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Uncomfortable questions on manpower

If it does nothing else, the Royal Commission research paper[1] on medical manpower shows the abysmal lack of strategic planning within the NHS. The Royal Commission asked two economists at York University to investigate future trends in the numbers and distribution of doctors in the Health Service. Reasonably enough, Maynard and Walker[1] began by looking at the factors that affect these numbers—the intake into medical schools, the career choices of graduates, the proportion of women and the use made of them, and immigration and emigration. Soon they found that many of the data they needed were not available or not reliable, deficiencies which have handicapped the Central Manpower Committee and about which the profession has long been critical. Furthermore, the authors found that accurate long-term forecasts—up to the end of this century—could be made only with answers that do not yet exist to a series of uncomfortable questions.

How many general practitioners shall we need in the next two decades? The report points out that with more use of practice nurses, for example, numbers could be reduced to one GP per 3000 population; at the other extreme a ratio of one per 1500 would require 36 000 GPs compared to the present total of 26 000. The number of GPs is of crucial importance in the second unresolved—and even more intractable—question: can a satisfactory hospital career structure be devised that does not rely on a subconsultant grade? The third variable is the use to be made of the growing proportion of women doctors. As Maynard and Walker observe, a high drop-out rate among women after a few years of hospital training would help preserve the current excess of hospital junior posts, but "it is a foolish way to use scarce economic resources." Finally, while some of the decisions that affect medical migration are beyond our control (whether or not the Irish continue to train more doctors than they need, and the restrictions on medical emigration to the United States) the British Government does have power to regulate the flow of doctors into and out of Britain.

Having looked at these factors, Maynard and Walker offer a "best guess" figure of 90 000 for the total number of doctors in the year 2000—a rise of nearly 40%. They suggest that the numbers of overseas doctors will fall (though more of them will be women); that the numbers of British and Irish women doctors will treble; and that the numbers of British and Irish men will rise by 30%. They go on to calculate the resource implications of these changes—the effects that more doctors will have on hospital costs and the NHS drug bill as well as their salaries—and put the increase in hospital expenditure at close to 50%. More doctors means more expenditure, and the Royal Commission will no doubt reach its own conclusions on whether or not that increased expenditure would produce returns that justify it. Certainly the current inequalities between NHS regions in the doctor population do not parallel differences in health; and the very much higher numbers of doctors in Scotland is an anomaly that bears closer examination. But whatever the Royal Commission proposes the Government will have to make the prickly decision on how many doctors the country can—or is willing to—afford.

These questions are not new but should have been given more attention in the past; they must be given priority in the immediate future. Indeed, if the Representative Body's recent censure of the BMA Council for inaction on the manpower problem[2] is any guide doctors see this matter as an urgent priority. Though earlier this year the Association persuaded the DHSS to set up a joint fact-finding body with the profession (attended also by university representatives) progress has been painfully slow. A report is, however, expected shortly. Meanwhile, the BMA will be telling the Royal Commission in oral evidence of its great concern about manpower.

The commission's own research paper underlines the urgency and makes several points that deserve support. Firstly, government departments have placed too little emphasis on collecting reliable data. Secondly, manpower estimates should include alternative forecasts to take account of variabilities in the factors that influence them—and these estimates should be revised at frequent intervals, probably every year. Finally, the report urges caution in making any changes in the hospital career structure. Fortunately the Royal Commission has visited other European countries and will have assessed the merits of practical, proved alternatives. No one would challenge the comment by Maynard and Walker that manpower forecasting and policy in the recent past have shown little imagination and little effort.

[1] Maynard, A, and Walker, A, *Doctor Manpower 1975-2000: Alternative Forecasts and Their Resource Implications*. London, HMSO, 1978.
[2] *British Medical Journal*, 1978, **2**, 369.

Correction

Contraceptive methods: risks and benefits

In the regular review by Professor M P Vessey (9 September, p 721) the number of pill users who would experience accidental pregnancies which would result in a term birth should have read 220 and not 200 as stated, and the number of IUD users who would experience accidental pregnancies which would result in a term birth should have read 500 and not 495.