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How many doctors does Britain need by 2010?

More than the Medical Manpower Standing Advisory Committee thinks

In the early 1980s fear of increasing medical unemployment led the BMA's representative body to pass several motions calling for a reduction in medical schools' intake. This fear was based on the apparent disparity between the number graduating from medical schools and the number of career posts becoming available each year. The substantial proportion of newly qualified doctors (18-25%) who never practise or who leave medicine within a few years was, however, ignored. Although the BMA's anxieties were not supported by a study carried out by the Department of Health's Advisory Committee on Medical Manpower Planning and published in 1985,[1] the association's policy did not change. In 1989 the same committee suggested that a possible slight shortage of doctors might occur by the first decade of the twenty first century. It saw no need for immediate action but recommended that the matter should be kept under review.

The Medical Manpower Standing Advisory Committee was set up in July 1991 to fulfil this role and has just produced its first report (p ???). Unlike its predecessor, the standing committee will continue working but has already felt able to recommend a small increase in the target number of places at medical schools. The size of the increase, amounting to 5·7% or 240 places, seems to have been determined purely on the basis of the amount of spare capacity in the medical schools, which could be used at no capital cost. The committee has also recommended an increase in the proportion of overseas students from 5·0% to 7·5%, which implies that barely half of the extra places will be available to local applicants.

These are extremely cautious recommendations, redeemed only by the hope of a more robust analysis in future. The committee has considered the numerous recent developments and trends in the provision of health care but has felt unable to judge the likely impact of most of them. Instead, it has chosen to develop "projections of demand based on the likely availability of resources rather than on detailed assessments of specialty needs." This approach was partly dictated by the committee's terms of reference, which required it to take "account of resource assumptions and other guidance which the Secretary of State... may give," and by the fact that its secretariat was provided by the Department of Health's Medical Manpower Executive. The report makes a fair attempt to assess the future demand for medical staff within these constraints but shies away from estimating the number of doctors required to provide both an acceptable service to patients and acceptable working conditions for doctors themselves.

The committee took evidence from a wide variety of sources and assessed it rigorously. It has accepted that progressive aging of the population necessitates a parallel increase in numbers of doctors. It is less persuaded of a trend to earlier retirement but has assumed an average fall in the retirement age of two years by 2010. It recommends an increase in the number of part time training posts and allows for a resulting modest fall in the average number of whole time equivalents that doctors work. It also assumes a drop out rate somewhat higher than that used by its predecessor and, unlike that body, expects growth in the number of general practitioners to continue after 2000 rather than tail off. Conveniently, the increase in demand resulting from all of these factors can be accommodated within the historically determined resource assumptions accepted by the committee.

Issues that the committee considered inconclusively included the impact of medical advances on the demand for medical time; possible changes in skill mix; the consequences on staffing of the interaction between purchasers and providers and of patients' charters; the need to reduce hours of work (only junior doctors are mentioned); possible changes to the career structure; and the increasing managerial and educational demands on consultants. Reliable data on the staffing consequences of these factors do not exist, and the committee recommends that research should be undertaken to quantify them, especially the effects of changing skill mix, the cost implications of employing more doctors, and the extent to which doctors are abandoning medical careers. It is questionable, however, whether the effects of these and many other factors can be precisely quantified, and the committee may find itself obliged to exercise its judgment less cautiously in future years.

Arguments in favour of a more substantial increase in the supply of medical staff come from several sources. It has long been recognised that the ratio of doctors to population in the United Kingdom, at 1 to 562, is the second lowest in western Europe, where the average is 1 to 338.[3] The consequences of this disparity are not completely offset by the greater efficiency of the NHS. Medical immigration from the European Community and elsewhere, which has previously made up any shortage of local graduates, is stable and unlikely to increase. A detailed study of medical staffing in Europe carried out by the Permanent Working Group of European Junior Hospital Doctors has shown that the substantial medical unemployment that exists in some parts of Europe is

likely to decline sharply after 2000 and that many countries, and Europe as a whole, will face a shortage of doctors before 2010.[5] This projection, based on modest assumptions of growth in demand, does not fully take into account reductions in working hours or demands resulting from technological advances.

There is little doubt among practising doctors, both in hospital medicine and in general practice, that the demands and pressures on them are increasing rapidly. Consultants' caseloads are mounting inexorably and technical complexity is increasing while junior support declines, both proportionately and in terms of doctor hours. At the same time, managerial demands multiply and educational bodies are insisting on a greater educational input as a condition of continued approval of posts.[6] Medical advances almost invariably increase the demands on doctors' time, and it is this increased intensity of working that has made the long hours of many doctors intolerable. Despite hopes that some tasks inappropriate to junior doctors can be delegated to other groups of staff the new deal on juniors' hours risks worsening the situation by increasing the intensity of work still further, notwithstanding the shorter working week. Meanwhile general practitioners, facing increased demands, have voted to explore alternatives to their current responsibility for 24 hour cover.

The extent of the frustration and demoralisation among junior doctors, both male and female, has been documented by Allen.[7] The conditions under which NHS doctors work are increasingly unhealthy and debilitating, and increasing numbers in all grades and specialties are seeking ways out. The undoubted job satisfaction of medical practice has insulated the NHS to a considerable degree from the expectation in society at large of increased leisure time, but this is changing. The steering committee itself states the need for better working practices, observing that "if these changes do not take place, disenchantment will grow,... leading to increased drop out rates" with "the potential for staff shortages." Disappointingly, the committee has so far felt able to recommend only a tiny step towards establishing acceptable levels of medical staffing in the NHS. The battle to achieve these is perhaps the most important one facing Britain's doctors during the 1990s. Failure is likely to have serious consequences, both for patients and for the medical workforce.

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On not achieving a balance

JPAC may be worsening the problems it was set up to solve

Achieving a Balance (1986) was meant to correct the severe bottlenecks in hospital careers by balancing the number of career registrar and senior registrar posts with realistic projections of how many consultant posts would exist.[1] The intention—set out in *Plan for Action*[2]—was to increase consultant numbers by 2·8% a year while keeping constant the number of senior registrars and reducing modestly the number of career registrars. Surplus junior posts were to be converted to consultant posts, with additional service work being met by the new staff grade and a small increase in the number of senior house officers. The changes were meant to be implemented by 1998, by which time juniors would spend an average of 6·5 years in the combined registrar and senior registrar grades. The Joint Planning Advisory Committee (JPAC) was given the task of setting and reviewing quotas for all specialties. What progress, if any, has been made?

The chances of achieving the goals of a balanced career structure and shorter training by 1998 seem slight, and JPAC is mainly to blame. Instead of keeping numbers of senior registrars constant, JPAC's quotas will see them rising by more than half to over 5100, while career registrar quotas are more than 40% over target at almost 4700.[3] These figures could be justified only if consultant expansion had substantially exceeded the 2·8% a year on which the numbers in *Plan for Action* were calculated. The average annual consultant expansion in Britain from 1987 to 1990 (the most recent available figures) has been only 2·6%.[4] Although the funded consultant posts for junior doctors' hours will help, these have been concentrated in a few specialties, and the recession has provoked concerns that the rate of consultant expansion may even fall.

The reasons why JPAC's quotas differ so greatly from what was intended are twofold. Firstly, *Plan for Action* assumed that it would be necessary to start with about 11% more career registrars than were needed to fill the expected consultant posts, whereas JPAC routinely accepts advice from specialty staffing representatives to calculate up to 50% more posts (for example, in general medicine and obstetrics and gynaecology). Secondly, JPAC has assumed that the number of consultant posts will consistently increase by over 4% a year. This is despite *Plan for Action's* estimate of 2·8% and the Department of Health's commitment to an expansion of only 2% a year. To produce 6·5 years of specialty training with an 11% wastage rate on JPAC's current quotas would actually require a consistent rate of expansion of almost 5%.

There are further problems. Quotas for career registrars were issued two years late, and those for research registrars have yet to be issued. Out of 14 specific recommendations made in *Plan for Action* only those regarding the "pump priming" consultants and the introduction of the staff grade have been entirely implemented. Early retirement and careers counselling have been partially implemented, but the 10 other recommendations have not been implemented at all or have been reversed. Numbers of senior house officers have risen by 14% in three years—far more than was intended—and, by not substantially reducing the number of registrars, JPAC has failed to keep to its terms of reference.

As it takes several years for the effects of changing the number of trainees to become obvious the failure to implement *Achieving a Balance* is only now becoming evident. Worst hit are trainees in thoracic medicine. Despite a review