Review body on doctors' and dentists' remuneration : seventh report, 1977 / chairman: Sir Ernest Woodroofe.

wellcome collection

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

Review Body on Doctors' and Dentists' Remuneration Seventh Report 1977

Chairman:
SIR ERNEST WOODROOFE

Presented to Parliament by the Prime Minister
by Command of Her Majesty
May 1977

LONDON
HER MAJESTY'S STATIONERY OFFICE
£1·35 net

Cmnd. 6800

Review Body on Doctors' and Dentists' Remuneration Seventh Report 1977

Chairman:
SIR ERNEST WOODROOFE

Presented to Parliament by the Prime Minister
by Command of Her Majesty
May 1977

LONDON
HER MAJESTY'S STATIONERY OFFICE
£1·35 net

Cmnd. 6800

ISBN 0 10 168000 7

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:

Sir Ernest Woodroofe (Chairman)

Professor R. H. Graveson, C.B.E., Q.C.

Dame Mary Green, D.B.E.

Ian W. Macdonald, Esq.

Sir Peter Menzies

Professor P. G. Moore, T.D.

Raymond W. Pennock, Esq.

Sir William Slimmings, C.B.E.

The Secretariat is provided by the Office of Manpower Economics.

CONTENTS

CONTENTS

CHAPTER I

INTRODUCTION

1. We drew attention in our Sixth Report[1] to the three main aims of the Royal Commission on Doctors' and Dentists' Remuneration in 1960[2] in recommending that the present form of review machinery should be adopted:

i. to avoid recurrent disputes between Government and the professions about remuneration;

ii. to provide some assurance to the professions that their standards of living would not be depressed by arbitrary Government action and thus to engender confidence that their remuneration would be settled "on a just basis";

iii. to safeguard the taxpayer who has to foot the bill.

These aims were valid in 1960 and in 1976, and they remain valid today. But this is the fourth time since we were appointed in 1971 that we have had to carry out our main annual review against the background of restraint measures which, in their most recent form, simply cannot be applied to some parts of the medical and dental professions "on a just basis". We shall spell out later in our report some of those anomalies and injustices that are peculiar to the professions. We have taken full account of the general measures designed to deal with the economic problems of the country as important factors in our deliberations and we have concluded hitherto that, so long as the general measures are applied consistently throughout the community, they should apply to doctors and dentists. On each occasion, the professions too have accepted the need to comply with the restraint measures, provided that they are applied with equal vigour across the board. But continued acceptance cannot be taken for granted if restraint measures that involve injustice continue indefinitely.

2. In common with many others in the community at comparable income levels, doctors and dentists have suffered a drop in their standards of living as a result of the redistribution of income brought about by the form of the restraint measures, by taxation, and by the effects of inflation over the past two years. Just under half of all doctors and dentists did not qualify (because of the £8,500 ceiling) for the increases recommended in 1976, which were the maximum permissible within the pay limits at that time. The increases for those who were eligible amounted to 6 per cent on average compared with the rise in the cost

---

[1]Review Body on Doctors' and Dentists' Remuneration, Sixth Report, 1976—Cmnd. 6473, May 1976 (paragraph 6).

[2]Report of the Royal Commission on Doctors' and Dentists' Remuneration 1957-1960 —Cmnd. 939, February 1960 (paragraphs 403-405).

of living as measured by the retail price index of 19 per cent for the year to April 1976. The cost of living has continued to rise since then, and at a rate that exceeds the increase in earnings allowed under the current pay limits. Against this, some relief has been afforded by the changes in income tax made last year and additional relief will be provided by the further changes announced recently by the Chancellor of the Exchequer for the coming year. The effect of all these factors on individuals will vary with personal circumstances but, taking a married man with two children under 11 years old as an example, between April 1975 and April 1977 the living standards[1] of a general medical or general dental practitioner with average earnings, or of a consultant with a few years' seniority, will have fallen by about 20 per cent (Appendix A). The fall in living standards of junior hospital doctors and dentists is much less marked when average income from extra duty allowances and Class A/B salary supplements are taken into consideration: the corresponding drop ranges from 8 per cent for new entrant house officers to 10 per cent for senior registrars on the scale maximum. By comparison, the fall in living standards over the same period of the *average* wage and salary earner (again taking a married man with two children under 11) is expected to be 6 per cent, and the fall in income (using a forecast for the second quarter of 1977 from the National Institute of Economic and Social Research) is between $3\frac{1}{2}$ and 4 per cent[2]. The fall in living standards for doctors and dentists other than those in the hospital training grades has been more severe than for many salary earners at comparable income levels because of the timing of the introduction of the restraint measures: but this is true of the greater part of the public services—including university teachers—because of the same accident of timing of their pay reviews. In the case of these doctors and dentists, average gross remuneration fell behind by about 14 per cent between April 1975 and April 1976 relative to those at comparable income levels: the shortfall for the medical and dental professions as a whole by comparison with our revised estimate of the position at April 1975 when we last brought doctors' and dentists' pay into proper relationship with the pay of other professional groups is 10 per cent on average (Appendix B). The whole situation is made worse by the anomalies with which the pay structure is now riddled as a result of the particular form of the restraint measures.

3. We recognise that, in the short term, some injustices may be inevitable in current circumstances, but we are bound to point to the consequences if a rational and orderly pay structure is not restored before long for doctors and dentists in the National Health Service. Only when this is possible will confidence be restored. Morale has suffered a serious decline in the last few years, and we see it as essential for the effectiveness of the National Health Service and for the good of the community as a whole for this decline to be reversed. We also see very real difficulties in the way of continuing to function as an independent Review Body unless it again becomes possible for us to have full regard to the principles behind the aims so clearly expressed by the Royal Commission on Doctors' and Dentists' Remuneration (paragraph 1) in the exercise of our collective judgment.

---

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

[2]These figures do not include the effect of the proposed 1977-78 tax changes.

4. The recommendations in our Sixth Report reflected the general measures for pay restraint for the year from 1 August 1975 introduced in the White Paper "The Attack on Inflation" in July 1975[1], and were accepted by the Government. These measures included a limit of £6 a week on increases in an individual's full-time remuneration in the year to 1 August 1976, subject to an earnings ceiling of £8,500 a year on eligibility for an increase. An immediate effect of the measures was the deferment of the implementation of the second (and final) stage of the 1 April 1975 increases in salaries above £13,000 that had been due to be paid with effect from 1 April 1976 in a wide area of the public services, including the National Health Service. Where fixed incremental pay scales were in operation, increments were withheld if earnings would otherwise have risen above £8,500 a year: this affected some hospital and community doctors and dentists[2]. New seniority allowances were withheld from general medical practitioners and general dental practitioners in the same circumstances. New distinction awards to replace those that lapsed because of the retirement, resignation or death of the holder and those recommended in our Fifth Report[3] were also withheld. But in all cases where increases had been staged or where payments were withheld (increments, distinction awards and seniority allowances), credit was given for them for superannuation purposes in recognition of the fact that the recommendations had been accepted by the Government and, in normal circumstances, would have been implemented.

5. The second year restraint measures cover the 12-month period from 1 August 1976 and were introduced in the White Paper "The Attack on Inflation —The Second Year" in June 1976[4]. Under them, pay increases are again limited *on an individual basis,* on this occasion to 5 per cent of total earnings subject to a maximum of £4 a week and a minimum of £2·50 a week, and the requirement that a 12 month interval should elapse between pay increases continues. Those who have had no increase since 1 August 1975 because of the £8,500 earnings ceiling under the previous measures, are not eligible for an increase until 12 months after the date on which they would otherwise have qualified for one had it not been for the existence of the ceiling. An increment which had been withheld from payment under the previous measures can now be paid on the anniversary of the date on which it was originally due; alternatively, if a further and larger increment has become due, it can be paid instead.

6. Little attention has been paid in formulating the second year measures to the comments in our Sixth Report[5] on the many anomalies that had already arisen in the well-established pay systems for the medical and dental professions, some of which we believe, from our collective experience, to be peculiar to those professions. We give two examples:

> ". . . the pay systems for general medical practitioners and general dental practitioners have to provide for widely varying workloads in

---

[1]Cmnd. 6151, July 1975.

[2]Consultants, district community physicians, and area and regional medical and dental officers.

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

[4]Cmnd. 6507, June 1976.

[5]Review Body on Doctors' and Dentists' Remuneration, Sixth Report, 1976—Cmnd. 6473, May 1976.

terms of numbers of patients, and for widely different levels of expenses directly related to patient care. They are based on fee scales and forecast practice expenses which, taken together with seniority payments reflecting experience and qualifications, are designed to provide a level of net remuneration that relates the individual's contribution equitably to the standards that we recommend as average. The counter-inflation measures of 1972-74 were not readily applicable to pay systems of this kind, and the present measures are still less so . . ." (paragraph 3).

". . . The withholding of increments and distinction awards from senior hospital and community doctors and dentists, and of seniority allowances from general medical and general dental practitioners is of particular significance, as it will reduce the normal pay expectations of these doctors and dentists . . ." (paragraph 16).

7. A further year with fixed *individual* pay limits has accentuated the anomalies. For example, the earnings of general medical practitioners and general dental practitioners will reflect variations in their workloads still less equitably than in the last twelve months. This is because the current restraint measures require increases to be in the form of a supplement to earnings in the same way as under the previous measures. For the same reason, certain entirely new anomalies will be created as a result of the arrangements that have been found necessary to continue payment of last year's £312 supplement in the current year. We have been told that existing general medical and general dental practitioners who were ineligible for the £312 supplement in 1976 because of the £8,500 earnings ceiling will remain ineligible for it this year (although they may currently earn less than £8,500), but that new principals who have entered general practice since 1 August 1976 will receive it, regardless of their earnings. On the other hand, the arrangements for deciding the eligibility of hospital and community doctors and dentists will be unchanged and, as a result, the £312 supplement will not be paid to those doctors or dentists on points of the scale which, with the supplement, would bring their earnings to more than £8,500 a year: all those who qualified for the supplement last year will retain it as they move up the scale. Thus, different treatment is to be accorded between newly-appointed principals and existing principals in general practice, and also between new appointments in general practice and new appointments in the senior grades of the hospital and community health services. We cannot see any logic in these arrangements. The effect of the decision to pay one increment only to hospital and community doctors and dentists where a second has become due has been to create a new anomaly, in that those who have 'lost' an increment have, in pay terms, been overtaken by all those who qualified for the same payments up to a year later. The fact that this is not peculiar to doctors and dentists, and that it has happened in all cases where an incremental pay scale or other pay arrangements span the £8,500 earnings ceiling, does not lessen its impact as an anomaly. We repeat what we said in our Sixth Report: the longer the anomalies and injustices created by the application of restraint measures that are unsuited to the pay structure are allowed to continue, the more acute they become.

8. The legitimate pay expectations of doctors and dentists have been reduced as a result of the particular form of the measures. The amounts of pay 'lost' by individual doctors can be substantial: for example, consultants and community physicians who were on the second point of the salary scale when the pay restraint measures were introduced (in July 1975)[1] may lose £2,367 (over three years); consultants and community physicians who received new distinction awards in the Advisory Committee's 1975-76 review with an effective date of 1 January 1975 may lose between £2,394 and £3,558; general medical practitioners who qualified for a third payment for seniority after 25 years as a principal[2] may lose £585; and general dental practitioners who qualified for a seniority payment on reaching 55 years of age[3] may lose up to £520. These are examples only. In addition, the deferment of the implementation of the second stage of the 1 April 1975 increases in salaries above £13,000 a year has already involved a loss over the last 12 months of between £1,229 and £2,742 for consultants who have B, A or A+ distinction awards. We estimate that the remuneration of over one-third of all consultants will have been affected in one or more of these ways. We cannot see how the continued withholding of part of a salary increase that has been accepted as due on 1 April 1975 before the introduction of the pay restraint measures can be justified.

9. We are aware that anomalies of one kind or another will have been created in other pay structures at parallel levels, particularly in management. But we are concerned with doctors and dentists in the National Health Service, and we doubt whether so many and varied anomalies can have been created in any other single field. Furthermore, some of them have been seriously exacerbated by Government decisions in the face of expediency. One of the more serious distortions arises from the way in which the new contract for junior hospital doctors and dentists[4] has been implemented: as a result, on promotion the majority of maximum part-time consultants and many full-time consultants now receive less than their senior registrars (or even their registrars). A distortion of the pay structure of this magnitude ought not to be accepted in other than the most exceptional circumstances and in the short term only. It undoubtedly acts as a deterrent to those who are in the field for promotion; moreover, it is bound to create dissatisfaction and a sense of injustice among consultants. It is true, of course, that consultants can look forward to higher earnings in the longer term, but this does not lessen the injustice of the present situation, particularly in a time of inflation. In our experience, no organisation—be it in the private sector or in the public services—can be expected to function effectively if the pay structure itself is so wracked with anomalies that injustice is manifest within it. It is against the background of the need for pay restraint as one ingredient of the policies required if inflation is to be contained, and of the declared policy of the Government to provide a degree of flexibility in the measures that are under consideration for introduction from 1 August

---

[1]Because of the shortening of the scale from nine increments to four (in April 1975), these include consultants and community physicians appointed on the scale minimum from one to three years earlier.

[2]Subject also to having been registered for 30 years and having attended the required number of postgraduate educational sessions.

[3]Subject also to having received total net remuneration of £13,000 in the preceding 10 years.

[4]The new contract was introduced with effect from 9 February 1976.

1977, that we urge that the flexibility in practice should be sufficient to enable us to make a start on the restoration of order to the structure. Unless some freedom of manoeuvre is provided which will enable a move to be made towards bringing the pattern of pay into a proper relat.onship with the levels of pay of other professional groups, the pay structures of the medical and dental professions will be frozen into the general pay structure at a level dictated by chance. This would be unacceptable.

CHAPTER 2

OUR GENERAL CONCLUSIONS

10. We have considered written and oral evidence from the Health Departments on behalf of the Government and from the Review Body Evidence Committee (the Joint Evidence Committee) of the British Medical Association and from the British Dental Association on behalf of the medical and dental professions[1]. On this occasion, we have also examined particular problems in discussion with the Secretary of State for Social Services and the Parliamentary Under Secretary for Scotland. We have received written submissions from the Hospital Consultants and Specialists Association[2], from the Junior Hospital Doctors Association[2], from the Association of Scientific, Technical and Managerial Staffs on behalf of their junior hospital doctors' section, and from the General Dental Practitioners' Association. We have also received submissions from individual doctors and groups of doctors.

11. The Joint Evidence Committee have asked us to recommend the maximum increase consistent with the current pay limits for all doctors in general medical practice and in the community health service, and for doctors and dentists in the hospital service; in addition, they have sought a further increase of 10 per cent for general medical practitioners by reference to what they judge to be an equivalent increase in workload over the past twelve months. They have asked that, in the case of junior hospital doctors and dentists, part of the increase should be used to meet the cost of changing the basis of remuneration under the new contract to include payment of Class A/B supplements for the time spent in providing cover for other junior doctors and dentists on leave (which, under the agreed arrangements, is undertaken without additional remuneration). The Joint Evidence Committee drew attention to the deterioration in the earnings position of the medical profession as a whole, both in real terms and relative to comparable income groups in the year to April 1976 (which they saw as substantial), and they estimated that, after allowing for the maximum increase permissible within the present restraint measures, in April 1977 real earnings before tax would be 25 per cent lower than in April 1975. They told us that the anomalies and injustices created by the restraint measures had become more acute; that the morale of consultants in particular had

---

[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 speaks for dentists in the hospital service as well as for doctors. The BDA speaks for general dental practitioners and community dentists.

[2]Constituent body of the British Hospital Doctors' Federation.

deteriorated further; and that the future provision of health care to the community could be prejudiced permanently if the anomalies were allowed to continue. They also referred to the fact that doctors are now free to practise in all member countries of the European Economic Community and to the implications of this freedom, particularly for younger doctors. In addition, they told us that they were considering fresh proposals for new contracts for consultants and for medical assistants, and that they aimed to open discussions with the Health Departments on these later in the year.

12. The British Dental Association drew our attention to a reduction in dentists' earnings in the year to April 1976, both in real terms because of the application of the pay restraint measures and in relation to those of others in the same income groups, whose increases in pay had seemed to them to have come closer than their own to the rise in the cost of living. They asked us to recommend the maximum increase consistent with the current pay limits for all dentists in the general dental service and in the community health service (including those on 'protected' salary scales[1]). They referred to the distortion of the established pay structure for community dentists and of the system of remuneration for general dental practitioners that had resulted from the form of the pay restraint measures: they saw this as having affected doctors and dentists more severely than most other groups. They asked us to recommend the extension of the £312 supplement to all those who had not been eligible for it in 1976 because their earnings exceeded £8,500 a year, and the restoration of all elements of remuneration that had been withheld under the measures, all with retrospective effect to 1 August 1976. They proposed that the £312 supplement and the increase that they sought for 1977 should both be consolidated into target average net income (and hence into the basic fee-scale), in order to restore the established system of remuneration for general dental practitioners and avoid possible downward adjustment in the level of fees: it would also reduce administrative complications. They expressed concern about the detailed structure of increments within the pay scales of administrative dental officers and about their relationship to the scales of administrative medical officers, and asked us to review these at the earliest possible opportunity. They also told us that the necessary steps had been taken towards securing recognition of community dentistry by the Royal Colleges as a specialty in its own right, and asked us to recommend that regional and area dental officers should be eligible for distinction awards in future.

13. The Health Departments did not make specific proposals for the level of increase justified now in the remuneration of doctors and dentists, but the general approach in their evidence implied an assumption that an increase at the maximum amount permitted within the restraint measures was justified. They explained in detail the arrangements for payment in the coming year of last year's £312 supplement, and suggested that the arrangements which had been used on that occasion for deciding eligibility for it within the pay limits

---

[1]'Protected' salary scales exist for community dentists in the dental officer and senior dental officer grades who have not yet been appointed to grades in the new career structure for community health dental staff introduced in 1975.

should again be adopted in relation to our 1977 recommendations. They told us that the restraint measures again require increases to take the form of a separate cash supplement. The supplements would be payable in addition to earnings for hospital and community doctors and dentists, and as an addition to gross fees and allowances for general medical and general dental practitioners. They would be additional to the £312 supplement recommended in 1976 and, like it, they would be pensionable. All doctors and dentists who work full-time in the National Health Service (including more than one part of it) would receive the appropriate supplement in full, and those who work part-time would receive it on a pro-rata basis. They supported the proposal put forward by the Joint Evidence Committee that junior hospital doctors and dentists should receive additional Class A/B supplements under the new contract when they provide cover for other junior doctors or dentists on leave, and they told us that the restraint measures require the cost of improvements of this kind in conditions of service to be counted against the pay limits with a corresponding reduction in the amount of the supplement. They also explained that, under the Government's interpretation of the policy, provision for reimbursement of expenses could be kept in line with the underlying movements in those expenses without having to be counted against the pay limits. They provided us with statistics on manpower, workload and detailed payments to doctors and dentists in the year to 31 March 1976, and on the contracted units of medical time for junior hospital medical and dental staff.

Our views

14. We now describe our general conclusions in the light of the evidence submitted to us. We have drawn attention to some of the anomalies which have already arisen under the pay restraint measures and which have led to a reduction in the pay expectations of many doctors and dentists. We have referred to the temporary decline that can occur in the position of one particular group relative to other groups according to the timing of their pay review in an annual cycle and its relation to the effective date of the restraint measures. Indeed, when the Joint Evidence Committee saw us on 26 November 1976 to discuss changes that had taken place since the 1976 review and to prepare the ground for the 1977 review, it was suggested to us that there would be advantage in changing the effective date of our annual review recommendations to 1 August in each year, as this would coincide with the effective date of the current measures. We explained that we saw practical difficulties in deferring the date of the current review to 1 August 1977 as it would mean that some doctors and dentists would have had no review of their remuneration for 16 months: moreover, the effective date of possible future policy measures might be different, as it had been in the past. Meanwhile, the pay limits under the current measures represent for doctors and dentists increases in gross income terms that range from 5 per cent for house officers to just under 2 per cent for consultants on the maximum of the scale: even in net income terms after taking into account the effect of the changes in income tax made last year which were equivalent to an increase in net income of 0·9 per cent for house officers on

the minimum of the scale[1] and 4·2 per cent for consultants on the maximum of the scale[2], these increases are well below the increase of 16·2 per cent in the cost of living as measured by the retail price index over the past year[3]. The case for increases in the general level of remuneration of doctors and dentists of the maximum amount permissible within the current pay limits is clear.

15. We have considered the British Dental Association's general proposals that a £312 supplement should be paid to all those who were ineligible at 1 April 1976 because their earnings were above the £8,500 ceiling, and that all elements of remuneration (increments within salary scales, distinction awards for consultants and seniority allowances for general practitioners) which have been withheld under the pay restraint measures, should now be paid with retrospective effect to 1 August 1976. The same suggestion was made to us by the Joint Evidence Committee on 26 November 1976, but we were unable to recommend it. The current restraint measures[4] provide that the next increase in pay for all those affected by the £8,500 earnings ceiling cannot be earlier than the anniversary of the date on which the increase that was 'caught' would otherwise have been allowable. In the case of doctors and dentists, this is 1 April 1977. They also require the amount of any increase between 1 August 1976 and 31 July 1977 to be kept within the current pay limits. In addition, none of the payments that were withheld in the 12 months up to 1 August 1976 can be restored retrospectively and 12 months must elapse before they may be paid. There is no case for preferential treatment of doctors and dentists by comparison with others in this respect.

16. We have also considered the Joint Evidence Committee's proposal that the average net remuneration of general medical practitioners should be increased by 10 per cent outside the pay limits in recognition of increased workload over the past 12 months. We have not found the evidence sufficiently conclusive to support a case for an increase now. We discuss our reasons in detail in Chapter 4.

17. We make our recommendations for each of the groups within the professions in Chapters 3—6. We have been told by the Health Departments that the Government accepts that increases for hospital and community doctors and dentists do not require to be restricted on account of payment of increments within the scales: we are not in a position to make an independent check of the calculations ourselves.

18. The directives which introduce freedom for doctors to practise in all member countries of the European Economic Community became effective on 20 December 1976. We have been told that the measures to put them into effect in the United Kingdom, in France and in Italy are expected to be completed in the near future; in Denmark and in Italy, there is a surplus of doctors; West Germany on the other hand, depends to some extent on the services of

---

[1]Single.
[2]Married with two children under 11 years.
[3]Twelve months to February 1977.
[4]Comnd. 6507, June 1976 (paragraph 20).

overseas doctors. There are shortages in some specialties and in some parts of all countries. As we have said before, many factors affect decisions to emigrate—language, way of life, social environment, opportunities for training and facilities for research, as well as level of remuneration. We are aware that, at present, remuneration is significantly higher in the other member countries, but this is true of other professions and occupations, and of management generally. Many doctors in the NHS, particularly those in specialties such as anaesthetics and radiology that for working purposes require little fluency in the language concerned, already seek short periods of employment in other European countries. It must be expected, therefore, that some doctors will in future seek to practise in other Community countries, and that some from those countries will want to practise here. Moreover, a fundamental principle of the European Economic Community is that there should be freedom of movement of labour between member countries, and it is a feature of modern life that younger men and women want to broaden their knowledge and experience through close working contacts in other countries to a much greater extent generally than even a quarter of a century ago. So far as the medical profession is concerned, there are in any case signs that the pattern of migration between this country and other countries may be changing as a result of recent restrictions placed on foreign doctors who want to practise in North America and on doctors from the Indian sub-continent who want to practise elsewhere. The net out-flow of fully or provisionally registered United Kingdom and Irish-born doctors, which had increased in the three preceding years, fell back in 1975-76 to the level of 1973-74. Comparable figures are not available for the movement of foreign doctors. We indicated last year our concern should a situation arise in which a disproportionate number of the most able doctors in this country chose to emigrate. We shall continue to keep under review the pattern of migration and its consequences for the National Health Service.

19. Against the background of the evidence put to us, we have taken the opportunity to review again both manpower generally and the workloads of doctors and dentists in the National Health Service (Appendix C). We last did this in 1972, since when the rate of growth in the number of doctors and dentists in both the hospital service and in general practice has been more rapid than the rate of growth in the population so that, in these terms, the provision of medical and dental care under the National Health Service has improved. In addition, there has been a significant expansion in home care which, since the reorganisations of Local Government and of the National Health Service in April 1974, has come under the control of the new community health service. No difficulty has arisen in filling the expanding number of places in medical and dental schools. The current manpower targets, set by the Royal Commission on Medical Education in 1968[1] and by the Committee on Recruitment to the Dental Profession in 1956[2], have been met. However, a paradoxical situation has arisen, in that the number of doctors in the training grades is already higher than the number required to sustain the current

[1]Report of the Royal Commission on Medical Education 1965-68: Chairman, Lord Todd —Cmnd. 3569, April 1968.
[2]Report of the Committee on Recruitment to the Dental Profession: Chairman, Lord McNair—Cmd. 9861, October 1956.

complement of career posts, although the demand for junior medical staff in the hospital service is not yet satisfied. As long as a large number of overseas-born doctors continue to seek their training in this country, and as long as a high proportion of them do not want permanent employment here, the problem is not acute. But it would be shortsighted indeed to assume that the position will continue unchanged: if it were to change, it could quickly become acute. Early consideration ought to be given to ways and means of meeting the clinical requirements while at the same time providing reasonable career opportunities for the rising output of young doctors from medical schools in the future. In addition, in the light of the slowing down in the rate of population growth in recent years, there is a case for re-examining the present targets for medical manpower in each of the main branches of health care, both against the changed population forecasts and against more complex criteria of need than the extrapolation of past trends that was used in 1968. The wide difference between the lowest and the highest ratio of population per general dental practitioner in a region indicates that there is significant scope for improvement in the provision of general dental services in many parts of the country, as well as a need for a more uniform distribution of dentists. We hope that serious consideration will be given to the distribution problem by the Health Departments and the dental profession, as well as to the future manpower needs of the general dental service, with the aim of raising national standards of dental health.

20. Unfortunately the evidence available to us on workload is limited and inconclusive. Such indicators as waiting lists and length of hours worked do not fully reflect changing clinical complexity brought about through the continuing development and application of new techniques which enable more patients to be treated and are more demanding in resources. We referred in our 1972 Report to the need for detailed studies aimed at obtaining systematic information on workload in the different branches of the medical and dental professions: we regret that it has not yet proved practicable for these studies to be made. We recognised then that it would take time to collect useful results, and we are more than ever convinced from developments over the last two years that such studies are needed and ought to be made. We hope that steps will be taken to make them and to make the results available to us.

21. We draw attention once again to the anomalies that arise when pay increases are restricted at the same time as the pensions of those who have retired continue to move in line with changes in the cost of living. Because the pay increases permissible under the restraint measures have been substantially lower than the rise in the cost of living, those doctors and dentists who have retired since April 1976 receive lower pensions than those who retired earlier with the same length and pattern of service. As a result, an incentive has been created for doctors to retire as soon as they qualify for pension. This situation arises in a wide area of the public services, and is one result of artificial restriction of salaries combined with inflation-proofed pensions at a time of a high rate of inflation. The consequences for the National Health Service could be serious, as just over one out of every ten practising doctors and dentists is over the qualifying age for pension[1].

[1]The qualifying age for pension for all doctors and dentists is 60, but hospital doctors and dentists may continue to serve until age 65 and may be re-employed thereafter until age 70. There is no age limit by which general medical practitioners and general dental practitioners must retire.

CHAPTER 3

HOSPITAL DOCTORS AND DENTISTS

22. We now discuss our detailed proposals on the pay of doctors and dentists in each of the main branches within the professions in the National Health Service. We follow our usual practice of commenting on the changes that have taken place in the manpower position and the workload since our last review. We take first doctors and dentists in the hospital service, including ophthalmic medical practitioners. The total number of hospital doctors in England and Wales has increased by 2·7 per cent in 1976[1]: this is rather less than the average increase of the two previous years. The increase in UK and Irish-born doctors in 1976 was slightly lower than in 1975, but the rate of increase in the number of overseas-born doctors slowed down and the proportion declined marginally from 35·2 per cent in 1975 to 34·6 per cent in 1976. The number of medical consultants increased by 397 or 3·4 per cent to 11,882. One fifth of the increase was attributable to the regrading of senior hospital medical officers. The proportion of overseas-born medical consultants increased slightly from 14·3 per cent in 1975 to 14·8 per cent in 1976. 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 fell marginally from 702 in 1975 to 686 in 1976. Although the recruitment to advertised posts improved in 1976, the proportion of vacant posts that were advertised declined further, with the result that 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 242 in 1975 to 278 in 1976. Nevertheless, the balance of the posts[2] that were not occupied by either a full-time or a part-time locum was reduced slightly from 97 in 1975 to 95 in 1976, or 0·9 per cent of all medical consultant posts. The latest figures for hospital workload in Great Britain relate to 1975 and, in that year, the number of in-patients fell by 3·5 per cent, and the number of out-patients by 11·3 per cent; however, the number of patients awaiting hospital treatment increased by 11·6 per cent. The marked decline in the number both of in-patients and of out-patients, and the substantial increase in the number of patients awaiting treatment result mainly from industrial action taken in the course of 1975 by some consultants over the issue of pay beds and by some junior hospital doctors over the introduction of their new contract.

---

[1]Figures in this paragraph relate to numbers in post at end-September in the year indicated.
[2]In whole-time equivalent terms.

23. We expressed the hope in our Sixth Report[1] that the discussions on improvements to the existing contract for consultants, which had been suspended on the introduction of the restraint measures, could be resumed and brought to an early conclusion. We have been told by the Health Departments that, since then, discussions with the professions have been re-opened on a without 'commitment' basis on the introduction of emergency recall fees, and that they are ready to discuss recognition of voluntary extra sessions and payment for administrative work on the same basis, since they are all improvements that had been agreed in principle before the introduction of the pay restraint measures in 1975. But the Health Departments are not in a position to enter into formal negotiations on any of these matters until developments in the Government's pay policy enable improvements of this kind to be implemented. The professions have told us that they regard as necessary changes of a more radical nature which would incorporate the improvements already agreed in principle. Outline proposals for a new consultant contract have been put forward, and discussion of them with the Health Departments has been started with a view to negotiation and implementation when pay policy permits. In view of the length of time that has elapsed since 1972, when we were first told that the form of contract for consultants was under consideration, we hope that the discussions can be brought to an early conclusion. We attach great importance to a thorough and realistic examination of the basis of the contract, and we repeat our view (which we expressed in relation to the junior hospital doctors' contract[2]) that it is inappropriate to relate professional salaries directly to length of working hours. We should in any case require detailed information on the present pattern of work and responsibilities, before we could price a contract which specified an individual consultant's working commitment. We expect to be kept informed on developments.

24. We have been given further information on the implementation of the arrangements for the payment of fees for family planning work undertaken by hospital medical staff, which were introduced from 1 August 1975. Under these arrangements, payment is made to hospital doctors where this work is carried out on social grounds (as a result of the extension of the personal medical services provided by the National Health Service) as well as on grounds of medical need (for which additional remuneration was not available prior to 1 August 1975). We have been told that the implementation of these arrangements has been limited by the availability of resources and that, as a result of the present severe financial constraints, a few area health authorities in England and Wales have not yet implemented them. The present arrangements provide for the number of fees paid each year to individual consultants for certain work[3] in certain specialties[4], or to junior hospital doctors who undertake the work at their request, to be restricted, but there is no such restriction for hospital medical staff in other specialties involved in family planning work[5]. We understand that additional funds to permit fuller implementation

---

[1]Review Body on Doctors' and Dentists' Remuneration, Sixth Report, 1976—Cmnd. 6473. May 1976 (paragraph 19).
[2]Review Body on Doctors' and Dentists' Remuneration, Supplement to Fifth Report. 1975—Cmnd. 6243, September 1975 (paragraph 15).
[3]Surgical procedures and fitting of intra-uterine contraceptive devices.
[4]General surgeons, gynaecologists and urologists.
[5]Anaesthetists, pathologists and radiologists.

of the arrangements are unlikely to be available for some years to come. No limitation has been applied to the fees earned by general medical practitioners for parallel work.

25. Our recommendations in the Third Supplement to the Fifth Report for pricing the new contract for junior hospital doctors and dentists were designed so that, within the limitations of the information available and taking into account the expectation of some reduction in hours (paragraph 26), the cost of the Class A and Class B supplements would balance the annual cost of extra duty allowances[1]. The Health Departments have provided us with detailed information relating to the new contracts that were in operation on 10 May 1976. On the basis of the total number in post at 30 September 1975, this information implies an annual cost of £30·4m for Class A and Class B supplements, compared with the auditors' estimate of £14·2m for the total of extra duty allowance payable in 1975-76 on which our recommendations were based. We noted then that the cost would vary according to the extent to which the pattern and number of hours contracted for differed from those that provided the basis of our calculations, and this has happened in the event. Although the evidence shows that there has been little change in duty rosters, in practice a substantially greater degree of availability and longer hours are being contracted for than we were originally led to expect: we estimate that the increase in the ratio of stand-by duty to on-call duty accounts for nearly two-thirds of the excess over the estimated cost, and the longer hours for just over one-third. The pattern of contracted hours shows that, on average for all junior hospital medical and dental staff, 93 per cent of all units of medical time (UMTs) beyond the standard week (10 UMTs) are being paid for at the Class A rate of supplement (for standing by or working at hospital) whereas the evidence available from the survey that the Health Departments carried out on our behalf between May and July 1975 indicated that 46 per cent of duty hours in excess of 40 in the normal working week would be spent on stand-by[2]: the evidence of the survey (which is, of course, limited) was accepted by the Health Departments and by the professions as being reasonably representative. However, after the submission of our recommendations on the form and level of remuneration under the new contract, the Health Departments and professions reached agreement that a doctor at home should not necessarily be ineligible for the Class A rate of supplement if his availability were the same as when he was standing by at hospital. This introduced an entirely new provision into the arrangements and we were uneasy about it at the time: but we were told jointly by the Health Departments and the professions that the modification was designed to produce a small measure of flexibility in interpretation—for example, to cover the case of a doctor who lived mid-way between two hospitals in the same group and was on stand-by for work at both— and that it was unlikely to change the balance between Class A and Class B UMTs. The Health Departments have now reported to us that, in practice, this provision has been interpreted by the employing authorities quite differently from the way that was intended and that, for example, doctors resident in hospital who were on-call

---

[1]Review Body on Doctors' and Dentists' Remuneration, Third Supplement to Fifth Report, 1975—Cmnd. 6406, February 1976 (paragraph 13).

[2]Review Body on Doctors' and Dentists' Remuneration, Supplement to Fifth Report, 1975 —Cmnd. 6243, September 1975 (Appendix B, paragraph 9).

in their own quarters have generally been treated as being on stand-by[1]. Action is needed to clarify the definitions of the different types of duty outside the standard week so that they can be applied consistently throughout the hospital service.

26. The number of UMTs contracted for implies that the average weekly hours of duty[2] of all junior hospital medical and dental staff are 91·3 hours. However, the contracts in operation at 10 May 1976 included a substantial proportion entered into on the basis of additional payment for covering for other doctors during their absence on annual and study leave, as well as payment at the rate for the normal working week during periods of a doctor's own annual or study leave When allowance is made for this factor, the implied average weekly duty hours are reduced to 87·9, compared with the estimate of 81·5 hours on which our recommendations were based[3]. As we have mentioned (paragraph 25), the Health Departments have told us that the duty rosters on which the new contracts for individual doctors were based have mostly remained the same as they were previously. They have suggested that the difference in the number of hours contracted for compared with our estimate of average weekly duty hours could be attributable to two factors. The first of these, which we believe is the main cause of the difference, is that many employing authorities have agreed new contracts which include the addition of one or more UMTs for 'flexibility' outside duty roster hours to ensure continuity of patient care and to provide for eventualities, such as late work on evenings off and theatre lists or ward rounds which start early or end late. The cost of our recommendations was calculated on the basis of the agreed method of assessment *without* additional provision. Second, our estimate of average weekly duty hours was based on the distribution of weekly duty hours found in the survey and adjusted to be consistent with the auditors' forecast total of extra duty allowances for 1975-76; but some doctors did not in practice claim for small amounts of extra duty allowance to which they might have been entitled, and others would have been ineligible to claim as they had not spent the minimum time of two hours needed to qualify for payment, so that more hours were actually spent on duty than implied by the extra duty allowances claimed. But this could not have been a significant factor and, in any case, the results of the survey were adjusted to take account of it. We were also told jointly by the Health Departments and the professions that their strong impression was that average weekly duty hours were lower than the 85·6 hours found in the survey and that weekly duty hours were falling. For these reasons, the pattern and number of hours contracted for differ from

---

[1]Review Body on Doctors' and Dentists' Remuneration, Supplement to Fifth Report, 1975—Cmnd. 6243, September 1976 (paragraph 12).

[2]Average weekly hours of duty include the standard working week of 40 hours and those further hours spent on duty either standing by or working at hospital or on-call at home during which, when not actually called to patients, recreation or study may be pursued or rest taken. Working hours on weekdays are not standard throughout the hospital service, but it is generally accepted that the pattern of the normal working day, from start of duties to time of hand-over when responsibility for patients is allocated among staff on 'stand-by' or 'on-call', is an 8 hour period usually from 9 am to 5 pm.

[3]Review Body on Doctors' and Dentists' Remuneration, Third Supplement to Fifth Report, 1975—Cmnd. 6406, February 1976 (paragraph 7).

those that provided the basis of our calculations. As a result, the earnings of junior hospital doctors and dentists moved ahead by nearly 5 per cent on average between April 1975 and April 1976 relative to those at comparable income levels.

27. When the new contract for junior hospital doctors and dentists became effective on 9 February 1976, certain matters were left to be settled between the Health Departments and the professions. One important issue was the treatment of annual leave and study leave. Our recommendations in the Third Supplement to the Fifth Report were based on the contracted units of medical time as representing hours of duty on an annual basis, including time spent providing cover for other doctors on annual or study leave. It is history now that, following a failure to agree the method of treatment of annual and study leave, the Health Departments issued instructions to employing authorities on 12 July 1976 that payment should be made at an annual rate on the basis of the contracted weekly hours of duty, including time spent providing cover for other doctors on leave: new contracts that had been entered into on a more favourable basis (estimated now to have been as just over 50 per cent in England and Wales but none in Scotland) were to be allowed to stand. However, the professions argued that this approach was contrary to the spirit of their 12 December 1975 agreement with the Government[1], that the rate for the normal duty week should apply during periods of annual or study leave and that the contractual obligations to cover for other doctors on leave should be recognised by additional payment. Agreement was subsequently reached on 24 August 1976 on the basis proposed by the professions, and the Health Departments undertook to support them in proposing to us that it should be implemented with effect from 1 April 1977. Meanwhile, the basis of remuneration was changed so that junior doctors were paid at the rate for their normal duty week during periods of annual or study leave but did not receive additional remuneration for providing cover for other doctors on leave: the option was given for existing contracts on a less favourable basis to be converted to the new basis, and those that were on the more favourable basis were allowed to stand. At the same time, it was agreed to recommend to health authorities that, where possible and subject to the needs of patients, a doctor or dentist should be allowed a minimum of 88 hours per week off duty, including freedom from on-call liability.

28. The professions have suggested that, as a result of the 24 August 1976 agreement, junior hospital doctors and dentists cannot be required to provide cover for other doctors on annual or study leave if it would involve encroachment on the recommended minimum assured period of 88 hours per week off-duty time; they developed this suggestion in relation to a situation in which they would agree to provide such cover at the request of employing authorities and proposed that, in these circumstances, they should be employed on an internal locum basis and remunerated at the basic salary rate, instead of at the appropriate Class A or Class B supplement rate. The Health Departments have told us that the recommendation on off-duty time was

---

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

not intended either to introduce an 80 hour duty week, or to define unreasonable hours of duty, and that employing authorities will need to assess what is reasonable to ask an individual doctor to undertake in the light of the level of his or her responsibilities and other relevant factors.

29. This difference of opinion is yet another example of the problems that have surrounded the introduction of the new contract. Like the one that has arisen in relation to payments for annual and study leave (paragraph 27), this problem highlights the peculiar difficulty of attempting to achieve too precise a relationship between the emoluments of a salaried professional group and the length of their working hours. In the case of the junior hospital doctors' and dentists' contract, we commented that the need to combine the care of patients (which involves 24 hours cover and is an essential part of their training) with continuing study made it impossible to define their hours of duty in precise terms, and that the different types of duty made widely different demands on individual doctors. We hope that account will be taken of these difficulties in the discussions that the Health Departments propose to hold with the professions on the working of the new arrangements in practice. The need for the degree of commitment implied by the present proportion of Class A UMTs, and the requirement for additional UMTs for flexibility are clearly matters which require urgent examination. We should like to be informed of the outcome of these discussions.

30. We have again been asked by the professions to relate the present salary scale to the standard working week of 10 UMTs. As we said in our Sixth Report[1], under the terms of the new contract which was introduced with effect from 9 February 1976, junior hospital doctors and dentists continue to be paid according to the salary scales recommended in our Fifth Report. Those salary scales took into account part of the long hours that they spent on duty beyond the normal weekly hours and, at that time, extra duty allowances recognised the remainder. The extra duty allowance arrangements were replaced by the system of salary supplements payable for UMTs contracted for in excess of a standard working week of 10 UMTs and, as the salary scales remainded unchanged under the new contract arrangements, it followed that they continued to contain an element of recognition of the long hours of duty. In making our recommendations, we noted the view expressed to us jointly by the Health Departments and the professions that the basic salary scales recommended by us should represent payment in respect of the standard working week only, but it was apparent to us that the introduction in one step of a change of basis from salary related to up to 80 hours duty a week to salary related to a standard working week of 40 hours only would present serious practical problems and could not therefore be contemplated other than as part of a major review of salaries. The position is unchanged on this occasion.

---

[1]Review Body on Doctors' and Dentists' Remuneration, Sixth Report, 1976—Cmnd. 6473, May 1976 (paragraph 20).

31. In accordance with their 24 August 1976 agreement (paragraph 27), the professions and the Health Departments have asked us to recommend that the basis of remuneration should be changed to allow additional remuneration for providing cover for other doctors on leave, with effect from 1 April 1977. They have each proposed that, should we consider the junior hospital doctors and dentists to be eligible for the maximum increases allowed under the restraint measures on an individual basis, the change in the basis of remuneration should be the first charge against the increases on a group basis, and the balance should be used to provide an equal cash supplement to earnings for everybody. The Health Departments have told us that the Government is prepared to allow the increases for the group as a whole to be aggregated and a portion of this total to be distributed to individual doctors and dentists in amounts which would vary according to the extent to which each contracted to cover for other doctors and dentists on leave. The Health Departments have also told us that it is consistent with the current restraint measures for contracts that are already on the new basis at 1 April 1977 to be excluded from the calculation of the cost. The exclusion of contracts that are already on the new basis increases the amount available for distribution as a cash supplement. These contracts will expire within a few years. The cash supplement is permanent. In our view, the cost of these contracts ought to have been counted as part of the overall cost of the proposal, but we note that the Government has conceded the point and our recommendations reflect the concession.

32. We recommend that the supplement should be paid in full to all full-time hospital medical and dental staff other than those in the training grades. The cost of changing the basis of remuneration under the new contract for junior hospital medical and dental staff calculated by the method which has been agreed between the Health Departments and the professions will absorb £103 on average of the amount available within the individual pay limits for senior registrars, registrars, almost all senior house officers and most house officers: in the light of the Government concession, a cash supplement of £105 is therefore appropriate[1]. Everybody will receive this supplement but, because payment of Class A/B supplements for providing cover for doctors who are absent on leave will vary between individuals, those who do not provide such cover will receive less than the equivalent of the minimum individual increase of £130, and others will receive more than the equivalent of the maximum individual increase of £208 under the current restraint measures: this is a consequence of treating the cost of improvements in conditions of service on a group basis and of introducing a common supplement as we have been asked by both the Health Departments and the professions to recommend. We have considered whether the supplement should be adjusted where individual increases are less than the equivalent of £130 or more than the equivalent of £208. But the implications of the joint proposal must have been clear to both parties to it, and must therefore have been accepted by them; the practical problems of implementation would, in any case, be serious. The supplement for part-time staff will be on a pro-rata basis to the supplement for full-time staff. Under

[1]A very small number of senior house officers and some house officers are not eligible for the maximum permissible increase of £208, but the total cost for all grades is equal to the maximum amount available within the pay limits (based on the 1975 survey information).

the arrangements proposed by the Health Departments, general practitioners who hold hospital or community health appointments will be eligible for the level of increase that recognises both functions, provided that it is within the overall pay limits. This is in line with the arrangements for payment of the 1976 cash supplement recommended by us, and we therefore endorse them.

33. A limited number of appointments have now been made in the new hospital practitioner grade, and the review of existing posts for regrading is continuing. We said last year[1] that the salary scale recommended for the new grade in 1974 had been based on the assumption that work of a more responsible nature would be involved than in either the medical assistant and assistant dental surgeon grade or in the part-time medical and dental officer grade. However, at that time, we had not been provided with evidence to show that either more work or greater responsibilities would necessarily be involved, and we asked for evidence on the duties and responsibilities of the new grade, and on their relationship with those of other intermediate grades[2]. We have not yet received this evidence. However, we have now been told by the professions that the degree of responsibility that will devolve upon individual hospital practitioners will be decided by the responsible consultant, and will depend to a great extent on the practitioner's own experience and ability. Most medical assistants and assistant dental surgeons have extensive experience in their specialty, and already have a substantial amount of delegated responsibility. We understand that their duties and responsibilities can be greater than those of a hospital practitioner, and that there is no specific relationship between the responsibilities of the two grades. The professions have also told us that they hope to put forward proposals on a new contract for medical assistants and assistant dental surgeons for discussion with the Health Departments in the near future, and that they are giving consideration to the position of the more experienced part-time medical and dental officers who carry out the duties of clinical assistants, but who are not eligible for appointment as hospital practitioners because they are not principals in general practice. It has been represented to us that the introduction of the hospital practitioner grade and its restriction to general practitioners has given rise to much dissatisfaction among doctors and dentists in the existing intermediate career grades, and that, until the duties and responsibilities of the new grades and the relationships with those of other grades have been clearly defined, more and more anomalies will be created as more hospital practitioner appointments are made—with obvious consequences. We see this problem as a part of the wider issue of providing career opportunities for the growing number of doctors and dentists under training to which we have referred (paragraph 19). We hope that early consideration will be given to clarification of the roles of doctors in the intermediate career grades and to the numbers required.

34. **Career grades: Distinction awards.** We understand that no further progress has been made on the proposals for replacing the present system of distinction awards put forward by the Health Departments in December 1974

---

[1]Review Body on Doctors' and Dentists' Remuneration, Sixth Report, 1976—Cmnd. 6473, May 1976 (paragraph 25).

[2]Review Body on Doctors' and Dentists' Remuneration, Fourth Report, 1974—Cmnd. 5644, June 1974 (paragraph 33).

for discussion with the professions. In the absence of developments on these, we have carried out a detailed examination of the operation of the scheme as it now is, including an analysis of the distribution of awards among specialties and between regions. We have found that, although the proportion of consultants holding an award has remained relatively stable at just over one-third since the inception of the scheme in 1948, the proportion of those who spend a full career (to 65 years or over) in the hospital service and who secure an award has risen steadily in recent years and is now more than 60 per cent, of whom one-half retire with a B award or higher. In general, the way in which the scheme has been operated seems in some ways to be similar to a system of promotion within a hierarchical structure: a consultant is not normally considered for a higher level than a C award unless he or she already holds an award in the level immediately below, except when a new specialty is established in its own right (for example, community medicine in 1974). However, conferment of an award is selective, and there is no automatic entitlement related to length of service. The variation in the proportion of consultants with awards within a specialty is fairly wide, but the distribution of awards between regions (with the exception of the four Thames regions and the Oxford region, in which there are major long-established teaching hospitals) is virtually uniform. The procedures for regional selection have recently been extended and strengthened through the establishment (in 1975) of regional advisory committees to consider candidates eligible for A and B awards, in the same way as has been the practice in the past in relation to C awards: in addition, no differentiation is now made between consultants in teaching hospitals and in non-teaching hospitals in considering eligibility. The gradual phasing out of the senior hospital medical officer and senior hospital dental officer grades since 1959, and the regrading of a large number of individuals and posts to consultant status has enlarged the field of those eligible for awards. At the A and A+ levels, the scheme has fulfilled one of its original objectives, in that it provides a level of earnings for a significant minority of consultants which compares with those available at the top of other professional career structures. But there is some evidence that, at the lower levels in particular, distinction in the sense of excellence is no longer the only consideration, and that the system has been operated as if it were a promotion system. We were told by the Health Departments last year that they were ready to re-open discussions with the professions on a without commitment basis of the proposals put forward by them in December 1974 to replace the existing distinction award scheme. We understand that these discussions have not yet begun. It will be important for revisions of the distinction award scheme to be considered at the same time as any revisions of the contract itself.

35. We have discussed the problem and the present position with the Chairman of the Advisory Committee on Distinction Awards (Sir Stanley Clayton), and also the future operation so long as it continues in being. We have consulted him on the number of awards that he sees as justified in the coming year. In the light of his advice, we are satisfied that an increase in the number of awards is justified at this time. We said in our Sixth Report that an increase in number was already justified last year but, at that time, we decided to defer consideration of our detailed recommendations until we knew the details of the post-1 August 1976 restraint measures, since we did not want to mortgage

part of such freedom of manoeuvre as might have been available to us. In practice, under the measures, those distinction awards that have fallen vacant because of the retirement, resignation or death of a holder have been treated in the same way as increments within a fixed incremental scale, which have been withheld because earnings would have exceeded the £8,500 ceiling, and they have been re-distributed from 1 August 1976 (or 12 months after they fell vacant). We now recommend an increase of 200 distinction awards over the total which we recommended in 1975, bringing the total to 5,342. We are satisfied that this will not increase the overall cost of distinction awards in relation to the number of eligible consultants and community physicians for 1977-78 over 1976-77. We propose that the value of existing awards should remain unchanged. Our detailed recommendations are in Appendix D.

36. **Fees and allowances.** We propose no change in the fees or allowances payable to hospital doctors and dentists.

37. **Ophthalmic medical practitioners.** In our Sixth Report we discussed the findings of the study by management consultants into the time involved in sight-testing by ophthalmic medical practitioners. Based on the data from a survey in that study, we estimated the average time involved to be 20 minutes per sight test. We have been asked by the Joint Evidence Committee to re-assess this time to include provision for all time spent travelling to and from work and for time wasted on broken appointments: we have not however been provided with any new evidence. We have re-examined our estimate of the average time involved per sight test, and our view remains unchanged. The Joint Evidence Committee have also proposed that the net remuneration element of the sight-testing fee should be increased in line with the maximum amount permissible within the current pay limits. The Health Departments on the other hand have suggested that no increase should be recommended as the rate of average net remuneration for full-time ophthalmic medical practitioners of £9,300 a year implied by our estimate[1] was considered by them to be too high in relation to the requirements of the job. They have repeated their view that remuneration should be related to the pay of ophthalmic opticians, whose function in testing sight is identical; whom they regarded as better trained for prescribing particular types of lens; and whose competence in detecting an eye condition that requires medical attention has increased. They do not consider that comparison with the salary of a hospital consultant or with the average net remuneration of general medical practitioners provides a valid basis for deciding the appropriate level of remuneration for ophthalmic medical practitioners. The profession do not agree that ophthalmic medical practitioners are less adequately trained than ophthalmic opticians for prescribing lenses, and point to the fact that ophthalmologists who also practice as ophthalmic medical practitioners are involved in the training of ophthalmic opticians, and require to have a full knowledge and continuing experience of refraction work.

---

[1]Taking account of the normal weekly hours of work (38½) and leave on the same basis as for senior hospital medical staff (6 weeks a year and public holidays).

38. We have considered the position of ophthalmic medical practitioners in the light of the evidence. Like the rest of the medical and dental professions, they will have experienced the same rise in cost and the same marked fall in standards of living since April 1976, and we would not feel justified in excluding them on this occasion from our general recommendation that the maximum supplement for which doctors and dentists are eligible under the current measures should be paid. We recommend that ophthalmic medical practitioners should be paid a cash supplement of 4·2p to the net remuneration element of the sight-testing fee subject to a maximum of £208 a year. We note that it is intended to carry out a detailed inquiry into the practice expenses incurred by ophthalmic medical practitioners, and we have been told that the Health Departments propose to discuss with the profession the amount of the expenses element of the sight-testing fee in the light of the results.

39. Our detailed recommendations are in Appendix D.

CHAPTER 4

GENERAL MEDICAL PRACTITIONERS

40. The total number of general medical practitioners rose by 1·2 per cent in 1976 thus maintaining the upward trend of recent years, although at a slightly reduced rate of increase of just under 1 per cent in the case of principals providing unrestricted services. Again, British-born women doctors and overseas-born doctors account for the increase: the number of British-born men doctors has fallen for the second year in succession and the number of Irish-born doctors has continued to fall. Average list size has shown a further small contraction. Following the halt last year to a steady decline over a long period, the number of principals who provide restricted services (for example, maternity medical services only) or who have limited lists (for example, hospital staff) has again fallen slightly over the past year. The number of salaried assistants has increased, thus reversing the trend of the previous two years, and the number of trainees has continued to rise. Enabling legislation is now in existence and provides for the introduction of mandatory arrangements for vocational training for all doctors entering general practice. These arrangements are expected to be introduced by 1980, and the vocational training requirements will be similar to those at present required to qualify for the vocational training allowance. These require a minimum of 4 years training from the date of provisional registration before becoming a principal, made up of 3 years in approved hospital posts and 1 year as a trainee in general practice.

41. We have referred earlier to the Joint Evidence Committee's proposal that the average net remuneration of general medical practitioners should be increased outside the pay limits of the current restraint measures in recognition of increased workload over the past 12 months (paragraph 16). The profession has told us that doctors in general practice have had to work harder to meet the additional demands that result from the current constraints on the resources available for the social services; from the shifting of priorities within the health services towards primary health care[1]; from the restriction of the facilities for hospital treatment that followed industrial action by hospital medical staff; and from financial constraints generally. They drew attention to lengthened hospital waiting lists, to the reduction in the number of hospital in-patients, to the earlier discharge of patients, and to the increased number of requests by general medical practitioners for pathological and radiological examinations of patients and for domiciliary visits by consultants. They also drew attention to figures showing an increase since 1972 in the number of consultations per

[1]Indicated in the consultative document 'Priorities for Health and Personal Social Services in England' published by the Department of Health and Social Security, March 1976.

week per doctor[1] and in the number of prescriptions per patient on NHS prescribing lists. They referred to the growing role of the general medical practitioner in health education and preventive medicine and to the extra workload that falls on general medical practitioners at times of high unemployment. The profession recognised the difficulty of quantifying an increase in workload in precise terms, and acknowledged that it had not been possible to measure changes in pattern and quality of the services provided: nevertheless, they considered it reasonable to conclude that, over the past 12 months, the workload of general medical practitioners had increased by about 10 per cent.

42. We find that the evidence is not such as to demonstrate that the general level of workload of general medical practitioners has changed during the year to 1 April 1977 to an extent that justifies a special adjustment on this account. We are aware that some general medical practitioners will have experienced a greater demand for their services as a result of the industrial action taken by some consultants and some junior hospital doctors during 1975, but the additional demand on this account will have declined as the hospital service returned to normal in 1976. This is reflected in statistics for weekly consultations and for prescriptions which are also related to the general level of morbidity in the community. These data show that the average weekly number of consultations and of prescriptions per doctor has risen steadily since 1971, to levels in 1974 and 1975 that are comparable to those experienced in the previous peak years of 1966 and 1967. Other broad indicators of workload include the average list size and the volume of fees as measured by gross income per head on a constant fee basis: both of these fell slightly in 1974 and 1975, and list size also fell in 1976. To the extent that certain items of service attract separate fees (for example, vaccination and immunisation), short term fluctuations in workload will be reflected in the remuneration of general medical practitioners, and to recommend a further increase on account of such additional work would involve a measure of double payment, which would clearly be wrong. In the longer term, the demand for general medical services will be affected by advances in clinical and therapeutic practice, as well as by changes in the demographic structure of the population. It may also be affected by the allocation of increased resources to primary health care, as now envisaged by the Government. But, while demand may increase in the future for these and other reasons, it is reasonable to assume that more doctors will enter general practice as the output of the medical schools increases, and that the increased demand will be met in this way and through the trend towards larger group practices if it continues (Appendix C, paragraph 19). In considering our recommendations on the remuneration of general medical practitioners, we have regard to overall workload and general levels of responsibility.

43. **Fees and allowances.** We recommend that the supplement should, like the £312 supplement, be paid in full to all eligible principals who receive the full rate of basic practice allowance, and on a pro-rata basis to those who receive a partial basic practice allowance. Those principals who receive Type A or Type B initial practice allowances or inducement payments should

---

[1]Based on a regular survey by Intercontinental Medical Statistics Ltd.

be paid the full rate of supplement. Family Practitioner Committees should have discretion to pay the full rate of supplement to those general practitioners who have small or specialised practices and who do not receive the full basic practice allowance but who are effectively working full time in general practice. For the purpose of determining the amount of the supplement payable to individual doctors, we agree with the Health Departments' proposal that net income should be assessed by deducting from gross payments (after subtracting trainees' expenses, and direct reimbursement of the costs of ancillary staff, of rent and rates, and of the supply of drugs and appliances) the amount for expenses that is used for the calculation of pensionable earnings. This arrangement was used in 1976 to establish eligibility for the £312 supplement on that occasion. Provision should be made for doctors with net incomes below £4,160[1] to be assessed individually if they have earnings from other NHS work; or if the partnership shares declared for superannuation purposes do not reflect the income they receive.

44. The profession has expressed concern to us about the position of trainee general practitioners as a result of the introduction of the new contract for junior hospital doctors. During the year spent as a trainee in general practice under the vocational training scheme, doctors are paid the equivalent of the basic salary that they would have received if they had continued to be employed in the hospital service. Since the new contract was introduced in February 1976, junior hospital doctors who spend more than 40 hours a week on duty have been eligible for Class A/B salary supplements, whereas formerly they received extra duty allowances only when they spent more than 80 hours a week on duty. As a result, the remuneration of many trainee general practitioners could be reduced by substantial amounts during the year in training in general practice. The profession has suggested that this could have a serious effect on recruitment to general practice and has asked that protection of trainees' hospital earnings should be provided. We understand that the Health Departments have considered the problem sympathetically, but that it has not been found possible under the current restraint measures to provide for protection of hospital earnings in this way. Nevertheless, for the future, the Health Departments recognise the need to reassess the pay of trainee general practitioners, and have begun an inquiry into their level of responsibility and pattern of work so that changes can be considered as soon as the restraint measures allow. We welcome the recognition of the need to deal with the problem, and the results of the inquiry will be of considerable interest to us. We are aware that the position has changed as a result of the introduction of the new contract for junior hospital doctors, and we are also aware of the importance of maintaining a steady flow of trainees for general practice so that plans for the implementation of the mandatory arrangements for vocational training can go ahead smoothly in the near future. In the meantime, we propose that trainee general practitioners should be eligible for the full £208 supplement recommended by us on this occasion.

---

[1]The annual rate of earnings above which the maximum limit of £208 for increases under the current pay restraint measures applies.

45. We have been provided with further information on the progress of the scheme to extend personal medical services to include contraceptive services for patients where there is no medical need, which was introduced on 1 July 1975. The proportion of general medical practitioners who provide these services has risen from 92 per cent of all principals in 1975 to 94 per cent in 1976. The number of patients who receive the services has also risen, from 1·4m patients for ordinary services in 1975 to 2·2m in 1976, and from 15,000 patients for IUD services in 1975 to 58,000 in 1976. The average prescription provision has decreased slightly from just under 4½ months supply in 1975 to 4 months supply in 1976. The Health Departments take the view that income from the provision of contraceptive services should be aggregated with other income for the purpose of establishing average net remuneration, but have recognised in discussion with us that the pattern of these services is clearly not yet fully developed. Until it has become established, we shall continue to treat the income separately from the total of average net remuneration.

46. In our Sixth Report, we repeated our view that further serious consideration ought to be given to the problem of direct reimbursement of the expenses of employing wives and dependents as ancillary staff by single-handed rural practitioners. We have been told by the Health Departments that, although a change in the conditions for reimbursement of expenses would be inconsistent with the provisions of the current restraint measures unless it were counted against the pay limits, consideration is nevertheless being given now to proposals for a system of payments to general medical practitioners in respect of employment of relatives as ancillary staff for introduction when the provisions of pay policy permit. We welcome this development: we hope that a suitable scheme will be agreed with the profession that provides adequate safeguards in an acceptable way and that is straightforward to administer. We look forward to receiving evidence in due course.

47. **Practice expenses.** In our Sixth Report we estimated that average practice expenses for 1976-77 would total £4,260. This was £685 higher than the provision (£3,575) for 1975-76, and we proposed adjustment to the fee scale to provide for this amount. Our estimate of the average practice expenses for 1977-78 is £4,500. In view of our recommendation that the increase in remuneration should again be by means of a supplement to gross fees and allowances related to the amount of the basic practice allowance, we propose on this occasion also to increase the proportion reimbursed through capitation and other fees to a rather greater extent, and the proportion reimbursed through practice allowances to a lesser extent than we would in normal circumstances. We propose that £213 should be reimbursed through capitation and other fees and £20 through practice allowances. We propose that a further £7 should be used to finance an appropriate increase in the rural practices funds, and to provide an increase in the assistant allowance. We also recommend an increase in the maximum rate of locum allowance as we have been asked to do both by the profession and the Health Departments: this allowance is payable for the employment of a locum tenens during periods of sickness or prolonged study leave[1].

---

[1]Normally not less than 10 weeks or more than 12 months.

48. We have again been asked by the profession to consider an adjustment to average net remuneration to compensate for increases in the National Insurance contribution payable by self-employed people. They pointed out that the increase received by general medical practitioners in 1976, after allowing for the reduction in income tax, had been substantially offset by the increase in contribution payable (£104), and that doctors will need to meet from any increase recommended by us in this current review the further increase in contribution payable in 1977 (£40). They also suggested that other self-employed people are in a better position than doctors and dentists to offset this increased contribution by raising their earnings from fees, in order to cover the higher level of contribution. As we have said before, the contribution is a personal liability that provides entitlement to personal benefit and any relief on it is a matter for the Government.

49. **Average net remuneration.** We believe that misunderstanding continues about the practice that we follow each year of indicating the average net remuneration of general medical practitioners. We adopt this practice in order to avoid any doubt in the future about our estimate of the amount that the "average" practitioner should earn from the recommended levels of fees and allowances after deduction of "average" practice expenses (other than those reimbursed by direct payments). It has been put to us, however, that income from certain fees and allowances ought not to be included in the average net remuneration figure, as a misleading impression is given of what many doctors earn; that the level should reflect changes in the amount of work for which specific fees are paid; and that new work outside the existing contract should be seen to attract extra pay. We discussed these points in some detail in our Fifth Report[1], when we concluded that payments which were intended to encourage a redistribution of income in favour of some doctors should continue to be included in average net remuneration; that where changes as measured by itemised service fee income can clearly be identified as involving extra effort by doctors, the benefit should accrue to them; and that remuneration from new work which is also extra work should be treated separately from other income, at least in the first instance until a pattern has been established. On that occasion, we indicated the average net remuneration that our recommendations were designed to produce assuming no change in the general level of workload and responsibility, together with the estimated average net income from certain items that involved new and additional general medical service work which we saw as right then to treat separately. As many general medical practitioners work part-time in hospitals and also do other work for health authorities or for Government Departments, we provided an estimate of the additional average net income received by general medical practitioners from hospital work and from other official sources.

50. In deciding the level of average net remuneration from fees and allowances that our recommendations are designed to produce, we have always recognised that it is not possible for this level to be achieved exactly. There are two sources of uncertainty: in the first place, it is not possible to forecast with precision the average gross income that doctors will receive, as this is directly

---

[1]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraphs 38 to 44).

related to output or to the volume of fees paid as well as to the number of principals in general practice, both of which may vary each year. Moreover, when we make our recommendations for a particular year, a provisional estimate only of the total payments from Family Practitioner Committees and of the average number of practitioners for the previous year is available to us, and actual payments are not known until several months later. Second, there is the problem of forecasting accurately a realistic level of average practice expenses, particularly when there is a high rate of inflation which can vary greatly in its effect on individual items such as rent and rates, heat and light, and motoring expenses, among the factors which make up general medical practitioners' expenses. Furthermore, no information is available on the actual level of expenses for the previous year, and only a limited amount on the level for the preceding year. Firm figures of average gross remuneration are not available until nearly a year has elapsed[1], and final figures of average practice expenses, and thus of average net remuneration, until nearly two years after the end of the financial year to which they relate[2]. Thus a degree of uncertainty about the amount of any over-payment or under-payment in average net remuneration is inevitable, both in the current year and in the two preceding years. In spite of these difficulties, the extent to which the forecasts of average gross remuneration and the provision for average practice expenses have diverged from the out-turns has been quite small, averaging less than 1½ per cent over six years and the balance is negligible, as the following table shows:

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

Year	*Intended*			*Difference between actual and intended*			
	Gross remuneration (a)	*Practice expenses*	*Net remuneration* (a)	*Gross remuneration*	*Practice expenses* (b)	*Net remuneration*	
	£	£	£	£	£	£	*per cent*
1971-72	7,265	2,080	5,185	35	36	71	1·4
1972-73	7,805	2,230	5,575	–80	–60	–140	–2·5
1973-74	8,110	2,360	5,750	46	–91	–45	–0·8
1974-75	9,131	2,845	6,286	–46	–14	–60	–1·0
1975-76(c)	12,060	3,575	8,485	–74	75	1	0·0
1976-77(c)	12,853	4,260	8,593	–43	285	242	2·8
1977-78	13,318	4,500	8,818				

Notes:

(a) Including threshold payments of £139 in 1974-75; estimated cash supplement of £108 in 1976-77; and estimated cash supplements of £126—latest estimate of 1976 supplement—and £207—estimate of 1977 supplement (paragraph 53)—in 1977-78.

(b) Where the difference is shown as negative the provision was less than the actual expenses incurred.

(c) The differences for 1975-76 and 1976-77 are based on our provisional estimates of the out-turns: firm figures will not become available until March 1978 and March 1979 respectively.

[1]Late 1977 for firm figures of average gross remuneration for 1976-77.
[2]March 1979 for the final out-turn on average practice expenses and average net remuneration for 1976-77.

The table also shows that, following a surplus in 1971-72, there was a small shortfall in average net remuneration in each of the three succeeding years for which firm information on the out-turns is available, but our provisional estimates of the out-turns for 1975-76 and 1976-77 indicate a surplus sufficient to balance the previous shortfalls. We do not attempt to carry forward either under-payments or over-payments into the calculation of next year's remuneration, but our aim has always been to ensure that there is no persistent tendency either to under-payment or to over-payment, taking one year with another.

51. Our recommendations for 1975-76 were based on the volume of fees indicated by the provisional estimate of payments by Family Practitioner Committees for the previous year, and were designed to produce an average net remuneration of £8,485 after allowing for average practice expenses. The table shows that, on the basis of the actual payments made by Family Practitioner Committees, the average gross remuneration was about £46 less and expenses £14 higher than had been estimated in 1974-75: average net remuneration was therefore about £60 lower than the intended £6,286. Average gross remuneration in 1975-76 was lower by an estimated £74 (including the reduction due to withholding of seniority payments under the pay restraint measures), but expenses are also estimated to be lower by about the same amount. Judged by the level of gross fees, output appears to have been maintained in 1976-77. The requirement that the increase in net remuneration on this occasion should again be by way of a cash supplement means that, apart from seniority payments and assuming no change in workload, average net remuneration for 1977-78 will continue to reflect the volume of fees related to 1975-76. We regret that the restraint measures have again prevented us from following our established practice of adjusting for changes in output so as to avoid carrying forward over-payments or under-payments in net remuneration into the next year; we see this as one of the anomalies that will need to be corrected as soon as it becomes possible to do so.

52. The reduction in the average net remuneration for 1975-76 that results from the withholding of seniority payments of £35 is temporary and will have disappeared by 1978-79. A large part of the reduction is attributable to the fact that some doctors had not completed the required number of post-graduate educational sessions when the shorter qualifying time on the Medical Register was introduced following the recommendations in our Fifth Report[1], and were unable to do so before the introduction of the restraint measures; the balance is due to the withholding of new or enhanced seniority allowances from those general medical practitioners whose earnings either exceeded £8,500 a year, or would have exceeded that level if they had been paid.

53. The average net remuneration which our recommendations were designed to produce in 1975-76 was £8,485: this includes £577 on account of payments from items of remuneration that are not received by all general medical practitioners[2]. Some doctors will have received the full supplement of £312

---

[1]Review Body on Doctors' and Dentists' Remuneration, Fifth Report, 1975—Cmnd. 6032, April 1975 (paragraph 40).

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

that we recommended last year or a smaller supplement if they were ineligible for the full rate of basic practice allowance, whereas those whose earnings would have exceeded £8,500 a year will not: the latest estimate of the average amount for all general medical practitioners is £126 and we expect that this average will be unchanged in the current year. We estimate that the new supplement will average £207[1] for all general medical practitioners in 1977-78. The effect of withholding for 12 months the payment of the new and enhanced seniority allowances that became due between 1 August 1975 and 31 July 1976 from those practitioners whose earnings from all sources would exceed £8,500 a year will reduce average net remuneration by about £2. We estimate that general medical practitioners will also receive an average net income of £495 from contraceptive service fees and other payments in respect of additional general medical service work, and about £245 from hospital work and from other official sources.

54. Our detailed recommendations are in Appendix D.

[1]This amount is less than £208 as some doctors who do not receive the full amount of basic practice allowance will not be eligible for the full rate of supplement.

CHAPTER 5

GENERAL DENTAL PRACTITIONERS

55. The number of practitioners in the general dental service has increased further over the past year by 2·6 per cent. The number of assistants has continued to decline, and is now less than 2 per cent of all practitioners. There has been a further small but encouraging improvement in the population to dentist ratio in the worst areas, and between the highest and lowest ratios in all areas. The steady growth in the number of courses of treatment continued and increased by 1 per cent in total in 1976, but the number per practitioner declined by 1·6 per cent. The 1975 agreement on the introduction in England and Wales of the experimental 'salary plus bonus' scheme based on publicly provided premises was designed to reduce the imbalance on distribution, but progress in introducing it has been slower than expected and no appointments have yet been made. We understand that the aim is to introduce the scheme in at least two areas during the coming year. The small number of salaried health centre dental practitioners has remained virtually unchanged in the past year.

56. The last inquiry into the hours worked by general dental practitioners was carried out by the Dental Rates Study Group in 1974 and the results relate to 1973. We commented on these results in our Fifth Report[1], and we expressed the hope then that inquiries would be carried out in future at intervals of about three years. The Study Group subsequently proposed that the interval between inquiries should be fixed at five years, largely because of the other administrative demands on dentists, but we regard this as too long for our purposes. We have been told by the Health Departments that preliminary arrangements will be put in hand by the Study Group in the course of the coming year to carry out an inquiry in 1978, and that the intention is to carry out an inquiry into the timing of individual dental operations in 1979. The information in the 1978 inquiry will relate to hours worked by general dental practitioners in 1977. We welcome the intention to shorten the proposed interval before the next inquiry to four years, and we hope that three years will become normal thereafter. We attach great importance to having regular and up-to-date information on hours, and it is clearly in the interests of all concerned to co-operate in these inquiries.

---

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

57. **General dental practitioners.** We recommend that the supplement should be paid in full to all principals whose net income (excluding the £312 supplement paid since 1 April 1976) is at least £4,500 a year, and on a pro-rata basis to those who earn less. Net income should be assessed by applying the 1977-78 practice expenses ratio (or, until this is known, the ratio for 1976-77[1]) to gross payments from fees and allowances (after subtracting the salaries of assistants employed). These arrangements are on the same lines as those that were used in 1976 to establish both eligibility for the £312 supplement and the amount payable to individual practitioners. Provision should be made for dentists whose net income is below £4,500 (excluding the £312 supplement) to be assessed individually if they have earnings from other NHS work.

58. Our attention has been drawn to difficulties encountered by the Dental Rates Study Group in adjusting fees so as to ensure that, on average, general dental practitioners achieve the target average net income that we recommend. General dental practitioners' income is made up of gross fees and allowances out of which practice expenses have to be met. In adjusting the fee scale each year, the Study Group has to take into account changes in volume of fees (that is, in output), and in practice expenses. Among the factors that affect output are the introduction and use of new equipment or improved techniques, and changes in the level of charges to patients for treatment. The main difficulty in forcasting practice expenses is that 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. Prior to 1974, this resulted in substantial gaps between the intended and the actual results and, since 1974, the Study Group has adjusted the provision for average practice expenses within the fee scale each year, to correct for under- or over-provision in the preceding three years. We have been told that the Health Departments intend to propose that a similar 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.

59. Since 1970, an amount has been included in the fee scale for a notional rent to reflect what owners of practice premises would have to pay if their premises were rented: this is known as notional rent allowance. It was introduced on the recommendation of the previous Review Body, and the level was based at the time on information obtained by the British Dental Association, which has been brought up-to-date annually since. We understand that the Dental Rates Study Group is now carrying out an inquiry with the help of the Inland Revenue Valuation Office to review the basic information on which the level of the allowance has been assessed in the past, and to enable an up-to-date assessment to be made on the basis of present rental values. The intention is to carry out inquiries of this kind at intervals of three years as the basis of reviews of the amount of the allowance.

---

[1] 62 per cent.

60. The Dental Rates Study Group will need to adjust the fee scale to provide for estimated changes in output and for reimbursement of the estimated increases in practice expenses required to maintain average net earnings from fees at the equivalent to the 1975-76 target average net income of £7,643. Many dentists will have received in full the £312 supplement recommended last year, but those whose earnings exceeded (or would have exceeded) £8,500 a year did not: the average of the supplements paid was £178 for all general dental practitioners (compared with our forecast of £155), and we expect that this average will be unchanged in the current year. We estimate that the average amount for all general dental practitioners represented by the supplement recommended in this Report will be £190[1] in 1977-78. The effect of withholding those new seniority payments that became due for payment between 1 August 1975 and 31 July 1976 for 12 months because of the £8,500 ceiling for any increase during that period will be to reduce average net income by less than £1.

61. **Salaried health centre dental practitioners.** In order to conform with the provisions of the NHS Reorganisation Act 1973, responsibility for the employment of salaried health centre dental practitioners was transferred to Area Health Authorities in the course of 1976. However, they remained functionally responsible to Family Practitioner Committees. Their conditions of service were agreed centrally. Salaried health centre dental practitioners who work full-time will receive the full supplement which we recommend; those who work part-time will receive it on a pro-rata basis.

62. Our detailed recommendations are in Appendix D.

[1]This amount is less than £208 as those dentists whose net income excluding the £312 supplement is less than £4,500 will not be eligible for the full rate of supplement.

CHAPTER 6

COMMUNITY DOCTORS AND DENTISTS

63. **Community medicine staff.** We have been told that the main administrative posts at regional and area level have all been filled but that no further progress has been made in filling the balance of the complement of community physician posts. There are 738 established posts in England and Wales, of which 121 are vacant—five more than in 1975. Notwithstanding the decision in May 1976 to go ahead with appointments on the special salary scale recommended in 1973 for use should it be found necessary to fill community physician posts, on an interim basis, by candidates who did not satisfy the full requirements of appointments committees, very few candidates have come forward and, so far, one such appointment only has been made. Doctors in training posts have to achieve Membership of the Faculty of Community Medicine before they are eligible for appointment as fully qualified community medicine specialists, and it takes time and experience to reach this standard. However, there has been a small but encouraging increase in the number of senior registrars and registrars in post in community medicine from 59 in 1975 to 76 in 1976.

64. The profession has drawn our attention to the fact that principal officers outside the administrative medical (and dental) field of Area Health Authorities in Scotland and Wales have a small financial lead over principal officers in England in recognition of the additional responsibilities that they carry because there is no regional tier of authorities. Area administrators, area treasurers and area nursing officers are paid in a higher salary band in Scotland and Wales than in England. The salary bands are related to the type of area (multi-district or single district and teaching or non-teaching) as well as to the size of population. The salary scales for area medical officers are banded by population size only, and the population sizes correspond to those for area administrators, area treasurers and area nursing officers[1]. When we made our recommendations for the pay of administrative medical staff in June 1973[2], the pay structure for principal officers generally had not been settled, and we were invited to recommend uniform salary levels for appointments for England, Scotland and Wales. The profession has told us that, like other principal officers, the area medical officers in Scotland and Wales also have certain additional responsibilities as a result of the different administrative structure: examples put to us are personnel matters concerning senior hospital medical and dental staff, including recruitment of consultants;

---

[1]Those for area dental officers are similar.

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

participation in the formulation of health policy (in co-operation with the Scottish Home and Health Department or with the Welsh Office); and guidance on operational health care matters. The Health Departments acknowledge that there are some differences in responsibilities in area medical officer posts in Scotland and Wales from those in England. For our part, we see this as a matter for discussion between the Health Departments and the profession in the first instance: we are of course prepared to consider proposals that relate to the pay arrangements in due course.

65. We have been told by the Health Departments that they have been unable to agree to a proposal from the profession that a fee should be paid for domiciliary consultations by community physicians, on the same basis as for consultants. Apart from the implications of the current restraint measures, the Health Departments do not regard a fee of this kind as appropriate: they see visits to a patient at home as a normal part of a community physician's work, and community medicine in general as sufficiently different from a hospital consultant's clinical work to justify a distinction between the two forms of contract. But they recognise that, if a new form of contract for consultants were agreed, it might well have some implications for community physicians (who are paid on the same salary scale as consultants). They have said that they are ready to discuss with the profession modifications to the contract for community physicians in the light of any future changes. They have also agreed to discuss, on a 'without commitment' basis, proposals which the profession have under consideration now for the training grade structure in community medicine. We will await evidence.

66. **Community dentistry staff.** Appointment of regional dental officers has continued to be deferred. Some 44 district dental officer posts have now been filled in England and Wales, out of a total 58 posts approved initially, mainly in multi-district areas where the area dental officer needs substantial administrative assistance in professional matters. All area dental officer posts and, in Scotland, all district dental officer posts were filled in 1975. When we were considering our initial recommendations on the pay of administrative dental staff in 1973, we were asked jointly by the Health Departments and the profession to recommend that regional dental officers and area dental officers should be eligible for distinction awards. We were unable to agree with this proposal as community dentistry had not at that time been recognised by the Royal Colleges of Surgeons as a specialty in its own right. We have been told by the Health Departments and by the profession that the steps necessary for the recognition of community dentistry as a specialty in its own right have now been taken, but that it will be some time before these lead to the creation of training posts and procedures, and to the completion of the training of the first members of a future specialty of community dentistry. No Faculty of Community Dentistry has yet been established, and the Royal Colleges of Surgeons have not yet defined criteria which might be applied to existing area dental officers. In the circumstances, we propose to defer recommendations affecting the eligibility of community dentists for distinction awards until a future review. We shall also consider the structure and pattern of remuneration for administrative dental officers including relationships with administrative medical officers at a future review: we shall need to be provided with evidence to assist us.

67. **Community health medical staff.** The number of community health medical staff (senior medical officers, clinical medical officers and other medical staff) in England and Wales has increased by 9·1 per cent from 6,285 in 1975 to 6,858 in 1976. Most of them (about three out of four) work part-time only and, in whole-time equivalent terms, the increase was 5·2 per cent, from 2,084 in 1975 to 2,198 in 1976. The Committee on Child Health Services has now reported[1], and the Government has invited early comments on its recommendations from organisations and individuals concerned with child health care. The Committee proposes that two new classes of doctor should be introduced to provide child health services: principals in general practice with special training in child health (to be known as general practitioner paediatricians) who would act as school doctors at local schools for not less than two sessions a week under contract with the Area Health Authority, in addition to their usual responsibilities for providing general medical services to patients on their lists including young children; and consultant community paediatricians, who would combine hospital clinical work in children's departments with child health community work. The Committee envisages that a number of existing clinical medical officers, after suitable additional training, would become general practitioner paediatricians, and that some senior medical officers would become consultant community paediatricians after further training (where necessary). Interim arrangements are suggested under which other existing clinical medical officers would be employed as child health practitioners and senior medical officers as clinical specialists in paediatrics. Clearly, adoption of these proposals would involve a thorough reorganisation of the community health medical staff structure.

68. We endorsed in our Sixth Report[2] a proposal put to us jointly by the Health Departments and the profession that the fees and allowances formerly payable by Local Authorities or by the Family Planning Association, and now payable by the Area Health Authorities, should be revised in future by the Health Departments in consultation with the profession in the light of our recommendations. We have now been told that new arrangements have been agreed which provide an alternative basis of remuneration for work in family planning clinics. This work is done mainly by doctors who were formerly employed by the Family Planning Association on a sessional basis, but some of it is carried out on a regular basis by general medical practitioners and by doctors who used to be employed by Local Authorities. The new arrangements provide for assimilation of these doctors into the clinical medical officer and senior medical officer grades.

69. **Community health dental staff.** The total number of community health dental staff (consultant anaesthetists, consultant orthodontists, senior dental officers, dental officers and other anaesthetists) has fallen slightly from 2,093 in 1975 to 2,083 in 1976. Just over one-half of them work part-time and, in whole-time equivalent terms, the total has remained virtually unchanged at 1,425. Some of the proposals in the report of the Committee on Child

---

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

[2]Review Body on Doctors' and Dentists' Remuneration, Sixth Report, 1976—Cmnd. 6473, May 1976 (paragraph 57).

Health Services relate to improvements in dental care. Strengthening of the school dental service, the appointment of consultants in a new specialty of paediatric dentistry, and an increase in the number of consultant orthodontists have been recommended. An investigation into the provision of a primary care service for children based on the general dental service and remunerated by a capitation fee has also been proposed. All the proposals are based on the new structure for community health dental staff that was introduced early last year.

70. We recommend that the supplement should be paid in full to all full-time community doctors and dentists, including those on protected salary scales. It should be applied on a pro-rata basis to part-time staff. Dentists paid on a sessional basis, other than part-time consultants, will not be eligible for the supplement. Our detailed recommendations are in Appendix D.

CHAPTER 7

SUMMARY OF RECOMMENDATIONS

71. Our recommendations for junior hospital doctors and dentists are based on the proposals put to us by the Health Departments and the professions and they take account of the assessment of the cost of changing the basis of remuneration agreed between them (notwithstanding our reservations about it). With this exception, we have satisfied ourselves that they are generally consistent with the provisions of the White Paper "The Attack on Inflation—The Second Year". We have been assured by the Health Departments that the increases for hospital and community doctors and dentists do not require to be restricted on account of payment of increments within the scales, and we are satisfied that the number of distinction awards does not increase the overall pay bill for eligible staff. The main effect of our recommendations can be summarised as follows:

	Increase in 1977-78 *over* 1976-77 *(in NHS earnings)*
Hospital doctors and dentists (whole-time salaries)	
House officers	£105 (3·3—2·9 per cent)
Senior house officers	£105 (2·6—2·4 per cent)
Registrars	£105 (2·4—1·9 per cent)
Senior registrars	£105 (2·0—1·6 per cent)

When account is taken of the cost of the change in the basis of remuneration, the total increases for house officers, senior house officers, registrars, and senior registrars are equivalent to the maximum permissible under the current restraint measures[1]: the percentage increases relate to earnings from basic salary including the 1976 supplement of £312.

Consultants	£208 (2·7—1·9 per cent)
Community doctors and dentists (whole-time salaries)	£208 (4·7—1·6 per cent)
General medical practitioners (net remuneration from fees and allowances)	£208 (2·3 per cent on average[2])
General dental practitioners (net remuneration from fees and allowances)	£208 (2·4 per cent on average[2])
Ophthalmic medical practitioners (net remuneration from sight-test fees)	£208[3] (2·2 per cent)

The detailed changes recommended are in Appendix D.

---

[1]The total increase in earnings (including Class A/B supplements) for all doctors and dentists in these grades is 3·5 per cent on average.

[2]Based on the average amount for all practitioners.

[3]Maximum based on the notional number of sight-tests carried out by a full-time ophthalmic medical practitioner.

72. We estimate the overall cost of the increases, excluding provision for practice expenses and employers' superannuation and national insurance contributions, to be about £15·9 million or 2·5 per cent of net remuneration in 1976-77.

73. We have drawn attention to the anomalies that have been created within the pay structure of the medical and dental professions as a result of the particular form of the restraint measures that were in operation at the time of our last review (Chapters 1 and 2). Under the current measures, some of these—for example, the withholding of increments and seniority allowances—will eventually resolve themselves, but others—for example, the disruption of the pay systems for general medical and general dental practitioners—will be accentuated. We have indicated our concern at the serious distortion of the relationships between junior hospital doctors and consultants during the last two years, brought about by the form of the restraint measures and by the way in which the new contract has been implemented: the position bears harshly on consultants. We have emphasised the need for sufficient flexibility in the post-1 August 1977 measures to enable us at least to make a start on the restoration of order to the pay structure and the elimination of injustices. We foresee very serious problems for the future, when the time comes—as come it must—for the cash supplements to be consolidated into the salary and fee scales and for appropriate differentials again to be introduced. This will be costly. At that stage, the provision of adequate resources will be essential if sense is to be restored to the internal pay structure and if an appropriate relationship between the medical and dental professions and other occupations is to be re-established. We therefore draw attention now to the magnitude of the problem, to enable early and thorough consideration to be given to it in the face of competing demands on the available resources for other purposes, and bearing in mind the essential role of the National Health Service in the maintenance of the well-being of the community.

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
1 April 1977

APPENDIX A

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

The table below shows the effects of tax changes and price inflation on the earnings of doctors and dentists compared with those on the average earnings for all full-time wage and salary earners:

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 at 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*[a]	*After tax*[b]	*April 1976*	*April 1977*	*April 1976*	*April 1977*
	£	£	£	£	£	£				
Single										
House officer (minimum)[c]	3,572	2,558	4,372	3,099	4,580	3,259	121·1	127·4	101·9	92·1
Married with 2 children under 11										
Senior registrar (maximum)[c]	7,133	5,063	8,491	5,951	8,699	6,280	117·5	124·0	98·9	89·7
Consultant (minimum)	7,536	5,274	7,848	5,619	8,056	5,900	106·5	111·9	89·6	80·9
Consultant (maximum)	10,689	6,662	10,689	6,937	10,897	7,409	104·1	111·2	87·6	80·4
Consultant (C award)	12,714	7,401	12,714	7,689	12,922	8,253	103·9	111·5	87·4	80·6
Consultant (A+ award)[d]	18,636	9,091	18,636	9,403	18,844	10,134	103·4	111·5	87·0	80·6
General medical practitioners[e]	8,485	5,739	8,593	6,002	8,800	6,336	104·6	110·4	88·0	79·8
General dental practitioners[e]	7,643	5,327	7,798	5,592	7,988	5,859	105·0	110·0	88·3	79·5
Full-time men (average earnings)[f]	3,162	2,590	3,734	3,049	4,131	3,372	117·7	130·2	99·0	94·1
Personal disposable income (April–June)							114·2	127·9[g]	99·1	96·3[g]

Source: Office of Manpower Economics

(a) Assuming increases in basic remuneration of the maximum permissible within the current pay limits.
(b) At proposed 1977-78 tax rates excluding the conditional reduction in the rate of basic tax from 35 to 33 per cent.
(c) Includes average income from extra duty allowances and Class A/B salary supplements.
(d) Based on actual salaries after taking into account the withholding of the second stage of increases above £13,000.
(e) Intended average net remuneration from fees and allowances, and from cash supplements.
(f) Based on average earnings of full-time men (whose pay was unaffected by absence) from the New Earnings Survey up-dated by the monthly index of average earnings (new series) and from forecasts by the National Institute of Economic and Social Research.
(g) Estimated in February 1977 (before the announcement of the proposed changes in 1977-78 tax rates) by the National Institute of Economic and Social Research.

APPENDIX B

MOVEMENTS IN DOCTORS' AND DENTISTS' EARNINGS TO APRIL 1976

1. An analysis of movements to April 1975 in doctors' and dentists' earnings compared with earnings at comparable levels of salaried incomes was included in the Sixth Report[1]. The effect of the recommendations in that Report is shown in the table below, which relates to April 1976. The figures for movements in the earnings of comparable income groups are based on the results of the New Earnings Survey for April 1976. The position at April 1977 after taking account of the recommendations in this Report will not be known until the results of the New Earnings Survey for April 1977 become available in late 1977.

2. The general form of the analysis remains the same as used in previous reports, but three revisions have been incorporated. The coverage of the table has been widened to include ophthalmic medical practitioners and certain grades of hospital and community doctors and dentists; changes have been made in the alignment of individual grades and relevant percentiles (column (d)); and revised weights (based on more up-to-date statistics on manpower and paybills) have been used to calculate the overall figures for the two professions. Figures for the average earnings of all doctors and of all dentists, and of the professions as a whole have been included (columns (a) and (b)).

3. The analysis is based on levels of remuneration recommended in the Fifth Report and includes the £312 supplement recommended in the Sixth Report. 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 practitioners and general dental practitioners earning £8,500 or more a year. The overall effect of these restrictions in pay is under 1 per cent, and is not sufficient to alter the differences from the April 1975 position (column (f)) for all doctors, all dentists, and all doctors and dentists shown in the table. For hospital doctors and dentists, the analysis is based on salaries (and distinction awards), but includes average income from extra duty allowances for 1975 (column (a))[2] and Class A/B salary supplements for 1976 (column (b)) paid to the training grades since the latter are contractual payments which replace the non-contractual extra duty allowance payments[3].

---

[1]Review Body on Doctors' and Dentists' Remuneration, Sixth Report 1976—Cmnd. 6473, May 1976 (Appendix A).

[2]These figures differ from those figures in the Sixth Report (Appendix A) because the latter did not include extra duty allowances.

[3]If no account were to be taken of these additional earnings, the shortfalls for all doctors and for all doctors and dentists would be increased from 10 per cent to 13 per cent, and for hospital training grades the surpluses or shortfalls shown would be replaced by shortfalls ranging from 11 per cent for senior registrar (4th point) to 5 per cent for house officer (minimum).

Movements in earnings compared with corresponding NES percentiles at April 1976 (revised basis)

	(a)	(b)	(c)	(d)	(e)	(f)
	Earnings[1]			Corresponding NES percentile earnings April 1976		Difference in earnings from April 1975 earnings relative to percentile[2]
	April 1975	April 1976				
	Amount	Amount	Index (April 1975=100)	Percentile	Index (April 1975=100)	
	£	£				per cent
House officer (minimum)	3,572	4,372	122	50th	117	+ 5
Senior house officer (minimum)	4,262	5,338	125	25th	117	+ 7
Registrar (minimum)	4,951	5,940	120	25th	117	+ 3
Senior registrar (minimum)	5,672	6,588	116	10th	117	− 1
(4th point)	6,548	7,729	118	10th	117	+ 1
Consultant and Community medicine specialist (minimum)	7,536	7,848	104	2·5th	116	−11
(maximum)	10,689	10,689	100	0·75th	115	−15
(with C award)	12,714	12,714	100	0·5th	113	−13
Medical assistant (minimum)	4,548	4,860	107	25th	117	− 9
and Senior dental officer (maximum)	7,812	8,124	104	2·5th	116	−11
Clinical medical officer (minimum)	4,422	4,734	107	25th	117	− 9
(maximum)	6,273	6,585	105	5th	117	−11
Senior medical officer (maximum)	8,307	8,499	102	2nd	116	−14
Dental officer (minimum)	4,152	4,464	108	25th	117	− 9
(maximum)	6,258	6,570	105	5th	117	−11
Ophthalmic medical practitioner	9,281	9,281	100	1st	116	−16
General medical practitioner	8,485	8,593	101	1·5th	117	−15
General dental practitioner	7,643	7,798	102	2·5th	116	−14
All doctors	7,637	8,062	106		116	−10
All dentists	7,482	7,678	103		116	−13
All doctors and dentists	7,605	7,983	105		116	−10

Source: Office of Manpower Economics

[1]The earnings shown are basic 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 training grades, based on the latest 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 the level of consultant and community medicine specialist (minimum) and below; 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. For general medical and general dental practitioners, no allowance has been made for the difference between intended average net remuneration and the latest provisional estimate of the actual out-turn, or for the difference between the April 1976 estimate of the average cash supplement and the current estimate.

[2]Column *(f)* is the difference between indices of doctors' and dentists' earnings (column *(c)*) and NES percentile earnings adjusted for backdated settlements in the public sector in 1975 (column *(e)*) as a percentage of the former.

APPENDIX C

MEDICAL AND DENTAL MANPOWER AND THE WORKLOAD OF DOCTORS AND DENTISTS IN THE NATIONAL HEALTH SERVICE

Introduction

1. This Appendix reviews the available information on medical and dental manpower and on the workload of doctors and dentists in the National Health Service in the longer term. The tables analyse the trends since 1970 and, in some instances, for earlier years as well. The data are based on the series of statistics prepared and published annually by the Department of Health and Social Security supplemented by statistical information submitted by the Health Departments as part of the evidence for the annual review of remuneration. Some information has been obtained from other sources, and this is indicated in the tables.

Medical manpower

2. The career pattern of hospital doctors has not changed significantly in the last five years, and the average age on appointment as consultant remains 37-38 years, in spite of the long standing aim of the Health Departments and of the professions to reduce it to 32-33 years. Promotion from house officer to senior house officer and from registrar to senior registrar has been accelerated and, as a result, the greater part of the overall increase in the number of junior hospital doctors is reflected in the senior house officer and senior registrar grades. The only alternative career path for those who want to continue a full-time hospital career but who do not want to become consultants is in the medical assistant grade, to which entry continues to be restricted in number[1]. The proportion of doctors entering general practice who have undertaken vocational training has risen steadily since 1971, and more than three-quarters of the entrants now undertake voluntarily the three year training period in hospital and one year in general practice that is required under the trainee practitioner scheme before becoming a principal. This training is expected to be obligatory for all new principals from 1980. The new grade of hospital practitioner has been established to attract more general medical practitioners into part-time hospital work and to encourage those already serving to devote more time to it. The community health service now offers a third career path within the National Health Service, as a result of the transfer to it of the parallel services which, prior to 1974, were provided by the Local Authorities. Under the present arrangements, community doctors can serve in a clinical capacity either as a clinical medical officer (broadly equivalent to registrar and senior registrar in the hospital service) or as a senior medical officer (the main career grade). Alternatively, after a short period as registrar and senior registrar, they can be appointed as community medicine specialists who are equivalent in status to hospital consultants and who also have an administrative medical role at district, area or regional levels[2].

---

[1]Prior to 1966, the senior hospital medical officer grade provided an alternative career outlet; the grade was closed in 1966 and the number in it is now very small.

[2]District community physician or other community medicine specialist, area medical officer, and regional medical officer.

3. In Great Britain in 1975 there were 24,464 unrestricted principals in general practice; 13,200 consultants and 20,508 in the training grades in the hospital service; and 7,515 in the community health service[1]: the estimated total number of NHS doctors (in whole-time equivalent terms) was 63,650. The increases since September 1970 are 6·5 per cent in unrestricted principals in general practice, 17·8 per cent in consultants and 28·2 per cent in the training grades[2]. The proportion of overseas-born doctors in each of these three groups has increased also in the last five years; they now form 16·6 per cent, 13·3 per cent and 46·5 per cent of the respective groups, compared with 13·2 per cent, 11·5 per cent and 45·3 per cent in 1970: overall, the rate of increase in the proportion of overseas-born doctors has slowed down but the proportion itself continues to increase and 27 per cent of all doctors are now overseas-born. The main explanation of the significantly higher proportion in the training grades than of consultants or of doctors in general practice is that most overseas-born doctors come to this country for training and experience only[3], and either return to their own countries or move to other countries to practice: on average, it is estimated that these doctors spend between three and four years in this country.

4. As indicated in the 1972 Report[4], a position in which nearly half of the doctors in the training grades come from overseas is clearly unsatisfactory, as the inflow of foreign doctors could well be reduced or the outflow increased at any time by developments that are beyond the control of this country. Indeed, steps are already being taken to reduce the outflow of qualified doctors from some countries whose doctors by custom are trained in the United Kingdom. This is a development that is bound to continue in the face of the needs of the country of origin and there are already indications that the net inflow of overseas-born doctors into the NHS in England and Wales may now be declining after rising to a peak in 1974. A new factor—which may well affect the number of overseas-born doctors who come here for further training and experience in the future—is the recent introduction of the special linguistic and professional qualifying examinations for temporary registration by the General Medical Council: since the start of these examinations in June 1975 the proportion of applicants failing each examination has averaged 65 per cent. However, so far there has been no shortage of applicants to join the National Health Service and the introduction of the qualifying examinations must clearly be beneficial to the standards provided. The increase in output of graduates from 2,200 at the beginning of the present decade[5] to an estimated 3,200 by the end as a result of the expansion of the medical schools should compensate for any decline in the net inflow of overseas doctors, but it will not be sufficient if the number of those of them who join the NHS begins to fall.

---

[1]These figures relate to the numbers of hospital and community doctors at 30 September 1975 and to the number of general medical practitioners at 1 October 1975. Information is not yet available on the number of doctors in the NHS in Great Britain in 1976.

[2]Information is not available on the total number of doctors employed by Regional Hospital Boards and Local Authorities in community health care prior to 1974.

[3]The proportion of overseas-born doctors in training grades leaving the NHS between 1972 and 1975 with the intention of emigrating was 90 per cent.

[4]Report of the Review Body on Doctors' and Dentists' Remuneration, 1972—Cmnd. 5010, June 1972 (paragraph 11).

[5]1971-80.

5. The number of applicants for places at medical schools has increased proportionately more than the number of places available over the five year period, following the trend in the previous five years, although at a slower rate. In 1971, there were just over three applicants for every available place; by 1976, this had risen to nearly three and a half. Over the same period, the proportion of newly qualified graduates increased from 87 per cent to just under 91 per cent of the corresponding intake, and the proportion of successful candidates with three A-level qualifications remained virtually unchanged at around 99 per cent[1]. These figures demonstrate that sufficient numbers of adequately qualified students have continued to be attracted to fill the increased number of medical school places. The proportion of women graduates has risen from 22 per cent in 1971 to 31 per cent in 1976, and is expected to rise to 40 per cent or higher in the future: it has been estimated that, on average, women doctors practice for about four-fifths of the number of years spent in practice by men. However, they do significantly more of their work on a part-time basis. By 1980, the number of places is expected to have increased to just under 4,000, which implies a further increase in the output of graduates in 1985. On the assumption that at the least the present number of applicants will be sustained, no difficulty should arise in filling the expanding number of places in medical schools up to 1980.

6. The rate of expansion of the medical schools increased significantly following the recommendations of the Royal Commission on Medical Education in 1968[2], which were designed to produce an annual increase of 2 per cent in the total number of doctors up to 1990. The rate of increase was based on the pattern of growth in demand as measured by the number of economically active doctors per million people established by past experience, and the expected rise in the total population. Among the factors taken into account in assessing the expansion required in the number of graduates from medical schools was the need to replace losses by death and retirement of practising doctors and to meet an assumed annual net loss through emigration of 430 British-born doctors. Against these losses, an annual net gain of 250 overseas-born doctors[3] was expected. In practice, the annual net loss of British-born doctors has been lower than was assumed—320 since 1968, although there are indications that the outflow is now increasing—and the number of overseas-born doctors has risen steadily: as a result, the total number of doctors has increased at a higher rate than was envisaged in 1968. Nevertheless, because at the beginning of the period considered by the Royal Commission the actual number did not match the estimated demand at the time, the present number is still a little below the Royal Commission's target. However, the rate of population growth has slowed in recent years, and the present population total is slightly below the level forecast. As a result, on the basis of the latest estimate by the Health Departments of the number of economically active doctors[4], the number of doctors per million people now exceeds by a small margin the ratio which the Royal Commission considered would be required to meet demand in 1975[5].

---

[1]Table 4.

[2]Report of the Royal Commission on Medical Education 1965-68: Chairman, Lord Todd —Cmnd. 3569, April 1968.

[3]Fully or provisionally registered.

[4]77,000 in 1975.

[5]1,413 doctors per million people compared with the Royal Commission's target of 1,385 doctors per million people.

7. In 1972, the Health Departments said that their overall target for the increase each year in the number of NHS doctors to meet the underlying increase in demand was 2 per cent—the same as the target rate of growth in the number of economically active doctors. This allowed for a rate of increase of rather less than 2 per cent in the number of doctors in general practice and of substantially more than 2 per cent in the hospital service. The actual rate of increase in the hospital service has averaged 3 per cent over the past five years and the overall target has therefore been met; but the increase in general medical practitioners has averaged only 1 per cent and has not been enough to reduce the average list size to the level—2,250 patients—on which the overall target was based. However, the current average list size—2,290[1]—is close to this target and, if the present trend of increase in the number of general medical practitioners continues, it should be reached in the next few years. In addition, a substantial increase in the number of doctors in general practice and in the hospital service will be required in the future to provide for child health care: part of this demand will be met by existing community health medical staff (paragraph 67).

8. Within the hospital service itself, the target set for the annual growth in the number of consultants was 4 per cent for the ten years from 1968 and, for junior hospital doctors, just above 2 per cent. The aim was to achieve a suitable balance between the training grades and the career grades by 1978. In practice, since these targets were set, the annual increase in the number of consultants has exceeded 4 per cent in one year only (1973) and the average is 3·4 per cent. In contrast, the average annual increase in the number of junior hospital doctors over the same period has been 5·5 per cent. The effect of failing to meet the target for the consultant grade (the career grade) and of exceeding it for the training grades is that a serious structural imbalance has developed between them. However, since nearly half of the growth in the number of junior hospital doctors is attributable to overseas doctors, most of whom come here for training only, and the position in relation to British-born doctors is reasonably balanced at present, it should be possible to reduce the average age on appointment as consultant in the next few years.

9. Nevertheless, even after allowing for wastage, for the expected growth in the number of consultant posts, for the increasing proportion of women doctors (who on average make their contribution over a shorter period), and for movement into general practice, the present total number of British-born doctors in the training grades would remain higher than is needed, in theory at least, to sustain the current number of career posts if the average age for promotion to consultant were reduced as low as 32 or 33 years. In addition, there are almost as many overseas-born doctors in the training grades as British-born doctors. But notwithstanding this, there are some signs—notably the long hours of duty of junior hospital doctors—that the demand for junior medical staff in the hospital service is not yet satisfied. It becomes increasingly important to resolve these apparently conflicting requirements. The Royal Commission on the National Health Service has said that it intends to examine the medical career structure, and the special problems of overseas-born doctors, immigration and emigration, among other manpower problems[2].

---

[1]At 1 October 1976.

[2]The Royal Commission on the National Health Service, October 1976—"The Task of the Commission".

Dental manpower

10. The majority of dentists go into general dental practice on registration after graduating from dental schools at age 22-23. A few enter the hospital service where the staffing structure is the same as for junior hospital doctors. The assistant dental surgeon grade (a parallel grade to the medical assistant grade) is the only full-time career alternative to consultant[1] within the hospital service. Since 1974, the community health service has provided a third choice of career within the National Health Service. In it, dentists may serve either as dental officers or senior dental officers in clinical posts, or as district, area or regional dental officers in administrative posts.

11. In Great Britain in 1975 there were 12,620 principals and 301 assistants in the general dental service; and 506 consultants, 163 senior hospital dental officers and assistant dental surgeons and 643 in the training grades in the hospital service. The estimated total number of NHS dentists (in whole-time equivalent terms) was 15,900; after excluding those in the community health service, this represents an increase of about 8 per cent since September 1970. A further 2,577 were in the community health service. In contrast with doctors, a small proportion only of dentists in the NHS are overseas-born.

12. Attention was drawn in the 1972 Report[2] to various indicators of the need to pay particular attention to the rate of recruitment to the dental profession, and the developments over the last five years have been reviewed. The number of places in the dental schools has continued to increase since 1970, and nearly 950 places are now available; this is just short of the target of 1,000 places set by the Committee on Recruitment to the Dental Profession in 1956[3]. There has been an encouraging increase in the number of applicants for places and in the educational standard of candidates. In 1970, there were just under one and a half applicants for every available place and 90 per cent of the candidates had three A-level qualifications: by 1975, the number of applicants for each available place had risen to just over three, and the proportion of successful candidates with three A-level qualifications to 98 per cent[4]. This is a significant and welcome improvement in the position reported in 1972. At present, about 25 per cent of graduates are women: on average, women dentists work for about 10 per cent fewer years than men. If the present demand is maintained, there should be no difficulty in filling the dental schools with students of the right quality.

13. The broad target accepted by the Committee on Recruitment to the Dental Profession for the number of registered dentists in the United Kingdom was 20,000, and it should be reached this year. The target was intended as a standard against which to assess the future graduate output, student intake and requirements of dental schools, and not as an assessment of the optimum

---

[1]Prior to 1966, the senior hospital dental officer and the general dental surgeon grades provided alternative career outlets, but both grades were closed in 1966 and only a very small number of senior hospital dental officers remain.

[2]Report of the Review Body on Doctors' and Dentists' Remuneration, 1972—Cmnd. 5010, June 1972 (paragraph 18).

[3]Report of the Committee on Recruitment to the Dental Profession: Chairman, Lord McNair—Cmd. 9861, October 1956.

[4]Table 9.

number of dentists needed to meet all future demands. The Dentists' Register includes many dentists who have ceased to practice on account of age, or who have left the country after practising here for a period: about two-thirds of those on the Register are in active employment in the NHS. The ratio of population to dentist (principals and assistants) has declined slowly over the last five years from 4,416 in 1970 to 4,192 in 1975. The distribution has improved marginally over this period, but a substantial disparity remains between the ratio in the South of England, where it is well below average, and elsewhere in Great Britain, where it is well above average: if the ratio of population per general dental practitioner in the country were to be reduced to the lowest ratio in the regions—3,234—an additional 3,850 dentists would be required.

Doctors' workload

14. **Hospital doctors**[1]. Between 1970 and 1975, the number of beds available each day for in-patients fell by 7·8 per cent, but the proportion actually occupied remained stable at around 80 per cent. Because the number of consultants increased, the number of in-patients[2] per consultant per year under care declined by a greater extent—20·4 per cent—from 618 to 492. Overall, both the number of in-patients and the number of out-patients[3] declined marginally over the five year period by 0·6 per cent and 1·5 per cent respectively, but per doctor fell to a somewhat greater extent by 20·4 per cent and 21·0 per cent respectively. But, because the average length of stay per patient has been reduced over the period—from 14½ to 13½ days for other than psychiatric cases—the number of in-patients treated provides a better measure of workload. The decrease in the length of stay reflects shorter provision for convalescence as an in-patient and reduces the doctor's workload to a marginal extent only. The increase in the number of new accident and emergency cases who are more likely to require intensive care has been disproportionately large (8·9 per cent), but the number per doctor fell by 7.8 per cent. The reduction in the number of in-patients treated has been accompanied by a reversal of the declining trend of numbers waiting for treatment shown at the beginning of the period, and the number waiting for treatment has increased in each year since 1972: part of the increase in 1975 and 1976 may have been due to industrial action taken by hospital doctors, which also may have affected the numbers of in-patients and out-patients (paragraph 22).

15. Very little firm evidence is yet available on the trend of duty hours. As noted in the 1972 Report, a survey conducted by the Regional Hospital Consultants and Specialists Association[4] in 1971 indicated that full-time consultants then spent an average of 38 hours a week on clinical work and a further 70-80 hours on emergency call. A survey carried out in connection with the deliberations of the Joint Working Party that began discussions on a new consultant contract in 1974 (noted in the Fifth Report), found that the average amount of time spent on clinical work by a full-time consultant was just under 40

---

[1]Includes hospital dental staff.
[2]As measured by deaths and discharges.
[3]Out-patient attendances.
[4]Subsequently, the Hospital Consultants and Specialists Association.

hours a week, and that a further 24 hours was spent on other work (including teaching, domiciliary consultations and research) and 51 hours on-call. Neither of the surveys can be regarded as wholly representative (and neither is up to date): the 1971 survey covered about three-quarters of all consultants only and the response was relatively low, and the figures indicated by the 1974 survey have not been validated. Limitations and qualifications apart, it is of interest that the surveys themselves provide no evidence of a significant change in hours of duty between 1971 and 1974.

16. Two surveys of the hours of work of junior hospital doctors have been carried out: the first[1] in 1968 by the Management Services branch of the Department of Health and Social Security and the second in 1975 by the Health Departments on the Review Body's behalf. But again neither survey can be considered sufficiently representative: the first covered a very small number of doctors only and the second had a poor response. The average hours of duty disclosed by these surveys (88 and 86 hours a week respectively) in any case do not show a significant trend. On the other hand, information that is available on the number of units of extra duty allowance paid since its introduction in 1970 to the time of its replacement in 1976, shows a marginal decrease in the average claimed per doctor over the period to July 1974 when the threshold for payment was lowered from 102 to 80 hours a week, and a small increase over the period since then. The extra duty allowance information also casts doubt on the figures of average weekly duty hours obtained from the two surveys, and suggests that the average weekly duty hours of all medical staff were somewhat lower than indicated by the limited information from the surveys. Following the introduction of the new contract for junior hospital doctors in February 1976, information has been provided on the number of 4-hour units of medical time contracted and paid for under the new system. After adjustment for the different basis of payment, the implied average weekly hours of duty are 87·9 hours (paragraph 26), compared with the estimate of average weekly hours of duty adjusted to be consistent with the audited information on extra allowance payments of 81·5 hours[2], although most duty rosters have remained unchanged. This suggests that there has been little, if any, change in the hours of duty of junior hospital doctors over the period since 1968.

17. **General medical practitioners.** The main indicator of workload for general medical practitioners is average list size. This has continued to fall slowly since 1970, when the average was 2,413 patients per general medical practitioner, in line with the increase in the number of principals in general practice, to 2,307 in 1975. This modest reduction in the average number of patients for whom each general medical practitioner provides general medical services has to be seen also in the context of the increase—also small— in the proportion of older people in the population (65 years and over) who need

---

[1]"All in a Working Day": a report by thev Joint Working Party on the Organisation of Medical Work in Hospitals published in Noember 1971.

[2]Review Body on Doctors' and Dentists' Remuneration, Third Supplement to Fifth Report, 1975—Cmnd. 6406, February 1976 (paragraph 7).

more care. But, based on the latest information available on consultation rates[1], the increase in the number of consultations per person that results from the change in the population structure does not seem to have been sufficient to offset the reduction in the number of patients per doctor stemming from the fall in list size. These statistics imply that in practice there has been a small overall reduction in the number of consultations per year per doctor of about 5 per cent over the last five years, assuming that consultation rates have remained constant. However, there is some evidence of a limited nature (based on information from an annual survey of 2,000 doctors[2]) to show that consultation rates were nearly 3 per cent higher in 1975 than in 1970, and, based on this evidence, the number of consultations per year per doctor shows a small decline of about 2 per cent.

18. Another indicator of workload is output as measured by gross income from individual fees and allowances per doctor on a constant fee basis. If allowances which are not directly related to the volume of general medical services work (for example, seniority allowances) or which are received only by a limited proportion of practitioners (for example, fees for dispensing and supply of drugs) are discounted, the figures for average output measured by gross income from the remaining fees and allowances indicate a marginal decline in general medical services work of about 2 per cent over the last four years. However, since the extension of the provision of contraceptive services in July 1975, family planning work by general medical practitioners has increased, the remuneration from which in most cases will have been more than sufficient to make up the decline in income from general medical services work, although in some cases at least there will have been some reduction in corresponding work (and remuneration) in private practice.

19. The trend towards larger group practices has continued since 1970. The number of practices in England and Wales has fallen by 2·8 per cent (from 9,786 in 1970 to 9,516 in 1975); the proportion of partnerships has remained relatively stable at around 60 per cent, but there has been a marked increase in the number of large partnerships of five principals or more. A large number of these doctors in partnerships of this size work in health centres provided by area health authorities. Working in group practices in modern purpose-built premises with a team of trained ancillary staff enables a much higher standard of primary medical care to be provided than is possible in most single-handed practices based on surgeries in the doctor's own home. Between 1970 and 1975, the number of health centres in England and Wales has increased by 234 per cent from 212 to 707, and the proportion of all doctors working in them has risen from 5 per cent to 17 per cent.

Dentists' workload

20. The rising trend of the 1960's in the average number of courses of treatment carried out by general dental practitioners has continued. In 1970, 1,986 courses of treatment per dentist were carried out compared with 2,332 in 1975: this represents an increase over the period of 17 per cent. However,

[1]1973 General Household Survey.
[2]Carried out by Intercontinental Medical Statistics Ltd.

because courses of treatment vary and the pattern may change each year, a more realistic estimate of the increase in output is the rise in average gross earnings from fees at constant rates, and this is 2·3 per cent over the same period; this difference reflects an increase in courses of treatment for conservation and a fall in the number for extraction of teeth. In addition, hours spent on general dental service work have been declining, as revealed by the most recent inquiry by the Dental Rates Study Group: between 1967 and 1973, they fell from 1,863 hours to 1,755 hours—an average reduction of 0·9 per cent a year. It is clear, therefore, that the increased output of general dental practitioners has been achieved by a rise in productivity and not by working longer hours.

OFFICE OF MANPOWER ECONOMICS

LIST OF TABLES

Hospital medical and dental staff in Great Britain 1970-1975 and England and Wales 1975-1976 by grade and place of birth

Grade and place of birth	*Number of staff in post at 30 September*									
	Great Britain							*England and Wales*		
	1970	1971	1972	1973	1974[a]	1975	*Change* 1970-1975	1975	1976	*Change* 1975-1976
							per cent			per cent
All grades[b]	30,110	31,259	32,696	34,008	34,995	36,641	21·7	31,611	32,466	2·7
UK and Irish born	20,974	21,897	22,675	23,217	23,687	24,720	17·8	20,744	21,489	3·6
Born elsewhere	9,136	9,362	10,021	10,791	11,308	11,921	30·5	10,867	10,977	1·0
Consultants	11,637	11,986	12,357	12,929	13,344	13,706	17·8	11,923	12,328	3·4
UK and Irish born	10,332	10,617	10,924	11,383	11,662	11,922	15·4	10,258	10,550	2·8
Born elsewhere	1,305	1,369	1,433	1,546	1,682	1,784	36·7	1,665	1,778	6·8
Senior hospital medical and dental officers	670	613	576	442	356	324	−51·6	262	155	−40·8
UK and Irish born	565	517	489	382	314	286	−49·4	232	137	−40·9
Born elsewhere	105	96	87	60	42	38	−63·8	30	18	−40·0
Medical assistants and assistant dental surgeons	1,161	1,227	1,279	1,256	1,321	1,412	21·6	1,150	1,121	−2·5
UK and Irish born	789	845	873	843	898	984	24·7	768	734	−4·4
Born elsewhere	372	382	406	413	423	428	15·1	382	387	1·3
Senior registrars	2,084	2,272	2,453	2,623	2,703	2,852	36·9	2,435	2,565	5·3
UK and Irish born	1,679	1,786	1,887	2,013	2,040	2,137	27·3	1,782	1,888	5·9
Born elsewhere	405	486	566	610	663	715	76·5	653	677	3·7
Registrars	5,691	5,862	5,924	6,067	6,059	6,457	13·5	5,266	5,408	2·7
UK and Irish born	2,673	2,818	2,897	2,943	2,872	3,007	12·5	2,297	2,406	4·7
Born elsewhere	3,018	3,044	3,027	3,124	3,187	3,450	14·3	2,969	3,002	1·1
Senior house officers	5,634	6,036	6,728	7,554	7,992	8,618	53·0	7,838	8,093	3·3
UK and Irish born	2,282	2,647	2,848	3,209	3,366	3,721	63·1	3,190	3,482	9·2
Born elsewhere	3,352	3,389	3,880	4,345	4,626	4,897	46·1	4,648	4,611	−0·8
House officers	3,065	3,109	3,238	3,090	3,161	3,224	5·2	2,690	2,741	1·9
UK and Irish born	2,510	2,534	2,635	2,402	2,503	2,631	4·8	2,186	2,251	3·0
Born elsewhere	555	575	603	688	658	593	6·8	504	490	−2·8

Source: Department of Health and Social Security

(a) May be understated due to the reorganisation of the National Health Service at 1 April 1974.
(b) Includes a small number of junior hospital medical officers (up to 1973) and ungraded staff.

TABLE 2

Community health medical and dental staff[a] in Great Britain 1975 and England and Wales 1975-1976 by grade and place of birth

Community health medical staff					Community health dental staff				
Grade and place of birth	Number of staff in post at 30 September			Change 1975-1976	Grade and place of birth	Number of staff in post at 30 September			Change 1975-1976
	Great Britain	England and Wales				Great Britain	England and Wales		
	1975	1975	1976			1975	1975	1976	
				per cent					per cent
All grades	7,515	6,956	7,557	8·6	All grades	2,577[b]	2,251	2,224	— 1·2
UK and Irish born	6,389	5,874	6,297	7·2	UK and Irish born	2,332	2,028	2,015	— 0·6
Born elsewhere	1,126	1,082	1,260	16·5	Born elsewhere	245	223	209	— 6·3
Regional medical officers	14	14	13	— 7·1	Area dental officers[c]	112	98	98	—
UK and Irish born	14	14	13	— 7·1	UK and Irish born	107	94	94	—
Born elsewhere	—	—	—	—	Born elsewhere	5	4	4	—
Area medical officers[c]	112	98	97	— 1·0	District dental officers	29	—	43	—
UK and Irish born	106	95	94	— 1·1	UK and Irish born	28	—	40	—
Born elsewhere	6	3	3	—	Born elsewhere	1	—	3	—
District community physicians[d]	205	176	173	— 1·7	Chief/Deputy chief dental officers[e]	60	60	—[f]	—
UK and Irish born	189	164	163	— 0·6	UK and Irish born	57	57	—	—
Born elsewhere	16	12	10	—16·7	Born elsewhere	3	3	—	—
Specialists in community medicine	441	324	340	4·9	Consultant orthodontists	15	15	20	33·3
UK and Irish born	418	308	320	3·9	UK and Irish born	15	15	19	26·7
Born elsewhere	23	16	20	25·0	Born elsewhere	—	—	1	—
Senior registrars	17	17	18	5·9	Senior dental officers (Cat. A)[g]	—	—	95	—
UK and Irish born	14	14	16	14·3	UK and Irish born	—	—	89	—
Born elsewhere	3	3	2	—33·3	Born elsewhere	—	—	10	—
Registrars	42	42	58	38·1	Senior dental officers (Cat. B)[g]	—	—	160	—
UK and Irish born	35	35	47	34·3	UK and Irish born	—	—	148	—
Born elsewhere	7	7	11	57·1	Born elsewhere	—	—	12	—
Senior medical officers	—	—	116	—	Orthodontists	56	56	—[f]	—
UK and Irish born	—	—	106	—	UK and Irish born	50	50	—	—
Born elsewhere	—	—	10	—	Born elsewhere	6	6	—	—
Senior clinical medical officers	349	349	545	56·2	Senior dental officers/Consultant anaesthetists	446	446	82[h]	—
UK and Irish born	304	304	460	51·3	UK and Irish born	403	403	72	—
Born elsewhere	45	45	85	88·9	Born elsewhere	43	43	10	—
Clinical medical officers	2,829	2,792	3,119	11·7					
UK and Irish born	2,280	2,249	2,454	9·1	Other anaesthetists	—	—	144	—
Born elsewhere	549	543	665	22·5	UK and Irish born	—	—	134	—
					Born elsewhere	—	—	10	—
Other medical staff[i]	3,506	3,144	3,078	— 2·1					
UK and Irish born	3,029	2,691	2,624	— 2·5	Dental/ex-Area dental officers[j]	1,576	1,576	1,578[k]	— 0·1
Born elsewhere	477	453	454	0·2	UK and Irish born	1,409	1,409	1,419	— 0·7
					Born elsewhere	167	167	159	— 4·8

Source: Department of Health and Social Security

[a] Where staff hold appointments in both medical and dental services, they are counted in both parts of the table.
[b] Includes 283 (263 UK and Irish born) community clinical staff in Scotland.
[c] Includes chief administrative medical/dental officers in Scotland.
[d] Includes district medical officers in Scotland.
[e] Includes 5 UK and Irish born deputy chief dental officers.
[f] Assimilated into other grades.
[g] Senior dental officers in Category A are engaged on clinical work related to an additional registerable qualification such as orthodontics: all other senior dental officers are in Category B.
[h] Consultant anaesthetists only from 1976.
[i] Former local authority doctors, ungraded doctors on clinical duties and doctors working occasional sessions.
[j] Former area dental officers were assimilated into the dental officer grade from 1976.
[k] Dental officers "new style" from 1976 including dental officers employed to administer anaesthetics only.

TABLE 3

Number of applicants for and admittances to pre-clinical courses at medical schools in Great Britain and number of students attaining a first registerable qualification: 1966-1976 and later

Academic year (ending 31 July)	All students				British based				Others			
			Qualifying[c]				Qualifying[c]				Qualifying[c]	
	Applying[a]	Admitted[b]	Number	Percentage of students admitted 5 years previously	Applying[a]	Admitted[b]	Number	Percentage of students admitted 5 years previously	Applying[a]	Admitted[b]	Number	Percentage of students admitted 5 years previously
				per cent				per cent				per cent
1966	6,274	2,478	1,939		4,917	2,312	1,750		1,357	166	189	
1967	7,361	2,502	1,933		5,722	2,391	1,810		1,639	111	123	
1968	6,948	2,560	2,105		5,624	2,442	2,005		1,324	118	100	
1969	6,946	2,693	2,126		5,733	2,556	2,029		1,213	137	97	
1970	7,577	2,695	2,114	85·3	6,417	2,582	2,005	86·7	1,160	113	109	65·7
1971	8,971	2,878	2,190	87·5	7,477	2,770	2,097	87·7	1,494	108	93	83·8
1972	11,177	3,032	2,343	91·5	9,274	2,929	2,263	92·7	1,903	103	80	67·8
1973	12,915	3,323	2,289	85·0	10,759	3,229	2,185	85·5	2,156	94	104	75·9
1974	13,003	3,276	2,594	96·3	10,746	3,183	2,492	96·5	2,257	93	102	90·3
1975	12,046	3,281	2,644	91·9	9,936	3,186	2,542	91·8	2,110	95	102	94·4
1976	12,015	3,468	2,749	90·7	9,697	3,354	2,662	90·9	2,318	114	87	84·5
1977		3,617	3,025	91·0		3,514	2,940	91·0		103	85	90·4
1978		3,735	2,980	91·0		3,635	2,895	91·0		100	85	91·4
1979		3,750	2,985	91·0		3,650	2,900	91·0		100	85	89·5
1980		3,920	3,155	91·0		3,820	3,050	91·0		100	105	92·1
1981			3,290	91·0			3,195	91·0			95	92·2
1982			3,400	91·0			3,310	91·0			90	90·0
1983			3,410	91·0			3,320	91·0			90	90·0
1984			3,565	91·0			3,475	91·0			90	90·0

Source: University Grants Committee, the Universities Central Council on Admissions and Department of Health and Social Security

[a]Applying through UCCA in previous September. In addition, some prospective students applied direct to the university.
[b]Figures after 1976 refer to places available.
[c]Figures after 1976 are based on actual and projected figures of student intake and projected wastage rates.

TABLE 4

Admissions to medical schools in the United Kingdom, and GCE 'A' level performance of candidates admitted: 1970-1976

Academic year (ending 31 July)	*Admitted to medical schools*		*Successful candidates for whom 'A' level performance is known*			
	Total	*Number who applied through UCCA*	*Total*	*Percentage of total admitted*	*Average score*[a]	*Percentage of candidates with 3 'A' levels*
				per cent		per cent
1970	2,802	2,411	2,058	73·4	10·6	97·8
1971	2,992	2,595	2,327	77·8	10·9	98·3
1972	3,150	2,737	2,360	74·9	11·2	98·6
1973	3,466	2,955	2,472	71·3	11·7	98·6
1974	3,416	3,092	2,613	76·5	12·1	99·1
1975	3,421	2,993	2,583	75·5	12·6	99·1
1976	3,611	3,208	2,792	77·3	12·6	99·1

Source: University Grants Committee and the Universities Central Council on Admissions

[a] 'A' level results are translated into a score as follows:—

Grade	A	B	C	D	E	Fail
Score	5	4	3	2	1	0

TABLE 5

Migration of fully or provisionally registered doctors to and from Great Britain by place of birth: 1966-1974[a]

Year (ending 30 September)	Total			Born in UK or Irish Republic			Born elsewhere		
	Inflow	Outflow	Net change	Inflow	Outflow	Net change	Inflow	Outflow	Net change
1966	2,500	2,010	+490	560	940	−380	1,940	1,070	+ 870
1967	2,450	2,420	+ 30	580	1,030	−450	1,870	1,390	+ 480
1968	2,690	2,420	+270	590	1,070	−480	2,100	1,350	+ 750
1969	2,620	1,730	+890	520	840	−320	2,100	890	+1,210
1970	2,280	2,180	+100	650	930	−280	1,630	1,250	+ 380
1971	1,980	2,360	−380	530	850	−320	1,450	1,510	− 60
1972	2,430	2,110	+320	700	800	−100	1,730	1,310	+ 420
1973	2,390	2,240	+150	630	1,010	−380	1,760	1,230	+ 530
1974	2,350	1,940	+410	550	900	−350	1,800	1,040	+ 760

Source: Department of Health and Social Security

[a]All figures are provisional estimates.

TABLE 6

Number of unrestricted principals in general medical practice and average list size by region: 1970-1975

Region[a]	Year (1 October)						Change 1970–1975
	1970	1971	1972	1973	1974	1975	
							per cent
North:							
No. of principals	1,315	1,333	1,348	1,357	1,301	1,321	+ 0·5
Average list size	2,528	2,504	2,474	2,465	2,471	2,434	− 3·7
Yorks and Humber:							
No. of principals	1,919	1,938	1,959	1,958	2,023	2,044	+ 6·5
Average list size	2,549	2,536	2,510	2,513	2,484	2,450	− 3·9
East Midlands:							
No. of principals	1,351	1,367	1,386	1,433	1,524	1,533	+ 13·5
Average list size	2,596	2,591	2,580	2,510	2,490	2,495	− 3·9
East Anglia:							
No. of principals	702	720	731	747	766	773	+ 10·1
Average list size	2,336	2,313	2,321	2,309	2,282	2,302	− 1·5
South East:							
No. of principals	7,441	7,556	7,713	7,793	7,757	7,825	+ 5·2
Average list size	2,427	2,408	2,367	2,339	2,331	2,309	− 4·9
South West:							
No. of principals	1,723	1,743	1,783	1,815	1,941	1,955	+ 13·5
Average list size	2,241	2,244	2,224	2,211	2,189	2,188	− 2·4
West Midlands:							
No. of principals	2,004	2,047	2,117	2,144	2,171	2,187	+ 9·1
Average list size	2,608	2,571	2,493	2,473	2,447	2,424	− 7·1
North West:							
No. of principals	2,644	2,670	2,738	2,750	2,736	2,739	+ 3·6
Average list size	2,578	2,559	2,502	2,481	2,466	2,454	− 4·8
England:							
No. of principals	19,099	19,374	19,775	19,997	20,219	20,377	+ 6·7
Average list size	2,478	2,460	2,421	2,398	2,384	2,365	− 4·6
Wales:							
No. of principals	1,258	1,259	1,269	1,269	1,291	1,290	+ 2·5
Average list size	2,192	2,203	2,197	2,207	2,189	2,193	—
Scotland:							
No. of principals	2,604	2,619	2,678	2,699	2,745	2,797	+ 7·4
Average list size	2,045	2,051	2,015	2,001	1,973	1,939	− 5·2
Great Britain:							
No. of principals	22,961	23,252	23,722	23,965	24,255	24,464	+ 6·5
Average list size	2,413	2,400	2,363	2,343	2,327	2,307	− 4·4

Source: Department of Health and Social Security

(a) Various boundary changes were made in 1974 principally in the North, North West, Yorks and Humber, and East Midlands regions so that the regional figures prior to that date are not directly comparable with those at later dates.

TABLE 7

Number of principals and assistants in general dental practice and population per general dental practitioner by region: 1970-1975

Region[a]	*Year (30 September)*						*Change 1970-1975*
	1970	1971	1972	1973	1974	1975	
							per cent
North:							
No. of principals	487	503	513	528	518	532	+ 9·2
No. of assistants	37	34	37	34	28	21	−43·2
Population per dentist	6,391	6,128	5,982	5,845	5,725	5,650	−11·6
Yorks and Humber:							
No. of principals	802	806	835	857	907	930	+16·0
No. of assistants	49	46	33	34	33	31	−36·7
Population per dentist	5,640	5,630	5,539	5,408	5,194	5,078	−10·0
East Midlands:							
No. of principals	531	539	551	580	599	638	+20·2
No. of assistants	27	23	23	16	21	18	−33·3
Population per dentist	6,144	6,152	6,067	5,899	5,976	5,662	− 7·8
East Anglia:							
No. of principals	288	297	301	313	332	350	+21·5
No. of assistants	12	6	8	6	5	5	−58·3
Population per dentist	5,489	5,457	5,428	5,360	5,135	4,941	−10·0
South East:							
No. of principals	4,964	5,039	5,127	5,117	5,054	5,105	+ 2·8
No. of assistants	204	157	143	131	95	100	−51·0
Population per dentist	3,309	3,280	3,246	3,257	3,273	3,234	− 2·3
South West:							
No. of principals	910	928	954	1,000	1,114	1,126	+23·7
No. of assistants	37	32	38	35	34	30	−18·9
Population per dentist	4,024	4,007	3,917	3,805	3,619	3,617	−10·1
West Midlands:							
No. of principals	808	824	888	914	944	978	+21·0
No. of assistants	32	31	17	15	11	13	−59·4
Population per dentist	6,151	5,974	5,676	5,546	5,415	5,216	−15·2
North West:							
No. of principals	1,198	1,226	1,251	1,278	1,312	1,315	+ 9·8
No. of assistants	40	36	31	28	16	14	−65·0
Population per dentist	5,420	5,277	5,198	5,111	4,964	4,947	− 8·7
England:							
No. of principals	9,988	10,162	10,420	10,587	10,780	10,974	+ 9·9
No. of assistants	438	365	330	299	243	232	−47·0
Population per dentist	4,413	4,356	4,284	4,243	4,192	4,126	− 6·5
Wales:							
No. of principals	408	426	446	472	493	517	+26·7
No. of assistants	9	9	13	16	12	14	+55·6
Population per dentist	6,536	6,248	5,936	5,621	5,453	5,194	−20·5
Scotland:							
No. of principals	1,009	1,004	1,045	1,065	1,110	1,129	+11·9
No. of assistants	84	88	78	81	66	55	−34·5
Population per dentist	4,746	4,754	4,616	4,526	4,424	4,374	− 7·8
Great Britain:							
No. of principals	11,405	11,592	11,911	12,124	12,383	12,620	+10·7
No. of assistants	531	462	421	396	321	301	−43·3
Population per dentist	4,516	4,460	4,377	4,322	4,624	4,192	− 7·2

Source: Department of Health and Social Security

[a]See footnote (a) to Table 6.

TABLE 8

Number of applicants for and admittances to courses at dental schools in Great Britain and number of students attaining a first registerable qualification: 1966-1976

Academic year (ending 31 July)	*Applying through UCCA*	*Admitted*	*Obtaining first registerable qualification*	
			Number	*Percentage of those admitted 5 years earlier*
				per cent
1966	681	745	531	
1967	833	784	565	
1968	1,206	774	568	
1969	1,224	778	593	
1970	1,155	791	620	83·2
1971	1,170	822	696	88·8
1972	1,442	882	646	83·5
1973	1,911	894	680	87·4
1974	2,448	928	694	87·7
1975	3,065	940	664	80·8
1976	2,591	941	745	84·5

Source: University Grants Committee and the Universities Central Council on Admissions

TABLE 9

Admissions to dental schools in the United Kingdom, and GCE 'A' level performance of candidates giving dentistry as first choice: 1967-1976

Academic year (ending 31 July)	*Admitted to dental schools*		*Successful candidates for whom 'A' level performance is known and who gave dentistry as their first choice*			
	Total	*Number who applied through UCCA*	*Total*	*Percentage of total admitted*	*Average score*[a]	*Percentage of candidates with 3 'A' levels*
				per cent		per cent
1967	791		304	38·4	6·3	81·6
1968	793		441	55·6	6·5	79·8
1969[b]	808		458	56·7	7·4	91·1
1970	813	761	454	55·8	6·9	87·6
1971	823	764	444	53·9	7·4	89·9
1972	892	836	475	53·3	7·2	91·2
1973	960	872	527	54·9	7·5	94·9
1974	949	876	619	65·2	8·1	95·6
1975	973	874	676	69·5	9·3	96·2
1976	972	898	673	69·2	9·6	97·6

Source: University Grants Committee and the Universities Central Council on Admissions

[a] 'A' level results are translated into a score as follows:—

Grade	A	B	C	D	E	Fail
Score	5	4	3	2	1	0

[b] The figures for 1969 exclude overseas candidates and include those for whom dentistry was not the first choice.

TABLE 10a

Hospital workload statistics: Great Britain 1970-1975

	1970	1971	1972	1973	1974	1975	*Change* 1970-1975
	thousands						per cent
Number of NHS hospitals	2·81	2·76	2·75	2·72	2·74	2·68	− 4·6
Available beds[a][b]	513	508	501	491	483	473	− 7·8
All specialties							
In-patients							
Beds occupied daily[c]	426	421	415	400	393	382	−10·3
Waiting list[b][d]	607	578	563	606	610	681	+12·2
Discharges and deaths[e]	6,028	6,207	6,278	6,158	6,219	5,994	− 0·6
Out-patients[f]							
New patients	9,279	9,319	9,336	9,353	9,246	9,119	− 1·7
Total attendances	38,095	38,678	38,795	38,944	38,972	37,542	− 1·5
Accident and emergency							
New patients	8,877	9,131	9,283	9,717	9,567	9,669	+ 8·9
Total attendances	15,080	15,055	14,963	15,254	14,852	14,696	− 2·5
Non-psychiatric specialties							
In-patients							
Beds occupied daily	230	231	229	221	221	215	− 6·5
Waiting list	599	570	557	600	603	675	+12·7
Discharges and deaths	5,800	5,977	6,041	5,924	5,987	5,759	− 0·7
Psychiatric specialties							
In-patients							
Beds occupied daily	195	191	186	178	172	167	−14·4
Waiting list	8	8	7	6	6	7	−12·5
Discharges and deaths	227	231	237	234	231	234	+ 3·1
	numbers						
Average length of stay in days							
All specialties	25·8	24·8	24·1	23·7	23·1	23·3	− 9·7
Non-psychiatric specialties	14·5	14·1	13·9	13·6	13·5	13·6	− 6·2
Non-psychiatric excluding geriatrics and units for younger disabled	10·8	10·4	10·2	10·0	9·9	10·0	− 7·4
Number on waiting list per 100 beds available (non-psychiatric)	204	194	190	208	209	237	+16·2
Number on waiting list per daily number of discharges and deaths (non-psychiatric)	38	35	34	37	37	43	+13·2

Source: Department of Health and Social Security

[a] Staffed beds available daily including beds set up temporarily.

[b] At 31 December for England and Wales and 30 September for Scotland.

[c] Total of the daily numbers of in-patients for the year (at the night count) divided by the number of days in the year.

[d] Total number of patients recorded on waiting lists excluding expectant mothers, deferred admission cases and patients already occupying beds in the hospital but waiting for admission to another hospital.

[e] All patients who have gone through the full admission procedure and who have subsequently been discharged or have died in hospital.

[f] Excludes all accident and emergency work.

Hospital doctors and dentists[a]: indicators of workload—Great Britain 1970-1975

	1970	1971	1972	1973	1974	1975	*Change* 1970-1975
							per cent
Beds occupied daily (all specialties)							
Average per consultant[b]	44	40	38	35	33	31	−29·5
Average per junior doctor[b]	27	25	23	21	20	19	−29·6
Average all doctors[b]	16	15	14	13	12	11	−31·2
Out-patients[c]							
Average per consultant	3,903	3,666	3,550	3,413	3,290	3,083	−21·0
Average per junior doctor	2,371	2,300	2,172	2,084	2,026	1,834	−22·6
Average all doctors	1,395	1,341	1,281	1,236	1,201	1,102	−21·0
Accidents and emergency[c]							
Average per consultant	1,545	1,427	1,370	1,337	1,254	1,207	−21·9
Average per junior doctor	939	895	838	816	772	718	−23·5
Average all doctors	552	522	494	484	458	431	−21·9
Discharges and deaths (all specialties)							
Average per consultant	618	588	574	540	525	492	−20·4
Average per junior doctor	375	369	351	330	323	293	−21·9
Average all doctors	221	215	207	195	192	176	−20·4
Number of individual patients under care per year[d]							
Average per consultant	2,477	2,337	2,279	2,211	2,113	2,035	−17·8
Average per junior doctor	1,505	1,466	1,394	1,350	1,302	1,211	−19·5
Average all doctors	886	855	822	801	771	727	−17·9

Source: Office of Manpower Economics

[a] Based on the whole-time equivalents of hospital doctors and dentists at 30 September.

[b] Senior hospital medical and dental officers with allowances have been included with consultants. Junior hospital doctors are defined as house officers, senior house officers, registrars and senior registrars and their equivalents for dental staff. All doctors includes dental staff, and also includes the grades not classified as consultants or junior doctors.

[c] Averages are based on the total attendances for each year.

[d] The figures for individual patients under care per year have been derived by adding the number of discharges and deaths in a year to the number of new patients admitted as out-patients and as accident and emergency patients and dividing by the relevant number of doctors. The resultant total of individual patients per year is an approximation in so far as some accident and emergency cases become in-patients and are thus counted twice, while the numbers of new out-patients and accident and emergency patients will not include patients registered in the previous year.

TABLE 11

General medical practitioners: number of practices of unrestricted principals by practice size and number of health centres: England and Wales 1970-1975

	1970	1971	1972	1973	1974	1975	*Change* 1970-1975
							per cent
Practice size [a]							
1 principal	4,244	4,152	4,044	3,901	3,849	3,746	−11·7
2 principals	2,509	2,440	2,338	2,295	2,271	2,275	− 9·3
3 principals	1,756	1,754	1,825	1,803	1,810	1,774	+ 1·1
4 principals	808	876	918	959	976	998	+23·5
5 principals	302	310	352	384	413	436	+44·4
6 or more principals	167	196	216	243	260	285	+70·7
All sizes	9,786	9,728	9,693	9,587	9,579	9,516	− 2·8
Average principals per practice	2·1	2·1	2·2	2·2	2·2	2·3	+ 9·5
Number of health centres [b]	212	304	409	520	636	707	+233·5
Average principals per centre	5·7	5·5	5·5	5·4	5·4	5·5	− 3·5

Source: Department of Health and Social Security

[a] In practices where one or more partners provide restricted services or maternity medical services only, all partners have been counted when determining the practice size. Where two or more partnerships have common members, the practice size has been determined by counting the doctors as members of one combined practice. Figures relate to 1 October each year.

[b] Figures relate to 31 December each year. At 31 December 1975, an additional 94 health centres were under construction in England. Health centre practices are included in the practice size statistics shown above.

TABLE 12a

General medical practitioners: consultation rates in Great Britain 1970-1973

Age and sex of patients		Morbidity Statistics from General Practice[a]		General Household Survey		
		Average number of consultations		Average number of consultations per person		
		per person	per person consulting			
		1970-71	1970-71	1971	1972	1973
Males	0–4 years	3·8	4·2	4·7	4·3	4·3
	5–14	1·9	3·0	2·1	2·3	2·1
	15–44	2·0	3·4	2·5	2·9	2·6
	45–64	3·0	5·0	3·5	3·7	3·9
	65–74	3·7	5·7	5·1	4·1	4·7
	75+	4·5	6·5	7·0	6·8	5·8
	All ages	2·6	4·1	3·2	3·3	3·2
Females	0–4 years	3·5	3·9	4·4	4·6	3·4
	5–14	1·9	3·0	2·1	1·9	2·0
	15–44	3·8	5·1	4·6	4·9	4·4
	45–64	3·2	4·8	4·3	4·0	3·6
	65–74	3·8	5·8	5·4	4·8	4·2
	75+	4·5	6·6	7·4	7·7	5·7
	All ages	3·4	4·8	4·3	4·3	3·8
All persons		3·0	4·5	3·8	3·8	3·5

Source: Morbidity Statistics from General Practice 1970-71, and General Household Survey 1971, 1972 and 1973.

[a]Relates to England and Wales.

TABLE 12b

General medical practitioners: average daily number of patient contacts[a] 1965-1975

Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Average
1965	38	35	34	35	35·5
1966	39	35	34	35	35·8
1967	36	36	35	35	35·5
1968	37	37	32	33	34·8
1969	35	35	30	38	34·5
1970	37	35	34	37	35·8
1971	33	33	32	32	32·5
1972	33	33	32	32	32·7
1973	34	32	33	33	33·3
1974	37	36	34	36	35·4
1975	39	36	35	37	36·7

Source: Intercontinental Medical Statistics Ltd.

[a]Based on the number of patient contacts over a year of a changing sample of some 40 general medical practitioners per week.

TABLE 12c

General medical practitioners: indicators of workload—Great Britain[a] 1970-1975

	Unit	1970	1971	1972	1973	1974	1975	*Change* 1970-1975
								per cent
Pharmaceutical services[b]								
Number of prescriptions	millions	295·5	294·4	304·9	313·8	326·0	334·6	+13·2
Number of people on NHS lists	millions	52.8	52·9	53·1	53·3	53·6	53.5	+ 1·3
Prescriptions per person	number	5·6	5·6	5·7	5·9	6·1	6·3	+12·5
Prescriptions per GMP	thousands	12·9	12·7	12·9	13·1	13·4	13·7	+ 6·2
Maternity services								
Births: In hospital	thousands	772·2	791·4	749·3	716·2	689·6	678.4	−23·2
At home	thousands	111·2	89·6	64·6	43·0	28·4		
Rate per 1,000 population	number	16·4	16·3	15·0	14·0	13·2	12·5	−23·8
Births per GMP	number	38	38	34	32	30	28	−26·3
New claims for injury and sickness benefits	millions	11·5	9·5	10·3	10·8	10·6	10·2	−11·3
Average per GMP	number	499	410	433	449	435	419	−16·0
Cases of infectious diseases notified	thousands	430	239	213	190	186	210	−51·2
Cases of measles included in above	thousands	333	151	151	133	117	149	−55·3
Cases of disease notified per GMP	number	19	10	9	8	8	9	−52·6
Total deaths	thousands	639	629	657	652	650	646	+ 1·1
Rate per 1,000 population	number	11·9	11·6	12·1	12·0	11·9	11·8	− 0·8
Cervical cytology								
All examinations	thousands	1,835	1,995	2,124	2,338	2,476	2,498	+36·1
At hospital clinics	thousands	620	649	640	551	477	423	−31·8
At other places[c]	thousands	796	868	945	1,156	1,214	1,262	+58·5
By GMPs	thousands	419	478	540	630	785	814	+94·3
Examinations per GMP	number	21	23	26	30	36	38	+81·0

Source: Department of Health and Social Security

[a] Figures for cervical cytology relate to England and Wales.

[b] Excludes prescriptions given by and persons registered with dispensing doctors, but includes prescriptions at those NHS hospitals and clinics without dispensing facilities and those given by dentists.

[c] Mainly local health authorities and family planning associations.

TABLE 13a

General dental practitioners: indicators of workload—Great Britain 1970-1975

Type of treatment[a]	1970	1971	1972	1973	1974	1975	*Change* 1970-1975
	millions						per cent
Courses of treatment and cases of emergency treatment	22·7	24·0	25·5	26·9	28·1	29·4	+29·5
Diagnosis (X-ray, examination and report)	23·6	24·9	26·1	27·5	28·8	30·2	+28·0
Conservation (filling, crowning, scaling, etc)	20·8	22·0	23·1	23·4	24·6	25·8	+24·0
Extractions	3·8	4·0	4·2	4·2	4·2	4·1	+ 7·9
General anaesthetics	1·4	1·4	1·4	1·3	1·3	1·2	−14.3
Dentures							
Supply	1·8	2·0	1·7	1·8	1·8	1·9	+ 5·6
Repairs and additions	1·5	1·5	1·5	1·4	1·3	1·3	−13·3
	units						
Average per dentist[b]							
Courses of treatment	1,986	2,067	2,142	2,222	2,266	2,332	+17·4
Conservation treatments	1,821	1,895	1,940	1,931	1,985	2,043	+12·2
Extractions	333	348	349	349	336	323	− 3·0
Supply and repair of dentures	290	300	267	258	250	248	−14·5

Source: Department of Health and Social Security

[a]All items refer to courses of treatment the content of which may vary.

[b]Excluding assistants.

TABLE 13b

General dental practitioners: fees at constant prices and percentage changes in "output"

Year ending 31 *March*	*Estimated average gross earnings from fees at constant prices*	
	Index (1970=100)	*Percentage change over previous year (change in "output")*
		per cent
1970	100·0	
1971	100·6	+0·6
1972	103·4	+2·7
1973	99·5	−3·8
1974	100·2	+0·8
1975	102·3	+2·1
1976	105·1	+2·8

Source: Dental Rates Study Group

TABLE 14

Age distribution of the total population of the United Kingdom and related workload indicators for general medical practitioners: 1970-2001[a]

	1970	1975	1981	1991	2001
Population (thousands)	55,522	56,042	56,252	58,214	59,853
Index: Population 1970=100					
14 years and under	24·1	23·6	21·3	23·0	24·3
15-64 years	62·9	63·3	65·1	66·7	68·9
65-74 years	8·4	9·1	9·2	8·9	8·2
75 years and over	4·6	5·0	5·7	6·3	6·4
All ages	100	100·9	101·3	104·8	107·8
Males	48·6	49·2	49·4	51·4	53·0
Females	51·4	51·8	51·9	53·5	54·8
Index of population weighted by capitation fees at April 1975 rates [b] (1970=100)	100	101·3	102·1	105·7	108·4
Index of population weighted by consultation rates per age group[c] (1970=100)	100	101·2	102·3	106·4	108·5

Source: Office of Population Censuses and Surveys
and Office of Manpower Economics

[a]The 1970 population figures are based on the 1971 Census but from 1975 onwards all figures are projections based on mid 1974 projection from the 1971 Census.

[b]April 1975 capitation fees were for persons under 65 : £2·20 a year
65–74: £2·90 a year
75 and over: £3·55 a year.

[c]Based on consultation rates from the General Household Survey 1973 (see Table 12a).

APPENDIX D

DETAILED RECOMMENDATIONS ON AMOUNTS OF REMUNERATION

The 1976 cash supplement will continue to be paid during the current year.

Operative date

1. The new levels of remuneration set out below should operate from 1 April 1977.

Hospital medical and dental staff

2. All full-time hospital doctors and dentists other than those in the training grades (senior registrar, registrar, senior house officer, and house officer) should be paid a cash supplement of £208 a year. Full-time hospital doctors and dentists in the training grades should be paid a cash supplement of £105 a year. The supplement for part-time staff should be pro-rata. Where a supplement is payable from other sources of employment in the National Health Service, the amount of the supplements from all sources should be restricted so that the total does not exceed the amount of the supplement payable to full-time staff. For hospital doctors and dentists in the training grades, the assessment of units of medical time to be contracted for should include any additional Class A or Class B units required to provide for the cover of annual and study leave of other doctors and dentists. The salary scales and the rates of Class A and Class B salary supplements should remain unchanged.

3. The number of distinction awards should be increased as follows:

A plus	...	from 130 to 134
A ...	...	from 487 to 500
B ...	...	from 1,390 to 1,431
C ...	...	from 3,135 to 3,277.

The annual values of distinction awards should remain unchanged.

4. Locum appointments in the hospital service of doctors and dentists who are not otherwise employed in the National Health Service should be paid a cash supplement according to the basis of their contract as follows:

£4 a week; or

36p a notional half-day; or

40p a unit of medical time.

The weekly and sessional rates (per notional half-day or unit of medical time) should remain unchanged.

5. General practitioners who work in general practitioner hospital units or who are employed as part-time medical officers or part-time general dental practitioners or who do occasional work in the blood transfusion service under terms and conditions of service detailed in paragraphs 89, 94, 107 and 108 should be paid a cash supplement as follows:

a. Payment to staff funds for general practitioner hospital units	£2·70 per bed
b. Payments to part-time medical officers at convalescent homes etc. and for part-time general dental practitioner appointments	£18·93 a year for each weekly half-day; £4·97 a year for one hour or less per week; £9·94 a year for over one hour but not more than two hours per week.

The payments per bed, the weekly "half-day" payments and the hourly payments should remain unchanged.

6. Hospital practitioners should be paid a cash supplement of £18·93 a year for each weekly notional half-day. The salary scale should remain unchanged.

Ophthalmic medical practitioners

7. All ophthalmic medical practitioners should be paid a cash supplement of 4·2p per sight test, subject to a maximum of £208 a year. Where a supplement is payable from other sources of employment in the National Health Service, the total amount of the supplements from all sources should be restricted so as not to exceed £208 a year. The net remuneration element in the ophthalmic medical practitioner's fee should remain unchanged.

General medical practitioners

8. All principals who provide unrestricted general medical services and who are in receipt of a full basic practice allowance, should be paid a cash supplement of 5 per cent of earnings, subject to a minimum of £130 a year and a maximum of £208 a year. Principals who are in receipt of a partial basic practice allowance should be paid a supplement pro-rata to the amount of basic practice allowance payable, except those who are also in receipt of Type A or Type B initial practice allowances or inducement payments, who should be paid the full supplement. Where a supplement is payable from other sources of employment in the National Health Service, the total amount of the supplements from all sources should be restricted so as not to exceed £208 a year.

9. The full rate of basic practice allowance should be increased from £2,575 to £2,595 a year; the proportional rate and the leave payment should be increased pro-rata.

10. The allowance for the employment of a full-time assistant should be increased as follows:

Ordinary level	from £1,075 to £1,115 a year
Where the principal receives the designated area allowance	from £1,500 to £1,555 a year.

11. Standard capitation fees should be increased as follows:

Patients under 65	...	... from £2·35 to £2·45 a year
Patients aged 65 to 74	...	from £3·25 to £3·30 a year.

The fee for patients aged 75 and over should remain unchanged at £4·00.

12. The maximum payment for trainee's salary and board and lodging under the trainee practitioners' scheme should be increased by the full supplement of 5 per cent of earnings, subject to a minimum of £130 a year and a maximum of £208 a year.

13. The maximum weekly rate of locum allowance should be increased from £80 to £90.

14. Rural practices funds should be increased by 3 per cent.

15. All other fees and allowances payable to general medical practitioners should remain unchanged.

General dental practitioners

16. All principals working in the general dental services whose net income from fees and allowances for general dental services work is £4,500 or more a year should be paid a cash supplement of £208 a year. Those principals whose net income from general dental services work is less than £4,500 a year should be paid a supplement pro-rata to the amount of their net income. Where a supplement is payable from other sources of employment in the National Health Service, the total amount of the supplements from all sources should be restricted so as not to exceed £208 a year.

17. The Dental Rates Study Group should recast the scale of fees so as to provide for the increase in expenses likely to be incurred in the year beginning 1 April 1977 over the provision made in the previous year.

18. All full-time salaried health centre dental practitioners should be paid a cash supplement of £208 a year. The supplement for part-time staff should be pro-rata. Where a supplement is payable from other sources of employment in the National Health Service, the total amount of the supplements from all sources should be restricted so as not to exceed £208 a year. The salary scales should remain unchanged.

Community doctors and dentists

19. All full-time community doctors and dentists should be paid a cash supplement of £208 a year. The supplement for part-time staff should be pro-rata. Where a supplement is payable from other sources of employment in the National Health Service, the total amount of the supplements from all sources should be restricted so as not to exceed £208 a year. The salary scales for community medical and community dental staff should remain unchanged.

Printed in England for Her Majesty's Stationery Office by Oyez Press Limited
Dd294742 K88 5/77

BRITISH MEDICAL ASSOCIATION
TAVISTOCK SQUARE LONDON WCIH 9JP

Telephone: 01-387 4499
Telegrams: MEDISECRA LONDON WCIH 9JP

Secretary: E. Grey-Turner
MC TD MA MRCS LRCP

Your Reference

Our Reference GHP/VH

13 June 1977

TO: MEMBERS OF THE NORTH-WEST THAMES REGIONAL COMMITTEE FOR HOSPITAL MEDICAL SERVICES

It has been decided to call a special meeting of the CCHMS to consider the report of the Review Body. Since it is not practical, owing to shortage of time, to call a meeting of the Regional Committee, it has been decided that members should let me have their views on the Review Body report by MONDAY 27 JUNE 1977 at the very latest, so that I can inform the CCHMS of the Regional Committee's opinions.

I particularly draw your attention to an article on the Review Body report by Mr A H Grabham, Chairman of the CCHMS, which will appear in the 18 June issue of the British Medical Journal. I think it would be useful if you could let me have your comments after you have had an opportunity to read this article. If you have not received a copy of the Review Body report, these can be obtained from the above address.

W F MILLNER
Honorary Secretary

BRITISH MEDICAL ASSOCIATION
TAVISTOCK SQUARE LONDON WCIH 9JP

Telephone: 01-387 4499
Telegrams: MEDISECRA LONDON WCIH 9JP

Secretary: E. Grey-Turner
MC TD MA MRCS LRCP

From: R. V. Woods
Assistant Secretary

Your Reference
Our Reference RW/KM

April 1977

Dear Member

I have pleasure in sending you a copy of the recently published report of the Review Body. As in previous years, in the interests of economy, we are not circulating copies of the profession's evidence but copies are available from the Secretary of the Association on request.

It is obviously not possible at this early stage to comment, but the Report will be considered in detail by or on behalf of the CCHMS.

Yours sincerely

Assistant Secretary

To: Members of Regional Committees for Hospital Medical Services in England and Wales.

Members of Area Committees for Hospital Medical Services in Scotland.

Members of the CCHMS.

Members of the Medical Assistants Subcommittee.

Members of the SHMOs Group Committee.

Telegrams: MEDSERCA LONDON WC1N 1EB

From: R. V. Woods
Hanson Surgery

Your Reference
Our Reference RW/KM

April 1977

Dear Member

I have pleasure in sending you a copy of the recently publi
report of the Review Body. As in previous years, in the i
of economy, we are not circulating copies of the professio
evidence but copies are available from the Secretary of th
Association on request.

It is obviously not possible at this early stage to comment
the Report will be considered in detail by or on behalf of

Yours sincer

Assistant S

To: Members of Regional Committees for Hospital Medical Se
in England and Wales.

Members of Area Committees for Hospital Medical Servic

Members of the CCHMS.

Members of the Medical Assistants Subcommittee.

Members of the SHMOs Group Committee.

HER MAJESTY'S STATIONERY OFFICE

Government Bookshops

49 High Holborn, London WC1V 6HB
13a Castle Street, Edinburgh EH2 3AR
41 The Hayes, Cardiff CF1 1JW
Brazennose Street, Manchester M60 8AS
Southey House, Wine Street, Bristol BS1 2BQ
258 Broad Street, Birmingham B1 2HE
80 Chichester Street, Belfast BT1 4JY

Government publications are also available through booksellers

ISBN 0 10 168000 7