IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation Submission to the Public Service Pay Commission on

Non-Consultant Hospital Doctor (NCHD) Recruitment and Retention Issues

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Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel: (01) 6767 273
Fax: (01) 6612 758
E-mail: codowd@imo.ie
Website: www.imo.ie

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Introduction

Recruiting doctors into the Irish public healthcare system, and retaining those doctors once they are appointed has rarely, if ever, been more challenging. At present, when analysed comparatively, Ireland is already precariously short of doctors with only 2.9 practising physicians per 1,000 population, compared with an EU average of approximately 3.4.[1]

One part of this shortage that is worrying indeed is that it represents a break from the historical pattern of doctors going abroad to enhance their skills before then returning home. In recent years however, there has been a radical alteration to this pattern of emigration, as research conducted by the Royal College of Surgeons in Ireland (RCSI) confirms:

> "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 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."[2]

It is worth reminding ourselves that the role of the doctor cannot be replicated by other professionals within the health system. The practice of medicine has entered an era of unprecedented complexity. Patients, and their doctors, are today faced with an array of disease classifications, diagnostic assessments, and treatment regimes far in excess of those available just a generation ago. As the understanding of human physiology and disease pathology advances, the provision of healthcare requires an ever more detailed understanding of the myriad clinical factors and scientific principles that constitute disease. The medical practitioner is uniquely educated and trained to manage this complexity and to translate its nuances into an accurate diagnosis and effective treatment of the patient's disease.

The centrality of the doctor's role as both a scientist and central to the provision of high quality healthcare was well described by the New Zealand Medical Association's *Consensus Statement on the Role of the Doctor in New Zealand*. Here, in agreement with other medical bodies,[3] the Association wrote that:

> "[d]octors have the ability to access, interpret and assimilate new knowledge critically, have strong intellectual skills and grasp of scientific principles, and are capable of effectively managing uncertainty, ambiguity and complexity. They have the capacity to work out

[1] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, Physicians, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[2] A.M. Walsh and R.F. Brugha, *Brain Drain to Brain Gain: Ireland's Two-Way Flow of Doctors*, Royal College of Surgeons in Ireland, Dublin, 2017, p. 13.

[3] The *Consensus Statement on the Role of the Doctor in New Zealand* is endorsed by: the New Zealand Medical Association; the Cardiac Society of Australia and New Zealand (New Zealand Branch); the Royal Australian and New Zealand College of Psychiatrists; the Royal College of Pathologists of Australasia; the Royal Australian New Zealand College of Radiologists; the Royal Australian New Zealand College of Obstetrics and Gynaecologists; the Council of Medical Colleges; the New Zealand College of Public Health Medicine; the Australasian College for Emergency Medicine; the Australian and New Zealand College of Anaesthetists; the New Zealand Rural General Practice Network; and the Royal New Zealand College of General Practitioners.

solutions from first principles when patterns do not fit, and the ability to work outside guidelines when circumstances demand."[4]

The importance of strong medical workforce within the hospital system is reinforced by the overwhelming evidence available to demonstrate that consultant-delivered care, care which is provided by comprehensively trained medical experts with extensive experience, is the best model by which to organise hospital services; immediate steps should be taken to ensure its implementation in Ireland. While there has been a gradual increase in the number of consultants and NCHDs employed in the HSE, NCHDs still outnumber consultants by two-to-one and one in eight consultant posts currently remain unfilled.[5] Working conditions in over-crowded hospitals have led to unprecedented recruitment and retention issues, and many of our newly trained doctors are emigrating or planning to emigrate while we, in turn, are becoming increasingly reliant on foreign-trained physicians. This practice of recruiting physicians from outside of the European Union risks contravening Article 5 of the World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel, which sets out that "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers".[6] Staffing our hospital system in a manner that provides for real consultant-delivered services, ensures NCHDs' time for training is maximised, and enables faster access for patients must be afforded high priority in public policy planning.

Additionally, Public Health Medicine is one of the core medical specialties of any functioning health service and this is true in Ireland as elsewhere. Uniquely amongst medical specialties, a substantial part of the Public Health Medicine function is mandated by national and international legislation. The Sláintecare report calls for strengthening of Public Health as a major aspect of reforming the health service and describes it as an essential enabler in the reconfiguration of the health services over the next 10 years. Accordingly there is an imminent and urgent need to address the current terms and conditions that prevail in Public Health Medicine, as it is a key enabler in designing and delivering a health service that adequately meets the needs of our population in a structured and coherent way.

A factor contributing to the low number of doctors working in Ireland are unattractive working conditions and levels of remunerations that both drive emigration of doctors from Ireland, and inhibit the return of doctors who have already emigrated. This affect all levels of current and aspirant medical practitioners. A Medical Workforce Analysis, published by the Department of Public Expenditure and Reform from 2015 highlighted that 87% of medical students are either intending to emigrate or contemplating it,[7] while a Medical Council examination of the retention intentions of Irish trainee doctors revealed that just 58% of trainees see themselves practising in Ireland for the foreseeable

[4] New Zealand Medical Association, *Consensus Statement on the Role of the Doctor in New Zealand*, Wellington, 2011, p.

[5] The latest HSE census report shows that there are currently 2,764 consultants and 5,762 NCHDs employed in the HSE. HSE Census Report May 2016 downloaded from http://www.hse.ie/eng/staff/Resources/Employment_Reports/Census-Report-May-2016.pdf.

[6] World Health Organisation, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva, 2010, p. 7.

[7] T. Campbell, *Medical Workforce Analysis: Ireland and the European Union compared*, Dublin, Department of Public Expenditure and Reform, 2016, p. 1.

future.[8] Last year a quarter of all advertisements for consultant posts had to be closed due to the lack of a suitable applicant, while around one-in-ten advertisements failed to attract a single application.[9]

Unless radical action is taken to resolve the recruitment and retention crisis within the medical professional in Ireland, we will be unable to deliver the kind of specialist and specialised medical care taken as a right in other jurisdictions. The IMO welcomes the opportunity to make the following submission to the Public Services Pay Commission, and urges the Commission to make recommendations that can act to mitigate the scale of this crisis within the Irish public health service.

[8] Medical Council, *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, Dublin, 2016, p. 6.

[9] Public Appointments Service (business correspondence, 21 November 2017).

SELECTED NCHDS' COMMENTS FROM THE IMO NCHD SURVEY ON RECRUITMENT AND RETENTION ISSUES, NOVEMBER 2017

Difficulties Concerning NCHD Recruitment

The difficulty in recruiting NCHDs is well demonstrated by the significant rise in the health service's reliance on foreign-trained doctors in recent years. At present 41.6% of all doctors working in Ireland are foreign-trained,[10] and the country employs a greater proportion of foreign-trained doctors than any other European state, with the Irish figure of 41.6% contrasting sharply with the EU average of just 11.3%.[11] Paradoxically, Ireland also produces 23.7 medical graduates per 1,000 population each year, the highest figure in the entire OECD and approximately double the OECD average of 11.8.[12] The fact that Ireland produces more medical graduates *per capita*, yet employs more foreign-trained doctors *per capita*, than almost any other developed state should give a clear indication of the recruitment and retention crisis engulfing the public health service. Ireland should, with its high proportion of medical graduates and relatively low level of medical posts, be better placed than almost any other nation to ensure that its public health service is staffed by professionals trained from its own human resources. This has not transpired, and instead these Irish-trained doctors leave the Irish health service in large numbers, requiring significant volumes of foreign-trained practitioners to take their places.

As aforementioned, approximately four-in-ten doctors working in the Irish health system are foreign-trained, and therefore are integral to health service provision in Ireland. The proportion of foreign-trained doctors has risen substantially from 13.4% of all registered doctors in 2000 to 33.4% by 2010, to 41.6% in 2016. The largest increase was in foreign-trained doctors from outside the EU, rising from 972 (7.4%) in 2000 to 4740 (25.3%) of registered doctors in 2010.[13]

Ireland is a signatory of the World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel, however has been in consistent and increasing contravention of one of the Code's central tenets: "[a]ll Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible", rather than seeking to recruit medical practitioners from developing states, and thus denying those nations the benefit of the practitioners they have trained.[14]

The WHO predicts a global deficit of 18 million skilled health workers by 2030 while in the European region, the European Commission has estimated a potential shortfall of around 1 million health workers by 2020.[15] This shows that self-sufficiency in producing qualified doctors will become and ever more vital to the Irish health service, and reliance on a strategy of importing an ever greater number of practitioners from outside the EU looks an increasing folly.

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[10] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Workforce Migration, Foreign-trained doctors by country of origin – Stock, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[11] Ibid.

[12] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, Graduates, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[13] P. Bidwell *et al.*, 'The national and international implications of a decade of doctor migration in the Irish context', *Health Policy*, Vol. 110, No. 1, April 2013, pp. 29-38.

[14] Article 5, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva, 2010.

[15] S. Harris, Minister's speech at the Opening Ceremony of the Global Forum on Human Resources for Health, Dublin, 13 November 2017.

The issues generating the present recruitment difficulties in attracting NCHDs are also those which have resulted in the severe retention crisis in that sector, and are given detailed treatment within that section of this submission. However, the increasing need for reliance on foreign-trained doctors, despite the training of more than adequate numbers of doctors in Ireland to fulfil all medical posts in the Irish health system is the most clear symptom of the deep unattractiveness with which the Irish health system is viewed by doctors trained in this country.

The Longer Doctors Stay Away, the Less Likely They Are to Return

One strong barrier to the recruitment of Irish-trained NCHDs who have moved to other jurisdictions back to the Irish health service is the negative experience of those NCHDs of working in Ireland. A survey of 388 health professionals, 307 of whom were doctors, found that, while over half had originally intended to spend less than 5 years in their destination country at the time of emigration. However, these intentions changed over time, with the desire to remain abroad on a permanent basis increasing from 10% to 34 % of doctor respondents. Only a quarter of doctors intended to return to practise in Ireland in the future.[16]

This supports the conclusion that the longer health professionals remain abroad, the less likely they are to return to their home countries.[17] These respondent doctors emigrated because of difficult working conditions in the Irish health system, including long working hours and uncertain career progression, which compared poorly with conditions in the destination country. Respondents' noted that their experiences in the destination country vindicated their decision to emigrate and complicated the decision to return. Their return to Ireland, they stated, was contingent upon significant reform of the Irish health system and an improvement in working conditions.[18]

This is reinforced in the responses of a canvassed group of overseas NCHDs, who in setting out which measures would prove useful in recruiting them, and their peers, to posts within the Irish health service: 78.9% sought improved opportunities to avail of training and continuous professional development in Ireland, improved doctor staffing levels in Ireland, and improved workplace atmosphere, culture, and supports in Ireland; 75% sought reduced working hours in Ireland; 71.1% sought improved levels of pay in Ireland; and 65.4% sought improved medical facilities in Ireland.[19]

Therefore it is clear that considerable reform and improvement in HSE working conditions must be undertaken to render the Irish health service an attractive employer for NCHDs.

[16] S. McAleese *et al.*, 'Gone for good? An online survey of emigrant health professionals using Facebook as a recruitment tool', *Human Resources for Health*, 14:34, June 2016, doi.org/10.1186/s12960-016-0130-y.
[17] Ibid.
[18] N. Humphries *et al.*, ''Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland', *Human Resources for Health*, 13:35, May 2015, doi.org/10.1186/s12960-015-0022-6.
[19] IMO NCHD Survey on Recruitment and Retention Issues, November 2017.

Difficulties Concerning NCHD Retention

NCHD Turnover

NCHDs are typically employed on three, four, or six-month, fixed-term contracts, after the conclusion of which NCHDs are then required to seek, or are assigned to, a subsequent fixed-term contract. This process generally continues until an NCHD achieves specialist qualification and obtains a permanent specialist post. Turnover figures regard all NCHDs who end contracts within the public health service as leavers, regardless of whether they take up a subsequent contract with the HSE, however, approximately 14% of all NCHD leavers resigned their posts, amounting to 647 NCHDs.[20] The reasons for these resignations are not published though, and it is difficult to infer whether emigration is their primary driver. Given, though, that many NCHD contracts are generally of three to six month duration, resignations may be an indicator of an intention to leave the public health service.

Additionally, exits from the medical register in Ireland give some indication of the extent of the problem in retention.

The table below demonstrates the percentage of doctors in various age categories who left the medical register in 2015 for Ireland, and 2014 in the United Kingdom. These are the most recent available statistics in both jurisdictions.

Irish Medical Council age group	**% exiting the medical register in Ireland**	**General Medical Council (UK) age group**	**% exiting the medical register in the UK**
Under 25	6.3%	20-29	1.6%
25-34	8.7%	30-39	3.4%
35-44	6.4%	40-49	4.0%
45-54	3.2%	50-59	6.0%
55-64	4.5%	60-69	14.9%
65 and over	11.6%	70 and over	18.0%

Source:[21]

This means that approximately one-in-ten doctors aged between 25 and 34 are leaving the Irish medical register, likely for medical posts abroad. Furthermore, an examination of exit rates from the medical registers in both Ireland and the United Kingdom reveal that, for younger age groups of doctor, the exit rate in Ireland far exceeds that of the United Kingdom. These exit rates point to an unusually high level of emigration from Ireland, far above the accepted norm of Ireland's nearest neighbouring health system.

Though figures for doctor emigration in Ireland are not being collected, Medical Council exit rates have been acknowledged in research, particularly for lower age cohorts, to be "the best available proxy for emigration",[22] as emigration appears to be a significant factor in driving exit rates in these age groups.[23] The paucity of research on doctor emigration from Ireland creates significant difficulties in assessing the true extent of doctor emigration from Ireland, however the Organisation for Economic

[20] Health Service Executive, *Staff Turnover Report 2016*, Dublin, 2016, p. 8.
[21] Medical Council of Ireland, *Medical Workforce Intelligence Report*, Dublin, Aug 2016, p. 32; General Medical Council of the United Kingdom, *The State of Medical Education and Practice in the UK: 2016 Reference tables – based on registration data*, London, 2016, tables 4 and 132.
[22] A. Walsh and R. Brugha, *Brain Drain to Brain Gain: Ireland's Two-Way Flow of Doctors*, Royal College of Surgeons in Ireland, Dublin, May 2015, p. 3.
[23] Ibid, p. 8.

Co-operation and Development (OECD) does provide some insight into the consistent trend in recent years of an increasing number of doctors moving from Ireland to English-speaking jurisdictions. These statistics reveal a 128% increase in the number of doctors, who received their medical degrees in Ireland, moving to practise in the UK annually, between 2008 and 2016 (108 to 246 per annum).[24] This increase is similarly pronounced in other English-speaking jurisdictions. In Australia, the number of Irish-trained doctors practising in that country has leapt from 828 to 1051, or 27%, in just two years (2013 to 2015). The total number of Irish-trained doctors working in New Zealand has grown from 139 in 2008 to 245 in 2016, a 76% increase, while the number of Irish-trained doctors working in Canada has grown from 1,198 in 2008 to 1,527 in 2015, a 28% increase (annual inflow increased from 97 to 210 in these years).

Other research confirms the extent of this emigration. A review of interns who entered the Irish health system in 2010 found that a year later, 45% were no longer working in the Irish public health system,[25] and that it was likely the majority had emigrated.[26]

NCHD Migration Intentions

While the extent of doctor emigration from Ireland can only largely be inferred, some significant research work has been conducted on the migratory intentions of Irish-trained doctors. The Medical Council's *Your Training Counts: Spotlight on trainee career and retention intentions* provides some insight into the intentions of trainees concerning emigration. In a survey of trainees, who were asked if they intended to practise medicine in Ireland for the foreseeable future, 24% said "yes, definitely", 34% said "yes, probably", 23% said "undecided", 13% said "no, probably not", and 7% said "definitely not".[27] All trainees, other than those who answered "yes, definitely", were subsequently asked why they were considering practising abroad. Responses are set out in the table below.

"I am considering practising medicine abroad because . . ."	**% of respondents in agreement**
I feel my workplace is understaffed	82.2%
I am expected to carry out too many non-core tasks	74.5%
There are limited career progression opportunities available to me here	71.8%
I can earn more abroad	69.7%
I do not have flexible training options	65.0%
I feel my employer does not support me in my work	61.9%
The working hours expected of me here are too long	60.2%
The quality of training available to me here is poor	51.5%
I have family/personal reasons for leaving	28.9%
I am not respected by senior colleagues	18.6%

[24] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Workforce Migration, Foreign-trained doctors by country of origin – annual inflow, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[25] Health Service Executive, *Implementation of the Reform of the Intern Year: Second Interim Report*, HSE Medical Education and Training, Dublin, April 2012, p. 22.

[26] N. Humphries *et al.*, ''Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland', *Human Resources for Health*, Vol. 13, No. 35, May 2015, doi:10.1186/s12960-015-0022-6.

[27] Medical Council of Ireland, *Your Training Counts: Spotlight on trainee career and retention intentions*, Dublin, 2016.

IMO NCHD Survey on Recruitment and Retention Issues

The IMO surveyed 474 NCHDs currently working in Ireland on issues pertinent to their recruitment and retention in the Irish health service.

In their responses just over 80% of NCHDs indicated that they were considering taking up a post abroad in the foreseeable future. Of the NCHDs considering taking up a post abroad in the foreseeable future, the most frequently cited factors leading them to consider a move were:

(i) better opportunities to avail of education, training and continuous professional development elsewhere (75.9%);
(ii) better workplace atmosphere, culture, and supports elsewhere (71.1%); higher doctor staffing levels elsewhere (70.1%);
(iii) shorter working hours elsewhere (66.7%);
(iv) higher levels of pay elsewhere (65.4%); and
(v) better medical facilities elsewhere (56.4%).[28]

As is evident from these responses, a multiplicity of factors converge to create migration intentions amongst NCHDs, of which pay is a significant factor, with approximately two-thirds of NCHDs who are considering a move abroad deeming pay to be a core motivating factor.

The centrality of pay as a driver of NCHD emigration is reinforced by the fact that:

- 66.2% of NCHDs perceive pay to be a primary reason for the emigration of their peers from Ireland, the second most popular response to this question, after better workplace atmosphere, culture, and supports elsewhere (71.1%).
- 82.3% of NCHDs believe their pay would be increased by moving abroad.
- 76% of NCHDs stated that improved levels of pay in Ireland would prove useful in ensuring their retention, and that of their peers, within the Irish health service, the most popular response to this question, ahead of improved opportunities to avail of training and continuous professional development in Ireland (75.1%), and improved workplace atmosphere, culture, and supports in Ireland (73.2%).
- 83% of NCHDs feel the pay disparity between existing consultants and their future colleagues since the 2012 consultant pay cut will impact on their decision whether or not to apply to consultant posts in the public system in Ireland.[29]

Additionally, 58.4% of NCHDs state that they have been approached by an agency or employer seeking to recruit them to a medical post in another jurisdiction, once again demonstrating the concerted efforts made by health employers in other jurisdictions to recruit Irish-trained doctors.

Pay as a Factor in Doctor Emigration

As is evident from the above responses, a multiplicity of factors drive NCHDs to consider working outside of Ireland. While workplace understaffing, expectations to carry out too many non-core tasks, and limited career progression in Ireland are identified as important drivers for NCHDs to consider emigration, the prospect of superior pay abroad also features prominently. Seven-in-ten NCHDs in Ireland are considering emigration at least partly on the basis that their earning potential is deemed to be better in other jurisdictions.[30] This research is supported by a recent assessment of the reasons for planned emigration amongst a cohort of 423 surveyed NCHDs based in Ireland, which found that,

[28] IMO NCHD Survey on Recruitment and Retention Issues, November 2017.
[29] Ibid.
[30] Ibid.

of those, only 18% were definitely committed to staying in Ireland.[31] Of those who did not express a definite intention to stay in Ireland, 76% cited pay as a factor influencing their decision to practise medicine abroad.[32]

Pay has been repeatedly found to be a driver of doctor emigration abroad. A study of over 2,200 medical students in Ireland found that 88% were definitely or contemplating migrating away from Ireland, while of these 65% cited pay as a main reason for planned migration.[33] The study's authors noted that salary was "a key factor influencing intentions to migrate".[34]

Migration Intentions of Foreign-Trained NCHDs

As aforementioned, today approximately four-in-ten doctors working in the Irish health system are foreign-trained, and therefore are integral to health service provision in Ireland. Many non-EU trained doctors are hired to fulfil service posts, or non-training posts, in the HSE, with these positions often unpopular with Irish-trained doctors due to the limited career progression they can provide. Non-EU trained doctors who take up these posts feel that their hopes for career progression and postgraduate training in Ireland had gone unrealised and that they were becoming de-skilled, and as a result most are actively considering onward migration from Ireland.[35]

The majority of non-EU trained doctors are planning to migrate from Ireland. Motivations for moving on related closely to respondents' initial reasons for coming to Ireland, namely to get access to structured training and progress their careers. These findings demonstrate the importance of aligning the needs of the destination country with those of the individual migrant doctor.[36]

A survey of 345 foreign doctors working in Ireland revealed that 30% planned to remain in Ireland, 23% planned to return home and 47% to migrate onwards. Country of origin, personal and professional reasons for migrating, experiences of training and supervision, opportunities for career progression, type of employment contract, citizenship status, and satisfaction with life in Ireland were all factors statistically significantly associated with the these migratory outcomes.[37]

Medical Training Costs and Student Debt as a Driver of Emigration

In addition, doctors in training bear significant costs associated with their training. NCHDs are required to attend supplementary courses and training conferences at home and abroad. While the HSE contributes to the cost of some of the courses, the recent removal of the training grant has resulted in a large increase to the cost of training for NCHDs, which is paid for from NCHDs' disposable income. It is estimated the average NCHD spends €20,000 to fund their training.[38] This estimation is supported

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[31] N. Clarke et al., 'Factors influencing trainee doctor emigration in a high income country: a mixed methods study', Human Resources for Health, Vol. 15, No. 66, 2017, doi:10.1186/s12960-017-0239-7.
[32] Ibid.
[33] P. Gouda *et al.*, 'Ireland's medical brain drain: migration intentions of Irish medical students', *Human Resources for Health*, Vol. 13, No. 11, Mar 2015, doi.org/10.1186/s12960-015-0003-9.
[34] Ibid.
[35] N. Humphries *et al.*, 'A cycle of brain gain, waste and drain - a qualitative study of non-EU migrant doctors in Ireland', *Human Resources for Health*, 11:63, December 2013, doi.org/10.1186/1478-4491-11-63.
[36] N. Humphries *et al.*, 'Chapter 10: "I am kind of in stalemate". The experiences of non-EU migrant doctors in Ireland' in Buchan *et al.* eds., *Health Professional Mobility in a Changing Europe: New dynamics, mobile individuals and diverse responses*, Vol. 2, World Health Organisation, Copenhagen, 2014, p. 245.
[37] R. Brugha *et al.*, 'Passing through – reasons why migrant doctors in Ireland plan to stay, return home or migrate onwards to new destination countries', *Human Resources for Health*, 14:35, June 2016, doi.org/10.1186/s12960-016-0121-z.
[38] Irish Medical Organisation, *Irish Medical Organisation Submission to the Public Service Pay Commission*, Dublin, January 2017, p. 9.

in peer-reviewed research that appeared in the *BMJ Open* in November 2017. This study examined the expenditure on training incurred by 58 Irish medical trainees and found that these trainees spent an average of €902 on mandatory courses, €2,164 in non-mandatory courses, and €1,183 on conferences in the past year in non-reimbursed expenditure.[39] The study also found that, since graduation, the average trainee had incurred €4,004 in non-reimbursed expenditure on exams since graduation.

The recent IMO NCHD Survey on Recruitment and Retention Issues of 474 NCHDs revealed that 95.6% stated that they had to pay out-of-pocket for training, 86.3% stated that they had to pay out-of-pocket for conferences, and 77.2% stated that they had to pay out-of-pocket for equipment, during the last two years. 96.8% of all NCHDs stated that these out-of-pocket payments had not been fully reimbursed, and 77.6% felt that these payments created difficulties for them in managing their household budgets.[40]

This level of expenditure by NCHDs operates as a substantial barrier to practising in Ireland. Whereas in the past a training grant had been available to NCHDs to cover the cost of occupational training, this has been removed. NCHDs should not be required to fund the costs of necessary or beneficial training, professional examinations, or equipment out-of-pocket, and all such expenditure should be borne by the HSE.

Student debt appears to play significantly on the minds of medical students in Ireland. An analysis of medical students at University College Cork recently found that 26% of direct entry medicine (DEM) students and 61% graduate entry medicine (GEM) students have loans with an anticipated average debt of €17,300 and €80,000 on graduation, respectively.[41] This study found that with "a monthly salary after tax of €2,072 for newly qualified interns, many graduates are struggling to meet repayments in the order of €1,300 per month to service a €100,000 Graduate [Entry] Medicine Loan," and that international research has demonstrated debt levels to be a strong predictor of medical workforce migration.[42]

NCHD Dissatisfaction with Working Conditions and Training

Broadly, NCHDs working in Ireland perceive many facets of their working conditions to be of a poor standard. Long working hours for NCHDs, far in excess of legal working time limits, have been a persistent feature of employment within the Irish health service, with recent research reporting that junior hospital doctors typically work 80 to 90 hours per week.[43] Though there has been some improvement in European Working Time Directive compliance since this research has concluded, NCHDs in many areas of the country still routinely work above 48 hours per week. Survey work conducted by the Royal College of Physicians of Ireland from 2014 found that hospital doctors work an average of 57 hours per week.[44] These problems have persisted despite legal action and the 2013 strike action by the IMO as part of its '24 No More' campaign.

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[39] J. O'Callaghan *et al.*, 'Cross-sectional study of the financial cost of training to the surgical trainee in the UK and Ireland', *BMJ Open*, Vol. 7, No. 11, Nov 2017, doi: 10.1136/bmjopen-2017-018086.
[40] IMO NCHD Survey on Recruitment and Retention Issues, November 2017.
[41] C. Haugh, B. Doyle, and S. O'Flynn, 'Debt Crisis Ahead for Irish Medical Students', *Irish Medical Journal*, Vol. 107, No. 6, Jun 2014, pp. 185-186.
[42] Ibid; M.S. Grayson, D.A. Newton, and L.F. Thompson, 'Payback time: the associations of debt and income with medical student career choice', *Medical Education*, Vol. 46, No. 10, Oct 2012, pp. 983-991.
[43] Y. McGowan *et al.*, 'Through doctors' eyes: A qualitative study of hospital doctor perspectives on their working conditions', *British Journal of Health Psychology*, Vol. 18, No. 4, November 2013, pp. 874-891.
[44] B. Hayes, G. Walsh, and L. Prihodova, *National Study of Wellbeing of Hospital Doctors in Ireland: Report on the 2014 National Survey*, Royal College of Physicians of Ireland, Dublin, April 2017, p. 4.

Dominant themes in an analysis of working conditions for hospital doctors in Ireland included the following: (1) unrealistic workloads, characterized by staff shortages, extended working hours, irregular and frequently interrupted breaks; (2) fatigue and its impact: the quality of care provided to patients while doctors were sleep-deprived was questioned; however, little reflection was given to any impact this may have had on NCHDs' own health; (3) undervalued and disillusioned: insufficient training, intensive workloads and a perceived lack of power to influence change resulted in a sense of detachment among NCHDs. They felt their roles were underappreciated and undervalued by policy makers and hospital management. Respondents were concerned with the lack of time and opportunity for training.[45]

Similarly, a study of 522 NCHDs found that 219 (45.8%) were slightly dissatisfied and 142 (29.7%) were extremely dissatisfied with practising medicine in Ireland. Major sources of dissatisfaction included the state of the health system, staffing cover for leave and illness, the dearth of consultant posts and the need to move around Ireland. The most important reason for NCHDs wishing to leave was to seek better training and career opportunities abroad. When asked about the quality of training 42.2% (198) rated training as acceptable, 40.3% (189) as poor, 15.4% (72) as good, while 2.1% (10) rated training as excellent. The study concludes that, in order to retain NCHDs in Ireland, they must be provided with attractive training and career opportunities.[46]

NCHD Burnout and Mental Health

A recent study, published by the Royal College of Physicians in Ireland about the health and well-being of hospital doctors in Ireland, found that one-third of hospital doctors suffer burnout; eight out of ten doctors have worked when ill or injured; 10% suffer from severe or extremely severe levels of stress, while 7% suffer from severe or extremely severe levels of depression; only half of all hospital doctors report normal psychological well-being.[47]

A separate study noted that Irish NCHD ten months into clinical practice were more burned out than a sample of US medical residents (72.6% and 60.3% burned out, respectively). The study also found that there was a significant increase in emotional exhaustion from four months of clinical practice to ten months of clinical practice. At ten months of clinical practice, of those respondents who were burned out, 66% reported making an error. A total of 48% of the NCHDs who were not burned out at ten months of clinical practice reported an error, marking a clear distinction between the two groups.[48]

The significant pressure placed on hospital doctors in Ireland has led to a deterioration in the mental health of many practitioners. A study of over 700 NCHDs in Ireland examined their responses to stress in their working environments. 60% of NCHDs were unable to take time off work when unwell, with 'letting teammates down' (90.8%) and 'difficulty covering call' (85.9%) the leading reasons. The high-level of NCHD working commitments has meant the 85% of NCHDs felt deterred from attending a GP regarding their illness. 55% of respondents had to move away from partners or dependants due to

[45] Y. McGowan *et al.*, 'Through doctors' eyes: A qualitative study of hospital doctor perspectives on their working conditions', *British Journal of Health Psychology*, Vol. 18, No. 4, November 2013, pp. 874-891.
[46] R. Bruce-Brand et al., 'Diagnosing the Doctors' Departure: Survey on Sources of Dissatisfaction Among Irish NCHDs', *Irish Medical Journal*, Vol. 105, No. 1, January 2012, pp. 15-18.
[47] B. Hayes, G. Walsh, and L. Prihodova, *National Study of Wellbeing of Hospital Doctors in Ireland: Report on the 2014 National Survey*, Royal College of Physicians of Ireland, Dublin, April 2017, p. 4.
[48] P. O'Connor *et al.*, 'A longitudinal and multicentre study of burnout and error in Irish NCHDs', *Postgraduate Medical Journal*, August 2017, doi: 10.1136/postgradmedj-2016-134626.

work, negatively affecting the social supports of 82.9%.[49] Estimates would indicate that between 12% and 15% of practitioners may experience problems with mental health or substance use issues.[50]

[49] S. Feeney *et al.*, 'Practise what you preach: health behaviours and stress among non-consultant hospital doctors', *Clinical Medicine*, Vol. 16, No. 1, February 2016, pp. 12-18.
[50] Practitioner Health, *Practitioner Health Matters Programme Report 2015-2016*, Dublin, 2016, p. 12.

Irish Doctors Trained for Export

28%

Increase in Irish trained doctors working in Canada from 2008-2015

128%

Increase in Irish trained doctors moving to UK annually from 2008-2016

27%

Increase in Irish trained doctors working in Australia from 2013-2015

76%

Increase in Irish trained doctors working in New Zealand from 2008-2016

A Failure to Address the Problems of a "Toxic Employer"

There has been a failure to make serious attempts to address the recruitment and retention difficulties within medical posts in the Irish health service. When NCHDs working in Ireland were asked if they were aware of any initiatives by the HSE or Department of Health that aim to retain doctors in Ireland, 91.4% replied "no".[51]

Quite apart from making no serious effort to launch effective recruitment and retention initiatives, the HSE has actively failed to tackle many serious barriers to recruitment and retention.

Dr. Rhona Mahony, current Master of the National Maternity Hospital, Holles Street, in her presentation at the IMO's Doolin Memorial Lecture noted that "the HSE is perceived to be a toxic employer – a damning indictment of a body that is meant to facilitate the delivery of healthcare in Ireland. . . and the current policies of the HSE surrounding recruitment and retention of doctors in Ireland are failing."[52]

Numerous cultural issues that act as a barrier to recruitment and retention within the HSE have often failed to be meaningfully addressed by the organisation's initiatives. Bullying, harassment, and sexual harassment appear to remain common features of medical practice in Ireland, despite efforts to curtail their impact and prevalence. The Medical Council's *Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2015* shows that 35% of trainee doctors working in Ireland reported that they had been victims of bullying and harassment, while 46% said they had been the victims of undermining behaviour, at least once, as a result of the actions of a consultant or general practitioner.[53] There appears, from this research, to be an inverse correlation between the clinical experience or seniority of the trainee and the probability of him or her being a victim of bullying, as 48% of interns, 34% of those in basic specialist training, and 28% of those in higher specialist training, report being bullied at least once in their posts.[54]

Research conducted by the Irish Medical Organisation shows that 27.7% of female NCHDs, 13.2% of female consultants, 10.4% of GPs, and 5% of community health and public health doctors surveyed report being bullied on the basis of their gender during the last two years, while 21% of female NCHDs reported being sexually harassed in the workplace in the same time period.[55]

Discrepancies in specialty choice is a core issue that has not been adequately addressed. Approximately 41% of all doctors practising within the state are female,[56] and 39% of consultants within the public health service are female.[57] This headline figure, however, belies considerable nuance within the overall structure of medical leadership in hospitals and the disparities that exist between the ratios of male to female consultants across various specialities. Dermatology, geriatric medicine, medical oncology, obstetrics and gynaecology, paediatrics, pathology, psychiatry, and

[51] IMO NCHD Survey on Recruitment and Retention Issues, November 2017.
[52] R. Mahony, *Presentation to the Irish Medical Organisation Doolin Memorial Lecture*, 2 December 2017.
[53] Medical Council, Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2015, Dublin, 2015, p. 29.
[54] Ibid.
[55] IMO Survey on Gender Issues in Irish Medicine, December 2016.
[56] Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 58
[57] Health Service Executive, *Consultants by Specialty (HSE & S38 Agencies): December 2016*, 2016, p. 1.

ophthalmology, for example, are some of the areas of specialisation in which there is approximately equal gender representation or, in some areas, female dominance in terms of representation in consultant posts, relative to the percentage of female doctors in practice generally. Other areas, however, such as cardiology, endocrinology, nephrology, neurology and most of the surgical specialties exhibit disproportionately high male representation.[58] In fact, only about one-in-ten consultant surgeons in Ireland are female.

Dr. Mahony's presentation at the IMO's Doolin Memorial Lecture also pointed to the lack of flexibility in medical training that inhibits the balancing of family commitments and the pursuit of a career in medicine. She noted that:

> "at no time have discussions surrounding our supports for parents been more relevant and this is not just politically correct but this is a political imperative. And this conversation is particularly needed in medicine. . . women are deferring childbirth to accommodate training demands. And many fathers are deeply involved in parenting but how do we facilitate parents to rear their children healthily but still pursue demanding careers? Flexible working structures and robust affordable childcare would be a good start."

She furthermore remarked on the need to:

> "honestly appraise training locations and ensure that trainees are circulated around the country for real training purposes and not for service. The ritual annual circulation of obstetric trainees to hospitals all over Ireland creates real stress for young families on registrar salaries, who spend time separated from their families and with the financial burden of relocation."

Our health services ensure that all medical practitioners are protected from discrimination on the basis of their gender, and that harmful behaviours that undermine the dignity and welfare of those providing care to patients are eliminated from the workplace. Similarly, significant gender disparities within individual fields of medical practice should not be permitted to continue unchallenged, as predominance of one gender over another in leadership risks producing cultural barriers to practice in specific areas, and can lead to the perception of bias. Improved efforts must also be made to better the work-life balance experienced by medical practitioners and their abilities to comfortably meet their family commitments, through extended supports and revised management practices.

[58] Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 60.

The Recruitment and Retention Crisis and the Effect on Our Health Services

1993's *Medical Manpower in Acute Hospitals: A Discussion Document* (The Tierney Report); 2003's *Report of the National Task Force on Medical Staffing* (The Hanly Report); and 2006's *Preparing Ireland's Doctors to Meet the Health Needs of the 21st Century* (The Buttimer Report) all placed a focus on significantly reducing the ratio of NCHDs to consultants and employing greater numbers of consultants to provide a consultant-delivered, rather than led, health service.[59] Regrettably, however, there has been little change in the NCHD to consultant ratio which has stood at roughly 2:1 for the past 25 years, despite consistent calls throughout that period for a move to a consultant-delivered service and a reduction in the NCHD to consultant ratio. Consultant-delivered care been widely accepted as the most effective and appropriate method of providing health services in a hospital setting, resulting in improved quality of care and patient safety as important clinical decisions would be made faster and at a higher level. Accordingly, a failure to recruit and employ a sufficient number of consultants to deliver services to patients has resulted in the suboptimal delivery of care in Ireland. According to ratios provided in The Hanly Report, based on population the Irish health service should employ approximately 4,400 consultants,[60] however at present only around 3,000 consultant posts have been approved, while just 2,427 have been permanently filled.[61]

Greater effort must be made to ensure progression of NCHDs working in Ireland to consultant posts. Ireland already possesses far fewer doctors per capita than the EU average (2.9 practising physicians per 1,000 population, compared with an EU average of approximately 3.4),[62] and accordingly the health service requires a considerable expansion of its medical workforce to ensure appropriate service provision. This expansion in hospitals should occur within the consultant workforce, with provisions emplaced to better facilitate the transition of doctors-in-training in Ireland into these roles.

The inadequacy of medical staffing in Ireland has contributed to high profile service failings across numerous specialties, which have been highlighted in recent months. For example, in late 2016 staffing inadequacies at the Mater Misericordiae University Hospital's cardiology unit garnered national media and parliamentary attention, where Prof. Kevin Walsh, a consultant cardiologist at the hospital, noted that a failure to employ adequate numbers of staff was leading to severe restrictions. He pointed out that UK NHS recommendations state that there should be four full-time consultants at the Mater Hospital's cardiology unit for the number of patients being treated, however instead there were just two part-time consultants filling those essential roles.[63] He also added that lives were being risked by the failure to staff the service in the correct manner. Throughout this hospital 240 consultant posts have been approved but only 144 (60%) have been permanently filled. Similarly, the report of

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[59] Department of Health, *Medical Manpower in Acute Hospitals: A Discussion Document*, Dublin, 1993; National Task Force on Medical Staffing, *Report of the National Task Force on Medical Staffing*, Dublin, 2003; The Postgraduate Medical Education and Training Group, *Preparing Ireland's Doctors to meet the Health Needs of the 21st Century: Report of the Postgraduate Medical Education and Training Group*, Dublin, 2006.

[60] National Task Force on Medical Staffing, *Report of the National Task Force on Medical Staffing*, Dublin, 2003, p. 14.

[61] R. Bruton, Seanad Éireann Debates, 22 June 2017.

[62] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, Physicians, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[63] D. Buckley, 'Top role in cardiology at Mater Hospital 'had no applicants'', *The Irish Examiner*, 20 October 2016.

the Ombudsman for Children on the standard of paediatric scoliosis treatment identified a lack of qualified consultant orthopaedic surgeons in Ireland as a core reason for the unacceptably long waiting lists in this area.[64] Again, recently, the Seanad Éireann Public Consultation Committee Report on Children's Mental Health Services recognised the "HSE's chronic inability to recruit nurses and child psychiatrists to commission" children and adolescent mental health service in-patient beds, and to "to operate the existing bed compliment in Ireland".[65] Many aspects of these psychiatric services operate far below even their approved medical staffing complement. For example Dublin South's child and adolescent mental health services have six consultant psychiatrist posts approved, however this service currently operates with a single part-time consultants. This report specifically referenced consultant pay disparity between equally qualified colleagues due to the 2012 consultant pay cut as a barrier to consultant recruitment in Ireland,[66] and that "[h]ealth staff ought to be remunerated at an internationally competitive level".[67]

These examples do not serve as evidence of particular difficulties within these individual specialties, but rather as evidence that the problems arising from insufficient medical staffing span across the entire health service and touch all areas of practice. Even a cursory glance at hospital waiting lists produced by the National Treatment Purchase Fund reveals excessive in-patient and outpatient waiting lists across all specialties, which have approximately trebled over the past two years in terms of the number of patients waiting longer than 12 months for treatment.[68]

[64] Ombudsman for Children, *Waiting for Scoliosis Treatment: A Children's Rights Issue*, Dublin, March 2017, p. 8.
[65] Seanad Éireann Public Consultation Committee, *Seanad Éireann Public Consultation Committee Report on Children's Mental Health Services*, Dublin, Oct 2017, p. 8
[66] Ibid, p. 16
[67] Ibid, p . 38.
[68] National Treatment Purchase Fund, National Waiting List Data.

An International Pay Comparison

Intense competition exists to recruit trained medical practitioners globally. In 2013 the WHO estimated that there existed a global shortage of approximately 2.6 million doctors.[69] Across Europe considerable deficits in the healthcare workforce exist, with 21 of 29 European countries reporting vacancies in their healthcare workforce in a recent European Commission study, including Ireland where difficulties in the recruitment of doctors was specifically noted.[70]

The majority of doctors working in Ireland have been specifically contacted by agencies or employers from other jurisdictions, seeking to recruit them to medical posts abroad. In a recent IMO survey 58.4% of NCHDs said that they have been approached by an agency or employer seeking to recruit them to a medical post in another jurisdiction. Various media reports in recent years have established the concerted recruitment efforts being made by employers in other English-speaking jurisdictions to lure Irish-trained doctors to posts within their states.[71]

Pay Comparisons with Other English-speaking Jurisdictions

In its submission to this Commission earlier this year, the IMO set out a pay comparison between the salaries of NCHDs working in other, major English-speaking jurisdictions. This pay comparison established that, when rates of taxation and purchasing power parity is taken into account, salaries offered in Ireland often fall below that available in comparator health systems. The pay comparison from that submission is set out below, for your consideration.

NCHDs' Pay – An International Comparison

Payment is an acknowledged 'pull-factor' for Irish doctors, that is to say a lure for doctors to move to work outside of Ireland. The Medical Council's *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, which surveyed doctors in training in Ireland, revealed that, of those considering practising medicine abroad 70% agreed their potential ability to garner better payment abroad was a motivating factor.[72]

When comparing Ireland to other developed healthcare systems in English-speaking jurisdictions, it is evident that this belief is rooted in reality. Table 1 compares the post-tax pay for NCHDs in Ireland across eleven points on the salary scale (one as an Intern, three as a Senior House Officer, and the remaining seven as a Specialist Registrar), with comparators in other English-speaking jurisdictions. These jurisdictions are England, New South Wales in Australia, Victoria in Australia, Ontario in Canada, British Columbia in Canada, as well as the urban and rural pay rates for New Zealand comparators. While net pay comparisons, the pay available after taxation has been deducted, do provide some indication of where the remuneration of doctors in Ireland sits in relation to comparable health systems, it is inferior to a comparison of net pay which has been aligned to reflect 'Purchasing Power Parity'.

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[69] World Health Organisation, *Global strategy on human resources for health: Workforce 2030*, Geneva, 2016, Annex 1.

[70] European Commission, *Mapping and Analysing Bottleneck Vacancies in EU Labour Markets: Overview report Final*, Brussels, 2014, p. 68-69.

[71] B. Heffernan, 'Canada offering €380,000 carrot to Irish GPs', *Irish Independent*, 3 March 2012; G. Culliton, 'Entry to Canada has been streamlined for Irish doctors', *Irish Medical Times*, 29 October 2015; C. Kenny, 'An Irish welcome: how Australia recruits doctors and nurses', *The Irish Times*, 14 October 2014; C. Kenny, 'Why has Ireland lost so many doctors and nurses?', *The Irish Times*, 7 September 2015.

[72] Medical Council, Your Training Counts: Spotlight on Trainee Career and Retention Intentions, Dublin, 2016, p. 24.

Table 1 - Net Pay in Euro (Post Tax)

Year on Scale	Ireland	England	Australia (N.S.W.)	Australia (Vic.)	Canada (Ont.)	Canada (B.C.)	New Zealand (Urban)	New Zealand (Rural)
1	€26,523	€24,963	€35,223	€36,580	€32,754	€30,190	€31,306	€32,382
2	€30,381	€28,309	€40,249	€38,519	€35,943	€33,204	€33,285	€34,664
3	€31,471	€32,824	€43,682	€41,255	€38,459	€35,816	€34,902	€36,357
4	€33,100	€32,824	€48,474	€51,906	€40,711	€38,238	€36,521	€38,044
5	€41,271	€40,269	€51,887	€54,373	€43,544	€40,812	€38,485	€39,585
6	€42,316	€40,269	€55,315	€56,112	€45,708	€43,295	€40,219	€41,603
7	€43,063	€40,269	€58,605	€58,486	€47,219	€45,776	€41,938	€43,393
8	€43,592	€40,269	€64,831	€65,328	€49,332		€43,673	€45,194
9	€44,132	€40,269		€68,158	€51,269		€45,388	€46,979
10	€45,602	€40,269					€53,283	€55,195
11	€47,024						€55,282	€57,267
12							€57,344	€59,414
13							€59,495	€61,649
14							€61,735	€63,980

[73] See footnote for salary sources.

The alignment of net pay to account for 'Purchasing Power Parity' provides a more accurate comparison of payment rates. Using data provided by the Organisation for Economic Co-operation and Development, these salaries scales have been weighted to reflect their actual purchasing power in their corresponding jurisdictions, relative to the purchasing power of Irish salaries. The net effect of such an alignment is to raise, in terms relative to Irish pay rates, the salaries in England and Canada, where the cost of living is generally lower than Ireland, and depress them in Australia and New Zealand, where the cost of living is generally higher than Ireland.

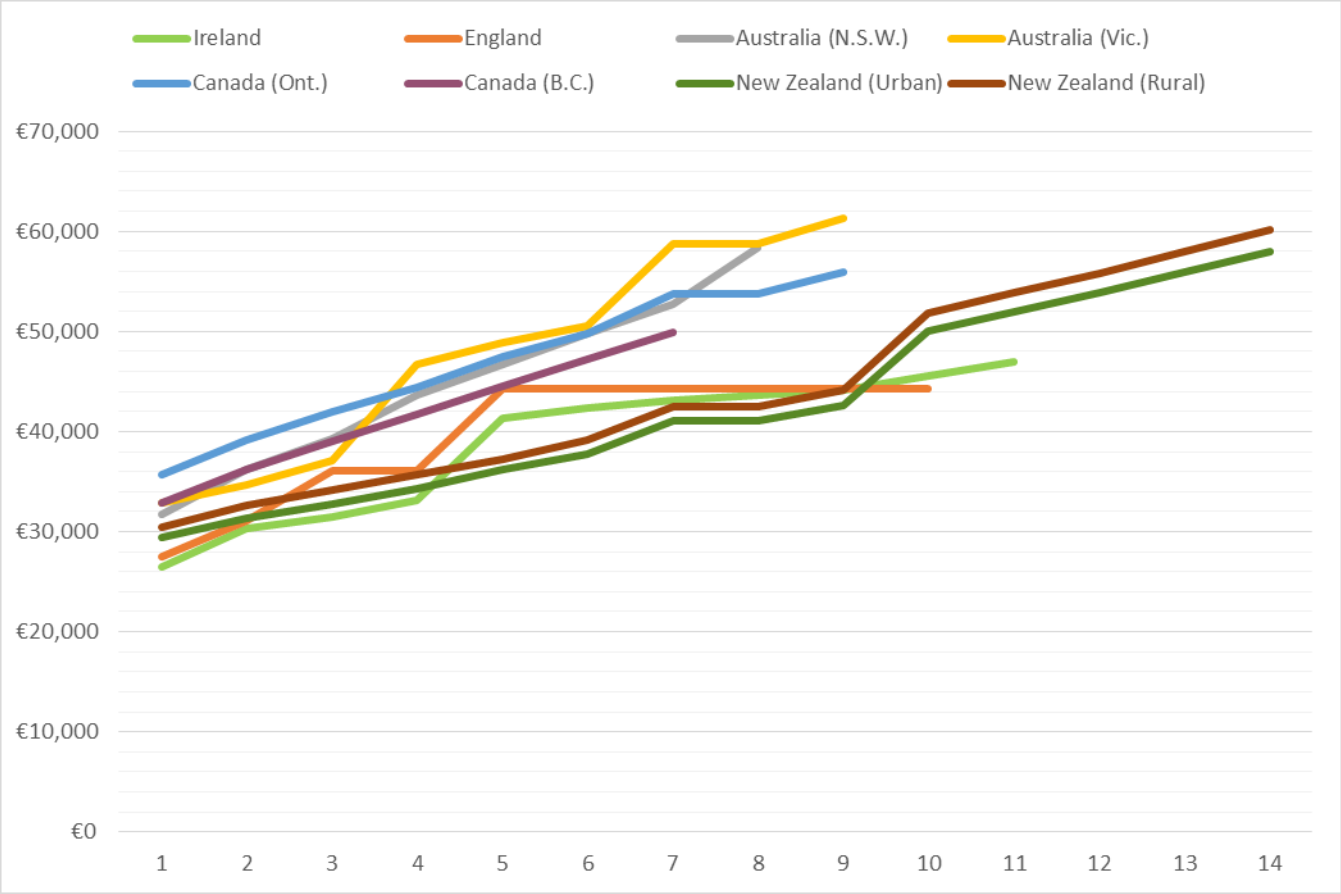
Table 2 - Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted

Year on Scale	Ireland	England	Australia (N.S.W.)	Australia (Vic.)	Canada (Ont.)	Canada (B.C.)	New Zealand (Urban)	New Zealand (Rural)
1	€26,523	€27,459	€31,701	€32,922	€35,702	€32,907	€29,428	€30,439
2	€30,381	€31,140	€36,224	€34,667	€39,178	€36,192	€31,288	€32,584
3	€31,471	€36,106	€39,314	€37,130	€41,920	€39,039	€32,808	€34,176
4	€33,100	€36,106	€43,627	€46,715	€44,375	€41,679	€34,330	€35,761
5	€41,271	€44,296	€46,698	€48,936	€47,463	€44,485	€36,176	€37,210
6	€42,316	€44,296	€49,784	€50,501	€49,822	€47,192	€37,806	€39,107
7	€43,063	€44,296	€52,745	€58,795	€53,772	€49,896	€41,053	€42,482
8	€43,592	€44,296	€58,348	€58,795	€53,772		€41,053	€42,482

[73] NHS Employers, *Pay and Conditions Circular (M&D) 1/2016*, July 2016, available at: http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Pay%20and%20Conditions%20Circular%20MD%202201625072016.pdf; New South Wales Government Ministry of Health, *Salary Increases for Staff in the NSW Health Service - HSU and ASMOF Awards*, September 2016, available at: http://www0.health.nsw.gov.au/policies/ib/2016/pdf/IB2016_049.pdf; Australian Medical Association Victoria, *Rates of Pay: Doctors in Training*, December 2015, available at: https://amavic.com.au/page/Doctors_in_Training/What_is_the_AMA_doing_for_you/Rates_of_Pay_Doctors_in_Training/; The Professional Association of Residents of Ontario, *2013-2016 PARO-CAHO Agreement*, available at: http://www.myparo.ca/Contract/PARO-CAHO_Agreement#Annual Salary Scale; Professional Association of Residents of British Columbia, *Collective Agreement between HEABC and PAR-BC*, 2014, http://residentdoctorsbc.ca/wp-content/uploads/2015/05/2014-2019-CA.pdf; New Zealand Resident Doctors' Association, *Multi-employer Collective Agreement*, available at: http://www.nzrda.org.nz/wp-content/uploads/RDA-and-DHBs-MECA-21-1-15-to-29-2-16.pdf.

9	€44,132	€44,296		€61,342	€55,883		€42,665	€44,160
10	€45,602	€44,296					€50,086	€51,883
11	€47,024						€51,965	€53,831
12							€53,903	€55,849
13							€55,925	€57,950
14							€58,031	€60,141

Figure 1 – NCHDs' Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted – Line Graph of Table 2 Data



It is clear from Table 2, and the above graph, that pay rates for NCHDs in Ireland do not, on the whole compare favourably with those from comparator jurisdictions and are inferior to those available in England, Australia, and Canada. Irish pay rates are superior to those in New Zealand for the middle portion of an NCHD's career, however are inferior to those available in New Zealand at the start and towards the end of the NCHD salary scale.

Payment rates for NCHDs in Ireland are based on contracts for a thirty-nine hour working week. This compares with a forty hour week in England; a combination of thirty-eight and forty-three hour weeks in Victoria; a thirty-eight hour week in New South Wales, and between a forty and forty-four hour week for Category F doctors in New Zealand, on which the New Zealand salary figures presented here are based. Irish NCHDs, however, frequently work overtime hours far above the thirty-nine for which they are contracted, which has the effect of reducing the work-life balance and thus the quality of life of Irish NCHDs relative to their international comparators. This is not adequately compensated for under existing pay arrangements.

The large discrepancy between the pay available for NCHDs in Ireland and elsewhere in the English-speaking world renders the retention of Irish NCHDs extremely difficult in an increasingly competitive and international market in which medical practitioners from Ireland are highly regarded. There is no reality to the prospect of successful retention of NCHDs within the Irish health system where wages lag so far behind those available elsewhere. Accordingly, significant increases in salary, to bring them into line with those available in Canada, Australia, and elsewhere, will be required for NCHDs if their continuing exodus from Ireland is to be stemmed.

A History of State Failure to Honour NCHD' Contracts

In the Irish public health system, the relationship between Doctors and their employers has been marked by protracted disputes that have fed into a lingering sense of alienation among the medical profession. While one must accept that there are few industrial relations issues that lend themselves to speedy resolution, the length of time taken in resolving some issues in the medical profession has, all too often, resulted in those issues being brought before the Courts. Quite aside from the expenses incurred, the perception that it is only through the Courts that issues can be resolved, has served to foster disaffection among those Doctors whose skills and expertise we need to recruit and to retain.

Some examples may serve to illustrate the point.

Over and above contracts, Doctors have had to take radical steps to secure their basic rights and entitlements. The European Working Time Directive (EWTD) was incorporated into Irish law via the Organisation of Working Time Act (1997). While Ireland secured a derogation from the Directive as it applied to Non Consultant Hospital Doctors (NCHDs), when the derogation lapsed in 2009, little if any work had been done by the employer to bring NCHD working hours into line with the law. In order to secure these basic rights – rights to reasonable working hours and appropriate rest times – NCHDs had to firstly vote for industrial action, in 2009 and then, through the IMO, pursue the matter through the High Court, in 2010.

Simultaneously, NCHDs and the IMO have continuously had to fight to secure contractually obligated payment for overtime worked, and access to previously agreed training time and training funding.

It was the HSE's ongoing inability to implement the EWTD for NCHDs that was the direct cause of the most recent Doctors strike - the 2013 '24 No More' industrial action. This action was, primarily, in pursuit of the elimination of 24 hour shifts. Doctors want to be treating patients, this is what they are trained for and what they are committed to, and yet, as recently as four years ago, one group of Doctors were compelled to take industrial action so they wouldn't have to work for a whole day without a break.

It is worth saying that such routine flouting of the basics of health and safety rules and regulations doesn't happen anywhere else, and that Doctors had to strike to stop it happening to them should be a cause of shame to health service management.

As recently as last year, the IMO was forced back to Court on behalf of NCHDs to get the employer to even talk to the IMO about the restoration of an allowance that was withdrawn in 2012. It is a grim situation indeed, when Doctors have to go to Court to even get into talks.

If we are serious about recruiting Doctors into the Irish public health system and retaining them once we have them, the disingenuous disregard shown to legitimate grievances and concerns raised by Doctors has to end. To this day, the IMO remains engaged in working to have contractual terms and conditions, nationally agreed, implemented. It is immensely frustrating for Doctors to have to fight to have agreed terms and conditions honoured. It is also damaging and self-defeating for the health service if the intention is to retain skilled medical professionals within that service.

Protracted industrial relations disputes, all too often culminating in legal proceedings, have done dreadful reputational damage to the Irish public health service among medical professionals; if we are serious about recruitment and retention this has to end.