IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation Submission to the Public Sector Pay Commission

January 2017

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Contents

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An Executive Summary

Ireland faces significant issues in the area of medical staffing. This country possesses one of the lowest ratios of doctor to population in the developed world, at just 2.8 per 1,000 population, which compares to an EU average of 3.4.[1] Low medical staffing has been observed to have profoundly negative consequences for patient outcomes and the operation of healthcare systems, and is a contributing factor to hospital overcrowding.[2] The limit that low medical staffing places on the ability of any given hospital to admit, diagnose, and treat patients who present to Irish healthcare services, is demonstrated by persistent capacity crisis within public hospitals in this country.

There is a high level of emigration amongst Irish-trained doctors. A survey which tracked doctors who completed internships in the Irish health system in mid-2011 found that 45% were no longer working in the public health system in Ireland, and it is likely that the majority had emigrated.[3] In 2015 alone the Irish medical register experienced an exit rate of 8.7% for doctors aged between 25 and 34, underscoring the severity of the problem.[4]

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. The paucity of these conditions of work affect all levels of current and aspirant medical practitioners. A Medical Workforce Analysis, published by the Department of Public Expenditure and Reform this summer, highlighted that 87% of medical students are either intending to emigrate or contemplating it,[5] 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 future.[6] This report stated that the chief motivations for emigration amongst those definitely or considering leaving were: workplace understaffing (82%); the carrying out of too many non-core tasks (75%); limited career progression

[1] Organisation for Economic Co-Operation and Development, *OECD Health Statistics 2016*.
[2] S Lamble *et al.*, 'Waiting times in California's emergency departments', *Annals of Emergency Medicine*, Vol. 44, No. 1, Jan. 2003, pp. 33-44; S.M. Schneider *et al.*, 'Emergency department crowding: a point in time', *Annals of Emergency Medicine*, Vol. 42, No. 2, Aug. 2003, pp. 167-172; N.R. Hoot and D. Aronsky, 'Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions', *Annals of Emergency Medicine*, Vol. 52, No. 2, August 2008, pp. 126-136; B. Starfield *et al.*, 'Contribution of Primary Care to Health Systems and Health', *The Milbank Quarterly*, Vol. 83, No. 3, Sep. 2005, pp. 457-502.
[3] Health Service Executive, *Implementation of the Reform of the Intern Year: Second Interim Report*, HSE Medical Education and Training Unit, Dublin, 2012, p. 22; N. Humphries *et al.*, "'Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland", *Human Resources for Health*, 2015; 13:35.
[4] Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 32.
[5] T. Campbell, *Medical Workforce Analysis: Ireland and the European Union compared*, Dublin, Department of Public Expenditure and Reform, 2016, p. 1.
[6] Medical Council, *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, Dublin, 2016, p. 6.

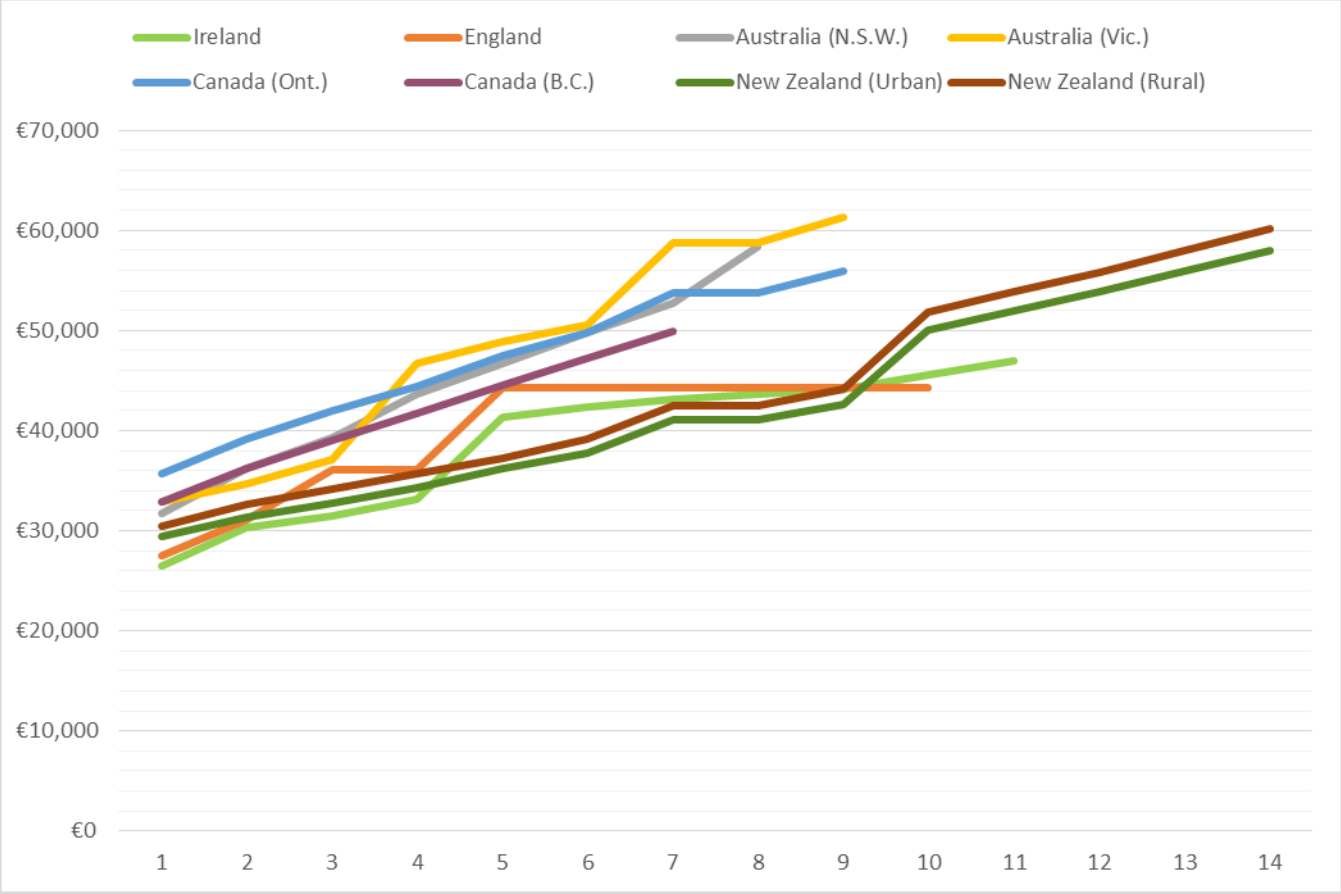
opportunities (72%); ability to earn more abroad (70%); and an absence of flexible training options (65%).[7]

The fact that pay available to virtually all cohorts of doctor in Ireland is inferior to that on offer in other English-speaking jurisdictions, operates as yet another 'push factor', as highlighted by Medical Council research. Pay cannot act as a measure to compensate for shortfalls in other areas of doctors' working conditions, however it remains an important consideration for doctors in determining in which jurisdiction to practise.

Pay Disparity and Pay-related Issues

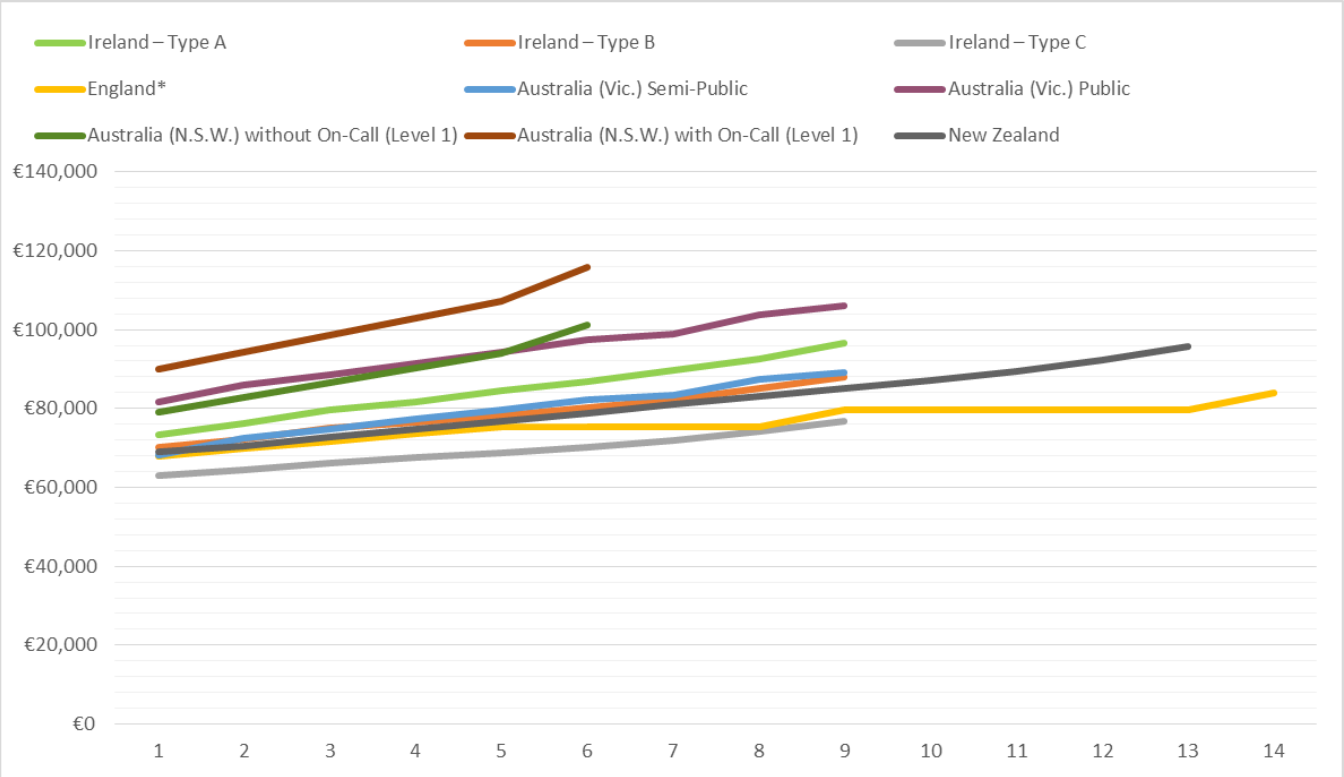
The below graphs highlight the relative superiority of the pay levels available to NCHDs and consultant doctors in other English-speaking jurisdictions. In an international marketplace for skilled medical practitioners, the pay rates available to doctors in Ireland are simply not competitive with states such as Australia and Canada in particular. This compounds the existing reluctance of doctors to work in Ireland due to inadequate staffing, poor resources and support, and an absence of a satisfactory work-life balance. There are a number of other pay-related issues that affect Irish doctors, as briefly set out below.

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



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

Consultants' Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted – Line Graph of Table 4 Data



* Figures from England do not take into account monies received from Clinical Excellence Awards. These are performance-related pay bonuses. On average, each consultant in England receives a bonus to the value of €11,847 (gross, PPP adjusted) annually, in addition to the basic pay listed in this table.

Non-consultant Hospital Doctors

- NCHDs have been subjected to reductions in pay and associated benefits applied to all those working in the Irish public system during the years of financial crisis, the reductions in the pay of those over €65,000 within the health service is disproportionate and contributes to the difficulties in retaining doctors at this level.
- While the HSE contributes to the cost of some of training courses for NCHDs, the recent removal of the training grant has resulted in a large increase to the cost of training for NCHDs, which is paid for from NCHDs' disposable income. It is estimated the average NCHD spends €20,000 to fund their training.

Consultant Doctors

- At any one time, around 250 vacancies for consultant posts remain vacant due to a lack of suitable applications. One quarter of advertised consultant posts receive no applications. Consultant posts in the Irish health system are not deemed to be attractive roles.
- The unilateral breach of contract and 30% cut in pay carried out in 2012 by the then Minister for Health has not been fully reversed. Accordingly, consultants' pay in Ireland remains poorer than that in many other English-speaking states.

Public Health and Community Health Doctors and Community Ophthalmic Physicians

- Unlike comparator jurisdictions, Specialists in Public Health Medicine are not afforded the same status and pay as hospital consultants. This is despite numerous recommendations for independent bodies that this situation, and the relatively poor pay rates amongst public health doctors in Ireland, be rectified.

- Over the course of the financial crisis, community health doctors have suffered approximately a 12% pay reduction. Additionally, there are no increments, with no potential for additional payment for taking on additional duties or specialist roles, or to acknowledge long length of service for this class of doctor.

- Historically, the salaries available to Community Ophthalmic Physicians have been kept at an artificially low level, despite their autonomy and expertise in the crucial practise of a vital community medical service.

Conclusions and Recommendations

Ireland has one of the lowest numbers of doctors, per capita, of any developed health system. Irish medicine is in the midst of a recruitment and retention crisis, which can only be effectively remedied by immediate and ambitious efforts to improve pay and working conditions for doctors to resemble those in other, English-speaking jurisdictions.

The IMO here sets out a number recommendations on doctor remuneration which it believes will reduce the flow of qualified, Irish-trained doctors from this country and better enable the Irish health services to attract medical practitioners of a high-calibre to its employment.

The IMO asks the Commission to adopt the following recommendations:

- The effects of the FEMPI Acts, 2009-2015, must be withdrawn, as they apply to medical practitioners.

- The 30% unilateral pay cut imposed on consultant doctors in 2012 must be completely reversed, to restore pay parity among colleagues.

- An independent review of doctors' remuneration and working conditions in Ireland should be carried out, which will include an assessment of the attractiveness of the Irish health services as an employer in terms of pay and conditions, relative to other English-speaking jurisdictions, such as Australia and Canada.

- Grants, support schemes, and tax benefits must be developed for all NCHDs to ensure that all costs associated with an NCHD's training are borne by the HSE.

- A new contract for Consultants in Public Health Medicine should be drawn up and offered to new entrants and existing Specialists in Public Health Medicine, placing such physicians on par with their consultant colleagues in terms of remuneration, and with regard to out-of-hours arrangements.

- A supported recruitment and retention programme, specifically designed at attracting Irish-trained doctors back to Ireland must be developed.

- Tax relief on loan repayments for graduate entry medical students must be provided.

- New NCHDs' and consultants' contracts must be negotiated.

Irish Medical Organisation Submission to the Public Sector Pay Commission

Introduction

Ireland faces significant issues in the area of medical staffing. This country possesses one of the lowest ratios of doctor to population in the developed world, at just 2.8 per 1,000 population, which compares to an EU average of 3.4.[8] Low medical staffing has been observed to have profoundly negative consequences for patient outcomes and the operation of healthcare systems, and is a contributing factor to hospital overcrowding.[9] The limit that low medical staffing places on the ability of any given hospital to admit, diagnose, and treat patients who present to Irish healthcare services, is demonstrated by persistent capacity crisis within public hospitals in this country.

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. The paucity of these conditions of work affect all levels of current and aspirant medical practitioners. A Medical Workforce Analysis, published by the Department of Public Expenditure and Reform this summer, highlighted that 87% of medical students are either intending to emigrate or contemplating it,[10] 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 future.[11] This report stated that the chief motivations for emigration amongst those definitely or considering leaving were: workplace understaffing (82%); the carrying out of too many non-core tasks (75%); limited career progression opportunities (72%); ability to earn more abroad (70%); and an absence of flexible training options (65%).[12]

Evidence of Emigration

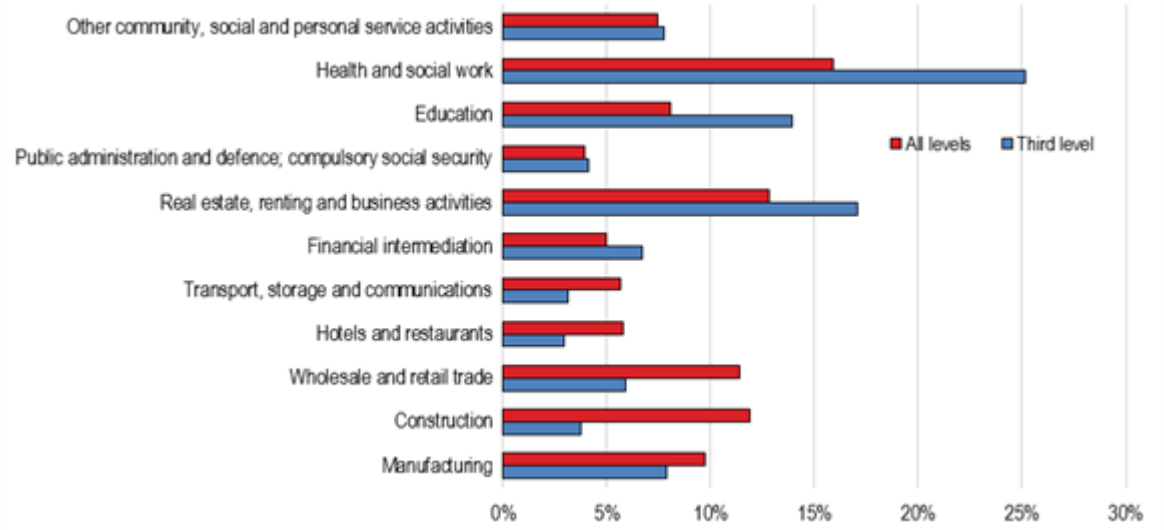
A survey which tracked doctors who completed internships in the Irish health system in mid-2011 found that 45% were no longer working in the public health system in Ireland, and it is likely that the

[8] Organisation for Economic Co-Operation and Development, *OECD Health Statistics 2016*.
[9] S Lamble *et al.*, 'Waiting times in California's emergency departments', *Annals of Emergency Medicine*, Vol. 44, No. 1, Jan. 2003, pp. 33-44; S.M. Schneider *et al.*, 'Emergency department crowding: a point in time', *Annals of Emergency Medicine*, Vol. 42, No. 2, Aug. 2003, pp. 167-172; N.R. Hoot and D. Aronsky, 'Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions', *Annals of Emergency Medicine*, Vol. 52, No. 2, August 2008, pp. 126-136; B. Starfield *et al.*, 'Contribution of Primary Care to Health Systems and Health', *The Milbank Quarterly*, Vol. 83, No. 3, Sep. 2005, pp. 457-502.
[10] T. Campbell, *Medical Workforce Analysis: Ireland and the European Union compared*, Dublin, Department of Public Expenditure and Reform, 2016, p. 1.
[11] Medical Council, *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, Dublin, 2016, p. 6.
[12] Medical Council, *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, Dublin, 2016, p. 24.

majority had emigrated.[13] In 2015 alone the Irish medical register experienced an exit rate of 8.7% for doctors aged between 25 and 34, underscoring the severity of the problem.[14]

A recent OECD report has revealed that one-in-five of all emigrants from this country work in the health and social work sector (Figure 1).[15] This is the largest sector of employment for Irish emigrants, ahead of real estate and construction respectively.

Figure 1 - One out of five Irish emigrants is employed in the health and social work sector



OECD Economic Surveys: Ireland, 2015.

Additionally, at any given time over 250 consultant posts remain vacant within the public health system, with many advertisements for such posts during the last year not receiving a single application, let alone one from a suitable candidate. Such evidence points to an ongoing recruitment and retention crisis for medical personnel within the public health service that shows little signs of abating.

Despite this, the Irish health services and management have not engaged in any serious effort to formulate a coherent and effective recruitment and retention plan that focuses on medical practitioners. As aforementioned, Ireland possess one of the lowest numbers of practising doctors in the EU, yet employs more nurses per capita than all but one EU state, at 11.9 per 1,000 population (EU average 8.0 per 1,000 population).[16] Failing to place appropriate focus on addressing doctor recruitment and retention, given such disparity in staffing levels between healthcare professionals, will only lead to the continuing worsening of conditions within hospitals, given the relative lack of medical manpower.

[13] Health Service Executive, *Implementation of the Reform of the Intern Year: Second Interim Report*, HSE Medical Education and Training Unit, Dublin, 2012, p. 22; N. Humphries *et al.*, "'Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland", *Human Resources for Health*, 2015; 13:35.
[14] Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 32.
[15] Organisation for Economic Co-operation and Development, OECD Economic Surveys: Ireland, Sep. 2015, p. 100.
[16] Organisation for Economic Co-operation and Development, OECD Health Statistics 2016, Health Care Resources, Nurses.

Working Conditions and Pay Are Both Drivers of Doctor Emigration

Fundamentally, the unattractiveness of the Irish health system stems from the conditions in which doctors are forced to work. Peer-reviewed research into this phenomenon has shown that many doctors in Ireland believe they work in a health system that is "quite obviously failing" and are left with "no option but to leave".[17] A key finding throughout such research is that doctors feel they are not treated with respect by the Irish healthcare system, a recurring theme in the HSE's employee survey results in 2015.[18] Those who emigrate feel vindicated in doing so as the Irish health system compares poorly to the destination countries, "particularly in relation to training and working conditions" for doctors. In the words of one respondent: "it was not until I worked abroad that I realised the full extent of this abuse. The absolute disregard for our training, lifestyles, good will is a disgrace".[19] Those who leave have little interest in returning to a system that is "over stressed, understaffed and has ever worsening morale".[20] The fact that pay available to virtually all cohorts of doctor in Ireland is inferior to that available in other English-speaking jurisdictions, operates as yet another 'push factor', as highlighted by Medical Council research. Pay cannot act as a measure to compensate for shortfalls in other areas of doctors' working conditions, however it remains an important consideration for doctors in determining in which jurisdiction to practise.

[17] N. Humphries *et al.*, "'Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland", *Human Resources for Health*, 2015; 13:35.

[18] Ipsos MRBI, *Have Your Say 2014: The Health Services Employee Survey*, Health Service Executive, Dublin, 2014, p. 16.

[19] N. Humphries *et al.*, "'Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland", *Human Resources for Health*, 2015; 13:35.

[20] Ibid.

Non-Consultant Hospital Doctors

Non-consultant hospital doctors (NCHDs) represent the largest cohort of doctors employed in the public health system. This group broadly encompasses two types of doctor: those in specialty training programmes, and those working in a clinical function in hospitals but not undergoing specialty training. NCHDs play a vital role in the delivery of the country's health services and it is crucial that they are retained. Due to the nature of training arrangements, the vast majority of these doctors work on short-term contracts of six or twelve months, invariably missing out on the benefits afforded to staff with longer service, while availing of necessary opportunities to train abroad results in many having reduced pension entitlements and other benefits.

The challenge to the public health service is to meet the need to recruit, retain and motivate a sufficient number of doctors with the qualifications, skills and flexibility required to fulfil these roles. The 2006 Report of the Postgraduate Medical Education and Training Group (also known as the Buttimer Report) warned of the urgent need to make significant efforts to improve the working and training environment for NCHDs in order "to avoid a 'brain drain' from Irish medicine".[21]

There is a shortage of trained medical professionals globally, and such shortages extend to many developed states. Accordingly, Irish-trained doctors are highly sought after in English-speaking countries including Australia, Canada, the United Kingdom, and New Zealand. Moving to these jurisdictions frequently results in Irish doctors enjoying superior salaries, working conditions and training opportunities to increase their learning and enhance their skills.

Regrettably, NCHDs have been subjected to the reductions in pay and associated benefits applied to all those working in the Irish public system during the years of financial crisis. This has contributed to a deterioration of NCHDs' living standards, and while such reductions remain it is unlikely that remuneration for NCHDs in Ireland will appear attractive relative to comparator states. The clinical contribution of senior NCHDs, at an advanced level of training, to the Irish health service is significant, however the extent of reductions in the pay of those over €65,000 within the health service is disproportionate and contributes to the difficulties in retaining doctors at this level. Additionally there are a number of other factors relating to the retention of NCHDs requiring urgent action which is not directly related to payment. These have been set out separately in the various reports that encompass the Strategic Review of Medical Training and Career Structure (also known as the McCraith Reports).

The pressing need to achieve safe working hours for doctors was reflected in the struggle to implement the European Working Time Directive (EWTD) which resulted in NCHDs, through the Irish Medical Organisation, taking industrial action in October 2013. This was necessary in the interests of safe working hours for doctors and more importantly for the safe care of patients. The implementation of the Directive over the following years has seen average doctors weekly working hours reduced from eighty-eight hours in 2013 to approximately forty-eight hours at present. That NCHDs felt compelled to take industrial action to achieve legal working hours is telling. However, the ongoing implementation of the EWTD has resulted in reduced overtime and reduced remuneration for NCHDs.

[21] The Postgraduate Medical Education and Training Group, Preparing Ireland's Doctors to meet the Health Needs of the 21st Century: Report of the Postgraduate Medical Education and Training Group, Dublin, 2006, p. 6.

As can be seen in the table below on average NCHD earnings have dropped on average by 46%. This is the cost to NCHDs arising from the implementation of EWTD. A reduction was foreseen and a review was incorporated into the NCHD Contract 2010. This review never took place, however, and NCHD earnings have remained reduced. This positon is unsustainable and is a barrier to retaining Irish trained doctors in the health service.

Box 1 – Fall in NCHDs' Earnings

Doctor Type	Average Monthly Income 2010	Average Monthly Income 2016	Reduction
Intern	7,150	3,370	53 %
SHO	7,795	4,012	49 %
Registrar	10,151	6,198	39 %
Senior Registrar	13,045	7,435	43 %
Specialist Registrar	12,122	6,239	49 %

NCHDs' Education and Training Costs

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

Uniquely in the health service, NCHDs have additional costs that must be funded from their net income but have a negative impact on their finances. All doctors are required to pay a registration fee to the Medical Council, which has increased in recent years, in addition to the need to possess individual clinical indemnity cover. Many also need to provide specialised equipment, some of which is funded by the employer but some of which is not. The nature of medical training requires doctors to work in a number of locations across the health service in both tertiary and secondary hospitals. In many cases this is over the course of six month rotations. The challenges and costs associated with constant relocation, in a housing market that is under pressure, are considerable.

The introduction of the Graduate Entry Medicine degrees is a welcome development and has allowed a new group of doctors with different skill sets and experience to contribute to our health system. These graduates have funded their own education through borrowing, however many now struggle in servicing the interest on the debt accumulated in progressing through their medical education. They face the choice of the status quo or moving abroad to better remunerated posts so they can reduce the debt and benefit from an improved quality of life. The lack of financial support in Ireland makes it very difficult for these experienced practitioners to meet their financial obligations and contribute to the Irish health service.

It is essential that the pay rates offered to NCHDs match the rate for the job and are sufficient to attract and retain the best doctors in the Irish Health system. While there are many factors influencing doctor emigration, of the NCHDs who indicated they are thinking of practicing medicine

abroad, 70% responded indicated their potential ability to earn more abroad as a factor. While training abroad was always part of the training process for doctors the conditions were such that they returned, particularly to take up consultant posts. It is now clear that many doctors who go abroad do not return and are taking up permanent posts in the countries they travel to for training. This is a concerning development which if it continues will deprive the Irish health service of the services of Irish trained doctors. The implications of this are significant although it will be a number of years before the full impact of this trend is realised and quantified.

NCHDs' Pay – An International Comparison

Payment is an acknowledged 'pull-factor' for Irish doctors, that is to say a lure for doctors to move to work outside of Ireland. The Medical Council's *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, which surveyed doctors in training in Ireland, revealed that, of those considering practising medicine abroad 70% agreed their potential ability to garner better payment abroad was a motivating factor.[22]

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

Table 1 - Net Pay in Euro (Post Tax)

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

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

[23] See footnote for salary sources.

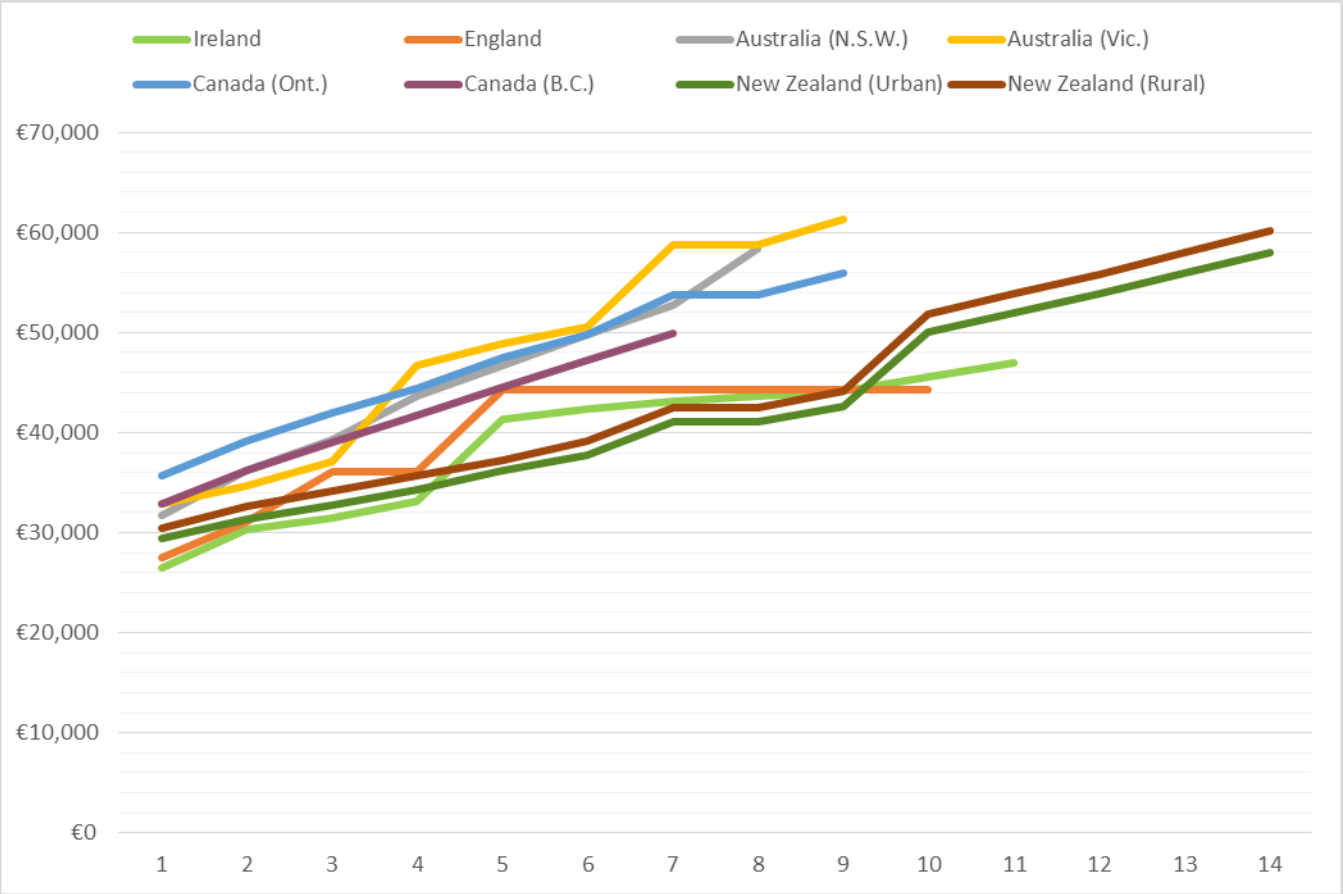
The alignment of net pay to account for 'Purchasing Power Parity' provides a more accurate comparison of payment rates. Using data provided by the Organisation for Economic Co-operation and Development, these salaries scales have been weighted to reflect their actual purchasing power in their corresponding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

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

Year on Scale	Ireland	England	Australia (N.S.W.)	Australia (Vic.)	Canada (Ont.)	Canada (B.C.)	New Zealand (Urban)	New Zealand (Rural)
1	€26,523	€27,459	€31,701	€32,922	€35,702	€32,907	€29,428	€30,439
2	€30,381	€31,140	€36,224	€34,667	€39,178	€36,192	€31,288	€32,584
3	€31,471	€36,106	€39,314	€37,130	€41,920	€39,039	€32,808	€34,176
4	€33,100	€36,106	€43,627	€46,715	€44,375	€41,679	€34,330	€35,761
5	€41,271	€44,296	€46,698	€48,936	€47,463	€44,485	€36,176	€37,210
6	€42,316	€44,296	€49,784	€50,501	€49,822	€47,192	€37,806	€39,107
7	€43,063	€44,296	€52,745	€58,795	€53,772	€49,896	€41,053	€42,482
8	€43,592	€44,296	€58,348	€58,795	€53,772		€41,053	€42,482
9	€44,132	€44,296		€61,342	€55,883		€42,665	€44,160
10	€45,602	€44,296					€50,086	€51,883
11	€47,024						€51,965	€53,831
12							€53,903	€55,849
13							€55,925	€57,950
14							€58,031	€60,141

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

Figure 3 – NCHDs' Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted – Line Graph of Table 2 Data



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

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

In general, an increase in payment would be required to bring the wage levels of NCHDs in Ireland on par with those working in other English-speaking jurisdictions. At the median point of an NCHD's salary scale (point 2 SpR, or point 6 on above table) a 5% increase in net pay would be required to bring wages up to the corresponding level in England, an 18% increase to bring wages up to the level in Victoria, a 19% increase to bring wages up to the level in New South Wales, an 18% increase to bring wages up to the level in Ontario, and a 12% increase to bring wages up to the level in British Columbia. The large discrepancy between the pay available for NCHDs in Ireland and elsewhere in

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

Consultant Doctors

A consultant is a medical professional who must hold specialist registration with the Irish Medical Council, and who by virtue of their expertise, is consulted with by other medical professionals, and others, in the delivery of patient care. In order to qualify as a consultant, a medical professional must undergo rigorous training and be successful in a competitive interview process. Quite often, this will involve spending time outside of Ireland pursuing training and other professional opportunities. Upon employment in Ireland, a consultant assumes responsibility for the full delivery of medical care to patients under their care, irrespective of the individual who actually delivers that care.

Given the scope of training required in successfully attaining a consultant post, and the level of responsibility attached to the post, consultants have been among the highest paid public servants. In addition to this, consultant salary levels have had to take account of the significant international demand for Irish, and Irish-trained, consultants.

In recent years, however, as aforementioned, the recruitment and retention of Irish and Irish-trained consultants has become increasingly challenging for the Irish public health service. This is a function both of difficult working conditions and also steep reductions in remuneration. Indeed, as recruitment and retention has become more difficult, so fewer consultants have been appointed, or remained in public health service employment, resulting in more difficult working conditions for colleagues, which in turn has led to more consultant retention problems.

To demonstrate the depth of the reductions suffered by consultants under the various pieces of FEMPI legislation, it is worth considering the two most common contract types; Type A, which allows for public only practice and Type B, which allows for some element of private practice. A consultant who signed the Type A 2008 Consultant Contract (clinical), was placed on an interim pay scale the top point of which was €226,461 as at 1st September 2008. The top point of the same pay scale today is €178,593, which represents a reduction of €47,868 or twenty one percent. The same figures for a colleague who took a Type B Contract shows a salary reduction of €41,516 – from or twenty percent from €205,176 to €163,660. In both cases, the starting salary was reduced by similar percentages.

It is also important to understand, that under FEMPI 2013, two pay scales were merged together, which lengthened the time that individual consultants would take to reach the top point of their scale, and incremental progression was frozen for consultants meaning that those consultants who had not reached the top point of their incremental scale would now take longer to reach the top point of an extended scale.

Consultants who opted not to take the 2008 Contract suffered similar reductions, with, for example, some Category I consultants on the 1997 Contract suffering reductions of ten percent, albeit on a lower starting salary. It is worth noting that the 1997 version of the Consultant Contract is not offered to new entrants, or to individuals moving posts. The majority of consultants in post, therefore, and all of those appointed since 2008 have been appointed to contracts the remuneration that attached to which has been reduced by approximately twenty percent.

These cuts in remuneration were accompanied by much negative comment about the, by now reduced, remuneration of consultants. Quite aside from the financial cost to consultants, this caused deep unease among consultants, who feared that they had become a ‘political football’ and were depicted as emblematic of the ills of the pre-crash period.

This has been most unfortunate and has served only to foster a sense of alienation among the consultant workforce. This is something that can be ill afforded at a time when the Irish public health service is finding it increasingly difficult to recruit and retain highly skilled medical specialists to permanent posts.

In addition to the cuts and reductions provided for in FEMPI legislation, the IMO must draw the attention of the Commission to the catastrophic impact of the 30% reduction in salary imposed on new entrant consultants in September 2012. That unilateral reduction, which has created significant difficulties in attracting and retaining consultant doctors, has had disastrous consequences for the delivery of health care in Ireland.

As the IMO warned at the time of the reduction, such a swingeing cut in salary could only have one outcome; increased numbers of vacant posts at senior medical decision maker level. Unfortunately, but predictably, this has proven to be the case, with in excess of 250 consultant posts unfilled by a permanent employee at any given time. Furthermore, one quarter of advertised consultant posts receive no applicants, and IMO research shows that over half of Irish trained medical graduates plan to practice medicine abroad. These figures are without precedent in the history of the Irish public health service.

These deficits in medical staffing, particularly at senior medical decision maker or consultant level restrict patients' access to care, and the quality of that care. The 2003 Report by the National Task Force on Medical Staffing, when applied to our current population, sets out a requirement for 4,400 consultants in the health service. Today, however, there are just over 2,700, and as a result we have long-waiting lists for out-patients and procedures across virtually all medical specialties. This does not auger well for the future of hospital care in Ireland.

The IMO did agree an amended pay scale for new entrant consultants in January 2015 with health service management. That scale undid some of the damage caused by the 2012 reduction, but the message that that reduction sent to emerging consultants is not so easily undone. Indeed, no sooner were those new scales agreed than they were undermined by management delay and prevarication. Today, almost two years after the agreement, some of our best medical talent still await relief from the 2012 reduction.

The IMO urges the Commission to make a special recommendation that the thirty percent pay reduction imposed on new entrant consultants be fully reversed.

It has been an article of faith that the Irish public health service should become a consultant delivered service. Yet, the reductions in consultant remuneration imposed under the FEMPI legislation, accompanied by less than optimal working conditions, restricted access to support staff and theatre / clinic time, has served to make this goal less and less likely. This has consequences for the delivery of patient care and for the quality of that care. The FEMPI Acts addressed a declared national emergency consultants more than played their part in tackling that emergency; an emergency that was not of their making. As Ireland emerges from the emergency, the IMO would urge that consultant remuneration be restored to pre-emergency levels, as part of the response to another emergency, namely the unprecedented flight from the Irish public health service of our medical specialists.

Consultant Doctors' Pay – An International Comparison

As previously discussed, three types of consultant contract are currently offered in Ireland: Type A, which requires thirty-nine hours of service to the public health system and precludes private

practice; Types B and C are similar to Type A but permit private practice on the basis that it does not exceed more than 20% of the consultant's clinical workload and differ on the basis of where such private practice may be carried out.

Many comparable English-speaking jurisdictions offer alternative contracts to consultants. In England, publicly-employed consultants may carry out private practice on the basis that it does not conflict with their commitments to their public contracts, but sets no express limit on the clinical workload that can be devoted to private practice; in Victoria, like Ireland, separate contracts are offered for consultants who wish to work exclusively for the public system or those who wish to hold private practice in addition to their public contract; in New South Wales contracts do not preclude private work, however Level 1 contracts, in return for the assignment of the billings from the Staff Specialist's private practice to the Public Health Organisation, grant the consultant a 20% salary bonus; and in New Zealand, consultant contracts permit private practice, which again must not impinge on the performance of the public contract. These differences should be borne in mind when viewing the figures presented in Table 3. It is also pointed out that figures from England do not contain monies awarded as part of Clinical Excellence Awards, which are performance-related bonuses and open to all consultants.

Table 3 - Net Pay in Euro (Post Tax)

	Ireland – Type A	Ireland – Type B	Ireland – Type C	England*	Australia (Vic.) Semi-Public	Australia (Vic.) Public	Australia (N.S.W.) without On-Call	Australia (N.S.W.) with On-Call	New Zealand
1	€73,478	€70,118	€62,918	€60,691	€75,897	€90,622	€88,021	€100,122	€73,316
2	€76,166	€72,134	€64,358	€62,424	€80,407	€95,451	€92,089	€104,898	€75,087
3	€79,718	€74,918	€66,278	€64,053	€83,197	€98,443	€96,153	€109,669	€77,301
4	€81,638	€76,358	€67,478	€65,681	€85,880	€101,575	€100,229	€114,455	€79,516
5	€84,518	€78,278	€68,678	€67,304	€88,504	€104,808	€104,297	€119,231	€81,730
6	€86,918	€80,198	€70,118	€67,304	€91,233	€108,174	€112,435	€128,785	€83,944
7	€89,798	€82,118	€72,038	€67,304	€92,667	€109,939			€86,159
8	€92,438	€84,998	€74,198	€67,304	€97,057	€115,350			€88,373
9	€96,518	€87,878	€76,838	€71,170	€98,945	€117,680			€90,587
10				€71,170					€92,801
11				€71,170					€95,016
12				€71,170					€98,116
13				€71,170					€101,880
14				€75,037					
15				€75,037					
16				€75,037					
17				€75,037					
18				€75,037					
19				€78,318					

* Figures from England do not take into account monies received from Clinical Excellence Awards. These are performance-related pay bonuses. On average, each consultant in England receives a bonus to the value of €10,770 (gross) annually, in addition to the basic pay listed in this table.

[24] See footnote for salary sources.

[24] British Medical Association, Pay scales for consultants in England, October 2016, available at: https://www.bma.org.uk/advice/employment/pay/consultants-pay-england; Australian Medical Association Victoria, Specialists in Public Hospitals: Rates of Pay, 2014, available at: https://amavic.com.au/page/Specialists_in_Public_Hospitals/Public_Hospital_Working_Conditions/Rates_of_pay/#1; New South Wales Government Ministry of Health, Salary Increases Staff Specialists NSW Public Health

Much as is the case when viewing comparisons of NCHDs' salary figures, a truer reflection of the earnings derived from the figures listed here can be obtained by aligning salaries for 'Purchasing Power Parity'. Such an alignment is shown in Table 4.

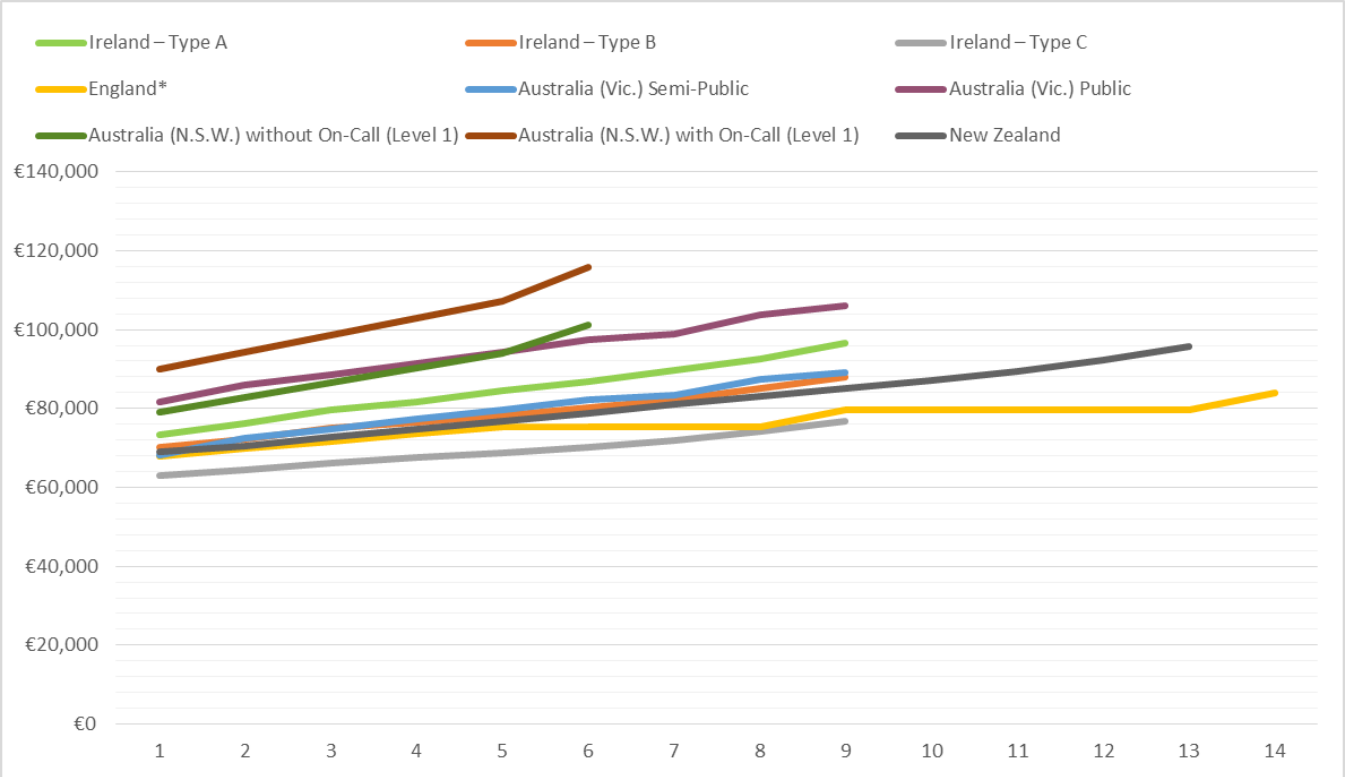
Table 4 - Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted

	Ireland – Type A	Ireland – Type B	Ireland – Type C	England*	Australia (Vic.) Semi-Public	Australia (Vic.) Public	Australia (N.S.W.) without On-Call (Level 1)	Australia (N.S.W.) with On-Call (Level 1)	New Zealand
1	€73,478	€70,118	€62,918	€67,974	€68,307	€81,560	€79,219	€90,110	€68,917
2	€76,166	€72,134	€64,358	€69,915	€72,366	€85,906	€82,880	€94,408	€70,582
3	€79,718	€74,918	€66,278	€71,739	€74,877	€88,599	€86,538	€98,702	€72,663
4	€81,638	€76,358	€67,478	€73,563	€77,292	€91,418	€90,206	€103,010	€74,745
5	€84,518	€78,278	€68,678	€75,380	€79,654	€94,327	€93,867	€107,308	€76,826
6	€86,918	€80,198	€70,118	€75,380	€82,110	€97,357	€101,192	€115,907	€78,907
7	€89,798	€82,118	€72,038	€75,380	€83,400	€98,945			€80,989
8	€92,438	€84,998	€74,198	€75,380	€87,351	€103,815			€83,071
9	€96,518	€87,878	€76,838	€79,710	€89,051	€105,912			€85,152
10				€79,710					€87,233
11				€79,710					€89,315
12				€79,710					€92,229
13				€79,710					€95,767
14				€84,041					
15				€84,041					
16				€84,041					
17				€84,041					
18				€84,041					
19				€87,716					

* Figures from England do not take into account monies received from Clinical Excellence Awards. These are performance-related pay bonuses. On average, each consultant in England receives a bonus to the value of €11,847 (gross, PPP adjusted) annually, in addition to the basic pay listed in this table.

System – Staff Specialists (State) Award, July 2016, available at: http://www0.health.nsw.gov.au/policies/ib/2016/pdf/IB2016_033.pdf; Association of Salaried Medical Specialists (New Zealand), New Zealand District Health Boards and Senior Medical and Dental Officers - Collective Agreement, 2013, http://www.asms.org.nz/wp-content/uploads/2014/05/2013-16-DHB-MECA-signed_159277.6.pdf.

Figure 3 - Consultants' Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted – Line Graph of Table 4 Data



* Figures from England do not take into account monies received from Clinical Excellence Awards. These are performance-related pay bonuses. On average, each consultant in England receives a bonus to the value of €11,847 (gross, PPP adjusted) annually, in addition to the basic pay listed in this table.

The only contracts that may be easily compared with the Irish Type A contract are the Victoria 'public only' contract and the New South Wales Level 1 contracts. It is evident that the remuneration provided by Type A Irish consultant contracts, when compared to those available in Australia, is low. At the median point in the Irish salary scale (point 5), salaries from these Australian territories are between 11% and 27% higher, in net terms, than those available under the Type A contract in Ireland.

It should also be borne in mind, when assessing this comparison that a relatively long time is spent in postgraduate training by Irish-trained doctors before becoming a consultant, which ordinarily ranges between ten and fifteen years of practice. By contrast, medical residency (or post-graduate training) often ranges between three and seven years in Canada or the USA before taking up a specialist post. This can mean that Irish-trained doctors often spend longer in training before obtaining a consultant post than international comparators, and so remain on lower pay scales for longer, thus resulting in lower earning capacity.

Part of the challenge in recruiting consultants also relates to the increase in the number of salary points to reach the top of the Consultant salary scale coupled with a freeze in increments which has the impact of reducing life time earnings for consultants and in turn will impact on their future pension. This coupled with numerous failures to honour consultant contracts by the employers' side, reductions in terms and conditions, reductions in excess of all other workers in the context of the additional 30% salary cut for all new entrants superimposed on an in excess of 20% cut and reduced or no access to private practice and the lack of parity between existing and newly appointed

consultants with regards to pay has led to difficulties in recruitment and an unprecedented number of consultant resignations from the public hospital system in Ireland.

The salary scale for the Type B contract in Ireland can be viewed as, initially, broadly-similar to comparable contracts in England, Victoria, and New Zealand. There are key differences, between these contracts however. The English salaries listed in Table 4 do not contain monies paid through Clinical Excellence Awards which amount to, on average, a payment of €11,847 (gross, PPP adjusted) to each consultant annually. In Victoria, contracts of employment carry with them an allowance of up to 25,077AUD for approved expenses incurred in connection with continuing medical education, while in New Zealand bonus payments for the performance of on-call duties are available to the value of between 1% and 8% of salary, depending on the number of hours devoted to on-call responsibilities. None of these contracts, unlike Type B and C contracts in Ireland, contain an express restriction on the workload that a consultant can undertake privately at the same time as she performs her public contract.

In view of such restrictions, Type B and C contracts may be viewed as relatively unattractive. With the scope for private practice limited, they contain neither performance-related bonus payments, nor the strong support or additional payments contained in other contracts. An unwinding of FEMPI and a reversal of the 30% pay cut imposed unilaterally on consultants in 2012 would be required to render the remuneration available under the Irish Type B and C contracts as sufficiently attractive in an international marketplace.

Public Health and Community Health Doctors

Public Health and Community Health Doctors specialise both in the treatment of populations and the treatment of individuals within those populations. Public Health Doctors specialism lies, in the main, in epidemiology, that is the study of illness and the devising of strategies to best combat illness, including systemic programmes and the arrangement of health services to best meet threats to the public health, both current and emerging. Community Health Doctors provide clinical assessments and interventions to individuals in targeted groups in accordance with HSE service plans, for example to infants and children.

An agreement concluded between the Irish Medical Organisation and health service management in 2003 provided for a compliment of 280 Public Health and Community Health Doctors across the public health system. However, the system currently is running well below this figure having suffered from retirements, incentivised or otherwise, and a failure to fill posts since 2009. While it must be acknowledged that recruitment is again underway, this is only starting to restore capacity that was lost during the financial downturn. In common with other doctors and other public servants, the remuneration of these categories of doctor was substantially reduced over the period of the financial emergency.

Specialists in Public Health Medicine and Directors of Public Health

Public Health Medicine is one of the core medical specialties of any functioning health service and uniquely amongst medical specialties, a substantial part of the Public Health Medicine function is mandated by legislation, both national and international, including the Health Acts 1947, 1953, and 2004, and the International Health Regulations, 2005.

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 and agreed with the Irish Medical Council. This may involve spending time outside of Ireland pursuing training and other professional opportunities. Upon employment in Ireland, a SPHM assumes responsibility for the investigation of threats to the health of the population that they serve, whether current or emerging, to report on those threats and to take the necessary steps to protect the health and wellbeing of both individuals and the population as a whole.

Directors of Public Health (DPHs) are SPHMs who also manage 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.

SPHMs in Ireland are unique internationally in not being accorded the same pay and remuneration as their hospital consultant colleagues. This is despite the recommendation arising from an independent review of Public Health Medicine in 2001 by Capita Consulting (commissioned by a group appointed under the auspices of the Minister for Health) which noted that

> *"It is clear from the findings of this review that continuing to maintain these posts as Specialists* (as opposed to consultants) *is having a detrimental effect upon the ability of senior Public Health doctors to add real value at a senior level within their organisations".*

The report went on to note that "...the key issue is less about whether these changes can be afforded, and more about whether the Irish health services can afford not to make this investment."

A Public Health Review Group, which was to be undertaken pursuant to the 1994 agreement, was delayed and its report only issued in April 2002. As a result of this delay Public Health Doctors were deprived of pay increases which were made to virtually all other public sector workers.[25] However, the Brennan Report, as it came to be known, did not provide any structure or mechanism within which the recommended change in status could be implemented. Payments due under previous national agreements (the Programme for Competitiveness and Work and Partnership 2000) had been deferred and the Brennan Review coincided with the work of the Public Service Benchmarking Body (2002). The Public Service Benchmarking Body received the Brennan Report, from the Irish Medical Organisation on 21st May 2002. In reaching its conclusions and forming its recommendations for these grades, the Public Service Benchmarking Body was not in a position to take account of the issues raised by the Public Health Review Group. The body recommended increases of 14.2% for DPHs and 10.1% for SMOs. The 2.5% awarded to SPHMs was interpreted at the time as anticipating that the recommendations of the Brennan Report would be implemented (i.e. that negotiations would take place with regard to consultant status).

An industrial dispute ensued, which was resolved following an agreement under the auspices of the Labour Relations Commission. Included in the terms of that agreement was that payments due to public health doctors under the local bargaining clause of the Programme for Competitiveness and Work and Partnership 2000 would be referred to an agreed third party for adjudication, to be concluded without delay. In addition it was agreed that the issue of consultant status and remuneration of DPHs and SPHMs would be referred to the next iteration of the Higher Remuneration Body.

In 2007, the Review Body on Higher Remuneration in the Public Sector (Report No. 42) examined remuneration for SPHMs. Unlike the other groups examined in this report, a job evaluation of SPHMs was not carried out. In addition, it did not believe that consideration of consultant status for public health doctors was within its remit. Nevertheless, the Review Body recommended that SPHMs should get a 20% increase in their salary to €130,000 per annum. An increase of 15%, to €145 000, was recommended for DPHs. These awards were not honoured by the employer.

Eventually, however, in June 2009, 5% of that pay increase was sanctioned for payment by the Department of Health, along with a general round increase of 2.5% that had been withheld. This occurred as a result of an agreement between the IMO and the HSE to establish a Public Health Medicine out-of-hours Service, as required by the State's international obligations.

In line with the World Health Organization (WHO) International Health Regulations (2007) this service assesses and manages infectious and environmental public health threats arising from travel to and from Ireland, as well as those arising locally. The total payment of €576 covers being on call from 5 p m. to 9 a.m. Monday to Thursday and from 5 p.m. Friday to 9 a.m. Monday. This is totally unacceptable to the doctors whose personal lives revolve around this commitment when on call. It is a priority for the IMO to have this derisory payment addressed and brought into line with comparable payments to other medical specialists.

Similar to other public services salaries subsequently decreased due to the economic downturn. In 2009 SPHMs were on a salary of €119,067; this was reduced to €109,660 on 1 January 2010 (as part of the FEMPI Acts) and to €102,887 on 1 July 2013 as part of the Haddington Road Agreement. Similar decreases were experienced by DPHs; in 2009 they were on a salary of €138,909; today they are paid €119,067 per annum. Since these are single point salaries without increments, there is no

[25] Extract from the Adjudication Board's History of the Claim, Labour Relations Commission, June 2003.

potential to reward those who take on additional duties, attain further specialist expertise or acknowledge longer length of service.

SPHMs thus remain seriously disadvantaged when compared with their hospital consultant colleagues a situation which, as noted, is unique to Ireland and which disregards the recommendations of the aforementioned Capita Report in 2001 and the 2010 Saunders Review which noted that

> *"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".*

Doctors in the UK with comparable training are similar with respect to pay and conditions with medical consultants who work in hospitals. In addition to basic pay, they may receive awards ranging from bronze to gold for duties similar to those which many public health doctors in Ireland frequently undertake, including training, chairing committees or leading on key projects. Thus, any comparison of basic salaries would be meaningless.

There is recent evidence of the impact of lower salaries in Ireland compared to the UK when there were no applicants after the post of Director of the National Health Protection Surveillance Centre was advertised for the second time. Potential candidates who made informal contact with SPHMs working at the HPSC were clear that the salary on offer (equivalent to that of DPH) was not commensurate with the expertise required and the duties and responsibilities of the post.

The MacCraith Reports (2014) made recommendations on improving the retention of young doctors in Ireland, with attention to training, workforce planning and recruitment. However, for public health medicine it was recommended that yet another review be carried out (see Box 2 below). There was substantial slippage in the time line. The review which was to report by June 2015 is now due to be completed by June 2017.

Box 2 - Recommendations in Relation to Public Health Medicine

3.5.2 Recommendations

Taking into account the above observations and conclusions, the Working Group wishes to make the following recommendation in relation to public health medicine.

5. In the context of Action 46 of *Future Health* (DoH, 2012), *Healthy Ireland* (DoH, 2013) and emerging service developments, as well as national and regional demand for public health expertise, 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.

Source: Department of Health, *Strategic Review of Medical Training and Career Structure - Final Report*, Dublin, June 2014, p. 43.

A new contract for the position of Consultant in Public Health Medicine should now be drawn up and implemented as a matter of urgency. This should be the Type A hospital consultant contract which reflects the fact that those who choose a career in public health medicine are precluded from developing a separate private practice. The extension of this contract to SPHMs will solve the current contract issues and make provision for OOH services as well. This contract should apply to all current and future appointments at Specialist/Consultant level in Public Health Medicine.

Senior Medical Officers – Public Health

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 DPH and SPHMs have overall responsibility for assessing and managing risk. SMOs provide an essential service managing cases notified to departments of public health which involves liaison with medical, environmental and other health professionals, as well as with patients, families, employers, school principals etc., in situations such as the following:

- Gathering surveillance data in accordance with national guidance
- Identifying contacts of diseases such as meningitis and prescribing prophylaxis to reduce risk of further cases
- Involvement in outbreak control teams, for example for VTEC (a very toxic E Coli which results in serious illness) for which Ireland has one of the highest rates in the world due to the combination of large population of cattle, high rainfall, variety of water schemes

- Managing cases of tuberculosis (TB), screening to identify cases associated with newly diagnosed cases, and managing the contacts that are diagnosed as having 'latent' TB
- Providing information and guidance to avoid ongoing transmission to patients with highly sensitive diagnoses such as sexually transmitted diseases or hepatitis
- Developing special expertise in some of the above areas, contributing to training of other staff in their departments and in other clinical settings.

The starting point of the SMO salary was reduced from €82,817 to €72,798. At that salary level they suffered the consequences of the downturn without benefitting from lower deductions and earlier restoration offered to those on salaries of €65,000 or below. While increments are awarded according to service, these were frozen in recent years and the upper level (€86,323) does not adequately recognise the expertise and clinical roles performed by these doctors.

Community Health Doctors

Community Health Doctors specialism lies in delivering the objectives contained in national health plans. This work is of such importance that it is mandated by legislation, namely the Health Act of 1970. Some of their work is monitored through national key performance indicators, such as population coverage of childhood immunisation programmes. The outturn is reported to WHO because deficits present threats at international as well as at national level.

Community Health Doctors are those medical professionals who perform the actual delivery of vaccination and other campaigns. These campaigns, whether required by legislation or political commitments, are targeted at specific segments of the population, such as the very young, or the elderly.

Community Health Doctors, among other duties, lead in vaccination programmes that deliver specified public health aims to targeted populations, which could include, for example, school children. Historically, Ireland has had fewer of these doctors than comparable countries. As a result of this, each departure from the service, and consequent non filling of post, has been keenly felt by the remaining staff.

Given the increased emphasis on maintaining the health of the population – keeping people well, rather than caring from them when they fall ill – it makes little sense to actively discourage the very professionals that we task with carrying out this vital work.

In common with all other doctors, the grades within Community Health suffered steep reductions in salary since the onset of the financial crisis. For the most senior Community Health Doctors – Principal Medical Officers – salary was reduced from €106,230 to €92,258, a reduction of €13,972 or thirteen percent. There are no increments, with no potential for additional payment for taking on additional duties or specialist roles, or to acknowledge long length of service.

For Senior Medical Officers, the reduction was from €99,062 to €86,232 (top of scale), a reduction of €12,739 or twelve percent, while Area Medical Officers suffered a reduction from €84,045 to €73,843 (top of scale), representing a reduction of €10,202, or twelve percent. These salaries do not reflect the training which these doctors have prior to commencing work or the expertise they gain over time.

Community Ophthalmic Physicians

Community Ophthalmic Physicians (COPs) provide a specialist level, community based medical eye service. They, by virtue of their medical registration, are entitled to practice independently, and diagnose and treat various conditions of the eye. Historically, the salaries available to COPs have been kept at an artificially low level, mirroring those of their Senior Medical Officer colleagues. Consequently, COPs suffered similar reductions in salary, by virtue of FEMPI legislation, to those endured by Senior Medical Officers.

Given the length of ophthalmological waiting lists, the IMO would argue that these supposed savings represent a false economy. Indeed, the state should be moving to have more medical eye care delivered in community settings, and as employed specialists, COPs are ideally placed to do just that.

However, the terms and conditions attached to the role render it unattractive to young doctors. While there is much to be done to ameliorate that situation, the IMO would recommend the prompt unwinding of the FEMPI salary reductions as a necessary step in the right direction.

Conclusion and Recommendations

As set out within this submission, medical practitioners in Ireland have, in many cases, borne a disproportionately heavy burden from reductions in public sector pay. This has reduced the attractiveness, and thus the competitiveness, of the Irish health services as an employer within a global market for the services of highly-skilled medical practitioners. Pay ranks as a significant consideration for almost three-quarters of trainee doctors who are contemplating leaving this country, and the poor pay and conditions available in Ireland, relative to some other English-speaking jurisdictions, has unquestionably contributed the high levels of doctor emigration and low uptake in consultant posts in Ireland.

The IMO here sets out a number recommendations on doctor remuneration which it believes will reduce the flow of qualified, Irish-trained doctors from this country and better enable the Irish health services to attract medical practitioners of a high-calibre to its employment.

The IMO asks the Commission to adopt the following recommendations:

- The effects of the FEMPI Acts, 2009-2015, must be withdrawn, as they apply to medical practitioners.
- The 30% unilateral pay cut imposed on consultant doctors in 2012 must be completely reversed, to restore pay parity among colleagues.
- An independent review of doctors' remuneration and working conditions in Ireland should be carried out, which will include an assessment of the attractiveness of the Irish health services as an employer in terms of pay and conditions, relative to other English-speaking jurisdictions, such as Australia and Canada.
- Grants, support schemes, and tax benefits must be developed for all NCHDs to ensure that all costs associated with an NCHD's training are borne by the HSE.
- A new contract for Consultants in Public Health Medicine should be drawn up and offered to new entrants and existing Specialists in Public Health Medicine, placing such physicians on par with their consultant colleagues in terms of remuneration, and with regard to out-of-hours arrangements.
- A supported recruitment and retention programme, specifically designed at attracting Irish-trained doctors back to Ireland must be developed.
- Tax relief on loan repayments for graduate entry medical students must be provided.
- A new consultants' contract must be negotiated.
- A new NCHDs' contract must be negotiated.