

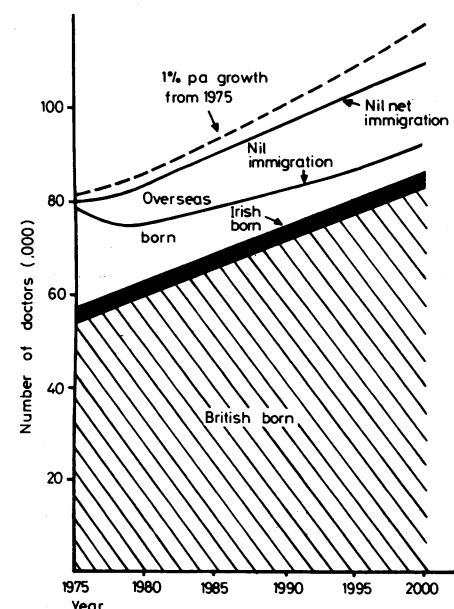
Medical manpower: the next twenty years

Government discussion paper

The Government has issued a discussion paper intended as a basis for debating "the assumptions underlying the present medical manpower policy and the broad developments . . . expected to flow from that policy." We print here extracts from the introduction and the full summary of the report, which was prepared, and is distributed by, the DHSS, the Scottish Home and Health Department, and the Welsh Office.

Introduction

It is generally accepted that the number of places in British medical schools should be set in accordance with the best estimate that



Total stock of active doctors (numbers)

can be made of the number of doctors the country will wish to employ in future years. There has been a substantial increase in the number of places in recent years from under 2000* in the early 1960s, with a current target of just over 4000 places in the early 1980s. No decision has yet been taken on whether there should be any change in the intake of students after this target is achieved, and it now seems timely to start discussion on where our present medical manpower policies are leading us and whether any changes in student intake are required. The purpose of the present paper is to promote such discussion and to provide the background information on which it may be based.

This paper is not an attempt to assess the total demand for doctors in future years. It

aims to set out as a basis for debate the assumptions underlying the present medical manpower policy and the broad developments that could be expected to flow from that policy. Another aim of this paper is to identify areas where further study or research is needed.

It is important to recognise the relevant time scale. The undergraduate medical course takes at least five years, and the requirements laid down for specialist training by educational bodies generally amount to eight years' postgraduate training. When vocational training for general practice becomes mandatory, the postgraduate education of a general practitioner will take at least four years. This means that to a large extent the number of doctors who will be available for career posts over the next 10 years is already determined by the number in training now, and that the question of the appropriate medical school intake must be looked at in the light of the need for doctors in the late 1980s and on to the 1990s. This very long time span produces difficulties—the present staffing position reflects the decisions taken in the 1950s more than those of the 1960s—and it is important not to let short-term issues or the experience of the past year or two dominate the discussion.

Summary of report

Our aim in this paper has not been to reach conclusions and on several of the problems we have raised it has been clear that the evidence is not yet available for conclusions to be drawn. The intent rather has been to stimulate discussion and to identify the areas where more research is needed.

It has become generally recognised in recent years that it will never be possible to meet all demands for health care and that it is not sensible simply to identify some figure as the future "need" for doctors and to train the number of doctors necessary to meet that "need." Choices have to be made as to which demands can or should be met; alternative ways of meeting them must be explored; we must look for areas in which we can manage with less doctors as well as areas in which we cannot manage without more. In this paper we have tried to show the consequences of what might be regarded as conservative working assumptions—generally that past trends will continue and that there will not be major changes in the nature of medical work or in the role of the doctor. We hope that the projections we have given will go some way towards reassuring those who have suggested that present policies based on these assumptions will result in massive overproduction of doctors. Before it is clear that these policies are the best possible it will be necessary to examine these assumptions critically and to explore alternatives.

The main issues raised in this paper, on

which views are invited by the Health Departments, are summarised briefly below.

FORECASTING AND RESOURCES

(a) Although the first question to be asked in considering the future annual intake of medical students is how many doctors will be needed in future years, no country has yet succeeded in devising a satisfactory means of assessing this. Is it sensible to assume that because medical practice is constantly changing and public expectations are constantly rising, demand is always likely to exceed feasible supply so that the more appropriate question is how many doctors are we likely to be able to afford? Are there techniques which could be developed to give better forecasts of future demand? (paragraphs 17 to 23). We have made projections on certain assumptions of the long-run growth of resources (section III) and of the potential growth in the number of doctors (section V)—are there any other possible sets of assumptions that should be considered?

(b) The Royal Commission on Medical Education suggested that resources should be available to afford a growth of 1.5% per annum in the number of doctors. Is this a reliable indicator of future growth for planning purposes? Would the money available for extra doctors be better spent on other types of staff or facilities in the Health Service (paragraphs 25 to 33)?

DEMAND

(c) It is possible to identify a number of ways in which extra doctors could be used. These include maintaining the present level of care for a growing and aging population (paragraphs 37 to 43), reducing existing geographic disparities (paragraphs 44 to 47), meeting present shortages in certain specialties (paragraphs 56-59), improving services and introducing new techniques (paragraph 51). More doctors would be needed to meet the commitment given by the Secretary of State to reduce working hours (paragraph 53) or as a result of other changes in medical practice (paragraphs 48 to 50). Are the various estimates in part IV of the number of doctors necessary for these purposes reasonable? What priorities should be given to these various goals? Are there any other obvious uses of doctors which should be given a high priority in the period under consideration?

(d) To what extent is there scope for reducing the number of doctors employed in various areas at present? Can one estimate the savings in manpower to be achieved by greater emphasis on prevention or on self-medication? (paragraph 62).

(e) What scope is there for the greater use of non-medical staff? What areas of research into this would be most fruitful? (paragraph 58).

*Unless the contrary is stated all figures quoted in the paper refer to Great Britain.

a first instalment and that next year it would go up again. Negotiations with the defence societies had been conducted with bitterness, and it would seem the only way to make headway with the defence societies was once again to consider talking to Bowrings.

The Council referred the matter to the Executive Committee for further consideration.

The Council approved proposals by the Private Patients Plan for a new special private health insurance scheme for BMA members.

Dr J S Noble said that he believed that there was a potential for private general practice in this country, and that the Association should foster it as an alternative to the NHS. If it did not, he suggested, the profession would continue further down the slippery slope to a full-time salaried service.

Confidentiality

Lieutenant Colonel M J G Thomas presented the report of the Central Ethical Committee, and, referring to the confidentiality of medical records, he reported that over 900 letters had been written to MPs and prospective parliamentary candidates. Over 300 personal replies had been received. Most had supported the committee's belief that the patient had a right to believe that what he said to a doctor in a consultation would remain private. The secretary of the committee had attended a meeting of the Child Health Computing Committee and had arranged for a deputation from the CHCC to come to the next meeting of the Central Ethical Committee. It had also been arranged to set up a working party with the CHCC to look into the feasibility of setting up a school health computerisation scheme.

The committee was awaiting the report of the Data Protection Committee, and the Council endorsed the recommendation that the BMA should prepare draft legislation ready to put forward if there were not either relevant or adequate legislative proposals in the report of the Data Protection Committee.

Doctors and social workers

The Council considered the reappointment of the Committee on Doctors and Social Workers. The committee met on average once a year, and at its last meeting in June 1976 it had discussed the lack of social work cover at nights and weekends; delays in the transfer of medical records; the education and training of social workers; non-accidental injury to children; communication between GPs and medical staff in other specialties; sterilisation of children; and priorities for health and personal social services.

The ARM in Cardiff had criticised the Council for choosing to wait for the report of the Royal Commission before acting on the resolutions of the ARM 1976 and the ARM 1977. (Those resolutions had deplored the effects of the segregation of the social services from NHS administration, and pressed for the reintegration of the health and welfare services within the NHS.)

But Dr J S Horner saw no possibility of any change in the organisation between the health and social services in advance of the Royal Commission's recommendations. So

it was difficult to see what Council could do when charged with implementing a policy which it recognised could not be implemented.

Dr B L Alexander recalled that the item was deferred at the 1978 ARM because the meeting did not have adequate information. There were two different issues. One was a political issue whether the health and social services should be integrated. The other was whether there should be a committee dealing with social workers and all the other paramedical organisations. Before the committee was reappointed with its present terms of reference it should be expanded.

A DHSS committee (chaired by Dame Albertine Winner) which was concerned with collaboration had just reported, Dr Joan Dawkins told the Council. Its recommendations could be passed to the Committee on Doctors and Social Workers and to the Central Committee for Community Medicine, because community physicians had a vital role to play in collaboration. The first of the committee's recommendations was that the problems of collaboration could be partly overcome if health and social services staff were better informed about each other.

Medical manpower—continued

(f) Would changes in the proportion of doctors in the various hospital grades make a significant impact on the numbers needed to provide a 24-hours-a-day service in hospitals? (paragraph 49).

(g) Is there scope for increasing the productivity of doctors by the better use of technology? In which areas would it be profitable to conduct research? (paragraph 51).

(h) Can one estimate the possible effect on doctor numbers of the policy of adjusting the balance of care to provide greater support in the community (13)?

SUPPLY

(i) The results of various projections of future doctors numbers are shown in the figure (p 1032). This shows that the present programme of medical school expansion will lead to a growth in doctor numbers of less than 1.5% per year unless there continues to be substantial medical immigration. Are the assumptions made in these projections reasonable? (paragraphs 66-79).

(j) To what extent is it possible to meet the demand for more doctor time by encouraging later retirement or by inducements for doctors with domestic commitments to work full time rather than by training more doctors? (paragraphs 82-85).

(k) What proportion of doctors in this country should be British graduates? How many posts should be made available for doctors from overseas coming to this country for postgraduate training, and to what extent should the needs for career posts be filled by doctors trained overseas? (paragraphs 75-79).

(l) The present period of long training makes it difficult to introduce any substantial measure of flexibility into forward planning. Is there scope for changes in the training of doctors which would lead to greater flexibility?

(m) The EEC Directives on free movement

Dr Joan Sutherland suggested that trouble might ensue if all professions allied to medicine which were already part of the NHS and had codes of ethics were included. Social work was not under the medical profession and had no code of ethics, though efforts had been made to produce one.

Action on the ARM resolution should have nothing to do with the committee under discussion in Dr R B L Ridge's view. The Chairman of Council should take action on the ARM resolution in the form of an appropriate letter to the Secretary of State. It would be detrimental to the potential success of the Committee on Doctors and Social Workers if it were saddled with the task of pursuing the policy when social workers did not feel they should be under the NHS.

The chairman of the Representative Body, Dr E B Lewis, suggested that the BMA had been lumbered with a policy it could not do anything with. The reason was that a two-thirds majority was required to reverse policy. Information was badly needed before further progress could be made.

The committee was reappointed with the same constitution.

of labour and the 1978 Medical Act are likely to affect the pattern of migration. Are there other potential developments at home or abroad that should be taken into account?

SHORT-TERM PROBLEMS

(n) The uneasy pyramidal shape of the medical staff structure within hospitals is only maintained through the employment of doctors from overseas who provide support at junior levels during their temporary stay in this country. British replacements of staff at this level, seeking a life-time career, would have no outlet within the hospital service. The extent to which medical work can be classified as appropriate for a trainee or a doctor in a permanent post is not known, and has not been explored in this paper; but an alteration in the staffing structure would appear to carry with it the inevitable consequence of change in the level at which work is done. What would be the effect of changes in the career structure on the provision of medical services, and on the number of doctors needed? (paragraphs 91-97).

(o) How can British graduates be attracted into the specialties and the parts of the country where they are most needed? (paragraph 98).

DECISION MAKING

(p) What is the best way to reach a consensus on these various questions and how should the problem of medical manpower best be kept under review?

Comments are invited on the paper and should be sent to Division P1B, DHSS, Room 402, Eileen House, 80-94 Newington Causeway, London SE1 6EF; the Scottish Home and Health Department, Edinburgh; or the Welsh Office, Cardiff.