

# DÁIL ÉIREANN

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## COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

## COMMITTEE ON THE FUTURE OF HEALTHCARE

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*Dé Céadaoin, 28 Meán Fómhair 2016*

*Wednesday, 28 September 2016*

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The Joint Committee met at 9 a.m.

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### MEMBERS PRESENT:

Deputy Mick Barry,	Deputy Billy Kelleher,
Deputy John Brassil,	Deputy Alan Kelly,
Deputy James Browne,	Deputy Josepha Madigan,
Deputy Pat Buckley,	Deputy Hildegarde Naughton,
Deputy Joan Collins,	Deputy Kate O'Connell,
Deputy Michael Harty,	Deputy Louise O'Reilly.

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

*The select committee met in private session until 9.09 a.m.*

### **Universal Health Care and the NHS: Discussion**

**Chairman:** I welcome Professor Allyson Pollock to this morning's meeting and thank her for making herself available to talk to the committee remotely and to share her experience of the National Health Service, NHS, with members. I believe the professor is aware of the task the committee has undertaken and we look forward to speaking to her this morning and learning from her experience. I invite the professor to make her presentation.

**Professor Allyson Pollock:** Good morning. As I am having difficulties hearing, I hope members are not having the same difficulties. My name is Professor Allyson Pollock and I am professor of public health research and policy at Queen Mary University of London. I have an opening statement and if it goes on for too long, feel free to interrupt or cut me off.

**Chairman:** Very well.

**Professor Allyson Pollock:** I cannot see the members and unfortunately can only see myself but I will continue.

The decision to have a universal public health care system always is political and that of course is what the committee is doing. Many countries have decided that universal health care, by which I mean access to services on the basis of need and free at the point of delivery, is the hallmark of a civilised society and that it is necessary and affordable for governments to legislate for their citizens to that end. The question of how much any country should spend on public health care is inextricably linked to the chosen model of funding and provision, the degree of marketisation and how much risk selection and denial of care a government is prepared to tolerate in its health system.

**Chairman:** I ask Professor Pollock to pause for a moment because the sound quality is not great. I have been asked by staff to remind those present to turn off their mobile phones, or turn them onto airplane mode, because they are interfering with the sound system. I apologise for interrupting.

**Professor Allyson Pollock:** Would you like me to continue?

**Chairman:** Yes, please.

**Professor Allyson Pollock:** Okay. The sound quality is not great at this end either.

It is important to note that no country in the world has delivered a universal single-tier health care system through the market, for-profit provision or private insurance. That is because it is in the nature of markets to operate through selection and exclusion. They transfer risks and costs back to service users and inevitably deny care to those who need it most. Risk selection and exclusion is built into the design of market bureaucracies. By contrast, inclusion and redistribution must be built into the systems of public administration for universal health systems. As we all know, risk selection and risk avoidance mechanisms undermine the goal of access and universality.

I would like to refer to the United States, which is the best example of risk selection and risk avoidance at work. With health expenditure of approximately 18% of GDP, the US denies

more than one in five of its population access to health care. A report from the Institute of Medicine has shown comprehensively that overtreatment and denial of care, health care fraud, catastrophic costs and spiralling health expenditure are features of the US health care system. Health expenditure in the US is out of control for both public and out-of-pocket payments. The countries that have adopted the US model of mixed public and private funding, together with public and private provision, have more marketisation, higher administration and transaction costs, the greatest inequalities in access and health outcomes, a lack of coverage and the highest out-of-pocket payments. As this committee has repeatedly seen and heard, out-of-pocket payments are major barriers to access in Ireland. They have a major impact on patients and their access to health care.

According to a report on the Irish health system published by the European Observatory on Health Systems and Policies, in 2008 the full out-of-pocket costs for primary health care were being paid by two thirds of the population. This committee has heard evidence from GPs involved in the Deep End initiative about the operation of the inverse care law in Ireland. There is maldistribution of funds and services because resource allocation does not follow need. Of course the inverse care law is attributable to a Welsh GP, Dr. Julian Tudor Hart, who wrote in *The Lancet*:

The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.

The second of those sentences is seldom quoted. To paraphrase, when health care becomes a commodity, it becomes distributed just like champagne: the rich gets lots of it and the poor do not get any.

The UK established its National Health Service in 1948. The legislation had been enacted in 1946. The NHS is a universal integrated public health system which is free at the point of delivery and funded through central taxation. It is generally agreed by all organisations, including the World Health Organization and the World Bank, that central taxation is the fairest and most efficient way of funding health care. There is consensus on this in all the reports. The NHS - the legislation underpinning it and the system itself - is important because it became the model for the health systems of many countries around the world. For the first 40 years of its operation, the NHS was the lowest cost, most efficient and fairest system. In Bevan's words, the NHS guaranteed health care to all citizens without fear of catastrophic health care costs or being denied care. This freedom from fear was very important.

In 2012, following over two decades of market incrementalism, the Government in England abolished the universal public model by removing from the Secretary of State the duty to provide key health services throughout England. Instead, it made commercial contracting virtually compulsory and introduced new mechanisms for fragmenting and dismantling care and reducing services and entitlements. The structure of the foundation trusts that had been brought in was changed in 2004 to make them 49% private. As a result, they can generate up to 49% of their income privately. This has diverted the attention of the boards of the trusts and, as a result, they now have a greater focus on private income. At the same time, US-inspired market risk selection mechanisms have been introduced over the past 20 years. Most recently, there was a switch to membership-based organisations, as opposed to planning services on the basis of need, and to diagnosis related groups, trusts and tax breaks. This has had catastrophic consequences for universal public health care.

It should be noted that Scotland and Wales have retained the universal single-tier integrated

public NHS model. As the UK Treasury in Westminster controls funding through the block grant allocation, their systems are coming under severe pressure. However, they are experiencing nothing like the catastrophic chaos that is ongoing in England, where 75% of foundation trusts are in serious financial deficit. Barely a week goes by without a chief executive losing his or her job or a failure regime coming into play. By contrast, no hospital in Scotland is going to the wall because hospitals and community services there are integrated into and directly managed by health boards, which in turn are accountable to and responsible for local health needs. It might be worthwhile for the committee to look at an interesting experiment in Scotland that involves the integration of health and social care.

If universal health care is the goal of this committee, as I understand it is, it needs to understand how the principles of universal health care underpinned by public health need, redistribution, risk pooling and social solidarity are alienated by markets and marketisation. In addition, clear and strong laws are needed to enact universal health care. I disagree with the argument that incrementalism might be the best strategy for Ireland because the pace of change would be too slow and might take the health system in the wrong direction. There has been an erosion of entitlements since 2008. I refer, for example, to the introduction of means-testing for medical cards in 2009 and to the increases in the levels of payments and charges for some services. I accept that the eligibility criteria that apply to the GP-visit card were extended in 2015.

Of course every country must build on its existing infrastructure and take account of its own history and services. All countries with a national health service have put in place laws and strong legal frameworks to ensure that universal national health service happens and that parliament commits to it. It does not remain an aspiration. If what this committee seeks to do is to be done, a strong political consensus needs to be built to overcome the many vested interests that would retain the fragmented and marketised private elements of the service and jeopardise the health of many people for the benefit of a few others. My understanding is that given the committee's commitment to articulating a vision for a universal single-tier health service, an NHS Bill for Ireland is the essential first step in a ten-year plan.

If a law is enacted which commits the Government to providing universal health care to all citizens and residents throughout the land, the Oireachtas will decide how much it will spend. It is the task of the administrative bureaucracy to determine how the functions will be implemented, to ensure resources are allocated fairly, appropriately and according to need, and to develop formulae accordingly. A bottom-up approach to change can be adopted. Access to universal health care requires strong systems of public administration and adherence to six common principles: fairness of financing; fairness of resource allocation; risk pooling and social solidarity in service provision; political accountability and control; service integration through geographic units of administration; and public accountability through strong systems of information and monitoring and surveillance systems.

The committee has heard from experts representing the Irish Medical Organisation and many other organisations that primary care teams are essential because they are the gatekeepers to acute and specialist care and have a major part to play in prevention, rehabilitation and working with social services. A strong primary and social care system that is rooted in strong information systems is essential to ensure health care for all. As the committee has already heard, primary care is seriously underfunded and is under capacity. This creates pressure on acute services, social services and the family. In my opinion, a Bill to put in place the necessary legal framework for a national health service throughout Ireland is essential. It would be the first necessary step in achieving the sustainable development goals for universal health care and

access to rational, essential and affordable medicines.

**Chairman:** I thank Professor Pollock for her presentation. I hope she can hear me all right.

**Professor Allyson Pollock:** I can, although it is not great.

**Chairman:** We will struggle on and see how we manage. I would like to raise a couple of points before I bring in members. Professor Pollock has stressed that legislation is necessary to put a duty on the Minister for Health of the day to provide universal health care. I suppose the challenge for us is to work out how we get from where we are now - with a disjointed two-tier hospital-centric system - to a point where we can recommend a particular course of action. Given that the Irish health system is so hospital-centric, does Professor Pollock believe we should seek to change the model of care to move activity from the hospital to the community before we legislate for a basket of services to which people would have a legal entitlement, or does she think both sides of the equation can be done simultaneously? Does Professor Pollock think we should concentrate on providing a legal entitlement to community and primary care services-----

**Professor Allyson Pollock:** I am afraid I cannot hear the Chair.

**Chairman:** Okay.

**Professor Allyson Pollock:** I could hear the first question, which related to whether there should be a shift in the model of care from secondary to primary before legislation is enacted, but I could not hear the second question.

**Chairman:** I will try again. My second question relates to how we can provide for a legal entitlement to services. I noted Professor Pollock's recommendation that we should not do this on an incremental basis. In light of the ground we need to make up here in Ireland, does Professor Pollock think we should seek to provide legal access to those services at community and primary care level before dealing with acute hospital care?

**Professor Allyson Pollock:** Most countries that have put in a national health service began from an imperfect base. The UK was no exception. It was highly fragmented. There was a patchwork of services with significant inequalities. For that reason, a law is needed that places on the Minister a duty to provide services throughout Ireland. That is the only way to overcome the fragmentation, imbalance and inequity in resources.

Of course there is a move to try to improve resources all the time, but that cannot be done without an Act of Parliament. This course of action would not preclude the committee from beginning to work to improve primary care services, to increase the level of funding and to take initiatives forward. I would argue that this needs to be part of the plan. There is nothing preventing Governments from putting more money into primary care by increasing funding from the current level of 3%, which is abysmally low, and by increasing cover. If the big picture and the big vision for this committee is universal health care, it must stick to that. There are risks associated with zooming in and out. If one zooms in too close, into the very micro-details of the health system, one has to cover everything from how primary care and acute health services are run in small areas to the allocation of resources. I feel that the committee's job should be to focus on the big picture - the big vision of how Ireland can get to universal access and how it can provide for the duty I have mentioned. There is nothing to preclude anyone from building up primary care as legislation is going through, or from putting the planning in place. I know it can take a couple of years or more for legislation to go through. I would not say it is a case of

one or the other - I would do both at the same time.

The Chair also asked an interesting question about human rights. She seemed to be wondering whether individuals can argue that they have a legal entitlement to health care. I would caution against such an approach. Brazil, for example, provides for a right to health and to health care in its constitution, but it has not managed to address the huge inequities in its health system. The courts there have been used by individuals who can afford access to justice to exercise their right to health care, but that is not solidaristic. If those courts make very peculiar decisions under the Brazilian constitution, that creates even more chaos and inequality. I think I need to understand more from the committee about what it has in mind when it talks about a legal entitlement to primary health care and community care at the local level. My view would be that if the duty flows from the Minister - in the UK, the Secretary of State for Health - all the structures and resources would follow those duties, powers and functions.

**Chairman:** I would like to get some clarification in that regard. If a duty to provide services is being placed on the Minister, I presume there is a need for the legislation to be quite specific about the services to which citizens are entitled.

**Professor Allyson Pollock:** Yes.

**Chairman:** I wonder how that is actually quantified. What was NHS experience in this regard in 1948?

**Professor Allyson Pollock:** It is important to note that the original founding duty was to promote comprehensive health care. Underpinning the duty to promote comprehensive health care - this refers to the full range of everything - was a duty to provide key services under section 3 of the relevant legislation. I draw the Chair's attention to an NHS Bill that we have drafted and which will have its Second Reading in November. I sent the committee a link to it in advance of this meeting. The intention of this Bill is to reinstate the NHS for England. Part of its function is to bring together the legislation. It looks at the Secretary of State's duty to provide certain services, including mental health services and local pharmaceutical services. The full range of services has been listed in the relevant legislation since 1946. If the Minister is given an overarching duty to promote comprehensive health care, which is the real goal, and a secondary duty to provide key services, that should help to reconcile some of the issues the Chair is struggling with.

**Chairman:** All right. I will call the members in groups of three. I ask Professor Pollock to bank the questions before responding to them together.

**Deputy Louise O'Reilly:** I thank Professor Pollock for her presentation. I am keen to ask a question with regard to the difference between Scotland and England. Obviously, there is a shift in England towards privatisation. It does not seem to be the same in Scotland. Will Professor Pollock explain this by way of a difference in legislation or in terms of legal obligations? Is it simply the difference of choices made by the Minister?

My next question refers to the strong information systems referenced by Professor Pollock in her document. To what extent are these systems underpinned, named, financed and funded? Specifically, how is this done under the legislation?

My third question relates to accountability. Professor Pollock referred in her presentation to accountability by the Minister. Is it only to the parliament or is there some further level of accountability that is not necessarily obvious to us?

**Deputy John Brassil:** I thank Professor Pollock for her presentation. I have two brief questions. Does Professor Pollock believe there is a role for private health care in any functioning health system, given that Scotland and Ireland have approximately the same demographic?

**Professor Allyson Pollock:** I am sorry. I cannot hear. Can Deputy Brassil speak into the microphone?

**Deputy John Brassil:** Does Professor Pollock believe there is a role for private health care in a functioning health system?

**Professor Allyson Pollock:** Does the question relate to Ireland? Will Deputy Brassil please speak into the microphone? I cannot hear him.

**Deputy John Brassil:** At present, approximately 44% of the population are covered by private health insurance. I am keen to hear the thoughts of Professor Pollock on how we move from that model.

**Deputy Josepha Madigan:** I thank Professor Pollock for her very interesting presentation. As we know, health is not only the absence of illness. What does the NHS do to promote or cultivate health as opposed to fighting disease? Are there specific programmes and initiatives around that?

**Professor Allyson Pollock:** I am really sorry. What is the question? Does it relate to what the NHS is doing to promote prevention?

**Deputy Josepha Madigan:** I am wondering whether there are any initiatives or programmes that the NHS has undertaken or that it promotes relating to cultivating health as opposed simply to fighting disease.

**Professor Allyson Pollock:** Deputy Madigan's question is not coming through. I am really sorry. It is something to do with the sound. Can someone else try that question for me?

**Chairman:** I will try to repeat that, if you can hear me all right. Deputy Madigan is asking about particular initiatives that the NHS may be involved in relating to health promotion and prevention of disease.

**Professor Allyson Pollock:** Okay.

**Chairman:** If you could address those questions, we would appreciate it, please.

**Professor Allyson Pollock:** Would you like me to answer these questions now?

**Chairman:** Yes, please. We would appreciate that. Thank you.

**Professor Allyson Pollock:** The first question was really about the difference between Scotland and England. One of the important things to note is that England introduced an internal market purchaser-provider split in 1990. That model was followed by Wales and Scotland. However, when devolution came in 2000, Scotland and Wales took the step of deciding to abolish their internal markets. That was pretty much a silent revolution. People do not realise it even happened. It took place through legislation. They abolished the purchaser-provider split and reintegrated hospitals and services into health boards, making them responsible for the needs of the population. This required legislation. It was a legislative process. They have now gone further in that they are now moving to integrate social services into health services using

a bottom-up approach, which is an interesting approach. That is the difference between Scotland and England and what has been happening in the past 13 years. Scotland has gone further. There was a political declaration by the Scottish National Party not to have private provision.

The second question was about information systems. These are the lifeblood of any health system. Scotland operates an information system, ISD Scotland. It is part of a special health board or authority. That is how information is managed. It is superb. It is the jewel in the crown of the Scottish health service. It means we can undertake many comprehensive studies. It very much mirrors the systems in place in Scandinavia.

Committee members will be well aware of the debacle over information in England, not only fragmentation but the care data scenario as well. The intention of the Bill we are writing is to put information back under the direct control of the Secretary of State and a health authority. At the moment, information in England is deeply problematic, especially care data, what has happened with general practitioner practices and the ability to get data.

The Deputy asked a good question about accountability on the part of the Minister. Again, my view is that if Ireland were developing legislation, those responsible should strengthen systems of accountability. I am referring not only to the Parliament but to accountability to the people as well. This is an area where we have seen a major weakening in England. We used to have community health councils, which had a direct right of appeal to the Secretary of State. We had a number of good mechanisms at local, district and regional level whereby the Secretary of State and the Parliament could be brought to account by local people. I think the question about accountability is singularly important. This point should be worked out in legislation. I hope that answers the questions of the first speaker.

The question of the second speaker related to the role of the private health care system. I would put it the other way around. I will put the following questions to committee members. What evidence is there that incorporating private health insurance and private providers actually ameliorates the inequity we see in the system? What evidence is there that they can deliver universal health care and social solidarity? What evidence is there that they can keep the costs of health care and transaction costs low and ensure there is no subsidy from the public to private sectors? That is what I would be going on. What is the evidence for private health insurance and private provision in ameliorating and preventing inequalities in health care and in ensuring universal access? There is considerable evidence to the contrary. All the evidence points the other way and suggests it does not.

There was a question about the 44% of people covered by private health insurance. Work needs to be done to understand the extent to which people use that insurance and the extent to which tax subsidies exist. We know there are such subsidies for people who use private health insurance. We know there are tax breaks to private health providers.

It is about building political consensus such that people can believe the system will be there when they need it and such that they do not need private health insurance. I think if there was major legislation setting out the intention, people would find that private health insurance would wither on the vine. It should wither away. Indeed, in the United Kingdom in spite of all the chaos in England, coverage by private health insurance is less than 10%. The figure has been falling since 2008. That is partly as a result of the financial crisis, but the level is far lower than the level in the Irish health system. Some countries prohibit private health insurance, such as Canada. The setup in Canada prohibits a two-tier system from existing. Under the Canada Health Act health care is provided in the public system and people cannot use private health



insurance as an alternative route. These are things that need to be debated and discussed. The central issue is whether private health care, private health insurers or private providers reduce inequalities, increase access, decrease costs and ensure social solidarity. I am happy to come back in on that.

Deputy Madigan asked me about health promotion initiatives. As a result of marketisation, most public health functions in England have been transferred under Public Health England to local authorities. This has been catastrophic because local authorities have faced major cuts in social services expenditure and are facing cuts of £200 million in public health expenditure. Many vital health promotion and prevention programmes that were in place in areas like school nursing, health visiting, district nursing, smoking prevention and cessation and alcohol intervention are being seriously cut at the moment. Indeed, some of these services will no longer exist in local authorities. At the same time, because there is no longer a duty of provision on the Secretary of State, the individual clinical commissioning groups that have replaced the old primary care trusts and area-based health authorities are now decommissioning whole ranges of services. The criteria for hip arthroplasty and cataract procedures, for example, have been changed. Many preventative services, including some forms of surgery, can be seen as preventative. Hip arthroplasty, which is the most common elective surgery operation, can be preventative if it is done on time because it prevents people from falling and becoming disabled and enables people to continue to live at home. A range of services are being decommissioned, slashed or no longer funded in local authorities. I do not have a good news story for the committee from England. All of this flows from the abolition in 2012 of the Secretary of State's duty to provide.

**Chairman:** I will bring in the next group of three speakers.

**Deputy Alan Kelly:** I thank Professor Pollock for her stimulating presentation. I will ask a few quick questions. I was very taken by Professor Pollock's answer to my colleague's question about private health insurance. If we were to pursue a certain strategy and take a certain legislative route to provide for universal health care, would she recommend that we should work towards the Canadian model of ensuring no private health insurance is available? I have to say it is a very interesting theory.

Speaking of theories, we are all familiar with the work of the NHS since its inception in the 1946 to 1948 period. There was a change in policy in the early 1990s with Thatcherism, etc. Has a lack of consistency in political thought under various Governments in the UK had a negative effect on how the NHS has been working in recent years? I refer also to the changes in the internal market, etc. Professor Pollock spoke in detail about primary health care and particularly the model that is adopted in Scotland, as opposed to Wales and England. Can she get into the details of the differences between what is done in Scotland and the rest of the UK? What does the NHS do so successfully to maintain staff in its system? This is a topical issue in Ireland because staff retention is a particular problem here.

**Deputy Joan Collins:** I hope Professor Pollock can hear me.

**Professor Allyson Pollock:** Yes. I will ask members to repeat their questions as I go along if I have not heard them properly.

**Deputy Joan Collins:** This committee has been established to discuss how to provide a health service that is free at the point of entry and to which everybody can have equal access. There are interests in this country's health system that do not want such a service to be provid-

ed. Health care is a lucrative area for private companies, including private hospitals. We must base our recommendations on evidence. I would like more information about the US health care system, which is perhaps not a health care system. I would like to get evidence from Scotland, Canada and other places. We should be discussing such matters at this committee. I do not think Professor Pollock can deal with all of that today. She has given us an outline of the US system, which does not provide equal access for the people of that country. She referred to the UK example as well. I wish her well in her campaign to reinstate the NHS in Britain because I think it has been a beacon for many countries. I was very interested in her presentation.

**Deputy Mick Barry:** I have three questions for Professor Pollock. Can she hear me okay?

**Professor Allyson Pollock:** Yes. The Deputy must be speaking into the microphone.

**Deputy Mick Barry:** I am moving in as close as I can. I thank Professor Pollock for her presentation. I would like to ask three questions. It has been suggested that there should be a shift in the Irish health service towards the establishment and strengthening of a model of hospital trusts. These trusts would have the power to raise their own finances independently and to outsource services from the private sector. I understand this has been a feature of the health system in the UK in recent years. I wonder if Professor Pollock can tell us whether it has been a good or bad experience. What has actually happened?

Professor Pollock has argued that systems which are based on private health care are more expensive. Can she explain why she thinks that is the case? Is it fundamentally a case of profiteering or of wastage that might be associated with duplication or markets? Could Professor Pollock break down some of the information on that issue? In her book *NHS plc: The Privatisation of Our Health Care*, Professor Pollock argues that universal health care systems are superior to systems that target services and health care provision. Can she explain why she thinks that even though targeting of services and provision sounds fair, it often does not seem to work out that way?

**Chairman:** I invite Professor Pollock to respond to the questions that have been asked by the three Deputies.

**Professor Allyson Pollock:** I was asked whether private health insurance should be outlawed for treatments that are being provided by the public sector, as in the Canadian health care system. There is a strong argument to be made for that on the basis of the evidence on private health insurance. I return to my original point about whether there is any evidence that private health insurance reduces or ameliorates inequalities. There is really no such evidence. The Canadian health model is a very interesting one to look at, although it is under challenge at the moment. There is a constitutional court challenge being made in British Columbia on the very issue of private provision, private payments and private health insurance. Canada is under attack at the moment from a particular doctor, Dr. Brian Day, who has a very large private practice in British Columbia. All the available evidence shows that private health insurance does not reduce equalities or ameliorate health care, does not give the subsidy people argue it gives and results in greater inefficiency. Importantly, it also diverts staff and services. In Ireland, for example, I understand that 20% of beds in public hospitals can be used for private patients with private health insurance. That is a diversion of public capacity and it will get worse if hospitals are given more powers to generate private income. It means that staff and services that should be available for the public health and universal health system are being diverted and leads to distortions in the system.

The second question was on lack of consistency in government policy in England. The government has been entirely consistent in its policy direction. We had the Thatcher reforms on the Internal Market, which was followed by the period when John Major was Prime Minister. Apart from one small period when Frank Dobson was the Secretary of State for Health, the new Labour government was very consistent in pushing through greater marketisation. It introduced foundation trusts, for example, and continued with the private finance initiative, albeit against a backdrop of the largest ever increase in public expenditure. It was this increase that made these changes possible without hurting the system greatly. If one is marketising and privatising, one needs to push in a great deal of money, which is what has happened. We have, therefore, had an entirely consistent ideologically driven rather than evidence-based programme from the late 1980s onwards, culminating in 2012. The dismantling Acts of Parliament, which would not have been possible without all the implementing legislation that went before it.

That takes me into general practice. One of the key Acts of Parliament in 2003 and 2004 was not just the law on foundation trusts but the changes to the way primary care was organised and delivered. Previously, contracts for general practitioners were between the secretary of state and the individual GP. What the 2003-04 Act of Parliament brought in was legislation introducing new contractual forms. After this, in addition to the traditional general medical services, GMS, contract, we also had the alternative providers of medical services, APMS, contract and variants thereof known as personal medical services, PMS, contracts, which could be negotiated with GPs. The APMS contract resulted in companies coming in, running and owning GP practices and employing general practitioners. This has created major problems and schisms in England. General practitioners on conventional GMS contracts are being underfunded and are handing back to the keys to their practices, with the result that some areas of England will no longer have general practices. At the same time, large companies such as Virgin, Care UK and UnitedHealthcare, a big American corporation, came in to run and operate GP practices and to salary the GPs. Some of these practices are not doing very well and the companies in turn are simply walking away from the contracts. As there is no duty on the Secretary of State to provide any more services, there is a very real risk that whole areas of England will be without a service.

One must be very careful if one wants to corporatise and bring in commercial companies to run and operate GP practices. The legislation was accompanied by more recent legislation which will allow GP practices to take patients from anywhere in the country. Practice boundaries were dissolved as of January 2016 and a variety of complex changes have been introduced that have changed health care from being area based to being membership based. I can explain more about that.

In contrast, while Scotland also has a crisis in the recruitment and retention of staff, it is nothing like the crisis affecting England. This is partly because Scotland has refused to introduce the APMS contract form, which means there are no commercial companies providing and delivering care. This is the result of a battle and legislation introduced in 2010 or 2011.

One comes to the very interesting question of how Ireland will retain staff in its national health service. My understanding is that it appears from OECD figures - these may be skewed and I am not sure how true this statement is - that general practitioners and hospital consultants are among the best paid in Europe when compared with their counterparts. I do not know how true that is as there was a problem in that the OECD could not include private practice in its figures.

Retaining staff requires a number of initiatives to be taken. There is the idea of being sala-

ried. Terms and conditions and pay are what the trade unions and Irish Medical Organisation negotiate. However, there are other initiatives to do with professionalisation of the workforce. Our royal colleges have played a major role in this regard. There are lots of other cherries that go with one's status, however. It is not necessarily only related to pay, but also to doing a good job, being appreciated and being able to take and drive forward new initiatives. In my experience, these factors are a much greater motivator for most doctors and clinical staff than money. Salaries are important but much more important for staff is the day-to-day job they are doing and having the resources and capacity to innovate and drive change. One of the greatest triumphs of the national health service for many years was its ability to drive innovation and, through clinical innovation, to drive change.

The committee heard a great deal about the motivation of doctors in the two most recent sessions of evidence. The retention and recruitment of staff is important. We need to put plans in place but this is difficult when junior doctors are leaving medical school with debts of €100,000 or €200,000. They may not share the public service ethos or commitment that I and all my colleagues had. I did not pay any charges or fees when I did my degree. These issues need to be thought about and one needs to have an education system that encourages people to have a public service ethos and an obligation to give back and pay back for the rest of their lives. This is something we lose sight of in the national health service where there is an extraordinary feeling of obligation and giving back among staff every day. This will be lost now that students pay catastrophically large fees. The health system in Ireland must also think about the higher education system and training.

Deputy Joan Collins commented on her interest in universal health care and the problems with the US health care system and referred to the need to look at the systems in place in Canada, Scotland and Scandinavia. I would advocate looking at the Scottish model. While no model is perfect, the Scottish model always aspires to be perfect and it is a good model to look at. The Canadian health system, which is under threat from the constitutional challenge to which I referred, is another model to look at and think about. It is a more federal system. The Institute of Medicine report from 2012, for which I can send the committee a link, sets out very well that the US health care system is not only the most expensive and unfair system in the western world but also one that has enormous transaction costs. Up to \$3 trillion has been spent in 2012. Almost \$1 trillion was actually spent, or was wasted, due to administration costs, fraud, unnecessary tests and unnecessary investigations, including surgery.

I will now turn to the question of trusts and the move in Ireland to establish hospital trusts to raise their own finances and add some services. We have been there before. In 1990 we inaugurated the internal market and allowed hospitals to become corporate bodies and use private finance initiatives, PFI, and outsourcing. The whole idea of raising one's own money is to look to the markets and private finance and of course the private finance initiative is a totally discredited policy on all sides of government. We are left with these major debts and not just in health but also in education, the courts, prisons, roads and so on. We have this extraordinary debt that we are now servicing for the next 30 to 60 years and very little control. So, if one wants to look at the catastrophe of allowing trusts to raise their own finances look at where our foundation trusts are today. Most of them have PFIs. They have been allowed to raise their own finances, they are carrying these debts which must be serviced off their annual income and 75% of foundation trusts are now in deficit with serious financial difficulties.

Allowing trusts to rely on PFI in that source has been problematic. The private finance initiatives, or public private partnerships, PPP, also include a mechanism for outsourcing ancillary

staff and services. That was a disaster and many, if not most, PFIs have actually brought their services back in-house when the contract has allowed that to happen. They found that when outsourcing quality and standards fell, the costs were high and they were getting very poor value. That was instrumental in returning services back in-house into the hospitals. Foundation trusts that outsourced and raised finances are left with a very big problem in that as much as 15% or 16% of their income will now be going to service the debts of PFI. Everybody knows it is much cheaper for the Government to raise the money either through Government borrowing or through taxation. Look at the histories and experiences of PFI, including the recent report by the UK's Treasury Select Committee. It is a totally discredited policy.

The other big problem with allowing hospitals to raise more of their money privately is that they become much keener to look at income and they are no longer integrated into the health service. They are no longer putting the National Health Service services as a top priority. The income generation becomes really important. If the committee is really interested in the effect of allowing hospitals to do their own thing and to raise their own income only, look at the Mid-Staffordshire NHS foundation trust report, the result of an inquiry which lasted over 18 months. It is an enormous report which shows that at the heart of the problem was that the trust board were focused on income and income targets, including private income, to the detriment of patients and patient care. It is another argument for taking hospitals out of trust status and reintegrating them into the health service. The other argument is that while our hospitals are pursuing their own agendas, they are not now necessarily focused on the primary care, the rehabilitation and the prevention which is what we are interested in. They move further and further away into the risk selection and risk avoidance mechanisms when they are focused only on the bottom line.

Reference was made to universal health care programmes as opposed to targeting health programmes. It is a reality that in many universal health care systems one will also have targeted health programmes. One will have programmes such as breast screening, cervical cancer screening or immunisation. There will be programmes to target specific needs while under the umbrella of universal health care system. Problems arise when one does not have a universal health care system. This can be seen at its extremes in low income countries such as in Africa and India where one has practical health programmes with separate funding that are brought in but there is no universal health care system. They would have a focus, for example, on HIV and AIDS, on TB, malaria or diabetes, but they are not thinking comprehensively or holistically about the patient. Targeted health programmes have their place within the universal health care system. However, targeted health programmes have no place if one has no universal health care system. We should not be dealing with two.

The committee has not asked about the National Treatment Purchase Fund and our experience of using the equivalent of the National Treatment Purchase Fund, which was the fund for the independent sector treatment centres, ISTC. This was where doctors and patients could refer to the private sector under the rubric of choice. Some £4 million was top-sliced by the Government for the ISTC programme, which included NHS and private providers. However, the health select committee reports, of which there have been several, show that the ISTC programme did not provide value for money, it increased the costs, was inefficient and there was no evidence of innovation. That ISTC programme has been significantly rolled back.

I will stop there and I hope I have answered the committee's questions. If not then please come back to me.

**Chairman:** I thank Professor Pollock for her comprehensive responses. Deputy Barry

wishes to clarify a point?

**Deputy Mick Barry:** I would like clarification on the question that had been asked on the issue of why systems with private health care are more expensive, in Professor Pollock's opinion.

**Professor Allyson Pollock:** The Institute of Medicine report sets this out very well. The first issue is the huge transaction costs. Administration, billing, invoicing and the administrative costs of the market are, we know from the US studies, anything from 30% to 50% of the US dollar. That is very high indeed. In the UK, in the publicly administered services the transaction costs because of administration were only 6%. They were 5% if one looks at the first 40 years of the total budget, which is very low indeed. When we move to the internal market, with trusts and internal billing and invoicing, we move to 12%. It is very likely now, because we have compulsory contracting, that we are moving to the 20% or 30%. It is very likely because we now have teams of lawyers, accountants, management consultants on both sides - the trusts and the companies. Every time one has gone out to tender, there are six or seven bidders and all the process which that involves. That is the first big reason. It is the type of market which is very much more expensive than a public administration.

The second reason of course is the profit motive, which is hidden in all sorts of ways. One has profits but one also has to do marketing. If it is a commercial company it has to sell its goods so it will spend a lot on marketing and public relations. There are other costs. Given that there is risk selection and risk avoidance, one has to put in very expensive systems in order to select carefully the patients who will be treated, the more profitable patients and the healthier patients. Protocols would have to be developed and there would have to be risk management systems so that the costs are off-loaded when those patients get too expensive. That in turn generates a new system of costs for the rump public sector that is left behind, which is inevitably the service that picks things up. In the UK, when things go wrong in our private treatment centres for elective surgery, and one needs to go back into intensive care, the first place one goes is back to the NHS. One always goes back there. Whether it is for outpatient or intensive care treatment, it is the NHS that picks up the pieces. Of course, the other thing is because the private sector is into risk avoidance, we will not get the same levels of primary prevention.

I noticed that in some of the evidence given to the health select committee Kaiser Permanente was cited. I will happily send the committee a paper we published more than ten years ago looking at the claims of Kaiser Permanente around its prevention and rehabilitation. Kaiser Permanente is a health maintenance organisation, HMO, in the US. It is highly selective in the patients it recruits to the insurance system and the patients it treats. It does not have a universal service obligation which means it selects out the more profitable patients, that is, those who can pay their health insurance, and the more profitable services. There is a huge mythology around Kaiser Permanente and I am happy to send the committee our published paper, which refutes and rebuts it.

**Chairman:** I thank Professor Pollock and call Deputy Michael Harty.

**Deputy Michael Harty:** I thank the Chairman and Professor Pollock for engaging with our committee. I have just one question. Our system is very fragmented, which reduces the quality of care to our patients, and there is a lack of integration, communication and information technology as well as a lack of resources in primary care and a lack of accountability in decision making. All these factors lead to a very inefficient service, poorer outcomes, longer waiting lists and trolley queues in our accident and emergency departments. Many decisions in our sys-

tem are made on an *ad hoc* basis and without consultation with the main stakeholders. We have proved, I think, that this cannot work given the state of our health service. My question relates to the incremental introduction of a new system. Professor Pollock suggested it is not a good idea. Is she suggesting that on a particular day, the system should change from what we have at the moment to a new system with a legislative framework and background? Further, would huge resources need to be put into primary care before such a transformation would take place?

**Chairman:** I call Deputy O'Connell

**Deputy Kate O'Connell:** I have a few questions. I spent a stint of my own life in the NHS in 2003 or 2004.

**Professor Allyson Pollock:** Sorry. Would the Deputy mind speaking into the microphone? I really cannot hear her.

**Deputy Kate O'Connell:** Can Professor Pollock hear me now?

**Professor Allyson Pollock:** I can.

**Deputy Kate O'Connell:** I worked in the NHS in 2003 or 2004. Around that time, if my memory serves me correctly, there was a sort of realignment of the NHS, because the costs were getting out of control when it came to pensions, and there was a huge renegotiation of contracts. I was a junior at the time and I was not really thinking about a pension at that stage. Has Professor Pollock any suggestion as to how we can anticipate such overruns and how we might manage those if we are looking at a universal health care model in this country?

I may not be right but my experience in the NHS was that there was a very good basic level of care, which was quite universal, and an extensive menu of services but that higher levels of treatment were not necessarily, in my experience, as good as perhaps we have here. There were huge restrictions. One thing that struck me when I returned to Ireland was that in Ireland, one got whatever treatment one required. Depending on the type of cancer one had, there seemed to be fewer restrictions. In the UK, there was huge input by the pharmacoeconomics departments into working out the cost-benefit of drugs. On the ground what that meant was that people did not get the same level of treatment that people in Ireland were getting for some complex illnesses. What is Professor Pollock's experience in that regard?

My understanding is that GPs in the NHS must reach specific targets when it comes to certain conditions. For example, they must do X amount of smears in a month and X amount of interventions with people with diabetes. I happen to have a family member who is a GP in London. From chatting about it, sometimes, in order to reach those targets for those specific and very important health measures, day-to-day bread and butter stuff like children with tonsillitis and other bits and bobs tend to get pushed to the side because GPs are so focused on meeting their targets for certain things within the basket of treatments that their surgery is to deliver. What are Professor Pollock's views on that and how it has trickled down and affected people's lives?

The prescription service in the NHS - I think the forms were called FP10s but the name may have changed - was free at the point of delivery. There were no prescription charges for pregnant women, army veterans or students as well as those who satisfied a means test. My experience as a pharmacist in Ireland is that sometimes we need a small barrier - not a massive one - at the point of delivery, so that people appreciate things and there is less waste. Does Professor Pollock agree?

I think that is it. Will Professor Pollock address the pitfalls in the GP contract, the levels of care comparatively between the two countries, that there are no barriers to access and the pressures unrestricted access to certain services put on a system?

**Chairman:** Thank you, Deputy O’Connell. We would appreciate it if Professor Pollock addressed those questions.

**Professor Allyson Pollock:** I am trying to remember the first question. I cannot remember what the first speaker asked me. Would he remind repeating it?

**Deputy Michael Harty:** It related to the introduction of a new system. Professor Pollock suggested that doing it incrementally was not a good idea.

**Professor Allyson Pollock:** Yes. The question really is whether we should have a single piece of legislation to create a national health service for Ireland. I said my opinion was “Yes”. If one looks at all the countries that have introduced a national health service, theirs were usually fragmented, inequitable and a patchwork of services. However, that is not a reason not to introduce a single national health service. One builds on what one has got. Legislation will take a year or two years to enact and a further year to implement. During that time, the Civil Service and politicians need to be working in great detail to plan that service so that, as Deputy Harty said, it can open on a particular day. I think 6 July 1948 was the inaugural day for our national health service.

I would advocate having a single piece of legislation that makes the duty on the Minister very clear. Some of the best brains in the country are in the Civil Service and around this table and they could be working and planning for it. Of course, it does not just happen by enacting an Act of Parliament. It needs all the work that underpins it to thrash it out. I would go further in advocating that one would want to understand all the legislation that came before and bring it all together in one comprehensive piece of legislation. I worked with a brilliant barrister on our NHS Bill over a period of five or six years. I would say, “Go for it”. Go for a really clean universal health care and a single tier health care system, I say, “Do it.” One will never get there on the back of incrementalism. The lobbyists and vested interest groups are too strong and powerful and will always hold one back.

I thank Deputy O’Connell for the second set of questions. They were dating from 2003 and 2004, which was really a time of increasing marketisation. This was the time of the new general medical services contract, which brought in the alternative providers of medical services.

I was asked a good question about pensions. Pensions in the NHS have always been pay-as-you-go. Actually, they have returned more to the UK Treasury than they have taken out. Last year, I gather £2 billion was returned to the Treasury, but I will need to double-check that. Anyway, more money was returned than taken out. Since then the UK Government has acted in a number of ways to put a brake on the total pension sum that a person can hold and to change benefit and pension entitlements. There are always things that governments can do if they believe pensions are out of control. However, pensions have never been out of control in the NHS. It is a pay-as-you-go model and it has been a good system, unlike other pensions.

The second question was whether Ireland was providing better specialist or tertiary services. If that was put to the people in our teaching hospitals, I wonder how they would respond. I have in mind Guy’s Hospital and St. Thomas’ Hospital, as well as St. Bartholomew’s Hospital, where I work now. I think people can only make those sorts of claims in two ways. The first is



using the research and evidence available. I would look at treatment rates for common things, including hip, plastics, cataract and cardiac treatment. I have a feeling that the United Kingdom is doing equally as well as Ireland. I am not meant to say we are doing better or worse unless I have the comparative data to say as much. In Scotland we recently finished a study looking at elective hip and cataract replacement. Can the health services here provide me with similar data to undertake a similar study in order that we could show that we are providing the same sort of access on the basis of need? That is why information is really important. We need to collect the data to look at that. Patients' perspectives are important as well. The Commonwealth Fund continues to rate UK health services highly, indeed, above Ireland, if we are to believe the ranking scores and surveys.

The third question related to pharmacoeconomics. We have two issues. We have the dilemma of prioritisation and how we prioritise resources and services, as well as the issue of effectiveness, in other words, the evidence of effectiveness and benefit. The UK Government set up the National Institute for Clinical Excellence in 1999 or 2000 especially to examine evidence of effectiveness of drugs. The institute includes the quality and cost dimensions in its considerations. There is an issue here for Ireland because when I have looked at the health systems and transition reports, it appears that Ireland, even though it could be a monopsony purchaser on the part of Government, has very high drug costs. Of course those costs get passed on to patients. If those involved were to do more negotiation with the drug companies, they might be able to get drug costs down and that would have a significant impact on the budget in Ireland.

The UK National Institute for Health and Care Excellence is important because it brings some evidence of efficacy and effectiveness, as well as the cost-benefit analysis. It has been an important body in terms of negotiation on the entry of drugs into the public system, as well as helping as part of the negotiation around cost. It is a model we should look at to see whether it is something that would suit Ireland. One of the major problems we have with drugs in all countries arises when we give a drug marketing approval. Our regulators give approval for the market and then, it is a free-for-all. One of the issues for a public system is the nature of the evidence of the benefit and on what basis should we give access to the public system. That is always a dilemma, whether for vaccines or drugs. That is why we need a scientific approach. We also need to negotiate hard with the manufacturers, because the prices of drugs and technologies are one of the greatest inflationary costs, much more so than staff costs. They are an enormous inflationary driver. We have to control those costs and ensure far more rational medicine and diagnostic use.

I was asked a good question about targets for general practitioners, GPs, and whether the targets were actually preventing them from being more holistic in their approach. Indeed most GPs would argue in favour of this view. The NHS quality and outcomes framework, QOF, has been greatly disliked by GPs because it links payment to targets. They believe this undermines their more holistic role. The system was brought in as part of the new corporate framework, the alternative provider medical services and general medical services contract revisions. Scotland now has abandoned and got rid of its QOF and England is beginning to move away from it more and more. I hope that answers the question. Targets were part of a market critique. The idea was that we had to have market incentives and payments but what resulted was that these market mechanisms created perverse incentives to focus not on the patient but on the numbers. The focus was on the numbers rather than what the needs of patients were and whether given treatments were the right treatments.

I was asked about FP10 prescription charges. In England it is indeed the case that the major-

ity of people who receive a prescription are actually exempt because they fall in to the category of pregnant women, children under 18 years of age or older people. Scotland and Wales have now abolished prescription charges completely. There has been no obvious evidence of an inflationary effect. I will offer some anecdotes here. Some GPs argue that it has actually improved their prescribing. Before, they were conscious that patients had to pay for the prescriptions and therefore gave the patients double or triple courses and far more drugs than they needed for longer periods. Now, they can give short courses, see the patient again and, as a result, there is less waste in the system. The evidence of prescription charges is that they curtail access. They are a major barrier to access. There is no evidence that having a prescription charge is a good thing or that it results in rational medicine prescribing or use. Again, Scotland and Wales would be good to look for. There is still a movement in England to abolish prescription charges. There is also evidence that the cost of collecting those charges is problematic. The cost of the administration is greater than the prescription charges income. There is good evidence on that as well. I can send the material to the committee. I hope I have dealt with those questions.

**Chairman:** Thank you very much, Professor Pollock. I have one further question. You referred earlier to the geographic organisation of health services. In Ireland, the HSE is a national organisation, but it has recently reorganised the hospital sector into six hospital groups - these were referred to earlier - with some intention to move towards hospital trusts. At the same time, the primary and community care services are organised in nine different community health organisations. I would welcome your opinion on whether that is a viable way of organising services when there is no alignment between hospitals and primary and community services.

**Professor Allyson Pollock:** This is horizontal integration. The market moves towards vertical and horizontal integration. This is rather reminiscent of what happens in the United States, where there are hospital groups and primary and community care service groups. I think it is deeply problematic because the idea of the Secretary of State having a duty to provide is that this duty is then devolved or delegated down to contiguous areas that cover all the population in a country. We really want those areas to be responsible for providing and delivering the services their residents need, including primary care, community care, mental health, acute services, rehabilitation and prevention. That cannot be achieved if silos are created like hospital groups which become increasingly powerful, or primary care community groups. The funding, 3% of the budget for primary care, is so small that they will never be able to withstand the hospital groups and it is much more likely that they will be incorporated into the hospital groups in a sort of accountable peer organisational model. That is the real risk because these accountable care organisations, ACOs, like the American health maintenance organisations, HMOs, which were the forerunner of ACOs, are coming into play. What is needed are area-based populations with responsibility in those areas for providing and ensuring universal services which are integrated in that area. That can never be achieved through hospital groups and silos of primary and community care. If anything there is a risk, under the HSE, of creating the American type of ACO which would have mechanisms for cherry-picking and risk selection. I think that is a very worrying development, especially if hospitals and these hospital groups will be given more powers to raise their own income through private finance and private income generation. That is a very worrying and disturbing development.

That development has been paralleled in England which has now abolished its area-based structures. We had area-based health authorities, which became primary care trusts but they were always area-based, and in place of them are clinical commissioning groups, CCGs, but they are membership-based and only look after the residents who are members of their CCGs. One becomes a member by joining a general practice. The legislation is in place for us to move

much more to the sort of grouping the committee describes. We are seeing this happen with our hospitals and our primary and community care organisations with federated structures in order that hospitals and primary care and community trusts are merging across large areas. We are seeing that under the guise of the national system but it is a move towards a US HMO accountable care organisation with all the dangers and warnings that brings from the Institute of Medicine. If this is happening in Ireland, it makes the case for legislation to bring in a national health service even stronger.

**Chairman:** That completes the questions from the committee. I thank Professor Pollock very much for her contribution to the important work of this committee, for being so generous with her time and answering our questions so thoroughly. We appreciate it very much.

**Professor Allyson Pollock:** I thank the Chairman and wish the committee very good luck with its deliberations. It is so important for the people of Ireland to get this right. It is marvellous that there is cross-party political support for this. I wish the committee very good luck in its endeavours. If there is anything I can do now or in the future to help, please let me know.

**Chairman:** Thank you very much.

*Sitting suspended at 10.34 a.m. and resumed at 10.57 a.m.*

### **Management of Chronic Care Illness: Discussion**

**Chairman:** We will resume in public session. I welcome the representatives from the Irish College of General Practitioners. We are joined by Dr. Brendan O'Shea, director of the postgraduate resource centre, Dr. Brian Osborne, assistant director of the postgraduate resource centre, Dr. Mark Murphy, chair of the communications committee, and Dr. Laura Noonan, director of the network of establishing general practitioners. They will present us with a briefing on the management of chronic care illness. I thank them all for coming.

I wish to advise the witnesses that by virtue of section 17(2)(l) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. If, however, they are directed by the committee to cease giving evidence on a particular matter and continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing ruling of the Chair 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 the witnesses to make their presentations.

**Dr. Brendan O'Shea:** On behalf of the Irish College of General Practitioners, we are very obliged for the opportunity to come and present to the committee on chronic disease management. We recognise the absolute importance of collectively delivering good chronic disease management in our surgeries and in the communities of this country. There is pressing work to be done on the issue. We are making a joint presentation by way of opening comments.

At the Irish College of General Practitioners, we support the development of a five-to-ten-year plan to address the challenges facing our health care service. We are here today to outline cost-effective solutions aligning care nearer to patients in the community and delivering safer, better and more efficient chronic disease care. The more the patient is taken out of the community, the worse the care is and the more expensive it becomes. Patients want to be cared for in their communities. Some of our solutions, as addressed in our main submission, can be implemented today. There are things we can do immediately through effective legislation and it must be remembered that the committee's members are legislators. Other recommendations may take longer to implement, but we congratulate the Oireachtas on providing for a ten-year timeframe and depoliticising the issue. We wish members the very best in their work in this committee. There is an urgent and critical need to agree to a new contract for general practice to effectively support the care of the complex patient in the community. GPs and general practice are central to this process.

I am director of the postgraduate resource centre in the Irish College of General Practitioners, ICGP, as well as a family doctor in Newbridge, County Kildare. My locum had to leave and I spent the whole summer trying to find cover for my partner who is on maternity leave. This morning my patients are being looked after by Dr. Eamonn Dillon and Dr. Noel Caffery. It was a horrible summer. Dr. Brian Osborne is assistant director of the postgraduate resource centre and a GP in County Galway. Dr. Laura Noonan is the director for new and establishing GPs at the Irish College of General Practitioners and responsible for GPs who have graduated in the past five years. She set up her own practice seven weeks ago. Dr Mark Murphy, ICGP chair of communications, is a GP in County Dublin.

In the ICGP's opening statement we will briefly provide context by outlining a typical day in the life of a GP. We will discuss the challenges facing patients with complex comorbidities, a particularly vulnerable group. We will highlight current concerns, but we have brought solutions, if members will listen and legislate. If they do not legislate, they will fail us all. We will discuss the core challenges facing patients with chronic diseases in our struggling and very difficult secondary care system and outline solutions.

There is a need for a new contract for general practice as a matter of urgency and we should relax a little about it. In all the agencies which negotiate contracts for general practice there is a feeling that it is such a difficult and awful job that once we have done it, we will have to leave it there for 20 or 30 years. That process has failed patients; therefore, we call for a new contract as a matter of urgency and for it to be subject to continuous review every 18 or 24 months, no matter how difficult it is to do. If we do not get together to discuss the difficulties, poor patients will suffer disease and die younger. It is as simple as that.

**Dr. Mark Murphy:** I will contextualise the role of the general practitioner in modern Ireland. A typical GP on the islands and in the towns and cities of Ireland consults directly with approximately 40 patients daily and makes clinical decisions on a further 20 to 40 patients through telephone consulting, repeat prescriptions and actions arising from medical correspondence. We have a very busy day and manage a wide range of acute and chronic conditions. GPs provide comprehensive care and manage every single complaint that comes through the door. We provide for continuity of care and get to know families and patients over time, which is probably why general practice is so effective. We co-ordinate the care needs of patients through a very fragmented and complicated system and are the first point of contact. In addition, we gate-keep entry to secondary care.

Over nine out of ten of the presentations included in the submission to members are effec-

tively managed by us without onward referral in the health care system, which makes it very effective. Strong evidence supports investment in general practice and primary care services. Adding one GP per 10,000 population reduces mortality, which is not necessarily true in the case of a secondary care consultant. It will reduce the number of emergency department visits, inpatient admissions and outpatient visits and improve the level of health care inequalities.

The GP has hit a roadblock and in the last decade, particularly since 2007, the impact of FEMPI legislation cuts on the PCRS-eligible population, together with concurrent reductions in private income, have seen a fundamental destabilisation of general practice in Ireland. Regrettably, there was a tipping point during the winter of 2015-16. The prioritisation of acute, urgent presentations in general practice above chronic diseases has resulted in a dangerously stressed workforce in general practice which will be unable to consistently deliver excellence in care unless resourcing shortfalls are addressed urgently.

I will outline seven solutions to fix general practice and enable us to manage chronic diseases. Chronic disease management refers to cardio-metabolic conditions, arrhythmias, heart failure, respiratory conditions such as chronic obstructive pulmonary disease and pain conditions such as osteoarthritis, as well as mental health conditions, which are managed by us. The current model of chronic disease management, CDM, in Irish health system is expensive, inefficient and lacks patient-centredness. It has historically been based on an underfunded single-disease model, with poorly defined management between primary and secondary care services. Effective chronic illness management in general practice reduces overall health care costs, improves outcomes for patients and reduces secondary care utilisation. As we get to do what we are trained to do, it improves our working environment and delivers more care services in the community. For example, the Heartwatch programme, led by GPs and practice nurses, dealt with the secondary prevention of heart disease. The death rate was 5% in Heartwatch patients, as against 14% for those not in the programme. It is a cost-effective solution in chronic disease management. It is unjustifiable and inexplicable that it was not rolled out nationwide. Patients have died because a cost-effective GP-led chronic disease management programme was not rolled out.

We recommend the urgent contractual provision of GP-led chronic disease management in communities, fully encompassing the care needs of the complex individual with comorbidities. GP-led chronic disease management will enable hospitals to do what they do best. General practice needs an enhanced role in integrated care programmes, as well as clinical care programmes

Access to diagnostics is also crucial in chronic disease management. We do not have reasonable or effective access to diagnostics, especially radiological tests, CT scans, MRIs and ultrasounds. Some GPs have no access to them. We are also talking about endoscopic and cardiac investigations such as an echocardiograph or a BNP blood test. The end result is that patients end up on an outpatient waiting list or a trolley in an emergency department. It is ludicrous. Providing GPs with access to diagnostics enables patient management in the community. Diagnostic facilities should be considered to be separate from hospitals. We recommend a uniform national standard waiting time for key investigations based on reasonable international standards.

Consultation rates are rising with chronic diseases and an ageing population. The under-sixes and other cohorts have free access to GP care; therefore, we need to increase capacity in general practice and primary care services. We need more GPs and a new contract. We need to train more GPs, but we are still awaiting the service level agreement to be signed with the

HSE. Once that is done, we can train more GPs, but it does not make sense to train more only for them to emigrate. All my friends are in Australia and Canada. We have to focus on recruitment and retention strategies, chief among them being a new contract to improve our working conditions. We need to focus on certain groups, particularly rural practices and practices in the deprived inner city. We also need to increase the numbers of GPs and of practice nurses to deal with chronic disease.

We do not use IT efficiently. We utilise electronic health records which hospitals have, but the two systems do not communicate. Therefore, we need to expedite the introduction of the individualised patient identifier. Having a central summary record is one suggestion. We can now e-refer patients to consultants. That has helped, although there has been a slow uptake in the past six months for a few reasons. We sometimes want to make an informal, unstructured query to a consultant through health mail, but that system has not yet taken off. We need to utilise routinely collected data as we do not know what is happening. Members of the Oireachtas want to know what is happening, too, and data help to bring accountability, quality and safety. Therefore, we need to resource these structures.

On the question of capacity in primary care services, we need to expand the number of primary care professionals, including psychologists, occupational therapists and physiotherapists. We need to resource public health nurses, carers and assistants because that leads to keeping elderly citizens at home for longer.

On community supports, GPs have first-hand knowledge that senior citizens would prefer additional supports in the community setting to enable them to remain at home or in adapted accommodation for longer. Home care packages are essential to the provision of adequate services to elderly patients, providing autonomy, dignity and the ability to live where they want. Primary care teams are a priority for certain patient groups, and it is essential that primary care team meetings take place. We are well disposed to primary care teams. However, only a minority of GPs report positively on their experience. We can elucidate on that later.

On universal primary care, there is no doubt that we are an outlier. Most countries have removed cost barriers to general practice and primary care services, either through free access or subsidised payments. We support increasing access to general practice and primary care, but that is contingent on manpower, IT and built infrastructure capacity. That can only transpire if an adequate number of GPs are trained and retained in the system through a new GP contract, and expanding access through means testing is the fairest mechanism.

We can also prevent chronic diseases as GPs. A Government-wide approach on Healthy Ireland is needed to tackle obesity, sedentary lifestyle, smoking, problem alcohol use and stress. GPs, practice nurses and primary care professionals can make brief interventions to tackle effectively those lifestyle issues. That can reduce mortality, morbidity and costs, but we need to have the time and capacity to do that.

Finally, on general practice, we spend about 3% of our public health budget in general practice. The members heard from Professor Allyson Pollock this morning that the United Kingdom spends 11%. We recommend resourcing Irish general practice in line with other countries.

I will make three brief points about accessing secondary care that are pertinent to chronic disease management. To give a typical experience as a GP, one patient will wait two years to get her hip replacement. The next patient will wait two weeks, and on it goes for the 40 patients seen throughout the day. Only those 5% to 10% of patients need referral. That is deplorable.

The Irish College of General Practitioners, ICGP, supports the creation of a single-tier secondary care system, underpinned by principles of solidarity, equity, fairness and efficiency. We recommend that an all-party task force works with key health care stakeholders to consider the funding options that can deliver a single-tier system.

On emergency department overcrowding, chronic conditions become acutely uncontrolled because we are not looking after the patients appropriately. Those patients end up in the emergency department and are then admitted on trolleys. We are part of the solution. GP-led chronic disease management, more step-down facilities, enhanced social care in the community, enhanced GP co-operative roles, and the development of primary palliative care packages will help.

We would like to alert the committee to the hazards of an increasingly fragmented, “corporatised”, “commoditised” health care system. For-profit corporations are targeting citizens and incentivising them to get investigations that might not be evidence based. That destabilises the health care system and chronic disease management. Effective public general practice and primary care is a proven way to add cohesion and continuity to a system which patients frequently experience as very frustrating.

In summary, a new GP contract with built in continual periodic review is essential to permit GP-led chronic disease management and build capacity. The new contract must embrace the needs of patients with multi-morbidity, that is, multiple chronic illnesses. It is essential to consolidate and build the numbers of GPs and practice nurses. I thank the members for listening.

**Chairman:** I thank Dr. Murphy.

**Dr. Brendan O’Shea:** In concluding our opening presentation, members will see on Appendix 1 - we have thought about this, and it refers to legislation - that we have a list of six quick wins for everybody in society. First, payment must cease to be a barrier to essential medical care such as general practice. Second, with regard to universal use of electronic medical records, it would be welcome if it became illegal for every health care professional to write on paper from 2019. Third, build capacity in primary care. We have our ICGP strategy, which is mercifully short. It is not rocket science. It has been done in Denmark, Canada and in the United Kingdom. They are even doing it in parts of America. Fourth, fully establish chronic disease management in primary care. Our hospitals are drowning in work that should be done in the communities. They will never succeed and be effective at what they are designed to do unless that work is put where patients want it, which is close to their homes. Fifth, support end of life care in the community. Research done by the Irish Hospice Foundation sequentially during the past decade repeatedly shows that people want to be close to their community in their final weeks and months, but we do not do that. We very expensively shunt them into the acute hospital system. Sixth, if health insurers are allowed to continue to be active in the Irish economy, they must recognise primary care if they are licensed to operate.

Those are six quick wins. They have clear legislative tags on which the members can act. If they do, this will be a better society. If they do not, some of us will leave. I thank the members for listening to our submission. We are keen to be asked questions.

**Chairman:** I thank all the witnesses. I would like to pose a question. The witnesses said in their presentation that they identified a problem with the roll-out of chronic disease management, which we have been talking about for many years. They spoke also about the need for an enhanced role in integrated care programmes. Can they expand on that? Why are we not seeing

the roll-out of chronic disease management? Given that it is best practice in terms of approach, why is it not happening? What are the blockages?

**Dr. Brendan O'Shea:** There are two main reasons in our collective opinion. The first, regrettably, is that the political process has not served these patients. There has not been clarity and effective action at a political level to legislate appropriately. We have brought a lot of research with us today, and some great works of fiction. We have brought former Minister Deputy Brendan Howlin's cardiovascular strategy from 1999, which stated that there would be echo cardiography and BNP testing for all GPs. None of that has happened.

Another whopper is former Minister Deputy Micheál Martin's quality and fairness in primary care strategy. It is excellent policy, but none of it has translated. A nice way of saying it is that it is a sub-optimal political process. I do not think the former Minister, Senator James Reilly, got to write a glossy document.

We do not have a policy deficit. We have quite good policies but there has been a failure to legislation and it is by legislation that we will change the system, not by lobbying. Those of us in general practice have done a good deal of complaining, but we recognise that will not serve the patient either. We have to legislate. That is one of the reasons care has not been provided and chronic disease management has not been rolled out.

**Chairman:** Dr. O'Shea makes the point that general practice needs an enhanced role in integrated care programmes and clinical care programmes. Is the problem at the level of the design and implementation of the programme? There was an issue a number of years ago where they were consultant led and consultant resourced. Has that not been addressed? What needs to happen now in terms of the structure of the programmes?

**Mr. Mark Murphy:** The Chairman might be aware that the ICGP pulled out of all these clinical care programmes. Some 40% of the population have a medical card. That is an acute care contract. I cannot manage chronic diseases. Patients would have to be charged. In effect, patients have multiple chronic illnesses, so we are faced with managing their acute exacerbations. Some 60% of the population have to pay for services. That is outside the contract. We need a new contract to specify and regulate how we can meaningfully manage chronic illnesses.

On the matter of chronic illnesses, we provided a narrative in our submission of a typical patient whom we called Mary Smith. Dr. Liam McGlynn, an academic GP, has shown us that 66% of patients over 50 have multi-morbidity. This patient has asthma, depression, arthritis, heart failure and ischemic heart disease. She is on 13 or 14 medications. There is psycho-social chaos going on in her life. How do we meaningfully manage those diseases? We can return to the clinical care programmes. It all well and good having a single disease focus on, say, the way we manage asthma. There is a diktat and this is what we do. However, that is not the reality on the ground. We manage all those conditions together.

The management of multi-morbidity has been cogently outlined in the evidence. One needs to resource GPs to enable them manage all of these conditions together. How that is done in the contract, through a weighted capitation for multi-morbidity and deprivation, can be addressed with those organisations, but the Government needs to resource us. There are also guidelines for managing all of those illnesses when they occur together. Multi-morbidity is a key concept. We would like to get back involved in those processes. We are core, not peripheral, to those clinical programmes.



**Dr. Brendan O'Shea:** Much of the early research on chronic disease management originated within hospitals where specialist colleagues chiselled out heart failure, hypertension and chronic obstructive pulmonary disease, COPD, undertook studies and work, and designed their hospital services around those single disease models. That is impossible to translate. It is expensive to deliver. All the really great research on the complex co-morbid patient now is coming out of general practice and we are leaving the committee several excellent examples. Dr. Liam Glynn's study is of 6,000 patients and relates to Irish health care. One may view the history of it, but we are here today with these patients. There are considerable efficiencies that can be delivered if primary care is resourced to look after it. We can embrace complex co-morbid patients and the evidence from abroad strongly suggests that we can make a real difference.

**Dr. Laura Noonan:** The important fact to remember here is that the poor and vulnerable in society are more likely to suffer from multiple morbidities. I am not sure whether we outlined that multiple morbidities means patients who have more than two complex medical conditions, such as heart disease, diabetes and asthma. These conditions interact. When we look at the numbers, for example, those who have hypertension or high blood pressure, we say that in 2014 approximately 800,000 patients had hypertension. When we project forward to 2020, we expect that number to have increased to almost 1.2 million patients. These patients then are at risk of other illnesses and diseases. It is important that we target them at the primary care level with the GP at the core - the GP is the centre of primary care - to try to reduce the burden of this disease because although patients are living longer, the burden of chronic disease on these patients means that their quality of life is dramatically reduced.

**Chairman:** Dr. O'Shea might clarify this. There are the individual clinical care programmes for different diseases and he is arguing for a programme to deal with co-morbidities, which is the challenge for those in primary care. Is there such a programme in place at present or does that need to be devised?

**Dr. Brendan O'Shea:** We would point the committee in a particular direction. There are various models that have been elaborated. The World Health Organization elaborates the chronic care model. In the United States, in the early 2000s, they suddenly realised that they were spending more on health care, through a specialist delivered hospital based insured fee-per-item chronic disease management system, than on weapons. Obamacare is the switch-on of community-based primary care. There is the Patient-Centered Primary Care Collaborative, which is an umbrella group that has quickly gathered a considerable volume of information from a variety of different sub-systems in the United States, and there is clear objective evidence that it is effective and there are clear guidelines in terms of how it works. If we go back to our strategy, for example, at present there are 4,000 GPs and approximately 1,900 practice nurses, many of whom are part time. In effective systems, it is at least a one-to-one ratio. In the college, we would believe that we probably need closer to 5,000 GPs and 5,000 practice nurses.

**Chairman:** We might move on to that in a moment. Is there a programme in place for dealing with multiple morbidities?

**Dr. Brendan O'Shea:** No.

**Chairman:** Therefore, that would have to be devised.

**Dr. Brendan O'Shea:** Yes.

**Dr. Mark Murphy:** We would say that has to be negotiated because that work, which we

are doing for the medical card population, needs a new contract. Although I do not want to go over it, we need access to diagnostics. We need IT capacity, bill capacity.

**Chairman:** Sure.

**Dr. Mark Murphy:** The solutions we highlighted earlier will enable that.

**Dr. Brian Osborne:** I was the GP clinical lead for the paediatrics programme from 2011 to 2013 when there was engagement. Paediatrics, as a programme, was a little different because it is a generality in itself. We did some good work and came up with algorithms about how issues should be managed in the community, in the emergency department and in outpatients so that everybody is singing from the same hymn sheet. There was, however, in various programmes, single disease focus and also they were more consultant-led with a little GP input as opposed to a collaborative altogether approach. Where GPs are caring for 90% of this in the community, the consultant opinion mattered more. That was the view with regard to the programmes at the time.

**Dr. Laura Noonan:** In response to the question of whether there are structures in Ireland for that, there are not. If we look at international data, however, there are structures that support that. For example, the CARE Plus study in Glasgow is an intervention that comprised of structured longer consultations of 30 minutes to 45 minutes, relationship continuity where a patient saw the same GP repeatedly, practitioner support where the GP was given extra supports to deal with patients with multi-morbidity, and patients were given important self-management support putting the patient in charge of his or her own diseases. That showed patients living in areas of deprivation improved and there were significant gains in their quality of life, and this was cost effective. The cost-effectiveness ratio was approximately £12,000 per adjusted year of life gained and this is far below the acceptable threshold in cost-effectiveness analysis used in Irish health care. It has been done abroad. We need to look at patients with multi-morbidity and multi-morbidity in the Irish health service.

Some 90% of patients who have diabetes have at least one other medical condition. A quarter of them have four or more other medical conditions. We cannot simplify patients into those who have heart disease, diabetes, hypertension. In essence, these patients are the same patients. They merely present with a number of conditions. This is fragmentation of the health-care service at its very best.

**Chairman:** I thank the witnesses. I will open up the discussion now to members. I invite the members to contribute in groups of three and I ask the witnesses to bank the questions and respond to them as a group.

**Deputy Hildegard Naughton:** I thank the witnesses for their excellent presentation here this morning. They outlined clearly their key objectives.

They explained quite well the need for GP access to diagnostics. Could they expand on the structure that they would like? Is it in the primary care setting? We have spoken previously in this committee about diagnostics being in the hospital setting because they are there already and GPs may have access to them, but there could be a conflict. In the longer-term, the GPs may not have the access that they would require and their access would be eroded. How best could we as a committee look at that?

My second question relates to GPs as the first point of contact. The local doctor is the first point of contact for patients with a wide variety of conditions and mental health is a significant

issue at present. How would they see this being dealt with in the short and medium to long-term? They spoke about increasing the number of psychologists and psychiatric nurses in the community. How best could we support GPs in their endeavours to deal with mental health?

There is also the issue of GP retention in rural areas. There is an ongoing initiative where trainee GPs are placed in rural practices across the country. What are their views regarding the effectiveness of that in retaining GPs and providing them with an incentive to locate eventually in rural or disadvantaged areas?

Dr. Osborne made reference to the relationship between consultants and GPs. Although he might be able to expand in other areas, I was thinking initially of where there can sometimes be a conflict with regard to patients coming in to a hospital through accident and emergency with a GP referral, how that is taken on board when the patient reaches the hospital, how such communication and relationship could be improved and what he would like to see happen. There are other issues with community care and in terms of preventing users from presenting in the first instance, but the relationship between GPs and the consultants, especially when patients come in through accident and emergency, is an important one. Those are my questions for now.

**Deputy Louise O'Reilly:** I thank the witnesses for their presentations and for attending this morning.

We heard from GPs and consultants in the Carlow-Kilkenny area who told us that 5% of chronic disease management should be in the hospital and the balance of it should be in the community. Would Dr. O'Shea agree, but I can see by his nodding that he does.

**Dr. Brendan O'Shea:** Deputy O'Reilly got it right.

**Deputy Louise O'Reilly:** With regard to the diagnostics and following on from Deputy Naughton, a wide variety of diagnostic procedures can be carried out at the level of the GP. To what extent are GPs doing that now, if at all, and what capacity exists to do it? I refer specifically to what is known as "near-patient testing". I would be interested to hear whether the witnesses have any ideas about how that could be improved, what sort of resources the GPs would need, and whether GPs need the assistance of other health-care professionals in terms of a primary care resource setting and how that might work.

Do the delegates believe having salaried GPs will work? Clearly, there is an issue with retention in some areas, but not in others. There is considerable talk about primary care. This committee focuses on it very heavily. Apparently, the whole world is focusing on it. We have been consistently asking the Minister questions on the number of additional staff planned for the primary care centres. The answer we get is a very comprehensive one, a nice round figure of zero. With regard to the delegates' vision for a primary care resource or centre that works, do they believe there is a need to establish a certain ratio of patients to health care professionals? Should we go down that road? Should we examine it? Would it work? If we are to go in this direction, is there an area we could examine that would help us ascertain the socioeconomic profile of patients? Clearly, there is a difference in the ratio in affluent areas by comparison with areas of deprivation.

**Deputy John Brassil:** I thank the delegates for their presentation. This commission recognises that there is no need for any further reviews or reports; they are all available and it is a question of implementing something for a change and getting on with it. The delegates have struck a chord with me on that point.

I firmly believe that, to start putting our health system in order, we must start with primary care. If we do not get primary care right, we will not know what we are fixing above primary care. It is really a simple enough task in my head. If we get primary care sorted, the challenges up the line will become far clearer and we will be able to deal with them much more easily. I hope other members of the committee agree.

The delegates stated, perhaps half a dozen times, that there is a need for a new GP contract. Could they expand on that for us? What is needed in a new contract? The delegates are passionate about this. If we are to deliver a new contract, I would like to know more specifics.

Deputy Louise O'Reilly referred to having GPs directly paid by the HSE. Is that part of the delegates' model? Last week, Professor Garry Courtney and Dr. Ronan Fawsitt from the Carlow-Kilkenny area made an excellent presentation to us. Things work quite well in their area. I got the impression that there was very good primary care team interaction with the GPs. Dr. O'Shea said it is not positive from his experience so could he expand on that a little? Is it that those in Carlow and Kilkenny are doing it right while everybody else is doing it incorrectly? I am interested in the delegates' comments on that.

**Dr. Brendan O'Shea:** That is a lot of questions. We strongly recommend that Deputy John Brassil be appointed Minister for Health next. They are very long questions so we will try to give quite short answers. Our college is completely available to talk to anybody who wishes us to elaborate on these answers. I shall ask Dr. Osborne to handle Deputy Naughton's question on access to diagnostics.

**Dr. Brian Osborne:** GP access to diagnostic facilities is crucial. Consider the circumstances when patients present at an early, undifferentiated stage of illness, often with vague symptoms. If we do not have access to diagnostic facilities, it is very difficult to diagnose anything.

At the back of the circulated pack, there are results of a study produced earlier this year by the Irish Cancer Society and Irish College of General Practitioners earlier this year. It compares the effects of access to diagnostic facilities in the public and private systems. Currently, the waiting periods for chest X-rays are quite similar, at a day or two. For a private ultrasound scan, there is a five-day waiting list. For a public ultrasound scan, there is an 80-day waiting list. For a CT scan of the brain, chest or abdomen, a private patient must wait for less than a week while a public patient must wait up to 55 days. Accessing an MRI scan privately takes from five to six days. Accessing an MRI brain scan in the public system takes 125 days. In any civilised, decent, fair society, this cannot be right.

With regard to who has access, 20% of GPs do not even have access to ultrasound facilities. Some 80% do not have access to CT and 90% do not have access to MRI. Without access to diagnostic facilities, we are left out in the cold.

On the question of whether there should be separate approaches, there should be a ring-fenced budget. The college feels there should be a ring-fenced budget, most likely associated with a separate centre. Thus, if a GP requests an investigation, it will not be put to the back of the system if an emergency patient walks in. There should be a separate budget for each case.

I have referred to one diagnostic type. There is a blood test that can diagnose heart failure called the B-type natriuretic peptide, BNP, test. Professor Ken McDonald, the HSE's clinical lead for the heart failure programme, has shown that heart failure costs Irish society €660 million per annum, with a direct cost to the HSE of €147 million. BNP is a test that can diagnose

heart failure quickly. Where GPs have had rapid access, there has been a 30% reduction in the need for echocardiography and a 60% reduction in the need for a consultant review. This ties in with other studies showing that only 30% to 40% of patients who go to heart failure clinics are actually diagnosed with heart failure. This is because it can be very difficult to differentiate between heart failure and COPD, frailty or other illnesses.

I will outline exactly what heart failure is and what it does to patients. It causes chronic fatigue, shortness of breath and anxiety. People feel like they are drowning in their own fluids. A six-month delay in diagnosis of heart failure leads to a 23% increase in unscheduled hospital admissions, with all their attendant costs.

At the back of the documentation circulated, there is a map that shows GP access to BNP testing throughout the country. Those in the green category have access while those in the red category do not. Over half of the GPs in the country do not have access to BNP testing for their patients, which leads to increased costs and worse outcomes.

**Dr. Brendan O’Shea:** To summarise, we do not have access to diagnostics. This is the cause of the bloated waiting lists in the hospitals. I cannot get an MRI scan for a patient. If I refer a patient to an orthopaedic unit, it might be possible. We have 500,000 people on a waiting list. Once upon a time, it might have been too expensive to get MRIs or CT scans. They used to cost €500 or €600 but they now cost €200. These diagnostic tools need to be made available to us at primary care level. They need to be made available for our patients.

**Dr. Brian Osborne:** Dr. Niall Sheehy, the HSE’s clinical lead in radiology, carried out a study in St James’s Hospital last year on direct access to ultrasound for GPs. He noted there was a 30% pick-up rate regarding pathology. There was a reduction in the number of patients referred to accident and emergency services and to outpatient departments. It makes sense to give GPs access to diagnostic facilities in the community for their patients.

**Deputy Hildegard Naughton:** Consider the strategic location of diagnostic facilities in the primary care setting. In some areas, perhaps the hospital setting could be used also. Do the witnesses believe there would be a conflict if GPs could have access to the hospital facilities?

**Dr. Brendan O’Shea:** It must all depend on real-time, measured performance. Different combinations could actually work quite well. Historically, our experience with a hospital has been so difficult that we are actually disenchanted with it. Therefore, many of us feel the facilities should be taken out of the hospital setting and put in stand-alone facilities. There are examples in various general practices. I refer to bigger practices. In my own co-operative, KDOC, we have a radiology department on site. We are not that fussy about where diagnostic facilities are located but they must be made available to the complex comorbid patient quickly.

The concept of salaried GPs could possibly work. However, our history with the HSE and the Department of Health regarding salaried colleagues is quite poor. We would refer the committee to what has happened with salaried doctors in the secondary hospital system. Historically, year after year, doctors have been taken out of the Sudan, India and Pakistan to prop up our hospital system. These are salaried doctors. We do not want that coming into primary care, not because we have any difficulty with the doctors concerned but because when one takes doctors out of the Sudan, Pakistan and India, one is killing people in those villages.

**Chairman:** That is a different argument though, is it not?

**Dr. Brendan O’Shea:** If one wants to take a concerned global citizen’s perspective, it is a

relevant thing to say. Salaried positions could work well if they are adequately resourced and supported. They are part of the solution for younger colleagues entering into practice. If we could be confident of engaging with the HSE and the Department of Health, our professional representative organisations - the IMO and the NAGP - would, I suspect, take an energetic interest in it. However, if it is more of the same from the HSE and if it is not done properly, we will not have much time for that.

May I pass one of Deputy Naughton's questions down the line? It concerns the number of additional staffing required for primary care.

**Dr. Brian Osborne:** It is important to state what a primary care team is. The vast majority of consultations in general practice and clinical activity happen with a general practitioner and a practice nurse. Four or five times a month patients in the practice might need primary care team involvement, depending on different practices. The primary care team would be a GP, practice nurse, public health nurse, speech and language therapist, occupational therapist and physiotherapist. That does not have to happen in the one building; it can happen via phone calls. There are already constant phone calls between GPs and public health nurses.

A recent membership study shows that more than two thirds of GPs are positively disposed to primary care teams but only 13% feel they are working effectively. Only one in four GPs wants to co-locate with a primary care team. One has to remember that GPs invested heavily in their premises before the downturn. They cannot just give that up and go into a new primary care centre paying more rent. There has also been a historic distrust and poor engagement with local area managers. GPs have to give up two to three hours per day to attend primary care team meetings, which is not feasible with an already overstretched population.

**Dr. Brendan O'Shea:** An important feature of the new contract is that the current business model of general practice locks us into 100% consulting. The minute we stop consulting it creates a business risk for us in our practices. We would refer the committee to the Veterans' Administration model which has one GP, two practice nurses - one of whom has a technical slant and the other a clinical slant - and an administrator. That GP is enabled and encouraged to spend about 20% to 30% of his or her time outside of face-to-face consulting, so that he or she has time to go to multi-disciplinary meetings. The GP has time to engage in online consulting with specialists and telecommunications with his or her patients in nursing homes.

There are a whole lot of models that work. Our primary care strategy from 15 years ago would have worked quite well but I am going back to it. One has to legislate and there must be a contract to enable us to engage effectively. We are not engaging not because we do not want to; it is because our business model has us absolutely strapped to full-time consulting. If the committee can address that, it will do us and our patients a great service. If a new contract is devised, it will not be perfect, so it will have to be reviewed in 18 months. The last contract was devised in 1988.

**Dr. Mark Murphy:** I will move on to the issue of mental health. It might surprise the committee to hear that we see 30 or 40 patients per day. We spend on average ten minutes per patient. Every patient typically brings two issues on average. Sometimes there is a list of eight. Those issues are identified by the GP, so the evidence for continuity of care is crucial. We know patients and recognise patterns. We may meet a wife in the street or in the local supermarket and she will say something. That issue may bring up a mental health issue. A GP may ask, "How are you getting on? You're looking quite stressed."

Approximately one fifth of all presentations have a mental health component. When we say that we manage the majority of mental health complaints in the State, we are talking about stress, anxiety, panic attacks, obsessive compulsive disorder and all the anxiety disorders. We are talking about mild depression and sometimes severe depression with suicidal ideology. We are talking about addictions. We treat methadone and gambling. The problem of alcohol use is everywhere. We manage these conditions effectively by ourselves. In effect, we are a counselling service. We are trusted and patients are well managed.

The next step is if someone needs treatment. The NICE guidelines all state that patients should receive psychological therapy as the first-line treatment after holistic social treatments. We do not have meaningful access to primary care psychology services - no cognitive behavioural therapy. We are talking about a patient who is in distress, has severe crippling anxiety, is not working and is taken out of society and yet we must say, "There is no CBT. I'm really sorry, there's none." That is what we are dealing with and it is absolutely crazy. That is at the primary care level.

**Chairman:** Can Dr. Murphy explain what the NICE guidelines are?

**Dr. Mark Murphy:** Medicine is underpinned by evidence-based principles. We have to do what the evidence and guidelines tell us to do. There are Irish guidelines and English ones. The NICE guidelines are a set of UK-based guidelines that most doctors around the world know. The NICE guidelines tell us how to manage anxiety. The first-line treatment for an anxiety disorder is usually psychological, including cognitive behavioural therapy and relaxation therapy. Unfortunately, that leaves us in a difficult position because mental health conditions exacerbate and get worse. We then might have to prescribe an anti-depressant which can be used for severe anxiety. We do not want to do that but after a few months we might have to.

The condition can get much worse, so that the person is really crippled. Maybe they have suicidal ideology and are really thinking about it. We will now have to refer this person to secondary care and yet they have resource issues, particularly for secondary care psychiatry services. At primary care, one intervenes at the lowest level of complexity. It is patient-centred and cheaper. It is extremely dissatisfying, as a GP, to be unable to do my job and to see the harm that happens to patients. Lives are lost or the quality of life is ruined because the system is not working.

My friends in Canada and Australia get the ultrasound the next day, so they are managing chronic illnesses. They get the psychologist to see a patient, as the psychologist is in the same building or nearby. They tell the patient to come back in a month, which is satisfying for us and ultimately better for patients.

**Chairman:** There was a question about primary care staff ratios from Deputy Louise O'Reilly. Are there best practice ratios in terms of allied health professionals?

**Dr. Brendan O'Shea:** What we are looking at here is whether one size fits all or if there is one right answer. From looking at systems internationally, we understand that there are several right answers but unfortunately we have got a really bad answer in place at the moment. Different ratios can be used. We referred to the Veterans' Administration model where there is one GP to two practice nurses and an administrator as the core engine. Other systems have a 1:1 ratio. We have done several studies on Irish chronic disease management. We currently have a system where doctors are inappropriately involved at a lower level of complexity, holding the fort and metaphorically putting on Band-Aids. In fact, however, quite a lot of work could be

handled effectively by more practice nurses' in-put.

We can look at the big picture figures in terms of how many doctors and GPs our system needs. From OECD data, we know that the Irish figures are shockingly low. Recently published figures are in the order of 35 up to about 57 GPs per 100,000 population. In Canada, the figure is closer to 80, 90 or even exceeds 100, so we are very short of GPs here.

Our college can switch on GP training if the process is supported in good faith by the legislature and the HSE. We can switch that on and we have increased it in the last several years. We will only do so if we are confident that our young graduates can enter into a system that will take them up and provide them with a contract that satisfies their professional ambitions and provides them with fair pay for fair work. We are competing on a global level with the economies of the UK, Australia and Canada where our graduates are highly prized.

**Deputy Louise O'Reilly:** My question referred not just to GPs but also to the make-up of a primary care team. I am not asking Dr. O'Shea to necessarily put a figure on it but just to point us in the direction where we might get some idea of ratios. When the issue of primary care teams and staff is discussed, the answer we often get is that while everybody wants a fully staffed primary care team, what does that look like? We want to know what it looks like in terms of occupational therapists and psychiatric liaison nurses. What would make up a fully-staffed primary care team? We are at 57 GPs per 100,000. Is there a figure for other health care professionals?

**Dr. Brendan O'Shea:** We are very glad the committee is exercised about this. Again, we would look to other, better performing systems. Certainly, there is a need for a GP, one or two practice nurses and at least one full-time administrator. There needs to be quick and easy access to a psychologist. In Ireland, most practices include two to four GPs and they are very short of practice nurses. That is a priority. If one had a practice with two to four GPs and a psychologist split between two or three such practices, that would be very helpful. Dieticians are, arguably, further down the scale. Physiotherapy is particularly important, especially when one is looking after the care of patients with chronic diseases. As doctors, we are sometimes quite funny. If a diabetic patient comes to us, we look in particular at the diabetic things. We ask about HbA1C, if blood pressure is well controlled and whether the patient is taking aspirin or ACE inhibitors. A lot of the time, they have come back from hospital and are not on these things. What we forget to ask the patient is how he or she is feeling and what are his or her problems. We know these patients have a relatively high level of depression and quite a lot of pain. When we actually ask the patient, these are the issues. It is a curious feature of the current primary care team, as it is set up, that there is no input from the community psychiatric nurse. Those nurses are not part of our team, which is incredible.

The quick wins would be to increase practice nursing capacity immediately and to follow that up in short order with the allied disciplines. The big thing, as Dr. Mark Murphy will elaborate, is that this must be measured by automated, real-time electronic medical records. The good news is that we have those in general practice. They do not have them in hospitals. We can provide staggering data that will provide one with a very clear idea as to whether whatever one inputs next is working. One will know within six months.

**Dr. Brian Osborne:** There is the CHO structure and organisations with the nine areas and ten teams. As such, there will be 90 primary care teams. If one is going to divide it, and that is going to be population based, it would be reasonable to have a cohort of allied health professionals per team in that 90. That would make sense and would be a fairer allocation of resources.



**Deputy Louise O'Reilly:** Should that be better staffed? Should the staffing ratios be higher in socio-economically disadvantaged areas?

**Dr. Brian Osborne:** They should be higher in areas with higher socio-economic deprivation.

**Deputy Louise O'Reilly:** As such, basing it on population alone is not really going to-----

**Dr. Brian Osborne:** It is by population but with a deprivation weighting.

**Dr. Brendan O'Shea:** We concur strongly with all the inputs of our colleagues on the deep-six group. They are absolutely correct in relation to that. One of the mistakes we have made consistently has been to try a one-size-fits-all approach. People and communities are more complex than that. We had automated, real-time electronic data return with Heartwatch, albeit that was switched off and not extended, and every one of the patient contacts Dr. Mark Murphy referred to in the opening address left a detailed electronic footprint in our record systems. We can generate such data at the point of contact and we can channel the information in. It is not black and white and our professional representative organisations will have a particular point of view on how that is set up with due regard for patient confidentiality, practices and resources. However, we can put that in place. The other more high performing systems I have referred to have it in place. This is supposed to be the smart economy. Bring it into health care, in particular primary care.

**Chairman:** Without wanting to get into negotiations, Deputy Brassil asked for an indication of the principal issues GPs will seek to have addressed in the context of a new contract.

**Dr. Mark Murphy:** I might touch on that quickly and my colleague can touch on GP retention. Let us be clear regarding the contract that ours is a training body for GPs. We are the professional body for GPs in terms of quality, standards, research, education and training. We do not negotiate the contract. We are not a negotiating body. Obviously, we have many thoughts about what should be in the contract. The GMS contract is an acute care contract. It is 30 years old. Health care has changed. I have been qualified for 11 years and health care has changed dramatically. There are secondary prevention drugs for chronic diseases. The management of those chronic diseases was not present when the contract was created. We need a new contract that recognises that chronic disease management takes place and specifies how it takes place. We can feed into the quality and standards but the resources behind that, I am afraid, are a matter the committee will have to ask the negotiating GP union about.

**Dr. Laura Noonan:** I will go back to one of Deputy Hildegard Naughton's question, which is quite important and which I am afraid might get skimmed over. We are talking about retention of GPs in rural areas and everywhere else. I represent new and establishing GPs within the College of General Practitioners. I am a new and establishing GP myself. I graduated from my GP training scheme approximately four years ago and I have been representing establishing GPs for the last 12 months. As a group, we need to look at the challenges facing new GPs. Why are they leaving and, if they leave, are they likely to come back? To answer that, we must look further at the actual manpower crisis facing general practice and at the few statistics we know about. We know, for example, that 33% of GPs are over 55 years of age. That is not encouraging. We know that the statistic is even worse in some areas. In Mayo, for example, 52% of GPs are over 55 years of age and 28% of GPs in Clare are over 60 years old. We are looking at a looming crisis. It is on the way and we cannot avoid it. We are training new GPs to the highest standard. The GP training schemes in this country are training the best quality GPs

they have ever managed to train. They are trained clinically and trained to manage practices. They are entrepreneurs, business people and excellent clinicians. Patients in Ireland need our trainees to stay here and look after them. We are saying that we face a tide of multi-morbidities and co-morbidities. Patients are getting older, frailer and more difficult to look after and yet we are letting the people trained to look after them simply leave.

**Chairman:** What are the principal reasons for that?

**Dr. Laura Noonan:** GP trainees are trained in the system they are going to be working in. Unfortunately, for the past number of years, there have been nothing but decimating cuts to the services being provided and the resourcing of general practice. When one is training as a GP, one is working for a GP trainer who is a principal GP in a practice. One spends one's time rotating through two practices, often a rural and an urban one. When one sees GPs struggling, it is very hard for one to envisage oneself working in that job until the day that one retires. That is very disheartening for GP trainees. We have done a study through the ICGP, the Bridging the Gap study, which was authored by Dr. Gerry Mansfield, Dr. Claire Collins and Dr. Margaret O'Riordan. The study looks at recent GP graduates and trainees and what they were planning on doing on leaving their schemes or what they had done since leaving. The results are not encouraging. They are very worrying and, unfortunately, despite the fact that these reports have been placed in the public domain and presented to the HSE and the Department of Health, they have not been acted on or responded to. We know that approximately 50% of our current GP trainees will leave after they are trained.

**Chairman:** Why is that the case?

**Dr. Laura Noonan:** They are leaving because they see that general practice is not adequately resourced. They are looking at increased demands on services, more complex patients, increased complexity of patients and more difficult to manage patients with less time in which to manage them. The traditional GP visit or appointment varies between ten and 15 minutes. That is an ideal day. When extra acute presentations, which are what our actual GMS resources us to do, arrive, they often have to be double booked into an appointment which is already set aside for a very complex patient with five or six medical problems. One ends up seeing the acute patient as an extra and running behind while there are ten people waiting in one's waiting room. We are working harder and harder. There are no idle GPs. GPs are working as hard as they possibly can. They are not getting to take breaks and they are not doing their paperwork. They are doing consultations and paperwork is happening in the evenings. For example, I have just set up my own practice in rural Ireland. I have a dual-centre practice in Ballymore, Westmeath and Ballymahon in Longford. I move between premises at lunchtime and have house calls to do on the way. At 6 p.m. in the evening, my child needs to be collected from her after-school service. I do not see my four-year old child anymore. I am in practice doing paperwork, worrying about my patients, integrating blood results, calling people about abnormalities, trying to plan for their chronic management and trying to plan for their care. Somebody else reads my child her bedtime story. She is growing up behind my back. However, I want to do this work because I care about my patients. Other graduates like me care about their patients too but they are leaving. They are flocking to Canada, which is our main exportation site, followed closely by Australia. They go there to work in a service that works.

**Chairman:** To what extent is the issue of premises a factor in this? The point has been made that many GPs have invested heavily in their practices. If that is the case, it needs to be recognised in a contract. However, there are many people who go into training here as doctors and who want to operate as doctors rather than as entrepreneurs and business people. I made

the point earlier that we would not expect teachers to provide their own schools. Why do we put that burden on young doctors coming out of training when the model does not seem to fit without capital behind it? I was wondering why the witnesses were somewhat ambiguous about the idea of salaried GPs.

**Dr. Mark Murphy:** I completed my GP training about four years ago. One gets into medicine for all the right reasons - being empathetic and wanting to care for patients. All one wants to do is see patients and then one realises that there is a whole business outside that, including managing resources - the team. I think it is fair to say that the independent contractor model of general practice is extremely efficient for the State. The workload is all on us. Dr. Noonan is in work until all hours. I was in until 7.30 last night. We are working very hard. It is an efficient model. One begins to realise that the contract for services - the GMS, the mother and infant scheme and childhood immunisations - coupled with private income sources is a very efficient model when it works.

However, in the past ten years the funding has reduced to such a level that it is now broken. We cannot invest in our existing premises, develop services or hire staff. It is not that the overall system is broken; the system works. Most countries employ GPs as independent contractors through publicly funded source contracts. We are not talking about corporates. It is an efficient model.

We should be allowed to do what we are trained to do and deal with chronic diseases and access diagnostics through primary care. We like the system and if the Government can fix the funding models, we will stay as independent contractors. We are all for supporting salaried GPs, including those in inner city deprived practices and in rural areas. There are salaried GPs on some offshore islands. However, the current model should be fixed as it is. We have highlighted the broken aspects. They should be fixed first.

**Chairman:** What about premises?

**Dr. Brian Osborne:** In areas of deprivation or in rural areas - underserved areas where it is difficult to get GPs at present - consideration should be given to subsidised or rent-free periods to GPs in premises that are Government owned. There could be education grants, practice support grants and equipment grants to attract people to an area. If doctors are attracted to an area, they are more likely to stay with professional support, social support, personal support as well as financial support. Financial support will bring in people but it will not get people to stay in the long term. We need to change the dynamic to increase the numbers in those areas.

**Dr. Brendan O'Shea:** GPs are leaving for two reasons. One is professional repugnance at the way that patients with chronic diseases are managed and what they can do for them. There is also the socioeconomic pull of salaries in other health systems that are more remunerative. We need to recognise that.

With respect to premises, when politicians are designing the new contract, it should have some degree of complexity. One size will not fit all. We know there are pressing areas of concern in rural practices and practices in inner city areas. They will probably need different solutions than mainstream general practice, if such can be said to exist. The Government should try not to do one size fits all. Most important, it should be set up in order that real-time evidence is coming back and the Government is not three years behind on the data. The contract should be reviewed after 18 or 24 months. In that case it will be progressed within the committee's five to ten year timeframe. It is not rocket science. It has been done in other systems and can

be done here.

**Deputy Joan Collins:** Many of my questions have already been asked and I will not go over them again. Our health system between hospitals, GPs, care etc. is fairly broken. Up to 2007 or 2008, GPs were able to make a good living. Consultants and hospitals were protecting whatever they had. I have listened to what the witnesses said about implementing that care in the community, changing the mindset of the hospitals and GPs, and linking into the other services. I think there will be a bit of a bulwark there. The witnesses have said they have been let down by hospitals and consultants and that they cannot get what they need from them promptly and on time. Obviously, a certain cohort in the hospitals will look to protect their own position in the hospital. We need to find a way to get everybody to buy into something that will benefit everybody, particularly the patient. We need to focus on that. Is the new GP contract being negotiated at the moment?

**Dr. Brendan O'Shea:** The Minister has indicated he will consult widely in October and the negotiation will start in earnest in November. Please, bring it on.

**Deputy Joan Collins:** Do we have to be part of that? Should we be recommending what the GPs are explaining to us here?

Having listened to the witnesses who have contributed to date, I am convinced that care in the community should be the focus. The question is how we do that. We talked to people about the Carlow-Kilkenny model last week. Why are other GPs not organising themselves to do that with their own hospitals locally? If that is not done, we need to try to deal with that because that connection needs to be there.

**Deputy Kate O'Connell:** I thank Dr. Murphy for his presentation and wish him well with his new practice. He is brave. He referred to patients with multiple illnesses. When we met Dr. Fawsitt last week, I believe Professor Susan Smith spoke about the capitation rate for GMS patients and suggested having an increased rate for more complex patients. Obviously, a straightforward seven year old who has nothing wrong is one sort of patient, but then there is the diabetic with high blood pressure, missing a foot and various other things. Are there any suggestions for how GPs would get paid relative to the complexity of illness of the patient in order that they get paid properly? A GP might spend 30 minutes with a very complex patient and can get somebody else through in three minutes. From last week's discussions I was inclined towards two different pay scales. However, from what I have heard today, I feel that there is a vast difference between somebody with nine things wrong and someone with three things wrong. How would the witnesses like to see that happen?

I mentioned this to Professor Susan Smith when she appeared before the committee. I may be wrong in this. I am a pharmacist. When a patient is worth more financially to a doctor, is there a risk that GP groups would want the sicker patients because the headage payment is better? There might be a concentration of people with a huge amount of illnesses in one practice. Would that be a good thing or would it be better for GPs to see a cross-section of society in order to keep up to date? Is it better to have all the very sick people in one place or all spread out? What is the optimum? I do not want very sick people to be used as a commodity.

Nobody mentioned community pharmacists as part of the primary care team.

**Dr. Mark Murphy:** I apologise.

**Deputy Kate O'Connell:** It is okay. In the NHS it is very important. I would deal with

GPs in that other job sometimes more than any other profession.

The access to mental health services in the community is horrendous. Last weekend a lady whose GP had diagnosed chronic depression told me that it cost her €5,000 to get herself fixed. While she is not loaded, this lady has a good job and has private health insurance. It struck me that many people would not have €5,000 to set themselves right. There are long-term costs to the Exchequer of people ending up admitted to an acute psychiatric unit. I want to put on the record the shock I felt in this regard. In the witnesses' experience, is that happening all the time? All she required were antidepressants and cognitive behavioural therapy, CBT, but she had to have the insight herself and, with the support of her GP, the wherewithal to go about paying this amount of money to fix herself and get her back into the workforce. I assume this is something the witnesses see every day, but I was so shocked. I believe her; she is not making it up. That is all I want to ask the witnesses today.

**Deputy Michael Harty:** I thank the witnesses for having come in. I must declare, I am a member of the Irish College of General Practitioners and have been since its foundation in 1986. It has brought general practice out of the dark ages and into the 21st century and has been essential for the development of general practice. It is involved in education, standards and research and training. It is not involved in negotiating contracts, as Dr. Murphy has said. I also compliment the ICGP on having brought young GPs in because we are seeing a profession whose members are ageing and it is good to see young GPs coming in and staying in Ireland.

The most important aspect of general practice is the continuity of care that GPs provide to their patients. We know their medical illnesses but we also know their psychological, social and financial backgrounds, which are all very important components of general practice. Continuity of care is a critical component of general practice, and we want to maintain that. Our first difficulty is that general practice and primary care are not properly funded. Our second difficulty is that even if we were properly funded, there would still be a huge gap between the integration of primary care with secondary care. We have heard of the Kilkenny model, which is working superbly, and it has been asked why all GPs and hospitals are not engaging. It is a wonderful question because we should be engaging and there should be huge communication between primary care and secondary care. That is the purpose of this committee, apart from bolstering primary care, namely, to bring about a situation of being able to integrate primary care and secondary care. It is a terrible term, but there should be a seamless transition between primary and secondary care. General practitioners look after their patients for 99% of their time. In their lifetime, 1% of patients' time or even less may be spent in a hospital. They go to hospital and they come back to us. We are the people who look after them in their multi-morbidity state, and it is important to state that GPs look after multi-morbidity. Patients go to the diabetic clinic and get tablets from that. They go to the heart failure clinic and get tablets from that. They go to all these clinics, and we are the people who integrate.

The solutions to our problem in devising a new system are recruitment and retention, increasing our bed capacity and increasing our access to diagnostics. All three are work practices, and GPs as well as consultants must alter their work practices.

**Chairman:** Will the Deputy ask some questions, please?

**Deputy Michael Harty:** They are coming. I would like the panel to outline their views on the corporatisation of general practice. There are huge groups of GP practices now being taken over by corporate entities. What are the witnesses' views on the quality of care that can be delivered to a public patient, as opposed to a private patient? I find that it is easier to look

after a public patient than a private patient because of the continuity of care. Will the witnesses comment on the streaming of patients into hospital, how we can better do it and how a new GP contract can be flexible to accommodate all types of practice?

**Deputy Joan Collins:** Professor Pollock said earlier that for us to go even any way to bringing in a universal health care system, we must legislate first. Are the witnesses saying that legislation must come first and everything else should then fall into it?

**Dr. Brendan O'Shea:** The time is shortening, so we might give some punchy answers. We are saying that nothing will happen without legislation, that we have had acres of policy that has become meaningless. Members must legislate. They can legislate for the electronic medical record and make the hospitals catch up with general practice. They can legislate around a contract. They can ring-fence funding for primary care. We are not all that concerned about what stream it comes under, but it should be protected in order that our primary care system is funded at least in line with other OECD countries.

Regarding the insurance industry, members can legislate so that if insurers are to be allowed to operate in this space, they must recognise general practice. If I operate on an ingrown toenail in my surgery, the insurer will have the same procedure funded in a private hospital for four times the amount, so there are perverse incentives that are costing. This is what is driving up insurance premia.

We will move on to the members' questions. Deputy Harty raised a very interesting point about whether there is an inevitable bulwark or obstruction between primary and secondary care. In Ireland we do many things twice. There is the private secondary care system and the public secondary care system. We are concerned about our colleagues in the public hospital system because they are in a very difficult space, even as we are, and we feel that the majority of our specialist colleagues in the public hospital systems are absolutely equally demoralised about what is going on. When we get an opportunity to talk to them, good things will happen. We can see it in Carlow-Kilkenny, and several questioners have asked whether Carlow-Kilkenny is good or bad. Carlow-Kilkenny is progress. Carlow-Kilkenny is an improvement on what was. Carlow-Kilkenny-----

**Chairman:** The question is why it is not happening in other places.

**Dr. Brendan O'Shea:** This is a good question. We have had a high level of expertise come in and overview. One of our advisers, Dr. Paul Grundy, who is a global expert in health system design, said that there was a blank space in the regional space, that in our practices we actually do good work. At a national level we do good work now and we do good work in the college, but there is a vacuum in the regional space. We can populate that. The community health care organisations, CHOs, might be part of it if their terms and conditions are properly negotiated. GP co-operatives are bigger than the standard GP practice of two to four GPs, so there are 140 GPs. In my own co-operative in County Kildare, we have had a minor injuries service where we have really pushed suturing and have had access to out-of-hours trauma films. We can leave the study for members to read. GPs can do this, providing we can get away from being locked into face-time consulting.

The regionalisation vacuum significantly reflects the current General Medical Service, GMS, contract which has us handcuffed to 100% consulting all the time. To go back to the Veterans' Administration, if the new contract to be given to us allows any of us to spend 20% or 30% of our time not locked in face-to-face consulting, we can liaise with the pharmacist,

we can go to primary care team meetings and we can talk. Carlow-Kilkenny has been built on the sweat of GPs and specialists who went to committee meetings and hammered it out. They got some bit of flexibility from their funding manager. The tragedy of Carlow-Kilkenny is that it is only Carlow-Kilkenny. In members' legislation and their recommendations, they should try to work in provisions in order that they do not impose a one-size-fits-all model. They must encompass the needs of rural GPs, and they must be able to support the-----

**Chairman:** I think we have that point. I call Dr. Murphy.

**Dr. Mark Murphy:** I will try to address the contributions as briefly I can. I am sure Dr. Noonan will develop and better some of my points. Regarding integration, like all workers, we work based upon a contract, which must be operationalised by a union. I am afraid to say that, but it is the way the world works. If we are to take on work and integrate and communicate with our hospital colleagues in an improved way, which we should, that must be operationalised with unions. That comes first but it must happen.

To respond to Deputy O'Connell, the multiple pharmacists I deal with on a day-to-day basis would be appalled if I did not say that they are absolutely the core trusted people in the primary care team. I talk to them every day. I apologise for that omission absolutely. Regarding multi-morbidity, in the NHS there is a deprivation weighting in the capitation payment and a multi-morbidity weighting. I could talk at length about the IT aspects that could be improved. Our capitation can be weighted based on multi-morbidity. It is done over there. We can do it here.

Regarding Deputy Harty's second point about inverse incentives, the inverse care law, as he knows, is alive and well. Care is not where it should be, as he said last week. There is no perverse incentive in this regard. We want GPs working with our deprived communities and multi-morbid populations, and I do not see any perverse incentive.

Deputy O'Connell's final point pertained to mental health and the €5,000. I will expand on this matter. This is a typical reality. We need universal health care. At present, 40% of the population receives free GP care. Those people get good quality care. They have free access to primary care and counselling in primary care, which Dr. Osborne may speak about, but there is a nine-month waiting list. This means that 60% of the population must pay to see me. Someone who is severely depressed must come back frequently and pay for 12 or 14 sessions of cognitive behavioural therapy. This is not uncommon. Both of these scenarios are completely untenable and involve Irish patients making catastrophic out-of-pocket payments, which is a technical academic term, which patients in other areas of Europe do not have to make. These are the issues over which we lose sleep. It is very difficult.

On the corporatisation element to which to Deputy Harty referred, we must operate on evidence. We know publicly-funded general practice is the cheapest and most efficient way to manage care. There are for-profit insurance companies and large corporate pharmacy chains trying to get into the market, and this is how they see it. They see this as a market, and it must be stated on the record they see persons as consumers and they are trying to extract money from them. The best way to manage health care is to enable GPs to manage illnesses and refer people to publicly-funded secondary care if possible.

It is very substandard. The typical reality is people come to our practice with fancy medicals from corporatised health care environments, and it is left to us to put the pieces together, as Deputy Harty knows.

**Dr. Laura Noonan:** I will look at a few of the areas Dr. Murphy has spoken about briefly. Deputy Collins mentioned the idea of fragmented care and integration between primary and secondary care. I will not speak about the Carlow-Kilkenny model again, but we need to think about this issue. If we are reducing attendance and demand on secondary care it must be accompanied by a transfer of these resources into primary care, and this type of dynamic decision on the relocation of resources needs to be made. If GPs are to conduct the care previously provided by hospital consultants and hospital-led clinics, they need to be resourced to do so. They can do it once they are resourced.

On Deputy O’Connell’s point on multi-morbidity capitation and remuneration, I am very concerned that anybody would think that GPs would target and hone in on patients with multi-morbidity issues or who live in areas of deprivation because they can make a quick buck on them. This is not possible. In most general practices, we see a wide range and diverse types of patients. Certainly, most people walking into my waiting room will not know whether a patient is on the GMS and has a medical card or is private, or whether a child has an under six card or is seven years of age. All patients sit in the same waiting room, are seen by the same doctor and nurse and are provided with the same care. Issues arise when it comes to referring onwards. Somebody with a medical card can access a service such as counselling in primary care. Somebody with no medical card and no private insurance finds it very hard to access counselling. There is no onward referral pathway for them to counselling in primary care because it requires a medical card. This is when health inequalities exist.

I am also concerned by the fact that we speak about patients who are more difficult and for whom we deserve more money. Every patient becomes a different patient on a different day. The patients who might take me three minutes this week could take me half an hour next week because something complex has happened in their lives. As GPs, we know patients in the context of their physical, psychological and social backgrounds and these items cannot be disregarded. They are so complex and so important. Starting off in a new practice I do not know my families and patients very well yet, but I know that over the years I will develop this relationship and I will understand the patients better. We cannot reduce patients to being either a complex or simple patient. While there are indicators that people have complex comorbidities and may be more difficult, a mental health issue may arise in a patient the GP has not predicted may become a complex patient.

Access to mental health is inequitable. As I mentioned, patients who do not have a medical card cannot even be referred on to counselling in primary care. This is quite a difficult situation. Patients pay a lot of money to private counsellors.

**Dr. Brian Osborne:** I reiterate my apology to Deputy O’Connell. It really was a slip.

**Deputy Kate O’Connell:** I am over it.

**Dr. Brian Osborne:** Pharmacies are valued members of primary care teams. The counselling primary care service was established in 2013 in collaboration with the Irish College of General Practitioners and the HSE, and in that time 10,500 patients have been seen and 63,000 counselling sessions have been attended, with approximately 200 counsellors throughout the country on part-time contracts. This should be extended. It should provide psychology and not just counselling. It works and it should be extended.

**Deputy James Browne:** Do the capital and service costs involved in the first few years of the independent contract model act as a barrier to entry? Are GPs not going into practice or



do people choose not to become GPs because they simply cannot access capital supports or do not make a profit or make a loss in the first years? How can this be addressed in context of the current independent contract model? The increase in the availability of diagnostic resources sought by GPs sounds quite reasonable. Is it purely an issue for the Department of Health in supporting GPs to be able to access these or are there intra-professional issues? Are there other professionals who would prefer GPs not to have access to diagnostics? Would this involve stepping on other people's toes? I would like to get a handle on where the blockages are located.

**Chairman:** I would like clarification on several points that have been raised. Is there a diagnostics model elsewhere which the witnesses believe we should emulate in terms of stand-alone facilities? The big danger is that if an empty wing in a hospital is used in time it will be taken over by the hospital and we will have the same type of blockages. Is there a regional diagnostic centres model? With regard to the input of the Irish College of General Practitioners into the contract, I accept what the witnesses have said, namely, that it is a policy-based organisation and not a trade union. Given its policy base, however, is it keeping trade union representatives informed of the ratios that exist in GP practices? I refer, for example, to the ratio of practice nurses to GPs. Is the Irish College of General Practitioners having an input on what is the best model? Has it identified premises as an issue that needs to be addressed in the contract?

**Dr. Brendan O'Shea:** The question on whether we are inputting into the process of contract negotiations is critical. Collectively, all of the stakeholders in the process have found entering negotiations, and doing so effectively for patients, historically very difficult. Certainly the college understands in detail what is required to be done and, therefore, this is germane to the contract negotiations. Our information, knowledge and standards-based approach are available to the contract negotiation process. Conversely, we would see it as bad for the contract if we were locked out of it. This is the position of the Irish College of General Practitioners.

On the question of whether there is a model of diagnostics that works, the problem is that several models work quite well elsewhere. We must try not to succumb to the fallacy of one size fits all. A very important question related to access to diagnostics and why blockages happen is whether it is because of competition between different professional groupings. We are not certain this is the case. However, we do see - in a funding model that is so focused on the acute hospital system, where budgets are so protected regarding the hospital - that our patients in the community are perennially at the bottom of the queue. It comes across in how budgets are disposed and managed by hospital-based managers who, regrettably, seem to view it on a short-term basis. There are also the practicalities of it. My local hospital does blood tests on an almost 24-hour basis but all of the samples in my practice must be taken between 9 a.m. and 11.30 a.m. on only four mornings each week because there is no blood collection on Fridays. Trying to manage chronic diseases with patients who need ongoing monitoring requires us to have them all in before 11.30 a.m. on four days each week. That is an operational decision which reflects hospital priorities. One should not put oneself under significant pressure to get the contract right the first time. There is a need to build in reviews. This is a feature of the more effective systems that we have studied. People must determine what is working and what is not every 18 months. The Irish health system is paper based, so our data are usually two or three years behind. In general practice, we will deliver real-time data that will allow one to finesse the next round of contract negotiations. Historically, that process has been adversarial and competitive and has ignored the patient. We need to move to a truly collaborative system. If this committee can help us to do that, it will have done great work.

**Dr. Mark Murphy:** I will address Deputy Browne's point. As a thought experiment, let us

say that there are 2,000 General Medical Services, GMS, lists out there. If there are too few general practitioners, GPs, and someone returning from Australia wants to start as a GP and picks a town in rural Ireland, an inner city deprived area or anywhere that does not have one, what would logically happen? A wonderful thing happened a few years ago, in that the GMS lists were opened up. That was long overdue. I can now get a GMS list. Starting on zero patients, my overheads for a premises, staff and equipment would be astronomical and my income would be zero in the first year. We need more GPs. Dr. Noonan has taken over a new list and I am thinking of doing the same, but what we really need is for GPs to set up from scratch and take on patients when more persons enter the system and get GP access cards. That is a major risk, though. There is no capital for GPs to do this. While it is great that the medical card system has opened up, in reality only a handful of my friends throughout the country have done so because it is financially the most loss-making decision that one could ever make for one's family. GPs have done it only to emigrate. We need to consider capital incentives for this situation. That is important. If a premises is rent free, for example, it makes a great deal of sense. If a GP can take over premises and pay the rent, that will also be okay. We do not need to have a fixed position on that issue, but we need to support that GP from a capital point of view so that he or she can work in that environment. We will not get GPs setting up *de novo* unless this happens.

**Dr. Laura Noonan:** The resources and the remunerations that we are discussing in terms of general practice - namely, the capitation and subsidies - are made to pay for premises, secretarial support and practice nurse support. Without this money, it would be impossible to grow a practice. Someone starting with a zero list has no patients and, therefore, has no input from the HSE in terms of capitation or subsidy payments. One must have a list of a certain size for subsidies, a model that is very anti-setting up in practice.

**Dr. Brian Osborne:** I trained in Ballymun for a year and was a locum there for approximately six months. I would love to have stayed on and set up in Ballymun but the system precluded me from doing that. I am an example of the inverse care law at work. If everything that Dr. Murphy and Dr. Noonan alluded to was *in situ* at the time, I would probably be working and living in Ballymun now.

GPs who are not in primary centres can be excluded from primary care teams. This issue needs to be addressed.

**Chairman:** We need flexibility.

**Dr. Brian Osborne:** Yes.

**Chairman:** I invite Dr. O'Shea to wrap up.

**Dr. Brendan O'Shea:** I thank members for listening to us. We sense their interest and knowledge. They have become somewhat expert in the inverse care law, so I will not restate it. However, there is a corollary. Dr. Julian Tudor Hart, a Welsh GP, stated that the impact of the inverse care law is most destructive where health care was commercialised, that is, where commercial influences are allowed to operate in the economy. In certain respects, we are seeing that here in terms of the corporatisation of general practice, cherry-picking and rationing that happens in those kinds of health care systems.

The Chairman has asked me to wind down, so I will. It can be done, and we are sending the committee a copy of this. It is evidence from the US, which we have not looked on as a leading model in primary care but which has generated evidence in the past ten years. It is actually

inspiring stuff and we would regard it as required reading for members.

We have done a quixotic thing, in that we asked the patient what he or she thought. This is a study of 600 patients with complex comorbidities. The data were gathered in community pharmacies by the Adelaide Health Foundation. When we asked the patients where they would like their chronic disease management to be done, they overwhelmingly stated that they would like it to be done in a GP-led service in the community. They did not rate as highly a consultant-led service in the hospital or in the community. They wanted it to be done by GPs and, to some extent, practice nurses. There is a great deal of useful data. Some of it is hurtful in terms of the inequalities that come across. I wish to refer to one sad paper by Professor Ivan Perry *et al* that examines the extent to which we carry out lower extremity amputations on our diabetic patients. It is a key marker of how good we are at chronic disease management. The paper notes that, between 2005 and 2009 in the UK, the number of such amputations per 100,000 diabetics decreased from 275 to 250. That was with an older population. In Ireland, it increased from 144 to 175. We are failing at chronic disease management in a bad way. There are other papers of which the committee is aware. We were asked about Dr. Margaret O’Riordan’s paper, so I will not reference it, and I have here Dr. Liam Glynn’s paper on complex comorbidities.

There have been some wins. Carlow-Kilkenny has been inspiring. There was an engagement approximately a year and a half ago when we communicated to the Minister of the day the need to move ahead on chronic disease management, and there was some progress as a result. A cycle of care for diabetic care was introduced through the appropriate channel. It is a small start, so may we please accelerate it? Chronic disease management in patients attending a general practice setting amounts to 9.2 visits per year and most of the care delivered by GPs. Of those 9.2 consultations, only 1.7 were delivered by the practice nurse. If the Government delivers a new contract that merely allows us to turn that around, we will begin to imitate systems that are more effective and less expensive. What we are doing has a shocking cost in terms of more complex chronic diseases being diagnosed lately and managed far less efficiently.

A number of lovely studies have been done in practice that illustrate what GPs can do, that we can intervene in breast-feeding rates in antenatal care and that we can check the weight of children and parents are welcoming of it. They have been done by registrars, many of whom have left the system. We wonder whether they will ever return. We will leave the committee with a copy of these.

I thank members for listening to us. I hope that we have not spilled over too much into their time. We wish them the very best success because we are all depending on one another in this regard. We are going to turn into the people with complex comorbidities. We sincerely hope that the system can become kinder to us when our time comes.

**Chairman:** I thank the witnesses for their comprehensive presentation and for addressing all of our questions so thoroughly. We appreciate their time and expertise.

The select committee went into private session at 12.38 p.m. and adjourned at 1.10 p.m. until 9 a.m. on Wednesday, 5 October 2016.

