The IMO would like to thank the Chair and the Committee for the invitation to discuss issues relating to the employment of consultants and non-consultant hospital doctors in public hospitals.

Doctors go into work each day with the objective of doing the job for which they are trained and doing their very best for the patients they treat. Unfortunately the system in which they work does not enable them to meet that objective and in many cases actually imposes obstacles that stops them – ultimately this has negative consequences for both patients and doctors

The consistent narrative of record levels of health budgets and the additional numbers employed in the health service masks the reality of the demands on the health service and the deficits in funding for over a decade. While the health service, like all public services, must provide value for money it must be funded appropriately to meet the needs of a growing and ageing population and that is simply not the case currently.

Population growth and living longer are things to be celebrated and supported but it must be recognised that this has an impact on our health services as more patients seek care and that care is more complex. Our health service has not matched that population growth in terms of physical capacity or increasing the workforce required to meet that demand. The mantra of doing more with less or the call to healthcare staff to "do better" in the absence of appropriate support is both insulting and demoralising.

Decades of underfunding in capacity, poor policy decisions around recruitment and retention and a lack of a coherent workforce plan has led to a system that is struggling to deliver care in a timely manner. These are the critical issues for doctors who are employed in our public hospitals. The provision of healthcare must be funded on the principle of demand and supply whereby we assess the healthcare needs of the population and supply the healthcare staff and facilities to meet those needs.

These underlying systemic issues are not a theoretical concept – they have real life consequences for patients and for the doctors who work in our public

hospitals and they feed into the reality of the issues of employment of consultants and NCHDs.

Underfunding in Capacity – Beds, Clinics, Diagnostics, Theatres, Team Supports

There is no argument that decades of underfunding has led to a situation where we have too few acute hospital beds. We need an additional 5,000 acute hospital beds over a relatively short period of time. This lack of bed capacity is most visible when it comes to the dangerous year round levels of overcrowding in our Emergency Departments. The practice of boarding patients on trolleys – patients who have been deemed ill enough to be admitted – is dangerous for the patient and unsustainable for the staff working in our Emergency Departments. Ireland has a quoted hospital bed occupancy rate of in excess of 97%, the actual occupancy rates often exceed 105% in many of our acute hospitals. For the patients in Emergency Departments this has an immediate effect of not being able to receive appropriate and timely care but it also impacts on all other patients who are awaiting elective/scheduled care and whose care is routinely cancelled due to lack of bed capacity leading to risk of poorer health outcomes.

Across a wide number of specialties consultants are appointed, some to new posts and some to vacant posts – which is very welcome – but very often, particularly with new appointments they are not provided with the basic supports to enable them to do their job. It is not unusual for a consultant to be appointed with no admin support, no office, no team members, insufficient or no clinic times, no theatre time and challenges in accessing diagnostics.

Consultants are consistently battling in a highly bureaucratic system to get basic resources and are seen very often as a “cost centre” rather than an asset requiring the supports to enable them to see and treat patients. At the end of April 2024, there were 828,605 patients waiting on an NTPF waiting list of which almost 699,672 have yet to receive a date for their appointment or procedure. Even after the patients receive their appointment the inevitable next challenge is when can treatment be delivered – whether that be diagnostic, surgery or follow-up.

Rather than invest in public hospitals and provide all the wrap-around supports that are needed, the system will very often choose the alternative pathway of diverting those patients into the private system for care. There are insufficient levels of capacity, even when we consider both the public and private bed capacity, to meet demand and there is simply no sustainable alternative but to significantly ramp up investment in our public system – this is a choice for the political system and it is not the fault of the doctors working in the system.

For both consultants and NCHDs the failure to invest in capacity means that each and every day they are fighting against the system to access care for their patients – they leave work feeling demoralised and frustrated. To compound matters regular out-of-context reports are made by the employer or the political system around productivity levels, overtime payments, black holes of spending – all leading to a feeling that they are neither valued nor respected. This in turn has led to very worrying levels of burnout amongst doctors.

Our own research carried out over a number of years shows:

- 94% of doctors reported having experienced some form of depression, anxiety, exhaustion, stress, emotional stress or other mental health condition relating to, or made worse by work.
- 80% of doctors are at risk of burnout.

One of the most worrying aspects of our research is the level of burnout amongst our NCHDs who are at the start of their medical career. The system and the unnecessary pressures brought about by the underfunding of the system is making those who work in in at greater risk of burnout. This is a significant factor in terms of attrition and emigration and is supported by other research. It is not necessarily higher incomes that drive emigration – Australia, Canada, North America and the UK are targeting Irish trained doctor and offering them better work life balances and the opportunity to work in a system that supports them and enables them to care for patients.

Recruitment and Retention and Lack of Funded Workforce Plan to match demand

It is ironic that we are speaking today about the employment issues for consultants and non-consultant hospital doctors seven months into a Recruitment Embargo. It is inconceivable that such an embargo is in place at a time when we need more doctors not less and at a time when there is a global shortage of doctors.

For our NCHDs the recruitment freeze has meant:

- An increase in Illegal and unsafe working hours with 83% of NCHDs routinely working beyond 48 hours per week. This is illegal in terms of the Organisation of Working Time Act. It is also unsafe for patients. And it is a breach of contractual entitlements. This risk to both doctors and patients is embedded in the system and has been made worse by the recruitment freeze. The day before the recruitment freeze was announced the HSE advised the IMO that it would take targeted recruitment of up to 800 additional NCHDs to bring working hours to legal and safe levels.
- 68% of NCHDs report that they are regularly working beyond 10 consecutive days - without compensatory pay or additional rest days in almost half of these cases. Again this breaches a contractual entitlement designed to improve patient and doctor safety.
- NCHDs are entitled to 10 days guaranteed study leave every 6 months to study and undertake mandatory exams. 65% were unable to take such leave due to gaps in the rota.
- 77% of NCHDs are being pressurised by their employer to work extra shifts, often at short notice, to cover gaps in the rota.
- The HSE cannot provide even the most basic of guarantees around providing cover for maternity leave which again leaves a gap in the rota requiring the other team members to work those shifts.

In 2022 an NCHD strike was averted by virtue of an agreement reached between the IMO, the Department of Health and the HSE. The main objective of this agreement was to reduce working hours, guarantee rest and improve the work/life balance of NCHDs. On almost every metric that agreement is not being implemented in full and emigration of NCHDs continues to increase.

The Minister launched the Report of the Taskforce on NCHDs and while we welcome many of the recommendations around reform - we need to see change now with the employer meeting legal and contractual obligations. We are about to enter negotiations on a new NCHD contract but this is in the context of flagrant breaches of the current contract.

NCHDs are our future consultants yet 75% of NCHDs do not feel valued, respected or supported by their employer.

There are almost 9,000 NCHDs in the public health system and we rely heavily on International doctors (doctors who graduated outside of Ireland) who fill 80% of non-training NCHD Service posts. These doctors, who have made Ireland their home and without whom the health system could not function, are not treated equitably in terms of career progression. They too leave the system, disillusioned with working conditions and the lack of training and career opportunities. Medical Council figures show that, on average, International Doctors spend six years on the General Division, before moving.

International Doctors are frequently here on what are called *Critical Skills Permits* or *Multi-site General Employment Permits*, and they are entitled to seek a Joint Family Visa. However, they and their families experience significant delays in the processing of their visa applications, leaving families separated for long periods. This country has asked these doctors to work here, we need them to stay so we must do better to support them and enable their families to be with them.

In relation to the consultant workforce:

- While the number of consultants employed in the HSE has increased, the number of consultants employed still falls far below the numbers required for a consultant delivered service
- Ireland has one of the lowest consultant: patient ratios in the OECD
- Of approximately 4,500 approved consultant posts, just 3,700 posts are filled on a permanent basis while an estimated 6,000 consultants are required to provide a consultant delivered health service based on our current population.

- In some specialties (including many of the surgical specialties and psychiatry) the number of consultants employed is up to 50% below the recommended levels resulting in significant waiting lists.

The new Public Only Consultant Contract became effective in March 2023 – and to date 2,229 consultants are on that contract – 470 who are new appointments and 1759 who have transferred to the new contract. The contract provides for private practice to be removed from public hospitals and for the ability to roster consultants over an extended working day and week. However the new contract will not, in and of itself, solve the chronic problems the health service is facing in the context of capacity and workforce requirements as outlined earlier.

It is not realistic to infer that the health service will see tangible benefits if consultants are consistently rostered outside 'normal' working hours. With the deficits in our workforce there is no room for manoeuvre – we are quite literally adopting a policy of robbing Peter to pay Paul. Along with the requisite number of doctors, this rostering arrangement could only properly work if all other support staff and resources are in place and services are accessible at all times when a patient requires admission – currently we are a long way from getting to this point. It is important to point out that consultants already work outside of "normal hours", throughout the night and over the weekend irrespective of what contract they are on through the obligatory on call arrangements. Additionally many consultants have to provide cross cover for colleagues for annual leave, sick leave and other absences as in most instances locums are not provided.

On a general point, regarding the employment of both consultants and NCHDs in our public hospitals, we need to recognise the unsocial hours that are a requirement and the impact that is having on those doctors who have children and need childcare. It is unreasonable to expect that we can recruit doctors into a system that requires them to work throughout the night and at weekends without the provision of onsite childcare or supported childcare offsite.

Covid exposed the fragility of our health services. In June 2020, at a hearing of this committee we asked that Government significantly ramp up investment in capacity and the workforce – unfortunately the level of investment is not matching demand and at best we are running to stand still.

Doctors are trained over many years to deliver high quality and appropriate care to patients. However the lack of investment in our public health services make it almost impossible for doctors to deliver safe care in a timely manner. There are of course solutions, and we want to work with Government to deliver those solutions but we must accept that significant funding is required if we are to have a service that delivers for patients and is capable of recruiting and retaining the doctors we need to deliver that care.

Thank you.