Irish College of General Practitioners

Is the face of Irish general practice changing?

A survey of GP trainees and recent GP graduates 2017

AUTHORS

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Acknowledgements

We would like to thank all of the respondents who took the time to complete the survey and inform this topic.

Summary

General practice is essential in the delivery of primary healthcare. In Ireland, 80% of all patients who visit a GP have a chronic disease. In combination with other consultations, GP practices in Ireland have more than 20 million visits per year, with an average of 4.3 visits per year by persons over the age of 15. Given the consideration of the number of consultations and the prevalence of chronic disease, it is expected that a drastic increase in the demand for GPs will take place in the coming years. In 2015, there were 3,523 registered GPs, which according to the HSE is a significantly insufficient GP workforce for Ireland; furthermore almost 17% of GPs in Ireland are over 60 years of age and close to retirement and a significant number of newly qualified GPs have emigrated in recent years. Therefore, due to the lack of manpower, increased pressure on health providers and the growth of negative health statistics, primary healthcare in Ireland is experiencing an ongoing crisis. It is essential for that reason to investigate the potential emigration plans of GP trainees and recent GP graduates; the reasoning behind their decisions; and expectations in terms of working arrangements in Ireland, which was the aim of the survey reported on here.

Key findings

- 30% of GP trainees are considering emigration.
- 18.1% of recent graduates have already emigrated.
- An additional 17.4% of recent graduates definitely or possibly will emigrate.
- 'Financial prospects' and 'Quality of life' were the primary reasons cited by both trainees and recent graduates for emigration.
- The predominant reasons ('Family reasons' and 'Partner's working requirement') for staying in Ireland were not specific to the profession of general practitioner.
- 9.5% of recent graduates do not see themselves working in general practice in any capacity in five years' time.
- Over a third of recent graduates work less than eight sessions per week currently.
- In five years' time almost two thirds of both recent graduates and GP trainees envisage themselves working less than eight sessions per week.
- Only 2% of recent graduates see themselves as a single-handed GP principal in five years and 1.6% of GP trainees see themselves as a single-handed GP principal 10 years post-training.
- The majority of both recent graduates and trainees stated that they believe the ICGP should have a leadership role in manpower planning in general practice and the design of their future professional role.
- Just one third of recent graduates expressed a preference to be part of a primary care team (PCT).
- Only 36% of recent graduates and 30.9% of trainees either strongly agreed or agreed with the statement "I find the traditional responsibilities of a practice principal/partner attractive".

Conclusions

The brain drain among the medical profession reported elsewhere is seen here among recently graduated GPs also. The most popular countries for emigration, Canada and Australia are known to have on average less working hours and higher incomes. Both the level of emigration and part-time working plans indicated here suggest that we will not have sufficient replacement and therefore we will continue to have an insufficient workforce capacity for general practice in the future. Furthermore, the lack of enthusiasm for taking on the responsibilities of running a practice, for working in primary care teams and for single handed practice may have implications for stated Government policy and for the delivery of primary care in certain areas of the country. It is incumbent upon the ICGP, the unions and the state to work together to create an efficient, rewarding and sustainable workplace environment for GPs to implement national healthcare policy. It is time for all those responsible to understand that their plans to improve patient care and save money in the hospital system cannot be realised without a general practice infrastructure or workforce.

Introduction

General practice is essential in the delivery of primary healthcare[1]. It represents a cornerstone of the prevention and management of medical conditions with a strong focus on person-centred care[2,3,4]. Since a general practitioner (GP) is the first point of contact with a patient, services including provision of advice, medicine prescription, patient treatment and specialist referral are provided[4]. Screening and immunisation, health promotion and disease management programmes are also incorporated in regular services of the practice[4]. By possessing both diagnostic and management skills, GPs in Ireland are equally responsible for the treatment of acute conditions, chronic diseases and multimorbidities[5].

Chronic diseases are a major health challenge[6] which cause the highest levels of mortality and morbidity in Europe[7]. In Ireland, 76% of all deaths are due to chronic diseases[8]. It is estimated that almost one million people in Ireland are affected by one of the four main categories of chronic disease including: cardiovascular disease, cancers, chronic obstructive pulmonary disease and diabetes[8]. A high number of patients (38%) with chronic diseases are over 50 years of age[9]. Since the population of Ireland is ageing rapidly[10] an increase in the prevalence of chronic conditions is expected. GP practices are the main setting where the majority of people with illnesses are treated[11]. In Ireland, 80% of all patients who visit a GP have a chronic disease[9]. In combination with other consultations, GP practices in Ireland have more than 20 million visits per year[12], with an average of 4.3 visits per year by persons over the age of 15[13]. Given the consideration of the number of consultations and the prevalence of chronic disease, it is expected that a drastic increase in the demand for GPs will take place in the coming years[1]. In 2015 there were 3,523 registered GPs[14], which according to the HSE is a significantly insufficient GP workforce for Ireland[1]. As a result, GPs commonly experience increases in workloads arising from long hours and the high number of consultations. Therefore, due to the lack of manpower, increased pressure on health providers and the growth of negative health statistics, primary healthcare in Ireland is experiencing an ongoing crisis.

Since 2012, one of the primary focuses of the Irish Government is to reform the healthcare system[15]. The emphasis in primary care was put on improving the quality and access to services, as well as the rational allocation of the medical workforce in order to meet population demands[15]. In 2015, the allocation of GPs in Ireland accounted for 76 per 100,000 population[14], in comparison with other advanced health care systems such as Canada or Australia, where the number of GPs is in excess of 100 per 100,000[14]. According to a report from 2015, almost 17% of GPs in Ireland are over 60 years of age and close to retirement[16]. There is a significant number of newly qualified GPs who either work abroad (16.5%) or plan to emigrate (24.5%)[17]. Therefore, shortages of GPs in Ireland already exist; a trend that appears will continue. It is essential for that reason to investigate the potential emigration plans of GP trainees and graduates; the reasoning behind their decisions; and expectations in terms of working arrangements (sessions per week) in Ireland.

Emigration

According to the WHO report, Ireland experiences a continuous emigration of Irish trained doctors, mainly due to a dissatisfaction with working conditions and a lack of desirable career opportunities[18]. It was also noted that the emigration of doctors in recent years is occurring at an earlier stage of their training, most commonly within the first two years of graduation[18].

In relation to general practice, the ICGP conducted two surveys in 2014 and 2015[17,19] among GP trainees and GP graduates. The results of these surveys revealed that there was a high intention towards emigration among both groups[17,19]. A large number of GP trainees (47.8% in 2014 and 41.4% in 2015 survey) suggested that they would definitely or possibly emigrate, followed by one quarter of GP graduates (26.8% in 2014 and 24.5% in 2015 survey) expressing the same intention[17,19]. Canada and Australia were the most desirable locations[17,19]. The main reasons for emigration were 'Concerns regarding the viability of general practice', 'Quality of life' and 'Financial prospects'[17,19]. As both Canada and Australia have greater numbers of GPs per capita[14], less working hours per week and higher annual incomes for GPs[20], the desire to emigrate to one of these countries can be understood. This is consistent with a systematic review of previous studies which addressed the crisis of GPs retention[21]. It was suggested that job satisfaction in terms of less working hours, less paperwork, more support and recognition, is one of the most important determinants in retaining GPs[21]. Although 'Financial prospects' are found to be important, an increase in income could not compensate for overall job dissatisfaction[21].

Part-time employment

According to the Irish Medical Council, the number of GPs who are practicing part-time in 2016 was 25.8%[22] which represents a slight increase in comparison with previous years[23,24]. Part-time employment in general practice is the 4th highest among other areas of practice, following Ophthalmology (29.9%), Public Health Medicine (30.8%) and Sports and Exercise Medicine (45%)[22]. Female doctors are more likely to work part-time in comparison with their male counterparts across all age categories[22]. This is consistent with Irish general practice as well, where according to a survey from 2015, of those who were employed part-time at the time of survey, 80.8% were female doctors and 19.2% were their male colleagues[16]. Working part-time is likely to continue in the future, as high numbers of GP graduates (47.3% in 2014 and 49.7% in 2015 survey) and GP trainees (48.4% in 2014 and 51.8% in 2015 survey) expect to be employed on a part-time basis in five years' time[17,19]. GPs employed part-time nevertheless challenge the traditional understanding by which high quality patient care could be accomplished by only full time employees[25]. However, part-time employment is found to be an appropriate response to increasingly difficult work environments[25]. GPs who choose to have a reduced number of sessions (5-7 a week) do so in order to retain high professional standards and a strong commitment to their patients' well-being[25].

Aims and Objectives

The aim of the 2017 surveys, which inform this report, was to provide data regarding the professional plans of GP trainees and recent GP graduates and on the current status of recent graduates.

Within this, the specific objectives were:

- To establish the career aspirations of both groups in terms of both clinical commitment and employment status;
- To document the emigration plans of both groups and to establish the current emigration status of recent graduates;
- To ascertain the relative importance of a set list of factors influencing the decision to emigrate or remain in Ireland.

Methodology

The career intentions survey was emailed in March 2017, followed with a reminder a week later, to: 684 GP Trainees and 579 recent GP graduates (from 2012 to 2016).

The survey was completed by 217 trainees and 175 recent graduates, which gives a response rate of 31.7% for trainees and 30.2% for recent graduates. The response rate was lower in comparison with the previous career intentions surveys[17, 19] but is consistent with a downward trend generally being observed in terms of GP survey response rates.

Results

GP trainee survey

The demographics of the respondents are shown below in Table 1.

Amongst respondents, 34.7% (n=75) were male and 65.3% (n=141) were female. The vast majority of the respondents, 79.7% (n=173) were in the age range 25-34, married or with a partner (73.3%, n=159) and without children (71.9%, n=156). Also, over half of the respondents were on either the third or fourth year of training (57.6%, n=124).

Table 1. Profile of respondents

	%	N
Gender		
Male	34.7	75
Female	65.3	141
Age		
25-29	35.5	77
30-34	44.2	96
35-39	17.1	37
40-44	1.8	4
45+	1.4	3
Relationship status		
Single	26.7	58
Married or with Partner	73.3	159
Children		
Yes	28.1	61
No	71.9	156
Year of training		
1st	19.1	41
2nd	23.3	50
3rd	27.9	60
4th	29.8	64

According to the survey, 30% (n=65) of trainees stated that they definitely or possibly plan to emigrate (Table 2). Only 7.7% (n=5) of these participants expressed that they

would permanently leave Ireland. While 49.3% (n=32) said that they plan to stay abroad for less than two years. Australia (29.4%, n=5) and Canada (29.4%, n=5) were equally preferable destinations for participants who definitely plan to emigrate (Figure 1). The most common reasons for emigration were 'Financial prospects' (42.4%, n=25) and 'Quality of life' (30.5%, n=18) (Figure 2). The participants (n=30) highlighted that the main reasons which would encourage them to stay are better financial support and working conditions. The survey revealed that the decision to emigrate was not significantly related to gender, age or relationship status. However, participants with children were twice as likely to stay in Ireland, in comparison with ones without children ($p < 0.01$).

Table 2. Emigration Plans

	%	N
	Plan to Emigrate	
Yes, definitely	8.3	18
Yes, possibly	21.7	47
Undecided	25.3	55
No	44.7	97
Timeframe abroad if definitely or possibly plan to emigrate		
< 1 year	3.1	2
1 year	18.5	12
2 year	27.7	18
3 year	10.7	7
4 year	0.0	0
5 year	6.2	4
6 years +	1.5	1
Permanently	7.7	5
Unknown	24.6	16

Figure 1. Preferable destinations of those who definitely plan to emigrate

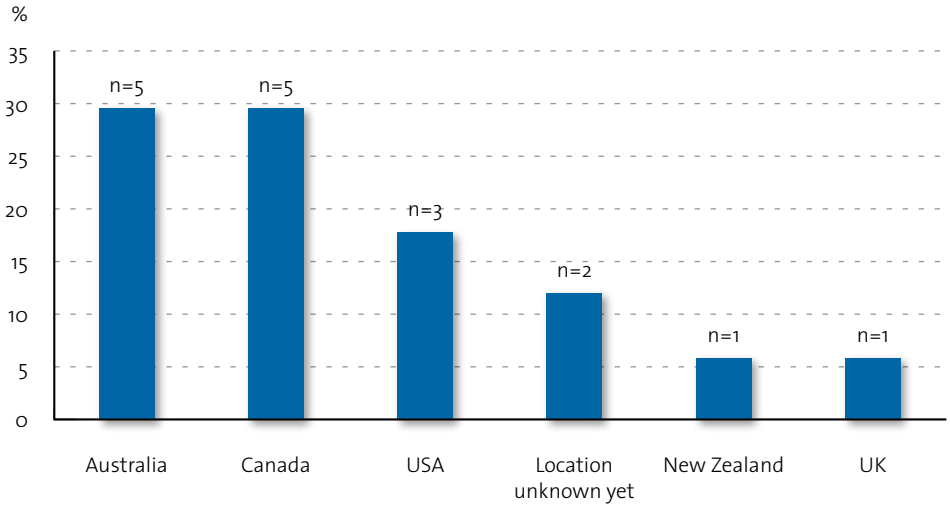
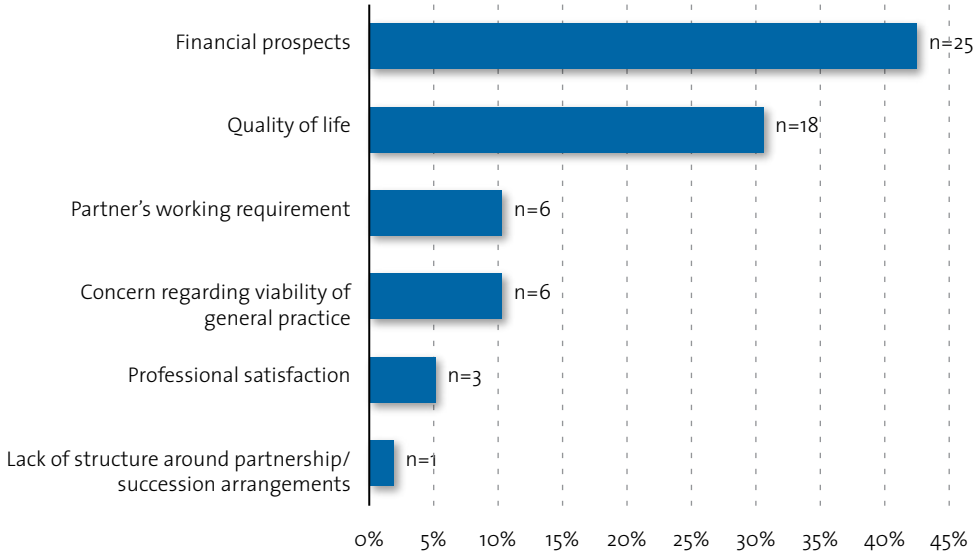
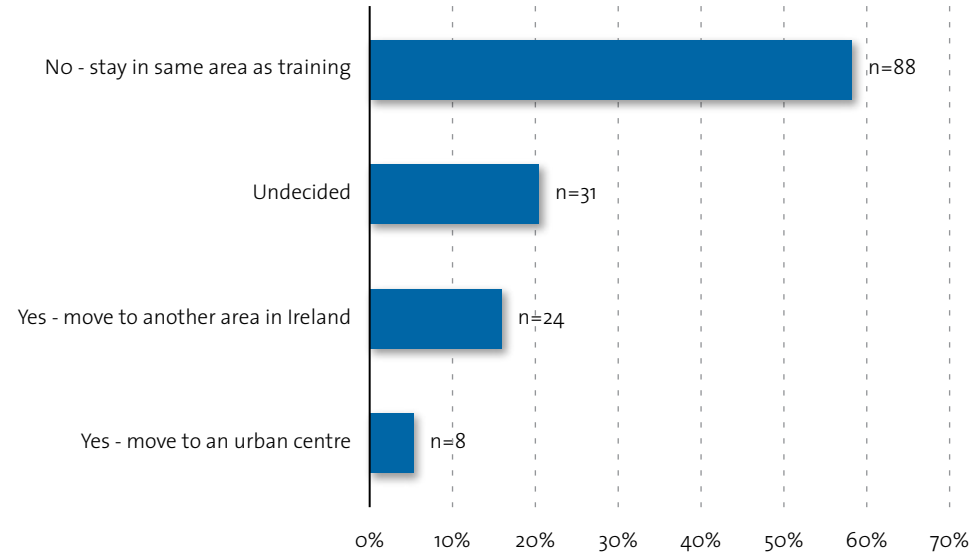


Figure 2. Reasons for emigration



For the trainees who relayed that they plan to stay in Ireland, the majority (58.3%, n=88) expressed that they plan to stay in the same area where the GP training was conducted. However, 21.2% (n=32) of respondents stated that they intend to move, either to an urban area (5.3%, n=8) or another area in Ireland (15.9%, n=24). One third of respondents were undecided (20.5%, n=31) (Figure 3). Participants' decisions about potential location post-training were not related to any profile characteristics.

Figure 3. Location of respondents post-training



Although a vast majority of participants (90.2%, n=193) said that they plan to definitely or possibly stay in general practice, the ones who were undecided (8.4%, n=18) expressed the most interest in 'Hospital Medicine' (50%, n=8). For trainees who decided not to stay in general practice, the most commonly outlined reasons were: 'Quality of life' (41.2%, n=7), 'Professional satisfaction' (29.4%, n=5) and 'Concern regarding viability of general practice' (23.5%, n=4).

The participants were asked in what position they saw themselves one and ten years after completion of training. One year after the training, the majority of respondents expected to hold the position of Locum GP (28.5%, n=55), Regular Sessional GP (21.8%, n=42) or Full time Assistant (21.4%, n= 41). However, after 10 years, the positions of GP Principal (52.3%, n=101) and Salaried Partner (18.1%, n= 35) were the most anticipated (Table 3). Almost all of the participants 95.3% (n=182) stated that they would be satisfied to reach their anticipated positions 10 years after training.

Table 3. Expected position one and ten years post-training - all trainees

	% (N)	% (N)
	1 year post-training	10 years post-training
GP Principal in a partnership or group practice/ Equity Partner	5.2 (10)	52.3 (100)
Salaried Partner	5.2 (10)	18.1 (35)
Single-handed GP principal	0.5 (1)	2.6 (5)
Full time Assistant	21.4 (41)	2.1 (4)
Part-time Assistant	8.3 (16)	5.2 (10)
Regular Sessional GP	21.8 (42)	3.1 (6)
Locum GP	28.5 (55)	0 (0)
Combined clinical/academic general practice	6.2 (12)	7.3 (14)
Academic general practice	0.5 (1)	0.5 (1)
Combined clinical/general practice training role (PD/APD)	0 (0)	5.8 (11)
Not working in general practice in any capacity	2.6 (5)	2.6 (5)

Also, with focus only on the 4th year GP trainees, the survey revealed that the expectations changed significantly when comparing year one and year ten post-training. Therefore, most respondents one year post-training expected to be in the position of 'Full time assistant' (23.6%, n=13) or 'Locum GP' (23.6%, n=13). These less secure positions were the least expected to be held 10 years after training, accounting for only 3.7% (n=2) of trainees. The majority of 4th year trainees saw themselves 10 years post-training being employed as 'GP Principal in a partnership or group practice/ Equity Partner' (53.7%, n=29) (Table 4).

Table 4. Expected position among 4th year trainees one and ten years post-training

	% (N)	% (N)
	1 year post-training	10 years post-training
GP Principal in a partnership or group practice/Equity Partner	7.3 (4)	53.7 (29)
Salaried Partner	3.6 (2)	14.8 (8)
Single-handed GP principal	0 (0)	1.9 (1)
Full-time Assistant	23.6 (13)	3.7 (2)
Part-time Assistant	12.7 (7)	5.6 (3)
Regular Sessional GP	16.4 (9)	3.7 (2)
Locum GP	23.6 (13)	0 (0)
Combined clinical/academic general practice	7.3 (4)	9.3 (5)
Academic general practice	1.8 (1)	0 (0)
Combined clinical/general practice training role (PD/APD)	0 (0)	3.7 (2)
Not working in general practice in any capacity	3.6 (2)	3.7 (2)

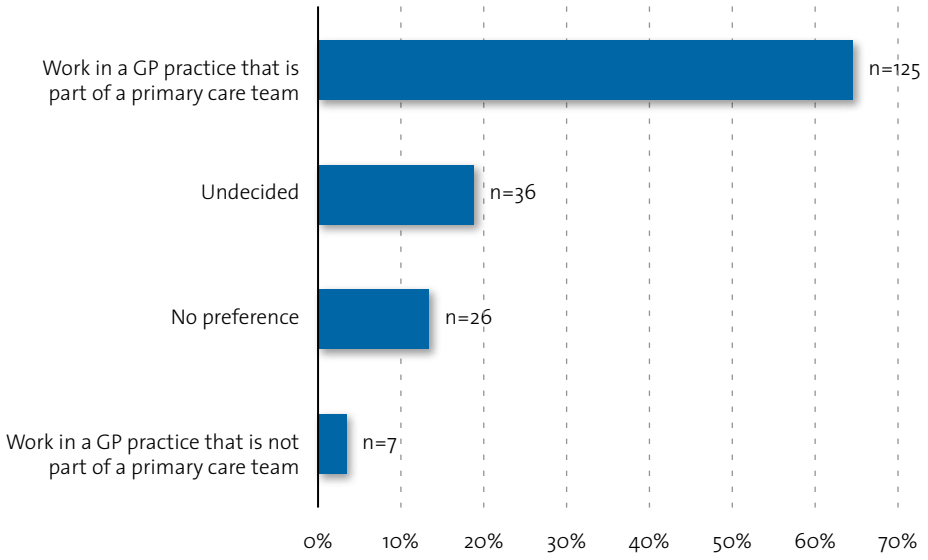
In terms of the number of clinical sessions trainees envisage in the future, the survey revealed a slight increase in anticipated part-time working comparing five and ten years post-training (Table 5). Most notable are the relatively low proportions, 39.3% and 30.9% respectively at five and 10 years post training, who stated that they expect to work eight or more sessions per week.

Table 5. Number of clinical sessions trainee envisage five and ten years post-training

	% (N)	% (N)
	5 year post-training	10 years post-training
None	1.5 (3)	2.1 (4)
1-4	4.6 (9)	8.2 (16)
5-7	54.6 (107)	58.8 (114)
8-10	39.3 (77)	30.9 (60)

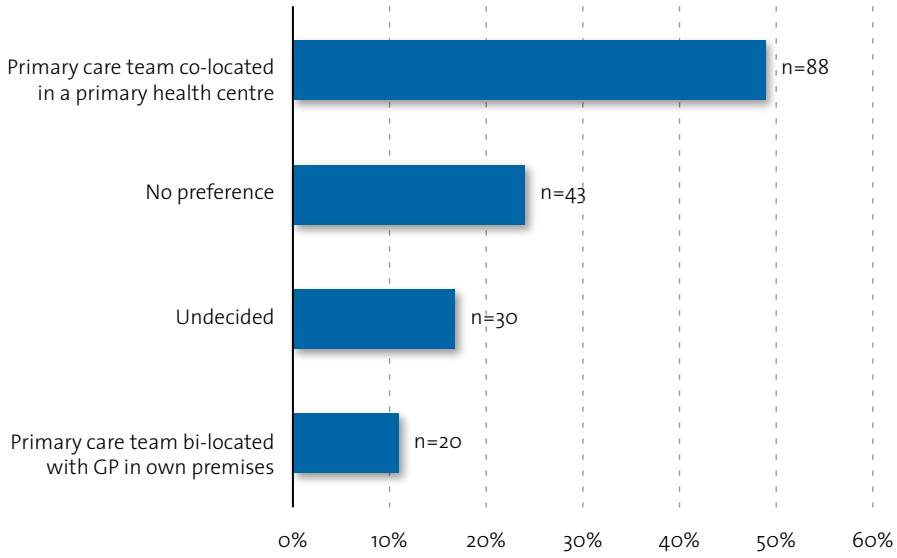
According to the survey the majority of respondents (64.4%, n=125) favoured working as part of a primary care team (PCT). However, one third of trainees (32%, n=62) were either undecided or without a preference (Figure 4).The main reason why trainees would choose to work as part of a PCT was because they see integrated care as an essential aspect of primary care. Trainees (n=37) expressed that through integrated care, easier access to a multidisciplinary team, better support and care for patients is provided.

Figure 4. Preference in terms of a primary care team



In terms of working location, almost half of the respondents (48.6%, n=87) suggested that they would prefer if the PCT is co-located in a primary health centre. On the other hand, 11% (n=20) of the participants favoured bi-location with the GP in their own premises. One third of participants were either without a preference (23.8%, n=43) or undecided (16.6%, n=20) (Figure 5). The most common reasoning behind co-location of the PCT in a primary health centre was found to be integration of care. Trainees (n=30) expressed that this improves access to services and communication between a multidisciplinary team.

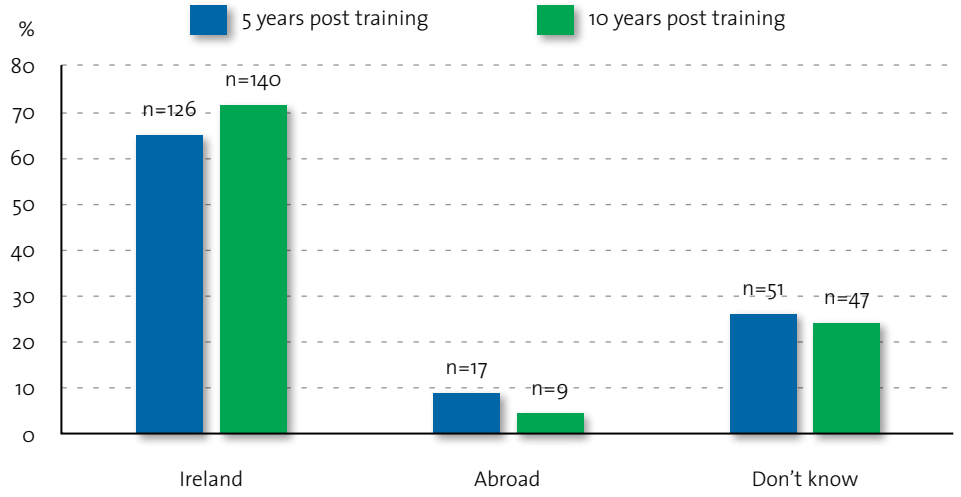
Figure 5. Preference in terms of working location with regard to primary care teams in general practice



A large number of participants stated that they see themselves living in Ireland, five (64.9%, n=126) and ten (71.4%, n=140) years post-training. Only 8.8% (n=17) thought

they would be abroad five and 4.6% (n=9) ten years post-training. No significant difference was found while comparing future locations of trainees by current year of training (Figure 6).

Figure 6. Potential location of trainees five and ten years post-training



When asked about their intentions of staying in general practice, a vast majority of trainees expressed that they would definitely (71%, n=152) or possibly (19.2%, n=41) work in a career of general practice in the future (Figure 7). However, among those who would not, career options such as 'Hospital medicine' (50%, n=8) or 'Academia' (18.8%, n=3) were most commonly suggested. The main reasons why trainees would not stay in general practice were found to be 'Quality of life' (41.2%, n=7) and 'Professional satisfaction' (29.4%, n= 5) (Figure 8).

Figure 7. Intentions to stay in general practice post-training

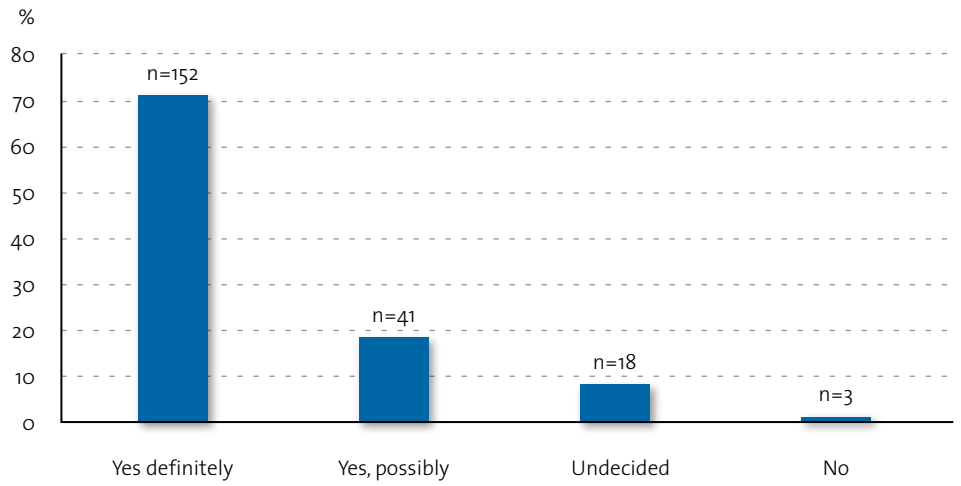
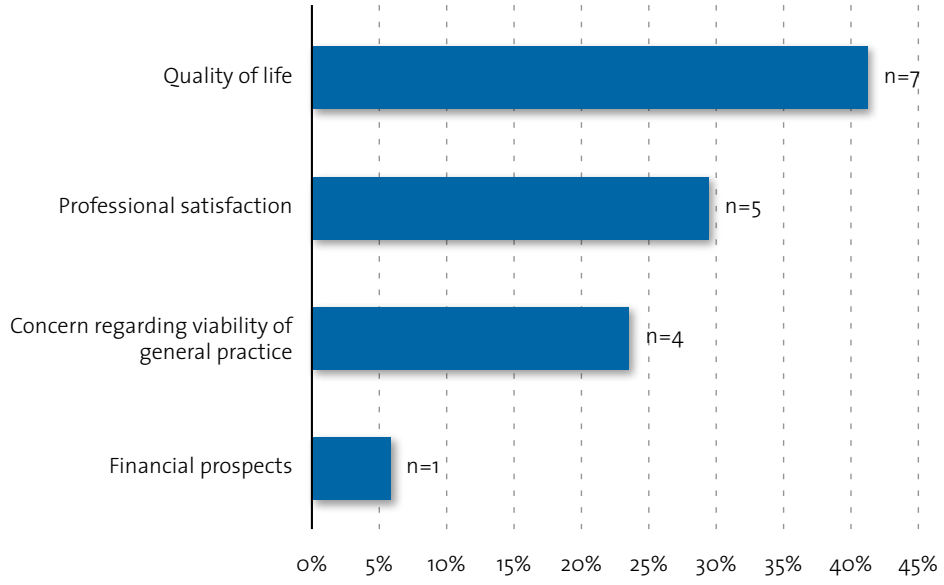


Figure 8. Main reasons why trainees would not stay in general practice post-training



Trainees were provided with a list of statements, and asked to indicate their level of agreement with each of them. A large majority of the respondents (more than 80%) agreed that: chronic disease management should be moved largely into general practice and that if resourced, they would like to provide chronic disease management services. Furthermore, just over half (52%) agreed that they would like to focus on the clinical aspects of the job exclusively and also not to have responsibility to employ staff. Only 31% agreed that they find 'being accountable for the financial, property and employment coordination of the whole practice' attractive (Table 6).

Table 6. Trainee views on clinical and non-clinical aspects of and changes in general practice

	STRONGLY AGREE %	AGREE %	NEUTRAL %	DISAGREE %	STRONGLY DISAGREE %
Chronic Disease Management should be moved largely into general practice, assuming resources, funding and services are provided to general practice	42.0	41.4	7.7	6.6	2.2
If resourced, I would like to provide chronic disease management services	50.3	35.4	5.0	6.6	2.8
As a GP, I would like to focus on the clinical aspects of the job exclusively	21.0	30.9	23.8	18.8	5.5
I find the traditional responsibilities of a practice principal/partner attractive. These include accountability for financial, property and employment coordination of the whole practice	10.5	20.4	21.5	31.5	16.0
I would prefer if I did not have to take on the responsibilities of being an employer of staff	24.9	27.6	19.9	17.1	10.5

The vast majority of trainees (86.6%, n=162) thought that the ICGP should be involved in determining the evolution of the role of general practice (Figure 9). Trainees were also asked to rate the importance of the tasks of the ICGP for the next four years. For a large proportion, 'Improving use of Information Technology throughout the healthcare system' (70.9%) and 'Increase resources for general practice team training activities' (70.5%) were important (Table 7).

Figure 9. Involvement of the ICGP in determining the evolution of the role of general practice

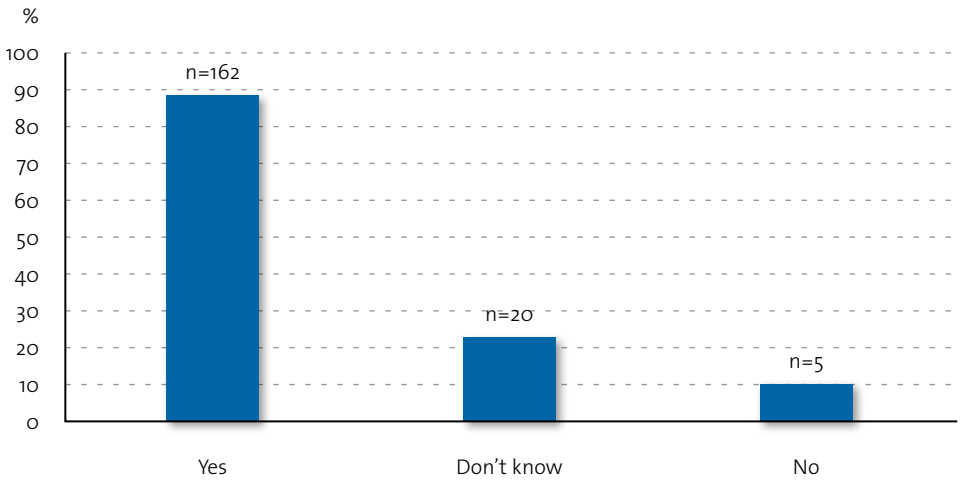


Table 7. Importance of tasks for the ICGP over next four years

	NOT IMPORTANT %	MINOR IMPORTANCE %	IMPORTANT %	VERY IMPORTANT %	EXTREMELY IMPORTANT %
Lead in the design of the role of general practitioners for the present and future	12.3	8.6	20.3	31	27.8
Leadership role in development and implementation of chronic disease management in the community	11.8	8.6	15.6	31.2	32.8
Leadership role in manpower planning in general practice, including general practice postgraduate training	12.4	9.2	16.8	30.3	31.4
Greater involvement of GPs in high level healthcare planning	16.7	6.5	11.8	28	37.1
Increase resources for general practice based research	15.1	8.1	11.8	25.3	39.8
Improving use of Information Technology throughout the healthcare system	16.1	4.8	8.1	29	41.9
Increase resources for general practice team training activities	15.1	6.5	8.1	29.6	40.9

Recent Graduate Survey

Most respondents (93.6%) were aged 30-39 and were female (68.8%). A complete breakdown of demographic information can be seen in Table 8.

Table 8. Profile of Respondents

	%	N
Graduating Year		
2012	15.8	27
2013	24	41
2014	28.7	49
2015	25.7	44
2016	5.8	10
Age Range		
30-34	46.2	79
35-39	47.4	81
40-44	5.3	9
45+	1.2	2
Gender		
Male	31.2	53
Female	68.8	117
Relationship Status		
Single	14.6	25
Married or with Partner	85.4	146
Children		
Yes	59.6	102
No	40.4	69

Overall, 18.1% (n = 28) of recent graduates stated that they were living abroad (Table 9). Emigration was not found to be significantly related to any of the above demographic variables. The only noticeable trend occurred in the children variable where 14.1% (n=13) of those with children were located abroad, compared to 23.8% (n = 15) of those without children.

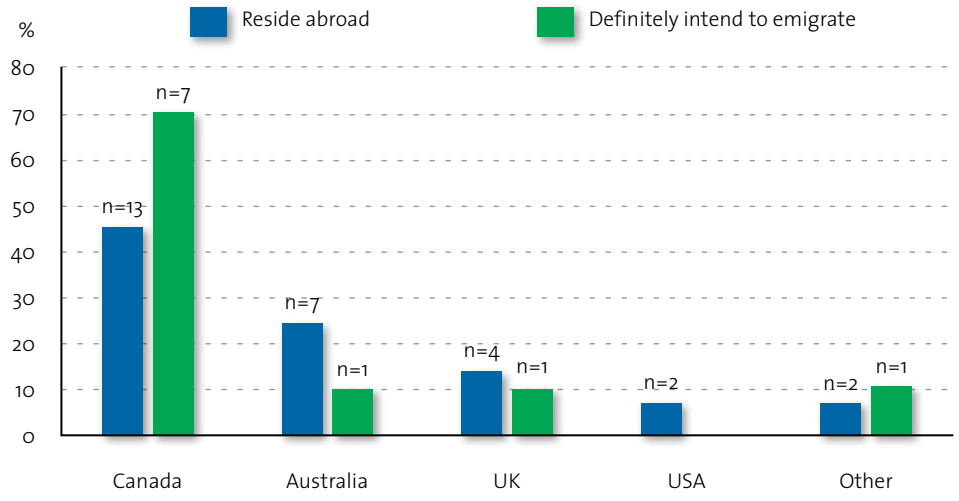
Amongst respondents who responded that they were located in Ireland, 7.9% (n=10) stated that they definitely plan on emigrating and 9.5% (n=12) stated that they possibly plan on emigrating (Table 9). Therefore, 22.2% (n=38) of respondents were either currently residing abroad or were definitely planning on emigrating. Chi square tests revealed that emigration plans were not significantly related to any demographic variables. However, trends did appear; 25% (n=10) of males relayed that they definitely or possibly plan to emigrate, compared to 13.9% (n=12) of females. Also, 15.7% (n=17) of those married or with a partner were definitely or possibly planning to emigrate compared to 27.8% (n=5) of those who are single.

Table 9. Emigration Status and Plans

	%	N
Current Location		
Ireland	81.9	127
Abroad	18.1	28
Plan to Emigrate		
Yes, definitely	7.9	10
Yes, possibly	9.5	12
Undecided	19.8	25
No	62.7	79

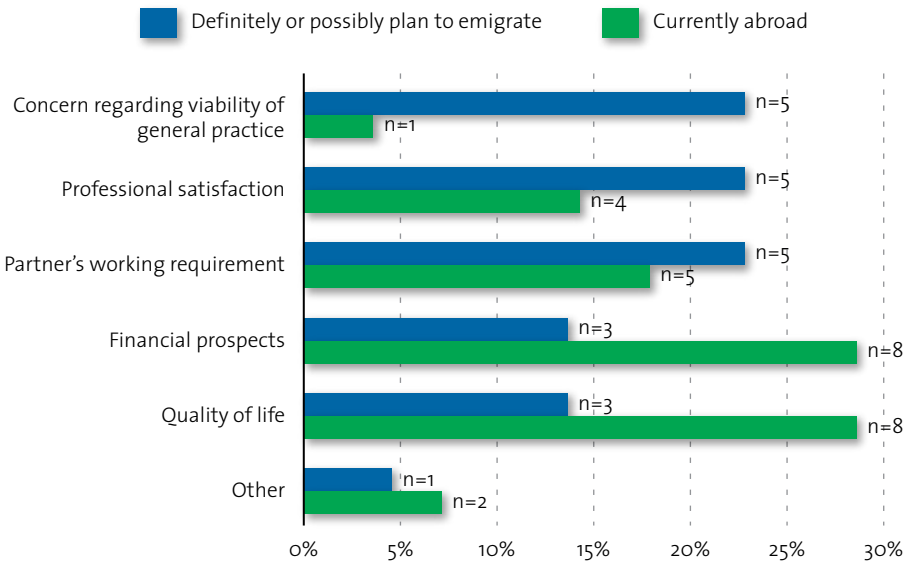
Of the 18.1% (n=28) of respondents who were located abroad at the time of survey, 46% (n=13) stated that they were in Canada. Similarly, amongst those definitely planning on emigrating, Canada was their preferred destination with 70% (n=7) of respondents choosing it. Further information on location of those residing abroad and intended destination of those who responded that they definitely plan on emigrating can be found in Figure 10.

Figure 10. Location of graduates residing abroad, intended destination of those planning to emigrate



Respondents residing abroad and those who are definitely or possibly planning to emigrate were asked to provide the reason that best describes why they will emigrate/have emigrated. Almost one third (28.6%) of those who already reside abroad stated that their reason was 'Quality of Life'. Amongst those who possibly or definitely plan to emigrate 22.7% (n=5) stated that 'Concern regarding the viability of general practice' is the reason. Further breakdown of reasons for emigrating are seen in Figure 11.

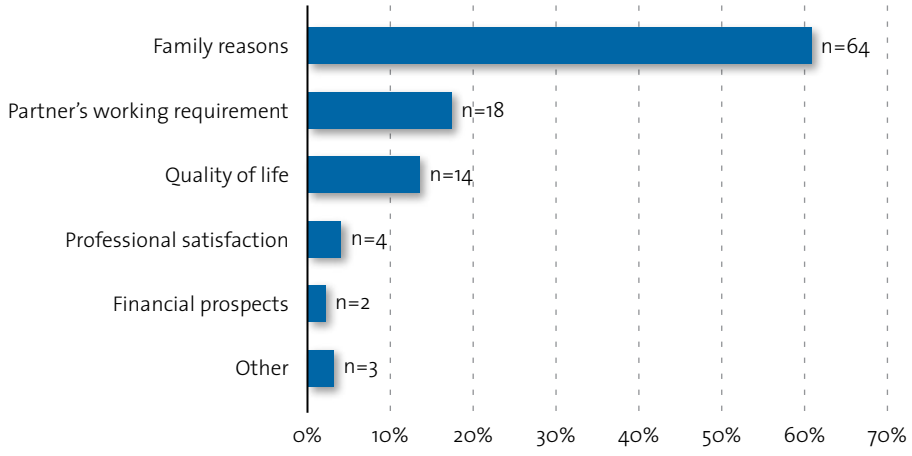
Figure 11. Reason for emigration



Amongst those who are currently residing abroad, 17.9% (n=5) said they have plans to return to Ireland in the near future. Amongst those who possibly/definitely plan to emigrate, only 4.3% (n=1) said they plan on going for 1 year, 39.1% (n=9) plan on going for 2-3 years, 30.4% (n=7) plan on going for five years or more and 26.1% (n=6) stated they don't know how long they will go for. For those who already reside abroad, 29.6% (n=8) had been there for less than a year and 63% (n=17) had been abroad for 1-3 years and 7.4% (n=2) had spent four years abroad.

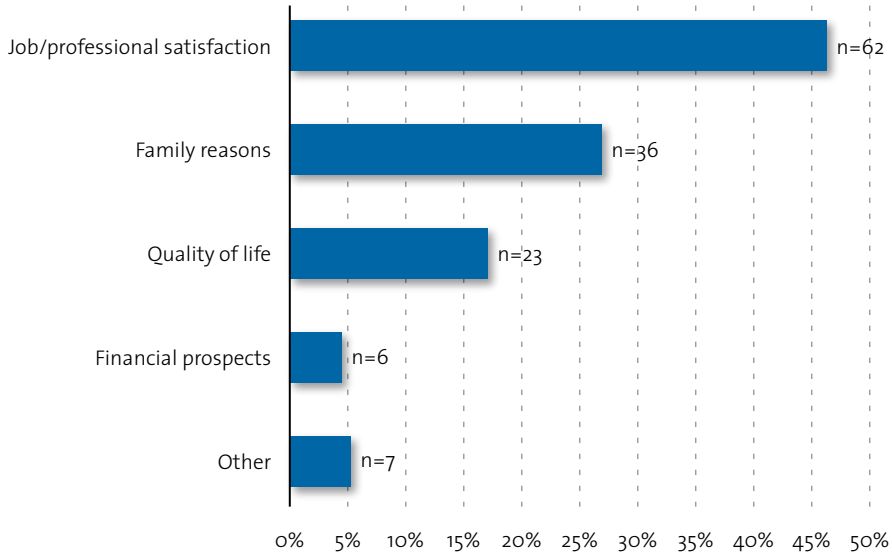
Amongst those who relayed that they currently reside in Ireland and don't have any intention to emigrate, the majority (61%) were staying for family reasons (Figure 12).

Figure 12. Reason for remaining in Ireland amongst those residing in Ireland with no plans to leave



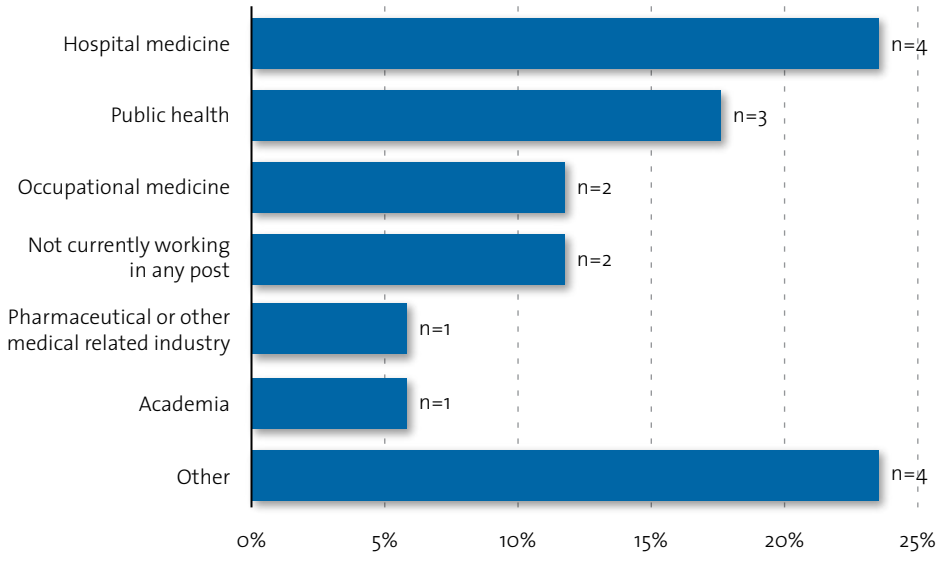
Overall, 92.1% (n=139) of respondents responded that they currently work in general practice. Respondents were asked to give the reason that best describes why they stayed in general practice. The most common response was job/professional satisfaction (46.3%) (Figure 13).

Figure 13. Reason for staying in general practice



Of those who stated that they do not currently work in general practice, 24% (n=4) were working in hospital medicine. Figure 14 details the careers of respondents who were no longer working in general practice.

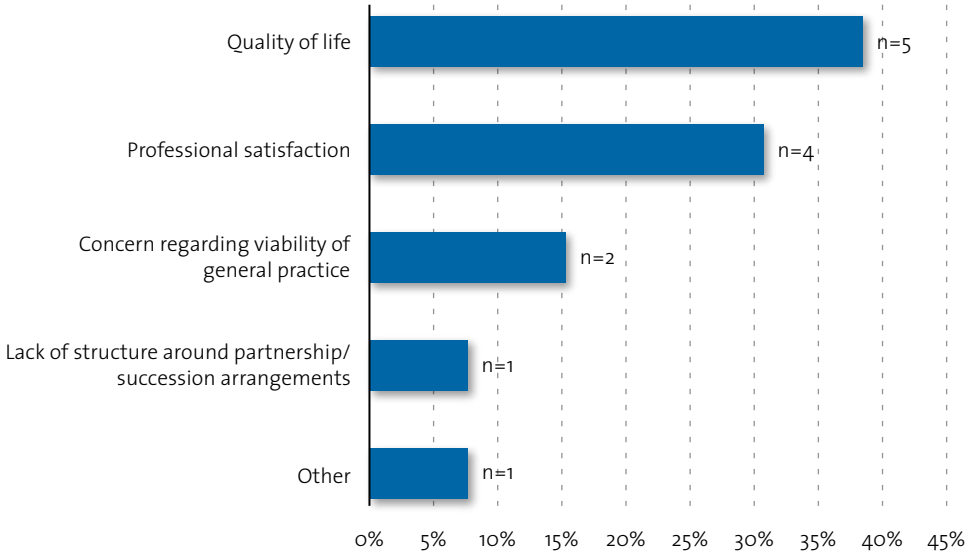
Figure 14. Current area of those not working in general practice



Only 8.3% (n=1) of those not in general practice planned on returning to general practice in the near future.

Respondents who stated that they do not work in general practice were asked what best describes their reason for not working in general practice. The primary response was 'Quality of life' (38%) (Figure 15).

Figure 15. Reason for not staying in general practice



Respondents were then asked what their current position is and what position they see themselves in in five years' time. Just over one fifth (21.7%) were already GP principals and almost half (46.9%) stated that they see themselves being GP principals in five years' time (Table 10).

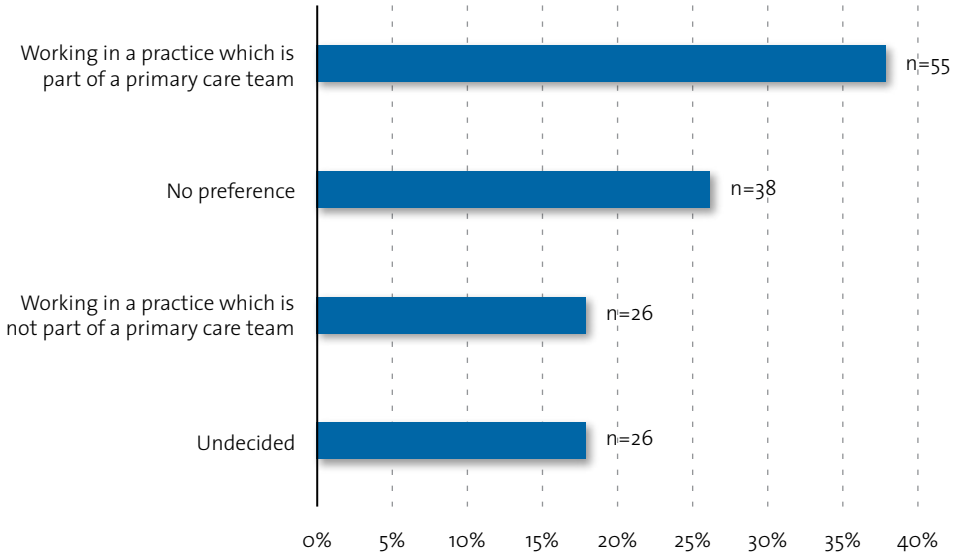
Table 10. Respondents' current position and what position they see themselves in 5 years

	% (N)	% (N)
	Currently	In 5 years' time
GP Principal in a partnership or group practice/Equity Partner	21.7 (34)	46.9 (69)
Salaried Partner	7.6 (12)	15.6 (23)
Single-handed GP principal	3.2 (5)	2 (3)
Full time GP Assistant	20.4 (32)	1.4 (2)
Part-time GP Assistant	10.8 (17)	5.4 (8)
Regular Sessional GP	14.6 (23)	6.1 (9)
Locum GP	7.6 (12)	1.4 (2)
Combined clinical/academic general practice	2.5 (4)	6.8 (10)
Academic general practice	0 (0)	0.7 (1)
Combined clinical/general practice training role (PD/APD)	2.5 (4)	4.1 (6)
Not working in general practice in any capacity	8.3 (13)	9.5 (14)
Other	0.6 (1)	0 (0)

Amongst the respondents in table 10, 85.9% (n=122) said that they would be happy if they were in their expected position in five years' time.

Recent graduates were then asked if they would prefer working in a practice that is part of a PCT or not. Over a third of respondents (38%) stated they would prefer working in a practice which is part of a PCT (Figure 16).

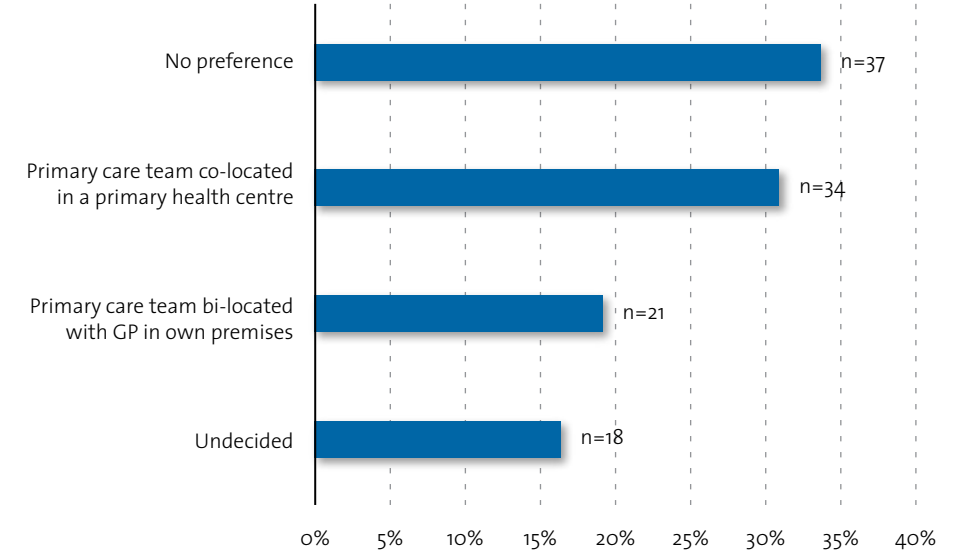
Figure 16. Whether recent graduates prefer working as part of a primary care team



When asked to comment on their response, those who preferred working in a practice which is not part of a PCT most often stated that PCTs are 'extra hassle and responsibility' and 'not efficient'. Whereas those who preferred working in a practice which is part of a PCT commented that a PCT brings 'better access to supports' and 'provides better care'.

Irrespective of respondents' answer to the above question, they were asked their preference in terms of working location with regard to PTCs in general practice (Figure 17).

Figure 17. Recent graduates' preference for primary care team working location



Participants were asked to comment on their above response. Amongst those who preferred a co-located PCT, some commented that this brings "increased access to services". Whereas amongst those who preferred bi-location, many stated that it was better for "autonomy" while another stated it was "better to have some distance".

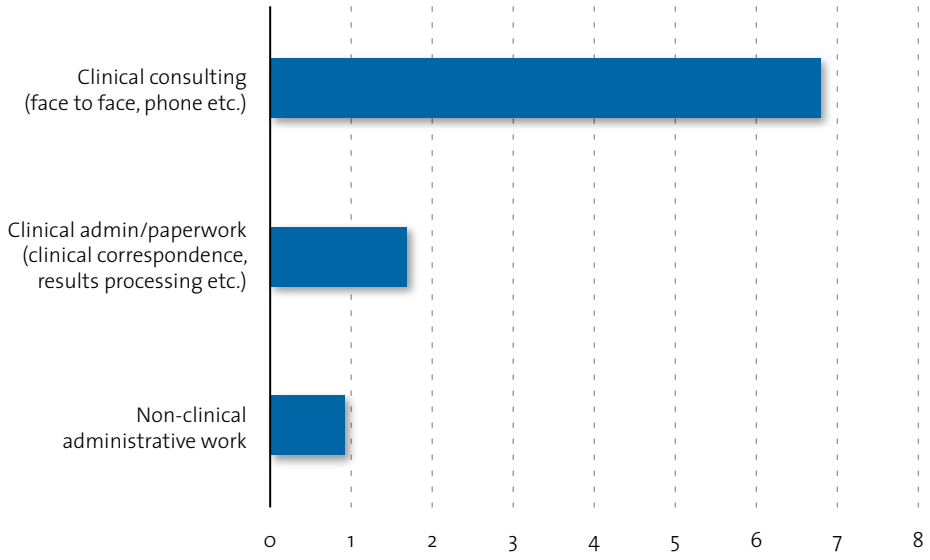
In terms of the number of clinical sessions respondents are working, the majority (62.9%) relayed that they are working 8-10 sessions. In five years' time, the number of GPs who said that they see themselves working 8-10 sessions drops to 35.8% (n=53) (Table 11).

Table 11. Number of sessions respondents currently work and plan to work in 5 years

	% (N)	% (N)
	Currently	In five years' time
None	5.3 (8)	4.1 (6)
1-4	7.3 (11)	2.7 (4)
5-7	24.5 (37)	57.4 (85)
8-10	62.9 (95)	35.8 (53)

GPs were asked how many hours per day they spend on several activities. The results showed that GPs spend the most time on average on clinical consulting (6.8 hours) (Figure 18).

Figure 18. Average number of hours spent on various clinical activities



Amongst these activities, 37% (n=54) of respondents stated that they think that some clinical consulting could be undertaken by someone else in the practice, 59.6% (n=87) think clinical admin/paperwork could be undertaken by someone else, and 80.3% (n=110) think non-clinical administrative work could be undertaken by someone else.

Also, 28.3% (n=41) of respondents relayed that they think the time they spend on clinical consulting is excessive, 64.1% (n=93) of respondents think the time they spend

on clinical admin/paperwork is excessive, and 61.5% (n=83) think the time they spend on non-clinical administrative work is excessive.

Respondents were presented with a series of statements and asked to rate on a scale from one (strongly agree) to five (strongly disagree) the extent to which they agree with each statement (Table 12). The most agreed with statement was 'If resourced, I would like to provide chronic disease management services', 74.8% (n=104) either agreed or strongly agreed with the statement. The most disagreed with statement was 'I find the traditional responsibilities of a practice principal/partner attractive' with 46% (n=64) of respondents either disagreeing or strongly disagreeing with the statement.

Table 12. Recent graduates' views on clinical and non-clinical aspects of and changes in general practice

	STRONGLY AGREE %	AGREE %	NEUTRAL %	DISAGREE %	STRONGLY DISAGREE %
Chronic Disease Management should be moved largely into general practice, assuming resources, funding and services are provided to general practice	32.6	39.7	7.8	11.3	8.5
If resourced, I would like to provide chronic disease management services	40.3	34.5	7.9	7.9	9.4
As a GP, I would like to focus on the clinical aspects of the job exclusively	25.9	30.2	21.6	15.1	7.2
I find the traditional responsibilities of a practice principal/partner attractive. These include accountability for financial, property and employment coordination of the whole practice	11.5	24.5	18	26.6	19.4
I would prefer if I did not have to take on the responsibilities of being an employer of staff	24.8	24.8	21.9	19	9.5

Respondents who strongly agreed or disagreed with the statement 'I would prefer if I did not have to take on the responsibilities of being an employer of staff' were asked to comment on their response. The most common response amongst those who disagreed was that they were unequipped or unqualified to carry out this role.

Participants were then presented with a series of statements about the ICGP's priorities over the next four years and asked how important they felt each was. The two that were most often rated as very or extremely important for the ICGP were 'Greater involvement of GPs in high level healthcare planning' (60.4%) and 'Leadership role in manpower planning in general practice, including general practice postgraduate training' (58.7%) (Table 13).

Table 13. Recent graduates' views on the importance of tasks for the ICGP over next four years

	NOT IMPORTANT %	MINOR IMPORTANCE %	IMPORTANT %	VERY IMPORTANT %	EXTREMELY IMPORTANT %
Lead in the design of the role of general practitioners for the present and future	18.7	13.7	14.4	23.7	29.5
Leadership role in development and implementation of chronic disease management in the community	15.1	13.7	16.5	23.7	30.9
Leadership role in manpower planning in general practice, including general practice postgraduate training	14.5	13.0	13.8	23.2	35.5
Greater involvement of GPs in high level healthcare planning	18.7	10.1	10.8	22.3	38.1
Increase resources for general practice based research	15.8	10.8	21.6	20.1	31.7
Improving use of Information Technology throughout the healthcare system	14.5	10.9	18.1	19.6	37.0
Increase resources for general practice team training activities	16.5	12.2	16.5	20.1	34.5

Finally, respondents were asked if the ICGP should be involved in determining the evolution of the role of general practice. The majority (79.4%, n=112) of respondents said they think the ICGP should be involved, 8.5% (n=12) thought they should not and 12.1% (n=17) stated 'Don't Know'.

Discussion

General practice faces continuous workforce planning concerns. This survey revealed that a notably large proportion of GP trainees and recent graduates are not in Ireland or plan to emigrate from Ireland; 30% of GP trainees are considering emigration while 18.1% of recent graduates have already emigrated and another 7.9% of them definitely plan to emigrate. Canada and Australia were given as the primary destinations for those seeking to emigrate, both of which were the preferred locations in the equivalent 2014 and 2015 surveys[17, 19]. Not only are many GP trainees and graduates planning on emigrating, 9.5% of recent graduates see themselves not working in general practice in any capacity in five years' time. For trainees, 2.6% see themselves not working in general practice 10 years post-training. This exodus reflects wider evidence of a brain drain amongst medical doctors in Ireland[18].

'Financial prospects' and 'Quality of life' were the primary reasons cited by both trainees and recent graduates for emigration. Addressing these issues through improved remuneration and a reduced workload could stem the outflow of GPs

and thus go some way in addressing the increasing demands being placed on Irish primary care[8, 10]. These reasons align with the fact that Canada and Australia were the top choices for emigration. Canadian and Australian GPs have on average less working hours and higher incomes than Irish GPs[20].

The issues highlighted may be mitigated by the fact that this represents a trend of lower proportions of GP trainees and graduates planning on emigrating. The 2014 survey[19] revealed that 47.8% of trainees and 26.8%% of recent graduates were definitely or possibly planning on emigrating, these numbers dropped to 41.4% and 24.5% in 2015[17] and then to 30% and 17.4% respectively in 2017. However, the workforce capacity will not simply be determined by the number who stay but more importantly by their productivity; the volume of workload achieved per unit time when working and the number of sessions they actually work.

When looking at the reasons respondents gave for staying in Ireland, the predominant ones were not specific to the profession of general practitioner. Recent graduates stated that 'Family reasons' and 'Partner's working requirement' were the main reasons they stayed in Ireland. The same reasons for staying in Ireland emerged on top in the 2014 and 2015 surveys[17, 19].

Supply of primary healthcare is not only affected by the number of GPs, it is also affected by the number of sessions GPs will work. Currently, over a third of recent graduates work less than eight sessions per week. In five years' time almost two thirds of both recent graduates and GP trainees envisage themselves working less than eight sessions per week. These results are markedly increased since 2014[17, 19] and reflect trends being seen in the profession[22, 23, 24]. For GPs who choose to remain in Ireland, reducing one's sessions may be a means of addressing quality of life issues that those emigrating cite as their reason for leaving[25]. It may also be a means of addressing the high levels of burnout found amongst Irish GPs[26]. These trends of decreased sessions have stark consequences for a profession which has had a consistent short supply of GPs. It also reiterates the ESRI's prediction that there will be a large shortfall of GPs by 2021[27]. These results emphasise the need to address workforce planning issues for the cohort that remains in Ireland as well. We need further data to identify the volume of work our cohort intend to perform. The growing medical complexity of an ageing population increases the number of presenting complaints patients bring to a consultation and furthermore the time needed to safely address those issues. There is a need for further Irish data in this domain. The Australian BEACH project[28] is an illustration of the type of relevant data that can be collated.

Many recent graduates expect their professional position to change between now and five years' time. Currently, 31.2% of recent graduates are full-time/part-time GP assistants and in five years' time only 6.8% of recent graduates expect to be in these positions. In five years' time, 46.9% of recent graduates see themselves as being a GP Principal in a partnership or group practice/Equity Partner. Similarly, 45.3% of 4th year GP trainees see themselves being a GP Principal in a partnership or group practice/ Equity Partner 10 years post-training. This may reflect a means of improving financial prospects. The position of GP principal also leads to greater security and higher responsibility potentially leading to a higher quality of life and greater professional satisfaction. There was little variation in the expected position of GP trainees across all years. There is currently no coordinated pathway for these expectations to be realised. The state has no involvement in career planning or progression in General Practice in Ireland presently, other than offering contracts for service to doctors.

Only 2% of recent graduates see themselves as a single-handed GP principal in five years and 1.6% of GP trainees see themselves as a single-handed GP principal 10 years

post-training. With quality of life being to the fore and a desire to work part-time, it would not be sustainable for these general practitioners to be in single handed practices. This group of doctors most likely have many reasons for not wishing to work alone; professional support, camaraderie, a desire to work in multi-disciplinary teams and the economies of scale to make lean infrastructure resources go further. This compounds the issues of a drop in rural GPs: In 2010 it was estimated that only 7% of the rural population were in walking distance of their GP whereas the figure for the urban population was 89%[29]. With the restrictions around the rural practice allowances[30] being redrawn which has led to a reduced number of GPs receiving the grant, rural general practice faces a worsening crisis.

Similarly to 2015[17], the majority of both recent graduates and trainees stated that they believe the ICGP should have a leadership role in manpower planning in general practice, including general practice postgraduate training.

Just one third of recent graduates expressed a preference to be a part of a PCT. This may lead to issues as the Government has committed to funding eighty primary care centres[31], a trend which may continue. There is a need to determine which factors may be causing this. It could be a fear of additional work arising from the proximity to HSE employees. It could also be a fear of additional property costs as the HSE is not purchasing primary care centres but chooses to be the anchor tenant in a building where the GP practice would be expected to fund its own space. Again, there is currently no state support within the General Medical Services contract available to GP practices for premises.

Only 36% of recent graduates and 30.9% of trainees either strongly agreed or agreed with the statement "I find the traditional responsibilities of a practice principal/ partner attractive". We know that a majority of those surveyed prefer to focus on their clinical role. However, there is no state personnel to step in here and replace the traditional GP principal's duties. Traditionally GP principals deal with the non-clinical demands of their general practice, after the clinical day has concluded. This is not attractive to those seeking improved quality of life. There is no financial recognition of the work done by managing partners in group practices by the state. There are increasing computer, staff (clinical and non-clinical) and commercial property costs. These are our top academic achievers and there is no financial attraction to working longer hours, with greater responsibility and liability. Our respondents have learned to avoid burnout by seeking a work life balance. Presently, they are finding it overseas or by taking purely clinical roles in Irish practices on a part-time basis.

Two aspects of the research undermine its validity. It is possible that the sample is biased; those residing abroad have less of a stake in Irish primary care and may therefore be less likely to respond to a questionnaire from the ICGP. Also, the low response rates effect the validity of the findings.

Conclusion

Greater demands placed on primary care each year and clear issues arising around the supply of GPs, sharpens the focus on the need to invest in keeping GPs in the country and attract those abroad back to the country.

The demographics of the Irish population is changing and government health policy needs to change too. There has been a realisation that moving even more healthcare towards general practice has many advantages. This has broadened the group of healthcare professionals included in the primary care domain.

Presently, the state has no general practice infrastructure of its own. There are many financial advantages to the state in maintaining the contract-for-service relationship and there has been no alternative policy proposed. The government has reduced the infrastructural resourcing available to the small and medium size enterprises, which provide the state's care to its General Medical Services (GMS) patients, meanwhile government policy was also to increase workload. There is no significant funding available to general practice businesses outside of the GMS contract. The decision to reduce secretarial, nursing and managerial subsidies under FEMPI legislation prohibits the logical investment in practice infrastructure that must precede workload expansion.

Worryingly, it makes more financial sense for existing general practice principals to contract their clinical practice. By contracting practice capacity, they can protect profitability by reducing all expenses which do not receive ongoing state support e.g. Commercial rent/premises provision, computer workstations and most drastically-doctors. There is no resource support for practices to provide employment opportunities to those general practitioners seeking to establish themselves as principals. The results of this survey tell us that career progression is vital to our next generation but the current state model of additional work upon weakened infrastructure goes against that. Unlike their hospital colleagues (superannuation) there is no entitlement or resource provision for establishing general practitioners to have an employer pension contribution. Despite also being PAYE employees there is no resourcing for employed doctors to have sick pay, educational leave or maternity pay. On the pathway to permanency, all doctors employed in the Irish public hospital system will have these supports. When Canada sought to provide an adequate general practice workforce they identified the factors needed and successfully put them in place. Ireland is not the first country to face this issue, there are successful examples that demonstrate simple solutions to many of the Irish problems. It is incumbent upon the ICGP, the unions and the state to work together to create an efficient, rewarding and sustainable workplace environment for GPs to implement national healthcare policy. It is time for all those responsible to understand that their plans to improve patient care and save money in the hospital system cannot be realised without a general practice infrastructure or workforce.

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The Irish College of General Practitioners (ICGP) is the professional body for general practice in Ireland. The College was founded in 1984 and is based in Lincoln Place, Dublin 2. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.

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