WHY THE POOL ?

SOME REFLECTIONS UPON THE REMUNERATION OF FAMILY DOCTORS

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"The doctor has great power and no one can tell if he is abusing that power. We have to trust him. And therefore, he must be a man of substance and character and be paid accordingly by the community."

Adam Smith in *Wealth of Nations*.

Though there have been short periods of comparative relief, family doctors have been concerned by the inadequacy of their incomes for many years, and since the inception of the National Health Service they have had cause to lament the failure of government to heed the words of wisdom quoted above. Recently, on the recommendation of the Royal Commission on Doctors' and Dentists' Remuneration (1957-60), the Government has set up a standing Review Body to advise the Prime Minister on the remuneration of doctors and dentists taking any part in the National Health Service. The Review Body is expected to make its first recommendations by the end of the year and during the coming months the profession will be making its views known to it. The time is therefore opportune for all doctors to reflect upon the issues which must be raised and to make their views known to those who will represent them. I shall restrict my observations to the remuneration of general practitioners.

Since July, 1948, all family doctors, with the exception of a small number in private practice outside the National Health Service, have had their remuneration calculated by the "pool-capitation system." This system was instituted by the Government with the agreement of the profession largely as a result of experience under the old N.H.I. service, which was restricted to the poorer section of the working population, from the Spens report, and from the attitude of the Government to the way in which the Spens recommendations should be implemented. The issue of its propriety and the degree of justice it affords to general practitioners, collectively or individually, has never, so far as I know, been examined with an open mind by any independent arbitrator.

The Spens Committee defined what the range of general-practitioner incomes had been in the years immediately before the second world war, expressed an opinion upon what general practitioners should have been receiving at that time, and indicated the principles which should guide others in their assessment during later years, in changed circumstances, of the proper income for family doctors. Spens (paragraph 13) stated specifically, "We are in no way concerned to express an opinion on the question whether a general practitioner's remuneration should be paid in whole or part either by means of capitation fees or by a method of payment which takes capitation into account. The evidence put before us showed that capitation affords a method of differentiation which is acceptable to the majority of the profession." Mr. Justice Danckwerts was merely asked to determine the size of the Central Pool and did so. The Pilkington Commission, while remarking that the system was unique in the field of payment by the State for personal services, merely listed

some of its advantages and added the comment that because the profession was accustomed to it and on the whole liked it they would recommend its continuance.

The B.M.A. has never disputed with the Government the desirability of the pool-capitation system, and indeed could never with justice have done so; for not only has there never been any expression of general dissatisfaction from its members but such surveys of opinion that have been made, notably the Brotherston, Cartwright, and Martin survey (*Brit. med. J.*, 1959, 2, Suppl., 119-124), and the evidence collected from Divisions by the Committee which drafted the Association's reply to the questionnaire submitted by the Medical Services Review Committee in 1960, have revealed discontent on the part of only a minority. However, at both the Conference of Local Medical Committees and the Annual Representative Meeting in 1961 resolutions were passed which questioned the propriety of the existing pool arrangements and also the adequacy of remuneration in relation to the volume of work done by general practitioners. There have also during the past year been many protestations that the increased work on behalf of local authorities brings no increase in the practitioners' net average remuneration.

Impact of Pool-capitation

I propose, therefore, to examine in some detail the impact of the pool-capitation system upon the fortunes of family doctors. To do this effectively it is necessary to make some brief reference to history.

Following the publication of the Spens report in 1946 it was estimated by Professor (now Sir Austin) Bradford Hill that the average pre-war net income of general practitioners was £938 per annum, and that the pre-war doctor had been underpaid, in relation to other professional men and women, to the extent of £173 a year. This estimate was accepted by the Government and the profession. It formed the basis for the calculation of a pool of money from which general practitioners might be paid in such a way as to leave them a net average income of £1,111 plus the 20% betterment which the Government regarded as appropriate in order to reflect the change in the value of money and in other comparable incomes. To the figure $£1,111 \times 6/5 \times 17,900$ (the number of principals in the Service at the time) was added the sum of £17,590,000, representing the aggregate of general practitioners' expenses in 1939 plus 55% betterment and a further £1,240,000 on account of the rise in population since 1939. Thus early in the days of the N.H.S. it was recognized that increased work (represented here by the figure for population increase) should logically be rewarded by increased remuneration. The total sum, which on the first Government estimate was £42,700,000, became known as the Global Pool. It was intended to represent the total gross earnings of general practitioners engaged in the N.H.S. in any given year. Before a capitation fee could be calculated certain deductions had to be made from this Global Pool to provide for the income which general practitioners were receiving under two main headings:

(a) *From Outside the N.H.S.*—This included payment from local authorities, from Government departments, and from private practice.

(b) *From Within the N.H.S.*—This included payment for Part II services in hospitals, the Exchequer superannuation contributions, payments for maternity medical services, payments for sight-testing by G.P.s, mileage payments, initial

practice allowances, supplementary annual payments, emergency fees, fees for temporary residents, anaesthetic fees, money for the inducement fund, payments for the provision of drugs, training grants, and a grant towards the group practice loans fund.

Most of these items were deducted from the outset; others, such as the group practice loans fund, as the various schemes evolved during the early years. Because some of the figures could not be precisely estimated in advance, a sum of money was always left in the Pool to be distributed as a final settlement for the year in question. It was all done in such a way that the Government commitment would never exceed and indeed would always fall well short of the sum represented by the Global Pool. The result in terms of capitation fee per patient, after taking the final settlement into account, was an average of 16s. 7d. There were minor variations in this figure from area to area for reasons which do not presently concern us.

A Central Pool

As an administrative procedure it became desirable to think in terms of a basic Central Pool representing that part of the Global Pool from which the principal Executive-Council payments would be made to general practitioners.

From the outset the profession disagreed with the Government on the betterment factor to be applied to the Spens-Bradford-Hill £1,111 in order to take into account changes in the value of money and incomes in other professions. The issue could not be resolved by negotiation, and the dispute was referred to Mr. Justice Danckwerts for adjudication. He gave judgment in March, 1952, to the effect that for the year 1950-1 a betterment factor of 100% should be applied and that for 1948 it should be 85%. The Government and the profession accepted this arbitration award and agreed that the figure of 85% should apply to years before 1950-1.

At this time the Government was also in disagreement with the profession on the basis of calculating the Pool in the future. The Government argued that, though at the outset it had been necessary to have regard to the number of doctors in the Service, for years subsequent to 1948 the only factors which merited consideration were the betterment factor and changes in the population using the Service. The profession insisted that the Pool should be based upon both the number of doctors in the Service and the betterment factor, and not upon the numbers using the Service. If the object was to maintain at all times a predetermined average net remuneration for doctors providing general medical services under the N.H.S. Act, the profession was correct; and Mr. Justice Danckwerts so found. Moreover, there can be no doubt that, so long as the doctor-population ratio either remained constant or was increasing, the new method of calculating the Pool gave the greatest chance of justice to the individual doctor within the limitations inherent in the pool-capitation system. It is equally true that if the doctor-population ratio should fall then doctors would find themselves doing more work for the same pay. In this connexion Mr. Justice Danckwerts made only this comment: "There is no evidence before me that an unnecessarily large number of doctors are likely to enter the Service within the next few years, but if the number of doctors in the Service became unreasonably large this point

would require reconsideration." Let us look at what has happened.

Variations in the Total United Kingdom Population, 1952-9

Year	Population	Year	Population
1952	50,444,000	1957	51,456,000
1955	50,968,000	1958	51,680,000
1956	51,208,000	1959	51,985,000

(Source: Registrars-General mid-year estimates—*Annual Abstract of Statistics*, 1960.)

Projected Total United Kingdom Population, 1959-79

Year	Population	Year	Population
1959	52,157,000	1974	55,385,000
1964	53,236,000	1979	56,393,000
1969	54,324,000		

(Source: Government Actuary's Department and Registrars-General—*Annual Abstract of Statistics*, 1960.)

The population, then, increased by 1.08% between 1952 and 1955, by 1.39% from 1955 to 1958, and by a further 0.59% from 1958 to 1959. Using the projected figures, which Lafitte and Squire (*Lancet*, 1960, 2, 538) considered to be conservative, we can expect a further rise of the order of 2.34% between 1959 and 1964, with a fairly steady rise around 1.9% in each five-year period from 1964 until 1979.

Change in the Number of General Practitioners in the N.H.S.

Year	No. of G.P.s in N.H.S.	Annual Increase	Year	No. of G.P.s in N.H.S.	Annual Increase
1949-50	18,969	—	1955-56	21,445	312
1950-51	19,227	258	1956-57	21,784	339
1951-52	19,444	217	1957-58	22,051	267
1952-53	19,735	291	1958-59	22,246	195
1953-54	20,650	915	1959-60	22,391	145
1954-55	21,133	483			

(Source: B.M.A. Records from Ministry of Health.)

There was thus an increase of 5.13% in the number of G.P.s in the N.H.S. from 1952 to 1955—an average increase of 1.71% per annum, an average increase of 1.24% per annum from 1955-6 to 1958-9, and an increase of 0.65% for the period 1958-9 to 1959-60.

Unfavourable Factors

During the first few years after the Danckwerts award the number of G.P.s in the Service was rising at a much greater rate than the population of the country. However, by 1959-60 the rise was almost identical in rate, though still slightly in favour of the general practitioner, at 0.65% as against 0.59%. The G.P. doctor-population ratio remained slightly higher for 1959-60 than it was at 1952-3—0.000429 as against 0.000391. But the population is continuing to rise steadily at around 1,000,000 every five years—a much faster rate than during the early 1950's—and it is estimated it will continue to do so for the next 20 years. The rate of increase in the number of G.P.s in the Service is in contrast falling sharply, and if the present trend continues we may soon reach a stage when two things will have happened: the G.P. doctor-population ratio will have fallen below what it was in 1952-3 and the percentage annual rise in population will be greater than the percentage annual rise in the number of doctors in the Service. The second of these two eventualities may already be upon us, for the Ministry of Health has estimated that the average number of patients per doctor in the N.H.S. has risen slightly during the last year. The Danckwerts formula is no longer operating in favour of the general practitioner.

Two other factors come into this picture, neither of them favourable to the profession. The number of graduates from medical schools is falling every year and the number of British graduates is falling at an even

greater rate. Thus the number of British doctors likely to be available to enter general practice during the next five or even ten years is much smaller than the number who were available during the period up to 1959. The following figures taken from the Platt report illustrate my point.

Year	Graduates from Great Britain		Graduates from Overseas
	Men	Women	
1960	1,428	412	152
1961	1,275	411	158
1962	1,264	427	150
1963	1,281	438	193
1964	1,330	400	185

There were 1,939 graduates from medical schools in 1959. I am not aware of the number from overseas.

Emigration of doctors from this country seems to be increasing. It is difficult to obtain precise figures, but John Seale (*Brit. med. J.*, 1962, 1, 782), after an exhaustive inquiry, concluded that over 600 doctors from this country are registering annually in other lands. This represents almost one-third of the number graduating from our medical schools each year and makes even more unfavourable the prospects of any substantial increase in the number of family doctors in this country, particularly at a time when the number of retirements from the Service due to age is increasing annually.

The Danckwerts adjudication has undoubtedly sheltered the profession from some of the most severe effects of a Government decision to *provide* medical services for the nation rather than content itself, as many, including myself, think it should have done, with *organizing* a scheme whereby people are enabled to meet the cost of medical care.

Without doubt the major factor in the gradual fall in the rate at which new doctors are entering general practice is the fall in the number of British graduates from our medical schools. Here the major responsibility rests upon the Government, though it must be said that it was misled, as Lafitte and Squire have shown, by the Willink Report of 1957.

Before turning to other detailed aspects of medical remuneration I should like to make some general observations. Although private practice is still open to most doctors, the State is largely a monopoly employer. It influences the demand for medical services; fixes the charges to be imposed for advice, drugs, and treatment available to patients; and controls the number and size of the medical schools. It controls to considerable degree the behaviour of doctors by the terms of service it imposes and determines their remuneration. As Professor John Jewkes put it in his Memorandum of Dissent in the Report of the Royal Commission, "The responsible Government Departments are therefore in the extraordinary, and perhaps unique, position that they largely control the demand for, the supply of, and the price offered for the services of the medical and dental professions. It is a position both powerful and delicate: powerful because all the important levers lie in their hands; delicate in the sense that unless they maintain the proper co-ordination between the three variables, maladjustments will occur as indeed they have occurred on more than one occasion since 1948." Our profession, if it is to prosper under a monopoly employer, must resolutely determine to achieve a fair price for its services. I do not believe that any system of remuneration of professional men and women of varying capacity, working in communities whose environment, morbidity rates, and attitude to medical attention varies considerably, can ever be just unless it

provides a fair average return for each individual item of service rendered.

Let us now examine the pool-capitation system against that background and do so by considering its two components in turn, for it may turn out to be possible that one component should be retained without the other.

The Pool

The Pool is thought by its advocates to have the following advantages:

(1) It guarantees that the doctor receives a predetermined average income.

(2) In so doing it enables the Government to budget accurately for the major part of its commitment to the N.H.S. family doctor.

(3) As the Royal Commission said, so long as the Pool is calculated on the number of doctors in the Service rather than on the number of patients in it, and is allied to the capitation system, the Government is fully protected against inaccuracy in wrongly computing the number of patients for whom a doctor is responsible.

(4) The Royal Commission also said that the Pool forms a convenient basis on which to calculate changes in remuneration from time to time. It is, in fact, neither more nor less convenient in this respect than several other alternatives. It has the defect that whenever an upward revision is made there is a considerable time-lag before implementation, while further discussions, which can, as recent events bear witness, be prolonged, take place on the distribution of the new money.

The Pool system, with a pool calculated on the basis of the number of doctors in the Service, has much in common with what, in trade union circles, is known as the guaranteed minimum wage, for it really goes no further than making it probable that a doctor with any particular number of patients will receive a certain minimum income. Like any such system it can be of value only if conditions are such that any reasonable alternative system of payment exposes the supplier of service to the risk of realizing a lower income.

It is manifest to me—and I will illustrate the point later—that the system has provided considerably lower incomes to family doctors ever since the Service began than any honest, competent, diligent doctor would have received had he been paid on the basis of a fair fee (calculated on fees customary in 1939 plus betterment to allow for the change in the value of money) for each item of service given.

There is a further grave defect in a pool system based on the concept of a guaranteed average income from all calculable sources. Though earnings from private practice were discarded from account by the Royal Commission (because of the difficulty of making an accurate calculation of their amount), all earnings from official sources—central and local government—are deducted from the Global Pool from which capitation payments for the treatment of N.H.S. patients come. The Government by this device is in effect able to obtain, almost entirely free, a wide variety of medical service over and above its commitment to the community in respect of the N.H.S., for under the Pool concept with its guaranteed average income the Government would be compelled to provide precisely the same aggregate sum of money, even if none of this other work were performed by N.H.S. doctors. Work currently performed by family doctors for local

authorities, hospitals, and Government departments accounts for £4-4½m. annually. Any doctor who does such work thereby increases his personal share of the global sum available but does so at the expense of the capitation payment he and his colleagues receive for their N.H.S. patients. Paul is paid for this other work by robbery from his, Peter's, and everybody else's capitation fees. This truly Gilbertian situation has survived two adjudications upon professional income. I do not think it would have survived had the profession not requested that it should. I believe that the mass of the profession has simply never understood it.

Surely the only fair way to calculate payment for work done in family doctoring involves separating it entirely from the payment for work which is performed in addition, and basing N.H.S. payments upon the volume of family-doctor care provided and the skill and responsibility which it involves. There is no evidence whatsoever that the work done for local authorities, etc., reduces the service N.H.S. family doctors give to their patients, and in the absence of such evidence there is no justification for these deductions made from the Pool. This serious defect in the present system derives entirely from the concept of a guaranteed average income, which in fact is a maximum possible average income. If family doctors should in future work more in hospitals, as is being suggested, the money they would earn for this would, under present arrangements, be deducted also from the Pool, thus increasing the magnitude of the injustice.

Capitation

The capitation system has been said to have the following attributes: (1) It is relatively easy to administer. (2) It reduces clerical work by the doctor to a minimum. (3) Income is not subject to seasonal variations. (4) It is fair in the sense that the reward corresponds roughly to the amount of work undertaken. (5) It is good for the doctor-patient relationship.

Let us examine these alleged advantages. The first is correct and is an advantage to the Government rather than to the doctor. The second is correct and is, in my view, the only solid advantage which can be justly claimed for this system of payment: it is the factor which weighs most heavily with many doctors.

The third point listed has merit to limited degree. It is doubtful whether there is now, taking the country as a whole, the variation in volume of work as between one season and another that there was before the N.H.S., and even if there was such variation the overall size of a doctor's income is more important to him than the dates on which he gets the various amounts due to him. The capitation system must be judged according to whether it can provide fair remuneration for the services the individual doctor gives his patient and to whether it is harmful or beneficial in its impact upon the doctor-patient relationship.

Proportional Reward

Can a capitation system in which the capitation fee is uniform as between one area and another and as between one doctor and another ever be fair in the sense that reward is proportional to the amount of work performed? I do not think it can. The contention that in a rough-and-ready sort of way it does would be true only if (a) distribution of illness was uniform through-

out the country, (b) the age distribution of the population was uniform, (c) the opportunity to achieve any desired size of list was the same everywhere, (d) all doctors gave the same quantity and quality of service to their patients. None of these conditions obtains to-day nor have they ever obtained. The capitation system relies upon size of list as the determining factor in the differentiation of incomes, and size of list is influenced primarily by such factors as geography, population distribution, and the attractiveness or unattractiveness of any particular area. The dangers of such a system were foreseen by the Spens Committee, which, anticipating the intention to use it for the N.H.S., expressed itself on these matters in three specific recommendations (4-6) which I quote below.

(4) The difference which has existed between the incomes of rural and urban practitioners should be reduced, the Highlands and Islands Scheme should be applied to other sparsely populated areas, and the remuneration under that scheme should be increased.

(5) Additional remuneration should be given in areas which prove so unattractive as not to draw an adequate supply of practitioners.

(6) An adjustment in the method of payment in so far as this depends on capitation should be made in the case of practices involving an altogether abnormal number of aged persons and chronic invalids.

Recommendation (4) has been adopted since the beginning of the Service by the creation, as one of the basic charges upon the Pool, of the inducement fund, but no attempt has ever been made to implement recommendations (5) and (6). In regard to (5), in the early days of the Service, before the institution of loadings upon selected bands in the list, the uniformity of the capitation fee, combined with the very large lists customary in the unattractive areas, did ensure that doctors' incomes in them were considerably higher than elsewhere. Recommendation (6) has always been regarded as administratively difficult. I shall show presently that factors other than those hitherto officially recognized must influence our deliberations on these two matters.

The quantitative distribution of illness is not uniform throughout the country, and the very young and the very old customarily require much more medical attention than those of working age. In areas with

Morbidity Statistics, 1960 (Source: Annual Abstracts of Statistics and Annual Report M.P.N.I.)

(1) Region	(2) Population	(3) Sickness Benefit. New Claims	(4) (3) as % of (2)
Great Britain ..	50,963,000	8,319,000	16.3
Northern ..	3,246,000	652,000	20.1
E. and W. Ridings ..	4,170,000	813,000	19.5
N. Western ..	6,543,000	1,285,000	19.6
N. Midland ..	3,595,000	583,000	16.2
Midland ..	4,688,000	727,000	15.5
Eastern ..	3,655,000	429,000	11.7
London and S.E. ..	11,072,000	1,601,000	14.5
Southern ..	2,785,000	323,000	11.6
S.-Western ..	(Ex. Dorset) 3,372,000	409,000	12.1
Wales ..	(Inc. Dorset) 2,629,000	562,000	21.4
Scotland ..	5,208,000	935,000	17.9

N.B.—In sickness benefit tables the following sections of the public are excluded. (a) Men over 65 and women over 60 who are retirement pensioners; all men over 70 and women over 65. (b) Members of the armed Forces. (c) Mariners while at sea. (d) Most non-industrial civil servants (who do not normally claim sickness benefit for illness of less than 6 months' duration). (e) Married women and certain widows who have chosen not to be insured for sickness benefit.

good climatic conditions and high social standards the incidence of illness is much lower than elsewhere. I shall now seek to illustrate the impact these factors have upon the volume of work performed by family doctors in various parts of the country. Fortunately, abundant statistics are available to illustrate the points I wish to make.

In 1938 and 1939, at the request of the British Medical Association, Professor Bradford Hill investigated the volume of work carried out by N.H.I. doctors on N.H.I. patients, and his results were published in 1951 (*J. roy. stat. Soc.*, 1951, 114, 1). Using a random sample of 6,000 doctors, he revealed that at that time the average number of surgery attendances (A's) per patient per year was 3.69 and the average number of domiciliary attendances (V's) per patient per year was 1.12, giving a total average rate of 4.81 attendances per patient per year. These figures relate only to persons of working age, and it is reasonable to assume that the average number of attendances would have been higher if the investigation had been made in respect of the entire population.

In 1949 Dr. Stephen (now Lord) Taylor conducted a comprehensive survey of general medical practice on behalf of the Nuffield Provincial Hospitals Trust, and his findings were published in 1954 in his book *Good General Practice*. In assessing numerically the volume and pattern of general practice Taylor utilized figures provided by the Registrar-General. His investigation showed that there was enormous variation in the work load of general practitioners in different parts of the country. The number of items of service rendered per patient per year varied from 7.8 in Wales to 3.84 in the southern region of Oxford, Bucks, Berks, Hants, and Dorset, with 6.48 in the North-west, 6.24 in the North-east, and around 5 in all other areas. These figures confirmed his impressions of morbidity as seen in the many practices he visited, from which he concluded that the least healthy areas were South Wales, Lancashire, and the Newcastle area. Amongst the practices visited by Taylor there was still wider local variation within the broad regional classifications from 3.5 items per patient per year to 8.7 such items.

A recent survey of two practices comprising four doctors in a large city in 1961 (Richard Scott, *Journal of the College of General Practitioners*, February, 1962) reveals that each patient received an average of 7.2 items of service per year. A similar assessment of my own practice in the North-east of England two years ago showed an average item of service per patient per year figure of 6.3.

There is also wide variation in the surgery attendance/visit ratio as between one practice and another, depending on the geography of the practice, the habits of the patients, and the habits and inclinations of the doctor. Taylor found that the A/V ratio varied from 1.2:1 to 4.6:1, and concluded from his observations "that an efficient and conscientious doctor will probably have an A/V ratio of somewhere between 1.3:1 and 3.0:1. There are a number of doctors who see nothing wrong with A/V ratios of 4, 5 or 6 to 1, and they may be able to give good service. Nevertheless, it is worth suggesting that any doctor who finds his A/V ratio above 3:1 should ask himself candidly whether he may be exerting too great a pressure on his patients to come to the surgery, or under-visiting those who are ill at home."

Variation in the average age of patients in a practice considerably influences the average number of attendances per patient per year. Dr. John Fry (*Brit. med. J.*, 1952, 2, 249) found that the number of surgery attendances varied from 2.5 per patient per year in the 10-19 year age-group to 7.0 for the over-70s and 7.7 for the over-80s. Social survey figures for this country reveal that men over 65 require on average double the attention of men between the working ages of 16 and 65. For women of 65 and over the increase is nearly as great, and they require rather more attention than men during the 16-65 age period. In the Richard Scott survey there was an overall A/V ratio of 2:1 with variation in A/V ratio from 1:1 in the 1-5 age group with 7.5 items per patient per year, through 2:1 in those under 1 year with 15.4 items per annum, to a 1:2 ratio in the over-65 age group with 12.2 items per annum. This confirms earlier findings and emphasizes the extent to which the work of a family doctor is inevitably increasing with the rising number of old people living in our country. The following figures illustrate the trend.

Age Distribution in the United Kingdom, 1954-74

Year	Total Population	No. over 65	Over 65s as % of Total
1954	50,784,000	5,716,000	11.25
1957	51,456,000	5,935,000	11.53
1959	51,985,000	6,044,000	11.63
1964	53,236,000	6,417,000	12.06
1969	54,234,000	7,031,000	12.96
1974	55,385,000	7,707,000	13.92

(Source: Registrars-General, *Annual Abstract of Statistics*, 1960.)

Taylor found that the number of services rendered per doctor per day varied from 24 to 87, with the highest figures in the industrial and the lowest in the rural practices. In general there was, within any particular area, a fairly constant relationship between the number of items of service rendered per day and the size of list, but there were definite variations which could be ascribed only to the quality of service given by the particular doctor, sufficient variation in this respect to invalidate list size as the sole criterion for assessing work done. In general there was, however, greater variation in the A/V ratio than there was in the number of items of service per day when practices of similar size were compared.

All these figures well illustrate the injustice of the capitation system as a means of determining proper differentials in family doctors' incomes regardless of whether the system is combined with the concept of a fixed Pool. Some of the inequalities are smoothed out by the Mileage Fund for rural practitioners, by the payments for maternity medical services on an item-of-service basis, by the sundry miscellaneous disbursements from the Pool, and by the system of loadings which has been in operation since 1952 and which has been extended by the Working Parties of 1960 and 1961-2. But the magnitude of the variation in work-load from practice to practice is such that these factors reduce but cannot correct the degree of injustice arising from the capitation system.

In considering the alleged attributes of the capitation system I am left with the claim that it exerts a beneficial influence upon the doctor-patient relationship. It is true that the removal of financial barriers to medical treatment has in some sections of the community enabled the individual to enjoy a better standard of medical care than he or she could previously afford, but this attribute

is associated with the absence of direct payment by the patient rather than with the method by which the doctor is remunerated, and could apply to any system of remuneration except one which, in addition to being financed by heavy taxation, also required substantial direct payments to be made by the patient for advice or treatment. I believe that in many cases the capitation system has brought about a deterioration in the doctor-patient relationship. Both doctors and patients are subject to human frailties, and in a society in which money is the primary means of exchange it is perhaps natural for a doctor to regard consultation as "troubling" him when the fact of consultation brings increased work for no increased financial reward. I do not recall hearing the phrases "disciplining patients" and "organizing practices" other than rarely prior to the N.H.S., and even then only in connexion with N.H.I. practice: they are now commonplace, and, as Dr. J. G. M. Hamilton pointed out in his address to the Border Counties in November, 1959 (*Brit. med. J.*, 1960, 1, *Suppl.*, p. 23), "imply a less than perfect relationship between a professional man and his patient." It is necessary here to beware of attributing too much of the changed doctor-patient relationship to the capitation system, for undoubtedly some part of the change is due to the transfer in the mind of the patient of something, formerly regarded as kindness and privilege, to the status of a right received in return for taxes paid, and also the tendency of some patients to regard the doctor as either tradesman or superior technologist. But clearly the capitation system is an aggravating factor and is probably more than that.

Adequacy of the Doctor's Remuneration

I suggested earlier on that no system of remuneration for personal professional services to individuals could ever be regarded as just unless it provides a fair average return for each item of service given, and no review of the remuneration of any section of the community is complete without some reference to its adequacy. Before we get down to figures it is necessary to make some general observations.

It is axiomatic that, for society generally to flourish, all professions must receive a reasonable share of the best pupils from our schools, and it is equally true to say that if the practice of medicine is to flourish upon the broad division into consultant practice, family doctoring, and public health practice then each of these three components must receive its fair share of the best graduates from our medical schools. The Spens Committee recognized that in a comprehensive public service embracing specialist as well as family-doctor care "a much increased menace to the recruitment of general practitioners in the future will lie, in our judgment, in the competition of other branches of medicine than general practice. We, and not least our lay members, consider that it would be disastrous to the profession and to the public if general practice were recruited only from the less able young doctors. We consider, however, that unless the financial expectations in general practice are substantially improved the great majority of the abler men will seek to become specialists in view of the fact that as specialists they have an equal outlet for their interests in medicine, can more easily keep close contact with hospitals and with medical progress, and will have a less arduous life. There is a further factor to which we attach considerable importance. The help, support, and comfort which a doctor can give to his patients

must, in our judgment, be seriously affected if a doctor himself is seriously worried."

The fears of the Spens Committee were indeed prophetic. To-day, the career earnings of the average family doctor fall short of the career earnings of the average consultant by at least £30,000, and this calculation takes account only of the earnings of the consultant from N.H.S. sources. The differential is greatly widened if we take into account the consultant's income from private practice, in which his prospects are naturally better than those of the family doctor at any time. The family doctor is positively discouraged by the failure of the Government to make available to private patients the drugs for which they have paid in taxes. The consultant is assisted by the development of provident institutions during recent years. Moreover, in private practice the consultant is not almost totally immersed in a "Pool." He has ample scope to rise by his skill and industry, whereas the family doctor, engaged in a much more hazardous work, is hedged round with professional and financial restrictions. This inequality of opportunity must be corrected and the differential in income between the average family doctor and the average consultant reduced.

Before 1948 medical incomes were determined mainly by market processes. Family doctors obtained about one-third of their incomes from the N.H.I. scheme and the remainder from private fees. If prices rose medical incomes could be maintained in purchasing power by raising fees. There was some post-war rise in fees too as a result of persistent increase in demand. In 1948 these factors were superseded by the N.H.S. A staunch defender of the present system, Professor Titmuss, said in 1957 that "whatever else may be said about the National Health Service, it can at least be concluded that, under the new regime, doctors have prospered." (D. S. Lees, *Health Through Choice*, p. 44—"op. cit.", 164.). Many people still believe that this statement is true, so let us dispose of it at once.

The Danckwerts award restored the average real incomes of family doctors in 1950-1 to their pre-war level—in other words, to a level at which they were found by the Spens Committee to be deficient by around 20%. Their incomes have been eroded by inflation ever since. At 1959 the average earnings of G.P.s was 9% above the Danckwerts level, but by this time prices had increased by one-third over what they were in 1951, thus reducing the real value of the doctors' incomes by a little over 20%. During the same period the general standard of living in the "never-had-it-so-good" era, measured by Gross National Product per head at constant factor cost, rose by 22%. Thus the standard of living of the average family doctor decreased by about one-fifth at a time when that of the community rose by approximately the same amount. The gap, considered by the yardstick of what would have happened without the N.H.S., is thus around 40%. The Royal Commission findings resulted in an improvement of the order of 22.8% over the Danckwerts level, but since 9% is already accounted for in our consideration of the 1959 period the family doctor remains at least 26.2% worse off than he should have been. I do not think this can be said of any other section of the community except the nurses and medical auxiliaries, who suffer with us the financial veto imposed by the State. The picture contrasts sharply with what has occurred during the same period of time in the Commonwealth and in Europe outside the iron curtain. But our colleagues in

these other lands have been spared the pool-capitation system.

Let us now take a look at the same issue from an entirely different angle. I propose to compare the income received by an average family doctor with 2,200 patients on his list for comprehensive family-doctor care (a) under the present system, assuming the report of the Joint Working Party on the reserved £1m. to be implemented, with (b) what it would be on a uniform item-of-service basis in which the fee for each item is based upon fees which were customary for the poorer section of the community in 1939 multiplied by a factor 3 as representing the change in the level of retail prices since that time (which happens to be rather lower than the figure necessary to have strict regard for the change in the value of money).

(a) *Under Pool-capitation System*

Gross earnings.	2,200 × 19s. 10d.	£2,181 15s.
Loadings		£877 10s.
Total		£3,059 5s.

(b) *Under Item of Service*

I have taken for this calculation 3s. 6d. as the surgery consultation fee in 1939 and 5s. as the fee for a visit. I have assumed an item of service per patient per year figure of 5, which is 0.7 lower than what is believed at present by the G.M.S. Committee to be the national average, and I have taken an A/V ratio of 3:1, which again, in the light of the most recent survey of an urban area, is erring on the side of underestimation for my purpose. We are thus calculating on the basis of 3.75 surgery consultations per patient per year at 10s. 6d. per consultation and 1.25 visits per patient per year at 15s. per visit. Be it noted that these fees are low even by local authority standards as fixed by Whitley Committee C, never a very generous arbitrator.

Each patient would therefore receive, on average, service valued at $1.25 \times 15s.$ plus $3.75 \times 10s. 6d.$ —total 18s. 9d. plus 39s. 4½d.; that is, £2 18s. 1½d. Therefore 2,200 patients receive service valued at $2,200 \times £2 18s. 1½d.$; that is, £6,393 15s. If we adopt 2:1 as the proper A/V ratio, as the Richard Scott survey suggests we should, simple arithmetic will reveal the gross income as £6,600.

I have deliberately excluded income from the practice of midwifery from my calculation for two reasons. It is already remunerated on an item-of-service basis at a reasonable rate, and to include midwifery fees would merely increase the gross income under the two methods by approximately the same amount.

Are family doctors grossly underpaid? Are the minority who have consistently advocated item-of-service payment foolish? There was clearly great truth in the words used by Lord Hailsham on May 7, 1962, in addressing the A.G.M. of the Cities of London and Westminster Conservative Association: "... even those who do not benefit by it have got to be taught that some professions, in particular those which demand long periods of training and a high degree of personal devotion and self-sacrifice, have been persistently undervalued in the past and must be better valued in the future."

Summary

I have analysed the pool-capitation system by which family doctors in the N.H.S. are paid and have illustrated its deficiencies as an instrument for relating their remuneration either to the quality or to the quantity of their work.

The Pool concept gives the Government the advantages of accurate budgeting, of complete insulation against any increased charge upon its Exchequer as a

result of any rise in the volume of work which it commissions from the profession, and of absolute protection from administrative failure to calculate the list of a doctor accurately. The same concept prevents a family doctor from being financially rewarded for any service he may render to his patients over and above the bare minimum, and, by taking into account the additional work performed by family doctors for hospitals, local authorities, and Government departments, reduces the fees they would otherwise receive for services to their patients. I have shown that while the calculation of the Pool upon the basis of the number of doctors in the Service was of some advantage to doctors during the immediate post-Danckwerts years, this advantage is dependent on an increase in the family doctor-population ratio and is a rapidly diminishing asset. It is turning into a positive liability as the population of the country increases by 200,000 a year and the output of British graduates from our medical schools falls substantially and an increasing number of them emigrate to other lands.

The only advantage of the capitation system is that it tends to reduce the doctor's clerical work. But it impairs the doctor-patient relationship and fails to distribute either the Pool with which it is linked, or indeed any sum of money which might be available, in proportion to the work-load borne by one doctor as compared with another. I have shown that this work-load must vary considerably because morbidity in some parts of the country is almost twice that of others. There is a pronounced variation (from 3.8 to 8.7) in the number of items of service given on average per patient per year by different practices, and surveys of general practice carried out in recent years have demonstrated that these variations correspond with the variations of morbidity in different areas. The system also fails to reflect differences in the quantity or quality of work as shown by differences in the surgery consultation visit ratio (from 1.2:1 to 4.6:1) from practice to practice, even within the same locality. It has no regard whatever to the variations in the age distribution of the population and fails to provide for the fact that the very old and the very young, both increasing in number year by year, require much more medical attention than other members of the community. It imposes no effective penalty for laziness and unkindness and provides no reward for diligence and devotion to the care of sick people. It is unjust to the doctor, unjust to the community, and unworthy of the British nation.

I have shown that a family doctor's income to-day is less than half of what it would have been if the market values which were its main determining factor before July, 1948, had continued to operate. This is a direct result of the irrational concept of the pool-capitation system, which not only distributes money unjustly but also seeks to effect a fixed average annual income, unrelated to work done, instead of a fair fee for each item of service given.

During 1961 10,977 deaths in London were reported to coroners. This represented 28.7% of the total. In 1,858 cases the coroners directed that necropsies should be carried out. There were six verdicts of murder compared with four in 1960 and 13 in 1959; 1,022 people met death by accident compared with 903 in 1960 and 977 in 1959; 22 deaths were caused by chronic alcoholism compared with 16 in 1960 and 23 in 1959. (London County Council meeting, April 3.)