of their time to counselling patients and their families and, inevitably, supervising their continuing and terminal care. Many patients have no other hospital based specialists to turn to. Attempts to reduce junior staffing levels to ensure that well trained juniors will eventually find consultant posts and moves to limit their working hours have also exacerbated problems within the specialty.

Faced with similar problems, the Royal Australian College of Radiologists started putting numbers to its complaints, estimating how many patients were being deprived of essential treatment and how much the delays in treatment were costing.³ Perhaps the royal college here should follow this

lead. Unless more clinical oncologists are appointed standard care for Britain's patients with cancer looks likely to continue well into the next century.

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General practitioners' pay

Unsettling pool debts

Many general practitioners believe that they worked harder in the first year of their new contract than ever before. They will therefore be surprised to discover that under existing arrangements nearly £6000 may be clawed back from their pay.¹ To understand how this could happen requires a detailed knowledge of the workings of the pay system.

Each year the review body on doctors' and dentists' remuneration recommends what gross income (net income plus expenses) the average general practitioner should receive the following year. By multiplying this amount by the estimated number of general practitioners a sum of money is arrived at: the remuneration pool. This is distributed among general practitioners by way of fees and allowances. Their uptake determines whether the average intended gross income is delivered.

The review body's ultimate intention is to deliver average net income as accurately as possible. Its success is known only after three years and depends on the findings of a survey of general practitioners' expenses conducted by the Inland Revenue. Any errors in delivering gross income are (as happened with last year's overpayment) apparent earlier. The review body has an explicit mechanism for dealing with underpayments or overpayments of net income. In any one year 5% of average net income or 20% of new money (whichever is the smaller) may be recovered from or added to the current year's award.

Before the 1990 contract the pay system worked smoothly, regularly delivering within 2% of the expected net figure. Any underpayments or overpayments were made good by the government or the profession, with little impact on subsequent awards and no fuss. Predicting that the new contract would disrupt this steady state was not difficult: all the elements already mentioned—manpower, uptake, and expenses—were liable to change significantly and unpredictably.

Last year there were fewer general practitioners than forecast to share total remuneration, leading to a larger average income than intended. Workload under the new contract exceeded all expectations, particularly in the newly remunerated fields of minor surgery, health promotion, and procedures rewarded by target payments. This led to greater uptake than had been predicted. Expenses remain the unknown quantity, and these may alter the eventual size of the overpayment.

The overpayment would not have been as high as £5951

had it not been for two special factors affecting target payments. Firstly, despite a review body recommendation to the contrary, the government included the premiums on higher rate target payments within average net remuneration for the first nine months of the financial year. Although these were expected to average £400 per doctor, the actual yield from higher rate target premiums for the full year has been over £2000. Their inclusion for three quarters of the year has contributed £1400 to the overshoot. Secondly, government accounting convention dictates that payment for work done in any given year must be brought to account in that year, regardless of when it was actually received.

This affects target payments because the Department of Health agreed to initiate the scheme with a one off double payment. (If it hadn't then because payments are made one quarter in arrears doctors would have received only three quarters of what they were due in the first year of the contract.) Accruals based accounting, however, has pulled into the first year of the contract payments made to doctors in June this year—meaning that the equivalent of five quarters' payments is being included in calculations for 1990-1. This has contributed another £700 to the overspend.

These are essentially technical problems capable of solution. Much is at stake: clawing back large amounts of money from future pay awards will surely threaten any cautious acceptance of the new contract that may be building up. But there are more long term considerations. Should the receipts from work sensitive payments be regarded as a bonus or merely one more element affecting how a given pool of money is divided up? Can the current system withstand the stress that an overpayment of this size (12% of average intended gross income) imposes on it? Arguments for change are included in two GMSC publications, *Building Your Own Future* and *Your Choices for the Future*. General practitioners will surely want to participate in this debate.

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3 General Medical Services Committee. *Your choices for the future*. London: GMSC, 1991.