maximum part-time consultants, and a fall in those with other part-time contracts, changes which "represent an increase in formal commitment to the NHS."

● does not see distinction and meritorious service awards as part of career earnings progression or as a form of long-service increment; recommends an increase of 130 in the number of awards—40 more B awards and 90 C awards.

● observes that fees paid by the NHS—85% from domiciliary visits and most of the rest from family planning work—amount to just over £1000 a year per consultant and wants more detailed information on the distribution of these fees between specialties.

● states that it is "important that the DMTs should not be hampered by difficulties in attracting clinical members in the period following restructuring, which both parties agree is likely to have an important but as yet uncertain effect on their work. Members or potential members should not be expected to suffer a financial penalty." It has "taken these considerations into account in recommending a modest relative increase in the level of payment this year. . . . We shall want to review the payment when there is clear evidence of the effects of NHS restructuring on the nature and level of the responsibilities entailed, and in the light of any further evidence of recruitment problems."

### General economic considerations

"As they did last year, the Health Departments emphasised the importance attached by the Government to the system of controlling public expenditure through cash limits," the Review Body states in chapter 2. "We were told that the 1982-3 cash limit for the hospital and community medicine service as a whole provided for a 4% increase in pay and a 10·3% increase in prices; and that the Government expected similar financial discipline to be applied to expenditure on the family practitioner services, which are not subject to cash limits. It was put to us that excessive increases in pay reduce the scope for growth in output and employment and that no group in the public services should be immune from the need for realistic pay settlements compatible with what the country can afford. As noted in chapter 1, however, we were assured that our recommendations would not be pre-empted by a figure which had been determined in advance. We have had due regard to the economic circumstances affecting the nation generally as one of the range of factors relevant to our judgment of appropriate levels of remuneration for the medical and dental professions."

## Junior hospital doctors

● recognises that "there are indications of some difficulties facing junior hospital doctors in finding suitable posts, although much of the evidence to support this is fragmentary and anecdotal," but does not believe 'that there has been any decline in the long-term employment prospects of those entering the hospital service.'

● emphasises, in the light of complaints from juniors that health authorities were too strict in interpreting terms and conditions of service, that it did take account of contractual terms and conditions of employment, and changes to them, in making recommendations on pay.

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# Survey of work and responsibility of junior doctors

The Review Body reported that results from a survey of junior hospital doctors and dentists carried out last year by the Office of Manpower Economics were available. The survey covered a representative sample of about 900 junior hospital doctors and dentists in 16 health districts in Great Britain. It was based on continuous diary recording of the time spent on different types of duty and activities over a period of seven days. The response rate to the survey was 88%.

"The results show," the report states, "that doctors in the sample were on average contracted for 88·8 hours a week, and spent on average 83·8 hours on duty. When on duty, average hours actually working were 55·3, or about two-thirds of average hours on duty. But the proportion of duty hours spent working varied between different periods of the day: for example, 90% of duty hours between 9 am and 5 pm on weekdays were spent working against only 47% of duty periods outside these hours. In addition an average of 3 hours per week were worked in free time. These average figures conceal substantial variations between the different grades and specialty groupings. Broadly, the more senior the grade the lower are the average hours on duty, the lower is the proportion of duty time spent in hospital and the lower is the proportion of duty hours spent working. For example, senior registrars on average recorded 46·4 hours working out of 78·2 hours on duty per week, whilst for house officers the averages were 63·0 hours and 89·0 hours respectively. In the specialty groupings used for analysis, average weekly hours on duty ranged from 62·1 in mental illness and psychiatry to 101·4 in traumatic and orthopaedic surgery, whilst average hours worked when on duty ranged from 41·5 to 69·7, with the same two specialty groupings again representing the extremes. Nearly a quarter of all doctors surveyed recorded working hours of 40 or less in the week and just over 10% recorded more than 80 hours—although about 44% overall were on duty for more than 80 hours in the week. . . . The results of the survey are also highly relevant to any discussion of future developments in the contractual arrangements for these grades. We shall continue to have regard to them in considering the remuneration implications of any such developments."

## The Review Body . . .

*Junior hospital doctors—continued from page 1488*

● made clear in previous reports its view that every effort should be made to secure a reduction in excessive contracted hours of duty and hours worked by junior hospital doctors. It "welcomes the indications that progress is now being sought in a number of ways as a result of the conference held in February and we hope this will lead to early evidence of a reduction in juniors' hours."

● is "anxious to consider further evidence on any new agreements or proposals affecting hours of duty which may be reached . . . and we will then if necessary reconsider the arrangements for remuneration with a view to doing whatever we can to assist in moving towards a reduction in juniors' hours. We therefore urge . . . agreement on a constructive programme of change . . . in time to allow us to consider the matter fully in our next review if not before then."

● considers as a separate issue the payments appropriate to junior hospital doctors under the existing system of remuneration in the light of evidence from the OME survey about their work and responsibility.

● concludes that existing levels of remuneration do not adequately reflect the amount of work and responsibility generally undertaken by the hospital training grades.

● recommends a higher percentage increase in the basic salary scales of the training grades as compared with other groups of doctors and dentists. This will result in proportionately higher increases in the amounts paid for additional UMTs.

● proposes slight changes to existing differentials between the training grades to reflect the tendency for the amount of duty and work to decrease the more senior the grade.

● in the case of house officers—though their hours of duty and hours of work were shown to be the longest—has also taken into account the preregistration status of the grade, in which most doctors spend only one year of their training.

## General practitioners

● reports that evidence shows that "recruitment to general practice has become relatively more popular and that many more doctors are now entering general practice as a first choice," and on the basis of detailed investigation of manpower developments concludes that "there are at present no signs of any difficulties in attracting sufficient numbers of suitably qualified doctors into general practice."

● concludes that "on present indications the introduction of self-certification is unlikely to lead to any significant change in the overall work load of GPs."

● analyses in detail the use of deputising services and the relation to GPs' out-of-hours responsibilities (p 1491).

● judges that overall there was no evidence to suggest a significant change in work load of GPs which should be taken into account in assessing the appropriate level of remuneration.

● declines to recommend any changes in the existing maternity services fee structure before the matter has been discussed between the profession and the Health Departments.

● rejects the profession's request to price a new system of paediatric surveillance by GPs until the profession and Health Departments have made progress in their discussions.

● reviews the position of dispensing doctors' income, which since 1975 has risen faster than that of other unrestricted principals, has not adjusted the gross remuneration for dispensing to take account of this, but has asked the DHSS and the profession to review the position.

● reports that in 1980-2 there was an overall shortfall in actual average gross remuneration from fees and allowances of £550 per GP compared with what it intended—a shortfall separate from any variances in practice expenditure.

● aims to ensure that there is no persistent tendency to overpayment or underpayment of gross remuneration (taking one year with another) and has, in calculating fees and allowances for 1982-3, "moved towards restoring a broad balance."

# Examples of salary scales and fees

The salary scales recommended for full-time hospital and community doctors are set out below, together with the BMA's estimation of the effects of the Government's decision to implement only the cash differences between the recommendations in last year's report and those in this year's report without restoring the amount by which the recommendations in the 1981 report were cut by the Government. Rates of payment for part-time staff should be increased pro rata. Percentage increases over existing scales for junior doctors range from 6·5% to 8·5%, and for career grades about 5·5%.

## Hospital medical staff

| Grade | Present scales (£) | Review Body's recommended scales (£) | BMA's estimate of scales payable from 1 April 1982 (£) |
|---|---|---|---|
| House officer | 5 730 | 6 340 | 6 180 |
| | 6 100 | 6 750 | 6 580 |
| | 6 470 | 7 160 | 6 980 |
| Senior house officer | 7 100 | 7 900 | 7 700 |
| | 7 590 | 8 430 | 8 200 |
| | 8 070 | 8 960 | 8 730 |
| Registrar | 8 070 | 8 960 | 8 730 |
| | 8 490 | 9 410 | 9 170 |
| | 8 910 | 9 860 | 9 610 |
| | 9 330 | 10 310 | 10 050 |
| | 9 840 | 10 850 | 10 570 |
| Senior registrar | 9 330 | 10 310 | 10 050 |
| | 9 840 | 10 850 | 10 570 |
| | 10 360 | 11 380 | 11 100 |
| | 10 870 | 11 930 | 11 620 |
| | 11 390 | 12 470 | 12 150 |
| | 11 900 | 13 010 | 12 670 |
| Consultant | 16 440 | 17 830 | 17 370 |
| | 17 590 | 19 090 | 18 590 |
| | 18 750 | 20 350 | 19 820 |
| | 19 910 | 21 610 | 21 050 |
| | 21 060 | 22 870 | 22 270 |
| Senior hospital medical officer | 16 440 | 17 830 | 17 370 |
| Associate specialist | 10 020+1 070 (6)− 16 440 | 10 870+1 160 (6) 17 830 | 10 590+1 130 (6) 17 370 |
| Clinical assistant* | 1 240 | 1 340 | 1310 |
| Hospital practitioner* (limited to a maximum of five weekly sessions) | 1 240×6 1 640 | 1 340+75 (6) −1 790 | 1 310×6 −1 740 |

Class A UMTs remain at 30% of basic pay; class B UMTs remain at 10%.
*Annual rate per weekly notional half-day.

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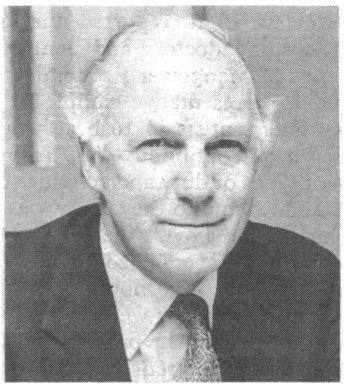
## Review Body members



The chairman of the Review Body, Sir Robert Clark.

Sir Robert Clark (chairman), chairman of Hill Samuel.
Sir Peter Menzies, director, National Westminster Bank Ltd and Commercial Union Assurance Ltd.
Professor P G Moore, professor of statistics and operational research, London Business School.
Mrs A C R Rumbold, governor, National Foundation for Educational Research.
Sir William Slimmings, chartered accountant, partner, Thomson McLintock & Co, 1946-78.
Professor G F Thomason, Montague Burton Professor of Industrial Relations, University of Wales, Cardiff.
Mr J K Warburton, barrister-at-law, director, Birmingham Chamber of Industry and Commerce.
Sir Graham Wilkins, chairman, Beecham Group.

**The Review Body . . .**—*continued from page 1489*

## Community medicine and community health staff

● notes that 53 people were recruited to community medicine training grades in 1981 compared with 35 in 1980 and significantly more than in any of the previous five years.

● reports that having successfully recommended in January 1982 that the salaries payable to district medical officers in England and Wales should be set at the same rate as those for area medical officers it has maintained the same equivalence in the 1982 proposals.

● is not persuaded that the relative value of chief officer supplements should be raised and regards it as illogical to offset these against distinction awards.

● sees some attraction in "a distinct award scheme for community medicine, particularly as this might help to clarify the total pay relationship between community physicians and hospital consultants" and asks for views on this for the next review.

● reports that the OME is surveying the work and hours of community medicine trainees.

● has not received any evidence to suggest that the nature of the senior clinical medical officer job has changed significantly but notes that discussions on the development of the grade are continuing.

● points out that the existing SCMO scale is relatively long and "is adequate to reflect different levels of training and expertise within the work required of a single grade. . . ."

## Ophthalmic medical practitioners

● argues that the decline in both the proportion of all sight tests and the average number performed by OMPs is relatively modest.

● doubts whether this work is "entirely appropriate to OMPs' level of training and expertise, particularly in the case of those who hold consultant posts" and recommends an interim increase to 99p in the expenses element and a rise in the net remuneration element of the sight testing fee to £3·77. (This second figure will be reduced to £3·66 because of the Government's cut.)

# General practitioners

## Estimated remuneration for 1982-3

The Review Body has recommended increases in gross fees and allowances designed to yield a 5·5% increase in average net remuneration over and above its *recommendations* in its Eleventh Report last year. This would take annual net remuneration to £19 500, after meeting average practice expenses of £9260. Details of the award showing the percentage increases in fees and allowances will be published when the revised figures have been calculated.

### Net remuneration

The BMA estimates that average net remuneration will be increased from £17 970 to about £18 990 (5·6%) instead of £19 500 as a result of the Government's abatement of the recommendations. In addition, it is estimated that GPs will receive an average net income of some £410 from hospital work and other official sources. Thus total average net remuneration during the year 1982-3 is expected to be about £19 401.

### Practice expenses

It is recommended that indirectly reimbursed practice expenses be increased from £8500 to £9260, a rise of 8·9% for the year. The Government will be paying this in full.

## Review Body on practice expenses

On GPs' practice expenses the Review Body states: "In the Eleventh Report (paragraph 114) we estimated that, on the basis of the information available at the time, there appeared to have been a shortfall in the provision we made for expenses between 1977-8 and 1980-1 amounting in total to some £1400 per GP. The most recent evidence indicates that the underprovision in these years was somewhat lower at about £1150 per principal and provisional estimates for 1981-2 show that the amount provided for expenses in the Eleventh Report (£8500) exceeded actual average practice expenditure by about £550. It remains our general aim to ensure that there is no persistent tendency to overpayment or underpayment taking one year with another. Taking account of this and other relevant considerations, we calculate that the average expenses provision necessary for 1982-3 is £9260. Our recommendations in appendix A make provision for this amount to be reimbursed on average through gross fees and allowances. In calculating the provision, we have taken account of a £12 deduction from expenses agreed between the profession and the Health Departments to accommodate the additional costs arising this year from the related ancillary staff scheme."

**Examples of salary scales**—*continued from page 1490*

### Community medicine staff

| Grade | Present scales (£) | Review Body's recommended scales (£) | BMA's estimate of scales payable from 1 April 1982 (£) |
|---|---|---|---|
| Trainee | 8 070 × 8 — 11 900 | 8 960 × 8 — 13 010 | 8 730 × 8 — 12 670 |
| Community medicine specialist (district medical officer basic scale) | 16 440 | 17 830 | 17 370 |
| | 17 590 | 19 090 | 18 590 |
| | 18 750 | 20 350 | 19 820 |
| | 19 910 | 21 610 | 21 050 |
| | 21 060 | 22 870 | 22 270 |

### Community health medical staff

| Grade | Present scales (£) | Review Body's recommended scales (£) | BMA's estimate of scales payable from 1 April 1982 (£) |
|---|---|---|---|
| Clinical medical officer | 8 730 × 7 — 12 070 | 9 470 × 7 — 13 110 | 9 220 × 7 — 12 770 |
| Senior clinical medical officer | 12 420 × 7 — 17 860 | 13 470 × 7 — 19 350 | 13 120 × 7 — 18 840 |

# GPs' deputising services

The Health Departments provided information relating to 1 October 1981 on the use of deputising services, obtained by questionnaire from family practitioner committees in England and Wales and from Scottish health boards. This showed that there were 10 659 GPs in Great Britain—some 40%—with consent to use deputising services. The number of such GPs in England and Wales was 5·4% higher than in 1980 and about a third above the 1974 level. The Review Body points out that claims for night visit fees were the only readily available indicator of actual use of the services (and these were likely to understate the true position because they are payable only for visits between 11 pm and 7 am rather than the whole out-of-hours period). They showed that, in the period April-June 1981, 41% of all night visits in England and Wales for which fees were claimed were carried out by doctors from deputising services. The figure for the equivalent period in 1980 was 40%. The evidence also showed that both consents to use and actual use of deputising services varied widely between the different FPCs and health boards. It was estimated that, in Great Britain as a whole, about 75% of GPs who could make use of an existing deputising service have consent to do so.

### Satisfactory quality

Both the profession and the Health Departments, the Review Body states, were generally well satisfied with the quality of service provided by deputising services. Though no reliable figures were available, the profession thought that the GPs themselves might now account for a half or more of all deputising doctors throughout the country, though with substantial variations between areas. They argued that doctors were able to provide a better service to patients during the day if they were not constantly involved in night work and that deputising services had the advantage of generally ensuring that an immediate response could be given to a call. The profession did not anticipate any further major changes in scale or coverage of deputising services. The Health Departments detected a falling off in the spread of commercial deputising services, which were for the most part now well established in areas of the country where they were viable. They estimated that around 4000 GPs in Great Britain could still become new users of existing services, though many had presumably already decided not to do so. However, turnover among GPs and the entry of new doctors to the profession suggested there could be a continuing, though gradual, increase in the use of deputising services.

The profession and the Health Departments had considered whether it would be appropriate to institute a lower level of night visit fee for visits made by a deputising service, but have not reached agreement. The profession agreed that a differential fee would lead to anomalies in cases where a night visit was made by a doctor other than the patient's own GP, but not by a commercial deputising service. Moreover, any reduction in the night visit fee was likely to have a serious effect on the provision of out-of-hours services, particularly in areas such as inner cities, which were heavily

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# Profession asked to forgo £50m, says BMA

The BMA issued the following statement on the Review Body's Twelfth Report:

"For the second year running the Government's decision will leave NHS doctors' and dentists' remuneration below the levels which the Review Body considers to be appropriate. This has arisen because the Government is prepared only to implement the cash differences between the recommendations in last year's report and those in this year's report, without restoring the amount by which last year's recommendations were cut by the Government. In effect, the professions are being asked to forgo about £50m in addition to that which was withheld last year.

"The Review Body has emphasised in this year's report that it remains of the opinion that the recommendations it made last year were right, and has said that it attaches the greatest importance to a continuing commitment by the Government that its recommendations will not be modified except in the most exceptional circumstances. The Review Body also said that it had due regard to the economic circumstances affecting the nation generally as one of the range of factors relevant to its judgment of appropriate levels of remuneration for the medical and dental professions.

"Accordingly, we have asked the Secretary of State to let us have in writing a clear statement of the reasons for the decision and an indication of the Government's intention to restore the 3% cut which was made in the levels of remuneration recommended last year.

"We are also seeking a meeting with the chairman of the Review Body to discuss the position which has arisen as a result of the Government's failure, for the second year running, to implement in full the Review Body's recommendations."

## Early warning arrangements on negotiations

The Review Body commented as follows on early warning arrangements:

"In our Eleventh Report (paragraphs 9-14), we pointed to the overlap between our role as an independent Review Body charged with the task of making recommendations for the whole remuneration structure, and the role of the professions and the Health Departments in negotiating changes in contractual terms and conditions of service. We asked the Office of Manpower Economics (OME) to explore the possibility of an arrangement whereby the parties could give us early warning of potential agreements which might have significant implications for remuneration so that we could, if necessary, give our preliminary views on questions of remuneration or costing.

"Discussions on this matter have resulted in agreement between ourselves, the Health Departments and the professions on a broad framework within which suitable arrangements to this end can operate. The objective is to minimise the difficulties which can arise when prospective new agreements are not considered by us at a sufficiently early stage. We regard it as important that such early warning arrangements should not interfere with either the negotiating process or the Review Body system and that they should operate flexibly and informally. It will be for the parties to agree jointly whether and at what stage to approach us with details of prospective contractual changes. This will enable us to make clear our attitude towards the financing or pricing of a potential agreement. We regard these arrangements as experimental at this stage. In our view their success will depend on the way in which they are used in practice."

# Threat to medical education

The BMA has warned that the failure to pay medical teachers at the same rate as their NHS hospital colleagues will have a serious effect on medical education. In a press statement the BMA states: "Doctors working in medical schools have been told by the universities who employ them that a 4% pay limit on salary increases has been imposed, whereas it is now clear that NHS doctors and dentists are likely to receive increases of at least 2% in excess of this. Yet most university doctors on the clinical scales spend up to half their time working alongside consultants in NHS hospitals caring for inpatients and running outpatient clinics in addition to their teaching commitments to medical students and their research work."

Professor J P Payne, chairman of the Medical Academic Staff Committee (MASC) of the BMA, the committee which represents all doctors working in the universities, has written to the Committee of Vice-chancellors and Principals to express its concern over the cash limits on the pay of clinical academic staff compared with their colleagues in the NHS. Professor Payne says: "Broad comparability enables medical staff, both in the training and the career grades, to transfer between NHS and academic posts and enables flexible arrangements to be developed for the funding of academic departments and posts which have a strong service element. It is a principle which is vital to the quality of medical education, and as such is important not only to clinical academic staff but to the medical profession as a whole."

The statement continues: "The BMA is adamant that comparability of salaries between medical academics and NHS consultants should be maintained. Medical academics work with NHS doctors, both carrying responsibility for patients in NHS hospitals. They are also responsible for the education of the country's future doctors and a considerable amount of research work is carried out in the medical faculties. The Council of the BMA reaffirmed on 5 May its determination to "maintain comparability between the remuneration of clinical academic staff and hospital medical and dental staff in the NHS."

**Deputising services**—*continued from page 1491*

dependent on commercial deputising. The Health Departments, on the other hand, saw merit in the payment of a reduced fee or even no fee for a night visit made by a deputising service when neither the responsible practitioner nor another principal on the medical list acting for him was suffering disturbance. They accepted, however, that a distinction based on whether or not a commercial deputising service was used would be arbitrary.

"The Health Departments referred again to the question of 'double payment,' which they put in evidence last year (Eleventh Report, paragraph 103). Their point was that the costs of an increased use of deputising services (or other similar paid arrangements) would be fully reflected in higher gross fees and allowances paid to GPs as a whole, while the work load of GPs would decline to the extent that they no longer undertook night visits."

The Review Body concludes that the standard of care provided by commercial deputising services was not significantly different from that provided by GPs who undertook their own night visits, or through other informal arrangements. It says that it must look closely at the implications for GPs' remuneration of an increase in the use of deputising services and any consequent reduction in individual GP work load. GPs were not expected to provide a personal 24-hour service throughout the year. At the same time, the existing remuneration arrangements had been designed to take account of the element of personal disruption involved in a GP's work, particularly the out-of-hours commitments and responsibilities. The evidence on the use of commercial deputising services pointed to a gradual but significant reduction in the amount of out-of-hours work undertaken, and in the disruption suffered personally, by GPs.

The Review Body was handicapped by the absence of reliable evidence on the additional cost to the individual GP of employing a deputising service to undertake night visits, but it believes that the acceptance in principle that such a service can be used implies an additional cost to the NHS which should not be fully and directly offset against GPs' income.

It was inevitable, the Review Body declares, that there would be an element of rough justice in the remuneration of individual practitioners for out-of-hours work under the existing arrangements. It concludes that there was no satisfactory means of achieving a more equitable method of payment under the present system. Consequently, it has not recommended any relative changes to the existing payments for different elements in out-of-hours remuneration, but has taken account of the reduction in the amount of out-of-hours work undertaken, and personal disruption suffered, by GPs in its overall assessment of changes.