Irish College of General Practitioners

Bridging the gap

– How GP trainees and recent graduates identify themselves as the future Irish general practice workforce

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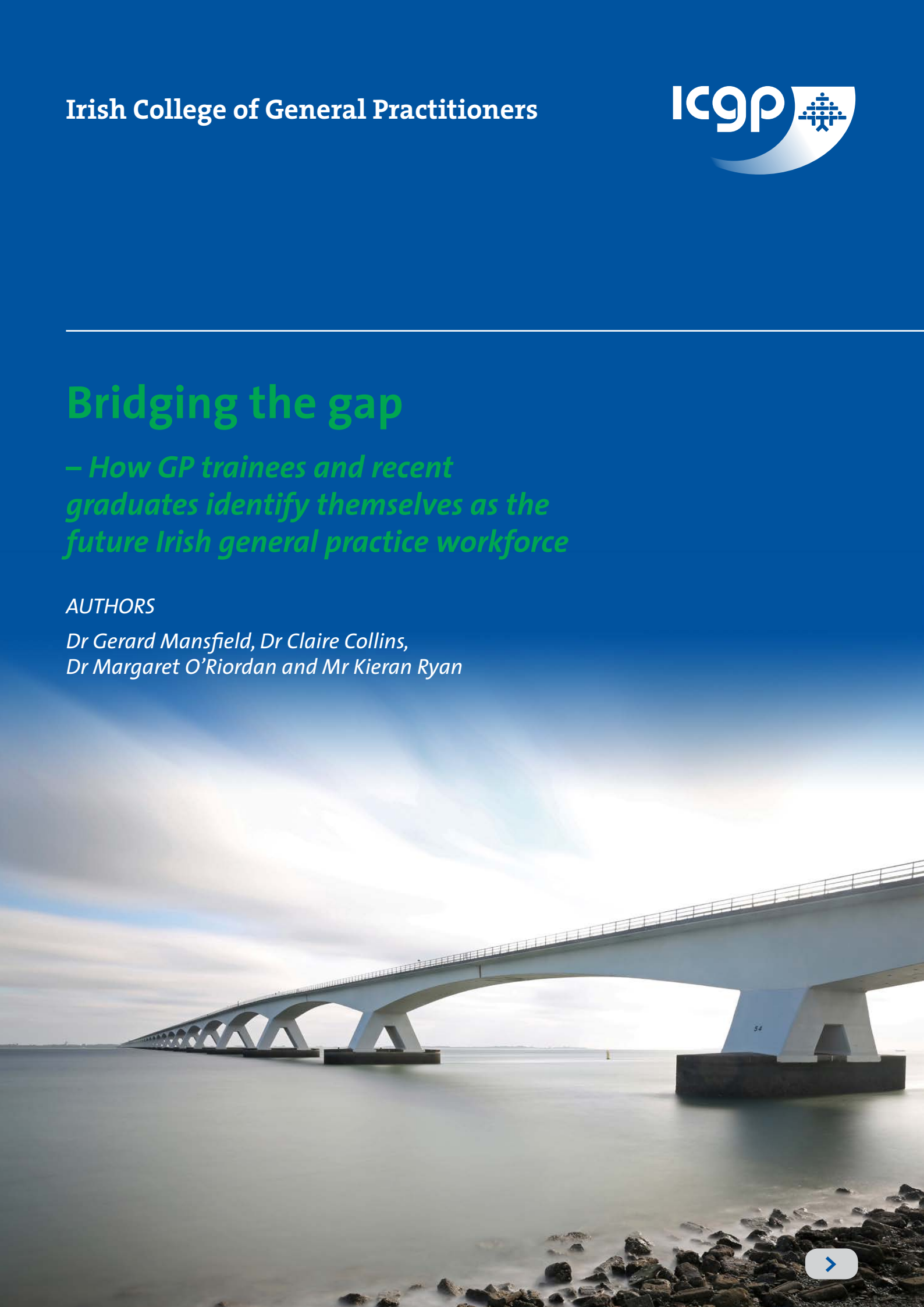

Acknowledgements

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Summary

At the time of our initial survey in 2014, there was significant uncertainty as to how Irish general practice would be expected to change. At that time, the viability of Irish general practice was the number one concern for trainees and recent graduates alike. Furthermore, a majority could not commit to definitely staying in Ireland.

This survey took place in March 2015. At the time, there was an expectation that all children under the age of 6 years and adults of 70 years and over would be able to access their GP under the GMS or Doctor Visit Card commencing in 2015. GMS Contract renegotiations were also scheduled to commence in 2015. Such changes will likely influence how trainees and recent graduates view their future professional life. The aim of the 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.

Surveys of current GP trainees and of recent GP graduates were undertaken. The response rates were 36.2% and 34.2% respectively.

Key findings from the trainee survey:

Over half of current trainee respondents are still undecided as to whether they will emigrate stating 'undecided' or 'possibly', while 13.1% of current trainees are definitely planning to emigrate. This leaves one third 'planning to definitely stay in Ireland'. However, this represents a slight improvement compared to 2014 (28%).

When we look at reasons for considering emigration, under 20% cited the viability of general practice compared to 35% in 2014 while financial prospects are now the leading concern (35.7%).

Less than half (46%) of trainees see themselves working full-time five years post training and this decreases further at 10 years post training (40%).

While over half of trainees indicated a preference to work in a practice that is part of a primary care team, almost one-fifth are undecided. Less than two in five have a preference to be co-located with a primary care team in a primary care centre.

The majority (85%) support the move of more chronic disease management into general practice if appropriately resourced and supported.

Significant proportions of trainees find the financial and employer responsibilities of being a principal/partner GP unattractive.

The majority (90.4%) of trainees who responded thought that the ICGP should be involved in determining the evolution of the role of general practice.

Key findings from the GP graduate survey:

Similar to 2014, 9 out of ten recent graduates are still working in general practice. A total of 16.5% are currently working overseas and of this group, one quarter are planning to return to Ireland to work, an increase compared to 17% in 2014.

Of those still in Ireland, one quarter definitely or possibly plan to emigrate in the near future. Among the reasons for considering emigration, the viability of general practice (25.6%) is predominant but is equalled by financial reasons. In 2014, almost 43% of recent graduates considering emigration cited viability of general practice as the key reason.

Again, we see that being a single-handed GP is not a preferred or anticipated career end point.

With regard to productivity, approximately one third of recent graduates are currently working less than eight half day sessions per week but almost half see themselves doing so within the next five years.

While over half of recent graduates indicated a preference to work in a practice that is part of a primary care team, almost one-fifth are undecided. Less than one third have a preference to be co-located with a primary care team in a primary care centre.

The majority (over 80%) support the move of more chronic disease management into general practice if appropriately resourced and supported.

Worrying proportions of recent graduates find the financial and employer responsibilities of being a principal/partner GP unattractive.

The majority (92.9%) of recent graduates thought that the ICGP should be involved in determining the evolution of the role of general practice.

Conclusion:

There have been significant changes in the past year. Our survey shows that our trainees and recent graduates feel that the ICGP must play a significant role in areas such as the design and implementation of best clinical practice and manpower planning. Medical workforce planning remains topical – we consider that the data reported here by GP trainees and recent graduates may inform these discussions. We surmise that there is still a GP workforce planning concern with a worryingly low percentage of current trainees and recent graduates definitely committed to working in Ireland and a large proportion of both trainees and recent graduates having a desire to work more flexibly and less than full-time in the future.

The Irish population's general practice healthcare is at risk of a chasm developing between the traditional comprehensive role of established GPs and the desires and expectations of the future general practice workforce. It is the shared responsibility of all involved in service and workforce planning to endeavour to construct a 'bridge' to help our specialty trained general practitioners transition from training to establishment as a principal clinician in practice.

Introduction

Irish general practice has been weathering a time of unprecedented uncertainty and change. At the time of our initial survey in 2014, there was significant uncertainty as to how Irish general practice would be expected to change. It was accepted that change was imminent, as the Irish government had made clear that primary care and general practice were expected to change. Would change only involve the minority of the population covered under the general medical services (GMS) scheme or would broader change be expected? With practice premises, information technology, staff employment and overall financial control of general practices lying outside of the HSE, how would such change be supported and facilitated? The small and medium size enterprises that are owned in the main by the general practitioner (GP) principals, had suffered massive infrastructural damage through successive FEMPI cuts. The diminished infrastructural resourcing available through the GMS made the viability of Irish general practice the number one concern for trainees and recent graduates alike. A majority could not commit to definitely staying in Ireland.

This survey took place in March 2015. At the time, there was an expectation that all children under the age of 6 years and adults 70 years and over, would be able to access their GP under the GMS or Doctor Visit Card commencing in 2015. GMS Contract renegotiations were also scheduled to commence in 2015. Such changes should influence how trainees and recent graduates view their professional life ahead. As a greater part of each practice population is proposed to fall under state contracts, how do respondents view themselves as clinicians and moreover does it influence their traditional aspiration to progress to practice principal? How will these changes influence the career aspirations of our trainees and recent graduates?

There has been no change to the state's expectation that someone else will provide premises, practice management, administrative staffing and information technology in order for there to be a general practice service. The state is funding more clinical care built upon an infrastructure it procures but does not own or control. It does not afford the security of employee status to anyone within this infrastructure and is completely dependent on GPs choosing to take up a contract for service from the state.

With expanding co-morbidities and an ageing population, the demand for GP services in Ireland is expected to continue to increase[1]. The workforce in general practice is a major concern for the Government as they seek to move additional services into general practice and the community[2,3].

Irish Government policy in recent years has the expectation of Irish general practice performing at the same level as much higher ranked healthcare systems, such as those in France and Canada, with the ratio of GPs to population and percentage of total registered physicians being lower in Ireland in comparison[4–5].

Irish general practice has 22% of its workforce working part-time, according to the *Irish Medical Council Workforce Intelligence Report*[6]. To give context to this, we note the proportions for several other specialities are higher – clinical pharmacology (50%), genito-urinary medicine (43%) and public health medicine (30%). There is an age related increase in the percentage of all doctors working part-time. Among those under 35 years, 6.1% of males and 7.3% of females work part-time. This figure increases for females in the 35–44 age bracket, with 4.4% of males and 23% of females working part-time, and increases further in the 55–64 age bracket to 9.8% and 36% respectively. In 2012, 59% of new specialist entrants to the general practice

division of the specialist register were female. This corresponds to the total number of female medical graduates from Irish medical schools. That report shows that across all doctors, female doctors are twice as likely as their male counterparts to work part-time.

The purpose of this report is to present the findings from surveys of GP trainees and recent graduates regarding their professional plans and their view of changes in Irish general practice from 2015 with comparisons to the 2014 findings.

Aims and Objectives

The aim of these annual surveys is to provide data regarding the professional plans of GP trainees and recent GP graduates and on the current status of recent graduates. This survey will be undertaken each year, commencing in 2014, in order to provide comparative data over time.

Within this, the specific objectives of the surveys are:

- To establish the career aspirations of both groups both in terms of clinical commitment and employment status
- To document the emigration plans of both groups and 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 methodology in 2015 was the same as in 2014. Two separate surveys were undertaken in March 2015:

- An online survey was emailed to all 668 current GP trainees with a reminder issued one week later.
- An online survey was emailed to all 576 GP graduates from 2010 to 2014 with a reminder issued one week later.

Overall, 242 GP trainees responded, representing a 36.2% response rate, while 197 recent graduates responded, representing a 34.2% response rate.

These response rates, which may be considered marginally low are in fact typical of these groups[7–10]. Low response rates raise concerns about bias and certainly it could be the case with such a survey that estimates of, for example, current emigration status may be underestimated in the case of current graduates as non-responders may be more likely to have already emigrated. However, the concern of bias is somewhat negated by the distribution across all trainee and graduate years, and further so as the demographic distribution is representative.

Results

The full results from the 2014 survey have already been published are available at www.icgp.ie/CareersReport2014.

2015 GP Trainee Survey

Basic demographics are shown in Table 1 across all years.

One-third of respondents do not plan to emigrate and one quarter are undecided, with 13.1% definitely planning to do so (Table 2).

For those who definitely plan to emigrate, Canada (44.8%) is the most popular location (Figure 1). Those who definitely or possibly plan to emigrate were asked to indicate their main reason (one only) from a provided list for this decision – financial prospects (35.7%), quality of life (25.5%) and concern regarding the viability of general practice (19.4%) were the most often selected reasons (Figure 2). The planned timeframe abroad is undecided for two in five with 7.1% planning to emigrate permanently.

Table 1: Profile of respondents

	%	N
Year		
1st	18.4%	44
2nd	16.7%	40
3rd	33.5%	80
4th	31.4%	75
Age Group		
25–29	37.7%	90
30–34	47.3%	113
35–39	11.3%	27
40+	3.7%	9
Gender		
Male	34.5%	82
Female	65.5%	156
Relationship Status		
Single	25.2%	60
Married or with partner	74.8%	178
Children		
Yes	30.1%	72
No	69.9%	167

Table 2: Emigration plans

	%	N
Plan to Emigrate		
Yes, definitely	13.1%	31
Yes, possibly	28.3%	67
Undecided	25.3%	60
No	33.3%	79
Timeframe abroad if definitely or possibly plan to emigrate		
<1 year	1.0%	1
1 year	6.1%	6
2 years	29.6%	29
3 years	8.2%	8
4 years	3.1%	3
5 years	6.1%	6
6 years+	4.1%	4
Permanently	7.1%	7
Unknown	39.8%	39

Figure 1: Planned location of those who definitely plan to emigrate post training (n=31)

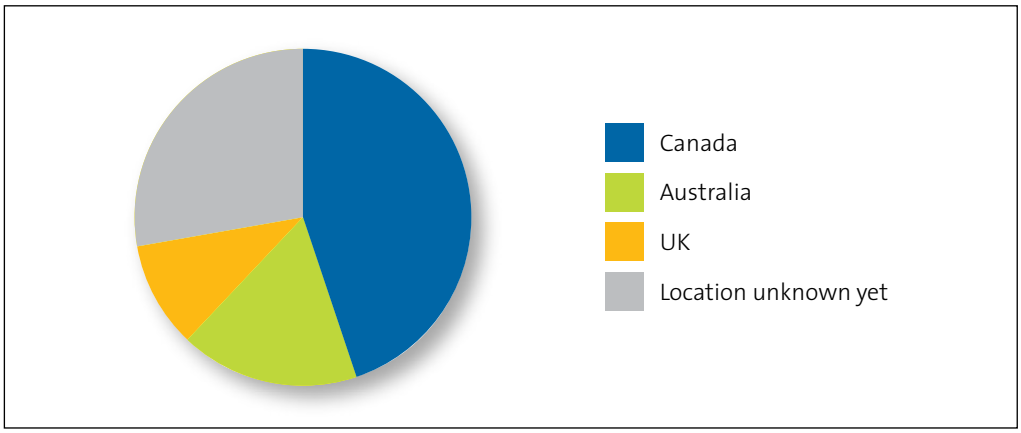
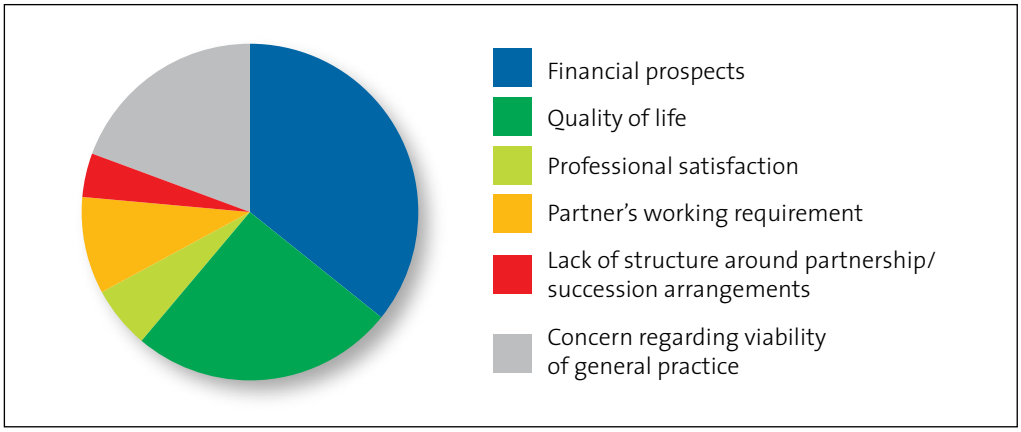


Figure 2: Main reason for emigrating if definitely or possibly planning to emigrate post training (n=98)



For those not planning to emigrate, over half plan (58.6%) to stay in the area where they are conducting their GP training, while 5.7% plan to move to an urban area, 15% to another area in Ireland and 20.7% are as yet undecided.

The majority (61.9%) of all respondents definitely plan to remain in general practice post training, 27.1% will possibly do so, while 8% are undecided. Only 3% definitely do not plan to remain in general practice post training. Of those who provided an alternative career among those who definitely plan to leave general practice or are undecided, the majority (n=7; 46.7%) intend to practice hospital medicine. The reasons selected for this choice were most often concern over the viability of general practice (n=7; 38.9%), professional satisfaction (n=6; 33.3%) and quality of life (n=5; 27.8%).

All respondents were asked what position they saw themselves in one and 10 years after completion of training. Locum, sessional and full-time assistantships most often feature in ambitions for one year post training, while being a GP principal or salaried partner featured as ambitions for 10 years post training (Table 3).

While 14.2% think they will be abroad five years after completing training, a lower percentage of 5.3% of respondents foresee that they will be abroad 10 years post training. However, 34.7% and 27.4% respectively in each timeframe do not know at this point if they will be in Ireland or abroad.

In terms of the number of sessions trainees see themselves working in five and 10 years post training, we see a slight shift in terms of 5–7 sessions and 8–10 sessions showing a small reduction in those anticipating working 8–10 sessions in this time period (Table 4).

Table 3: Anticipated position one and 10 years post training

	1 YEAR POST TRAINING	10 YEARS POST TRAINING
GP principal in a partnership or group practice/ equity partner	2.2%	43.1%
Salaried partner	3.6%	22.2%
Single-handed GP principal	0.9%	1.8%
Full time assistant	25.0%	2.7%
Part time assistant	4.0%	3.1%
Regular sessional GP	22.8%	6.2%
Locum GP	28.1%	0.0%
Combined clinical/academic general practice	8.5%	12.4%
Academic general practice	0.0%	0.4%
Combined clinical/general practice training role (PD/APD)	2.7%	5.3%
Not working in general practice in any capacity	2.2%	2.7%

Table 4: Number of clinical sessions trainees envisage working five and 10 years post training

	5 YEAR POST TRAINING	10 YEARS POST TRAINING
None	2.2%	2.0%
1 – 4	3.6%	4.0%
5 – 7	48.2%	53.7%
8 – 10	46.0%	40.1%

While over half (56.1%) have a preference to work in a practice which is part of a primary care team, 8.8% would prefer to work in a practice that is not part of a primary care team, 18.9% have no preference and 16.2% are undecided.

In terms of working location, 38.8% would prefer to be co-located with a primary care team in a primary care centre, 14.9% would prefer bi-location with the GP in own premises, 29.4% have no preference and 16.9% are undecided.

Respondents were provided with a list of statements and asked to indicate their level of agreement with each. The majority (almost 90%) agree that chronic disease management should be moved largely into general practice (assuming resources, funding and services are provided to general practice) and that if resourced, they would like to provide chronic disease management services. Fewer but still a majority (nearly 55%) agree that they would like to focus on the clinical aspects of the job exclusively. Only a third find the financial responsibility of practice attractive and almost half would prefer not to take on employer responsibilities (Table 5).

Table 5: 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	53.2	32.5	5.9	3.5	34.9
If resourced, I would like to provide chronic disease management services	54.7	33.5	3.9	3.5	4.4
As a GP, I would like to focus on the clinical aspects of the job exclusively	18.2	36.5	18.7	24.1	2.5
I find the traditional responsibilities of a practice principal/partner attractive. These include accountability for financial, property and employment coordination of the whole practice	8.4	25.1	22.2	33.0	11.3
I would prefer if I did not have to take on the responsibilities of being an employer of staff	17.8	30.7	19.3	25.3	6.9

Table 6: 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	9.7	14.2	15.9	28.4	31.8
Leadership role in the development and implementation of chronic disease management in the community	10.9	10.9	10.3	32.0	36.0
Leadership role in manpower planning in general practice, including general practice postgraduate training	10.9	13.7	9.1	33.7	32.6
Greater involvement of GPs in high level healthcare planning	11.4	11.4	11.4	26.1	39.8
Increase resources for general practice based research	9.1	15.9	14.8	29.0	31.3
Improving use of information technology throughout the healthcare system	13.1	9.7	10.9	26.3	40.0
Increase resources for general practice team training activities	14.9	9.8	11.5	27.6	36.2

The majority (90.4%) of trainees who responded thought that the ICGP should be involved in determining the evolution of the role of general practice; 1.4% thought it should not and 8.2% were undecided. Table 6 shows the list of items respondents were asked to indicate the importance of in relation to role of the ICGP over the next four years. While over 58% considered all items listed as very or extremely important, the mean importance scores were highest for greater involvement in high level healthcare planning and leadership in the development and implementation of chronic disease management in the community.

2015 Recent Graduate Survey

Basic demographics are shown in Table 7.

Overall, 16.5% of recent graduates who responded are currently working.

Of those still in Ireland, 9.2% definitely plan to emigrate in the near future and another 15.3% will possibly do so (Table 8). Therefore, one quarter of respondents are either currently working abroad or definitely plan to emigrate.

Of those already abroad, 58.6% are in Australia, 20.7% in Canada and 17.2% in the UK. For those who definitely plan to emigrate, Canada is the anticipated location for 46.2% and Australia for 30.8%.

Table 7: Profile of respondents

	%	N
Year		
2010	16.8%	33
2011	21.8%	43
2012	13.7%	27
2013	25.4%	50
2014	22.3%	44
Age Group		
25–29	3.6%	7
30–34	54.8%	108
35–39	35.5%	70
40+	6.1%	12
Gender		
Male	39.7%	77
Female	60.3%	117
Relationship Status		
Single	21.7%	42
Married or with partner	78.3%	152
Children		
Yes	55.6%	109
No	44.4%	87

Table 8: Emigration status and plans

	%	N
Current location		
Ireland	83.5%	162
Abroad	16.5%	32
Plan to Emigrate		
Yes, definitely	9.2%	15
Yes, possibly	15.3%	25
Undecided	20.3%	33
No	55.2%	90

Those already abroad and those who definitely or possibly plan to emigrate were asked to indicate their main reason (one only) for this decision from a provided list. Concern regarding the viability of general practice was cited most often along with

financial concerns by those currently in Ireland who are considering emigration. However, the viability of general practice was not one of the top three reasons cited by those who have already emigrated (Figure 3).

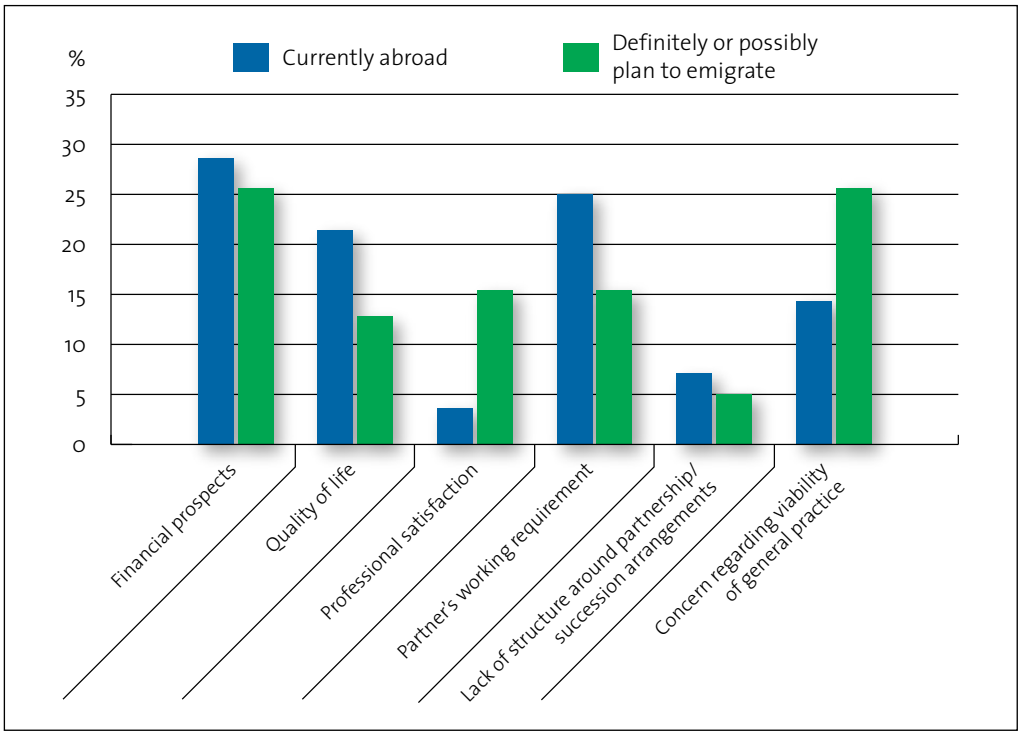
Over one quarter of those abroad (26.7%) have current plans to return to Ireland in the near future. One in 10 (13.2%) of all survey respondents saw themselves abroad in five years, 27% did not know and over half (59.8%) saw themselves in Ireland.

The planned timeframe abroad for those definitely or possibly planning to emigrate is undecided for two in five (n=17; 42.5%) and is currently estimated at 2–3 years for just less than one third (n=12; 30%). Just under half (n=13; 41.9%) of those already abroad have been there <1 year.

Of those currently in Ireland, who have no definite or possible plans to emigrate, the majority (84%) noted family reasons or their partner's working requirements as the main reason for staying in Ireland, with an additional 12.6% selecting quality of life.

The majority (91.5%) of all respondents are currently working in general practice. Of the 16 respondents who are not, 41.2% plan to return to general practice in the near future. The main reasons selected from a list provided for staying in general practice were job/professional satisfaction (56.7%), family reasons (18.9%), quality of life (15.9%) and financial prospects (8.5%).

Figure 3: Reason for emigration



All respondents were asked for their current position and what position they saw themselves in five years from now. Almost one third are currently full time GP assistants. The majority envisage they will be GP principals or salaried partners in five years times (Table 9).

Over two thirds of recent graduates are currently working 8–10 sessions in general practice. In terms of a five-year plan, there is clearly a shift with more aiming for 5–7 rather than 8–10 as time passes (Table 10).

Table 9: Current position and anticipated position five years from now

	CURRENTLY	IN 5 YEARS
GP principal in a partnership or group practice/ equity partner	19.5%	53.0%
Salaried partner	3.2%	9.9%
Single-handed GP principal	2.7%	2.8%
Full time assistant	30.8%	3.3%
Part time assistant	9.7%	9.4%
Regular sessional GP	10.3%	4.4%
Locum GP	10.3%	0.0%
Combined clinical/academic general practice	3.8%	8.3%
Academic general practice	0.0%	0.6%
Combined clinical/general practice training role (PD/APD)	1.1%	3.3%
Not working in general practice in any capacity	8.7%	5.0%

Table 10: Number of clinical sessions currently worked and envisaged in 5 years

	CURRENTLY	IN 5 YEARS
None	7.4%	2.7%
1 – 4	5.8%	6.3%
5 – 7	18.9%	43.4%
8 – 10	67.9%	47.6%

While almost half (42.6%) have a preference to work in a practice which is part of a primary care team, 16% would prefer to work in a practice that is not part of a primary care team, 24.5% have no preference and 17% are undecided.

In terms of working location, 29.6% would prefer to be co-located with a primary care team in a primary care centre, 21.7% would prefer bi-location with the GP in their own premises, 33.6% have no preference and 15.1% are undecided.

When asked to indicate their level of agreement with a provided list of statements, the majority (over 80%) agree that chronic disease management should be moved largely into general practice (assuming resources, funding and services are provided to general practice) and that if resourced, they would like to provide chronic disease management services. Fewer but still a majority (nearly 65%) agree that they would like to focus on the clinical aspects of the job exclusively. Approximately half find the financial responsibility of practice unattractive and would prefer not to take on employer responsibilities (Table 11).

Table 11: Graduate views on the 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	51.1	31.3	5.0	7.6	5.0
If resourced, I would like to provide chronic disease management services	50.8	30.4	5.0	7.7	6.1
As a GP, I would like to focus on the clinical aspects of the job exclusively	25.0	33.3	18.3	15.0	8.3
I find the traditional responsibilities of a practice principal/partner attractive. These include accountability for financial, property and employment coordination of the whole practice	8.9	17.8	26.7	34.4	12.2
I would prefer if I did not have to take on the responsibilities of being an employer of staff	18.4	32.4	18.4	21.2	9.5

Table 12: 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	15.3	10.4	10.4	24.0	39.9
Leadership role in the development and implementation of chronic disease management in the community	15.9	10.9	6.6	23.0	43.7
Leadership role in manpower planning in general practice, including general practice postgraduate training	14.8	9.3	7.7	29.7	38.5
Greater involvement of GPs in high level healthcare planning	14.2	9.3	4.9	29.0	42.6
Increase resources for general practice based research	13.7	12.0	12.6	29.5	32.2
Improving use of information technology throughout the healthcare system	13.7	11.0	12.6	28.6	34.1
Increase resources for general practice team training activities	12.8	14.4	10.6	29.4	32.8

The majority (92.9%) of recent graduates who responded thought that the ICGP should be involved in determining the evolution of the role of general practice; 1.1% thought it should not and 6% were undecided. Table 6 shows the list of items respondents were asked to indicate the importance of in relation to role of the ICGP over the next four years. While over 60% considered all items listed as very or extremely important, the mean importance score was highest for greater involvement in high level healthcare planning, with leadership in the development

and implementation of chronic disease management in the community and leadership in manpower planning coming joint second in terms of importance in the opinion of recent GP graduates.

Key Trends and Comparison 2014 to 2015

Similar proportions of trainees in 2014 and 2015 are still undecided as to whether they will emigrate, and comparable proportions (12.3% in 2014 and 13.1% in 2015) definitely plan to emigrate. A slight improvement is evident compared to 2014 (28%). When we look at trainees' reasons for considering emigration, under 20% cited the viability of general practice compared to 35% in 2014, while financial prospects is now the leading concern for 35.7%, compared to 30% in 2014. The anticipation among trainees that the number of clinical sessions worked will decrease at 10 years post training compared to five years post training from 8–10 sessions to 5–7 sessions remains a consistent trend.

A similar proportion of recent graduates in 2015 compared to 2014 are currently working overseas but the proportion of this group planning to return to Ireland to work has increased from 17% to 25%. Of those still in Ireland, one quarter definitely or possibly plan to emigrate in the near future, as in 2014. Among the reasons for considering emigration, the viability of general practice is key for a smaller proportion, 25.6%, in 2015, compared to 42.6% in 2014. Financial reasons were as likely to be reported as viability in 2015. Again, we see that being a single-handed GP is not a preferred or anticipated career end point. Again, the intention to work less than full time is evident.

Commentary

Traditionally, each general practice in Ireland developed their own business model. Two large elements decided whether that practice remained viable, the first being the patient population and the second being the costs incurred by the practice to deliver optimal care to that population. There was no management or strategic planning role whatsoever for the state or the HSE within this traditional model. The practice principal(s) procured staff, services and premises as they deemed appropriate.

Within a given area, with known demographics, two very differently structured practices could coexist – one possibly with large numbers of medical, nursing and allied health staff and the other practice with a fraction of those numbers. The non-medical staff supporting such different clinical sites would vary accordingly. The costs arising to provide premises, IT costs and overheads could also vary significantly. Those practices could differ significantly in their capacity for care provision. Each practice had sufficient control of their resource income and expenditure cost to remain viable. In the 2014 survey, the viability of Irish general practice was the highest concern among trainees definitely intending to emigrate. This remains a concern but personal financial prospects have now equalled or eclipsed this for both recent graduates and trainees. Although there are state subsidies within the GMS system for secretarial, nursing and practice management staff, there is nothing for the employment of doctors. The terms of this employment are bespoke to the employer-employee in each instance. Thus, the immediate short and long-term financial prospects in Ireland of the respondents are heavily influenced by the financial wellbeing of each practice.

The expansion of the percentage of the Irish population covered under the GMS system significantly impacts upon the business models of Irish general practices. So too will the proposed delivery of clinical care programmes for chronic disease

management. Screening initiatives and the proposed advent of state resourced preventive health care will result in a higher percentage of work capacity of Irish general practices being resourced by the state.

Our survey added new questions this year to try to establish how trainees and recent graduates feel about these changes. We believe this is the first significant survey of its kind. It shows that the proposed model, where GPs will retain all of their existing non clinical responsibilities, liabilities and accountability, is not universally attractive. We see a lower percentage of trainee respondents identifying equity partner/principal as their career endpoint (43% vs 49% in last year's survey). This is a significant issue for future workforce planning. Current government policy for the delivery of general practice services is contingent upon the traditional non-clinical infrastructure being in place. Our survey highlights a major concern regarding the certainty of that infrastructure. If the next generation of GPs do not wish to take over the non-clinical role of the traditional Irish GP, then the service is at risk of collapse.

There is a need to determine why more trainees and recent graduates do not find that role attractive. We recognise the need to clarify why our respondents feel this way. It should be a significant concern for anyone dealing with primary care and general practice workforce planning.

Government policy that general practitioners should ideally be located in purpose built primary care centres with co-habitation among other primary care providers received mixed support. A minority of 29% of both trainees and recent graduates were in favour of co-location. This identifies a need to determine what reservations our respondents hold. Presently, given that it is expected that general practices are responsible for their rent and associated expenses within these buildings, the reservations of the respondents may or may not be clinical. The need for consideration and clarity around such infrastructural support issues is not confined to young doctors and has been highlighted previously by GPs[11].

Trainees and recent graduates feel that the ICGP must play a significant role in the design and implementation of best clinical practice and in manpower planning. This desire to be involved shows a significant commitment to maintenance of quality and clinical standards. This highlights the need for the training and professional body of general practitioners to be included in processes previously seen as the sole jurisdiction of the contractor and the relevant union(s).

Conclusion

There was uncertainty as to how the sector would be affected by the changes being proposed at the time of the 2015 survey and we are not surprised therefore that, once again, emigration is being considered by a large proportion of trainees and graduates.

Since then, the government has offered new contracts to GPs to provide services to all children aged up to six years of age. This decision and the expectation that all those over 70 years will now receive a GMS card irrespective of personal means have somewhat reduced the uncertainty that was present in the 2014 and 2015 surveys, and are introducing potential change to the model employed by practice principals. The third significant change is the offering of funding to GPs to provide services to children under six years with asthma and a limited programme of diabetic care to adults. This condition specific funding is the first step on the way to acknowledging the role that GPs play in chronic disease management.

Our survey highlights the importance of resourcing general practitioners as self-employed persons to participate in the evolution of clinical care pathways and

any amendments to state contracts as these will unavoidably have a significant impact on the resources and infrastructure upon which clinical care is delivered. Trainees and recent graduates are willing to participate in such developments as the provision of chronic care management if resourced and supported. While they support multi-disciplinary working, co-location in primary care centres is not favoured. The financial and other non-clinical responsibilities of practice are not currently attractive to our trainees and current graduates. As in almost every profession and sector in the economy, general practitioners are interested in modern and flexible working environments. This is evident in the shortage of young graduates willing to work in remote and rural areas. Policymakers and society need to adjust their expectations of general practice, and public planning needs to address the growing chasm between the traditional comprehensive role of the established GP and the future general practice workforce. For as long as our GPs can access more modern working environments elsewhere, they will continue to emigrate. It is incumbent on all involved in workforce planning, including the ICGP, to identify all obstacles widening this divide. It is our shared responsibility to endeavour to construct a 'bridge' to help our specialty trained general practitioners transition from training to establishment as a principal clinician in practice.

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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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