Psychiatric Bulletin (1992), **16**, 374–375

The College

Medical manpower in Europe: from surplus to deficit?

MICHAEL VAN BEINUM, Collegiate Trainees' Committee

In the mid-1970s the Permanent Working Group (PWG) of European Hospital Doctors was formed when it became apparent that junior doctors in different European countries shared many common problems and experiences. The PWG now represents 17 national organisations of junior hospital doctors and is recognised by European institutions such as the European Commission; British doctors are represented by the British Medical Association. The PWG organised a conference in Maastricht in the Netherlands in 1982 bringing together politicians, planners and the medical profession to try to plan the future supply of doctors to match the anticipated demands for services at a time when large-scale unemployment was beginning to appear in a number of western European countries. From this developed a major study of medical manpower in western European countries which formed the core of a conference on 'Medical Manpower in Europe: from surplus to deficit?' on 31 October 1991, hosted by the PWG in Florence. Europe in this context was defined as the member states of the EEC and EFTA.

Medical manpower: the next 20 years

Dr Saugmann-Jensen from Denmark outlined the main findings from the study commissioned by the PWG. There had been a great deal of concern among doctors that there was an over-production of medical graduates, particularly in some member states such as Italy and Germany, leading both to unemployment among doctors in those countries but also to migration of unemployed doctors of neighbouring states. From a careful analysis of age-structures within the medical profession it would appear that the medical profession is experiencing the effects of a baby boom. There is in most European countries an ageing working medical population due to a sudden increase in medical manpower in the 1960s and 1970s, with many doctors coming up for retirement in the next ten years. Assuming that demand for medical man-power would continue to rise in line with the forecasted increase in gross national product (GNP), this means that, although there will continue to be appreciable medical un- and under-employment for the next five to ten years, by the year 2003 demand for doctors will roughly equal supply and will thereafter increasingly exceed it.

The rest of the meeting looked at aspects of the PWG study and considered other aspects of medical training in Europe.

The PWG model varies greatly between countries; the UK is unique in the EEC in not conforming to it, as in this country we do not have an age imbalance and medical manpower supply is expected to continue accurately to meet demand for the foreseeable future. The Scandinavian countries, who in terms of medical manpower appear to operate as a unified block, again expect no great imbalance between supply and demand; their main worry is seen as immigration of poorly qualified doctors from Eastern Europe. In Austria, the forecasts of manpower were said to be more a statement of political desire than reality, and in Italy estimates of manpower production were said to be accurate to within only 20%. Italy, Spain, Germany, and, to a lesser extent, The Netherlands, have the highest percentage of unemployed doctors in Europe.

Forecasting is a notoriously dangerous activity, and many factors could upset the predictions. The growth in demand for doctors over the past 20 years has risen in line with growth in GNP; this trend may not hold in the future. A major identified trend was the rising number of female doctors, although sexual discrimination was felt to prevent women from occupying as many top posts as their total numbers would lead one to expect in most European countries; Portugal appeared to be an exception here. Medical under-employment, as opposed to unemployment, was common in many countries, with people both not working to their potential nor as many hours as they would wish. At the same time, the trend towards doctors in some countries – notably the UK – working fewer hours in the future would increase the demand for doctors. The UK has one of the highest population/doctor ratios in Europe of around 560/1, compared to an European average of around 300/1. This is reflected in British doctors having much longer working hours than their European colleagues. The changing role of paramedical staff, such as community nurses prescribing medication, would also alter the demand

https://doi.org/10.1192/pb.16.6.374 Published online by Cambridge University Press

for medical specialists in the future. Who does what becomes important. Demand for doctors may increase as new medical developments allow more diseases to be treated and public awareness of what is possible is raised. There appears to be an evolving and changing relationship between the medical profession and their patients, with patients becoming better informed and more demanding of new treatments.

There are basically two ways of financing health services in Europe: either state funded services such as the NHS or insurance financed services. State funded services have been successful in keeping down costs, but suffer from two problems. Governments try to shrink taxes and this requires the health services to become more efficient, and budgets to become more and more flexible. Secondly, public opinion is increasingly critical of the service provided, leading to a more market-orientated system. Insurance based services do not suffer from taxation problems, but suffer from spiralling costs and are not self-regulating. Manpower planning needs to be considered in the light of this financial dilemma.

Much concern was expressed about migration of unemployed doctors from one country to another. The free movement of medical labour in Europe, however, has been a reality since 1975 when considerable unemployment was in existence, and no significant migration of doctors has taken place to date. This may, of course, change in the future, particularly for doctors from Eastern Europe, where the population/doctor ratio is around 240/1 and wages are extremely low. A major worry here is the low standard of training of many Eastern European doctors, and especially higher specialist training; some doctors coming from the USSR and Romania to Scandinavia were said to have "a frighteningly low standard" of specialist training. Many of these were originally from Third World communist states who trained in the USSR and who are rejected both there and by their native countries and who are now claiming refugee status in the West as doctors.

A major concern emerged over higher specialist training. It was recognised that such training varied widely across Europe, and a clear need for some form of harmonisation was identified. People were careful to avoid the notion of standarisation, instead preferring to look at agreed minimum standards of training. Currently the European commission has laid down minimum standards in terms of length of time in higher specialist training, but has not as yet specified content of training. The ACMT (Advisory Committee on Medical Training) of the European Commission has issued a number of recommendations, one of which is that the monospecialist sections (UEMS) should form specialist boards, whose task is to specify conditions required for training of specialists in Europe, advise the ACMT, and issue a certificate of higher specialist training.

Training conditions should include the curriculum, the criteria for training centres, a system of peer control between countries, exchanges between EEC countries, and the establishment of a European Board Qualification. Such Boards would be required to co-opt the universities and specialist organisations such as the Royal colleges. It is envisaged that the Board for each specialty would consist of one member from each country who is also a member of the UEMS, as well as a university representative and a specialty organisation representative; junior doctors are expected to be allowed to attend their UEMS boards, and this would suggest that the Collegiate Trainees' Committee of the Royal College of Psychiatrists should have representation on the psychiatry specialist board. The boards are due to meet in Brussels in plenary session in April 1992. It is advised that the College argues for a high standard of specialist training, such as currently exists in the UK, rather than opt for a lower minimum standard which would likely become the norm for training in the future. Links with training organisations in other European countries will become important, and the College should actively pursue these.

https://doi.org/10.1192/pb.16.6.374 Published online by Cambridge University Press