Mortality, morbidity, and resource allocation

SIR,—I should like to support the view of Dr M J Goldacre and Mr R I Harris (6 December, p 1515) that the use of International Classification of Diseases chapter-specific standardised mortality ratios (SMRs) in resource allocation may be inappropriate. They demonstrate very clearly that most chapters include both conditions which are important causes of mortality but account for the use of relatively few hospital beds and conditions which although important from the point of view of bed usage give rise to few deaths. I have previously drawn attention to this anomaly in respect of chapters X and XVII,[1] but was not fully aware of the implications in other chapters for resource allocation to individual specialties.

If SMRs are to be applied to any allocation formula, they should be used only to weight that part of the resource allocation which is directly attributable to the conditions causing death and then only if death is a sufficiently consistent outcome of the condition to justify its use as a surrogate for morbidity. A subcommittee of the Resource Allocation Working Party of the East Anglian RHA is at present examining the application of appropriate condition-specific SMRs to individual specialties.

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[1] West RJ. *Journal of Epidemiology and Community Health* 1978;**32**:1.

SIR,—The article on disease classification used as a means for planning resource allocation by Dr M J Goldacre and Mr R I Harris (6 December, p 1515) made most interesting reading so far as hospital costing of resources is concerned.

As 90% or more of doctor-patient activity occurs outside hospital, and with the application of the resources of other members of the practice team and facilities outside the practice environs, it is equally important to assess the directions in which community care resources will be potentially effective. The use of the International Classification of Health Problems in Primary Care (the second version of which, as ICHPPC-2, has been published by Oxford University Press) allows of more suitable grouping of rubrics cross-referable with ICD-9. This classification gives more appropriate collections of conditions under each rubric that will be compatible with everyday family practice; and although there is considerable room for improvement it has the additional benefit of allowing international as well as intranational comparisons of morbidity to be made.

The way is open for considerable experimentation in either selective or complete classification of diseases in practice, with the appropriate facility for classifying undefinable doctor-patient contacts where necessary, until such time as more definitive diagnoses can be made. The practitioner is not, therefore, forced into a premature diagnostic labelling procedure.

The Classification Committee is further embarking on the development of a "reasons for contact" classification, which may even further and more fundamentally reflect the directions in which resources should best be allocated. There is scope here for the better use of scarce NHS money in the sphere of preventive medicine in the community setting.

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SIR,—Dr M J Goldacre and Mr R I Harris (6 December, p 1515) raise some important questions concerning the use of the standardised mortality ratio (SMR) for International Classification of Diseases (ICD) chapters in revenue allocation and hospital planning. A number of issues warrant further comment, however.

Firstly, the analysis of the deaths and hospital use due to individual conditions within an ICD chapter largely repeats an exercise already published.[1] Its conclusion, that for a number of ICD chapters the mortality ratio is dominated by diseases which are unimportant as causes of hospital utilisation, confirms the earlier finding. The implication is that for such diseases the SMR should not be used in calculating revenue budgets. However, it should not be overlooked that the budgeting implications of any such change depend on the size of population for which services are being planned. At regional level, for example, the impact would typically be very small.

The second stage of the analysis by Dr Goldacre and Mr Harris considers individual specialties where similar problems arise. However, the impression they leave is that for some conditions specialty planning based on SMRs may be appropriate. This overlooks the unreliability of disease-specific SMRs for small populations due to random influences. Our results[2] suggest that regions should exercise considerable caution in any use of recent district mortality data for planning purposes, even for diseases which are major causes of death. The numbers of deaths in a single district even over four years is too small for most diseases to avoid undue annual fluctuations in the value of the SMR.

The unreliability of district mortality data leaves cost and population data, together with judgments on priorities, as the inevitable foundations of hospital planning below regional levels.

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[1] West R. Bed usage and disease specific mortality within ICD chapters. *J Epidem Comm Health* 1978;**32**:38-40.
[2] Palmer SR, West PA, Dodd P. Randomness in the RAWP formula: the reliability of mortality data in the allocation of National Health Service revenue. *J Epidem Comm Health* 1980;**34**:212-6.

Manpower planning and accurate information

SIR,—In your issue of 15 March (p 796), you published a letter from Mr R S Viner of the British Postgraduate Medical Federation in which he stated that he knew that area health authorities in the SW Thames Region were creating registrar posts without proper authority.

This was an extremely important statement for two reasons: firstly, although this has been alleged before in other regions by HJSC spokesmen (2 February, p 344), Mr Viner was in a position to be able to know the facts indisputably; secondly, if this is going on at all widely, it makes complete nonsense of the agreement between the profession and the DHSS and totally negates all the efforts of a large number of people and organisations. That it indeed has gone on widely can be inferred in anaesthesia from the great discrepancy between the number of new registrar posts authorised in recent years and the increase in the total figures which are reported in the annual national staffing tables. It is absolutely vital that this should be stopped and the DHSS would undoubtedly bring pressure to bear on any delinquent authority if it could get the evidence. Condign punishment is essential "pour encourager les autres."

As the chairman of the registrar and junior grades subcommittee of the Central Manpower Committee, it was clearly my responsibility to take an interest and it was therefore distressing to find that neither Mr Viner nor Professor Dick, the postgraduate dean, were willing to produce any evidence to support this assertion on the grounds that it could jeopardise their relationship with the relevant officers of the authorities. Professor Dick has even declined to give me his personal word that the assertion could be substantiated.

Because of the crucial importance to doctors and to the NHS of determining whether registrar posts really have been created without authority, may I make one final appeal to the British Postgraduate Medical Federation, the postgraduate dean, and any others in a position to know, to produce any evidence there may be to justify their allegations. We have a right to know, if these claims can be substantiated; and if they cannot then that, too, should be made known.

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The revised consultant contract

SIR,—Having now had either written or verbal communication from more than half the health board areas in Scotland, I thought that it would be reasonable to make some final observations on the revised consultant contract.

To date I have not had a single comment critical of the points which I put forward in my letter (6 September, p 686), apart from the comments of Mr Roger Hole (20 September, p 812), which were more than adequately handled in Dr J A T Duncan's letter (4 October, p 946). Mr Hole's comments on the Scottish situation display exactly the lack of perception which I blamed in my original letter as being responsible for the present unsatisfactory situation. Although the population of Scotland is only one-tenth of the total for the United Kingdom, the geographical size of Scotland means that every service, whether medical or non-medical, costs considerably more than in densely populated areas and also requires a higher level of staffing. Hence, if both the population and land area are taken into account, the allocation of resources to Scotland has in fact been far from generous in past generations. Incidentally, I did not claim that Scottish consultants worked harder than those in other parts of the UK. My only point was that a consultant who was completely committed to the NHS, either by choice or owing to lack of alternative facilities, should receive remuneration equivalent to what would be available to his whole-time