COMMENTARY

Policy options for medical manpower

RUDOLF KLEIN

In one of those sudden mass conversions usually associated with religious revivalism, it has become accepted almost overnight that Britain faces an impending surplus of doctors. The spectre of medical unemployment—on the model of teacher unemployment—haunts the profession. Nor are these fears unreasonable. All the available evidence seems to support them. A recent survey of medical manpower by two economists comes to the conclusion that there will already be a small excess of doctors by 1980.¹ Moreover, throughout the Western world—in Europe and in North America—the medical schools are still expanding, threatening to internationalise the surplus. So not surprisingly, less than 10 years after Lord Todd's Royal Commission on Medical Education recommended that the number of places at medical schools should be doubled by 1990,² the Royal Commission on the National Health Service is now being asked to halt, and indeed reverse, this expansion.³

The fact that the balance appears to have changed so dramatically in so short a period should, in itself, act as a warning against drawing over-confident conclusions about what is still very much an uncertain future. There appears to be a very real danger of a manic-depressive cycle developing, where medical manpower policy is reversed every 10 years or so. Just as the Todd Commission reversed the recommendations of the 1957 Willink Committee, so quite conceivably a decision to abandon the Todd policy now might be yet a further somersault in the mid-eighties.

Fragile assumptions

To make this point is not to criticise the calculations of those who forecast a surplus of doctors: these are almost certainly right, given current assumptions. It is rather to argue that these assumptions are inevitably and inescapably fragile, and that any debate about policy options ought therefore to start by examining a range of possibilities and allowing for uncertainty. Extrapolating an expanding number of doctors into a static future—assuming, in other words, that the constraints and pattern of health care will not change greatly in the coming decades—is bound to lead to the conclusion that there will be an excess of medical manpower. But, of course, it cannot be taken for granted that either the economic environment or the structure of the National Health Service are fixed for all time, and I want to examine some of the options which might be available on the assumption of change.

To start with, it is worth emphasising the amount of guess-work that has to go into any calculations about the future demand for, and supply of, doctors (even leaving aside such crucial issues as the balance between career and training posts). Firstly, there are estimates

about future population size, and on the past record it is a great deal easier to pick the winner of the Grand National than it is to forecast Britain's population in the year 2001.⁴ Secondly, there is the uncertainty about the future intentions of the immigrant doctors, on whom the hospital services so largely depend at present—while no one can be sure that the stream of replacements will continue to flow. There are, additionally, similar, if lesser, uncertainties about the likely career patterns of women doctors. Lastly, there is the question of Britain's economic prospects—and what assumptions ought to be made about the future availability of funds for employing doctors (among others).

No accident

For it is no accident that the agitation about an excess of doctors has coincided with a period of economic crisis. Although there may be scope for argument whether the NHS is getting its right share of the national income (a somewhat metaphysical concept, anyway), there can be no argument whatsoever about the fact that the main prospect of extra resources—and jobs—depends on the growth of that national income. Taking expenditure on health in advanced industrial countries, the evidence suggests that spending levels have little to do with the organisation of the medical care system but everything to do with the size of the Gross National Product.⁵ As this rises, per head of population, so does expenditure on health. In other words, the main reason why Britain spends less of her GNP on health services—and employs relatively fewer doctors—than, say, Germany or the United States is that she is a poorer country. If it is assumed that this state of things will continue—that Britain has become a static, non-growth society—then clearly a policy of medical manpower contraception is appropriate. If, however, it is assumed that this is a temporary rather than a chronic condition, and that growth will be resumed again, then different considerations apply.

But even if the crystal-ball of economic forecasting were more reliable than it is, there would still remain a very large doubt about how many doctors Britain will be able to afford. The real case for cutting down the prospective number of doctors is not, after all, that their actual salaries will be more than the NHS will be able to afford. It is that their activities will generate demands beyond the capacity of the system: that an increase in medical salaries will mean a much bigger rise in total medical care expenditure.

In the current financial year, for example, expenditure on the general medical services (including practice expenses) is planned to be £359 million. But expenditure on the pharmaceutical services—that is, spending largely determined by the prescribing policies of GPs—will be £547 million.⁶ And even this under-

states the expenditure generating activities of the family practitioner, since it leaves out of account the costs of tests or referrals. Precisely the same point applies to hospital doctors since their clinical decisions can have even more expensive consequences.

To emphasise this argument, all too familiar in other contexts, is to suggest that the answer to the question of how many doctors can be employed depends largely on the attitudes and policies of the medical profession itself. General practitioners, for instance, frequently argue that they could cut down the number of prescriptions they issue if only they had more time with patients. So if increasing their numbers were to bring about a compensatory fall in prescribing costs—or, more important still, a reduction in hospital referrals—this might turn out to be a good bargain. Again, if increasing the number of hospital doctors meant cutting costs per case, reducing the number of inpatients and halting the rise in tests ordered, then such a rise might well pay for itself. Even to mention this option as a possibility may seem totally unrealistic and impracticable: it does, however, emphasise that the constraints on medical employment reflect not only economic circumstances and Government policies but also professional practices. If these change, then so may the prospects for employment. Here, then, is yet a further element of uncertainty and unpredictability.

Cost of errors

Given, therefore, the likelihood that almost any guess about the future is likely to be proved wrong, what is the cost of error in different circumstances? Given the near-inevitability of making a mistake, which is likely to be the least burdensome blunder? On the face of it, cutting down the number of medical school places would seem to be the most sensible way of minimising the risks. If, in fact, there is economic growth—or if, less plausibly, there is another population explosion—then, instead of reversing policy yet again, it might be possible to pursue an active policy of substituting less expensively trained manpower for highly qualified doctors. In effect, the medical profession could be turned into a small, technological élite in charge of an ever-growing supporting army of technicians, nurses, and other ancillaries. Whether this is the model which doctors would like to adopt is, of course, another matter, but it is certainly one possible way of coping when the demand for medical manpower leaps ahead of the supply.

In contrast, a policy of continuing with the present programme of medical training would seem to carry higher risks. Each graduate costs something like £30 000 to train. To invest amounts like this, if there is any possibility that this will simply increase the number of unemployed, would seem to be recklessly

wasteful. As against this, however, it could be argued that a surplus of doctors will bring down the relative level of medical salaries, and thus make it possible to employ more doctors; an outcome which, though clearly repugnant to existing members of the profession, would benefit the public as a whole. There are already signs, after all, that professional incomes are falling in comparison with others, and it may well be that doctors—like university professors and others—will slide down the earnings hierarchy, both in Britain and in other countries which have expanded higher education so rapidly over the past decades. In other words, this approach might put incomes rather than jobs at risk, and imply a very different evolution of the medical profession as simply one of a number of health care professions, less distinguished in terms of rewards and status from the rest.

If the risks involved in either the cutting-back or full-steam-ahead strategies seem excessive, are there any other policy options? It is tempting to reply that, given uncertainty, it is best to plan for flexibility: to try to design a system which can adapt quickly and sensitively to constant change. Unfortunately, the scope for doing so in the case of medical

manpower seems limited. Graduates cannot be put in moth-balls or in the deep-freezer.

Nevertheless, it would seem to be worth discussing the costs and benefits of two options. Firstly, given that a surplus of doctors becomes apparent in the 1980s, what would be the cost of a policy of early retirement with generous compensation? Similarly, given the likelihood that a general surplus might well be accompanied by specific shortages in certain specialties or parts of the country, what would be the cost of retraining and relocation schemes designed to bring about more flexibility within the medical labour force?

Secondly, would it be possible to devise a health care manpower training policy to replace the present medical manpower training policy? Given the scope for substituting different kinds of manpower, there would seem to be a strong case for an education programme which facilitates such a process instead of making differences more rigid. In particular, there would seem to be a persuasive argument for experimenting—as in North America—with a shared basic, initial health care curriculum for doctors and nurses alike. This might make it easier both to achieve a suitable mix of skills and perhaps also allow

mid-career changes, with nurses eventually qualifying as doctors after a second period of study.

All this no doubt sounds highly speculative and fanciful. So, in a sense, it is. But trying to predict the precise number of doctors required in the next millenium, and adjusting medical school places accordingly, is no less speculative and fanciful, given all the uncertainties.

References

- ¹ Maynard, A, and Walker, A, *Lloyds Bank Review*, 1977, No. 125, p 24.
- ² Royal Commission on Medical Education, 1965-8, *Report*, Cmnd 3569. London, HMSO, 1968.
- ³ *British Medical Journal*, 1977, 1, 465.
- ⁴ Central Policy Review Staff, *Population and the Social Services*. London, HMSO, 1977.
- ⁵ Newhouse, J P, *Income and medical care expenditure across countries*, The Rand Papers Series P-5608-1. Santa Monica, Cal, The Rand Corporation, August 1976.
- ⁶ *The Government's Expenditure Plans*, Vol II, Cmnd 6721-II. London, HMSO, 1977.

Centre for Studies in Social Policy, London
WC1N 2LS
RUDOLF KLEIN, MA, senior fellow

Health Services Board

BMA advice to consultants

In a letter (13 June) to health authorities the Health Services Board has listed hospitals where in 1975 and 1976 the occupancy of private pay-beds was at or below 50%. The board thinks that "this finding may be an indication that there is not a reasonable demand for all the pay-beds currently authorised" and suggests, therefore, that the number could be reduced. The CCHMS has taken the advice of a leading Queen's Counsel and the latest linkman letter suggests how consultants can minimise the impact of the proposals. The board has invited authorities to submit verifiable factual evidence by 28 July that the demand for private facilities is not realistically shown by the recorded bed occupancy.

In the light of Counsel's opinion the CCHMS has suggested the following examples of factors which might have affected occupancy figures:

- Closure of private beds during 1975-6 by industrial action or staff or other shortages.
- Difficulty in booking private patients into beds because they were in use for NHS patients.
- Inability to admit private patients requesting private treatment because private beds were fully occupied.
- Extensive use of beds for private day cases sufficient to modify the occupancy figures which do not record day admissions.
- Evidence that the keeping of records and statistics is subject to error.

Private consulting room facilities

The Health Services Board has now agreed to withdraw private consulting room facilities

only from hospitals which show a "nil return." If consultants can assure themselves, from information obtainable from the sector administrator, that a return was made to the board showing that consulting rooms were in use no action need be taken at present. If such facilities are in use and the administration put in a "nil return" the board should be informed. If the administration had failed to make a formal application to the Secretary of State for authority for private consultations, though it

had been accepting fees for the use of the facility, Counsel has stated that the position of consultants would be protected in the Courts. X-ray, pathology, and other diagnostic facilities are not affected.

Communications should be sent, by 28 July, to The Secretary, Health Services Board, 157-168 Blackfriars Road, London SE1 8EU, with copies, if possible, to the CCHMS Secretary, BMA, BMA House, Tavistock Square, London WC1H 9JP.

DHSS planning

A comprehensive DHSS circular (HC(77)19) issued recently sets out the Department's planning guidelines for 1977-8. The document contains financial assumptions for the planning period up to 1979-80 based on the White Paper on Public Expenditure (Cmnd 6721) (see table). Another section gives general guidance on the need for compatibility of financial, service, and manpower plans and

projections; it also provides information on the likely availability of consultant manpower now that the medical manpower planning forms part of the NHS planning system. The circular concludes with Mr David Ennals's 12-point plan to achieve value for money in the NHS. Comments on the consultative document, *Priorities for Health and Personal Social Services in England* (HC(76)17) are being analysed and regional strategic plans will be discussed with RHAs in the autumn.

Forward planning assumptions: RHA revenue figures (including service increment for teaching)*

Regional health authority	1978-9			1979-80		
	Health services	Joint financing	Total	Health services	Joint financing	Total
Northern	248.9	1.0	249.9	253.8	1.3	255.1
Yorkshire	282.6	1.1	283.7	285.7	1.5	287.2
Trent	332.3	1.3	333.6	339.1	1.8	340.9
East Anglia	137.8	0.6	138.4	140.1	0.8	140.9
North-west Thames	341.3	1.1	342.4	341.3	1.5	342.8
North-east Thames	373.7	1.3	375.0	373.7	1.6	375.3
South-east Thames	352.3	1.4	353.7	352.3	1.8	354.1
South-west Thames	274.2	1.0	275.2	274.2	1.4	275.6
Wessex	201.2	1.0	202.2	204.5	1.3	205.8
Oxford	162.8	0.6	163.4	162.8	0.8	163.6
South-western	245.5	1.1	246.6	248.6	1.5	250.1
West Midlands	387.8	1.4	389.2	393.4	1.9	395.3
Mersey	213.5	0.8	214.3	215.3	1.0	216.3
North western	342.8	1.3	344.1	349.8	1.8	351.6
Totals	3896.7	15.0	3911.7	3934.6	20.0	3954.6

*Source: DHSS Circular (HC(77)19) DHSS Planning Guidelines for 1977-8.