Junior doctors' workload survey

At its meeting on 1 October the Hospital Junior Staff Committee was encouraged to participate fully in the workload survey that the Office of Manpower Economics is conducting on behalf of the review body (12 October, p 1061). The outgoing chairman of the HJSC's negotiating subcommittee, Dr Timothy Fenton, has written to the mess presidents in the hospitals in those districts selected for the survey. Dr Fenton's letter is set out here.

"You will doubtless be aware that one of the major issues affecting hospital junior doctors at present time is that of hours of work. Progress is being made towards the reduction of unduly onerous rotas and the available statistical indicators suggest a steady decline in the overall hours of duty, of junior doctors, totalling some three hours per week, since 1981. Hours of work have clear implications for the remuneration of hospital junior staff and as such, are a legitimate interest for the review body on doctors' and dentists' remuneration, the independent body that recommends the levels of pay of doctors taking any part in the National Health Service.

"In its 15th report the review body indicated its intention to undertake a further study of juniors' hours of work, having previously conducted such a survey in 1981. This survey has been commissioned by the review body from its own secretariat, the Office of Manpower Economics and advice and assistance has been sought from the DHSS and from the profession. The Office of Manpower Economics has asked the Social Survey Division of the Office of Population Censuses and Surveys to carry out the sampling and interviewing on its behalf. As chairman of the negotiating subcommittee of the Hospital Junior Staff Committee, I have been asked to act as the liaison doctor for the survey and am writing to you to seek your cooperation in this exercise.

"The survey will be similar to that carried out in 1981 and will provide up to date information about the pattern of work and hours of duty of junior hospital doctors and dentists.

"Sixteen health districts in Great Britain are included in the survey and your district is among them. The districts have been selected to match as closely as possible those included in 1981. In the next few weeks an Office of Population Censuses and Surveys interviewer will visit district offices to produce a list of the junior doctors based at hospitals in the district. A representative sample of about half the doctors on full time NHS contracts will be selected. Interviewers will contact these doctors in November to ask them to take part in the survey. Each doctor will be asked a few basic questions—for example, grade, specialty—and then briefed on how to complete a simple diary questionnaire to record their hours of duty and the type of work carried out over a seven day period. The interviewer will see each doctor again at the end of the seven day period to collect the diaries and resolve any problems.

"Information collected about individual doctors will be held in strict confidence by the Office of Manpower Economics and the survey results reported only in aggregate so that individual doctors, hospitals, and districts are not identifiable.

"I should be very grateful if you could publicise this letter to all junior doctors in your hospital so that they know about the survey. The Office of Manpower Economics is also writing to consultant members of district management teams. If you, or they, have any immediate queries or foresee any difficulties please contact, in the first instance, the industrial relations officer for your region, or failing this, Mr J C Ford at BMA House (01 387 4499 ext 254), who will be dealing with day to day contact with the Office of Manpower Economics over detailed aspects of the survey."

Correction

Life assurance reports

In the report of increased fees for life assurance reports (5 October, p 988) it was stated that an additional fee of £11 was payable in addition to the personal medicals attendant's report. This is incorrect; the additional fee is for agreement between the individual doctor and the office making the request.

Talking Point—*continued from page 1140*

invalid as it would make unfair comparisons of contributions and consumptions, which in the aggregate society are nearly balancing each other at any (real) point in time.

Discussion

The worth to society of an average individual at any point in his lifespan has been expressed in a modified human capital approach by the cumulative past economic benefit and the origin has been set at birth (age 0). Net consumption in childhood and in old age and net contribution during the productive years have been compared on equal terms without discounting, because at any point in time society comprises millions either consuming or contributing at real terms prices appropriate to that time. This economic model better describes implicit societal choice than previous human capital models, which have calculated future economic contributions alone or future economic consumptions and contributions at relatively high rates of discount. The difference has shown up particularly in the estimate of value of a newborn infant. Previous conventional human capital models have given various estimates of present value of an overall future *cost* in the region of £20 000 (even at 1979 prices).[12] The present model would estimate an overall future contribution by the time that the infant has lived his full life of approximately £10 000. Since this average credit accumulates over about 70 years, it fits with the concept of a small economic growth. The logical societal strategy implied by the estimates of the former model would be to abort all fetuses and avoid all childbirths,[7] while the logical societal strategy implied by estimates of the latter model would be to replace the present population age distribution with a similar population age distribution in future years to maintain relatively constant the ratios of consuming children and elderly to contributing adults. The latter seems the more logical on simple common sense grounds.

The particular relevance to health service managers and planners of this model is in cost benefit analysis of screening programmes for neural tube defects or Down's syndrome. The principal narrowly defined economic costs of a screening programme depend on unit cost, prevalence of the disease, and sensitivity and specificity of the programme (not only of the test). Costs of neural tube defect screening programmes have been estimated at approximately £5000 per case terminated.[12] The corresponding narrowly defined economic benefits of the screening programme are the costs of caring for the afflicted children that may be averted if screening is successful and if abortion is offered and accepted. Because many babies with neural tube defects die young and few survive to become adult contributors the cumulative overall cost per case may be in the region of £25 000 (at 1979 prices).[12] If averted by screening this represents the benefit per case of screening. This estimate of benefit is higher than previous estimates by discounters and therefore the difference between costs and benefits is greater than previously suggested by discounters. The conclusion must be that society can ill afford not to screen for neural tube defects.

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