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Review Body on Doctors' and Dentists' Remuneration Eighth Report 1978

Chairman:
SIR ERNEST WOODROOFE

Presented to Parliament by the Prime Minister
by Command of Her Majesty
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REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

The Review Body on Doctors' and Dentists' Remuneration was appointed in July 1971 to advise the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service.

The members of the Review Body are:

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The Secretariat is provided by the Office of Manpower Economics.

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CHAPTER 1

INTRODUCTION

1. The Chairman's letter of 7 December 1977[1] to the Prime Minister contained our views on a request from the medical and dental professions that we should carry out an interim review of their remuneration, and indicated our intention to make known in our next report the levels of remuneration that would bring doctors and dentists in the National Health Service into an appropriate relationship with other professional groups at 1 April 1978. As we explained, we take this unusual step on this occasion in an effort to secure just treatment for the medical and dental professions, in the light of the continuing deterioration of their position in the pay structure generally, which strict application of the Government's current guidelines[2] will do nothing to halt: it is also necessary, in our view, in order to restore confidence in the effectiveness of the present review system. In reaching this conclusion, we were influenced by three main considerations: first, the need to reverse the serious decline in morale that has accompanied the decline in pay and standards of living relative to others in comparable walks of life since 1975; second, the existence of anomalies and associated injustices which have been created in the medical and dental pay structures by the restraint measures—which, from our experience, we judge to be greater than in almost any other single field; and third, the fact, which the Government recognises, that the guidelines on pay do not provide enough scope both to tackle the anomalies and to provide for a general increase which would prevent further ground from being lost vis-a-vis the rest of the community. Moreover, one result of the various measures designed to bring inflation under control since 1975 has been that, at the level of incomes earned by the majority of doctors and dentists, purchasing power has been eroded steadily. Our proposals are not designed to provide a means whereby doctors' and dentists' incomes can be exempted from this process, but only to ensure that they do not fare worse than other professions and occupations. Our judgment of *fully up-to-date levels of remuneration* based on present evidence are indicated in this report in *italics* beside levels of pay consistent with the Government's guidelines which, in our view, are a minimum requirement for implementation from 1 April 1978. Our detailed recommendations are in Appendix A.

2. This is the fifth time since 1971 that we have carried out our main review against a background of general pay restraint, and it is now three years since we were last able to bring the remuneration of doctors and dentists into the

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[1]Hansard, Volume 941, No. 33 of 9 January 1978, column 668-671.

[2]"The Attack on Inflation after 31 July 1977"—Cmnd. 6882, July 1977.

relationship that we judged appropriate with the pay of other professional groups. We are in no doubt about the overriding importance in the national interest of bringing inflation under control, and of the need for general economic measures to deal with the situation. But we have been greatly concerned that the form of the measures as they apply to incomes has been designed to fit a shop floor situation in industry, and has failed to come to grips with the very real problems that have been created at higher levels of remuneration and in other fields—including the one for which we are responsible. The plain fact is that the pay structure for the medical and dental professions has been seriously distorted as a result of the impact of the 1975 and 1976 restraint measures, and their remuneration has fallen progressively further behind that of their recognised counterparts in April 1975. We described the position in some detail in our Seventh Report[1] last year, and we drew attention to the consequences of failure to restore a rational and orderly pay structure. We urged then that sufficient flexibility should be provided in the measures then under consideration for introduction from 1 August 1977 to enable us to make a start on restoration of order to the structure. The provisions of the current guidelines on pay indeed allow a measure of flexibility within an overall rate of increase in earnings of 10 per cent. Where appropriate, self-financing productivity schemes can be introduced outside the overall limit at any time after 31 July 1977, without infringing the overall requirement that a 12 months interval must elapse between pay settlements. This illustrates the fact that, once again, the measures are directed primarily at industrial situations: and, to the extent that use is made of this provision in improving salaries outside the National Health Service at the levels with which we are concerned here, the pay of doctors and dentists will inevitably again decline relatively. The concept of a "self-financing productivity scheme" is not and cannot be appropriate to the basis of remuneration for a profession whose continuing concern is with the prevention and control of disease and with the care and treatment of patients.

3. The passage of time since 1960 has not lessened the importance of the Royal Commission's aims in recommending the present form of review machinery. They are as vital today as they were then: the avoidance of disputes between Government and the professions over remuneration; the provision of an assurance to the professions that their remuneration would be settled on a 'just' basis; and the provision of a safeguard for the taxpayer against unreasonable demands by the professions. But the guidelines do not permit more than a start to be made on dealing with the worst of the anomalies that have been created by the 1975 and 1976 restraint measures: in particular, they do not enable any move to be made towards restoring the position of those groups who, as a direct result, have experienced a deterioration in their earnings relative to other groups which previously had been at comparable income levels. We drew attention in our Seventh Report last year to the substantial shortfall in doctors' and dentists' remuneration that already existed in April 1976 by comparison with our April 1975 judgment. In the year to April 1977, the shortfall increased significantly and a further deterioration in

[1] Review Body on Doctors' and Dentists' Remuneration, Seventh Report, 1977—Cmnd. 6800, May 1977.

their relative position will have taken place by April 1978, in part because self-financing productivity arrangements have been a feature of many outside pay settlements since 31 July 1977 in addition to increases within the overall limit of 10 per cent. Some of the increasing shortfall can also be explained by the fact that, in general, earnings drift in the medical and dental pay structure is confined to the training grades, whereas the indications are that it is more extensive outside. It is the failure to take account of the need to correct these injustices that, in our view, is the principal cause for the decline in the morale of the medical and dental professions over the last three years. We have said before—and we repeat now, because the position has undoubtedly worsened—that, if this decline is not reversed, the consequences for the National Health Service and for the community as a whole will become increasingly serious.

4. We are aware that doctors and dentists are not the only group affected by the injustices that we have outlined: all of the public services at comparable levels have been affected in much the same way, but not to the same extent, because of the differences of pay structure. But the community can ill afford to prolong indefinitely a situation in which the rewards of those whose responsibility it is to provide care for the health of the community are left to lag substantially behind rewards in other fields, some of which may not be as essential to the general needs of the community. We accept that it may not be possible for the injustices to be corrected in one step and that the economic situation may require their correction to be staged. We note that, in a settlement elsewhere within the public services, recognition of the cumulative shortfall position of the group concerned has been given, together with an assurance by Government that it will be rectified within a period of two years. We have given careful consideration to the period over which the introduction of up-to-date pay levels for the medical and dental professions should be staged and, in our view, no less favourable conclusion can be defensible in relation to the pay of doctors and dentists. We see the introduction of the rates of pay which we indicate in this report, up-dated as appropriate, at the earliest practicable opportunity, and in any case not later than 1 April 1980, as essential to the maintenance of an effective and efficient National Health Service for the benefit of the community as a whole. This will necessitate a move at least midway towards the re-establishment of the appropriate relationship between the medical and dental professions and other occupations no later than our 1979 review. Unless an assurance is given that this will be done and that the pay rates that we judge to be right now will be brought fully up-to-date and implemented by 1 April 1980, we do not believe that it will be possible to re-establish confidence in the effectiveness of the present review system for settling medical and dental remuneration on a just basis or, indeed, to restore the confidence of the professions in their part in the National Health Service. In these circumstances, an independent Review Body cannot function in the way recommended by the Royal Commission in 1960 and accepted by Government.

CHAPTER 2

THE EVIDENCE

5. We have considered written and oral evidence from the Health Departments on behalf of the Government and from the Review Body Evidence Committee of the British Medical Association (the Joint Evidence Committee) and from the British Dental Association on behalf of the medical and dental professions[1]. We have again discussed particular problems with the Secretary of State for Social Services and the Parliamentary Under-Secretary of State for Scotland. We have also received written submissions from the Junior Hospital Doctors Association, from the Association of Scientific Technical and Managerial Staffs on behalf of its junior hospital doctors' section, from the General Dental Practitioners' Association and from individual doctors and dentists.

6. The Joint Evidence Committee have told us that the morale of doctors and dentists has never been lower since the introduction of the National Health Service some 30 years ago: the sense of frustration created by the unfair way in which the professions felt that they had been treated was now heightened by a growing mood of militancy and disillusionment, which would have serious consequences for the standards of medical care in the National Health Service if it were not remedied. They drew our attention to the problems that have arisen over the last 30 years in relation to questions of medical and dental remuneration. They had hitherto accepted the constraints of Government incomes policies, but they indicated that they were no longer prepared to acquiesce in the current measures which, in their view, discriminated unfairly against doctors and dentists. They asked us to ensure that the anomalies created by the restraint measures would be corrected, and that their financial position in relation to those who had been at comparable levels in April 1975 would be restored before it was too late. They estimated that this would require an overall increase in remuneration in excess of 30 per cent, and they told us that the response to their proposal would be a major factor in deciding the quality of the professional medical services in the National Health Service over the next 10 years. They took the view that, if our recommendations for the current year were to be framed in such a way as to provide an immediate increase within the Government's current overall 10 per cent guideline, they would prefer an

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[1]The Review Body Evidence Committee of the British Medical Association represents the Central Committee for Hospital Medical Services, the Hospital Junior Staffs Committee, the General Medical Services Committee and the Central Committee for Community Medicine. Representation on these committees is open to all doctors regardless of whether they are members of the BMA. By agreement with the BDA, the Joint Evidence Committee also represents dentists in the hospital service. The BDA presents evidence on behalf of general dental practitioners and community dentists.

across the board increase for each group, without correction of anomalies. In this event, they asked us to indicate the latest date by which fully up-to-date pay rates should be implemented. They also asked us to recommend that the up-to-date rates should be used as the basis for calculation of pensions. They repeated their request that we should make provision for offsetting inflation during the coming year: they suggested that this could be done either by recommending levels of pay appropriate to the mid-point of the review period or by making retrospective payments to compensate for inflation during the previous six months.

7. The Joint Evidence Committee reported that there was no certainty that agreement would now be reached on a new contract for hospital consultants as they had hoped, and they put forward a number of proposals for improving the remuneration of the career grades. They asked if we would be willing to price a new contract for consultants on a 1 April 1978 basis if agreement were reached on its form before the next review. They also reported that they hoped to discuss with the Health Departments a new contract for medical assistants, along the lines of the proposals for consultants, and they asked us if we would be willing to price it on a 1 April 1978 basis, assuming that agreement would be reached in parallel with agreement on a new consultant contract. They proposed that the number of increments in the medical assistant scale should be reduced from fourteen to six to reflect the 1975 shortening of the consultant scale. They asked us to change the basis of our recommendations for junior hospital doctors and dentists to relate the basic salary scales to the standard working week of 10 UMTs (40 hours), and to recommend that the Class A UMT rate should be not less than the standard rate. They reported that they had negotiated an additional week of annual leave for senior house officers and registrars with the Health Departments with effect from 1 April 1978 which, under the current restraint measures, had to be counted against the pay limits. They drew attention to what they saw as additional responsibilities of general medical practitioners through the provision of continuing care in the community, and asked us to recognise this in our recommendations on remuneration. They also asked us to re-assess the level of payments for the out-of-hours responsibilities of general medical practitioners. They drew our attention to proposals for a new contract for community medicine trainees which had been put forward by the Health Departments, and they asked us to price them. They also referred to a study by the Organisation for Economic Co-operation and Development, which showed that, in 1974, the ratio of the earnings of doctors to the average of all workers was lower in the UK than for the average of eleven member countries for which information was available.

8. The British Dental Association expressed the view that the sacrifices made by the medical and dental professions had been disproportionate, and suggested that special steps outside the current guidelines were justified to put medical and dental pay on course. They referred to our December 1977 judgment of the shortfall since April 1975 in the earnings position of doctors and dentists, and estimated that an increase of more than 30 per cent would be required to bring general dental practitioners' remuneration into line with the rewards of other

comparable professional groups at April 1978. They suggested that the pensions of dentists who had retired since April 1975 should be increased with retrospective effect, to compensate for the estimated shortfall in their earnings before retirement by comparison with comparable income groups. They proposed that remuneration which had been lost through the application in 1975 of the £8,500 earnings ceiling on all pay increases should be restored. They asked that our recommendations should establish an up-to-date level of target average net income for general dental practitioners. They also asked us to recommend that the benefit (or loss) from changes in output within the standard hours from year to year should accrue to (or be borne by) dentists. They referred to the impasse that had arisen within the Dental Rates Study Group over the revision of the fee scale for 1977-78 as a result of disagreement over the principle of retrospective correction of expense forecasts, and asked us to recommend that the Dental Rates Study Group should abandon the use of retrospective correction. They suggested that the link between the salary scale of dental officers in the community health service (and between the scale of salaried health centre dental practitioners) and the scale of assistant dental surgeons should be at least two increments higher, and proposed that in future the pay of area dental officers should be adjusted by reference to the pay of community medicine specialists instead of, as now, to area medical officers. They also provided us with statistical information on the trends in dental care, treatment costs, manpower and movements in dental earnings and fees in Australia, Canada, New Zealand and the USA.

9. The Health Departments did not make specific proposals for the level of increase justified now in the remuneration of doctors and dentists. They expressed reservations about the reliability of comparisons of movements in pay based on New Earnings Survey data, and suggested that the estimates of the shortfall in doctors' and dentists' remuneration made in our Seventh Report and in the Chairman's 7 December 1977 letter to the Prime Minister were too large. They drew our attention to the Government's guidelines on pay increases, and referred to the effect of policy measures in the last year to maintain living standards through reductions in income tax and the improvement of child benefits. They explained that, so far as the Government's guidelines were concerned, it was open to us to recommend different levels of increase for different parts of the professions, provided that the overall increase for all doctors and dentists was within the overall limit, and that it might be necessary to tackle the anomalies that have been created in the last two years on a phased basis, or to leave some of them for consideration in a future year. It was their preference that we should leave to the Government the timetable for the implementation of the fully up-to-date pay rates that we had said we would make known to the Prime Minister. They asked us to make a move towards the restoration of a sensible differential between the consultant's scale and the earnings of junior hospital doctors and dentists, and asked that we should consolidate into the net remuneration of general medical and general dental practitioners the cash supplements that we recommended in April 1976 and in April 1977. They explained that the restraint measures required improvements in conditions of service to be counted against the pay limit, but that provision for the reimbursement of expenses could be kept in line with

the underlying movements in costs, and that expenses which had previously been reimbursed through fees and allowances could be made directly reimbursable without having to count against the pay limit. They asked us to make known our view both on the principle of making retrospective adjustment to correct for over-estimates or under-estimates of general dental practitioners' expenses and output made by the Dental Rates Study Group, and on the methods at present used. They asked us to recommend a 'sessional fee' for dentists who provide emergency dental services organised by health authorities. arrangements for community medicine trainees which had been recently agreed They also asked us to make recommendations related to new contract with the profession. They provided us with statistics on manpower, workload and detailed payments to doctors and dentists in the year to 31 March 1977.

CHAPTER 3

OUR GENERAL CONCLUSIONS

10. We now describe the general conclusions that we have reached in the light of the evidence submitted to us. We have given full weight to the view of the professions that their remuneration ought to be brought fully up-to-date with effect from 1 April 1978. Equally, we have had full regard to the importance that the Government attaches to limiting the general level of pay settlements to within 10 per cent overall in the common interest of reducing inflation. Since we share the view of the Royal Commission that it would be wrong for doctors and dentists to be singled out and used to give a lead in the community in matters of remuneration[1], we have sought information from the Health Departments on the pattern of major settlements at all levels of income since the introduction of the current measures. This information shows that, in a very small number of settlements, groups of workers—mainly manual—have secured increases in excess of an overall 10 per cent, but that the great majority of settlements—those covering 95 per cent of some 3½ million employees who had settled by mid-March—have been within the guidelines. In particular, no settlement that covers employees in the public sector has been outside the guidelines, and settlements in the NHS itself so far have been at the overall level of 10 per cent. In all cases where cash supplements have been consolidated into basic pay, or where improvements have been made in conditions of service such as holiday entitlement, the cost has been included in the overall cost of the settlement. In addition, self-financing productivity schemes covering some 650,000 workers have been introduced, of which just under one-half are in the public sector. We have already made plain that we see it as essential for a substantial move to be made towards bringing the pay of the medical and dental professions into an appropriate relationship with that of other professional groups in 1979. In the circumstances, we are in no doubt that there is a clear case now for increases in remuneration up to the limit of the Government's guidelines on pay, for the following reasons: first, to remove at least some of the anomalies that permeate the medical and dental pay structure; second, to minimise the substantial shortfall between doctors' and dentists' earnings and the earnings of other professional groups by comparison with our April 1975 judgment; and third, to offset at least some of the further rise in the cost of living over the last twelve months which has added to the decline in the professions' standards of living since April 1975. We discuss each below.

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[1]Report of the Royal Commission on Doctors' and Dentists' Remuneration 1957-60—Cmnd. 939, February 1960 (paragraph 28).

11. We have already made known (in the Chairman's letter of 7 December 1977 to the Prime Minister) our intention to make a start on the restoration of order to the pay structure and the elimination of injustices within that structure. Unlike the 1975 and 1976 measures, the current guidelines do not provide fixed limits on what individuals may receive, but are applicable on an overall basis. The professions have indicated that, in recommendations that reflect the guidelines, they would prefer us to treat each main group of doctors and dentists separately as a group, each with its own entitlement to a 10 per cent overall increase. We have concluded, however, that it would not be right to do so. Three of the four main groups—consultants, general medical practitioners and general dental practitioners—have fared much worse than the fourth—junior hospital doctors and dentists—in relation to comparable income groups since April 1975[1], and we regard it as important to take account of the individual position of each group, and thus to take a positive step towards fulfilment of the general aim of restoring order to the pay structure as soon as possible.

12. Our recommendations provide for the correction of the structural distortion created by the application of the £8,500 earnings ceiling in 1976, for the consolidation of the 1976 and 1977 cash supplements into salary and fee scales, and for the restoration of the established systems of remuneration for general medical and general dental practitioners. On this occasion, too, we have been able to change the basis of remuneration for the hospital training grades, and to relate the salary scales to the standard working week of 10 UMTs (40 hours), as we have been asked by the professions and the Health Departments to do. We have also restructured the medical assistant and assistant dental surgeon scale at their request. In addition, we have taken account of the cost of the improvements in conditions of service for junior hospital doctors and dentists and for community doctors and dentists which have been agreed between the professions and the Health Departments for introduction with effect from 1 April 1978. We regard the implementation of the second stage of the April 1975 increase in salaries above £13,000 a year as a separate issue. The further deferment of those increases was a direct result of the introduction of the restraint measures in July 1975, and not of the form of those measures. We see no justification for the continued withholding of part of increases that were accepted by Government some *three years* ago, and we are in no doubt that they ought to be implemented independently of the restraint measures.

13. In our Seventh Report, we estimated that the overall earnings for the medical and dental professions at April 1976 (after taking into account the recommendations in the Sixth Report) were on average some 10 per cent behind comparable income groups, by comparison with the revised estimate of the position at April 1975. Since then, we have assessed the shortfall position in the light of information from the April 1977 New Earnings Survey. We estimate that, on a total earnings basis for the medical and dental professions as a whole (after taking into account our recommendations in the Seventh

[1]The pay of the hospital intermediate career grades, of community doctors and dentists, and of ophthalmic medical practitioners move in line with the main group of hospital doctors and dentists at comparable levels.

Report), the shortfall increased by some 5 per cent between April 1976 and April 1977, and amounted to over 15 per cent at April 1977. It ranged from near-parity on average for junior hospital doctors and dentists as a group, to nearly 20 per cent for consultants on the scale maximum, and on average for general medical practitioners and general dental practitioners: our estimate of the detailed position is in Appendix B.

14. The Health Departments have drawn attention to limitations on the accuracy of the New Earnings Survey data as an indicator of the level of pay settlements which make comparisons over short periods unreliable; in their view, such a comparison needs to be made over at least five years to provide a reliable picture. They have also referred to the fact that changes in the national pay structure and in the medical and dental pay structures can distort comparisons, and have drawn our attention to a seeming drift in the earnings of doctors between April 1976 and April 1977 and to a seeming improvement in them relative to the earnings of all men between April 1973 and April 1977 on the basis of the figures for 'medical practitioners' in the New Earnings Survey. Furthermore, they have argued that movements of comparable income groups ought to be compared on the basis of an August-August pay year as this has been the annual pattern for settlements at a common level of increase since 1975.

15. As we have said before[1], we are aware that the information in the New Earnings Survey has limitations for our purposes: for example, it is restricted to the employed population only; it covers only one in every one hundred employees, so that the numbers in the sample at the highest salary levels are small; and the value of superannuation arrangements and of other benefits that are relevant to total remuneration is not reflected. It also excludes earnings due at the survey date from settlements that have been reached subsequent to it and are then back-dated. Experience suggests that the overall effect of this factor is not generally significant, particularly in the longer term, but on the occasions when the difference has been significant, we have made adjustments to reflect known major settlements to ensure that we have as accurate a picture as possible. Furthermore, salaried doctors and dentists are included in the population samples for the survey: although the effect of movements in their earnings on the comparisons is also not significant, particularly in the longer term, we make a small adjustment based on the data for 'medical practitioners' to exclude as far as possible the effect of movements in their earnings from the earnings with which we make our comparisons. However, we do not use the earnings of these 'medical practitioners' as the basis for our comparisons, because they relate to a very small number of individuals only—230 or just under one per cent of the 24,000 full-time hospital and community doctors but less than one half per cent of a total of 63,000 doctors in the National Health Service—and they do not include any part-time hospital and community doctors or any general medical practitioners, who are regarded as self-employed, and who total 24,000, which is a very substantial proportion of the total number within our terms of reference. Moreover, the NHS doctors'

[1]'Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 9).

earnings that are reflected in the New Earnings Survey invariably exclude pay increases that are due to them, but that have not been paid at the time when the survey is carried out, because the April-April timing of our reviews precludes the implementation of our recommendations until after the survey information has been collected. We estimate that this latter factor accounts almost wholly for the element of seeming drift in doctors' earnings between April 1976 and April 1977, and of seeming relative improvement in them between April 1973 and April 1977 as shown by the figures for 'medical practitioners' to which the Health Departments drew our attention.

16. Changes in the general structure of pay are, of course, reflected in the information in the New Earnings Survey. But the effect of changes from regrading, or scale restructuring, or for other reasons, is unlikely to be significant, except in the longer term. On the other hand, grading changes which reflect changes in numbers in different grades are not reflected in the earnings figures used for doctors and dentists in our comparisons which are based on the manpower structure at the time when remuneration was last brought up-to-date in relation to other professional groups. However, examination shows that average earnings of hospital doctors and dentists have not been affected to any significant extent by structural changes over the period since 1975 (or since 1972). In addition, the Health Departments have told us that earnings have again been examined for any drift as a result of the payment of increments within scales: as in 1976 and 1977, this has been found to be negligible. In making our comparisons, we exclude from our assessment of consultants' earnings additional remuneration from fees for lectures, domiciliary and exceptional consultations, family planning work, and other official work: we are not provided with detailed information on the extent of the payments involved, but we understand that they are small. We also exclude income from contraceptive services from our assessment of general medical practitioners' remuneration, since the extension of these services to patients in social need in 1975 involved new and extra work and we saw it as right to treat it separately from intended average net remuneration, at least in the early stages. Even if reliable and up-to-date figures were available for private practice earnings of doctors and dentists, we would not regard it as appropriate to include these in total earnings, since we are concerned with the remuneration for NHS work: past figures show that, except for part-time consultants, the amount is in any case relatively small.

17. We have always recognised that the information in the New Earnings Survey cannot be used to provide an exact measurement of the difference in movements of doctors' and dentists' earnings from those at the same income levels outside. Clearly, the longer the period over which comparisons are made from a baseline, the smaller will be the effect of errors arising from uncertainties about the information, particularly on the timing of settlements and, as a cross check in the process of making our judgments, we have looked back to 1972 and earlier (to 1960). Nevertheless, as we have said before, April 1975 is the baseline for our judgments since that was the last occasion on which the remuneration of the medical and dental professions was brought fully up-to-date in relation to pay in other occupations. We regard the New Earnings

Survey as the best and most up-to-date yardstick available with which to make comparisons of general movements in earnings at the levels with which we are concerned, but it provides part only of the evidence on which we make our judgments.

18. Our 1975 recommendations, like all our recommendations both before and since, were designed to take effect from 1 April and, if we were to have based our comparison then on an August-August pay year basis, it would have meant that we should have had to take account at some stage in our considerations of the expected level of settlements between April and August 1975. As we made clear in our 1971 Report[1], when we decided to carry out our reviews at more frequent intervals than had been the practice previously, we considered that it would be wrong to anticipate inflation since to do so would contribute to further inflation, and our judgments of levels of pay have therefore been designed to be right at the time from which they are put into effect. While the general level of pay increases since August 1975 has reflected settlements on an August-August pay year basis, in line with the timing of the three successive rounds of restraint measures, the extent to which this concept of a 'pay year' can legitimately be superimposed on a system of annual reviews effective from 1 April each year is open to question, particularly when a recent (1975) review resulted in a deliberate adjustment in the level of relativities. But it is our function to assess the relative position of doctors and dentists in the pay structure generally at the time from which our recommendations take effect—that is, at 1 April—and we therefore see it as right to make our comparisons of movements in earnings on an April-April basis, bearing in mind the need for some adjustment. Again, we emphasise that we share the view of the Royal Commission[2] that it would be wrong for doctors and dentists to occupy a fixed position in the general pay hierarchy, or for their pay to be decided on the basis of some automatic formula. Other important factors are relevant: changes in the cost of living, the quality and quantity of recruitment to all professions, the need to retain highly qualified men and women in the service of the community, and changes in workload and responsibilities or in the working environment. We have looked again at all these factors in making our assessment of up-to-date pay levels.

19. We noted last year[3] that, like others in the community at comparable income levels, doctors and dentists had suffered a fall in their standards of living as a result of three main factors—the effects of inflation over the period 1975-1977, the redistribution of income brought about by the form of the restraint measures, and taxation at the higher levels. Since our last report, additional tax relief has been provided as part of the general measures to control inflation and to halt the fall in living standards. We now estimate that, between April 1975 and April 1977, the living standards[4] of a general medical

[1]Report of the Review Body on Doctors' and Dentists' Remuneration, 1971—Cmnd. 4825, December 1971 (paragraph 19).

[2]Report of the Royal Commission on Doctors' and Dentists' Remuneration 1957-60—Cmnd. 939, February 1960 (paragraphs 424 and 425).

[3]Review Body on Doctors' and Dentists' Remuneration, Seventh Report, 1977—Cmnd. 6800, May 1977 (paragraph 2).

[4]As measured by income after tax, including family allowances, at constant prices.

practitioner or general dental practitioner, or of a consultant with a few years seniority, married with two children under 11 years old, fell by some 18-19 per cent (Appendix C): this is slightly less than the estimate of the position that we made a year ago. The fall in living standards of junior hospital doctors and dentists (taking into account average income from extra duty allowances and Class A/B supplements) ranged from about 6 per cent for new entrant house officers[1] to about 9 per cent for senior registrars on the scale maximum. By comparison, the fall in the living standards of the average wage and salary earner was less than 5 per cent. Over the past year, the cost of living as measured by the retail price index rose by 9·5 per cent[2] and average earnings by 9·4 per cent[3]; the annual rates of increase from August 1977 are 6·5 per cent and 12·0 per cent[4] respectively. Because of the timing of the introduction of the restraint measures and the greater extent of earnings drift elsewhere in the community, the fall in the living standards in terms of the real disposable income of doctors and dentists (other than those in hospital training grades) has been greater than for many others in comparable walks of life, and will continue to compare unfavourably until action is taken to restore them to the position in the pay hierarchy that recognises their current value to the community.

20. We have considered the Joint Evidence Committee's proposal that provision to offset inflation during the coming year should be introduced, either by recommending levels of pay appropriate to the mid-point of the review period or through retrospective payments in respect of the current year equal to half of the increases in the recommended levels of pay for the review period. The first proposal would involve a return to the practice of our predecessors, which we discarded as inappropriate in 1971, when we decided to carry out reviews at annual intervals instead of every two to three years, as had been the previous practice. As we said in 1975, when this proposal was last put forward[5], our view that it would be wrong to provide for inflation in advance remains unchanged, as to do so would itself be inflationary. Nor do we consider that retrospection of the kind proposed is justified: our judgments of levels of pay are designed to be right at the time from which they are put into effect. We agree with the view expressed by the Royal Commission in 1960 that retrospective payments are not appropriate in principle for doctors and dentists[6]: for the same reasons, we do not consider as justified either the proposal from the British Dental Association that the pensions of dentists who have retired since April 1976 should be increased, since this would imply retrospective adjustment of the super-annuable earnings on which their pensions were based, or the proposal from the Joint Evidence Committee that those senior hospital medical and dental

[1]Single.

[2]Twelve months to February 1978.

[3]Twelve months to January 1978 (New Series covering whole economy).

[4]Figures of the underlying trend in average earnings may be less reliable than in previous years because of delay in reaching settlements due in the last six months of 1977 and the effect of subsequent bunching on settlements and of back-payments.

[5]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 17).

[6]Report of the Royal Commission on Doctors' and Dentists' Remuneration 1957-1960, Cmnd. 939, February 1960 (paragraph 395).

officers who were excluded from a 1973 review, but who were regraded in a 1975 review, should now be paid compensation in respect of the notional loss of earnings in the years between the two reviews. We have considered the Joint Evidence Committee's request to us to recommend that the pensions of those who retire after 1 April 1978 should be calculated on the basis of the up-to-date levels of pay which we make known in this report, in the same way as was done in 1975 in relation to increases which took salaries over £13,000 and were staged, both in this field and in some other parts of the public services. As in 1975, the problem will inevitably extend to a much wider field than doctors and dentists in the National Health Service, and we see this as a matter for Government to consider on that basis. But we draw attention to the life-long implications of retirement on artificially restricted salary levels which will not necessarily be balanced in the years ahead by the undoubted advantage of an inflation-proofed pension.

21. We drew attention last year to the need to consider the problems created by the serious imbalance in the hospital staffing structure. The Health Departments have told us that the joint view of the professions and themselves is that service needs should be met primarily by doctors in career posts, and that the number of training posts should be decided by future career opportunities. They recognise that the hospital service depends heavily at present on doctors in training, a substantial proportion of whom come from overseas, but this has been because the rate in the growth of demand has not been matched until recently by expanded output from the medical schools. They expect that the increasing number of medical graduates will eventually enable the hospital service to be staffed mainly by British-born doctors, and with a higher proportion in the career grades than at present. They recognise that restoration of balance in the hospital staffing structure will require changes in the organisation of medical work in the hospital service. The expansion of the medical schools has given rise to a certain amount of difficulty in relation to the provision of an adequate number of pre-registration house officer training posts to meet the increasing number of medical graduates; this problem has now been considered by a working group composed of representatives of the Health Departments, the universities and the health authorities, and targets have been set for the number of posts required in each region over the next five years to take account of the expected output of medical graduates and to provide a small margin in addition to give a measure of flexibility and choice. There are already indications that the degree of dependence on overseas doctors in staffing the hospital service is beginning to decline, because the number who come to this country for training is falling; the number of temporarily registered doctors reached a peak in 1975, and since then the trend has been downwards. This change in trend accentuates the need to create more career posts to meet service requirements.

22. The profession have confirmed that it continues to be much more difficult for doctors who want to do so to practise in Canada and in the USA because of restrictions and because of the increasing number of their own medical graduates. However, there has been no sign of change yet in the net outflow of fully registered and provisionally registered United Kingdom and

Irish-born doctors which, in 1977, continued at around the higher level that was reached in 1974 and has been maintained since. The number of British-born doctors who, when leaving the National Health Service, have expressed their intention to emigrate increased last year and was the highest total for at least seven years—surpassing the previous peak in 1975. New opportunities for medical employment have opened up in the Middle East, but there is no evidence yet of a trend towards emigration to other EEC countries, and the number of specialist certificates issued by the General Medical Council to enable doctors to practise in member countries remains small. World demand for doctors in certain specialties—for example, anaesthetics, radiology and pathology—remains high and could have consequences for the National Health Service. We shall continue to keep the situation under review.

23. The output from the medical schools has been growing steadily since the 1968 expansion. The proportion of women graduates has risen over that period and reflects the increasing percentages of women students admitted. Since 1974, the output of men graduates has remained virtually unchanged; and women graduates have accounted for the growth in total output. This situation is likely to continue at least until 1980. At present, nearly one in three newly qualified doctors is a woman, and the proportion of women may rise further in future. In considering the future structure of medical services, it will be important to provide adequate career opportunities in the National Health Service for the increasing number of women doctors who want to practise, but some of whom will have domestic and family commitments which may limit the degree of service that they can give at a particular stage of a career.

24. The *fully up-to-date levels of remuneration* at 1 April 1978, which we indicate in *italics* in Chapters 4–7 side-by-side with our current recommendations at that date, represent our judgment of what is required to bring the remuneration of the medical and dental professions into a proper relationship with the rewards in other occupations at 1 April 1978, taking account of all the relevant factors. We emphasise the inherent importance of achieving those rates of pay, brought further up-to-date at least annually, not later than 1 April 1980. Meanwhile, we put forward recommendations for implementation with immediate effect at 1 April 1978, that represent an overall increase in remuneration of 10 per cent. We have distributed the total amount available within the guidelines in a way that reflects the individual differences between the current rates of pay (including the 1976 and 1977 cash supplements) and those that we regard as fully up-to-date for each main group[1]. Before considering the increases in basic pay for the different groups, we have taken account of the cost of the correction of those anomalies within each group that we consider must be dealt with now, and also of the cost of the introduction of improvements in conditions of service which have already been agreed. Thus each individual group will have borne the cost of correcting anomalies within that group and of improving its own conditions of service: at the same time, a step will have been taken towards restoring order to the pay structure. On the occasion of our review next year, we intend to look again at the levels

[1]See paragraph 11.

of pay that we have indicated as being fully up-to-date in our judgment at the present time, and to re-assess them at that time. We shall again examine the shortfall position since April 1975 relative to comparable income groups at that time. Meanwhile, we draw attention to the fact that, on the evidence that is becoming available on the pattern of increases generally since 31 July 1977, a further relative falling back is inevitable: the most recent assessment of the position made in the Bank of England Quarterly Bulletin of March 1978 is that, after allowing for "the changing composition of the labour force, productivity schemes, job mobility and other wage drift, earnings seem likely to rise by 13 per cent or more in the current wage round"[1].

[1]Other recent forecasts of the increase in earnings over the period broadly covered by the current guidelines include:

The National Institute of Economic and Social Research—National Institute Economic Review, Number 83 (February 1978): 15 per cent.

London Business School Centre for Economic Forecasting—Economic Outlook 1977-1981, Volume 2, Number 5 (February 1978): around 15 per cent.

Phillips and Drew—Economic Forecasts (March 1978): about 15 per cent.

CHAPTER 4

HOSPITAL DOCTORS AND DENTISTS

25. The total number of hospital doctors in England and Wales increased by 2.8 per cent to 32,221 in 1977[1]: this is in line with the increase in 1976, but rather less than in each of the two previous years. The increase in overseas-born doctors was again less than the increase in UK and Irish-born doctors, and the proportion declined marginally from 34.6 per cent in 1976 to 33.7 per cent in 1977. The number of medical consultants increased by 122 or 1.0 per cent to 12,004: this is a significantly smaller increase than in any of the previous five years—the average over this period was 3.6 per cent—and is regarded as due mainly to the financial constraints imposed on employing authorities, but also in some part to the reluctance of some doctors to accept appointments that would involve a reduction in their income (for example, senior registrars on promotion to consultant, in present circumstances). The proportion of overseas-born consultants increased to 14.9 per cent last year from 14.7 per cent the previous year, but the proportion of overseas-born junior hospital doctors decreased to 45.5 per cent from 47.6 per cent the previous year. The number of temporarily registered doctors in the hospital service fell by 8.6 per cent in 1977 and is now 10.6 per cent of all medical staff. The average age on appointment as a medical consultant remained unchanged at 37½ years. The number of vacant medical consultant posts in England and Wales increased substantially from 686 to 819 in 1977. Although the proportion of vacant posts that were advertised remained virtually unchanged in 1977 and recruitment to advertised posts improved slightly, the number unfilled for more than a year (either because they had not been advertised or because they had not been filled as a result) increased from 278 to 356. The balance of the posts[2] that were not occupied by either a full-time or a part-time locum increased from 96 to 106, or 1.0 per cent of all medical consultant posts. At present, difficulty is being experienced in filling vacancies in anaesthetics, geriatrics, mental illness and radiology (as well as in community medicine), and there is a surplus of candidates for general medicine, general surgery, gynaecology and obstetrics, and paediatrics. As part of the proposals under consideration for a new consultant contract, the Health Departments have suggested that consultant posts which have been vacant for at least a year and have been advertised twice without attracting suitable applications should be re-advertised offering a starting salary at the scale maximum (subject to approval from the Department). The number of

[1]Figures in this paragraph relate to numbers in post at end-September in the year indicated.

[2]In whole-time equivalent terms.

dental consultants increased from 446 in 1976 to 468 in 1977, or by 4.9 per cent; the total number of hospital dentists increased by 3.4 per cent to 1,164 in 1977, compared with 1.5 per cent in 1976. The latest figures for hospital workload in Great Britain relate to 1976, and in that year the number of in-patients increased by 5.0 per cent and the number of out-patients by 1.1 per cent. These numbers reflect the levels in the years prior to 1975, which was the year in which the numbers of patients fell as a result of industrial action by some consultants over the issue of pay beds and by some junior hospital doctors over the introduction of their new contract.

26. We referred in our Seventh Report[1] last year to discussions which had been re-opened between the professions and the Health Departments on a new contract for consultants, which we hoped then could be brought to an early conclusion, as 5 years had already elapsed since consideration of a new form of contract first began. We understand that a substantial measure of agreement had been reached between the professions and the Health Departments by mid-November 1977, and that it had been the aim to include the new contract in the present review. In the event, this did not prove to be possible, and we have been asked to base our recommendations on the existing contract. However, the professions have also asked if we would be prepared to price a new contract on the lines under discussion, as an extension of the present review, if agreement were to be reached within a reasonable period.

27. We have given careful consideration to the professions' request, but we see difficulties about it in present circumstances. We have carried out this review on the basis of the existing 'open' contract arrangements and of a salary scale that, in principle, is intended to recognise all the duties and responsibilities of consultants other than those that attract payment of a separate fee—for example, for domiciliary consultations. Under the proposed 'closed' contract arrangements, a full-time consultant's basic commitment would be remunerated by a basic salary, and additional commitments would attract additional payment at the equivalent rate to the basic salary. Other duties and responsibilities would attract new allowances. On this basis, consultants with the heavier duties and responsibilities would receive higher remuneration, and those with the less heavy would receive lower remuneration than under the present contract arrangements, and the present single salary scale. The differences in remuneration of full-time consultants could be substantial. But, since protection of an individual consultant's position is envisaged through provision of an option to retain their present contracts, and we have no means of knowing at this stage how many would opt to do so, it is inevitable that the introduction of a new contract on these lines would involve an element of additional cost. The dilemma is clear, and we do not see how it would be practicable for us to consider a change of the significance contemplated other than when there is scope to accommodate the additional cost. We would in any case need to be provided with information on the likely pattern of contracted duties under the new arrangements and on the number of consultants expected to continue on the present contract.

[1]Review Body on Doctors' and Dentists' Remuneration, Seventh Report, 1977—Cmnd. 6800, May 1977 (paragraph 23).

28. Steps have been taken to provide us with detailed information on the existing pattern of consultants' work and responsibilities that we would need before we could consider the remuneration for a new contract that specified an individual consultant's working commitment. The only information available to us hitherto has been limited to a provisional and partial analysis of a survey which had been carried out in 1974 in connection with earlier discussions on a new consultant contract (but which had not been validated) and the outcome of a survey conducted in 1971 by the Regional Hospital Consultants and Specialists Association[1]. Only the main findings from each survey were available, and neither of them provided sufficiently detailed or up-to-date information on the pattern of work and responsibilities of consultants which would have enabled us to cost recommendations related to a new contract on the lines of the outline proposals then under discussion between the professions and the Health Departments. The Office of Manpower Economics therefore carried out a survey on our behalf in July 1977 to provide the information that would be needed to enable such a contract to be priced and also, at the request of the parties represented on the special Joint Working Group, to assist them in their discussions of the form of the contract. We are grateful to all those who co-operated in our survey: although (for various reasons beyond our control) the response was not as high as we had hoped at the outset, we are satisfied that the results provide a representative picture of consultants' present working commitments. The detailed results of the survey are in Appendix D.

29. It is clear from these results that the majority of consultants work longer weekly hours than is generally regarded as the normal working week in the community as a whole, and that a significant minority work unusually long hours. For example, full-time consultants reported spending on average 49 hours a week over a range of duties, and one in five a total of 56 hours or more. It is of course not uncommon in other walks of life for people at comparable levels of responsibility to work long hours, and to go through periods of working unusually long hours. But, in the main, they can plan ahead and tailor their life pattern to the incidence of this demand. The demand on consultants' time cannot be planned and foreseen in the same way, and emergencies will always be the overriding unknown factor. Our assessment of the fully up-to-date levels of remuneration is designed to recognise this situation, but we nevertheless consider that the length of the hours that some consultants now work regularly cannot be in the best interests of the standard of care and efficiency in the National Health Service generally.

30. We understand that discussions between the Health Departments and the professions on the working of the new contract arrangements for junior hospital doctors and dentists have resulted in a number of further changes. Indeed, the arrangements that were put to us at the outset were changed after our recommendations had been published, and the changes resulted immediately in a different pattern and number of contracted hours from the pattern that had been envisaged by the Health Departments and the professions, and that had provided the basis of our original calculations. The

[1]Subsequently the Hospital Consultants and Specialists Association.

definition of eligibility for Class A UMTs has now been qualified to include a requirement to be physically present, either working or standing-by at the hospital, or available for work within a specified period of time. The on-call requirement attached to Class B UMTs for doctors who do not live in hospital has been defined as being available to give advice by telephone, for consultation and for occasional non-urgent call-out: doctors who are voluntarily resident in hospital are now eligible for Class B UMTs for on-call availability outside the time when they are required to be physically present and immediately available for work. In assessing average weekly duty hours in future, no automatic addition of UMTs will be made for flexibility to take account of irregular commitments outside normal rostered hours, as has happened in many instances in the past: the assessment is intended to take account only of commitments outside normal rostered hours, that are recognised as necessary for the continuity of patient care. To give a measure of practical expression to a recommendation that the minimum assured period of off-duty time should be 88 hours a week, it has also been agreed that, in drawing up duty rosters and entering into contracts, employing authorities should try as far as possible, and consistently with the needs of the service, to avoid unnecessary social inconvenience to doctors; in particular, doctors on a 1 in 2 rota for stand-by or on-call duty (equivalent to 104 hours duty per week) will not be expected to contract to provide cover for other doctors absent on annual leave or study leave. The Health Departments do not expect the clarification of these aspects of the working of the new contract arrangements to result in any significant change in the pattern and number of contracted hours. They have also confirmed that agreement has been reached with the professions for an increase in the annual leave entitlement for senior house officers and registrars from 4 weeks to 5 weeks with effect from 1 April 1978; this will bring them into line with other groups in the NHS at comparable pay levels: we have made provision in our recommendations for the cost of introducing this improvement in conditions of service.

31. We regret that no progress has been made towards an examination of the long hours of duty of junior hospital doctors with the object of reducing them, notwithstanding the fact that the need for such an examination was agreed between the professions and the Secretary of State in October 1975. The professions have said that they see difficulty in making real progress until the effect of the introduction of a new contract for consultants on consultants' pattern of work and on the maintenance of an adequate standard of patient care can be established. For our part, we would have expected that a beginning could have been made on considering the problems involved in parallel with discussions on the consultant contract. As we have said[1], we consider the extent to which junior hospital doctors are called upon to spend very long hours on duty is unusual by comparison with most other professional people, and is undesirable: as a regular requirement, it can hardly fail to have adverse consequences for the standard of patient care and for the efficiency of the National Health Service generally as well as for the doctors themselves. It seems to us to be the responsibility of both parties to ensure

[1]Review Body on Doctors' and Dentists' Remuneration, Supplement to Fifth Report, 1975—Cmnd. 6243, September 1975 (paragraph 13).

that an early start is made on the examination of junior hospital doctors' duty hours which both accepted as necessary two and a half years ago. In the meantime, in considering fully up-to-date levels of pay, we have retained a substantial measure of relative improvement in the earnings of junior hospital doctors and dentists from the introduction of their new contract.

32. The professions have again asked us to relate the salary scales for junior hospital doctors and dentists to the standard working week of 10 UMTs, and we have decided to use the flexibility provided by the current guidelines to do so. We have not been able to take this step before because the form of the general measures of pay restraint which have been in operation since April 1975, when we last reviewed the salary scales, has been unsuited to a change in the basis of remuneration of this kind: the increases that we recommended in 1976 and 1977 were cash supplements to earnings (and the level of the supplement that we recommended in 1977 recognised the change in the conditions of service under which additional Class A/B supplements are paid for providing cover for other doctors and dentists on leave). The present salary scales are those that we recommended in our Fifth Report with effect from 1 April 1975 and, as we said at the time[1], were designed to recognise all duties of junior hospital doctors other than those that attracted extra duty allowances. Since, as we specifically noted in the Supplement to our Fifth Report[2], the salary scales remained unchanged on the introduction of the new contract on 9 February 1976, when the Class A/B supplements replaced extra duty allowances, they continued to contain an element of recognition of part of the long hours spent by junior hospital doctors and dentists on duty beyond the normal weekly hours and the supplements as recognising the remainder. As we indicated in the Third Supplement to our Fifth Report[3], a change of basis on the lines proposed would inevitably involve *relatively* lower basic salary scales for all junior hospital doctors and dentists and *relatively* higher earnings from supplements for those who qualify. The general increase in the basic salary scales for the training grades that we recommend below, after consolidation of the 1976 and 1977 cash supplements into the salary scales and taken in conjunction with the effect of consolidation on earnings from Class A/B supplements, implies a relative adjustment between earnings from salary and earnings from the Class A/B supplements. It represents the change in the basis of remuneration that the professions have asked for, and it is our judgment of the appropriate relationship between the basic salary scales of junior hospital doctors and dentists and the standard working week of 10 UMTs.

33. The professions have asked that the rate of payment for Class A UMTs should be not less than the rate implied by the basic salary for standard UMTs, since the duty involved relates to night and weekend work of a

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[1]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 25).

[2]Review Body on Doctors' and Dentists' Remuneration, Supplement to Fifth Report, 1975—Cmnd. 6243, September 1975 (paragraph 21).

[3]Review Body on Doctors' and Dentists' Remuneration, Third Supplement to Fifth Report, 1975—Cmnd. 6406, February 1976 (paragraph 15).

demanding nature which in some other walks of life is remunerated at not less than the rate for normal working hours. As we have said before[1], we do not regard it as appropriate to draw comparisons between the premium rates paid to manual workers and to some non-manual workers in industry for overtime work and the payments to junior hospital doctors and dentists for stand-by and on-call duty. Our recommendations for the rate of payment for Class A/B UMTs take into account the varying nature of the duty, only part of which relates to clinical work as distinct from availability, and the average amount of call-out involved.

34. We recommend the introduction of the following salary scales for hospital medical and dental staff[2]:

		Recommended scales from 1 April 1978 (excludes earnings from Class A/B supplements for training grades[3])	*Fully up-to-date to scales appropriate to 1 April 1978*
		£	£
House officer ...	minimum of scale	3,420	*(3,897)*
	maximum of scale	3,876	*(4,407)*
Senior house officer	minimum of scale	4,257	*(4,881)*
	maximum of scale	4,767	*(5,535)*
Registrar	minimum of scale	4,767	*(5,535)*
	maximum of scale	5,766	*(6,696)*
Senior registrar ...	minimum of scale	5,460	*(6,345)*
	maximum of scale	6,990	*(8,100)*
Consultant	minimum of scale	9,528	*(11,325)*
	maximum of scale	12,084	*(14,361)*
Medical assistant and assistant dental surgeon	minimum of scale	5,892	*(6,843)*
	maximum of scale	9,528	*(11,325)*

The 1 April 1976 and 1 April 1977 cash supplements have been consolidated into the recommended scales, and the distortion in the salary structure created by the £8,500 earnings ceiling in 1976 on eligibility for any increase has been removed. We have also provided a measure of relative decompression in the salary structure between the consultant and senior registrar scales, through a higher general increase for the consultant than for the training grades (who have benefited relatively to consultants since 1975), combined with a reduction in the span of the consultant scale to reflect more closely than at present the general rate of progression in scales at comparable levels of pay elsewhere. The scale that we recommend for medical assistants and assistant dental surgeons takes into account an agreement reached between the professions and the Health Departments to shorten the scale by removing the two lowest

[1]Review Body on Doctors' and Dentists' Remuneration, Supplement to Fifth Report, 1975—Cmnd. 6243, September 1975 (paragraph 15).

[2]Scales have not been rounded because of the need to preserve established inter-grade relationships based on expected career progression and to provide for equal monthly payment and an even pattern of increments where appropriate.

[3]We estimate that the earnings from Class A/B supplements will involve an addition to basic salary ranging from just over 33 per cent for senior registrars to just under 42 per cent for house officers on average.

points and each alternate point (reducing the number of annual increments from fourteen to six), and is designed to preserve the existing relationships with other hospital doctors and dentists. The professions have told us that proposals for a new contract for medical assistants and assistant dental surgeons have been put forward for discussion with the Health Departments on the lines of the proposed consultant contract, and have asked us if we would be willing to price it on a 1 April 1978 basis as an extension of the current review, if agreement can be reached within a reasonable amount of time. On the assumption that a significant change in the basis of remuneration and protection arrangements would be involved (reflecting the proposals for the new consultant contract), we would see great difficulty in considering a new contract for medical assistants and assistant dental surgeons other than in the context of a new review. However, we understand that no-one in the obsolescent senior hospital medical and dental officer grade is paid at a point in the scale below the maximum—which is linked to the maximum of the medical assistant and assistant dental surgeon scale—and we have therefore recommended a flat rate salary. We also recommend increases in the pay of hospital practitioners and clinical assistants (part-time medical and dental officers) in line with those for general medical and dental practitioners: since we have not yet been provided with the evidence *which we first asked for in 1974* on the duties and responsibilities of the new hospital practitioner grade, and on their relationship with those of other intermediate grades, we have not been able to consider the structure and pattern of remuneration for these grades, including the relationship with other hospital grades. Full details of the recommended scales are in Appendix A.

35. **Career grades: distinction awards.** We have been told in evidence that, in addition to the proposals for a new consultant contract, consideration is being given to changes in the system under which distinction awards may be conferred, with the object of extending recognition to a greater extent to a high degree of merit of the kind that is widespread, particularly in the regions, and is rather different from clinical distinction alone. It is envisaged that, in future, the procedure for regional selection of awards should be strengthened by inviting Regional Medical Officers to put forward formal recommendations to the regional advisory committees (instead of seeking their advice only), and that the distribution of new awards recommended by the central advisory committee would be made with a longer term aim of changing the balance of the share of awards between regions (including those with long-established teaching hospitals) to achieve a greater degree of balance in the number of consultants with awards. Steps would also be taken to achieve a more uniform distribution of award-holders between specialties. To assist the central advisory committee in its new objectives, the intention is to appoint a small number of regional consultants to serve on the central committee, in addition to the present appointees who are nominated by the Royal Colleges for England and Wales and for Scotland, by the Committee of University Vice-Chancellors, and by the Medical Research Council. At the same time, confidentiality would be modified to provide access to the list of award-holders to consultants and community physicians. The list would also be made available to members and senior officers of area and regional health authorities and—we understand—to Members of Parliament.

36. In the meantime, we have been asked by the Joint Evidence Committee to recommend a larger overall increase in the number of awards than would be required simply to take account of the increase in the number of consultants in post, and to provide more of them at lower levels to enable long service to be recognised in lieu of promotion opportunity, and to enable the proportion of awards to community physicians to be brought more closely into line with the proportion for clinical specialties. We invited Sir Stanley Clayton to put his views to us as Chairman of the Advisory Committee on Distinction Awards. We recommend an increase of 50 awards, bringing the total number of awards to 5,392. We make no provision for additional awards for the purposes proposed by the Joint Evidence Committee, as we do not consider it appropriate for distinction awards in their present form to be used other than for the original purpose of rewarding professional excellence or exceptional individual merit. We still do not regard it as appropriate to distinguish between different specialties and we do not therefore earmark a special share for community medicine[1], which must continue to be considered on equal terms with the other specialties.

37. We said in our Fifth Report[2] that, if the present award system continued in its existing form, we should want to review the past practice under which the value of each award has been increased by the same percentage as the maximum of the consultant scale. Our recommendations on that occasion maintained this practice, so that the recommended value of the A+ award is currently equal to the consultant scale maximum: in practice, since increases which took salaries over £13,000 in 1975 were staged, and the second stage has not yet been implemented, the value of the A+ award is currently just below three-quarters of the consultant scale maximum. We have now reviewed the position in the light of the aims of the Inter-Departmental Committee on the Remuneration of Consultants and Specialists in 1948 in recommending the adoption of the present system of distinction awards[3]:

i. to provide for a significant minority to earn incomes comparable with the highest in other professions;

ii. to ensure a level of remuneration sufficient to attract the most able specialists to the public service and to retain them;

iii. to reward adequately more than ordinary ability and effort.

These aims were endorsed by the Royal Commission on Doctors' and Dentists' Remuneration in 1960[4], and we are satisfied that they have been met. But there is some evidence which suggests that the balance between the additional

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[1]Review Body on Doctors' and Dentists' Remuneration, Supplement to Third Report, 1973—Cmnd. 5377, July 1973 (paragraph 13).

[2]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 29).

[3]Report of the Inter-Departmental Committee on the Remuneration of Consultants and Specialists—Cmd. 7420, May 1948 (paragraphs 12 and 13).

[4]Report of the Royal Commission on Doctors' and Dentists' Remuneration 1957-60—Cmnd. 939, February 1960 (paragraph 224).

remuneration represented by distinction awards and the scale maximum itself needs to be considered, particularly at the highest levels of awards. We believe too that the absolute amounts at the highest levels now provide adequate reward to attract specialists of the highest ability to the National Health Service and to retain them. Between 1958 and 1971, the proportion of whole-time consultants with distinction awards increased from just under 20 per cent to 30 per cent, and the proportion of part-time consultants with awards remained virtually unchanged at around 37 to 38 per cent compared with the average for all consultants of 35 per cent; the proportion of whole-time consultant award-holders with A+ and A awards increased to approach closely the proportion of part-time consultants with A+ and A awards. During this period, the top level of consultant remuneration (salary maximum and A+ award) was maintained at around twice the maximum of the consultant scale notwithstanding the steep rise in salaries and the compression at higher levels of income that had occurred generally since 1959[1]. We consider that it is no longer appropriate to maintain a fixed and rigid relationship between the value of each distinction award and the maximum of the consultant scale, and that, in deciding the values of the awards, some regard should be paid to the general factors that we take into account in assessing remuneration generally, including movements in earnings of other professions at comparable levels. We see it as consistent with the first aim of the present system (i above) for the top level of consultant remuneration to reflect the general pattern of increases for professional groups as a whole, which has shown a taper at higher levels of income since 1975 and, indeed, since 1959. We propose no immediate change in the value of distinction awards: we consider it important that the increases in remuneration for consultants that we recommend with effect from 1 April 1978 should be concentrated on improving the basic scale, and on the removal of the distortion that has been created. Our detailed recommendations on distinction awards are in Appendix A.

38. **Fees and allowances.** The fees and allowances that are payable to hospital doctors and dentists—including those for domiciliary consultations, family planning work, lectures and membership of District Management Teams—have not been increased since 1975. The professions have suggested that they should now be increased substantially, and cite the fee for domiciliary consultations as particularly important, because of the rising costs of the provision and maintenance of portable equipment to enable treatment to be given in the home, as well as to encourage recruitment to shortage specialties such as geriatrics. They have also drawn our attention to an increase in fees for private work of just over 32 per cent with effect from April 1977, which has been approved recently by the Price Commission, as an indication of the level of increase that might be justified. We do not consider that any change in the relativities between the domiciliary consultation fee and other fees and salary is justified on recruitment grounds: a proposal for a change in the additional fee payable to doctors who provide their own equipment, which is directly linked to the service fee, is a matter for discussion with the Health Departments in the first instance, but our recommendations for increasing the

[1]Royal Commission on the Distribution of Income and Wealth, Report No. 3—Cmnd. 6383, January 1976 (paragraphs 40-42).

level of fees will have the effect of increasing the additional fees payable in these circumstances. Nor do we accept that an increase in fees for work which is not identical, and which has been approved in a different context, is relevant: moreover, that increase relates to a shorter period than we are considering (the previous increase was in April 1975) and includes an element for expenses as well as for remuneration. In our view, the right course is to restore the relationship between the various fees and allowances and the pay of the relevant grade which was established by our 1975 recommendations. We have adjusted them in this way: our detailed recommendations are in Appendix A.

39. **Ophthalmic medical practitioners.** The profession have asked us to consolidate the 1977 cash supplement of 4·2p into the net remuneration element of the sight-testing fee, and to recommend an increase in the fee in line with the general increase that we propose for others. They have suggested that the present level of the net remuneration element (including cash supplement) of the sight-testing fee compares unfavourably with the scale of payment recently agreed between the profession and the Department of Health and Social Security for medical examinations by doctors in connection with claims for non-contributory invalidity pensions for married women[1]. They told us that the opening hours of eye-centres, where the great majority of sight-tests by ophthalmic medical practitioners are carried out, are generally restricted to 3 hours in the morning and 3 hours in the afternoon from Monday to Friday each week, and that this meant that it was not possible in practice to carry out more than 4,140 sight-tests a year, based on our estimate of 20 minutes for the average time involved for sight-tests and allowing for annual leave of six weeks: this implied an average net remuneration for full-time ophthalmic medical practitioners of £7,908 (including the 1977 cash supplement). They drew our attention to a number of advertisements for ophthalmic opticians which offered employment at salaries ranging in the main from around £9,000 to around £10,000 a year, and in some cases involved refraction work only. They also referred to their proposal, on which discussions with the Health Departments had begun, on the extension of the role of ophthalmic medical practitioners to enable them to treat patients where an eye condition which required medical attention was detected during a sight-test.

40. The Health Departments have again suggested that we should not recommend an increase in the net remuneration element of the sight-testing fee, as they regarded the rate of average net remuneration of £9,508 (including the 1977 cash supplement) for full-time ophthalmic medical practitioners, implied by our estimate based on 4,990 sight-tests a year, as too high in relation to the requirements of the job. They described the two principal considerations that they saw as affecting the level of remuneration for ophthalmic medical practitioners—the training, qualifications and experience required for entry into practice as an ophthalmic medical practitioner, and the nature of the work carried out by them for the General Ophthalmic Service. By comparison with ophthalmic opticians, who are required to spend a total of 4 years in training (3 years of optical training and 1 year in clinical training, followed by professional examination), ophthalmic medical practitioners spend at least

[1]For examinations involving less than 1 hour's absence from the surgery (including travelling time) the fee is £9, for 1-2 hours absence £10, and for over 2 hours absence £15.

7 years in training (5 years medical training prior to registration, and a minimum of 2 years experience in hospital ophthalmic appointments, leading to a diploma in opnthalmology or equivalent experience, and appointment as consultant ophthalmologist or equivalent status). They acknowledged the higher level of clinical training required of ophthalmic medical practitioners, but drew attention to the longer training in dispensing of ophthalmic opticians; they accepted that ophthalmic medical practitioners were no less adequately trained for prescribing particular types of lens than ophthalmic opticians, and withdrew the view that they had expressed to us in earlier reviews that this was not so. The ophthalmic medical practitioner's function in testing sight under the General Ophthalmic Service was identical to the function of the ophthalmic optician. The Health Departments took the view, therefore, that the remuneration of ophthalmic opticians (£6,579 including cash supplements and a 7½ per cent provision for employer's superannuation contribution) was at least as relevant an indicator of the appropriate level of remuneration for ophthalmic medical practitioners as the mid-point of the consultant's scale (£9,319 including the 1977 cash supplement), which the profession regarded as the appropriate standard.

41. For our part, we do not consider it appropriate to relate the remuneration of ophthalmic medical practitioners either to a particular point in the consultant's scale or to the negotiated pay of ophthalmic opticians. In making comparisons with earnings in other occupations and within the medical and dental professions as a whole, which we have now been able to do since the 1975 study by management consultants into the time involved in sight-testing by ophthalmic medical practitioners, we find it helpful to make an assessment on *a notional basis* of the average net remuneration of ophthalmic medical practitioners. For this purpose, we have used our estimate of the average time involved per sight-test of 20 minutes and related it to the normal weekly hours of work (38½ hours) and leave (6 weeks a year and public holidays) for senior hospital medical staff. Taking into account the addition of one public holiday since 1976 and two additional days paid holiday agreed in 1974, we now estimate that the notional number of sight-tests carried out by a *full-time* ophthalmic medical practitioner would be 4,920 a year: this implies a notional average net remuneration (including the 1977 cash supplement) at the rate of £9,315 a year for full-time ophthalmic medical practitioners. It would in any case be wrong, in our view, to assess average net remuneration from sight-testing on the basis of the average hours of opening of eye-centres, even if adequate information were available on those hours. We have been asked by the profession to recommend an increase in the expenses element of the sight-testing fee[1] but, as we said last in our 1974 Report[2], it is not within our remit to propose adjustments in the expenses factor. Meanwhile, we await the results of the detailed inquiry into the practice expenses of ophthalmic medical practitioners which, we understand, will be carried out in the course of the coming year. We recommend that the net remuneration element of the sight-testing fee should be increased with effect from 1 April 1978 to £2.10 (*£2.50*): the 1977 cash supplement has been consolidated into the basic fee.

[1]The expenses element of the sight-testing fee was increased from 55p to 65p with effect from 1 April 1977.

[2]Review Body on Doctors' and Dentists' Remuneration, Fourth Report, 1974—Cmnd. 5644, June 1974 (paragraph 35).

CHAPTER 5

GENERAL MEDICAL PRACTITIONERS

42. The total number of general medical practitioners rose to 26,848 in 1977. The rate of increase of 1·6 per cent was slightly higher than in 1976, and also slightly above the trend of the previous five years. The number of principals who provide unrestricted services rose by 1·2 per cent to 24,948. For the first time since 1974, there has been a small increase in the number of British-born men doctors, but the greater part of the overall increase is attributable to the increase in the number of British-born women doctors and of overseas-born doctors. All doctors in general medical practice are required by the General Medical Council to hold the professional qualifications required for full registration and to be registered before they can practise. The number of principals who provide restricted services (for example, maternity medical services only) or who have limited lists (for example, hospital staff) fell again last year, thus continuing the declining trend which has been the pattern over at least the last 20 years, subject to only one small interruption in 1975. The number of salaried assistants increased in 1977 for the second year in succession. There was a further encouraging rise in the number of trainees, and the proportion of women trainees now reflects the percentage of women medical graduates. The Health Departments expect vocational training to become mandatory for all doctors entering general practice in 1981. Following general discussions between the Health Departments and the profession on the problem of under-doctored areas, including the effectiveness of the designated area allowance in helping to achieve an equitable distribution of doctors and the future provision of general medical services in inner city areas, a working party is being set up to examine the problem further and to make recommendations. The working party will include representatives of the Health Departments, of the profession, of the Family Practitioner Committees and of the medical practices committees, and will consider the criteria by which under-doctored areas might be identified, and measures to achieve a satisfactory distribution of doctors in those areas.

43. The profession have described to us the ways in which the workload in general practice has changed and how, in their view, it has increased in recent years. General medical practitioners were responsible both for 'curing' patients and for 'caring' for them, and increased access to diagnostic facilities on the spot meant that they were much less dependent on specialist services in the hospital than they had been in the past. In their view, statistical information on the number of consultations or the number of home visits did

not reflect adequately the overall clinical and administrative duties and responsibilities of general practitioners. They drew our attention to a number of recent developments which have led to a change in the pattern of general practice workload. These included the wide range of screening measures now available in general practice which involve more preventive medicine than hitherto and, in particular, the proposed introduction of regular screening examinations for children and for the elderly; the growth of health care teams brought to light an increasing number of problems of a clinical or social nature, and these had to be considered by the general practitioner; moreover, their management role had increased partly as a result of the employment of increased numbers of ancillary staff and the attachment of district nurses and health visitors to practices, and partly because of the need to maintain contact with the large number of administrative and professional bodies and committees concerned with the provision of medical and social services at different levels of Government. They also told us that, in their view, the present average list size of 2,294[1] was too large in relation to the increasing workload and complexity of work of general practitioners, and that no individual doctor should be responsible for more than 2,000 patients: this implied a target average list size of 1,700 in the future.

44. We have no material evidence to show that the overall level of workload has changed to a significant extent over recent years. As we noted in our Seventh Report last year, in the period between 1970 and 1975, some indicators showed a declining trend—for example, in average list size, in consultations per year per doctor, and in output as measured by gross income from individual fees and allowances per doctor on a constant fee basis. Average list size and output also fell again by a small amount in 1976, but consultations per year per doctor rose. At the same time, the annual number of prescriptions per doctor and of sickness benefit claims per doctor have risen, reflecting increased morbidity among the population. Since morbidity varies from year to year, and over the long term has shown substantial improvement as a result of the virtual eradication of diseases such as tuberculosis, it does not seem to us that these divergences from the long term trend provide conclusive evidence of an increase in the general level of workload in general practice.

45. **Fees and allowances.** The profession have asked us to re-assess the net remuneration for out-of-hours responsibilities separately from our assessment of remuneration for normal hours responsibilities. They have suggested that, on the basis of an hourly rate calculation, the net remuneration for out-of-hours responsibilities compares unfavourably with the rate payable to a general medical practitioner for a night duty session as a clinical assistant in hospital. We are unable to agree with this proposal, since the terms and conditions of service for general medical practitioners include an obligation to provide a service throughout the full 24 hours each day, although they are free, subject to the consent of their Family Practitioner Committee, to make arrangements to be relieved of part of their responsibilities—for example, those that relate to out-of-hours work. Our recommendations on remuner-

[1]This figure relates to 1976: the population per unrestricted principal in that year was 2,205.

ation are based on the overall workload and responsibilities of general medical practitioners and it would be wrong to consider remuneration for one part of those responsibilities separately from the rest: exceptionally, we have considered fees for contraceptive services separately from other remuneration since so far we have seen these as involving new and extra work, the pattern of which has not yet developed fully. We are concerned that the proportion of total remuneration represented by payments in respect of out-of-hours responsibilities (supplementary practice allowance, supplementary capitation fees, and night visit fees) should provide adequate compensation for those responsibilities. We are satisfied that the balance is right: the rates are high enough to cover the use of deputising arrangements (or other arrangements for organising out-of-hours responsibilities on a collective basis) without being so high that the prospective financial loss deters those who want to opt out from doing so: the provision of deputising services has been growing, and nearly one-third of all general medical practitioners now use them. We do not accept that a valid comparison can be made on an hourly rate basis between the out-of-hours payments for general medical practitioners and the night sessional payments for clinical assistants. Apart from the fact that the definition of out-of-hours[1] is used only as the criterion for payment of the fees concerned, there is a wide difference in the nature of the work involved in a general medical practitioner's out-of-hours responsibility and in the work involved in a clinical assistant's night duty session in hospital. We understand that, on average, a general medical practitioner makes around 18 out-of-hours calls per month, of which only two are between 11 pm and 7 am the following morning; a clinical assistant on the other hand can expect to have the same amount of call-out in the course of a night as other hospital doctors, and this can involve up to 3-4 hours a night. Our recommendations provide for maintenance of the April 1975 relationships between out-of-hours payments and the corresponding payments for normal hours (basic practice allowance and standard capitation fees).

46. Because of the form of the restraint measures which applied to the community as a whole, our recommendations for increases in the net remuneration of general medical practitioners in 1976 and in 1977 were by way of cash supplements to gross fees and allowances. As we have already said, we intend now to consolidate both of the supplements into the fee scale. At the same time, we propose to remove the imbalance between fees that has resulted from concentrating the increased provision for practice expenses on the practice allowances and capitation fees in the last two years. Our recommendations are designed to restore the relativities generally to reflect the pattern that we recommended in 1975, but with two exceptions. In the case of temporary resident fees, we maintain the present relationship with the capitation fees, as they reflect the current workload relationships more closely. This is consistent with the approach that we adopted in 1975 on the basis of our examination at the time: we have not yet been provided with information on the extent of the additional workload which the treatment of temporary residents involves. We also propose to maintain the

[1] 7 pm on weekdays to 8 am on the following morning and 1 pm on Saturdays to 8 am on the following Monday morning.

present relationship between the ordinary contraceptive service fee and the capitation fees for the same reasons: we recommend an increase in the IUD contraceptive service fee to bring it into line with the fee payable to hospital doctors for the same service. We make no recommendations for change in the level of dispensing fees: under an arrangement agreed in 1975, the dispensing payments under the drug tariff basis[1] were brought into line with those paid to pharmacists and have been kept in line since then. However, we have been told that changes have recently been agreed that will affect the structure of payments under the drug tariff basis[2] and that the Health Departments and the profession are now discussing the implications for general medical practitioners' remuneration. We have been told that discussions have been held between the Health Departments and the profession on the introduction of developmental paediatric screening by general medical practitioners, and we have been asked by the profession to recommend that the work should be regarded as new work and that remuneration for it should be treated separately from other income. We are not in a position to consider the profession's proposal at this time since we have not been provided with any evidence on the detailed arrangements that are under discussion or to show that extra work will necessarily be involved: we shall await evidence in due course.

47. The profession have again expressed concern about the position of trainee general practitioners, as a result of the introduction of the new contract for junior hospital doctors. Trainees are required to spend 3 years in hospital training posts and 1 year under training in general practice. The training year in general practice can be spent at any time during the vocational training period and, during this year, the trainee is paid the equivalent of the basic salary that he would have received if he had continued to be employed in the hospital service. As a result of the introduction of the new contract for junior hospital doctors which provides for supplementary payments in recognition of all hours spent on duty beyond the standard 40 hours working week, compared with the previous arrangement under which extra duty allowances were payable only beyond 80 hours a week, many trainee general practitioners find that their remuneration is reduced substantially during their general practice training year. Currently, trainee general practitioners receive the full £208 supplement which we recommended last year, whereas junior hospital doctors receive a reduced supplement of £105 to take account of the change in the basis of their remuneration to allow additional remuneration for providing cover for other doctors on leave. We have been provided by the Health Departments with information on the pattern of work of trainee general practitioners obtained from medical postgraduate deans, which shows that, on average, a trainee's normal working week amounts to about 40 hours: in addition, most trainees are on-call on one night a week and on one weekend a month. The Health Departments have told us that they intend to discuss proposals for revised arrangements

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[1]Approximately three-quarters of the 12 per cent of practitioners who do their own dispensing choose to be paid wholly on a drug tariff basis: the remainder are paid partly on a capitation fee basis and partly on a drug tariff basis.

[2]The payment for each prescription is calculated on the basis of the net ingredient cost at drug tariff rates, plus a percentage for on-costs, a container allowance and a dispensing fee.

for the remuneration of trainee general practitioners shortly. In the circumstances, we make no recommendations, but we expect account to be taken of the increases that we have recommended for junior hospital doctors from 1 April 1978. We would like to be informed of the outcome of the discussions. We have been asked by the profession and by the Health Departments to put right an anomaly which has been created by the restraint measures, whereby trainees in the London area who did not come from a London hospital have not been paid London weighting, whereas those who came from a London hospital continued to be paid London weighting. We propose that all of the trainees should be brought into line in this respect, and that all of them should receive London weighting if they otherwise qualify for it. We have taken account of this recommendation in our costing.

48. We understand that agreement has been reached between the Health Departments and the profession on an experimental scheme for payment in respect of the services of wives and related dependents who are employed as ancillary staff. We welcome this development, the need for which was first brought to our notice in 1975, although it had been raised first in 1967 and again (with the Health Departments) in 1972. The scheme is designed at present to apply to single-handed rural practitioners[1] only, and will be subject to review after two years of operation. It provides for the payment of an allowance to a practitioner normally in respect of the employment of one relative only (wife or other dependent) although, in exceptional cases, the allowance may be paid in respect of two relatives[2]. The practitioner will be required to certify that the relative is employed on a regular basis for at least 19 hours a week on duties that are ancillary to the work of the practice—for example, nursing and treatment, secretarial and clerical work, receiving patients, making appointments and dispensing. Approval for payment of the allowance will be at the discretion of the Family Practitioner Committee, who will be required to arrange for each claim to be verified by a visit to the practice concerned. The investigating team will consist of a senior officer of the Committee who is not on the list of the practice, and a representative of the Local Medical Committee, who should preferably be a doctor practising in a different part of the area from the doctor making the claim. The allowance will be regarded as relating to employment on a half-time basis only, and the amount will be linked to the average full-time rate of payment made to all unrelated ancillary staff during the previous year, adjusted as necessary by reference to any increase for the current year for ancillary staff employed in the NHS, and will reflect the proportion that is reimbursed directly[3]. It will be treated as a direct repayment of expenses in the same way as direct repayments in respect of expenses of other ancillary staff. The intention is to introduce the scheme from 1 April 1978: we have therefore made allowance in the provision for practice expenses for the reduction in the amount of expenses reimbursed through gross fees and allowances that is expected to result. We have also made provision in respect of the expected reduction in expenses reimbursed through gross fees and allowances arising from the agreement by the Health Departments to reim-

[1]Defined as those in receipt of rural practice payments or of an inducement allowance to practise in sparsely populated rural areas.

[2]Subject to approval by the Secretary of State.

[3]70 per cent.

burse directly the national insurance contributions and any other superannuation payments for ancillary staff[1] together with certain other expenses of a minor nature[2] with effect from 1 April 1978.

49. The profession have asked us to make provision in the remuneration of general medical practitioners for a payment in recognition of the capital investment in equipment that every doctor who enters general practice has to make. We have been told that the amount of the capital involved may vary widely. We share the view of our predecessors that the Royal Commission in 1960 must be assumed to have allowed for the need to find such capital, in deciding the level of average net remuneration. The provision of capital for investment in premises and equipment in the first instance must be a matter for the individual practitioner, as it is for an individual practitioner in any other professon, and the medical profession cannot expect to be treated differently in this respect from other professions. Our predecessors also took the view that interest on the capital employed was a proper charge to the practice, whether the capital was borrowed or provided by the practitioner from his own resources. In the case of interest on capital invested in premises that are owned by the practice, the annual rent is assessed on a notional basis by the District Valuer, and the 'notional rent' is repaid direct to the individual practitioner (or the appropriate proportion of it in the case of members of partnerships) under the scheme for direct repayment for rent and rates, and in the same way as the rent for leased premises. The present practice is for the amount of the notional rent to be reassessed at three year intervals[3], so that it bears a proper relationship to the up-to-date value of the premises: in this way, a practitioner who joins an established partnership will receive interest on the capital that he has had to find to buy his share of the premises related to the up-to-date value of the premises, and not to the historic cost. Different considerations apply to interest on capital investment in equipment. The Inland Revenue allow the cost of new equipment (or the capital element in hire-purchase charges) other than a car to be written off through capital allowances for depreciation in one year (or alternatively, within five years) and, for a car, within four years; if equipment is leased, the rental (or the rental element in hire-purchase charges) is treated as a deductible expense for tax purposes. Reimbursement of expenses, including capital allowances incurred by general medical practitioners as a whole, is effected through the provision for average practice expenses that we make in our recommendations for fees and allowances, so that the only cost that practitioners have to bear themselves is the interest on the capital invested in the purchase of equipment in the first instance, and before it is written off. Although the annual amount of capital allowances per practitioner allowed by the Inland Revenue is known, the average period over which it is written down is not known, so that the amount of capital outstanding, and hence the interest on capital invested, cannot be established. From the information that is available on capital allowances for equipment, we would not expect the amount to be significant. We consider that the Health Departments and the profession

[1]This concession covers only those ancillary staff who are eligible to have a proportion of their expenses directly reimbursed under the ancillary staff scheme.

[2]Water rates for surgery premises and the element of service charges (lighting, heating and telephone) for that part of the premises used by area health authority staff.

[3]Prior to 1 October 1976, the interval between re-assessment was five years.

should examine this problem further, including the method of assessment of the amount of capital involved, with a view to agreeing arrangements that might recognise the interest on capital invested in equipment by practitioners.

50. **Practice expenses.** In our Seventh Report, we estimated average practice expenses for 1977-78 at £4,500 and we made provision for this amount. After adjustment of £210 to take account of the transfer of expenses to direct reimbursement under the experimental scheme for payment of an allowance in respect of related ancillary staff, and under the arrangements for repayment of national insurance contributions and superannuation payments for ancillary staff generally, and of certain other expenses, our estimate of the average practice expenses for 1978-79 is £4,800: the adjustment to the fee scale that we recommend makes provision for this amount to be reimbursed on average through gross fees and allowances.

51. **Average net remuneration.** We have already indicated our intention to consolidate the 1976 and 1977 cash supplements into the fee scale and to restore the established system of remuneration for general medical practitioners. The average net remuneration which our recommendations were designed to produce in 1975-76 was £8,485, to which must be added the current rates of payment of the cash supplements that we recommended in 1976 and 1977—£166 and £207 on average respectively: this produces a total average net annual income based on our recommendations of £8,858. The increases in the existing fees and allowances listed in Appendix A are designed to increase the estimated average net remuneration of general medical practitioners[1], after allowing for practice expenses, from these items to £9,785 (*£11,640*) in 1978-79, assuming no change in the general level of workload and responsibility, and taking into account extension of the £312 supplement to those general medical practitioners who were not eligible for it in 1976: this includes £951 (*£1,070*) on account of payments from items of remuneration that are not received by all general medical practitioners[2]. We estimate that general practitioners will also receive an average net income of £445 (*£506*) from contraceptive service fees and other payments in respect of additional general medical service work[3], and about £258 (*£307*) from hospital work and from other official sources.

[1]Unrestricted principals excluding salaried partners.

[2]Designated area allowance, initial practice allowance, inducement payments, trainer's grant, rural practice payments and dispensing payments.

[3]Expenses relating to this work are included in the general provision for average practice expenses.

CHAPTER 6

GENERAL DENTAL PRACTITIONERS

52. The total number of practitioners in the general dental service rose by 2·3 per cent to 13,564 in 1977 and maintained the upward trend of recent years. The proportion of assistants again declined, and is now only 1·5 per cent of the total of all practitioners. The number of courses of treatment continued to increase, and rose by 3·1 per cent in 1977; the number per practitioner increased by 0·8 per cent, thus resuming the steady rise over a long period following the small decline last year. There has been no significant change in the distribution of dentists, which continues to show a marked variation between regions in the southern part of England and in the remainder of the country. Progress on the introduction in England and Wales of the experimental 'salary plus bonus' scheme based on publicly provided premises, which was designed to reduce the imbalance in the distribution of dentists, continues to be disappointingly slow: one appointment has been made, and the aim is to introduce the scheme in at least two other areas during the coming year: four dentists are now employed in Scotland under a parallel scheme. We have been told by the Health Departments that the current target for the number of dentists in the National Health Service is 20,000, including those in the hospital and community dental services: on present indications, this target is unlikely to be reached for a further seven years. In the meantime, an inquiry is to be made into the general problem of dental education, training and manpower in the light of current and foreseeable needs[1].

53. We have been asked by the Health Departments to recommend an appropriate sessional fee for practitioners who provide emergency dental services under arrangements organised by health authorities. We understand that the extent to which emergency dental services are provided is limited at present to a few authorities, although in some instances individual practitioners have made their own arrangements to provide emergency treatment generally for their own patients. There are no formal arrangements and, in some cases, health authorities have arranged for official premises and equipment to be used and, in others, for dentists to provide the services in their own surgeries. Neither the length of a session nor the times of coverage have been standardised, but a typical health authority scheme involves a daily morning session of three hours at weekends and on public holidays. The need for the provision of emergency dental services was first considered

[1]The inquiry is being sponsored by the Nuffield Foundation.

some sixteen years ago, but the conclusion reached then was that special emergency arrangements were not justified since there was little evidence of demand. More recently, in 1975, following the recommendations of a joint working party composed of representatives of the Health Departments and of the profession, agreement was reached on the introduction of a scheme on an experimental basis designed to assess the need for the provision of emergency dental services generally. The experimental scheme was to be limited to four areas and to the provision of services at weekends and public holidays; surgery facilities were to be provided by the health authorities; and the dentists who participated in the scheme would be paid a sessional fee of the same order as the fee paid to part-time salaried health centre dental practitioners. However, the profession considered that the proposed level of fee did not provide adequate reward for work done outside normal weekdays: they have suggested that the sessional fee should be based on double the equivalent rate per session implied by the recommended target average net income and the average number of hours spent on general dental service work. We have given careful consideration to the Health Departments' request, but we are not in a position to reach conclusions in relation to arrangements of such an informal nature as those for the existing health authority schemes for the local provision of emergency dental services seem to be. The introduction of the experimental scheme has already been delayed for nearly three years, and we see it as important for the two parties to reach general agreement on the type of remuneration arrangements that they want without further delay, otherwise momentum will be totally lost.

54. **General dental practitioners.** The recommendations in our Seventh Report were accepted and have been put into effect, but the Dental Rates Study Group has not yet been able to agree the changes to the fee scale needed to provide for the estimated change in output and the reimbursement of the estimated increase in practice expenses in the current year. We explained last year that, in adjusting the fee scale each year, the Study Group has to take into account changes in the volume of fees (that is, in output) and in practice expenses[1]. Difficulties arise in forecasting output as a result of the introduction and use of new equipment and techniques, and of changes in the level of charges to patients for treatment. In forecasting expenses, the main difficulty is that full information on actual practice expenses is not available for either of the two preceding years, so that the baseline for projecting the level for the current year is three years old. To reduce the gaps between the intended and the actual results the Study Group has, following the profession's suggestion in 1974, adjusted the practice expenses' provision within the fee scale each year to correct for under-provision or over-provision in the preceding three years on a cumulative basis. The following table illustrates the adjustments since 1974-75, and the projected adjustments for 1977-78 (assuming no change in the method of adjustment) based on the Health Departments' estimates and on the profession's estimates:

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[1]Review Body on Doctors' and Dentists' Remuneration, Seventh Report, 1977—Cmnd. 6800, May 1977 (paragraph 60).

Adjustment to correct forecast expenses: 1974-75 to 1977-78

Year	*Recommended target average net income*	*Adjustment to correct forecast expenses (a)*				*Total adjustment*
		1973-74	*1974-75*	*1975-76*	*1976-77*	
	£	£	£	£	£	£
1974-75	5,789	+291				+291
1975-76	7,643	−140	+97			−43
1976-77	7,798	−175	−156	−52		−383
1977-78(b)	8,011		−299	−669	−773	−1,741
				(−426)	(−345)	(−1,070)
Difference between out-turn and provision made for expenses		−24	−358			

Notes: (a) The adjustment is made to the provision for practice expenses included in the forecast of gross remuneration used in calculating the fee scale.

(b) The adjustments shown in the first line are based on the Health Departments' forecasts and those in brackets on the profession's forecasts.

55. Last year, the Health Departments proposed to the Study Group that the same approach should be adopted to average gross income, so that any difference between forecast and actual output (as measured by average gross income) would be corrected each year. The profession were not prepared to agree, and they themselves proposed to the Study Group that adjustment to correct for under-provision or over-provision in practice expenses should cease to be made. They argued that adjustment tended to produce large balancing factors in times of high inflation, and that these could seriously affect dentists' standards of living from one year to the next: they pointed to the implied reduction, based on the Health Departments' forecasts, of £1,741 in the 1977-78 expenses provision as an example of what could happen if this system of adjustment continued. The Health Departments favoured the continuation of adjustment in principle but suggested that, in the case of practice expenses, it should be made only in respect of the year for which the actual out-turn was known, and not on a cumulative basis in the future, which would imply a reduction in the 1977-78 expenses provision limited to £299. In the absence of agreement on the approach to be used in the calculation for the 1977-78 fee scale, the Chairman of the Study Group reported to the Secretary of State that he was unable to recommend a revised scale of fees. He expressed his own view that, while there was mutual benefit to both the profession and the Health Departments in the adjustment approach (as it ensured that dentists received the total average net remuneration recommended by us—no more and no less—over the long term), the relatively large swings in net income produced by the adjustment approach, because of the over-estimates of practice expenses in recent years which had arisen largely as a result of uncertainties about the rate of inflation and about dentists' workloads, had resulted in confusion among dentists about the level of income that they could expect to receive. The Health Departments and the profession have now each asked us to review the principle and methods of retrospective adjustment.

56. The Health Departments referred to the difficulty of forecasting the expenses and output of general dental practitioners in periods of high inflation. They suggested that the Royal Commission's view that retrospective payments were not appropriate in principle for doctors and dentists[1] was based on the assumption that a much higher degree of accuracy in forecasting expenses and output would be achieved than had proved practicable in the event. They considered that the circumstances of the particularly high rate of inflation in 1974 had justified acceptance of the profession's proposal that expenses should be adjusted retrospectively, and that circumstances since then justified extension of the principle to adjustment for output. They saw it as contrary to the Royal Commission's recommendations that dentists should gain or lose fortuitously from unforeseen developments outside the control of the Review Body or of the Dental Rates Study Group. They estimated that dentists had received £1,201 more in net remuneration from fees in 1976-77 than the target average net income of £7,643, because expenses had been lower and output higher than forecast; they considered that, although output had increased by 3·3 per cent in that year[2], it did not justify ignoring the large excess payment. They recognised that it is our job to take account of changes in output and in hours worked in making our recommendations on the target average net income for dentists, but they themselves took the view that, on average, dentists should receive the recommended amount only: since precision in forecasting expenses and output was impossible, some form of adjustment remained necessary. To avoid large balancing adjustments that can create confusion about the intended level of net income, the Health Departments suggested that a new arrangement might be introduced whereby a deduction of 2 per cent would be made from gross target average remuneration to provide a 'pool' out of which any under-payment of net income (whether on account of under-estimate of expenses or over-estimate of output) would subsequently be paid out as a cash supplement based on fee income received, and a deduction would be made in respect of any over-payment of net income. A scheme of this kind would mean that the fee scale would not be affected by the adjustment process, and that dentists would be guaranteed 98 per cent of the target average net income, regardless of the amount of any over-payment.

57. The British Dental Association explained to us that, in practice, dentists equate their profitability, and hence their attitude to general dental service work, to the fee scale. They pointed to the fact that, notwithstanding the high rate of inflation since 1975, the fee scale had remained unchanged and profit margins had been eroded. The background to this is that, for 1976-77, the Study Group considered that the small increase in target average gross income did not justify an increase in the level of fees, and that practitioners should instead be paid a cash supplement equivalent to 3 per cent of fee income; there has been no change since then. They drew our attention to the increase in output between 1962 and 1976 which, in terms of courses of treatment per dentist, had averaged 2·5 per cent a year and, in terms of volume of fees, 1·4 per cent a year, and told us that the absence of any

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[1]Report of the Royal Commission on Doctors' and Dentists' Remuneration 1957-1960 —Cmnd. 939, February 1960 (paragraph 395).

[2]Dental Rates Study Group assessment.

direct reward for rising output had long been a cause of discontent among dentists. They indicated their agreement with our proposal, which we made first in 1973, that the Study Group should take account only of changes in productivity within the standard hours and should avoid adjusting the fee scale for anticipated changes in output arising from changes in personal effort—a distinction, however, which the Study Group had said they were not in a position to make. They suggested that the Study Group should base the fee scale for the coming year on the actual output of the past year so that, in this way, the benefit of an increase in output above the level to which the target average net income was related would be retained by the dentist, and the effect of a reduction in output would be borne by the dentist for that year only. They opposed the Health Departments' proposal to extend the process of retrospective adjustment to correct for over-estimates or under-estimates of output, since this would mean that dentists would not gain any benefit from rising output, and asked us to pronounce against continuation of the system of retrospective adjustment in respect of over-estimates or under-estimates of expenses. They drew our attention to the argument against retrospective adjustment—which they had already put forward in the Study Group—that the swings in dentists' living standards that had resulted from its adoption were out of proportion to the possible benefits from the process. They also pointed to the fact that, in the period 1962-1973 before retrospective adjustment was introduced, there was a net under-payment in remuneration that, in April 1975 prices (estimated by them as £875), more than compensated for the sum of the outstanding adjustments in respect of the actual over-payment of expenses in 1974-75 (£299) and their estimate of the over-payment of expenses in 1975-76 (£426). Even in the modified form suggested by the Health Departments, they saw the adjustments as objectionable, since their impact would be felt three years later by dentists who had not been involved in the original over-payment, and their effect in changed circumstances could have severe financial consequences for individuals. Moreover, the over-payment could have the effect of moving individual dentists into a higher tax bracket than when the adjustment was subsequently made, with the result that there would be a net under-payment after tax. They considered that the results over the 12-year period showed that the Study Group was able to achieve its objective without the need for retrospective adjustment.

58. The following table set out the changes in general dental practitioners' incomes since 1971-72:

Changes in average remuneration of GDPs from fees, allowances and supplements (before tax): 1971–72 to 1977–78 (a)

Year	*Intended*			*Difference between actual and intended*						
						Net remuneration				
	Gross remuneration	*Practice expenses (b)*	*Net remuneration (c)*	*Gross remuneration*	*Practice expenses (d)*	*Before adjustment*		*Adjustment (e)*	*After adjustment*	
	£	£	£	£	£	£	per cent(f)	£	£	per cent(f)
1971-72	10,146	5,493	4,653	56	−116	−60	−1·3			
1972-73	11,038	5,988	5,050	−195	−272	−467	−9·2			
1973-74	11,886	6,729	5,157	−147	24	−123	−2·4			
1974-75	14,115	8,326	5,789	189	358	547	9·4	291	838	14·5
1975-76(g)	18,067	10,424	7,643	389	721 (478)	1,110 (867)	14·5 (11·3)	−43	1,067 (824)	14·0 (10·8)
1976-77(g)	19,818	12,020	7,798	423	779 (351)	1,202 (774)	15·4 (9·9)	−383	819 (391)	10·5 (5·0)
1977-78(g)	20,354 (21,511)	12,343 (13,500)	8,011					−1,741 (−1,070)	−1,741 (−1,070)	−21·7 (−13·4)

Notes: (a) The presentation of the information in this table does not follow that normally used by the Dental Rates Study Group.
(b) Includes notional rent allowance: for 1977-78, since no new estimate has been made, an allowance at the 1976-77 rate has been included.
(c) Includes adjustments of £195 and £83 for errors in forecasting output and expenses in respect of 1972-73 and threshold payments of £139 in 1974-75; estimated cash supplement of £155 in 1976-77; and estimated cash supplements of £178—the latest estimate of the 1976 supplement— and £190—the current estimate of the 1977 supplement—in 1977-78.
(d) Where the difference is shown as negative the provision was less than the actual expenses incurred. For 1976-77 the differences include £6 rounding adjustments to the addition made to fee income in that year (paragraph 57).
(e) The adjustment is made to the provision for practice expenses included in the forecast of gross remuneration used in calculating the fee scale. For 1977-78, the adjustment shown is based on the method used in 1974-76.
(f) Percentage of intended net remuneration.
(g) Estimates based on Health Departments' forecasts: figures in brackets are based on profession's forecasts.

It is clear from this that the extent of the divergences of the forecasts for average gross remuneration and average practice expenses from the outturns has more often than not been relatively large in the last six years. Where the differences have been additive, as in 1972-73 and 1974-75 and as is expected to be both in 1975-76 and in 1976-77 on the basis of current forecasts, the actual average net remuneration has (or is estimated to have) differed significantly from the target average net income recommended by us. Based on the Health Departments' forecasts for 1975-76 and 1976-77, the average difference over the period is equivalent to 8·7 per cent of intended average net remuneration, and the balance on a cumulative basis is a surplus of 26·5 per cent; the corresponding figures based on the profession's forecasts for these two years are 7·3 per cent and 17·8 per cent respectively. The effect of introducing an adjustment to correct for under-provision or over-provision of average practice expenses in the three previous years has had negligible effect so far on the average difference between actual and target average net income, and little effect on the balance.

59. We have discussed the problem and the present position with the Chairman of the Dental Rates Study Group (Mr. S. M. Duncan). He has

confirmed that the relatively large divergences in recent years are due to the substantial difficulties involved in forecasting the trend of dentists' costs during a period of high and fluctuating rates of inflation, combined with general measures of pay restraint that had led dentists to cut back on their practice expenses to an unforeseen extent in order to improve their income. At the same time, difficulty had arisen in forecasting accurately the effect on dentists' output of changes in demand from the public, in reaction to changes in the levels of charges to patients for dental treatment. Moreover, if an intention to increase charges in the following year were announced after the fee scale for the current year had been decided, as happened last in 1976, it was not possible to provide for the surge in demand for courses of dental treatment to begin before charges were increased. He told us that his aim was to avoid such large divergences in the future, by seeking to develop and to refine the techniques used in forecasting the level of expenses and of output. To this end, the Study Group had put in hand a number of studies: these included proposals to widen the basis of the Inland Revenue sample on which information on practice expenses was provided; the use of a standardised account form by dentists, which would provide a more comprehensive breakdown of their expenses than at present; an annual inquiry into the employment of ancillary staff; and the provision of information on the trend of dentists' expenses in the interim period between the latest year for which Inland Revenue information was available and the year for which the fee scale was being set. He also confirmed that the Study Group intended to carry out a fresh inquiry into the time taken for various dental operations in 1980: the last such inquiry on timing was in 1969. He believed that, as a result of these studies, it should be possible to reduce divergences from the forecasts to an acceptable level in the future, both in relation to expenses and to output.

60. For our part, we understand the practical difficulties of forecasting the level of expenses in relation to general dental practitioners' remuneration during a period of high inflation: we have experienced the same kind of difficulties ourselves in relation to general medical practitioners' remuneration. There is, however, a fundamental difference between the two systems of remuneration that makes the forecasting of the level of output more difficult in the case of general dental practitioners. They are paid by way of a separate fee for each item of service, whereas the major part of general medical practitioners' income is made up of the standard and supplementary practice allowances and capitation fees, and a relatively small part of their income only comes from item of service fees. Moreover, patients are required to pay part of the cost of dental treatment at the time, but are not required to pay part of the cost of their medical treatment (other than a small contribution to prescriptions in the majority of cases). Unless changes in patients' charges for dental treatment are known before the Dental Rates Study Group has set the fee scale for the year, it is impossible to forecast the effect on demand and to reflect it in the fee scale. Change in demand will also affect the provision to be made for practice expenses, although to a limited extent only. It is true that, by making adjustment to correct for the divergence of forecasts from the out-turns, over the long run the total of average net remuneration received will be the same as the total of target average net income recommended by us, but in the short term this will not necessarily be so. The

effect in times of high inflation of large adjustments that result in correspondingly large swings in net income undoubtedly creates difficult financial problems for those whom the system is intended to benefit, and creates uncertainty among them about the level of income that they can expect. These factors alone weigh against continuation of retrospective adjustment. But two other considerations are important also. Because the adjustment process has to be retrospective and because it applies to general dental practitioners as a group, newly appointed principals have their remuneration adjusted in respect of income that they did not receive, and the adjustment for individual principals will not be related to the actual incomes that they did receive. Moreover, where the adjustment process results in a reduction in net income at a time when the cost of living is rising sharply—as in 1974—the natural tendency on the part of dentists will be to make economies in their practice expenditure—for example, by deferring the purchase of new equipment—which will obviously have an adverse effect on the quality of service and on the productivity of dentists. If this reaction were not foreseen—as seems to have happened in 1974—a further downward adjustment would be necessary in the following year, with the same adverse effect. If the process were to be repeated in future years, the cumulative detrimental consequences for the provision of general dental services within the National Health Service would be very serious indeed. We take the view, therefore, that retrospective adjustment is inappropriate in principle, and that a system closer to the system which we adopt for dealing with general medical practitioners' expenses should be explored.

61. We now turn to the problem of output. Our recommendations for target average net income are designed to provide the 'average' general dental practitioner who spends broadly the 'average' hours on general dental service work with the level of remuneration that we judge to be appropriate, taking into account all relevant considerations. These considerations include the factors that affect output, including changes in working hours and improvements in productivity: the 'average' hours are those that we have accepted as standard[1]. Since at least 1952, the productivity of dentists (as measured by the volume of fees after correction for the effect of changes in age and practice structure and in the relativities within the fee scale) has increased steadily. Like our predecessors, we take the view that, where output has increased because of higher productivity which does not directly involve greater individual effort, the benefit should be shared between the dentist and the community; but, where output has increased because longer hours have been worked, the full benefit should accrue to the dentist. Between 1963 and 1973, hours of work fell and output rose, so that productivity (in the terms that we have defined) rose by just under 23 per cent in that period. We estimate that just over one-half of the benefit has been retained by the dentist in the form of reduced hours of work, since no adjustment has been made to target average net income on this account, and just under one-half by the community in the form of reduced costs, as the fee scale has been based on a projection of output throughout the period.

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[1]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 57).

62. The function of the Dental Rates Study Group is to decide the gross fee for each item of treatment so that the target average net income is achieved in the standard hours of work. In order to carry out its task, the Study Group needs to know the average time taken to complete the individual dental operations that make up the structure of the general dental service work of the 'average' general dental practitioner. Over the longer term, the times will change in the light of changes in dental techniques, and the structure will change in the light of changes in the pattern of demand. We welcome the intention of the Study Group to carry out a fresh inquiry into the timings of dental operations: we regard it as important that up-to-date information is available on which to base the fee scale. The Study Group also carries out on our behalf inquiries into total hours worked in a year by general dental practitioners and, as we have said before, we attach great importance to having regular and up-to-date information on which to base our recommendations. The last inquiry was carried out in 1974 and the next inquiry is being carried out in the current year: we welcome the decision to carry out inquiries at regular intervals of three years in the future, as we asked last year should be done. It follows that, if there is a significant change in the average hours spent on general dental service work, it should be reflected in the average net income received by general dental practitioners. This situation could arise if dentists were to take on a higher or lower proportion of work outside the NHS while maintaining the overall level of their workload unchanged, or if they made more (or less) personal effort than the level assumed in our target figure. Like the parallel system for general medical practitioners, the system of remuneration for general dental practitioners is designed to reflect variations both in the workload of individuals and in the general level for the group as a whole. Unless it becomes possible to differentiate between changes in output due to changes in personal effort (including working hours)—essentially a short term factor—and changes in productivity related to efficiency—essentially a long term factor—and we have been told by the Study Group on two previous occasions that it is not[1], adjustment as proposed by the Health Departments to correct for the difference between forecast and actual output (as measured by average gross income) means that the system will not operate flexibly and equitably. This is true also—but to a lesser extent—of the profession's suggestion that the fee scale for the coming year should be related to the previous year's output, since the benefit of increased productivity over the year would accrue to the dentist and, on the assumption that productivity will continue to rise, it would mean that, for a given amount of personal effort, dentists would earn a consistently higher level of remuneration each year than the target set by us. We, therefore, do not agree either with the Health Departments' proposal to adjust average gross income to correct retrospectively for under-estimates or over-estimates of output, or with the profession's proposal to base the fee scale simply on the level of output achieved in the previous year. We recognise the difficulty of achieving an acceptable degree of accuracy in attempting to distinguish the productivity changes that arise from the introduction of new equipment and improved techniques from those that arise

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[1]Review Body on Doctors' and Dentists' Remuneration, Fourth Report, 1974—Cmnd. 5644, June 1974 (paragraph 55).
Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 58).

from individual effort, but we nevertheless hope that the Study Group will be able to give further consideration to the problem to enable the fee scale for the coming year to be based on projected output within the standard hours in the future.

63. In dealing with the parallel problems in relation to general medical practitioners' remuneration, we have always taken the view that under-payment or over-payment—whether due to under-estimates or over-estimates of the volume of fees or the level of expenses—should not be carried forward into the calculation of the next year's remuneration. Our aim is to ensure that there is no persistent tendency in either direction, taking one year with another and assuming no change in the general level of workload and responsibility. The fact that there will be variations from the estimated average net remuneration that our recommendations on fees and allowances are designed to produce is inevitable in a system that has to rely on forecasts and is based on evidence of income and expenses that is up to two years out of date: provided that we continue to achieve our aim of keeping a balance taking one year with another, this seems to us to be the most acceptable system.

64. In the circumstances, we suggest that the Dental Rates Study Group should discontinue the practice of making adjustments each year to correct for under-provision or over-provision of average practice expenses. In our view, it would not be appropriate for retrospective adjustments to be made in respect of those years for which the out-turn for practice expenses is not yet known (that is, for 1975-76 and 1976-77) particularly since, as we have indicated, many dentists would be affected by the adjustment who had not been involved in the over-payment. We consider that, in future, when making provision for practice expenses, the Study Group should follow the principle of ensuring that there is no persistent tendency to under-payment or over-payment taking one year with another. But we take the view that the retrospective adjustment process should be completed in respect of 1974-75 since the out-turn is already known, in relation to the fee scale for 1977-78. Our proposals would involve making the third and final adjustment in respect of 1974-75 practice expenses—a deduction of £299—completing the cumulative process for that year, and making at the same time a compensatory adjustment to cancel out the initial adjustment in respect of 1975-76 practice expenses made to the 1976-77 practice expenses' provision—an addition of £52: the result would be to reduce the 1977-78 provision for average practice expenses by £247. This would then make way for a fresh start on the new system.

65. As we have explained (paragraph 12), we intend to consolidate the 1976 and 1977 cash supplements into the fee scale and to restore the established system of remuneration for general dental practitioners. The current rates of payment of the cash supplements that we recommended in 1976 and 1977 of £156 and £190, when added to the target average net income that we recommended in 1975 of £7,643, produce a current average rate of net income of £7,989. For 1978-79, we recommend that the target average net income should be £8,829 (*£10,511*).

66. **Salaried health centre dental practitioners.** We recommend the following salary scale for salaried health centre dental practitioners:

		Recommended scale from 1 April 1978	*Fully up-to-date scale appropriate to 1 April 1978*
		£	£
Salaried health centre dental practitioner ...	minimum of scale	4,896	*(5,691)*
	maximum of scale	7,137	*(8,283)*

The 1976 and 1977 cash supplements have been consolidated into the recommended scale.

CHAPTER 7

COMMUNITY DOCTORS AND DENTISTS

67. **Community medicine staff.** Difficulty in filling community physician posts has continued in 1977. Of 738 established posts in England and Wales, 122 have remained vacant—one more than in 1976. However, two appointments have been made on the special salary scale which we recommended in 1973 for use should it be found necessary to fill some of the posts on an interim basis, by appointing candidates who did not satisfy the full requirements of the appointments committees. There has been a further encouraging increase in the number of senior registrars and registrars in training posts in community medicine from 76 in 1976 to 108 in 1977.

68. We have not yet received proposals on the pay arrangements for administrative medical (and dental) officers in Scotland and Wales. The Health Departments recognised last year that there were some differences in responsibilities in area medical posts in Scotland and Wales from those in England, and we indicated that the implications of this were a matter for discussion between them and the profession in the first instance. The profession have drawn our attention to the fact that our 1975 recommendations altered the relationship established by us in 1973[1] between the chief officer supplements payable to community physicians in administrative medical posts and distinction awards. They have asked that the 1973 relationships should be restored. We for our part have never taken the view that there should be a fixed relationship between the chief officer supplements and distinction awards, nor do we regard a fixed relationship as appropriate now. Our 1975 recommendations established new relativities within the profession which we judged to be right at the time. The profession have told us that, if a new contract for hospital consultants along the lines of the proposals currently under discussion were agreed, they would want to negotiate a new contract for community physicians that would incorporate some of the features of that contract, and possibly some features of the general medical practitioners' system of remuneration as well. They have asked us to express a view on the form that a new contract for community physicians might take, but we do not consider it appropriate for us to do so: however, we would like to be kept informed of the progress of discussions on a new form of contract for community physicians, as we have been on developments on the consultant contract.

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[1]Review Body on Doctors' and Dentists' Remuneration, Supplement to Third Report. 1973—Cmnd. 5377, July 1973.

69. The Health Departments have told us that a new contract has been agreed for doctors in training posts in community medicine. At present, trainee community physicians are graded as registrar or senior registrar, and are paid on the equivalent hospital grade salary scale. From 1 April 1978, there will be one training grade only. The Health Departments have proposed a nine-point salary scale corresponding to the combined registrar and senior registrar scales in the hospital structure, with the object of facilitating assimilation on transfer between the two structures, and ensuring no reduction in the freedom of employing authorities to give incremental credit. The profession have suggested a six-point scale spanning the first point above the minimum of the registrar scale and the maximum of the senior registrar scale, in order to provide a measure of compensation for potential loss of earnings from Class A/B supplements on leaving the hospital training grades for the new specialty, and because the recommended training period in the new specialty does not exceed six years. A new form of supplement to salary will be payable to community medicine trainees in recognition of certain on-call commitments outside normal working hours[1]. The payments will relate primarily to duties as medical officer for environmental health in relation to communicable diseases and food poisoning, for which an emergency rota allowance is currently paid to doctors other than community physicians (or trainees), and for representing their employing authorities at certain committee meetings held in the evenings. Like the Class A/B supplements payable to junior hospital doctors, the supplements for out-of-hours commitments of community medicine trainees will be agreed with their employing authority and written into their contracts: they will also be payable at the rate for the normal duty week during periods of annual or study leave. There will be two rates of supplement: a payment in respect of duty on a weekday night from Monday to Friday, and a weekend payment in respect of all duties from Friday evening to Monday morning. Other than in exceptional circumstances, a community medicine trainee will not be contracted for a total out-of-hours commitment that exceeds one night in three and one weekend in three on average. The profession have suggested that the rates of supplement should be related to the level of earnings associated with on-call duties in hospital as a clinical assistant, work in a family planning clinic, and employment with a deputising service to provide out-of-hours cover for general practitioners on a sessional basis. For our part, we agree with the Health Departments' proposal for a nine-point scale corresponding to the combined registrar and senior registrar scale. Moreover, we understand that the form and period of specialist training in the new specialty is similar to that of doctors in clinical specialties at the same level. We consider that employing authorities should have discretion to fix the starting salary to take account of age, experience and qualifications. Since the responsibility that falls on community medicine trainees in relation to their environmental health on-call duties will be no different from the responsibility that falls on other community health medical staff in the same circumstances, it would not be appropriate for different rates of payment to apply: our recommendations are based on this approach.

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[1]40 hours a week.

70. **Community dentistry staff.** There has been a small reduction in the number of area dental officer and district dental officer posts that have been filled in England and Wales, from 140 in 1976 to 136 in 1977. Appointment of regional dental officers continues to be deferred. We have been told by the Health Departments and the profession that community dentistry has now been recognised by the Royal Colleges of Surgeons as a specialty in its own right, but that this does not imply recognition of consultant status. An Advisory Group on Training Posts in Community Dentistry has been set up and procedures have been agreed; as a result, progress is now expected to be made towards establishing a number of higher training programmes leading to accreditation in the new specialty of community dentistry. Until the consultant status issue is resolved, we shall continue to defer recommendations affecting the eligibility of community dentists for distinction awards. We have again been asked by the profession to restore the relationship between area dental officers and community medicine specialists that were established by the recommendations in the Second Supplement to our Third Report in 1973. We have given careful consideration to the profession's proposal, but we are unable to agree with it. The corresponding grade in the administrative medical structure to the area dental officer is the area medical officer, and the corresponding grade in the administrative dental officer structure to the district community physician (and community medicine specialist) is the district dental officer. The recommendations in the Second Supplement to our Third Report recognised these relationships, and those in our 1975 Report continued to do so. Our current recommendations do so also.

71. **Community health medical staff.** The number of community health medical staff (senior clinical medical officers[1], clinical medical officers and other medical staff) in England and Wales increased by 2·6 per cent to 7,036 in 1977. After consultation with interested organisations, the Government has accepted the general concept of an integrated child health service on the lines recommended by the Committee on Child Health Services[2]. But the Committee's proposal that there should be two new classes of doctors—general practitioner paediatricians and consultant community paediatricians—has not been accepted. The intention is that the provision of specialist paediatric services should be available increasingly on a community basis, and that all general medical practitioners should in future have adequate training in child health and should play a greater role in preventive work, particularly for children below school age. Since it will not be possible for general medical practitioners to take over responsibility for all preventive work for many years to come, a need is seen for other doctors with appropriate training to provide preventive services, particularly in schools, and to strengthen the services provided in under-doctored areas. The Health Departments intend to discuss with the profession the future career structure for community health medical staff in the light of these developments. The profession have again proposed that, in principle, the existing structure should be regarded as consisting of a career grade (senior clinical medical

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[1]The senior medical officer grade has been renamed senior clinical medical officer.

[2]The Report of the Committee on Child Health Services: Chairman, Professor S. D. M. Court—Cmnd. 6684, December 1976.

officer) and a training grade (clinical medical officer) although both are normally career grades. When we considered this proposal in 1975[1], we said that we could not attempt to anticipate possible changes in the future career structure of community health medical staff and we still take that view. We have taken account in our recommendations of the agreed increase from 4 weeks to 5 weeks in the annual leave entitlement of those clinical medical officers who are not at present eligible for 5 weeks annual leave[2] (and for doctors in training posts in community medicine).

72. **Community health dental staff.** The number of community health dental staff (consultant anaesthetists, consultant orthodontists, senior dental officers, dental officers and other anaesthetists) in England and Wales rose slightly by 0·7 per cent to 2,099 in 1977. In whole-time equivalent terms, the increase was higher at 2·0 per cent to 1,454. The profession have again suggested that the dental officer scale (and the salaried health centre dental practitioner scale which is linked to it) should be related to the first ten points of the assistant dental surgeon scale, which would effectively raise it by two increments. As we said when this proposal was put to us in 1975[3], we do not consider it would be appropriate for a dental officer on appointment to be paid the same salary as an assistant dental surgeon on appointment, since no service qualifications are required for entry into the dental officer grade, whereas four years service after registration is required for entry into the assistant dental surgeon grade. Our recommendations make provision for the extension of eligibility for day subsistence allowance to community health dental staff when working away from their normal clinic with effect from 1 April 1978 as proposed by the profession and agreed by the Health Departments[4].

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[1]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 66).

[2]Clinical medical officers on the first 7 points of the salary scale (and registrars in community medicine).

[3]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 67).

[4]Eligibility for day subsistence allowance has also been extended to community health medical staff in the same circumstances.

73. We recommend the following salary scales for community doctors and dentists:

		Recommended scales from 1 April 1978 (excluding earnings from out-of-hours supplements for trainees[1])	*Fully up-to-date scales appropriate to 1 April 1978*
		£	£
Community doctors			
Clinical medical officer	minimum of scale	5,175	(*6,012*)
	maximum of scale	7,155	(*8,292*)
Senior clinical medical officer ...	minimum of scale	7,362	(*8,529*)
	maximum of scale	10,152	(*12,069*)
Trainee in community medicine ...	minimum of scale	4,767	(*5,535*)
	maximum of scale	6,990	(*8,100*)
District community physician ...	minimum of scale	9,528	(*11,325*)
	maximum of scale	12,084	(*14,361*)
Area medical officer	minimum of scale (Band E)	12,180	(*14,481*)
	maximum of scale (Band C)	13,839	(*16,569*)
Regional medical officer ...	minimum of scale (Band B)	13,812	(*16,533*)
	maximum of scale (Band A)	14,565	(*17,691*)
Community dentists			
Dental officer ...	minimum of scale	4,896	(*5,691*)
	maximum of scale	7,137	(*8,283*)
Senior dental officer	minimum of scale	7,386	(*8,571*)
	maximum of scale	9,528	(*11,325*)
District dental officer	minimum of scale	7,224	(*8,502*)
	maximum of scale	9,300	(*10,770*)
Area dental officer ...	minimum of scale (Band E)	9,771	(*11,586*)
	maximum of scale (Band C)	11,100	(*13,254*)
Regional dental officer	minimum of scale (Band B)	11,076	(*13,227*)
	maximum of scale (Band A)	11,814	(*14,154*)

The 1976 and 1977 cash supplements have been consolidated into the recommended salary scales.

74. Our detailed recommendations are in Appendix A.

[1]We estimate that earnings from out-of-hours supplements will involve an addition to basic salary of just under 10 per cent on average for trainees.

CHAPTER 8

SUMMARY OF RECOMMENDATIONS

75. We have explained why we believe it to have been in the interest of doctors and dentists themselves, as well as of the community as a whole, that observance of the restraint measures should take precedence over our normal criteria in assessing the amounts within the up-to-date rates of remuneration to be introduced immediately. We are satisfied that the increases which we recommend in doctors' and dentists' remuneration for immediate introduction with effect from 1 April 1978 are consistent with the Government's current guidelines[1], and we summarise our main recommendations below:

		Recommended scales from 1 April 1978 (excluding earnings from Class A/B supplements for training grades)	*Fully up-to-date scales appropriate to 1 April 1978*
		£	£
Hospital doctors and dentists (main grades) (whole-time salaries)			
House officers ...	minimum	3,420	*(3,897)*
	maximum	3,876	*(4,407)*
Senior house officers	minimum	4,257	*(4,881)*
	maximum	4,767	*(5,535)*
Registrars ...	minimum	4,767	*(5,535)*
	maximum	5,766	*(6,696)*
Senior registrars ...	minimum	5,460	*(6,345)*
	maximum	6,990	*(8,100)*

The above scales take into account adjustment for the change in the basis of remuneration to relate basic pay to the standard working week, and the cost of one week's extra leave for senior house officers and registrars. The effect of consolidating the 1976 and 1977 cash supplements will be to increase individual earnings from Class A/B supplements over and above the increases implied by the recommended scales.

Consultants ...	minimum	9,528	*(11,325)*
	maximum	12,084	*(14,361)*
Community doctors and dentists (selected grades) (whole-time salaries)			
Clinical medical officers	minimum	5,175	*(6,012)*
	maximum	7,155	*(8,292)*
Dental officers ...	minimum	4,896	*(5,691)*
	maximum	7,137	*(8,283)*

[1]"The Attack on Inflation after 31st July 1977"—Cmnd. 6882, July 1977.

	Recommended rates from 1 April 1978 £	*Fully up-to-date rates appropriate to 1 April 1978* £
General medical practitioners		
Average net remuneration from fees and allowances	9,785	*(11,640)*
General dental practitioners		
Average net remuneration from fees and allowances	8,829	*(10,511)*
Ophthalmic medical practitioners		
Net remuneration element of sight-testing fee	2·10	*(2·50)*

The detailed changes that we recommend are listed in Appendix A. We estimate the overall cost of these increases and of agreed improvements in conditions of service, excluding provision for practice expenses and employer's superannuation and national insurance contributions, to be about £66·2 million or 10·0 per cent of net remuneration in 1977-78.

76. The levels of salary indicated in *italics* in this table are those that we judge to be *appropriate for introduction on 1 April 1978* in the light of the evidence already available to us and of our normal criteria, were it not for the existence of the current restraint measures. Implementation of these rates would involve a further increase of £135 million or 18·5 per cent in overall net remuneration.

77. By comparison with others in the community at the same income levels in 1975, junior hospital doctors and dentists have fared not too badly following the introduction of their new contract. But consultants have fared particularly badly over the same period, and most general medical practitioners and general dental practitioners have not done much better. Over the next 12 months, their relative position will deteriorate further. Because of this, we feel bound to focus attention yet again on the demonstrable injustice of the impact of successive stages of restraint measures on pay systems and structures with which they were not designed to be compatible. The up-to-date rates of remuneration speak for themselves. The consequences for the community will be increasingly serious if members of the medical and dental professions continue to be subjected to treatment that is so patently discriminatory. We regard it as essential that rates of pay based on those indicated in *italics* in the table updated in the light of the relevant information at the time should be introduced in not more than three stages —of which our present recommendations are the first—and should be fully in operation in that form not later than 1 April 1980. The difference between the levels of pay that we recommend for implementation now and those that we judge to be appropriate is the measure of the extent to which remuneration has fallen below the true worth of the professions since 1 April 1975. We see an assurance that it will be brought fully up-to-date no later than 1 April

1980 as essential to the restoration of a measure of confidence in the future treatment of doctors and dentists in the NHS.

ERNEST WOODROOFE, *Chairman*
R. H. GRAVESON
MARY GREEN
IAN W. MACDONALD
PETER MENZIES
P. G. MOORE
RAYMOND W. PENNOCK
W. K. M. SLIMMINGS

OFFICE OF MANPOWER ECONOMICS

4 April 1978

APPENDIX A

DETAILED RECOMMENDATIONS ON REMUNERATION

PART I: PRESENT AND RECOMMENDED SALARY SCALES

The salary scales that we recommend for full-time hospital and community doctors and dentists are set out below: rates of payment of part-time staff should be increased pro rata. The 1976 cash supplement of £312 and the 1977 cash supplement of £208 (or £105 in the case of the hospital training grades) payable in addition to the present scales have been consolidated into the recommended scales: the figures in *italics* shown in brackets indicate the levels of remuneration that are appropriate to a *fully up-to-date 1 April 1978 pay structure.*

A. Hospital medical and dental staff

	Present scales	Recommended scales payable from 1 April 1978 (excluding earnings from Class A/B supplements for training grades)	*Fully up-to-date scales appropriate to 1 April 1978*
	£	£	£
House officer	2,859	3,420	(*3,897*)
	3,075	3,648	(*4,152*)
	3,294	3,876	(*4,407*)
Senior house officer	3,663	4,257	(*4,881*)
	3,906	4,512	(*5,208*)
	4,152	4,767	(*5,535*)
Registrar	4,152	4,767	(*5,535*)
	4,374	4,998	(*5,805*)
	4,596	5,229	(*6,075*)
	4,818	5,460	(*6,345*)
	5,109	5,766	(*6,696*)
Senior registrar	4,818	5,460	(*6,345*)
	5,109	5,766	(*6,696*)
	5,403	6,072	(*7,047*)
	5,694	6,378	(*7,398*)
	5,985	6,684	(*7,749*)
	6,279	6,990	(*8,100*)
Consultant	7,536	9,528	(*11,325*)
	8,322	10,167	(*12,084*)
	9,111	10,806	(*12,843*)
	9,900	11,445	(*13,602*)
	10,689	12,084	(*14,361*)
Senior hospital medical and dental officer	7,242		
	7,476		
	7,644		
	7,812	9,528	(*11,325*)

A. Hospital medical and dental staff—*continued*

	Present scales	Recommended scales payable from 1 April 1978	*Fully up-to-date scales appropriate to 1 April 1978*
	£	£	£
Medicalassistant and assistant dental surgeon	4,548		
	4,806		
	5,064	5,892	(*6,843*)
	5,322		
	5,580	6,390	(*7,419*)
	5,814		
	6,036	6,888	(*7,995*)
	6,258		
	6,480	7,386	(*8,571*)
	6,702		
	6,924	8,100	(*9,489*)
	7,146		
	7,368	8,814	(*10,407*)
	7,590		
	7,812	9,528	(*11,325*)
	annual rate	per weekly notional half-day	
	£	£	£
Clinical assistant (part-time medical and dental officer appointed under paragraph 94 or 107 of Terms and Conditions of Service)	610	702	(*834*)
Hospital practitioner (limited to a maximum of 5 weekly sessions)	610	702	(*834*)
	646	744	(*885*)
	682	786	(*936*)
	718	828	(*987*)
	754	870	(*1,038*)
	790	912	(*1,089*)
	826	954	(*1,140*)

B. Community medicine staff

	Present scales	Recommended scales payable from 1 April 1978 (excluding earnings from out-of-hours supplements for trainees)	*Fully up-to-date scales appropriate to 1 April 1978*
	£	£	£
Trainee in community medicine (formerly Registrar (Community medicine) and Senior Registrar (Community medicine))	4,152	4,767	(*5,535*)
	4,374	4,998	(*5,805*)
	4,596	5,229	(*6,075*)
	4,818	5,460	(*6,345*)
	5,109	5,766	(*6,696*)
	5,403	6,072	(*7,047*)
	5,694	6,378	(*7,398*)
	5,985	6,684	(*7,749*)
	6,279	6,990	(*8,100*)

B. Community medicine staff—*continued*

	Present scales £	Recommended scales payable from 1 April 1978 £	*Fully up-to-date scales appropriate to 1 April 1978* £
District community physician or other community medicine specialist (of consultant status)	7,536	9,528	(*11,325*)
	8,322	10,167	(*12,084*)
	9,111	10,806	(*12,843*)
	9,900	11,445	(*13,602*)
	10,689	12,084	(*14,361*)
Area medical officer* (Band E—Area 150,000–450,000 population)	10,785	12,180	(*14,481*)
	10,983	12,381	(*14,733*)
	11,184	12,582	(*14,985*)
	11,385	12,783	(*15,237*)
	11,586	12,984	(*15,489*)
Area medical officer* (Band D—Area 450,000–800,000 population)	11,256	12,651	(*15,075*)
	11,454	12,852	(*15,327*)
	11,655	13,053	(*15,579*)
	11,856	13,254	(*15,831*)
	12,057	13,455	(*16,083*)
Area medical officer* (Band C—Area over 800,000 population)	11,643	13,038	(*15,561*)
	11,841	13,239	(*15,813*)
	12,042	13,440	(*16,065*)
	12,243	13,641	(*16,317*)
	12,444	13,842	(*16,569*)
Regional medical officer (Band B—Region under 3·5 million population)	12,417	13,812	(*16,533*)
	12,618	14,013	(*16,785*)
	12,819	14,214	(*17,037*)
	13,020	14,415	(*17,289*)
Regional medical officer (Band A—Region 3·5 million population and over)	12,735	14,130	(*16,935*)
	12,936	14,331	(*17,187*)
	13,137	14,532	(*17,439*)
	13,338	14,733	(*17,691*)

*Chief administrative medical officer in Scotland.

1. The supplement payable to area medical officers in areas which include a teaching hospital should be increased from £460 to £516 (*£615*).

2. The agreed salary scales for area medical officers in areas with a population of less than 150,000 should be increased in line with the recommended scale for area medical officers in areas with a population of 150,000–450,000.

3. The scale for interim appointments to community medicine specialist posts should be increased from £6,450 × £345 (7) — £8,865 to £7,362 × £450 (7) — £10,512 (*£8,529 × £567 (7) — £12,498*).

Former administrative medical staff of Regional Hospital Boards (protected salary scales)

	Present scales £	Recommended scales payable from 1 April 1978 £	*Fully up-to-date scales appropriate to 1 April 1978* £
Senior administrative medical officer (largest Regional Hospital Boards) ...	11,610	13,005	(*15,519*)
	11,844	13,239	(*15,813*)
	12,078	13,473	(*16,107*)
	12,312	13,707	(*16,401*)
	12,546	13,941	(*16,695*)
	12,780	14,175	(*16,989*)
Principal assistant senior medical officer	7,143	9,210	(*10,947*)
	7,536	9,528	(*11,325*)
	7,929	9,849	(*11,706*)
	8,322	10,167	(*12,084*)
	8,718	10,488	(*12,465*)
	9,111	10,806	(*12,843*)
	9,507	11,127	(*13,224*)
Assistant senior medical officer ...	6,480	7,386	(*8,571*)
	6,813	7,923	(*9,261*)
	7,146	8,457	(*9,948*)
	7,479	8,994	(*10,638*)
	7,812	9,528	(*11,325*)
	8,157	9,849	(*11,706*)
	8,502	10,167	(*12,084*)
Administrative medical superintendent in Scotland (largest hospitals) ...	7,329	9,264	(*11,019*)
	7,716	9,582	(*11,394*)
	8,103	9,900	(*11,769*)
	8,490	10,218	(*12,144*)
	8,880	10,536	(*12,519*)
	9,270	10,854	(*12,894*)
	9,660	11,172	(*13,269*)

C. Community health medical staff

	Present scales	Recommended scales payable from 1 April 1978	*Fully up-to-date scales appropriate to 1 April 1978*
	£	£	£
Clinical medical officer	4,422	5,175	(*6,012*)
	4,605	5,373	(*6,240*)
	4,788	5,571	(*6,468*)
	4,971	5,769	(*6,696*)
	5,157	5,967	(*6,924*)
	5,343	6,165	(*7,152*)
	5,529	6,363	(*7,380*)
	5,715	6,561	(*7,608*)
	5,901	6,759	(*7,836*)
	6,087	6,957	(*8,064*)
	6,273	7,155	(*8,292*)
Senior clinical medical officer	6,450	7,362	(*8,529*)
	6,633	7,641	(*8,883*)
	6,819	7,920	(*9,237*)
	7,005	8,199	(*9,591*)
	7,191	8,478	(*9,945*)
	7,377	8,757	(*10,299*)
	7,563	9,036	(*10,653*)
	7,749	9,315	(*11,007*)
	7,935	9,594	(*11,361*)
	8,121	9,873	(*11,715*)
	8,307	10,152	(*12,069*)

Former Medical Officers of Health (protected salary scales)

Population group	Present range	Range of minimum salaries: Recommended range from 1 April 1978	*Fully up-to-date range appropriate to 1 April 1978*
	£	£	£
Up to 100,000	6,204– 8,052	7,077– 9,789	*(8,202–11,616)*
100,001/200,000	7,521– 9,282	9,510–11,010	*(11,301–13,083)*
200,001/400,000	8,508–10,389	10,395–11,745	*(12,354–13,959)*
400,001/600,000	9,516–11,271	11,139–12,669	*(13,236–15,096)*
Over 600,000	At discretion	An addition of 12·4 per cent, rounded to the nearest multiple of £3*.	*(An addition of 34 per cent, rounded to the nearest multiple of £3*.)*

Population group	Present increments	Annual increments: Recommended increments from 1 April 1978	*Fully up-to-date increments appropriate to 1 April 1978*
Up to 100,000	4 × £210	4 × £249	*(4 × £291)*
100,001/200,000	4 × £219	4 × £267	*(4 × £318)*
200,001/400,000	4 × £306	4 × £360	*(4 × £427)*
400,001/600,000	4 × £339	4 × £387	*(4 × £462)*
Over 600,000	At discretion	An addition of 12·4 per cent to the existing increments, rounded to the nearest multiple of £3*.	*(An addition of 34 per cent to the existing increments, rounded to the nearest multiple of £3*.)*

Allowances payable depending on number of appointments held

Appointments	Present allowance	Recommended allowance from 1 April 1978	*Fully up-to-date allowance appropriate to 1 April 1978*
	£	£	£
2	492	555	*(660)*
3	645	729	*(867)*
4 or more	732	828	*(984)*

*To provide for equal monthly payment.

D. Community dentistry staff

	Present scales	Recommended scales payable from 1 April 1978	*Fully up-to-date scales appropriate to 1 April 1978*
	£	£	£
District dental officer	5,652	7,224	(*8,502*)
	6,243	7,743	(*9,069*)
	6,834	8,262	(*9,636*)
	7,425	8,781	(*10,203*)
	8,016	9,300	(*10,770*)
Area dental officer* (Band E—Area 150,000–450,000 population)	8,628	9,771	(*11,586*)
	8,787	9,933	(*11,787*)
	8,946	10,095	(*11,988*)
	9,108	10,257	(*12,189*)
	9,270	10,419	(*12,390*)
Area dental officer* (Band D—Area 450,000–800,000 population)	9,006	10,149	(*12,060*)
	9,165	10,311	(*12,261*)
	9,324	10,473	(*12,462*)
	9,486	10,635	(*12,663*)
	9,648	10,797	(*12,864*)
Area dental officer* (Band C—Area over 800,000 population)	9,315	10,458	(*12,450*)
	9,474	10,620	(*12,651*)
	9,633	10,782	(*12,852*)
	9,795	10,944	(*13,053*)
	9,957	11,106	(*13,254*)
Regional dental officer† (Band B—Region under 3·5 million population)	9,933	11,076	(*13,227*)
	10,092	11,238	(*13,428*)
	10,254	11,400	(*13,629*)
	10,416	11,562	(*13,830*)
Regional dental officer† (Band A—Region 3·5 million population and over)	10,188	11,328	(*13,551*)
	10,347	11,490	(*13,752*)
	10,509	11,652	(*13,953*)
	10,671	11,814	(*14,154*)

*Chief administrative dental officer in Scotland.
†For full-time appointments: pro rata for part-time appointments.

1. The supplement payable to district dental officers in districts which include a dental teaching hospital should be increased from £330 to £369 (*£438*).

2. The supplement payable to area dental officers in areas which include a dental teaching hospital should be increased from £370 to £414 (*£492*).

3. The agreed salary scales for area dental officers in areas with a population of less than 150,000 should be increased in line with the recommended scale for area dental officers in areas with a population of 150,000–450,000.

E. Community health dental staff

	Present scales	Recommended scales payable from 1 April 1978	*Fully up-to-date scales appropriate to 1 April 1978*
	£	£	£
Dental officer	4,152	4,896	(*5,691*)
	4,374	5,145	(*5,979*)
	4,548	5,394	(*6,267*)
	4,806	5,643	(*6,555*)
	5,064	5,892	(*6,843*)
	5,322	6,141	(*7,131*)
	5,580	6,390	(*7,419*)
	5,814	6,639	(*7,707*)
	6,036	6,888	(*7,995*)
	6,258	7,137	(*8,283*)
Principal dental officer	6,480	7,386	(*8,571*)
	6,702	7,743	(*9,030*)
	6,924	8,100	(*9,489*)
	7,146	8,457	(*9,948*)
	7,368	8,814	(*10,407*)
	7,590	9,171	(*10,866*)
	7,812	9,528	(*11,325*)

Part-time dental surgeon:

	Present rates	Recommended rates from 1 April 1978	*Fully up-to-date rates appropriate to 1 April 1978*
	£	£	£
Sessional fee (per hour)			
Dental surgeon	3·87	4·40	(*5·10*)
Dental surgeon holding registrable higher qualifications	4·80	5·85	(*6·95*)
Dental surgeon employed as consultant	6·17	6·95	(*8·30*)

PART II: DETAILED RECOMMENDATIONS ON FEES AND ALLOWANCES

The 1976 cash supplement payable to general medical practitioners and general dental practitioners, and the 1977 cash supplement payable to general medical practitioners, general dental practitioners and ophthalmic medical practitioners have been consolidated into the recommended fees and allowances.

(Note: Some of these items have not been revised since April 1975).

Operative date

1. The new levels of remuneration set out below should operate from 1 April 1978: figures in *italics* shown in brackets indicate the levels of remuneration considered appropriate to a *fully up-to-date 1 April 1978 pay structure*.

Hospital medical and dental staff

2. The annual values of distinction awards to consultants remain unchanged (*the annual values considered appropriate to a fully up-to-date 1 April 1978 pay structure are as follows: A plus award £12,912, A award £9,873, B award £5,871 and C award £2,547*). The number of A plus awards should be increased from 134 to 135, of A awards from 500 to 505, of B awards from 1,431 to 1,444 and of C awards from 3,277 to 3,308.

3. The allowance for a consultant, general medical practitioner or general dental practitioner member of a District Management Team appointed to represent their District Medical Committee should be increased from £950 to £1,089 (*£1,296*) a year.

4. The allowance for a senior hospital medical or dental officer occupying a post graded as a consultant post should be increased from £1,299 to £1,371 (*£1,518*) a year.

5. The special allowance for the medical superintendents of psychiatric hospitals should be increased from £681 to £771 (*£915*) a year.

6. The maximum rate of allowance for junior hospital doctors in peripheral hospitals should be increased from £324 to £375 (*£429*) a year.

7. Extra duty allowances for medical assistants and assistant dental surgeons should be increased from £20·50 to £24·80 (*£29·30*) per unit.

8. The fee for domiciliary consultations should be increased from £10·90 to £12·30 (*£14·65*) a visit. Additional fees should be increased pro rata.

9. The fee for exceptional consultations should be increased as follows:

Consultant	from £20·40 to £23·10 (*£27·40*).
General practitioner	from £6·85 to £7·90 (*£9·40*).

10. The fees for lectures to nurses and other non-medical and non-dental staff should be increased as follows:

Consultant	from £7·50 to £8·90 (*£10·55*).
Senior hospital medical and dental officer	from £5·90 to £7·20 (*£8·55*).
Medical assistant, assistant dental surgeon and senior registrar	from £5·30 to £6·00 (*£6·95*).
Other grades	from £4·40 to £5·05 (*£5·85*).

11. The fee for a lecture on a professional subject to a group of hospital doctors or dentists should be increased from £10·20 to £11·55 (*£13·70*).

12. Weekly and sessional rates for locum appointments in the hospital service should be increased as follows:

Consultant appointment ...	from £179·85 to £213·40 (*£253·55*) a week; from £16·35 to £19·40 (*£23·05*) a notional half-day.
Medical assistant, assistant dental surgeon, senior hospital medical and dental officer appointment ...	from £126·50 to £144·10 (*£167·20*) a week; from £11·50 to £13·10 (*£15·20*) a notional half-day.
Senior registrar appointment...	from £106·15 to £119·50 (*£138·50*) a week; from £10·62 to £11·95 (*£13·85*) a unit of medical time.
Registrar appointment ...	from £88·00 to £100·00 (*£116·50*) a week; from £8·80 to £10·00 (*£11·65*) a unit of medical time.
Senior house officer appointment	from £74·25 to £86·00 (*£99·00*) a week; from £7·43 to £8·60 (*£9·90*) a unit of medical time.
House officer appointment ...	from £59·40 to £70·50 (*£80·00*) a week; from £5·94 to £7·05 (*£8·00*) a unit of medical time.
Hospital practitioner appointment	from £13·80 to £15·90 (*£18·95*) a notional half-day.
Clinical assistant appointment (part-time medical and dental officer appointment under paragraph 94 or 107 of Terms and Conditions of Service)	from £11·80 to £13·60 (*£16·20*) a notional half-day.

13. Payments to general practitioners who work in general practitioner hospital units or who are employed as part-time medical and dental officers at convalescent homes, general practitioner maternity hospitals or other types of hospital, or who do occasional work in the blood transfusion service under paragraph 89, 94, 107, or 108 of Terms and Conditions of Service should be increased as follows:

a. Payment to staff funds for general practitioner hospital units	from £86·85 to £100·20 (*£119·20*) per bed.
b. Payments to part-time medical and dental officers at convalescent homes, general practitioner maternity hospitals or other types of hospital	from £610 to £702 (*£834*) a year for each weekly notional half-day, the maximum to be increased from £5,490 to £6,318 (*£7,506*); from £160 to £186 (*£219*) a year for one hour or less per week; from £320 to £372 (*£438*) a year for over one hour but not more than two hours per week.
c. Payments for occasional work in the blood transfusion service	from £3·30 to £3·80 (*£4·55*) per hour or part of an hour, the maximum to be increased from £9·90 to £11·40 (*£13·65*) per session.

14. Fees for family planning work should be increased by 11·3 (*34·4*) per cent.

15. The Health Departments should make the necessary adjustment to other fees or allowances as a consequence of our salary recommendations.

Ophthalmic medical practitioners

16. The net remuneration element in the ophthalmic medical practitioners' fee for sight-testing should be increased from £1·86 to £2·10 (*£2·50*).

General medical practitioners

17. The full rate of basic practice allowance should be increased from £2,595 to £3,030 (*£3,415*) a year and the proportional rate and leave payment pro rata.

18. The additions to basic practice allowance should be increased as follows:

Designated area allowance	
Type 1	from £750 to £940 (*£1,055*) a year.
Type 2	from £1,150 to £1,440 (*£1,620*) a year.
Group practice allowance ...	from £420 to £525 (*£590*) a year.
Seniority allowance:	
First stage	from £580 to £725 (*£815*) a year.
Second stage	from £985 to £1,235 (*£1,385*) a year.
Third stage	from £1,570 to £1,965 (*£2,210*) a year.
Vocational training allowance	from £580 to £725 (*£815*) a year.
Allowance for the employment of a full-time assistant:	
Ordinary level	from £1,115 to £1,345 (*£1,515*) a year.
Where the principal receives the designated area allowance	from £1,555 to £1,875 (*£2,110*) a year.

19. Standard capitation fees should be increased as follows:

Patients aged under 65 ...	from £2·45 to £2·70 (*£3·05*) a year.
Patients aged 65 to 74 ...	from £3·30 to £3·50 (*£3·95*) a year.
Patients aged 75 and over ...	from £4·00 to £4·30 (*£4·85*) a year.

20. Payments for out-of-hours responsibilities should be increased as follows:

Supplementary practice allowance (full rate)	from £515 to £595 (*£670*) a year, and the proportional rate pro rata.
Supplementary capitation fee (for each patient in excess of 1,000 on the list)	from 47p to 54p (*61p*) a year.
Night visit fee	from £4·60 to £5·75 (*£6·50*).

21. The fees for items of service carried out for reasons of public policy should be increased as follows:

Vaccination and immunisation:	
lower rate	from 80p to £1·00 (*£1·15*).
higher rate	from £1·15p to £1·45 (*£1·60*).
Cervical cytology test ...	from £2·30 to £2·90 (*£3·25*).

22. The fee for doctors on the obstetric list providing complete maternity services should be increased from £35·75 to £41·60 (*£46·80*) and other maternity medical services fees pro rata.

23. The temporary resident fees should be increased as follows:

Patients expecting to remain in the district for:	
not more than 15 days ...	from £2·00 to £2·20 (*£2·40*).
more than 15 days	from £3·00 to £3·30 (*£3·60*).

24. The fees for emergency treatment given by a practitioner in an emergency to a patient not on his list should be increased as follows:

Emergency consultation ...	from £4·60 to £5·75 (*£6·50*).
Minor surgical operation involving local or general anaesthetic	from £4·60 to £5·75 (*£6·50*).
Treatment of fracture ...	from £4·60 to £5·75 (*£6·50*).
Reduction of dislocation ...	from £4·60 to £5·75 (*£6·50*).
Administration of nitrous oxide or ethyl-chloride ...	from £4·60 to £5·75 (*£6·50*).
Administration of any other general anaesthetic ...	from £7·65 to £9·55 (*£10·75*).

25. The fees for the provision of an anaesthetist should be increased as follows:

Administration of nitrous oxide or ethyl-chloride ...	from £4·60 to £5·75 (*£6·50*).
Administration of any other general anaesthetic ...	from £7·65 to £9·55 (*£10·75*).

26. The fees for arrest of dental haemorrhage should be increased as follows:

lower rate	from £3·10 to £3·90 (*£4·35*).
higher rate	from £4·60 to £5·75 (*£6·50*).

27. The post graduate training allowance should be increased from £215 to £270 (*£305*).

28. The training grant under the trainee practitioner scheme should be increased from £1,300 to £1,625 (*£1,830*) a year.

29. The initial practice allowance should be increased as follows:

Type A	Maximum allowance
First year	from £4,000 to £5,070 (*£5,700*).
Second year	from £2,680 to £3,380 (*£3,800*).
Third year	from £1,330 to £1,690 (*£1,900*).
Fourth year	from £675 to £845 (*£950*).
Type B	Maximum allowance
First year	from £6,680 to £8,450 (*£9,500*).
Second year	from £2,680 to £3,380 (*£3,800*).
Type C	Allowance payable
First year	from £3,540 to £4,440 (*£4,980*).
Second year	from £2,655 to £3,330 (*£3,735*).
Third year	from £1,770 to £2,220 (*£2,490*).
Fourth year	from £885 to £1,110 (*£1,245*).
Type D	Guaranteed net income (for up to 5 years from date of appointment of first doctor)
First doctor	from £11,030 to £12,720 (*£15,130*).
Second doctor	from £8,485 to £9,785 (*£11,640*).

The Health Departments should negotiate the amount to be compared with total reckonable income for calculation of the appropriate initial practice allowance (Type A and B) and the amounts of the Type C allowance payable under superseded conditions.

30. Rural practice funds should be increased by 12·7 (*26·6*) per cent.

31. The Health Departments should discuss with the profession net payments in respect of the dispensing and supply of drugs and appliances.

32. The maximum weekly rate of locum allowance should be increased from £90 to £100 (*£115*).

33. The fees for contraceptive services should be increased as follows:

Ordinary fee	...	...	from £3·50 to £3·80 (*£4·30*).
Intra-uterine device fee	...	...	from £10·00 to £12·25 (*£14·80*).

General dental practitioners

34. The target average net income from general dental services for all principals, full-time and part-time together, working wholly or partly in these services, should be £8,829 (*£10,511*) in the year beginning 1 April 1978.

35. The scale for salaried health centre dental practitioners should be £4,896 (*£5,691*)—£5,145 (*£5,979*)—£5,394 (*£6,267*)—£5,643 (*£6,555*)—£5,892 (*£6,843*)—£6,141 (*£7,131*)—£6,390 (*£7,419*)—£6,639 (*£7,707*)—£6,888 (*£7,995*)—£7,137 (*£8,283*).

The sessional fee for part-time practitioners working six 3-hour sessions a week or less in a health centre should be £13·25 (*£15·35*) a session.

Community doctors and dentists

36. The supplements payable to trainees in community medicine for out-of-hours commitments should be as follows:

Night duty	...	...	£4·55 (*£5·25*) a night.
Weekend duty	...	...	£22·75 (*£26·25*) a weekend.

37. The Health Departments should make the necessary adjustments to other fees and allowances as a consequence of our salary recommendations.

APPENDIX B

MOVEMENTS IN DOCTORS' AND DENTISTS' EARNINGS TO APRIL 1977

1. An analysis of movements to April 1976 in doctors' and dentists' earnings compared with earnings at comparable levels of salaried incomes was included in the Seventh Report[1]. The effect of the recommendations in that Report is shown in the table below, which relates to April 1977. The figures for movements in the earnings of comparable income groups are based on the results of the New Earnings Survey for April 1977. The position at April 1978 after taking account of the recommendations in this Report will not be known until the results of the New Earnings Survey for April 1978 become available in late 1978.

2. The analysis is based on levels of remuneration recommended in the Fifth Report and includes the cash supplements recommended in the Sixth and Seventh Reports. It does not take account of reductions in earnings arising from the deferment of the implementation of the second stage of the April 1975 increases on salaries above £13,000 or which took salaries above that level; or from the temporary withholding for 12 months from 1 August 1975 under the pay restraint measures of payment of distinction awards received in the Advisory Committee's 1975-76 review, of increments to consultants and community physicians above the scale minimum, and of new or enhanced seniority payments to general medical and general dental practitioners earning £8,500 or more a year. The overall effect of these restrictions in pay on April 1976 and April 1977 earnings is under 1 per cent in each year: the difference from the April 1976 position (column (f)) is unchanged but the cumulative difference from the April 1975 position (column (g)) increases the shortfall for all doctors and dentists from 15 per cent to 16 per cent. For hospital doctors and dentists, the analysis is based on salaries (and distinction awards where payable), but includes average income from extra duty allowances and Class A/B salary supplements as appropriate paid to the training grades and medical assistants[2]. The corresponding New Earnings Survey percentile earnings include overtime pay and are adjusted to remove the effect of the movements of medical practitioners included in the sample (paragraph 14).

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[1]Review Body on Doctors' and Dentists' Remuneration, Seventh Report, 1977—Cmnd. 6800, May 1977 (Appendix B).

[2]If no account were to be taken of these additional earnings and the comparison was based on earnings excluding overtime pay, the cumulative shortfall (column (g)) for all doctors and dentists would be increased from 15 per cent to 19 per cent, and for hospital training grades the surpluses or shortfalls shown would be replaced by shortfalls ranging from 18 per cent for senior registrar (4th point) to 13 per cent for house officer (minimum).

Movements in earnings compared with corresponding NES percentiles at April 1977

	(a)	(b)	(c)	(d)	(e)	(f)	(g)
	Earnings[1]			*Corresponding NES percentile earnings April 1977*		*Difference in earnings from April 1976 earnings relative to percentile*[2]	*Cumulative difference in earnings from April 1975 earnings relative to percentile*[2]
	April 1976	*April 1977*					
	Amount	*Amount*	*Index (April 1976=100)*	*Percentile*	*Index (April 1976=100)*		
	£	£				per cent	per cent
House officer (minimum)	4,372	4,580	105	50th	111	—6	—1
Senior house officer (minimum)	5,338	5,546	104	25th	109	—5	+2
Registrar (minimum)	5,940	6,148	104	25th	109	—5	—3
Senior registrar (minimum)	6,588	6,796	103	10th	108	—5	—5
(4th point)	7,729	7,937	103	10th	108	—5	—4
Consultant and Community medicine specialist (minimum)	7,848	8,056	103	2·5th	108	—5	—17
(maximum)	10,689	10,897	102	0·75th	107	—5	—20
(with C award)	12,714	12,922	102	0·5th	108	—6	—19
Medical assistant (minimum)	5,270	5,478	104	25th	109	—5	—15
(maximum)	8,534	8,742	102	2nd	108	—5	—17
Clinical medical officer (minimum)	4,734	4,942	104	25th	109	—4	—14
(maximum)	6,585	6,793	103	5th	108	—5	—16
Senior medical officer (maximum)	8,499	8,707	102	1·5th	108	—5	—19
Dental officer (minimum)	4,464	4,672	105	25th	109	—4	—13
(maximum)	6,570	6,778	103	5th	108	—5	—16
Senior dental officer (maximum)	8,124	8,332	103	2nd	108	—5	—17
Ophthalmic medical practitioner	9,281	9,444	102	1st	108	—6	—21
General medical practitioner	8,593	8,818	103	1·5th	108	—5	—20
General dental practitioner	7,798	8,011	103	2·5th	108	—5	—19
All doctors[3]	8,071	8,283	103		108	—5	—15
All dentists[3]	7,681	7,892	103		108	—5	—19
All doctors and dentists[3]	7,990	8,203	103		108	—5	—15

Source: Office of Manpower Economics

[1]The earnings shown for doctors and dentists are salaries for hospital and community doctors and dentists, including distinction awards for consultants and average amounts of extra duty allowances and Class A/B salary supplements for eligible hospital grades based on information available for 1975 and 1976 respectively; intended average net remuneration for general medical practitioners (excluding income from the implementation of the extension of contraceptive services and the extension of the Women Doctors Retainer Scheme) and for general dental practitioners; and the implied average net remuneration for full-time ophthalmic medical practitioners (from sight-testing fees) as recommended in the Fifth Report: the earnings for 1976 include the full cash supplement of £312 for all grades of hospital and community doctors and dentists at or below the level of consultant (minimum) or equivalent; for senior medical officer (maximum), a reduced cash supplement of £192; for general medical practitioners, an estimated average of £108 cash supplement; and for general dental practitioners, an estimated average of £155 cash supplement: and the earnings for 1977 include the 1976 cash supplement (at revised estimated average amounts of £126 for general medical practitioners and £178 for general dental practitioners) and the full 1977 cash supplement of £208 for all grades of hospital and community doctors and dentists (hospital training grades received on average £103 from the change in basis of their remuneration and a reduced cash supplement of £105); an estimated average of £163 for ophthalmic medical practitioners; an estimated average of £207 for general medical practitioners; and an estimated average of £190 for general dental practitioners. For general medical and general dental practitioners, no allowance has been made for the difference between net remuneration and the latest provisional estimate of the actual out-turn. The corresponding NES percentile earnings include overtime pay and are adjusted to include backdated settlements in the public sector in 1975 and 1977, and to exclude medical practitioners from the sample.

[2]The differences shown are those between the indices of doctors' and dentists' earnings and the indices of corresponding NES percentile earnings as a percentage of the former.

[3]Totals are weighted by the numbers and levels of earnings of each medical and dental grade at the base date (April 1975).

APPENDIX C

CHANGE IN REAL INCOMES AFTER TAX: APRIL 1975—APRIL 1977

A table showing the effects of tax changes and price inflation between April 1975 and April 1977 on the earnings of doctors and dentists compared with those on the average earnings for all full-time wage and salary earners was included in the Seventh Report. The table has been revised to take account of the successive tax changes introduced during 1977 relating to the financial year 1977-78 and more recent information on the earnings of general medical and general dental practitioners and on the earnings of all full-time men.

Earnings before and after tax of doctors and dentists and of all full-time men: April 1975—April 1977

After tax figures include family allowances (and child benefits in April 1977) where appropriate.

Grade and point on salary scale	*Annual earnings at*						*Indices of net income (April 1975 = 100)*			
	April 1975		*April 1976*		*April 1977*		*At current prices*		*At constant prices*	
	Before tax	*After tax*	*Before tax*	*After tax*	*Before tax*	*After tax*	*April 1976*	*April 1977*	*April 1976*	*April 1977*
Single	£	£	£	£	£	£				
House officer (minimum) *(a)*	3,572	2,558	4,372	3,099	4,580	3,344	121·1	130·7	101·9	93·6
Married with 2 children under 11										
Senior registrar (maximum) *(a)*	7,133	5,063	8,491	5,951	8,699	6,438	117·5	127·2	98·9	91·0
Consultant (minimum)	7,536	5,274	7,848	5,619	8,056	6,052	106·5	114·8	89·6	82·2
Consultant (maximum)	10,689	6,662	10,689	6,937	10,897	7,595	104·1	114·0	87·6	81·6
Consultant (C award)	12,714	7,401	12,714	7,689	12,922	8,451	103·9	114·2	87·4	81·8
Consultant (A+ award) *(b)*	18,636	9,091	18,636	9,403	18,844	10,367	103·4	114·0	87·0	81·7
General medical practitioners *(c)*	8,485	5,739	8,593	6,002	8,818	6,509	104·6	113·4	88·0	81·2
General dental practitioners *(c)*	7,643	5,327	7,798	5,592	8,011	6,025	105·0	113·1	88·3	81·0
Full-time men (average earnings) *(d)*	3,162	2,590	3,734	3,049	4,087	3,447	117·7	133·1	99·0	95·3
Personal disposable income (April–June)							113·7	128·1	98·7	96·5

Source: Office of Manpower Economics

(a) Includes average income from extra duty allowances and Class A/B supplements.
(b) Based on actual salaries after taking into account the withholding of the second stage of increases above £13,000.
(c) Intended average net remuneration from fees and allowances, and from cash supplements.
(d) Based on average earnings of full-time men (whose pay was unaffected by absence) from the New Earnings Survey.

APPENDIX D

SURVEY OF CONSULTANTS' PATTERN OF WORK AND RESPONSIBILITIES IN THE NATIONAL HEALTH SERVICE

Scope and purpose

1. In July 1977, the Office of Manpower Economics carried out a survey of the pattern of work and responsibilities within the National Health Service of consultant doctors and dentists on behalf of the Review Body. Information was collected by questionnaire from a sample of consultants employed in the National Health Service. The purpose of the survey was to provide information to assist in the pricing of a new consultant contract on the lines of the proposals that were then under discussion between the professions and the Health Departments in a special Joint Working Group, and also to assist the Joint Working Group in their discussions. Members of the Joint Working Group were consulted on the design and piloting of the questionnaire and in drawing the sample. At the request of the British Medical Association and the University Grants Committee the scope of the survey was extended to cover the activities within the NHS of honorary contract holders as well as of NHS paid consultants; information about the honorary contract holders, other than on the rate of response, has not been included in this analysis.

2. A copy of the survey questionnaire is at Annex A. The questionnaire was prepared in the course of June 1977 and, after being piloted among some 40 consultants in three hospitals, was despatched in early July to the home addresses of a sample of consultants. Information was sought on the hours spent on the basic clinical commitment, on preparation for and attendance at NHS committees, and on NHS administrative duties, both in an average week and in the current week of the survey, and on undergraduate teaching in an average week. The questionnaire also asked about the extent of on-call commitments that required immediate availability to deal with emergency admissions and the frequency and duration of emergency recalls to hospital. The questionnaire did not cover post-graduate teaching under an approved programme, domiciliary or exceptional consultations, or lectures, since no change in their method of remuneration was envisaged; neither did it cover research activities for the same reason.

The sample

3. The sample drawn was one in every four consultants. The main sample was taken from lists held by the British Medical Association which included non-members and were classified by region and specialty. Subsidiary sample lists covering dental consultants and honorary contract holders were provided by the Health Departments. The total sample drawn was 3,152 but, because the lists were not quite complete and because they included some consultants that were out of the scope of the survey (for example, retired, or no longer holding a consultant appointment), the sample actually represented just over 20 per cent, instead of the 25 per cent that had been planned, of all consultants at 30 September 1976.

Response (Table 1)

4. The response to the survey is in Table 1. As explained in the footnote to the table, the usable response received by the closing date was 51 per cent of the estimated valid sample, or a little over 10 per cent of all consultants. The table shows that the response was reasonably well balanced between specialties and between types of contract, except for a low response from part-time consultants, other than those with maximum part-time contracts. Since it was important that the results of the survey should be correctly balanced between the different types of contract and the main specialty

groups, the usable survey response relating to 1,245 NHS medical and dental consultants was grossed to the total population of consultants for eleven groupings of specialties (based on the groups shown in Annex B) within each of the four types of contract (whole-time, maximum part-time, other part-time and honorary). Excluding the honorary contract holders, the average sample size in each of these sub-groups before grossing was 38, and the average grossing factor about 10. Locums, who were not asked to complete the main part of the questionnaire, have been excluded from the analysis.

5. The response rate to the survey of just over half, although not as good as had been hoped, is nevertheless considered adequate in the absence of any evidence of significant general bias in the response. While a survey based on returns from one in ten consultants provides acceptable sampling errors for the main results of the survey (see paragraph 17 below and Table 13), it also means that those parts of the survey that are based on small sample numbers are subject to very large sampling errors, and should be used with some caution. Similarly the more extreme figures in ranges may be suspect for reasons of sampling bias, or perhaps from errors in the returns.

Edit

6. A manual edit was carried out mainly to check for clearly spoilt or incomplete forms; to adjust figures only where there was clear evidence of misunderstanding and of its nature (for example, from accompanying comments or manuscript workings); to revise in consultation with the Health Departments and the professions the classification and eligibility of reported NHS committees of which the respondent was Chairman or member; and to repair minor errors and omissions. There was also a computer edit mainly to check for punching errors.

Mean hours in an average week (Table 2)

7. Table 2 shows the mean hours reported by consultants as spent in an average week on the various NHS activities covered by the survey other than on-call commitments or emergency recall. Overall, whole-time consultants reported spending on average 39·3 hours per week on clinical or equivalent work (including time allowed under current contracts for travelling between hospitals), 4·0 hours per week on NHS committee work, 4·3 hours per week on administrative work and 1·1 hours per week on medical undergraduate teaching (of which 0·8 hours represented time which was not specifically recognised either in the contract or by way of payment of honorarium)—in all, a total of 48·7 hours of work a week. By comparison, weekly time spent on clinical work (including travelling between hospitals) was reported in the 1974 survey[1] as 42·4 hours, on committee and administrative work combined as 4·6 hours and on formal teaching as 1·3 hours—a total of 48·3 hours for these activities. The only information available on the hours of work of whole-time consultants from the 1971 survey[2] relates to clinical duties, which were reported as 38 hours per week: for all consultants, an average of 2 hours a week was spent on NHS committee work, 3 hours a week on teaching, and 5 hours a week on travelling. Apart from certain differences of approach and subject to some qualifications, the figures from the 1971 and 1974 surveys confirm the general findings that full-time consultants work on average for about 10 hours longer per week than the notional full-time week of eleven 3½ hour sessions (38½ hours), and indicate that there has been no significant change in overall hours of work since 1971.

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[1]Carried out by the Health Departments on behalf of the Joint Working Party on terms of employment of senior hospital medical and dental staff (paragraph 28).

[2]Carried out by the Regional Hospital Consultants and Specialists Association, now the Hospital Consultants and Specialists Association (paragraph 28).

8. Maximum part-time consultants and part-time consultants on contracts for 9 sessions both reported substantially longer hours of work on average than the notional full week—43·2 hours and 42·7 hours respectively—and so did all other part-time consultants in whole-time equivalent terms—52·3 hours. Part-time consultants on contracts of less than 9 sessions a week averaged 29·4 hours. In whole-time equivalent terms, part-time consultants worked longer hours than whole-time consultants. Although average hours per consultant (in whole-time equivalent terms) were less in post-graduate teaching hospitals than in other types of hospital, additional hours will have been spent on post-graduate teaching which was not covered by the survey (paragraph 2). About one in every nine consultants had administrative charge of an X-ray or pathology department, and the average time spent on administration by these consultants was 5·5 hours. The average time spent on administration by all consultants was 3·5 hours.

Availability for immediate recall and duration of recalls (Table 3)

9. Consultants were asked about their commitment to be immediately available by telephone for recall to hospital to deal with emergency admissions other than as required for the care of their own patients. As explained in footnote (a) to Table 3, certain specialties were regarded by the Health Departments and the professions as not being liable to this type of duty, and any reported availability for immediate recall in these specialties has been excluded from the analysis. More than half of all consultants were required on at least one occasion during each week on average to be immediately available for recall to hospital to deal with emergency admissions or other emergencies. The average amount of time spent by consultants in attending either to their own patients or to new patients admitted in an emergency outside their normal working hours was 2·1 hours per week.

10. The rotas for on-call for emergency admissions that occurred most frequently were 1 in 2 or 1 in 3; 1 in 4 was a little less common. Rotas of 1 in 5, 6 or 7 were much less frequent and together involved less than 12 per cent of consultants. Consultants in the undergraduate teaching hospitals had heavier emergency on-call commitments than those in other types of hospitals, but in psychiatric hospitals under 1 per cent of consultants had any emergency on-call commitment.

Ranges of hours spent on various activities (Table 4)

11. Table 4 shows the ranges of hours spent on clinical work, on clinical work and unrecognised undergraduate teaching, and on all activities covered by the survey. A substantial proportion of whole-time and maximum part-time consultants—about one in five and one in ten respectively—reported that they worked for 56 hours or more a week overall. Low hours spent on clinical work that were reported by a few consultants were generally associated with some time spent on other activities, and this is reflected in the relatively small proportion of consultants with short hours in the ranges for all activities.

Analyses by specialty (Tables 5, 6 and 7)

12. Table 5 compares mean hours spent on the various activities, availability for immediate recall, and number and mean duration of recall by specialty group; the ranges of hours spent on clinical work and unrecognised undergraduate teaching by specialty group are in Table 6, and ranges of hours spent on all activities in Table 7. The specialties which had the longest hours in an average week were paediatrics (51·6 hours) and diseases of the chest (49·9 hours); those with the shortest hours (but still above the notional full week of 38½ hours) were dermatology (42·0 hours) and orthodontics (42·4 hours). Overall, some 3 per cent of consultants spent 56 hours or more on clinical

work and unrecognised teaching: among the specialties this proportion was significantly exceeded only by consultants in general surgery, where 11 per cent reported such long hours. In dermatology and orthodontics, no consultants exceeded 49 hours on clinical work and unrecognised teaching and the proportion who worked 28 hours or less was twice the proportion for all consultants (7·7 per cent). For all activities, over one-third of whole-time and maximum part-time consultants worked 49 hours or more and, in general surgery, pathology, geriatrics and diseases of the chest nearer one-half did so. In paediatrics, three-fifths of consultants worked longer than these hours, and at least seven out of eight exceeded the notional full week. Significant numbers of consultants, including at least five out of six of those specialising in diseases of the chest and in pathology and about four out of five of those in geriatrics and in radiology, also worked longer than the notional full week of 38½ hours. The greatest commitment to continuous on-call for emergency admission (nearly one in four consultants) was in infectious diseases and dental surgery and the least such commitment (around one in fifteen consultants) was in anaesthetics and general medicine. Overall, some 44 per cent of consultants had no recalls in the current week, but the position varied greatly by specialty from less than one in five consultants in paediatrics, general surgery and infectious diseases to more than three out of four consultants in dermatology, pathology and orthodontics. On average, consultants reported recall to hospital outside their normal working hours between once and twice during the week of the survey, either to attend to their own patients or to new patients admitted in an emergency: the estimated average duration of each recall (including travelling time) was 1½ hours. The specialties with the greatest average incidence of emergency recall were paediatrics and general surgery, and these together with anaesthetics also had the longest average total duration of call-out (between 4½ and 5 hours). Consultants in dermatology and pathology had the fewest emergency recalls and the shortest length of call-out.

Chairmanships and memberships of NHS committees (Tables 8 and 9)

13. Table 8 shows the relationship between the number of chairmanships and memberships of NHS professional and management committees held by consultants, and the hours spent by them on attendance and preparation (these hours may have been somewhat overstated, as explained in the footnote). Table 9 provides additional detail about the chairmen and members of certain specific NHS management committees. Some 95 per cent of consultants were members of one or more professional committees and about one in six consultants of five or more; in addition, about two-thirds of all consultants sat on management committees, but under 10 per cent sat on more than three. Chairmanships were, of course, much fewer than memberships, but over a third of all consultants acted as chairmen of professional committees and just over a tenth as chairmen of management committees. Chairmen and members of District Management Teams and chairmen of Medical Executive Committees and of District Medical Committees spent significant additional time on management committee work.

Undergraduate teaching (Table 10)

14. The hours spent on recognised and unrecognised undergraduate teaching are analysed in Table 10. Just over one-half of all consultants (50·7 per cent) reported an undergraduate teaching commitment, and the average time involved (including preparation) was 2·4 hours. However, a majority of these consultants (63·4 per cent) did not have their commitment recognised, although it occupied an average of 2 hours per week. For most consultants, the time spent on undergraduate teaching was 3 hours or less a week; the proportion who spent 7 hours or more (1 day or more per week) was under 5 per cent.

Recalls and availability for immediate recall (Table 11)

15. The number and duration of recalls are compared in Table 11 by availability for immediate recall. The overall number of emergency recalls and their total duration

relate both to recalls during periods of availability for immediate recall and to recall for dealing with a doctor's own patients outside normal working hours. The table shows that there is some correlation between the average number of emergency recalls in a week and the degree of availability.

Comparison of data between current week and an average week (Table 12)

16. Table 12 compares both for clinical work alone, and for the total of clinical work, NHS committee work and administration, the hours reported by consultants for an average week with those spent during the current week. It is possible that some consultants may have interpreted an average week as the average of all weeks taking abnormal periods into account, but the difference in hours of work on this account is unlikely to have been significant. In contrast, it is possible that the current week might have been abnormal in a number of ways; for example, normal week to week fluctuations of clinical work or the lack of NHS committee work during the leave season. On the whole, the table indicates a fairly wide range of differences in hours between current and average weeks. In the case of clinical work, the differences largely average out but, when NHS committee work and administration are included, current week hours tend to be rather shorter than average week hours. This is probably due to the fact that the survey had to be carried out in July when fewer NHS committee meetings take place. On the basis of this information, most of the analyses have been based on average week hours.

Sampling errors (Table 13)

17. Any sample is subject to sampling variations. The magnitude of these depends upon the standard deviation (the square root of the average sum of squares of differences of variables from their mean) and the number in the sample. These two factors can be used to derive the standard error, and there are nineteen chances in twenty that the mean in a sample will not vary from the true mean by more than two standard errors. The table shows that for total hours and their main component (clinical work) the possibility of sampling error in the survey is negligible. This does not preclude other forms of error, like bias in the responses.

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Technical note

1. *Teaching hours:* The reported hours of teaching per week in which teaching was given have been converted to a weekly average throughout the year, excluding an assumed average of six weeks annual leave.

2. *Whole-time equivalent (WTE):* Where results are given on a whole-time equivalent basis, recalls for part-time consultants (other than those for maximum part-time consultants which have been included without adjustment in the same way as those for whole-time consultants) have been adjusted on a pro rata basis to the contracted number of notional half-day sessions per week (out of a maximum of 11 per week).

3. *Rounding:* Because the figure for each item is rounded to the nearest digit shown, the sum of these rounded items across or down a table may not exactly equal the total.

4. *Reliability:* Means for items or analysis by ranges that are based on small sample numbers should be treated with caution: the data given in Table 1 provide a guide to the sample numbers on which each item is based. Similarly, extreme values shown in ranges, where these represent small numbers of consultants, will be less reliable for sampling and other reasons than the less extreme figures. Selected standard deviations and standard errors (derived from ungrossed data) are shown in Table 13.

Survey of consultants' pattern of work and responsibilities in the NHS: Response by type of contract, country and specialty group

Type of contract, country and specialty group	*Population*	*Usable response(a)*	
	No.	No.	Per cent
Whole-time	6,440	656	10·2
Maximum part-time	3,034	393	13·0
All other part-time	3,030	196	6·5
All permanent paid	12,504	1,245	10·0
Honorary	1,650	191	11·6
All permanent staff	14,154	1,436	10·1
(WTE)	*(12,616)*	*(1,312)*	*(10·4)*
England and Wales	12,327	1,278	10·4*(b)*
Scotland	1,827	158	8·6
General medicine	1,334	136	10·2
Paediatrics	498	58	11·6
Geriatrics	597	60	10·1
Diseases of the chest	759	83	10·9
Infectious diseases	188	23	12·2
Dermatology	336	30	8·9
Accident and emergency	798	80	10·0
Ear, nose and throat	1,082	96	8·9
General surgery	1,107	103	9·3
Gynaecology	808	83	10·3
General pathology	1,659	187	11·3
Radiology	1,099	103	9·4
Anaesthetics	1,704	148	8·7
Mental illness	1,671	169	10·1
Dental surgery	357	53	14·8
Orthodontics	157	24	15·3

(a) *Survey response:* 3,152 questionnaires were issued and 1,680 replies received by the closing date. The replies included 145 representing an invalid sample (mainly retired but others who had gone away or no longer held a consultant appointment), 73 were refusals, inability to comply for sickness or other reasons, and incomplete or spoilt forms; and 1,462 usable forms. The response rate for the forms analysed out of the estimated valid sample excluding locums was 51 per cent.

(b) The response rates from the NHS regions were reasonably well balanced, each being within 3 per cent of the overall response rate for England and Wales.

TABLE 2

Mean hours in an average week by type of contract and hospital type

Numbers where not otherwise stated

Type of contract and hospital type	*Number*	*Clinical work*	*NHS committees*					*Administration*	*Undergraduate teaching*	*Total*	*Administration by those in charge of X-ray or pathology departments*	
			Professional		*Management*		*Total*					
			Attendance	*Preparation*	*Attendance*	*Preparation*						
	No.	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours	No.	Hours
Whole-time	6,440	39·3	1·4	0·9	1·0	0·6	4·0	4·3	1·1	48·7	971	6·1
Maximum part-time	3,034	35·9	1·4	0·9	0·8	0·5	3·5	2·6	1·2	43·2	194	3·9
Sub-total	9,474	38·2	1·4	0·9	0·9	0·6	3·8	3·8	1·2	46·9	1,165	5·8
9 session part-time	2,241	34·2	1·5	0·9	1·2	0·8	4·5	2·6	1·4	42·7	147	4·0
(WTE)	*(1,833)*	*(41·9)*	*(1·9)*	*(1·1)*	*(1·4)*	*(1·0)*	*(5·4)*	*(3·2)*	*(1·8)*	*(52·2)*	*(121)*	*(4·8)*
2–8 session part-time	789	22·4	1·2	0·7	0·7	0·4	2·9	2·5	1·7	29·4	66	4·4
(WTE)	*(443)*	*(39·9)*	*(2·1)*	*(1·2)*	*(1·2)*	*(0·7)*	*(5·1)*	*(4·4)*	*(3·0)*	*(52·3)*	*(42)*	*(6·9)*
Total	12,504	36·5	1·4	0·9	0·9	0·6	3·9	3·5	1·2	45·1	1,378	5·5
(WTE)	*(11,750)*	*(38·8)*	*(1·5)*	*(0·9)*	*(1·0)*	*(0·7)*	*(4·1)*	*(3·7)*	*(1·3)*	*(48·0)*	*(1,327)(b)*	*(5·7)(b)*
Undergraduate teaching *WTE*	*3,076*	*38·8*	*1·6*	*1·1*	*0·8*	*0·5*	*4·1*	*4·0*	*3·2*	*50·2*	*403*	*5·7*
Postgraduate teaching *WTE*	*418*	*36·8*	*1·7*	*0·8*	*0·8*	*0·4*	*3·6*	*4·0*	*0·5*	*44·8*	*68*	*5·4*
District general *WTE*	*6,709*	*39·2*	*1·4*	*0·9*	*1·0*	*0·7*	*4·0*	*3·2*	*0·7*	*47·1*	*814*	*5·5*
Psychiatric *WTE*	*1,073*	*37·3*	*1·9*	*1·0*	*1·4*	*0·8*	*5·1*	*5·6*	*0·7*	*48·6*	—	—
Other *(a)* *WTE*	*474*	*38·7*	*1·0*	*0·7*	*0·8*	*0·6*	*3·2*	*4·2*	*0·7*	*46·7*	*42*	*11·1*

Note: In this and subsequent tables, honorary staff are excluded.

(a) Cottage hospitals, isolation hospitals, blood transfusion units etc.

(b) Of these respondents approximately 55 per cent are in pathology departments (average 7·4 hours) and 45 per cent in X-ray departments (average

TABLE 3

Availability for immediate recall and mean duration of recalls by type of contract and hospital type

Number

Type of contract and hospital type	*Total (=100 per cent)*	*Percentage on call(a) for one 24 hour period in:*							*Percentage not liable*	*Mean total duration(b) of recalls(c) per week*
		1	2	3	4	5	6	7		
	No.	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Hours
Whole-time	6,440	5·3	10·5	10·9	6·1	3·9	1·2	2·6	59·5	2·2
Maximum part-time	3,034	6·9	14·4	21·6	16·1	10·0	4·0	3·8	23·3	2·5
Sub-total	9,474	5·8	11·8	14·3	9·3	5·8	2·1	3·0	47·9	2·3
9 session part-time	2,241	7·0	21·9	12·6	19·3	6·8	0·6	7·5	24·3	1·9
2–8 session part-time	789	8·9	12·6	5·3	6·2	—	2·5	4·6	59·7	0·7
Total	12,504	6·2	13·6	13·4	10·9	5·6	1·9	3·9	44·4	2·1
Undergraduate teaching	3,357	9·3	11·1	8·5	14·4	3·9	3·0	8·6	41·0	1·9
Postgraduate teaching	448	4·7	13·0	12·8	5·0	13·4	—	5·8	45·4	1·7
District general	7,083	5·9	16·8	18·3	11·4	7·3	1·7	2·4	36·1	2·5
Psychiatric	1,127	0·9	—	—	—	—	—	—	99·1	0·7
Other(d)	489	2·9	17·6	8·2	8·7	—	2·1	—	60·6	1·7

(a) The percentages shown are adjusted to reflect the joint view of the professions and the Health Departments that certain groups of specialties (geriatrics, diseases of the chest (except thoracic surgery), dermatology, general pathology, radiology, mental illness and orthodontics) do not normally involve an on-call commitment for emergency admissions. The overall percentages as reported before adjustment were 13, 19, 17, 16, 8, 4 and 10 per cent for each of the on-call frequencies shown respectively and 15 per cent not liable.

(b) Assuming averages of ½, 1½, 2½ and 4 hours respectively for evening and weekend recalls in the ranges given in the questionnaire.

(c) Recalls include both those for dealing with emergency admissions during periods of immediate availability for recall and also recalls for dealing with a consultant's own patients.

(d) Cottage hospitals, isolation hospitals, blood transfusion units etc.

TABLE 4

Cumulative percentages[(a)] in ranges of hours spent on clinical work, on clinical work and unrecognised teaching and on all activities in an average week by type of contract

Number

Type of contract	*Ranges of hours*														*Total (=100 per cent)*	*Median*	*Mean*
	3½–10	10½–17	17½–24	24½–27½	28–31	31½–34½	35–38	38½–41½	42–45	45½–48½	49–52	52½–55½	56–62½	63–69½	70 *or over*			
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	No.	Hours	Hours
Clinical work																		
Whole-time	0·1	0·8	4·9	8·6	17·7	25·5	41·6	62·3	80·1	87·8	94·0	97·3	99·4	99·9	100	6,440	40	39·3
Maximum part-time	0·4	0·6	4·1	10·2	21·9	45·2	67·6	80·0	91·4	95·1	98·3	98·8	99·7	100		3,034	35	35·9
Sub-total	0·2	0·8	4·8	9·3	19·2	32·0	50·1	68·1	83·8	90·2	95·4	97·9	99·6	100·0	100	9,474	38½	38·2
9 session part-time	—	0·7	7·7	13·9	34·7	54·5	72·4	82·9	94·9	96·3	98·4	99·3	100			2,241	34	34·2
2–8 session part-time	6·8	29·9	56·9	63·5	90·7	92·1	95·8	100								789	23	22·4
Total	0·6	2·7	8·6	13·5	26·5	39·8	57·0	72·8	86·9	92·0	96·3	98·3	99·7	100·0	100	12,504	36	36·5
Clinical work and teaching without an honorarium																		
Whole-time	0·1	0·7	4·0	7·1	15·1	22·8	38·3	58·9	77·0	85·9	91·4	95·9	98·6	99·6	100	6,440	40	40·1
Maximum part-time	—	0·6	3·1	8·8	19·3	42·0	63·0	77·5	88·1	93·4	97·2	98·7	99·8	100		3,034	36	36·7
Sub-total	0·1	0·7	3·8	7·7	16·5	29·0	46·3	65·0	80·7	88·4	93·4	97·0	99·2	99·9	100	9,474	39	39·0
9 session part-time	—	0·7	5·4	13·3	31·0	52·2	70·9	80·0	92·5	96·4	97·8	98·4	100			2,241	34½	34·9
2–8 session part-time	6·8	29·9	53·1	59·2	81·3	85·8	93·2	97·3	97·3	100						789	24	23·6
Total	0·5	2·6	7·2	12·0	23·2	36·7	53·6	69·6	83·7	90·4	94·4	97·2	99·2	99·7	100	12,504	37½	37·3
All activities covered by the survey																		
Whole-time	—	—	0·4	0·7	2·1	4·7	9·9	19·5	39·6	56·8	70·7	80·5	91·7	97·5	100	6,440	47½	48·7
Maximum part-time	—	—	—	2·0	4·1	14·4	29·7	50·1	66·1	78·3	85·0	91·2	97·5	98·9	100	3,034	41½	43·2
Sub-total	—	—	0·3	1·1	2·7	7·7	16·2	29·3	48·1	63·7	75·3	83·9	93·5	97·9	100	9,474	46	46·9
9 session part-time	—	—	—	3·2	5·5	18·8	33·9	52·1	64·9	76·4	85·3	89·9	97·9	100		2,241	41	42·7
2–8 session part-time	2·8	17·9	31·8	39·3	54·8	65·6	78·3	87·8	91·5	98·6	100					789	30	29·4
Total	0·2	1·2	2·3	4·0	6·6	13·5	23·4	37·2	54·0	68·3	78·8	86·1	94·8	98·5	100	12,504	44½	45·1

(a) Percentages shown are cumulative to the tops of the ranges in which they appear.

Mean hours in an average week, availability for immediate recall, and distribution, mean number and duration of recalls in the current week by specialty group: Whole-time plus maximum part-time

Number

Specialty group	Number	Mean hours in an average week spent on					Availability for immediate recall (a)				Percentage of all consultants with number of recalls shown (b)					Mean total of recalls in the current week	
		Clinical work	NHS committees	Administration	Teaching	Total	Never	1 period in 2–7		Always	0	1	2	3 or 4	5 or more	Number	Duration (c)
	No.	Hours	Hours	Hours	Hours	Hours	No.	No.	Average (d)	No.	Per cent	Per cent	Per cent	Per cent	Per cent	No.	Hours
General medicine	768	38·2	3·5	2·8	1·8	46·2	19	694	3·8	55	30·3	36·1	15·3	15·7	2·6	1·5	2·1
Paediatrics	404	40·5	4·5	4·1	2·5	51·6	7	321	2·5	76	10·5	16·6	24·8	26·2	21·9	2·9	5·0
Geriatrics	454	39·0	4·4	4·2	0·7	48·3	454	—	—	—	57·0	14·0	16·5	7·4	5·1	1·0	1·1
Diseases of the chest	550	41·3	3·5	3·1	2·0	49·9	545	5	2·0	—	42·7	30·5	13·7	7·6	5·5	1·3	1·7
Infectious diseases	134	34·4	4·3	4·1	1·7	44·5	5	99	2·6	30	17·9	39·6	24·5	9·0	9·0	2·0	2·9
Dermatology	146	35·5	2·4	2·7	1·3	42·0	146	—	—	—	76·5	17·3	6·2	—	—	0·4	0·3
Accident and emergency	600	38·2	3·0	3·6	0·6	45·3	—	551	3·2	49	35·0	21·6	20·7	15·7	7·0	1·7	2·6
Ear, nose and throat	597	37·9	2·8	2·2	1·0	44·0	19	471	3·0	106	32·0	26·1	21·9	15·4	4·6	1·9	2·9
General surgery	613	40·5	4·1	2·5	2·3	49·4	8	535	3·8	70	15·8	27·6	22·1	17·6	16·7	2·7	4·6
Gynaecology	475	36·5	4·1	2·1	1·7	44·5	—	436	3·3	39	37·7	14·9	29·8	12·2	5·4	1·8	2·8
General pathology	1,030	37·3	4·1	6·3	0·9	48·7	1,030	—	—	—	77·6	13·0	4·7	4·0	0·7	0·4	0·6
Radiology	866	39·6	3·7	4·1	0·7	48·0	866	—	—	—	55·6	27·1	10·6	5·6	1·0	0·7	1·0
Anaesthetics	1,240	37·3	3·4	2·9	0·4	44·1	10	1,156	4·4	73	30·6	19·2	15·3	22·1	12·8	2·4	4·5
Mental illness	1,296	37·2	4·7	5·2	0·7	47·8	1,296	—	—	—	73·1	13·5	7·9	3·6	1·9	0·6	0·8
Dental surgery	213	38·4	3·6	2·9	2·5	47·4	44	118	2·6	51	32·8	24·4	19·5	20·9	2·4	1·6	2·5
Orthodontics	88	35·2	2·7	3·5	1·0	42·4	88	—	—	—	86·8	6·6	—	—	6·6	0·6	1·4
Total	9,474	38·2	3·8	3·8	1·2	46·9	4,537	4,386	3·6	551	44·3	21·7	15·5	12·2	6·3	1·5	2·3

(a) Results shown on adjusted basis: see footnote to Table 3.
(b) The percentages relate to all whole-time and part-time consultants. Overall 2·8 per cent and 7 or more recalls and 0·7 per cent had 10 or more.
(c) See footnote to Table 3.
(d) The averages shown relate to the on-call availability codes, viz, 2, 3, . . . ,7.

TABLE 6

Cumulative percentages[(a)] in ranges of hours spent on clinical work and unrecognised teaching in an average week by specialty group: Whole-time plus maximum part-time

Number

Specialty group	*Ranges of hours*													*Total (=100 per cent)*	*Median*	*Mean*
	24 or under	*24½–27½*	*28–31*	*31½–34½*	*35–38*	*38½–41½*	*42–45*	*45½–48½*	*49–52*	*52½–55½*	*56–62½*	*63–69½*	*70 or over*			
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	No.	Hours	Hours
General medicine	2·6	5·1	16·6	28·7	46·3	59·1	76·9	85·7	95·0	98·4	100			767	39½	39·3
Paediatrics	—	4·2	8·3	24·8	26·5	47·8	71·3	78·7	86·0	95·1	97·5	100		408	42½	42·3
Geriatrics	6·6	10·3	20·6	25·0	38·8	63·4	80·3	84·6	89·0	95·6	100			456	40	39·4
Diseases of the chest	6·4	6·4	10·0	15·5	28·9	46·9	68·5	79·3	86·5	95·5	98·2	100		550	42½	41·9
Infectious diseases	—	11·1	22·2	37·0	81·5	88·9	92·6	96·3	96·3	96·3	96·3	100		135	36	35·6
Dermatology	4·9	15·3	25·0	34·7	54·9	75·0	95·1	100						144	37½	36·4
Accident and emergency	2·0	6·2	15·8	31·1	51·1	68·4	79·4	91·0	98·0	98·0	100			601	38	38·5
Ear, nose and throat	—	6·7	13·3	38·1	52·5	68·5	84·1	92·1	97·0	98·5	100			596	37½	38·4
General surgery	1·3	2·6	8·0	20·2	38·5	56·8	66·2	80·4	83·2	89·2	98·0	100		613	40½	42·4
Gynaecology	3·4	3·4	15·3	37·2	52·7	69·5	86·8	96·6	100					476	37½	37·8
General pathology	7·9	11·0	20·4	31·0	43·5	64·0	82·3	90·2	97·7	98·4	99·2	100		1,030	39½	38·0
Radiology	0·8	0·8	12·0	23·1	39·4	61·0	80·5	86·9	92·1	96·1	98·7	100		865	40	40·1
Anaesthetics	3·5	9·8	19·7	34·7	55·4	76·9	87·4	91·4	94·1	97·1	98·1	99·0	100	1,240	37½	37·6
Mental illness	5·6	14·1	23·1	31·0	50·3	68·0	83·6	91·0	93·3	97·8	100			1,295	38	37·7
Dental surgery	3·3	3·3	10·0	20·4	45·0	65·9	79·6	79·6	90·0	96·7	100			211	39	40·2
Orthodontics	17·2	17·2	17·2	25·3	75·9	83·9	91·6	100						87	36½	35·5
Total	3·8	7·7	16·5	29·0	46·3	65·0	80·7	88·4	93·4	97·0	99·2	99·9	100	9,474	39	39·0

(a) Percentages shown are cumulative to the tops of the ranges in which they appear.

TABLE 7

Cumulative percentages[(a)] in ranges of hours spent on all activities in an average week by specialty group: Whole-time plus maximum part-time

Number

Specialty group	*Ranges of hours*													*Total (=100 per cent)*	*Median*	*Mean*
	24 or under	*24½–27½*	*28–31*	*31½–34½*	*35–38*	*38½–41½*	*42–45*	*45½–48½*	*49–52*	*52½–55½*	*56–62½*	*63–69½*	*70 or over*			
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	No.	Hours	Hours
General medicine	—	—	2·5	6·6	14·9	35·3	52·9	68·2	81·4	89·6	95·2	96·7	100	767	44½	46·2
Paediatrics	—	—	2·5	2·5	4·2	12·3	16·4	40·2	59·8	67·2	86·0	95·1	100	408	49½	51·6
Geriatrics	—	—	2·2	6·6	11·0	20·4	37·1	52·4	67·8	80·9	93·4	100		456	48	48·3
Diseases of the chest	—	1·8	1·8	3·6	9·1	16·4	36·9	51·3	59·5	79·3	88·2	95·5	100	550	46	49·8
Infectious diseases	—	—	—	3·7	18·5	48·1	63·0	81·5	96·3	96·3	96·3	96·3	100	135	42½	44·5
Dermatology	—	9·7	14·6	19·4	34·7	45·1	55·6	84·7	84·7	100				144	43½	42·0
Accident and emergency	—	1·3	1·3	11·1	25·0	42·1	59·4	71·9	77·4	84·9	93·8	98·0	100	601	43½	45·3
Ear, nose and throat	—	—	4·9	14·9	29·9	41·3	62·1	70·0	79·5	86·1	98·5	100		596	43	44·0
General surgery	—	1·3	1·3	2·6	10·0	30·2	45·7	54·5	63·3	72·1	87·1	95·9	100	613	47	49·4
Gynaecology	—	1·7	3·4	13·7	23·9	38·0	52·1	70·8	85·9	89·3	100			476	45	44·5
General pathology	0·8	0·8	1·6	3·1	5·5	17·8	41·7	53·3	68·9	83·2	92·2	97·7	100	1,030	48	48·7
Radiology	—	—	0·8	6·4	10·2	21·7	43·9	61·5	76·3	82·3	94·0	98·7	100	865	47	48·0
Anaesthetics	1·0	2·6	6·4	14·1	30·6	41·9	60·2	73·0	82·7	87·4	95·1	98·1	100	1,240	43½	44·1
Mental illness	—	0·5	1·3	5·3	12·8	23·2	43·1	67·4	78·5	85·9	92·5	97·8	100	1,295	46	47·8
Dental surgery	—	—	—	3·3	6·6	24·2	48·8	65·9	72·5	79·6	96·7	100		211	45½	47·4
Orthodontics	8·0	8·0	8·0	8·0	24·1	32·2	83·9	83·9	83·9	92·0	100			87	43	42·4
Total	0·3	1·1	2·7	7·7	16·2	29·3	48·1	63·7	75·3	83·9	93·5	97·9	100	9,474	46	46·9

(a) Percentages shown are cumulative to the tops of the ranges in which they appear.

TABLE 8

Cumulative percentages[a] of consultants holding chairmanships and memberships of NHS committees[b] by ranges of total hours spent on attendance and preparation in an average week: Whole-time plus maximum part-time

Number

Number of chairmanships and memberships	*Ranges of total hours spent on attendance and preparation*									
	0 or ½	*1 or 1½*	*2 or 2½*	*3 or 3½*	*4 or 4½*	*5 or 5½*	*6 or 6½*	*7 or 7½*	*8 or more*	*Total (=100 per cent)*
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	No.
NHS professional committees										
0	80·4	92·5	94·6	96·7	98·3	100				459
1	30·1	70·8	88·0	96·7	98·9	99·5	100			1,338
2	16·4	51·5	75·2	86·3	94·8	97·0	99·5	99·8	100	2,699
3	8·6	38·7	65·3	83·1	89·7	94·3	97·1	97·9	100	2,094
4	7·7	35·4	62·4	75·1	88·9	90·3	96·0	97·7	100	1,202
5	5·2	24·4	51·0	68·9	80·8	88·1	94·0	97·2	100	851
6	1·7	18·5	33·9	58·2	64·0	83·9	92·2	94·3	100	476
7 or more	—	7·3	25·9	39·7	59·7	70·4	72·4	81·4	100	355
Total (1 or more)	13·0	43·2	66·7	80·6	89·1	93·2	96·6	97·8	100	9,015
NHS management committees										
0	93·9	96·3	98·1	98·8	99·4	99·7	100			3,180
1	38·9	75·6	89·7	94·5	96·3	98·1	99·2	99·2	100	2,610
2	17·5	51·7	76·3	88·0	95·1	96·0	98·9	99·5	100	1,844
3	9·3	30·1	55·2	74·6	82·8	90·0	95·7	96·5	100	984
4	3·5	19·4	31·0	50·5	69·9	79·4	83·0	89·1	100	559
5	—	4·3	39·8	44·1	61·4	61·4	72·1	80·7	100	228
6 or 7	—	8·7	23·2	23·2	34·8	49·3	49·3	59·4	100	69
Total (1 or more)	23·1	53·2	72·6	83·0	89·6	92·8	95·6	96·9	100	6,294
Number of chairmanships										
NHS professional committees										
0	21·4	54·4	76·2	88·0	94·2	96·6	98·4	99·0	100	6,123
1	7·7	33·4	59·5	76·5	86·9	91·1	95·4	97·2	100	2,505
2	4·7	19·3	38·9	51·9	64·6	82·8	93·2	96·3	100	626
3	—	6·1	17·1	27·5	47·9	59·8	74·6	74·6	100	136
4 or more	—	19·0	19·0	44·0	64·3	64·3	64·3	78·6	100	84
Total (1 or more)	6·7	29·3	53·0	69·1	80·7	87·7	93·4	95·7	100	3,351
NHS management committees										
0	52·2	73·1	85·5	92·4	95·7	97·1	98·4	98·8	100	8,438
1	3·2	27·4	54·2	64·0	77·3	84·4	91·9	95·6	100	831
2	—	8·1	14·2	20·3	45·1	58·7	74·1	77·3	100	158
3 or 4	—	—	—	—	17·0	38·3	38·3	53·2	100	47
Total (1 or more)	2·6	23·3	45·8	54·5	69·8	78·5	86·8	90·9	100	1,036

(a) Percentages shown are cumulative to the tops of the ranges in which they appear.

(b) On advice from the professions and the Health Departments, 205 committees (reported by 1,233 consultants) were accepted as valid NHS professional committees (including 88, reported by 187 consultants, originally classified as management) and 47 committees (reported by 92 consultants) were accepted (in addition to those on the questionnaire) as valid NHS management committees (including 33, reported by 69 consultants, originally classified as professional): while 112 committees reported as professional by 236 consultants, and 62 committees reported as management by 96 consultants, were deleted. No attempt has been made to adjust the stated hours on this account.

Mean hours in an average week spent on NHS committees[a] by membership of each main type of management committee

Type of NHS management committee and membership status	*Consultants*		*Average number of other NHS committees*		*Mean hours spent on all NHS committees in an average week*		
	Number	*Per cent (12,504 = 100 per cent)*	*Chairmanships*	*Memberships*	*Professional*	*Management*	*Total*
	No.	Per cent	No.	No.	Hours	Hours	Hours
Medical executive:							
Chairman	315	2·5	2·0	4·9	3·0	6·5	9·5
Member	2,734	21·9	1·0	4·1	3·0	2·8	5·8
(Non member)	*(9,455)*	*(75·6)*	*(0·5)*	*(3·2)*	*(2·1)*	*(1·0)*	*(3·1)*
District management team:							
Chairman	83	0·7	1·7	4·0	2·5	6·1	8·6
Member	544	4·4	1·5	4·6	3·0	5·7	8·7
(Non member)	*(11,877)*	*(94·9)*	*(0·6)*	*(3·6)*	*(2·3)*	*(1·3)*	*(3·6)*
District medical:							
Chairman	161	1·3	2·0	4·4	3·1	7·0	10·1
Member	1,965	15·7	1·2	4·3	3·0	3·0	6·0
(Non member)	*(10,378)*	*(83·0)*	*(0·5)*	*(3·3)*	*(2·2)*	*(1·2)*	*(3·4)*
Area/Regional medical advisory and related specialist advisory:							
Chairman	421	3·4	1·4	4·1	3·7	4·5	8·2
Member	4,668	37·3	0·9	3·8	2·6	2·4	5·0
(Non member)	*(7,415)*	*(59·3)*	*(0·4)*	*(2·9)*	*(2·0)*	*(0·9)*	*(2·9)*
Health care programme/planning:							
Chairman	423	3·4	1·1	4·6	2·5	3·4	5·9
Member	1,625	13·0	0·8	4·0	2·6	2·7	5·3
(Non member)	*(10,456)*	*(83·6)*	*(0·6)*	*(3·4)*	*(2·2)*	*(1·3)*	*(3·5)*
Project planning, eg building:							
Chairman	111	0·9	2·0	4·5	3·7	4·8	8·5
Member	1,830	14·6	0·9	4·1	2·7	2·7	5·4
(Non member)	*(10,563)*	*(84·5)*	*(0·6)*	*(3·4)*	*(2·2)*	*(1·3)*	*(3·5)*
DHSS specialist advisory:							
Chairman	52	0·4	0·9	4·6	3·4	3·3	6.7
Member	866	6·9	1·0	3·4	3·0	2·6	5·6
(Non member)	*(11,586)*	*(92·7)*	*(0·6)*	*(3·6)*	*(2·2)*	*(1·5)*	*(3·7)*

(a) See footnote to Table 8. Overall, each consultant served on average as chairman and member of 0·7 and 3·6 NHS committees respectively.

TABLE 10

Cumulative percentages[a] of consultants involved in undergraduate teaching (including preparation) by ranges of hours in an average week

	Ranges of undergraduate teaching hours(b)				*Total (= 100 per cent)*	*Median*	*Mean*
	Under ½	*½–3*	*3½–6½*	*7 or more*			
	Per cent	Per cent	Per cent	Per cent	No.	Hours	Hours
Involved in teaching(c) but commitment not recognised	17·7	80·4	97·2	100	4,021	1½	2·0
Commitment recognised(d):							
By honorarium	10·4	59·7	92·9	100	1,888	3	3·1
In NHS contract	10·3	63·2	91·7	100	430	2	3·1
Total	15·0	73·0	95·6	100	6,339	2	2·4

(a) Percentages shown are cumulative to the tops of the ranges in which they appear.

(b) To the nearest half hour.

(c) 6,050 consultants reported having no regular involvement in undergraduate teaching.

(d) 115 of these consultants reported that their undergraduate teaching was recognised by an allowance of NHDs—one-half by 1 NHD, a third by 2 NHDs and the remainder by 4 NHDs. The time involved was under 7 hours in each case.

TABLE 11

Recalls[a] and availability for immediate recall[b]: Whole-time plus maximum part-time

Number and duration of evening and weekend calls	*On-call for one 24 hour period in:*								*Not liable for immediate recall*	*Total*
	1	2	3	4	5	6	7	*Total 1–7*		
All consultants										
Number	551	1,116	1,354	880	554	200	282	4,937	4,537	9,474
Average number of recalls in current week	3·3	2·5	2·1	2·0	1·4	1·3	1·3	2·2	0·7	1·5
Average total duration of recalls (hours)	5·2	4·4	3·2	3·3	2·3	2·5	1·9	3·5	0·9	2·3
Consultants with recalls										
Number	488	937	1,078	634	365	157	140	3,800	1,672	5,472
Per cent	*88·7*	*84·0*	*79·6*	*72·0*	*65·9*	*78·7*	*49·7*	*77·0*	*36·9*	*57·8*
Average number of recalls in current week	3·8	3·0	2·6	2·7	2·2	1·6	2·6	2·8	1·9	2·5
Average total duration of recalls (hours)	5·9	5·3	4·1	4·6	3·5	3·2	3·9	4·6	2·6	4·0

(a) Recalls in this table relate not only to those for dealing with emergency admissions during periods of immediate availability for recall, but also recalls for dealing with a consultant's own patients.

(b) See footnotes to Table 3.

Number and percentage of consultants within ranges of time spent on clinical work, and on clinical work, NHS committees and administration in an average week and in the current week: Whole-time plus maximum part-time

Number

Ranges of average week hours(a)	*Consultants whose current week hours relative to average week hours were:*					*Total (=100 per cent)*
	Two or more ranges lower	*One range lower*	*In same range*	*One range higher*	*Two or more ranges higher*	
	Per cent	Per cent	Per cent	Per cent	Per cent	No.
Clinical work						
20½ or under	—	—	95·3	4·7	..	214
21 –24	—	29·4	61·1	6·0	3·4	232
24½–27½	4·1	28·6	49·2	12·8	5·3	422
28 –31	13·1	12·3	49·3	20·4	4·9	939
31½–34½	4·6	20·1	61·5	9·2	4·6	1,211
35 –38	6·9	18·5	56·6	10·8	7·2	1,713
38½–41½	8·8	18·5	53·9	16·9	1·9	1,707
42 –45	6·0	17·6	51·1	16·8	8·5	1,490
45½–48½	6·2	22·1	46·2	16·1	9·4	607
49 –52	17·1	14·7	42·3	20·0	5·9	497
52½–55½	17·2	26·8	26·4	26·1	3·4	232
56 –62½	24·5	13·0	50·5	6·1	5·9	164
63 –69½	—	38·1	61·9	..	—	34
70 or over	100·0	..	..	—	—	12
Clinical work, NHS committees and administration						
20½ or under	—	—	100·0	..	..	20
21 –24	—	32·4	36·1	31·5	..	23
24½–27½	8·6	9·3	73·5	..	8·7	86
28 –31	2·0	31·9	50·3	10·9	5·0	244
31½–34½	4·0	18·2	44·2	24·1	9·5	524
35 –38	4·6	19·2	57·3	14·2	4·7	918
38½–41½	8·4	21·7	46·4	16·9	6·6	1,387
42 –45	11·2	22·9	36·3	20·5	9·1	1,788
45½–48½	15·3	21·6	36·2	18·6	8·3	1,452
49 –52	14·8	29·7	30·4	13·2	11·9	1,011
52½–55½	21·1	19·1	35·5	22·9	1·3	773
56 –62½	26·7	19·1	46·3	7·9	..	778
63 –69½	11·4	34·9	49·1	4·5	—	312
70 or over	..	19·4	80·6	—	—	158

Note: —Not applicable.

..Under 0.05 per cent

(a) Ranges at each end of the distribution span longer periods than the other ranges shown.

Mean hours spent in an average week by summary type of contract, standard deviations and standard errors[a]

Summary type of contract	*Mean hours spent in an average week on:*					
	Clinical work	*NHS committees*	*Administration*	*Undergraduate teaching*	*Total*	*Clinical work and unrecognised teaching*
	Hours	Hours	Hours	Hours	Hours	Hours
Whole-time (Sample number 656)						
Mean	39·3	4·0	4·3	1·1	48·7	40·1
Standard deviation	8·8	3·5	4·3	1·9	9·4	8·9
Standard error	0·4	0·1	0·2	0·1	0·4	0·4
Maximum part-time (Sample number 393)						
Mean	35·9	3·5	2·6	1·2	43·2	36·7
Standard deviation	7·4	3·1	2·6	1·9	9·0	7·6
Standard error	0·4	0·2	0·1	0·1	0·5	0·4
Other part-time (Sample number 196)						
Mean	31·1	4·1	2·6	1·5	39·3	32·0
Standard deviation	9·3	4·1	2·4	2·2	11·4	9·6
Standard error	0·7	0·3	0·2	0·2	0·8	0·7
Total (Sample number 1,245)						
Mean	36·5	3·9	3·5	1·2	45·1	37·3
Standard deviation	8·8	3·5	3·7	2·0	10·2	9·0
Standard error	0·3	0·1	0·1	0·1	0·3	0·3

(a) Derived from ungrossed data.

ANNEX A

OFFICE OF MANPOWER ECONOMICS

QUESTIONNAIRE ON CONSULTANTS' PATTERN OF WORK AND RESPONSIBILITIES IN THE NHS

		For OME use
1.	CODE NO.	(1-4)
2.	YEAR OF BIRTH 19☐☐	(5-6)
3.	SEX (Please ring appropriate code) Male 1 Female 2	(7)
4.	YEAR OF FIRST CONSULTANT APPOINTMENT IN THE NHS 19☐☐	(8-9)
5.	TYPE OF CONTRACT (Please ring appropriate code) (If you have more than one NHS paid consultant appointment please aggregate) Whole-time 1 Maximum part-time 2 Nine Session part-time 3 Limited session part-time* 4 Locum+ 5 Honorary* 6 Other (specify) ..... 7 ..... *If code 4 or 6 ringed, specify in box number of NHS sessions ☐	(10) (11)

		For OME use
6.	NHS EMPLOYING AUTHORITY (If more than one please state that with which you have your principal contract or commitment)	☐☐ (12 - 13)
7.	PRINCIPAL SPECIALTY ..... (If more than one please indicate above the one you spend most time in and state below your subsidiary specialty)	☐☐ (14 - 15)
8.	TYPE OF HOSPITAL (Please ring appropriate code) (If you work at more than one please ring code for the one you spend most time in) Undergraduate teaching 1 Postgraduate teaching 2 District general 3 Psychiatric 4 Other (specify) 5	(16)

+If Locum, please complete this introductory section (Questions 1-8) only, and disregard Sections A-F following.

The following sections (A to D) are designed to obtain information about the pattern of certain aspects of your present NHS activities during the current week (ie the first full working week immediately following receipt of the questionnaire) and an average working week. It is appreciated that some tasks may be carried out in parallel and care must be taken to allocate time spent on various activities in such a way as to eliminate any duplication; for example where committee work or undergraduate teaching is carried out in conjunction with clinical work during clinical sessions, the normal time for clinical sessions should be entered under that heading (Section A) and only the extra time due to the committee work entered in Section B or due to the teaching in Section D.

A. BASIC NHS CLINICAL COMMITMENT

Hours per week | For OME use

This should EXCLUDE time spent on the following activities:-

Activity	Section where dealt with
Committee work	Section B
Administration other than that related to the clinical care of patients	Section C
Undergraduate teaching	Section D
On-call	Section E
Emergency recall	Section F
Postgraduate teaching under an approved programme, research, domiciliary or exceptional consultations, lectures to non-medical staff	Not covered by this questionnaire

Time allowed under your present contract(s) for travelling to and between hospitals should be included.

A1. In the week following receipt of the questionnaire and in an average working week how many hours have you spent in performing your basic clinical duties (including laboratory or similar duties)?

(Please insert hours to nearest ½ hour in boxes under both headings)

Current week	Average week	For OME use
☐	☐	(17-18) ☐ (19-20) ☐

B. NHS COMMITTEE WORK

B1. Which of the following NHS committees do you regularly attend as a member or chairman? (Please ring appropriate code(s) or, where committee structures differ from those shown below, eg in Scotland, code(s) for most appropriate designation(s))

NHS Professional Committees	Member	Chairman	NHS Management Committees	Member	Chairman	For OME use
Divisional	1	2	Medical Executive	1	2	(25)
Medical advisory/staff	1	2	District Management Team	1	2	(26)
Others, such as Ethical, Medical Records, Theatre Users etc, please specify:			District Medical	1	2	(27)
(i)	1	2	Area/Regional medical advisory and related specialist advisory	1	2	(28)
(ii)	1	2	Health Care programme/ planning	1	2	(29)
(iii)	1	2	Project planning eg building	1	2	(30)
(iv)	1	2	DHSS specialist advisory	1	2	(31)
(v)	1	2	Others, please specify:			
(vi)	1	2	(i)	1	2	(32)
			(ii)	1	2	(33)

B2. In answering this question you should:
EXCLUDE time spent in committee during normal working hours
INCLUDE time spent in carrying out clinical duties which are displaced from the normal working day by the attendance at committees.

In the week following receipt of the questionnaire and on average each week in the course of the past year how many hours have you spent in these committees and on preparatory work?

(Please insert hours to nearest ½ hour in boxes under both headings)

	Current week	Average week	For OME use
NHS Professional Committees			
a. Attendance	☐	☐	(42-43) (44-45)
b. Preparation and follow-up	☐	☐	(46-47) (48-49)
NHS Management Committees			
a. Attendance (including travelling time)	☐	☐	(50-51) (52-53)
b. Preparation and follow-up	☐	☐	(54-55) (56-57)

For OME use: (34) ☐ (35) ☐ (36) ☐ (37) ☐ (38) ☐ (39) ☐ (40) ☐ (41) ☐

C. NHS ADMINISTRATIVE DUTIES

C1. In answering this question you should:

INCLUDE time spent on such activities as:
Organising the work of staff in your unit or department;
Dealing with correspondence not related to the clinical care of patients;
Liaising with colleagues inside and outside the hospital;
Outside liaison, eg with the Social Services, Local Authorities etc.

EXCLUDE time spent on activities relating to:
The clinical care of patients (in Section A) and committee work (in Section B).

In the week following receipt of the questionnaire and in an average working week how many hours have you spent on administrative duties?

(Please insert hours to nearest ½ hour in boxes under both headings)

	Current week	Average week	For OME use
Hours per week	☐	☐	(58-59) (60-61)

C2. Are you in Administrative Charge of an X-ray or Pathology Department? (Please ring appropriate code)

YES 1
NO 2

(62)

D. UNDERGRADUATE TEACHING

In answering the questions in this section you should:

EXCLUDE teaching of students under an honorary NHS contract and of students attached for short periods on an irregular basis

INCLUDE other teaching of medical or dental students for which you have a regular commitment.

☐☐ (63) (64)

D1. Are you involved in undergraduate teaching? (Please ring appropriate code)

YES 1
NO 2

If YES, please state in box the number of weeks per year ☐☐ (65-66)

If YES, also complete questions D2 and D3 (if NO, these do not apply)

D2. For weeks when you are involved in undergraduate teaching:

a. How many hours does this commitment add in an average working week to the time taken for your basic clinical duties as indicated in your answer to Section A?

(Please insert hours to nearest ½ hour in box provided) ☐ (67-68) ☐ (69)

b. How many further hours do you spend in an average working week on preparatory work? (Please insert hours to nearest ½ hour in box provided) ☐ (70-71) ☐ (72)

D3. Is the commitment already recognised wholly or partly in your remuneration?
(Please ring appropriate code)

NO	1
YES, by honorarium	2
YES, in NHS contract	3

(73)

If by an allowance of NHDs please state in box the number of NHDs ☐ (74)

Would you please look back at your answers in the column giving hours per week to see that these appear reasonable, bearing in mind that they may not cover all your NHS activities and that your hours of work should be allocated to one activity only without duplication.

E. ON CALL

For OME use

This section is concerned to identify the kind of immediate availability by telephone usually associated with being 'first on call' for emergency admissions. It is not concerned with the high degree of continuous service availability that all consultants provide to their existing patients or Departments.

E1. Does the discharge of your professional duties regularly require that you should be immediateiy available by telephone as described above, on one or more consultant rotas for giving advice and for recall to hospital? (Please ring appropriate number)

YES, for one 24 hour period in:	1 (ie constantly)	(75)
	2	
	3	
	4	
	5	
	6	
	7 (or less often)	
NO	8	

F. EMERGENCY RECALL TO HOSPITAL

F1. In the week following receipt of the questionnaire how many times were you recalled to hospital to provide emergency clinical treatment for each of the following lengths of time (including travelling time) between 7.00 pm and 8.30 am on Monday to Friday nights and at any time on Saturday or Sunday?

(Where more than one emergency was dealt with during a recall, the initial and subsequent emergencies should be treated as one for the purpose of determining the length of time spent)

(Please insert number if any)

Number of recalls lasting:

up to one hour		(76-77)
between one and two hours		(78)
between two and three hours		(79)
over three hours		(80)

OFFICE OF MANPOWER ECONOMICS
July 1977

ANNEX B

List of specialties

For the purpose of analysis, specialties have been grouped together as shown below. Where the group consists of two or more specialties, the first named has been used to described the group.

General medicine
Diabetes
Medical genetics
Clinical pharmacology and therapeutics
Endocrinology
Gastroenterology

Paediatrics

Geriatrics
Rheumatology and rehabilitation

Diseases of the chest
Renal medicine
Cardiology
Respiratory medicine
Nephrology
Cardiothoracic surgery
Neurology
Thoracic surgery

Infectious diseases
Communicable diseases
Urology

Dermatology
Genito-urinary medicine
Venereology

Accident and emergency
Traumatic and orthopaedic surgery
Orthopaedics

Ear, nose and throat
Audiology
Neurosurgery
Ophthalmology
Paediatric surgery
Plastic surgery
Audiological medicine

General surgery

Gynaecology and obstetrics

General pathology
Morbid anatomy
Blood transfusion
Clinical neurophysiology
Chemical pathology
Clinical neurological physiology
Cytopathology
Clinical physiology
Haematology
Clinical chemistry
Histopathology
Immunopathology
Neuropathology
Medical microbiology
Bacteriology
Clinical virology
Medical oncology

Radiology
Diagnostic radiology
Radiodiagnosis
Nuclear medicine
Radiotherapy

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Mental handicap
Mental illness—children
Psychotherapy

Dental surgery
Oral surgery

Orthodontics
Restorative dentistry

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