

Irish Medical Organisation Opening Statement

Meeting of the Oireachtas Committee on the Future of Healthcare

(Wednesday 29th October 2016)

[Dr. Peadar Gilligan]

Madam Chairman, members of the committee, ladies and gentlemen, good morning.

Thank you for affording this opportunity to the Irish Medical Organisation to set out the views of doctors in Ireland on the future of Irish healthcare. As you are aware, the IMO is both the representative body and trade union for the medical profession in this country, representing all categories of doctors, from non-consultant hospital doctors, to community health doctors, public health doctors, general practitioners, and consultants. The experiences of the medical profession in Ireland have informed our submission to this Committee, and the development of a caring and effective health service is core to the IMO's mission.

The written submission made by our organisation to this Committee provides recommendations on a wide range of health service activities, however this morning I would like to focus the opening statement that Dr. McGarry and I are making on central aspects of the future of Irish healthcare: 1. capacity, 2. staffing, and 3. the role of general practice. These are system wide issues that, unless appropriately resolved, will inhibit development in other areas of the health service.

The media coverage of Irish healthcare frequently centres on acute or secondary care, and in particular emergency department over-crowding. As an emergency medicine consultant I have been witness to the very real impact on patient care that cuts in health service funding have had. Our ability to provide high quality care to patients in a timely manner is truly compromised in Ireland, as manifested by admitted patients spending in excess of twelve hours in emergency departments following a decision that admission is necessary, and the increasing waiting lists for planned care delivery. One of the most significant reductions made within the health service was to bed capacity and the effect of this is evident in every acute hospital in the country on a daily basis.

There are about 12,800 acute beds within the hospital system, 800 fewer than in 2007. Of these, 10,800 are in-patient beds, 1,300 fewer than in 2007. Contrast those 10,800 in-patient beds with the 14,700 in-patient beds the Department of

Health said back in 2003 that we would need by 2011, or the approximately 14,600 in-patient beds we would have if we adopted the west European average. To put it bluntly, acute beds currently available within the acute hospital system are too few to provide care to patients in a safe manner and, unless urgent steps are taken to remedy this shortfall, patients will continue to experience significant delays, and preventable deaths will continue to happen. We have heard repeated promises of a bed capacity review, but no action appears to have been taken. Such a review is needed to determine precisely how many, and what types of, beds should be placed within the acute hospital system to provide adequate capacity on a medium to long-term basis. However, in the short-term, in-patient beds must be restored to the system at a faster rate than is currently occurring.

Deficits in medical staffing restrict patients' access to care, and the quality of that care. The 2003 Report by the National Task Force on Medical Staffing, when applied to our current population, sets out a requirement for 4,400 consultants in the health service. Today, however, there are just over 2,700, and as a result we have long-waiting lists for out-patients and procedures across virtually all medical specialties. Comprehensive manpower planning must be under taken to develop a consultant-delivered health service. At present, however, we are being forced to cope with a grossly understaffed hospital system where the patient experience of care is not as their doctors would wish. Both consultants and non-consultant hospital doctors, the next generation of consultants, are being pressed into excessive levels of service provision which diminish their educational opportunities, and jeopardise patient care through the generation of unacceptable clinical workloads. It is little wonder that few doctors see working in Ireland as an attractive choice, or one compatible with their professional development. Accordingly, we have one of the lowest numbers of practising doctors *per capita* in the EU, at just 2.8 per 1,000 population, compared to an EU average of 3.4.

As a directly result of a failure to honour consultant and trainee contracts, public sector cuts, and the further catastrophic 30% reduction in salary to all new consultants imposed in 2012, there are in excess of 250 unfilled consultant posts in Ireland, with one quarter of advertised consultant posts receiving no applicants. This does not auger well for the future of hospital care in Ireland. Irish-trained doctors continue to leave the country in significant numbers. Figures gathered by the OECD reveal that Ireland has the highest reliance on foreign-trained doctors of any country in the EU. Our own research has found that just 40% of Ireland's medical graduates plan to practise in Ireland, while studies by the Medical Council demonstrate that health service understaffing is

the leading reason why our doctors consider practising abroad. Until these issues, are satisfactorily resolved we will struggle to fill medical posts in our health service.

Inadequate resourcing of hospitals in Ireland has compromised patient care and as a result patients, and the staff caring for them, are suffering. There are also significant challenges for our colleagues in general practice, a subject which Dr. McGarry will now address.

Dr. Padraig McGarry to take over delivering the Statement.

Good morning.

Despite its role at the heart of medical care and its presence in communities throughout Ireland, general practice is often neglected when it comes to health service planning. I work as a GP in Co. Longford, and from first-hand experience I can tell you that the under-resourcing of general practice in Ireland is one of the fundamental causes of its current inability to adequately meet patient demand. Population growth, shifts in population age distribution, and increasing multi-morbidity in patients place greater pressures on general practice, while an ageing GP workforce and high-levels of GP emigration restrict general practice's ability to cope with this increased workload. In ten years' time Ireland will likely have around 60% more patients aged 65 years old and over than it does today, however with 34% of GPs currently over 55 years of age, and 17% of our newly qualified GPs working abroad, significant investment will be needed to meet future healthcare demands in general practice. The HSE has estimated that by 2025 an additional 1,380 GPs above projected levels may be required to maintain existing service provision, while an additional 2,055 may be required to provide universal care in general practice.

While attaining these increases in medical manpower may appear to be a daunting challenge, it is one that can be met. The agreement of a new, fit-for-purpose contract for GPs that properly resources the work of doctors in communities; investment in evidence-based chronic disease management programmes; allowances for the employment of practice staff; supports that address the specific needs of practices and patients in rural and deprived areas; incentives for GPs to develop their practices; and swift access to diagnostic equipment for patients in general practice will result in the retention of newly-qualified and existing GPs and a return of many who have left to practice overseas.

I also want to briefly address some remarks that have been made to the Committee in other meetings about the independent contractor model versus salaried GPs, and the role of other health professionals in general practice. On the first point, while there may be some merit to examining the role salaried GPs could play in some circumstances, the independent contractor model that currently exists in Ireland, and most other developed healthcare systems, broadly remains superior to other models in terms of its patient focus and value for money. GPs invest significantly in their practices and, once established, tend to remain within their communities. This provides for a strong continuity of care experienced by patients and a lasting doctor-patient relationship. Such continuity of care in general practice, where a patient typically receives care from his or her specific GP, is associated with lower patient mortality, and superior patient health outcomes. This continuity of care may be threatened where GPs are merely salaried, and thus less rooted in their communities. This contractor model is to be distinguished from the corporate model, in which private firms invest in community healthcare for the purpose of extracting profit from the provision of services to patients. Such commercially-driven enterprises do not support the continuity of care in general practice that benefits patient welfare.

On the subject of the role of other health professionals in the delivery of care, and this is relevant to all categories of doctor, it must be borne in mind that different health professionals are educated and trained to perform different tasks. While there is scope for limited task transfer in some areas of the health service, the shifting of significant aspects of a doctor's work to the remit of other health professionals carries negative consequences. In general practice, for example, non-physician health professionals often spend twice as long on consultations with patients as GPs, and use more health resources generally than GPs as a result of consultations. I point out this research only to demonstrate the reductions in efficiency and cost increases that occur when health professionals move into areas of practice for which they are not trained, and thus unsuited. All health professionals' education and training is highly specialised and tailored to the performance of specific tasks. We are not interchangeable. We must focus on ensuring the employment of sufficient numbers of health professionals of all types to guarantee the best patient outcomes.

As Dr. Gilligan already mentioned, our statement this morning has focused on capacity, staffing, and the role of general practice. This is not to diminish the importance other aspects of our submission. For example, proper provision must be put in place for long-term and rehabilitative care; a new mental health strategy that puts mental health on a par with physical health and detailed plan

for its implementation must be put in place; and resourced and organised community health and public health services must be provided, including expansion of public health capacity through a new fit-for-purpose contract. Appropriately developed capacity, staffing, and general practice are the foundations on which all other aspects of the health service are built, however, which is why we have placed so much importance on improving healthcare in these central areas.

That concludes our opening statement, and I thank you for your attention. Dr. Gilligan, Mr. O'Dowd, and I will be happy to address any questions that you may have.