TALKING POINT

Changing gear: problems of selecting appropriate staffing ratios

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The response of the Government¹ to the Fourth Report from the Social Services Committee (the Short Report)² indicates broad acceptance of the recommendations. Two key proposals are to double the number of consultants over the next 15 years and to change the ratio of consultants to juniors from one to 1.8 to 1.8 to one. These are in response to the recommendation that a much higher proportion of patient care should be given by fully trained medical staff. No particular reason is given for the choices made and it is worth examining how these particular figures came to be selected and what will result from their adoption.

The Short Report does not recommend doubling the number of consultants, only that the number should increase with a decrease in the number of junior doctors and that at first approximation over half the hospital staff should be in career grades (para 108). It was noted (para 119) that one witness assumed the number would double. The report suggests that there should be a ratio of three career posts, including general practitioners, to every junior post (para 182). This is based on an average of eight years in training and a 30-year career as a consultant and longer as a GP. The arithmetic is unclear.

The initiative launched by the Chief Medical Officer in January 1981 referred to the need to increase the proportion of consultants and correct the career imbalance without suggesting detailed numbers. The first departmental reference to doubling consultant numbers seems to have been in a speech of the then Secretary of State to the British Association of Urological Surgeons in July 1981.³

In 1969 the first Progress Report⁴ suggested an expansion of the consultant grade by 4% and the training grades by 2.5%. This was expected to change the consultant to junior ratio from one to 1.5 in 1969 to one to 1.3 by 1978. This latter figure was the ratio in 1951. In evidence to the select committee on 29 April 1981⁵ the Secretary of State said that he would like to see the present ratio of one consultant to 1.8 juniors the other way around. There is no reference to such a change in the evidence of his senior officials.

Baselines

In January 1981 the latest available figure (for September 1980) showed 12 778 consultants in post in England and Wales. This is the basis of the figure of "about 13 000 extra consultants" referred to in chapter 3, paragraph 59, of the Government's response. The 1980 figure, however, includes 1423 consultants with honorary contracts who are employed mainly by universities. It is unreasonable to expect this number to double if only because the medical school teaching load will remain largely the same or fall.

The time scale of 15 years can be argued as starting in 1980, 1981, or 1982, but it is slipping all the time. Though it is possible to take up the slack of trained staff immediately in some specialties, expansion of the senior registrar grade will be necessary in others and additional consultants will not become available for another three years at least. The end point is currently seen as 1996. Does this mean that expansion largely takes place in 12 years or will the final target date be expected to slip as well?

At present about 650 consultants are appointed each year, about 450 of whom are in replacement posts. This figure, however, is likely to reach 650 a year by 1995 to correspond to

the increasing numbers already in post who will by then reach the normal age of retirement. In 1980 there were nearly 3000 senior registrars, of whom about 650 had honorary contracts. The movement of 650 a year to NHS consultant posts shows the imbalance present even if a small number also progress to academic consultant grade posts. The 1980 total numbers could support 1000 consultant appointments after three years in the grade or 750 after four years. Some honorary appointments, however, are in posts requiring more than the usual length of training so the actual number available will be rather less.

If doubling the number of NHS consultants is to be achieved by 1996 and current levels of expansion are maintained to 1984 at least 10 000 additional posts will be required in the following 12 years. This means about 850 a year and represents an initial increase of about 7% a year, and with the number required for replacements a total output (and intake) of 1300 rising to 1400 will be required. With a minimum training time of three years, as many as 4200 posts will be needed to train NHS consultants; these are general totals and the level of expansion will vary in different specialties. Similar reasoning will show that the output from the registrar grade must at least match the senior registrar intake, reaching a maximum of 1400. The number of posts will be determined by the length of training in the grade, the margin allowed for doctors who fail to complete the training, the extent to which training is offered to doctors from overseas, and the extent to which training at registrar level is appropriate for doctors who will seek careers outside hospital (armed Forces, community health, community medicine, occupational health, pharmaceutical industry, and research).

An increase in the input by 20% does not seem unreasonable to provide for this, which means a total of 3400 posts with two years' tenure or 5100 with three years' tenure. Some complementary flexibility in the lengths of training at registrar and senior registrar levels is usually allowed and it is difficult to be certain of these numbers.

The numbers required to be in training at SHO level are even more difficult to decide. Those entering general practice now must spend two years in the grade. Those entering hospital specialties are often said to require only one year, but there is increasing support for a longer period, thus allowing a broader but relevant experience before specialising. So it would be appropriate to provide SHO training for at least two years for those doctors who form the share of the output of the medical schools of Great Britain which can be notionally earmarked (on population grounds) to England and Wales. This is at present about 3000 and will inevitably rise to about 3250. So the minimum number of SHO posts needed is 6000, rising to 6500.

Ratios

The minimum numbers of posts needed for training in 1988 would, therefore, seem to be 4200 for senior registrars; 3400 for registrars; 6500 for SHOs; and 3250 for preregistration house officers. This gives a total of 17 350; by the same time something over 17 000 consultants, including honorary consultants, could be in post, provided that an expansion programme was started immediately. This would give the one to one ratio suggested as an interim target. The changes required would be 1200 more senior registrars, 2500 fewer registrars, and 3000 fewer SHOs.

We must, however, remember the constraints included—three years as a senior registrar, two years as a registrar (but with a 20% excess of posts), and two years as a SHO. These must surely be regarded as absolute minima but are necessary if the ratio of one to one is to be reached.

The number in the first year of training as NHS senior registrars is about 30% of the number holding preregistration posts six or eight years ago. This proportion has remained steady for some time but was about 40% in the early 1970s. An increased intake to 1300 next year would raise this proportion to over half of the relevant preregistration year. This would seem to be an unacceptably sudden distortion of career outlets and to contradict suggestions to increase the number of doctors entering general practice.

On the other hand, unless there is some increase in the intake to the senior registrar grade, an unduly large proportion of doctors will need to find career posts outside hospitals. It is not certain that general practice would be able to provide enough appropriate opportunities. Career aspirations seem to change slowly⁵ and sudden changes of actual opportunities can only lead to an increased number of disappointed and probably disgruntled doctors.

It has been shown above that the ratio of one to one can be reached in 1988 only by bringing the number of juniors down rapidly to the strict number required for training in the shortest possible time. There is a case for considering whether the average length of time a doctor holds registrar and SHO posts might not each be set at two and a half years. This would give about 2300 more posts and a ratio of one to 1.2.

An appropriate ratio for 1996 can only be determined when a decision is made about the rate of subsequent expansion. A policy of 1% annual expansion of consultants with minimum training time might require 3000 senior registrars, 2500 registrars, 4500 SHOs, and 2250 preregistration house officers. This adds up to 12 250 juniors and gives a ratio of about 1.8 to one junior.

Control of establishments

Authorities cannot respond immediately to increase the number of training posts because no additional senior registrar post can be created until after April 1983 if the present system of controls is maintained. This would delay expansion in many specialties by one year and further distort recruitment patterns if the 15-year timing is to be realised. The present control of consultant and senior registrar establishments by the DHSS on the advice of the Central Manpower Committee is a serious impediment to the implementation of regional plans. In addition, it has the effect of creating seemingly unnecessary administrative work. It requires a great deal of paper work and many meetings centrally and regionally to secure the approval of posts in most specialties when the result is a foregone conclusion.

In the majority of specialties consultant posts are, in effect, not subject to control but proposals have to follow the same long pathway as those in the few specialties in which control is thought to be required. The position at senior registrar level is even more difficult because there are few specialties in which expansion is thought to be required. This decision is based on known plans to recruit consultants and the consideration of the national picture.

The DHSS role here is surely equivocal. It was at least a party to the increased output from medical schools and would therefore seem to have some responsibility for ensuring appropriate employment for the doctors. By refusing to authorise additional senior registrar posts before there is an indication that authorities forecast a certain need for them, the Department will increasingly find itself unable to implement its own priorities for service development because of a lack of appropriately trained consultants.

The result is that a region cannot determine its own priorities for consultant development and decide to provide appropriate training. A single region would make little demand on the total national pool even if it wanted to expand its services considerably in one or two specialties which were not also subject to national expansion. Recruitment will therefore depend on attracting doctors from elsewhere in the country. Experience shows that this is not likely to happen unless there are many more senior registrars than consultant posts available.

Regional authorities are now asked⁶ to secure the required changes in the balance of hospital medical staffing. They may be reluctant to do so unless they have considerably more control than at present over the numbers they propose to train. One way of doing this would be to allow regions to establish consultant posts quite freely and to establish training posts corresponding to these plans. These proposals would be subject to discussion with regional staff interests and

would be unlikely to result in irresponsible actions by authorities. The past decisions to create inappropriate numbers of SHOs have almost always resulted from the incessant demands of consultants and have not been initiated by authorities.

The Central Manpower Committee and the DHSS exercise a negative control. They are not able to tell operational authorities to employ more staff. It is therefore not encouraging to read that the Joint Consultants Committee has asked the new chairman of the Central Manpower Committee to prepare suggestions which could give the committee more executive power.⁷ It is worth remembering that central control of manpower was introduced in 1952 in a circular entitled *Economy in Manpower* with the express purpose of restricting expansion.⁸ Exactly the opposite is needed now.

The future

Thought must be given to the position in 15 years' time when the accelerated expansion is over. It is unlikely that further expansion could exceed 1% per year. This, together with the replacement of retiring consultants, will not require the output of medical schools to continue at its present level.

A reduction of consultant appointments by the mid- to late 1990s, however, will require a reduction of medical school output by the 1990s and the intake by the mid- to late 1980s. If this is not done a disproportionately small proportion of graduates will be able to undertake hospital careers.

In addition, the medical schools will require to expand again 10 years later in order to provide replacements for the increasing numbers of consultants appointed between now and the end of the century. If the time scale for expansion were to be extended to 25 years (from 1980) instead of 15, the effect would be to cease rapid expansion at the time more replacements were needed and thus create a more even demand for doctors in hospital. The number of new posts would be about 520 a year for 20 years and would absorb, along with replacements, about 35% to 40% of medical school output. This would be a more acceptable proportion than that currently foreseen. This increased time scale would not mean that a start to expansion is any less urgent.

The total number of senior registrars required would remain, initially, at about the existing number of 3000, but changes would be required in the distribution between specialties—on the basis that some must expand more than others—and also in the length of time doctors were in post. Furthermore, the NHS would need a greater reduction in the number of registrars, though at more junior levels the numbers would be much the same as in the 15-year plan suggested earlier.

References

- 1 Department of Health and Social Security. *Government response to the fourth report from the social services committee*. 1980-1 session. Cmnd 8479. London: HMSO, 1982.
- 2 Social Services Committee. *Fourth report. Medical education with special reference to the number of doctors and the career structure in hospitals*. London: HMSO, 1981. (Short Report.)
- 3 Anonymous. Government's plan to double consultant numbers. *Br Med J* 1981;283:241.
- 4 Health Departments and the Joint Consultants Committee. *Hospital Staffing Structure (Medical and Dental)*. Progress Report on discussions. *Br Med J* 1969;iv, Suppl:53-6.
- 5 Parkhouse J, Campbell MG, Parkhouse HF, Phillips PR. Career preferences of doctors qualifying in the United Kingdom in 1979. *Health Trends* 1981;13:103-5.
- 6 Department of Health and Social Security. *Hospital medical staff: career structure and training*. HC(82)4. London: DHSS, 1982.
- 7 Anonymous. From the JCC: Hospital staffing structure. *Br Med J* 1982;284:434-6.
- 8 Ministry of Health. *National Health Service. Economy in manpower*. RHB(52)133. London: Ministry of Health, 1952.

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