



IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtóirí na hÉireann

IMO Position Paper on Manpower

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Irish Medical Organisation,
10 Fitzwilliam Place, Dublin 2.
tel: (01) 676 7273
fax: (01) 661 2758
e-mail: imo@imo.ie
website: www.imo.ie

Background

The IMO recognises that a vital element to the success of the health reform plans is investment in the resources necessary to implement the much needed reform. One resource area currently experiencing problems is the area of medical manpower.

There are a number of reasons why an increase in the overall level of manpower is necessary;

- The shortening of the working week as a result of implementing the European Working Time Directive (EWTD) will require a larger number of doctors.
- In order to implement the Hanly report recommendations of a consultant-provided service, the overall number of consultants needs to increase upon its current level.
- There is an urgent need to address the current shortage of General Practitioners (GPs) in the country.
- Globalisation of the medical profession and the migration of doctors presents both an opportunity and a challenge for medical manpower planning.¹
- The higher the proportion of female doctors to male doctors, the higher the absolute number of doctors that will be needed.² Current projections show an increase in the proportion of female doctors in the profession. Work patterns relating to family commitments (such as maternity leave, part-time work, etc) are more common amongst female practitioners. The change in gender balance within the profession is therefore likely to place greater pressures on the workforce as a whole. Consequently medical schools will need to alter significantly the structure and delivery of both education and training.

The IMO believes that it is important to acknowledge that recruitment and retention problems exist in all branches of medicine and stress that the current position whereby the rapidly increasing demands of the health service fall on a static pool of doctors is unsustainable. To address the problem a strategic approach to the manpower problem must be employed; it is necessary to expand the number of places in medical schools, improve training opportunities and develop structured career pathways for all doctors.

In summary, implementation of the health reforms will create the need for a greatly increased number of doctors in the Irish health system. This will have consequences for the entire continuum of medical education, training, and practice from undergraduate to consultant level. The importance of putting the appropriate changes and structures in place in order to recruit and retain medical staff to reflect current and future service requirements cannot be underestimated and should not be overlooked.

Undergraduate Education and Need For More Places

The IMO believes that the Department of Health and Children must work together with the Department of Education and Science and other stakeholders to institute a strategic system of planning and co-ordination ensuring that anticipated service delivery needs are reflected right back through the system of education, training, and recruitment. In particular, given the proposed reform of the hospital system and the ongoing shortage of general practitioners in the country, those with the responsibility for planning need to consider the appropriate relationship between numbers in the medical education and training system, and anticipated future demand for consultants & GPs.

The Department of Health and Children believes, and the IMO endorses the view, that the intake of medical schools will need to increase significantly in order to meet the manpower requirements of the Hanly Report. The IMO recognises that this will require change at two different points in the process;

- More places at undergraduate level
 - More graduates recruited into specific forms of practice e.g. general practice, consultancy
- However, the IMO deems that there are primarily four factors causing significant difficulties for the undergraduate education system and for the profession as a whole:
- Insufficient funding for medical education and training in Ireland.
 - The absolute number of student places is too low in relation to the labour requirements of the sector.
 - The 'cap' on the number of places for Irish/EU students i.e. there are too few places being funded for Irish/EU students.
 - The lack of a clearly defined medical career structure within and its effect on retention of graduates.

On this basis, in a recent submission to the Task Force on Undergraduate Medical Education and Training, the IMO recommended the following improvements to the undergraduate medical education system;

- An increase in the overall number of medical school places at undergraduate level. At the moment of the 850 places in medical school in Ireland, 350 are available to Irish or EU applicants.
- An increase in the proportion of the overall number of places allocated to Irish or EU applicants. The IMO recommends the removal of the 'cap' on Irish or EU student places.
- Per capita funding for medical students must be sufficient to ensure an adequate long-term supply of doctors.
- Comprehensive lifelong career planning for the medical profession in order to minimize loss of human capital from the healthcare system.

The IMO believes furthermore that these factors are of primary importance in order to improve the quality of the educational experience and professional training at third level and meet the demands of a rapidly changing health care service. Difficulties experienced at the present time do not arise as a result of fundamental problems with the undergraduate system per se but arise as a result of failure on the part of the government to provide adequate funding for the proper running and organisation of the existing system.

Postgraduate Training Opportunities

The National Task Force on Medical Staffing Report, published in 2003, recognises the need to ensure that every effort is made to align medical training numbers with future staffing requirements in the context of the proposed health reforms.³ The report also reflects the awareness that medical training is intertwined with service provision and that integrated planning of training and workforce numbers is essential to ensure that service deficits are avoided and that training numbers reflect future service requirements.⁴

The IMO firmly believes that better career planning is required in order that the numbers in medical education and training adequately reflect the future of service requirements. The process has already begun with respect to the shortages of physiotherapists, occupational therapists, and speech and language therapists. On 29 May 2002, the then Minister for Education and Science, Deputy Michael Woods, announced the provision of 175 extra professional therapy training places for students to tackle the acute shortage for these types of therapists in the health service in response to the recommendations contained in the report of Dr. Peter Bacon and Associates on current and future supply and demand conditions in the labour market (see appendix 1).

The Bacon Report (2001) concluded that a major expansion in the numbers of therapy professionals is essential over the next fifteen years to meet the long-term needs of the health service. It recommended an annual increase of 75 training places for both speech and language therapy and occupational therapy and an additional 25 training places in physiotherapy. The first increase took place in the academic year 2002/2003.⁵

Other key recommendations of the report included:

- Provision of sufficient clinical placements within the health service through the establishment of a national network of clinical placement co-ordinators;
- Need for fast-track qualification and review of the existing training system;
- Concerted recruitment from overseas;
- Establishment of the planned system of statutory registration consistent with the requirement for a patient-centred health service;
- Career structure, workload, working practices and skills-mix issues encompassed in the context of the report of the expert group on various health professions published in April 2000.⁶

But, for many people in education and training, it is difficult to see evidence of such planning. The IMO believes that lack of co-ordination and planning in the system has contributed to the following problems:

- A reduction since 1984 in the number of Irish nationals applying for NCHD posts;
- A marked increase in the emigration pattern of Irish medical graduates, particularly male graduates.

In addition, the IMO believes that there are serious 'choke points' in the system which make it difficult for medical students to know where their education and training will lead them and thus perpetuate the above problems. The factors contributing to the problem include;

- Lack of comprehensive manpower analysis and long term planning
- Lack of clarity in the relationship between post-graduate speciality training, career structure and permanent employment opportunities
- Lack of clarity in the relationship between post-graduate speciality training and increasing numbers of NCHD posts which are of a service nature
- Lack of clear career paths due to all of the above.

The IMO believes that these factors have contributed to one of the biggest problems facing the hospital system at the moment - that of retention of personnel. The findings of the IMO's National Benchmark Survey in 2001, for example, revealed a significant level of dissatisfaction amongst doctors with their chosen profession. In total, 31% of respondents said they would not choose medicine again if they had the opportunity to start their careers again. Moreover, the proportion of female respondents (36%) who stated that they would not choose medicine if given a second chance was higher compared to 29% of male respondents.

Too few doctors and the poor quality of training have been cited as causes of attrition amongst NCHD trainees. Some of the contributing factors may include low health professional staffing levels resulting in many doctors particularly NCHDs spending large amounts of their time performing duties more suitable to other staff. The IMO have identified several areas of work that should be transferred away from NCHDs to appropriately trained non-medical personnel e.g. phlebotomy/IV Cannulation, ECGs, filing of charts/reports, paperless lab requests, potering of samples/specimens etc.

Lack of clear career path development may be another factor contributing to NCHD attrition and the emigration of graduates. The IMO also noted in its submission to the Health Strategy that many young doctors are attracted by properly structured training schemes in Britain where consultant posts are more closely matched to training posts. In the UK, NCHDs are more confident of securing a consultant post once they successfully complete their training.⁷ It was estimated by the RCPI in 1998 that the statistical chance for serving NCHDs in Ireland of becoming a consultant in Ireland was as low as one in ten (Irish Medical Times, March 21 1998).

Changes in the regulatory environment have also had an impact on NCHD numbers. With the advent of the Medical Council entry examination there has been a significant shortfall in the numbers of non-national doctors entering the country. This is most noticeable in the peripheral hospitals where there was previously a surplus of non-national doctors with a sizeable portion of these doctors not in remunerated posts. These doctors were available to cover as locums.

The Hanly report recognises that a number of issues need further consideration including the lack of suitable training opportunities in Ireland and the potential for active marketing of Irish medical education and training and internships for all graduates of Irish medical schools. According to the report, the Task Force is undertaking a tracking study of a 1990 and 1997 cohort of graduates in order to establish a clearer understanding of the issues around career choice, perceived barriers, attrition factors and medical training and current workforce flexibility from the doctors' perspective.⁸ The study was published by the Medical Education and Training Group.

In order to address the problems, in its proposal on new working conditions which taken account of the implementation of the European Working Time Directive, the IMO endorsed Hanly's recommendation for a specific learning contract for NCHDs. The IMO believes that this will improve the quality of training provided and thus improve the retention of NCHDs.

A recent study, published in 2005, suggest that training and manpower problems must be addressed for NCHDs. 35% of trainees expressed an interest in flexible training.⁹ Career impediments cited by responds to a survey of Paediatric Specialist Registrars included.

Career Impediments

	Total	Male	Female
Children	44%	6%	66%
No consultancy in desired location	65%	76%	59%
Anti-Social Hours	41%	12%	59%
Stress	27%	24%	28%

A longitudinal cohort study of medical graduates of the National University of Ireland from 1978 to today reveals that 33% of the graduates were practicing overseas.¹⁰

Earlier work surveying the intentions of Interns highlights the fact that they perceived training in Ireland badly and that 93% intended to seek training overseas.¹¹

Medical Manpower: How Much Is Needed?

Manpower planning and development in the hospital sector needs to be prioritised in order to implement the various proposals as set out in the health reform plans. It is commonly recognised that the quality of medical care in Irish hospitals is under serious threat due partly to the over-reliance on "trainee doctors" and in part to the unsatisfactory quality of training. This in turn is related to too few consultant posts which has led to problems of retention of Irish doctors as many have had to leave the country to find work. A major boost in consultant numbers might change this trend. In any case, the provision of a consultant-provided service as proposed by the Hanly report requires a substantial increase in the number of consultants.

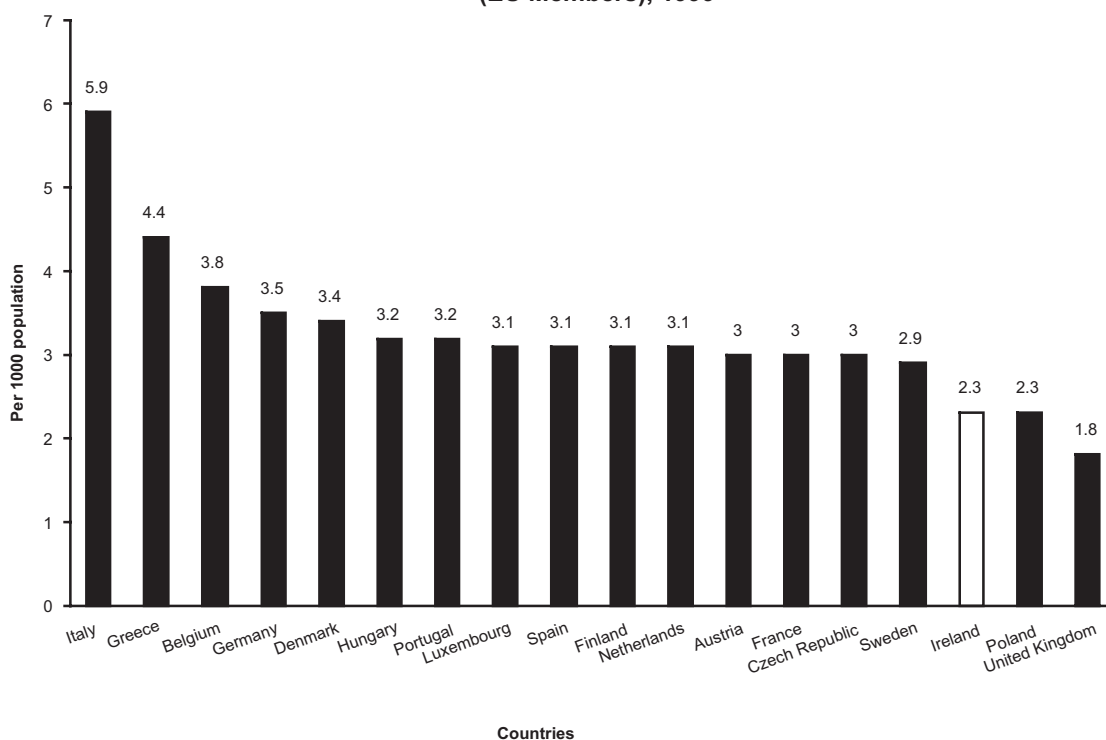
The question arises as to what is the appropriate level of medical manpower - what is the optimal number of doctors per a given number of the population? What is the appropriate ratio of junior doctors to consultants in the hospital system?

According to the latest figures available, the table below reveals that there are just over 2 doctors per 1000 population (including hospital doctors and general practitioners).

	Latest Numbers	Population¹² per doctor	Doctors Per 1000 Population
Consultants	1824 ¹³	2,148	.47 ¹⁴
NCHDs	3932 ¹⁵	996	1
Total Hospital Doctors	5756	681	1.47
GMS GPs	2184 ¹⁶	1836	.56
Total Doctors	7940	493	2.03

International comparisons are invariably difficult due to varying definitions, however the OECD estimated that Ireland ranked second lowest after the UK in 1999 with just 2.3 doctors per 1000 population.

**Doctors per 1000 Population - OECD Countries
(EU Members), 1999**



A number of issues require consideration in determining the manpower levels required:

- The number of accredited training posts should be tailored to the likely number of consultant posts.
- The changes in the ratio of consultant to training posts will require greater and more effective use of paramedical and non-medical staff in hospitals.
- The out-of-hours workload must be included in the calculation when determining the manpower levels required.

Hanly recommends that the NCHD : consultant ratio, which currently stands at 2.2:1 falls to 1:1 by 2009 and to 0.6:1 by 2013. However, as per general motion 38 carried by its members in 2004, the IMO recommends that the Department of Health implements the change in the NCHD : consultant ratio without decreasing the numbers of NCHDs but by increasing the numbers of consultants. This would imply that no change would occur in NCHD numbers, currently 3,932 (Jan 2004¹⁷), and that the number of consultants would increase from 1,824 (Jan 2004¹⁸) to 3,932, an increase of 116%, by 2013 to maintain a ratio of 1:1.

If the health reforms are to be implemented effectively and in a co-ordinated manner, simultaneous consideration must be given to the level and type of additional support staff and other hospital personnel, as well as their training needs, alongside the changes to be implemented in level and type of hospital doctors. Continuity of care suffers where units operate with low staffing ratios.

It must be remembered that manpower is just one factor in determining the quality or otherwise of a health service. The health service is dependent on a number of interrelated factors which must be in place in order to ensure that practitioners can work effectively and efficiently; for example, the infrastructure, equipment and facilities available (hospitals, beds, air and road ambulances, diagnostic equipment, primary care premises etc), the level and quality of support staff and other ancillary services, the type and distribution of specialist services, the opportunities and accessibility of continuing medical education and training, the level and type of funding available etc.

The Importance of Enhancing the Availability of General Practitioners

The literature identifies a number of factors important in the improvement of health outcomes via a cost-effective provision of health care services.

- The strengthening of health system *via* primary care
- Integrated workforce planning throughout the health system, encompassing health services outside the hospital services
- Increasing the number of primary care providers or general practitioners in the population

The Strengthening of Health System *Via* Primary Care

The World Health Organisation has underlined the critical need for adequate health care throughout the world in a series of resolutions and conferences including the International conference on Primary Health Care (WHO/Unicef) held in Alma-Ata, USSR, in 1978.¹⁹ The declaration emanating from this conference emphasised that in order to provide all citizens with essential health services, primary health care should be the central function and main focus of a country's health care system.²⁰ It identified primary care as the most cost-effective way to deliver essential health care services.²¹ The declaration called on all countries to prioritise service provision in this area to their populations. The reason for the emphasis on primary care was due to its capacity to respond comprehensively to the health needs of individuals and communities, even when resources are limited.²²

The 2003 World Health Report 2003, *Shaping the Future*, emphasised the need for 'strengthening of health systems to meet the vast and growing array of health inequalities...strengthened health systems must be based on Primary Care'.²³

Integrated Workforce Planning

The practice of medicine is an integrated process with the patient expected to move seamlessly between different providers of health care. The role of the GP as a primary care physician and as 'gatekeeper' to the secondary health care services needs to be recognised and considered in any review of manpower planning for hospitals. In this context, the Hanly report recognises the 'need to achieve more integrated workforce planning throughout the health system', that is, that the hospital medical workforce planning function should take account of the requirements for a) doctors outside the hospital system, such as general practitioners and public health doctors and b) other health professionals.²⁴ This, the report states, can best be achieved by national level workforce planning.²⁵

Increasing the Number of General Practitioners

Improvements in health outcomes are positively correlated with improvements in the availability of General Practitioners.²⁶ A study by Shi (1994) cited by the IGCP (2004) found that a consistent relationship existed between the availability of Primary Care Physicians in the US and positive health levels, including lower mortality rates from cancer, heart disease and stroke, the three major causes of death in the USA. The study also found that higher numbers of primary care physicians correlate with lower infant mortality, lower overall mortality and higher life expectancy.

Starfield (1998) found in her study of the impact of primary care in 12 European and North American countries, that countries with more highly developed systems of primary care tend to have lower costs, lower mortality rates, longer life expectancy, and greater satisfaction with their health care system.

In this context, a joint policy statement issued by the ICGP and the IMO entitled *A Vision of General Practice: 2001-2006*, outlined a number of key issues in relation to manpower in this area. Both organisations recognise that a comprehensive workforce policy needs to be developed. General practice is expanding rapidly in response to rising patient expectations and the widening range of services being provided. Additional workforce, above current training programme output, is now urgently required. In particular, rural practice needs more doctors to address the current workforce crisis. The ICGP has called upon the Department of Health and Children to establish a representative task force to review GP manpower needs in the medium/long term.²⁷

Factors affecting the requirement for GPs include the following;

- Varying levels of commitment and the need for flexible and part time work
- The desire to combine regular GP service with other 'special' interests and skills
- The need for career breaks and flexible retraining/re-entry programmes
- More involvement of GPs in health service management
- More time for in-service professional development and assessment of performance
- The increasing role of practice nurses, practice managers, public health nurses and sessional GPs.

Action is required now in the following ways to support the increased demand and expectations for general practice services;

- Given the 'lead in' time, the number of training places in this speciality needs to be increased.
- Special consideration needs to be given to ensuring an appropriate and adequate geographical distribution of GPs.
- New out-of-hours arrangements *via* co-operative service schemes need to be prioritised and adequately funded, particularly in rural areas in order to make practice attractive to young graduates (particularly women) while enabling doctors approaching retirement to reduce their night work on an equitable basis.
- In rural areas, the unavailability of locums makes it difficult to take annual leave and special arrangements must be put in place to provide a reliable supply of locums. For these doctors, study leave is largely inaccessible so therefore new models of distance learning and residential courses need to be developed and funded for rural GPs. With respect to the particular conditions and circumstances under which rural doctors must work, the IMO/ICGP recommend that a preferential package of income and other benefits in essential for rural doctors.
- The IMO and IGCP also recommend that the retirement age for all contracts should be 65 with optional retirement from age 60.

Appendix 1

An Inter-Agency Working Group, comprising representatives of his Department, the Department of Health and Children and the Higher Education Authority, was established to seek proposals from third level institutions to ensure the rapid provision of the additional places as an urgent priority.

Following the Report of the Inter-Agency Working Group, Dr. Woods agreed to provide extra professional therapy training places in:

UNIVERSITY COLLEGE CORK, NATIONAL UNIVERSITY OF IRELAND - CORK

- 25 places - Bachelor of Science in Speech and Language Therapy
- 25 places - Bachelor of Science in Occupational Therapy

NATIONAL UNIVERSITY OF IRELAND, GALWAY

- 25 places - Bachelor of Science in Speech and Language Therapy
- 25 places - Bachelor of Science in Occupational Therapy

UNIVERSITY OF LIMERICK

- 25 places - Master of Science in Speech and Language Therapy
- 25 places - Master of Science in Occupational Therapy
- 25 places - Bachelor of Science in Physiotherapy

Source: *Dáil Éireann - Volume 560 - 30 January, 2003; Written Answers. - Health Service Provision. Response by the Minister for State at the DOHC), Tim O'Malley.*

References:

- 1 *Sixth International Medical Workforce Conference Report*, Canada, 2003 (publisher Health Canada) and Australia Medical Workforce Committee, International Medical Workforce Collaborative, Fifth International Medical Workforce Conference Report report, at http://www.healthworkforce.health.nsw.gov.au/amwac/amwac/5th_conf.html
- 2 Postgraduate Medical and Dental Board figures show that in 2001 55% of Irish medical graduates were female and in 2003, 53% of Irish NCHDs were female. For 8 consecutive years, between 1994 and 2001, there were more Irish female than Irish male graduates - in 2002, according to the PGMDB's fourth report, almost 62% of Irish undergraduates were female. The HEA's Fourth Survey of Access to Higher Education report also found that the number of women enrolling in medical sciences more than doubled between 1992 and 1998 and stated that medicine has "attracted a disproportionate number of female students". Due to the fact that many female graduates drop out or reduce their hours as a result of family commitments, the number of places needs to increase, as well as increased flexibility of working and training contracts.
- 3 David Hanly, *Report of the National Task Force on Medical Staffing*, June 2003
- 4 Ibid
- 5 DOH press release, 20th May 2002
- 6 Ibid
- 7 *Irish Times* July 25th 2000.
- 8 Hanly, 2003, p.56
- 9 O.C. Byrne et al. 'Training and manpower Issues for Specialist Registrars in Paediatrics. How are We Doing and Where are We Going?' in *IMJ*, vol. 98, no. 1, January 2005. pp. 13-15.
- 10 P. Finucane et al. 'Medical Graduates of the National University of Ireland in 1978: Who and Where are They?' in *IMJ*, vol. 98, no. 1, January 2005. pp. 20-21.
- 11 P. Finucane et al., 'The Career Plans of Irish Interns: Results of a National Survey,' in *IMJ*, vol. 97, no. 5, p.149
- 12 Based on the 2002 Population Census figure of 3,917,203.
- 13 By January 2004, there were 1824 permanent consultant posts in the public sector in Ireland - source: Comhairle na nOspidéal.
- 14 Method: number of consultants/population x 1000
- 15 Ibid
- 16 General Medical Services (Payments) Board, Report for the year ended 31st December 2002.
- 17 Comhairle na nOspidéal, Consultant Staffing, January 2004
- 18 Ibid.
- 19 *Putting Prevention into Practice: A Guide for the Implementation of Prevention in the General Practice Setting*; 1st Edition 1998, the Royal Australian College of General Practitioners
- 20 Ibid
- 21 *Improving Health Systems: The Contribution of Family Medicine - A Guidebook*, WONCA, June 2002 (Wonca is the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, or World Organization of Family Doctors for short).
- 22 Ibid
- 23 Drawn from ICGP, 2004, *Healthcare Reform: The ICGP Response*, www.icgp.ie.
- 24 The report states that this is particularly relevant given the emphasis placed by the Task Force on skill mix, which aims to maximise the potential of all staff and enable them to concentrate as much as possible on work for which they are best trained. The task force notes that the Health Strategy (2001) indicates that integrated workforce planning will be introduced on a national basis in a way that will i) align workforce planning with the service planning process; ii) promote the use of skill mix; and iii) ensure that training places match the demand for specific skills in the health sector. This will involve close co-operation between the education, training and professional bodies. *Report of the National Task Force on Medical Staffing*, June 2003, p.107.
- 25 Ibid.
- 26 ICGP, *Healthcare Reform: The ICGP Response*, 2004, p.3
- 27 Response to GP Motion 2004/32, IMO (2004), Crisis or Opportunity, Programme for the AGM 2004, p.52.