

SOCIETY FOR SOCIAL MEDICINE

EVIDENCE SUBMITTED TO THE WORKING PARTY ON MEDICAL ADMINISTRATORS

INTRODUCTION

The Society for Social Medicine has just under 250 medical and non-medical members, the majority of whom hold academic and research appointments. It also has members holding administrative posts in all the branches of the health services in the UK.

The Society defined the role of social medicine as an academic discipline and discussed its place in undergraduate and graduate teaching in the evidence it submitted to the Royal Commission on Medical Education (*Brit. J. prev. soc. Med.* (1966), **20**, 153). In that document we used the term 'social medicine' to indicate the academic subject comprising (a) epidemiology (i.e., the application of population methods to problems of human disease and human biology) and (b) the study of the medical needs of society. The term 'medical administration' is taken to refer to the work of medically qualified people employed on administrative and supporting administrative work in any branch of the health services. In this evidence we shall use the term 'community medicine' as an umbrella term to include both medical administration and social medicine.

The Society is convinced that there should be defined career structures with unified salary scales for medical administrators and sees the concept of the community physician mentioned in the last Green Paper as a reference to all posts within this career structure. The Society accepts that for organizational reasons (e.g., identifying a medical administrator who is also the statutory medical adviser to local government units) it may be necessary to use the term 'community physician' but it does not accept that this term represents a separate speciality from medical administration.

The Society believes that many doctors in clinical practice must be concerned with, and take part in, the management and administration of the health services. For example, the contributions of the chairmen of hospital medical executive committees and chairmen of health centre committees are vital. However, the problems of the functions and training of these groups are not considered in this document which focuses on the functions and training needs of full-time medical administrators.

FUNCTIONS OF MEDICAL ADMINISTRATORS

They are:

- (a) the assessment of the health of a defined population by the use of epidemiological and survey methods and the collection and analysis of statistics;
- (b) the planning and allocation of resources for all the clinical services;
- (c) the organization and management of population-based preventive services, e.g., immunization, prescriptive screening, and health education;
- (d) the co-ordination of various sectors of the health services and their co-ordination with social and other services. This is of particular importance in child health, occupational health, mental health, and the continuing care of the physically handicapped, the chronically ill, and frail aged people;
- (e) monitoring the effectiveness of clinical, preventive, and rehabilitative health services;
- (f) developing the organization of the health services.

The matching of these responsibilities with the level of posts must depend upon the size of population involved at each level of administration. We do not have sufficient data to be precise about minimum and maximum sizes of population. However, the Society expects that all these functions will be practised at area, regional, and central government level but with varying emphasis.

Much of the concern of the present public health departments with environmental control should pass to other specialists. For example, the day-to-day management of water supply, sewage disposal, clean air, over-crowding, and unfit houses, etc., should be entirely the responsibility of public health engineers and public health inspectors. The medical contribution to these services would be exercised through the continuous monitoring of health indices of the community and advice to the responsible authorities. In addition, the Society believes that epidemiologists trained in communicable disease control should be appointed to the staff of Public Health Laboratories to act as consultants to the medical administrators and that Regional Toxicological Laboratories for the investi-

gation of physical, chemical, and radiological hazards in the general environment as well as in factories should be established with supporting medical and scientific staff.

CAREER STRUCTURES AND RECRUITMENT

Recruitment to the present branches of medical administration is a critical problem. Both training and established posts in medical administration must offer salaries comparable to those of the clinical specialties, not only to attract young doctors into medical administration, but also to enable some experienced clinicians to move to full-time medical administration. We assume that the health services will be unified in time but even before this occurs it will be necessary to introduce comparability of pay, etc., between the present different branches. In future, medical administrators should be trained in and practise 'health service administration' without financial or other distinction between hospital administration, public health, etc. There should be full transferability between medical administrators within the health services and between the health services and academic and research appointments. A number of appointments within the health service, particularly in intelligence and research units, should be of a combined nature on the lines, for example, of the present joint appointment of a Principal Medical Officer at the Department of Health and Social Security and the London School of Hygiene and of an Assistant Senior Medical Officer at the Sheffield Regional Hospital Board and the Department of Preventive Medicine and Public Health at the University.

FORMAL TRAINING

In most branches of medicine, postgraduate training has consisted of a steady progression through a series of training posts, combined with private study and attendance at short courses on specialized aspects of the particular branch concerned. At some stage competence has been formally recognized by the passing of a national examination (e.g., M.R.C.P. or F.R.C.S.), but the concept of a progression has not been the pattern in public health. In this field stress has been laid on attending a formal course of instruction, usually at a university. There are two main reasons why this is so; first, because undergraduate medical education lacks a thorough grounding in social medicine and as a result the prospective specialist does not have sufficient basic knowledge to make private study fruitful; and second, because the fragmentation of the health services, and especially the large number of local authorities, has so far blocked any attempt

to organize a system of training posts in community medicine analogous to the junior hospital posts in the clinical specialties.

The Society believes, therefore, that a formal course of one full-time academic year, or its equivalent, should remain a major, if not obligatory, part of postgraduate training in the subject. After completion of this course the education of the trainee should be continued through one or more supervised training posts appropriate to the specialty.

At present there are two main groups of doctors who need postgraduate training to enable them to practise community medicine:

(1) those concerned with local and central medical administration in this country (in hospital services, local government, central government departments, and national organizations); and

(2) those intending to make a career in academic social medicine (teaching and research).

The Society is strongly of the opinion that there should be a basic postgraduate training for all prospective medical administrators in common with those who intend to make a career in academic social medicine. The arguments for this are three-fold:

(1) The essential framework for practice in all branches of community medicine is the same, i.e., an understanding of the principles and practice of epidemiology and of how advances in medical knowledge have been and may be applied to the measured medical needs of society.

(2) A formal course can never be more than an introduction to a special field of community medicine. Acceptance as a trained specialist, fit for a responsible post, comes after a period of vocational training under supervision. It is this vocational training, not the basic introductory course, which should be tailored to the specific needs of different fields of community medicine.

(3) The multiplication of formal specialist postgraduate diplomas and degrees in branches of community medicine will restrict the career opportunities of students and reduce recruitment to the superficially less attractive branches. However, the common training pattern should include optional modules and electives.

We support the Todd Recommendations for three years of general professional training (G.P.T.) and at least two years of further professional training (F.P.T.). The academic course we have referred to should begin either in the third year of G.P.T. or the first of F.P.T. Prior to this academic course the student should have acquired a wide experience.

We broadly agree with the suggestions outlined in appendix 5 of the Todd Report; but we consider that appointments in sociology, statistics, psychology, and research and intelligence departments would also provide relevant experience. Appointments in infectious disease and microbiology would be particularly suitable for the future epidemiologists working with the P.H.L.S. We would add a general junior post in a pathology department as an alternative in the second year; and, of course, would accept a junior post in an 'area health board' should these replace the local health authorities and present regional hospital boards. If the student holds such an administrative post in his third year of G.P.T., then he could spend his first year of F.P.T. on an academic course; the second year of F.P.T. could be spent on consolidating and developing the investigative and evaluative skills he has acquired on his course. For this he will need to be under the guidance of a tutor or preceptor and be freed of all routine administrative work. If, however, the student has attended his academic course during the third year of G.P.T., then the first year of his F.P.T. will be so occupied and his second year will be in a junior administrative post in central government or an area board. An alternative to one year's full-time formal course followed by a consolidation year might be an appropriately designed two-year programme combining formal and consolidating study.

In structuring a series of posts for the young entrant to community medicine, special regard must be had to the need for an individual to change from one specialty to another. This is especially important in administrative medicine for two reasons. First, young doctors have little experience of the specialty and therefore are unlikely to choose this specialty early in their careers; secondly, administrative medicine needs to be able to recruit suitably gifted experienced clinicians.

CONTINUING EDUCATION AND IN-SERVICE TRAINING

Two objectives must be distinguished here. One is the immediate but transient need for some re-orientation training for doctors now engaged in medical administration in the various branches of the health services, in order to ease the transition to the unification of these health services, and to facilitate the appointments of present staff to the new posts. The other objective is permanent; it is to provide for the continuing education (or post-experience training, in business terminology) of all specialists in community medicine.

Experimental courses differing in design, style,

content, length, and setting will be required for both these purposes. Some may be residential; some organized within an academic department; some within an administrative department. Some may be structured on a day-release basis (as has been successfully pioneered in Scotland); and some on a sandwich system. Such details will depend on the precise objectives of each course, the resources available and the amount of time for which the medical administrators can be spared from their service responsibilities. For re-orientation, for re-thinking accepted means and ends, people from different areas with different tasks need to be brought together in an academic environment. For these purposes a residential course of four to six weeks' duration, followed six months to a year later by a further residential period of four to five days, may prove to be a suitable pattern. Certainly there is evidence from the experience of the Institute of Local Government Studies, Birmingham University and from the business schools to support this. If the objective is to provide an appreciation of the scope of some new technical development, then a one-day course may well be sufficient. In-service training is suitable for acquiring certain technical knowledge and skills and for the development of a team approach.

The Society considers it essential to develop integrated teaching focused on the problems of the health services. Much of the existing management sciences teaching is, quite rightly, concerned with industry and commerce; to apply this to the problems of health services needs a multi-disciplinary approach, which is likely to grow most quickly where joint research is being conducted within one centre. For the re-orientation and later the continuing education of medical administrators we suggest that, for reasons of access, the number of people involved, and especially the limitations of staff available, five centres might be developed. Initiation of such a programme is urgent, and besides its re-orientation functions, its early purposes should be seen to include the recruitment of teachers, the structuring of courses, and the assembly and testing of teaching material and methods. We should not underestimate the time it may take to bring satisfactory courses into operation on the basis of present resources.

The Society foresees the need for a staff college type of course for medical administrators in the years immediately preceding their promotion to the most senior posts in the administrative hierarchy. The emphasis here would be on 'top management' rather than on the special expertise of the medical administrator.

CONTENT OF TRAINING

The Society believes that the one year basic course should include the following areas of study:

- (1) evaluation of the contribution of different influences to the health of the community;
- (2) study of how medical services have evolved in response to social pressures and the prevalent patterns of disease in this and other countries;
- (3) assessment of the nature and extent of medical problems;
- (4) assessment of the effectiveness and administrative efficiency of existing services;
- (5) study of the way in which services may be improved;
- (6) estimation of future needs.

The main subjects in a course designed to cover these topics are epidemiology, statistics, operational research, behavioural sciences, management and organization theory, information engineering and use of computers, and administration and economics of health and other social services. The method of teaching should ensure that the main subjects are not taught in isolation. Emphasis should be placed on work done by the students themselves designed to demonstrate the inter-relation of the several disciplines and their relevance to community medicine.

These suggestions are in line with the Recommendations of the G.M.C. as to Diplomas in Public Health and Similar Qualifications (1967) and with the syllabi of some D.P.H. courses, the D.S.M. at Edinburgh and the M.Sc. courses at London and at Manchester.

The Society cannot be so precise about the content of courses for the re-orientation of persons now in service because there is little, if any, information about what courses such people have already attended. However, the same subjects would be covered but, depending upon the type of course and the experience of the participants, the content of teaching and training would vary.

RESPECTIVE ROLES OF MEDICAL AND NON-MEDICAL ADMINISTRATORS

The Society knows of little or no data that it could offer to guide the Working Party about the respective roles of medical and non-medical administrators.

The Society would like to see the creation of posts for statisticians and social scientists at area or regional level (depending on the size of population served) of comparable pay and standing to other non-medical consultants (e.g., physicists and bio-

chemists) in the National Health Service (see also Report of the Committee 'Hospital Scientific and Technical Services' (1967-68), paragraphs 1.5 vi and 42, 43 and 44).

TEACHING STAFF

A serious obstacle to the expansion of education in social medicine is the shortage of suitable teaching staff. For re-orientation and post-experience courses mature teachers, some with experience in medical administration as well as in academic and research departments, are required. Unfortunately, the different rates of pay between medical and non-medical teachers, between clinical and non-clinical, between those with N.H.S. consultant contracts and those without, and between university staff and medical and social service administrators outside the universities have become chaotic. The differentials are so large (of the order of £1,000 p.a. is common and the differences may reach £5,000 p.a.) that recruitment of first-class staff with the necessary experience is now almost impossible, and staff in the universities is continually tempted to move to other, more remunerative, posts. Not only must there be comparability of pay between academic staff and medical administrators, but also between these and equivalent grades in the N.H.S.

FINANCING OF COURSES

A further obstacle to development along the lines we have suggested is the lack of any national policy on the financing of the necessary courses and the payment of the students' fees and expenses. This problem has never been solved satisfactorily by the local authorities for their D.P.H. students, although a few local authorities act generously and far-sightedly in this respect. The position now is that a few bursaries at registrar/senior registrar emoluments are available at the London School of Hygiene and Tropical Medicine, and the Scottish Home and Health Department offer three fellowships each year. In addition Regional Hospital Boards and the D.H.S.S. are prepared to second staff to attend courses. The Society considers that there should be a central focus for the financing of the courses and the payment of student allowances; a solution to this problem is urgent. We suggest that the creation of a Health Services Training Board, perhaps on the lines of the Local Government Training Board, might be the solution. Such a Board, in addition to acting as a grant-making body, could also centralize information about available courses, formulate national policy, and concentrate effort by the sponsoring or otherwise of

courses. For the short-term re-training programme centrally deployed finances should be made available immediately.

ORAL EVIDENCE

The Society would be willing to develop further any points and to send representatives to meet the members of the Working Party.

SOCIETY FOR SOCIAL MEDICINE: SUMMARY OF EVIDENCE TO THE WORKING PARTY ON MEDICAL ADMINISTRATORS

1. This memorandum of evidence is concerned only with the function and training of full-time medical administrators; but the Society recognizes the important contributions that must be made to the management and administration of the health services by many clinical specialists and general practitioners.

2. The functions of medical administrators are the assessment of the health of the community, the planning of services to meet the health and medical needs, the co-ordination of services, and their evaluation and future development.

3. There should be a single specialty of medical administration with career prospects and conditions of service (including pay) comparable to those of the clinical specialties, in order to attract recruits of suitable calibre and to enable transferability between posts to occur.

4. A formal course of instruction will continue to be a major part of postgraduate training in medical administration and social medicine.

5. This formal course might be attended by the younger doctors entering administrative medicine during the third or fourth year after full registration. A number of posts (many listed in the Todd Report) would provide relevant experience prior to attending the formal course.

6. There is an immediate but transient need for some re-orientation training for doctors now en-

gaged in medical administration in order to ease the unification of the health services and to facilitate the appointments of present staff to the new posts. In the future, all medical administrators, like other specialists, will require 'continuing education'. For both these purposes, experimental courses of different designs and content will be required. Much of this effort should be concentrated at a small number of centres.

7. The main subjects taught in the one-year basic courses are epidemiology, statistics, operational research, behavioural sciences, management and organization theory, medical information systems, and administration and economics of health and other social services. The content of the re-orientation and continuing education courses must vary with circumstances, such as the previous experience of the participants and the precise objectives of each course.

8. The Society knows of little or no data that it could offer to guide the Working Party about the respective roles of medical and non-medical administrators.

9. A serious obstacle to the expansion of education in social medicine is the shortage of suitable teaching staff, which is due, in part, to the substantially lower rates of pay of some of the teachers. There must be comparability of pay between academic staff and medical administrators and between these and equivalent grades in the N.H.S.

10. Another obstacle is the lack of a national policy on the financing of the necessary courses and the payment of the students' fees and expenses. Consideration should be given to the creation of a Health Services Training Board to act as a grant-making body, centralize information about available courses, formulate national policy, and concentrate effort by sponsoring or otherwise of courses.

11. The recommendations 6, 9, and 10 above are interrelated and should be regarded as urgent.