Meeting of the Joint Oireachtas Committee on Health

(16 October 2019)

Opening Statement by Dr. Padraig McGarry, President, Irish Medical Organisation

The IMO would like to thank the Chair and the Committee for the invitation to discuss the critical issue of medical workforce planning and the crisis in medical staffing which is having a significant impact on the delivery of healthcare services in Ireland.

The Irish Medical Organisation is the Trade Union and Representative Body for all doctors in Ireland and welcomes the opportunity to highlight the issues of recruitment and retention that exist across our health services in both the acute and community settings.

The main point we wish to make today is that the crisis in medical manpower that this country is facing is having severe adverse effect on patients with growing waiting lists and inability to deliver appropriate and timely care. Over the years of austerity we repeatedly warned that cuts to our health services would lead to a reduction in services, longer waiting lists and an inability to recruit and retain medical practitioners. It gives us no pleasure to say that this has now come to pass but we again use this opportunity to call on this Committee and Government to seriously address the deficits that exist in our medical workforce as to do so improves the overall health of our nation.

The key contributing factors to the current crisis in medical manpower can be identified as follows:

1. **Absence of planning and investment for the number of doctors required to meet the health needs of a changing demographic of patients.**
   - Ireland's population is growing but the key factor in terms of planning is the increase in the rate of growth of those over the age of 60. In order to meet the increased but expected needs of the population we need more doctors.
   - The latest OECD figures show that with 1.44 specialists per 1,000 population Ireland has the lowest number of medical specialists in the EU. (EU average 2.48 per 1,000 population).
   - The HSE's NDTP (National Doctor Training and Planning) office show that there are approximately 520 consultant posts remain unfilled or filled on a temporary basis while figures obtained by the IMO show that almost half of consultant posts advertised by the HSE in 2018 received few suitably qualified applicants, or none at all
   - The demographic of the medical workforce at specialist level is very challenging with a high level of expected retirements over the coming years: - almost 700 GPs are due to exit the system in the next 5 years – a quarter of consultants are due to retire over the next ten years and 50% of our public health specialists are due to retire in the next five years.
   - The direct consequences of this lack of planning are that:

a) In many areas such as Consultant staffing levels fall well below the recommended ratios by the National Clinical Programmes and Colleges. In orthopaedics, paediatrics and psychiatry the consultant staffing levels are 50% below recommended staffing levels while in ophthalmology the staffing levels can be up to 70% lower.
b) 770,000 patients are on hospital waiting lists.
c) In many areas of the country patients cannot register with a General Practitioner due to lack of capacity which has a negative knock on effect of increased presentations to an already stretched GP out of hours service and in Emergency Departments across the country.

2. A poorly resourced health service and a hostile overly pressurised work environment which is leading to high levels of emigration of doctors

- Over 700 graduates enter basic specialist training each year in Ireland, however we are training are doctors for export Since 2015 the number of voluntary withdrawals from the register has almost doubled from 828 to 1,453 in 2018. Data from the Medical Council shows that approximately a third are Irish graduates while almost a quarter leave the specialist register. And while a small percentage leave to retire, the vast majority (almost 70%) leave to practice medicine in another country.
- Reasons cited include understaffing, expectation to carry out too many non-core tasks, lack of respect, limited career progression, higher earnings abroad, family, reasons, more flexible training options abroad, lack of support from employer, long working hours, and poor quality of training
- There is a growing body of evidence that demonstrates that doctors are suffering from burnout due to the highly pressurised working environment and this coupled with a lack of support from the employer is a significant contributing factor to emigration.
- Doctors are trained over many years to deliver high quality and appropriate care to patients. The lack of investment in our public health services make it almost impossible for doctors to deliver that care in a timely manner due to lack of beds, understaffing and poor access to diagnostics and access to other healthcare professionals including counselling services, occupational health and physiotherapy. This starts with the GP being unable to access timely referrals for patients and carries on through to the hospital system or community system with intolerable and dangerous waiting times for outpatient appointments and then in many cases long delays before the prescribed treatment can be delivered.
- The Health Capacity Report clearly identifies the deficits in terms of infrastructure within the system yet the policy of Government is to significantly increase investment into the private system through the National Treatment Purchase Fund while starving the public system of the required investment.
- Our GP workforce is also emigrating. A survey by the ICGP of GP trainees and graduates in 2017 reveals that one in five recently qualified GPs have already emigrated while a further 30% of newly qualified GPs are considering emigration.

While over 50% of GP trainees see themselves in as a GP Principal in a partnership or Group practice in 10 years' time, concerns about the viability of general practice, financial prospects and quality of life are the key factors influencing their decision to migrate. It is important to note that the recent GP Agreement merely provided a pathway to reinstate the funds lost during the years of austerity and what is required is significant planned investment in the development of GP services to patients.

3. **Failure to make our Public Health Services an employer of choice for medical professionals and a culture of disrespect of doctors by employer and Government**

- Our doctors continue to emigrate to health systems that pay more, offer better supports, reasonable working environments and value doctors.
- Over the past 5 years the IMO, on behalf of its members, have been forced by Government and the HSE to take legal action to enforce legally binding contracts entered into by the Employer, to ensure doctors work safe and legal hours and to allow doctors to be represented in terms of contractual matters. This does not assist in the development of a culture of respect and value on employees.
- Consultants employed pre 2012 were denied their contractual payments and these were only secured on foot of legal action.
- Consultants employed post 2012 were subject to a discriminatory and unilateral cut of 30%. This was in addition to the cuts already applied across the public service. The impact of this particular policy has been the inability of the HSE to recruit consultants and has led to the situation that we have more than 500 vacant posts and over 100 non specialist doctors working in consultant posts. We see examples of this across the country and it has been most recently evidenced by the inability to recruit sufficient consultants for the opening of Phase 1 of the National Children's Hospital and the growing problems in psychiatry services.
- Rather than increasing our consultant staffing levels we are becoming increasingly more reliant on foreign trained doctors with over 40% of doctors registered in Ireland trained abroad. However research shows that the majority of foreign trained doctors equally intend to move on, either to return home or migrate onwards concerned about deskilling and disillusioned by the lack of training and career opportunities.
- NCHDs contracts are routinely breached by hospitals across the country where our doctors are forced to work in excess of legal hours, are not paid for all the hours worked and in many cases have cited poor and inflexible training with poor career progression options.
- Our own research suggests that two thirds of NCHDs perceive pay to be the primary reason for emigration and 83% believe the pay disparity at consultant level will impact on their decision as to whether to apply for consultant posts in Ireland. Current disparities in pay between consultants employed pre and post

2012 rise to up to €50,000 a year for colleagues doing the same job and carrying the same level of responsibility.

- In terms of Public Health, Ireland differs from other English speaking countries in that specialists in public health medicine are not remunerated on an equal basis to other consultant specialists within the health system, despite the fact that they are required to be on the specialist register and must undergo specialist training. If properly resourced public health doctors could play a pivotal role in commissioning services, analysing health data, conducting needs assessments, assembling the evidence base for interventions, monitoring services and quality assuring parts of the health service such as screening services.
- The development of General Practice is the cornerstone of many reform proposals including Sláintecare however GPs have until recently been left to shoulder the burden of reduced funding while delivering a greater level of service. There is no clear strategy or funding for the development of General Practice.

All of the above are the factors that have led to this crisis and they have been much publicised and highlighted by the profession and the IMO for many years now. However lack of commitment, investment and respect by successive Governments and the HSE have led to a situation of low morale among the existing workforce, high levels of emigration and inability to recruit sufficient doctors to deliver existing levels of care, let alone the development of new services.

We are at a tipping point and unless we seriously address this problem doctors fear for the health service and the safe delivery of care to patients.

More reports and promises of reform are not what the health service and our patients require, nor is it helpful to talk about “black holes” in the health budget. The simple fact is that notwithstanding the spin around high levels of health spending the budget is insufficient to meet the needs of the population and it is time for politicians and policy makers to be honest about this.

In terms of the Medical Manpower issue there are some immediate steps that must be taken now.

- **Resolve the discriminatory pay issue for consultants. Until this is dealt with there can be no new contract discussions which are required for any reform measures and we cannot hope to recruit consultants to our public health services. There is simply no defence for the current policy and the impact of this politically motivated 30% cut has been disastrous for our patients and our services.**
- **Invest in the capacity and supports within General Practice to allow it to develop and deliver a fuller range of care in the community. The Expansion of Medical Cards and Doctor Visit Cards should only be given on the basis of means or medical need not on age cohort, - the long held tradition of**

successive Governments using medical cards as vote getting exercises must stop.

- **The training of doctors must be modernised reflecting changes in the practice of medicine and the changing demographics of doctors in training. This requires initiatives to consider the duration of training to bring arrangements in line with international norms. A differentiated model which provides clearer career paths with greater predictability of training arrangements, responsibility, location and working conditions must be developed in line with the recommendations made in the report of the Strategic Review of Medical Training and Career Structures ('MacCraith Review').**
- **Each year over 700 doctors enter basic specialist training, however that number falls to 484 doctors entering higher specialist training. Therefore we are currently only just about training enough specialists to replace the number of specialists that leave the register each year. There also seems to be a mismatch in the number of posts on offer. While around 55 higher specialist training posts are not filled each year in other specialties there are insufficient training posts on offer to meet either demand or the shortage of consultants in that speciality.**
- **There are vacant posts with both Public Health and Community Health which is putting health planning and the delivery of vital vaccination and screening programmes at risk. The Crowe Howarth Report, commissioned by the Department of Health, must be implemented to improve the role and function of public health specialists, training and career structure of public health medicine and ensure that public health specialists are valued and offered contractual terms in line with other specialists.**

In conclusion doctors want to work in a system in which they can care for patients, that is why we became doctors. Care delayed is care denied and the cost of denying this care has never been assessed in terms of the personal cost to the patient's quality of life, the cost to the system of delivering more expensive and complex care at later stages and the cost to society through days of work lost and benefit payments as many patients await care that will allow them to live a full and productive life.

We need reform that makes a difference to patients but any reform is simply impossible in the context of the current medical workforce crisis. Reports and reform proposals without significant and appropriate investment is actually making the situation worse not better and there can be no hope of either reforming the system or developing new and much needed service with the level of understaffing we have in the system. We must have a system that cares for patients and values doctors, we have seen the consequences of a system that currently does neither.