IHCA Submission to the Public Service Pay Commission

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1. Introduction

The IHCA represents 85% of all hospital consultants working in Ireland's acute hospital and mental health services.

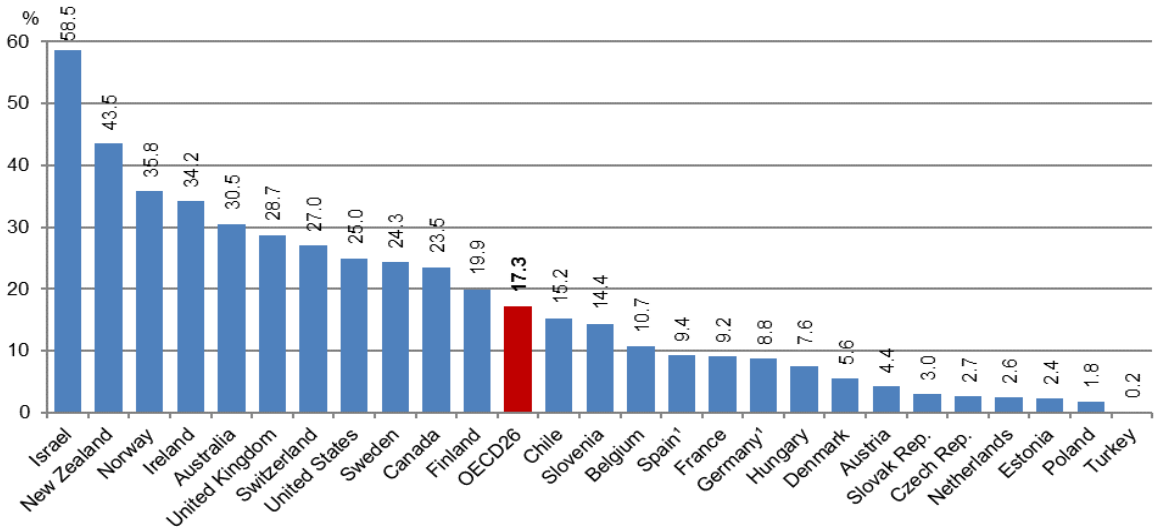
It welcomes the opportunity to present this submission to the Public Service Pay Commission (PSPC) and relevant government ministers who will be considering appropriate decisions on pay issues in 2017. The submission outlines the factors that need to be considered to restore competitiveness in filling vacant consultant posts and the effective recruitment and retention of internationally mobile specialists who are in high demand worldwide.

Ireland has been suffering an escalating hospital consultant recruitment and retention crisis for nearly a decade. Acute hospitals and mental health services have around two thirds the number of consultants recommended in the Hanly Report 13 years ago. In the interim, the demand for care has grown substantially due to the country's increasing and ageing population.

In some specialties, the country has around one third to half the number of hospital consultants compared with the recommended international norms. Under these circumstances it is not surprising that the public health system is failing to provide the level of high quality timely care that the public requires. There is an increasing failure to fill approved permanent consultant posts due to the State's breaches of the 2008 Consultant Contract salary terms and discrimination against new entrant consultants. This combined with frontline under-resourcing and the failure to honour other contract terms has critically undermined the attractiveness of the Irish health service to highly trained internationally mobile specialists.

The State's refusal to provide parity for new entrant consultants in terms of salary, and the failure to restore basic trust has further reduced Ireland's competiveness in terms of recruiting consultants. All of these factors give rise to an extremely serious risk of the loss of a generation of highly trained specialists and consultants who are emigrating to pursue their careers in other countries. This is reinforced by the Medical Council's annual trainee experience survey for 2015 which confirmed that 42% of trainees are not intending to practise in Ireland following graduation. 2013 OECD data confirms that Ireland has one of the highest dependence on foreign trained doctors among EU countries.

Figure 1 - Share of foreign-trained doctors in OECD countries



Source: OECD Health at a Glance 2015

Ireland is without doubt suffering a damaging medical brain drain that is not replicated in other countries. There is a pressing need to resolve this crisis before the country loses a generation of highly trained specialists and consultants.

2. Medical Leadership

Ongoing advances in science, knowledge and technology mean that medical practice continues to evolve and change at a rapid pace, especially in acute services and tertiary centres. The pace of change has accelerated over the course of the past decade having regard to the development of new therapies, drugs and standards of care.[1] As a small country with a population of approximately 4.7 million, we must strive to ensure that we do not become a backwater in international medicine. To keep abreast of new developments and medical advances, our acute hospital and mental health services must recruit and retain consultants who are at the forefront of medical practice and who are capable of leading and adapting to change and ongoing innovation.

The capacity of our health system to consistently deliver high-quality care to patients on a par with other countries therefore requires, among many other factors, good medical leadership. All hospital consultants must strive to improve the quality of the service within their specialty, practice or unit. Leadership in this context involves communicating a vision, engaging with key stakeholders and motivating colleagues and junior medical staff to achieve ambitious targets and goals for their unit or service. By definition, it requires consultants to instigate, lead and adapt to change which can often be unanticipated and unplanned.

It is important that our health service does not just follow, but also leads out on change and innovation. Our hospitals and universities must therefore be assisted in fostering the kind of innovative climate and environment that facilitates the development of new and improved medical practice. It is imperative that we attract and retain high calibre medical specialists who can deliver the kind of leadership that is required in both clinical and academic settings to achieve these aims.

In recent years, hospital consultants have played a pivotal leadership role devising and implementing key clinical programmes that have dramatically improved health services in Ireland and delivered better patient outcomes. These programmes include Acute Medicine, Surgery, Critical Care, Emergency Medicine and other programmes. Their ongoing success is contingent on the recruitment and retention of high calibre hospital consultants who are capable of providing the necessary leadership, governance and management.

Ireland has a long tradition of excellence in medical education. Hospital consultants play a key role in shaping and implementing national policy on medical education and training, and the setting of standards of medical education for basic and specialist qualifications. Hospital consultants also play a pivotal role in terms of research and development. This is a key area that government is keen to promote and it is vital to the goal of building the country's knowledge-based economy. Hospital consultants effectively play a number of roles in terms of project leadership, development of concepts, preparation of draft proposals and applications for funding and overall management and implementation of projects.

Candidates for consultant posts operate in an international market, and possess a high level of mobility which is often influenced by the standard of living and taxation regime of other countries. As such, medical colleges and teaching hospitals are finding it increasingly difficult to attract and retain highly qualified consultants who are capable of delivering medical leadership as terms and conditions

[1] Laiteerapong N, Huang ES., (2015), The pace of change in medical practice and health policy: collision or coexistence? *Journal of General Internal Medicine*, Jun;30(6):848-52

available internationally are proving more attractive. Reductions in salary levels, higher taxation levels, increasing pension levies and other changes in recent years have all contributed to the current difficulties in this regard. As outlined in a later section this state of affairs is confirmed through the steep reduction in the number of applicants for advertised posts in recent years.

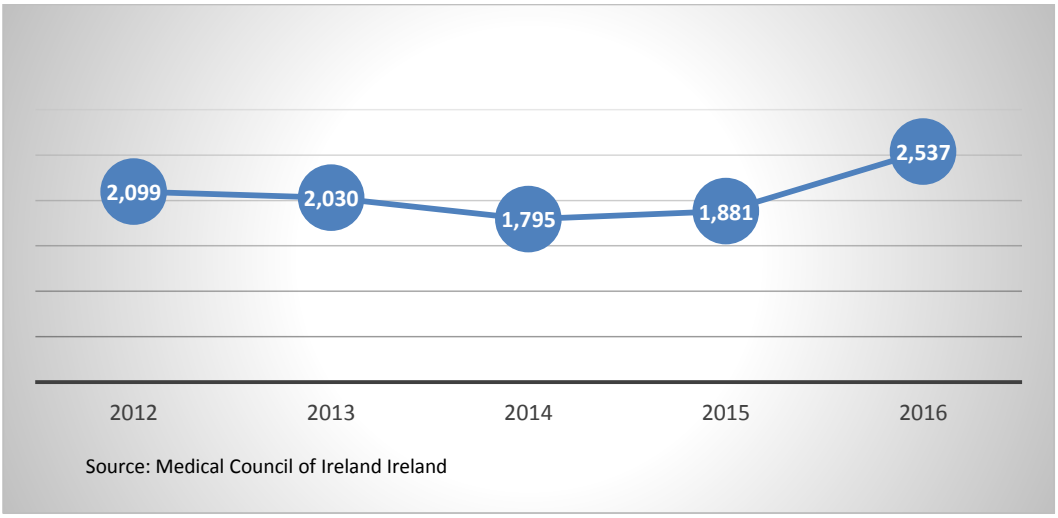
3. Future Sustainability of the Health Service

As noted above, Ireland faces a significant challenge recruiting and retaining consultants who are at the forefront of medical practice and who are capable of leading and adapting to change and innovation. It is imperative that we attract and retain high calibre medical specialists who can deliver the kind of leadership that is required in both clinical and academic settings to ensure the creation and maintenance of an environment in our health services that facilitates the development of new and improved medical practice.

This has significant implications in terms of attracting newly qualified consultants in future to work in the Irish health service. They will base their decision about whether to return to the Irish health service on criteria such as the level of medical leadership that is available within their respective specialties and the calibre of senior colleagues that they will be working alongside. As matters stand, the Irish health service risks losing a new generation of Irish trained specialists who are not returning to Ireland on account of their perception that medical leadership is not valued by the health service. In addition, the existing cadre of leaders are approaching retirement, and others have emigrated.

This is confirmed by the sustained increase in the issue of Certificates of Current Professional Status (CCPS) required to confirm the good standing of doctors and specialists emigrating abroad. The overall number of CCPS issued in 2016 was 2,537, which is 586 or 30% higher than the average number issued in the previous four years.

Figure 2 –CCPS issued to doctors and specialists (2012 – 2016)



Source: Medical Council of Ireland: *The figures for 2016 represent the year to date

This has serious implications for the ongoing sustainability of our health service across all specialties. There is a significant danger it could lead to a downward spiral in Irish medicine, such that it fails to keep pace with the developments in other countries. Once such a scenario takes hold it will prove extremely difficult to reverse.

The health service is currently overly reliant on the utilisation of agency and locum consultants, employed on a temporary basis to fill the gaps in service. Temporary and agency staff of necessity must plan their next appointment and thus lack long-term commitment to develop the health service. This neglects the essential ongoing development of an integrated network of clinicians and hospitals that is required to deliver care of a contemporary standard for Irish patients. In the many departments operating with high levels of agency or locum consultant appointments, there is an ever present risk that the lack of cohesion that accompanies the constant flux in locum consultant staff will undermine the quality of patient care. Certainly providing medical care with a constantly changing pool of locum consultants precludes the evolution of a sustainable integrated health service.

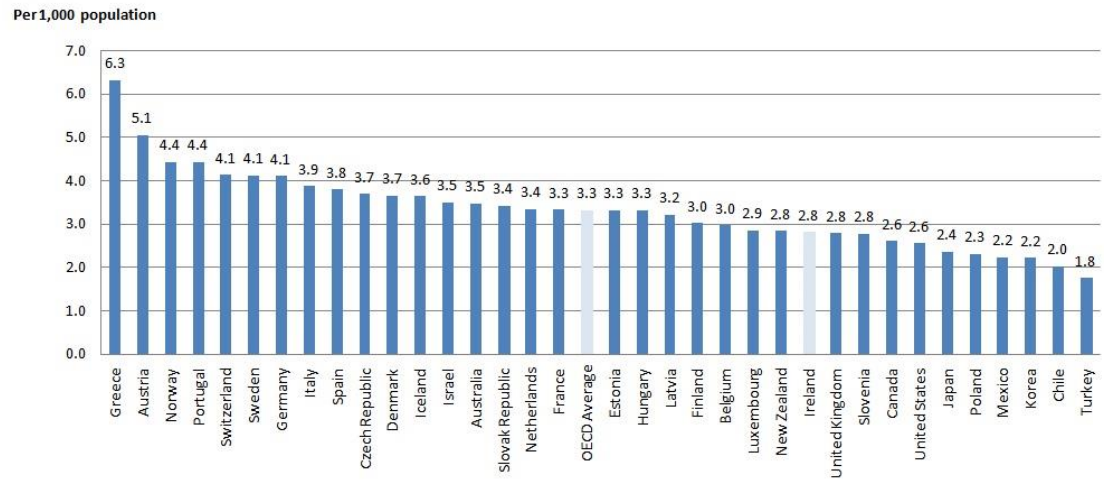
4. National and International Training

Unlike most other categories of public service staff, consultants and specialist trainees are highly-mobile and sought after internationally. They generally practise for periods during their careers in other English-speaking countries. Specialist trained doctors not only complete a 5 or 6 year university undergraduate degree programme, but they follow that with between 8 to 10 years' specialist training in Ireland or abroad. This involves the satisfactory completion of basic and higher specialist exams while working full time often on onerous rosters involving long working hours. This is generally followed by the completion of 1 or 2 years' fellowship training in a leading academic teaching centre abroad.

5. Workloads

International comparisons confirm that the Irish health service has one of the lowest number of practising doctors in the OECD on a population basis with 2.8 doctors per 1,000 of population which is 18% below the OECD average of 3.3**.**

Figure 3 - Doctors per 1,000 of population (2014 or nearest year)



Source: OECD Health Statistics 2016

Due to the relatively lower number of doctors and consultants in Ireland their workload is much higher in comparison with international peers as demonstrated by higher on-call rota commitments in hospitals and with numbers of patients routinely assessed in hospital outpatient clinics and ward rounds, which are often multiples of the numbers in other countries.

6. Recruitment and Retention Difficulties

Up until 2008, the Irish public health service was seen as an attractive location in which to be employed as a hospital consultant. Since then, there is verifiable evidence that this no longer pertains.

The 2008 Consultant Contract was agreed by the then Minister for Health and the health service management with a view to repositioning the health service's competitiveness in recruiting and retaining consultants. However, the payment of specified salary scales provided in the contract was not honoured by the State and health service employers in 2009. Essentially this constituted a universal breach of contract for the consultants who accepted the revised terms. During this period other English speaking countries continued to increase remuneration for specialists.

Data from the Public Appointments Service (PAS) show that the average number of applicants for each advertised consultant post declined dramatically. In the years after 2008 a significant number of recruitment campaigns have had no applicants or only a single applicant. The falloff in applications can be traced to the introduction of the 2008 Consultant Contract and in particular the failure to honour its terms in 2009 and thereafter.

TABLE 1 – CONSULTANT RECRUITMENT (2008 - 2012)

Year	No of posts advertised	No of empanelled applicants	Ratio	No of recommend/ In Clearance	No. Unfilled	% unfilled
2008	97	455	4.69	83	14	14
2009	136	322	2.37	120	16	12
2010	132	279	2.11	120	12	9
2011	103	193	1.87	77	26	25
2012	119	NA	NA	NA	20	10

Source: PAS.

In 2012 the PAS ran 104 competitions for a total of 120 consultant vacancies. Of the 120 vacancies that were processed, one was withdrawn, leaving 119 posts to be filled; 20 vacancies had no attendees at interview or no qualified candidate turned up. As a result, no recommendation to appoint could be made. The 2012 unfilled post information is based on partial information and represents an underestimation.

Overall, the data confirms a continuing declining interest in advertised consultant posts compared with 2008 and earlier years, when competition for advertised posts was higher. The low number of applicants per post results in a particular pressure on hospital employers who may be left with the option of not filling a vacancy or accepting an applicant that otherwise might not have been successful.

Throughout the period from 2008 to 2012 there were at least 70 unfilled posts out of a total 587 advertised consultant posts. These recruitment and retention issues were exacerbated by the FEMPI salary cuts in January 2009 of between 8% and 15% and July 2013 of between 5% and 7% for consultants. The higher cuts were applied to academic and Type A contract holders. These steep cuts

in gross salary and take home pay were exacerbated by increased taxation. Pension levies were also increased by approximately 10% in 2009.

The circumstances of new entrant consultants were further exacerbated by the steep cuts in remuneration imposed on new entrant consultants appointed from 1 October 2012. With regard to this latter group, salaries were cut by 30% compared with their consultant colleagues appointed before that date. While the 30% cut was modified to a limited degree in 2015 with the introduction of a 9-point scale, new entrants still earn 25% less than the usual consultant salary at the first point on the scale and do not reach parity even after 9 years.

The partial reversal of the July 2013 FEMPI reductions to take place over the next 3 years is a positive first step but it is widely acknowledged that it will not be sufficient to address the unattractiveness of hospital consultant positions in the Irish health service.

In addition, a significant number of emigrating graduates are opting not to return for higher specialist training to Ireland, despite having earlier indicated their aspiration to do so. The continued failure to take corrective action with regard to the deterioration in remuneration of consultants is having serious consequences. One in four advertised hospital consultant posts received no applicants in 2015 and in addition a similar number had only one applicant per post. In effect there was no competition for roughly half of all consultant posts. Such a lack of interest in otherwise sought after positions is without precedent, and if this is not addressed it will undermine the clinical leadership of the health service.

7. Vacant Consultant Posts

There are now hundreds of approved consultant posts which cannot be filled on a permanent basis, some of which have been vacant for several years and advertised several times. There were 370 vacant permanent approved Consultant posts on 30 September 2016. This was equivalent to 15% of the 2,518 approved consultant posts in publicly funded hospitals as confirmed in the HSE reply to a parliamentary question from Senator Colm Burke in October 2016. It is also probable that a significant number of additional consultant posts are vacant in the Mental Health Services as the answer to the parliamentary question does not address that service.

The extent of the vacancies together with the steep reductions in the number of applicants responding to competitions for consultant posts confirms the extent and persistence of the recruitment crisis.

Not only does the extent of vacancies seriously undermine the provision of care to patients and the development of acute hospital and mental health services, but it is also a false economy. The HSE has confirmed that the reliance on agency medical costs has increased significantly in recent years due to consultant and NCHD vacancies. The extent of the problem is confirmed by the fact that medical agency costs in 2015 totaled €113.5 million.

It is widely acknowledged that the cost of an agency consultant can be up to twice the usual consultant's salary and up to three times the reduced new entrant consultant's salary. Such false economies highlight the importance of adjusting consultant salaries upwards to reposition the health service to be more competitive in recruiting and retaining consultants.

In addition to the need to replace consultants retiring at normal retirement age and fill new consultant posts, it is anticipated that consultants will increasingly retire early to emigrate and practice medicine abroad, at a more appropriate pace and with considerably greater remuneration. Again the root cause of this practice lies in the ongoing breaches of the consultant contract salary terms.

8. Consultant Remuneration

OECD reported comparisons of specialist salaries do not provide like for like comparative information in the key English-speaking countries to which Irish trained doctors and consultants are emigrating. The reported UK specialist salaries include physicians in training, which results in an underestimation of the salaries in the UK compared with Ireland. In addition, the UK figures do not include awards, which are a significant part of the salary income of UK specialists. These awards include payments on an annual basis of up to £35,832 in local awards and up to £76,554 in national awards. It should be noted that most consultants in the UK benefit from these awards.

It is also important to note that the OECD average specialist salary reported for Ireland in 2016 is significantly above the salary level on offer for new entrant consultants and other contract holders. In view of the inconsistencies in the published OECD information on comparative salaries for specialists, the table below provides details on the average salary levels as reported in those English-speaking countries to which our consultants and specialists are emigrating to practise. However, it must be stressed that Irish specialists and consultants employed in those countries have confirmed higher salaries are being paid to them than the averages in the table below or outlined in the source reports.

TABLE 2 – COMPARATIVE CONSULTANT SALARIES

Country	Gross salary	Euro Conversion
Ireland*	€162,319	
United States**	US $297,423	€286,570
Canada***	CA $392,000	€281,763
Australia****	AU $304,626	€216,064

Source: *OECD Remuneration of specialists (2015);**Medscape Physician compensation Report (2016); *** Canadian Institute of Health Information (2014 - 2015); ****OECD remuneration (2014)

Taking account of the remuneration levels being paid to Irish registered specialists and consultants in those countries and the comparative salary levels in the table above, it is clear that salaries in the United States, Canada and Australia are well in excess of those being paid to consultants in Ireland. Likewise, when the local and national awards and other factors are taken into account, a similar situation pertains in the United Kingdom.

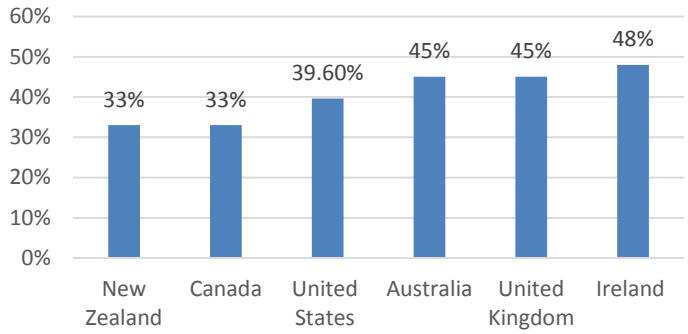
In addition, Irish consultants working in the Gulf States are being paid up to three times the equivalent salary being paid in Ireland.

In summary based on OECD data the average consultant salary in Ireland has been cut by 22% from €208,034 to €162,319 in the 6 years up to 2015. The reduction imposed on new entrant consultants is significantly greater, exceeding 40%. In stark contrast the average salaries of specialists in other English-speaking countries have increased significantly over the same period.

9. Personal Income Tax Comparisons

Ireland's marginal rate of personal income tax is up to 10% to 15% higher than the marginal rate of personal income tax nationally in several other English-speaking countries.

FIGURE 4– MARGINAL RATE OF PERSONAL INCOME TAX NATIONALLY (2016)



Source: KPMG website

Based on KPMG comparisons, the effective income tax rate for an employee at a salary of €150,000 in Ireland is 44.75% some 5.3 percentage points above the UK at 39.45% and 16.18 percentage points above the US at 28.57%.

In Australia consultants and doctors benefit from a system tax minimisation called 'salary packaging' which allows them to receive up to 30% of their salary tax free. Irish consultants working in the Gulf States earn up to three times the equivalent Irish gross earnings tax free. In addition, in some Gulf States accommodation and the cost of children's education is also provided on top of basic remuneration.

10.Cost of Living Comparisons

The OECD publishes information containing the monthly Comparative Price Levels (CPL) for OECD countries. CPLs are defined as the ratios of Purchasing Power Parities (PPPs) for private final consumption expenditure to exchange rates. They provide a measure of the differences in price levels between countries. The monthly PPPs used to derive Table 3 are based on OECD data. It confirms that comparative prices and therefore the cost of living are lower in Canada (-8%), the UK (-9%) and in the US (-7%) than in Ireland based on the October 2016 data.

TABLE 3 – MONTHLY COMPARATIVE PRICE LEVELS (OCT 2016)

Country	Comparative price levels
Canada	92
Ireland	100
United Kingdom	91
United States	93

Source: OECD Monthly Comparative price levels (Oct 2016)

11. Global demand for Consultants

Demand for specialists and consultants exceeds supply worldwide and especially in developed economies. Irish trained medical graduates, specialists and consultants are in particularly high demand as the standard of training here is regarded as one of the best in the world. Internationally there are significant shortages in surgical, medical, diagnostic and other specialties. For example, January 2016 UK National Statistics for 2013 to 2015 reveal that there were 243 consultant vacancies in emergency medicine and 221 consultant vacancies in paediatric specialties. New Zealand has estimated that it will need an extra 2,280 specialists or 380 specialists every year to reach the OECD average number of specialists on a population basis by 2021. The Association of American Medical Colleges in 2016 estimate that there will be a sharp decline in the supply of surgical specialties in the US resulting in a projected shortfall of between 25,200 to 33,200 surgeons in the US by 2025.

These international shortfalls are driving the demand for highly trained specialists and consultants. This in turn is resulting in shortages across a range of key medical specialties in Ireland as well**.** Demand for specialists and hospital consultants continues to increase in Ireland and internationally due to the following factors:

- Growing and ageing populations worldwide, especially in developed countries worldwide
- Advances in medical treatments, therapies, procedures and technology
- Higher more demanding quality and safety standards
- Rising public expectations
- Advances in training and new requirements
- Changing models of service

Conclusion

There is an opportunity for the State and the Irish health service to properly address the current difficulties in recruiting and retaining doctors and consultants. This will require the restoration of trust and a number of fundamental actions to provide an improved platform to start rebuilding our international competiveness in the effective recruitment and retention of hospital consultants including:

- Honouring the 2008 Consultant Contract terms. This applies in particular to the salary payment which was payable on 1 June 2009 and which remains unpaid
- Ending the discrimination against new entrant consultants appointed from 1 October 2012 who are being remunerated at significantly lower levels than their consultant colleagues who were appointed before that date
- Reversing the FEMPI salary and other cuts introduced between 2009 and 2013
- Restoration of trust through the honouring of other terms and conditions of employment

The Association would welcome an opportunity to meet the Public Service Pay Commission to discuss the factors impacting on consultant recruitment in more detail.

IHCA

16 December 2016