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A
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Foreword

Primary generalist care is now widely recognised internationally as having a central role in the provision of equity, relevance, quality, and cost effectiveness in health services. In Ireland this recognition is reflected in the recently published health strategy *Quality and Fairness – a Health System for You*, and the separate publication of a primary healthcare strategy *Primary Care – a New Direction*. Change in medical education generally, and in general practice training and research in particular, is essential to the development of this vision. The publication of this report on the present position and future needs of departments of general practice in the medical schools of Ireland is an opportunity to begin that process of change.

The creation of chairs and departments of general practice were amongst the most important aspirations of the founders of the Irish College of General Practitioners in 1984. Naively perhaps it was assumed that a professorial appointment would be accompanied by a critical mass of academic staff, a significant role in the curriculum, and funding for teaching practices and a research agenda. This expectation was based on the gathering pace of undergraduate curriculum reform in other European countries and international recognition for the importance of community based primary medical care experience for all students.

This report describes the current state of each of the five departments of general practice. It documents not only the extent to which expectations have not been met but describes the demands made on the current professors as ‘unreasonable and likely to prove unsustainable’.

Fortunately the report does not regard these problems as insoluble. It sets out a realistic plan based on successful initiatives in other countries. Most of the proposed solutions will require partnership with statutory and non statutory bodies. The report describes the structures necessary to achieve this. It makes specific estimates of the funding and other resources required. In the context of health service costs, the amounts required are very modest.

This is an important report that could not have come at a better time. All those concerned with the future of Irish general practice and the future of medical education and research should consider its contents carefully and implement its recommendations.

Michael Boland

*Director, Postgraduate Resource Centre at the Irish College of General Practitioners
President, World Organisation of Family Doctors (Wonca)*

February 2002

Background

Description of the AUDGPI

The Association of University Department of General Practice in Ireland (AUDGPI) was established five years ago to promote excellence in academic general practice. It is supported by the five academic departments of general practice in the Republic of Ireland and the two departments in Northern Ireland. Its main activity has been the annual scientific meeting which is a shop window for research in primary care on the island of Ireland.

With the establishment of departments in all the medical schools in the Republic of Ireland, we considered it timely to review the current state of academic general practice, to review its progress and to examine any barriers to continued progress. This report provides comprehensive baseline data on the staffing and activities of the departments which have been gathered from the departments and their faculties. The authors of the report have met with the Department of Health and Children, the Higher Education Authority, the Medical Council, universities and medical schools and some health boards. The report defines the immediate and longer term needs of the departments but more importantly it provides signposts for the direction in which academic general practice can develop for the benefit of general practice, primary care and medicine in Ireland.

Finally, we would like to thank the Department of Health and Children for financial support in the conduct of this review.

Professor Tom O'Dowd
Chairman AUDGPI

Professor Andrew W. Murphy
Secretary AUDGPI

Background to the authors

We are fortunate to have had both Professor John Howie and Mr Fionan O'Cuinneagain to conduct the review process and to write this report. John Howie was Professor of General Practice in Edinburgh University until recently and is an internationally renowned researcher and educator in general practice. Fionan O'Cuinneagain is Chief Executive of the Irish College of General Practitioners and has carefully guided the ICGP through many years of change.

Summary

Chapter 1

- 1** *Chapter 1* outlines the context in which this report is set. As everywhere, health services in Ireland are increasingly dependent on a strong primary care base from which to deliver patient care. Medical schools are recognising that undergraduate education needs to embrace community thinking and experience, and are becoming aware of the greater contribution that departments of general practice can make to their wider life. As emphasis on the need for an ‘evidence base’ to health care and its delivery grows, it is recognised that a strong contribution from general practice/primary care needs to be part of the process.
- 2** The academic discipline of general practice has an obvious contribution to make to teaching and to research. It has an equally important role to play in helping to determine the philosophy of medical care, and acting in an advocacy role on behalf of patients and primary care professionals.

Chapter 2

- 3** The first half of *Chapter 2* traces the evolution of the departments of general practice in the five medical schools in Ireland. It describes their current activities, and comments on their staffing and funding.
- 4** The second half of the chapter identifies common issues that are affecting their development. The first and most critical is the absence of adequate critical mass. The five professors are the only full-time medically qualified staff employed by the medical schools, and the demands on their time and the expectations held regarding their roles are unrealistic and almost certainly unsustainable. Secondly, teaching of undergraduate students remains confined to traditional attachments to general practitioners, and its proper potential is still to be realised. Postgraduate teaching is a heavy demand on teaching time for the small numbers enrolled, and much effort is duplicated across the five schools. Inevitably, the research profiles of the departments tend to be small scale, concentrating on local/reactive work as against the more proactive/national work which they have potential to undertake in the long-term.
- 5** The underlying difficulty faced by these departments is that they work against an as yet insufficiently sympathetic professional climate. Whereas primary care is at the centre of health care provision, these departments operate in an environment where their share of available medical school funding is around 5% of that provided by the Higher Education Authority. General practitioners as a professional group are wary of ‘academics’; and the medical institutions worry that a better supported and more effective academic general practice community might divert limited resources.

Chapter 3

- 6** *Chapter 3* starts by outlining the funding of medical education in Ireland. The largest contribution comes from the Health Education Authority (HEA) through its block grant for undergraduate teaching. The HEA also supports postgraduate education and research training, and periodically supports identified developmental needs in the university sector.
- 7** The Department of Health and Children (DoHC) contributes indirectly to medical school activities through special financial provisions for teaching hospitals, and by employing clinical and other staff who contribute to teaching and to research. DoHC also supports the Postgraduate Medical and Dental Board. The Health Research Board has an important role in supporting the research base of Irish medicine, the greater part of its resource inevitably being spent in the hospital rather than in the primary care sector. Several health boards make important direct or indirect contributions to academic medicine, a particularly important example being the support given to the Department of General Practice at NUI, Galway.
- 8** The second half of *Chapter 3* describes ways in which support for academic general practice has been provided in three countries facing similar funding issues to those in Ireland. Two of these are in Scotland: an NHS payment to support teaching of medical students in the community (GPACT); and support from a group of agencies for the Scottish School of Primary Care which funds both research training and some project work. The third is a programme in Australia (GPEP) which, over a decade, has supported research projects and programmes as well as a research advisory and training service. And the fourth is a community based PhD programme which was promoted by the Norwegian Medical Research Council.

Chapter 4

- 9** *Chapter 4* is devoted to defining the immediate/medium-term ‘needs’ of the discipline of academic general practice, and proposing possible ways of meeting them. The needs are defined in relation to the functions of philosophy, advocacy, teaching and research and include the provision of an adequate level of senior staff and of staff at training levels. The need to fund general practitioners properly for the student attachments they provide is noted. The report recommends extending the present senior registrar scheme managed by the ICGP, and introducing a part-time PhD programme for general practitioners. Finally we recommend identifying more ear-marked funding to support project-based community R&D.

The long term implications of implementing the complete programme would be €3.8m (IR£3m) per annum, as follows:

- **philosophy/advocacy: infrastructure/core staff – €2m (IR£1.6m) per annum**
- **teaching: practice attachments – €507K (IR£400k) per annum**
- **research: €1.27m (IR£1m) per annum**

Not all would be required in the first three years.

- 10** The final section of the report explores structures and funding mechanisms which could enable the identified objectives to be met. Three principles underpin the suggestions: partnership, focus and quality. One set of suggestions centres on local initiatives and solutions. The second identifies a cluster of activities which we suggest should be managed on a national basis through an Irish consortium for teaching and research in primary medical care.
- 11** We hope that the issues raised and suggestions made in this report will lead to active discussions amongst the bodies involved. We believe that an active and effective academic wing is essential if general practice/primary care is to fulfil its full role in providing health services for the people of Ireland, for the teaching and training of those who will provide these services, and for the development and evaluation of the best ways of delivering them.

PREFACE

General practice in Ireland

In reviewing the development and future needs of the university departments of general practice it is helpful to retrace briefly the structural development of general practice in Ireland.

Under the **Poor Relief (Ireland) Act 1851**, basic medical care was provided to the sick poor by a network of salaried, part-time doctors who were obliged to reside in a particular area and to treat patients at a public dispensary. Necessary medicines were supplied at the dispensary. The system ensured an equitable geographical distribution of general practitioners (for both public and private patients) and the provision of a generally acceptable standard of care for the poorest groups. The service was, however, an integral part of the poor law and, despite radical changes in the administrative structure and basis of eligibility of the service, it long retained a stigmatising character.

The white paper on the **Future Development of Health Services** of 1966 proposed the replacement of the dispensary doctor service with a service involving private practitioners and based on the greatest practical degree of choice of doctor. After considerable negotiation the *General Medical Services Scheme (GMS)* came into operation in 1972 and has been the subject of a number of reviews since then.

In October 1971 the **Consultative Council on General Medical Practice**, under the chairmanship of Professor James McCormick, was established; and the Consultative Council issued its first report in 1973. This report was the first comprehensive report to examine general practice and made a series of recommendations relating to undergraduate education, vocational training, continuing education, health education and practice development, amongst others.

Vocational training schemes were independently established in Galway (1971), Cork (1972), Dublin (1975), Donegal (1981) and Sligo (1982) but were much under-funded and little else took place in the intervening years in relation to the development of general practice other than in the context of the GMS Service.

A further development was the establishment in 1975 of the **Irish Institute of General Practice** as the professional body competent to deal with postgraduate general practice education. The Institute functioned with the support of the Postgraduate Medical and Dental Board. The stated objectives of the Institute were broadly the promotion of education, training and research in general practice; as well as establishing standards for training.

At a meeting of the Institute in September 1983 the establishment of an **Irish College of General Practitioners (ICGP)** was considered. One of the issues considered by the Institute was the question “Why do Irish GPs need an Irish college?” The main reasons promoted at the time included:

- for our own good
- to fill an administrative vacuum

- to give informed advice to the government and the profession
- to take our place internationally
- to help those entering our specialty
- to help the public understand the service we offer.

The College was formally founded on 28th May, 1984. Currently 96% of practising GPs are members.

Priority areas from the outset included:

- the establishment of the membership examination (now the end-point assessment for GP training/specialist registration)
- the recognition of general practice as a specialty
- the establishment of GP vocational training in each health board region
- the establishment of a national programme of continuing medical education
- the establishment of departments of general practice in all medical schools
- the provision of a comprehensive policy for the development of general practice.

In general terms, these priorities have been achieved, although it could be argued that it is only now that the last of them is being addressed at the level appropriate to a contemporary health care system.

A further significant development in 1984 was the publication of the *Report of the Working Party on the General Medical Service*. Again this is a very comprehensive report and along with the report of the **Consultative Council** of the early 70s contributed significantly to developing a focussed momentum for general practice.

The Future Organisation of General Practice in Ireland ('The Blue Book') published by the ICGP in 1988, dealt in great detail with issues impacting on the development of general practice including:

- equity and uniformity
- patient choice, incentives and eligibility
- the extent of government interest in general practice
- transfer of care and resources
- practice organisation
- manpower and training.

The document provided a platform for the College and for policy/decision makers in subsequent years. A major breakthrough was the adoption of the blue print for the development of general practice agreed between the Department of Health and the Irish Medical Organisation in 1990.

The publication in 1994 of the health strategy *Shaping a Healthier Future* by government placed a particular emphasis on primary care and general practice.

A further significant development was the establishment of the **ICGPPostgraduate Resource Centre** in 1997 which moved the postgraduate education/training/research agenda to another level and provides for a greater degree of coordination between all of the interests involved in general practice education and research.

In the spring of 2001 the ICGP and the IMO jointly published a *Vision of General Practice*, which outlined the development needs of the specialty.

In November 2001 the government published its strategy *Quality and Fairness – a Health System for You*, followed by the publication of a specific strategy for *Primary Care – a New Direction*. Both documents emphasised the development and central role of primary care.

This preface outlines the environment in which the specialty of general practice has developed in Ireland over the years, against which this present report on the specific needs of the departments of general practice in Ireland can be better understood.

Chapter 1

Introduction

Health in Ireland

- 1** The people of Ireland place a high value on health. In 1994, *Shaping a Healthier Future* drew attention to the facts that expectation of life at birth for both male and female patients in Ireland remained somewhat below the EU average. It identified the main reversible causes of preventable mortality as cardiovascular disease, cancer and accidents. Having identified the associated risk factors, it proposed an integrated multi-sectoral programme of action to reduce them. The document also emphasised the need to target mental illness, the needs of children and of the elderly, drug misuse and palliative care in the years ahead.
- 2** All of these areas of clinical endeavour are particularly well suited to being addressed in the general practice sector. Indeed the 1998-2001 strategy document, *Working for Health and Well-being*, calls for measures to be taken to develop the role of general practice and to integrate it better with other health services.

Health services in Ireland

- 3** Modern health services are increasingly expensive to provide, particularly because of the costs related to the high technology required in the acute services sector. In 1998, Ireland spent 6.4% of its gross domestic product on health, the second lowest proportion in the EU. In absolute terms, its per capita spend on health was the fourth lowest in the EU. Nevertheless, Ireland boasts having acute hospital services 'which are recognised as being on a par with those in considerably more affluent countries'.
- 4** General practitioner/primary care provision is financed through a mixed economy of patient payments, insurance and state provision. Such a system is well suited to dealing with acute and 'serious' illness, but the cost to 'well' patients of repeated attendances, may make it less well suited to caring for continuing health problems and to providing preventive medical care and health promotion.

Medical education in Ireland

- 5** Undergraduate medical education is provided in four university-based medical schools and at the Royal College of Surgeons in Ireland. At all of these institutions, the pattern of learning follows

what are best described as traditional curricula, with six-year courses in which a pre-clinical phase is followed by a longer clinical phase being progressively replaced by more integrated five-year courses.

- 6 By far the greater part of clinical teaching still takes place within the hospital setting, although in all five medical schools there is now a component of teaching in the community, organised by the relatively new departments of general practice. There are several purposes for which such teaching is ideal. Firstly, students can see how the acute and life-threatening illnesses that cluster in hospitals and form the basis of hospital teaching present and are managed in the community. They can also see how patients cope and are coped with on discharge. Students learn about the presentation and management of the large volume of health and illness problems which are never seen in hospital. And they acquire a wider perspective on the care of continuing health problems over time than can be achieved in a hospital setting on its own.
- 7 Students also find the community setting an ideal place to learn the skills of history taking in particular and of communication in general. There they are able to place illness in the wider context of patients' lives and learn how to integrate the physical, psychological and social components of illness in a way which is less easy in hospital. In addition, freed from the overwhelming influence of the pathology of serious illness, they have the opportunity to reflect on the core values and attitudes which are important to patients (and to most doctors) namely holism, continuity of care, and respect for the views and beliefs of patients.
- 8 A major thrust of this report is that more teaching in the community will improve the experience of medical education for students, and in the long run will lead to the development of a workforce in Ireland that would be more able to provide the kind of approach to care which is needed to meet the health targets for the population in the decades ahead.
- 9 Although the report is about university departments of general practice, their work is not confined to teaching undergraduate medical students. They are actively involved in components of post-graduate training for general practice, and contribute to the continuing professional development of doctors in general practice and the colleagues who work with them. Many of these activities are referred to further in *Chapter 2*.

Research in Ireland

- 10 The role of research in developing the quality and effectiveness of health care in Ireland is explored fully in the 2000 consultation document *Making Knowledge Work for Health*. Starting with the recognition that Ireland spends less of its health budget on research and development (0.26%) than does any other EU country, the Health Research Board describes priorities for improving the value-for-money of what is available. Important strategic developments referred to in an updated version published in September 2000 are referred to in *paragraph 80*.
- 11 It is clear – and not necessarily surprising – that maintaining the capacity of the biomedical research domain will remain an important issue. The importance of health services research is emphasised, as is the need for more 'practice-based research' – although that is taken to mean research in the service setting generally, rather than research in general practice in particular. The document refers to an absence of an adequate 'research floor' in Irish universities (despite a higher education authority initiative to address this) and confirms that this results in research in the sector tending to be 'opportunistic, responding to whatever source of funding becomes available...'

Although that document included occasional references to research in general practice, there was at that time no explicit undertaking to make significant tranches of centrally controlled State funding available to the discipline – a situation now being addressed in a constructive manner (*see paragraph 80*).

Academic general practice

- 12** Academic general practice has a comparatively recent pedigree, having been first conceived in 1948 at the University of Edinburgh. For it to fulfil its potential to contribute to education, to research and to health services planning and evaluation, and to the evolution of the philosophy and values of medicine generally, it has to win support and a better share of available resources from those who hold most influence at present.
- 13** Given the reducing resources available in the higher education sector generally, the ever-increasing competition for the available resources in the health R&D arena, and the inevitable insecurity which existing institutions always feel when a new and potentially articulate ‘competitor’ arrives on the scene, it is not surprising that the new departments of general practice in Ireland feel disadvantaged by the relatively modest infrastructure support they have received thus far.

The potential of academic general practice

Philosophy

- 14** The central premise underlying this report is the belief that general practice is a discipline in its own right, and not merely the expression of specialist medicine in the community. General practice qualifies as an independent discipline through having its own spectrum of health and illness problems to manage, by having particular skills which mark its approach to problem solving (reflected in the hypothetico-deductive approach taken by most of its practitioners at consultations), by having the ability to support an independent body of research, and by having an identifiable philosophy. That philosophy is embodied in the commitments to holism, to the valuing of the involvement of patients in identifying, prioritising and solving their own clinical problems, and by valuing continuity of care and the creation of relationships between doctor and patient as part of the process of care. Although the component parts of this philosophy reflect values that are shared by and often used by specialists, the centrality of them to the routine work of the discipline of general practice is probably the defining characteristic of the discipline.
- 15** From that starting point, it is relatively easy to argue that general practice has an independent contribution to make to the provision of care in any community; and that as with any other discipline, the essentially applied part of the discipline (provided by the ‘service’ general practitioners) needs the support of a trained, insightful and effective academic wing.

Teaching

- 16** Again consequent to the above assumptions, the contribution of a department of general practice to teaching in a medical school is neither an alternative nor an add-on to the ward-based teaching which has served medical education well over many years, but a distinctive and complementary contribution in its own right.
- 17** Current general practice teaching programmes are generally limited to demonstrating the routine working of a general practice and general practitioner. Some aspects of population care, general medicine and primary care are touched on, but these do not form significant parts of the programme. An enhanced programme should demonstrate the components and potential of a more integrated healthcare system. In addition to demonstrating general practice’s core elements of primary, personal and continuing care, such a programme would enable students:
- to work in a clinical setting in which they can experience the value of good collaboration between primary and secondary care
 - to encounter the problems which presently limit the achievement of optimum partnership working

- to understand the ‘gatekeeping’ role of general practice
- to understand the role of general practice in shared care, chronic disease management, and in the support of carers
- to acquire and enhance clinical skills previously only associated with hospital-based teaching in, for example, medicine, surgery, paediatrics or psychiatry
- to work in a team-based structure in the community
- to understand the influences on care in the community of demographic issues and of economic problems
- to have a better opportunity to consider general practice as a career option, and
- to appreciate better how doctors working within the hospital sector can facilitate the care of patients in the community.

18 Within the medical school, an effective and properly established department can provide early clinical experience (for example through a family attachment scheme), assist with the teaching of introductory clinical skills (including doctor-patient communication skills) and administer a clinical attachment in the senior clinical years, which ideally should last four weeks. In addition, staff of such a department (ideally with qualifications in an appropriate social science) are well placed to contribute to the teaching of the MB course in behavioural sciences.

Research

19 Research has been simply defined as ‘organised curiosity’ and should be an integral part of the professional profile of any clinician in any discipline. However, it is reasonable to expect that the research contribution from an academic department will be more than simply the haphazard aggregation of the interests of those who work in it. There is no simple answer to the question of whether a department’s research profile should define the work that individuals within it undertake, or whether their interests should be allowed to develop independently of that department’s apparent strengths. However, the following general statements about the overall profile of a clinical department’s research portfolio would probably have a good level of support.

- 20** A department of general practice might wish to work towards having within its research portfolio:
- At least one core programme of work based on the theory of the discipline and attempting to extend the understanding of the nature of the discipline whether at basic or applied science level; such research should be generalisable to either national level or beyond. Such a programme might be composed from a series of logically progressive individual projects over time, or centre round a single evolving longitudinal study.
 - At least one project addressing applied problems relating to the delivery of clinical care in the local area, whether centred round a specific illness or health problem or about patterns of organisation and delivery of care; such research should be of interest at a national as well as at a local level.
 - Evidence of support for multi-disciplinary working, and willingness to use a multi-method approach to investigative work.
 - An environment which encourages research training, ideally including two or more researchers in training and working towards higher degrees by research.
 - Willingness to collaborate appropriately with other research groups, whether from other disciplines or other institutions, when appropriate opportunities arise.

Advocacy

21 Improved health in Ireland will be associated with improved health services. A stronger contribution from general practice is needed to achieve both. In turn, better general practice will be achieved when its research base and its capacity to contribute to medical education generally have also been

strengthened. The ‘academic’ contribution from general practice will make a material contribution to these processes through its day-to-day contribution to thinking, to the collection and dissemination of evidence, through teaching, and through the provision of personal clinical care. The translation from evidence, commitment and belief to practice is however a complex process. It involves the presentation of material and the negotiation of change between and within institutions, between and within professional groupings, and at the interfaces between government, providers of care, patients and the public. Experience in other countries has shown that members of the academic general practice community have the skills of advocacy to help these processes, and that as they are generally in a politically neutral position in the main conflicts that can and do arise, they can often contribute usefully to achieving progress. There is already evidence that this is a reality in the Irish setting. But time spent on this activity is once again an opportunity cost, and must be protected if it is to be used to its greatest potential.

This report

- 22** This report will argue that significant benefits to the health services and their users in Ireland, to universities and their students and staff, and to professional organisations and their members, could and would flow from a modest investment in the infra-structure support available to the still new departments of general practice in the five Irish medical schools.
- 23** *Chapter 2* of the report describes briefly the evolution, achievements and problems being faced by each of the five departments in turn and identifies common issues that are adversely affecting their individual and corporate evolution. *Chapter 3* explores the resourcing of academic medicine in Ireland and looks at alternative models which have brought benefits elsewhere. *Chapter 4* presents and costs a list of proposals/models which the authors of the report believe merit serious consideration as a package which would go a substantial way to creating benefit to all involved.

Chapter 2

Academic general practice in the Irish medical schools

This chapter is in two parts. The first presents brief profiles of the five departments of general practice (or their equivalents) in the Irish medical schools, highlighting their individual contributions and strengths as well as pinpointing areas of difficulty. The second part identifies some common issues which appear to be hindering the ability of the departments in their progress towards having the impact on Irish medicine that they believe they have the potential to make.

Profiles of the departments

Trinity College Dublin

- 24** The Department of Public Health and Primary Care at TCD is the longest established of the five Irish departments. Although it has had a professor from the discipline of general practice since 1972, its chair of general practice was not filled until 1993.
- 25** The combined disciplines of public health and primary care/general practice contribute to three of the six years of the MB course, with 120 students in each of the clinical years. Teaching in the early years is on human development and communication, ethics, computing and biostatistics. It is not until the fifth year that the department teaches in the clinical setting of general practice; that teaching is then divided between department-based tutorial teaching and practice-based attachments. The staff contribute tutorial/lecture time to group and whole-class teaching, and tutor time to one-to-one teaching. Altogether, this provides 5.5% of the whole MB course, and 7% of the clinical course. The department has run MSc courses both in community health and in general practice, but the latter is being discontinued as the commitment of staff time to it cannot be justified by the recent intake of students which is currently four per year.
- 26** The research profile of the department is mainly quantitative, although the general practice component uses qualitative approaches as well. Current areas of activity include study of drug abuse and HIV; access to, and uptake of, care with a focus on equity; cardiovascular disease and type 2 diabetes; domestic violence, men's health and 'crisis' pregnancy. The annual research spending attributable to primary care/general practice research was €141,036 (IR£111,075) in 1999 and €200,763 (IR£158,114) in 2000. The publication profile for general practice is commendable given the infrastructure support available. The relative absence of such support has resulted in the

department being without a research management structure, and the consequent absence of training and support for junior researchers. The department has recently secured EU funding to help create a network of future research collaborators in EU countries.

- 27** The department has recently been rehoused at the Adelaide and Meath Hospital in west Dublin. There are excellent teaching facilities. Office accommodation is becoming inadequate and is not particularly flexible. The university funds one permanent full-time post (the professor) and one contract half-time post in general practice on a recurrent basis. Two temporary part-time general practitioner posts are based in the department, all supported by ‘soft’ money. Ninety general practitioners take students on attachment. The cost of attachment teaching is €30,500 (IR£24,000) annually and this is met by the university. The professor and the ‘established’ part time lecturer work three and five sessions respectively in two different local practices which have informal connection with the medical school. They are registered as principals with the Eastern Regional Health Authority. Seventy five percent of the professor’s practice income is returned to the university, but none to the department.
- 28** The professor is heavily involved in medical and political activities outwith the department. Until recently he was Vice-Dean of the Faculty of Medicine. He is committed to the work of the Irish Medical Council (chairing the Education and Training Committee) and to the work of the Health Research Board. The professor is involved in the work of the board of Tallaght Hospital (a Trinity College teaching hospital). In addition he has commitments to the ICGP and to the Medical Defence Union, as well as undertaking the standard responsibilities to medical journals and to external examining.

The Royal College of Surgeons in Ireland

- 29** The RCSI medical school differs from the other four Irish schools in being outside the university funding system and dedicated to the single activity of medical education. Its chair in general practice was established in 1987, and its first holder is now the senior professor of general practice in Ireland.
- 30** The department of general practice has as its mission statement ‘to introduce students in a supportive and enquiring environment to health and illness in the community’. In pursuit of that goal, it now teaches in three years of the MB course, providing early patient contact in year one, courses in communication skills (jointly with the department of psychology) and in ‘medical ethics and law’ in year three, and tutorial teaching and a general practice attachment each of two weeks duration in year four. The department’s contribution represents 2.5% of the complete course, and its clinical teaching 4% of the clinical course. The challenges of teaching inter-personal skills in the context of health care are particularly marked at RCSI where 75-80% of the annual intake of 200 students come from outside Ireland, representing typically some 30-40 different nationalities. The department has pioneered the training of practice nurses in Ireland, and now collaborates with the Faculty of Nursing and Midwifery at RCSI with which it has launched a higher diploma course. It has recently launched an MSc programme in collaboration with the Departments of Nursing and Epidemiology to which it has attracted 12 students from a range of health care practices. In addition, the department is involved in vocational and higher professional training for general practitioners and for nurses. Finally the department contributes to training of general practitioners in Bahrain.
- 31** The department has found it difficult to develop a substantial research programme mainly due to the absence of a critical mass of suitably qualified tenured staff. Until recently most of the department’s research has been undertaken in collaboration with other groups within or outwith RCSI. Research spend has been modest (typically around €12,700 (IR£10,000) per annum) and not surprisingly not much has been published in major peer-reviewed journals. However, the arrival of the department’s new lecturer (whose background is in the social sciences) has helped develop new programmes in the fields of medical education and of palliative care, and these initiatives seem likely to develop a momentum of their own.

- 32** The department is integrated with the general practice based in the Mercer Medical Centre adjacent to RCSI. All five partners contribute to the work of the department although only the professor and one part-time lecturer are funded for their academic work by RCSI. The professor works three sessions weekly in the practice and the part-time lecturer four sessions each in the department and the practice. The total academic staffing complement is six, but equal to only three FTEs. Two are full time, one half-time and two working two sessions each per week. Only the professor has a tenured post. Eighty general practitioners take students on attachments. The attachment teaching costs €50,500 (IR£40,000) per annum and this is met by the medical school. This equates to an honorarium of €127 (IR£100) a week to the practice per attached student (which is the current standard in all five departments). The department enjoys good accommodation and facilities within RCSI.
- 33** The professor is vice-dean for medical education and at present has responsibilities for exploring the possible introduction of a four-year graduate entry MB course, as well as for implementing changes relating to moving from a six to a five year basic undergraduate course. He is external examiner for the MSc course in primary care at the University of Ulster. He is a member of Council of the Association for the study of Medical Education (ASME). The course director of the MSc course in primary health care is also part-time registrar to the Sudden Infant Death Association.

University College Cork

- 34** UCC supported the development of the largest vocational training programme in general practice in the 1970s, but did not establish a chair in general practice until 1990. The first holder of the post took office in 1997.
- 35** The department teaches undergraduates in four of the five years of the MB course, running a family attachment scheme in year two, contributing to a short clinical introductory course which includes teaching on communication skills in year three, providing a morning attachment scheme to general practices in year four (each student attends on 16 mornings over four weeks), and a two-week full time attachment supported by seminar teaching in year five. The department also contributes to, but does not organise, teaching in behavioural sciences and in ethics. A particular feature of the department's educational activities is an unusually heavy burden of student assessment. The department contributes to a postgraduate diploma in health promotion and plans to develop (probably jointly with NUI, Galway) a modular masters programme in primary care which would use distance learning techniques. The department is also involved in supporting vocational training and continuing education in general practice, although without administrative responsibility for either. There are 120 students in each year, and the department teaches 5% of the complete course and 6.3% of the clinical course.
- 36** The UCC department probably has the most conceptually distinctive research profile of the five Irish departments. This is a natural progression from the work the professor brought with him to Cork, which included a long-standing interest and international reputation in the field of the determinants of the prescribing behaviour of doctors. His other expertise includes health services research, in particular relating to assessment of the delivery of quality of care in general practice. A part-time lecturer brings expertise in the fields of education and epidemiology (particularly relating to bowel cancer). A recently appointed research fellow has an interest in mental health. The department has attracted support for two research fellows from Wellcome and from the Health Research Board to further the professor's Prescribing Research Programme. The department has achieved published outputs in the international peer-reviewed journals of the discipline. Its research spend in 1999 was €25,000 (IR£20,000).
- 37** The professor has a part-time clinical attachment to a general practice in Cobh, to which he allocates between three and six sessions per week, but he has not yet been assigned a General Medical Services number and thus cannot earn GMS income. It is hoped that it will become possible to establish a clinical professorial unit by creating a partnership between a local group practice (which

is still in the process of being constituted), the Southern Health Board, and UCC. The total academic staff complement is eight, but only three have permanent contracts (all are doctors) and only the professor is funded on a full-time basis (the other two contracts add to one half-time post only). One of the temporary appointments is full-time (a social scientist). Three academic posts and a part of a fourth are funded by UCC. Some 80 general practitioners in 65 practices take students on attachments at a cost of some €73,500 (IR£58,000) per year. Funding for this has not been formally agreed, but has been accepted by the university on an annual (non-recurrent) basis thus far. The department shares leased accommodation with the Department of Epidemiology and Public Health near Cork city centre. The space is cramped and temporary staff lack their own office space, having to park out at unoccupied desks or in the computing laboratory (which is designated as a teaching facility). Being a small group without the backing of influential patronage in the medical school, the department feels vulnerable to plans within the university to reform faculty and departmental structures and to move to devolved budgeting.

- 38** The professor is active within the wider life of the university and faculty, being a member of the Student Discipline Committee, and the Board of Studies of the Centre for Adult and Continuing Education, and leading the faculty group on modularisation of the clinical course. He is involved with the cardiovascular forum at the Southern Health Board, with the diabetes task group of the ICGP, and with a voluntary organisation for the homeless in Cork. He is also Honorary Secretary of the ICGP and editor of the European Journal of General Practice, as well as being on the management committee of the UK-based Drug Utilisation Research Group.

University College Dublin

- 39** The first professor of general practice at UCD was appointed in 1991 within the department of public health medicine. The department of general practice became a separate academic unit in 1993, and in 1995 it integrated with the General Practice at Coombe Healthcare Centre to become a 'practice-based' department.
- 40** The department provides undergraduate teaching in years one, three, four and six of the MB course. In year one, the 'early patient contact' course includes a lecture block, visits to patients and health care sites and small group seminars. There is a separate contribution to the course on emergency care. In year three, the department teaches a communication skills module within the introductory clinical skills course. In year five, the department provides a lecture course and two-week clinical attachments to general practices for all students; there is also a contribution to the ethics course. In final year, the department contributes to the courses in obstetrics and paediatrics. There are currently 160 students in each clinical year. The department's contribution forms 5% of each student's complete MB course; however this represents year round teaching because of the small group teaching methods used. The department runs a master of medical sciences (GP) postgraduate course for an intake of up to 10 students each year, and provides courses on aviation medicine (for doctors), emergency medical technology (for ambulance personnel), and immediate care (for GPs and practice nurses, jointly with NUI, Galway and the ICGP). Since 1998, the department has supervised teaching at the Department of General Practice at Penang Medical College, a medical school run jointly by UCD and RCSI.
- 41** The department's principal research interest has been in the fields of intravenous drug abuse/HIV/infectious diseases and the evaluation of different approaches to the delivery of emergency care. These have brought publications in international peer-reviewed journals. The department has a wide range of other research commitment, both internally and jointly with others, covering work in the fields of diabetes, hypertension, health economics, IT, and inequity. In 2000, the research spend was around €76,000 (IR£60,000).
- 42** UCD funds the professor and two full-time medically-qualified lecturers. Only the professor's post

is tenured. Three of the four members of staff commit three sessions to the department's attached general practice. The department has obtained outside funding for four researchers (all non-medical; three full-time and one 0.8 of full-time). The practice funds a half-time medically qualified lecturer, a half-time general practitioner, a full-time practice nurse and two practice secretaries. UCD funds a full-time department administrator. Some 60 general practitioners take students on attachment at a total annual cost of €20,000 (IR£16,000), which is met from faculty teaching funds. The department's academic accommodation is adequate, but there is poor access to teaching facilities. The department sees forthcoming curriculum reform as an opportunity to increase its contribution, but is concerned at the increasing diffuseness of its activities as commitments increase without staffing to match.

- 43** The professor is president of the Medical Council, a substantial commitment involving an average of three half-days work per week; he is also a member of the Pre-hospital Emergency Care Council. Lecturers have roles in the ICGP's diabetes shared-care programme and research ethics committee.

National University of Ireland, Galway

- 44** The department of general practice was created out of a partnership between NUI, Galway and four health boards which was first agreed in 1991, with the eventual establishment of a department in 1997.
- 45** The department of general practice provides undergraduate education in years one, two and five. The largest education commitment is a three-week module to the MB course in the penultimate year of the course. Two weeks of the three are spent in full-time attachments to local practices, the third being made up of small group sessions within the department. The teaching is well rated by students, of whom there are 80 in each year. The department also arranges overseas elective exchanges with two students each visiting Western Australia and Washington, USA annually. Considerable effort has been invested in teacher training, and in recruiting and training simulated patients for communication skills teaching. The department has arranged for external teaching audit by an international expert in the field. The department's contribution represents 1.4% of the complete course, and 2.8% of the clinical course. The department contributes to an integrated early patient contact course in year one. A pilot course in early patient contact in the community in year two, was delivered in 2001 with full implementation planned for 2001/02. The department launched a new one-year diploma course in primary care in 2000 with the first cohort of students graduating in 2001. The programme is multi-disciplinary and has been strongly supported by the North Western Health Board. The external examiner to the course was closely involved in the development of the multi-institutional Scottish masters in primary care. Admission to a masters in primary care is planned for 2002/3. The department is also involved in supporting vocational training and continuing education in general practice, especially, in collaboration with UCD, in the area of immediate care.
- 46** The department has put considerable emphasis into developing a research programme of relevance to its local region, but at the same time of sufficient depth to produce results which have been published nationally and internationally. The programme has four distinct themes: rural medicine; management of cardiovascular disease in the community; the primary care/hospital service interface; and education. The programme embraces both quantitative and qualitative methods, and involves staff in other departments of NUI, Galway, local health boards and hospitals, and departments of general practice in other Irish medical schools. Four projects have received financial support from the Health Research Board, and a substantial grant was awarded by the North Western Health Board and the Department of Health. Two Health Research Board health service research fellows are based in the department and are pursuing PhDs. The typical average annual research spend is some €108,000 (IR£85,000). The department arranges a series of lunch-time seminars, video-conferenced to the North Western Health Board, on research issues. The department (with the Department of Health Promotion as the lead) was awarded, in 2000, €381,000 (IR£300,000) over

five years by the Health Research Board to establish a research unit in the area of 'Health Status and Health Gain'. In collaboration with Queens University Belfast, the department is the lead southern partner in a recent Health Research Board Cross-Border Health Services Research Grant of €305,500 (IR£240,000).

- 47** Ten names appear on the department's current staff list, but only the professor and three non-medical researchers have full-time contracts (and only the professor has a tenured post and funding from the founding partners group). Apart from the professor, the founding partners fund a half-time tutor in general practice and a secretary. The remaining staff are on part-time and short-term contracts supported by research money or by funding from the ICGP senior registrar scheme. The attachment scheme is made possible by the support of 12 practices in Galway city and a further 60 on the western seaboard. The costs of the attachment teaching total €29,200 (IR£23,000) per year which is met by the founding partners group. The university has developed a link with Turloughmore Health Centre which is a rural practice some 12 miles from Galway city, and the professor devotes four sessions a week to work with that practice. A new purpose built health centre, including educational facilities, was opened in 2002. The relationship between the university and the practice has been formalised with written contracts. The department's main facilities within NUI, Galway are just sufficient for its present commitments. The original consortium which established the department involved NUI, Galway and four geographically contiguous health boards, two of which had less involvement in the scheme and have since withdrawn. At present negotiations are proceeding to establish a second five-year understanding between NUI, Galway and the North Western and Western Health Boards to include the appointment of a tenured senior lectureship and a junior lectureship.
- 48** The professor is a member of the Scientific Advisory Group of the Meningitis Research Foundation in London, the Advisory Forum of the National Cardiovascular Strategy and of the Public Health and General Practice Committee of the Health Research Board. He is a member of Council of the ICGP and secretary of AUDGPI, as well as having responsibilities to several North Western and Western Health Board working groups. He has been involved in the production of primary care strategies for the North Western (1999) and Western Health Boards (2000). He is presently involved in the implementation groups for both these strategies. He holds an external examinership with the University of Birmingham and is a referee for national and international journals.

Common issues

It is clear from reviewing the five profiles above and the various annual reports and other documentation which the departments have available that a number of common issues are adversely affecting the evolution of general practice as an academic discipline in Ireland. Equally there are common strengths. This section looks at four issues, namely critical mass, teaching, research, and climate.

Critical mass

- 49** The five departments have a total of 39 members of staff on their roll. Only 22 of these have full-time contracts. Five are professors, and they are the only medically qualified staff with tenured full-time contracts. Part-time staff have an average commitment of four sessions per week.
- 50** There is a serious absence of experienced middle-grade staff. Only one person (a doctor) holds a senior lectureship. The majority of the 39 members of staff referred to above have less than two years experience in their posts, and had no previous experience of academic work when they were appointed. Only three social scientists hold full-time appointments, none of whom have tenured posts. Two of the three are employed on research grants.

- 51 There are no members of staff on research training posts. Three departments have doctors appointed through the ICGP senior registrar scheme, but their main commitment is to clinical work, and any academic training they receive is unstructured.
- 52 The net result of the staffing balance described in the preceding paragraphs, is an unhealthy and probably eventually unsustainable responsibility on the professorial heads of departments. Initially single-handedly, and more recently with minimal added support (although that support is from staff with an extraordinary commitment to the ideals that their departments espouse) they have combined the tasks of setting up undergraduate teaching programmes, developing post-graduate diploma and MSc courses, and promoting research both personally and corporately. In addition they see patients (particularly difficult for academics in the setting of general practice, where continuity of care is a defining characteristic of clinical work, and the clinical base is either in outlying surgeries or in patients' homes) on an average of three sessions per week. And finally they carry significant roles on behalf of the promotion and administration of both university and professional life, both locally and nationally.
- 53 It is uncertain what the greatest risks of this clearly inadequate staffing pattern is. One possibility is that the current group of professors will not stay the course unless they are more adequately supported. The second risk is that there will be no suitably qualified replacements for them; certainly if matters continue as at present none of them will be succeeded by academics with a background of academic life in Ireland. The third risk is that there will be no suitably trained staff to take up middle-grade opportunities when these become available, as this report hopes and concludes will become possible in the relatively near future. **Whatever the chances of academic general practice achieving the potential described in this report they are not possible with the levels and balance of staffing which pertain at present.**

Teaching

- 54 The five departments have made significant contributions to the teaching programmes in their individual medical schools. All have gained teaching time in several years of the curriculum. All contribute to the teaching of communication skills, several combining this with the provision of early clinical experience for students. The core undergraduate teaching contribution is through senior student teaching, always in small group format, and incorporating a period of attachment on a one-to-one basis to a local general practice. All departments have invested heavily in providing appropriate supporting course material. All departments have similarly invested in training for their general practice teachers. The teaching which is provided to undergraduates is almost all heavily labour intensive. The commitment to student assessment is also a substantial one, and indeed seems unrealistically heavy in several medical schools.
- 55 All five departments have worked hard to develop diploma/masters courses for doctors and other members of primary care teams. These have often been organised jointly with other departments. These courses have also required the generation of substantial supporting course material. The courses are heavily demanding on staff time (even when constructed to use distance learning techniques) and it is uncertain to what extent the numbers who will be recruited to these courses in the years ahead will justify the investment in them.
- 56 General practitioners enjoy the stimulus that an attached student gives to them. However, a student attached to a practice does require a time commitment from the doctor if the student's experience is to be other than that of a passive observer. At present most attachments are relatively short. Experience elsewhere in the world confirms that an increasing proportion of clinical teaching will move to the community as the nature of hospital practice becomes increasingly specialised and patient stays become shorter. Further, students can get only a limited understanding of the evolution of illness and of the meaning of continuity of care within patients and families from

attachments of only two weeks. If medical education evolves in Ireland as might be expected, medical schools are likely to depend on the availability of general practitioners to teach in their practices. It does not appear that there are consistent policies in place to fund this teaching. Sooner rather than later, this issue will have to be addressed.

Research

- 57** It is not surprising that the tradition of research has not yet become as well developed as has that of teaching. Although there are some examples of research developing on a multi-disciplinary, multi-method basis over time (notably in the fields of the study of intravenous drug misuse and of prescribing behaviour of doctors), it would be reasonable to say that the overall research profile is rather piecemeal in nature.
- 58** Much of the research currently being undertaken appears to be reactive to what are perceived to be the clinical opportunities of the time, and is quite properly undertaken on a collaborative basis with colleagues in specialist practice. Such research has traditionally been easier to fund than work on the general nature of care in general practice.
- 59** It is perhaps disappointing that relatively little research is currently in hand which could be described as specific to general practice. There remains a need to track the natural history of illness in the community, and to increase understanding of the core issues which make general practice care different from that delivered in hospital (for example the influence of continuity of care and the importance of the holistic approach to clinical decision making).
- 60** Training in research method and experience of conducting research are part of the career pathways for the majority of young doctors in training for hospital specialties. There are no similar opportunities for doctors entering careers in general practice.
- 61** Research funding is at a premium in Ireland. It is relatively hard to attract funding from the Health Research Board for work that is outside the area of biomedicine, and medical charities focus on supporting work within their particular field of interest. There is no body with a particular commitment to funding research or research training in general practice/primary care, and it is unrealistic to expect a rapid upturn in the quantity and quality of research being undertaken while the position remains as at present.

Climate

- 62** It is the lot of a new discipline to have to compete for recognition and support against those who will be asked to make concessions for it to have a chance to grow. This is a particular problem when overall levels of resourcing are shrinking and when other new competing areas are inherently more glamorous.
- 63** Nevertheless it is clear that departments of general practice have become disadvantaged compared to others within faculties of medicine in terms of staffing and infrastructure support. Their average share of funding support appears to be in the region of as little as 1% of disposable faculty budgets. This is compounded by their relatively disadvantageous position in relation to research funding.
- 64** Equally important is the ambivalence of support for academic general practice from the discipline of general practice itself. General practitioners fear that ‘academics’ will criticise the work they do, call for the application of inappropriate measures of performance to their daily work, and promote unwanted ‘modernisation’ of their part of the profession. Similarly, the institutions of general practice have understandable concerns that a small group of articulate though atypical colleagues will reduce their political influence both within the profession and with government.

Chapter 3

The funding of academic medicine

This chapter starts by describing in broad outline the way in which academic medicine is funded in Ireland. It then describes the position in Scotland, perhaps the country whose size and approach to the organisation of medical education is most similar to that in Ireland. In the second section, particular comment is made on how the problems relating to the particular position of academic general practice (which underlie the preparation of this report) have been addressed in Scotland, and refers to separate initiatives to support primary care research in Australia and in Norway, both of which are relevant to the position in Ireland.

The position in Ireland

65 The funding of medical education worldwide has lain uneasily across the boundaries of ministries of education and health, and the position in Ireland is no different. The principal explicit funding agency is the Higher Education Authority, but the Department of Health and Children (DoHC) makes a substantial hidden contribution through its funding of teaching hospitals.

The Higher Education Authority block grant

66 The Higher Education Authority provides the core funding to universities and a number of other institutions through the allocation of block grants. The amount of funds for the different sectors of the education system, is decided by government after considering submissions from the HEA and other agencies. As is the case in most comparable countries, universities guard their autonomy jealously and have a degree of discretion over how they spend the budgets allocated to them, but observe government policy in regard to wage policy to whom they are ultimately accountable for their use of state funds. The amounts allocated to them do reflect unit costs of various types of students.

Within medicine, the HEA funds on average, a total EU student population of 1,800 students per annum. This excludes the RCSI which is not yet funded through the HEA. The unit cost per student is currently €7,135 (IR£5,619), apportioned between staff costs (around 70% of allocations), and other academic infrastructure costs. This means that the direct contribution from HEA funding to medical education is in the order of €12.7m (IR£10m) per annum.

Research initiatives

67 The block grant referred to above includes a separate element to support the routine infrastructure costs needed by institutions to support research. However, the government has recently provided major funding to support significant new initiatives in the research activities of the higher education institutions €700m (IR£550m in the years 2000/06). The funding, which is provided on a competitive basis may be used to support both capital and recurrent costs, and to promote capacity building. Collaborative bids are seen as desirable. Funding is accessed through an annual funding round, interested parties going through a two-tier bidding process using standard published procedures. Thus far, no institutional proposal has included a project involving academic general practice, partly because the mechanisms are seen as requiring an unrealistic amount of time for a small group of academics with no spare resource, and partly because of the perception that the kind of research that departments of general practice wish to undertake is not regarded as of sufficient theoretical interest to command support. Indeed the call for applications has specifically excluded 'health care' from the preferred agenda and has emphasised the intended focus on basic sciences, and also requires that bids are in areas that institutions have identified in their strategic plan. As yet no institution has identified general practice in this way.

Postgraduate medicine

68 The HEA additionally funds taught courses in postgraduate medicine, and an element of postgraduate research infrastructure. Colleges indicate the courses and student numbers taught and a unit cost is then calculated. In 1998/99, 1,040 students were taught at a unit cost of €6,650 (IR£5,238). Three hundred and forty eight postgraduate research students attract funding at the level of €25,646 (IR£20,198) each, of which little or any is applied to general practice.

The Department of Health and Children

69 The current (2001) budget for the health service in Ireland is €6.7b (IR£5.3b). This represents a 23% uplift over the previous financial year, and includes an earmarked component for 'service development' representing 8% of the total budget. Given that the population of Ireland is 3.8m, then the per capita spend on Health is around €1,904 (IR£1,500), a figure approaching twice that which applied in the UK prior to the increases announced there during 2000/1, but still to be applied.

Service improvement

70 The 8% of DoHC funding identified to support 'service improvement' (*see paragraph 69*) has been stated as being 'to improve quality, access, equity, patient-centredness and accountability'. These are all areas where the contribution of general practice to patient experience will be of particular relevance, and where the contribution of academic general practice staff to their conceptualisation, delivery and evaluation will be essential. As yet, no explicit spend against this budget has been identified in the general practice/primary care arena.

Arrangements in hospitals

71 At the present time there is no explicit formula applied to determine the funding of hospitals which provide general and acute care, and no method of differentiating between the costs of teaching and non-teaching hospitals. It is, however, recognised that a trade-off exists between 'academic' and 'service' medicine across the health and education sectors. In general, the cost of academic clinical posts is split variably between the health service and the medical school; health service consultants who teach receive an honorarium from the university for doing so.

72 How accurately these arrangements reflect the value of academic and clinical medicine to each other is almost certainly too difficult to determine. Probably wisely, it has been accepted that

arrangements which have developed on a largely historic basis should be left as they are, and recognised that attempts to cost such ‘knock-for-knock’ exchanges are unlikely to produce either meaningful or generalisable results.

Arrangements in general practice

73 Approximately one-third of the population have their ‘general medical service’ (general practitioner) costs met from the health service budget. Full-time university-based academic general practitioners (and this at present implies only the five professors) generally receive payment packages which equate to those of other clinical academic professors. Those at more junior levels and with posts split between service and academic contracts are significantly disadvantaged in comparison with full-time service general practitioners and with clinical academics in hospital medicine. Any remuneration paid to service general practitioners for teaching undergraduate students in their practices is fully met by the medical schools for whom they are teaching. The rate of remuneration has been arbitrarily set at around €127 (IR£100) for a week-long attachment. It is generally agreed that having a student attached to a practice results in clinical care taking longer to provide. Using the reasonable assumption that student teaching adds ten hours per week to ‘clinical time’, this means that student teaching is being rewarded at around €12.7 (IR£10) per hour. (The fee for other external teachers brought in to support medical school teaching is normally €127 (IR£100) for a three-hour session).

The Postgraduate Medical and Dental Board

74 The Postgraduate Medical and Dental Board has statutory responsibility to promote the development of postgraduate medical and dental education and training and to co-ordinate such developments; to advise the minister on all relevant matters, including financial matters; and to provide career guidance for registered medical practitioners.

75 The board collaborates with the recognised professional training bodies, (the ICGP in respect of general practice), in carrying out its functions. The Board approves and provides funding to the professional bodies for structured training programmes and continuing medical education. Currently the board funds the appointments of the national and assistant directors of continuing medical education and of 30 GP CME tutor appointments under the aegis of the ICGP, funding for a number of GP specialist training programmes and the ICGP Postgraduate Resource Centre. The board also employs a regional network of postgraduate co-ordinators. The co-ordinators assist the board in co-ordinating and facilitating structured training and continuing education at regional level for all categories of the medical profession. The board has recently invited proposals for the introduction and implementation of further systems of quality assurance and quality improvement in respect of the CME structure. The board’s remit does not include research. In the year 2000, the board expended €4.8m (IR£3.8m) on its education and training functions, of which €1.02m (IR£0.8m) (21%) related to general practice.

76 Vocational training for general practice is funded by the ten health boards (*see paragraph 81 below*). Through funding provided by The Postgraduate Medical and Dental Board (*see paragraph 75 above*), the health boards employ the ten programme directors, the assistant programme directors and secretaries, as well as the cost incurred in running the day release programmes, in their respective health board areas. The health boards also pay a training grant of the order of €8,888 (IR£7,000) p.a. to each training practice to cover the costs incurred by practices in having a trainee attached. The salaries of trainees during their SHO posts in hospitals are paid by their respective hospital employers whereas their third training year (the registrar/trainee year) is funded by the health board with responsibility for their training scheme.

Training for academic medicine

77 Doctors training for academic medicine in hospital share a common training pathway with those who wish to follow a full-time clinical career. During that training they have natural opportunities to acquire experience of research and to contribute to the teaching of students in the hospital setting. On the other hand, those training for general practice will not normally be introduced to either research or teaching in the course of their postgraduate experience. The exception to this has been the recent ICGP initiative where a limited number of fellowships/senior registrars (the aim is to place one in each medical school department of general practice) have been created to allow around half the time of an appointee to be devoted to teaching and research during a two-year appointment. These posts have been supported with DoHC funding.

The Health Research Board

78 In January 2000, the Health Research Board published a consultative document entitled *Towards a Strategy for Research and Innovation for Health*. It identified the then current HRB support in the fields of biomedical and health related biological sciences research, epidemiology, health services research, health research and practice-based research, and asked, among other questions, whether there were gaps in the health-related research which was being carried out. It identified that only 0.26% of the health spend €10.8m (IR£8.49m) went on research expenditure, and of that only €6.3m (IR£5.1m) was allocated for the HRB to spend. These low figures were recognised as being lower than those for 12 comparator EU countries. Plans are now in place to increase the HRB budget.

79 In identifying priorities for Health Research, the HRB referred to the need to increase available levels of funding, the need to support research infrastructure, and the need to link basic and clinical science through the support of research units. The need for appropriate career structures for researchers was also emphasised. In the sections relating to epidemiology, health research and practice-based research, there was virtually no reference to potential or actual contributions from general practice, although the document did include three pertinent questions:

- How should research in the personal social services be addressed?
- Should there be agreed research agendas for priority objectives of the health services?
- If there should be such research agendas, how should they be agreed and financed?

80 Until recently, the HRB has supported little in the way of project or programme work from the field of general practice. However, the recent policy initiative to support ten programmes of research at the level of €1.27m (IR£1m) over five years and including one in general practice offers an opportunity for progress. Even an initiative of this size, however, quickly reduces when expressed as an annual figure, divided amongst several collaborators, and having to bear the project overhead costs which so rapidly eat into costs. The basic problem of ‘capacity building’ will still require to be addressed by complementary strategies from a combination of sources. The provision of hospital research consultants offers another model to address the capacity deficit in general practice research.

The health boards

81 The ten health boards receive money from the Department of Health and Children to support hospital and community services in their localities. The health boards carry the costs of local vocational training schemes for general practice, but there are no specific requirements placed on them to support undergraduate education in general practice, or to promote R&D in their localities. But neither are there any barriers to them doing so where this is seen to offer medium or longer term benefit to their communities, and the promotion of primary care R&D may well follow as a consequence of ‘rolling out’ the DoHC’s own R&D strategy.

82 In 1997, the Midland, Mid-Western, North-Western and Western Health Boards joined as a founding partners group to support the development of the Department of General Practice at NUI,

Galway. At the present time, a new five-year plan involving NUI, Galway, North-Western and Western Health Boards aims to consolidate the core educational and research activities of the university department and at the same time expand and make explicit the contribution of the department to the supporting health boards.

The position in comparable countries

Various means of addressing the problems of the inevitably high costs of supporting education and R&D in clinical medicine have been developed in different countries. Initially most have evolved on a chance basis rather than being developed from basic principles. As issues like value-for-money and transparency have assumed centre stage in countries attempting to contain the costs of both education and healthcare, so attempts have been made to rationalise systems which have proved to be effective. This has tended to highlight where further gaps exist, in turn leading to the fashioning of solutions to meet identified needs. In this section, the history of the evolution of funding arrangements in Scotland is described in some detail, as it highlights issues particularly relevant to the setting of academic medicine in Ireland. Specific comment will then be made on the position relating to academic general practice, concluding with short notes on two schemes which have helped achieve important progress in Australia and in Norway.

Scotland

- 83** In 1974, The Scottish Office started an attempt to rationalise the costs of the National Health Service aiming to create a model for the allocation of resources based on population and needs. The results of this process were published as the SHARE report (*Scottish Health Services Revenue Equalisation*) in 1978 which has been the baseline for significant change in the years since. The issue of principle, most relevant to this report was the recognition that teaching hospitals had become progressively more expensive than district general hospitals, and that any resource allocation formula had to recognise that the reasons for this included the more complex case-mix handled in teaching hospitals, the higher levels of medical and nurse staffing required to support the teaching of students and doctors in training grades, and to underpin the overheads associated with a clinical research capacity.
- 84** A similar and contemporaneous project took place in England and Wales, and agreement was reached between the two projects that the Additional Cost of Teaching (ACT in Scotland; also known as the Service Increment for Teaching – SIFT – in England) represented three-quarters of the difference between the average cost of a group of teaching hospitals and a matched group of non-teaching hospitals. The sum was divided by the number of clinical undergraduates in training at that time and a weighting of €13,585 (Stg£8,372) per clinical student per year identified as the support given (and required) from the National Health Service to the Department of Education to enable clinical teaching to be achieved within the budget otherwise available to university medical schools.
- 85** In the years since, the figure has risen progressively to match inflation, and by 1990 had reached €73,021 (Stg£45,000) per clinical student per year – a figure substantially exceeding the target medical school unit cost of just below €14,603 (Stg£9,000) per clinical student provided from university funding. In the UK reforms of the early 1990s, 8% was added to the ACT/SIFT budget to recognise the increasing costs of supporting research infrastructure. However, with later policies leading to the creation of a competitive funding market for NHS R&D, 25% was deducted from the ACT/SIFT budgets and allocated to the NHS R&D budget, the remaining 75% remaining as the NHS support component for medical education.
- 86** One problem of this system was that this stream of NHS funding was a rationalisation of an historic

funding stream, and was not in fact ‘cash’ available for easy redistribution. Nevertheless, as moves to transfer more undergraduate teaching to district hospitals were put in place, it became necessary to identify an element of teaching support funding which would ‘follow the student’. In order to protect the infrastructure funding of teaching hospitals, it was agreed (explicitly in England but not in Scotland) that around 70% of SIFT would stay in teaching hospitals as fixed basic support funding, and that the remaining 30% would be identified as teaching fees and be available for transfer when teaching took place elsewhere. In recent years as the system has become more sophisticated, the core funding element has been re-defined as making up a proportion (nominally around one session a week) of all consultant posts in recognition of their responsibility to help with clinical teaching. The practical effect of the ACT/SIFT support mechanism is that the sum available in the ACT budget in a typical medical school area may now be twice that available through the University Funding Council (the equivalent of the HEA).

- 87** Throughout the early years of the period described above, general practice was excluded from any of the hidden or explicit benefits of NHS funding support for its undergraduate teaching activities. This was acknowledged to be an inappropriate and perverse result of earlier assumptions that all clinical teaching (and indeed research) would normally be hospital based. However, by 1990, the NHS had recognised that it had a responsibility for supporting the extra teaching costs associated with the longer time required for teaching surgeries in the service general practice setting. An item-of-service NHS fee for undergraduate teaching was introduced; this is now set at between €40 (Stg£25) and €49 (Stg£30) for a surgery session. In 1993, the NHS further agreed to make some ‘infrastructure’ funding available to departments of general practice to help with capacity building and to provide support to free up some of the time spent by full-time academic general practitioners in their practices.
- 88** In Scotland, the unofficial target is that 5% of ACT should eventually be available as ‘real’ money to support the academic activities of general practice. In practice, the figure now lies between 4% and 5%; the implication is that a typical department of general practice in a population centre of 750,000, might have available in the region of €1.62m (Stg£1m) of NHS ACT support, around 60% going to pay fees to practices with teaching commitments, and 40% supporting the in-house activities of the department. Both these elements would substantially exceed the infrastructure funding available through the medical school. A department of general practice in Scotland/ UK will now typically teach 10% of the clinical curriculum.

The Scottish School of Primary Care

- 89** In 1999, following a joint initiative by The Royal College of General Practitioners, the Scottish Council for Postgraduate Medical and Dental Education, and leaders of the undergraduate and post-graduate departments of general practice, agreement was reached to create a ‘virtual’ Scottish school of primary care. After a two year period of trial funding from the Chief Scientist Office and from the Scottish Higher Education Funding Council, the school has now secured funding for a further period of eight years. Its remit includes commissioning primary care R&D, supporting higher training fellows and mounting an MSc programme for primary care professionals. The school was initially led by a part-time social science academic on secondment from a department of general practice, who became full-time director at the start of 2002.

Australia

- 90** The Australian academic scene has much in common with that prevailing in Ireland. Its university funding stream makes no real concessions to the higher costs of clinical medical education, and its Department of Health – while recognising that teaching hospitals subsidise clinical teaching – has neither tried to cost the support provided nor to fashion an equivalent element of support for teaching undertaken in general practice or by departments of general practice. Up to some ten years ago, the result was that many of the country’s departments of general practice were too small to be

properly viable, and the academic work they were able to undertake was reactive and small scale rather than proactive and substantial.

- 91** In 1992, the Department of Health and Housing committed a significant sum of money (around €1.17m (AUD\$2m) over three years) to an R&D programme entitled *The General Practice Evaluation Programme* (GPEP). GPEP has supported project and programme developments both inside and outside academic departments and has been available to all primary care professionals and to social scientists working in the primary care field. The programme also funded a specialist support team (initially within a Department of Epidemiology) to run training courses and provide support to individual researchers in its early years, and has supported an annual conference and a quarterly newsletter. The cumulative results of nearly ten years of funding has been the creation of a substantial and diverse research capacity in the primary care arena, now in turn able to offer support to the new divisions of primary care around which primary care services in Australia are being increasingly centred. In recent years, the level of funding has arisen to €2.76m (AUD\$4.7m. per annum.

Norway

- 92** In the mid 1980s, the Norwegian Medical Research Council recognised that there was an absence of research proposals and of research capacity in the primary care arena and responded by creating twelve three-year research training fellowships in each of three consecutive years. The fellows were again supported by experienced researchers both through training modules and by personal project supervision.
- 93** To external eyes, the scheme was successful, and the product of it is now visible in a much stronger academic and primary care R&D capacity than existed previously. However, the Norwegian MRC's 'performance indicator' was the completion by fellows of PhD theses within five years of setting out on their training. At the time of the deciding evaluation, one third of the fellows had graduated PhD, a third still appeared to be in a position to obtain their higher degrees, and the last third had not made enough progress to have a realistic chance of success. Although this success rate would have appeared encouraging in a field with relatively undeveloped traditions in R&D, it was felt too low by its more traditionally biomedically orientated sponsors and the scheme was discontinued.

Conclusions

- 94** The funding of academic clinical medicine relies on the combination of resources from universities and from departments of health, the second being provided mainly through the resources of teaching hospitals. Most arrangements have evolved reactively on a local and historic basis. This policy is ill-suited to dealing equitably with a new discipline, and this problem is magnified when that new discipline is based outwith the hospital setting and in the community where no comparable traditions of teaching and research exist.
- 95** There are examples of systems which have evolved to quantify and then to redistribute the Health Department 'subsidy' to clinical academic medicine through the historically more generous staffing of teaching hospitals which has allowed clinical medicine to survive world-wide. Perhaps the best developed of these is that found in Scotland/UK, and known as ACT in Scotland and SIFT in England.
- 96** In recent years analogues of the ACT and SIFT systems have been developed to support the activities of departments of academic general practice, with the result that such departments are relatively well resourced in terms of numbers and skill-mix of staff members, have greatly extended their contribution to undergraduate clinical teaching (with great acceptability to students), and are steadily developing the research capacity expected of any academic clinical discipline.

- 97** Other attempts to develop the research capacity in academic general practice/primary care are being or have been tried in countries of similar size and with health services comparable to those in Ireland, and valuable lessons can be learned from studying them.

Chapter 4

Present needs and possible solutions

In this concluding chapter, a ‘wish-list’ of needs is identified, achievement of all of which may be a medium term (say three to five year) goal rather than an immediate aspiration. Finally, the chapter discusses the structural and funding issues that are implicit in the earlier paragraphs of the chapter.

The ‘needs’ of the discipline

98 In setting out a resource ‘wish list’ for the academic discipline of general practice, it is probably helpful to re-use the headings used already in this report. Although this part of the report cannot look other than a request for new or protected funding support for a special interest, the thrust of the whole document continues to be that the overall interests of patients – through promotion of better teaching and research in the community – will be materially improved by the ‘academic wing’ of the general practice sector being adequately and securely underpinned.

Philosophy/advocacy

99 In the fast-changing world of scientific discovery, of the explosive development of IT, and of the increasingly complex ethical issues that follow from their interaction, the concepts of philosophy and advocacy sketched out in *paragraphs 14, 15 and 21* can be seen to encompass a necessary but as yet under-developed contribution which academic general practice is ideally placed to contribute.

100 In *Chapter 2*, the issues of ‘critical mass’ were discussed in *paragraphs 49-53*. The fact that the five professors are at present the **only** tenured medically qualified staff in the five departments of general practice reflects an untenable base both for sustaining the status quo in the medium term, and for forming a base for future growth or succession. For proper development of the agendas implicit in this report, it is equally important that departments should include senior tenured staff from the social sciences, able to take their share of responsibilities for headship as well as for developing the internal and external roles appropriate to senior academic personnel.

101 **Each department should have three tenured staff at senior level, preferably two of whom would hold professorships, and two of whom would be medically qualified and one a social scientist.**

102 Any properly balanced enterprise requires a proportion of middle-grade staff, experienced enough to undertake the full range of activities of senior staff, and expecting to or able to gain promotion

to senior leadership positions when these become available. The complete absence of personnel in this position in the five departments represents a warning about the urgency of providing an adequate base for the future of the discipline.

103 Each department should have two members of staff at lecturer level, at least one of whom should be medically qualified. These posts might be tenured, but should at least carry five-year terms of contract and be renewable.

104 Although it is now common for academic staff to undertake a substantial proportion of their own clerical and secretarial work, departments of general practice connect to widely dispersed networks (particularly for teaching) in the community, and require full-time secretarial support.

105 Each department requires full-time and experienced secretarial support.

106 Financial implications: The core staff ‘needs’ listed in *paragraphs 101, 103 and 105* will not, of course, all represent new costs, as all departments already include professors and secretarial support at varying levels. The creation of, say, four new posts in each medical school at the levels suggested could be achieved for an outlay of just over €380k (IR£300k) per school; with the addition of a modest secretarial supplement, the required new budget would not exceed €406k (IR£320k) per department. A pro rata contribution to the needs of the department at RCSI, would bring the total of new funding required to around €2m (IR£1.6m).

Teaching

107 The core teaching activity of the departments of general practice will continue to be in the undergraduate curriculum. In keeping with world-wide trends, it is likely that the proportion of teaching undertaken in the community will increase significantly over the next decade. With the improved staffing structure envisaged in the previous paragraphs, there should be adequate core staff to deliver the teaching on core principles and theory, but attachment teaching to service general practitioners will become an even more important component of the teaching programme of medical schools than it is now.

108 General practitioners who teach students in their practices will increasingly expect to be trained for the task, and to teach within a specified curriculum for which a degree of preparation is needed, and protected extended consulting time when students are present is built in to the day’s work. The present ‘going rate’ for attachment teaching of €127 (IR£100) per week does not reflect what will be appropriate for the task in the future. It is worth commenting on the fact that this was the rate which applied in the UK until the major review of the funding of community-based teaching which reformed the position from 1990 onwards, since when the average rate has been in excess of €405 (Stg£250) per week. In return, general practitioners teaching students now normally have formal contracts to deliver the teaching programmes of the local department, and are accountable for delivering the teaching expected.

109 Student attachments to general practices should be funded at the rate of €317 (IR£250) per week.

110 Departments of general practice also have postgraduate teaching commitments. These have been referred to in *paragraph 55 of Chapter 2*, and include the organisation and delivery of MSc courses and the training of individual doctors and social scientists in the research methods appropriate to community-based research. These activities will continue, although there is a case for looking at alternative ways of resourcing these activities. If the infrastructure issues addressed in *paragraphs 99-106* are able to be resolved, no additional staffing resources would need to be identified under this head.

- 111** Although medical schools see competition for fee-paying postgraduate students as an important part of their futures, for general practice in Ireland it would make more sense to promote a modular all-Ireland diploma/MSc in primary care (including training in research methods appropriate to community-based research), and for each department to contribute a component to it. Staff of departments also have the role of contributing to vocational training and to continuing medical education on both a local and a national basis, as well as to providing training for future academic staff holding junior posts in their departments.
- 112 The way in which MSc courses are delivered, and the training of future community-based research workers is organised, need to be re-examined on an all-Ireland basis.**
- 113 Financial implications:** The cost of providing attachment teaching for some 500 students for four weeks each year at €317 (IR£250) per week would be €635k (IR£500k) per annum. It appears that around €127k (IR£100k) is already being provided by medical schools for this purpose.

Research

- 114** Research is a core activity of any university department, and ought to be a prominent consideration in the organisation of all health service activities. It should also be a component of the day-to-day portfolio of skills all health professionals espouse. In *paragraphs 19-20 in Chapter 1* and in *paragraphs 57-64 of Chapter 2*, the very real difficulties which apply in terms of culture, training and funding have been outlined.
- 115** When work on this report started, a postgraduate training scheme supported by funds from the DoHC and under the direction of the ICGP was already in place (*see paragraph 77*), supporting higher training fellowships in three of the Irish departments of general practice. The purposes of this scheme include gaining awareness of research methods – and possibly undertaking some original work – but are broader than simply training for a career including or centring on research. We recommend that this scheme be extended, ideally to allow ten registrars (two in each medical school) to have two years of such experience. A cadre of ten registrars (five appointed each year) would provide a critical mass who would feed on the group’s own development and could participate in a mix of structured training experiences and individual learning.
- 116 The present scheme for academic training for general practice senior registrars (directed by the ICGP) should be extended to ten posts of two years (five new appointments per year)**
- 117** Although these training posts are an excellent contribution to addressing the long-term development of Irish general practice, another gap exists in the provision of opportunities for new or established general practitioners to acquire training in research methods or to undertake significant original work in a supported/protected environment. We were impressed by the Norwegian PhD programme as a model which might be reproduced in Ireland (*see paragraphs 92-93*). Under normal PhD regulations, three years of full-time study or four years of part-time study are required, and the number, placing and timing of posts in such a programme would need to be thought through further and be flexible. Initially we suggest appointing three doctors per annum over a four-year experimental period. Supervision could either be provided at local departmental level, or by a senior national academic/researcher with protected time for the purpose. Although this suggestion presently relates to medically qualified staff, it could be extended to other health professionals and to social scientists.
- 118 The possibility of developing a PhD programme for general practice should be explored.**
- 119** The absence of ear-marked funds to support research in or relating to general practice/primary care has been referred to earlier (*for example paragraph 11*). The new protected funding from

HRB for general practice/primary care (*paragraph 80*) will contribute around €254k (IR£200k) per annum for such purposes. Welcome although this will be, more funding than this will be necessary to create the critical mass of evidence-based activity to properly underpin service provision at local and national level. Health boards have the potential to fund such work, either directly through project support or indirectly through providing infrastructure support (*see paragraph 82*) and we would like to encourage all health boards to contribute to this work.

120 Further ear-marked funding to support research programme/project work is needed.

121 Financial implications: Ten posts for ‘academic senior registrars’ would cost €762,000 (IR£600,000) per annum; a PhD programme with three posts appointed annually would cost around €127,000k (IR£100,000k) to start with if the doctors were working part-time, this rising to €508,000k (IR£400,000k) in year four. If the health boards contributed the same sum between them as the HRB has indicated, this would provide a further €254k (IR£200k) per annum. Thus, a funding requirement of up to around €1.5m (IR£1.2m) per annum could be envisaged; at present around €254k (IR£200k) is probably already ‘in the system’, leaving a shortfall of €1.27m (IR£1m).

122 It is immediately clear that within the near future, the academic profile described in *Chapter 1* and implicit in the proposals listed above, is outside the reach of most of the five departments of general practice individually. However, it is not unrealistic to argue that the five departments working together could achieve such a profile on a collaborative basis. This could be achieved either through a national centre based in one of the medical schools, or through a ‘virtual’ centre or ‘institute without walls’ to which all departments contributed. At first sight, the second option seems much the more attractive, not least because it is the more inclusive. Such a centre would require some infrastructure support, and would probably be best managed by a researcher with some years post-PhD experience and either epidemiological or social science research experience or both. It would also require an acceptance from the institutions whose departments were to take part, that collaboration rather than competition in the research arena was an acceptable way forward for this discipline.

123 Summary

- **philosophy/advocacy:** The new infrastructure support required for core-staff as described above appears to be in the order of €2m (IR£1.6m) per annum.
- **teaching:** The additional funding required to support practice attachments at the level proposed is €508k (IR£400k) per annum.
- **research:** The additional funding required to support research (including postgraduate training) is €1.27m (IR£1m) per annum.

Total: €3.81m (IR£3m) per annum

Structure and funding

Principles

Before presenting suggestions about how the package outlined above might be funded and administered, it seems appropriate to define the principles which underpin them.

Partnership

124 The first of the principles is **partnership**. This applies at three levels. The first is **between institutions**. In the present day higher education environment, the five Irish medical schools are undoubtedly competing against each other for resource and prestige. That inevitably leads to duplication of initiatives and limits the opportunities for less well developed disciplines to benefit from the advantages of sharing strengths and resources. We strongly recommend that in the

situation presently faced by the discipline of general practice, the five departments in Ireland are encouraged to work together, not simply in spirit – as they already do – but in practical terms through greater sharing of educational and research partnerships than is the case at present.

- 125** The second level at which we hope to see partnership at work is **between funding bodies**. Between *paragraphs 66 and 82 in Chapter 3*, we identified five major interest groups who contribute to the funding of medical education (at undergraduate and postgraduate level) and of clinical care for patients. The two principal ones are the Higher Education Authority and the Department of Health and Children, but their boundaries are not absolute, and the Postgraduate Medical and Dental Board, the Health Research Board and the individual health boards all serve specific functions within their broad umbrella. From our informal discussions, it seems that all five bodies recognise the importance of the issues raised in this report, are aware of the difficulties faced by the departments of general practice in finding mechanisms to resolve these difficulties, and would be willing to contribute to a negotiated way forward.
- 126** Third is the issue of partnership **within the field of general practice itself**. As in other countries, a tension exists between service doctors and those bodies who work with them either educationally or politically. The ICGP, the Irish Medical Organisation (IMO) and the AUDGPI (the Association of University Departments of general practice in Ireland) are all in this position. It is essential that for the proposals in this report to work to their best advantage, all involved are comfortable with the contributions of each other.

Focus

- 127** This report has moved between discussing the needs of academic medicine and of the health service. The second principle we wish to centre on is that of **focus**. We believe that this initiative should be seen as firmly positioned in trying to improve the care offered to patients in the community. This involves improving the medical education of all doctors, no matter whether their careers will be in hospital, community or administrative practice. It involves continuing education of those whose careers are in community practice. It also involves improving the ‘evidence base’ for health care delivery, both at individual consultations and in terms of its organisation more generally. Thus the issues of philosophy and advocacy, teaching and research must be taken forward with the clear intention of making a measurable impression on the quality of care received by patients in the community. At present the focus of the report is undeniably on medical practice. This is because it is the setting in which the problems have been recognised. We would like to make it clear that by ‘general practice’ we include all the professional groups that contribute to care in the general practice setting; and by ‘academic general practice’ we include the social science disciplines which contribute essential input to their work. For some parts of our package, activities and their impact will have a local focus; for others the focus will be national.

Quality

- 128** The world-wide emphasis on ‘value-for-money’ which disturbed both institutional and personal complacency in the fields of education and of health service provision about a decade ago, undeniably brought important improvements in both efficiency and effectiveness. However, many (or probably most) who work to deliver these services now feel that quality is being compromised by unrealistic expectations and requirements of managers to continue a process that seems to have achieved all it can safely do. The third principle behind this report is that of achieving quality in the initiatives it promotes. We urge, therefore, that commitment to the proposals we make is at an adequate level (particularly in terms of achieving a critical mass of staff) to allow the work undertaken to be done properly. The present expectations on staff (senior staff in particular) are, we believe, unrealistic and cannot be met at the level of quality that is acceptable to the staff

themselves. The position creates dissatisfaction and demotivation, and may soon prove to be unsustainable. At the same time we welcome the concept of accountability, and will encourage both individual appraisal and institutional review of any appointments and structures which emerge as a consequence of this report.

Recommendations

- 129** In formulating the recommendations on ways to fund and structure the package we feel necessary to achieve our aims, as well as suggesting the use of existing mechanisms, we will draw on four successful support systems referred to in earlier paragraphs. These are:
- the senior registrar academic practice scheme funded by the Department of Health and Children and directed by the ICGP, which is referred to in *paragraph 77*;
 - the Scottish Health Service support scheme for clinical teaching and its infrastructure known as GPACT (Addition for Clinical Teaching) which is described in *paragraphs 83-88*;
 - the programme to fund research projects and programmes in primary care, and to support the development of a trained workforce, which has operated in Australia and is known as the General Practice Evaluation Programme (GPEP). It is described in *paragraphs 90-91*;
 - the primary care PhD programme funded by the Norwegian Medical Research Council which is described in *paragraphs 92-93*;
- 130** We have also followed the creation of the Scottish School of Primary Care (*paragraph 89*) and think the ideas on which it has been created could be adapted to help forward the position in Ireland.

Locally managed initiatives

- 131 Medical school support:** Perhaps not surprisingly, we found it almost impossible to determine how much resource was available within university medical schools. Although the figure made available to departments of general practice naturally varies from school to school, it seems that an average total of up to €254k (IR£200k) per department would not be far from the mark. This probably represents around 5% of available resources through the HEA. Given that the departments of general practice are now teaching around 5% of the curriculum in the five medical schools, this seems a reasonable share of available medical school resources. Of course medical school income includes income from non-EU students, making the share of total resource going to departments of general practice a considerably smaller proportion
- 132 Health service support for clinical teaching:** This is the most important of our recommendations. In *paragraphs 71-72*, we referred to the ‘internal market’ which exists in teaching hospitals and medical schools between clinical care on the one hand, and teaching and research on the other. This exists in all countries; the only one where we know that a serious attempt has been made to cost the market is the UK. In the end, the process was found to be too difficult to do reliably. Nevertheless, the component of UK NHS costs now regarded as supporting medical education/medical schools is very considerable. In Scotland the figure is €121m (Stg£75m). For around 750 medical students graduating annually, that represents an investment of some €162 Stg£100k per student over a complete course of training. The target is that 5% of that should become available to support clinical teaching in general practice, and thus far a figure of around 4% has been achieved. Considerable debate has arisen in the hospital sector as to how much of the support money should fund teaching fees, and how much should support ‘infrastructure’ (mainly salary costs), and the prevailing balance is around 70:30 infrastructure:fees. In the general practice setting the ratio is reversed in most schools, but that still allows considerable support for both staff costs and for fees to general practitioners taking students on attachments.
- 133** We cannot claim to be able to calculate a ‘true cost’ figure for what might be a support contribution from DoHC to teaching in general practice which would be analogous to the support which

is presently helping academic hospital medicine achieve its present level of efficiency and effectiveness. However, we understand (*paragraph 70*) that DoHC has identified an 8% increase in budget to support 'service improvement' and that general practice is regarded as an important target for that improvement. For the spirit of the proposals in this report to have a realistic chance of being met, it seems essential that DoHC makes a generous contribution.

We recommend that new funding of €5.7k (IR£4.5k) per graduating EU student per annum is made available to the departments of general practice; around three quarters of this would be used to fund the new posts identified in *paragraphs 99–106*. Investment at this level would provide new funding of €2m (IR£1.6m) per annum on the basis of 350 HEA-funded EU students graduating each year.

134 If this support became available, it would still require to be supplemented by existing sums of money presently being spent by medical schools on payments to service general practitioners.

135 Health board partnerships: Elsewhere in this chapter we expressed the hope that health boards would fund or continue to fund departments of general practice to undertake locally-relevant R&D projects (*paragraph 119*). We are aware that a significant partnership has already been developed between the North Western and Western Health Boards and the department at NUI, Galway (*see paragraphs 47 and 82*) and feel that it would be inappropriate to suggest here what sums other health boards might set-aside for similar local purposes.

Nationally managed initiatives

136 The MSc programme: We have already suggested in *paragraph 111* that it might make sense for the five departments to pool resources and teach a single diploma/MSc course on an all-Ireland basis. Different departments could take responsibility for individual modules, and distance learning methods supplemented by residential weekend/summer school activities could add opportunities for group and one-to-one teaching as required. A national scheme would not require additional funding, although we find it impossible to find out whether current postgraduate fees paid to institutions for MSc courses at present actually benefit directly those departments that teach them. We recognise that the awarding of degrees following centrally organised teaching may require negotiation between universities, but we would expect that difficulties should be able to be overcome.

We recommend that an all-Ireland MSc in primary care/general practice should replace the various local arrangements currently in operation.

137 A PhD programme: In *paragraph 117*, we proposed that a primary care/general practice PhD programme similar to that introduced in the 1980s in Norway should be developed. With three new entrants each year, and appointments being on a four-year part-time basis, the initial cost would be €127k (IR£100k) per annum rising to €508k (IR£400k) per annum when the scheme was fully operational. Although the intention would be to spread the appointments and supervisory responsibilities round the five departments, consideration would need to be given to where students were located. The complete programme would be best managed on a national basis, again with opportunities for students to share aspects of the teaching packages available. We are aware that the experiment in Norway was discontinued, but think that that decision was made prematurely. We would hope that a proper period would be allowed to give the scheme time to bed in and to attract good applicants.

We recommend the introduction of a national primary care/general practice PhD programme. We believe that mechanisms for funding the teaching of it are already available under present HEA practices. However, locum costs for participating GPs needs to be found.

138 Senior registrar/academic practice scheme: We believe that the current academic practice

senior registrar scheme should be extended as described in *paragraphs 115-116*. The scheme is presently funded by the DoHC, and we hope that that body would be willing to increase the resource spent in this way. If ten posts were eventually supported (five new appointments each year) the total cost would be around €760k (IR£600k) per annum, of which around €190k (IR£150k) per annum is already in the system. Again we would encourage the use of a national approach to making appointments and providing supervision (already in place).

We recommend extension of the present senior registrar/academic practice scheme.

139 A programme/project fund for primary care/general practice research: In *paragraph 119* we proposed the creation of a protected fund to support programme and project funding for research in primary care/general practice. We welcome the new proposal by the Health Research Board to invest €1.27m (IR£1m) over five years in a venture of this general kind. We have also suggested that, between them, the ten health boards (possibly excluding the North Western and Western Health Boards who are already committed to parallel investment) might contribute a similar sum to promote R&D which has national as well as local relevance. We are aware that the new Scottish School of Primary Care has been able to gain agreement for a similar investment from all thirteen Scottish equivalents to the Irish health boards.

We recommend the creation of a fund to support nationally relevant primary care/general practice research. We encourage the Health Research Board and the ten health boards to share the funding of this venture.

An Irish consortium for teaching and research in primary medical care

- 140** In *paragraphs 136-139*, we have suggested the creation of four national programmes of investment to promote the development of solutions to the problems facing the evolution of the academic component of the discipline of general practice which this report has identified. In *paragraph 89*, we described the creation of the Scottish School of Primary Care, and we believe that a similar venture could prove successful in Ireland. At this stage we are proposing the use of the term ‘primary medical care’ (as against primary health care or primary care) in order to confirm that the focus of the initiative is on improving the care of patients in the community.
- 141** The Scottish school is a ‘virtual’ centre, and in this way has gained the support of all Scottish medical schools – in contrast to the arrangement in England where the decision to place the National Primary Care Research and Development Centre in one medical school has generated a mix of reactions from other medical schools who had competed for the resource themselves.
- 142** The Scottish school was underpinned for its first five years by funding from the Scottish Higher Education Funding Council (the equivalent of the HEA), and the Chief Scientist Office of the National Health Service in Scotland (the equivalent of the HRB). It has succeeded in generating funds to support higher training fellowships (the equivalent of the academic registrar and MSc programmes) and has raised money to support research project work from the primary care trusts (the equivalent of the health boards). It was initially headed by a part-time senior social scientist, who has now been confirmed full-time director. A number of senior support staff (also social scientists with a background in departments of general practice) have also been appointed to assist with the supervision and training of the researchers who will undertake funded R&D.
- 143** If the recommendations we make in *paragraphs 136-139* above were accepted, the various funding bodies (HEA; DoHC; the Postgraduate Medical and Dental Board; HRB; and the health boards) would properly wish to oversee and influence how their investments were used. Similarly, general practice bodies directly or indirectly dependent on or affected by the proposals (AUDGPI; ICGP; and IMO) would want involvement. We note that although a similar range of supporters have facilitated the evolution of the Scottish school, its management body is small and thus able

to take decisive policy and strategic decisions. We would strongly recommend that an Irish consortium school separates the issues of policy and strategy from those of implementation in a similar way.

- 144** We have not commented on how the directorship and management of an Irish consortium might be best managed and funded. Initially, the post of director might be on a part-time basis, using a part of one of the posts envisaged in *paragraph 101* and funded as in *paragraphs 131-33*. However, HEA does have discretion to invest in activities it regards as necessary to promote academic growth of new disciplines, and it might be that HEA would earmark a modest initial sum to recruit and support a full-time director for the first period of the consortium's life.
- 145** Although all the programmes we have described above relate to research or to postgraduate training, an Irish consortium might also manage the recruitment and training of a cadre of 'expert' teaching practices which would teach students on behalf of all five medical schools and on a more regular basis than they do at present. Such practices would be the natural base for the attachment of senior registrars, and could in time develop R&D capacity making them equivalent to clinical units in teaching hospitals.
- 146** Finally, an Irish consortium would provide the natural base for collaboration in teaching and/or research between Ireland and Northern Ireland, the UK and other EU countries.

We recommend that interested parties explore the creation of an Irish consortium for teaching and research in primary medical care.

Conclusions

- 147** This chapter has attempted to sketch out ways to address the problems presently hindering the proper development of the academic discipline of general practice. At first sight, the most important problem is the absence of an adequate critical mass of senior staff. However, it is quickly apparent that an equally serious problem is the virtually complete absence of significant planning for the future training of an academic workforce in the discipline.
- 148** As a result of the present position, the current professors are expected to undertake a volume and range of work that is unreasonable and is likely to prove unsustainable. It is indeed possible that not all the present cadre of professors will remain in their posts unless the present position is addressed in the near future. Finding their replacements will not be easy. Two of the present five received their academic training in the UK, and it is unrealistic to expect that their replacements will be found within Ireland.
- 149** Even if the complete package outlined in our recommendations was implemented immediately, it is unlikely that suitable applicants would be available for the middle- and senior-level appointments we believe are needed to address the present difficulties.
- 150** The new investment, which we hope the funding agencies will agree to support, will eventually represent close to €3.81m (IR£3m) per annum. This will provide around €761k (IR£600k) per annum to each medical school which may seem a considerable sum. This sum will, however, include monies that will be paid to support general practitioners taking students in the community, and is we believe the minimum investment that needs to be made. Not all of this resource is likely to be called on immediately, and it might well be five years before the complete range of research and training posts were able to be filled appropriately.
- 151** In the present climate of opinion, we believe that the ministries of both education and health have commitments to promote the development of medical care in the community, and we hope that they will actively support and promote the recommendations that we have made in this report.