



NATIONAL
DOCTORS
TRAINING
& PLANNING

An Expert Stakeholder Informed Workforce Review of Six Specialties of Medicine in Ireland 2024-2038

Clinical Neurophysiology, Dermatology, Medical Oncology,
Neurology, Palliative Medicine, and Rehabilitation Medicine



HSE
National Doctors Training & Planning



Trinity College Dublin
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**INSTITUTE
OF MEDICINE**
ROYAL COLLEGE OF
PHYSICIANS OF IRELAND



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Foreword: Medical Director – National Doctors Training & Planning

It is with great pleasure that I announce this publication detailing the workforce and training requirements for a range of specialties in the discipline of medicine. We have chosen to co-report on the specialties in this document as the specialty training programmes have a common baseline entry of General Internal Medicine and are all accredited within the Institute of Medicine in RCPI. However, it is recognised that these specialties are standalone distinct clinical specialties with distinct specialty training programmes. This report is the product of collaboration between NDTP, National Clinical Programmes, postgraduate training programmes in the RCPI, and the Centre for Health Policy and Management in Trinity College Dublin. I would like to thank all those who contributed their time and expertise to this work.

The purpose of this review is to provide evidence-informed recommendations regarding the future consultant workforce required to support the delivery of safe, equitable and sustainable healthcare services aligned to the needs of the population. The specialties examined in this report are **clinical neurophysiology, dermatology, medical oncology, neurology, palliative medicine, and rehabilitation medicine**. Each of which support acute hospital services, enable diagnostic and therapeutic pathways, and increasingly contribute to community-based and integrated models of care.

Ireland's health system is undergoing significant change. Demographic ageing, population growth, and increasing clinical complexity are driving higher demand for specialist services. At the same time, national reform under Sláintecare, the development of the HSE Health Regions, and the expansion of national Models of Care are reshaping how services are delivered. These developments require not only additional consultant capacity but also increased consultant leadership, governance, and participation across networks of care.

Across the specialties reviewed, the analysis identifies substantial existing unmet need as well as projected future growth in demand. In several areas, services are unevenly geographically distributed, and access to specialists varies by Health Region. Addressing these challenges will require expansion of the consultant workforce, supported by appropriately scaled training programmes and, in the short to medium term, some targeted recruitment of consultants from outside the domestic training pipeline to satisfy immediate unmet demand.

The long timelines involved in specialist medical training necessitate forward planning. It is the goal of NDTP to support the development of a self-sufficient domestic training pipeline wherever possible, while ensuring that services can meet patient needs during the transition. Additionally, it will be necessary to revisit demand estimates within a 3 to 5 year period to ensure that training and workforce recommendations continue to reflect future developments in patient demographics, therapeutics, technology, and clinical practice.

NDTP remains committed to working with clinical and educational partners to support the development of a resilient, well-distributed consultant workforce capable of delivering high-quality care for the population of Ireland in the years ahead.



Prof. Anthony O'Regan
Medical Director, National Doctors Training & Planning

Executive Summary

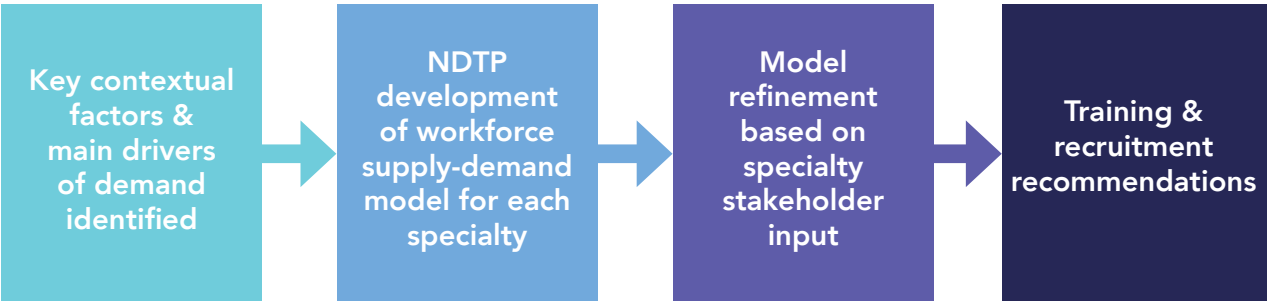
This report is an expert stakeholder-informed review of six of the specialties of medicine in Ireland which have a standalone speciality training programme i.e. clinical neurophysiology, dermatology, medical oncology, neurology, palliative medicine, and rehabilitation medicine.¹ The purpose of this report is to outline the projected future demand for consultants across specialties in order to inform the required postgraduate medical training numbers to meet this demand over the projection period 2025-2038.

This report was produced through a consultative and collaborative process between HSE National Doctors Training & Planning (NDTP) and expert stakeholders in National Clinical Programmes (NCPs) and postgraduate training programmes in the Royal College of Physicians Ireland (RCPI), with support from the Centre for Health Policy and Management in Trinity College Dublin. [1-4]

Methodology

In order to project the future demand and supply for consultants and NCHDs, a workforce planning methodological framework was used. [5] Workforce supply was modelled using a stock-flow approach which modelled the annual inflows into and exits from the consultant workforce underpinned by analysis of historic workforce data and clearly stated assumptions. Future workforce demand was estimated with stakeholder consultation on a specialty-by-specialty basis, accounting for a number of major drivers for future service demand. A high-level summary of the methodological process is presented in Figure 1.

Figure 1: Overview of methodological process used to produce workforce projections in this report.



Baseline Workforce

Baseline consultant workforce data used in this work is for December 2024 and was sourced from NDTP’s Doctors Integrated Management E-system (DIME), HSE National HR Census, and the Irish Medical Council (IMC). [6-8] The baseline workforce in publicly funded services is summarised in Table 1 (in both headcount, HC, and Whole Time Equivalent, WTE) with additional key workforce metrics.

¹ Note that genito-urinary medicine and occupational medicine, which also have standalone training programmes, have not been included in this report. The development of a national clinical model of care is currently underway for genito-urinary medicine, while workforce projections and recommendations for occupational medicine are considered in a separate publication.

Table 1: Baseline consultant workforce data in publicly funded services as of December 2024. [6-8]

Specialty	Headcount	Whole Time Equivalent	WTE Rate	% Female	% Over 55 Years	% Fulltime Posts	% Permanent	% Temporary ¹	% Vacant ²	% Posts Vacant >18 Months ³
Clinical Neurophysiology	17*	16.5	97%	47.1%	47.1%	90%	88.2%	11.8%		
Dermatology	64	59.3	92.1%	71.9%	21.9%	87.5%	93.8%	6.2%	12.5%	5.6%
Medical Oncology	75	68.6	91.3%	45.3%	22.7%	86.7%	86.7%	13.3%	5.3%	1.3%
Neurology	71	63.9	89.9%	42.3%	21.1%	84.5%	88.7%	11.3%	7.9%	
Palliative Medicine	66	52.1	78.7%	78.8%	21.2%	62.1%	86.4%	13.6%	4.5%	
Rehabilitation Medicine	18	14.9	82.1%	66.7%	22.2%	72.2%	72.2%	27.8%	5.6%	

1: Temporary contracts include agency and locum contracts.

2: Consultant posts which have been approved by the Consultant Applications Advisory Committee but are currently unfilled (as of December 2024).

3: Percentage of approved posts which have been vacant for more than 18 months (as of December 2024). This value is included in the total vacant post in the previous column.

* 1 consultants WTE is reduced to 0, inferring 16 HC consultants in active employment.

The baseline Non-Consultant Hospital Doctor (NCHD) workforce is from October 2024 and is reflective of the training year July 2024-July 2025. This includes NCHDs enrolled in Higher Specialty Training (HST) programmes and those NCHDs who are not enrolled in any formal training programmes (Non-Training Scheme Doctors, NTSDs). The breakdown of NCHDs by specialty is shown in Table 2. The number of HSTs in a given programme is taken to be the de-facto number of trainees in a given specialty programme. Other cohorts of trainee doctors such as interns rotate through numerous specialties throughout their intern year, while Basic Specialty Training (BST) in medicine is a single training programme for General Internal Medicine (GIM). Graduates of GIM BST are eligible for a number of HST programmes in addition to the specialties dealt with in this report.

Table 2: NCHD workforce as of October 2024 (training year July 2024-July 2025). [6]

Specialty	HSTs (HC)	NTSDs (HC)
Clinical Neurophysiology*	0	0
Dermatology	32	49
Medical Oncology	32	81
Neurology	40	45
Palliative Medicine	24	32
Rehabilitation Medicine	5	17

*Note that publication of this report takes place during the training year July 2025-July 2026. The HST programme for clinical neurophysiology commenced in July 2025, with two trainees enrolling in this first intake. All modelling and projections in this report reflect actual HST intake for July 2025.

International Benchmarks

A benchmarking exercise was conducted to compare the medical workforce per 100k population in other comparable international jurisdictions to that of Ireland. The consultant workforce per 100k population is presented by specialty in Table 3. NCHD workforce comparisons and data sources are included in the relevant specialty sections of this report. Note that stakeholder feedback outlined that different countries were deemed appropriate for benchmarking for the different specialties due to the nature of specialty registration and service delivery in different countries. Additional jurisdictions are included for the specialties of Clinical Neurophysiology and Medical Oncology as specialist qualifications in Ireland differ to those in the UK, Australia, Canada and New Zealand.

Table 3: International comparison of the consultant workforce (WTE per 100k population) across comparable jurisdictions for each specialty.

	Ireland	England	Scotland	Wales	Australia	New Zealand	Canada	USA	Denmark	Norway	Sweden
Clinical Neurophysiology	0.30	0.18	0.02	0.10					0.60	1.00	0.5
Dermatology	1.39	1.20	1.30	1.28	2.35	1.72	1.87				
Medical Oncology	1.50	1.01	0.53	0.73	3.12	1.58	1.82	3.00			
Neurology	1.3	1.75	1.55	1.11	2.84	1.20	3.30				
Palliative Medicine	1.00	0.72	0.72	0.89	1.39	1.54	1.57				
Rehabilitation Medicine	0.30	0.28	0.33	0.19	2.01	0.58	1.57				

Drivers of Demand

The key drivers of demand which were identified for each specialty are summarised in Table 4.

Table 4: Summary of drivers of demand by specialty.

Driver of Demand	Clinical Neurophysiology	Dermatology	Medical Oncology	Neurology	Palliative Medicine	Rehabilitation Medicine
Demographic ageing and population growth	✓	✓	✓	✓	✓	✓
Increased prevalence of chronic conditions, multi-morbidity, and complexity	✓	✓	✓	✓	✓	✓
Increased cancer incidence		✓	✓		✓	✓
Unmet demand/waiting list management	✓	✓		✓		✓
Model of Care implementation		✓	✓	✓	✓	✓
Supporting care pathways	✓		✓	✓	✓	✓
Staffing model			✓	✓		
Population benchmark	✓	✓		✓	✓	✓
Supporting integrated regional care networks		✓	✓	✓	✓	✓

Key Recommendations

The key recommendations are summarised as follows:

- Expansion of consultant workforce across all specialties reviewed.
- Increased annual intake into HST programmes, enabled by conversion of NTSD posts to structured training posts, where viable.
- Recruitment of additional consultants from outside of the domestic training programmes, where necessary, to meet short to medium term consultant demand.
- Regular review of demand estimates to ensure that projected demand remains up to date and accounts for service development, epidemiology, and therapeutic developments.
- Regional workforce planning to ensure equitable integrated community-acute specialist services across all Health Regions.

The specifics of these recommendations for each specialty are presented in Table 5.

Table 5: Key recommendations on the annual HST intake and additional consultant recruitment by specialty.

Specialty	HST Intake	Additional Consultant Recruitment from outside the Irish training pipeline*
Clinical Neurophysiology	Build to 2 trainees per year.	24 additional consultants.
Dermatology	Sustain at of 8 trainees per year.	2 additional consultants.
Medical Oncology	Build to 14 trainees per year.	18 additional consultants.
Neurology	Build to 14 trainees per year.	34 additional consultants.
Palliative Medicine	Build to 16 trainees per year.	40-45 additional consultants.
Rehabilitation Medicine	Sustain at 4 trainees per year.	4 additional consultants.

* Additional recruitment of consultants who completed specialty training outside of the domestic Irish programmes. Such consultants may be Irish individuals who completed specialty training abroad, or individuals entirely new to Ireland.

Training Projections

Table 6 summarises the annual total projected intake of HSTs on each training programme on the basis of the recommendations set out above. Values for 2025 are aligned with actual values for the training year 2025-2026.

Table 6: Total projected intake of HSTs in-programme annually by specialty.

Specialty	2025	2026	2027	2028	2029	2030
Clinical Neurophysiology	2	4	6	8	8	8
Dermatology	33	33	36	38	39	40
Medical Oncology	35	40	42	46	52	54
Neurology	39	41	49	55	61	66
Palliative Medicine	22	24	32	44	54	60
Rehabilitation Medicine	9	11	14	16	16	16

Workforce Projections

Table 7 outlines the projected national consultant workforce across the public and private sectors for each specialty (in WTE) annually to 2038, on the basis of the supply recommendations and modelling assumptions outlined in this report. This information is visualised for key time points in Figure 2.

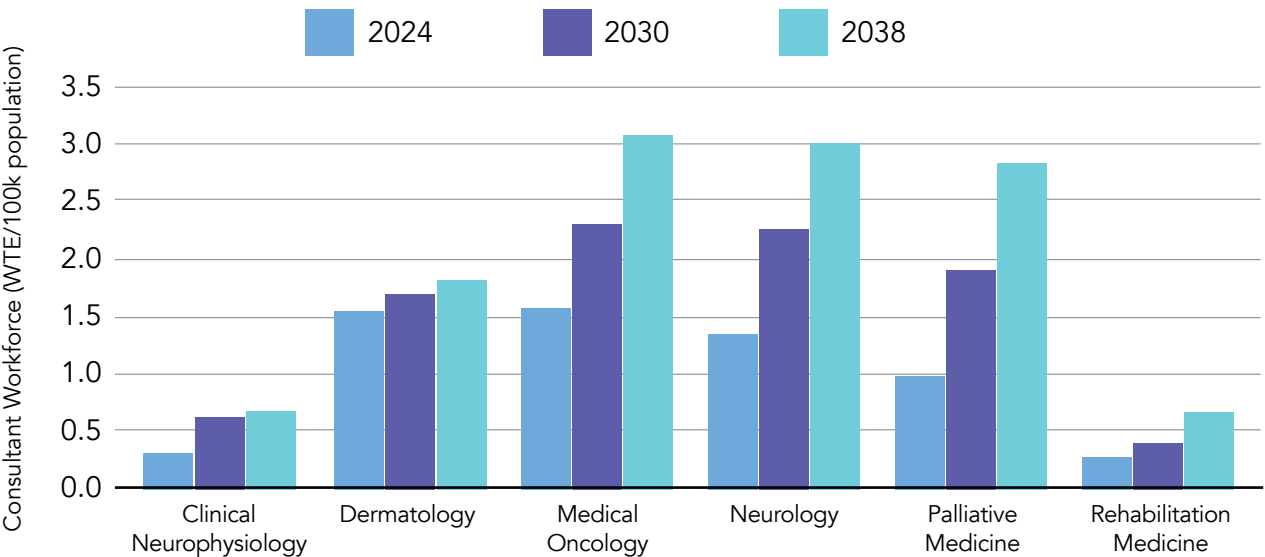
Table 7: Projected consultant workforce (WTE, public and private) by specialty to 2038 at year end.

Specialty	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Clinical Neurophysiology	17.7	20.2	23.7	27.1	32.1	35.7	38.2	37.9	38.2	38.5	39.0	39.5	39.9	40.3
Dermatology	86.7	87.7	90.2	93.2	93.7	95.0	94.7	94.2	94.8	96.5	98.2	100.7	103.7	106.7
Medical Oncology	87.8	95.2	108.7	114.0	121.6	125.7	128.6	134.7	141.4	149.6	157.9	166.2	173.5	180.8
Neurology	78.4	87.6	99.0	110.0	116.8	125.9	130.5	134.9	140.1	146.7	154.4	161.8	169.1	176.7
Palliative Medicine	64.1	76.5	92.8	98.7	106.2	106.2	110.2	115.8	123.2	132.2	142.7	150.8	158.8	166.8
Rehabilitation Medicine	16.1	18.6	20.0	21.1	21.6	22.7	25.3	27.9	29.9	31.9	33.8	35.8	37.7	39.7

Conclusions

In order to meet the future demand for consultants across the six specialties of medicine reviewed in this report, it will be necessary to increase the annual HST intake into related training programmes. Where available, NTSD posts should be converted to structured training posts to facilitate increased training capacity. Furthermore, it will be necessary to recruit additional consultants from outside the domestic training programmes to meet demand for consultants in the short to medium term. This will be necessary as the current training pipeline is not sufficient to meet demand in the coming years across most specialties. The ever-changing demographic profile in Ireland and evolving nature of diagnostics and therapeutics mean that the exercise in estimating future demand must be repeated every 3 to 5 years approximately, to ensure that demand estimated are aligned with patient service needs.

Figure 2: Growth profile of national consultant workforce (in WTE/100k population) for each specialty.





1. Introduction

1.1 HSE National Doctors Training & Planning

The HSE National Doctors Training and Planning (NDTP) unit operates within the HSE's Office of the Chief Clinical Officer and has roles in the following: [1]

- Medical education and training.
- Medical workforce planning.
- The consultant post approval process.

In accordance with this, each year NDTP makes recommendations on the number of interns and medical trainees required for each specialty. Recommendations are aligned with expert informed estimates of future demand for consultants across these specialties. This information then feeds into the medical education and training role of NDTP via the funding of medical training required to meet workforce needs and supporting the retention of doctors upon completion of their training.

1.2 National Clinical Programmes and Postgraduate Medical Training Programmes

A number of National Clinical Programmes (NCPs) are in place with the collective aim of improving quality of patient care, access to services, and cost-effectiveness across HSE funded services while working closely with each HSE Health Region. [2] Specifically, there are currently NCPs aligned with the specialties of dermatology, medical oncology, neurology, palliative care, and rehabilitation medicine. [9-13] Through structured governance, multidisciplinary collaboration, and evidence-based clinical Models of Care (MoCs) and care pathway design and implementation, these programmes contribute to the ongoing strategic development and integration of health care across the Irish health system.

The Royal College of Physicians of Ireland (RCPI) functions as the central training body responsible for developing highly skilled, patient-centred specialists across multiple medical disciplines, including the specialties of medicine which are the focus of this report. [3] Through its structured postgraduate programmes, the RCPI trains doctors with the skillset and expertise to enable practice as independent specialists skilled in leadership and management and in working within Multidisciplinary Teams (MDTs), and leadership in the health system. [14] By overseeing curriculum development, accreditation of training sites, faculty development, and ongoing evaluation, RCPI plays a pivotal role in shaping the next generation of specialists who can meet the complex and evolving healthcare needs of patients in the Irish health system.

This report is a collaboration between NDTP, the NCPs and representative clinical leadership from the specialties represented in this document, as well as training leadership from respective training programmes within the RCPI. Clinical and training leads from all specialties represented in this report were consulted in order to establish agreed demand and supply metrics to facilitate the development of the future medical workforce, both consultants and Non-Consultant Hospital Doctors (NCHDs). This report was developed with support from Trinity College Dublin, Centre for Health Policy and Management. [4]

The future workforce recommendations outlined in NDTP specialty review reports, for both trainees and consultants, are stakeholder informed. The implementation of these recommendations lies outside the remit of NDTP and will be dependent on funding, available posts, training capacity, and availability of candidates.

2. Aims and Objectives

The aims of this report are as follows:

- To outline expert informed demand projections for consultants in clinical neurophysiology, dermatology, medical oncology, neurology, palliative medicine, and rehabilitation medicine in Ireland.
- To make recommendations on the required HST intake numbers on an annual basis to meet consultant/specialist demand by 2038.
- To support regional planning of the consultant workforce through to 2038.

Identifying the needs for further training beyond achieving Certificate of Satisfactory Completion of Specialty Training (CSCST) in highly specialised areas within each specialty is beyond the scope of this report.

While high level recommendations are made to indicate workforce demand by Health Region to help inform workforce development strategies at a more local level, identifying and recommending demand at site level was deemed inappropriate for some specialties at this time. This is because of some uncertainty around future service developments. A review of the recommendations outlined in this report will be undertaken within the next 3-5 years approximately to ensure recommendations are up to date and aligned with service planning.

3. Principles Underpinning Medical Workforce Planning

The approach taken to Medical Workforce Planning (MWP) in this report is based on the methodology described in *Medical Workforce Planning Ireland: A Stepwise Approach*, [5] and encompasses the following principles as per existing government policies:

Medical Workforce Planning (MWP) Principle	Description
MWP recommendations should be aligned with government policy and health service strategy.	• Sláintecare Implementation Strategy and Action Plan 2021-2023. [15] • Organisational Reform: HSE Health Regions. [16] • A Trauma System for Ireland – Report of the Trauma Steering Group. [17] • New Children's Hospital. [18] • National Cancer Strategy 2017-2026. [19] • Health Service Capacity Review. [20] • Model 3 Hospitals Summary Report. [21] • Our National Service Plan 2024. [22] • National Taskforce on the NCHD Workforce Final Recommendations Report. [23] • Our People Strategy 2025-2027 [24]
MWP recommendations should be aligned with clinical MoCs.	• National Clinical Programme for Dermatology, A Model of Care for Ireland. [9, 25] • Adult Palliative Care Services Model of Care for Ireland. [12, 26] • National Clinical Programme for Neurology Model of Care. [11, 27] • National Clinical Programme for Rehabilitation Medicine Model of Care. [13, 28] • National Cancer Control Programme Systemic Anti-Cancer Therapy Model of Care. [10, 29]
MWP recommendations should be aligned with consultant delivered service development.	• The ratio of consultants to the population needs to be sufficient to ensure a consultant delivered service. This includes more consultants involved in bedside care, greater patient access to senior clinical decision makers, and a reduced reliance on NCHDs to deliver services. • The majority of NCHDs should be on a training scheme. • The ratio of trainees to consultants should be in the region of 1 consultant to 1 trainee. [23] • The number of NTSD posts should be reduced via conversion to training posts.
MWP recommendations should be aligned with the WHO Global Code on the International Recruitment of Healthcare Personnel (World Health Organisation, 2010, 2011). [30]	The Irish health service should be self-sufficient in the production of medical graduates, with reduced dependence on international medical graduates.
MWP recommendations should encompass medical workforce requirements for the entire population to include both the public and private healthcare systems.	The Irish medical training system should use the best available data to ensure a medical training pipeline for public and the private health system.
Development of medical staffing should ensure the appropriate skill mix to deliver health services in the future.	Trainee numbers for each specialty should be based on strategy and planning including MoCs and/or related service and workforce requirements of the future.

4. Data and Methodology

4.1 Data Sources and Limitations

Analysis presented in this report is underpinned by multiple data sources, including the following:

- HSE NDTP Doctors Integrated Management E-System (DIME), which receives data from the postgraduate medical training bodies, the Irish Medical Council, and each clinical site that employs doctors in the public health system in Ireland. [6]
- Hospital Inpatient Enquiry system, which contains data on inpatient and day case activity, broken down by age group and hospital for HSE funded services. [31]
- HSE Business Intelligence Unit, which collates data on outpatient activity across acute hospitals funded by the HSE. [32]
- National Treatment Purchase Fund (NTPF), which collates waiting list data for HSE funded services in acute sites. [33]
- The Irish Medical Council (IMC), which collects data on private sector workforce numbers through its annual registration process. [8] This information is less up to date and less granular than what is available for HSE-funded services but represents the best-available data on private sector capacity.
- Population projections from the Central Statistics Office (CSO, scenario M2) underpin all population-based calculations. [34]
- International health research groups and public health bodies, for example, Health Workforce Australia, the NHS in the UK, and equivalents in New Zealand and Canada, US and selected Scandinavian nations. [35-39]
- NCPs involved in the specialties of this report. [9-13]

DIME is dependent on clinical sites inputting details on their consultant workforce. The DIME data used in this report for consultants is for 31st December 2024, while data for NCHDs is for 31st October 2024 and is reflective of the training year July 2024-July 2025. DIME data was accessed on 5th January 2025 and has been subject to a data validation exercise. As DIME is a live system, it must be noted that there can be variances in the figures published dependent on the run date of the report. In addition, some entries can be made with a retrospective date.

4.2 Modelling

The statistical modelling used in this review simulates the supply of doctors in the health system on the basis of inputs such as training intake, retirement age, attrition, etc over the period 2025-2038. Due to the long timeframe between an individual entering training and taking up a consultant post, increases in the training intake will only impact on consultant numbers in the later years of the model. The modelling approach used here is an extended version of a statistical simulation model developed by FÁS (now Solas) and The Expert Group on Future Skills Needs, with distinct modules for supply and demand. [40] Although the principal aim of this workforce review is to estimate consultant demand in publicly funded posts, entire population needs must be considered, so the total public plus private workforce is considered in this model.

Modelling Supply

The supply module uses a stock-flow analysis of individuals progressing through the specialist training schemes and taking up consultant posts. The modelling and projections in this report span the period 2025-2038. Entrants into and exits from the training and consultant cohorts are modelled on an annual basis according to assumptions on gender, age, Less Than Full Time (LTFT) working patterns, attrition, and recruitment. These assumptions were arrived at through NDTP analysis of DIME data and stakeholder engagement and are summarised in Table 8. Baseline assumptions were established as follows:

- Baseline workforce: Combined public and private workforce (in WTE) as of December 2024, according to DIME and the IMC.
- Training Intake: Increases to training intake in supply modelling are supported by stakeholder advice on achievable rates of increase and likely availability of training posts. Trainee intake that was modelled for July 2025 is the actual number of trainees that enrolled at this time and is reflective of the training year 2025-2026.
- Supply modelling inflows (consultant workforce entrants) for all specialties for the year 2025 are configured so that the projected end of year 2025 workforce total is aligned with the actual reported December 2025 workforce as recorded on DIME.
- Post-CSCST attrition: analysis of historic CSCST retention rates were used to inform projected retention rates, in conjunction with expert insight from specialty stakeholders.
- Age of retirement: NDTP analysis shows that historically the median age of retirement of consultants from permanent posts is 62 years. [41] Accordingly, this value was used as the assumed age of retirement in projections contained within this report, with exceptions for certain specialties based on stakeholder feedback.
- Post-CSCST gap: NDTP analysis shows that historically individuals who have been awarded CSCST typically spend 1-2 years abroad in fellowships before taking up consultant posts in Ireland. Thus, modelling in this report assumes two years between achieving CSCST and entering the consultant workforce. The exception to this assumption is clinical neurophysiology, where expert stakeholder input indicated that this pattern is unlikely to hold for a variety of reasons.
- WTE rate: It is assumed that LTFT working patterns will become more common in the coming years, continuing current trends in this. Thus, the overall WTE rate is modelled to reflect this across all specialties over the projection period to capture this pattern.
- Private sector: the scale of the workforce in the private sector is estimated relative to that of the publicly funded workforce in all projections in this report. The specifics for each specialty are outlined in the relevant specialty sections.

Supply Modelling Assumptions

Table 8 below summarises the assumptions used in modelling supply of consultants for each specialty in this report.

Table 8: Summary of supply modelling for each specialty.

Modelling Parameter	Clinical Neurophysiology	Dermatology	Medical Oncology	Neurology	Palliative Medicine	Rehabilitation Medicine
Baseline workforce (WTE)	16.5	81.6	83.8	74.7	53.8	14.8
Post-CSCST attrition rate	10%	15%	Initially: 20% Decreasing to: 10%	Initially: 20% Decreasing to: 10%	10%	12%
Retirement age	64	62	62	62	62	62
CSCST-consultant gap (years)	0	2	2	2	2	2
WTE rate	Initially: 91% Decreasing to: 87%	Initially: 94% Decreasing to: 85%	Initially: 92% Decreasing to: 88%	Initially: 91% Decreasing to: 87%	Initially: 78% Increasing to: 86%	Initially: 82% Increasing to: 86%
Private sector capacity	None	42.9% of public capacity	12.5% of public capacity	8% of public capacity	5.3% of public capacity	None

Modelling Demand

Estimating future consultant demand is a bespoke exercise which involves extensive engagement with specialty stakeholders including clinical programme leads and national specialty directors. Demand estimates must account for future service development as set out by clinical MoCs and broader reorganisation of the HSE such as implementation of Sláintecare and the HSE Health Regions. Detailed discussion of the drivers for demand and estimated future demand for each specialty of this report are presented in the relevant specialty sections.

4.3 Drivers of Demand

Across all specialties reviewed in this report, demand is shaped by a set of universal drivers and pressures, with system-wide factors also influencing consultant demand.

Demographic Ageing and Population Growth

Demographic ageing and population growth are increasing the prevalence of chronic disease, multimorbidity, and age-associated conditions, resulting in higher volumes and greater complexity of care across hospital and community settings. Table 9 summarises the projected demographic growth in Ireland 2024-2038 (CSO Scenario M2), highlighting the pronounced growth in the older adult population, which places sustained upward pressure on healthcare demand and, consequently, consultant workforce requirements across all specialties. [34]

Table 9: Projected changes to the population of Ireland 2024-2038 by demographic age bands. [34]

Age Group	2024 Value	2038 Value	Average Annual Growth Rate
0-15	1,072,252	889,281	-1.3%
16-30	998,240	1,107,636	0.7%
31-45	1,166,477	1,157,372	-0.1%
46-60	1,053,876	1,259,042	1.3%
61-75	734,376	1,006,719	2.3%
76-85	253,668	399,674	3.3%
Over 85	76,499	161,426	5.5%
Total	5,355,388	5,981,150	0.8%

Structural Reform and Service Reconfiguration

National service reform is reshaping Ireland's public health system in a manner which has significant impact on consultant demand across all specialties. Sláintecare sets out a plan to shift towards consultant delivered care integrated across acute and community clinical settings, intending to reduce waiting times for acute care, strengthen multidisciplinary working, and shift more healthcare to settings closer to patients' homes. [15, 42, 43] Consultants will increasingly be required to provide outreach, governance, and clinical leadership outside of their core clinical responsibilities. The development of the Trauma Networks introduces a structured, tiered model of trauma care, with supra-regional Major Trauma Centres, Trauma Units, and linked rehabilitation and recovery pathways. [17] This model aims to centralise complex care while ensuring timely access to specialist review for patients across the country.

The move to six HSE Health Regions from 2024 represents a fundamental reorganisation of service planning and delivery. [16] The Health Regions are designed to improve local responsiveness, integrate hospital and community services, and enable population-based service planning. This regionalisation requires consultant involvement in service design, governance, and pathway development across larger populations and multiple care settings.

Clinical Models of Care

The expansion and maturation of national MoCs across multiple specialties and NCPs is a significant driver of consultant demand. MoCs define the optimal configuration of services, multidisciplinary workforce, and patient clinical pathways. As these models are implemented, they introduce new structures such as specialist clinics, MDTs, regional hubs, community pathways, and enhanced diagnostic and treatment protocols, all of which require consultant delivered care in addition to leadership and management.

MoCs typically outline patient pathways that may extend beyond traditional acute hospital-based care, embedding consultant input at multiple stages: triage, diagnosis, multidisciplinary decision-making, ongoing disease management, complex procedures, community-based follow-up, and governance of integrated networks. Across the specialties included in this report, MoCs outline the introduction of new services, expansion of scope or eligibility for existing services, and formalisation of care processes that previously varied between sites. These changes increase the volume and complexity of consultant workload while also driving the need for additional consultant roles in clinical leadership, pathway governance, multidisciplinary team functioning, and community outreach.

5. Clinical Neurophysiology

Clinical Neurophysiology (CN) is a hospital-based diagnostic specialty focused on the anatomy and physiology of the nervous system. It provides neurodiagnostic services including Electroencephalogram (EEG), Nerve Conduction Studies (NCS), Electromyography (EMG), and Evoked Potentials (EP). Other more complex neurodiagnostics including autonomic and small fibre testing, Intraoperative Neuromonitoring (IONM), ultrasound of muscle and nerve, intramuscular botulinum toxin injection for neurological conditions, and long-term video EEG monitoring are carried out in some departments. Many medical and surgical specialties including neurology, neurosurgery, plastic surgery, paediatrics, psychiatry, intensive care medicine, orthopaedics, general practice, and rehabilitation medicine refer patients for neurodiagnostic evaluation. The neurophysiology findings can help with diagnosis and can further assist with identifying appropriate medical/surgical treatment.

5.1 Clinical Neurophysiology Services in Ireland

CN has been a recognised specialty included in the Specialist Division of the IMC since 1997. National access to CN is unevenly distributed with services based predominantly in Dublin, as evidenced in Table 11, which summarises the location of the consultant workforce as of December 2024. There are nine departments (two paediatric) with 17 consultants (HC) appointed nationally. CN is a multidisciplinary specialty and highly dependent on scientists to help carry out EEGs, EPs, NCS and IONM, with all data interpreted and reported by consultant clinical neurophysiologists. The consultant workload is dominated by high-complexity, time-intensive studies (EEG/telemetry, EMG, ultrasound of muscle and nerve, and IONM). In addition to the medical workforce, CN is dependent on scientists, physical infrastructure and equipment, and dedicated space. While these must be addressed as part of the broader efforts to expand and upgrade CN services nationally, this report is limited to recommendations related to future expansion of the medical workforce.

5.2 Clinical Neurophysiology Training Pathway

A four-year HST programme in CN was recently established in RCPI with the first intake of trainees in July 2025 and first expected completions in July 2029. [14] Candidates may enrol in the CN HST programme on completion of the BST in General Internal Medicine (GIM) in RCPI and passing the MRCPI exam. All consultant clinical neurophysiologists currently working in Ireland completed their training in the UK or USA, the majority of whom are dual trained in neurology and CN. The RCPI CN curriculum largely follows that of the UK. Upon completion of the CN HST programme, candidates are awarded the CSCST and are eligible to register on the Specialist Division of the IMC.

At present, there are 5 NCHD posts which have been identified as suitable training posts for CN across Cork University Hospital, Mater Misericordiae, St. James's, and St. Vincent's University Hospital, indicating that currently the CN HST programme has capacity for 5 trainees in-programme in clinical roles at any one time. Engagement with management in clinical sites has sought to establish further training posts by 2027. The availability of funded training positions has implications when considering future expanded training output. Approximately 25% of the HST programme will take place in neurology clinical rotations facilitated by consultant neurologists, due to the inter-related nature of the two specialties.

5.3 Clinical Neurophysiology Workforce Analysis

As already discussed, the existing consultant workforce in CN trained abroad, given the lack of a domestic training programme to date. The status of the CN workforce as of December 2024 is summarised in Table 10, with Table 11 providing a detailed overview of the clinical settings and Health Regions in which publicly funded consultants in CN work.

Table 10: Baseline medical workforce in CN, December 2024. [6, 8]

Variable	Value
Consultant HSE funded services (HC)	17
Consultant HSE funded services (WTE)	16.5
WTE rate HSE funded services	94% (male) 100% (female) 97% (average)
Gender balance consultants HSE funded services	41.2% male, 58.8% female
Expected retirements by 2038 (HC)	Approximately 9-10
HST Years 1-4 (HC)*	0
NTSDs*	0

*As of July 2025, there are two HSTs in programme and 1 NTSD within the specialty of CN, reflecting the first intake of trainees into the CN HST programme.

Table 11: Location of publicly funded consultant clinical neurophysiologists by WTE, December 2024. [6]

Health Region	Model 4	Model 3	Specialist Paediatric	Total WTE
Dublin Northeast	7.5			7.5
Dublin Midlands	2.0			2.0
Dublin Southeast	1.0			1.0
Southwest	2.5	0.3		2.8
Midwest	0.2			0.2
West Northwest	1.0			1.0
CHI			2.0	2.0
Total	14.2	0.3	2.0	16.5

International Comparison

Comparing the medical workforce in CN across different international jurisdictions is challenging, as clinical practice and registration status of the specialty differ from country to country. Despite being a recognised specialty by the EU, in many countries it is practiced as a subspecialty of neurology. [44] In Australia, New Zealand, and Canada, CN is not a distinct recognised medical specialty at consultant level, with tests conducted by clinical physiologists or other neurophysiology practitioners, often within a neurology department. [45, 46] The International Federation of Clinical Neurophysiology published an article in 2022 highlighted the significant differences which exist between countries in the configuration and status of CN practitioners. [47]

With these differences in mind, a review of the size of the CN medical workforce (in WTE/100k population) was carried out as a benchmarking exercise across several international jurisdictions which are comparable to Ireland. The results of this are summarised in Table 12.

Table 12: International comparison of the CN medical workforce in WTE/100k.

	Ireland ¹ [6, 8]	England ² [37, 48]	Scotland ² [38, 48]	Wales ² [39, 48]	Denmark ¹ [49, 50]	Norway ¹ [51, 52]	Sweden ¹ [53, 54]
Consultants	0.30	0.18	0.02	0.10	0.60	1.00	0.5
Trainees	0.00	0.05	0.07	0.13			
NTSDs	0	0.01	0	0			

1: Combined public + private workforce.

2: NHS workforce.

5.4 Demand

Unmet Demand in Clinical Neurophysiology

Stakeholder engagement infers unmet demand at current service capacity and consultant workforce level in the specialty of CN. This is indicated by wait times to access services. However, CN activity and waiting times are not systematically recorded and reported by the HSE, implying unrecorded demand and posing challenges to measuring current activity and projected future demand for services measure current activity or project future demand.

An internal survey conducted by the National Clinical Advisor for CN in May 2023 reported that over 15,000 patients were awaiting routine neurodiagnostics. [55] At the time of this survey, the median wait time for EMG was approx. 18 months, carpal tunnel syndrome testing was approx. 12 months, while routine EEG was approx. 3 months. Significant variation was observed across clinical sites, with some reporting significantly higher waiting times.

Clinical stakeholders advised that some epilepsy patients report waiting times of up to 2 years for routine EEGs, despite clinical guidelines recommending EEG being performed within 6 weeks of referral to neurological services following first epileptic seizure. [56] Further clinical stakeholder input indicated that many acute hospitals currently lack on-site CN diagnostic services, despite having active neurology, Intensive Care Unit (ICU), paediatric, and acute medicine services, contributing directly to long waiting times and high backlogs.

As unmet demand for CN is not currently recorded in the form of NTPF waiting lists, volumes of patients awaiting services are recorded locally in acute hospitals which currently deliver CN services. As a structured and centralised system for recording waiting lists and hospital activity is developed and rolled out across CN services in the coming years, it will become possible to capture more accurate measurements of unmet demand.

Clinical stakeholders advise that every neurology department in an academic teaching hospital requires direct access to a CN service, as CN tests are considered an extension of a neurological consultation. Despite this, clinical stakeholders report that multiple neurology centres lack an on-site CN service. This is supported by consultant workforce data, which indicates that 12 Model 3 hospitals and 2 Model 4 hospitals have neurology departments with no direct access to CN consultant services. [6] Furthermore, workforce planning for neurology in this report (see Section 8) is configured to support neurology departments in every Model 4 and Model 3 hospital in Ireland. Currently, inpatients are transferred via ambulance for neurodiagnostic studies such as EEG or NCS. For example, patients in Bantry General Hospital are supported by CN diagnostic services in Cork University Hospital. Clinical stakeholder feedback indicates that this is not aligned with MoCs. In addition to consultant availability, CN services require dedicated inpatient and diagnostic facilities, both of which are beyond the scope of this report.

Drivers of Demand for Clinical Neurophysiology

Ireland's ageing demographic profile is expected to exert substantial upward pressure on CN demand in the coming years. [34] The population aged 60-85 is projected to increase by 2.6% annually to 2038, and those aged over 85, the group with the highest incidence of neuropathies, stroke, seizure disorders, and multi-morbidity, will grow by 5.5% per year. This expansion in older age cohorts and associated age-related conditions will materially increase referrals for EEG, NCS, and other neurodiagnostic investigations.

Given the lack of centrally recorded activity data for CN in acute hospitals or disease registries for relevant neurological conditions, it is not currently possible to directly project service demand on the basis of published Irish hospital activity data. Instead, broader projections and clinical observations on the incidence of diseases and conditions which drive demand for neurodiagnostic services underpin the case for increased future demand in CN are presented in Table 13.

Table 13: Overview of selected conditions which are anticipated to drive demand for neurodiagnostics.

Disease/Condition	Details	Sources
Epilepsy	Prevalence ~1% of population. At least one EEG per patient, estimated demand of 15,000-17,000 studies per year. WHO report that incidence in Europe is expected to increase, underpinned by demographic ageing.	Clinical Stakeholders [57]
Carpal tunnel syndrome	Prevalence 1-5% population (estimate). Neurodiagnostics (NCS/EMG) required for screening and confirmation of condition.	Clinical Stakeholders
Peripheral neuropathy	Required for accurate diagnosis of hereditary and acquired conditions and determine severity, including diabetic neuropathy and autoimmune disorders. Used to guide treatment plans, e.g. amyloidosis.	Clinical Stakeholders
Dementia	Prevalence of >1% of population, expected to grow beyond 2% due to demographic ageing. EEG indicated to exclude subclinical seizure in dementia patients.	[34, 58]
Intensive care medicine	20-30% of patients in ICU may experience subclinical seizures (no physical signs) which can only be detected with EEG. Delays in diagnosing seizures are associated with a higher mortality. EEG is also helpful for neuro-prognostication for patients post cardiac arrest, traumatic brain injury, or stroke. Continuous EEG is now standard of care in some international centres.	Clinical Stakeholders
Spinal and intra-cranial surgery	IONM is standard of care for scoliosis correction surgery and many intracranial/spinal tumours and epilepsy surgery.	Clinical Stakeholders
Neurology	Neurology departments require timely access to neurodiagnostics as part of neurological consultations. Neurology accounts for approx. 40% of referrals to CN. Drivers of demand for neurology services are discussed in Section 8.4	Clinical Stakeholders
Amyloidosis	Prevalence projected to grow by 2-3% annually, based on UK and USA age-related prevalence of systemic amyloidosis (all subtypes) applied to Irish population projections. Demand for neurodiagnostics is primarily driven by neuropathy-associated forms.	[34, 59, 60]

Demand for CN services in Ireland are heavily impacted by care pathways which are outlined in MoC and national strategy documents, including those for epilepsy, neurology, and amyloidosis. [27, 61, 62] Unpublished data arising from the survey of all CN departments led by the National Clinical Advisor for CN and the Irish Society of Clinical Neurophysiologists (ISCN) indicated that approx. 6,000 patients are discharged annually with epilepsy diagnoses, implying at least one EEG per epilepsy patient (some may require multiple or long-term regular EEGs). [63] There are approx. 10,000 refractory epilepsy patients needing one or more EEG annually, plus 1,750 EEGs for new diagnoses. Collectively, this implies an estimated total national EEG need of 15,000–17,000 studies/year. Of these patients, 5–7% are expected to require overnight telemetry or prolonged recordings (approx. 600 annually). [64]

CN testing is a prerequisite for amyloidosis treatments, as NCS and autonomic and small fibre testing are required to confirm neuropathy and plan amyloid therapies. Specialist amyloidosis centres should have direct and prompt access to CN testing to ensure efficient patient treatments and enable positive outcomes. Growth in demand for services such as trauma and orthopaedics, neurosurgery, and ICU further drives demand for CN services as standard neurodiagnostics and IONM is a required standard of care for many spinal and intracranial surgeries.

Future Demand in Clinical Neurophysiology

Stakeholder engagement has outlined a need to grow the consultant workforce in CN to 28 WTE nationally by 2028. This will support the development and expansion of services around the country, enabling more equitable access to CN services for the population and to address existing backlogs. In addition to the medical workforce, such expansion of CN services will require additional clinical scientists and hospital inpatient facilities, which are beyond the scope of this report. Longer-term, a figure of 1 WTE per 150,000 population has been identified as an appropriate workforce target, equating to a national consultant demand of 40 WTE by 2038. This would bring the consultant ratio per head of population more in line with that currently in Sweden and Denmark, where service delivery models are comparable to that in Ireland. The distribution of the consultant workforce will be guided by population need and will be aligned with several components of service demand, such as establishing new inpatient CN departments and increasing capacity in existing departments to handle waiting list volumes and increasing service demand underpinned by epidemiological changes outlined in Table 13.

Clinical Neurophysiology Demand Summary

Demographic ageing	Population aged 60-85 to grow by 2.6% annually to 2038. Population aged >85 to grow 5.5% annually. See Section 4.3. Age groups with highest prevalence of neuropathy, seizure disorders, cognitive decline, stroke, etc.
Current unmet demand	>15k patients awaiting routine testing. (May 2023 survey findings carried out by clinical lead and ISCN) Hidden demand due to inconsistent waiting list recording.
Supporting specialist care pathways	Neurodiagnostic services required to support care pathways in neurology, epilepsy, amyloidosis, ICU, spinal scoliosis in children, child and adult spinal and neurosurgery.
Service expansion	Development of CN departments around the country to meet population needs.
Population benchmark	1 WTE per 150,000 population or 0.67 per 100,000, bringing the workforce more in line with that in both Sweden and Denmark currently.
Future demand 2038	40 WTE nationally (public only).

5.5 Supply of Consultants for Clinical Neurophysiology

Achieving the consultant demand estimated above by 2038 will require the HST programme to establish a steady output of Irish-trained specialists in the medium-long term. Additionally, immediate consultant demand to support service expansion will need to be met through recruitment of specialists who qualified outside of the domestic Irish training pipeline. These individuals may be Irish doctors currently undertaking training abroad or may be entirely new to Ireland. The supply model assumptions for CN are summarised in Table 14. Note that no gap was modelled between CSCST and entering the consultant workforce for CN on the basis of stakeholder input.

Table 14: Assumptions in modelling supply of consultants into the CN workforce.

Modelling Parameter	Assumption
Baseline workforce (WTE)	16.5
Post-CSCST attrition rate	10%
Retirement age	64
CSCST-consultant gap (years)	0
WTE rate	Initially: 97% Decreasing to: 87%
Private sector capacity	None

Training Intake and Additional Recruitment

Current HST intake stands at 2 per annum, with the first intake commencing in July 2025. This intake rate is assumed to continue until at least the first cohort of trainees achieve CSCST in 2029. Increasing HST intake beyond this will require a review of the HST programme once a steady throughput has been achieved. Furthermore, the establishment of more CN services around the country may be necessary to enable further training posts to be established. With the first CSCSTs expected to graduate from 2029 onwards, consultant demand up to then must be met by recruiting into consultant posts from outside of the domestic training programme. Approx. 24 consultants will need to be employed in this manner up to 2031. The recommended annual profile of training intake and additional recruitment is summarised in Table 15 below.

Table 15: Recommended HST annual intake and additional consultant recruitment for CN to meet consultant demand.

	2025	2026	2027	2028	2029	2030	2031
HST intake	2	2	2	2	2	2	2
Additional Recruitment	2	3	4	4	4	4	3

Detailed Supply Summary

Table 16 provides a detailed summary of key annual metrics relating to the supply of consultants in CN based on the recommendations set out in Table 15. The specific annual values would be different if, for example, the rate of CSCST output or additional recruitment differs from that outlined in this report. The total workforce (in WTE) for 2025 is aligned with what was recorded on DIME for December 2025.

Table 16: Detailed summary table for supply of consultant clinical neurophysiologists to meet consultant demand in 2038.

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Consultant Supply (WTE) (@ year-end)	17.7	20.2	23.7	27.1	32.1	35.7	38.2	37.9	38.2	38.5	39.0	39.5	39.9	40.3
Replacement Posts (WTE) (Retirements & exits)	0.8	0.5	0.2	0.2	0.2	1.5	1.5	1.5	0.9	0.9	0.9	0.9	0.9	0.9
New Posts (WTE) (Service expansion)	1.2	2.5	3.7	3.6	5.3	3.9	2.9	0.1	0.7	0.7	0.7	0.7	0.7	0.7
Total Recruitment (WTE)	2.0	2.9	3.9	3.8	5.5	5.4	4.4	1.6	1.6	1.6	1.6	1.6	1.6	1.6
Irish-Trained CSCSTs	0.0	0.0	0.0	0.0	1.7	1.7	1.7	1.6	1.6	1.6	1.6	1.6	1.6	1.6
Additional Consultant Recruitment	2.0	2.9	3.9	3.8	3.8	3.7	2.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estimated Headcount (HC)	18	21	25	28	35	40	43	41	42	43	44	45	45	46

Irish-trained CSCSTs refers to individuals appointed to consultant posts who were awarded CSCST in Ireland.

Additional consultant recruitment refers to individuals appointed to consultant posts who completed specialty training outside of the Irish training programme. Some totals may not sum exactly due to rounding errors.

5.6 Recommendations

Continued development of CN services is required to improve access across all Health Regions and tackle growing waiting lists for diagnostic services. As such, considerable growth in the workforce is required. In parallel, the HST programme is in its infancy and will not be in a position to sustain workforce growth for a number of years. Consequently, workforce recommendations encompass a roadmap for HST intake and recruitment of consultants from outside of the training pipeline.

- HST: sustain annual intake of 2 trainees.
- Additional recruitment: 24 consultants recruited from outside of the Irish training pipeline.
- Repeat demand estimates exercise for CN in 2028-2030.

HST intake should be sustained at the current level of 2 per annum. To facilitate this, training posts must be identified to support expansion. In total, 8 Specialist Registrar (SpR) posts are required to sustain 2 trainees through each year of a 4-year programme. There are currently 2 such posts identified as suitable for the HST programme, with a further 3 viable posts identified and currently undergoing evaluation and accreditation. Meeting the recommendations of this report would require at least 3 further training posts be identified in the next year or two to support the steady intake of 2 HSTs per annum.

Concurrently, approx. 24 consultants who specialised in CN outside Ireland will need to be recruited in the short to medium term, enabling expansion of the consultant workforce, replacing anticipated age-based retirements, and rolling out new clinical services in regions of the country which do not have direct access to CN services. The latter will enable the expansion of the HST programme, as it will be easier to establish SpR posts with a greater number of hospitals having a functioning CN department. Beyond 2030/2031, it is projected that the needs of the consultant workforce will be supplied domestically through the HST programme.

Workforce demand estimates for CN should be repeated around 2028-2030, given the scale of change anticipated in this specialty. At this stage, revised training and recruitment recommendations would be issued, if necessary, to capture the changing demographic, diagnostic, epidemiological, and therapeutic landscape at the time.

5.7 Regional Workforce Planning

Table 17 outlines the regional consultant workforce in CN on the basis of the modelling in this report. The proposed regional distribution of the workforce is expert stakeholder informed and reflects the priorities in expanding clinical services equitably around the country in the short term and growing the workforce to match population growth. Specific regional workforce allocation will be impacted by the roll out and development of national and supra-regional specialist services (e.g. amyloidosis, ataxia, epilepsy, trauma networks) under the oversight of relevant clinical organisations. The regional profile outlined here could be used by decision-makers at Health Region level to support integrated regional workforce planning.

Table 17: Regional workforce expansion profile to meet consultant demand for 2038 in CN.

Health Region	2024		2030		2038	
	WTE	WTE/100k	WTE	WTE/100k	WTE	WTE/100k
Dublin Northeast	7.5	0.6	9.5	0.7	11.0	0.8
Dublin Midlands	2.0	0.2	5.5	0.4	6.0	0.5
Dublin Southeast	1.0	0.1	4.5	0.4	5.3	0.5
Southwest	2.8	0.4	4.0	0.5	4.8	0.6
Midwest	0.2	0.0	2.5	0.6	3.0	0.6
West Northwest	1.0	0.1	4.0	0.5	4.5	0.5
CHI	2.0		5.0		5.5	
Total	16.5	0.3	35	0.6	40	0.7

6. Dermatology

Dermatology is the medical specialty concerned with the diagnosis and management of diseases of the skin, hair, and nails, encompassing over 1,000 classified conditions. The majority of the disease burden falls into three major categories including: inflammatory skin diseases (such as psoriasis and eczema), autoimmune and connective tissue disorders, and skin cancers, which together represent a significant proportion of outpatient activity in both acute and community settings.

6.1 Dermatology Services in Ireland

Dermatology services in Ireland operate primarily through hospital-based departments and peripheral outreach clinics, following a hub-and-spoke model designed to ensure equitable access and efficient delivery of care. Adult services are currently delivered across 11 main dermatology departments supported by 16 peripheral clinics, while paediatric dermatology is provided in CHI with regional centres in Cork, Galway, Waterford, Limerick, and Drogheda.

The MoC for Dermatology sets out the framework for service delivery and capacity building, with key aims including: [25]

- Development of Dermatology Clinical Networks across the Health Regions to deliver care closer to patients and support GP education.
- Integration of nursing and advanced nurse practitioner-led clinics to expand capacity, potentially adding 1,700+ new patient appointments annually per site.
- Implementation of care pathways for common conditions such as acne, psoriasis, eczema, hidradenitis suppurativa, and melanoma (in collaboration with the National Cancer Control Programme).
- Enhanced capacity in primary care to manage lower-complexity conditions and improve self-management of chronic skin disease.

6.2 Dermatology Training Pathway

HST in dermatology in RCPI is a five-year outcome-based curriculum structured around six key training goals covering adult and paediatric dermatology, procedural and surgical skills, acute/emergency care, interdisciplinary collaboration, and quality improvement. [14] Trainees spend at least three years in Irish clinical posts and may complete one year of research or out-of-programme experience. Entry to the programme requires completion of BST in GIM and achievement of the MRCPI or an equivalent qualification. Upon completion, candidates are awarded the CSCST and are eligible for inclusion on the Specialist Division of the IMC.

6.3 Dermatology Workforce Analysis

The status of the dermatology medical workforce as of December 2024 is summarised below in Table 18, with Table 19 providing a detailed overview of the clinical settings and Health Regions in which publicly funded consultant dermatologists are based.

Table 18: Baseline medical workforce in dermatology, December 2024. [6, 8]

Variable	Value
Consultant HSE funded services (HC)	64
Consultant HSE funded services (WTE)	59.3
WTE rate HSE funded services	93.3% (male) 91.7% (female) 92.7% (average)
Gender balance consultants HSE funded services	28% male, 72% female
Expected retirements by 2038 (HC)	18 (7 male, 11 female) – aged 62 14 (6 male, 8 female) – aged 65
Exclusive private sector consultants (HC)	28
Exclusive private sector consultants (WTE)	22.7
HST Years 1-5 (HC)	32
NTSDs	49

Table 19: Location of publicly funded consultant dermatologists, December 2024. [6]

Health Region	Model 4	Model 3	Model 2	Specialist Paediatric	Academic	Total
Dublin Northeast	9.4	4.6				14
Dublin Midlands	14.7	1.7		0		16.4
Dublin Southeast	2.8	0.4	0.2		0.5	3.9
Southwest	1.4	0.4	6.1			7.9
Midwest	4.8		0.2			5
West Northwest	5.4	1.7				7.1
CHI				5		5
Total	38.5	8.8	6.5	5	0.5	59.3

International Comparison

A study of the size of the dermatology medical workforce (in WTE/100k population) in several international jurisdictions was carried out as a benchmarking exercise. The results of this are summarised in Table 20.

Table 20: International comparison of the dermatology medical workforce in WTE/100k.

	Ireland ¹ [6, 8]	England ² [37, 48]	Scotland ² [38, 48]	Wales ² [39, 48]	Australia ¹ [65, 66]	New Zealand ¹ [36, 67]	Canada ¹ [35]
Consultants	1.39	1.20	1.30	1.28	2.35	1.72	1.87
Trainees	0.60	0.71	0.78	0.90	0.00	0.16	0.00
NTSDs	0.89	0.39	0.49	0.13	0.00	0.12	0.00

1: Combined public + private workforce.

2: NHS workforce.

6.4 Demand

Unmet Demand in Dermatology

As of June 2025, NTPF records indicate that >61,000 people were awaiting dermatology services, as summarised in Table 21. [33] Over the course of 2025, the proportion of all adults who were awaiting inpatient/daycase services for more than 18 months increased by an average of 4.3% each month, while the proportion of those awaiting outpatient services for more than 18 months grew by 2.4% each month. For paediatric services, the proportion of the total awaiting services for more than 18 months grew at a greater rate; by 4.5% each month for inpatient/daycase services and by 3.4% each month for outpatient services. These figures indicate the impact of sustained unmet demand on waiting times. Paediatric dermatology capacity is concentrated in CHI Dublin with limited regional access, exacerbating delays for congenital and chronic paediatric conditions.

Table 21: NTPF waiting list records for dermatology services as of June 2025. [33]

Duration	Adult Services		Paediatric Services	Total
	Inpatient/Daycase	Outpatient	Inpatient/Daycase	Total
0-6 Months	29,465	864	1,822	32,151
6-12 Months	13,451	162	902	14,515
12-18 Months	7,175	69	560	7,804
18+ Months	6,013	124	713	6,850
Total	56,104	1,219	3,997	61,320

The data outlined above indicates that demand for services in dermatology exceeds public-sector capacity, with long waiting lists for both routine and urgent dermatology appointments. Limited public consultant availability, combined with high community need, has resulted in sustained unmet demand.

Drivers of Demand for Dermatology

Demand for dermatology services is driven by population growth and demographic ageing, leading to higher prevalence of skin cancer and chronic inflammatory conditions. Growing baseline hospital activity (inpatient and outpatient attendances) simply in line with population projections indicates that overall hospital attendances will grow by approx. 1.4% annually over the projection period in this report. [31, 34] Research indicates that the prevalence of chronic skin conditions such as dermatitis is expected to increase globally in the future, largely driven demographic ageing without significant changes to incidence rates. [68]

In addition to demography, the epidemiological context is expected to change in the coming decades. The National Cancer Registry Ireland (NCRI) projects that incidence of skin cancers will grow significantly in the coming years. [69] The median projections estimate that incidence of melanoma of the skin will grow by 3.4% each year in the coming decades, while Non-Melanoma Skin Cancer (NMSC) is projected to grow by 3.5% each year. This is largely driven by demographic ageing and lifestyle factors, such as long-term sun exposure.

Accounting for the above factors will require expansion of dermatologic surgery and biologic treatments, increasing case complexity and follow-up requirements. Ongoing service reform is shifting activity toward regional and community settings, requiring consultant-led outreach, governance, and cross-network clinical leadership, which impacts the geographic distribution of

the consultant workforce. The Royal College of Physicians in the UK has previously recommended a population benchmark of 1 WTE consultant dermatologist per 62,500 population, a metric of which the Irish workforce falls short. [70, 71]

Future Demand in Dermatology

The MoC for Dermatology in Ireland recommends 1 WTE consultant per 80,000 population. Adult and paediatric services are considered separately, with the latter provided through CHI in Dublin, with satellite CHI services in acute hubs around the country to ensure equitable access. Accordingly, projected national demand is split between adult and paediatric services.

Exclusive private practice accounts for approx. 28% of the consultant workforce across the combined public and private sectors. It was estimated that exclusive private practice will continue to account for 30% of the combined workforce over the projection period in this exercise. The projected increased prevalence of skin cancers and chronic conditions is anticipated to sustain a recurring demand for private services in the coming years.

The projected national demand for dermatology consultant services is summarised in Table 22.

Table 22: Projected national demand for consultant dermatologists 2038.

Service Category	Projected Consultant Demand (WTE)
Public (adult)	63.3
Public (paediatric)	11.1
Public subtotal	74.8
Private	32
Total	106.8

Dermatology Demand Summary

Demographic ageing	Population aged 60-85 to grow by 2.6% annually to 2038. Population aged >85 to grow 5.5% annually. See Section 4.3. Ageing population increasing burden of skin cancer and chronic dermatologic diseases.
Skin cancers	Incidence of melanoma of the skin projected to grow by 3.4% annually. Incidence of NMSC projected to grow by 3.5% annually.
Unmet demand	Long public waiting lists; limited consultant capacity; constrained regional paediatric dermatology access.
Utilisation growth	Baseline hospital attendances (combined inpatient & outpatient) projected to grow by 1.4% annually due to demographic ageing.
Complexity	Growth in biologics and dermatologic surgery; more frequent reviews and monitoring.
International benchmarks	1 WTE per 62.5k population (public & private services).
Model of Care for Dermatology	1 WTE consultant dermatologist per 80k population (public services). Shift to integrated regional/community networks.
Future demand 2038	106.8 WTE (public + private).

6.5 Supply of Consultants for Dermatology

Sustaining HST intake in dermatology at the current levels will see the consultant workforce reach demand levels in 2038 almost entirely through the domestic training programme. It is estimated that it will be necessary to recruit a small number of consultants from outside the domestic training programme to achieve the estimated consultant demand for 2038 outlined in the previous section. These individuals may be Irish doctors currently undertaking training abroad or may be entirely new to Ireland. The supply model assumptions for dermatology are summarised in Table 23.

Table 23: Assumptions in modelling supply of consultants into the dermatology workforce.

Modelling Parameter	Assumption
Baseline workforce (WTE)	81.6
Post-CSCST attrition rate	15%
Retirement age	62
CSCST-consultant gap (years)	2
WTE rate	Initially: 94% Decreasing to: 85%
Private sector capacity	42.9% of public capacity

Training Intake and Additional Recruitment

Current recommended HST intake for dermatology stands at 8 per annum, with 7 trainees commencing the programme in July 2025. Current arrangements should continue, with all training posts filled each year, sustaining an average intake of 8 trainees per year. Additionally, 2 further consultants will need to be recruited from outside the domestic training programme to reach the workforce target outlined above. This is summarised in Table 24.

Table 24: Recommended HST annual intake and additional consultant recruitment for dermatology to meet consultant demand.

	2025	2026	2027	2028	2029	2030
HST intake	7	8	8	8	8	8
Additional Recruitment		1	1			

Detailed Supply Summary

Table 25 provides a detailed summary of key annual metrics relating to the supply of consultants/dermatologists based on the recommendations set out in Table 24. The specific annual values would be different if, for example, the rate of CSCST output or additional recruitment differs from that outlined in this report. The total workforce (in WTE) for 2025 is aligned with what was recorded on DIME for December 2025.

Table 25: Detailed summary table for supply of consultant dermatologists to meet consultant demand in 2038.

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Consultant Supply (WTE) (@ year-end)	86.7	87.7	90.2	93.2	93.7	95.0	94.7	94.2	94.8	96.5	98.2	100.7	103.7	106.7
Replacement Posts (WTE) (Retirements & exits)	3.2	2.2	2.2	2.2	2.2	2.2	4.6	4.5	4.5	3.3	3.3	3.3	2.8	2.8
New Posts (WTE) (Service expansion)	0.0	1.9	3.4	4.0	1.6	2.3	0.7	0.6	1.4	2.5	2.5	2.5	3.0	3.0
Total Recruitment (WTE)	3.2	4.1	5.6	6.2	3.8	4.5	5.3	5.1	5.9	5.8	5.8	5.8	5.8	5.8
Irish-Trained CSCSTs	3.2	3.2	4.7	6.2	3.8	4.5	5.3	5.1	5.9	5.8	5.8	5.8	5.8	5.8
Additional Consultant Recruitment	0.0	0.9	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estimated Headcount (HC)	92	94	98	102	104	106	107	108	110	113	116	118	122	126

Irish-trained CSCSTs refers to individuals appointed to consultant posts who were awarded CSCST in Ireland.

Additional consultant recruitment refers to individuals appointed to consultant posts who completed specialty training outside of the Irish training programme. Some totals may not sum exactly due to rounding errors.

6.6 Recommendations

The agreed annual intake to HST currently sits at 8 per annum, with 7 enrolling in July 2025. Maintaining an average intake of 8 trainees each year will see the consultant workforce in dermatology reach desired levels by 2038, with 2 further consultants recruited from outside of the domestic training pipeline.

6.7 Regional Workforce Planning

Table 26 outlines the proposed regional workforce expansion roadmap for dermatology. Note that consultants working in CHI, a national tertiary centre for paediatric dermatology, are incorporated into the Dublin Midlands workforce total for the 2030 and 2038 columns. Similarly, workforce commitments to satellite CHI services in Cork, Limerick, Galway, and Drogheda are included in the respective regional workforces in Table 26. This regional roadmap is illustrative of how the workforce may develop at a regional level but is subject to many factors such as the pace at which acute inpatient services are developed, appointment of new consultant posts, infrastructure development, and funding allocation, all of which are beyond the scope of this report.

Table 26: Regional workforce expansion profile to meet consultant demand for 2038 in dermatology in 2038.

Health Region	2024		2030		2038	
	WTE	WTE/100k	WTE	WTE/100k	WTE	WTE/100k
Dublin Northeast	13.9	1.1	14.8	1.1	15.3	1.1
Dublin Midlands*	11.3	1.0	19.1	1.5	22.2	1.7
Dublin Southeast	8.9	0.9	10.7	1.0	12.4	1.1
Southwest	7.9	1.0	9.0	1.1	9.9	1.2
Midwest	5.0	1.2	5.1	1.1	5.5	1.2
West Northwest	7.0	0.9	8.0	1.0	9.5	1.1
CHI	4.9					
Private	22.7		28.1		32	
Total	81.6	1.5	94.9	1.7	106.8	1.8

*The projected regional workforce for 2030 and 2038 in Dublin Midlands includes Consultant Dermatologists based in CHI.

7. Medical Oncology

Medical oncology is the branch of medicine focused on treating cancer with Systemic Anti-Cancer Therapies (SACTs), including chemotherapy, immunotherapy, targeted, and hormonal treatments. These treatments are often administered parenterally or orally, with supportive medications to manage side effects. Most cancer patients receive one treatment modality or a combination of radiation therapy, surgery, and SACT, coordinated through multidisciplinary care. As treatments evolve and survival improves, medical oncology faces growing pressure for capacity, innovation, and workforce expansion.

7.1 Medical Oncology Services in Ireland

Cancer services in Ireland are delivered through hub-and-spoke Managed Cancer Control Networks (MCCNs) across the HSE Health Regions, as outlined in the National Cancer Strategy and the National Cancer Control Programme (NCCP) MoCs for SACT and Oral Anti-Cancer Medicines. [10, 19, 72] These models organise services into four tiers:

- Type 1: Cancer Centres (complex SACT and specialist referrals)
- Type 2: SACT hospitals with inpatient care (low-high complexity care)
- Type 3: Ambulatory SACT hospitals (low-medium complexity)
- Type 4: Community-based SACT services (low-medium complexity)

Specialist, low-volume, and complex therapies are delivered in Type 1 centres and Type 2 hospitals, while Type 3 and 4 services expand ambulatory and community delivery. Each MCCN is responsible for governance of SACT delivery sites, multidisciplinary meetings, and integration of acute oncology services across all hospital types.

There are currently nine designated cancer centres in Ireland (eight adult and one paediatric), with additional outreach SACT services across the regions. SACT delivery is primarily outpatient-based, though more complex regimens require inpatient management. The MoC for SACT estimates that approximately 30% of SACT occurs in the private sector, although data on private activity remain incomplete. The evolving landscape in therapeutic treatments suggests that this share of the workload will change in the coming years and must be accounted for in workforce projections.

Paediatric medical oncology is principally delivered by consultant paediatricians in CHI sites and workforce strategy for these consultants is dealt with in other policy reports. [73] The present document is limited to meeting demand for adult services in Ireland.

7.2 Medical Oncology Training Pathway

Entry to HST in medical oncology requires completion of BST in GIM from the RCPI and the MRCPI qualification, or equivalent. [14] The four-year HST programme follows an outcome-based curriculum (since 2024) structured around nine core training goals, covering areas such as cancer biology, diagnostics, therapy, and supportive care. Trainees rotate across the eight adult NCCP cancer centres, gaining experience in managing all common cancers and developing sub-specialty expertise. Academic and research participation is strongly encouraged, aligning with international oncology training frameworks. On completion of the HST programme, candidates are awarded the CSCST and are eligible for inclusion on the Specialist Division of the IMC. Stakeholder feedback indicated that each year, a small number of individuals are entered onto the Specialist Division of the IMC in recognition of clinical competencies developed in NTSD posts outside of the structured HST programme.

7.3 Medical Oncology Workforce Analysis

The status of the medical oncology workforce as of December 2024 is summarised in Table 27, with Table 28 providing a detailed overview of the clinical settings and Health Regions in which publicly funded consultant medical oncologists are based.

Table 27: Baseline medical workforce in medical oncology, December 2024. [6, 8]

Variable	Value
Consultant HSE funded services (HC)	75
Consultant HSE funded services (WTE)	68.6
WTE rate HSE funded services	93% (male) 89% (female) 91% (average)
Gender balance consultants HSE funded services	55.7% male, 45.3% female
Expected retirements by 2038 (HC)	21 (15 male, 6 female) – aged 62 16 (12 male, 4 female) – aged 65
Exclusive private sector consultants (HC)	13
Exclusive private sector consultants (WTE)	11.8
HST Years 1-4 (HC)	32
NTSDs	81

Table 28: Location of publicly funded consultant medical oncologists in WTE, December 2024. [6]

Health Region	Model 4	Model 3	Model 2	Specialist Oncology/ Radiotherapy	Specialist Maternity	Specialist Paediatric	Academic	Other	Total
Dublin Northeast	8.5	3.6							12.1
Dublin Midlands	9.2	2		1.1			0.5		12.8
Dublin Southeast	13.8				0.2		1.8		15.8
Southwest	5.9	2	0.3				1		9.2
Midwest	6		0						6
West Northwest	6.1	5.9							12
CHI						0.7			0.7
Total	49.5	13.5	0.3	1.1	0.2	0.7	3.3	0	68.6

International Comparison

A study of the size of the medical oncology medical workforce (in WTE/100k population) in several international jurisdictions was carried out as a benchmarking exercise. The results of this are summarised in Table 29. However, many other countries have other combined oncologist specialties, so a simple comparison of reported numbers of “medical oncologists” doesn’t capture the true scale of the consultant workforce which delivers medical oncology/ SACT services. The General Medical Council in the UK recognises the specialty of clinical oncology, which is a dual-trained specialty in medical and radiation oncology, leading to lower reported numbers of medical oncologists. Canada, Australia, and NZ report clinical and lab

haematologists, the former of whom do some work that would be done by medical oncologists in Ireland. In the USA, "oncologists" are dual certified in medical oncology and haematology, with clinical stakeholders indicating that roughly 2/3 of these specialists practice in a manner that could be considered equivalent to consultant medical oncologists in Ireland. [74, 75] The population ratio for the USA below is calculated on this basis. Table 29 is presented for context with the caveat that specialist service delivery differs across jurisdictions.

Table 29: International comparison of the medical oncology medical workforce in WTE/100k.

	Ireland ¹ [6, 8]	England ² [37, 48]	Scotland ² [38, 48]	Wales ² [39, 48]	Australia ¹ [65, 66]	New Zealand ¹ [36, 67]	Canada ¹ [35]	USA ³ [74-76]
Consultants	1.50	1.01	0.53	0.73	3.12	1.58	1.82	3.00
Trainees	0.86	1.44	0.66	0.85		0.58		
NTSDs	1.49	0.23	0.24	0.07		0.34		

1: Combined public + private workforce.

2: NHS workforce.

3: The value for the USA represents the estimated sum total of oncologists who practice in a manner equivalent to that of a consultant medical oncologist in Ireland.

7.4 Demand

Unmet Demand in Medical Oncology

Although the NTPF reports waiting lists for medical oncology, total waiting volumes are limited, with wait times mostly being <6 months in duration, see Table 30. [33] Consequently, unmet demand for services was quantified through a staffing model developed with stakeholders, rather than direct waiting list management.

Table 30: NTPF waiting list records for medical oncology as of June 2025. [33]

Duration	Inpatient/Daycase	Outpatient
0-6 Months	659	43
6-12 Months	27	0
12-18 Months	0	0
18+ Months	0	0
Total	686	43

Stakeholder contributions outlined proposed minimum consultant staffing requirements for the different SACT hospital types (Type 1-3), as outlined in Table 31. The consultant delivered services outlined for each tier of cancer treatment is aligned with National Cancer Strategy. [19]

Table 31: Demand for consultant medical oncologists by SACT hospital type.

Hospital Type	Consultant Services	Consultant Demand (WTE)
Type 1 cancer centre	Regional hubs, complex SACT & specialist care, subspecialisation, MDT leadership, MCCN clinical governance and oversight	12-13
Type 2 inpatient SACT hospital	Low-high complexity SACT, outreach clinics, treatment planning, clinical oversight	3
Type 3 ambulatory SACT hospital	Low-medium complexity SACT, outreach clinics, treatment planning, clinical oversight	2

This staffing model aggregates to a national baseline demand of 135 WTE in publicly funded services.

Drivers of Demand for Medical Oncology

Total cancer cases in Ireland are projected to rise in the coming years, with the NCRI projecting a 50% increase in annual invasive cancers (excluding NMSC) between 2015 and 2045. [69, 77] Expansion of targeted therapies, immunotherapies, and combination regimens has increased the complexity, duration, and monitoring of care of therapeutic treatments. Improved patient survival leads to a larger population requiring ongoing or maintenance SACT. The NCRI projects 70% growth in SACT demand by 2045 and regional equity remains a priority. [10] Expansion of oncology services in acute hospitals (Type 1-3 centres) and community SACT (Type 4 centres) services requires additional consultant oversight and governance.

Future Demand in Medical Oncology

Baseline hospital attendances for medical oncology are projected to grow by approx. 1.9% annually to 2038, accounting for demographic ageing and population growth. Projections from the NCRI underpinned by demographic change projects incidence of all cancers (excluding NMSC) to grow by 2.2% annually to 2038. However, this approach does not account for changing incidence rates of different types of cancer or by patient sex. When accounting for demographic change and projected changes to specific male and female incidence rates, the NCRI projects that overall cancer incidence (excluding NMSC) will grow by approx. 1.3% annually to 2038.

Growing the baseline consultant demand (135 WTE) by the above value of 1.3% annually results in a demand for 161.1 WTE by 2038. Expert stakeholders anticipate private sector growth requiring a minimum of 20 WTE by 2038, underpinned by changes to complexity and duration of therapeutic treatments driving more patients to undergo SACT in the private sector. This leads to a total demand for consultants of 181.1 WTE in 2038. These projections should be revised in 2028-2030 with recommendations updated, to reflect updated demand and supply requirements as cancer treatment and service delivery models evolve.

Medical Oncology Demand Summary

Demographic ageing	Population aged 60-85 to grow by 2.6% annually to 2038. Population aged >85 to grow 5.5% annually. See Section 4.3.
Hospital utilisation	Hospital utilisation projected to grow by 1.9% annually based on demographic change alone.
Unmet demand	Baseline demand of 135 WTE in public Cancer Centres. Type 1: 12-13 WTE Type 2: 3 WTE Type 3: 2 WTE
Complexity	Expansion of targeted/immunotherapies, longer treatment duration and monitoring.
Service model	Growth in SACT services in acute hospitals (Type 1-3) and community settings (Type 4); regional equity priorities.
Epidemiological growth	Overall cancer incidence rate to grow by 1.3% annually to 2038 (NCRI projections).
Future demand 2038	181.1 WTE (public + private).

7.5 Supply of Consultants for Medical Oncology

Stakeholder feedback indicates that each year a small number of specialists in medical oncology are entered onto the Specialist Register of the IMC outside of the structured HST programme in recognition of clinical competencies developed while working in non-training medical oncology posts in Type 1 Cancer Centres. These have been identified as a priority to incorporate into the structured HST programme in the next 2-3 years, allowing the HST intake to increase in that time period. Beyond that, further NTSD posts in Type 1 Cancer Centres will be identified as suitable for conversion to training posts. Additional consultants will need to be recruited to posts from outside the training programme to facilitate service expansion before 2030. These individuals may be Irish doctors currently undertaking training abroad or may be entirely new to Ireland. After this point, the HST programme is expected to supply the consultant workforce. The supply model assumptions for medical oncology are summarised in Table 32.

Table 32: Assumptions in modelling supply of consultants into the medical oncology workforce.

Modelling Parameter	Assumption
Baseline workforce (WTE)	83.8
Post-CSCST attrition rate	Initially: 20% Decreasing to: 10%
Retirement age	62
CSCST-consultant gap (years)	2
WTE rate	Initially: 92% Decreasing to: 88%
Private sector capacity	12.5% of public capacity

Training Intake and Additional Recruitment

A recommended roadmap for HST intake and additional consultant recruitment is shown in Table 33. Approx. 18 consultants will need to be recruited from outside the domestic training pipeline before 2030 to support service expansion. Beyond 2030, the HST programme is expected to support the consultant workforce through increased output of qualified specialists.

Table 33: Recommended HST annual intake and additional consultant recruitment for medical oncology to meet consultant demand.

	2025	2026	2027	2028	2029	2030
HST intake	8	12	12	14	14	14
Additional Recruitment		5	5	4	4	

Detailed Supply Summary

Table 34 provides a detailed summary of key annual metrics relating to the supply of consultants in medical oncology based on the recommendations set out in Table 33. The specific annual values would be different if, for example, the rate of CSCST output or additional recruitment differs from that outlined in this report. The total workforce (in WTE) for 2025 is aligned with what was recorded on DIME for December 2025.

Table 34: Detailed summary table for supply of consultant medical oncologists to meet consultant demand in 2038.

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Consultant Supply (WTE) (@ year-end)	87.8	95.2	108.7	114.0	121.6	125.7	128.6	134.7	141.4	149.6	157.9	166.2	173.5	180.8
Replacement Posts (WTE) (Retirements & exits)	0.9	2.1	2.2	2.9	2.9	2.9	2.6	2.6	2.7	3.0	3.1	3.1	4.3	4.4
New Posts (WTE) (Service expansion)	4.0	7.4	14.0	5.9	8.3	4.7	3.6	6.9	7.0	8.5	8.7	8.6	7.4	7.3
Total Recruitment (WTE)	4.9	9.6	16.1	8.8	11.1	7.7	6.2	9.5	9.7	11.5	11.7	11.7	11.7	11.7
Irish-Trained CSCSTs	4.9	5.0	11.5	5.1	7.5	7.7	6.2	9.5	9.7	11.5	11.7	11.7	11.7	11.7
Additional Consultant Recruitment	0.0	4.6	4.6	3.6	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estimated Headcount (HC)	95	103	119	125	134	140	144	151	159	169	179	188	197	205

Irish-trained CSCSTs refers to individuals appointed to consultant posts who were awarded CSCST in Ireland. Additional consultant recruitment refers to individuals appointed to consultant posts who completed specialty training outside of the Irish training programme. Some totals may not sum exactly due to rounding errors.

7.6 Recommendations

Current HST intake for medical oncology is 8 trainees per year. This should be increased to 14 trainees per year by 2028. This will initially be achieved by incorporating equivalent competence routes into the structured HST programme and then by identifying further NTSD posts in Type 1 Cancer Centres which are suitable for conversion to training posts. An additional 18 consultants will need to be recruited from outside of the domestic training pipeline to bridge the supply gap while the training programme builds in capacity.

Estimating demand should be repeated around 2028-2030 with revised recommendations issued, if necessary. This will ensure that the consultant workforce beyond 2030 is aligned with the needs of the population, accounting for developments within the health service, therapeutic treatments, and demographic change.

7.7 Regional Workforce Planning

Table 35 outlines the proposed regional workforce expansion roadmap for medical oncology in which the consultant workforce is distributed amongst Type 1-3 cancer treatment centres as outlined above. This regional roadmap is illustrative of how the workforce may develop at a regional level but is subject to many factors such as the appointment of new consultant posts, infrastructure development, and funding allocation, all of which are beyond the scope of this report.

Table 35: Regional workforce expansion profile to meet consultant demand in medical oncology to 2038 in medical oncology.

Health Region	2024		2030		2038	
	WTE	WTE/100k	WTE	WTE/100k	WTE	WTE/100k
Dublin Northeast	12.1	1.0	22.9	1.7	34.6	2.5
Dublin Midlands	16.6	1.4	20.7	1.6	26.3	2.0
Dublin Southeast	15.6	1.5	25.8	2.4	37.0	3.3
Southwest	9.2	1.2	15.6	1.9	22.7	2.7
Midwest	6.0	1.4	10.0	2.2	14.3	3.1
West Northwest	12.0	1.5	18.8	2.3	26.3	3.1
Private	11.6		15.2		20	
Total	83.1	1.6	128.9	2.2	181.1	3.0

8. Neurology

Neurology is the medical specialty concerned with the structure and function of the central and peripheral nervous systems, encompassing disorders of the brain, spinal cord, peripheral nerves, neuromuscular junction, and muscle. Neurologists diagnose and manage a wide range of conditions including stroke, epilepsy, movement disorders, Multiple Sclerosis (MS), neuromuscular disease, dementia, headache, and functional neurological disorders, with a substantial component of chronic disease management.

While primarily outpatient-based, neurologists provide essential inpatient consultation to ICU, acute medicine, stroke, and surgical services, and contribute to neuro-rehabilitation. The specialty interfaces closely with clinical neurophysiology, neuropsychiatry, and neurosurgery.

8.1 Neurology Services in Ireland

Adult neurology services operate under the auspices of the NCP for Neurology. [11] As of 2024, neurology services are present in 21 of 36 public hospitals, but only Model 4 hospitals have substantial inpatient neurology capacity. The MoC for Neurology recommends that there should be dedicated neurology wards across all Model 4 and Model 3 hospitals. [27] However, dedicated neurology wards remain the exception rather than the rule.

8.2 Neurology Training Pathway

Entry into HST in neurology in RCPI requires completion of BST in GIM and achievement of the MRCP or an equivalent qualification. [14] The HST programme spans five years and adopted an outcome-based curriculum in 2023. It aligns with European, Australasian, and North American standards and focuses on nine core domains:

- Cognition and consciousness
- Headache and cranial neuralgias
- Seizures and epilepsy
- Movement disorders
- Neuromuscular disorders
- Cerebrovascular disorders
- Neuroinflammatory disorders
- Neuroinfectious disease
- Functional neurological disorders

Training includes rotations in clinical neurophysiology, neuroimaging interpretation, neuropathology, ICU, acute stroke medicine, and specialised clinics. Trainees are awarded the CSCST on completion of the programme and are eligible for inclusion on the Specialist Division of the IMC.

8.3 Neurology Workforce Analysis

The status of the neurology medical workforce as of December 2024 is summarised in Table 36, with Table 37 providing a detailed overview of the clinical settings and Health Regions in which publicly funded consultant neurologists are based.

Table 36: Baseline medical workforce in neurology, December 2024. [6, 8]

Variable	Value
Consultant HSE funded services (HC)	71
Consultant HSE funded services (WTE)	63.9
WTE rate HSE funded services	87% (male) 93% (female) 90% (average)
Gender balance consultants HSE funded services	58% male, 42% female
Expected retirements by 2038 (HC)	22 (15 male, 7 female) – aged 62 18 (13 male, 5 female) – aged 65
Exclusive private sector consultants (HC)	9
Exclusive private sector consultants (WTE)	5.4
HST Years 1-5 (HC)	40
NTSDs	45

Table 37: Location of publicly funded consultant neurologists in WTE, December 2024.

Health Region	Model 4	Model 3	Specialist Maternity	Academic	Total
Dublin Northeast	16.4	2.2			18.6
Dublin Midlands	13.2	0.7		0.5	14.4
Dublin Southeast	8.4	0.4		0.6	9.4
Southwest	5.9	1.7	0.5		8.1
Midwest	4				4
West Northwest	5.7	3.2		0.5	9.4
Total	53.6	8.2	0.5	1.6	63.9

International Comparison

A study of the size of the neurology medical workforce (in WTE/100k population) in several international jurisdictions was carried out as a benchmarking exercise. The results of this are summarised in Table 38.

Table 38: International comparison of the neurology medical workforce in WTE/100k.

	Ireland ¹ [6, 8]	England ² [37, 48]	Scotland ² [38, 48]	Wales ² [39, 48]	Australia ¹ [65, 66]	New Zealand ¹ [36, 67]	Canada ¹ [35]
Consultants	1.3	1.75	1.55	1.11	2.84	1.20	3.30
Trainees	0.87	1.52	0.65	0.68	0.00	0.22	0.00
NTSDs	0.84	0.11	0.27	0.00	0.00	0.14	0.00

1: Combined public + private workforce.

2: NHS workforce.

8.4 Demand

Unmet Demand in Neurology

The volume of individuals recorded on NTPF waiting lists for neurology indicates a significant unmet demand for services, with approx. 22,000 patients awaiting services as of June 2025, see Table 39. Furthermore, the proportion of patients awaiting services for more than 18 months grew by an average of 1.5% each month over the course of 2025, indicating a sustained unmet demand for services.

Table 39: NTPF waiting list records for neurology as of June 2025. [33]

Duration	Inpatient/Daycase	Outpatient
0-6 Months	11,333	208
6-12 Months	5,222	55
12-18 Months	2,960	22
18+ Months	2,444	15
Total	21,959	300

In addition to patient waiting lists, unmet demand for consultant neurologists can be quantified by the existing gap to recommended consultant staffing levels across different hospitals. The MoC for Neurology sets out the expectation that each academic teaching hospital should have:

- A minimum of three consultant neurologists per service.
- On-site access to CN, neuroimaging, and multidisciplinary rehabilitation.
- Collaboration with related NCPs (Rehabilitation Medicine, Stroke, Dementia, Older Persons, Acute Medicine, Epilepsy, Critical Care). [13, 78-83]

Furthermore, regional coverage is uneven, with consultant concentration in Dublin and Cork and shortfalls across the Midwest, West-Northwest, and Southeast regions. Neurology services are increasingly dependent on telemedicine and cross-regional support to meet acute and chronic care demands.

Drivers of Demand for Neurology

Neurology is heavily impacted by demographic ageing, where growth in the older population will drive increases in stroke, dementia, neuropathy, and other neurodegenerative diseases. Neurology services underpin multiple NCPs such as Stroke, Dementia, Rehabilitation, Older Persons, and Critical Care, with increasing prevalence of comorbidities and complex therapies for conditions such as MS, migraine, Parkinson's disease, epilepsy, transthyretin amyloidosis, and other neuro-genetic diseases requiring neurologist input as part of MDTs. Table 40 outlines the projected growth rates in a number of conditions driving future demand for neurology services

Table 40: Overview of projected growth in selected neurological conditions which are anticipated to drive demand for neurology services in the coming years.

Disease/Condition	Projected Annual Growth Rate	Details	Sources
Dementia	3.9%	Projections of overall dementia prevalence in Ireland adapted to recent demographic projections.	[34, 58]
Stroke	2%	Stroke incidence projections for the Irish population.	[84]
Post-stroke dementia	1.9-2.4%	Post-stroke dementia prevalence projections for the Irish population, with different scenarios for case fatality and incidence.	[85]
Parkinson's disease	3%	Age-related prevalence derived from review and meta-analysis of studies on Parkinson's prevalence applied to Irish population projections.	[34, 86]
Amyloidosis*	2-3%	Age-related prevalence reported in the UK and USA applied to Irish population projections.	[34, 59, 60]
Epilepsy	N/A	WHO report that incidence in Europe expected to increase, underpinned by demographic ageing.	[57]

*These projections relate to systemic amyloidosis across all subtypes. However, demand for neurological services is primarily driven by neuropathy-associated forms.

The MoCs for Stroke and Dementia outline new and expanded clinical services across acute stroke units, Regional Specialist Memory Clinics (RSMCs), and Memory Assessment (MASS) clinics which are staffed, in part, by consultant neurologists. [78, 80] The NCPs for Epilepsy and Amyloidosis also require neurologist input. Increased complexity of therapies also raises consultant oversight requirements.

Future Demand in Neurology

Stakeholder input outlined an ambition to establish neurology departments in every Model 4 and Model 3 hospital in Ireland to ensure equitable and timely access to services for patients. Currently, not all such hospitals host neurology departments. Additionally, demand for consultant neurologists was mapped out in collaboration with specialty stakeholders to support MoCs in Neurology, Stroke, Dementia, Epilepsy, and Amyloidosis. [27, 45, 61, 62, 78, 79]

The demand for consultant neurologists by clinical site type is summarised in Table 41. These values reflect the consultant requirements for establishing inpatient neurology departments in every Model 3 and Model 4 acute hospital. Additionally, Bantry General Hospital (a Model 2 hospital) is included in this exercise, as this site currently has 24/7 medical admissions and covers a remote geographic area of the Southwest Health Region which is distant from the nearest Model 4 or 3 hospitals in Cork or Tralee, respectively. The consultant demand per site type reflects the complexity and volume of work in each site type. In practice, the consultant workforce in some sites may ultimately deviate from the values given here, but the national aggregate is expected to remain broadly the same.

Consultant demand for stroke services are configured to support the National Stroke Strategy, with acute stroke units established in every Model 3 and Model 4 hospital, plus Bantry General Hospital. The demand for consultant neurologists in stroke services in Table 41 accounts for the

fact that acute stroke units will be jointly staffed by consultant geriatricians. [79] In addition to individual acute stroke units, the National Thrombectomy Service is developing 24/7 Endovascular Thrombectomy (EVT) services in Beaumont and Cork University Hospitals, with consultant workforce uplift required to support these services.

Finally, national demand for consultant neurologists accounts for consultant demand in MASS clinics and RSMCs. The values in Table 41 reflect the specific demand for consultant neurologists, with further consultant staffing in these clinics expected to be filled by consultant geriatricians and psychiatrists, in accordance with the National Dementia Strategy. [78]

Aggregating the above to a national level, a consultant demand of 164 WTE is calculated. This is considered the minimum requirement to staff services with consultant neurologists without further considerations of demographic ageing, population growth, or increased disease presence. Inclusion of the private sector brings total estimated consultant demand for neurology to 177 WTE in 2038. Supply recommendations outlined below are configured to reach this target. However, demand estimates for neurology should be recalculated around 2028-2030 to account for service developments, advances in diagnostics and therapeutics, and revised demographic data, with revised supply recommendations issued at that stage.

Table 41: Staffing model comprising demand for consultant neurologists across neurology, stroke, and dementia services.

Acute Hospital Neurology		Acute Stroke Services		Dementia Services	
Hospital Model	WTE	Stroke Unit	WTE	Clinic Type	WTE
Model 4	5	Per Acute Hospital	0.75	Regional Specialist Memory Clinic (RSMC)	1 per clinic
Model 3	4				
Model 2*	3	Additional Uplift for Beaumont & Cork (EVT)	5.5	Memory Assessment (MASS) Clinic	0.3 per 150k population

*At present, Bantry General Hospital is the only Model 2 hospital for which there are plans for full neurology services, as this hospital has 24/7 medical admissions. No other Model 2 hospitals are currently under consideration.

Neurology Demand Summary

Demographic ageing	Population aged 60-85 to grow by 2.6% annually to 2038. Population aged >85 to grow 5.5% annually. See Section 4.3. Higher rates of stroke, dementia, neurodegeneration, etc.
Unmet demand	Significant waiting lists; limited consultant distribution; absent services in some hospitals.
Care pathways	Neurology staffing by hospital model. Acute stroke unit in each hospital. RSMCs and MASS clinics.
Complexity	Growth in MS, migraine, Parkinson's disease, epilepsy, and neurogenetic therapies requiring specialist oversight.
Future demand 2038	177 WTE (public + private).

8.5 Supply of Consultants for Neurology

The gap between consultant demand and supply in neurology necessitates increasing HST intake and recruiting additional consultants who trained outside the domestic training pipeline by 2030/2031. These individuals may be Irish doctors currently undertaking training abroad or may be entirely new to Ireland. The consultant workforce is expected to be supplied via the HST programme beyond 2030, with short term consultant recruitment serving to establish services around the country to facilitate a number of care pathways which depend on neurologist support. The supply model assumptions for neurology are summarised in Table 42.

Table 42: Assumptions in modelling supply of consultants into the neurology workforce.

Modelling Parameter	Assumption
Baseline workforce (WTE)	74.7
Post-CSCST attrition rate	Initially: 20% Decreasing to: 10%
Retirement age	62
CSCST-consultant gap (years)	2
WTE rate	Initially: 91% Decreasing to: 87%
Private sector capacity	8% of public capacity

Training Intake and Additional Recruitment

A recommended roadmap for HST intake and additional recruitment is summarised in Table 43. Approx. 34 consultants will need to be recruited from outside the training pipeline to meet immediate consultant demand while the HST programme builds capacity.

Table 43: Recommended HST annual intake and additional consultant recruitment for neurology to meet consultant demand.

	2025	2026	2027	2028	2029	2030
HST intake	9	11	13	14	14	14
Additional Recruitment	6	6	6	6	5	5

Detailed Supply Summary

Table 44 provides a detailed summary of key annual metrics relating to the supply of consultant neurologists based on the recommendations set out in Table 43. The specific annual values would be different if, for example, the rate of CSCST output or additional recruitment differs from that outlined in this report. The total workforce (in WTE) for 2025 is aligned with what was recorded on DIME for December 2025.

Table 44: Detailed summary table for supply of consultant neurologists based on recommendations to meet consultant demand in 2038.

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Consultant Supply (WTE) (@ year-end)	78.4	87.6	99.0	110.0	116.8	125.9	130.5	134.9	140.1	146.7	154.4	161.8	169.1	176.7
Replacement Posts (WTE) (Retirements & exits)	1.8	0.7	0.7	1.4	1.8	1.8	1.9	2.9	2.9	3.0	2.6	2.7	2.7	3.4
New Posts (WTE) (Service expansion)	6.5	9.2	12.2	10.9	6.6	9.0	4.5	4.4	6.0	7.5	8.5	8.4	8.3	7.6
Total Recruitment (WTE)	8.3	9.9	13.0	12.3	8.4	10.8	6.4	7.3	8.9	10.4	11.1	11.1	11.0	11.0
Irish-Trained CSCSTs	2.9	4.5	7.5	6.9	3.9	6.3	6.4	7.3	8.9	10.4	11.1	11.1	11.0	11.0
Additional Consultant Recruitment	5.4	5.4	5.4	5.4	4.5	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estimated Headcount (HC)	86	97	110	122	129	139	144	150	157	166	176	185	194	203

Irish-trained CSCSTs refers to individuals appointed to consultant posts who were awarded CSCST in Ireland. Additional consultant recruitment refers to individuals appointed to consultant posts who completed specialty training outside of the Irish training programme. Some totals may not sum exactly due to rounding errors.

8.6 Recommendations

The main recommendations to ensure the neurology workforce is equipped for the future demands of the specialty are as follows:

- HST intake building from current levels of 8 per annum to 14 per annum.
- Recruitment of 34 additional consultants from outside of the domestic training pipeline in the short term.
- Revise demand estimates around 2028-2030 and updated recommendations at this stage.

Expansion of the training programme should be enabled chiefly by conversion of NTSD posts to structured training posts. Subspecialty training will encompass stroke, epilepsy, neuromuscular disease, and neurophysiology. Accompanying service developments such as infrastructure investments in neurology wards and development/enhancement of integrated care pathways with other clinical programmes will also be necessary but are beyond the scope of this report.

8.7 Regional Workforce Planning

Table 45 outlines the proposed regional workforce expansion roadmap for neurology. This reflects the existing and planned location of clinical services. Note that workforce expansion is not equally distributed across the Health Regions, as current services are focused in Dublin-Northeast with service deficits particularly acute in Southwest and West-Northwest. The precise allocation of consultant resources across clinical sites is a matter for the relevant NCPs and is subject to future service pressures and revised priorities as development of services progresses.

Table 45: Regional workforce expansion profile to meet consultant demand for 2038 in neurology.

Health Region	2024		2030		2038	
	WTE	WTE/100k	WTE	WTE/100k	WTE	WTE/100k
Dublin Northeast	20.2	1.6	30.7	2.3	39.8	2.9
Dublin Midlands	14.5	1.3	25.4	2.0	35.2	2.7
Dublin Southeast	10.4	1.0	19.6	1.8	28.0	2.5
Southwest	8.0	1.0	18.0	2.2	27.2	3.2
Midwest	4.0	0.9	5.5	1.2	6.7	1.4
West Northwest	8.5	1.1	18.2	2.2	27.2	3.2
Private	5.5		8.7		13	
Total	71.1	1.3	126	2.2	177	3.0



9. Palliative Medicine

Palliative care improves quality of life for people with life-limiting or life-threatening illness (and their families) by preventing and relieving suffering through early identification, assessment, and management of pain and other physical and psychosocial problems. It is both an approach to care and a set of consultant-led services delivered within an integrated network of generalist and specialist providers. Consultants in palliative medicine play a central role in leading specialist palliative care services, providing expert clinical input for patients with complex symptom burdens, supporting MDTs, and advising generalist clinicians managing patients with life-limiting illness.

9.1 Palliative Medicine Services in Ireland

Palliative care services in Ireland are organised across three levels of need: [26]

- Palliative care approach (all healthcare providers),
- General palliative care (intermediate expertise),
- Specialist palliative care (consultant-led teams for highest complexity).

Specialist services are centred on specialist palliative care units (hospices), typically comprising an inpatient unit, education & research, community palliative care, ambulatory/day services, and bereavement supports, with formal links to hospital-based teams. Care is configured to enable seamless transitions between hospital, hospice, and community based on need and preference. The 2019 MoC and the 2024 National Adult Palliative Care Policy target universal palliative care, framed by four objectives; Right Care, Right Place & Time, Right People, and Good Governance; delivered via integrated generalist/specialist networks mapped to the six HSE Health Regions. [87]

9.2 Palliative Medicine Training Pathway

HST in palliative medicine in RCPI is a five-year outcome-based curriculum structured around six key training goals principles:

- Communication
- Optimising comfort/quality of life
- Care planning & collaboration
- Cultural/spiritual care (loss, grief, bereavement)
- Professional/ethical practice
- Core professional skills and required experiences. [14]

Entry to the programme and requires completion of BST in GIM and achievement of the MRCPI or an equivalent qualification, plus at least one additional year of experience in clinical practice of GIM. Upon completion, candidates are awarded the CSCST and are eligible for inclusion on the Specialist Division of the IMC.

9.3 Palliative Medicine Workforce Analysis

The status of the palliative medicine medical workforce as of December 2024 is summarised in Table 46, with Table 47 providing a detailed overview of the clinical settings and Health Regions in which publicly funded consultants in palliative medicine are based.

Table 46: Baseline medical workforce in palliative medicine, December 2024. [6, 8]

Variable	Value
Consultant HSE funded services (HC)	66
Consultant HSE funded services (WTE)	52.1
WTE rate HSE funded services	81% (male) 78% (female) 79% (average)
Gender balance consultants HSE funded services	21% male, 79% female
Expected retirements by 2038 (HC)	22 (8 male, 14 female) – aged 62 20 (8 male, 12 female) – aged 65
Exclusive private sector consultants (HC)	3
Exclusive private sector consultants (WTE)	1.5
HST Years 1-5 (HC)	24
NTSDs	32

Table 47: Location of publicly funded consultants in palliative medicine in WTE, December 2024. [6]

Health Region	Model 4	Model 3	Model 2	Hospice	Community	Specialist Oncology/ Radiotherapy	Specialist Paediatric	Academic	Total
Dublin Northeast	3.4	4.2	0.2	4.4					12.2
Dublin Midlands	3.7	1.8			0.5	0.3		0.3	6.6
Dublin Southeast	3	0.4	0.4	5.9	0.4			0.3	10.4
Southwest	2.2	3.3	0.7	3.3					9.5
Midwest	0		0.5		1.5				2
West Northwest	3.5	2.8	0.2	2.6	2.1				11.2
CHI							0.2		0.2
Total	15.8	12.5	2	16.2	4.5	0.3	0.2	0.6	52.1

International Comparison

A study of the size of the palliative medicine consultant workforce (in WTE/100k population) in several international jurisdictions was carried out as a benchmarking exercise. The results of this are summarised in Table 48.

Table 48: International comparison of the palliative medicine medical workforce in WTE/100k.

	Ireland ¹ [6, 8]	England ² [37, 48]	Scotland ² [38, 48]	Wales ² [39, 48]	Australia ¹ [65, 66]	New Zealand ¹ [36, 67]	Canada ¹ [35]
Consultants	1.00	0.72	0.72	0.89	1.39	1.54	1.57
Trainees	0.49	0.64	0.82	1.10	0.00	0.34	0.00
NTSDs	0.57	0.17	0.30	0.04	0.00	0.62	0.00

1: Combined public + private workforce.

2: NHS workforce.

9.4 Demand

Unmet Demand for Palliative Medicine

The National Adult Palliative Care Policy highlights significant variation in access to specialist palliative care services across Ireland, with uneven availability of community teams, inpatient hospice beds, and specialist support in acute hospitals. [26] Service provision was historically developed around end of life and cancer care and remains concentrated in certain regions, resulting in inequities in access for patients with other life-limiting conditions and for those living outside major urban centres. In addition, many patients who could benefit from earlier palliative care involvement are referred late in the disease trajectory, often during the final stages of illness. Expansion of consultant-delivered specialist palliative care services will be required to address these gaps and support more timely access to care.

Drivers of Demand for Palliative Medicine

Demand for palliative care services is driven by demographic ageing, increasing prevalence of chronic illness, and improved survival from serious disease. The ageing population will result in conditions such as cancer, cardiovascular disease, respiratory illness, and neurodegenerative disease becoming more common, increasing the number of patients who may benefit from palliative care. In addition, the CSO projects that the annual number of deaths is projected to increase by approximately 1.8% per year to 2038, reflecting both population growth and ageing. [34] A growing proportion of these deaths will involve individuals living with complex life-limiting illnesses, multimorbidity, and prolonged disease trajectories that require specialist symptom management, care planning and coordination of services.

At the same time, the role of palliative care in Ireland is expanding beyond the traditional emphasis on care in the final stages of life towards earlier involvement in the management of life-limiting illness to support quality of life, symptom control, and patient-centred care planning over longer disease treatment times. As a result, palliative care services are supporting patients for longer periods and across a wider range of clinical conditions. Consultants in palliative medicine play a central role within this model, providing consultant delivered services, supporting MDTs, and contributing to integrated care pathways across hospital, hospice, and community settings. Table 49 outlines the projected growth rates in a number of conditions which are expected to impact demand for palliative care services in the coming years.

Table 49: Overview of projected growth in selected conditions which are anticipated to drive demand for palliative medicine services in the coming years.

Disease/Condition	Projected Annual Growth Rate	Details	Sources
Cancer	1.3%	Overall cancer incidence rate in Ireland to grow by 1.3% annually to 2038, with increased survivorship and on-going symptom management and complex care.	[69]
Dementia	3.9%	Projections of overall dementia prevalence in Ireland adapted to recent demographic projections.	[34, 58]
Stroke	2%	Stroke incidence projections for the Irish population.	[84]
Post-stroke dementia	1.9-2.4%	Post-stroke dementia projections for the Irish population, with different scenarios for case fatality and incidence.	[85]
Parkinson's disease	3%	Age-related prevalence derived from review and meta-analysis of studies on Parkinson's prevalence applied to Irish population projections.	[34, 86]

Future Demand in Palliative Medicine

The MoC for Palliative Medicine outlines a consultant demand of 2.79 WTE per 100,000 population, equating to a total demand of 166.9 WTE in 2038. [26] Stakeholder input led to an assumption that the private sector will comprise 5% of the total national demand, leading to demand of 158.4 WTE in public services and 5.8 WTE in private services.

Palliative Medicine Demand Summary

Demographic ageing	Population aged 60-85 to grow by 2.6% annually to 2038. Population aged >85 to grow 5.5% annually. See Section 4.3. Ageing population with advanced multi-morbidity.
Annual deaths	Increasing by 1.8% annually.
Unmet demand	Uneven access; rising complexity; insufficient specialist coverage.
Service models	Palliative care services increasingly delivered earlier in life-limiting illnesses, moving away from simple end of life care. Universal access via regional networks; consultant-led MDTs.
MoC for Palliative Care	2.79 WTE per 100,000 population Equitable access across Health Regions.
Future demand 2038	166.9 WTE (public + private).

9.5 Supply of Consultants for Palliative Medicine

There is a substantial gap between current supply of consultants in palliative medicine and the estimated future demand. Bridging this gap will necessitate significantly increasing the annual intake into HST, while also recruiting a number of consultants who specialised outside the Irish domestic training pipeline. These individuals may be Irish doctors currently undertaking training abroad or may be entirely new to Ireland. The supply model assumptions for palliative medicine are summarised in Table 50.

Table 50: Assumptions in modelling supply of consultants into the palliative medicine workforce.

Modelling Parameter	Assumption
Baseline workforce (WTE)	53.8
Post-CSCST attrition rate	10%
Retirement age	62
CSCST-consultant gap (years)	2
WTE rate	Initially: 78% Increasing to: 86%
Private sector capacity	5.3% of public capacity

Training Intake and Additional Recruitment

Current HST intake stands at 8 trainees per annum. This should be gradually increased to an annual intake of 16 trainees by 2030. In the short to medium term, immediate consultant demand can be met by recruiting 40-45 consultants to posts from outside the training pipeline. A proposed roadmap for this is summarised in Table 51.

Table 51: Recommended HST annual intake and additional consultant recruitment for palliative medicine to meet consultant demand.

	2025	2026	2027	2028	2029	2030
HST intake	8	10	12	14	16	16
Additional Recruitment	12	6	6	5	5	5

Detailed Supply Summary

Table 52 provides a detailed summary of key annual metrics relating to the supply of consultants in palliative medicine based on the recommendations set out in Table 51. The specific annual values would be different if, for example, the rate of CSCST output or additional recruitment differs from that outlined in this report. The total workforce (in WTE) for 2025 is aligned with what was recorded on DIME for December 2025.

Table 52: Detailed summary table for supply of consultants in palliative medicine to meet consultant demand in 2038.

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Consultant Supply (WTE) (@ year-end)	64.1	76.5	92.8	98.7	106.2	106.2	110.2	115.8	123.2	132.2	142.7	150.8	158.8	166.8
Replacement Posts (WTE) (Retirements & exits)	1.7	1.8	1.9	2.0	2.1	2.2	2.3	2.4	2.1	2.2	2.2	4.6	4.7	4.7
New Posts (WTE) (Service expansion)	10.3	6.6	15.4	4.8	7.3	0	4.0	5.6	7.4	9.0	10.5	8.1	8.1	8.0
Total Recruitment (WTE)	12.0	8.4	17.3	6.8	9.4	1.8	6.4	8.0	9.5	11.1	12.7	12.7	12.7	12.7
Irish-Trained CSCSTs	1.5	3.1	11.9	2.3	4.8	0.0	6.4	8.0	9.5	11.1	12.7	12.7	12.7	12.7
Additional Consultant Recruitment	10.4	5.3	5.3	4.5	4.5	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estimated Headcount (HC)	75	88	106	111	119	119	124	130	138	149	160	170	179	188

Irish-trained CSCSTs refers to individuals appointed to consultant posts who were awarded CSCST in Ireland.

Additional consultant recruitment refers to individuals appointed to consultant posts who completed specialty training outside of the Irish training programme. Some totals may not sum exactly due to rounding errors.

9.6 Recommendations

The agreed annual intake to HST currently sits at 8 per annum, with this number enrolling in July 2025. HST intake should be gradually increased to 16 per year by 2030 and sustained at this level. It is expected that this increase in training posts will be supported by converting NTSD posts to structured training posts. In addition to increased training capacity, it will be necessary to recruit 40-45 additional consultants who specialised outside of the Irish domestic training pipeline to bridge the supply gap and reach the demand target by 2038. This recruitment would be spread over the next 6-8 years to enable service expansion until the HST programme output has increased. A review of demand estimates and resulting supply recommendations will be necessary in 3-5 years' time to ensure that the training and recruitment roadmap is aligned with service and population demands.

9.7 Regional Workforce Planning

Table 53 outlines the proposed regional workforce expansion roadmap for palliative medicine. This regional roadmap is illustrative of how the workforce may develop at a regional level but is subject to many factors such as the pace at which acute and community patient services are developed, appointment of new consultant posts, infrastructure development, and funding allocation, all of which are beyond the scope of this report.

Table 53: Regional workforce expansion profile to meet consultant demand for 2038 in palliative medicine.

Health Region	2024		2030		2038	
	WTE	WTE/100k	WTE	WTE/100k	WTE	WTE/100k
Dublin Northeast	12.2	1.0	24.6	1.9	36.7	2.6
Dublin Midlands	6.6	0.6	23.5	1.9	35.1	2.6
Dublin Southeast	10.4	1.0	19.8	1.9	29.5	2.6
Southwest	9.5	1.2	14.9	1.9	22.2	2.6
Midwest	2	0.5	8.2	1.8	12.3	2.6
West Northwest	11.2	1.4	15.0	1.8	22.5	2.7
CHI	0.2					
Private	1.5		2.5		8.5	
Total	52.1	1.0	95.4	1.9	166.7	2.8

10. Rehabilitation Medicine

Rehabilitation medicine is the branch of medicine dedicated to optimising function, independence, and quality of life for people who have experienced illness, injury, or disability. It takes a holistic and multidisciplinary approach, focusing not only on physical recovery but also on psychological adjustment, symptom control, and social reintegration. The specialty works closely with patients and their families to maximise participation in daily life and collaborates extensively with other fields such as neurology, neurosurgery, trauma, vascular surgery, and oncology.

10.1 Rehabilitation Medicine Services in Ireland

In the Irish context, rehabilitation medicine encompasses care from acute hospital to community settings, addressing the needs of people recovering from stroke, brain and spinal injury, limb loss, major trauma, and other disabling conditions. It provides both inpatient and community-based rehabilitation through structured programmes and Managed Clinical Rehabilitation Networks (MCRNs), with consultant specialists leading interdisciplinary teams to deliver complex, person-centred care. [28].

The MCRN approach is the cornerstone of service delivery in rehabilitation medicine in Ireland, structured across three tiers of care: tertiary specialist inpatient, regional specialist inpatient, and specialist community rehabilitation. These networks should be aligned with the six HSE Health Regions to ensure a coherent, regionally based system that integrates acute, post-acute, and community rehabilitation services. This approach underpins the demand for and organisation of rehabilitation medicine consultants around the country.

At present, the consultant workforce in rehabilitation medicine is heavily concentrated in the National Rehabilitation Hospital (NRH) in the Dublin Southeast Health Region, with some of these consultants having “outreach” clinics in other Dublin hospitals. The NRH is the national complex specialist centre (brain injury, stroke, spinal cord, limb absence/POLAR, paediatrics, and outpatient/outreach), with 120 single en-suite inpatient beds and day-case capacity. Outside the NRH, the consultant workforce is sparse but still focused on Dublin hospitals, with two consultants based in the Southwest region. The entire Midwest and West-Northwest Health Regions have no regular systematic rehabilitation medicine consultant or inpatient services. This is reflected in Table 55, which shows the location of consultants in rehabilitation medicine as of December 2024.

10.2 Rehabilitation Medicine Training Pathway

HST in rehabilitation medicine in RCPI is four years in duration and requires completion of BST in GIM and achievement of the MRCPI or an equivalent qualification. [14] Upon completion, candidates are awarded the CSCST and are eligible for inclusion on the Specialist Division of the IMC.

10.3 Rehabilitation Medicine Workforce Analysis

The status of the rehabilitation medicine medical workforce as of December 2024 is summarised in Table 62, with Table 63 providing a detailed overview of the clinical settings and Health Regions in which publicly funded consultants in rehabilitation medicine are based.

Table 54: Baseline medical workforce in rehabilitation medicine, December 2024. [6, 8]

Variable	Value
Consultant HSE funded services (HC)	18
Consultant HSE funded services (WTE)	14.9
WTE rate HSE funded services	83% (male) 82% (female) 89% (average)
Gender balance consultants HSE funded services	33.3% male, 66.7% female
Expected retirements by 2038 (HC)	10 (7 male, 3 female) – aged 62 8 (7 male, 1 female) – aged 65
Exclusive private sector consultants (HC)	0
Exclusive private sector consultants (WTE)	0
HST Years 1-4 (HC)	5
NTSDs	17

Table 55: Location of publicly funded consultants in rehabilitation medicine in WTE, December 2024. [6]

Health Region	Specialist Rehabilitation	Model 4	Model 3	Academic	Total
Dublin Northeast	0.5	3.3			3.8
Dublin Midlands	0.2	1.5			1.7
Dublin Southeast	7.1			0.5	7.6
Southwest		1.2	0.6		1.8
Midwest					
West Northwest					
Total	7.8	6	0.6	0.5	14.9

International Comparison

A study of the size of the rehabilitation medicine medical workforce (in WTE/100k population) in several international jurisdictions was carried out as a benchmarking exercise. The results of this are summarised in Table 56.

Table 56: International comparison of the rehabilitation medicine medical workforce in WTE/100k.

	Ireland ¹ [6, 8]	England ² [37, 48]	Scotland ² [38, 48]	Wales ² [39, 48]	Australia ¹ [65, 66]	New Zealand ¹ [36, 67]	Canada ¹ [35]
Consultants	0.30	0.28	0.33	0.19	2.01	0.58	1.57
Trainees	0.13	0.40	0.31	0.12	0.00	0.18	0.00
NTSDs	0.32	0.11	0.09	0.09	0.00	0.12	0.00

1: Combined public + private workforce.

2: NHS workforce.

10.4 Demand

Unmet Demand for Rehabilitation Medicine

Rehabilitation medicine is not included on NTPF waiting list reports. As such, it is not possible to quantify unmet demand on the basis of the number of patients and duration of time spent awaiting services.

Stakeholder input outlined significant gaps that exist in access to rehabilitation services, most acutely in equitable access to inpatient services around the country. In 2024, >99% of all hospital inpatient and day case attendances for rehabilitation medicine took place in the NRH. Of these attendances, 40% were by patients who provided their home address as being outside County Dublin. [31] In 2023, 87.5% of all outpatient activity in rehabilitation medicine took place in the NRH, although information on patient home residence was not available for this dataset. [32]

Further evidence on the unequal access to services around the country is borne out by the fact that DIME data for December 2024 indicates that 78.5% of national consultant WTE is accounted for in the NRH or the Model 4 hospitals in Dublin City, with 12% of consultant WTE in Cork City. [6] The remaining 9-10% of the national consultant WTE is allocated to smaller clinical and rehabilitation sites around Dublin. This outlines that all consultants in rehabilitation medicine are based in either Dublin or Cork, with no permanent consultant presence in the rest of the country.

While the NRH's status as a national tertiary referral centre will drive a large degree of centralisation of activity, the lack of access to inpatient and consultant delivered services outside of Dublin and Cork leads to prolonged waiting times, delayed discharge due to lack of rehabilitation beds, and limited specialist access for groups such as cancer survivors, critical illness survivors, functional neurological disorders, and mild traumatic brain injuries. Many community specialist rehabilitation teams are currently operating without input from consultants in rehabilitation medicine, owing to the poor reach of consultants across many parts of the country, highlighting the need to expand the consultant workforce.

Drivers of Demand for Rehabilitation Medicine

Demand for rehabilitation medicine services is influenced by a combination of demographic change, disease epidemiology, and improvements in survival following serious illness and injury. Demographic ageing is a key driver, as older populations have higher rates of chronic neurological conditions such as stroke, dementia, and Parkinson's disease, which contribute to sustained long-term demand for rehabilitation services. These conditions are frequently associated with progressive or persistent functional impairment, requiring specialist rehabilitation input and ongoing multidisciplinary management over the course of life.

Advances in acute medical care have significantly improved survivorship following stroke, major trauma, and neurosurgical, vascular, and oncological interventions. This has resulted in more patients living with complex disability who require prolonged and coordinated rehabilitation. As survival improves, a growing proportion of patients experience long-term functional impairments affecting mobility, cognition, communication and activities of daily living, requiring multidisciplinary rehabilitation across acute, post-acute and community settings. Table 57 outlines the projected growth rates in a number of conditions which are anticipated to impact demand for rehabilitation medicine services.

Table 57: Overview of projected growth in selected conditions which are anticipated to drive future demand for rehabilitation medicine services.

Disease/Condition	Projected Annual Growth Rate	Details	Sources
Stroke	2%	Stroke incidence projections for the Irish population.	[84]
Post-stroke dementia	1.9-2.4%	Post-stroke dementia prevalence projections for the Irish population, with different scenarios for case fatality and incidence.	[85]
Parkinson's disease	3%	Age-related prevalence derived from review and meta-analysis of studies on Parkinson's prevalence applied to Irish population projections.	[34, 86]
Cancer	1.3%	Overall cancer incidence rate in Ireland to grow by 1.3% annually to 2038, with increased survivorship and on-going complex care.	[69]
Dementia	3.9%	Projections of overall dementia prevalence in Ireland adapted to recent demographic projections.	[34, 58]

Future Demand in Rehabilitation Medicine

The total number baseline hospital attendances (inpatient and outpatient) are projected to grow by approx. 1% per year to 2038, based on projected demographic growth rates. As discussed above, the majority of activity underpinning this projected growth currently takes place in the NHR. Consequently, this growth rate does not capture increased demand for services based on servicing unmet demand and improving access to consultant delivered services around the country. Accordingly, future demand for consultants in rehabilitation medicine was not projected based on activity data but, rather, on the MoC for Rehabilitation Medicine recommendation of 1.5 WTE consultants per 250,000 population. Furthermore, stakeholders identified the need for further uplift in the workforce to fill roles in national leadership and academic research to ensure clinical WTE is not eroded by non-clinical activities. This is summarised in Table 58.

Table 58: Projected national demand for consultants in rehabilitation medicine 2038.

Demand Category	Source	Projected Consultant Demand (WTE)
Population Benchmark (1.5 WTE/250k)	MoC [28]	36
National Leadership	Stakeholder input	2.5
Academic Research	Stakeholder input	1
Total		39.5

To support the full implementation of the MoC, the future consultant workforce must be configured to strengthen both regional inpatient capacity and consultant-led community rehabilitation. Consultants will play a leading role in developing and integrating community rehabilitation teams, providing medical oversight, outreach, and governance for patients with complex needs in post-acute and community settings. These consultants will also support multidisciplinary collaboration and continuity of care between hospital and community services. As such, consultants in rehabilitation medicine should be based both within the NRH and across all six Health Regions.

This will allow each region to deliver the full three-tier model of rehabilitation, with consultant posts established in regional hospitals and major trauma centres so that patients can access specialist rehabilitation closer to home in a timely manner.

Rehabilitation Medicine Demand Summary

Demographic ageing	Population aged 60-85 to grow by 2.6% annually to 2038. Population aged >85 to grow 5.5% annually. See Section 4.3.
Increased survivorship	Higher survival after stroke (growing 2% annually), cancer (growing 1.3% annually), trauma, and neurosurgery
Unmet demand	Long waits; delayed discharge; insufficient specialist reach; underserved patient groups.
Service model	MCRN three-tier networks; need for consultant-led integration across regions. This will ensure appropriate staffing of tertiary, trauma, regional and community based services nationally. New inpatient services in underserved Health Regions. Collaboration with other specialties and services such as neurology, neurosurgery, trauma, vascular surgery, and oncology.
Population benchmark	1.5 WTE per 250,000 population. Leadership and research roles.
Future demand 2038	39.5 WTE (public only).

10.5 Supply of Consultants for Rehabilitation Medicine

The supply gap to estimated demand for consultants in rehabilitation medicine can largely be bridged through the HST programme provided that all training posts are filled each year. The number of individuals commencing HST in rehabilitation medicine has consistently been 0-2 trainees for the years prior to 2025. Maintaining this approach will not be sufficient to meet demand in 2038. However, filling the currently allocated training programme each year from 2025 onwards (4 trainees commenced HST in July 2025) will ensure that future demand can be met with minimal recruitment of doctors who trained outside of the domestic training pipeline. These individuals may be Irish doctors currently undertaking training abroad or may be entirely new to Ireland. The supply model assumptions for rehabilitation medicine are summarised in Table 59.

Table 59: Assumptions in modelling supply of consultants into the rehabilitation medicine workforce.

Modelling Parameter	Assumption
Baseline workforce (WTE)	14.8
Post-CSCST attrition rate	12%
Retirement age	62
CSCST-consultant gap (years)	2
WTE rate	Initially: 82% Increasing to: 86%
Private sector capacity	None

Training Intake and Additional Recruitment

Recommended annual intake to HST in rehabilitation medicine currently stands at 4 per annum, with this number of trainees commencing in July 2025. This level of annual intake should be sustained in the coming years. Additionally, 4 consultants will need to be recruited from outside of the domestic training pipeline to meet short term demand. Beyond this, future demand for consultants will be sustainably met entirely through the domestic training pipeline (Table 60).

Table 60: Recommended HST annual intake and additional consultant recruitment for rehabilitation medicine to meet consultant demand.

	2025	2026	2027	2028	2029	2030
HST intake	4	4	4	4	4	4
Additional Recruitment		2	2			

Detailed Supply Summary

Table 61 provides a detailed summary of key annual metrics relating to the supply of consultants in rehabilitation medicine based on the recommendations set out in Table 60. The specific annual values would be different if, for example, the rate of CSCST output or additional recruitment differs from that outlined in this report.

Table 61: Detailed summary table for supply of consultants in rehabilitation medicine to meet consultant demand in 2038.

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038
Consultant Supply (WTE) (@ year-end)	16.1	18.6	20.0	21.1	21.6	22.7	25.3	27.9	29.9	31.9	33.8	35.8	37.7	39.7
Replacement Posts (WTE) (Retirements & exits)	0.1	0.1	0.4	0.4	0.4	0.4	0.4	0.5	1.1	1.1	1.1	1.1	1.1	1.1
New Posts (WTE) (Service expansion)	1.3	2.3	1.3	1.1	0.3	1.1	2.6	2.6	2.0	2.0	1.9	2.0	1.9	1.9
Total Recruitment (WTE)	1.4	2.4	1.7	1.5	0.7	1.5	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Irish-Trained CSCSTs	1.4	0.7	0.0	1.5	0.7	1.5	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
Additional Consultant Recruitment	0.0	1.7	1.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Estimated Headcount (HC)	20	22	24	25	26	27	30	33	35	37	40	42	44	46

Irish-trained CSCSTs refers to individuals appointed to consultant posts who were awarded CSCST in Ireland. Additional consultant recruitment refers to individuals appointed to consultant posts who completed specialty training outside of the Irish training programme. Some totals may not sum exactly due to rounding errors.

10.6 Recommendations

The agreed annual intake to HST currently sits at 4 per annum, with this number enrolling in July 2025. However, rehabilitation medicine has historically had a lower intake of typically 0-2 trainees each year. Sustaining average intake at 4 per annum and recruiting a further 4 consultants from outside of this pipeline will see the consultant workforce grow to the required level nationally by 2038.

10.7 Regional Workforce Planning

Table 62 outlines the proposed regional workforce expansion roadmap for rehabilitation medicine. In line with MoC recommendations, each region is expected to build to a minimum of 4-5 consultants to support networked tertiary-acute-community care as outlined above. Further consultant staffing above this level will depend on the location of national or supra-regional services such as the NRH and Major Trauma Centres, with the precise distribution of the consultant workforce being a matter for the NCP to implement as inpatient and community services are established and developed around the country. NDTP is committed to supporting regional workforce planning across all specialties and will engage with the NCP as required over the coming years. It is anticipated that this workforce review will be repeated before 2030 to review workforce needs in line with ongoing service developments. The regional roadmap outlined below is illustrative of how the workforce may develop at a regional level but is subject to many factors such as the pace at which acute inpatient services are developed, appointment of new consultant posts, infrastructure development, and funding allocation, all of which are beyond the scope of this report.

Table 62: Regional workforce expansion profile to meet consultant demand for rehabilitation medicine to 2038 in rehabilitation medicine.

Health Region	2024		2030		2038	
	WTE	WTE/100k	WTE	WTE/100k	WTE	WTE/100k
Dublin Northeast	3.8	0.3	4.3	0.3	7.0	0.5
Dublin Midlands	1.7	0.1	2.3	0.2	6.0	0.5
Dublin Southeast	7.6	0.8	7.7	0.7	8.0	0.7
Southwest	1.8	0.2	3.0	0.4	6.0	0.7
Midwest		0.0	1.5	0.3	4.0	0.9
West Northwest		0.0	1.5	0.2	5.0	0.6
National			2.0		3.5	
Total	14.9	0.3	22.7	0.4	39.5	0.7

11. Summary Recommendations

Specialty	Workforce Recommendations
Clinical Neurophysiology	• Build consultant workforce to support equitable access to CN services and establish diagnostic services to support other specialties around the country. • Workforce target of 40 WTE by 2038 (public only). • Identification & conversion of NTSD posts to structured training posts to support HST expansion. • Increase HST annual intake to consistent 2 per annum. • Recruit 24 additional consultants from outside of the training pipeline in the short term. • Revise future demand estimates around 2028-2030.
Dermatology	• Future consultant workforce aligned with MoC for Dermatology and equipped to meet unmet and future demand. • Workforce target of 106.8 WTE by 2038 (public + private). • Sustain current HST intake level of 8 per annum. • Recruit 2 additional consultants from outside of the training pipeline in the short term.
Medical Oncology	• Build consultant workforce to achieve stakeholder-recommended staffing model per cancer treatment centre. • Future workforce expansion to keep abreast of epidemiological and therapeutic developments • Future workforce target of 181.1 WTE by 2038 (public + private). • Identification & conversion of NTSD posts to structured training posts to support HST expansion. In particular, incorporate unstructured recognition of equivalent competence into structured HST programme. • Increase HST intake to 14 per annum. • Recruit 18 additional consultants from outside of the training pipeline in the short term. • Revise future demand estimates around 2028-2030.
Neurology	• Build consultant workforce to support demand outlined in MoC for Neurology and national strategies for stroke and dementia. • Future workforce target of 177 WTE by 2038 (public + private). • Identification & conversion of NTSD posts to structured training posts to support HST expansion. • Increase HST intake to 14 per annum. • Recruit 34 additional consultants from outside of the training pipeline in the short term. • Revise future demand estimates around 2028-2030.
Palliative Medicine	• Build consultant workforce to support equitable access to specialist services around the country, supporting regional networks and consultant-led MDTs, as set out in the MoC for Palliative Care. • Future workforce target of 166.9 WTE by 2038 (public + private). • Increase HST intake to 16 per annum. • Recruit 40-45 additional consultants from outside of the domestic training programme in the short term.
Rehabilitation Medicine	• Build consultant workforce to extend equitable specialist care and inpatient services across the country and support integrated consultant-led care via MCRNs, as set out in the MoC for Rehabilitation Medicine. • Future workforce target of 39.5 WTE by 2038 (public only). • Increase HST intake to 4 per annum consistently (current agreed levels). • Recruit 4 additional consultants from outside of the domestic training programme in the short term.

12. Glossary

CN	Clinical Neurophysiology
BIU	Business Intelligence Unit
BST	Basic Specialist Training
CHI	Children's Health Ireland
CSCST	Certificate of Satisfactory Completion of Specialist Training
CSO	Central Statistics Office
DIME	Doctors Integrated Management E-System
EEG	Electroencephalogram
EMG	Electromyography
EP	Evoked Potentials
EVT	Endovascular Thrombectomy
EWTD	European Working Time Directive 2003/88/EC
GIM	General Internal Medicine
HSE	Health Service Executive
HST	Higher Specialist Training
ICU	Intensive Care Unit
IHA	Integrated Healthcare Area
IMC	Irish Medical Council
IONM	Intraoperative Neuromonitoring
ISCN	Irish Society of Clinical Neurophysiologists
LTFT	Less Than Full Time
MASS clinic	Memory Assessment clinic
MCCN	Managed Cancer Control Network
MDT	Multi-Disciplinary Team
MoC	Model of Care
MRCP	Membership of the Royal College of Physicians in Ireland
MWP	Medical Workforce Planning
NCCP	National Cancer Control Programme
NCHD	Non-Consultant Hospital Doctor
NCP	National Clinical Programme
NCRI	National Cancer Registry Ireland
NCS	Nerve Conduction Studies
NDTP	National Doctors Training & Planning Unit of the HSE
NRH	National Rehabilitation Hospital
NTPF	National Treatment Purchase Fund
NTSD	Non-Training Scheme Doctors
RCPI	Royal College of Physicians of Ireland
RSMC	Regional Specialist Memory Clinics
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent

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