What ratio of different grades of health personnel will be the best way of spending the limited budget for staff that can be afforded for a given district? The answer should determine what grades of personnel to train and in what numbers.

by Brian Abel-Smith

The world is currently heading for a doctor surplus of between 250,000 and 500,000—possibly even more—by the year 2000. This would be a wasteful mockery in the year that is the target date for Health for all.

Of course there will at the same time be countries who could make good use of these medical skills. But those countries are unlikely to be the ones that can afford salaries for their services. There are others which are failing to train enough nurses, para-medicals and auxiliaries to work with such doctors as they can finance. And while in some countries, for example, there are four nurses to one doctor, in others there are four doctors to one nurse.

One reason for the present imbalance is that national authorities have planned to achieve some ideal ratio of doctors or dentists per head of population without looking to see if they can afford to pay them. A second reason is that, in some countries, medical manpower has not been planned at all, but has grown in response to demand for it. Students and their parents see medicine as a prestigious and lucrative occupation and press for more openings in medical schools. Ministers of education respond to these pressures irrespective of the priorities of ministers of health.

If some regions or states have medical schools and the large hospitals which generally accompany them, other states or regions demand similar facilities. Very often students have free choice of their subject of study, and simply crowd into existing medical schools or into private schools created to cash in on the high demand.

Already many countries, both developed and developing, are faced with under-employed and unemployed doctors. In the 1960s and 1970s, the prospective problem was hidden from view as doctors migrated in large numbers to or between developed countries, or to countries which had suddenly acquired massive wealth from oil. These opportunities have steadily grown much more restricted as both developed countries and oil-rich countries are becoming able to meet their needs for doctors and dentists from their own training institutions. Nurses have also migrated on a considerable scale, and the demand for them is likely to continue longer in countries where nursing is not widely accepted culturally as a career for women, provided those countries can afford to pay them.

Medical unemployment does not only cause disappointed expectations; it wastes resources which could have been used to train the health manpower which the nation could afford to support. For the cost of training one doctor, three to six nurses or six to nine medical auxiliaries could have been trained. Moreover, under-employed doctors in the private sector may waste resources on excessive and unnecessary services. A pool of unemployed doctors leads to pressure to create jobs for them which, if conceded, would distort health priorities. If they are found jobs, there may not be the money to pay for the drugs, equipment and supporting staff to enable them to use their skills appropriately. And the jobs they most want are in the cities which are already much better provided with services than the countryside. Flooding the market with doctors may force some to work in rural areas, but the effect is likely to be patchy and only achieved at quite exorbitant cost. Nor is an excess of doctors likely to lead to a sharp drop in fees charged to patients or in the salary levels paid to doctors in government service.

Unemployment and under-employment are not the only manifestations of imbalanced health manpower. Some countries have too many specialists and too few general practitioners. Others have shortages in particular specialties such as anaesthetics, geriatrics and psychiatry. In some cases, medical curricula prepare doctors for work with all the supporting staff and...
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The most sensitive question today is how to stop the over-production of highly trained health manpower. The method used in one country may not be acceptable in another. The obvious action of closing whole medical or dental schools or charging their use may well be too politically explosive for most countries. Some countries hesitate to introduce quotas for entry, though others have had them for many years. The alternative of raising the standard of the first year examination to discard the weaker students may be thought less controversial. Changing the orientation of medical education is easier said than done. A change in curriculum may have little impact if teachers are not committed to the purpose of the change. Nor is it easy to change the basis of recruitment for training in the auxiliary grades from those with the best educational credentials to persons motivated to serve long periods in remote areas. But the fact remains: it is no use having a plan unless politicians are willing to take the difficult decisions to put it into effect.

The main price of unbalanced health manpower is not paid by the doctors who end up selling ice cream, driving a taxi or—at best—thrusting expensive and inessential drugs on medical colleagues for use on their private patients. The main price is paid by communities who do not even have a medical auxiliary, let alone a nurse or doctor. They may be in urban shanty towns or more likely in remote country communities. In all societies it is the poor who need the most health care and are least likely to receive it; and in some countries, the rich could do with less. By denying even a minimum of care to all the poor, unbalanced health manpower is a major and costly obstruction on the road to Health for all by the year 2000.