

This is a repository copy of *Reforming the contract of UK consultants*.

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/57/>

Article:

Maynard, A and Bloor, K orcid.org/0000-0003-4852-9854 (2001) Reforming the contract of UK consultants. *British medical journal*. pp. 541-543. ISSN 1756-1833

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

Reforming the contract of UK consultants

Alan Maynard, Karen Bloor

The NHS Plan expressed the intention of government to “fundamentally overhaul” the national contract for UK hospital specialists to “reward and incentivise those who do most for the NHS.”¹ How can this be achieved?

Current contract

The current UK pay system for hospital consultants is a fixed salary with selective bonus payments (distinction awards), which were introduced early in the existence of the NHS to reward “excellence.” UK consultants with a full time NHS contract can undertake limited private practice (with remuneration no higher than 10% of their NHS salary); those with a part time contract (including the “maximum part time” contract, in which consultants receive 10/11 of a full time salary) can undertake unlimited private practice.

Criticisms of current contract

Contributing to the renegotiation of consultants’ contracts, the House of Commons Select Committee on Health published a report aiming “to examine NHS consultants’ contracts in terms of their accountability, effectiveness, and efficiency” and to examine the impact of private practice on the NHS.² The committee expressed surprise that “the contract managing the work of these vitally important professionals remained, in essence, unchanged since the formation of the NHS in 1948.”² In evidence given to the committee, the contract was described as, among other things, “the ineffective hand in hand with the inequitable” (Professor John Yates) and “the worst of all worlds” (the BMA).

The existing contract for consultants has several drawbacks. There is a general absence of information, which limits accountability and fosters the general public’s perception that, whereas junior doctors work an 80 hour week, consultants spend too much time in plush private clinics and on the golf course. Although many consultants exceed their contractual commitments, lack of information and the conflict of interest implied by consultants working in both the public and private sectors, mean that this stereotype is difficult to dispel. In addition, NHS purchasers have limited leverage on consultants’ activity to meet local priorities. In future, with the devolution of purchasing to primary care trusts, general practitioners may expect greater responsiveness from consultants to their patients’ needs.

The select committee’s report criticised the absence of information about consultants’ activity; the apparent

Summary points

The contract for UK hospital consultants has been criticised by the BMA, the House of Commons Select Committee on Health, and the current government

It has failed to deliver consistent activity and accountability in both the NHS and the private sector

If the NHS Plan is to be carried out, existing variations in performance by consultants have to be better managed

A new contract could involve a basic salary supplemented by bonuses and a fee for each “item” of service

The contract would require appraisal and management of consultants’ activity

Informed debate about the design of a new contract is essential, as is its evaluation once it is introduced

See *Editorial* by Riordan and *News*

York Health Policy Group, Department of Health Studies, University of York, York YO10 5DD
Alan Maynard
professor

Department of Health Sciences and Clinical Evaluation, University of York
Karen Bloor
Medical Research Council research fellow

Correspondence to: A Maynard
akm3@york.ac.uk

BMJ 2001;322:541–4

wide and unexplained variation in the level of fixed commitments; the high level of fixed commitments not fulfilled by consultants; the lack of information on flexible commitments; the inadequate use of job plans and appraisal; and perverse incentives introduced by private practice.² The committee’s recommendations included systematic collection of activity data for consultants in the NHS and in the independent sector; more rigorous monitoring of the “10% rule” governing full time NHS consultants’ earnings; and a long term objective that consultants in the NHS should not undertake private practice.

Requirements of a new contract

The NHS Plan is rather vague about how the contract will be reformed. It is proposed that all new consultants should be full time in the NHS for seven years (later to be reduced to five years)—a form of indentured contract whereby the NHS gets a return on the public investment in consultants’ training. Also there may be a system of bonuses for those who work primarily for the NHS and at high levels of activity.



The stereotype of the consultant on the golf course is hard to dispel

A new contract must achieve certain objectives. After over two years of raised expectations about NHS services, the winter “crisis” of 1999-2000 resulted in a government pledge of real expenditure increases of a little over 6% a year for four years. Money alone, however, solves little. To increase activity it is necessary either to recruit and retain more practitioners or to increase the activity of existing staff. In the short term, recruitment is planned from doctor surpluses overseas, but this policy cannot alone deliver the service volume required by the NHS Plan. The government therefore requires the new contract and reward structure to provide incentives for increased NHS activity by consultants.

The contract should also increase the accountability of consultants, reduce the conflict of interest implied by work in both public and private sectors, and improve management of their activity. For many decades the NHS has collected data about NHS activity, but has not used them for management purposes. Decision makers at all levels of the NHS have systematically ignored longstanding efforts in the analysis of these data.³ Analysis of the hospital episodes statistics dataset shows that activity rates per consultant have been relatively constant over time and that large and often unexplained variations exist.^{4,5} Activity can and should be monitored centrally and by trust managers—for example, by including routinely collected data in annual performance reviews of consultants.

The hospital episodes statistics dataset provides only information on activity in the NHS; it would be useful to integrate data on private and public activity. The private sector is in favour of this, partly for the protection of patients (surgeons would not undertake procedures in the private sector for which they have limited experience). Merging data on activity could also benefit the public sector, ensuring adherence to contracts and avoidance of “burn out.”

Another government objective for the new contract is to introduce incentives to achieve policy targets (such as waiting times for inpatient and outpatient care). Overall therefore, the challenge faced by those renegotiating the contract is to raise the quality, activity, and accountability of consultants and their teams and to further the achievement of other policy targets. The pursuit of these different goals simultaneously requires

a contract reform that introduces new incentives by combining different types of remuneration.

Remuneration

One way of combining new incentives and different types of remuneration could be to offer consultants a basic salary plus a fee for each “item” of service and carefully targeted bonus payments. The salary element of this package would guarantee a basic income, with enhancements to reward greater activity. Fees for each item of service generally encourage increased activity; they increased general practitioners’ minor surgery rates after the introduction of the 1990 contract. This winter, a fee of £6.40 for each influenza vaccination has had a similar effect on activity.

Fees

The difficulties with a fee per item system are well chronicled. The first problem is maintaining quality and ensuring that activity stimulated by fees is effective and efficient. A second problem is defining and deriving a payment for each item. Will an item be an event—for example, a surgical intervention—or an episode of care? A third problem is that fees can considerably raise activity levels and therefore costs. The 1990 contract for general practitioners rewarded unproved interventions—for example, annual screening for people aged over 75 years—and created considerable budgetary pressure as doctor activity changed rapidly.

Bonuses

The final element of this possible contract would be a system of bonuses. Bonuses have proved successful in inducing activity in UK general practice in relation to achieving target coverage in immunisation and vaccination and increasing screening for cervical cancer. If bonuses were paid for having no one waiting more than 13 weeks for an outpatient appointment or more than six months for inpatient care, consultants’ responses to such a bonus scheme could facilitate achievement of targets in the NHS Plan. Such targets would give consultants a strong incentive to challenge general practitioners’ referrals and divert them back into the community, so general practitioners and consultants would have to manage the referral system jointly.

The UK government is currently negotiating new bonus systems with the BMA, and these, once in place, can be related to consultants’ activity and quality of care. The system of bonuses to be introduced soon (probably some time this year) could be related to activity and waiting list performance.

Incentive schemes

If fees and bonus payments were related to care packages and teams of providers, a central issue would be the basis on which payments are apportioned. Payment reform might focus on the activity of the team and might require alterations in the methods of payment to all team members, not just doctors. The possible reward of effective teams through a bonus scheme over and above basic pay is considered in the government’s pay review proposals and in the NHS Plan.^{1,6} The role of the team in monitoring quality and

activity levels may be considerable.⁷ If activity and waiting list bonuses are paid to doctors alone, other team members may limit their cooperation, activity, and quality control.

Incentive systems are always problematic. A review of the evidence suggests that employees do respond to incentive schemes.⁸ They respond, however, “in sophisticated ways, manipulating the quality or timing of what they do. These are generally responses that the organisation neither intended nor wanted.”⁸ Any system of rewarding consultants or healthcare teams requires careful design, evaluation, and monitoring to avoid unwanted results.

Conclusion

If any reform of the contract increased the availability of consultants in the NHS, would beds, theatre time, and nursing be available to increase productivity? Many NHS trusts have severe constraints on bed availability,⁹ exacerbated by an increase in “bed blocking” and by limited availability of support teams for both urgent and non-urgent procedures. The reform of the contract, if successful, could lead to practitioners being idle and frustrated if support teams and facilities are unavailable.

Contract reform and performance measurement for consultants is inevitable and an essential part of clinical governance. Primary care trusts are likely to establish contracts for integrated episodes of care

(rather than for isolated activities) and use hospital episode statistics and related outcome and activity data routinely in management. The pace of reform may be swift, and its cost is likely to be considerable.¹⁰ Evaluation of this social experiment, whatever its form, is essential, as is informed debate about its design.

Contributors: The initial draft was written by AM after discussions with KB; subsequent rewriting was led by KB. AM will act as guarantor for the paper.

Funding: AM's salary is partly funded by the Department of Health; KB's salary is paid by the Medical Research Council.

Competing interests: None declared.

- 1 Secretary of State for Health. *The NHS Plan: a plan for investment, a plan for reform*. London: Stationery Office, 2000. (Cm 4818-1.)
- 2 Parliamentary Select Committee on Health. *Third report: consultants' contracts*. London: Stationery Office, 2000.
- 3 Yates J. *Why are we waiting?* Oxford: Oxford University Press, 1987.
- 4 Barwell F, Harley M, Spurgeon P, Yates J. *Patterns of work amongst hospital consultants. Report to the Department of Health*. Birmingham: Inter-Authority Comparisons and Consultancy, 1999.
- 5 Davidge M, Harley M, Jayes R, Yates J. *Examining the workload of surgical teams. Report to the Nuffield Trust*. Birmingham: Inter-Authority Comparisons and Consultancy, 1997.
- 6 Department of Health. *Agenda for change: modernising the NHS pay system*. London: Stationery Office, 1999.
- 7 Bloor K, Maynard A. Rewarding healthcare teams: a way of aligning pay to performance and outcomes. *BMJ* 1998;316:569.
- 8 Burgess S, Metcalfe P. *Incentives in the public sector: a survey of the evidence*. Working Paper 99/016. Bristol: Centre for Market and Public Organisation, 1999.
- 9 Department of Health. *Shaping the future NHS: long term planning for hospitals and related services. Consultation document on the findings of the national beds inquiry. Report and supporting analysis*. London: Department of Health, 2000.
- 10 Klein R, Maynard A. On the way to Calvary. *BMJ* 1998;317:5. (Accepted 20 October 2000)

Commentary: To increase consultants' activity should not be the main aim

P Hawker

Everyone agrees that the contract for hospital consultants needs to change. For the BMA's Central Consultants and Specialists Committee the process of getting into serious discussions about this with the government has been deeply frustrating—it first wrote formally asking to open negotiations in November 1997.

The committee agrees with some of the reasons for change suggested by Maynard and Bloor. They rightly observe that the current contract leads to myths and stereotypes; it is now so ill understood, by consultants as well as by managers and the public, that debate is based on prejudice rather than information. A new contract that defines more explicitly what the NHS can and cannot expect from consultants will protect the dedicated and hard working majority from the tide of innuendo and denigration—often shamefully perpetrated by the government itself—that currently undermines their efforts.

A new contract is also needed because of the changing NHS and the society it serves. The committee accepts and welcomes the move towards a service increasingly delivered by consultants themselves. This will require different working patterns—more emergency work and perhaps periods of residence on call. But emergency duties can no longer be grafted on to a

full daytime commitment; they must be scheduled periods of duty, followed by appropriate time off. If staff are routinely to work nights and weekends for most of their senior professional lives their timetable must also leave space for family and outside interests—for a civilised life.

The current intolerable workload of consultants is, however, barely acknowledged by Maynard and Bloor. Changes in training and juniors' hours, increasing hospital throughput, pressure to reduce waiting times, restructuring and political initiatives, shortages of staff and resources, rising expectations of patients, and the unaccountable growth in emergency admissions have all added to the burden. The current contract provides little protection to individuals against the sense of professional duty, and the management pressure, to carry on doing more and more. This is leading to stress, exhaustion, and demoralisation. It cannot continue; the new contract will need to be closed, not open ended.

I cannot therefore accept Maynard and Bloor's assessment that the primary aim of the new contract must be to increase consultants' activity. Their activity should be defined more explicitly and planned more rationally, certainly. Providing the beds and staff to enable consultants to carry out their existing workload

Central Consultants and Specialists Committee, BMA, London WC1H 9JP
P Hawker
chairman

pchdoc@altavista.co.uk

would be a good start. But there is no scope to ask people to do significantly more—consultants are already working at least 50 hours a week for the NHS, beyond the legal limit. This is one reason why the government's ill conceived seven year prohibition on private practice has been so widely condemned—it would not affect the amount of NHS work done. Nor do I agree that bonus payments for meeting targets are the way forward. We have all experienced the distortions in good clinical decision making caused by undue emphasis on reducing waiting lists. What motivates professionals is quality

of care; the remuneration system should underpin that motivation, not introduce incentives to pervert it.

The Central Consultants and Specialists Committee believes that a new contract can deliver better quality of care for patients, ensure a reasonable life for future consultants, and enable managers to plan and deliver services more effectively. The committee has recently published some proposals for such a contract and is calling on the government to enter into discussions about it.

Competing interests: None declared.

Asylum seekers and refugees in Britain

Health needs of asylum seekers and refugees

Angela Burnett, Michael Peel

This is the second in a series of three articles

Medical Foundation for the Care of Victims of Torture, London NW5 3EJ

Angela Burnett
senior medical examiner

Michael Peel
senior medical examiner

Correspondence to: A Burnett
a.c.burnett@qmw.ac.uk

BMJ 2001;322:544-7

People who are seeking asylum are not a homogeneous population. Coming from different countries and cultures, they have had, in their own and other countries, a wide range of experiences that may affect their health and nutritional state. In the United Kingdom they face the effects of poverty, dependence, and lack of cohesive social support.¹ All these factors undermine both physical and mental health. Additionally, racial discrimination can result in inequalities in health and have an impact on opportunities in and quality of life.²

Refugees' experiences also shape their acceptance and expectations of health care in the United Kingdom.³ Those from countries with no well developed primary healthcare system may expect hospital referral for conditions that in Britain are treated in primary care. This can lead to disappointment for refugees and irritation for health workers, who may also feel overwhelmed by the many and varying needs of asylum seekers, some of which are non-medical but nevertheless affect health. Addressing even a few of these needs may be of considerable benefit.

Previous studies in the United Kingdom have found that one in six refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or depression.^{4 5} Disentangling the web of history, symptoms—which may be minimised or exaggerated for a range of reasons—and current coping mechanisms requires patience and often several sessions. Medication should be as simple as possible.

Physical needs

In a study carried out in the United States, 5% of Koreans and 15% of Cambodians were found to be positive for hepatitis B surface antigen.⁶ In Spain, 21% of migrants from sub-Saharan Africa were chronic carriers of hepatitis B⁷; hepatitis A and meningitis may be more prevalent, depending on country of origin.⁸ HIV prevalence is likely to mirror that in the country of origin, although some refugees may have been placed at particular risk. (HIV/AIDS will be covered in the last

Summary points

Asylum seekers and refugees are not a homogeneous group of people, and have differing experiences and expectations of health and of health care

Symptoms of psychological distress are common, but do not necessarily signify mental illness

Trained interpreters or advocates, rather than family members or friends, should be used wherever possible if language is not shared

Community organisations provide invaluable support and can reduce the isolation experienced by so many refugees

Particular difficulties which face women are often not acknowledged

Support for children, especially unaccompanied minors, needs to be multifaceted, aiming to provide as normal a life as possible

paper in this series.) Benign tertian malaria may not be seen until several years after arrival.⁶

In 1988, 3.4% of refugees arriving in the United States had tuberculosis.⁶ In Britain, new arrivals should be screened for tuberculosis at the port of entry, but in practice only a small proportion is screened, and tuberculosis in those who apply for asylum after arrival will not be identified until later. Currently no screening is carried out at the channel ports (P Le Feuvre, S Montgomery, personal communication, 2000), or at cargo ports, where some asylum seekers may arrive (P Matthews, personal communication, 2000). Some areas with large numbers of refugees have set up screening programmes, but their coverage varies. A study in Blackburn of a sample of 1085 immigrants found 11 cases of tuberculosis at the