RETAINING OUR DOCTORS:
MEDICAL WORKFORCE EVIDENCE, 2013-17

RCSI HEALTH WORKFORCE RESEARCH GROUP

13TH NOVEMBER 2017

RCSI

Chapter 3: Scale of outward migration of doctors from Ireland

Summary:

- Routine data from the main destination countries suggest large numbers of doctors had left or were about to leave Ireland during the period 2008-2014.

- Routine data from Ireland show high exit rates since 2012 in age categories 25-34 and 35-44 years, i.e. among early career doctors.

- 20-22% of trainees intend to emigrate (to make a long term career outside of Ireland) MC YTC 2014-2015, DEP 2016.

- 63% of final meds (2017) intend to leave, 54% of whom intend to return – 9% intend not to return (MedTrack)

Funded by the European Union

RCSI

Scale of outward migration of doctors from Ireland

Questions

1. *Is enough being done (can more be done) to ensure that Irish graduates who travel after internship have jobs and if possible training programmes in Ireland to return to?*

2. *Is training (e.g. fellowships) abroad always necessary? Is it encouraged even for those who wish to be generalists? - see 'culture of emigration' later?*

3. *Are the processes sufficiently streamlined whereby those who need to undertake fellowships abroad can be assured of permanent posts to return to in Ireland*

4. *What other or additional conclusions can be drawn from the findings? Do the findings point to other questions we should be asking?*

Funded by the European Union

World Health Organization

HRB Health Research Board

RCSI

Chapter 4: International Recruitment of Doctors

Scale of inward migration of doctors into Ireland

The Fottrell targets have been achieved (number of Irish (and EU) graduates up from 370 in 2006 to 730 by 2015) and modest increases in postgraduate training numbers.

Notwithstanding this, the pace of international recruitment and the recruitment of doctors to non-training posts is exceeding rates of recruitment of Irish trained doctors and recruitment to training posts.

Likely reasons are an increased demand for health services; the need to be European Working Time Directive (EWTD) compliant, which is a bigger challenge in small hospitals; along with high rates of emigration by Irish

Funded by the European Union

World Health Organization

HRB Health Research Board

RCSI

International Recruitment of Doctors

Changing profile of NCHDs in Ireland

The number of non-trainees is increasing four times as quickly as the number of trainees; non-trainees are generally older and most of these are likely to be in service posts with little or no prospect of entry to formal training programmes.

Funded by the European Union

World Health Organization

HRB Health Research Board

RCSI

International Recruitment of Doctors

Onward migration of doctors out of Ireland

Exit rates by country of qualification range from the lowest among graduates of Irish medical schools, followed by graduates of non-EU medical schools, to highest exit rates among graduates of other EU medical schools

Exits from the General Division of the register, where non-EU graduates are more likely to be registered, are around three times higher than exits from the specialist register. Onward migration is likely to account for this higher turnover.

In a 2013 survey of foreign doctors, less than one quarter (23%) planned to stay in Ireland, with almost half (47%) planning to migrate onwards to a third country.

Funded by the European Union

World Health Organization

HRB Health Research Board

International Recruitment of Doctors

Conclusion

Despite the expansion in domestic graduate numbers, the rate of international recruitment is faster.

Surveys and routine data point to a higher turnover among international medical graduates (IMGs) who, after having worked for a period in Ireland, usually in non-training posts, migrate onward to a third country rather than return home.

International recruitment, at this level, creates challenges in implementation of the WHO Global Code (World Health Organisation, 2010).

On the other hand, Ireland's IMGTI programme is an example of best practice in providing training and promoting circular migration back to the source country.

RCSI

Funded by the European Union

World Health Organization

HRB Health Research Board

RCSI

International Recruitment of Doctors

Questions

1. How sustainable is this faster upward trend in the recruitment of doctors outside of training programmes? What are the reasons for the trend?

    - To what degree is it due to the pressure to be European Working Time Directive (EWTD) compliant?

    - Given that Ireland has a statutory requirement to be EWTD compliant, are there better or other ways for HSE hospitals to achieve compliance?

    - Is it partly an effect of hospital configuration, whereby small hospitals are not suitable for training, and face challenges in recruiting consultants, and require greater numbers of NCHDs to be EWTD compliant?

Funded by the European Union

World Health Organization

HRB Health Research Board

RCSI

International Recruitment of Doctors

Questions continued….

2. *How can the trend of faster growth in non-training posts be reversed?*

3. *Could changes in specialist location patterns help to increase the number and ratios of training to non-training posts?*

4. *Are there better ways for HSE hospitals to address service delivery needs?*

5. *Do the findings point to other questions we should be asking?*

Funded by the European Union

World Health Organization

HRB Health Research Board

Chapter 5: Doctor Emigration from Ireland: Push and Pull factors

Summary

The body of evidence from three mixed methods research studies identifies common factors that are reported as *pushing* doctors to leave Ireland:

- stressful working conditions (notably, having to undertake non-core tasks);
- lack of protected and supervised training, which gets displaced by service demands;
- unclear and unattractive career opportunities.

The perception and experience that working, training and career opportunities are better abroad attracts (*pulls*) Irish trained doctors to go abroad to train and work; and

The lack of substantive improvements in conditions back in Ireland keep them abroad. Over time, the likelihood of Irish trained doctors returning to Ireland falls.

Funded by the European Union

Doctor Emigration from Ireland: Push and Pull factors

Questions

1. Is there evidence of improvements on the ground relating to working conditions, training and career opportunities, noting that 6-monthly consultations with NCHDs report “little tangible change or impact on their day-to-day working lives and training experience”?

2. What more needs to be done in the 3 critical areas *(new question)*?
   - Working conditions
   - Training
   - Career opportunities

Funded by the European Union

RCSI

Doctor Emigration from Ireland: Push and Pull factors

Questions continued….

3. Are appointments processes driven by inappropriate levels of competitiveness, whereby criteria for appointment are not necessarily suited to the post? Do the appointment processes need to be reviewed? Are the requirements of a vacant post assessed in terms of the needs of the patients in the hospital and matched to the applicant's skills set?

4. To what extent are trainees encouraged, unofficially, to get experience and build up a CV in areas that may not be directly relevant to the posts they will apply for; and what can be done about it?

Funded by the European Union

World Health Organization

HRB Health Research Board

Medical Workforce Planning – Specialty Reviews

Summary

Medical workforce planning specialist reviews show

- lower ratios of consultants to population in Emergency Medicine and Paediatrics in Ireland, compared to the UK and Australia (countries with comparable health systems).
- Around 20% of consultant posts in these specialties are filled by non-permanent staff;
- there are low ratios of consultants to NCHDs;
- low ratios trainees to non-trainees; and
- projected exits from training programmes are around 25-40% of that needed to meet current demand.
- The challenge in General Practice is its ageing population, with GPs continuing in post after retirement.

Funded by the European Union

Medical Workforce Planning – Specialty Reviews

Questions

1. Is the emerging evidence sufficient to determine that there are consultant shortages in some specialties? What further work needs to be done to determine the scale, nature and causes of such shortages?

2. Have optimal models of care, similar to that done for Paediatrics, been developed for other specialties and what needs to happen to take such work forward?

3. What are the rate limiting steps to addressing consultant and GP shortages in the short term (see Chapters 7 to 8 for future directions)?
   - How can the current consultant appointment bottleneck and funding gap in the HSE be addressed (see footnote)?
   - Locum consultant recruitment by hospitals impacts on the career opportunities of Irish trainees, contributing to emigration. How can this practice be curtailed?

Funded by the European Union

Medical Workforce Planning – Specialty Reviews

Questions continued….

4. To what degree would hospital reconfiguration help to attract consultants and address trainee retention issues
5. What other factors determine whether or not trainees, on securing CCSTs, will apply for permanent consultant / GP posts in Ireland? Are there further steps needed to attract good candidates?
6. Is there a need to reconfigure posts to attract more doctors who wish to work less than full time? Are there obstacles to this?
7. What can be done to compensate for the relatively low numbers of trainees coming through the training pipeline? What would attract back trainees and specialists including GPs from abroad?
8. Are there other questions we should be asking. . . . ?

Funded by the European Union

SláinteCare Report

Summary

The Sláintecare Report proposes developing new models of integrated, primary and community care (Committee on the Future of Healthcare, 2017).

To achieve this, it estimates that a 20% increase in consultant numbers will be needed, with posts based in hospitals, community health and general practice settings. It proposes that recruitment of staff – consultants and NCHDs – be to Hospital Groups.

Funded by the European Union

RCSI

SláinteCare Report

Questions

1. What thinking, planning and work have been done by the specialties in respect to the models of care that need to be developed so as to deliver on the policy objectives of integrated care and primary care models?

2. How do the specialties and professional bodies envisage working across the hospital - community care interface; and working across the professions and health and social care boundaries to develop and implement these models?

3. What are the advantages, disadvantages and obstacles to a shift towards NCHD and consultant appointments being made to hospital groups? And how might the hospital groups facilitate the development and implementation of the new models of care.

Funded by the European Union

World Health Organization

HRB Health Research Board

National Workforce Strategic Framework

Summary

The National Strategic Framework for Health and Social Care Workforce Planning provides a framework, grounded in the principles of the WHO Global Code and the need for health workforce self-sufficiency.

National decision makers need to agree how existing actions and structures, including the SRMTCS (MacCraith) implementation monitoring group, can be aligned and work with the new HSE National Workforce Planning Unit.

Funded by the European Union

National Workforce Strategic Framework

Questions

Framework Implementation *Action Area 3* envisages the establishment and operationalisation of a ***HSE National Workforce Planning Unit***, tasked with building workforce planning capacity.

a) How will current structures and processes – (i) the SRMTCS (MacCraith) IMG; (ii) NDTP and (iii) the Nursing Task Force – work with the new HSE National Workforce Planning Unit?

b) What links will the National Workforce Planning Unit have with other HSE divisions, eg Acute Hospitals and Clinical Programmes, which have important roles in staff recruitment and service configuration?

c) How will the national medical workforce stakeholders (including the bodies on the SRMTCS IMG) work with other health professional and social care cadres in integrated workforce planning

d) Do the SRMTCS (McCraith) recommendations need to be revisited, so as to sign off on successes, refashion recommendations that are not achieving impact, and propose new recommendations to address medical workforce retention in a more comprehensive way?

e) Does a broader range of implementers need to be represented on the SRMTCS implementation monitoring group, including the HSE Acute Hospital Division and Clinical Care Programmes?

Funded by the European Union

National Workforce Strategic Framework

Questions continued….

Framework Implementation *Action Area 5* proposes: ***Build the evidence base underpinned by research and evaluation***.

a) How can the work of the HSE NDTP and of the Medical Council in improving routine medical workforce data and data systems contribute to the development of the evidence platform envisaged by the Framework
b) What added value can be brought to this work, through data triangulation and routine data linkage so as to summarise trends, as undertaken by RCSI's "Brain Drain to Brain Gain" project?
c) What explanatory value can be brought to understanding trends, through consultation processes involving national medical workforce decision makers and NCHDs, the latter having been undertaken as part of the 2015-17 Medical Training and Career Structures implementation monitoring process?

Funded by the European Union

RCSI

Retaining Our Doctors

Thank You

Funded by
the European Union

World Health Organization

HRB Health Research Board