



IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation Submission to the Public
Service Pay Commission on

Public Health Doctor Recruitment and Retention Issues

#Trained4  port

IMO fighting to end Ireland's healthcare brain drain

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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).

Difficulties Concerning Public Health Doctor Recruitment

Directors of Public Health Medicine

Directors of Public Health (DPHs) are trained Specialists in Public Health Medicine who are responsible within their defined population for the delivery of measureable health improvement, health protection including actions for the prevention and control of infectious disease, environmental hazards and response to emergencies that threaten health, public health input to health and care service planning and commissioning and reduction of health inequalities. They are likely to have further responsibilities as senior leaders including corporate roles. The core purpose is to act as independent advocate for the health of the population and provide system leadership for its improvement and development. They lead local departments of Public Health, and assume responsibility for the multidisciplinary staff under their remit. There are currently eight such departments, serving between 3 and 6 city / county council areas. There is a one point pay scale for the DPH €122314 with no opportunity for progression regardless of service.

Currently there are 8 Directors of Public Health (DPHs) employed to cover the 8 Departments of Public Health. However the service has experienced great difficulties in recruiting DPHs on a permanent basis for a number of years. Doctors in the Director of Public Health / Assistant National Director grade also hold positions at national level, for example in the Health Protection Surveillance Centre (HPSC) and the National Cancer Control Programme.

The Department of Public Health for Dublin, Kildare and Wicklow have only recently filled the post on a permanent basis. From 2011 to 2017 the post was filled on an acting basis.

In Cavan/Louth/Meath/Monaghan the DPH post is currently filled on an acting basis and has been since 2006.

The South East (Carlow/ Kilkenny / South Tipperary/ Waterford/ Wexford) currently has an acting director in place.

In Limerick/Clare/North Tipperary the DPH position saw a number of doctors (5 in total) acting in the role from 2005-2017.

In Cork/Kerry the position was filled on an acting basis from 2014 to August 2017.

Recruitment to the Director of Public Health position on a permanent basis has proved extremely difficult across the service over the 8 public health departments but also for national roles. Recruitment to the position of Director of the HPSC in 2016 & 2017 failed to attract an eligible candidate despite a number of attempts and remains unfilled.

The Assistant National Director of Public Health is acting in that role and has also filled gaps in the out-of-hours on call rota in the North East for several years.

According to the most recent HSE data the vacancy for the position of Director of the HPSC still exists despite the numerous attempts to fill it. This is a strategic post with both national and international responsibilities; the failure to fill this post means that Ireland is deficient in meeting its obligations under International Health Regulations. This vacancy offers a stark demonstration that there exists

little to no competition for senior public health medical posts in Ireland, due to inadequate remuneration by international comparisons

Accordingly, health services management has little choice in the personnel it employs and in a significant number of cases has to appoint practitioners on an acting basis. It is clear that this state of affairs does not provide for the safe operation of an effective Public Health function in Ireland.

Specialists in Public Health Medicine

Specialists in Public Health Medicine (SPHM), in a manner identical to their hospital consultant colleagues, are medical professionals who must hold specialist registration with the Irish Medical Council, and who by virtue of their expertise, are consulted by other medical professionals, and others, in the delivery of patient care. As with hospital consultants, SPHMs must be successful in a competitive interview process to enter Higher Specialist Training and undergo rigorous training according to standards set by the Faculty of Public Health Medicine of the Royal College of Physicians of Ireland and agreed with the Irish Medical Council. The majority of Specialists in Public Health Medicine are based in local Departments of Public Health, and perform both national and local roles. There is a one point pay scale for the SPHM of €106274 with no opportunity for progression regardless of service.

The 2003 LRC agreement sets out that there should be 52 WTE SPHMs across the 8 public health departments. At present there are 40.34 WTE SPHMs across the 8 public health areas. These figures provided by the HSE are believed to include some SPHMs employed on a temporary or locum basis. There is a clear gap identified in the 8 departments of public health of 11.66 WTE SPHM; however, when SPHMs who are only nominally based in these departments but in fact work elsewhere (i.e. on Clinical Programmes) are taken into account this shortfall increases to 19.41 WTE.

In addition to departments of Public Health, a further 11 SPHMs work across the National Immunisation Office (2 WTE), HPSC (6 WTE), Saolta Healthcare (1.2) & Corporate (1.8).

Senior Medical Officers

Senior Medical Officers (SMOs) who work in departments of public health provide a clinical service to those with a notifiable disease as laid out by statutory regulations which are updated as infectious disease epidemiology evolves.

The 2003 LRC Agreement recognised a need for a complement of 40 WTE Senior Medical Officers. The latest figures available to us from the HSE show that there are currently 16.12 WTEs in post; a shortfall of some 23.88 or 54%. The top point on the salary scale is currently €85,156 after six years' service with a further two Long Service Increments which are available after three and six further years of service.

Of the 16.12 WTE referred to above, 2 are employed at the grade of Area Medical Officer, a grade that was phased out as part of the agreement concluded in 2003. Their status has not yet been regularised despite extensive engagement with the HSE on this issue.

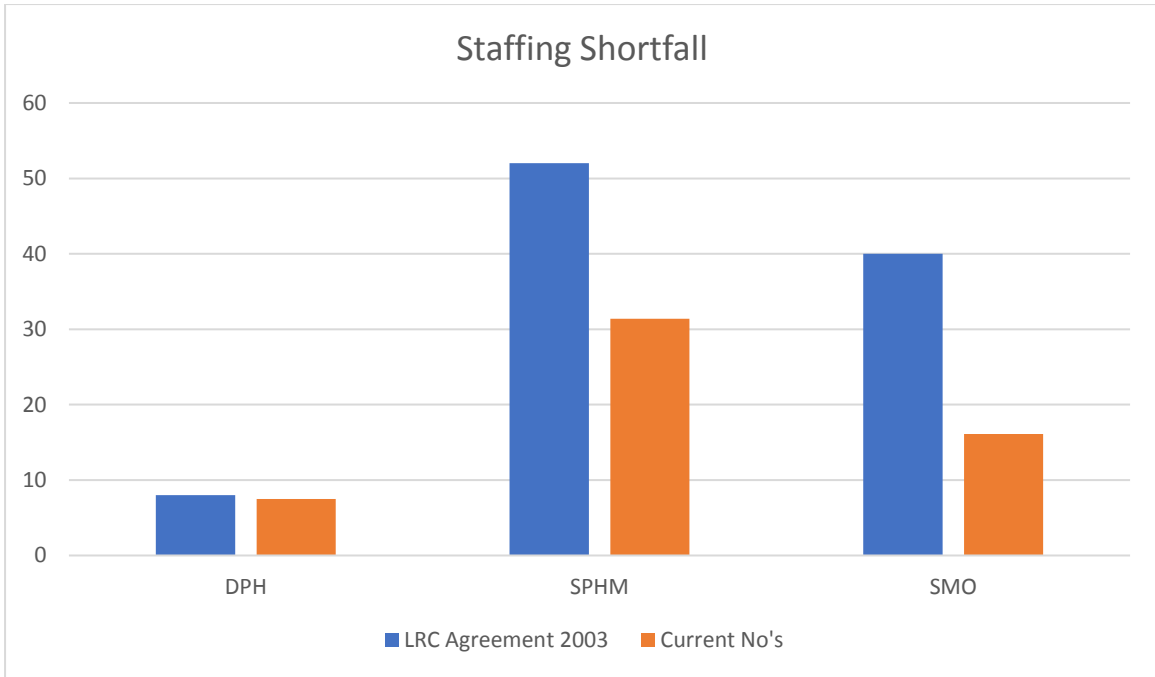


Figure 1 – Illustrates the shortfall of medical staff in Public Health Departments across all the grades.

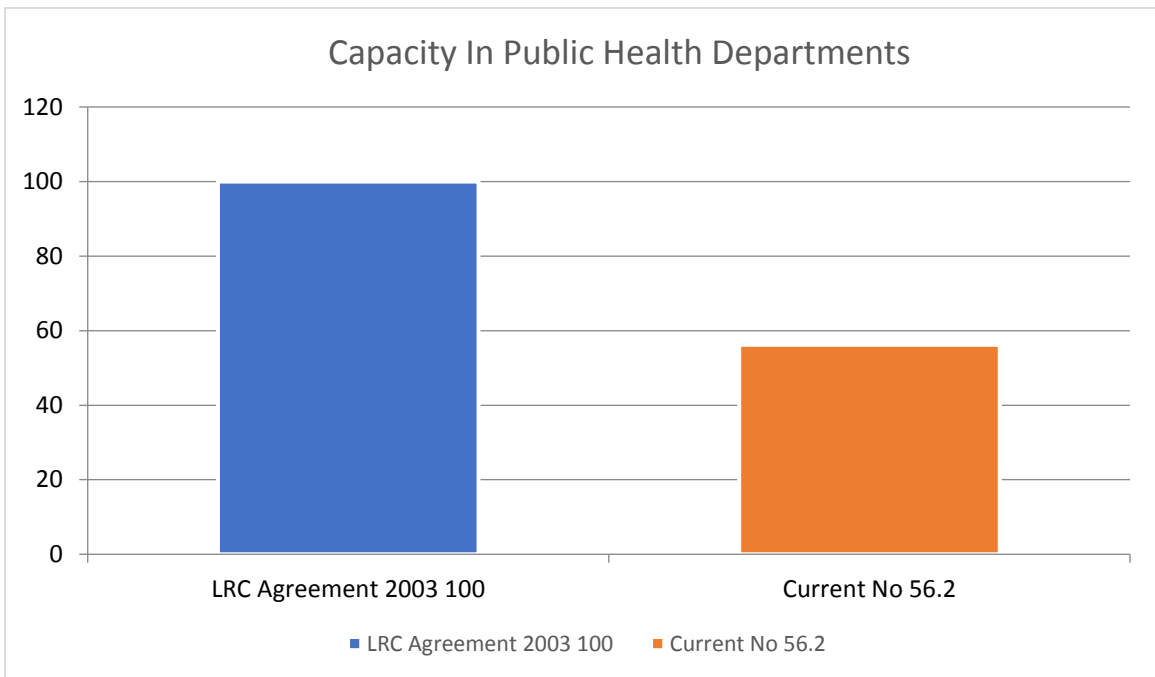


Figure 2 – Illustrates that across the Public Health Departments it is operating with 56.2% of agreed medical staffing.

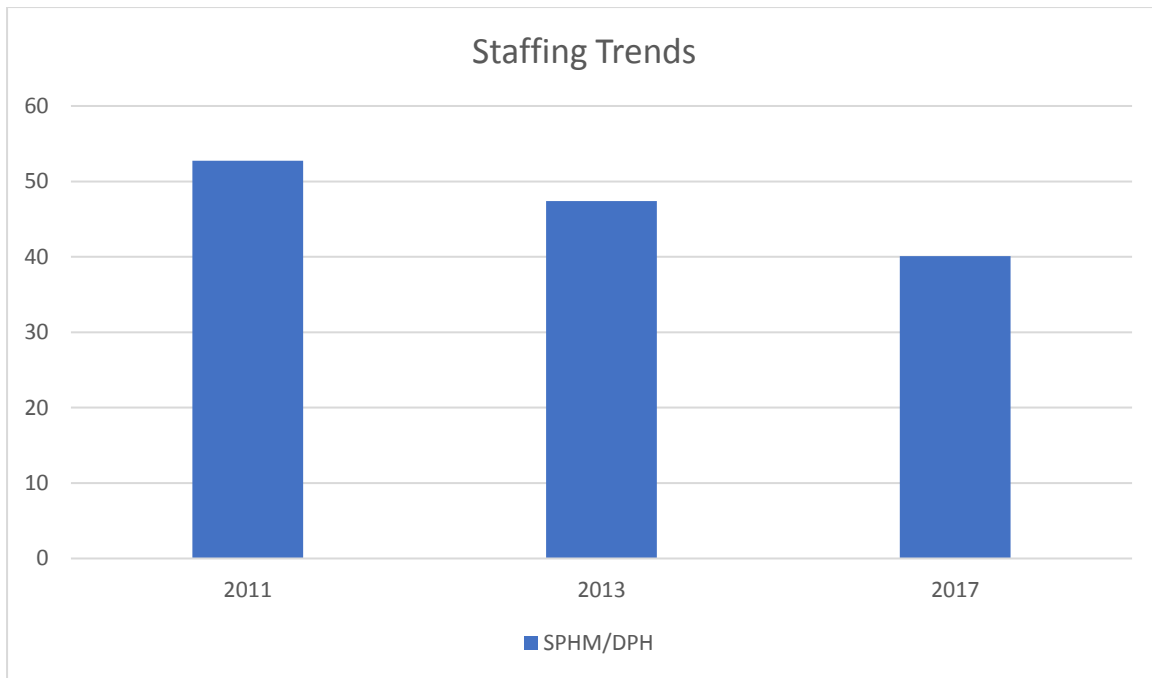


Figure 3 - Illustrates the downward trend in medical staffing numbers of DPH/SPHM in Public Health Departments

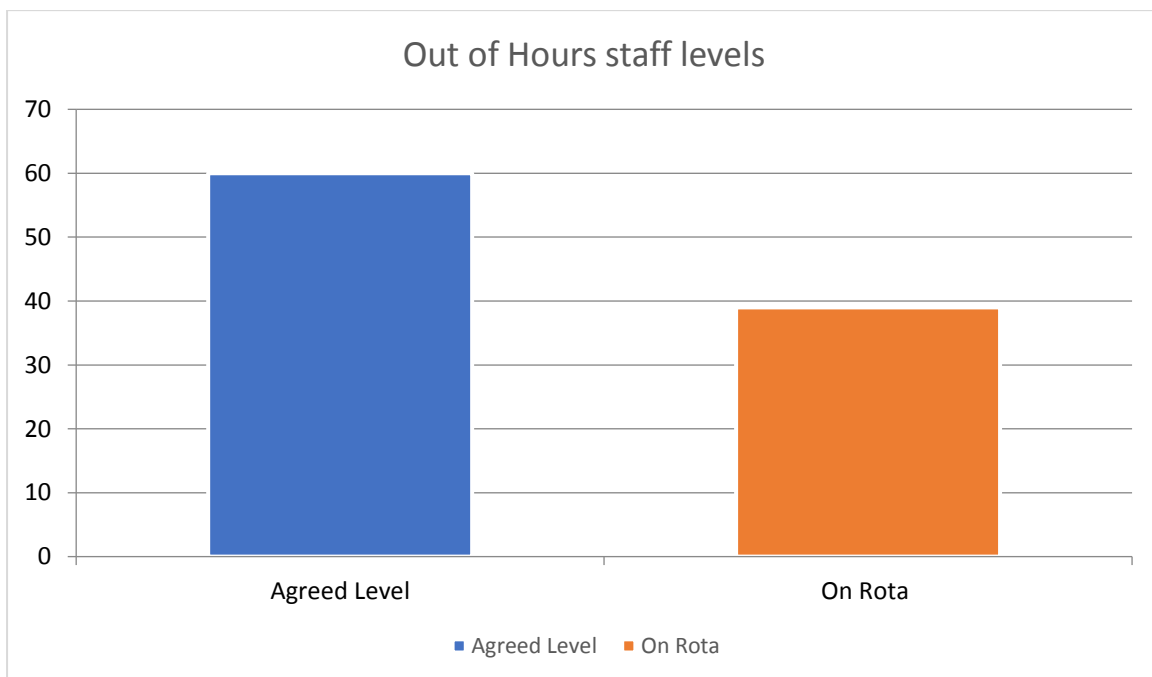


Figure 4 – Illustrates the shortfall of medical staff operating out of hours rota from the 2003 agreement to current levels resulting in deficits in meeting our legal obligations.

Due to the lack of equal status and remuneration of Consultant level Public Health doctors with their peers in other specialties, Public Health Medicine has had difficulties recruiting trainees to the Public Health Medicine Higher Specialist Training Scheme in the past. Retention of recently trained doctors continues to be an issue as consultant posts in the UK and other jurisdictions have more attractive

terms and conditions and equality with other specialties. Recent trainees have left to work in the World Health Organization, academia, and the European Centre for Disease Control. Of the last seven trainees to complete training in Ireland, just one is now working in a substantive post in Ireland; given that it costs approximately €300,000 per Public Health trainee trained in Ireland, this represents a significant loss to our health service and more generally to the current and future health of the Irish population.

Public Health Doctors Strike

It is noteworthy that the reference point for the agreed complement of staff across the discipline of Public Health is an agreement reached in 2003 under the auspices of the Labour Relations Commission, an agreement that came about as a result of Industrial Action. 270 doctors in Public and Community Health Medicine went on strike between 14th April and 20th June 2003. This dispute came about because the doctors involved were trying to get the 1994 Memorandum of Agreement on revised arrangements for Public Health Medicine and Community Care Medical Services implemented. After nine years, the frustration that they felt compelled these Doctors to take serious action. The agreement that brought an end to this strike in 2003 has still not been fully implemented.

The key issues included at the time included:

- 1) Delay in implementation of the Brennan Report and
- 2) Lack of parity of esteem with hospital consultants.

In its briefing paper at the time, the IMO noted that:

“The result of the prevarication and delay in terms of commitments entered into in 1994 is that the salary for the claimants is now 30% behind what were agreed as comparators at that time (i.e. the current salary gap between Directors of Public Health and CEO (category three rate) and on the basis of maintaining the differentials with the other three public health medical grades).”

The strike lasted approximately 10 weeks with Public Health doctors carrying out all its essential infectious disease functions throughout. It ended with an agreement under the auspices of the Labour Relations Commission (LRC). In coming to its conclusions, the LRC summarised the arguments advanced by both sides during this process. The LRC noted that:

“the Board has little doubt that there have been radical changes in many areas of Public Health since 1994 and that these changes could not have occurred without the agreement and active co-operation of Public Health Doctors. Extra duties and responsibilities were taken on, no doubt in the expectation that at some stage they would be rewarded when the public health review process was completed”.

The LRC recommended that both Directors and Specialists in Public Health Medicine receive an increase in pay of 13%, backdated to July 1999 (11% increase backdated to July 1997).

In relation to parity of esteem, the LRC noted that ***“it is agreed that the issue of consultant status and remuneration for the grades of Director of Public Health and Specialists in Public Health Medicine be referred to the next Review Body on Higher Remuneration in the Public Service. It is also agreed that this Body addresses the linked issue of a formally structured Out-of-Hours cover arrangement”.***

Under Resourcing of Public Health Medicine

To highlight the lack of investment in Public Health in Ireland it is useful to compare four countries in terms of staffing of Public Health Departments, numbers of local consultants (SPHMs) numbers of support staff, numbers of SPHMs working outside of local departments, and relating these numbers

to the population of the country concerned. In all comparator countries, SPHMs are afforded equal status and remuneration to other consultant specialties. The information on workforces was taken from several online sources, and also by conversations with colleagues in Public Health in New Zealand. The population of Scotland is 5.3 million, Wales is 3.6 million, New Zealand is 4.5 million compared to Ireland at 4.8 million.

The numbers of public health staff in Wales, New Zealand, Ireland and Scotland are compared and presented in **Table 1**.

Table 1: Comparison of Public Health staff numbers working in Public Health Departments between countries (based on 2014 numbers)

	Ireland	Wales	Scot	NZ
All PH specialist doctors (SPHMs and DPHs) (excluding trainees and academia) (wte)	76.6	80	119	158
SPHMs working in Public Health Departments (Including those working on projects outside their departments)s (wte)	41.3	23.5	78	61
Number of SPHMs outside local offices and Health Protection (excluding academia) (wte)	35.9	56.5	41	97
population in 100,000s	48	36	53	45
SPHM per 100,000 population	1.60	2.22	2.25	3.51
No of Public Health Departments	8	7	14	14

* Communicable disease control

The comparisons show that the numbers employed in Public Health in the Republic of Ireland (ROI) are much lower than other similar-sized jurisdictions. The average number of Public Health staff is 17 per 100,000 populations across Wales, Scotland and New Zealand combined. This compares with 4.8 Public Health staff per 100,000 populations in the Republic of Ireland. Figure 5 highlights these differences.

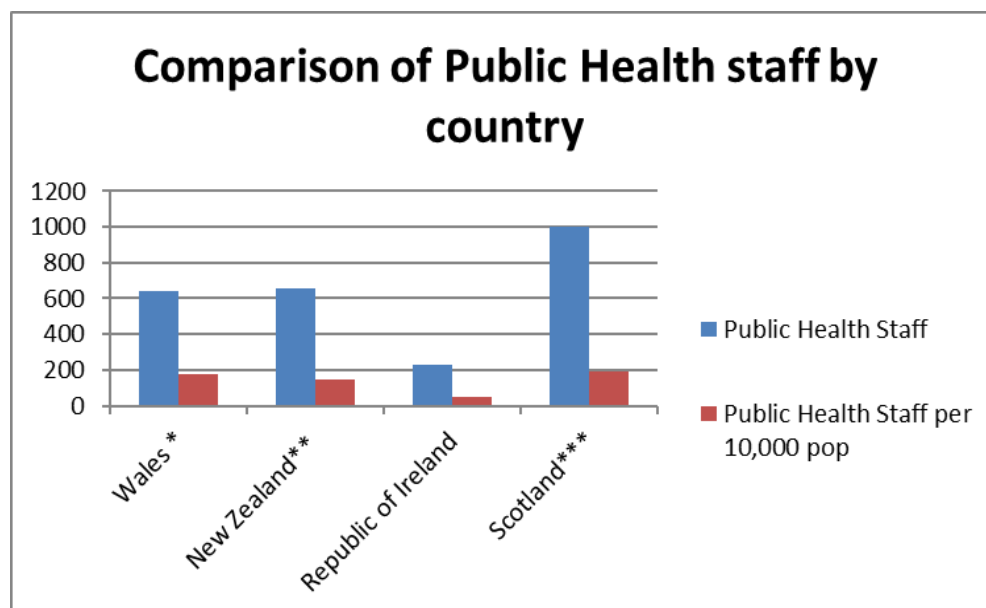
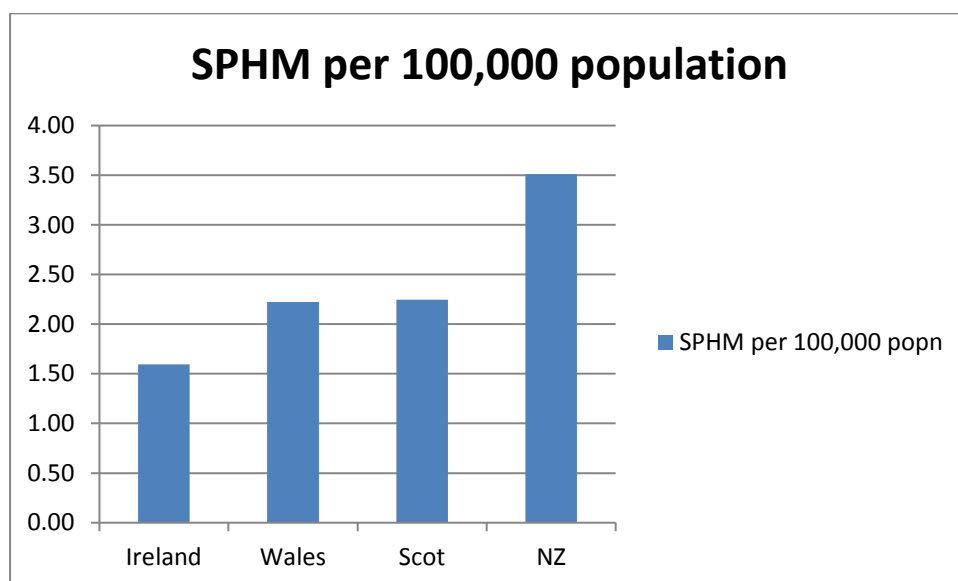


Figure 5 : Comparison between Wales, New Zealand, Ireland and Scotland

One of the main differences is the numbers of support staff working in Local Departments of Public Health in other jurisdictions, where Ireland features very poorly. Other jurisdictions have higher numbers of Specialist Public Health Doctors by head of population as shown in **Figure 6**



A New Zealand briefing paper published in 2009 looked at the need for investing in Public Health¹⁰. They outlined the need for investment beyond the 5.9% of health spending that was being spent on Public Health in New Zealand at that time. Ireland currently spends 1.7% of total healthcare spend on Public Health and prevention.¹¹

Previous Reports

In terms of pointing to evidence of the existence of issues with recruitment and retention of Public Health Physicians and the corresponding link to remuneration and investment in the service this question has been reviewed multiple times and culminated in various reports that have made a number of specific recommendations, none of which have been acted upon. The Chief Executive of the HSE has indicated in the past that he sees “Population Health as the intellectual driving force of the HSE”. The placing of Public Health Medicine the medical specialty underpinning Population Health as the apex of the three service pillars of the reform structure indicates its central importance and judicial function.

Report by Capita Consulting for the Public Health Review Group. 2001

“The difficulties surrounding the recruitment and retention of senior staff in Departments of Public Health, and the disparities in remuneration between Directors and Specialists in Ireland and their UK counterparts, with the real potential that experienced professionals in the Public Health field in Ireland will leave to take better paid jobs in the UK, and that Ireland will find it increasingly difficult to recruit such candidates from the UK, a major source of staff in the recent past”.

The Brennan Report (report of the Public Health Review Group). 2002

The Chairman stated his opinion that, in any industrial relations negotiations,

¹⁰ Canterbury District Health Board, *Investing in Public Health: A briefing paper*.

¹¹ HSE National Service Plan 2017

“due weight should be given to factors (‘young doctors unlikely to be attracted to a career in Public Health’, ‘perceived lack of status’ and ‘real lack of remuneration in comparison to all other specialties’

Saunders Review 2010

“the difference in status between doctors in Public Health medicine and doctors in hospital based specialties makes public health medicine an unattractive career choice for able and ambitious young doctors. I have very real concerns on the future sustainability of the (public health out of hours) OOH service and the consequent serious health protection risks that this poses to the health of the people of Ireland unless this difference in status is resolved”.

Despite this independent report identifying the clear link between the inability to recruit doctors into the speciality and provision of an effective service little has been done to address the situation.

MacCraith Report 2014

The Group noted the demographic profile of public health specialists and considers that it represents a significant risk to maintaining the viability of the training scheme and also limits opportunities for expansion of the training scheme in the near future. The Working Group also notes with concern vacant training posts on the public health training scheme and takes the view that the status of the specialty and limited exposure to public health medicine at undergraduate level are both factors in this regard.

Strategic Review of Medical Training and Career Structure. 2015.

A survey of Public Health Physicians noted amongst other things that there was a mismatch between the high level of responsibility, competence, expertise and commitment and corresponding remuneration, there is worsening attractiveness for new entrants with already excessive workloads and unfilled vacancies and limited career progression opportunities. Additionally, the contract was seen as outdated, vague, lacking detail, generic and inadequately reflective of the role. Specialist Registrars in Public Health Medicine were concerned about their prospects in Ireland and felt that terms and conditions were more attractive overseas. Others expressed concern about the sustainability of the discipline of Public Health Medicine in its current form in Ireland.

There was widespread concern that with the current terms and conditions, Public Health will fail to attract quality candidates for HST training and retain them after they complete specialist training. Since 2001 all of these different reports have all made definitive recommendations on the issue of recruitment/retention of Public Health Doctors and the inadequacy of their remuneration proportionate to their unique and important skill set. The evidence of the existence of recruitment and retention issues has been present for many years but has been ignored. The current data on staffing levels set out above is a testament to this inaction.

Difficulties Concerning Public Health Doctor Retention

SPHM Vacancies November 2017			
WTE	Service	Contract	Reason for Leaving
1	National Screening Service		Secondment
1	Public Health - Cavan/Monaghan	Permanent	New
1	Public Health - North East	Permanent	Retirement
1	Public Health - NCAGL	Permanent	New
1	Public Health - East	Permanent	Retirement
1	Public Health - South West	Temporary	Temp Promotion
1	Health Intelligence	Permanent	Retirement
1	Public Health - South East	Permanent	Resignation
1	Public Health - East	Permanent	Resignation
1	Public Health - East	Permanent	Promotion

DPH Vacancies November 2017			
WTE	Service	Contract	Reason for Leaving
1	Health Protection Surveillance Centre	Permanent	Retirement

This list represents the most recent information from the HSE on the number of vacancies that exist including the reasons for leaving. It is worth noting that 28% of recurrent vacancies are due to resignations which is a concerning trend but unsurprising given the unwillingness of the HSE to invest in its Public Health Function and the staff that operate it. The high number of retirements is also reflective of the age bracket of those working in the Speciality. This was identified in the McCraith report in 2014 as 55% are aged 55 plus and the recent IMO survey which identified 79% of respondents in the over 50 age group. These statistics further illustrate the crisis that will prevail unless there is urgent action taken to attract graduates into the speciality.

International research demonstrates that poor working conditions constitute a major driver of medical workforce migration, and that the likelihood of a practitioner returning to his or her source country is heavily dependent on improvements in working conditions.¹²

This is mirrored in Irish research on health professional emigration, which indicates that a significant portion of 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.¹³

¹² A. Sharma, T.W. Lambert, and M.J. Goldacre, 'Why UK-trained doctors leave the UK: cross-sectional survey of doctors in New Zealand', *Journal of the Royal Society of Medicine*, 105(1), 2012, pp. 25-34. doi: 10.1258/jrsm.2011.110146.

¹³ R. Brugha, S. McAleese, and N. Humphries, *Ireland: A Destination and Source Country for Health Professional Migration*, Royal College of Surgeons in Ireland, Nov 2015, p. 3.

IMO Public Health Doctors & Specialist Registrar Survey on Recruitment and Retention Issues

The IMO surveyed Specialists in Public Health Medicine and DPHs working in the Public Services and Specialist Registrars in Public Health on issues pertinent to their recruitment and retention in the Irish health service. The responses give invaluable insight into the issues that prevail in Public Health Medicine. It is noteworthy that this survey captures the views of 43 (over 91%) of Directors and Specialists in Public Health Medicine working in Public Health Departments and 21 (65%) of those employed at Specialist Registrar level.

In their responses just over 90% of respondents indicated that their Department was understaffed. Over 86% believed that the pay available in other jurisdictions was better and just under 50% had been approached by a private sector employer or an employer outside the jurisdiction. Given the relative size of the speciality of Public Health Medicine this is an extremely concerning statistic.

Some of the views expressed are indicative of the real effects of underinvestment in Public Health Medicine and the wholly inadequate remuneration of these senior doctors.

“Morale is shocking. No respect for the specialty”

“It is demoralising not to be regarded as an equal to your medical colleagues after completing higher specialist training”

“The failure to fill vacancies across all medical grades is putting the health of the public at risk.”

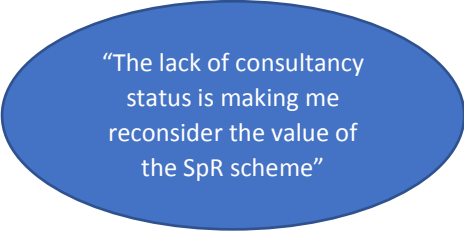
“Offering three month temporary contracts is an insult to these highly skilled doctors”

“The lack of appropriate remuneration is a festering sore that impacts on morale”

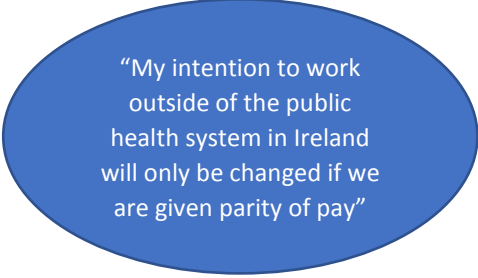
“There will continue to be major difficulty in recruitment and retention until the issue of parity of pay”

The survey identified 79% in the over 50 age group, a statistic it will be recalled that was flagged in the 2014 MacCraith Report.


It is noteworthy that this survey captures the views of 65% of all Specialists Registrars in Public Health Medicine. In respect of Specialist Registrars 86% of respondents said that they would give consideration to taking up a post abroad on completion of their training, with between 73% & 95% stating that the lack of career progression, lack of Consultant status and higher levels of pay was the motivating factor for such a decision. Between 85% & 95% of respondents stated that addressing the issue of Consultant status and improved levels of pay would assist with retention in the discipline. Over 70% of respondents have been approached by an employer seeking to recruit them to a position outside the Public Service in Ireland or abroad. It is clear that the skills of Public Health Physicians are in demand. However the continued failure to recognise this important skill set and remunerate it accordingly will exacerbate the current situation.




“The lack of consultancy status is making me reconsider the value of the SpR scheme”



“My intention to work outside of the public health system in Ireland will only be changed if we are given parity of pay”



“if we don't achieve parity with consultants in other specialties then I will move abroad or move into the private sector in Ireland”



“lack of consultant status minimises our ability to influence change or use our expertise appropriately”

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. All grades of Public Health Doctor were asked if they were aware of any such initiatives to which 95% replied “no”.¹⁴

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.”¹⁵

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.¹⁶ 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.¹⁷

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.¹⁸

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,¹⁹ and 39% of consultants within the public health service are female.²⁰ 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 ophthalmology, for example, are some of the areas of specialisation in which there is approximately

¹⁴ IMO Public Health Doctor Survey on Recruitment and Retention Issues, November 2017.

¹⁵ R. Mahony, *Presentation to the Irish Medical Organisation Doolin Memorial Lecture*, 2 December 2017.

¹⁶ Medical Council, *Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2015*, Dublin, 2015, p. 29.

¹⁷ *Ibid.*

¹⁸ IMO Survey on Gender Issues in Irish Medicine, December 2016.

¹⁹ Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 58

²⁰ Health Service Executive, *Consultants by Specialty (HSE & S38 Agencies): December 2016*, 2016, p. 1.

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.²¹ 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.

²¹ Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 60.

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

The Speciality of Public Health Medicine is currently under review by the Department of Health in 2017 as part of the MacCraith process of review of Higher Specialist Training, which stated “The Working Group recognises that there are particular issues and challenges in relation to the recruitment and retention of doctors in services beyond the acute hospital setting, including public health medicine, general practice and mental health services.”

The final report from the MacCraith process made additional recommendations with regard to Public Health Medicine stating: “ the Working Group recommends that a working group is established to examine matters including the following and make recommendations as appropriate:

The current and future role of the public health specialist in Ireland, including the appropriate skill mix in relation to public health functions;

The attractiveness of public health medicine as a career option;

The curriculum and content of the specialist training scheme, and associated administrative arrangements relating to the rotation of trainees around the system;

Any requirement for post-CSCST sub-specialisation

The replacement rates required to fill existing public health specialist posts in order to ensure the viability of the specialist training scheme and any expansion that may be required to plan for future service developments;

Measures to enhance the awareness of public health medicine as a career option at undergraduate level and during the Intern year.

This review is still ongoing three and a half years later.

The Future Health 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.²² The spheres of practice of Public Health Medicine working with multidisciplinary colleagues are health protection, health improvement, health service improvement and health intelligence, all of which centre around prevention and planning. As such it can be difficult to quantify the impact of failure to invest in Public Health. It is clear however that inability to recruit and retain staff across the speciality is having grave consequences for the provision of an adequate and effective Public Health function.

With the introduction of the HSE as the national health service provider in 2006, a national Public Health function was provided through the Population Health Directorate. There were however, no additional SPHM or research supports assigned to the national function, and these were expected to be provided through local departments. This practice has continued, and has led to further confusion with regard to roles, responsibilities and governance, with SPHMs whose line managers

²² Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*, 2017, at <https://beta.oireachtas.ie/en/press-centre/press-releases/20170530-future-of-healthcare-committee-publishes-slaintecare-a-plan-to-radically-transform-irish-healthcare/>

are the local DPH, contributing little or nothing to the local work of the department, and working directly to senior managers outside of their departments.

This practice makes it difficult for Directors of Public Health to adequately provide the local Public Health function. It also makes it difficult to provide a national function in any coherent way, with various individuals working to various senior management members on a variety of tasks. The result is that neither the local nor the national functions are properly resourced and are unlikely to be in the near future.

The current structure in Public Health Medicine highlights that the Leadership Team (made up of the national Directors and the Director General) no longer has direct input of Public Health Medicine for advice, despite the fact that the legislated objective of the HSE is “to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public” (Health Act 2004), and despite the statutory function of the Medical Officer of Health to report to the CEO (which was the structure in the pre-HSE era). Failure to address the issues with recruiting and retaining SPH/DPHs has been detrimental to service development and the sustainability of Public Health Medicine. Unless addressed it is difficult to see how it will be possible to attract graduates into a speciality where they are remunerated inadequately and do not have an appropriate input at senior level.

The Implementation of the International Health Regulations (2005), Report by the Director-General, was an agenda item at the Sixty-Sixth World Health Assembly convened by World Health Organization in April 2013. A key issue from WHO’s perspective is the extent to which the Regulations have been implemented in Member States. Appropriate staffing levels are essential to provide a safe ‘out of hours’ service. The Department of Health acknowledged in 2012 that there are human resource deficiencies, specifically that Human Resources are 40% of those required to implement the International Health Regulations. Only 25% of the required legislation has been implemented in Ireland.²³ This means that in the event of an international Public Health Emergency, Ireland is potentially a weak link in the chain of international defence against global threats (e.g. new and emerging infections)

The European Commission in 2011 initiated new legislation to address the existing deficiencies in tackling health crises. Decision No. 1082/2013 on Serious Cross-Border Threats to Health expanded the list of sources of danger to health to include not only communicable diseases but also biological, chemical, and environmental events, as well as events of unknown origin that may pose a risk to EU citizens. It has prompted countries to move to coordinated ‘all hazards’ planning and response structure for such events

The current health protection function in Ireland is inadequately resourced to control current communicable disease threats as well as those likely to emerge from changing economic models and health behaviours. It requires substantial expansion to meet our EU obligations in relation to Decision 1082. A notable example is the lack of a National Health Protection unit which deals with all the above mentioned hazards (currently, the HPSC is the only national unit and deals solely with surveillance of communicable diseases but has no remit for other threats to population health, e.g. environmental, chemical, radiation – required internationally as an ‘all hazards’ approach. In addition, there is a substantial gap in human resources as set out below as well as deficits in ICT and training.

²³ International Health Regulations, Report by the Director General at <http://www.who.int/gho/publications/en/>

In addition to the standard legislative requirements for all doctors, Specialists in Public Health Medicine carry out the Medical Officer of Health function which is necessary for health protection up to and including the health security of the state, and also for all other threats to human health. This important legislative aspect of the role is not referenced in the current contract of employment for the SPHM.

According to the HSE data there are currently 39 people operating an out of hours rota, which is a legal requirement and was examined in detail in the Saunders Review 2010. This is 21 WTE short of the agreed complement of 60, thus we are failing to meet the minimum international obligations in this regard. It is also worth noting that the applicable payment is significantly less than that which is payable to a junior doctor providing an on-call service.

The National Risk Assessment has identified multiple strategic risks to the health of the public such as climate change impacts on human health, major pandemics and anti-microbial resistance, all of which require leadership and expertise from Specialists in Public Health Medicine to prevent and/or control these national risks. Many other areas of risk identified will also require essential input from public health medicine in order to minimise the risk, such as health planning for demographic changes and the increase in chronic diseases. Analysis led by Public Health in the HSE in 2017 confirms that within the next ten years, the healthcare system as it is currently delivered will be unsustainable, and elective services will effectively cease as the system will struggle to cope with the level of acute activity predicted.

Transformation of the health service to a sustainable model of delivery is dependent on public health input at all levels²⁴ Adequately addressing issues with recruitment and retention in Public Health Medicine has the potential to ensure that effective health services can be planned and delivered in a structured and sustainable way. It could be claimed that the current mismatch between service delivery and need reflects the underinvestment in the Public Health Service Planning function which has been increasingly the case since the founding of the HSE.

Retention of recently trained doctors continues to be an issue as consultant posts in the UK and other jurisdictions have more attractive terms and conditions and equality with other specialties. Recent trainees have left to work in the World Health Organization, academia, and the ECDC. It costs approximately €300,000 per Public Health trainee trained in Ireland. This is a serious loss to our health service and the health of the Irish state, a loss that is avoidable should appropriate investment be made to make the speciality of Public Health attractive.

²⁴ Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*, 2017, at <https://beta.oireachtas.ie/en/press-centre/press-releases/20170530-future-of-healthcare-committee-publishes-slaintecare-a-plan-to-radically-transform-irish-healthcare/>

An International Comparison of Public Health Doctors

The Republic of Ireland is entirely unique amongst other English speaking countries and other parts of Europe in that it treats Public Health Medicine less favourably than other medical specialties. This is in contrast to the situation in the UK, Northern Ireland, throughout Europe and in Australia and New Zealand, where Public Health Medicine is considered an equal medical specialty and its specialist doctors have equal status and remuneration with those of other medical specialties. It is clear that the disparity in pay between SPHM/DPHs and their colleagues makes positions in other jurisdictions and/or the private sector significantly more attractive when one considers the fact that with **exactly the same** level of training and education the differential is as set out at table 2 below.

Full data and analysis of the numbers joining international employers is not available but the anecdotal evidence is that graduates are emigrating to take up positions abroad due to better terms and conditions and the consultant status which is denied Public Health Doctors in this jurisdiction. A recent survey of Specialist Registrars in Public Health conducted by the IMO indicated that 85% of those currently in training would be considering taking up a post abroad. Between 70% and 95% cited the reasons for this as the same position having consultant status abroad, better career pathway, incremental progression and proper recognition of their status.

SPHM Ireland	United Kingdom €	Australia NSW L1 €	Victoria Public €	Western Australia €
€106,274.00	€87,745.00	1-€125,271	1-€130487	1- €186490
	2- 90,494	2-132,636	2-139227	2- 192348
	3- 93,239	3-139,953	3-144636	3- 198501
	4- 95,978	4- 147299	4-150400	4- 204962
	5- 98719	5-154645	5-156,162	5- 211746
	6- 105,232	6-169369	6-162,235	6- 218869
	7- 111,745		7-165,428	7- 226371
	8- 118,251		8-175,211	8- 234225
			9-179,426	9- 242533

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These Scales do not factor in Clinical Excellence Awards in UK which can range from £2900 up to £77000.

²⁵ BMA – Pay Scales for Consultants in England at

<https://www.bma.org.uk/advice/employment/pay/consultants-pay-england>

AMA Victorian Public Health Sector Medical Specialists Enterprise Agreement 2013 at

https://amavic.com.au/Workplace_and_legal_advice/hospital-employed-specialists/2013-public-health-sector-medical-specialists-enterprise-agreement Salary Increases Staff Specialists NSW Public Health System

2017 at

http://www.google.ie/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwj_7Jul3ujXAhWHBcAKHa_p7A2oQFggNMAA&url=http%3A%2F%2Fwww1.health.nsw.gov.au%2Fpds%2FActivePDSDocuments%2FIB2017_024.pdf&usq=AOvVaw0Z4HrSsYmt8mndstblsJFP

The Importance of Public Health Medicine to Our Health Services

As part of Crowe Horwath's ongoing review of Public Health Medicine in Ireland, representatives from a number of Public Health Medicine representative groups met recently including The Faculty of Public Health Medicine of The Royal College of Physicians of Ireland, The Irish Medical Organisation, Directors of Departments of Public Health in Ireland, Public Health Medicine Early Career Network and Specialist Registrars in Public Health Medicine.

The representatives believed it important to put on record that there is strong agreement across organisations and groups representing public health physicians in Ireland that the Public Health function needs to be substantially strengthened, and that this function should consist of adequately resourced multidisciplinary teams. It is also agreed that a strategic plan and reformed structures are required to ensure a high quality, flexible yet sustainable Public Health function as appropriate to a modern health service and an open economy. The following are considered essential for a Public Health Medical function which delivers on the purpose of improving the health of the population and which meets international standards:

- 1) "A Public Health management structure should be established consisting of a national Public Health centre and regional departments of Public Health, collaborating to maximise efficiency and value for money, and to provide a comprehensive, safe service.
- 2) A national level team is required for each of the domains of Public Health Medicine, i.e. health protection, health improvement, health service improvement and health intelligence.
- 3) In accordance with legislative requirements, regional departments of Public Health should be resourced and empowered to deliver across all the domains of practice, addressing national strategic priorities, and working with CHOs and hospital groups, adjusted as appropriate to local circumstances.
- 4) In order to address the urgent challenges of population health in Ireland and in line with their expertise acquired through higher specialist training, their clinical expertise and professional autonomy, Specialists in Public Health Medicine should be granted a contract common with that of consultants working in hospitals."

Current government health policy centres on Healthy Ireland (HI), the vision of which is stated to be "A Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility."²⁶

The four goals of the HI strategy are to:

1. Increase the proportion of people who are healthy at all stages of life
2. Reduce health inequalities

²⁶ About Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 at: <http://health.gov.ie/blog/publications/healthy-ireland-a-framework-for-improved-health-and-wellbeing-2013-2025/>

3. Protect the public from threats to health and wellbeing
4. Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland²⁷

Public Health Medicine is the medical specialty that both informs these policy directions, and also is devoted to the full implementation of these public health goals. At the same time, the work of Public Health should go beyond this to:

- Support to the operational side of the HSE to organize and deliver high-quality, safe and cost-effective services
- Evaluate how well the HSE is achieving these goals
- Advocate for those aspects that are less well served, and
- Ensure that all levels of society are provided with a fair and equitable service, i.e. moving towards health justice for all

There are, however, an increasing number of public health challenges facing Ireland and the Irish health service. Ireland has one of the most overweight and obese populations globally. Alcohol consumption continues at harmful levels, our ageing population is growing, and the hospital-centric delivery of care for chronic diseases needs to be addressed. Antimicrobial resistance is a growing problem, with many hospitals now identifying patients who are colonized with Carbapenamase Resistant Enterococci (CRE) (which has in November 2017 been declared a Public Health Emergency in Ireland), and increasing numbers of infections from resistant microbes. Hospital acquired infectious outbreaks are frequently reported, hospital capacity is overstretched, resources are increasingly limited and the information on the best value for money is not always readily available.

Public Health Medicine has been assigned the statutory functions that mandate its work²⁸; this appears to have been forgotten about in various restructuring of the health service.

As a result, highly trained Public Health doctors have insufficient authority to adequately carry out their function. Currently, a Specialist reports to the Director of Public Health, who reports to the Assistant National Director of Public health and Child Health (a qualified Public Health Consultant), who reports to the National Director of Health and Wellbeing (non-medical), who reports to the Deputy Director (non-medical) who reports to the Director General. With each reporting level, the voice and authority of a Consultant in Public Health Medicine is diluted, and often is not heard at all. The most recent restructuring of the HSE has added an additional layer of management.

Recognising these doctors as consultants is an important first step in the investing in Public Health as a specialty and ensuring that it is sustainable into the future, attracting the best and the brightest that medicine has to offer.

Recent work looking at the Return on Investment (ROI) and cost benefits ratios (CBR) for Public Health interventions showed that the expected ROI on Public Health Interventions is 14:1, i.e. for

²⁷ Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 at <http://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf>

²⁸ S.I. No. 128/1949 - Health (Duties of Officers) Order 1949, S.I. No. 390/1981 - Infectious Diseases Regulations 1981

every €1 spent on Public Health Interventions, a €14 return in terms of health care savings or societal cost savings can be expected.²⁹

Some examples of areas of work where Public Health physicians lead on that are cost-saving are as follows:

Quality and Patient Safety: The OECD has recently published a report on the economics of patient safety³⁰. This report outlines the costs to health systems of 15% of hospital expenditure on adverse events. In Ireland this would amount to €600 million annually.

Antimicrobial Resistance and Health Care Associated Infections (HCAI): A 2014 WHO report on antimicrobial resistance states that: “Antimicrobial resistance (AMR) is an increasingly serious threat to global public health...means that standard treatments no longer work; infections are harder or impossible to control; the risk of the spread of infection to others is increased; illness and hospital stays are prolonged, with added economic and social costs; and the risk of death is greater—in some cases, twice that of patients who have infections caused by non-resistant bacteria. **The problem is so serious that it threatens the achievements of modern medicine. A post-antibiotic era— in which common infections and minor injuries can kill—is a very real possibility for the 21st century.**”

³¹Dame Sally Davies, CMO in the UK has said “*If we don't take action, then we may all be back in an almost 19th Century environment where infections kill us as a result of routine operations.*”

In Ireland 1 in 20 people admitted to hospital in Ireland will develop a HCAI. These add a considerable cost and capacity burden to the health service, especially in the hospital setting, but now also increasingly in community settings also. A study in a West of Ireland Nursing Home revealed that 56% of residents were carriers for a resistant organism.

Health Technology Assessment: Within the HSE, the Health Technology Assessment Group is also led by Public Health, and assesses the cost-effectiveness of Medical Devices. This important function is considered highly cost efficient, and a 2015 study by RAND Europe stated that for the NHS the:

*“10 studies analysed provided a potential net-benefit of £3.0 billion based on a value of £20,000 per QALY, and £5.0bn based on a value of £30,000 per QALY. According to NETSCC, the total research cost of the HTA Programme since 1993 was £317m, with the estimated overall cost of the HTA Programme £367m. The estimated overall cost of the HTA Programme includes the cost of NHS support for HTA research. We therefore conclude that **12 per cent of the calculated potential net benefit would cover the total cost of the HTA Programme from 1993 to 2012.**”* Internationally, this is the accepted return on investment to be expected from HTA work.³²

Chronic Disease Prevention: Behavioural risk factors are higher in Ireland than most countries, in particular overweight and obesity rates. The burden of chronic disease that this brings with it is only beginning to be felt by the Irish health service. It has been estimated that overweight and obesity

²⁹ Towards 2026 A Future Direction for Irish Healthcare, RCPI, March 2017 at <https://www.rcpi.ie/policy-and-advocacy/towards-2026/>

³⁰ L. Slawomirski, A. Aaraaen, N. Klazinga, *The Economics of Patient Safety Strengthening a value-based approach to reducing patient harm at a national level*, OECD, March 2017

³¹ Anti-Microbial Resistance – Global Report on Surveillance at <http://www.who.int/drugresistance/documents/surveillancereport/en/>

³² RAND Corporation NHS Study at <https://www.rand.org/search.html?query=nhs%202015%20>

have an annual cost to Ireland of €1.16 Billion³³. Alcohol use and abuse among our young people is of serious concern. The need for investment in prevention is urgent.

Health Service Planning: The Irish health service is facing a time of unprecedented financial and capacity pressures. A report by the Royal College of Physicians recently pointed out that the Health system is in crisis³⁴. Analysis led by Public Health in the HSE in 2017 confirms that within the next ten years, the healthcare system as it is currently delivered will be unsustainable, and elective services will effectively cease as the system will struggle to cope with the level of acute activity predicted³⁵. Both documents agree that urgent action is required to shift from hospital centric delivery of care towards a model of care delivery based more in the community and primary care settings. Ongoing monitoring and evaluation by Public Health will ensure that planning is effective and emerging risks and demographic changes will be factored in, in a timely way.

Child Health: The experiences that a child has in early childhood impact on the health of that child when he or she reaches adulthood. Adverse experiences which occur in the critical early developmental period impact negatively on the developing brain and on other sensitive organs. Such impacts can be seen in childhood but often manifest only in later adult years as chronic disease, such as cardiovascular disease, diabetes, obesity, mental health disorders. The health and wellbeing of our current child population, therefore, predicts the health of our future adult population. Investing in pregnancy and early childhood to reduce these adverse experiences and mitigate their effect makes economic sense and should be one of the pillars of building a sustainable health system in the future.

Public Health Doctors contribute leadership, advocacy, knowledge and expertise to strategy development, child health service development and programmes to address the wider determinants of children's health that all work to improve the lives and health of children and their parents in the short to medium term and will impact positively on the health of those children for the rest of their lives, reducing their needs for health services. Dynamic involvement of Public Health Medicine is needed to monitor, evaluate and lead on on-going service development.

Public Health in Ireland has achieved much, e.g. Ireland was a world leader in introducing the smoking ban, has excellent vaccination rates, and has reduced TB rates to tiny numbers in recent years. This however, is not a time for complacency, as the work of prevention is not felt until it fails. Reducing public health capacity is a mistake that has led to the resurgence of malaria in Africa (1990s), the emergence of multi-drug resistant TB in New York (1990s) and the inability of the Canadian authorities to deal with SARS in 2003. In order to address the multiple crises facing the Irish health service, a strong Public Health function is required, to provide population based needs assessments, and to provide evidence based solutions to the provision of care that is safe, affordable and sustainable into the future.

The Kings Fund in the UK outlined **10 priorities for transforming** the UK health care system in 2015.

³⁶ This was on foot of the increasing pressures for capacity within the UK acute hospital system. Their 10 priorities are:

³³ Dee *et al.*, Overweight and obesity on the island of Ireland: an estimation of costs. *BMJ Open* 2015;5: e006189. doi:10.1136/bmjopen-2014-006189

³⁴ Royal College of Physicians of Ireland, *Towards 2026: A Future Direction for Irish Healthcare*, Dublin, March 2017.

³⁵ Shifting the balance to high value care, A discussion and quantification of 2030 options for health services in Ireland, A Planning for Health report, 22/03/2017

³⁶ The Kings Fund, Priorities for Transforming UK Health Service at <https://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners/summary>

1. Active Support for self-management
2. Primary prevention
3. Secondary prevention
4. Managing ambulatory care sensitive conditions (tertiary prevention)
5. Improving the management of patients with both mental and physical health needs
6. Care co-ordination through integrated health and social care teams
7. Improving primary care management of end of life care
8. Medicines management
9. Managing elective activity referral quality
10. Managing urgent and emergency activity.

In Ireland Public Health Physicians are leading in delivering most of these programmes, or are leading in providing the evidence and data analysis to support these changes.

As stated previously investment in Public Health yields a 14:1 return on investment ³⁷

To put this in context a paper published in 2013 estimated that in Ireland “A 5% reduction in population BMI levels by 2030 is projected to result in €495 million less being spent in obesity-related direct healthcare costs over twenty years³⁸”. Smokers are known to cost the health service 70% more than non-smokers³⁹.

In Ireland up to 70% of all hospital care delivered is for chronic diseases that are preventable⁴⁰. Disinvestment in Public Health Medicine is a false economy, and a foolish risk for any health service. Failure to address the recruitment and retention issues that prevail will exacerbate this very real risk.

The funding and organisation of the health service poses a significant challenge. Happily, people are living longer and are surviving illnesses and injuries that would have been fatal a generation ago. However, it has to be acknowledged that these tremendous advances come at a financial cost to the health service.

Let there be no doubt, that cost is worth meeting, but in the ongoing debate over how, and how much, we should fund the health service, there is an urgent need to strengthen that pillar of the health service that is dedicated to interacting with the population before they become patients. Public Health Doctors are instrumental in planning and delivering population level care aimed at maintaining the health and wellbeing of the people in their care, with the goal of keeping people healthy. Unfortunately, in our reactive policy making environment, the long term benefits that could arise from early intervention, and strategic planning have been consistently overlooked. In a small

³⁷ Oireachtas Committee on the Future of Healthcare, *Sláintecare Report*, 2017, at <https://beta.oireachtas.ie/en/press-centre/press-releases/20170530-future-of-healthcare-committee-publishes-slaintecare-a-plan-to-radically-transform-irish-healthcare/>

³⁸ L. Keaver *et al.*, ‘Application of the UK Foresight Obesity Model in Ireland: The Health and Economic Consequences of Projected Obesity Trends in Ireland’, *PLoS ONE* 8(11), 2013: e79827. doi:10.1371/journal.pone.0079827.

³⁹ S.R. Rasmussen *et al.*, ‘The total lifetime costs of smoking’, *European Journal of Public Health*, Vol. 14(1), March 2004, pp. 95-100.

⁴⁰ B. Smyth *et al.*, *Health Information Paper 2015-2016*, Dublin, Health Service Executive, 2015.

specialty like Public Health every cut and every departure is keenly felt. Yet colleagues daily provide an expert, specialist service in often trying circumstances.

Granting a Type A consultant contract to current Specialists in Public Health Medicine and to all future entrants to Public Health Medicine who have completed the Higher Specialist Training Scheme in Public Health Medicine will help to provide an enhanced and safe Public Health Medicine service and address the current difficulties with recruiting and retaining medical staff in the specialty. It will address the contentious issues of status and remuneration, and lack of possible progression. Specialist Registrars and Specialists in Public Health Medicine justifiably see the pay and conditions of SPHMs as a major deterrent to entering the specialty, and if we want to attract the best we need to recognise employee's qualifications, training and expertise and remunerate accordingly". The SPHM contract is inadequate, inaccurate and inequitable and in no way reflects the current roles and responsibilities of the SPHM within the HSE. This needs to be addressed as a matter of urgency.