TALKING POINT

Allocation of additional consultant posts: critical review

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In some specialties the expansion of consultant posts is limited by the availability of suitably trained doctors. The Department of Health and Social Security has to decide how to distribute the inadequate supply with the advice of the profession through the Central Manpower Committee. In specialties where the supply is expected to be only slightly above the replacement requirements to fill vacancies resulting from resignations, retirements, or death, the present policy is that priority for additional posts will be given to regions with a low ratio of consultants in that specialty to their resident population.^{1,2} But should population be the only criterion in making this decision and, if so, is the resident population the most appropriate one? Several specialties are affected but I have examined the changes which would occur if other criteria were used in three—geriatric medicine, anaesthetics, and radiology.

Other criteria

The Report of the Resource Allocation Working Party³ determines financial allocations to RHAs. It takes into account the different morbidity by using a population weighted in respect of various factors which influence the need for medical care. I have looked at the differences which would occur if the RAWP-weighted populations were used instead of the resident populations in determining the relative positions of regions in respect of their consultant staff and their consequent need for additional staff.

In many of the shortage specialties most, but not all, of the work is referred by other consultants—for example, anaesthetics and radiology. To provide a balanced service to patients, the numbers in these specialties should maintain some kind of numerical relationship with consultants in medical and surgical specialties. The present reluctance to appoint additional surgeons in the absence of additional anaesthetists shows the general acceptability of this idea. So it seems appropriate to look at the ratio of surgeons to anaesthetists to identify regions where the ratio is high. Anaesthetists provide services in aid of other specialties and in connection with intensive care and pain relief, but for most consultants the central responsibility is for surgical cases. Radiologists can also be related to consultants in medical and surgical specialties, though patients are also referred to them by general practitioners and others.

POPULATIONS

The figures in this paper relate to 1975. The weighted populations for non-psychiatric inpatients have been used when dealing with anaesthetics and the aggregated populations when dealing with radiology. In dealing with

geriatric medicine it is usual to use populations aged 65 and over. The RAWP report does not give figures corresponding to this, but the application of the known proportion of old people in the resident population to the weighted aggregated population for all ages in each region has been used to give a suitable estimate of weighted populations aged 65 and over. The number of consultants are taken as whole-time equivalents from tables published by the DHSS.⁴

Geriatric medicine

There are four regions with a ratio of under four consultants in geriatrics for each 100 000 population aged 65 or over. About 10 additional consultant posts are established in a year in this specialty: if they were in the worst off regions, in order to raise all regions to the level of the best, the allocation would be South-western, four; Trent, two; North-west Thames, two; and South-west Thames, two. The use of RAWP populations would not affect these allocations.

When comparing the number of consultant anaesthetists with the number of consultants in the surgical specialties, the latter are taken to be ENT, general surgery, gynaecology and obstetrics, neurosurgery, ophthalmology, paediatric surgery, plastic surgery, thoracic surgery, traumatic and orthopaedic surgery, and urology.

The position in each region is shown in table II. There are major changes in the ranking of the regions. Trent, for example, has a low number of surgeons to anaesthetists as it is even further below the national average in the surgical specialties.

Additional anaesthetists could be allocated to those regions with the highest ratio of surgeons to anaesthetists so that the potential work load would become more equal. In doing this, there would have to be a restriction so that none were added to regions which had already more than the average in relation to population. To ignore this would be against the present spirit of resource allocation, but there might be special reasons for doing this. The population used could be either resident or RAWP. With restrictions in respect of

TABLE 1—Consultants (including SHMO with allowance) in anaesthetics per 100 000 population

Region	Using resident population		Using RAWP population	
	WTE per 100 000 population	WTE relative to national rate	WTE per 100 000 population	WTE relative to national rate
Northern	3.09	10.4	3.02	6.2
Yorkshire	2.63	-4.8	2.49	-10.2
Trent	1.99	-34.8	2.03	-32.8
East Anglia	3.03	4.9	3.15	6.6
North-west Thames	2.94	6.2	3.15	12.5
North-east Thames	2.87	3.9	2.97	7.6
South-east Thames	3.11	12.8	3.01	9.3
South-west Thames	2.62	-4.0	2.58	-5.1
Wessex	2.61	-4.1	2.65	-3.1
Oxford	2.54	-4.8	2.94	3.5
South-western	2.54	-6.9	2.41	-11.6
West Midlands	2.62	-7.2	2.78	0.8
Mersey	2.73	-0.7	2.64	-3.0
North-western	2.69	-2.8	2.43	-14.6
England	2.76	—	2.76	—

Anaesthetics

The numbers of consultants in anaesthetics and the relations to populations are shown in table I. About 36 additional consultant posts are established each year. Because surgical specialties need anaesthetic support, each region can expect at least one post. Such is the deficiency in relation to resident population in the Trent Region that even if 23 new posts were established there and one in each of the other 13 regions, its ratio would still be less than that of the second worst. When RAWP populations are used the position is slightly different. If Trent received 20, South-western three, North-western two, and each of the others one, the effect would be to raise all three at the bottom almost to the level of the fourth worst.

TABLE II—Consultant surgeons in relation to consultant anaesthetists

Region	Number per anaesthetist	WTE anaesthetists relative to national rate
Northern	2.31	-5.5
Yorkshire	2.35	-6.9
Trent	2.08	4.2
East Anglia	2.17	0.3
North-west Thames	2.17	0.8
North-east Thames	2.32	-6.4
South-east Thames	2.07	5.7
South-west Thames	2.12	2.4
Wessex	2.32	-4.2
Oxford	2.25	-1.6
South-western	2.09	3.5
West Midlands	2.10	5.5
Mersey	2.12	2.0
North-western	2.22	-1.9
England	2.19	—

resident populations posts under this method would be allocated as follows, with restrictions in respect of RAWP populations in parentheses: Yorkshire, eight (11); Wessex, seven (five); North-western, six (seven); Oxford, five (one); Northern, one (two); and North-east Thames, one (two). All others, one each in both cases.

Northern and North-east Thames Regions are allocated two posts because otherwise their ratio of surgeons to anaesthetists would be much higher than any other region. Even with all these additional posts the ratio of surgeons to anaesthetists in these two regions would only be slightly below average, and the number of anaesthetists in relation to population slightly above average.

Radiology

The same analysis in radiology shows similar features. It is appropriate to relate radiologists to the surgical consultants in the specialties listed above and also to medical specialties—cardiology, diseases of the chest, general medicine, genitourinary medicine, geriatrics, nephrology, neurology, paediatrics, and rheumatology and rehabilitation.

Table III shows that when related to populations (either resident or RAWP) almost all the available new posts (currently about 16) would be allocated to Trent. On the basis of resident populations, two would go to Oxford and one to Mersey; on the RAWP populations, two would go to Mersey. When compared with other consultants the picture is different (table IV). A policy of adding consultants in radiology to regions where they are fewest in relation to other specialties, with a restriction in regions where the provision in relation to population is already high, would lead to the following allocations.

The allocation with restrictions in respect of resident populations is set out first, with restrictions in respect of RAWP populations in parentheses: Oxford, five (two); Mersey, four (four); Wessex, three (three); West Midlands, two (three); Yorkshire, one (one); Trent, one (one); and Northern, nil (two).

This is clearly a different pattern from that obtained when population alone is used as a criterion.

Discussion

The allocation of financial resources to regions in accordance with the health needs of their populations must be matched by an opportunity to use this money in an appropriate way. Among the most important and most expensive items in a health service are staff. In the NHS only medical staff of registrar grade and above is subject to national control of numbers. It is therefore essential that this control be exercised in such a way as to allow the development of nationally advocated service policies.

The use of resident populations as a measure of the need for additional consultants can give a different result to that reached when

TABLE III—Consultants (including SHMO with allowance) in radiology per 100 000 population

Region	Using resident population		Using RAWP population	
	WTE per 100 000 population	WTE relative to national rate	WTE per 100 000 population	WTE relative to national rate
Northern	1.41	0.7	1.36	-0.6
Yorkshire	1.36	-1.0	1.30	-3.1
Trent	0.95	-19.6	0.96	-19.0
East Anglia	1.42	0.8	1.49	1.9
North-west Thames	1.43	1.6	1.52	4.4
North-east Thames	1.65	9.7	1.69	11.3
South-east Thames	1.62	8.6	1.59	7.9
South-west Thames	1.41	0.8	1.41	0.7
Wessex	1.29	-2.6	1.33	-1.3
Oxford	1.18	-4.5	1.33	-0.9
South-western	1.40	0.4	1.36	-0.8
West Midlands	1.23	-7.9	1.27	-4.3
Mersey	1.23	-4.0	1.17	-5.4
North-western	1.43	1.7	1.31	-3.2
England	1.38	—	1.38	—

RAWP populations are used. Because the latter populations are weighted to give an indication of health needs it would be more appropriate to use them. In this way those regions allocated extra finance to meet their above-average health needs would have an opportunity to use some of it to employ more medical staff. The fairly small differences between the two populations applicable to a region mean that the specialties with small numbers of consultants, like geriatric medicine, are not much affected.

The services to be developed to meet the health needs of a region must have the right balance of the different elements in them. It so happens that the so-called "service" specialties are prominent among those in which consultant manpower is short. To provide a greater volume of service requires more anaesthetists and radiologists, but the balance between these specialties and those which are most likely to require their service is more favourable in some regions than in others. The potential work load should be more evenly spread by giving priority (still within those regions low in terms of RAWP populations) to those regions with the least favourable balance of consultant staff. If this is not done, but additional posts approved only in relation to resident populations, then in the most favoured region each anaesthetist would work

with 1.75 surgeons and in the least favoured with 2.25. Such a range is unjustifiable. This is not to say that the lower figure is inappropriate (it corresponds to four theatre sessions for a surgeon and seven for an anaesthetist), only that it is more favourable than can be reached everywhere at the present time. To reach it with the present number of surgeons would require 1600 anaesthetists, an increase of about 300 (nearly 25%) over the current numbers.

But the number of other consultants is not stationary. The allocation of anaesthetic posts would require to take account of the additional surgical posts proposed by regions each year. The same arguments can be made in respect of radiology. When decisions are made about the precise location of an additional post other factors must be considered. These include the age and health of existing consultants, the presence of other senior staff, such as medical assistants, and the general convenience of existing facilities. For some years the Central Manpower Committee and the Department of Health and Social Security have wisely left such detailed considerations to regional authorities and regional manpower committees and they are not discussed in this paper.

Even so, those concerned with the national distribution to regions of additional consultant posts need to examine more closely the effects of the system currently used. It may be simple but it does not seem to be just. The use of RAWP populations and concern for achieving a balance between related specialties would be an improvement.

TABLE IV—Consultant physicians and surgeons in relation to consultant radiologists

Region	Radiologists per 100 physicians and surgeons	WTE radiologists relative to national rate
Northern	11.8	-4.0
Yorkshire	13.0	0.5
Trent	13.0	0.5
East Anglia	13.2	0.6
North-west Thames	11.4	-6.4
North-east Thames	13.1	1.0
South-east Thames	13.2	1.4
South-west Thames	14.8	5.3
Wessex	12.2	-1.7
Oxford	11.0	-4.2
South-western	16.0	8.6
West Midlands	12.7	-0.5
Mersey	11.8	-2.7
North-western	13.4	2.5
England	12.9	—

References

- ¹ *British Medical Journal Supplement*, 1973, 4, 43.
- ² Brown, D, *British Medical Journal*, 1976, 1, 1162.
- ³ DHSS, *Sharing resources for health in England*, Report of the Resource Allocation Working Party. London, HMSO, 1976.
- ⁴ DHSS, *Hospital Medical Staff—England and Wales: Regional Whole-time Equivalent Table*, Statistics and Research Division, 1976.

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