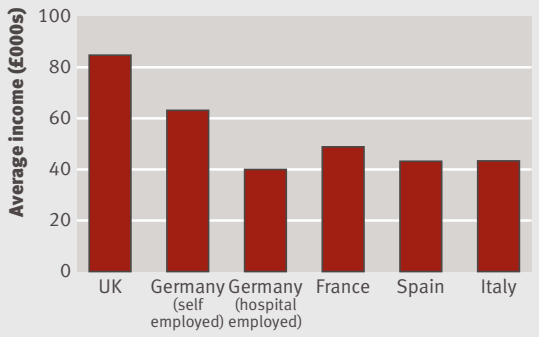
THE WEEK IN MEDICINE

So how much do doctors really earn?

According to the media, some UK general practitioners are reputed to be earning around £250 000 a year, but what is the truth behind the headlines, and how does UK doctors' pay here compare with elsewhere, asks **Michael Day**

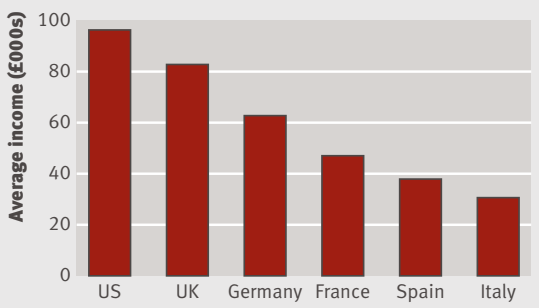
AVERAGE INCOME OF HOSPITAL DOCTORS (2003-4)*



*Full US data not available, but average is estimated at >£135 000

Source: HM Treasury

AVERAGE INCOME OF PRIMARY CARE DOCTORS (2003-4)



Source: *HM Treasury*

The rumbling political row over debt in the NHS means that the vexed issue of doctors' pay is not going to go away any time soon.

Are doctors in the United Kingdom overpaid? An obvious way to address the question is to compare the earnings of UK medics with those of their overseas colleagues. That is easier said than done, though: few if any direct comparisons exist, and any comparison is made difficult by different contractual agreements and working conditions. The UK Treasury has, however, made an attempt, in its latest 2007 comprehensive spending review for the NHS.

The report contains estimates of average earnings of GPs and hospital doctors in 2003-4 in 16 countries, including the UK's major competitors. The figures are based on research gathered by British embassies. It should be emphasised that the figures are estimates.

A widening gap

Nevertheless, a few things leap out from the data, including the large (and, in the case of hospital salaries, huge) lead that US doctors enjoy in pay terms. The second is the very large advantage that UK doctors have over their continental colleagues. GPs in Italy have remarkably low average earnings—the result of the marketplace being flooded with too many doctors.

Bear in mind that these are 2003 figures. The latest, very large pay rises given to UK doctors will almost certainly have widened the salary gap between British and continental doctors even further.

The Treasury report cites an average salary for GPs in the UK in 2003-4 of £82 000. The latest figures, for 2004-5, show that the average income of GPs, net of expenses, was £106 000, a rise of 30% in one year. For dispensing GPs the figure is even higher: they earned an average of £128 000 after expenses, a 31% rise.

In January the *Independent* newspaper reported that GPs' average earnings soared again last year (2005-6) to £118 000, according to estimates of the Association of Independent Specialist Medical Accountants. So in the three years from 2002-3, when NHS Information Centre data showed that GPs earnt on average £72 000, their earnings rose by a remarkable 63%.

As a result, the *Independent* noted, the average family doctor now earned, including private income, more than the Lord Chancellor, ministers of state, senior civil servants, and circuit judges.

The BMA has challenged the reliability of these figures. John Ford, the head of its economic research unit, said that the headline figures overestimate the extra amount reaching GPs' pockets, because under the new contract they must now pay employees' pension contributions.

He adds that the sample of practices used in the *Independent*'s estimates was unrepresentative, because it included a larger than average number of dispensing practices. Also, the BMA points out that salaried GPs (who often work part time in return for a guaranteed income) earn rather less; it estimates their income to be in the region of £70 000 a year.

The headline grabbing figures of £250 000 annual earnings of a handful of GPs is, said Mr Ford, down to a few practices exploiting the potential of dispensing practices rather than being the result of the new contract.

It's not in doubt, however, that GP partners have enjoyed very large pay increases in the last three years. And inevitably the contract that has led to the "pay bonanza," as the newspapers have called it, has come under fire. When reports of GPs earning £250 000 a year broke last year, the *Sun* newspaper, in an editorial entitled "Wads up doc," said it made sense "to cap doctors' salaries and stop patients being short changed."

Some of the broadsheets joined in. The *Daily Telegraph*'s Simon Heffer said: "I do not doubt that many GPs work hard . . . However, equally I do not doubt that a few are royally ripping off the Government and the taxpayer thanks to the stupidity with which the Government settled its deal with their trade union."

Renegotiations are under way

Some leading health economists, such as John Appleby of the think

tank the King's Fund, say that the recent contracts are "not set in stone." Professor Appleby says that behind the scene renegotiations are already under way.

In terms of the consultants' contract, ministers will be seeking to include new incentives to boost productivity rather than simply to reward the amount of time consultants spend in hospital. But the BMA says that initial predictions of the size of consultants' pay rises under their new contract have proved wide of the mark.

Between 2003-4 and 2004-5 their earnings rose by around 20% as the number of work sessions they attended rose from 10 to 12. Since then, however, Mr Ford says that rises in their salaries have stalled.

As far as GPs are concerned, ministers are keen to make performance related targets tougher. The BMA insists that the new contract had radically improved the care of patients, particularly for those with chronic diseases.

Hamish Meldrum, head of the BMA's GPs committee, said, "In the area of raised blood pressure alone, GP care under the new contract means that over a five year period 8700 patients in England will avoid having a heart attack, stroke, angina, or heart failure."

Nevertheless, outside the BMA there is a groundswell of opinion that GPs are being too generously rewarded for providing some aspects of care that should already have been regarded as routine.

Also, other observers, such as Niall Dickson, chief executive of the King's Fund, say that the contract may actually have cut GPs' productivity by allowing the closure of Saturday morning surgeries and the ending of 24 hour cover.

The government believes that value for money and its own pride could be partially restored if family doctors were to invest more of their expanding profits back into their businesses to improve patients' care. If that's the case, say its critics, then ministers should have drawn up a contract that required this.

Michael Day is a freelance journalist, London
miday@f2s.com

Left: how the London *Evening Standard* covered claims about high earning GPs last year, and, below, the front page of the tabloid *Daily Mail* earlier this week

"In the area of raised blood pressure alone, GP care under the new contract means that over a five year period 8700 patients in England will avoid having a heart attack, stroke, angina, or heart failure"

Head of the BMA's GPs committee **Hamish Meldrum**

ATLANTIC CROSSING **Uwe E Reinhardt**

Is the president's plan dead before arrival?

Bush's proposed health reforms would do little for the millions of low income, uninsured Americans

In his State of the Union address of 23 January, President Bush unveiled his much heralded health reform initiative to a perplexed nation. As is their wont, the television media swiftly unearthed staunch proponents and staunch opponents of the proposal, and unleashed the extremists upon one another, thus adding to the confusion. It did not help that the president delicately omitted from his speech an important but politically risqué feature of his proposal, most likely to enhance the public marketability of the policy (www.whitehouse.gov/stateoftheunion/2007/index.html).

The full proposal has three distinct facets.

Firstly, the president would make health insurance premiums paid by employers on behalf of employees—hitherto not included in the employees' taxable compensation—fully taxable with effect from 1 January 2009. The total loss to the US Treasury from this time hallowed tax preference has been estimated to range currently from $200bn to $220bn (£102bn to £112bn; €154bn to €170bn) a year, more than twice the sum that would be needed to move the nation to full universal health insurance coverage.

By itself, then, this facet of the proposal amounts to a sizeable tax increase. It is this facet of the president's proposal that he delicately omitted from his televised speech, although it is clearly set out in the associated fact sheet on the White House website (www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html).

Secondly, the president would allow Americans, regardless of insurance status, to deduct from taxable income $7500 for individual tax payers or $15 000 for a family. This is the felicitous facet of the proposal upon which Bush dwelt in his speech. On average, a standard health insurance policy for an American family now costs about $12 000, although by 2009, the onset of the president's plan, that figure is bound to be closer to $14 000. Americans whose employer in 2009 spent more on health insurance premiums than the standard deductions would, of course, pay added taxes on the excess. Because the standard deductions would be indexed over time only to general price inflation and not the much higher rate of inflation for health care, more and more Americans would find themselves in that position as time goes on.

Thirdly, the president would redirect funds the federal government already spends on health care to the budgets of state governors, who could use these funds to help their citizens gain access to health insurance. Neither Bush nor the White House fact sheet identifies which money already being spent would be redirected towards state government budgets, nor what the total sum of those funds might be. Everyone's best guess is that the president has in mind the so called disproportionate share (DSH) funds now paid to hospitals that treat a disproportionate share of uninsured patients or patients covered by the federal-state Medicaid programme for the poor. In many states these funds pay hospitals far less than it costs them to treat Medicaid patients. Mentioning such specifics in a televised speech would have triggered an immediate outcry from the hospital industry and the champions of the poor.

Economists of all political stripes have remarked favourably upon the proposed changes in the tax code. However, the president's plan perpetuates the regressive nature of tax deductions. The huge tax savings triggered by the proposed standard tax deductions continue to accrue disproportionately to high income families least in need of public subsidies for their health care.

"The huge tax savings . . . continue to accrue disproportionately to high income families least in need of public subsidies for their health care"

Worse still, in addition to these standard deductions, the president apparently would continue to allow individuals or families to deduct from their taxable incomes annual deposits into a personal health savings account, as long as the family chose a health insurance policy with a high deductible.

At the same time, Bush would do little for the millions of low income, uninsured Americans who would not much benefit from the standard tax deductions, especially if their income is so low that they do not pay federal income taxes and who lack the income to procure health insurance on their own. Simply to redirect federal funds from safety net hospitals catering disproportionately to the poor towards general state budgets, without any guarantee of full universal health insurance coverage, is a morally dubious, empty gesture—especially in light of the unwarranted public subsidies the proposal would continue to steer towards high income families.

As it happens, all of these musings are moot. The Democratic Congress already has signalled that the president's plan is not only "dead on arrival" but "dead even before arrival." And thus, after all the fanfare over the president's proposal has died down, American health policy continues to march according to Churchill's dictum that "you can always count on Americans to do the right thing—after they've tried everything else."

Uwe E Reinhardt is James Madison professor of political economy, Princeton University, Princeton, NJ, United States
reinhard@princeton.edu