working paper is whether the reward is for aggregated underspending by a family practitioner committee or whether all general practitioner practices should have an expenditure outturn within, say, 5% of budget. The sanction of last resort against those practices which overspend on their drug budget is to withhold doctors' remuneration. Such action is likely to create some interesting contractual problems because it is the individual doctor who is in contract with the family practitioner committee but the practice which will hold the indicative drug budget.

In conclusion, little indication is given in the working paper as to how the success or failure of the proposals will be evaluated. If the test is to be one of improved cost effectiveness the monitoring of reduced drug expenditure alone is inadequate. Data are required on the quality of patient care and treatment outcomes to determine whether they can be maintained, or even improved, at lower cost. The proposals are to be tried out in 1990-1; I hope that comparative trials will be designed to address questions of effectiveness as well as of cost.

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Distinction and merit awards: a £100m management tool?

James Raftery

The system of distinction and merit awards, which grew out of an agreement in 1948 between Anuerin Bevan and Lord Moran, president of the Royal College of Physicians, has survived with few changes for the 40 years up to the recent NHS review.¹

The white paper proposes that discussions should begin with the medical profession with the following changes in mind:

- To modify the criteria for C awards so that in future consultants must show not only their clinical skills but also a commitment to the development and management of the service
- To restrict progression of the remaining three levels of awards to those who have earned C awards
- To change the composition of the regional committees which nominate candidates for C awards. In future, each committee will be chaired by the regional health authority chairman and will include senior managers as well as clinicians
- To change the composition of the national Advisory Committee on Distinction Awards to provide for stronger management influence on the choice of award holders
- To make the new or increased awards reviewable every five years
- To make new or increased awards pensionable only if a consultant continues working in the NHS for at least three years.

The brief, 11 page, working paper provides details on some of the organisational changes envisaged—namely, that nominations for C awards would be expected to have the support of both clinicians and management and that membership of the Advisory Committee on Distinction Awards be supplemented by a senior person with experience of NHS management.² Thus, management will have a veto on the nominations for C awards as well as a greater input to the allocation of higher awards.

Criticisms of the merit awards

The system of distinction and merit awards has recently received considerable attention with the

publication of the first detailed description of its working³ and questions in parliament about the cost of the system. The House of Commons social services select committee, which suggested in 1983 that major change in the distinction awards might be salutary, has announced its plans to review the award system.

... the continuation of merit awards on top of locally determined salaries in the NHS trusts seems anomalous.

From its beginnings the award system has been controversial. It was seen in 1950 by the Treasury as a "blot on the landscape of public finance," which was accepted only on the grounds that "arguments of expediency outweigh those of principle."⁴ Extraordinary secrecy surrounded the awards, with the first limited information about the distribution of awards by specialty only becoming available in 1958 in response to parliamentary questions. Secrecy and the uneven distribution of awards by specialty, region, and sex have been the main subjects of subsequent criticism.

In a series of articles two of the more persistent critics concluded that the system should be abolished because "it remains immutably unfair, divisive and, in its secrecy, contemptible. No other profession would copy this system and consultants would gain respect by scrapping it—especially self respect."⁵⁻⁷ Other critics have echoed these points in more temperate language.

The first official criticism of the awards scheme emerged in 1988 when the review body on doctors' and dentists' remuneration, having expressed concern that the awards should benefit the NHS as well as reward individuals, suggested that awards should have an age limit and be subject to review with a greater managerial input into the selection process. The working paper on merit awards makes it clear that the white paper's proposals are based largely on these suggestions.

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Objectives of the award system

Five objectives of the award system have been outlined:

- To reward outstanding individual distinction
- To attract the highest calibre entrants to the medical profession
- To provide earnings comparable with the highest in other professions
- To provide a means of attracting consultants away from the major teaching centres
- To compensate consultants for loss of private practice.

Only the first objective retains contemporary relevance.

REWARDING DISTINCTION

Since most consultants take up their positions by the time they are 40 some form of incentive for continuing professional commitment seems appropriate. The key question concerns who should apply what criteria in allocating awards. Hitherto, the medical profession has been left to decide on the allocation of the awards in private, with neither the public nor general practitioners allowed to know who has an award. Indeed, other consultants were allowed only from 1979 to know who held awards and then only in their region.

The proposed changes in the system redefine "meritorious service and distinction" to include performance in a management context. At present district managers have indirect influence only on C awards through their regional chairmen, who can make recommendations to the regional committees. Regional committee membership has, until now, been confined to the profession and selected by existing award holders. In future these committees will be chaired by regional health authority chairmen and include several senior managers. This enhanced role of managers goes hand in hand with the proposal to provide defined job descriptions for hospital consultants, which will be reviewed annually, with management monitoring whether they are being met. Merit awards, by changing to reflect "commitment to service management as well as clinical excellence," will pull clinicians further into management, a process initiated by Sir Roy Griffiths 1983 report.⁸ That report led to the appointment of district and unit managers on short term defined contracts with salary scales comparable to consultants, plus performance related pay increments of up to 30%. The white paper, which was produced by a team which included Sir Roy Griffiths, extends the management approach to clinicians. Merit awards will become a type of performance related pay.

None of the other stated objectives seems relevant today. Recruitment to medicine can hardly have been affected by merit awards since they were so confidential. While merit awards undoubtedly raise medical salaries, this objective could and is being achieved in other ways—for example, through private practice and potentially through locally negotiated salaries in the NHS trust hospitals. Estimated consultants' private earnings at over £300m in 1987⁹ exceeded the total cost

of merit awards of just under £100m (see below). Merit awards, far from being used to disperse consultants away from the major teaching hospitals as envisaged by the 1948 Spens report, may have contributed to the opposite effect as the chance of earning awards was greatest in certain major centres and specialties.⁴ Compensation for loss of private earnings, which may have been relevant in the founding of NHS, has little relevance today when private practice is no longer frowned on by the government.

Costs

As many of the original objectives of merit awards have lost much of their relevance costs have risen as the awards have come to be used to supplement pensions.

... recruitment can hardly have been affected by merit awards since they were so confidential.

Seniority plays a large part in the allocation of awards, as shown by the fact that while only 36% of consultants on average hold awards at any one time, 70% do so by the time they retire. Superannuation is paid to consultants on the basis of final salary including merit awards. Since employees' superannuation contributions cover only a small part of the cost of pensions extra costs are imposed on the state by retired award holders. The total cost of the award scheme thus includes both revenue costs of current award holders and the increased, unfunded, superannuation payments to retired award holders.

REVENUE COSTS

The revenue costs of the award system can be readily estimated from the reports of the review body on doctors and dentists' remuneration. Each year's report contains data on the number of awards by type and the value of each type. Combining the numbers of award holders and the values of each type of award gives a first estimate of the revenue costs (see table). But as the review body has noted not all award holders are employed full time. The notional "authorised budget" overestimates spending as some award holders receive reduced awards because they work part time or hold honorary contracts. Although no central information is available on the numbers whose salaries and awards are thus reduced, the Department of Health estimates that 86% of the authorised total was paid out in the years to 1987 and 88% in 1988.

The results of these calculations put the revenue costs of the award system at £56.9m in 1987 and £63.3m in 1988. Both the number of consultants holding awards and the value of the awards have increased in recent years, but the percentage of eligible consultants holding awards has remained unchanged at close to 36%. Distinction and merit awards thus account for a fairly stable 4% share of the medical revenue budget and some 10% to 15% of all consultant salaries (based on the extremes of the consultant salary range).

SUPERANNUATION COSTS

Although detailed information on the superannuation costs of the award system is not available, these can also be estimated. The number of retired award holders can be calculated using an average life expectancy for those retiring of 14 years and an average of 500 retiring each year.¹¹ Combined with official estimates

Revenue costs of distinction and merit awards

	No of awards				Value (£m)				Authorised budget (£m)	Amount paid out* (£m)
	A+	A	B	C	A+	A	B	C		
14 1980	141	523	1498	3450	17.4	13.34	7.95	3.53	33.5	28.9
14 1981	144	532	1525	3511	18.62	14.34	8.59	3.83	36.9	31.8
14 1982	144	532	1565	3601	19.645	15.13	9.06	4.04	39.6	34.2
14 1983	147	542	1595	3750	20.825	16.04	9.605	4.28	43.1	37.2
14 1984	150	554	1631	3750	22.39	17.24	10.33	4.6	47.0	40.6
14 1985	162	602	1649	3792	27.3	21.02	12.01	5.35	57.2	49.3
14 1986	162	652	1679	3852	27.3	21.02	12.01	5.35	58.9	50.8
14 1987	182	652	1679	3902	29.55	22.75	13.0	5.79	64.6	55.8
14 1988	192	692	1679	3902	33.72	24.85	14.2	6.26	71.9	63.4

*This is obtained by adjusting the authorised budget by 86.3% for the years to 1987 and by 88.1% in 1988.

of the notional pension contributions necessary to finance merit awards, the total superannuation cost comes to £39.9m in 1987. Thus the total cost of the award system, comes to just under £100m in 1987, £57m being direct revenue costs and £40m superannuation costs. Previous estimates, which have ignored the superannuation costs, have seriously underestimated the real cost of the award system.

Conclusions

The white paper proposes to change the definition of merit and widen the award allocation process to include management. Hitherto, consultants made awards to their peers on criteria which were ill defined and primarily clinical. In future, awards will be made by management and clinicians on criteria related to job descriptions and services delivered. Although consultants' contracts will continue to be held by regional health authorities, they will be managed by districts who will have much greater say in the appointment and monitoring of consultants.

Hospital consultants will be moved towards a clinical version of performance related pay similar to that of managers. These proposals can be seen as the extension of the shift to a management culture in the NHS introduced by the Griffiths report on general management. The proposed changes will be achieved by threat and inducement: the threat being provided by means of the annual review of individual contractual obligations and the inducement being that of enhanced pay, whether through merit awards or higher salaries in NHS trust hospitals.

The rationale for nationally agreed merit awards combined with locally negotiated pay, however, remains unclear. The majority of larger hospitals that will be encouraged to become NHS trusts will control their own salary levels, including those of consultants. The continuation of merit awards, set at national levels, on top of locally determined salaries in the NHS trusts seems anomalous.

A judgment on the desirability of further incorporating clinicians in management depends on your view of the contemporary role of medicine. Much depends on whether and to what degree doctors respond to financial incentives and whether medicine can be managed.

The attempt to manage medicine and health services has spawned several new subdisciplines such as health economics and health policy studies. Experience else-

where, particularly in the United States, suggests that considerable progress can be made in categorising, quantifying, and managing what goes on within the black box labelled "clinical freedom." Tighter definitions of cases, such as diagnostic related groups, are already part of the resource management initiative that the white paper is building on. Similarly, the increased interest in measurement of outcomes by cost effectiveness studies and quality assisted life years signals future trends. Research is also proceeding in the United States on methods of remunerating doctors on the basis of human and physical resources required in carrying out certain procedures by means of resource based relative values, which implies that payment rates should vary by specialty.¹²

Recognition of both the increased power and limitations of medical interventions, combined with demands for greater individual choice and responsibility, plus increased concern over costs, all point to a widespread trend in favour of stronger management of health services. Since hospital consultants play a key role in making decisions it is difficult to see how they could remain aloof. Whether clinical freedom is alive or dead, what happens in the clinic will increasingly be judged by criteria which transcend the purely clinical.¹³ The proposed changes in the merit award system mark but one further step in the transformation of medicine in the United Kingdom from the era of administration to management of health services.

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ANY QUESTIONS

Does the intradermal route for typhoid immunisation provide a satisfactory level of protection?

The recommended route for typhoid immunisation has varied over the years. In 1984 the Department of Health and Social Security advised the use of the intramuscular or subcutaneous route for the first dose but allowed the intradermal route to be used for any subsequent immunisations. The current recommendations do not mention the intradermal route, and the correct assumption is that it should not be used.¹

Large scale field trials have shown that typhoid immunisation, when given by the intramuscular or subcutaneous routes, provides a high degree of protection.² It also has a high incidence of side effects. There are substantial data to show that antibody responses after intradermal and subcutaneous administration are comparable and that the incidence of side effects is much reduced after intradermal administration.³ The understandable assumption has therefore been that it is appropriate to use the intradermal route. There are no significant field trials, however, to

support this assumption, and the correlation between laboratory and serological studies on the one hand and clinical efficacy on the other is poor.⁴ All the data are now being reviewed, but until the review is completed the official recommendation is that only the subcutaneous and intramuscular routes should be used. Clinical trials are now unlikely to be carried out as the emphasis is on developing an effective oral vaccine.

It is fair to point out, however, that despite widespread use of the intradermal route there have not been many reports of vaccine failure. — DAVID ELLIMAN, *lecturer in community child health, London*

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