IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation Submission to the Department of Health on the Draft National Strategic Framework for Health Workforce Planning

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Are there any other global, regional or national supply or demand side considerations that should be taken into account?

While many potential generators of demand for health services are provided within the draft of *Working Together for Health*, a number of factors which increase demand for health professionals are given incomplete or cursory treatment.

1. The extension of universal general practice care to the entirety of the population, as proposed by the *Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report*, or the pressure that such a policy initiative would have on demand for medical services, are scarcely identified in the draft. The Irish Medical Organisation has expressed concern about this proposal, contained within the *Sláintecare Report*, as the report fails to properly consider the overwhelming effect that such an expansion of universal care would have on demand for the services of general practitioners, and by extension the demand for additional general practitioners within the medical workforce. The Health Service Executive's (HSE) National Doctor Training and Planning division has estimated in its report, *Medical Workforce Planning: Future Demand for General Practitioners 2015-2025*, that as many as 2,055 additional general practitioners, a more than 50% increase in the current GP workforce, would be required to provide medical services in general practice to patients by 2025 were universal GP care extended to the whole population.

2. As set out in the draft of *Working Together for Health*, the shift in the delivery of care to general practice advocated for in numerous health policy documents, including *Primary Care – A New Direction*, will place greater workforce demands on general practice. The treatment of the proposed shift in care to general practice identified in the draft of *Working Together for Health* focuses on utilising nursing and midwifery resources to deliver community care. Such a proposal largely demonstrates a misunderstanding of the evidence on the delivery of healthcare services in primary care. In its response to the Department of Health's public consultation on *Development of a Community Nursing and Midwifery Response to an Integrated Model of Care* and *Developing a Policy for Graduate, Specialist and Advanced Nursing & Midwifery Practice* the IMO pointed out that "[c]ontrary to the evidence supporting GP care, there is currently insufficient evidence to support nurse-led care in the community. Arguments in favour of nurse-led services centre around perceived quality of care and patient satisfaction and propose a solution to the imminent shortage of GPs, however, there is no evidence to suggest that patient outcomes are improved or that care is more cost effective." The IMO has stated that a significant of transfer of care to other health professionals in the community risks diminishing the continuity of care provided to patients by GPs. Accordingly, in order to ensure patient safety, quality and continuity of care any transfer of care from GPs to nurses should be made in agreement with GPs, and concordant with international evidence. Greater regard should be had in the final draft of *Working Together for Health* to the demand for an expanded GP workforce the transfer of care to general practice will have. Similarly, regard should also be had within the framework to the effect that the provision of various practice supports, financial or structural in nature, could have on recruitment and retention in general practice.

3. Additionally, insufficient regard is had in the draft of *Working Together for Health* to the demands for increased staffing created by accepted best workforce practices, as a context for strategic health workforce planning. Successive Irish governments, and the *Report of the National Task Force on Medical Staffing* (The Hanly Report), have acknowledged the

evidence-based benefits of providing medical care in Ireland on a consultant-delivered basis. This represents best practice in the provision of healthcare, and remains national policy (HSE, *Towards Successful Consultant Recruitment, Appointment and Retention*, 2016). According to the ratios set out in the Hanly Report, based on current population, Ireland would require approximately 4,400 consultants to provide a consultant-delivered, as opposed to consultant-led, health service, whereas at present roughly 2,800 are employed. Effective strategic workforce planning can only take place in the context of accepted health workforce best practices which seek to maximise the quality of care, and must be central to any framework. Also, the *Sláintecare Report's* recommendation of the phasing out of private care in public hospitals may have knock-on consequences for the demand for medical practitioners. This factor should be included as a consideration within this framework.

There are also important supply-side considerations to examine, the most pertinent of which in the inability of the Irish health system to adequately recruit and retain medical practitioners.

4. The extent of the emigration of medical professionals from Ireland was treated in a major report published by the Royal College of Surgeons in Ireland (RCSI), which outlined the factors leading to the flight of qualified doctors from Ireland. This report found that "[r]esearch on health professional emigration in the Irish context indicates that much recent emigration has been driven by dissatisfaction with working conditions in the health system and uncertain career progression opportunities, aggravated by austerity-related staff reductions, salary reductions and taxation increases".

   The RCSI report also notes that there has been a change in the pattern of emigration in recent years, with more doctors leaving at an earlier stage in their training, many within one or two years of graduation, and more doctors staying abroad rather than returning. Research indicates that the vast majority of doctors who have left this country have no plans to return, largely as a result of their poor experiences of working within the Irish health system, and the comparatively superior of pay and working conditions in their destination countries. An exploratory study of 388 health professionals, including 307 doctors, who had trained at undergraduate level or who had worked in Ireland but had subsequently emigrated, revealed that only 24% intended to return to practise medicine in Ireland in the future. 90% of respondents were Irish-trained doctors who had emigrated to Australia, the United Kingdom and the United States of America. Respondents described their main motivation for emigration as the working conditions and environment in Ireland, and the availability of better training and research opportunities abroad.

5. In 2015 8.7% of doctors in Ireland aged between 25 and 34 left the medical register, an acknowledged proxy for emigration, while approximately 400 consultant positions within the health service lie vacant and cannot be substantively filled. This has contributed to a dearth of medical professionals practising in Ireland. This country possesses one of the lowest numbers of doctors per capita in the European Union (EU), and places a greater reliance on the employment of foreign-trained doctors than virtually any other developed health system. Ireland possesses just 2.9 practising doctors per 1,000 population, compared with an EU average of approximately 3.5, while 42% of all doctors in Ireland are foreign-trained, the highest figure in the EU by a considerable distance and which compares to an EU average of 11% (OECD Health Statistics 2017). Ireland's inability to achieve medical workforce sustainability from its own graduates renders it incompliant with the WHO Global Code on the International Recruitment of Health Personnel.

Are there any other key interfaces between the health sector and other sectors nationally that should be taken account of?

Representative bodies of various healthcare professionals should also be included in discourse on health workforce planning. Such bodies are often in a position to provide data on the working conditions and practices of the professionals they represent, and thus offer a crucial source of information not otherwise readily available. For example, the IMO has conducted research amongst its members on issues such as supports for doctors during training, migration intentions, gender-related employment issues, and working hours, amongst others. The organisation is also in regular contact with many of its members on the many challenges faced by medical professionals in the course of their employment. Similarly, the IMO regularly contributes to public consultations on the provision of health services and highlights relevant international research to inform the formation health policy.

As aforementioned, recruitment and retention difficulties within the Irish health service are major barriers to an adequate supply of health professionals remaining available to the Irish health services. The push and pull factors influencing health professional emigration from Ireland are well-known to organisations representing health professionals, and therefore engagement with these representative bodies is crucial to rectifying these supply issues.

Furthermore, as independent research on health professional migration has revealed, taxation policy operates as a driver of emigration from Ireland. Additionally, the IMO has continually raised the issue of the financial burden placed on graduates of graduate-entry medical programmes, who are often forced to meet unsustainable loan repayments for costs incurred during their completion of medical education. On both of these issues the Department of Finance should be considered as a relevant stakeholder, and therefore input from this department should also be sought when addressing matters pertaining to health workforce planning.

Liaison should also be had with bodies responsible for managing considerations associated with the United Kingdom's withdrawal from the European Union. 'Brexit' has numerous potential implications for workforce planning, including: the possible change in arrangements regarding cross-border health services that may lead to increased demand here; the possible effects on mobility of health professionals; and the possible increased demand for Irish nationals to work in NHS, given the restrictions that may be imposed on citizens of other EU states from gaining permission to work in the United Kingdom following Brexit.

It is also necessary, in the context of this framework, for cognisance to be had of the impact that the utilised model of general practice and community care will have on workforce planning. The IMO, and indeed the weight of international academic literature, supports the efficacy and efficiency of utilising a general practice model which ensures continuity of care through personal knowledge of patients and their families, where care is consistently delivered by the patient's own GP. Insufficient efforts have been made to protect the delivery of care in this manner, which risks being replaced by models which do not support the doctor-patient relationship, and thus do not support continuity of care.

What gaps in information flows exist – either within the health sector or cross-sectorally – that should be taken into account in finalising the proposed structures and governance arrangements?

As has been highlighted in the recent RCSI publication *Brain Drain to Brain Gain: Ireland's Two-Way Flow of Doctors*, despite the severity of the recruitment and retention problem within the Irish health service, data on doctor emigration is poor. The report states that, "[g]iven the significance of emigration to the Irish health workforce, there is an urgent need for improved, comprehensive and accurate data on health worker emigration."

While independent researchers, such as those based at the RCSI, have engaged in detailed analyses of the reasons for doctor emigration from Ireland, similar published research by the HSE or the Department of Health appears not to have been undertaken. A major effort must be engaged in by statutory bodies to assess the extent of and reasons for health professional emigration from Ireland.

Similarly, there appears to be no centralised data within the HSE on the number of consultant posts within the Irish health service that are not substantively filled. Enquiries made by the IMO to the HSE's Health Business Services Division revealed that, while the HSE was aware of the number of open consultant vacancies for which it was currently advertising, it was unable to provide information on the number of permanent consultant posts that are currently being filled on a locum or part-time basis, or on the number of full-time consultant posts that are currently being filled on a part-time basis. Health workforce data of this nature must improve if satisfactory health workforce planning is to be achieved.

The quality of information being provided by state agencies to workforce planners must also be reviewed. For example, when estimating visitation rates to general practice state bodies have relied on studies that have employed questionable methodology. The examination of general practice visits per patient provided in the *Living in Ireland Survey*, a survey series which concluded in 2001, relied on retrospective reporting by survey respondents, who were asked to recall how many visits to general practice they had undertaken during the past twelve months. This method of estimation has been criticised due to its potential for memory error, which cannot be easily mitigated or controlled for (Short *et al.*, 2009; Wolinsky *et al.*, 2007). The most recent *Living in Ireland Survey* estimated that General Medical Services (GMS) scheme patients visit their general practitioner 5.3 times annually, on average. However, a more recent examination of visitation rates in Irish general practice, based on actual practice records rather than patients' recall over the past twelve months, concluded that GMS patients visit their general practitioner approximately 7.7 times annually, on average (Behan *et al.*, 2013). Thus it is crucial that the methodology behind all data utilised in workforce planning is carefully critically examined, to ensure only highest quality available research is relied upon.