Shortage of radiologists

SIR,—The situation described in the letter from Mr P Dawson-Edwards and Dr Michael Barrow (11 June, p 1531) on the shortage of anaesthetists in the Birmingham region could equally well apply to radiologists on a national scale.

At this hospital, for example, we are approaching a crisis point in regard to our radiological services. At the present time we have an establishment for four consultant radiologists and we participate in a local rotational scheme with the Royal Infirmary nearby so that we receive from them a senior registrar and a trainee registrar. One of the four posts, newly created, has so far failed to attract any candidate and within the past few weeks an established member of the existing staff has accepted an appointment in Australia, which will reduce our consultant staff to two part-time radiologists. Between us at present we provide 15 sessions of coverage per week. As our work load is 50 000 patient attendances per year such a reduced radiological staff will clearly be quite unable to cope.

Locally, then, we are faced with a situation in which we will have to reduce our x-ray services very considerably, concentrating on inpatient and emergency outpatient work only. All contrast investigations for local family practitioners will have to cease until replacement radiological assistance becomes available. However, it is clear that this situation is not confined to our particular hospital. It is apparently affecting many hospitals in the country and if the trend continues it will affect many more in the near future. The official emigration figures for last year were 52 radiologists, 14 of whom were evidently consultants. This has evidently been about the average figure now for several years, and of course many of our bright young consultants and registrars are included. The question that faces those of us who remain is, should we disregard the flow or try to rectify the situation?

Our colleague who is going to Australia is being attracted to a large extent by better pay and one suspects that this is the reason for most other migrations. The area he is going to has a radiological staff of 40 in a total population of 700 000, a ratio about three times as high as that which exists in Bristol and its environs, with a similar population. Each radiologist receives about three times or more the salary paid over here—a good many of them are, in fact, British! Salary arrangements in the Australian hospitals are different from ours in that half the salary is evidently a guaranteed amount and the other half is a share-out in the department of an item-of-service scheme whereby every examination carried out generates a standard fee, which is the same for, say, a chest x-ray film or an arteriogram. In this way security is provided and hard work is rewarded.

It seems that unless we in Britain study some of these schemes and adopt one or some of them our young radiologists will continue to go abroad. We all know that radiology here offers few chances of marginal rewards such as domiciliary consultations, private practice, etc, and that our pay may thus compare unfavourably with that of some other specialties. Internationally, of course, we are just not in the same league as many other countries. And yet radiologists are a relatively small but vital group in hospital practice and are often the linchpin that holds the service together. A

determined effort to alter our terms of service could well be rewarding.

Many of us in fact feel strongly about our responsibilities to our fellow colleagues and to our own particular hospital and would wish to continue a satisfactory service to them both. We would also like to provide an attractive environment whereby our younger colleagues would wish to join us and stay with us. At the present time this is clearly not the case. Surely some action should be taken to put the matter right before it is too late.

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Revenue sources for community health services

SIR,—In these times of financial stridency for, inter alia, the NHS it is becoming apparent that one major saving would be to transfer as much work to the community health services as possible. Therefore it is necessary to assess the capability of these services to meet this expanding need. To do this one must review the methods of funding them.

Following reorganisation in 1974 the community services came under the aegis of the NHS. Previously they had been, in the main, departments of the local authorities with a very small component hospital-based. The funding, of course, had derived from the parent authorities. Part of the function of the joint liaison committees was to identify the moneys involved, their source, and their destination in order that the services and their funding could be continued. As was shown by Buxton and Klein,¹ the distribution of hospital provision was riddled with discrepancies and inequalities, both between regions and within regions. This was after the hospital services had been organised by a single Ministry, ultimately the Department of Health and Social Security, for a period of 26 years, the aim of which department was to provide a uniform service.

The size, function, and budgets of the community services had been based on priorities decided by a multiplicity of local authorities which had many other departments to fund, so that the provision reflected the authorities' interpretations of need as seen against the requirements of other services and demands for cuts in the rates. The resultant hotch-potch taken over by the area health authorities varied widely in quality but was generally inadequate to meet the standards required of the Health Service.

The funding now being provided comes through the normal NHS channels and is subject to normal NHS practice. Thus, given the present cash limits imposed by the Government, any increase in funding can derive only from four sources: (1) revenue consequences of consultant appointments; (2) revenue consequences of capital schemes; (3) development revenue; and (4) reallocation of funds within a district. Of these, by far the greatest source of increased revenue is the second.

The first source cannot bring any money to the community services. The second is limited in that the only capital schemes in the community are either health centres or clinics, neither of which draws big revenue consequences and may in fact, by concentrating resources in a few such centres, create a vortex which sucks revenue from other parts of the district, causing further deprivation in the periphery. The third and fourth sources place the community services alongside other departments in the district, in competition for any meagre moneys not already irrevocably committed. In deprived areas in deprived regions these moneys can be very meagre indeed, depending on the financial climate and on the varying forces which have already led to the gross inequalities of the NHS.

The community services therefore find

themselves in a dilemma from which there is currently no escape—they are a low capital cost service with high revenue requirements in a financial environment which relates revenue to capital cost. Thus if they are to develop to parity with the hospital service some different principle of funding must be conceived and put into effect. It is only necessary to look at any area strategic plan to foresee the future. The list of priorities for primary care is there, but none attracts any revenue, while the priorities for general and acute services all involve capital schemes with high revenue consequences.

As at present funded the community health services cannot respond to the demand and may well become less able to do so. There is therefore an increasing urgency for the powers that be to "get this one right." Unless there is change the high-flying ideals of reorganisation with regard to the development of medicine in the community will founder in a morass of financial incompetence, no one having had the foresight to see just what the revenue consequences would be.

Plus ça change, plus c'est la même chose.

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¹ Buxton, M J, and Klein, R E, *British Medical Journal*, 1975, **1**, 345.

Home Office v the NHS

SIR,—Administrative inflexibility and policy misinterpreted have always been a handicap to large organisations, including the NHS; but one wonders how often the Health Service is jeopardised further by the cryptic policy of other ministries. An example follows.

A 25-year-old graduate (BSc) in physiotherapy, of European parentage and having English as her home language, planned to increase her professional experience and elected to visit Britain. After correspondence, during which she effected the necessary professional registration in Britain and communicated with senior hospital personnel, it became apparent that most instructional courses were of short duration and the most satisfactory approach would be to practise as a physiotherapist in a hospital department with the object of attending instructional courses periodically. Entry to long-term courses customarily is by interview selection and thus these posts could not be arranged in advance.

She was advised that since she had a professional qualification in an undersupplied field of the Health Service she would likely be assisted with entrance formalities. However, on arrival in Britain with adequate financial resources and personal sureties she was refused permission to work and directed to remain no more than two months, and her passport was endorsed accordingly. The immigration official declined to inspect her documentation but suggested she appeal to the Home Office if so inclined. This she did, but was told that the endorsement now in her passport was an immutable restriction and that it would be illegal for her to discuss or arrange employment while in Britain.

As planned, she proceeded with visiting various physiotherapy centres, where it materialised that without exception a shortage