Medical manpower two years on

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British Medical Journal, 1979, 1, 595-596

Summary and conclusions

Medical manpower in Britain, with particular reference to the NHS, was analysed for 1976 and 1977. The output of British medical schools increased. The total of doctors in the NHS rose by 2% between 1975 and 1976 and by 2.4% between 1976 and 1977. The highest and lowest growth rates were in junior and senior hospital staff grades respectively, while the highest growth rate in career grades seemed to be in community medicine and health. The inflow of overseas doctors remained high, though few tended to remain permanently in Britain.

Continuous evaluation of the medical manpower position is needed before long-term predictions can confidently be made.

Introduction

During the past two years I have published some rough analyses of medical manpower in Great Britain, with particular reference to the NHS, and given some forecasts based on alternative assumptions about what might happen.¹⁻³ My starting point was the data that I could obtain for 1975; most of the basic information is now available for 1976 and 1977, so that it is possible to look at what has actually taken place in these two years.

Manpower estimates

In my future estimates I tried to take account of various possible developments—for instance, that the NHS work force might stop growing due to economic restraint, that the inflow of overseas doctors might decline progressively, and that more overseas doctors might tend to remain permanently. This was coupled with my belief that what ought to happen was an increase in the size of the career grades, leading in due course to some reduction in the numbers of junior hospital staff.

By using the previous conventions, the positions in 1976 (30 September) and in 1977 were as shown in the figure. The figures for British graduates are derived from experience in sending career-preference questionnaires to preregistration house officers, and give a fair indication of the actual numbers of qualifiers from English, Welsh, and Scottish medical schools who entered medical practice in Great Britain in the calendar years concerned. The figures for overseas doctors are derived from GMC information, also for the calendar years, which concern numbers of doctors from abroad granted full registration or temporary registration for the first time. These are, therefore, as before, estimates of gross inflow with no attempt to distinguish which doctors remain permanently. The figure for community medicine and health is the total of numbers of doctors in community medicine and whole-time equivalents for doctors in community health, this being the nearest available approximation to the manpower position. No additional estimate is added for doctors in other forms of work (for example, occupational health) and in this

respect the "cell" differs from previously published analyses. Thus, the diagrams (figure) are confined to NHS medical staff, including locums.

Estimates of medical manpower (NHS medical staff only) in Britain in 1976 (above) and 1977 (below).

Growth rates

The output of the British medical schools has increased as expected. The total number of doctors in the NHS has continued to rise, by 2% between 1975 and 1976 and by over 2.4% between 1976 and 1977; this is at least as much as in recent previous years. The highest growth rate has been in the junior hospital staff grades and the lowest in the senior hospital staff grades, which increased by only a little over 1% between 1976 and 1977. The highest rate of growth in the career grades appears to have been in community medicine and community health. The inflow of overseas doctors has remained extremely high. For England and Wales, the number of foreign doctors occupying established posts in the senior hospital grades, as unrestricted principals in general practice and in community medicine, together with the number of whole-time equivalents for community health, was 247 more in 1977 than in 1976. During the same period, the total increase in the number of doctors in these grades was 460. The largest increase for overseas doctors was 202 unrestricted principals in general practice, where the total increase in numbers was 263. The number of overseas doctors in junior hospital posts, excluding locums, fell by 39 between 1976 and 1977, but this must allow for the fact that there were 123 fewer overseas doctors occupying preregistration posts. Further

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information would be needed to analyse this aspect properly, but it is still clear that, numerically, most overseas doctors are not tending to remain permanently.

The 1977 diagram (figure) includes a "cell" (bottom right) that gives a rough estimate of the total loss of doctors during the year and apports this according to the previously used estimates of death and retirement from the career grades. The residual loss of about 3500 doctors from the junior hospital grades can mostly be accounted for by overseas doctors; the model, with the data available, is not accurate enough to give a true estimate of the rate of emigration of British graduates, but this does not seem likely to have been more than a few hundred each year.

Comment

Detailed comment is unnecessary, except to reiterate the need for continuous evaluation of the medical manpower position before launching with any confidence into long-term predictions.

Much interest is still concentrated on what might happen in 20 years time, or might not,^{1,5} and on what should happen according to many different views. The continuing analysis of what is currently taking place is no less important, and perhaps more; it requires thoughtful study and more detailed information than can be found in the published tables of the DHSS.

References

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(Accepted 14 December 1978)

Letter from Chicago

Medical crises

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British Medical Journal, 1979, **1**, 596-598

A recent article entitled "The urban crisis leaves town" underscores some of the difficulties of trying to evaluate current socioeconomic trends in America.¹ One difficulty is the pronounced discrepancy between what the government says (or even believes) it is doing and what it is actually doing. This is best exemplified by President Johnson's Great Society fiscal programmes, which were supposed to help the cities but in reality hastened the destruction of neighbourhoods and the exodus to the suburbs; and by the Nixon-Ford administrations, which seemingly ignored the plight of the cities but in fact halted their decline with massive infusions of Federal funds.

Misconceptions also arise from underestimating the consequences of a giant the size of the Federal Government just sitting back and doing nothing. Another danger is failing to recognise the changes brought about by massive social, economic, demographic, and technological forces that exceed the Government's ability to control them. Furthermore, a perception gap of several years often separates the onset of a particular problem from the time it becomes recognised as a crisis, so that by the time a problem provokes great political concern it is often already being solved. We worry then, it seems, about the wrong things: "should be worrying about what we are not worrying about"; recognise as "crises" problems that are not crises at all, at least not at the moment when they are making the headlines; and "tend to confuse unstoppable evolutions with

sudden breaks in the dike."² These conclusions may well apply to some of our medical crises—budgetary, maldistribution, malpractice, and access crises—as well as to the recent predictions of an imminent surplus of doctors.

Surplus of doctors

The origins of this last problem go back to the late 1960s, when, in response to cries about a supposed doctor shortage and to intensive government prodding and cajoling, the medical schools greatly increased the size of their classes and their output of graduates. Within a decade the number of doctors per 100 000 population rose from 140 to 189; and by 1990 it is expected to reach 240, making for a total of 600 000, some 25 000 to 50 000 more than are needed. This year the Government at last realised that too many doctors costs a lot of money without necessarily ensuring better overall health; and in October Health, Education, and Welfare Secretary Califano told the deans and professors that they could now slow down and begin to cut the size of their classes—without either losing their capitation grants or creating a health-care crisis.

Regarding the "crisis" in primary care, much has already been done to satisfy the public, at least if one is to go by some of the articles in the lay press. Indeed, hardly a week passes by without some newspaper or magazine extolling the virtues of the new breed of family practitioners, how they have special training in almost everything, with boards and recertification and broad aims and responsibilities, willing to look after whole patients and whole families and not just after whole livers and lungs. Some 5000 doctors are now training in more than 350 approved three-year residency programmes, and in addition to passing their boards they will take recertifying exams every six years to keep up with modern techniques and developments. Their orientation is towards ambulatory care and avoidance of

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