TALKING POINT

Medical manpower and some of the effects

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Since there are so many variables both external and internal to the Health Service which can affect the future medical manpower requirements, a less rigid and less centralised system of control should be introduced.

There is evidence that there have been unexpected outcomes from the various NHS policy decisions on medical manpower, some of which may contradict the intentions. Since the Department of Health is moving towards a fairer system of allocating cash resources it is suggested that a more flexible system should be available to health authorities particularly now that a new career grade, the hospital practitioner, is being introduced.

Plethora of reports

People could be forgiven for being confused on the subject of medical manpower because the 1960s saw many reports on the subject.^{1,2} In 1966 negotiations began between the DHSS and the profession, based on a memorandum *Current Problems in Hospital Medical Staff*.³ The final report⁴ was issued in 1968 and contained the Panel 1 Report on career structure and planning, whose main recommendations were accepted and included: "The targets for consultant medical staffing derived from the Platt Report need revision, and new machinery for the fixing of establishments and control of staffing is needed . . ."; and "There is a continuing need for the medical assistant grade. . . ."

In 1968 also the Joint Consultants Committee formed a sub-committee on hospital staffing structure,⁵ which reported early in 1969 (Lewin Report) taking into account the Todd Report's recommendations, which were published in the same year.⁶ Among the recommendations contained in the Lewin Report were:

(1) . . . that there should only be two grades of permanent tenure in the hospital service, the consultant and the hospital practitioner grade. The latter would be separate from the training structure and geared to remuneration in general practice.

(2) There should be a controlled expansion of the consultant grade . . . and the number of doctors undergoing specialist training should be closely related to the number of consultant vacancies likely to arise. Registered specialists awaiting consultant posts should be offered temporary posts at the minimum of the consultant grade.

(3) Assuming the hospital practitioner grade and the "holding posts" for registered specialists are introduced, the medical assistant grade should be abolished. (A moratorium for whole-time posts in the latter grade had been introduced in 1968 after the Annual Representative Meeting carried a motion rejecting the grade).

The Joint Consultants Committee used the Lewin Report as a basis for discussions with the DHSS along with the Godber Report⁷ on the responsibilities of the consultant grade. The First Progress Report⁸ was published in December 1969 and it contained four main propositions (see Dr W J Appleyard's working paper on p 136).

In 1971 the Second Progress Report⁹ was published: it concentrated on establishing a new joint machinery to ensure better forward planning. The old Advisory Committee for Consultant Establishments (ACCE) would be replaced by a central manpower committee (CMC), which would: "Within the strategic objectives which had been agreed between the Health Department and the professions' representatives advise the Health Department in planning targets for staffing in the different grades and specialties both nationally and regionally. . . ."; ". . . identify particular problems and advise. . . ."; ". . . monitor progress. . . ." Regional manpower committees would also be established to enable the professions in the regions to express informed and considered views on the development of staffing, which regional hospital boards will regard as a valuable source of advice, without in

any way encroaching upon their responsibility for decisions. Approval of senior registrar and registrar posts would remain with the DHSS advised by training committees and two subcommittees of the Central Manpower Committee—the senior registrar and junior grades subcommittees.

Four per cent growth

In 1972 the Central Manpower Committee recommended that programmes of expansion of the number of consultants should be formulated, region by region, in such a way that the number of consultants would grow at 4% a year nationally and that the hospital medical staffing structure would become more equal, in relation to population, at a rate which, if maintained, would bring approximate parity within 10 years. Regional health authorities were invited to draw up rolling programmes on a three-year basis within their target allocation of additional posts.

The Third Progress Report,¹⁰ published in the same year, gave further details on the hospital practitioner grade and arrangements for senior registrars temporarily unable to obtain consultant posts on completion of training. The medical assistant grade would be established only on a personal basis, subject to DHSS approval following advice from the Central Manpower Committee and the support of the professions' regional manpower committees. Whole-time posts would not be advertised, except with central approval, and would be strictly limited but would ordinarily include posts in refraction, blood transfusion service, audiology, and dental services for long-term patients.

In 1973 the DHSS announced its proposals for redistributing senior registrar and registrar posts based on advice received from the Central Manpower Committee. Registrars in shortage specialties would not be redeployed since needs could be met by the creation of new posts. Implementation would be phased over a few years.

At the end of the year the first report of the Central Manpower Committee was published covering the period March 1972 to June 1973.¹¹ Since then there have been no dramatic developments apart from a tightening up of control on established consultant posts lying unfilled.

Present position

CONSULTANTS

In the old ACCE days each individual application for a consultant post was considered on its merits as against the other bids and the national position in terms of availability and distribution. Clearly one or two factors have not changed—namely, that the local people at district or area must want the post at the outset, and have the facilities and revenue to accommodate it. The priorities within specialties will still be based largely on the advice of regional advisory committees.

The Department, however, not only determines the regions' target figure but also rations specialty groups so that an area's or region's wishes may not relate to its specialty allocation from the DHSS. Ultimately, therefore, the DHSS determines how many consultants a region may have and the number within each specialty grouping. The only real difference is that authorities do not have to make the case to the DHSS any more. It is still left to the regional or area authority and its officers to decide whether it can afford its target allocation and if not, which ones should proceed. The medical profession is reluctant to decide priority between specialties and is usually happy to let authorities and their officers choose and then be made to defend their actions afterwards.

SENIOR REGISTRARS AND REGISTRARS

The position with senior registrars and registrars has remained unchanged over the years, with complete control centrally. Any senior registrar post falling vacant must be resubmitted to the DHSS for approval before advertisement. Proposals for additional posts have to receive the support of specialty training committees and the postgraduate committees before being submitted to the DHSS, but this is no problem in practice.

Proposals for medical assistants are also approved centrally, the only difference being that for these a case has to be made out by the authority.

Basically authorities are totally free to appoint only senior house officers, clinical assistants, and clinical medical officers provided they have the finance. Preregistration house officer posts must be approved by the parent university on behalf of the General Medical Council.

Consultant expansion and redistribution

It is still too early to assess the decision on redistribution but the expansion of the consultant grade has been a longstanding objective. In their first annual report the Central Manpower Committee reiterated its intention to expand at 4% per annum compound, but in fact for economic reasons this may no longer be possible. In 1974 the expansion was only 3.4% over the 1973 total but on the other hand in 1973 the expansion was 4.8% over the previous year, making a two-year figure of 4.2%. The table gives the figures over the last 10 years.

Total number of consultants 1965-74 with percentage increase over previous year

Year	No in post at 30 Sept	Expansion over previous year %
1965	8477 (previous year 7684)	10.3
1966	8757	3.3
1967	9015	2.9
1968	9198	2.0
1969	9431	2.5
1970	9701	2.8
1971	9979	2.9
1972	10 304	3.3
1973	10 796	4.8
1974	11 164	3.4

Medical assistants

Figure 1 shows the growth in the number of medical assistants since 1966, which was the first year in which the implementation of the new grade really occurred. There has been a steady expansion of the grade, with 1973 being the only year when there was a reduction,

mainly as a result of many being appointed as consultants in emergency departments, when 57 consultants were appointed and there was a drop of 19 medical assistants. As at 30 September 1974 724 of the 1011 medical assistants (72%) were whole time, which is less than the proportion in 1972 and 1970, which were 76% and 83%, respectively.

Figure 2 shows the importance of medical assistants in psychiatry, geriatrics, and ophthalmology—in contrast to general medicine, general

surgery, obstetrics, and especially certain branches of pathology and radiology, where they play an insignificant part. Over half the medical assistants in geriatrics are from overseas.

Relationship between training and career posts

In 1969 the Department introduced careers advice for the undecided with the first of its career prospect tables. Three hospital specialties received a four star rating, anaesthetics, geriatrics, and radiology. Eight specialties received a nil rating, indicating very poor prospects.

Since 1969 in anaesthetics the number of senior registrars born in the United Kingdom and Eire has remained virtually static and, although the specialty is still growing at a steady rate (242 additional consultants since 1969 making a 20% increase within five years), it is quite obvious that the additional consultant posts will have to be filled by doctors born overseas, since even its high rating is not attracting more local recruits. Radiology still attracts the highest rating in the latest prospects table but one wonders why; since, although there has been a steady growth in the consultant grade over the decade with 181 additional consultants representing a 35% increase over the 10 years, there are now 172 senior registrars, of whom 133 were born in the United Kingdom and Eire. The ratio of consultants to all senior registrars is 4.13:1, compared with 5.69:1 for anaesthetics. For senior registrars born in the United Kingdom and Eire the rates are 5.34:1 and 7.9:1, respectively. Unless we are training these doctors to work overseas we should surely either be expanding the number of consultants from an average of around 20 per year or reducing the number of senior registrar posts. I am assuming that the existing consultants are not grossly maldistributed in relation to age.

The third four-star specialty in 1969 was geriatrics, which currently still carries the top rating. The trend shows that there are barely enough senior registrars from the United Kingdom and Eire in post each year to fill the additional posts, excluding replacements for retirements, etc. At 30 September 1974 there were 24 additional consultant posts over the previous year and only 24 UK and Eire senior registrars in post. Some 60% of senior registrars are now from overseas and already over 30% of the consultants were born overseas. High prospects are apparently not sufficient to attract doctors in this specialty.

ZERO RATING

In 1969 there were eight specialties with a zero rating. Obstetrics and gynaecology was one of these specialties. Although the consultant expansion rate (15.5%) since 1969 has been slightly less than for radiology (19.3%)—which compares with it numerically (710 and 664 respectively)—the ratio of consultants to senior registrars in obstetrics is 6:1, as against 4:13:1 for radiology.

Several other specialties have joined those with a high star rating: these are mental handicap, venereology, child psychiatry, and chemical pathology. The specialty of mental handicap is expanding but fails to attract doctors born in the United Kingdom and Eire, and there were only four senior registrars born in the United Kingdom and Eire as at 30 September 1974.

The position for registrars in the shortage specialties is further evidence that the attraction of an early appointment to a consultant post is not enough and suggests that something much more fundamental is happening. Figure 3 gives the distribution of senior and junior registrars by place of birth for the commoner specialties. Even the popular specialties are very dependent on overseas born doctors in the registrar grade.

Discussion

The problem is more complex than can be portrayed on such yardsticks as crude numbers per 1000 population. We are dealing with the most highly trained person within a service which is becoming increasingly technical and specialised and therefore fragmented. If all the existing categories of nursing, scientific, and paramedical staff were to extend their roles and nothing else were to change, possibly considerably fewer medical staff would be necessary—indeed in many countries such a trend has arisen because of a shortage of doctors.

Ellis¹² has recently summarised in retrospect all the factors that the Royal Commission on Medical Education tried to consider to determine how many students should be trained to become doctors. He mentions population size and age structure, birth rate, economic growth rate, shorter working hours, medical advances, greater delegation, and better organisation. Many of their assumptions have since been proved wrong, particularly the economic growth rate of 3% per annum, the 16% proportion of women doctors, and possibly their migration estimates.

The future is even more difficult to forecast, particularly in relation to migration. There are the effects of the EEC directives, new restrictions in opportunities in the North American continent, and openings in the Middle East. Overseas doctors will probably diminish in number. The effect of the hospital practitioner grade is likely to be great, replacing not only the clinical assistant posts but also, possibly, many training posts. It will surely mean that the method of classifying practice areas will have to be amended from its population-only basis.

There is clearly a demand for a subconsultant grade (both part time and whole time) and this should be formally recognised since it is growing steadily and is an important grade of employment for women. The latter may suffer from diminished job opportunities as a result of the introduction of the hospital practitioner grade and any reduction of posts in clinical medical officer work.

Clearly if our own junior doctors are not interested in a specialty, the attraction of an early appointment as a consultant is not sufficient. The result has been that overseas born (and mainly trained) doctors have plugged the gap for both training and career posts. The causes of an inability to recruit our own doctors into the so-called "shortage specialties" may be different but it is quite clear that a critical review should be undertaken urgently on the recruitment problems associated with geriatrics and mental handicap and possibly other "shortage specialties" and the number of these posts should not be increased until the specialties' future position is clarified. This exercise is to be undertaken by the DHSS in the specialty of mental handicap.¹³

No mention has been made in this article of the way clinical assistant and senior house officer posts have changed over the years. The present position is, however, sufficiently disturbing to suggest that further experiments are necessary, and one wonders whether health authorities should not be allowed to develop their own staffing structures. Training posts must always be approved by the appropriate educational bodies, and the DHSS, in consultation with the profession, will determine the types of training and career grades within the Health Service and perhaps it could leave health authorities to determine their own staffing structure.

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¹ *Medical Staffing Structure in the Hospital Service*. Ministry of Health, London, HMSO, 1961.

² *Medical Staffing Structure in Scottish Hospitals*. London, HMSO, 1964.

³ *British Medical Journal Supplement*, 1967, 2, 93.

⁴ *British Medical Journal Supplement*, 1968, 1, 73.

⁵ *British Medical Journal Supplement*, 1969, 1, 75.

⁶ Royal Commission on Medical Education, *Report*, Cmnd 3569. London, HMSO, 1968.

⁷ *The Responsibilities of the Consultant Grade*, DHSS. London, HMSO, 1969.

⁸ *British Medical Journal Supplement*, 1969, 4, 53.

⁹ *British Medical Journal Supplement*, 1971, 3, 119.

¹⁰ *British Medical Journal Supplement*, 1972, 3, 143.

¹¹ *British Medical Journal Supplement*, 1973, 4, 43.

¹² Ellis, J, *Proceedings of the Royal Society of Medicine*, 1973, 68, 495.

¹³ *Mental Handicap Services* DS 76/75, DHSS, 1975.

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