TALKING POINT

University budgets and medical education

ANNE GRÜNEBERG

By the end of June the amount of money which will be allocated to individual universities for 1981-2 will have been decided by the University Grants Committee. Universities will be informed of these decisions before the start of their financial year (August-July). A warning that there will be an 8·5% reduction over three years in money allocated by the UGC has already been announced in a letter from the UGC to all vice-chancellors.[1] On the face of it this seems a marked but not catastrophic reduction in funding. Yet medical teachers have expressed alarm in response to this news.[2] Even so, many peripheral hospital consultants think that academic medicine has "plenty to spare" and that clinical academic staff have been protected from the shortages inflicted on the rest of us by sheltering behind their function as medical educators.

Funding of medical education

The Department of Education and Science allocates funds to the University Grants Committee, which distributes these to individual universities. The money is then allocated to the different departments within the universities. Academic medical departments receive most of their Government funds by this mechanism. For the first time the UGC will give institutions specific targets for the numbers of students.[1]

The data in the table show that in real terms the unit cost for medical education was much lower in 1978-9 than in 1971-2. So medical education has already been subjected to a "productivity deal" and its funding has not been well protected in unit cost terms. Since 1970 the proportion of the annual recurrent UGC grant supplied by the universities to medical and dental departments in the United Kingdom has consistently been 18% of the total. Annual student intake in all disciplines in 1980-1 was 28% more than 1970-1, while that for medicine was 32% more. Thus in the last decade the amount of UGC money spent on each student in other subjects has risen in comparison with that spent on medicine.[3]

If medicine is faced with its share of the proposed 8·5% reduction in funds over the next three years the money supply to many medical institutions will be curtailed to a much greater extent than this because of the loss of overseas students' fees. At the same time other sources of finance—for example, the NHS, the Medical Research Council, and industry—are also being curtailed. So the financial loss to medical education will be much greater than at first appears.

Postgraduate medical education has already been affected in the form of proposed closures and forced amalgamations of postgraduate institutes. As undergraduate medical education in the United Kingdom can now be obtained only by attending a medical school any damage to medical school standards would affect the quality of undergraduate medical education. Because over 80% of the UGC money allocated to medical education is spent on staff salaries, savings of the order proposed will necessitate a reduction in the number of academic staff. Clinical medical teaching is particularly vulnerable because of the importance of small group teaching in the discipline and the high turnover of junior academic clinical staff. Funds are unlikely to be available for additional NHS staff to make up any deficit. If the clinical load is constant and there are no other compensatory changes patient care will continue at the expense of teaching and research. Limitation of research means that the quality as well as the quantity of teaching will suffer.

Staff : student ratios and medical student numbers

The report of the Commission of the European Community's Advisory Committee on Medical Training—published on 10 March 1981—has now been distributed to the member States. According to this report the current United Kingdom clinical academic staff:student ratio averages 1:5·5, whereas the report recommends a staff:student ratio of 1:5. The recent proposals (March 1981) for reducing the clinical academic staff: student ratio to 1:7 have now been accepted by the London University Senate. This is a marked reduction compared with traditional staff:student ratios in Britain and is below the level accepted as appropriate by the Commission of the European Community.

UGC recurrent grant expenditure on medical academic departments, Great Britain (academic funding year August to July)

	Preclinical medicine			Clinical medicine		
	Total student load*†	Unit cost† (£)	Unit cost at 1978–9 price levels‡ (£)	Total student load*†	Unit cost† (£)	Unit cost at 1978–9 price levels‡ (£)
1971–2	8 876	1111	2820	11 389	1598	4056
1972–3	9 492	1210	2823	11 949	1741	4062
1973–4	9 832	1294	2678	12 949	1810	3746
1974–5	10 062	1540	2651	13 861	2107	3626
1975–6	10 512	1842	2618	13 970	2556	3633
1976–7	10 885	2008	2459	14 571	2721	3333
1977–8	11 436	2094	2315	14 878	2932	3242
1978–9	11 635	2313	2313	15 483	3240	3240

*Full-time equivalent.
†Source: *Statistics of Education Universities*, published annually by University Grants Committee.
‡Data supplied by BMA Economic Research Unit. Retail price index used to translate cost into 1978–9 values (August to July).

The United Kingdom medical student intake in 1980-1 was 4009 compared with 2983 in 1970-1. In London it has been proposed[4] that non-medical student numbers should be reduced by 10% by 1982-3. In contrast, the only curtailment of medical student intake proposed[5] has been in terms of a pause at present levels before a further increase in annual intake. If the new high level of medical school intake is maintained any reduction of UGC funds to undergraduate medical education means a further cut in unit costs. It has been argued that there is no evidence to suggest that a reduction in funding would produce a drop in standards. Given the productivity improvement already achieved in medical education, I submit that the onus rests on those who suggest a further reduction in unit costs to provide evidence that this reduction can be achieved without damage to standards.

The alternative to maintaining the level of student admissions

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BMA meets Secretary of State on pay award

A joint delegation from the BMA and the BDA, led by the Chairman of the BMA Council, Mr A H Grabham, and including three craft chairmen and a representative from the HJSC, met Mr Patrick Jenkin on 2 June. The meeting was sought because of the Government's imposition of its 6% pay limit on the Review Body's recommendations despite the fact that the Review Body on Doctors' and Dentists' Remuneration had taken economic factors into account in making its award. The BMA issued a press statement after the meeting and this is reproduced here.

"Mr Grabham emphasised that the committees had not decided whether to accept the Prime Minister's decision and that grave concern had been expressed throughout the professions at the consequences of the Prime Minister's decision to impose the Government's 6% limit on the independent findings of the Review Body. In spite of the Prime Minister's assurances, he said it was clear from the Department of Health's evidence to the Review Body that it had been the intention of the Government to prevent doctors' and dentists' pay rising for fear that others might follow.*

"In reply, the Secretary of State summarised the 'clear and compelling reasons' which had been given by the Prime Minister for reaching her decision and stated that it was most certainly not the policy of the Government that doctors and dentists should be used as an example to others. He emphasised the Government's determination to adhere to the 6% cash limit in the public sector and that it would apply to all workers in the NHS this year. Nevertheless, he confirmed that he attached enormous importance to the Review Body system as the best method of settling the professions' remuneration. The Government's decision was an exceptional one taken in exceptional circumstances.

"The Secretary of State said that he shared the concern of the professions about the situation which could arise over the next Review Body report. However, the Government recognised that a fixed cash limit is not a satisfactory way of settling pay in the public sector in perpetuity and that a greater degree of flexibility would be needed next year. Discussions had already been entered into with the Civil Service unions on this basis and they would be given an opportunity to discuss pay arrangements in advance of the fixing of cash limits for 1982. The Secretary of State fully acknowledged that an arrangement would have to be found which would ensure the continued independence of the Review Body and the professions' confidence in the Review Body system.

"When the doctors urged him to consider the issue of phasing the award and protection of pensions, the Secretary of State said that the Chancellor of the Exchequer had given an undertaking to Parliament that there would be no more staging of awards in the public sector following the strong criticisms of staging which had been made by the Treasury and Civil Service Select Committee on Public Expenditure. The pensions of those retiring from the professions during 1981-2 could not be notionally adjusted as the whole award would have to be scaled down in order to keep within the 6% cash limit.

"Reports of the meeting with the Prime Minister (on 15 May) and the Secretary of State are now being considered by the committees of both Associations representing all branches of medical and dental practice in the National Health Service."

*Paragraph 34 of the Eleventh Report of the Review Body on Doctors' and Dentists' Remuneration, Cmnd 8239, stated: "It was put to us that a relatively high pay increase for doctors and dentists might stimulate similar demands from the representatives of other NHS groups."

GMSC chairman reluctantly accepts Government's "unique" decision

After the meeting the chairman of the General Medical Services Committee, Dr John Ball, notified secretaries of local medical committees that he had accepted the Government's decision to reduce the Review Body's recommendations to an average of 6%. The Secretary of State was told that acceptance "could only take place reluctantly, on the strict understanding that this was a unique occasion." The DHSS had been told that payment of the increase should be authorised so that payments on account may be made at the end of June.

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is to reduce their number concomitant with the decrease in funds. There is still time for this option to be taken as 30% of medical school places are usually allocated by the clearance scheme run by the Universities' Central Council for Admission. If UGC funding of medical education decreases there is thus still time for the intake of students for 1981-2 to be reduced.

Under present circumstances it may be difficult for an individual university to resist pressure to maintain its medical student intake for fear of having its funds further reduced. Previously universities have been well able to maintain standards of undergraduate medical education without the intervention of the General Medical Council. Under the present exceptional circumstances the GMC's support might be helpful to any university worried about maintaining its standards of medical education. According to section 15 of the 1978 Medical Act it is the function of the Education Committee of the GMC to promote high standards of medical education and determine the requirements for the granting of primary United Kingdom qualifications. It is open to the Education Committee to recommend to the Privy Council that qualifications which do not measure up to those criteria shall not be registrable.

Conclusion

I submit that it is more important to maintain the quality of medical education than the present number of students. The challenge from reduced funds should be met by a reduction in numbers. Future medical manpower needs cannot be calculated accurately because the information on which to base them is not available. Insistence on maintaining the recently expanded medical school intake is based on guesswork. On the other hand, by extrapolation from experience in other countries we know what happens if standards of medical education are not maintained. My concern in this matter does not stem from any personal professional interest in medical education but from experience of the damage done by recent forced financial restriction to many hospital medical services to patients. How will it benefit these services and society if the recent increase in numbers of medical student is maintained but they are trained to a lower standard?

A reduction of student numbers should make a reduction in staff costs possible without adversely affecting staff:student ratios. A partial reversal of the hasty measures taken to accommodate the recent rapid increase in the level of medical student intake could occur. For example, the duplicate classes which have been introduced would not be necessary and this would save staff time and so, potentially, money.

I do not think that university education should be spared contact with national financial reality; nor would I suggest that medical education should be spared at the cost of other subjects. I propose that institutions responsible for maintaining standards of medical education should state that they intend to maintain those standards and that the Government will get only what it pays for in terms of quantity.

References

1 Geddes D. University department and staff cut threats confirmed. *The Times* 1981 May 19:4 (col 1-3).
2 Sir John Walton. An act of madness? *Br Med J* 1981;**282**:1150-2.
3 Data supplied by the Committee of Vice-Chancellors, May 1981.
4 Swimmerton-Dyer Report on London University non-medical education, June 1981.
5 Social Services Select Committee. *Medical education.* Evidence from Committee of Vice-chancellors and Principals. London: House of Commons, April 1981.