

**Business Impact Assessment
– Working time: Excluded sectors:
Supplementary Report:
Doctors in Training
Final Report**

February 2003

Newton Hall
Newton
Cambridge CB2 5PE
Tel: (01223) 871551
Fax: (01223) 871303
cpc@campolco.demon.co.uk

CONTENTS

Executive Summary.....	i
Preface	1
1. Approach	3
1.1. Introduction	3
1.2. The impact of reducing hours	3
1.3. The basis of the approach and its stages	6
2. The situation for UK, Ireland and France.....	11
2.1. Introduction	11
2.2. The UK	12
2.3. Ireland	15
2.4. France	17

EXECUTIVE SUMMARY

1. This study was a small extension to a larger study commissioned by the Employment and Social Affairs Directorate General of the European Commission in 1998 to explore the business impacts of the Working Time Directive for excluded sectors. The larger study made estimates of the long-term impacts of compliance with the Directive's requirements for a wide variety of sectors including Doctors in Training. The contract for our original study also made provision for supplementary contracts to allow for some additional analysis using the methodology developed in the main study – this study is the result of one such supplementary contract.
2. This supplementary report focuses on the options and constraints affecting the ability of Member States to adjust from their current state to one of complete compliance to the requirements of the Working Time Directive in the long-term with regard to Doctors in Training (DiT). The study considers the situation in three countries, the UK, Ireland and France. There was very limited opportunity for fieldwork. The study was hampered by an absence of available evidence on the dynamics of change for hospital staff, the limited information on their work practices and the effect of adjustments on the quality of service. This has made it extremely difficult to provide any robust estimates of the relative importance of individual issues and hence to give robust estimates of the adjustment periods.
3. The maximum requirement for recruitment is given by the increase in the number of junior doctors working 48 hours necessary to work the excess of hours over 48 hours existing junior doctors work. The longest time to achieve the additional recruitment would be if the increase was achieved by expansion in the throughput of medical schools. The study identifies six key internal adjustments that can be made:

- Re-organising work patterns, including adopting shift patterns that fully utilise the maximum hours available using the minimum number of people;
- Improving provision for rest, such as on-site accommodation and catering that maintains individuals' productivity;
- Have some of the routine clinical work undertaken by non-career grade doctors or senior nursing staff;
- Remove a substantial amount of the administration burden from the DiT grades and give it to other grades.
- Increase the retention of DiTs who currently leave the career grades;
- Provide an incentive for those who leave (particularly women for family reasons) to return in some capacity;

And three key external adjustments:

- Additional recruitment where there are junior doctors unemployed;
- Increase the number of DiTs by recruiting from overseas;
- Work more closely with the private sector to share the workload.

4. The broad conclusion is that the UK may well need an element of all the different adjustments, some of which have already been piloted. In Ireland, restructuring of grades and associated reductions in emigration of doctors in training will be the key changes and, in France, re-organisation, particularly to incorporate closer co-operation between public and private hospitals, will be the key change.

PREFACE

1. This study was a small extension to a larger study commissioned by of the European Commission in 1998 to explore the business impacts of the Working Time Directive for excluded sectors. The larger study made estimates of the long-term impacts of compliance with the Directive's requirements for a wide variety of sectors including Doctors in Training. The contract for our original study also made provision for supplementary contracts to allow for some additional analysis using the methodology developed in the main study – this study is the result of one such supplementary contract.
2. The focus of this supplementary contract is on the options and constraints on Member States to adjust from their current state to one of complete compliance to the requirements of the Working Time Directive in the long-term with regard to Doctors in Training. Therefore, it covers new ground to that covered in our original study. Whilst our original study could be undertaken through desk research drawing on fairly readily available information, the adjustment process implicit in the evolution of the provision of clinical medical services has not been well researched. Therefore, for this supplementary study it was essential to carry out some fieldwork, restricted to two meetings with the National Health Service in the UK and some telephone calls to Ireland and France.
3. This report attempts to summarise those issues identified during these discussions as important to the process of Member States adjusting to the requirements of the Working Time Directive for Doctors in Training. It became clear that, although there is some data on the stocks and composition of hospital staff, there is very little information on their workloads and practically nothing at all on how the process of change takes place. We have therefore used as a starting point for assessing the scale of the problem results from our larger study which estimated the additional 'staff time' required to fulfil the requirements of the Working Time Directive. However, the absence of research evidence on the dynamics of change for hospital staff and the limited information on their work practices makes it extremely difficult to provide any robust estimates of the relative importance of individual issues and hence a robust estimate of the adjustment periods.

4. This is a particular problem for assessing the possible extent to which overseas doctors can be recruited into the health services. There are unemployed doctors in some Member States, for example Spain, Germany and Italy (estimated by the Permanent Working Group of European Junior Doctors to be 8,600 in Germany and 19,000 in Italy). There is free movement of people between national labour markets, and mutual recognition of diplomas, certificates and other evidence of formal qualifications. Health services already employ overseas junior doctors. We have not seen any research which would help to understand the implications of incorporating an additional influx of overseas junior doctors, and hence have been unable to assess the potential contribution additional recruitment of junior doctors could make.
5. More research might unearth sufficient quantitative information that would allow a mechanistic calculation of how some of the effects identified might contribute to reducing the adjustment period, and it cannot be denied that such estimates could lead to very much shorter periods than are being discussed at present. However, there is no way of establishing that such changes would not also have a detrimental (perhaps significant) effect on the quality of clinical service. Estimates that do not take into account possible impacts, resulting from any changes or adjustments, on the *quality* of service cannot form an accurate basis for either research or policy decisions with regard to Doctors in Training. This link has not yet been adequately researched which is why this report contains no ‘guestimates’ of likely timescales.

1. APPROACH

1.1. Introduction

1.1.1. The aim of this study, commissioned by the Employment and Social Affairs Directorate General of the European Commission was to explore the issues affecting the adjustment period required to implement all of the requirements of the Working Time Directive. The study will focus mainly on the requirement to reduce average weekly hours to 48. Manpower planning and strategic planning for the desired level and quality of a health service is an extremely complex problem and this brief study cannot hope to address all of the issues.

1.1.2. Assessments of the issues have been made for the UK, Ireland and France. A major difference known between the three countries is the extent of a private sector.

1.2. The impact of reducing hours

1.2.1. Reducing average hours involves manpower planning with all that that implies about managing the process of change that seeks to increase the numbers of staff. If the sector is in steady state (whether growing or static), two core issues are:

- ◆ how can the capacity of the supply and development of staff be increased, attracting more people, providing increased training, changing the skill mix, additional capital investment and/or retention?
- ◆ what are the ‘ripple’ effects of the adjustment period in terms of interaction between the capacity and quality of provision and the composition by grade?

- 1.2.2. The scale of the problem for each Member State is the mechanical calculation of how many additional doctors in training are required to replace the hours of work lost by reducing hours from their current weekly average to 48 hours. The estimates made in our original study are shown at the beginning of each of the case studies.
- 1.2.3. Such an increase could not be achieved immediately. There has to be a period of adjustment which begins with additional entry into the grades of doctors in training from medical school, unless other short-term options are available. Additional entry has an initial stage of increasing the intake and the throughput of medical schools before there is any increase in doctors in training.
- 1.2.4. Increasing the number of doctors in training by increasing the throughput of medical schools is not the only way to increase the number. Other options, discussed further below, are to increase the inflow from other sources, reduce the outflows from the existing throughput or increase the amount of clinical work undertaken by junior doctors. However, there are issues arising from having more junior doctors which would arise wherever they came from.
- 1.2.5. Whilst in training, the junior doctors receive both structured formal education and on the job work experience. If senior grades, primarily consultants, are required to carry out the formal training, there will need to be an increase in their number to carry out the training. They are also responsible for the supervision and direction of work experience, and may have management and administrative tasks to perform as well.
- 1.2.6. The quality of service of the medical provision will depend on the amount of clinical hours that are available. These are provided primarily by consultants of different specialties, doctors in training and to some extent by nurses (at a minimum in terms of the administrative load if not the clinical functions).
- 1.2.7. Hence the core of the issue if the number of junior doctors increases is: how much can training be increased whilst still maintaining the quality of medical service (specifically the number and quality of clinical hours available)?

1.2.8. Health services provide clinical services through:

- consultants in the health service;
- doctors in training out of national medical schools;
- overseas doctors receiving training;
- nurses who undertake some routine preparation and/or work;
- contracting out to the private sector.

1.2.9. The flexibilities in the system which assist in reducing hours of each junior doctor include:

- increase the throughput of medical schools;
- additional recruitment where there are unemployed doctors;
- retaining doctors in training for longer and attracting back wholly or partially trained doctors;
- re-organising work patterns, including adopting shift patterns that fully utilise the maximum hours available using the minimum number of people;
- improving provision for rest, such as on-site accommodation and catering that maintains individuals' productivity;
- increasing the skill mix and division of labour for clinical work;
- transferring some of the non-clinical routine work to other staff, such as senior nurses;
- recruiting qualified doctors and doctors in training from overseas;
- work more closely with the private sector.

1.2.10. There are also a number of factors that make it more difficult to reduce average hours. These can be distinguished between those which drive the demand for services and those which impact on the ability of the medical service to deliver the quality of service that is desired.

1.2.11. The first group related to demand include:

- ◆ Any service gap perceived by the Health Service or National Government which it would like to close to raise service provision to the desired level and quality;
- ◆ An ageing population, arising from demographic change and increasing life expectancy, which both increases the volume of service required and also its intensity, due to the fragility of the patients;

1.2.12. The second group concerns factors related to the overall productivity of the services, specifically in terms of its capacity to deliver clinical services. These include:

- The proportion of staff leaving, arising from a growing proportion of entrants who are either women who are more likely to take career breaks or overseas doctors who come for training and are likely to return home when qualified;
- Changes in the demands that training places on consultants that reduce the time available for clinical work;
- Changes in the nature of training that reduce the availability of doctors in training for acquiring work experience and substituting for consultants' time.

1.3. The basis of the approach and its stages

1.3.1. The central concern is the increase in the size of the cohort that can be accommodated, given the other parameters determining the delivery of quality care. The underlying assumption is that the current delivery of the health service is either in steady state and/or that the existing manpower planning accommodates all external demand factors and shortages of supply currently known. The impact of the change in average weekly hours is assessed in the context of other work organisation pressures. Because the change in hours reduces the availability of doctors in training, the requirement is to adjust the organisation of their work, e.g. transfer some of their non-clinical work to other staff, or to recruit additional doctors in training. However this latter action has upstream consequences for medical schools and downstream consequences for the numbers of consultants.

1.3.2. There are a wide variety of specialties in the medical profession, some of which are more attractive/popular than others – more sexy, more intellectual, more money, etc. The specialties also vary according to the requirements of the job, the speed of procedures, time needed for diagnosis, speed of discharge, intensity of clinical tasks, etc. However this study does not take into account these differences – imbalances between demands and the supply of places and posts will only complicate the adjustment.

- 1.3.3. The following section discusses the key issues that have emerged in discussion with a variety of people with different perspectives across the three countries, including officials in the Health Services, people in the medical profession and/or management consultants.
- 1.3.4. Table 1.1 shows the steps required in the UK to qualify as a consultant in a specialty. Other countries have a similar structure, but the stages may differ in length. In the UK, there will be differences in how long people are in medical school or the various pre-consultant grades, either across specialties or by virtue of ability. Doctors in Training are those in the PRHO, SHO and SpR grades.

Table 1.1: Progression to qualifying as a consultant (the UK)

Steps	Time period	Options	Requirements
Interest in a medical career	Pre- medical school	Fail entry Progress	
Medical school entrant			A levels Places
Medical school graduate	5-6 years	School drop out Exam failure Choose another career Progress	Formal education Practical work Adequate degree
Take up pre-registration House Officer (PRHO) post	1 year		A degree A 'College' acceptance
Become a Senior House Officer (SHO)	2-5 years	Non- medical work Progress	Approval by a 'College Dean' Mentoring Direction Training Clinical experience Research
Apply for Specialist Registrar (SpR)		Staff Doctor Other medical work Progress	An appropriate CV
Obtain Qualification (Certificate of Completion of Specialist Training, CCST)	4 ½ - 6 years		
Become a Consultant in a specialty	Total 12 ½ - 18 years	Non-consultant career grade GP	A CCST and a post

Note: the shaded area are the grades which make up doctors in training

1.3.5. The effect of the Working Time Directive (Working Time Directive) is to reduce the amount of time available to existing doctors in training (DiT) in which they can perform their various tasks. These include administration and research/formal education as well as clinical work which may include both supervised and unsupervised work. Consultants are the provider of research and education teaching and supervision, and of the supervision for clinical work. Hence, an increase in the numbers of DiTs will increase the workload of consultants.

1.3.6. It is also the case that the amount of time spent on research and education will not be allowed to decline, and hence the full change in hours falls on the clinical time (and its associated administration). Thus the amount of time

available to each DiT for clinical work, and therefore the total amount of time available from existing DiTs, will reduce by the number of hours that total working time is reduced, unless reductions in their non-clinical workload can be made.

1.3.7. With no other such changes, the only answer is to recruit more DiTs. This means taking up any spare capacity in existing medical schools, building new extensions or building new medical schools. The alternative is to find ways of increasing the amount of time that existing DiTs have for clinical work, or increasing the inflow into/reducing the outflow from the DiT grades, using the flexibilities described in paragraph 1.2.9.

1.3.8. There are six key direct internal adjustments that can be made:

- Re-organising work patterns, including adopting shift patterns that fully utilise the maximum hours available using the minimum number of people;
- Improving provision for rest, such as on-site accommodation and catering that maintains individuals' productivity;
- Have some of the routine clinical work undertaken by non-career grade doctors or senior nursing staff;
- Remove a substantial amount of the administration burden from the DiT grades and give it to other grades.
- Increase the retention of DiTs who currently leave the career grades;
- Provide an incentive for those who leave (particularly women for family reasons) to return in some capacity;

1.3.9. However, there are also three key external adjustments that can be made as well:

- Additional recruitment where there are junior doctors unemployed;
- Increase the number of DiTs by recruiting from overseas;
- Work more closely with the private sector to share the workload.

1.3.10. The capacity of medical schools is a prior constraint on the number of indigenous DiTs. On the one hand, the internal and external adjustment mechanisms do not require an increase in the capacity of medical schools, and therefore can speed up the adjustment. On the other hand, the extent to which

the adjustments require additional training and supervision by consultants restricts the rate of increase in the number of DiTs.

- 1.3.11. In the following section, we have as far as has been possible taken a view on the key factors out of those above which appear to underlie the appropriate adjustment period in the UK, Ireland and France. The absence of adequate data makes it impossible to quantify with any certainty how these factors could affect the likely adjustment period in each country.

2. THE SITUATION FOR UK, IRELAND AND FRANCE

2.1. Introduction

2.1.1. It has been possible to hold two meetings and a number of telephone calls with the National Health Service (NHS) and British Medical Association (BMA) in the UK to explore the issue for the UK. This has provided an insight into the broader issues that may be involved. We feel that we understand these reasonably well for the UK. Contacts with Ireland and France have only been possible by telephone and our knowledge is based on these and any documents made available to us. We have quite limited evidence for Ireland and France, some of which cannot be substantiated with documentary evidence.

2.1.2. The UK is likely to be the most extreme case in terms of what would be required as a long term strategy. This is because:

- It is effectively 100% public sector (the majority of private work is carried out by NHS consultants) and therefore solutions are internal;
- The medical schools currently operate at full capacity so that throughput of graduates cannot be increased without additional capacity;
- There are fewer options to draw on additional qualified people, e.g. reducing emigration, buying in from an independent private sector, increasing the proportion of overseas doctors in all specialties, etc.

2.1.3. However, the discussion below suggests that there are short term strategies which can speed up the adjustment strategies, even for the UK. Hence the assessment should go beyond the comparative long term solutions to incorporate potential short term adjustments. When brought to light and judgements made about cross-country transferability of some of these short term adjustments, it may be that there is actually less variation between Member States in what is required than appears to be the case from the proposed long term solutions.

- 2.1.4. Data have not been readily available for assessing the likely magnitude of any of the effects. Two documents for the UK have been valuable in giving some idea of the relative importance of a number of factors. These are:
- the Statistical Bulletin 1999/15, Department of Health, 1999 (composition of medical staff);
 - the Review Body on Doctors' and Dentists' Remuneration, 28th Report, 1999, HMSO, Cm 4243 (the main source of allocations of time between management/admin, education, training and clinical work).
- 2.1.5. Each of the following sections begins with a view of the scale of the problem in each country, defined by the mechanical calculation of how many extra junior doctors would be required to maintain the quality of service if all existing ones only worked 48 hours. The estimates assume that there are no changes in the factors enabling shorter term adjustment discussed above: that is, there are no changes in working practices or skill mix or composition of hospital staff. These estimates have been taken from our original report for the Commission ('Business Impact Assessment: Working Time Directive: Excluded Sectors, Final Report', September 1998). The estimates of the number of junior doctors in each country used in our report were taken from information provided by the Permanent Working Group of European Junior Doctors (PWG) for 1996.

2.2. The UK

- 2.2.1. The PWG total for the number of junior doctors in the UK was 32,100 and the extra number of junior doctors needed estimated in our original study was 6727, an increase of 21%. The British Medical Association have indicated recently through their Brussels Office that their estimate of the shortfall is 5,600.
- 2.2.2. The UK has a consultant led service, through which perhaps 50% of the clinical services have been provided by Consultants and 50% by Doctors in Training. Consultants are responsible not only for clinical services but also for teaching in medical schools and training and supervising junior doctors. More recently, the proportion of time that they have been able to allocate to

clinical services has declined as the demands of administration and new approaches to training have risen.

- 2.2.3. Over the past decade (88-98), this has been accommodated by an increase in the number of consultants per junior doctor, from 0.65 to 0.70.
- 2.2.4. The policy has been to maintain and increase the quality of the service and 1000 new places in medical schools have been approved which mops up any spare capacity in facilities and teaching provision. Mainly these additional places are taking up spare capacity in existing medical schools, although a small proportion are new provision. However, these places will not become an annual inflow of 1,000 doctors in training until possibly as late as the year 2009. Roughly speaking there will be an additional cohort in the medical school entry of 500 in 1999/2000, rising to 1,000 in 2004/2005.
- 2.2.5. It has been argued that this increase over the 5 years of medical school courses will give 500 additional DiTs in 2005 and somewhere between 500 and 1000 in each year up to 2009 and that this will absorb a large part of the requirements of the WTD. Against this, it is claimed that these were planned to remove shortfalls in the quality of clinical service already perceived in the Health Service prior to the WTD. With more DiTs, adjustments that release time for clinical work will give more time in total. However, more DiTs in the system place a heavier workload on consultants.
- 2.2.6. The career progression from medical school to consultant grade takes between 12½ and 18 years: a course at medical school, 5-6 years; pre-registration house officer, 1 year; house officer, 2-5 years; and senior house officer, 4½ - 6 years (see Table 1.1). A further period of between 2 and 5 years should be added to the time required for a 'big-step' adjustment if there is a need to increase the capacity of medical schools (through extensions or new build).
- 2.2.7. The NHS believes that the indigenous growth of consultants (and therefore doctors in training) through medical schools is now at full capacity. Their strategy is to increase this growth with new capacity in the long term whilst adopting short term measures such as those outlined below to speed up the

adjustment to 48 hours. The remainder of this section explores ways by which the time scale could be reduced by other means.

- 2.2.8. Increasing the numbers of doctors in training by large scale additions to the output of medical schools is not feasible in the short term. Given consultants' responsibility for teaching, training and clinical supervision, there are severe limits to the extent to which these responsibilities can be increased without affecting the quality of clinical services provided.
- 2.2.9. In 1998, there was a hospital medical staff workforce of 54,420 whole-time equivalent units. Of these, some 23,460 were career grades (consultants, associate specialists and staff grade), 29,110 in junior grades (11,060 in the Registrar group, 14,600 SHOs and 3,440 HOs). The proportion of these who are non-EEA qualified staff are 16% for consultants, registrar group 27% and 29% for SHOs.
- 2.2.10. The mix of specialties also has an impact on the capacity for change. The number of consultants for each specialty is about 2½ - 3 times the number in the registrar group (between consultants and SHOs), with the exception of general medicine and obstetrics and gynaecology, for which it is considerably lower. Furthermore, the proportion of consultants who are women varies from 5% for the surgical group to 36% in paediatrics: the corresponding proportions for the registrar group are 13% in the surgical group up to 59% in clinical oncology. There are also variations in the number of overseas doctors, of which the majority are from outside the EEA. They are particularly important for the registrar group and SHOs.
- 2.2.11. These compositional characteristics allow some flexibilities in the system which can help to reduce the adjustment period. These include:
- **Retention of overseas doctors and women who leave during the registrar/SHO/HO period.** Overseas doctors (particularly the non-EEA residents) tend to return during their SHO/registrar period, and women are more likely to take a career break or leave for demographic reasons. Better support and schemes that keep people in touch with the hospitals are having an effect on the rate of return. Such schemes may also result, when applied to GPs, in more GP time spent in clinical work.

- **Skill mix substitution.** Some of the administration can be taken by nurses and ancillary staff (especially at night-time). Non-consultant career grades can take on some routine clinical activity without supervision. This is partly offset by the increasing age of the population and the added complexity that that brings to clinical treatments.
- **Larger hospitals, especially teaching hospitals, have more flexibility.** Smaller hospitals can have up to 80% of their clinical grades drawn from overseas, particularly in Obstetrics & Gynaecology. However, greater concentrations of specialisms create problems for remote local communities;
- **Increase the recruitment of overseas doctors.**

2.2.12. Many of these measures have been piloted and are proving to be helpful in moderating the recruitment requirement of the WTD. The NHS accepts that an increase in overseas doctors may also be part of a short term shift for some specialties. However, the long term sustainability of the quality of the health service depends on sufficient doctors in training qualifying as consultants. Recruiting overseas doctors is not necessarily a long term solution, particularly if they are residents of those countries for which there is a high propensity of the doctors to return home once qualified.

2.2.13. One other aspect that has been considered is the role that GPs play as a gatekeeper to the hospitals – referring people to consultants who are the people responsible for admissions (and discharges). It is thought that there may be some room for adjustment without jeopardising the quality of service overall.

2.3. Ireland

2.3.1. The PWG total for the number of junior doctors in Ireland was 2,400 and the extra number of junior doctors needed estimated in our original study was 93, an increase of 4%.

2.3.2. Ireland is a completely different case. The view internally is that the capacity of their medical schools is more than enough to produce the required number of graduates. However there is a major emigration annually to the UK and US to get training and a job, probably then returning to Ireland as a

consultant. The length of time from entry to medical school to qualifying as a consultant is not substantially different from the UK.

- 2.3.3. This creates a major shortfall in the number of junior doctors, and currently over 30% are from non-EEA countries. However, there is also a problem in the ratio of junior doctors to consultants which, at 2 for 1, is relatively high and has been rising because of the age cap put on consultants of 65 years. Recent measures have been adopted to increase the number of consultants by 400 to offset the increases.
- 2.3.4. Average hours of junior doctors are quoted as around 65 hours. In addition, junior doctors spend an average of around 7 hours a week on call, studying or on research. One of the difficulties in reducing hours is that the whole burden of change falls on the clinical time because the study and research time is protected.
- 2.3.5. However, the public health service is catering for only 58% of the population, the remaining 42% having private health insurance (for which the premiums attract tax relief at the standard rate). The relationship between the public and private sectors is very fluid and synchronising the adjustment would have a significant positive effect.
- 2.3.6. Clearly, the most obvious strategy is to increase the retention of graduates. However, in the short run, this would put more pressure on consultants. Hence additional strategies are being put in place. One of these is to roster non-consultant grades to take on some of the duties currently carried out by consultants. Another is to introduce another grade between junior doctors and consultant which in effect would reduce the number of junior doctors.
- 2.3.7. It may appear perverse to reduce the number of junior doctors when the hours are to be reduced. However, if some of the existing workload is borne by new grades employed with a 48 hour week, having fewer junior doctors reduces the scale of the adjustment required.

- 2.3.8. The fact that the capacity of the medical schools in Ireland is adequate for the scale of health service required means that, although the time to develop new consultants and junior doctors is similar to the UK, there is no need for new capacity. For that reason alone, the adjustment period in Ireland could be shorter than for the UK.
- 2.3.9. The long term strategy appears to be to reduce the emigration of graduates with a shorter term strategy of changing the structure to reduce the impact of the reduction in working time. What is unclear is how the two strategies fit together, in particular, whether the short term restructuring depends on reducing emigration or whether it can be accomplished say with more overseas doctors or upgrading existing non-consultant grades within the health service.
- 2.3.10. The timescale necessary for this adjustment is dependent on the success in implementing structural changes and reducing emigration rates, particularly by making the new grades attractive enough. The restructuring is crucial in containing the non-clinical workload on the existing consultants.

2.4. France

- 2.4.1. The PWG total for the number of junior doctors in France was 15,000 and the extra number of junior doctors needed estimated in our original study was 1471, an increase of 10%.
- 2.4.2. A consultant is fully qualified after 10 years of study. The French government have supported the Council's Common Position of an implementation period for the Directive of 13 years: 4 years to implement changes in organisations plus 9 years for the subsequent transition. France has twice as many doctors as the U.K. relative to its population. However, the scale of the particular problem is smaller, with only around 10 to 15 % of the doctors who are juniors. There are 1071 public establishments and 2717 private hospitals or clinics that provide all together 667,000 beds.

- 2.4.3. The education and training of consultants is defined by the law of the 23rd December 1982. Medical requirements are characterised by disparities between regions, between private practice and public practice and between the different specialties. In the first year of medical studies, a ‘numerus clausus’ limits the number of students allowed to pursue their studies. The competitive examination ‘concours d’internat’ is the only way to become a consultant, but the organisation responsible cannot guide future specialists towards those specialties that are going to be most in need.
- 2.4.4. The regional distribution and organisation of hospitals is being progressively transformed. The government is aiming to reduce inequalities of access to health care and to reorganise the hospital system into a network so that it better reflects the specific needs of local communities. As part of this strategy, it recently set up the new “Schémas Régionaux d’Organisation Sanitaire” (SROS), giving regional guidance for the organisation of the public hospital activity.
- 2.4.5. Much of the analysis below is drawn from a report ‘Rapport sur l’Adéquation entre les Besoins Hospitaliers et les Effectifs en Anesthésie – Réanimation, Gynécologie – Obstétrique, Psychiatrie et Radiologie’, Guy Nicolas et Michele Duret, Comité de santé publique, février 1998.
- 2.4.6. There are problems associated with the matching of demand and supply of medical services, both nationally and locally. The number of consultants currently trained in the specialties is less than the number ceasing to be consultants, especially in gynaecology-obstetrics. Many consultants tend to give up obstetrics at the end of their career and work only as gynaecologists. More generally, the population is ageing and needs more intensive healthcare services which requires more consultants overall. At a local level, the medical profession is characterised by its regional disparity, its ageing and feminisation which creates imbalances.
- 2.4.7. There are compositional problems related particularly to four specialties. Two specialties, gynaecology-obstetrics and anaesthesia-reanimation, are less popular because they involve working days and nights, with a high degree of activity during night work. They all imply a high level of personal

responsibility. Two other specialities tend to be in deficit in the hospitals, because of the conditions of work in these specialities. In radiology, the wages are very different between the public and private sectors.

2.4.8. There is also a difference in the proportion of consultants in the hospitals and the private sector as the consultants working in the public sector are associated with many activities related to public health rather than clinical services. Co-operation between the two sectors could be an appropriate way of reducing some of the supply problems existing in these specialities.

2.4.9. One of the reasons why there may be an imbalance between the supply and demand for different specialities is that wages and careers are the same for all specialities. However certain specialities have particular conditions of practice, different levels of responsibilities and different shift patterns. It is often claimed that wages and career prospects should reflect these differences.

Action on the numbers and composition of medical staff

2.4.10. The current organisation of the ‘concours d’internat’ is divided between 6 disciplines. Each discipline is allocated a fixed number of places. It is proposed to divide the disciplines into more categories so that the number of consultants being trained in each specialty could be identified with more precision.

2.4.11. It is also proposed that the number of places available for the ‘concours d’internat’ should be increased in two specialities: anaesthesia (200 in 1999, 350 in 2010), and gynaecology-obstetrics (110 in 1999, 150 in 2010). The total number of doctors in training would not be increased as a consequence because the number of places for the ‘concours’ would be reduced in other specialities such as cardiology, biology, pneumology, etc.

2.4.12. For the two other specialities, the issue is not how to increase the number of consultants but how to retain or attract them into the public sector.

Action on the hospital organisation

- 2.4.13. The report recommends that hospitals should not be in competition with each other but should co-operate to provide complementary services. The units of such a hospital network would be a geographical area of 150,000 to 300,000 inhabitants. The criteria of appropriateness for this new organisational structure would be safety, efficiency and accessibility.
- 2.4.14. ‘Service de garde’ (on call time) is perceived by consultants as an obstacle to working in the public sector, especially in those specialties where ‘service de garde’ is considerable. In these specialties, it is necessary to have relatively more consultants per patient.
- 2.4.15. A rationalisation of the ‘service de garde’ within the geographical units is suggested both inside the hospitals and between the hospitals so that the amount of on ‘service de garde’ could be minimised and a more appropriate mix of consultants and junior doctors achieved.

Human resources management

- 2.4.16. Another option is to transform the existing competitive examination into a national aptitude examination, so that the number of people taking the examination would not be limited to the number of places potentially available in the specialties.
- 2.4.17. Another option is to organise the recruitment of consultants inside a network of hospitals. This would be focused on improving the organisation of the supply of clinical services by increasing access to consultants of different specialties for localities so that the provision of services respond more flexibly to the needs of the local population served.
- 2.4.18. Another way of meeting the human resources needs could be to allow the contractual recruitment of hospital doctors, on the basis of a five year contract for places that have remained vacant for a few years.

- 2.4.19. Finally direct action could be taken to change the conditions of work. Weekly working time is 10 half days for full-time consultants and 6 half days for part-time ones. However consultants very often work all week-end, which affects the quality and safety of their work. Also, in some services, 'service de garde' work is more intense than in other specialties. However, this does not take into account differences in the nature of the hours worked. A system of financial compensation would reduce the inequalities between disciplines and improve the matching of the supply of doctors and consultants with the needs of local communities.
- 2.4.20. Overall, the problem in France appears to be smaller in scale and potentially re-organisation regionally, particularly if it incorporates co-operation between public and private hospitals, appears to be capable of absorbing a large proportion of the effects of the reductions in working time for junior doctors. However, the timescale is entirely dependent on the re-organisation which will be difficult to implement.

