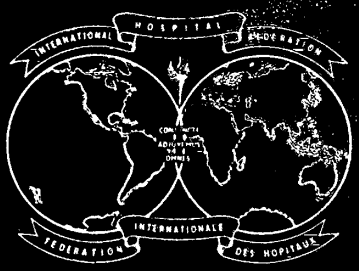
The International Hospital Federation
in collaboration with
King Edward's Hospital Fund for London

# The Hospital Services of Europe




## Report of the Fourth European Conference 15—19 July 1968 held at the King's Fund College of Hospital Management

# The Hospital Services of Europe

## Fourth European Conference

## Manpower in Hospitals and other Health Institutions

# Preface

The earlier conferences on hospital services in Europe were successful and the reports on them were of value to persons engaged in the organising and administration of such services. It was, therefore, decided to have a fourth conference and it was held in July 1968.

The theme chosen for the fourth conference was *Manpower in Hospitals and other Health Institutions*. The choice was made after considering the records of the proceedings of the previous conferences, which had dealt with the organisation and administration of hospital services, the problems arising and the pressures for expansion of the services.

The conference, like its predecessors, was convened by the International Hospital Federation and King Edward's Hospital Fund for London. It was held at the King's Fund College of Hospital Management in Palace Court, Bayswater, London.

Participants in the conference and observers, a list of whom is on pages 4 to 7, were invited in their personal capacities and not as delegates. Each participant was asked to prepare a paper on the theme of the conference, setting out the relevant facts in respect of his own country and making such comments as he thought appropriate. The questions that participants were requested to answer are reproduced in the theme panel on page 9.

The participants were from seventeen European countries. Each of them is well-informed on the hospital and other health services of his own country, but the statements made in papers or at the conference are not to be regarded as official pronouncements on behalf of national governments or other health service authorities.

The papers prepared by participants were circulated beforehand to all the persons who had been invited to attend the conference. At the conference, the authors presented their papers, gave explanations and made suitable supplementary statements of fact and opinion. Discussion, questions and answers followed each presentation. It was obvious that the several sessions were much enjoyed.

It had been arranged that Mr Roger Peers would be chairman of the conference but, to the great sorrow of all who had been privileged to know him, he died on 27 May 1968. At the opening session of the conference, tribute was paid to his work and his memory.

The duties of chairman were shared by Dr J C J Burkens, Mr F R Reeves and Professor Dr J B Stolte. At the end of the conference, Professor Stolte gave a summary and commentary which is presented on page 32. That contribution was received by participants and observers with much appreciation and pleasure.

There was a special reception at the college on the evening of 16 July and a guest night dinner on 18 July. On these occasions the conference participants and observers met, and had opportunities for talks with, many persons engaged in work associated with the administration of the health

service in England and Wales; members and officers of professional and voluntary organisations; and representatives of the press. The Minister of Health (the Rt Hon Kenneth Robinson MP) attended the reception on 16 July. Sir George Godber, Chief Medical Officer for England and Wales, was a guest and a much appreciated speaker at the dinner on 18 July.

The joint conveners of the conference record their thanks to all who contributed to the success of the arrangements. They include: the participants and the observers; Lord Hayter, chairman of the Management Committee of the King's Fund, who opened the conference and welcomed those who took part in it; Sir Arnold France, who gave the opening address; and Mr E H Jones who was the rapporteur and who wrote the general report of the conference.

In writing the general report, the rapporteur drew upon the papers presented by Sir Arnold France and the participants and upon his record of the proceedings of the several sessions held between 15 and 19 July. The report deals with the main subjects discussed, on a subject-by-subject basis, and does not purport to summarise the wealth of detail about the health service staffing and training arrangements of individual countries that will be found in the papers of the participants. Copies of these papers may be borrowed from the King's Fund College of Hospital Management, 2 Palace Court, London W2.

# 1 Participants

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|---|---|
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| **Switzerland** | **Dr jur F Kohler** Director<br>Inselspital<br>Berne |
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| | **Mr F R Reeves** Principal<br>King's Fund College of Hospital Management<br>2 Palace Court<br>London W2<br>(Joint Chairman of Conference) |
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# 2 General Report on Conference

**by Eric Harrison Jones**

## Introduction

The earlier conferences, in 1962, 1964 and 1966, dealt respectively with

**1** a general and comparative study of the hospital services of a number of European countries

**2** the changing problems of hospital administration in European countries and

**3** the pressure in European countries for more medical services, including hospital and other curative services.

All types of health care are arrangements in which skilled persons use their special knowledge and ability to promote the health of individuals or of the public generally. It follows that the health services must have adequate, well-educated, trained and experienced personnel. In short, manpower is the key to success. It accordingly was logical that the Fourth European Conference should deal with manpower in hospitals and other health institutions. The choice of this theme was welcomed by the participants and it proved to be one of great interest. The scope of the theme is outlined in the statement which is reprinted opposite.

It must be emphasised that it was not the purpose of the conference to reach a decision on any question, or to suggest the taking of action in any country. The intention was to bring together persons from many countries who would be able to state, explain and comment upon the manpower problems of the health services of their national areas; who would be competent to discuss relevant matters of general interest; and whose individual and joint efforts would produce a body of knowledge and observation which should be of value to all who are concerned with manpower in the health services.

There were participants from seventeen European countries and the conference also was attended by observers, some of whom made contributions to the discussions. The observers included two persons from the United States of America.

The countries from which the participants in the conference were drawn vary greatly in size, in population and in their arrangements for the provision and control of health services. It is not considered necessary to summarise all the information that was given by the participants but it may be of help and interest to note the following points.

Populations of the countries vary from under 3 millions to almost 60 millions; eight of the seventeen countries have populations of less than 10 millions each.

The number of hospital beds per thousand inhabitants varies from 2·4 to over 20.



Beds for psychiatric patients vary from 0·38 to 6·2 per thousand inhabitants;

there are seven countries each of which has fewer than two beds per thousand inhabitants.

The average length of stay of patients in 'general hospitals' varies from just over twelve days to more than twenty days.

The percentage of gross national product devoted to health services ranges from one to six; there are eight countries in which the figure lies between four and five per cent.

It might be thought that, in view of the range of the variations, there would be few manpower considerations of common application and general importance, but the proceedings of the conference proved the contrary to be true. There are many matters in which the seventeen countries, or most

## THEME
## Manpower in Hospitals and other Health Institutions

**1 What changes are anticipated in the pattern of the working population in your country, eg, are the professional categories expected to increase or the proportion of manual workers to decrease, etc?**

**2 What categories of health personnel are employed in your country? Please specify in terms of recruitment, training, utilisation and career structure.**

**3 What numbers are actually employed, according to sex and age, in the categories specified above?**

**4 What are the sources and methods of recruitment of the various categories and how are they trained?**

**5 What proportion of the various categories are employed in preventive medicine, in extra-mural curative care, in hospitals, in long-term care institutions and otherwise? Is there any tendency towards a change in this distribution?**

**6 What are the current problems of health manpower in your country and what steps are being taken or planned to solve them?**

**7 What research is being done into manpower problems in the hospital and health services in your country?**

of them, have similar if not identical experiences. The following merit mention.

All the countries, with the exception of Ireland, have growing populations.

In all countries there continues to be a reduction of the labour force engaged in agriculture and there are increases in the numbers employed in commerce and the 'services sector'.

The decline in agricultural employment and the growth of the numbers of workers engaged in other sectors have led in many areas to a reduction of rural populations, with consequent aggravation of the problem of providing rural districts with adequate health services.

The demands for health services, especially hospital services, continue to grow; the demands are for better services, more privacy in treatment, more personal attention and better 'hotel services' in hospitals.

School-leaving ages are higher; more young persons take advantage of opportunities to have advanced education; the pressure on the universities, particularly in the faculties of medicine, is severe; and the institutions for training health services personnel have heavy tasks.

Medicine makes ever greater use of science and technology and everywhere the demand is for more scientists, technicians and other highly skilled people.

The demand for nurses is satisfied in very few countries, Ireland being one of the few.

The work of nurses extends to tasks formerly performed only by doctors; and nurses cease to be responsible for non-nursing work which used to take up much of their time.

In nearly every country the 'assistant nurse', the 'nursing aide', the 'nursing auxiliary', the 'practical nurse' or the 'enrolled nurse' supplements the work of the 'registered (or fully trained) nurse' and the numbers of such personnel increase.

The working life of the citizen is shorter; beginning later and ending at an earlier age of retirement.

Hours of duty are fewer and, in consequence of the growing demand for leisure, continue to fall.

Remuneration in the health services has increased substantially and now generally compares well with that of employment in skilled sections of industry and commerce.

More and more married women are employed in the health services.

Everywhere there is realisation that health service manpower is part of the national manpower problem and that more research is needed to find the solution to difficulties.

In the remainder of this report the foregoing matters are referred to in more detail and relevant comments and suggestions made at the conference are mentioned.

## Population

**Growth and Age Structure** The increase in population which has occurred in all countries (except Ireland) was noted in Table I on page 35 of Dr Neville Goodman's report on the third conference. The increase necessarily involves a greater demand on the health services; and when populations grow more quickly than skilled workers can be trained and added to the labour force, the manpower difficulties of the services are aggravated.

The age structure also has been changing. In recent years there have been more old people, with a reduction in the proportion of the population who are in the working ages range.

**Working Population** Conference participants reported that there has been and continues to be a shortening of the working life. Young people enter employment later than had been the general practice and usually the age of retirement is lower than it had been in the past. The effect of these changes is moderated, if not offset, by the extended application of mechanisation and automation to work which formerly involved much human effort.

In every country there has been a decline, in some places a substantial decline, in the numbers of persons engaged in agriculture. There has at the same time been a great increase in the numbers of workers in commerce and in the 'services sector' of employment; in industry, the numbers after rising are levelling off or, in some instances, falling slightly.

**Distribution of Population** The wider use of mechanisation in agriculture and the reduction of the numbers employed in that activity have led to a movement of population from rural areas to the towns, especially to towns where large and developing industries are centred.

The movement has caused an important alteration in the age distribution of rural populations. Most of those who have changed residence are young and active and the areas they have left now have a high proportion of elderly people, a part of the population which makes fairly heavy demands upon the health services.

There are manpower factors contributing to the difficulty of providing health services for the people remaining in the rural areas. Doctors and other skilled health service personnel tend to be drawn to and to congregate in the larger towns. This is no doubt an unavoidable consequence of the application of science to medical work, the high cost of some of the equipment now in use and the need for team effort instead of diagnosis and treatment by an individual. Many countries report increasing difficulty in meeting health service needs in the remote areas and not even the development of fast road transport from country to town provides a satisfactory solution. Indeed, it was said at the conference that the replacement of railway travel by the private car means that in some instances elderly people cannot reach the towns unless expensive special arrangements are made to bring them there. Several countries, including England, Wales, Ireland, Poland and Romania have to make incentive payments or offer accommodation inducements to encourage doctors to live and work in rural districts remote from the towns.

**Emigration** In the past, the emigration of large numbers of the young and vigorous was a serious drawback to the advance of the prosperity of some countries. Italy, Ireland, Portugal and Spain were among the nations much affected by the outward movement of population. In the era after the end of the war of 1939–45, there was much emigration from certain areas to France, Germany, Sweden and Switzerland. There has been a reduction in the scale of the movement, which largely involved manual workers and certain technicians. Now there is the new phenomenon which Professor Stolte of the Netherlands labelled 'the nomadism of the intellectuals'. This leads some of the best brains in medicine and science to go from their homes to North America, or to go from less prosperous European countries to those of richer neighbours who can afford to pay higher rates of salary and spend more money on research.

The new pattern in emigration could have serious consequences for the countries being deprived of the work of highly skilled people and the movement is receiving much attention. The Government of the United Kingdom has been investigating the subject and recently sent representatives to North America to try to find out the precise reasons which had influenced numbers of doctors to go to Canada and the United States of America.

**Immigration** Some countries have legal barriers to the employment of foreign nationals in their health services. Reference to such restrictions on immigration were made by Dr König of Austria and Mr Peyssard of France. The position in Sweden and Switzerland is different as there are considerable numbers of doctors and other health service workers who have come in from many European countries. England and Wales always have had (in addition to many doctors from Scotland) large numbers of doctors, nurses, etc, from Ireland; and in the last twenty years doctors from Commonwealth countries, especially India and Pakistan, have been a substantial part of the junior medical staff of hospitals. Half the registrars are in this category.

It was suggested at the conference that the solving of manpower problems by obtaining staff from other national areas was at best an admissible temporary expedient and should not be allowed to stand in the way of plans to enable a country to educate and train its own doctors, nurses, etc. The difficulties that flow from differences in language were mentioned by Dr Kohler of Switzerland, in commenting on immigration, and it is well known that such differences can present problems for doctors, nurses and patients.

On the other hand, references were made to the Treaty of Rome and it was realised that its full implementation carries the observance of the principle of free movement of workers between countries which are adherents to the treaty. This is a subject that will require much study in the next few years.

## Other Manpower Influences

**The Structure of Society** The era of the two nations – the rich and the poor – has passed or is passing, and is being replaced by a society which predominantly consists of educated workers who are conscious of their right to have a good life and to have their health and the health of their families maintained and promoted. The growing interest in education, culture and health was commented upon and references were made to the

manpower consequences of such interest.

**The Advance of Science** The great developments in science in the last fifty years and the application of those developments to the health services were mentioned by numbers of the speakers. Many preventive and remedial measures which are in use today were unknown before 1914 and every year brings new advances. One consequence is that the health services need more and more highly skilled persons to deal with complex problems and intricate work. Another is that with the coming of mechanisation, automation and the computer, some heavy tasks no longer have to be performed so that fewer semi-skilled persons have to be employed. It was the general view that experience in the future will be similar and that further demands for well-educated and trained personnel should be expected.

**The Demand for Medical Services** The ever-growing demand for medical services was the subject of the third conference. The implications in relation to manpower are significant. People in all European countries now expect that good health services will be readily available to them, that services will be provided with due privacy, that the 'hotel care' in hospitals and other health institutions will be of a satisfactory standard and that the patient's interests will be paramount. To meet the demand, large numbers of persons have to be employed and it was stated that in nearly every national area the remuneration of staff is equivalent to about two-thirds of the total cost of the health services.

The determination of the extent of the services to be provided and the fixing of the standards to be aimed at are of prime importance in manpower planning. The question whether and, if so, where the rising cost of services should be arrested was discussed. Would it be proper to aim always at the best that money could buy or should the aim be to have the cheapest standard of service which would be acceptable? There were no answers given to such questions, but no doubt they will continue to be asked. It was, however, pointed out by participants from some countries – Portugal, Spain and Italy among them – that advances in the health services can be made only as fast as rising national prosperity permits. Decisions at national level are required on numerous issues, for only at that level can all the economic consequences of trying to provide better health services be fully and carefully assessed. Walter Bagehot, one of the greatest of England's great Victorians, said: 'all action costs money; all policy depends on money'. What was financial truth in 1867, remains the truth today.

One of the difficult problems – commented on by a number of participants – is how to decide the location of services and another is the determination of the size of the hospitals which should be built to meet future needs. Dr Yellowlees referred to the aim to provide large district hospitals in Great Britain and several persons spoke about similar aims elsewhere. The trend is not yet universal. Dr König said that about two-thirds of the hospitals in Austria are small and that there is not a proposal to close them, although the range of the work in some of them may alter. Professor Blanpain stated that the average number of beds in Belgian hospitals is about 100, but if the really large hospitals are excluded from consideration, the average number of beds is only 60.

There was some evidence that doctors, especially young doctors, prefer to

work in large hospitals and that smaller hospitals have difficulty in obtaining medical staff; but no information was put before the conference to show that if only large hospitals were in use, the cost of providing services would be lower. Similarly, there was no evidence as to the relative demands on manpower of small and large units. It appears that there is need for much more investigation and study in this matter.

**Education and Training** The conference had much information about the extension of educational and training arrangements in all countries.

Two reasons are given for the making of better educational arrangements. It is recognised that education to a high level should be available to all the people so that they may have the opportunity of enrichment through culture. Secondly, only the well-educated can cope satisfactorily with the demands of the new sciences and the new techniques which now are applied to industry, commerce and so many other fields of endeavour.

The consequence is that, as reported by participants, many more highly educated people are needed in the health services and many such persons are available. For example, Professor Stolte said that in the Netherlands:

in 1956 more than 35 per cent of males had primary education only;
in 1960 there were 22·8 per cent of males who had primary education only;
in 1965 only 14·2 per cent of males had primary education only; and it is expected that fewer than 7·5 per cent will be in that category in 1970.

Professor Stolte also said that it is expected that by 1980 the number of persons with academic degrees will be nearly three times the number so qualified in 1947.

The progress being made is gratifying; but it was stressed by speakers that the health service has to compete in the labour market for the better educated and must have attractions to offer to obtain its fair share of such people.

Training in special skills is an essential corollary to good general education. The hospital service has to train doctors, dentists, nurses, administrators, laboratory technicians, radiographers, and many other grades of personnel. More and more teachers are needed and more time has to be devoted to the tasks. In later paragraphs, further reference to the subject is made and information is given as to the steps which are being taken to discharge the responsibility.

**Status; Remuneration; Hours of Work; Other Conditions of Service** The status of an occupation undoubtedly influences the prospects of securing and retaining suitable staff. Generally, the health services have what in today's jargon is termed a 'good image'; but two participants mentioned that it was only in recent years that nursing had been freed in their countries from an unfavourable reputation. Now it is recognised as a worthy and attractive profession.

Several speakers said that in their national areas the health service occupations have good scales of remuneration compared with other types of employment calling for intellectual effort at a similar level; but some part of the emigration of doctors is attributed to unfavourable rates of pay in

'home' countries; and campaigns by nurses for higher remuneration, extending to strike action in at least one area, were referred to in the discussions. There are no illusions. Everywhere it is realised that rates of pay have a great bearing on the response to demands for manpower and the health services are not an exception to the rule. Devotion to a vocation is by no means only a thing of the past, but in the second half of the twentieth century the generosity of spirit and self sacrifice it invokes must not be unduly strained. In modern parlance, the 'fair do' has to be the aim in all negotiations about salaries and wages.

In common with other occupations, employment in the health services now has much shorter hours of work than formerly was the rule. Among the statements made on this point at the conference were these.

Finland: working hours have been cut to 40; doctors' hours to 37.

France: nurses work a 42-hour week; this may soon be 40 hours. (In Paris the figure has been 45; but a reduction to 40 is proposed.)

Germany: nurses used to work for 60 hours a week; now they work for 45 hours.

Professor Stolte said that hours of work may go down to 35 a week and that will add to the temptation to hold two jobs, to which some people already succumb. Mr Albinsson stated that the holding of a second job is forbidden in Sweden, but Dr Kohler said that numbers of hospital staff in Switzerland have a day employment and entirely separate evening work. The conference was told that this now is occurring in England and is referred to as 'moonlighting'.

It generally was accepted that the hours of work in health service employment must keep in line with the arrangements in other occupations.

**Age of Retirement** The lowering of the age of retirement adds to the manpower problems of the health service. Mr Peyssard said that in France the usual age at which retirement takes place is 60 years (55 for some occupations) and only in special circumstances is retention beyond that age authorised. In the Netherlands, nurses (including male nurses) retire at 60. Here again, the health services have to conform to the pattern of public services generally.

**Career Structure** The leading industrial and commercial firms, government and local government and public utility services now offer careers to young people and take much trouble to bring the attractions to the notice of all who might be interested. The health services must do the same and statements were made at the conference showing that this responsibility has wider acceptance; but it was thought that more could be done by employing authorities to present a better picture of the prospects attaching to posts in the services. Of course, care must be exercised to ensure that the prospects are real and the picture true.

**Mobility of Staff** Both geographical and horizontal mobility were discussed. It generally is accepted that special inducements may be required to encourage staff to take posts in areas which they regard as unattractive and it may be necessary to try to make rota arrangements under which unpopular duties will be shared in turn for short periods by a number of persons.

The other consideration is that (as industry has learned in the hard way and with much distress) the need for some types of work may end and the movement of personnel to other duties may be unavoidable. Goodwill and good training arrangements are essential to overcome the difficulties; but no less important is good foresight so that the approach of the problem may be seen in time to enable adequate preparations to be made for coping with it. Professor Stolte referred in this connection to the steps which had been necessary as a result of the great reduction in the incidence of tuberculosis. Some chest physicians had to have refresher training to enable them to take up other special duties.

**Architectural Considerations** Economy in the use of manpower was stressed as one of the aims of health service management and it was realised that properly designed buildings are a valuable contribution to the achievement of that object. The importance of the subject is accepted and it is not necessary to write at length about it. It may, however, be appropriate to refer to statements made at the conference about accommodation for the staff of hospitals. The principle of allowing staff to make their own arrangements and to live as private citizens in their off-duty time is one of merit, but it often is essential for a hospital authority to provide living accommodation for students and for other persons who otherwise would be unable or unwilling to accept work at the hospital. Dr Kohler said that at his hospital in Switzerland, where many of the staff come from other countries, it is essential to have a good deal of accommodation to meet the demand.

**Part-time Staff and the Employment of Married Women** The employment of doctors on a part-time basis has been common in the health service, but in the case of most of the other staff it was customary to offer only whole-time contracts. There has been a great change in the position and at present in most countries large numbers of part-time staff are employed, especially as nurses and domestic workers. Dr Yellowlees said that in England and Wales the ratio of part-time nursing staff in hospitals to whole-time staff had grown in the last twenty years from one in six to more than one in four; while there now are more part-time auxiliaries and aides than there are whole-time staff in these grades. More than 50 per cent of all hospital domestic workers are employed on a part-time basis. Dr Toftemark reported that in Denmark up to 75 per cent of nursing aides are part-time workers. On the other hand, Mr Peyssard stated that in France, while the hospital authorities advocated part-time contracts, there was little response and staff preferred to be whole-time employees. New part-time schedules recently were introduced in Portugal and an increase in the number of part-time staff is expected.

In the past, the employment of married women in Europe was largely restricted to the wives of the lowest-paid workers. In their case sheer economic necessity was the driving force, indeed the only force.

Two world wars, the experience gained in them and their impact upon culture changed the pattern of life in many European countries so that the position in 1968 differs substantially from that of 1914. The married woman has become a very important person in the operation of industry, commerce and the public services.

Nevertheless, there are considerable variations in experience. In some countries – Switzerland and the Netherlands were cited at the conference as well-known examples – there still is only a limited acceptance of the principle of employing married women. In other areas there continues to be an increase in the numbers engaged in remunerative work.

Taxation systems under which husband's and wife's incomes are added together in the making of computations; high transport charges for journeys between home and hospital; and the difficulty of obtaining assistance with family housework and the care of children were stated to discourage some married women from remaining in or resuming employment.

The conference heard statements as to the risk of deterioration of family life and the difficulty of providing for the proper care of children if the mother goes out to work; but no evidence was submitted on these aspects of the subject.

On the other hand, regard must be had to the statement made as to shortages of personnel in the health services which still occur in many countries. It certainly appears that without the work of married women some of the services in those countries might break down completely or be available at lower standards only.

This is a brief summary of relevant facts submitted at the conference.

Denmark: many married women are employed; 30 per cent of registered nurses and the majority of nursing aides are married.

Finland: number of married staff increased much in last ten years; in some areas up to 50 per cent of nurses are married.

France: the position is similar to that in Finland; married women appear to prefer whole-time work; persons over 40 years of age could not enter or re-enter nursing service in public hospitals, but this rule has been amended.

Germany: the number of married nurses has increased and will continue to increase.

Ireland: married women ordinarily are not eligible for permanent posts in public services; some are employed in a temporary capacity; they do not form a substantial part of the labour force; tradition, culture and under-employment in the past are important influences.

Netherlands: the number of married women in paid employment is very small, but may increase in the next few years; at the 1960 census only 3·6 per cent of nurses were married women; apart from midwives, few married women return to paid health service work.

Poland: there are few married nurses.

Portugal: not many years ago, married women were not allowed to practise in hospitals controlled by the Ministry of Health; the number now working in nursing services is increasing; in this connection, the new part-time work schedules help; work in departments with fixed hours of day duty, eg, out-patient department, is preferred; family life continues to be very important, but many need the additional income that the part-time

employment brings to the home.

Sweden: taking all occupations together (and not only those in health services), 10 per cent of married women worked in 1940 and 15 per cent in 1950; in the period 1960–65, the percentage rose from 23 to 29; married women are 67·8 per cent of the total number of registered nurses; special refresher courses are arranged for married women who have ceased employment for some time and wish to return to nursing.

United Kingdom: there are 13,000 women doctors under the age of 65 years; a survey in 1962 showed that over two-thirds of them were married; that one-half of the married doctors were employed whole time; that one-quarter were employed part time; and that one-quarter were not practising. More married women are in general practice than in hospital work. In 1964 in England and Wales, 33 per cent of senior nursing staff were married women; in Scotland the figure was 21 per cent; the professions supplementary to medicine also include numbers of married women, as do other health service occupations.

**Turnover of Staff** The turnover of staff has an important bearing on the manpower position. Turnover is higher in the case of women and the health service staff is predominantly female. Turnover declines with seniority; but most of the senior non-nursing posts are held by men. Turnover is higher among less skilled workers. They are a minority in the health service, but a fairly large minority. The turnover of domestic staff tends to be high.

## Hospital Services and Other Services

The bulk of the time of the conference was given to discussion of the manpower problems of hospitals, but some attention was directed to other aspects of the health services. The following points were mentioned in papers or in the talks.

Austria: the number of general medical practitioners rose from 4,994 in 1952 to 6,246 in 1961 but fell in 1966 to 5,819 (a decrease of 6·8 per cent in five years, which causes some concern).

Denmark: the general practitioner is the key figure in the health services, but the number tends to be stationary and in a few areas has declined; group practice is being encouraged; the public health services are well developed and maintained.

Finland: there are communal services and general practitioner services, but the greatest number of health service staff are attached to hospitals.

France: there is some shortage of state medical officers (for school health services, etc); nearly 60 per cent of doctors are in general practice.

Germany: 28 per cent of total health service personnel are engaged on work outside hospitals. About 57·5 per cent of doctors are in general practice.

Ireland: better community services are being planned.

Italy: there are large numbers of general practitioners.

Netherlands: general medical practitioners do about 70 per cent of the country's medical work; there is a strong tradition of home treatment; 70 per cent of births are domiciliary births; 17 per cent of active medical force is engaged on preventive and social medicine.

Poland: substantial numbers of staff are engaged in urban and rural health centres, preventive medicine, industrial medicine, etc.

Portugal: 13·9 per cent of doctors and 6·3 per cent of nurses work in preventive medicine; of total health manpower, 8·47 per cent work in preventive medicine; in curative medicine nearly all work in hospital; preventive services are being developed.

Romania: there are numerous district dispensaries and polyclinics.

Spain: there are large numbers of general practitioners.

Sweden: there are well-developed district medical services under the county councils and there are extensive general practitioner services; the trend is towards group practice; official policy at present is to concentrate on preventive and extra-mural curative care.

Switzerland: about one-quarter of doctors are general medical practitioners.

United Kingdom: the importance of the role of the general practitioner is stressed and it is stated that he is a specialist in his own field; group practice and work in health centres are encouraged and community services are being further developed.

Yugoslavia: the principal services are at hospitals, but there are medical centres, health centres and an institute for health protection.

During the discussions questions were raised as to the possibility and desirability of keeping patients out of hospital where this could reasonably be done; but doubt was expressed whether home care in some circumstances would be cheaper than hospital care and whether any saving in manpower could be achieved in this way. The subject requires more study.

## The Classes of Health Service Employment

The papers and the discussions clearly showed the wide range of work in the health services and the large numbers of different occupations involved. Even in the medical field alone there are some forty different specialties and recent years have seen the creation of many new types of work. In the sections which immediately follow, consideration is given to manpower questions as they affect the principal health service occupations, especially those which are found in hospitals.

## Doctors

Medical manpower problems are among the most difficult to solve. Apart from other considerations, there is the long period of education and training which has to be undertaken before a person is recognised as a well-qualified doctor competent to discharge the onerous duties that fall to the senior members of his branch of the profession. Need may be established long before the persons needed are available in sufficient numbers.

Nevertheless, all participants stated that there have been substantial increases in the numbers of practising doctors. In many instances the increases have been in the hospital services only and some countries report a slight decline in recent years in the numbers of general medical practitioners (Austria, Finland, Netherlands, England and Wales, Sweden).

The following are some of the details submitted to the conference.

Austria: practising doctors: 1952 = 11,805; 1966 = 13,108; specialists numbered 2,368 in 1952 and 4,403 in 1966.

Belgium: medicine attracts many young people; home practice is strongly favoured.

Denmark: doctors in general hospitals numbered 2,325 in 1960/61 and 2,637 in 1964/65.

Italy: now has one doctor for every 677 inhabitants.

Poland: there are four times the number of doctors there were in 1951.

Romania: in 1938 there was one doctor for every 1,895 inhabitants; in 1966 there was a doctor for every 662 inhabitants.

Spain: the country had 33,337 doctors in 1957; in 1966 the number was 40,840.

Sweden: now has one doctor to about 890 inhabitants.

United Kingdom: in England and Wales there were 6,900 consultants and specialists in 1958 and 8,000 in 1966; in 1962 there were 20,959 general medical practitioner principals and 20,408 in 1966; it was stated that the number of doctors working in hospitals had increased by two-thirds in the last twenty years.

Although there have been increases everywhere, of which the foregoing are only examples, very few participants stated that their countries, taken as a whole, have adequate numbers of doctors. Ireland, Italy and Spain appear to be near that happy position, but even in these instances there are problems of geographical distribution and the universal difficulty of providing fully for rural areas is experienced.

In every country there is a great increase in the number of students entering the faculties of medicine. Professor Blanpain said that in Belgium the medical schools are flooded with applications for admission; Austria had in 1966 about 96 per cent more medical students than there were in 1958; in Finland the applicants number twice as many as the places available in the schools; the Danish teaching facilities are described as strained; several countries have enlarged their medical schools substantially or have opened new schools; elsewhere, new schools are at the planning stage.

Professor Stolte drew attention to the fact that in the Netherlands there had on occasions been a cry that too many doctors were being trained, but in each instance that cry had been followed by strong representations that the country had too few doctors. A similar experience in the United Kingdom in the last decade was mentioned.

It was suggested – by Dr Yellowlees of the United Kingdom, Professor Stolte and other speakers – that some training arrangements, in particular those for the specialties in medicine, may be too long and the undue length may be one of the causes of the large drop-out of students which many countries report. There was much interest in the statement by Dr Yellowlees that the average interval in England between primary

qualification and the obtaining of a post as consultant is thirteen years. This was said to be much too long.

The conference also considered statements of shortage in certain specialties that are experienced in some countries. In a number of areas there is difficulty in obtaining enough consultant anaesthetists; in Ireland there is a lack of suitable applicants for vacant senior posts as psychiatrists, with the exception of the top posts in the mental health service as these are readily filled. It was appreciated, however, that although there are shortages of the kind referred to, there has been a considerable increase in the numbers actually in post and to some extent the difficulties may be accounted for by the fact that demands arising from extensions of services have developed more quickly than the growth of the numbers of fully trained personnel.

In Great Britain in the last few years there have been several investigations into matters affecting the numbers and quality of medical manpower. The basis of contracts and the principles on which remuneration is fixed have been examined by the government and the medical profession through a joint committee and important improvements have been agreed and made. There has been a Royal Commission on medical education which has made numerous recommendations for changes in the existing patterns of education, training and practice. The duties, including management responsibilities, of hospital doctors in England and Wales have been surveyed and reported upon by a third special committee (a similar and separate inquiry, with a report, has been made in Scotland). In other countries there also has been much investigation of medical manpower questions and there have been many consequential developments.

Great Britain and Denmark have problems arising from the emigration of doctors. Reference to this aspect of manpower has already been made in the section of the report dealing with population movement. Dr Toftemark said that despite shortages resulting from the emigration which takes place to Sweden and other countries, newly qualified doctors in Denmark have at times complained of the difficulty of finding posts in their home area. Here is a complex situation which shows how intricate manpower problems can be.

## Dentists

The conference spent a short time in considering statements about dental manpower.

The position was not as well defined as might be desired; it was stated that in some countries medical practitioners undertake dentistry and that it was rather difficult to say whether dental services are adequate and well distributed. Dr Bauhofer of the World Health Organisation gave particulars from records held by him which showed very substantial differences in dentist/inhabitants ratios. The figures quoted ranged from one dentist to 1,280 persons to one dentist to 11,000 inhabitants. It was agreed that, for the reason mentioned above, it was necessary to view the variations with caution.

The United Kingdom has a shortage of dentists in some areas and it is said that in the Netherlands the number is insufficient and is increasing too slowly. Dr Serigó mentioned that in Spain there had been a 17 per cent

increase in the number of dentists between 1957 and 1966 and that a new dental school has been opened.

## Nurses

Nurses, taking all grades together, usually constitute the largest group in the health services. All participants reported substantial increases in the numbers employed and the trend continues. The following are examples of the changes which have occurred.

Denmark: 75 per cent increase in hospital nurses since 1950.

France: registered nurses: 1954 = 66,000; 1965 = 78,000.

Germany: 20·5 per cent increase between 1960 and 1965.

Poland: the number of nurses has trebled since 1951.

Switzerland: 1953 = 14,064; 1965 = 22,854 (hospitals).

United Kingdom: England and Wales only: (hospitals): whole-time staff: 1958 = 152,000; 1966 = 186,000; part-time staff: 1958 = 41,000; 1966 = 78,000; (the all-over increase in nursing staff in the last twenty years has been of the order of 100,000).

Nevertheless, many countries reported the need for more nurses. Populations grow; the demand for hospital and other health services expands; the duties of nurses become more onerous and time-consuming; hours of duty are shorter; and holidays have been extended. Moreover, the drop-out from nursing is substantial, mainly through marriage. Recruitment is on the whole good and would be adequate if it were not for the losses which occur when female staff are still very young.

In most countries – Ireland is an exception – it has been necessary to supplement the services of 'registered (or fully trained) nurses' by training and employing 'enrolled nurses', 'practical nurses', 'nursing aides', or 'nursing auxiliaries'. In some national areas the numbers so employed are a substantial part of the total nursing strength.

The arrangements for educating and training nurses have been much extended and improved. These were some of the points made at the conference.

Austria: the curricula are being revised; admission to practical training at 17½ instead of at age 18 has been agreed; the period of training may be reduced.

Belgium: large numbers enrol in training programmes, especially since the training of nurses (and para-medical personnel) was raised to university level.

Finland: schools of nursing have more than enough candidates for admission.

France: substantial increase in number of nurse training schools.

Germany: candidates for admission to schools exceed the places available.

Ireland: more registered nurses qualify than Ireland needs and numbers go to Great Britain; on the other hand numbers of Irish girls who have worked in Great Britain return to Ireland.

Portugal: additional schools of nursing opened recently.

Sweden: there are more applicants for admission to the schools than there are places; there is not yet enough accommodation for girls wishing to train as auxiliary nurses and practical nurses.

The status, remuneration and conditions of service of nurses have been improved. In some countries where nursing had not been an attractive occupation and had not a high reputation, there has been a great change.

Countries which formerly relied to a large extent on nurse-members of the religious orders now draw only a small proportion of their staffs from such sources. In France where, in the nineteenth century, most nurses were members of a religious order, only about 7 per cent of the present total nursing staffs of public hospitals are attached to such orders. In the Paris hospitals of the Administration générale de l'Assistance Publique there are only 57 nuns.

## Male Nurses

The employment of male nurses was discussed. It is apparent that, with the exception of psychiatric hospitals and departments, only small numbers of men are engaged in nursing work. At the same time, it is appreciated that men usually remain in occupations for many years and that their employment in greater numbers could lessen nurse staffing difficulties. It was stated that in some areas more men are being attracted to nursing as a career, but the change is occurring slowly and large additions to the numbers of male nurses are not expected in the immediate future. Statements made were:

Belgium: as in all countries, the health services labour force is mainly female and there is some resistance to the employment of men in occupations traditionally filled by women; nevertheless, the number of men is increasing.

Denmark: the male nurse is not yet fully accepted everywhere, but there is hope that attitudes will change in the future.

France: 1954: registered male nurses=11,120; female=55,200;
1962: registered male nurses=10,840; female=62,980.

Germany: it is difficult to recruit male nurses.

Italy: has some male 'enrolled nurses'.

Netherlands: 5,000 out of 61,000 nurses are men; slowly the conviction is growing that it will be necessary to attract more men to the health services.

Sweden: there are very few male nurses, except at mental hospitals.

Switzerland: there are 2,700 male nurses and 19,000 female nurses; about 3·4 per cent of new registrations in 1956–66 were male nurses.

Professor Stolte stated that when inquiries were made in the Netherlands, it was found that numbers of boys entering employment had not heard of the possibility of becoming student nurses. Some publicity followed and a few boys showed an interest in the career. Professor Blanpain said that experience in Belgium had been similar.

## Midwives

Only brief reference was made to midwifery services. The following information as to persons employed as midwives was noted

France: 1954=7,700; 1965=8,300.

Germany: the number of midwives has been declining, despite the growth of the population.

Netherlands: midwifery is the one profession in which, in most cases, women stay at work when they marry.

Poland: the number has increased by 50 per cent since 1951.

United Kingdom: the number of midwives working in hospital has increased; the number in domiciliary services shows little change.

## Para-medical Professions; Professions Supplementary to Medicine; Pharmacists; Technicians; and Persons in Similar Occupations

In the hospital service there are now about thirty para-medical occupations or posts in 'special departments', some of which did not exist twenty years ago. In addition to posts in the long-established pharmacies, physiotherapy units and radiography departments, there are such new occupations as remedial gymnast, electro-encephalography technician, cardiological technician, electronic technician, central sterile supply department supervisor and artificial kidney technician. The range of work extends and the number of persons employed keeps on increasing.

The developments have occurred in all countries and while they add much to the effectiveness of the health service, they also contribute to making the hospital, already a complex organisation, even more difficult to manage.

Medicine has become more technical and the tendency is for nurses, who used to do much in the 'special departments', to withdraw from certain tasks and to be replaced by new professionals and technicians. Many of the occupations are still mainly staffed by women, but the number of men employed is increasing.

To a large extent the hospital service has to organise and provide the training required by persons who are to be employed in the 'special departments'. The task is a difficult one, for well-qualified teachers are not available in the numbers needed and in some instances accommodation for the training schools is not easily obtained.

The following references were made in the course of the conference or in the papers put before it.

Finland: applications to the schools exceed the places available; there are not yet enough teachers or enough places.

France: x-ray technicians numbered 1,700 in 1954; in 1965 the number was 4,000.

Ireland: there have been no serious staffing difficulties, but chiropodists are scarce (there is no training school in Ireland).

Poland: there has been a great increase in staff since 1951.

Portugal: the services are developing.

Sweden: much attention is being given to the task of training.

Switzerland: in 1953 the number of staff was 2,490; in 1965, 6,374 were employed.

United Kingdom: there is recent special legislation to control certain professions which are classed as 'supplementary to medicine'; a controlling council has been set up and much attention is being given to training; all the 'special department' occupations show large increases in staff, but it is difficult to secure and retain enough pharmacists.

Yugoslavia: a substantial expansion of the services is planned and may be achieved by 1970.

The possibility of having a common curriculum for at least part of the training of staff in the para-medical 'special departments' – and also other staff – was discussed and savings in time, money and manpower which might result from such an arrangement were mentioned. It was realised, however, that a good deal of inquiry and study would have to precede the framing of a policy involving a large measure of common training. In the United Kingdom a distinguished scientist is in charge of an examination of the subject.

## Other Health Services Staff

Little was said in the papers or at the conference about the large numbers of 'other staff' who are engaged in the health services. The great bulk of them are in occupations which are important in many fields of activity and the manpower problems to which they give rise are similar to those which are experienced in industry, commerce and public services other than the health service. The following points may be of interest.

### Administrative and Clerical Staff

Germany: male staff=9,193; female staff=24,018; arrangements have been made to provide some university courses in administration for personnel suitable for such courses; the arrangements cover both university graduates and other persons; the experiment will be extended; the total administrative staff increased by 60·1 per cent between 1956 and 1966. Efforts are being made to provide for training doctors in administrative work.

Italy: some training courses for staff have been developed, but as yet it has not been possible to provide in this way for medical staff.

Portugal: a chair in hospital administration has been established at the National School of Public Health and it is hoped to develop training for the career of hospital administrator.

Spain: numbers of courses for administrative staff are in progress; there are 1,729 medical administrators and 850 other senior administrators.

Switzerland: administrative staff in hospitals: 1953=1,676; 1965=2,624.

United Kingdom: in England and Wales the number of hospital administrative and clerical staff increased from 23,797 in 1949 to 39,292 in 1966; the arrangements for training such staff are well advanced and there now is a



National Staff Committee and 15 Regional Staff Committees; formal arrangements for training courses for administrative medical staff have not yet been made; but in Scotland fellowships are offered and the training arrangements for doctors wishing to make a career in administrative work are developing.

Yugoslavia: the number of administrative staff in 1963 was 4,661; in 1965 it was 5,268.

Professor Blanpain (Belgium) said that the hospital service attracted very few top brains to its administrative posts and that business seemed to be more successful in that matter. Mr Reeves (United Kingdom), in commenting on that observation, referred to the National Training Scheme for administrative staff which operates in the United Kingdom and said that the scheme had succeeded in attracting young persons with good brains to the hospital service who, after suitable training and experience, should be able to fill top posts satisfactorily.

Some participants stated that the employment of ward clerks had proved successful and had removed non-nursing work from ward sisters and their nursing staffs. Other countries – Switzerland was stated to be one of them – have not yet decided whether they should have ward clerks in their hospitals.

**Engineers**

Dr Caldeira Da Silva reported that there had been difficulty in obtaining a sufficient number of suitable engineers for hospitals in Portugal. The Ministry of Health had therefore set up a central pool of skilled engineers who go to hospitals and deal with engineering problems. The engineers have training in the special duties which arise at hospitals and the scheme is said to work very well.

**Domestic Staff: Hospitals**

An organisation with extensive buildings to clean and with the responsibility of providing meals, laundry, etc, for many people necessarily has to employ large numbers of domestic staff. The following examples illustrate the point.

France: public general hospitals; 1955=77,301; 1960=95,368.

Germany: all hospitals; 1956=120,289; 1966=164,710 (about 18 per cent are men).

Switzerland: domestic staff increased by about one-third between 1953 and 1965; substantial numbers come from other countries.

United Kingdom: in 1949 whole-time staff numbered 101,206 and part-time staff 27,148; in 1966 the numbers were 132,648 and 60,717 respectively.

Professor Stolte stated that in the Netherlands there was difficulty in having domestic work in hospitals done at the week-end and it had been necessary to pay substantially higher hourly rates of wages. There also was difficulty in recruiting and retaining female staff, but following the introduction of mechanisation more male staff have been brought into the hospitals and this arrangement has helped to stabilise and maintain the domestic services; nevertheless, some hospitals have to farm out domestic cleaning, etc, to commercial firms.

## Nomenclature

It is not uncommon for difficulties to arise at international gatherings through differences in the use of descriptive terms. The manpower conference had a few problems of this type (for example, 'medical technicians' and 'somatic hospitals'). It was suggested that efforts might be made to reach agreed names and definitions, following which it would be helpful to have a glossary of the approved names.

There were references at the conference to the desirability of avoiding the use of terms which tend to discourage persons from entering certain posts. Among the terms which are believed to be discouraging are 'aide', 'auxiliary', 'ancillary', 'assistant' and 'help'. Participants were interested to learn from Mr Elliott-Binns (Scotland) that difficulty in attracting doctors had been experienced when they were invited to seek admission to training courses in medical administration, but when the description was changed and applicants for 'fellowships in medical administration' were sought, there had been a good response.

## Research, Records and Statistics

The importance of research, records and statistics in relation to the avoidance or solving of manpower problems is not in question. Many speakers at the conference spoke on the subject and stressed the need to undertake more surveys and investigations, to design and keep good records and to publish and use relevant statistics.

The following notes are selected from the numerous statements made by participants and observers.

Austria: a committee of inquiry is investigating the conditions of medical training and related considerations; other inquiries also are in hand.

Belgium: a list of studies and investigations is needed so that interested persons may know what is being done in other countries; the obsession with the early discharge of hospital patients needs further study; some home care may be expensive and may not be the best arrangement for the patient; the work of the 'decision makers' and managers may need investigation; do managers tend to over-stress their importance? Manpower problems should not be dealt with in a piecemeal manner; it is necessary to study the whole field.

Denmark: studies are undertaken by the National Health Service, generally in collaboration with the Medical Association, the scientific medical societies, or similar representative organisations. The results are usually published in a monthly bulletin from the National Health Service.

Finland: several hospitals have carried out studies relating to the reduction of weekly working hours of staff; the need for more studies is widely appreciated.

Germany: there have been studies as to the actual content of the work of nurses today; more research into manpower problems is needed; there should be rationalisation; work study and operational research are tools which should be used; research into length of hospital stay is important.

Netherlands: a good deal of research into manpower problems has been

undertaken, but extrapolation of trends into the future is rather unreliable; more time and energy should be given perhaps to the development of a model of the overall labour market and of the health labour market within it; the model will show that there are many servo-mechanisms involved.

Portugal: the Ministry of Health has made numbers of surveys of health service manpower questions and pertinent legislation has followed them; it is hoped to give a great impetus to research.

Romania: studies on the training and distribution of staff lead to the taking of appropriate action.

Spain: some manpower studies are being undertaken.

Sweden: there are large numbers of studies.

Switzerland: the needs of 1980 have been the subject of a special study; an intensive study of nursing began in 1965 and should be finished in 1969; the use of staff and many other aspects of nursing are included; the study found that on average a nurse spends more than one-half of her time on work other than the direct or indirect care of patients (other countries reported similar results to similar investigations).

United Kingdom: there have been studies relating to manpower by the Ministry of Health, universities, regional hospital boards; voluntary organisations; much more investigation is required.

Yugoslavia: there have been studies of manpower problems in 200 economic organisations; the value of such studies is recognised.

## Management

In the course of brief references to management in the health services, it was made clear that the importance of this subject in relation to manpower problems is widely appreciated.

It is the duty of management, in consultation with trade unions and other staff organisations, to devise and develop a manpower programme within the principles of national policy on the subject. Arrangements for recruiting, training, encouraging and supervising staff have to be made and *esprit de corps* has to be promoted. Goodwill, good principles, good brains and good communications are essential to the attaining of success.

The under-employment of staff is not unknown in industry and there is no reason to believe that all health services are always free from this fault. It is part of the task of management to know what is happening and if there appears to be waste it must be traced, defined and eliminated. Some studies have revealed opportunities for suitable action to that end.

The art of management is no less difficult than any other art. In many countries it is now realised that it is not enough to leave management skill to develop spontaneously. Training can assist in the making of the good manager, even if only wide and long experience can complete the process. In Great Britain and elsewhere special arrangements have been devised to help in the development of management skills and they already extend to administrative, nursing and general staff. The next step – and a necessary one – is to extend management training to medical staff in charge of clinical work. Management – including the wise use of manpower – in that sphere

is no less important than management in other sectors of the health services.

It is essential to realise that positions alter and that what is a good arrangement today may be inadequate to meet the demands of the future. Professor Stolte, in this context, stressed certain principles which can be found in his own summing up which forms Part 3 of this report.

## Aims for the Future

The information placed before the conference and the discussions arising from it dealt not only with the manpower situation as it is at present, but also with the prospects and hopes for the future, taking into consideration the major problems that have not yet been solved.

The papers presented set out the aims of the several countries. Here it will be sufficient to refer to matters which appeared to be of concern to most if not all of the participants in the conference. They were:

the devising, compiling and use of better records to assist in assessing and solving manpower problems;

carefully planned research into many aspects of manpower, including the deployment and utilisation of staff;

the review of training programmes and the investigation of the possibility of having programmes common to several occupations so as to avoid wasting the time of scarce teachers;

the framing of better career structures;

the making of better arrangements to encourage married women to enter or return to the health services, including better arrangements for training and refresher training;

the training of more doctors, nurses and para-medical personnel;

extensions to existing schemes and the inauguration of new schemes for the training in management of staff who have, or will have, management responsibilities;

the development of community services and the avoidance or curtailment of hospital treatment and care where the patient's needs can be met by good extra-mural arrangements;

the better coordination of hospital and other health services;

the designing of new hospitals to meet the needs of patients more thoroughly and to avoid the wasteful use of hospital manpower;

the taking of all practicable and reasonable steps to provide for geographical and horizontal mobility of staff, where such mobility is shown to be essential or highly desirable;

the wise and extended use of mechanisation, automation and the computer to reduce the burdensome tasks that at present have to be undertaken by human effort;

the application to the health service, where appropriate, of productivity and bonus schemes;

the improvement of arrangements for cooperation between employing

bodies, and trade unions and other staff organisations; together with the giving of constant attention to the need for good communications within each organisation and between organisations.

## Summary

**Population** The growth of population and changes in its distribution have a bearing on the manpower position. The proportion of the population at work has fallen for several reasons. The drift of younger people from the rural areas is common. The task of providing adequate health services for rural districts becomes more difficult. Emigration has been a disadvantage to certain countries. Dependence on immigrants for staffing the health service is not a good long-term arrangement.

**Other Manpower Influences** The influences are many and include changes in society; the advance of science; the growing demands for health services; improvements in educational and training arrangements; the raising of the status of health service occupations; better remuneration, conditions of service and career prospects; retirement at earlier ages; mobility and lack of mobility of personnel; the design of buildings; the employment of part-time staff, including married women; and turnover of staff.

**Hospital Services and Other Services** While hospital services make the largest demands upon the manpower of the health services, there are important demands for domiciliary care and other types of community care. The great importance of good general medical practitioner services is frequently stressed.

The respective merits, costs and manpower demands of hospital care and extra-mural care require careful study and assessment.

**Doctors** Medical manpower problems are among the most difficult to solve. Medical manpower can be expanded only slowly by reason of the limited medical school facilities and the long period needed for medical education and training. There are unsatisfied demands for more doctors, but there has in recent years been a great increase in the numbers practising, especially in hospitals. Some training courses are too long and medical education generally is in course of re-examination and revision. Wastage through student drop-out causes anxiety, but there are more applicants for admission to medical schools than there are places.

**Dentists** More dentists are needed, but the need is not defined.

**Nurses** Everywhere there has been a great increase in the number of nurses, both whole-time and part-time staff, including married women. The work done by the 'registered nurse' has become more onerous, but many duties now are performed by 'auxiliary nurses', 'assistant nurses', 'nursing aides', 'practical nurses' and 'enrolled nurses'. Non-nursing duties have passed to para-medical personnel, ward clerks and domestic staff. There is less dependence upon nurse members of religious orders. More male nurses are employed and will be employed in the future, but opposition to this development is not yet at an end.



**Midwives** There is little change in the arrangements for the employment of

midwives, but the numbers in hospitals have increased and there has been a reduction in the numbers engaged in domiciliary midwifery.

**Para-medical Professions; Technicians, etc** A vast expansion has taken place and many new occupations have come into being. It has been necessary to set up new training arrangements. The trend continues.

**Other Health Services Staff** Administrative and clerical staff have increased in numbers. Special arrangements for training and developing skills are universally considered to be necessary.

Domestic staff also have increased in numbers, despite the introduction of mechanisation and the provision of much better equipment. More male workers are employed. Turnover of female workers is substantial. The provision of services at week-ends is difficult and expensive.

**Nomenclature** A glossary of manpower terms may be needed.

It is suggested that the use of terms which tend to indicate that posts have a low status should be avoided, eg, 'aide', 'help'.

**Research, Records and Statistics** Manpower problems can be avoided or solved only if management has facts which have been carefully collected and assessed. A good deal of investigation and research already has been undertaken in many countries, but the need for more work of this kind and for better records and statistics is generally recognised.

**Management** Good management is essential to the making and carrying out of good manpower policy. A useful beginning in management training has been made, but much more needs to be done.

Signs that show the emergence of manpower problems are referred to and some of the instruments available for dealing with the problems are listed.

**Aims for the Future** The many manpower planning aims include the devising, making and using of better records and statistics; more research; better training arrangements; better career structures; employment of married women; training of more doctors, nurses and para-medical personnel; more management training; development of community services; better coordination of hospital and other health services; good hospital design to avoid unnecessary work; geographical and horizontal mobility of staff: extended use of mechanisation, automation and computers; application in appropriate spheres of productivity and bonus schemes; better cooperation and better communications at all levels and in all branches of the health services.

# 3 Commentary on Conference

**by Professor Dr J B Stolte**

**This commentary was presented at the end of the conference and it particularly stressed points which were considered during discussion**

## Introduction

Throughout the conference it has become abundantly clear that it is not possible to study one part of the health service or even the health service as such in respect of manpower without taking into consideration all aspects of the problem. Indeed all things hang together. A great many factors are involved and they are intricately interrelated. Many feed-back phenomena and servo-mechanisms are at work.

As Professor Blanpain has pointed out, a holistic approach is indicated. However, a really holistic grasp of a system like the health service is beyond human power. Therefore one has to make do with studying manageable parts, always taking into account the unavoidable loss of some perspective and trying to allow for this. Perhaps in the long run the computer will be of some help in getting a better insight into the interplay of all factors. This is not yet the case, however.

All participants agreed that the manpower problem of the health service was closely related to the condition of the labour market of the country as a whole and the culture of the welfare state. People within the welfare state expect a maximum of social security and an ample spendable income to be earned in relatively few working hours. In the health service this is of consequence, of course. Another example of the need for a holistic approach was pointed out by Mr Albinsson, Mr Högberg, Dr Serigó and Professor Blanpain: pursuing efficiency within a part of the service may diminish the efficiency of the service as a whole, as it will sometimes only transfer cost to other parts, both in terms of money and manpower. Early discharge from hospital, although diminishing the amount of money to be spent there, could cause higher total social cost because of prolongation of convalescence. Home care is sometimes erroneously thought to be less expensive than institutional care. In fact it is probably more expensive. We have, however, to be careful to take all aspects into account. Using only the yardstick of immediate effect could make for the wrong conclusion. In the longer run, the effect of home care on the condition of the patient could be so much better that the greater expense would be quite justified. We just do not know. More study is needed to find out what we are buying and at what price.

Then again, in a given social structure, one way of dealing with medical matters will have excellent results at relatively low cost in terms of money and manpower, eg, maternity care in the home (Netherlands), whereas with another social pattern with perhaps different housing and household conditions it would not. Changes in society also have a profound effect, eg, urbanisation. This and industrialisation may upset the geographical balance between supply and demand of services. Mr Peyssard in particular asked for attention to be given to this aspect. The lack of balance may

take disturbing proportions, as it is often the elderly with a very great need for services that are left behind in rural areas, whereas the young ones who could deliver these services have left. With the more modern attitude towards the urbanisation trend, where planning the geographical distribution of urban areas is a feature (new towns), there is no doubt that the health services are very much involved. One has also to take into account that need for health services changes with urbanisation and industrialisation: industrial medicine, occupational diseases, the consequences of air and water pollution, etc, come into the picture.

That the manpower problem within the health service is not an isolated one is also demonstrated by the influence of similar markets outside the country. Amongst intellectuals in particular, nomadism has become almost a world phenomenon. Some countries like Ireland and Yugoslavia seem to produce more health personnel – doctors in particular – than they need themselves. Others lose some of their health personnel because they do not pay them enough, so that they prefer to go to other countries where the pay and perhaps other circumstances are considered to be better (Great Britain, Denmark). Some countries, like the United States, Sweden, Norway just do not take the trouble or are not able, due to divergent circumstances, to produce enough doctors, nurses and other health personnel of their own. The rich ones just buy these workers elsewhere. Foreign labour is shown to be a short-term solution only, however, as it is a definite drawback to planning for a more balanced situation in the future (England and Wales). Not all export of health personnel is considered a loss. Denmark sees quite a few go to Sweden, but they come back having gained in experience, we have been told. Then again, if the richer countries have a duty to help the less well-to-do, sending experts is perhaps one of the best ways.

## The Labour Market

The situation in the labour market as a whole is of the utmost importance for the recruitment of health personnel. As retirement age cannot be very different with the working population the span of working life is set there, as is the number of productive hours. With the reduction in working hours per week, however, the interesting phenomenon of 'moonlighting' and second jobs arises, in spite of the resistance of the unions. Formerly the shortening of weekly working hours was definitely a good thing and it brought with it a rise in productivity; but perhaps it has gone beyond the point where this is still true.

In recruiting for the health service, we have all had to focus on a rather small part of the labour market until recently, because of the educational level. The level is, however, rising steadily, so that the fund of labour from which we can draw is becoming larger. Because of that it has become possible to set higher standards of entry, getting even better results than were expected (eg, with nurses in Belgium and the Netherlands). We have also had to change the image of certain professions as being occupations for females only, and in many countries more and more men are called upon to fill vacancies as they make for a steadier working force. In many countries (Portugal, Belgium, Netherlands, France) the diminishing number of nuns is causing difficulties, because they filled many of the higher posts with some continuity. Perhaps in the long run more men will take up these jobs, as women seem to have less ambition in this respect.

Nevertheless in virtually all countries one is trying to mobilise all kinds of latent labour force, eg, married women. There was some doubt, however, whether society as a whole will not be footing a very high bill in the long run if one goes too far in this, as the deleterious effect on the children could cause a great demand for psychiatric services and social welfare in the future.

It has been suggested that perhaps the health service is trying to get more than its due share from the labour market. In countering this, attention was drawn to an important feature of the health service. It is providing an essential function in respect of the labour force as a whole by maintaining its strength and condition.

## Demand for Services

Demand for health services is of course a factor of paramount importance in respect of the number of health personnel needed. There will always be a discrepancy between what is technically possible (and wanted) and what can be produced. Therefore the problem of settling priorities arises. The technique of solving it has not yet been developed, however. Cost-benefit analysis is not the solution in its present form.

Dr Eichhorn pointed out that the opening up of new fields of activity should be weighed against the manpower needed for them, as otherwise personnel will be withdrawn from perhaps more essential (if less glamorous) parts of the service.

The standard of work is of importance too. High standards quite often require more and better personnel. Mr Albinsson advocated looking for the acceptable minimum standard so that a maximum amount of service of that standard may be rendered by the manpower available. As Dr Lambertsen pointed out, it is quite possible that by setting too high a standard of service, rehabilitation might be hampered as it could dissuade the patient from taking as much as possible upon himself. In this respect it was suggested that perhaps it was better to use the expression 'progressively diminishing care' instead of 'progressive care'. A point that was discussed at some length was whether the patient should be consulted as to the amount of care and its quality. As his experience is limited he is not really in the position to make a valid comparison. On the other hand, however, people know more and more about what they expect from an adequate health service. Too paternalistic an attitude on the part of those who are in the service has not much to commend it.

Of course better 'hotel service' and more privacy will have to be bought at a higher price both in terms of money and personnel. Possibly this is not just waste, however. It could be that the overall result of the treatment will be that much better. On the other hand we have to know whether we must and can afford to provide these so-called luxuries without diverting essential services from those in need of them.

## Training

Training was given much attention. Several participants stressed the importance of preventing waste with training. In many countries there

evidently were too many (expensive) drop-outs. It was suggested by Mr Högberg that perhaps a *numerus clausus* could to a large extent prevent this wastage. Others were not convinced, although almost everywhere the training facilities were in danger of becoming overburdened. Another form of waste was found in the excessive length of many of the training schemes. Perhaps training methods also left much to be desired. The plea for better training schemes was almost universal. It looked as if almost everywhere experiments were needed in this respect, but some doubt was expressed concerning the attitude of the professions and the ivory tower mentality of the teachers.

It was deemed necessary to study very closely what training is aiming at. Is it right to train for professions and occupations reflecting the traditional division of labour within the health service and the hospitals? Perhaps this pattern has to be analysed and altered according to the result of the analysis.

At the present time educational requirements for starting training for the health professions are rather high. Consideration should perhaps be given to another way of dealing with the fact that the educational level of the professions has of necessity to be pretty high. People can be taken in at a lower level to start with, the educational level being raised during the training. This could perhaps be considered in conjunction with setting up a career structure throughout the whole service, connecting the different tiers, so that the ceiling of some of them could be pierced, eg, by a nurse becoming a doctor without having to backtrack all the way.

This could ameliorate recruitment of males to the nursing profession without too much loss of nurses to the medical profession. Opinions did differ about this suggestion, of course.

In many countries planning in respect of training had been overtaken by the facts. It was pointed out therefore that training facilities and teachers must be brought up to the necessary amounts and numbers to cope with the needed increase in students. The time-lag between starting the expansion of training schemes and getting the results is a problem here, as training takes so much time. It may be all the more difficult as the teachers quite often have to be taken from the ranks, thus diminishing a number which is already too small. Emergency measures will be taken of course when they are necessary. The danger here lies with these becoming a set pattern.

An interesting problem was pointed out by Mr Aurousseau. Quite often the onus of training does fall on a relatively small geographical part of the country. The problem of cost is not the most important one. The real difficulty lies with the discrepancy between the great number of students and the training facilities, the number of teaching beds in particular. Affiliation could be a solution but it is not yet part of the normal pattern in European countries.

One has to be careful not to emphasise too much the technical aspects in the training. Of course extension of knowledge is to be furthered and technical development is an important factor in this. It is, however, of the utmost importance that the knowledge is applied so that the patients will profit. We must not only develop medical science, but it must be distributed

to the population to heal illness and to relieve suffering, spiritual suffering in particular; otherwise we will have to accept the tragedy of unused medical knowledge and that of lost medical skill. We need research people as well as doctors and nurses in the curative field. It was therefore suggested that the training for research people should branch off at a certain stage. This could perhaps be of importance for recruitment too, as the career would become clearer and training would perhaps take less time. This branching off should not however take place too early, as horizontal mobility within the service is important too. With nurses, the training of technical people should branch off again at a moment when the basic education has produced a common background, so that horizontal mobility is not handicapped more than is necessary. It was pointed out that, with specialisation, fragmentation was becoming an acute problem, demanding effective coordination. In many cases the machinery to bring this about was thought to be insufficiently developed. More attention should be given to this aspect.

## New Occupations Bring New Problems

Several aspects related to training were discussed in some detail.

Figures from Britain and Germany called attention to the fact that the growth of different parts of the service in terms of personnel was rather unequal. In many cases there was a shift of part of the workload to other people making for an enlargement of scope and a bigger output. Much work formerly done by doctors was now being taken over by nurses and para-medical personnel, as nurses turned some of their work over to ward clerks, practical nurses and also to para-medical personnel. In this way many new occupations were being created, all of them needing training schemes. It was considered worth while to study the possibility of combining training schemes, thereby making for more horizontal mobility within the service and so for more flexibility.

The professionalisation of the newer occupations, through the setting up of national organisations that lay down an ethical code, make for clear-cut requirements of knowledge and skill and raise the general standard, was welcomed, as this was deemed to be the best way to dissuade 'empire-builders' (big fish in little ponds) from setting up training schemes of their own just to strengthen their own position. On the other hand an almost tragic paradox may occur. Specialisation of course is almost the only means to compensate for the danger of obsolescence of knowledge and skill accompanying the outburst of technical and scientific advance; it narrows the field of interest so that keeping abreast remains possible. It contains a danger of its own, however, as the same rapid development may entail obsolesence of the profession itself (eg, chest diseases as a specialty).

## Efficiency

As waste will cause a need for more personnel, much thought was given to efficiency of the service. The biggest problem here is finding yardsticks. Setting a wrong kind of standard for performance may bring about a wrong perspective, particularly with the managers, and this will cause waste. The performance of managers should be judged by the performance of the organisations they control and not just by the bulk of work they do and

get done. The good manager may be the one who reduces the so-called importance of his institute to a minimum. As in most circumstances transport is not a problem any more, merging of small units was advocated. The resulting enlargement of scale will make for less waste, particularly because it creates the possibility of using mechanisation and automation to the greatest advantage and getting the most out of specialisation. Integration of different kinds of service was advocated too, eg, general practitioner service and general hospital, and also general and psychiatric hospitals. This and several other ideas will have to be put to the test; experiments are needed as tradition may be petrifying. With experiments, however, it is essential to state accurately in advance the standards against which the result will have to be matched.

Financial and quantity yardsticks may be used but their importance as such is possibly quite small. Quality is probably more important. The more costly quality work may be more efficient in the long run as it may produce better and more lasting results. We just do not know. Studies in this respect have only just started. Maybe they will produce some answers, but these will have to be looked at again in the light of getting the maximum done at the lowest acceptable level of quality.

Of course bad performance will be rather easily detected. By finding out about this, insurance funds may dissuade their insured from going to bad hospitals as, the conference was told, happened in France.

## Balance of Labour Market: Signals and Adjustments

There is no doubt that the situation of any labour market is in delicate if somewhat doubtful balance. One has to be very careful in manipulating in this field. The factors involved have to be analysed and quantification should be tried whenever this is feasible. It is necessary to build up our knowledge of the instruments we have at our disposal to manipulate on the labour market and to extend the system of signals showing the reaction of the market, so that one may observe the results of putting the instruments into operation. This feed-back is needed for adjusting the application of the instruments to their effect.

Some signals have an immediate or short-term significance; with others it is more long-term. Short-term signals include

**1** manpower drain to other countries

**2** manpower drain to occupations outside the health service

**3** unwanted drain of manpower from some part of the service to another one, eg, general practitioners going into social medicine in the Netherlands.

Some long-term signals are

**1** the number of people entering the training schemes

**2** the number of trainees finishing their training

**3** the number of people with different degrees of education joining the country's labour force

**4** changes in demand for services both as to quantity and kind.

Many of these signals are of a statistical nature. Almost all countries do realise now the importance of statistics in this respect. Newcomers to the conference (Romania, Poland) were able to give a lot of information in this way and Dr Kohler now could produce many interesting figures about Switzerland. Mere figures of course have only limited value. They have to be gathered with a definite purpose so that intelligent interpretation may result. In this respect much research has still to be done. At the moment it is perhaps best to concentrate on obviously critical points like the general practitioner problem. There are also signals of a nature other than statistical. They are connected with the development of medicine and its implications.

Quite a lot seems to be known about the instruments with which to manipulate the labour market although their scope has to be ascertained as yet. From many countries experience was related about the importance of clear career structures. Status of course is of the utmost importance, perhaps even more than remuneration, although in the long run status is determined by remuneration too. In Ireland and other countries, with psychiatry in particular, it was difficult to fill the vacancies. Of course income (and salaries) was amongst the most powerful instruments. With progressive taxation, however, people seem to look more and more to spendable income as an inducement. That pension schemes and social security have great influence was pointed out by Dr Toftemark. The way the income is gathered could have some influence too. Dr ffrench O'Carroll suggested that there might be some psychological point in the relation between the professional status (of doctors) and private entrepreneurship. Here again more insight will have to be gained from research.

In some situations fringe benefits may be almost essential. Lodging for staff may be indispensable, as Dr Kohler pointed out. Nevertheless it puts an onus on the hospital that the community should take upon itself. It distorts ideas about the cost of the health service.

In many countries the distribution of doctors and other health personnel over the country was rather uneven. In many cases attention was drawn to the trend of urbanisation (Austria, Poland), so that it was difficult to fill vacancies in the more rural areas. Instruments like income and fringe benefits to influence geographical distribution were shown to be rather difficult to use as this may upset the delicate balance both in the rural areas and in the country as a whole. In many cases it did meet with resistance from the authorities or from the unions.

The state, the professions and trade unions are all involved in manipulating the labour market. The difficulty at the moment lies with their having no model, no analysed system at their disposal. Because of that time and again the balance is disturbed and overshooting occurs (Great Britain, Netherlands). One of the dangers resulting is the spiral of living costs and wages; higher income of some in the service brings about an overall increase of wages within the service; this does increase the cost of the service and thus brings about the necessity of higher insurance; this again, insurance being an essential part of the living costs, causes higher wages in general and because of that the health service, being in competition with other services and industry to recruit the personnel needed from the labour market, has to raise its bid again, etc.

In some countries strikes had occurred within the health service, causing bad public relations as adequate health care has come to be considered a citizen's right. As more and more key positions are created, with progressive specialisation and fragmentation, the danger of strikes of small groups paralysing the service increases. On the one hand ethics are involved. It is of the utmost importance to provide the specialised groups, however technical their specialism, with a sense of professionalism and an attitude of service. On the other hand it has become almost essential to set up machinery for settling these arguments without strikes and the like.

## Final Comments

There was no doubt in the minds of the participants that designing a perfect system for handling the problems of manpower within the health service and the hospitals is beyond human capabilities and even if such a perfect system did exist it would be impossible to carry it out perfectly. Even trying to set up a perfect system was considered to be perhaps too ambitious and possibly dangerous. Circumstances change constantly and so-called perfect systems tend to become rigid, not allowing for adaptation and amelioration through experiment. As Professor Blanpain pointed out, it seems better not to put all one's eggs in one basket. Routes of escape have to be kept open and reserve schemes have to be preserved.

# The International Hospital Federation

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The International Hospital Federation, founded in 1929 when it was known as the International Hospital Association, is a non-profit making, non-political federation of all who work in or for hospitals. The official languages of the federation are English and French.

In pursuance of its objectives, the federation, which has its headquarters in London at the King's Fund Hospital Centre, 24 Nutford Place, London W1H 6AN, maintains a library and information bureau on hospital matters; offers advice and assistance to members on their special problems and in particular arranges hospital visits in any member country to meet individual needs and furnishes personal letters of introduction.

The federation holds an International Hospital Congress every other year, at which representatives of all branches of the hospital service can meet their colleagues from other countries and discuss common problems. Since 1949 these congresses have been held in Holland, Belgium, England, Switzerland, Portugal, Scotland, Italy, France, Sweden and the United States of America.

In the intervening years the federation organises study tours of hospitals in order to give members first-hand knowledge of hospital work in different countries. Countries visited so far include: Sweden, Italy, France, Ireland, Germany, USA, Belgium, Israel, Finland and Switzerland. Both congresses and study tours are open to non-members, but members receive priority in the allocation of places and pay reduced registration fees.

The federation supports international study committees on current hospital problems and runs courses in hospital administration. It also publishes a quarterly international hospital journal, *World Hospitals*, in English, with summaries in French. This journal is issued free to members to keep them informed of the latest developments in the hospital world.

Membership of the federation is divided into four categories.

**1** National hospital organisations, governmental or non-governmental, including national associations of public or private hospitals, ministries of health, and any other organisations concerned with hospitals at national levels.

**2** Any other organisations, associations and institutions whose aims or activities are directly concerned with the hospital service including professional organisations, regional or local health authorities, groups of hospitals and individual hospitals.

**3** Members of all categories of hospital staff, or professions concerned with hospital work, of hospital management committees or boards and any other persons actively interested in hospitals and their work.

**4** Professional, commercial and industrial firms concerned with the hospital field and publishers of hospital journals.



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