VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Should we use pay incentives for shortage specialties?

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The crisis in recruitment and retention of the clinical workforce is the biggest threat to the viability of the health service in the UK. This stark reality has been acknowledged by think tanks, royal colleges, unions, professional organisations, and NHS leadership bodies.¹⁻³

One in 10 medical vacancies is unfilled,⁴ and in the annual British Social Attitudes survey the public cited staff pressures and shortages as key concerns. Some clinical specialties are struggling especially hard to fill posts and to retain staff close to retirement age, with big geographical inequities.⁵ We need a whole variety of actions to train, support, re-enthuse, and retain more staff.

Might pay incentives and differentials attract doctors to the hardest pressed specialties or to less popular parts of the country, especially with talk of workforce planning being devolved more to local systems?

In the UK, specialist doctors are salaried employees working to national terms and conditions, and training numbers in each specialty are centrally determined. Across specialties the salary progression scales are the same, and the average NHS pay of GP partners (though not salaried GPs) is of the same order as that of secondary specialists.⁶

Specialties with a high degree of on-call intensity or unsociable hours do have this recognised to some extent, in on-call premiums.^{7,8} The NHS also allows for limited use of recruitment and retention premiums,⁹ and some specialties offer the opportunity to boost NHS earnings with private practice.¹⁰

But the NHS doesn't have the huge discrepancies between, say, the tertiary care interventionism and primary care generalism seen in some health systems with greater marketisation or where specialist doctors are contractors, not employees.^{11,12} So, why not deliberately decide to pay (for instance) emergency, intensive care, acute internal, or geriatric medicine doctors, or GPs, half as much again as the largely outpatient specialties with limited out-of-hours work and less intensity? Why not also liberate hard pressed regions by adding local premiums?

Here's my best guess at the arguments against.

The NHS benefits from a sense of solidarity and commitment to a national service. The approaches above might accelerate divide and rule, set specialties against one another, and further fragment the workforce. They might also allow better funded or more successful institutions or localities to game the system and merely increase disparities in the number and quality of staff.

Most of all, I don't think that people who are drawn to some of those areas of practice—struggling with work intensity and recruitment, unable to offer much private work—are much motivated by financial gain in the first place. They're more attracted by the nature of the work and their affinity with it, and I'm not sure that we'd want people to pick them simply for pay.

I suspect that we need to play closer attention to factors other than pay, especially when you consider what NHS doctors say about their motivation, wellbeing, and morale. That may be childcare, flexible working, better opportunities for career breaks, or sabbaticals. Or it may be personal development, compensatory rest periods, and portfolio careers so that they don't find themselves burnt out, disengaged, or leaving altogether.

Maybe I'm wrong. If so, please send a rapid response. It's a conversation we need to have.

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