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CABINET

MINISTERIAL COMMITTEE ON ECONOMIC STRATEGY

1979 REPORT OF THE REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

Note by the Secretary of State for Social Services

The latest Report of the Review Body on Doctors' and Dentists' Remuneration (DDRB) has been in the hands of the Governments since 12 April. Our predecessors (rightly in my view) took no action upon it, but it has now become urgent that we reach conclusions on its proposals and publish them with the Report.

2. As colleagues will know, morale in the National Health Service is at a very low ebb for a variety of reasons. This is particularly true of doctors, who on top of the frustrations caused by some aspects of the 1974 reorganisation, and the apparently rising tide of industrial disruption in the NHS, have felt very aggrieved that their pay has fallen far behind that of comparable professional men. If we are to set about restoring morale in the NHS, it is of the highest importance that we start off on the right foot by responding appropriately to the recommendations in this latest DDRB Report. Colleagues will remember that last year the DDRB recommended a phased implementation of pay increases for doctors and dentists, to bring them back to fully up-to-date levels of remuneration not later than 1 April 1980, and to move at least mid-way towards these levels not later than its 1979 Review. In Opposition, we gave a clear undertaking to honour the phased implementation of this pay award, and this was very well received by the profession at the time.

3. There are two main elements in this latest Report:

i. Updating of Pay Rates

The Report sets out rates of pay which bring doctors and dentists half way towards the fully up-to-date rates as assessed for 1 April 1978, updated to 1 April 1979. The Review Body estimate the cost at about £199 million or 25.7 per cent of net remuneration of all doctors and dentists in 1978/79.

ii. New Contracts

Our predecessors negotiated new contracts with two hospital career grades (consultants and medical assistants) and for GPs in certain hospital jobs. These new contracts relate pay more closely to the individual doctor's and dentist's workload and responsibilities (Appendix 1 gives some of the details, and sets out some of the main considerations which weighed with the Departments and the professions). Our predecessors were very reluctant to accept the new consultant contract because it clearly offered facilities for the wider development of private practice; nevertheless they were prepared to accept it and I would regard it as unthinkable that we should now try to go back on an agreement which they reached. The profession accepted the new contract, subject to pricing, and it was left to the DDRB to recommend rates of pay. The cost this year of the new consultant and medical assistant contracts is unlikely to exceed £5-£6 million since it will be the end of 1979 and probably later before any doctors start to be paid on them. The Review Body estimate that the cost in a first full working year could amount to £23.2 million. The new arrangements for general practitioners might cost a further £400,000. A summary of the recommended new rates of pay is at Appendix 2.

4. The Cabinet agreed on 17 May (CC(79) 2nd Meeting Conclusions) that NHS cash limits should be adjusted on the basis decided by the previous Government and provision will be made accordingly to cover the full cost of the DDRB recommendations.

5. Because we gave a firm commitment on the phased uprating of pay levels under existing contracts, and because we could not contemplate resiling from the new consultant contract, I do not believe we have any practical alternative but to accept the DDRB's recommendations. Indeed, I believe that it will stand the Government in very good stead in the future if we make it clear to the profession from the outset that we are on their side, that we recognise in full the sense of grievance which they have felt over recent years, and that we are prepared to make amends as swiftly and as effectively as we can. There is no doubt that doctors set the tone within the Health Service in general, and in hospitals in particular. A happy and contented medical profession is the key that will unlock many of the problems which we have inherited from our predecessors such as lengthening waiting lists, etc. Added to this is the point that we have consistently supported the Review Body system, because it provides continuing assessment by independent and experienced people. Unlike some other pay reviews in the public sector, there is no question of doctors and dentists trying to get back to some inflated "norm" set by a one-off, ad hoc enquiry. It was a Conservative Government which in 1961 set up the DDRB and our predecessors (in 1970) gave an assurance that its recommendations would be accepted, unless there were "clear and compelling" reasons to the contrary.

6. There is one tiresome dispute which we inherit, namely the proposal by the junior hospital doctors that they should negotiate directly with the Health Departments and take themselves out of the Review Body system. I have made it clear to them before the Election, that we do not favour this course, but have said that it is our intention to restore the profession's confidence in the Review Body system. Unless we accept this Report in its entirety, however, we face the prospect of a lengthy, embarrassing and possibly disruptive argument not only with the hospital juniors but also with the consultants. This would do the Government no good at all.

7. I therefore invite colleagues to agree to acceptance and implementation of the DDRB's recommendations in full, with a corresponding adjustment of cash limits. The Secretaries of State for Scotland and for Wales support the views in this paper.

8. If my colleagues do accept the recommendations, the Whitsun recess causes a problem in timing the announcement and publication of the Report. As I have mentioned, the Report was submitted on 12 April and it is self-evidently desirable not to leave the announcement any longer than we have to after six weeks of uncertainty have already passed. I hope my colleagues will agree with me that we should get the announcement - the usual method is a Written Answer - out of the way before the recess.

PJ

18 May 1979

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THE NEW CONTRACTS APPENDIX 1

NEW CONSULTANT CONTRACT

1. The present consultant contract provides a salary for a whole-time consultant which assumes eleven working half-days ('notional half days': NHDs). The salary is an inclusive figure covering virtually all his commitments outside 'normal' working hours such as emergency recalls to hospital and availability on-call. The whole-time consultant gives up the right to do private practice. The consultant who prefers to retain that right - the "maximum part-timer" - is paid at only 9/11 of the whole-timer's salary rate, but is expected to do substantially the same amount of NHS work (though his employing authority will try to arrange his commitments to work for them in such a way as to leave him reasonable opportunities for private practice). In other words, some maximum part-timers are expected to work a full 11 sessions, but many are in fact contracted only for 9 or 10 sessions; and survey data show that maximum part-timers have considerably lower workloads on average than whole-timers.

2. The new contract. The main points of difference from the present contract are:

(a) Provision for extra paid sessions (NHDs) over a standard commitment of 10 where workload justifies this;

(b) inclusion in the standard 10 NHDs of one for "continuing clinical responsibility" - the consultant's basic commitment to be on-call for patients in his care - and one for the consultant's regular administrative and management duties;

(c) in place of the present whole-time salary and the maximum part-time salary (9/11 of whole-time) for those retaining the right to private practice, differential maximum allowable sessional commitments of 15 NHDs for those without and 13 NHDs for those with private practice;

(d) separate fees in recognition of "acute on-call" commitment and certain particularly onerous committee chairmanships; and

(e) changes in the system under which consultants are eligible for 'distinction awards'. The changes should improve regional distribution, give explicit recognition to meritorious NHS service and modify the existing confidentiality of the scheme.

3. The professions sought the new contracts in order:=

(a) To remedy increasing dissatisfaction with a standard salary as a reward for widely differing workloads, by relating pay more closely to the demands on the individual consultant;

(b) as a response to the phasing out of pay beds in the NHS to end the maximum part-time option which was no longer seen as a fair bargain but as imposing a penalty.

4. The Departments agreed to a new contract in order:

(a) To achieve a more contented workforce by seeking to match pay to responsibility;

(b) consistently with the availability of resources, to encourage consultants to increase their commitment to the NHS by taking on extra paid sessions;

(c) to improve the balance of the hospital medical career structure by encouraging consultants to do more work themselves and to require fewer junior staff;

(d) indirectly as a result of (c) to encourage recruitment to shortage specialities to which juniors are not at present drawn; and

(e) to improve the distinction awards system as described above.

5. Final acceptance of the new contract by the profession is subject to satisfactory pricing by the Review Body and it was accepted last year in a ballot of the professions on this understanding. A further ballot is likely before the professions give a final decision.

NEW MEDICAL ASSISTANT (MA) CONTRACT

6. The main features of this correspond (with unimportant variations) to para

(a) - (d) above of the new consultant contract (there are however no automatic NHDs for continuing clinical responsibility (which MAs do not have) or for administration). MAs are not eligible for distinction awards. The adoption of this contract was a natural consequence of the negotiation of the new consultant contract. Again, final acceptance by the professions is subject to satisfactory pricing and a ballot is likely.

GPs IN HOSPITAL

7. The new arrangements for paying GPs in hospital where they carry full clinical responsibility for their patients (ie cottage hospitals and other small hospitals) substitute for the existing payments (a "bed fund" consisting of a fixed payment per occupied bed which is divided between the participating GPs on a basis agreed between them plus ad hoc arrangements for casualty services in some hospitals), separate payments into a "staff fund" as follows:

(a) payment for in-patient work on a modified 'bed fund' basis; and
(b) payment for casualty work also paid into a fund to recognise
    (i) availability; and
    (ii) actual work.

Division of the funds will continue to be for agreement by the GPs concerned. There has been much dissatisfaction by GPs for some time with the existing basis of the bed fund and their object in negotiation was to clarify it in order (again) to match payments more precisely to responsibilities. The Health Departments were in sympathy with this aim (the basis of the bed fund has remained unchanged since 1948 and no longer reflects current realities).

SUMMARY OF RECOMMENDATIONS

APPENDIX 2

	Point on scale	Recommended basic scales 1 April 1979 £	Expected average earnings from fees and allowances £
Hospital doctors and dentists - main grades (whole-time salaries)			
House officers	minimum	4,164	
	maximum	4,710	1,860
Senior house officers	minimum	5,175	
	maximum	5,829	2,020
Registrars	minimum	5,929	
	maximum	7,086	2,320
Senior registrars	minimum	6,720	
	maximum	8,550	2,540
Medical assistants (present contract)	minimum	7,233	
	maximum	11,859	*
Medical assistants (new contract)			
10 notional half days (NHDs)	minimum	6,720	
	maximum	9,600	
13 NHDs	minimum	8,736	
	maximum	12,480	1,730
15 NHDs	minimum	10,080	
	maximum	14,400	
Consultants (present contract revised)			
	minimum	11,211	1,650 (£2,520 including distinction awards)
	maximum	14,259	
Consultants (new contract)			
10 NHDs	minimum	8,880	
	maximum	10,920	
13 NHDs	minimum	11,544	2,050 (£2,920 including distinction awards)
	maximum	14,196	
15 NHDs	minimum	13,320	
	maximum	16,380	

General medical practitioners
General dental practitioners
overleaf

*Average earnings from extra duty allowances are about £950 a year but for those concerned (about a third of all whole-time assistants during the period of our survey) the average is about £2,850 a year.

General medical practitioners

Intended average net remuneration	12,327	
Fees from contraceptive services		540
Fees from hospital work and other official sources (excluding improved payments for casualty work in hospitals)		380

General dental practitioners

Target average net remuneration	11,128