# DÁIL ÉIREANN

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## AN COMHCHOISTE UM SHLÁINTE

## JOINT COMMITTEE ON HEALTH

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*Dé Céadaoin, 14 Feabhra 2018*

*Wednesday, 14 February 2018*

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Tháinig an Comhchoiste le chéile ag 9 a.m.

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The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair/Members present:

| Teachtaí Dála /Deputies | Seanadóirí /Senators |
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| Bernard J. Durkan, | Colm Burke, |
| Billy Kelleher, | John Dolan. |
| Margaret Murphy O'Mahony, | |
| Kate O'Connell, | |
| Louise O'Reilly. | |

I láthair/In attendance: Senator Rose Conway-Walsh.

Teachta/Deputy Michael Harty sa Chathaoir /in the Chair

## Business of Joint Committee

**Chairman:** As we have a quorum I call the meeting to order. I propose that we deal with housekeeping matters in private session. Is that agreed? Agreed.

*The joint committee went into private session at 9.05 a.m. and resumed in public session at 9.45 a.m.*

## Scrutiny of EU Legislative Proposals

**Chairman:** We will now deal with scrutiny of EU legislative proposals COM (2017) 756, COM (2017) 757, COM (2017) 758, COM (2017) 759, COM (2017) 764, COM (2017) 765, COM (2017) 766, and COM (2018) 031. It is proposed that these proposals do not warrant further scrutiny. Is that agreed? Agreed.

## Review of the Sláintecare Report (Resumed)

**Chairman:** This morning the committee will engage with the researchers from the Economic and Social Research Institute, ESRI, on its Projections of Demand for Healthcare in Ireland, 2015-2030 report and with Professor Tom O'Dowd, emeritus professor of general practice, public health and primary care at Trinity College centre for health services, and a GP in Tallaght, on his report A Future Together - Building a Better GP and Primary Care Service. The committee is holding this engagement as part of its discussions around primary care expansion, as recommended in the Sláintecare report. I remind witnesses to turn off their phones or switch them to airplane mode. On behalf of the committee I welcome Dr. Maev-Ann Wren and Dr. Conor Keegan from the ESRI and Professor Tom O'Dowd from Trinity College Dublin.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of the evidence they are to give to the joint committee. If, however, they are directed by it to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable. Any submission or opening statement submitted to the committee may be published on its website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable.

I invite Dr. Maev-Ann Wren to make her opening statement.

**Dr. Maev-Ann Wren:** I thank the Chairman and we thank the committee for the opportunity to present on our research. I am here in my capacity as senior research officer at the ESRI. I am joined by my colleague Dr. Conor Keegan, research officer at the ESRI. We are both health economists and are the leading authors of the ESRI research series report, Projections of

Demand for Healthcare in Ireland, 2015-2030, which was published last October and which the Chairman, Deputy Michael Harty, has invited us to discuss with the committee.

This report provides annual projections of demand for public and private health and social care services in Ireland for the years 2015 to 2030. These projections are based on new ESRI projections for population growth, the first projections to be published based on the 2016 census of population. The report contains the most comprehensive mapping of public and private activity in the Irish health care system to have been published. The main findings are that, over the years 2015 to 2030, the population of Ireland is projected to grow by between 14% to 23%, adding 640,000 to 1.1 million people; the share of population aged 65 and over is projected to increase from one in eight to one in six; the numbers of people aged 85 and over are projected to almost double; demand for health and social care is projected to increase across all sectors, with the greatest increases for services for older people; demand for home help care and for residential and intermediate care places in nursing homes and other settings is projected to increase by up to 54%; demand for public hospital services is projected to increase by up to 37% for inpatient bed days and by up to 30% for inpatient cases; and demand for GP visits is projected to increase by up to 27% while demand for practice nurse visits is projected to increase by up to 32%.

New analysis in the report of the mix of public and private provision in 2015, which is our base year, finds that public hospitals delivered approximately 85% of total inpatient bed days and private hospitals delivered 15%, public hospitals delivered approximately 69% of day patient cases and private hospitals delivered 31%, and people paid privately for 27% of total home help hours.

The report also provides projections of demand for inpatient and day cases in public and private hospitals, maternity services, public hospital emergency department and outpatient services, pharmaceuticals, pharmacy consultations, home care packages, public health nursing and public community therapy services. The report includes the effects of unmet need and demand where possible.

There are important policy implications from this report's findings of substantial projected demand increases for health and social care in the years to 2030 due to projected population growth and ageing. These projected increases in population and demand come after two decades of rapid population growth, a decade of cutbacks in the public provision of care, and a consequent build-up of unmet need and demand for care. The additional demand projected in this report for the years to 2030 will give rise to demand for additional expenditure, capital investment and expanded staffing and will have major implications for capacity planning, workforce planning and training. Additional investment will be required in most forms of care to meet the needs of a rapidly growing and ageing population. The projected population growth will, however, also lead to an increase in the numbers at work and contribute to national income and the revenue base.

In future analysis the ESRI will examine the expenditure implications of the report's demand projections. While it assumes no change in models of care, further research is examining the potential effects of policy developments which could reduce projected increases in demand and capacity need in some sectors but increase projected demand and capacity need in others.

This is the first report to be published which applies the Hippocrates projection model of Irish health care demand and expenditure which has been developed at the ESRI in a programme of research funded by the Department of Health. The programme applies economic

analysis to explore issues related to health services, health expenditure and population health, to inform the development of health policy and the Government's health care reform agenda. It is overseen by a steering group which comprises nominees of the ESRI and the Department which agrees its annual work programme. Research studies produced under the programme are public goods which are published following national and international peer reviews.

The full report has been circulated to the committee and is available on the ESRI's website.

**Professor Tom O'Dowd:** I thank the Chairman and members of the joint committee for inviting me. Lest it go unmarked, it is nice to spend part of St. Valentine's Day with all of them. Members may be punch drunk on figures at the end of this, but I will try to keep them as straightforward as possible. I have just circulated the report to them and it is also available on the websites of the HSE and Trinity College Dublin. It was commissioned by the HSE with the involvement of the Department of Health to review how primary care systems operated internationally. It includes a big chunk of patient consumer research about general practice and also targeted interviews with key individuals in the wider health service.

Reform of the primary care system has been on the agenda for years. I have attended many meetings at which a Minister said, "Yes; this is the way it's going to be." However, the current system remains fragmented, poorly developed and unfair. Achieving reform in the health service requires a decisive shift towards general practice. For this shift to occur, it needs a change in the contractual arrangements with general practitioners. I would be misleading the committee if I did not convey the sense of brittleness in general practice. I have spent many winters in general practice and this one has been very difficult. Many of my colleagues reflect the instability that is emerging in general practice.

The overall spend on general practice in Ireland in 2014 was €858 million, the same as the amount spent on running St. James's Hospital. Approximately 42% of the population is covered by the GMS. The vast majority of GPs' income, 63%, comes from the GMS, with the other 37% coming from private practice, but that figure covers nearly 60% of the population. On average, GMS patients consult 5.63 times year, which is more than the figure for private patients. Although they are more ill, the divide is not great and it is much more of a spectrum than we realise. In compiling the report which took us a year we estimated that 4.5% of the entire budget was spent on payments to GPs. This is the lowest percentage in all of the comparable countries we studied. The role of private health insurers is underdeveloped in Irish general practice and almost non-existent. It is a secondary care resourced system.

On the number of GPs per 10,000 population, the number in Ireland is broadly similar to that in Denmark, Germany and the Netherlands but significantly lower than that in Scotland. One would not think that if one were in Scotland, but it is lower. Countries that are rated highly on access and services have higher numbers of practice-based staff. The key seems to be having practice-based staff, including practice nurses, physiotherapists and pharmacists. However, Ireland has the lowest number of practice-based staff in the countries at which we looked.

We are focusing - I think the State is also doing so - on chronic disease management, for which a better term is long-term illness. Anyone who has just had a single disease at any of our ages will have lived a pretty charmed life. Most people will have more than one and they are not diseases that can be managed by the same drug. They need a variety of medications. Most people over 60 years have two or more diseases which, unfortunately are well advanced. There is good evidence that seeing the same doctor regularly results in significantly fewer admissions for patients. That is an important finding which was published last year in the *British Medi-*

*cal Journal* . Seeing the same doctor on eight or more occasions in the year resulted in 12.5% fewer admissions. That monetary value can be attached to it, but, of course, it takes time.

The survey of patient satisfaction levels was carried out online and by telephoning patients who had recently visited the GP. The satisfaction rates astonished all of the GPs who were very defensive about satisfaction surveys being carried out at the time. More than 90% of patients were satisfied with their last visit to the GP and prepared to go on a waiting list for a recommended GP. Word of mouth is very important in Ireland. Ease of access to appointments was also rated highly, with most parents of children being given priority. The comments were very positive. People said they had gone along without an appointment but were fitted in. Therefore, there is a child-focused approach adopted by GPs. Based on research in which others and I have been involved, we know that the cost of seeing a GP deters one in three patients. The figure is highest among those paying for the service and younger patients.

One of the big successes in the past decade has to be the out-of-hours services. Over 1 million out-of-hours consultations are provided per year. Out-of-hours work is not easy; it is the mucky end of the stick. It occurs after a day's work and late into the night, yet it has been hugely successful. Accessibility has also been seen as successful, although all of the co-operatives found it very difficult in the Christmas 2017 period.

GPs have been early adopters of information technology. We use it for the recording of administrative, clinical and prescribing details and screening programmes. We are beginning to make electronic referrals to hospitals, particularly for cancer patients, but the links are a source of concern for GPs. The lab results are quite good and now received electronically.

Diagnostics, in particular, have got worse. For the past 30 years I have been involved in a longitudinal research study of general practitioners. The last time we did it, which was approximately five years ago, access to diagnostics had actually deteriorated. It is not possible to run modern medicine without access to diagnostics, by which I mean X-rays, ultrasound and MRI scans and so on. Access has actually decreased for public patients. In fairness, the cost of MRI scans has come down but families still often have to club together to pay for a scan.

When we did focus groups with our general practitioners in training, one reason they said they would not stay as general practitioners was the clinical disrespect they felt from being unable to have access to diagnostics. We cannot underestimate that. We train GPs first as doctors and then as GPs. If they say they are going to go to psychiatry or clinical medicine or whatever because they cannot practice as a doctor, then there is major waste in our system.

GPs in training do not see themselves as single-handed practitioners. The number of single-handed practitioners is reducing. When I started in practice, it was the norm that a person set up in practice. The numbers for single-handed practitioner are coming out at approximately 18% and they have fallen considerably. Yet people are fond of a single-handed practitioner who knows them. Anyway, younger doctors do not see themselves in this light. The job has become too complex and they want colleagues.

Many are unwilling to take on a General Medical Services contract because it is so complex. It requires a great deal of attention to detail. There are risks to being an employer as well. I am an employer of staff and I worry about keeping them afloat. Income is tight and the past ten years have impacted on sole traders and small practices. Many of our younger GPs say they do not want it. They have said to us that they are interested in being salaried GPs when they come out and then would like to move into partnership before becoming managing partners. It is a

little like the law firms, which have a similar model.

The heroes in the consumer studies were undoubtedly the nurses. Practice nurses rated highly. They are seen as central to developing high-quality services. They are great consumers of further education. They see themselves playing a role in long-term illnesses. They are a great source of security to the patients, especially those with chronic illness. We have had a great deal of representation from the pharmacists. Pharmacists see themselves as being able to share some of the aspects of chronic disease management with GPs. As it is, community pharmacists play an important role in medicine safety and preventing drug interactions. The most common interaction I have as a general practitioner is with my local community pharmacist, who looks out for me and for the patients.

Clinical pharmacy is being developed in the National Health Service. It really is an important adjunct and ingredient in the management of chronic illness. The professionals are employed by the practices. They are not involved in the retail end but in the management and provision of medications. Medications have become more complex. This allows the GP to focus more on the medical aspects. It is not uncommon for patients to be on ten medications. That can happen easily and many of these medications interact.

I wish to comment on allied health professionals. It is interesting to read the literature and to interact with physiotherapists, occupational therapists and psychologists. They want far more interaction with patients in primary care. They realise that by the time patients get into the hospital sector it is too late, especially for intervention by allied health professionals. Behaviours are set. Diseases have advanced, even diseases that can be prevented. They are open to working in primary care, which is the pattern internationally with these professions.

Inevitably, every time anyone appears in this room they are asking for more money. That seems to be the modern way.

**Deputy Billy Kelleher:** That is only the politicians.

**Professor Tom O'Dowd:** It is only the doctors.

**Deputy Billy Kelleher:** It is only us.

**Professor Tom O'Dowd:** Let us deal with the money end of it. There is no doubt about it. People see the health budget as a fairly sealed entity. I believe we have to look at transferring funds. In providing long-term illness and improved diagnostic services, practice-based staff and information technology all require funding. Some of this would be once-off funding. IT funding is very much once-off funding, as is funding for diagnostic services especially for equipment. The equipment has fallen in price. The other side relates to primary care as structured. I listened to Dr. Wren's statement. As general practice is structured now, it simply would be unable to cope with that workload. It is only hanging in there at the moment. I would be misleading committee members if I did not highlight that it is no more than hanging in there at the moment.

Transitional funding could be spread over several years. It needs to be strengthened to international standards. There are quick wins. We studied the situation in Vermont, where they transitioned the system from a hospital-based system to a system based far more on primary care. Those involved reduced the spend on health, often by providing allied health professionals, having some transitional funding, and it gave them considerable longer-term gains.

At this stage of my career, it is frustrating to see that many of the pieces are available but not joined up. This is frustrating in our system. We have very good people working in the system but they are not joined up. This includes, at my end of the profession, a well-trained cohort of GPs and an entrepreneurial GP workforce. The medical profession can be snide about entrepreneurship but it is important. If we want to keep a general practice system going on 4.5% of the health budget, then we need a lot of business smarts to keep it going. Premises have to be modernised. The Chairman, Deputy Harty, and I will remember the time when a GP bought the garage in a corner house to set up a practice. Those days are long gone. We have an active college of general practitioners with a large membership and we have a referral system that works through the efforts of the Medical Council. There was a time, when I went into practice, when patients could refer themselves directly into secondary care and never see a GP. That has gone so the gatekeeper effect is far more important. All our doctors are registered and indemnified.

The evidence supports a decisive shift to primary care. This is central to the transformation of the health services. I believe there is an unusual consensus now among politicians, including those present, who are leaders in our State, policy makers and clinicians that this is the way to go. Although it is the way to go, it will not be easy. We are a conservative country. Our patients do not like change. Our system does not like that change. It will require much courage and leadership to make it happen.

At the moment we need a shift from an institutional and inappropriate and expensive method of care. Our private health insurers have not played a role. They have a distorting effect on health care in Ireland. They are hiding in plain view. The income for a GMS patient for a GP is approximately €280 per year. For a private patient, it is approximately €116. This private practice has leached into private clinics that are funded or reimbursed by private health insurers and this is having a distorting effect on the provision of health care. This is a legitimate area of concern for legislators. Moving from the current system we have to a primary care led system will be a philosophical, political and financial journey. I do not know anybody who is against it, but I think it requires political leadership at this stage.

**Chairman:** I thank Professor O'Dowd and Dr. Wren for their opening statements.

**Deputy Kate O'Connell:** I thank Dr. Wren for the report, which I read last night. It is obvious it was written by a general practitioner, GP. None of us can deny that the financial emergency measures in the public interest, FEMPI, had a very serious impact on this sector over ten years, as they did on the pharmacy sector and on services for patients, which we have all tried to mitigate as much as possible. Professor O'Dowd mentioned that GPs want to be salaried GPs in the earlier phase of their lives, which is understandable. Nobody who has undertaken seven years studying to obtain a degree would be want to end up in precarious employment.

Based on my first reading of the report, I have concerns relating to the clinical pharmacist element of it. I worked as clinical pharmacist in the NHS for a number of years. I note there is to be a distinction between pharmacist and clinical pharmacist. I also worked for ten years as a community pharmacist, to which I brought the skills I had obtained at undergraduate level and intern level and the experience I gained in the NHS. Most community pharmacists, in particular those who have come through the modern system of training, would consider themselves to be clinical pharmacists. I would be opposed to the concept of a two-tier pharmacist. Many of my pharmacist colleagues work in the hospital sector and they do a certain amount of training in CPD through their jobs to upskill them in the areas of oncology and so on.

It was mentioned that a pharmacist's role is in the area of drug safety and drug interaction.

I believe a pharmacist's role in the community is far greater. Throughout the recession we all took on roles that were not our natural roles. I believe the relationship between the community pharmacist and his or her patient cohort is unique. That said, I believe that the general practitioner should be the anchor for people in the community. In other words, the person to whom the patient should go in the community is the person, the GP, who knows all about him or her. I am delighted to hear that the practice of self-referrals has ended, which addresses the concern regarding who reads results, etc.

It is shocking that only 4.5% of the overall health budget goes to GPs. We seem to be getting very good bang for our buck from that 4.5% given the number of people who go through the GP setting. On the proposal regarding the clinical pharmacist role, which is to be based on the NHS model, I am very much against us copying the NHS in any regard, apart from its ideology with regard to universal health care. The NHS system does not seem to work. Based on the population of Ireland, a community pharmacist would have a very close relationship with approximately 2,000 patients. The proposal to bring community pharmacists into a primary care setting under the employment of the GP for one day per week-----

**Chairman:** Somebody's phone is causing interference.

**Deputy Kate O'Connell:** It is not mine.

While I understand the rationale behind the proposal to have a community pharmacist in a GP practice, a practice in which there are four GPs would cater for approximately 8,000 people and for a community pharmacist employed for one day a week to trawl through the medication histories of those patients would not be practical. It is not a solution. A more appropriate solution would be a collaboration between the GP practice and the community pharmacist in the community setting. If, as a pharmacist, I am employed by a GP to scrutinise his or her prescribing and he or she is a bad prescriber but is paying my salary I might not be open to telling him or her that I do not agree with his or her prescribing or that it is not in line with the National Institute for Health and Care Excellence, NICE, guidelines. There would be an automatic conflict there. In my experience patients have different relationships with their pharmacists to those they have with their GPs. Often the information that pharmacists get versus what GPs get is different, so when pharmacists have conversations with GPs we improve outcomes for patients. I would be concerned about that proposal and about the proposed new role of clinical pharmacist and what that means. We do not have clinical GPs. Rather, we have GPs who are on the specialist register and trained to a high level.

I welcome the statistics which show that when patients have a regular GP and they see him or her eight times per year it leads to a reduction in hospital admissions, which is something that anyone who works in the community knows without having to look at the statistics. We know that when people have a go-to gatekeeper they have better outcomes.

Access to diagnostics was considered in the context of the Sláintecare report. I am concerned that we have not seen any move in this regard. One of the main concerns of GPs was getting access to diagnostics for patients. I may have missed reference to this in the ESRI report. The Sláintecare report recommended stand-alone diagnostic units for GP referrals. Do the witnesses agree with that concept and, if not, what in their view is the solution, bearing in mind that we cannot have MRI machines in every GP practice?

It was mentioned that cost in terms of visiting a GP is a deterrent to one in three private patients. In the Sláintecare report, any barrier to access was seen as a negative. Are the witnesses

saying that we should be looking at universal free access to a GP and, if not, what would they suggest to mitigate the cost deterrent? People who need to see a doctor but cannot do so owing to cost usually end up in a far more serious situation in our acute hospital setting. I have to leave the meeting at 10.30 a.m. as I have another appointment. If the witnesses do not get an opportunity to answer my questions before I leave, I will follow up on them when the transcript of the meeting is available.

**Chairman:** I will take questions from members in groups of three.

**Professor Tom O'Dowd:** I see. That is how it is done.

**Chairman:** If that is okay, Professor O'Dowd can keep track of the questions. We will bring in Deputies Louise O'Reilly and Billy Kelleher.

**Deputy Louise O'Reilly:** Good morning and happy Valentine's Day to everyone. I want to address a few issues, the first of which is workforce planning. Similarly to Deputy O'Connell and others here, I was a member of the Committee on the Future of Healthcare. Workforce planning formed a considerable part of our discussions. Looking at the future, we have general practitioner, GP, practices that are full. In Fingal, we have the youngest and fastest-growing population in the State. There are now GP practices that are full for kids, which is causing a huge problem. On workforce planning, while serving on the Committee on the Future of Healthcare, it became apparent that workforce planning was not something the HSE was on top of. I had experience of workforce planning units being disbanded and people being moved to other duties when staffing levels were cut. The witnesses might be able to comment on what we need to do with regard to workforce planning. It strikes me that we may not be prepared. We seem to arrive at situations that are very easy to plan for, especially relating to the age of the population, which is probably one of the easiest things to plan for, before even considering illness profiles, yet successive Ministers seem to be shocked that people get older as the days go by. The witnesses might enlighten us as to what we could recommend for workforce planning.

On practice nurses, the unsung heroes of the GP world, do the witnesses see scope for practice nurses being able to expand their role? Will they comment on the method for payment? Some GPs have said to me that the mechanism by which one runs a GP practice, which will bring me to my next point, is quite cumbersome and complicated. There is a huge amount of paperwork. Can we fix that by simply putting in place salaried GPs alongside salaried allied health professionals and salaried nurses working directly for the HSE? Would the witnesses see it only as a model whereby salaried GPs would be there for the start of their career but would then move into their own practice - entrepreneurial was the word used - and run that? Do the witnesses have specific recommendations about the expanded role for the practice nurse with regard to what the nurse could be doing? We have had the Irish Nurses and Midwives Organisation, INMO, and SIPTU, here on several occasions. They are never shy about saying that their members are up for change and embracing new roles. There are obviously industrial relations issues that will arise from that but there does not seem to be an unwillingness on the part of nurses to take on an expanded role. Do the witnesses see that as part of future expansion?

I have questions about IT equipment, specifically the availability of diagnostics. The average person would say that if there was a scanner in the doctor's surgery, he or she would not have to go to hospital and that would be marvellous. What type of equipment are we looking at putting into GP surgeries to facilitate hospital avoidance? It does not seem sensible for one to have to go to a GP to be told by the GP to go to hospital to get a scan. There obviously cannot be an MRI machine in every GP surgery but is there some scope there? I had discussions with

companies involved in equipment for near-patient testing, infection control and so on, so that people are not sent to hospital.

On e-health and hospital referrals, if one goes out to Merrion Square, one will see women coming out of Holles Street hospital with big paper files. If one talks to people, particularly those involved in the health area, from anywhere outside of the State, they would be shocked at how dependent we are on paper files. It strikes me that there is not a huge focus by the Department on rolling out the e-health strategy. I know that one key member of staff was lost to that project. What will it take to get us to the level where we can see the elimination of as much paper as is reasonable and practical?

**Deputy Billy Kelleher:** I welcome the witnesses. We have had many reports and observations from professional bodies and research groups about the demands that will be placed on the health service because of demographic changes, the ageing profile and the complexities in society with regard to illnesses, diseases and the levels of and increased sophistication of prevention that allow people to live longer. We all know that huge demands will be placed on health services in the coming years. The key question from our perspective is how we plan for that, how we implement the plan itself and the costs of it. On Deputy O'Reilly's question, it is often the case that we can, with some degree of accuracy, predict what we require in capital development projects, including how many beds we need, how many hospitals or how many kilometres of road or whatever other infrastructure capital is required for. We seem to have an inability to assess our human capital requirements, primarily the skill sets required for the economy and, in this context, the health services too. I assume that because of the research done by the Economic and Social Research Institute, ESRI, by Dr. Wren, as well as by Professor O'Dowd, that we should have some window into the future showing what specialties we most need in the years ahead. I assume geriatricians and similar specialties would be a key component in any future planning but we do not seem to be doing that in advance. I find that we consistently wake up with skill shortages on a continual basis. Do we need to do more work on that or is there enough evidence to tell us exactly what we should be doing as policy makers with professional bodies and oversight bodies to establish additional capacity in training and changing existing training programmes and regimes to allow for that projected change in demand in the health service in the years ahead?

Everybody has accepted that we should move from hospital-centric care to primary care and community care. It is a huge leap of faith because we will have a major problem if it does not work. We will have spent a lot of money to develop primary care but if we still end up with a huge drag into the hospital system, then we will have the worst of both worlds since our primary care and community care system will not be stopping the flow of patients into the hospital system. Has any country moved from the disparate, broken type of system that we have with primary care and community care, with no joined-up thinking or interconnecting, to having a very successful system? Is there any country of comparable size or geographic make-up that has successfully made or at least started the journey to success in developing a proper primary care and community care infrastructure?

With regard to diagnostics, we have to accept that the idea that a GP has to refer a person to an emergency department to get an X-ray or MRI scan is just bizarre. I cannot understand why it happens frequently. It happens all the time in Cork, where one sees people going to emergency departments with their letters and it is primarily because a doctor cannot get a diagnosis in a reasonable time and so refers a patient to the emergency department. That is a huge waste of resources and an imposition not alone on patients but also on emergency departments, which

are the sections of the hospital system that are under the most stress.

Where should diagnostics be located and what should be available to general practitioners, GPs, in terms of being able to refer diagnostics directly? I note that there is strong collaboration between GPs and consultants in areas such as cardiology, but it does not seem to be as effective in other specialties. Is there any blueprint in that regard or what should be done to allow and facilitate GPs to refer for diagnostics directly? What increase in infrastructural capacity would be needed? Must such facilities be attached to hospitals, could they be stand-alone units or at what level and where should they be provided?

As regards nurses and nurse specialists, there is no doubt we are moving to subspecialties in all key areas, including nursing. Nurses have been underutilised and much abused in Irish health care systems in the sense that they are highly skilled, very flexible and, as was pointed out, consistently strive to professionalise themselves further in terms of education. Although they are at the centre of delivery of care, that is not the case in regard to the decision-making process, and that should be looked at.

I do not raise this point because a pharmacist is a member of the committee. I do not understand why highly qualified pharmacists leave college after seven years but are given no key role in the health services in terms of the professionalism they bring to it. There is a pharmacy in almost every town, village and street in the country, but GP services are bursting at the seams and are unable to see patients on a same day basis. The role of community pharmacists is not fully utilised and could complement GPs and GP services. Pharmacists cannot diagnose continually but could do so for minor ailments. That people have to go to GPs regularly and have to do so consistently to renew prescriptions should be looked at. In my six or seven years observing the situation in terms of health care as a spokesperson for health, I note a continuing huge resistance to change by professionals in respect of matters that may lead to others encroaching upon their areas. I invite observations in that regard.

**Chairman:** I thank Deputy Kelleher. Some leeway will be given to Senator Dolan who must attend Commencement Matters in the Seanad. His questions will be brief and we will then revert to the witnesses to respond.

**Senator John Dolan:** I thank the Chairman for that accommodation. I apologise for not being present at the start of the presentation. I wish to focus on sustainability and development. My interest in the area comes about from my involvement in the disability movement. I have a personal interest in several chronic conditions and know that ground quite well. Professor O'Dowd mentioned that many of the pieces of the puzzle are there but there is frustration that they are not joined up. What could be done to help to join up those pieces? Primary and secondary care and hospitals and so on have been mentioned but I am conscious of and very familiar with the work done by many support organisations or patient groups, those being organisations set up to support those with particular conditions such as post-polio syndrome, muscular dystrophy, multiple sclerosis, motor neurone disease and epilepsy. Could there be a better role for those groups, which are close to people and families and some of which are involved with clinicians in certain areas? Could they be part of joining up some of the pieces?

Professor O'Dowd mentioned that 8.5 GP visits per year is the optimum in terms of best supporting people. Could the service sustain 8.5 visits per year or would it crack open? In several respects, it is very clear that the current system is vulnerable and not very healthy in terms of sustainability.

Professor O'Dowd mentioned private health insurers not in the primary area. Towards the end of his presentation he discussed a shift from the institutional model of care and said that a bias exists which is pushing things away from the primary area.

It registers very strongly with me that he stated that, at the hospital level, behaviours are set and diseases are at an advanced stage, which is obvious. He stated that many health professionals want to be in front of and support people earlier on. There is no doubt that developments in recent decades have meant that many permanent, chronic and long-term conditions can be diagnosed far earlier, and thus earlier intervention is possible. There may be other views on that point. Thirty years ago there was not the same awareness of patients' conditions. There is now a greater opportunity for early intervention than was previously the case. If I am not present for the replies to my queries, I will check the record in that regard.

**Chairman:** Many questions have been posed. Perhaps Professor O'Dowd will deal with Deputy O'Connell's reference to clinical versus community pharmacists and their involvement in general practice.

**Professor Tom O'Dowd:** The report concerns more than clinical pharmacy. I presume Deputy O'Connell addressed clinical pharmacy because of her background. "Clinical pharmacy" is a bad term. The report deals with community pharmacists but, in hindsight, practice-based pharmacy should probably have been included.

I take Deputy Kelleher's point about people going to pharmacists in regard to minor illnesses, many of which can be treated with very cheap medication. However, if a pharmacist stocks a medication that he or she wishes to sell or on which there is a good margin and so on, that introduces conflicts of interest. Retail pharmacists have to face such conflicts of interest, which is why the NHS has moved towards practice-based pharmacists who are not involved in the retail end of the business. This cannot be dismissed as only occurring within the NHS. In my practice, we have appointed a clinical pharmacist whose first role is to conduct a brown bag review. The patient brings in his or her medication in a brown bag and the pharmacist goes through that medication. This takes time but is very important because there are some medications of which people are very fond, such as sleeping tablets, and others that they do not take, such as diuretics, perhaps because they are going into town and do not want to have to rush to a toilet. There are many kinds of sophisticated, yet quite simple, approaches to doing that. There is also the fact that many patients are on ten or more medications.

The most dangerous work that I do as a GP is repeat prescribing. It is an absolute burden and a medical and legal minefield. I sign these things at speed, yet there are medications that interact. We have disabled the interaction alert on the computer because it says that everything interacts. Some sort of common-sense approach to this issue is necessary. We should ask the patient if they are coughing or falling over when taking these medications. That takes time, and it cannot be done in a retail pharmacy. It is confidential work, particularly when it comes to older people. They do not want to be standing in a shop with a queue of three or four people behind them and telling people that they are having various side effects from medicines. It cannot be dismissed just like that. The safety issue with medications is now quite important. One in three people has a reaction to a medication. It could be anyone. As people get older, clearly the number increases.

Access to diagnostics was brought up by a number of members of the committee. This is a real problem. I am better qualified medically than some of the people to whom I refer patients, but I cannot get access to diagnostics. It is bad medicine if I cannot access diagnostics. The

situation is poor. Deputy Kelleher asked where diagnostics should be located. We have developed a new centre in Tallaght with a 5,000 sq. ft area into which we are going to put diagnostic equipment. In choosing what diagnostic equipment to install, we have stayed away from radiology because it requires so many health and safety precautions, including lead lining. We are installing ultrasound, DEXA scanning and MRI equipment. There is a lot of footfall in this area. The ideal situation for us would be if some of the radiologists from a local hospital would take an interest in it and take it over, and if extra resources are required they should get them. There is no doubt that patients, especially as they get older, find hospital access and traversing the hospital system very difficult. There is also no doubt that once our hospital colleagues come out into the community, it rearranges their heads and they begin to see people who are dressed like normal people, who have views and opinions, talking about politics or the price of things. It humanises them, whereas many of our hospital systems, sadly, dehumanise people. Diagnostics should be located in an area which serves a number of practices, not just one. It is a community approach which stays away from the dangerous stuff, such as radiation.

Deputy O'Reilly asked a number of questions. I must say that workforce planning is what I would call a dark art. I am quite sure that there are many management consultants who have made a fortune out of workforce planning, but it seems that everybody gets it wrong. We can only plan ahead for four or five years. We cannot plan ahead for a large number of years.

The Deputy asked what we should do about our current GP primary care problems where practices are full. It is not in the nature of sole traders to turn down business, but this is what is happening. GPs are saying that they are full and cannot take on any more patients. People such as myself can stay on until we turn 72. That has been an improvement. I believe we have to expand allied health professionals - a terrible name, but that is the name we use - so that, for example, a physiotherapist with a patient presenting with back pain could certify a patient as fit or unfit for work, as is the case in the NHS and in some of the American centres. There are many little changes that could be made. It is the same situation in our clinical or practice-based pharmacies. There are a number of things we can do in that area.

Expanding the role of the practice nurse is important too. To expand on Deputy Kelleher's point, there is no doubt that the systems that work well, where there is good patient satisfaction, a better range of clinical services and more fairness, are the systems that have many extra staff. Practice nurses are key to this. The practice nurses at the moment are nurses who have left the hospital sector and who perhaps have gone part-time or left to have a family and then come into practice. General practice is one of the areas that hugely values people who have been mothers and who have looked after sick children in the night. Patients value them as well because they have street credibility. The practice nurse in my practice spends a lot of time doing phlebotomy, which is taking blood. It is a very expensive way of taking blood. Part of the rigidity of the current contract is that it does not resource us to employ somebody like a technician, a medical attendant or a phlebotomist at a lower rate. That is a very important area of the contract. In my own practice we have taken on a phlebotomist to free up the practice nurse to do more work in the area of chronic disease. Our practice nurses initially came in to work in women's health when that was underutilised and underprovided, and they have upskilled themselves. They now see that they need to specialise in long-term illness.

On the question of electronic referrals, we still have a fax machine in my practice. People are shocked to hear that in this day and age. We could not do without it. That is the level of technical advancement we are working at. We have a lot of IT as well. When I carried out this report I spoke to a man called John Macaskill-Smith, from Hamilton, on the North Island

of New Zealand. He told me that they have developed their primary care IT hugely and the hospitals have developed their own IT systems. However, the two IT systems do not talk to each other. The idea of interoperability, where the two systems work together, is now being discussed. The company Mr. Macaskill-Smith was talking to is a group that works in Nutgrove in Rathfarnham. This company is providing interoperability for New Zealand while we are still relying on our fax machines. The expertise is there.

**Dr. Maev-Ann Wren:** I want to respond to Deputies O'Reilly and Kelleher's very pertinent questions about workforce planning. The model that the ESRI has developed was designed with a view to informing planning, including planning for capacity, staffing and spending when we develop the expenditure phase. In this country we tend to do these things as once-off exercises. We look at a particular specialty, a particular professional, and we look at demands at a moment in time. One of the things we need to be doing is repeatedly reiterating these exercises and updating them with the latest population projections. This brings us to the need to collect data routinely. One of the questions to which there are many answers is how many GPs there are in Ireland. This is not a routinely collected piece of administrative data. The HSE produces a personnel census every month for all the employees of the HSE, right across all of the programme areas, by grade and specialty, etc. General practice is developed within a private market and routine administrative data for general practice have not been collected. In response to Deputy Kelleher's question about what policymakers can do, if we want to have primary care expansion, it would be of assistance if routine collection of data in this area were required. The comparison between health and education comes to mind when I reflect on what we might aim for. In education, we know in any given year what the pupil-teacher ratio will be and we know in any given school or area what the pupil-teacher ratio will be. It is not unreasonable to expect that we would in any given year know what the GP to population ratio or the GP to young children ratio will be in Fingal, for instance. That requires routine collection of data.

The ESRI has looked at the role of practice nurses in this report and in some of its other work. I concur with Dr. O'Dowd that the evidence shows that there is a great deal of scope for increasing the amount of care that is delivered by practice nurses in primary care in Ireland. In Northern Ireland, or indeed in the UK in general, the ratio of visits to nurses to visits to GPs is quite different. Much more care is delivered by nurses there. At a time when we are talking about primary care expansion and when there are concerns about the availability and supply of GPs, I suggest this is a really important part of the answer for Ireland.

**Dr. Conor Keegan:** I would like to respond to Deputy Kelleher's comments about the demands that are being placed on services due to population growth and ageing. He spoke in that context about where we plan to invest. At a broad level, the overarching findings of our report are that due to population growth, where an increase of between 14% and 23% in the population is expected, and population ageing, the number of people over the age of 65 is expected to increase dramatically. It is important to note that we are speaking on the basis of no change in the models of care when we say we envisage that there will be increases in demand for health and social care services across the board, particularly services predominantly used by the older population, such as home care services and long-term care services. We are seeing increases of 54% or 55% in such services. This gives a broad idea of where investment may need to be allocated.

I will speak about the skill sets that will be required in primary care as we move forward. Our results suggest that by 2030, general practice visits will increase by between 20% and 27% and practice nurse visits will increase by between 26% to 32%. All of our projections factor

in the relationship between increased life expectancy and health. In primary care and general practice, we adopt quite a pessimistic view of the relationship between ageing and health. This ties in with the whole notion of what is known in academic circles as the epidemiological transition. Fifty or 100 years ago, people were not living that long and were dying of infectious diseases. Nowadays, people are living a lot longer and the mix of reasons for death has changed. People are living longer and often die with a number of chronic diseases. It is important to appreciate that as we move forward, we will need primary care workers who are able to deal with individuals who present with a number of co-morbidities or who are on a number of different medications.

I would like to pick up on what Dr. Wren said in response to Deputy O'Reilly's question about the expanded role for public health nurses. In our projections, we have not looked at changes in the models of care. This is a very important issue as we decide how best we can allocate resources as the level of demand for primary care increases and as we consider the expenditure implications of this. There is work to be done on substitutability, not just between acute and non-acute services but within primary care as well. We hope to do this work in the future. The Hippocrates model we have developed has the capability to look at these questions.

**Chairman:** I thank Dr. Keegan. I have a few questions for Dr. Wren. How will the demographic changes predicted by the ESRI be reflected in the demand for care? We all see such changes happening at the moment. It is almost an actuarial equation. Given a certain population and a certain age profile within that population, we know that there will be a certain number of strokes, hip replacements, heart attacks and predictable illnesses. We do not know who will get those illnesses, but we can predict within 1% or 2% the percentage of people who are likely to present with them. That must be a source of important information when determining what is needed to meet the level of demand that is going to come down the line. It seems that we never actually supply the service that we are predicting is going to be required. We are always chasing, which means there is always an unmet need. How does the ESRI envisage that the health service will respond to the predictable nature of what is coming down the line, in light of the failure to provide the infrastructure to deal with that?

**Dr. Maev-Ann Wren:** If we had consistently planned for the past 15 years, we would be in a very different position from where we are now. The history of health care expenditure in Ireland shows that expenditure tends to follow the electoral cycle. It tends to increase coming up to elections, with cutbacks in intervening periods when Governments want to reduce tax. For that reason and for other reasons that need no explanation, we substantially reduced the public service workforce during the period of austerity at a time when our population was still growing. We substantially reduced the number of people working in our hospitals and across our health care system. We incentivised retirement and carried a pension cost for that. If we were to acknowledge and regularly update our demographic projections, look at our current use, as we have done, and project the implications of that use into the future, it would represent a considerable advance on the way in which the Irish health care system has historically been run. This has been done at an earlier point in other countries.

Deputy O'Reilly or Deputy Kelleher asked about countries that have provided better primary care. There are countries which have placed a deliberate focus on targeting the provision of more care in the community than in hospitals. Sweden, for example, has changed its whole system of financial incentives for hospitals and for local government, which supplies community care, in an incredibly effective way. I think planning can be quite effective in this area. I emphasise that there is still uncertainty about population projections. That is why we

are providing a range. As my colleague has mentioned, there is uncertainty about the evolution of health as life expectancy extends. That also affects the range of our projections. There has been a welcome development in recent months. Since we published our report and since the Department published its other work, there has been a recognition that we need to respond to population growth and ageing and increase capacity across the health care system. I think that is really a sea change in health policy in Ireland.

**Chairman:** It is assumed on the second page of the report that there will be no change in the model of care.

**Dr. Maev-Ann Wren:** Yes.

**Chairman:** The Sláintecare report recommends a substantial and almost revolutionary change in the model of care. How do the ESRI's predictions feed into an altering model of care?

**Dr. Maev-Ann Wren:** We are very explicit about that. We adopted that approach initially because when one is building a model, one has to start from the *status quo*. Although we can now apply the model to an examination of the effects of changes, that requires having evidence about substitution. If we are modelling an increase in primary care, we need to apply evidence of how that might affect acute care. The capacity review that was published by the Department of Health recently acknowledges that there is a paucity of quantifiable evidence in this area. We are working very closely on this issue. Another ESRI study, which is funded by the Health Research Board, is looking at the effects of non-acute supply on the use of acute hospitals by region throughout Ireland. It is our hope and plan to apply the findings, within the model, to looking at the substitution effects and changes in models of care.

**Chairman:** I have another question before opening the discussion to other members. Sláintecare proposes a separation of private care in public hospitals. Dr. Wren refers in her opening statement to the mix of private and public care. Sláintecare sees the mix of private care in public hospitals as an inhibitor of change and believes it has a negative effect on the provision of care. Does Dr. Wren have an opinion on how one might separate private care from public hospitals or does she think it is possible or beneficial to do so?

**Dr. Maev-Ann Wren:** We have not addressed that issue directly in our research. We have not looked at the specific way in which it is proposed in Sláintecare. Much has been written and researched at the ESRI about the effects of the co-existence of public and private care within public hospitals. Clearly, private practice in public hospitals has an effect on public waiting lists and there is a body of research that supports that view. However, we have not looked specifically at what the consequences would be of implementing the policy in that way.

**Chairman:** I will bring in some of the other members and we can return to some questions that have not been addressed. I call Senator Colm Burke who will be followed by Deputies Margaret Murphy O'Mahony and Bernard J. Durkan.

**Senator Colm Burke:** I thank the delegates for all of the work they have done in their comprehensive research and reports. It is appreciated.

My first question is about care of the elderly. The report states there are now approximately 640,000 people over 66 years of age and that the figure will be 1.1 million by 2030. The current ratio of people in nursing homes and community hospitals - there are approximately 23,500 under the fair deal scheme - is 27,000. That figure might be wrong, but that is the one I have worked out. On that basis, if by 2030 there will be 1.1 million people over 66 years of age,

46,000 nursing home or community hospital beds will be required. There must be a better way of dealing with this issue. Obviously, the way to deal with it is by expanding home care services. There is an urgent need to fast-track their expansion. That ties into the workload of GPs. If one expands home care services, one will also expand the amount of work GPs must do. Has there been consideration of how we should deal with that challenge? There would be a huge cost involved. The fair deal scheme costs approximately €1 billion per annum. If the number is increased to 46,000 by 2030, it will probably cost €2.5 billion or even €3 billion to fund it. There is also the issue of value for money. Is there a better way of doing it through home care provision? How does one improve it? That is an issue we must examine.

My second question is for Dr. O'Dowd. It concerns the lack of a connection between GPs and the hospital system. I recently spoke to somebody who works in Canada as a GP. If a patient is pregnant, the GP can go to the hospital and carry out the delivery. We seem to have a system under which GPs cannot even make a telephone call to consultants. I am not blaming any single group for this. I am not blaming consultants as they will say they are extremely busy and that it is not easy to set time aside to do it. However, we have a problem in training hospital doctors. Many are dropping out of the system, particularly out of obstetrics and gynaecology. I met two people recently who had spent six years training in that area and dropped out because of the stress levels and demands made. I met another person who had trained for nine years but who was going on to general practice training to become a GP. The people referred have huge skills, but there is no opportunity for them to do some hours in the local hospital in the area in which they live. There does not appear to be the same apparent disconnect in other countries. Has that issue been examined?

I was speaking to members of the National Association of General Practitioners and met some of the young doctors in the association, every one of whom was afraid of setting up practice on his or her own. They were afraid they would not have sufficient income. I put forward the idea of four three-hour sessions per week in a hospital, which would mean that they would know that they would definitely be paid. They were quite enthusiastic about that suggestion, but there is no system in place to allow it, even to allow them to work in emergency departments and establish that connection with the hospital. We do not appear to have done this. Should we consider it and look at how other countries do it, where there is a direct link between hospitals and general practitioners? That is one of the problems.

The other issue is that the composition of the GP cohort has changed substantially in the past ten or 15 years. There are many young GPs who have young families and are trying to achieve a work-life balance between working and caring for their young family. Does Dr. O'Dowd envisage a change in that cohort in the next ten or 20 years and, if so, how do we plan for it?

The next issue ties into that matter and relates to a GP working from 8 a.m. until 5 p.m. or 6 p.m. As a large percentage of the population find it difficult to get time off work to go to their GP, they tend to visit their GP after 6 p.m. Do we need to examine the hours GPs are available? I accept that they are available under the out-of-hours service contract, but the problem is that one will not see the same doctor each time. If one visits a doctor on a Tuesday, the same doctor will not be there if one returns on Thursday night. Do we need to examine that issue? How do we incentivise GPs to be available on a reasonably regular basis after 6 p.m.? In fairness, some practices operate after 6 p.m., but many find it difficult to do so because of the demands on GPs. It is something we must consider.

The final issue relates to the roll-out of the scheme for children under six years of age. The big complaint among GPs is about how the scheme has increased the demands on them. They

say that in many cases people are calling unnecessarily. If we are considering rolling out a free GP scheme for children under the ages of 12 and 18 years, what changes should be made to ensure there will be a balance between people who really need to see a GP and the overuse of a free service? It appears that if we roll out a free scheme for those under 12 years of age, it will create such a demand on the GPs that they will be unable to cope. For example, I heard from one GP that a family had called 19 times in a very short period. There was nothing wrong with the child, but there was obviously a concern on the part of the parent. It might well have been a genuine concern, but the GP felt the scheme for the under six year olds had created its own pressures and that GPs were finding it difficult. If we wish to extend the scheme to children under 12 and 18 years old, what changes should be made?

I again thank the delegates for the research they have carried out and the contributions they have made.

**Deputy Margaret Murphy O'Mahony:** I welcome the delegates and wish everybody a very happy St. Valentine's Day. One might wish to be in a more romantic setting, but we have been in worse, too.

**Deputy Bernard J. Durkan:** How could it be more romantic than this?

**Deputy Margaret Murphy O'Mahony:** I want to hear the delegates' thoughts on the new contract for GPs. I believe the last one which was called the fire brigade model was drawn up in 1970, but things have moved on very much since. Mr. Keegan alluded to the fact that people were living longer with chronic illnesses.

The idea has been expressed that in the future there will be no health insurance and that people will be seen on the basis of need rather than money. Do the delegates think this is possible, viable and realistic? I note their comments on technology. At this committee last week I brought up a technological matter with the Minister which had to do with the very poor broadband service in Bantry General Hospital. It is having a detrimental effect on the services the very good doctors there can offer. Do the delegates often come across similar issues? There is not only a question about the technology but also the lack of broadband, particularly in rural hospitals.

**Deputy Bernard J. Durkan:** Speaking of romance, what more romantic date could one have than meeting downstairs in a committee room on St. Valentine's Day? We are underselling ourselves.

The statistics which have been presented by the delegates are very interesting. I note the anticipated increase in the size of the population. Are there ways to update the data on a regular basis? They are three years out of date if the base year was 2015. To what extent can they be updated to give a snapshot on a regular or annual basis?

The very sizeable projected increase in the population will depend, of course, on economic progress. Are there projections for the increase in demand under the various headings, for example, paediatrics, maternity services and home care services? We have received some information in that regard, but can the delegates update it for us?

I note the reference to public hospitals accounting for 85% of the total number of inpatient bed days and private hospitals accounting for 15%. Do the delegates have suggestions for how, in the short term, the private hospitals could assist where there are particular bottlenecks at specific times?

I am sorry about the questions which I am formulating as they come into my mind.

On the rapidly ageing population, I get a little sensitive, as one does and as the Chairman knows. With the very large expected increase in the size of the population, what age group is expected to be the most demanding? Obviously, there will be a cohort of young people. There must be a huge counterbalance in the form of the younger generation, including children and young professionals coming into the country. To what extent have the delegates incorporated it into their findings?

Traditional GP practices have changed. That is correct. I remember that in my county once upon a time we had the third or fourth generation GPs in the one hospital, the old district hospital, who took great pride in their role. They were traditional, committed to their vocation and their word was the rule. There was a huge degree of patient satisfaction and it was very seldom that things went wrong, including in maternity wings, in the old hospitals. Is there anything we should learn from it? Can we learn from the traditional GP practice where a son or a daughter entered the practice which was carried on in the particular area, leading to huge patient satisfaction and their reliance on the GPs? Has that practice ceased? Has the chain or link been broken and, if so, to what extent?

A question comes to mind about the new services coming on stream. My colleague referred to the under-sixes scheme, which does place a demand on services. What has the benefit been? Has there been a diagnosis of issues in particular areas that would not have come to the attention of the practices otherwise? Of what consequent benefit has it been in streamlining services?

The Chairman will be glad to know that I will come to an abrupt halt in a minute.

There was a question about the out-of-hours service. It is a good service, but there have been some issues with it such as the lack of continuity, the lack of knowledge of the patient and so on. Sometimes that can be good as a new or second opinion can pick up on something that was not noticed previously. Do the delegates have any comment to make in that regard?

I do not think the running of a business should be part and parcel of the burden of running a medical practice. A way or means has to be found to deal with that issue. Running a business can be a stressful activity. As we all know, it can divert attention to a huge extent, particularly during an economic downturn, which can sap the energy of all those involved to an extent that outweighs the benefit of having this model of the GP being the employer, etc. There are far too many more urgent issues to which they should be able to attend. I know that GPs have mixed views on this issue, but it looks to me as though some element of a salaried system will have to be introduced, for some GPs or a period of time, initially at least. It is hugely beneficial for practices to have people with experience who built a practice over a number of years. That means building a business also, but that is neither here nor there. The point is that they have dedicated themselves to it. There are surgeries at 8 a.m., 2 p.m. and 6 p.m. and they also make house calls. That did not come easy and it entailed a huge commitment, with time being taken out of their lives. How do we reward that commitment? What model do the delegates have in mind to possibly recognise the input and contribution made and the loss of time incurred in family life and so on? We want to provide the best possible service for the general public which, as we all know, can be demanding, but we live in competitive and demanding times and it now expects the highest possible quality of service.

Back in the old days, pharmacists had a different role. They were effectively GPs and regarded as such. Over time that has changed and they are now dispensing drugs on prescription

and so on. Is there a need for a re-evaluation of their role to give them an opportunity to participate more actively in the delivery of services to the community?

**Chairman:** Perhaps Dr. Wren might like to lead off in answering those questions.

**Dr. Maev-Ann Wren:** I will respond first to Senator Colm Burke's very welcome questions about the care of older people. To briefly recap on some of the detail of our findings, which I did not share in the opening statement, our projections for the population aged 65 and over is for an increase in the region of 300,000 to 400,000. The figures Senator Burke gave were for our overall population increase but-----

**Senator Colm Burke:** No, the figure I quoted was 640,000 of our population is aged over 66 and that figure will increase to 1.1 million by 2030.

**Dr. Maev-Ann Wren:** Yes. Our figures project that the population will increase from 600,000 in 2015 to approximately 990,000 at our high projection.

**Senator Colm Burke:** Okay.

**Dr. Maev-Ann Wren:** However, the Senator's extrapolation from that to the demand for residential long-term care was very much in accordance with our projections. We project that demand will increase from approximately 29,000 residents now - we are including not only people in the fair deal scheme but people in short-stay beds, transitional care beds, palliative care beds and so on - to a range from 40,700 to 44,600, depending on our assumptions about population and about the evolution of health and disability as people age. We adopt a pretty optimistic view of the evolution of disability in line with recent trends in Ireland. These projections see the proportion of the population aged 65 and over in residential long-term care dropping from 4.5% of the population in 2015 to between 3.9% and 4.4%. What that underlines is that we have quite a challenge in meeting the demand for residential long-term care, even at our most optimistic. The additional places would range between somewhere over 11,000 to over 15,000 at our highest projection. That is based on optimistic assumptions about people living longer, healthier and less disabled lives.

The Senator alluded to home care demand. We see that in parallel with there being a very considerable increase in demand for home care of a similar proportion, 40% to 50% or over 50%, which would mean an addition of some 5.4 million to 7.7 million home help hours over those years by 2030. There is a substantial challenge in terms of both of those.

My colleague, Dr. Keegan, will address some of the other questions.

**Dr. Conor Keegan:** I will address some of Deputy Durkan's questions, particularly his first one on updating data on a regular basis. That is a good point. It is something we have considered and that we hope to do, particularly in light of the uncertainties of these projection models in terms of where there will be population growth, changes in activity rates and so on.

We have a huge number of data agreements with both public and private providers because of the fragmented nature of the system for our base year 2015 and our activity data on which these models are predicated for 2015. Those data agreements are largely rolling and, therefore, we can update them to access more up to date data. An issue is that there will always be a lag between the availability of data and our ability to run projections. For example, by the time 2017-18 data are available and have been provided by our data providers, it could be 2021 by the time we get that 2017-18 data. There are those types of lags in place between when data

become available and running our projections but as the research progresses, we hope to continually update and validate our models.

**Dr. Maev-Ann Wren:** When the Central Statistics Offices produces its population projections following the 2016 census, which it has not yet done, and they differ in detail from ours, we can re-run our projections. Therefore, it will be possible to show the sensitivity of our projections to any different view about population. In some areas our data will be updated more rapidly.

**Dr. Conor Keegan:** On the question on demand increases for particular types of care, for example, for paediatrics and maternity care, in our acute analysis of public hospital care, given the scope of this report, we have not focused on particular areas such as paediatrics, rather we have focused on demand increases, for example, for day patients cases, inpatient discharges, inpatient bed days and so on. We focus on maternity services as a separate area of activity, the reason being it involves all women, they are in a particular age range, they report particular diagnoses and they generally have a lower average length of stay than the rest of those reporting to hospital in terms of discharges. Maternity services is an interesting case as it is one of the areas of activity under one of our assumptions where we see a reduction in demand by 2030. The reason for that is that in one of our population scenarios there is an absolute reduction in the number of women aged 30 to 39, who also have the highest specific fertility rate, which leads to lower births over time, although the positive effect of migration helps dampen that effect. When we model higher population growth through time, we see an increase in demand for maternity services, but it is in an interesting area in that in one of our main projections we see a decrease in demand.

Deputy Durkan had another question related to the age groups that experience most demand for health care services. That will differ across our different activities and in all our different sectoral chapters in the report we provide graphs of activity rate distributions across the age distribution. The Deputy can note that relationship between age and activity or demand. In general, as most of the members of the committee can probably guess, as individuals age, there is an increase in the intensity of use of most services. That is particularly strong if we consider examples of measures such as inpatient bed days where much of that activity is captured among older ages, partly because that is a combination of both older people reporting to hospital more often and they stay longer in hospital. There is quite a amount of activity located among older age groups. Also, in terms of services used mainly by people such as home care services and long-term care services, much of that activity is concentrated among those in older age groups.

Regarding general practitioner, GP, services, we see an increase across age distribution but also in the middle of the age distribution there is quite a high level of activity. That would also come across for emergency department care, where we see activity increasing as individuals get older but there is quite a relatively large bulk of activity in the middle of the age distribution.

In terms of these projections, as a general rule, the more activity tends to be concentrated in those in older age groups, all else being equal, the larger we are seeing projected demand increases as the population grows and ages through our projection horizon.

**Chairman:** Thank you Dr. Keegan.

**Dr. Maev-Ann Wren:** If I could return to the question about paediatrics, while we do not report specifically on paediatrics in this report, we analyse use of hospital care by single year of age. It would be quite possible, for instance, for us to take just an age group and look at it year

on year out to 2030.

**Dr. Conor Keegan:** In addition to that, the public hospital data we have is quite granular and there is a great deal of information in it. We could also look, for example, at particular diagnoses and project forward activity for paediatrics or for different services. Given the scope of the report, it was not feasible to report on it for this research.

**Chairman:** I am sure Professor O'Dowd would like to address a number of questions.

**Professor Tom O'Dowd:** I am glad that Deputy Kelleher has come back because I thought he got to the heart of the matter from a politician point of view.

**Deputy Billy Kelleher:** I came back for the answers. I hope they are good.

**Professor Tom O'Dowd:** They are not actually and that is why they are interesting. Capital development is easier, of that there is no doubt. There is also the matter of human capital. As regards what specialties we need in the future, we need a workforce that takes on board ongoing training and that must be adaptable. If we appoint a number of cardiothoracic consultants and cardiologists get on with stenting people, so that there are no more bypass operations, we will have a problem so there has to be flexibility in the system.

Managers have improved in the use of the data. They used to be administrators but are now involved in management and data cannot be left just to doctors. Policy makers, politicians and managers have to be involved.

If something does not work and we are left on a mountain without any trousers, we are in a very difficult position. All systems are on a journey and all are orientating themselves towards primary care. I have divided the systems into new and old. The old systems, such as ours and those of the Netherlands, Denmark, New Zealand and Scotland, provide a really good service and a broad range of trusted services to patients. The new systems provide a lot of data and include Vermont, which has legislated primary care into its system. The governor recently ran for election and was re-elected on health care, even though health care usually takes a back seat to economics in elections. He ran for election on a programme of reorientating the system towards primary care. His rationale was essentially economic because for every dollar he put into primary care he saved $5. Dr. Craig Jones headed up the policy and published the results. Nobody is visiting Ireland to say they want to see our wonderful health care system and replicate it. Even the countries of the Middle East do not come here and they have lots of money to spend on American-style hospitals.

The point about nurses is right. I come from a family of nurses and they bend my ear regularly about how badly they have been treated. We need to look at practices and at having nurses as partners so that they are involved in the decision making.

There has been a lot of talk about pharmacies. I would like it if we could send prescriptions online to the local pharmacist as it would make my life, and that of patients, a lot easier. There are regulatory issues in respect of this, about which the Medical Council and the Pharmaceutical Society of Ireland, PSI, have to get together but pharmacists would be able to reorientate their IT systems very quickly. It may limit patient choice but it would increase patient safety.

Senator Dolan's questions go to the core of the issue. Things are not joined up and the GP-hospital interaction is often poor or non-existent. The IT systems are completely different and if they change their IT in my hospital they never even tell us, even though we are the people who

refer patients. It is poor. There was a question on access to procedures and I do not see why I cannot refer patients indirectly to the room where they carry out gastroscopies or colonoscopies.

The other area where we have to join things up is the local community. In my own, we have nearly 300 self-help organisations, many funded by the State, and we now have a member of staff who keeps a library of these organisations, to whom we now refer patients. Our consulting rate and our prescribing of psychotropics has gone down for those patients, whom we have entered into the social prescribing module. This is a very interesting area and is something we have stolen from the US, where there is a lot of volunteer activity.

I am always asked if the system can cope. The system analysis is predicated on things not coping and if these do not change they become unaffordable. We have an American-style system of inappropriate secondary care built on an old British-style system of general practice, as Deputy Durkan described it. The two do not mix and there is a systematic bias, which is driven increasingly by private health insurers. We all have private health insurance and when I came back to Ireland I was told to make sure to get my VHI in line because, if anything happened, I would not be able to afford it. People took out insurance unquestioningly and it is rising in price, incentivising inappropriate and secondary care.

Senator Burke spoke about the lack of connection between GP and hospital, which I have dealt with. Many people get years of training and people often say we "end up in general practice" which upsets us because we do not want to think of ourselves as ending up anywhere. The system has become very inflexible and rigid. One of my colleagues, who is very well trained in dermatology, does a session in the local hospital on dermatology but is not paid much for it. She does it because she is interested and because it is a skill and an area of medicine she loves. Many of my colleagues are getting involved in teaching because medical schools are expanding teaching in general practice, though it is not as well remunerated. There will be more than 200 GP trainees this year and they all need mentors and teachers. There was a good question on the GP cohort over the next ten years and there are interviews today for new GPs to start in July. Between 70% and 80% of those will be female and this is a factor in workforce planning, to which Deputy O'Reilly referred. Both males and females are working less but this is true to a lesser extent in the case of females, who also retire earlier. This would not have happened 20 years ago so we need to build it into workforce planning.

There is a huge conflict between dedication and availability. GPs are like everybody else and at every meeting to which I go there is a module on self-care, because the job is so stressful. They say we should not be available all the time but should look after ourselves but that leads to a conflict. On the other hand, it is good for the GP and for the system if a patient sees the same GP all the time. Incentives work and if one incentivises the availability of GPs after 6 p.m. it will work, even if they are not available at 9 p.m. Young people take their children from the crèche and bring them to the out-of-hours service when it opens, which has driven demand in that sector.

I was also asked about changes in respect of under sixes and I believe a report on the out-of-hours service is coming out shortly. I think it may be quite imaginative in its approach. We will need to tell people about managing minor illness. I think we have overdone it on meningitis. Everyone who comes in with a snotty-nosed child with a rash thinks it is meningitis. We have got that message through but now everyone is fearful about it, rather than having heard a complex message. Online stuff works with young parents as does telemedicine, which is to say telephone conversations over FaceTime or the old-fashioned way. We had a meeting with the CEO of the Department of Veterans Affairs, which looks after 9 million US veterans who

can be quite damaged people. She told us that from a primary care point of view, 50% of the administration's consultations are by telephone. People are willing to use the telephone albeit one has to develop new skills and there is clearly a risk.

Moving on to Deputy Murphy O'Mahony's question on thoughts about the new contract, to call it a "fire brigade contract" was a good way to put it. The problem is that with modern contracts, people are moving the dial, as the Americans say. They move the dial every five years. The idea that a contract will see out several generations is bad management. We need a contract for five years so that in five years time when behaviour has improved or set, or things, including diseases, change, one changes the contract. One has that expectation. Our negotiators need to be in permanent negotiation. Things change and people take on new stuff and it needs to be much more flexible than it is. It needs also to be based on incentives. Sole traders respond to incentives. That is very unfashionable to say in some quarters but it is how things work. When they brought in the National Health Service in the UK in 1948, it almost led to the abolition of general practice. That almost died off because of the demand. If one brings in a sudden change at the interface between general practice and the public without some expansion in GPs and allied health professionals, including nurses, the system will collapse. It is very fragile at the moment, following a long, miserable winter.

I cannot comment on the lack of broadband for the Deputy, although my family in the west complain about it a lot. That is their worry-----

**Deputy Margaret Murphy O'Mahony:** Professor O'Dowd has his own worries.

**Professor Tom O'Dowd:** -----and the Deputy's, clearly.

**Deputy Margaret Murphy O'Mahony:** We all have our own.

**Professor Tom O'Dowd:** Deputy Durkan asked about GP changes. That is a blast from the past. The system I entered was a family business and all kinds of changes have occurred, although one of the practices in Rialto is now in its third generation. People like that. A lack of continuity with the out-of-hours service is inevitable. In my own out-of-hours system, there were 50 doctors. As such, it is inevitable where one is on once every 50 sessions. The other thing is that the IT system we use in the out-of-hours service is not linked with the IT system we use in practice. As such, there is quite a bit of development to be done there.

As to introducing a salaried system, GPs are big employers of other GPs. As such, there is already a salaried system. It is not an exploitative relationship, but there are set rules. GPs employ other GPs as assistants on a salaried or sessional basis. It is not a new system.

**Deputy Bernard J. Durkan:** Has the inclusion of the under sixes generated any diagnostic trends? Is there early diagnosis? Is anything happening? The school medical examination system used to be in place but it did not start until a child was five. Has anything shown up which indicates that there is a benefit from including the under sixes in the general medical card system?

**Professor Tom O'Dowd:** I think that politically the Deputy will find it very beneficial.

**Deputy Bernard J. Durkan:** I was not talking about the political benefit. I was not talking about the political doctor, I was thinking about another-----

**Deputy Billy Kelleher:** Patients do, doctors do not.

**Professor Tom O'Dowd:** It has increased demand, including out-of-hours demand. Parents come home after the crèche has phoned to say that little Johnny needs to see the doctor. I have no evidence for the following so I have to be careful about it. From my own work, the prescribing of antibiotics may have fallen because we can now say to a parent that if an under six child does not get better within three or four days, he or she can bring the child back to the surgery. Usually, as is the nature of minor illness, it is a bit better in three or four days. That is an important advantage.

**Senator Colm Burke:** Electronic communication is an issue. Our problem here is that we have something like 1,700 different computer systems in our health service currently. In Denmark, they have 25 and are working down towards five. I understand that in Denmark there is a patient medication card. If one is in hospital or with a doctor, it is possible to get one's file up from the card and to put the prescription on it. One gets the card back and brings it to the pharmacy which can get the prescription from its computer rather than to have it hand-written. Has that been looked at from an Irish point of view?

**Professor Tom O'Dowd:** No, it has not, actually. I am aware of it. One can never get around the fact that talking about the Irish health service is a misnomer; they are Irish health services. People have voted to have a private and a public system. Even if one brings that in, one is bringing it in for less than 42% of the population. One is always dancing around this kind of thing. If one has a universal system - and I do not think it matters whether private insurers or a state pays for it - one can bring in things like that with less cost and more utilisation. At the moment, however, people mention it, but they do not mention the downstream effects of having this kind of system that people seem to want.

**Dr. Maev-Ann Wren:** I had meant to respond to Deputy Murphy O'Mahony's question, which very much picks up from Professor O'Dowd, as to whether a universal treatment with treatment according to need was possible or realistic. We can all disagree about elements of how one gets there, but the reality is that it is the norm throughout Europe and, therefore, possible and realistic in all neighbouring countries and many other parts of the world. Universal health coverage is a World Health Organization objective and one it is promoting strongly. That should tell us that we are playing catch up here. Of course, it should be possible and realistic.

**Chairman:** I have two questions on Sláintecare for Dr. Wren and then some for Professor O'Dowd. Sláintecare promoted universal care delivered on the basis of need not the ability to pay. That was its founding principle. One of the principal recommendations of the Sláintecare report, as with many others, is that there must be a fundamental shift from hospital care to primary, community and social care. I think that is accepted. Another major chapter in Sláintecare related to integrating primary and secondary care. They are currently fragmented. There is a huge financial loss in the failure to integrate. If one integrates services, there will undoubtedly be savings. That is not to say the health service will be cheaper, but one will get better value for money if the service is integrated. Does the ESRI have the capacity to project the cost of adopting the Sláintecare reform plan? How long would that take? One of the objections we hear from Government is it is a costly process. The first question we were asked is how much it will cost and when we said €5 .8 billion, which was our projected cost, the Government said it did not agree with our costings and would do its own. During the deliberations of the Sláintecare committee, the Minister said we would have to wait until the Sláintecare report came out before we talk about health reform. The report has come out; it is now nine months since it was published and the Minister has not produced his response to the report. There is a huge delay in implementing reform. One of those is as a result of costings. If the ESRI could project cost-

ings, it would be an advantage.

Can the ESRI project the number of GPs that will be needed should a universal system come into play in which there is universal coverage in primary care? How many GPs would be needed to deliver that, given the changing demographics and the unmet need we have at the moment?

The question for Professor O'Dowd is on the fact we are in the middle of a manpower crisis. It is not coming; it is here already. We have 660 GPs over the age of 60. Our younger GPs are looking at our GMS contract and saying it is a 24-7, 365 days a year contract in which the doctor pays for everything and takes on all the responsibility. I have a feeling the GP negotiations are not producing a new GP contract; they are producing chronic care on the back of the existing contract. That will not attract our young GPs in. Will Professor O'Dowd speak about that?

There is a difficulty with the visitation rates. The visitation rate mentioned was 5.63, but many people feel it is far more likely to be 8. If one is going to develop costings on developing general practice and one is out by 33% or 40%, it will lead to difficulties in costings. Will Professor O'Dowd refer to visitation rates, which refer to how often one has visited one's GP in the past year? It is an interesting question to ask patients because they cannot remember. If one asks a person how often he or she has visited his or her GP in the past two weeks or past four weeks, one will get an accurate answer which might produce more accurate visitation rates. Visitation rates to general practice refer to face-to-face contact with one's GP. If a GP sees 40 patients in a day, his practice nurse may have seen 20 or 25 patients that day. He may have made 20 phone calls which make material difference to the care of a patient. Combined, that amounts to 80 interactions. The nurse may have had ten or 12 interactions which affect patients' care. In that case, a practice has only seen 40 patients face-to-face but has generated 100 consultations. They are not picked up in any of the data but are a huge part of practice work.

Will Professor O'Dowd comment on the morale of general practice which is a serious issue at the moment and is inhibiting younger GPs coming into the profession?

**Dr. Maev-Ann Wren:** The Chairman's first question was about the costing of Sláintecare. The development of the model came from previous work the ESRI did which was costing a previous proposal for universal health insurance based on the 2014 White Paper. When we developed the model, we did it very much with a view to being able to cost future such reform proposals. Having said that, we still have to develop the expenditure phase. The committee is very conscious of time and delay but realistically it will be at least another year before we have the expenditure phase fully developed. It will probably be somewhat longer than that but then the ESRI should be very well placed to cost reforms like Sláintecare. Based on our earlier work looking at the cost of universal health insurance, we have some forthcoming work looking at the cost of free GP care alone on various assumptions. It is possible with the data and knowledge available to us to look at discrete components of the reform in that way. What the Chairman said about visiting rates and their pertinence to cost is very much on point. We based the work we did recently on the Healthy Ireland survey, which uses four-week recall and includes phone consultations and separately records practice nurse visits. We feel we have a much better base now so in our recent costing, we looked at both the 12-month recall and four-week recall periods for GP visiting.

**Chairman:** Was there much difference between those number based on those two methods?

**Dr. Maev-Ann Wren:** Yes. There is quite a bit of difference. The visiting rates are higher

with the four-week recall and they are closer to GP's own records. It is good to have that. We do not have the figures for the under-50s.

**Chairman:** Will Dr. Wren send that data to the committee?

**Dr. Maev-Ann Wren:** Yes. We will send the committee the data we have on Healthy Ireland visiting rates. It is a survey that was established and administered by the Department of Health. In terms of projecting the number of GPs that would be needed with universal coverage in primary care, we have done two separate exercises. We looked at the potential for increased visiting as a result of universal access to primary care and universal health insurance. Our finding was that visiting by people who did not previously hold a medical card or GP visit card would in aggregate increase by about 49%. That translated into an 18% increase in visiting as a whole across the entire population. If the same proportion of care was delivered by GPs on the same model of care, we could translate that into a *pro rata* figure of an 18% increase. In addition, we have projected the effects of population growth and ageing. Clearly there is a substantial demand coming down the track. In the work we have done, we have looked at ways in which that could be met and the cost could be reduced by changing the skill mix between general practitioners and practice nurses.

**Professor Tom O'Dowd:** On the manpower issues, there has been much talk about primary care in both the Sláintecare report and my report. It has been in the media and has filtered through to people so patients now think things are better because they are hearing about it. The hospitals drive GPs mad saying the patient needs a particular test and asking the GP to organise it because they believe he or she has better access than the hospital. It drives GPs mad because we do not have that access. As a result of all the talk going on, the sense on the street is that things have changed and that GPs are better resourced than they were. All it has been is talk; there have been no resources. It has impacted very much on our young colleagues. We spoke to them in this report. I would be very sad if the contract amounted to chronic care bolted on to what we are doing at the moment. They talk about wanting to build a team, better support for patient care and a new career structure. It is a new contract they want, not a revised one. Morale is very brittle. February is resignation month in general practice. One thinks one has gotten over the winter and then something else comes along so it is always a difficult time.

I am more worried about the business basis of general practice. It is unstable. This morning while I am attending at the committee, I put in a locum who will make more than I will for the morning. That is a zombie business. It is what the BMA calls a zombie business. It is not a stable business on which to build anything. Deputy Kelleher is right. It is a paradox that we are trying to develop a new system based on our weakest link. It presents political, medical and other kinds of risk. There is a thing called the primary care paradox, which exists internationally. In order to change the system of care, people are looking at something that is probably the weakest link in the system. It is a profound question.

**Chairman:** In GP manpower, as Professor O'Dowd will probably be aware, there is a difficulty in people accessing their GP because there are not enough GPs to service the population. Deputy Louise O'Reilly referred to it - GP lists are closed. There is the growing entity of walk-in GP clinics. A GP sets up on a street corner and anyone can just walk in. There is no continuity of care. It is a one-off consultation. It is easily accessible by the public. It is probably cheaper but it does not give the quality of care that we know comes with the continuity of care of an established general practice.

The other development is, because GPs are disillusioned with the present contractual ar-

rangements which have decimated by the FEMPI application to GP funding, GPs are looking for a way out of practice and are now becoming corporatised. There are corporate entities coming into general practice which are taking over practices. GPs see it as a retirement package. It is an exit strategy for them. It makes sense. However, for the patient to be looked after by a corporate entity rather than by a practice entity will not be good for the patient or the population in the long run. Professor O'Dowd might comment on that.

**Professor Tom O'Dowd:** On the walk-in, we cannot be overly romantic about general practice. No doubt my children, who are young adults, and others are not terribly interested in having a relationship with a GP because they want to go in for what they want, they want to be seen on time, they want it to be reasonable and they want to leave. However, that is the demographic that suits the walk-in. Many of the walk-in clinics are based on that business.

Once people start having children themselves or once they start developing illnesses, they want a trusted person who, as the Law Society says, is in their corner. They very much need that. Because the hospitals have become so difficult, one needs somebody who is able to advocate on one's behalf for the local hospital. Sad and all as it is, one needs that.

On corporatisation, I have seen some of my colleagues who have been corporatised and I must say they looked much better than I did when they had done the deal. However, I cannot say that it is good for general practice because the very nature of a corporation is that one can be bought and sold. If one is sold on to another corporation which wants the practice done differently and always cheaper, and it will have shareholders, it takes stuff out of the system. It is a tricky area. Corporatisation is small at present. We measured it in our last survey of general practice. It is growing because I see it growing on the ground.

There are strong defenders of the corporate system. I have read what some of those who are employed by the corporates say. I am also aware of somebody who has left a corporate system because she did not like it. It is not for everybody. The big issue is it introduces another instability into the business model of general practice.

For the rural areas, it is only a matter of time from what I can see, if we are having difficulty appointing rural doctors, until there is a corporate response with GPs moving in for particular times during the day and moving out. People will want doctors in rural areas but if our current GP registrars and trainees do not want to work in single-handed practices, we cannot square that circle. It leaves patients vulnerable. If corporatisation gets a view on it and if they copy, say, an Australian model that works, then it introduces yet another vulnerability.

**Chairman:** The UL department of general practice is proposing a system where graduates who come out of GP training schemes would work in a practice that has difficulty recruiting a doctor. One would put two GPs in a practice and they would work 60% opposite each other so that each would be there three days a week, they would overlap one day a week and the rest of their commitment would be to the university or to a hospital department. One would have an academic career, a service career and a hospital career rolled into a package. One might sign up for a two-year contract on this and then the training scheme or the university would roll that over. One could have at least a supply of service to practices which were unsuccessful in attracting a doctor but here one would have GPs rotating through that practice, providing a service but also giving the doctor the opportunity to expand his or her career.

**Professor Tom O'Dowd:** That is a good model. The universities, as they have gone, and the medical schools that I can talk more knowledgeably about, have reneged on their social con-

tract with society. The pressure is on to publish, get research grants, etc., but medical schools have an important local leadership. What the Chairman described is a local leadership model that has no teaching without service, which is an excellent model. We do not have the universities honouring the social contract that they have with society and they have gone down a North American model. The model to which the Chairman refers is a particularly nice one.

**Chairman:** Have we not asked Dr. Wren any questions we should have asked her?

**Dr. Maev-Ann Wren:** We were certainly asked many good questions. If the Chairman is asking if there something that we would like to add, I suppose it would be purely to say that the report, which, I apologise, is lengthy, is on our website and we are happy to take follow-up questions on any component of it. It is broad in scope.

**Chairman:** Has Senator Dolan any other questions?

**Senator John Dolan:** I have expired.

**Chairman:** The Senator has expired. On behalf of the committee, I thank Dr. Wren, Dr. Conor Keegan and Professor O'Dowd for coming in and sharing their thoughts this morning. That concludes our business for today.

The joint committee adjourned at 12.07 p.m. until 9 a.m. on Wednesday, 21 February 2018.