DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 29 Samhain 2017

Wednesday, 29 November 2017

Tháinig an Comhchoiste le chéile ag 9 a.m.

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair/Members present:

Teachtaí Dála/Deputies	Seanadóirí/Senators
Bernard J. Durkan,	Colm Burke,
Billy Kelleher,	Keith Swanick.
Margaret Murphy O'Mahony,	
Louise O'Reilly.	

Teachta/Deputy Michael Harty sa Chathaoir/in the Chair.

The joint committee met in private session until 9.35 a.m.

Primary Care Expansion: Discussion

Chairman: The purpose of this morning's meeting is to engage with the Irish Medical Organisation, the Irish College of General Practitioners, the National Association of General Practitioners and the Irish Congress of Trade Unions health committee regarding primary care expansion as recommended in the Sláintecare report. This meeting will be held over three sessions. For our first session, we will engage with the Irish Medical Organisation and the Irish College of General Practitioners. On behalf of the committee, I welcome Dr. Pádraig McGarry, Dr. Ray Walley and Ms Vanessa Hetherington on behalf of the Irish Medical Organisation, and Dr. Mark Murphy and Dr. Brendan O'Shea on behalf of the Irish College of General Practitioners.

On behalf of the committee, I draw the attention of the witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a 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 they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any opening statement made to the committee will be published on its website after the meeting. Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I invite Dr. McGarry to make his opening statement.

Dr. Pádraig McGarry: On behalf of the IMO, I thank the Chairman and the committee for the invitation to discuss primary care expansion. Since the World Health Organization, WHO, Alma Ata Declaration of 1978, many countries have recognised the need to orientate health care towards GP-led care in the community, based on an extensive body of international research which shows that continuity of care and the patient-centred approach that is specific to the general practice model of care is associated with better health outcomes, equity of access, reduced inequalities in health, more appropriate utilisation of services and long-term cost-effectiveness.

Numerous recent studies have reaffirmed the value of general practice. For example, a 17 year study of more than 1,700 older patients found that continuity of care through attending the same general practitioner was associated with lower mortality. Continuity of care in general practice has also been linked to reduced probability of patient hospitalisation, an uptake in screening programs and immunisation, improved medicine use and adherence, and lower health care costs. Elements of high-quality general practice, including robust continuity of care, greater first contact access and use, more person-focused care over time, a greater available range of services provided when needed, and co-ordination of care are strongly linked with superior patient outcomes and lower health care costs. In particular, areas with greater general practitioner activity have been found to be associated with lower hospital activity, more co-ordinated care and lower health care costs. The efficiencies and cost savings delivered by investment in general practice were demonstrated by an analysis conducted by Rhode Island's department of

health that indicated that higher general practice utilisation rates are associated with decreased per person health care costs and improved patient outcomes. At the same time the prevalence of chronic disease is expected to increase by between 4% and 5% per annum over the next ten years. Currently, care for patients with chronic conditions is fragmented, with the majority taking place in hospital settings at significant expense to the taxpayer. The current model for managing chronic disease is fragmented and is focused on the acute hospital system. That system is overburdened and underfunded, with emergency department, ED, overcrowding, intolerable waiting times for outpatient appointments and inequity of access. Acute services are now undertaking an enormous volume of work that could, if resourced properly, be managed in general practice. Such a move would ensure that care could be delivered to the patient in the community, outcomes would improve and, importantly, capacity in the acute services could be freed up to deal with cases of greater complexity. The Irish Medical Organisation, IMO, has been consistently calling for a shift in the model of care towards general practice and care in the community, with additional supports including maximising the use of practice nurses and equitable access to allied health care professionals in the community. The model of care must be GP-led to ensure continuity and a patient-centred approach, and to avoid duplication and further fragmentation of care.

In May 2017, the Oireachtas cross-party Committee on the Future of Healthcare published the Sláintecare report, laying out an ambitious ten-year plan for reform of the health care system. In line with international evidence, the cross-party group reached consensus on the need to reorientate care towards general practice and care in the community. The IMO has some concerns about the visitation rates, costings and timelines for implementation.

There are currently 666 GPs over the age of 60 who will be retiring in the next five to seven years, of which 244 GPs are over the age of 65 and are likely to retire in the next two years. With current difficulties in recruiting GPs, rural areas are likely to be most affected.

The HSE Health Service Planning Office estimates that with the introduction of the under-six GP visit card, demand for GP consultations in this population will have increased by 65.7% in 2017 and by 42.4% by 2022. Based on conservative estimates by the HSE National Doctors Training and Planning Office, by 2025 Ireland will need an additional 1,380 GPs to meet current demand, while an additional 2,055 GPs will be needed to expand free GP care to the entire population.

Cuts to general practice under the Financial Emergency Measures in the Public Interest Acts of up to 38% have had a significant impact on GPs' morale and their ability to recruit additional staff. A recent survey by the Irish College of General Practitioners highlights a number of causes of general practitioners' dissatisfaction with their working conditions. Roughly half of all general practitioners rate their morale as either poor or very poor, three quarters report their stress levels to be either high or very high, and more than half of those who tried to recruit a sessional doctor or assistant during the past year were unable to do so.

Some 17% of newly qualified GPs work abroad, with many more planning to emigrate. A survey of GP trainees found that more than half are undecided as to whether they will remain in Ireland, one eighth are resolved to leave Ireland, and just a third plan on remaining to practise in Ireland.

There is no infrastructure in place to support multi-disciplinary team working. Waiting lists apply to allied health and social care services in the community, and many of these services are simply not available to patients outside the General Medical Service, GMS, regardless of their

ability to pay.

The most recent national system of health accounts released, those for 2015, demonstrate that just 3.5% of public current expenditure on health is spent in general practice. By contrast, the United Kingdom's National Health Service spends 8.1% of its budget on general practice, and has committed to increasing this proportion to 11% of its budget. In Australia this figure sits at approximately 6.4% of public current expenditure. Ireland is losing its newly qualified GPs to countries where the value of GP care is recognised, and where governments apportion a greater percentage of public spending to GP care.

Experience from other jurisdictions shows that in order to reap the benefits, the development of general practice and care in the community requires significant investment over time. Even if general practice was to be fully funded tomorrow, there is not enough capacity in general practice to deal with the predicted additional workload. The under-six contract brought in 240,000 additional patients. The Sláintecare report recommends that free GP care be extended to 500,000 additional patients per annum. As it is currently constituted, this will lead to waiting lists in general practice as demand will outstrip capacity. Additional supports for infrastructure and practice staff, specifically additional practice nurses, will be needed to allow GPs build up capacity. Consideration must also be given to supports for GP principals to hire additional GPs, as well as administrative support. Many practices will need to physically expand to cope with the additional workload and create capacity. This may require grants for extensions, additional rooms, etc. GPs must be able to access diagnostics and allied health and social care professionals on an equitable basis.

Same-day service and continuity of care are part of what makes Irish general practice work well. By increasing demand through making service available free at the point of use without also increasing capacity we threaten these very principles. It is important, therefore, that the impact of any measures is fully thought through, with a more detailed examination of the increased workload and capacity that will be required to ensure that care is delivered to the patients that need it. There is no point in removing one barrier to access in the form of cost if we only create another in the form of time.

In line with the IMO recommendations to the Oireachtas Committee on the Future of Healthcare, the IMO is calling on the Department of Health and the HSE to agree a strategy with the IMO for the development of general practice and GP-led care in the community over the coming decade. Priority should be given to negotiating a new GP contract with the IMO that is properly resourced and fit for purpose for a 21st century health service. This contract should focus on investment in evidence-based chronic disease management programmes for which GPs are already trained. The IMO would be pleased to discuss any aspect of our statement further with the committee.

Dr. Brendan O'Shea: The Irish College of General Practitioners, ICGP, is the professional body for general practice in Ireland. We thank the members of the Joint Committee on Health for the invitation to reflect on the planned expansion of primary care. I am the director of the post-graduate centre in the Irish College of General Practitioners, and a general practitioner in Newbridge.

Dr. Mark Murphy: I am a GP in Dublin, and I am the chair of communications with the Irish College of General Practitioners.

Dr. Brendan O'Shea: General practitioners are at the heart of the Irish health care system.

Every day, thousands of people all over the country get to see their family doctor without a significant wait, getting quality attention and care for urgent and pressing problems. To ensure that we can continue to provide that cradle-to-grave service to an expanded population with more challenging conditions, and address our retention and manpower crisis in general practice, we urgently need to commit to greater resources and a new contract. In this submission, we will show the committee what that expansion means, what the challenges are, and what our legislators need to do to ensure that general practitioners and their practice teams can continue to be at the heart of a reformed and improving health service.

It is the view of the college that the remainder of primary care, the secondary care sector and the broader health system will never function safely, efficiently or effectively unless adequate capacity is built in GP-led primary care. In addition to chronic underfunding of GP-led primary care over decades, there are separate intractable difficulties regarding the way that secondary care is delivered in the Irish health system, and it is not the task of GPs or primary care to fix these hospital-related problems.

Protracted and grave difficulties relating to critical bottlenecks in emergency departments, in waiting times for most public hospital services, in sub-optimal health outcomes, in perceived and actual gross inequalities in access, and in well-identified system risks arising from overcrowding and health care-acquired infections will all continue as the inevitable consequences of a hospital-centric system where decades of systematic under-resourcing of GP-led primary care are clearly evident. This is what we have done badly in the past.

Specialist services, referred to as "consultant-led", in a hospital-centric model, remain, and will continue to remain, unable to safely or effectively address the present volumes of clinical workload. Much of this workload is best addressed in the community setting, not in hospitals. It is best delivered by teams of GPs and practice nurses working in a generalist, not a specialist service, and based in practices that are adequately supported by administrative staff and allied health care professionals, with access to diagnostics, so that more of the health care needs of most people can be addressed in the community, closest to where they live and at the most appropriate levels of cost and complexity. If we want to do it expensively, we should do it in a hospital.

Strong international evidence from various health systems exists in respect of developing a system based on strong GP-led primary care. Development of universal access to strong GP-led primary care delivers substantial benefits to all citizens and must now be considered as relatively inexpensive in the context of whole-system health care costs. In our statement, and the accompanying briefing documents, the position of the ICGP regarding the expansion of primary care is set out in detail.

Initial steps towards achieving a health system based on GP-led primary care must involve the immediate reversal of cuts introduced under the FEMPI legislation and the replacement of our 39-year old GMS contract with one that addresses both the needs of people who have an immediate need for ongoing medical care in their communities and those of the general practice teams. These two issues - FEMPI and contracts - are constantly to the fore in our consultations with our members, with allied organisations - including the GP representative organisations, namely, the IMO and NAGP, and the Irish Practice Nurses Association, IPNA - and in our engagement with other health disciplines within the health care sector. It is the view of the ICGP that FEMPI legislation has destabilised general practice, most acutely in rural and deprived communities.

Dr. Mark Murphy: The next four paragraphs outline what we believe to be stronger primary care. This will resonate with what the committee will hear from us, the IMO, the NAGP and ICTU this morning and in the context of the reports with which it has been involved during the past year.

The first feature relates to capacity, which predominantly relates to persons. Health care is provided by persons, namely, GPs, nurses and other allied health care professionals. We spend €1 billion on drugs and another €600 million on high-tech drugs. Most health care is delivered by people and we need to invest in those people. The ICGP has played its part in this regard. Applications for GP training increased from 285 to 421 this year. We are doing our best to paint a positive picture of general practice. However, we need all these policies to come into place so that we can retain them into the future. It is not just GPs. We need a lot more practice nurses and we will work with the IPNA to develop and train those nurses. That is a priority. Capacity is not just persons though, we need better information technology. When we take on more workload and capacity is increased, we need our premises to be expanded and that needs to be supported.

Our second point relates to the independent contractor model. There is much discussion regarding model to use and how are we going to employ and pay for these services. Most countries' health services use an independent contractor model, even the NHS. We have an independent contractor model. To enable GP-led primary care, we need to bolster and improve the current model. We need it to be supported with increased numbers of practice nurses and other staff within the GP environment so that we can provide unfragmented comprehensive continuous carer to patients.

Our third point is that we need to shift care from hospitals to primary care settings. What are we talking about? We are talking about people with multiple chronic conditions, people who have six to ten chronic conditions and are on ten to 15 medications. It is the majority of our workload in consultation. In the final years of their lives, people can be over-medicalised in a hospital-centric system. If we want them to have the care they deserve, with their preferences and their quality of life maintained, we need to support the generalist approach to health care. That would allow us and the teams within general practice to care for those persons and that needs to be reflected in a new contract.

We need that capacity to be team-led within general practice. The GPs, practice nurses and other allied health care professionals need to be supported. In particular, practice nurses need better terms and conditions and that needs to be reflected too. This will develop a stronger primary care system.

Dr. Brendan O'Shea: Over 4,000 of our practitioners identified general practice as the discipline for the purposes of professional competence. Most are members of ICGP. We have over 600 GP trainees. We have consulted widely among ourselves and allied stakeholders. This committee has a very difficult brief because health is a very complex issue, fraught with risk and cost. For ease, we have identified action points at the end of our document regarding the expansion of primary care. We feel that these are the pressing issues. There is a list of them at the end of our opening statement.

Cuts to general practice resulting from FEMPI measures should be reversed. There should be an effective contract for general practice, delivering adequate flexibility, resources and development. Adequate numbers of generalist practice staff must be recruited and trained, with planning for a population of 5 million. That has to be set in train now and we are doing our part in

the ICGP to make that possible. Adequate and accountable capacity in allied health disciplines in communities should also be made available. That means electronic data that is available to drive and guide development. There should be active, ongoing, effective collaboration between the ICGP, the GP representative organisations and the HSE. Private health insurers should engage with GP stakeholders and State agencies on the challenge of multi-morbidity. Private health insurance largely does not recognise primary care management of chronic disease.

Protected transformation funds for education and research relevant to general practice development are needed. GP involvement in nursing home care and end-of-life care requires targeted funding. There should also be targeted funding for GP diagnostics in radiology and for specific clinical workloads. Expansion of GP training capacity is required, as is the development of practice nurse education to include continuing medical education for practice nurses as a priority. The use of electronic medical records and administration should be extended beyond general practice, where it is already strong, throughout the remainder of the health system, particularly hospital based services. It is incredible that most of the rest of the health care system is operating on paper. The members of the primary care team run by the HSE have no contact email addresses. That is inexplicable.

Overall, key policies relevant to expansion of primary care as a national strategic priority must be implemented urgently and aggressively as a national strategic priority, in the interest of equity, clinical safety and improving medical care. We have previously submitted evidence-based documents to this committee and to the Committee on the Future of Healthcare. We refer members to those documents. I thank the committee very much for seeking our views.

Chairman: I thank Dr. O'Shea. Before we start, I would like to declare that I am an ordinary member of the IMO and the ICGP. We are going to open the meeting to our members. The first three speakers, Deputies O'Reilly, Murphy O'Mahony and Kelleher, might bank their questions.

Deputy Bernard J. Durkan: Me too.

Deputy Louise O'Reilly: I will go first and then it can be decided. I thank the witnesses for coming in and for all the information they have provided. I was a member of the Committee on the Future of Healthcare and we would have felt the loss of the witnesses' input because it is very helpful to hear from people who are actually delivering the services. It is all very well for us to imagine what it might look like but it is quite another thing to hear from the experts.

I have a number of questions. The recent resignation of Richard Corbridge, or his moving on, is a huge blow in the context of the development of information technology. It often struck me when I represented people in the health services that the higher up the chain one reached in terms of management, the farther away one got from the patient and the more one was to encounter the use of BlackBerrys, as was, iPads or some other forms of mobile electronic devices. It is really sadly lacking. Perhaps the witnesses could expand on what exactly would be needed in terms of information technology?

We do not want to get ahead of ourselves, but just bring us up to what would be considered basic in more advanced information technology. The people who should have access to this technology are those who are operating within and move about the community. The witnesses might give us a flavour of how much access there is and what can be done. Who needs to have access to mobile information technology? How would that work? I am thinking in terms of access to near-patient testing and other things that might actually help in the delivery of health

care. It did often strike me that the higher up one went and the farther one got away from the patient, the more likely one was to see technology in use. It was a kind of a reward as opposed to something to be used in a practical sense. There are health care professionals who have to use their own electronic devices, which is not acceptable. What improvements can be made in this area and what would it take to achieve them?

In regard to the breakdown of the fee structure, we see the large sums making the headlines in the newspapers, the Dr. X whose practice received X amount of money. Will the delegates explain what makes up GP income, which percentage is from fee-per-item income and which percentage is from GMS income? I appreciate that the ratios will vary from practice to practice but a guideline breakdown would be helpful. The large sums will always hit the headlines but representative organisations tell us that the income from the State by no means amounts to a bonanza. Where there is a fee-per-item structure, how much of that work is done directly by the GP, how much by the practice nurse and how is all of that remunerated?

Reference was made to the interaction between GPs and primary care teams, allied health professionals and others delivering services in the community. In practice, those interactions are not usually managed by the GP. Are GPs willing to manage that service more closely or is it the witnesses' view that the two arms should function separately? I am asking about what their preference would be in an ideal world. Should we have an independent general practitioner model and, ancillary to that, allied health professionals providing additional primary care services? I understand there is huge frustration among GPs at the difficulties in accessing therapy and other specialist services for patients. Might that problem be resolved by bringing those services under the remit of GPs or is it more a question of enhancing communication between the GP on the front line and the broader HSE service provision?

I have spoken to people who say we are about to see an influx of multinationals into the provision of GP services. We could sit here all day and detail all the reasons that the relationship between patient and local GP is a positive thing, where the doctor knows the person's history and family and is himself or herself a member of the community. People who are cheerleading for an increased input by multinational service providers, of whom I am not one, argue that it will solve the problem of a difficulty in accessing GPs in rural areas and areas of deprivation. I am not convinced of that but am interested in the delegates' view.

I am sure the witnesses are aware of my view on GP salaries, just as I am familiar with their position. There was talk in the media in recent months about the prospect of some form of industrial action. I fully appreciate, as someone who practised in that area, of the challenges involved in advocating for the rights of workers in a particular sector. What we are hearing is that there is an issue not only in regard to recruitment and retention, which is undeniable, but also in terms of the morale of the GPs providing the services. Will the delegates comment on that?

On the GP contract, we are not asking our guests to negotiate it here with us or, indeed, to give away any negotiating position they might have adopted. We often note in this committee that every question we ask of the Department of Health regarding primary care and GP services is met with the response that the outcome of negotiations is awaited, after which every problem will be fixed. I do not know how good the GP contract will be but it seems unlikely to solve every problem that has ever existed in primary care. Will the delegates give us an idea of when they see the negotiations coming to some sort of conclusion? I am not the only person in this committee or in the Oireachtas who is frustrated at the lack of progress, which is not to say that both sides are not working hard to move things along. It seems, however, that a great deal of stuff has been put on hold pending agreement on GP contracts.

Deputy Margaret Murphy O'Mahony: I welcome the witnesses and thank them for their contributions. I acknowledge the fantastic work GPs do and the huge pressures and responsibilities under which they operate. I represent the rural constituency of Cork South-West where many GP positions are unfilled, presumably because we are so far from cities and the hospitals and other health care facilities located there. What can be done to make it more inviting for younger doctors, in particular, to apply for rural positions?

The Spotlight report on benchmarking the health care system observed that it is rare for GPs to work alongside other health professionals in an integrated way. Do the delegates agree that a close working relationship between doctors and ancillary service providers is vital for a more effective and progressive primary health care system?

My final question concerns a local issue that I have raised several times. Management at Bantry General Hospital has stated on numerous occasions that it has the capacity to oversee a larger number of procedures if it is granted the endoscopy and rehabilitation unit it has been requesting for years. If that request were granted, would it alleviate pressures on doctors in the locality?

Deputy Billy Kelleher: I welcome the delegates, with whom we have had discussions on a previous occasion regarding the Sláintecare report. We were very conscious in examining proposals for a ten-year strategy for the health service that primary care must be at the heart of it. All the experts who came before the committee spoke about the need for an increased and enhanced capacity in primary care.

An issue that is critical in this regard is the number of GPs. That is determined by two factors, the first being a training programmes for the roll-out of new GPs and, second, whether or not there is sufficient remunerative attractiveness to retain GPs in this country. I do not expect the delegates to divulge where they are in negotiations, but if we are to roll out primary care as the bulwark of health care, then I assume the Sláintecare report and all that flows from it is central to those negotiations. Otherwise, we at risk of developing a strategy that cannot be underpinned by GPs and the primary care service in general. Will the delegates elaborate on where we are in terms of the recommendations in the Sláintecare report and how those recommendations are being mirrored in the discussions on the GP contract and its implementation? Of course, what is at issue here is not just the contract but the broader picture that encompasses practice nurses, nurse specialists and secondary therapeutic care in a community setting.

I am making an observation rather than a criticism in pointing out that the IMO is primarily concerned with representing its members. The Department of Health and the Department of Public Expenditure and Reform, meanwhile, have a view on what should and can be made available in terms of resources. It seems to me there is a critical component missing from the engagement between the parties. Does the Irish College of General Practitioners have an oversight view on the contract negotiations? I assume the patient and clinical outcomes are critically important. I am not saying the IMO or the Department will not take them into account but, at the same time, we need some independent clinical oversight in terms of outcomes for patients and what people believe is the best for patients as opposed to the best for doctors or the Department of Health. I ask the witnesses to expand on this a little.

Reference has been made to the increased number of GPs in training programmes. I know the views of the IMO and others on salaried GPs, but does anybody see a role for salaried GPs, particularly in view of the fact we have huge challenges in socio-economically deprived urban areas and rural peripheral areas where it seems to be impossible to attract GPs? Even if we un-

wound all of the FEMPI cuts imposed on GPs in recent years, would that be sufficient to bring doctors into the areas where it is most difficult to recruit?

We speak about dispensing GPs. Is that role being diminished or undermined? Is there a need for greater emphasis on dispensing GPs? I ask the witnesses to elaborate.

With regard to practice nurses and nurse specialists, we speak about chronic care, chronic disease, enhancing capacity and moving patients from our hospital-centric system and out into the community setting. Realistically, do we have the expertise in terms of GPs and nurse specialists? How much of an increase in personnel would we need to allow for movement from the hospital system to a primary care setting in a structured phased manner? Have the witnesses done work on this? The risk is if we invest and front load primary care and it does not work, we will have a system whereby we have heavily-funded primary care but it does not deliver the savings required. This is a risk for policy makers. I know there is international evidence on this, but it has to be done in a way that works. This is why, in the context of the negotiations, there has to be some independent assessment of what is being negotiated in terms of patient outcomes and outcomes for the health services in general.

We looked at diagnostics in the Sláintecare report, and observations were made by the IMO and the National Association of General Practitioners and others in terms of access to diagnostics. Will the witnesses elaborate as to what they envisage in this regard? Is it the case there would be diagnostic centres or would they be attached to hospitals? Would it still be referrals through consultants? How exactly do the witnesses see this working in terms of diagnostics? Do they think there should be some form of diagnostic centres separate from the hospital system so people could be referred directly for diagnostics, as opposed to diagnostics been dependent on the emergency departments of hospitals? I ask the witnesses to elaborate on this.

With regard to prescribing, we seem to have high dependency on antibiotics and benzodiazepines. Are we out of kilter with other European countries on prescribing? Are there reasons for this? Is it the health of the population or the demographics? Is it our prescribing habits? There is a lot of evidence now with regard to reducing antibiotics. There are campaigns and some GPs are very involved in it. We seem to prescribe benzodiazepines and other medications more than other European countries.

Chairman: I will turn to the Irish Medical Organisation first to address some of those questions.

Dr. Pádraig McGarry: With regard to Deputy O'Reilly's question on IT, general practice has been to the forefront of developing IT independently for years, and we are way ahead of our secondary care colleagues. Most general practices are now computerised. There is no interaction, or very little interaction, between secondary care and primary care from an IT perspective other than IT referrals. It is improving and certainly Richard Corbridge had a vision that it would improve. Unfortunately, to date, we have not seen a huge appetite for it to happen. It needs to happen because it is front and centre to all of the other issues on chronic disease management and referrals. GPs have been to the fore in investing their own funds in this. Uniquely in the health service it falls on them, and certainly it is an issue which is very much to the forefront in the initial discussions and consultations on the GP contract. This has been acknowledged by the Department of Health and the HSE. It is very much an issue that will need to be addressed, or else it just cannot go forward.

With regard to primary care teams, Dr. O'Shea mentioned we are very much IT based.

Primary care teams can be all paper-based, and people felt the meetings taking place between allied professionals were not working out terribly well. They were not structured terribly well and there was very little outcome from them. This can be developed and needs protected time. In a lot of cases, the meetings could be done through Zoom or Skype. IT can help in this.

With regard to allied professionals, I work in a primary care team and quite often the allied professions to which we would like to refer patients just do not exist. If somebody goes away on sick leave or maternity leave there is no replacement and a physiotherapist, dietician or podiatrist just does not happen to be there. The whole system breaks down. We start developing what we have never wanted to do in general practice, which is waiting lists. If we are going to create primary care teams we have to protect whole-time equivalents to make sure that if people do go away on whatever leave they have that there is a back-up and fallback position. At present this does not exist.

A question was asked on the corporatisation of general practice. There has been a move in this regard and I can understand it. Many GPs in their mid-50s and coming into their 60s have invested heavily in their practices over the past ten or 15 years with the hope and expectation it would be funded appropriately. Many GPs have found themselves in dire financial straits and certain corporate entities have provided them with an exit strategy which otherwise just is not there. If general practice was properly funded the traditional follow-on, if it was financially viable, would be likely to happen. Unfortunately, trainee GPs and younger GPs do not see this happening so there has not been a natural progression from trainee GPs to younger GPs to principalships because of the uncertainty that exists. Corporates have come in and offered exit strategies to GPs in that situation. There is a danger in this. There is anecdotal evidence that initially when GPs go into corporate practices it looks fine, but they lose their autonomy. Many GPs who have gone into corporate practices after a while find that this is not what they bought into. I suppose it is the individual care that GPs give all the time that attracts them to the job.

Corporates will respond to financial imperatives. There was an example from Scotland where a corporate group bought up 25% of the practices in an area and it went broke. The government or whoever was left to pick up the pieces. It is a huge risk. If one ensures the financial viability of 2,500, 3,500, 4,000 or however many GPs are there, one is much less likely to run the risk of the whole system imploding. Some, for whatever reasons, perhaps making wrong decisions, may not necessarily survive but, by and large, if one allows appropriately funded practices to flourish, they will remain in place. By opting for the corporatisation, one runs the risk that the corporates may move on.

The other issue in relation to that is, from a clinical point of view, there is a loss of that continuity of care which is so important to the patient. It has been well documented that having one's own GP on an ongoing basis leads to much better outcomes in the long run. There is a huge risk that, if corporatisation comes in, that will be lost and the cost to society in general can be exponential.

Dr. Ray Walley: There is a recent study done by Imperial College in the UK. The good thing about having our neighbour, the UK, is it has thrown so much money at issues. They have shown the evidence base there and what has worked and what has not. A recent study looking at what patients thought was best, found that individual GP principal-led group practice provided more satisfaction, more continuity and fewer referrals. One must bear in mind that the cost of the health care system is in the hospitals and if one has somebody making a decision that refers everything to the hospital, it is ultimately the State that pays for it. The evidence is that corporate does not work.

Corporate works at scale. The evidence is that practices of approximately three GPs know their patients and there is continuity of care and as a result, one maintains best practise. Patients want to know their GPs. In many corporates, they do not know their GPs. The evidence base is there to show that it is not effective health care. The biggest example is America. American health care is not something one wants to replicate.

Deputy Louise O'Reilly: Is it Dr. Walley's opinion that it would lead to more additional testing on the basis that if a person's GP knows the patient, he or she will know the family history?

Dr. Ray Walley: Yes.

Deputy Louise O'Reilly: Clearly, none of us favours a move towards the corporate but the danger is that one drifts into that without necessarily having the conversation. However, one of the big impacts of corporate is likely to be a massive rise in additional and perhaps unnecessary - probably necessary created by the circumstances but unnecessary in reality - tests and an additional cost to the Exchequer.

Dr. Ray Walley: The evidence, based on Australia, the United States, the United Kingdom and Holland, is that one gets vertical integration. What happens is the corporates have a voracious appetite for buying up all health care. They buy the diagnostics and rates of referrals to different diagnostics occur, not necessarily because the corporates are doing this. The problem is one loses continuity. If I have a patient for whom a blood test was done a year or six months ago, it may not need to be repeated. The problem is, if one does not know the patient, one will order the blood test. That is where all the exponential costs of this go and it is a waste of money. We will need more money in an era of scarce resources and more need. We need to ensure there is an evidence base against what we do.

Chairman: I will move to the representatives of the Irish College of General Practitioners. Perhaps they might address the questions in the context of the Sláintecare report, which is really the purpose of the meeting this morning. They might contextualise the answers. There were some other questions. Perhaps they might talk about how we can deal with recruitment, retention and manpower issues.

Dr. Mark Murphy: I will address the Sláintecare issue, recruitment, retention and a few other questions. There were 19 in total. I will be very quick.

To contextualise it, take a 70 year old woman who has five medical conditions: obstructive pulmonary disease, arthritis, diabetes and high blood pressure. She would be on 19 medications at five different times in the day. She would be on 15 non-pharmacological medications. There are 16 interactions between her conditions and her drugs. That is the typical model of managing her care in a secondary hospital. Sure, we can manage single diseases in the 40s, 50s up to 70s, but what we can also do is integrate all that knowledge together. When one talks about prescribing, over 20% of over 65s are now on ten or more medicines. We have had an ever increasing rise in prescribing but what we have actually seen is a reduction in potentially inappropriate prescribing - that is from a large paper published in Ireland last year the reference for which I can give to the committee. GPs are doing a better job of managing all these complex pharmacological interactions. We can probably do a better job if the members give us the resources for chronic disease management and to be able to manage medicines.

Benzodiazepine is an issue. On quality prescribing, we will always stand over quality and

standards. There is a big issue with legacy prescribing. It is hard to know what to do with someone who has been on a benzodiazepine for 30 years. It is a difficult issue. Certainly, going forward, that is not an issue anymore. We are doing a very good job. We would be benchmarked against our peers.

On the e-health issue, most of the issues we need to deal with relate to communication. That is what a telephone call can do. One does not need novel communications to do that. We can just pick up a phone. It is a pity that has been lost in some rural community hospitals. However, we do need data to have formal and structured and unstructured communication, and the HSE has enabled that. On the secondary care side, there is still no consultant with an email address. We have one.

We collect so much data. We need to use that data in research to underpin the quality of care. It is a shame that is not happening. We want that to happen. We need our electronic health record to communicate with secondary care - those are called summary care records. That needs to happen and we want it to happen.

There will not be a big role for IT to help with diagnostics. In terms of diagnostics, we are really talking about laboratory tests on both bloods and urine, we are talking about radiology, including X-rays, ultrasounds, CTs and MRIs, we are talking about cardiac investigations and we are talking about gastrointestinal endoscopy investigations. In general, laboratory tests are okay. Some services have a courier a couple of times a week. It needs to be better and we can do near testing.

However, the real shame comes into more complex radiography. We do not have access to CTs and MRIs. Those patients end up in outpatient and emergency departments. They get sicker and it is an absolute disgrace. Much good work is being done in terms of endoscopy. Wherever it happens, we just need patients to get those tests. We are flexible with that.

On an issue to do with the salary of GPs, I am not sure that the thesis is correct that there are areas in the south inner city and north inner city that are crying out for GPs because we need a salaried doctor model. I have looked into this. I am a 37 year old GP. I would like to set up. The business model is not there. That is because of ten years. If one fixes the problem which is that the risks are too great and the rewards are too little and if one fixes the business model and comes up with an innovative start-up package in urban areas, that will fix retention in the inner city area. In rural practice, it is different. One needs other types of supports to cater for those and that is a particular issue. There may well be a need for salaried doctors, but my gut instinct and the instinct of our members is that if one fixes the independent contractor model the rest will follow. There is an issue with premises and set-up costs but that can come on.

The last point I will touch upon is the primary care team. To contextualise it, why do we need to talk to our excellent colleagues? We are talking about the community pharmacists. I talk to them over the phone. When I make an error on a prescription, they will ring me and we talk, and I will sort it out. That is the communication. We do not need any more communication with them. It is already excellent. With the physio and the public health nurse, we do not need to be in the same building. We are talking about complex, perhaps deprived and very difficult social issues or very elderly patients with a lot of complex needs. We just need to meet once every month. It is not something for which we need to be in the same building. Too much emphasis is placed on geographical co-location. We just need to be able to pick up the phone, know people and have a little bit of time. We can then sort out all that stuff. We do not have to be under the same roof to do that. Although it would help, it is not the big issue.

Dr. Brendan O'Shea: In terms of the college's response to the Sláintecare report, it is broadly supportive of Sláintecare in general and a more recent report, A Future Together - Building a Better GP and Primary Care Service, from the HSE. We have good reports and policy. It is a question of implementing them and moving forward.

Touching on some additional questions, Deputy Murphy referred to the difficulties of the people of west Cork. On unfilled positions in rural practice, salaried positions may be part of the answer. The overwhelming consensus among most GPs is to fix the independent contractor model. With respect to west Cork, there could be deprivation weightings or geographical incentives. One of the problems is that there are several different ways to fix this, but anything would be better than the paralysis of the past 39 years.

We were asked about closer working relationships with other health care professionals. The ICGP has conducted its own research on primary care teams. It is a lovely idea, but it is not working. Some 70% of ICGP members are positively disposed towards the idea of primary care teams, but only 13% indicated a positive experience for all of the reasons we have elaborated on.

I would like to discuss a contentious issue which relates to our experience as GPs with primary care physiotherapy and private physiotherapy. The primary care physiotherapist works on a paper-based referral system and there is a wait time of anywhere from two to 12 weeks. Patients come back reporting on it. Private physiotherapy is available with a mobile phone number, email address and telephone which is answered, and a patient will be seen on the same day. Patients report more positively on that. It highlights, in microcosm, some of the important differences between a State service which is managed in the way it is and some of the benefits of the independent contractor model. Private physiotherapists operate in the private sector.

We share the concerns expressed about corporatised general practice. It seems attractive in certain respects. They have nicer buildings and a bigger business imperative, but there is an evidence base around continuity of care. It must be what people want and, most important, continuity saves money for all of the reasons on which we have elaborated.

In respect of continuity of care, a problem for us in general practice under the current system is our interaction with secondary care. The secondary care system is paper-based. There are 7,000 junior hospital doctors, some of whom are managed and trained excellently well, but the system relies on them. They, too, repeat tests, bring people back to outpatients departments and feed into bigger waiting lists. That partly contributes to the difficulties we are experiencing in terms of accessing tests for our patients directly. A junior hospital doctor, who may or may not be supervised, has better access to important diagnostic tests than GPs.

With respect to the preamble to Deputy Kelleher's question, he very properly said that if we fixed the training issue and remuneration issue, things would work well. There is a third dimension to that which is particularly important to our junior colleagues. Our doctors coming off our training schemes, who are whipped up everywhere else and are top-quality graduates, will not work in a system where if one patient comes to me as a private patient and another as a public patient, I will worry for weeks about whether the public patient will get a colonoscopy or endoscopy. They will not make seven phone calls to a hospital to chase up results. They are leaving for the NHS, Scotland, Canada and Australia where all of these things work smoothly.

A big chasm between general practice and touching on one of Deputy O'Reilly's issues relates to information technology. We cannot emphasise the importance of this enough. Whatev-

er we collectively decide here will not be perfect, but will almost certainly be an improvement. The quickest way to know whether something is working is information technology which is real time and data driven. Everything we in general practice and our nurses and administrators do is incredibly transparent because of electronic data. One falls off a cliff when one goes to the rest of the primary care team. The hospitals are a morass.

Members made several comments regarding the shift of care to general practice. There is an assumption that what is going on in hospitals is adequate chronic disease management, but it is not. We need to build capacity in evidence-based primary care which is data driven and involves integrated teamwork. The college is happy to revisit primary care teams in a meaningful way with our colleagues, the GP representative organisations and the HSE. We cannot support what is going on at the moment. Likewise, we are happy to revisit primary care centres, but for many of us they simply do not work.

Chairman: I do not want to interrupt Dr. O'Shea, but a number of other groups want to come in. In respect of the Sláintecare report, there is concern among many members of the committee that the pace of implementation of the report is slow. The Government is still considering it and no actions have been delivered. Will both groups give a brief critical analysis of the report? They said they broadly accepted it, which means there are areas of it with which they have difficulty. I ask Dr. McGarry or Dr. Walley to give their comments on the report. Concern was expressed about visitation rates in the report which may not represent the reality of what is happening.

Deputy Billy Kelleher: The contracts were not referred to in the terms which were raised. I also referred to oversight.

Dr. Pádraig McGarry: On the Sláintecare report, there is a question mark over visitation rates. The rates referred to in the report were based on data which arose from the Trinity College evaluation. That has been questioned because it was based on patient recall over a year as opposed to actual visitation rates. Healthy Ireland has done similar work and its visitation rates are much more aligned to actual visits rather than rates. This issue was raised at the rural practice conference, and an undertaking was given to look at it. Visitation rates are, on average, about 7.7 visits per annum for general practice, whereas the Sláintecare report referred to 40%, which is somewhat less. That indicates that there is a significant mismatch between actuality and what is going to happen. That is based on current practice.

On top of that, when GP cards for those aged under six years of age were introduced, we projected that the visitation rate would increase, and it has increased by 67.5%. That was not expected by the HSE. If the threshold for a visitation is lowered, visits will rise. It is proposed to include an extra 500,000 patients per annum over the next five years. That will cripple the capacity and the ability of general practice to develop it unless there are accurate data as to what the proposal will affect. We need to have clear data on what the actuality will be.

What is probably central to the contract is the need to provide chronic disease management in general practice where it is most appropriate to do so. That will bring about a significant increase in visitation rights. We need to be clear about what we are dealing with from the outset, rather than creating something only to find it cannot be implemented and waiting times are higher than ever before. The cost element has been taken away but people are not allowed to have the necessary time. We should work very closely to make sure that we are working along the same lines rather than working and growing apart.

Dr. Ray Walley: The health care system that wins all the awards is the Dutch system. When they developed GP and community care, they took 30 years to do it. The funding of community care in Holland is 10% of the budget and the funding of general practice is also of the order of 10% of the budget. They did not do it over five years. Five years is incredibly ambitious in a system whereby the secondary care system is in paralysis. We are all about ambition but we want reality because ultimately general practice is left with the difficulties. Let us look at the figures. Many GPs face impending retirement and there is an ageing workforce. The average age of a general practitioner is of the order of 43 to 44 years of age. We have a workload problem. We need to prioritise things.

Deputy Louise O'Reilly inquired about industrial action. Industrial action is already happening. The ultimate industrial action is emigration. Younger GPs are not waiting to see what will happen because we have been listening to this for 12 or 13 years. Unless general practice and community care are funded now, it will cost even more money, but we have to get away from the peaks and troughs. We have had troughs of many billions taken out. Now we are at a peak. We are spending what we should spend but we are not necessarily replacing the money to ensure that we are dealing with the troughs for many years.

Getting back to Deputy Kelleher's question, when that happens, if one does not have appropriate funding, one has increased inappropriate prescribing. For example, the country with the lowest prescribing of antibiotics is Holland. One could ask why that is. It is because they have near-testing for C-reactive protein, CRP. We have looked for that. They have excellent daily, repeated access to blood tests. A person does not need to have it done in the surgery but he or she needs to access it somewhere. In the same way, it does not matter whether the X-ray is done in a hospital, in a surgery or a community care centre. As long as the machines are active all the time and being utilised in order that there are economies of scale, it does not matter where their location is. There is a higher incidence of antibiotic prescribing in some countries where there is not access to those tests. Ireland is at the lower level of antibiotic prescribing in the OECD but we need to improve on that. Last night I did a co-op shift. Three patients came in to me saying the only reason they were there was for an antibiotic. They were not interested in my opinion or an examination and none of the three satisfied the criteria for giving an antibiotic. As a result, I could not prescribe it. General practice and community care have to be funded to ensure we have effective health care going forward.

Ms Vanessa Hetherington: I want to reiterate that a new contract has to be brought in on a phased basis, as the capacity allows within the system. As Dr. Walley indicated, any strong primary care system has to be built over a period of time – ten or 20 years. Looking at what has happened in general practice over the past ten years, it is exactly the opposite. The financial emergency measures in the public interest, FEMPI, cuts have led to a reduction of 38% in funding per patient. That is exactly the opposite of developing a GP-led service.

Chairman: I thank Ms Hetherington. Just before anyone responds to my question on a critical analysis of the Sláintecare report, I will bring in Senators Colm Burke and Keith Swanick and then the witnesses might answer those questions, perhaps in the context of the Sláintecare report.

Senator Colm Burke: I thank the witnesses very much for their presentations and the work they are doing. I am quite concerned about the time it is taking to complete the contract negotiations. From my experience and previously when the Department was dealing with contract negotiations in other areas of health care, they took a number of years. If the witnesses wanted to fast-track a particular aspect of the contract negotiations which could be implemented, what

would they identify? The witnesses said it would have to be worked on gradually. Could an agreement be reached at this stage with an element of the contract that could be implemented immediately that would assist GPs with further development?

Last night I downloaded the contract produced in Scotland. It is called the 2008 general medical services contract. I understand the expectation is that there will be a shortage of 1,000 GPs in Scotland unless they get their act together there. Have the witnesses looked at the proposal and are there any aspects of it that we could adopt here to fast-track a better contract for GPs here? One of the issues raised in this document is that GPs should have a minimum income of £80,450 sterling. Have we looked at that and can we use part of the contract? We will be competing with Scotland if it has a more attractive contract than the Irish one. We are competing on a world market for GPs. Therefore, we must be conscious of what others are offering.

The third issue I wish to raise relates to the system in England. I was in Plymouth recently looking at medical services there. We were in one practice where the big boast was the fact that they had reduced the waiting times to see patients from 15 days to eight days. We found another practice where all the GPs had handed back their contracts and walked out the door and left a practice of 20,000 patients. I hope that will never happen here in Ireland. What do we need to do to make sure that we fast-track elements of the contract negotiations to put them in place? Otherwise, we are going to face the same problem with shortages. We already have a shortage of staff in certain areas.

My understanding is that in Cork and Kerry they have introduced electronic communication for maternity services. I believe there was a problem with that in relation to communication with GPs. Have the teething problems with electronic communication in maternity services been resolved in order that the system can be fast-tracked around the country? Are GPs able to work with the HSE on this issue to fast-track the system for the entire country? It is important that work proceeds in that regard.

I sent a question to the Minister yesterday on electronic communications with patients. A number of companies are offering to set up electronic communications systems for medical practitioners. Such a system will have to be incorporated at this stage rather than looking at it in ten or 15 years. We are already behind a country such as Denmark where electronic communication has been used very effectively. How can we fast-track the system as part of the contract negotiations? The most important question is what element of the contract we could sign off on in the morning without having to wait for the entire process to be progressed.

Deputy Bernard J. Durkan: My apologies, as I was absent for a few minutes. Needs must. I welcome the witnesses. I do not wish to go over the previous questions in too much detail but I am a great believer in having local knowledge on each subject on the basis that it represents a microcosm of the total picture. From the point of view of both organisations, what do they see as the main points in terms of challenging their ability to deliver what is required in the provision of primary care in both urban and rural settings?

Reference has already been made to the GP contract. I am aware the witnesses have some reservations, but not as many as I have, about primary care centres. How valuable are they in the system, taking into account the considerable capital investment involved? They are supposed to cater for a population of approximately 50,000. Some of them appear to me to be like small hospitals. Are they effectively intercepting the patient before he or she has to queue up at an accident and emergency department or he or she becomes a day patient?

People become ill on a 24-7 basis and on continuity and the pooling of cover, in particular out of hours and at weekends, have we yet achieved the ultimate in terms of providing the required cover for patients or do they have to go to accident and emergency departments, with obvious consequences?

A number of GP practices have received a lot of attention, particularly throughout rural Ireland, over recent years. To what extent has the negative comment impacted on the attractiveness of the practice to newly qualified doctors, and nurses for that matter? Do the witnesses see a particular way of dealing with the requirements of rural Ireland, which are distinct and different from those of the rest of the country, without necessarily going overboard spending hard-won money that we do not have? Good organisation is the key to any business, be it in the public or private sector. Good organisations know how the job can be done best and most efficiently in terms of the turnover of patients in the respective practice areas. What are the issues that curtail GPs' ability to deal with those quickly, effectively and in a way that lends itself to enhancing the role of the GP, because everything is critical nowadays? Everything that everyone in the public sector does is criticised. Sometimes this is legitimate but there is a tendency in the goldfish bowl to be overly conclusive regarding the issues.

From a delivery perspective, what are the witnesses' experiences as deliverers of service to the community? What are their experiences in terms of how they see it, apart from the GP contract and other things that need to be dealt with? What do the witnesses see as coming from the patients? What is the most common criticism they get from patients? I know that in our businesses, our patients do not take long in telling us what we should be doing at various times and how we could do better. This is a good thing. That is fine. To what extent do the witnesses get that flow of information from the base in which they work, and how do they respond?

Based on their own experiences in dealing with an individual patient at any time, be it an acute condition or a long-term illness, how do the witnesses see their practices affected by the place to which they refer their patient in the event of the need for referral? For example, can they be sure of the outcome when they refer a patient to a consultant or hospital accident and emergency department? What is the outcome? Is it quick enough? Is it effective? Do they see that patient again? This is the kind of thing we need to know about. I am saying this with tongue in cheek because we get the same queries ourselves. We do not deal with them medically but we try to deal with them in the best way we can. It does not always work either. The point I want to emphasise is that unless we can find a streamlined system that provides in an uninterrupted way a stream of services to the various types of patients who present themselves, we are wasting our time and money. If we cannot do that, we are wasting our money and will not solve it by providing more money. We will just complicate it further. In particular, we can start at the bottom, provide primary care to the best standard we can and then find out the challenges after that, where we are going, where there is congestion and what happens when a GP refers a patient.

All of us in this business know about my last point. There are many patients on waiting lists for various treatments, including elective procedures, or to see consultants. We go through the procedure ourselves. There is a presumption in some parts that, effectively, we are trying to help a patient jump the list. I have never wanted any patient to be able to jump the list but I want a patient who is ahead of another patient to get ahead in order that the second patient can be dealt and we have continuity of effective action and service.

Chairman: I will bring in representatives of the Irish College of General Practitioners to look at some of those questions and then contextualise it in respect of the Sláintecare report.

Dr. Mark Murphy: The Irish College of General Practitioners supports the Sláintecare report. Health has not been the focus and there has not been a political consensus in my lifetime, and I have been a qualified doctor for 12 years. For those who have been working since the 1980s, there has been no joined-up thinking with regard to health. I commend the Deputies and Senators here today on coming together to get a long-term vision. Taking a broader perspective, we saw Oonagh Smyth's documentary last week about inequality with regard to accessing secondary care. We know we need more orientation towards public health and Healthy Ireland. Obviously, the only show in town is to support the generalist to manage chronic conditions in communities with GP-led primary care, and we support Sláintecare's initiative.

There is one issue and that is capacity. It has to be done slowly in a phased way in order that capacity is not over-reached, so to speak. We want to tackle health care inequalities. The main danger would be if this was done too quickly. If we give free GP care to everyone, very soon we will end with a two-tier general practice system where someone working in the newly built primary care centre in Crumlin will be seeing medical card patients with a two-week waiting list while a fee-paying practice next door will see patients that day. I do not want that to happen and we need to make sure it does not happen, so it needs to be phased. We fully support Sláintecare and its goals of achieving a better health care system for all in a sustainable way.

In response to Senator Burke, the ehealth project in Cork exemplifies the core issue about ehealth. The GP gets the discharge immediately from the maternity hospital so there is no squiggle on a script that I cannot read. I get the discharge that day, not three weeks later. It makes sense. To our knowledge, the results are still coming in. There were some hiccups with the piloting and involving GPs, but this is exactly the kind of stuff we need and that Richard Corbridge drove through. It looks very promising.

In respect of econsultation, I must say very clearly that there is an issue with demand and supply in health care. If one keeps increasing supply of the wrong type of health care, it will just keep getting consumed. I am afraid there is no evidence for electronic communication being more effective than face-to-face communication. I can consult someone face to face or pick up a phone to communicate a result. I can send the patient a text message or email them or we can use a nice fancy tablet to look at each face to face. I am afraid a lot of econsultation is a corporate marketing strategy that overmedicalises things and will deliver care in the wrong way. It has to be done within the context of the GP team to follow up results and it must be evidence-based. There is a lot of this going around at the moment and it is a misappropriation of the term "GP". Insurance providers providing GP care through tablets is not GP care and we will not stand over that.

A point was made about negativity with regard to recruitment and rural practices. It is a double-edged sword. We have done our bit. We have engaged and tried to communicate what an important job it is and the joy it can bring even though it is very challenging. We have a campaign called #beagp. We have tried to put across that spin of the professional rewards that can follow. We have done our bit and are trying recruit and train more GPs, but we really need that other piece to follow. We need the funding and the whole system thinking and we commend Sláintecare to do that.

Dr. Brendan O'Shea: Senator Burke asked how we could fast-track the contract negotiations. From the perspective of the Irish College of General Practitioners, the key thing is that we need more men and women working in GP-led primary care, so we welcome any actions around the contract that will improve recruitment and retention. We can train the graduates in the college but recruitment and retention are critical, so any aspects of the contract that will en-

able more GPs and more practice nurses to work in communities probably constitute the surest way of improving things on a number of different fronts.

Senator Colm Burke: Has an area been identified where agreement could be reached that would help progress immediate implementation, not implementation in 12 months or two years, and which would help what Dr. O'Shea is talking about?

Dr. Brendan O'Shea: As that is a contractual matter, I would defer to the expertise of the GP representative organisations, including my colleagues from the IMO. We have spoken about half a dozen different things. It would be nice to be able to reduce the rate of antibiotic use. It would be nice for GPs to go to more primary care team meetings. It would be nice for us to do more multidisciplinary work. We need more bodies if we are to be able to do all of those things. We can do none of them without more bodies.

Electronic communication with patients is a new technology. We are optimistic that there will be an evidence base to prove its efficacy in due course. At the moment, the most likely thing that an electronic consultation will do is furnish an anonymous patient with a doctor who does not know him or her and with a prescription for an antibiotic. That is corporate cherry-picking. The ICGP is committed to researching this. Our view at this point is that telemedicine between specialists, advanced nurse practitioners, GPs and practice nurses could add a layer of efficiency if it is properly resourced. There needs to be a GP in front of the screen. At the moment, GPs are running everywhere.

Deputy Durkan asked a fiendishly cunning question about the negative things that our patients are most likely to say to us. My patients most commonly greet me by telling me it is very hard to get to see me. The next difficulty that is most commonly mentioned is cost. There is ongoing hardship and difficulty, not among the affluent crowd or, arguably, among medical card patients, who enjoy a range of benefits and services, but among the middle people who are squeezed. They do not attend for regular checks. They go off their medications for cost reasons. They agonise. They have rows at reception about the fees we have to charge. As employers, we have obligations to our staff. The negative things we most frequently hear about are time pressures and the out-of-pocket costs that people have to meet. That would be my view in response to the Deputy's excellent question.

On the subject of information technology, reference was made to the national maternity and child electronic medical records scheme in Cork. We have worked closely with the HSE through the national general practice information technology group, which is a good interface between the ICGP and the Department of Health. We are confident that electronic medical records can be rolled out if this group is maintained and resourced. We need to decide to do it. In this day and age, it is too expensive to deliver health care without such technology in place. More of it is needed in primary care and a start needs to be made with it in secondary care. The national maternity and child scheme is a tiny piece of hospital care. We can have no reassurance that there is huge progress to be made in this regard without strong driving from the clinical and legislative sides.

Chairman: I thank Dr. O'Shea. Perhaps Dr. Walley would like to respond to some of the questions relating to the contract that have not been answered.

Dr. Ray Walley: Senator Colm Burke asked about Scotland. For the past 20 years, 8% of the budget there has gone to general practice and 10% has gone to community care. It has had chronic care programmes and infrastructure supports in place. The problem is that Scotland is

coming from a different position. It has a modern-day contract. The Scottish system is outside the UK system. This self-management allowed the Scottish authorities to discontinue tasks like quality and outcomes frameworks, QOFs, which were box-ticking exercises that diminished patient care by focusing on spreadsheets. They changed things. Scotland is a good example, but I am afraid we are not up there. I emphasise that it took 30 years to develop GP community care in the Netherlands and in Scotland. We are in the early throes of that. We need to move on.

Deputy Durkan asked about our priorities. This country has a GP recruitment and retention problem and a resourcing problem. Funding is a big issue, given that just 3.5% of the national budget goes into general practice.

The Deputy also asked about primary care centres. Primary care centres do not see patients. Individuals see patients. We need to focus on GPs and allied health care personnel. They will work virtually anywhere. Shiny new buildings should not be developed unless they are needed. The need for some of them is questionable. New buildings need to be constructed in areas of deprivation and some rural areas, but they should not replace existing buildings if those buildings are adequate.

I will answer the Deputy's question about what we want from the best health care system by saying it was set out in the primary care strategy 14 years ago. We want continuity of care, timely access, accountability, equity of care, efficiency and quality. All of this occurs in general practice, but we can do better. All of this is not occurring in the hospital system, to some extent, because one cannot get into it.

The Deputy also asked about telemedicine, which is being looked at. We all agree on this without even talking about it. Telemedicine involves cherry-picking. In recent weeks, a Cambridge University study showed that telemedicine increases consultation rates because patients' problems are inadequately dealt with. There are examples of good practice in this area. In Norway, a patient can email his or her GP on a public contract in the knowledge that the GP will get back to him or her within five days. That works because it takes the emergency out of it. One cannot deal with an emergency issue on a telephone only. GPs need to have the ability to ask their patients to come to them, or to go to see those patients. That is not what happens under these cherry-picking private set-ups. My colleague, Dr. McGarry, will speak about the contract issue.

Dr. Pádraig McGarry: Senator Colm Burke asked whether any element of the contract could be implemented in the morning. We have gone a long way towards addressing many of the components that require the first phase of a contract. The chronic disease programme, which involves chronic disease management by GPs in the community, is probably central to that. Every time we try to address one issue, another issue comes up and suddenly a whole raft of issues have to run in parallel. The ability to recruit practice nurses has to be developed. That, in itself, raises employment and contract issues that need to be addressed if we are to attract practice nurses into the service. The capacity to have more GPs in the service has to be developed. That brings resource implications with it.

There are other issues in the first phase with palliative care, medical management and special types of services that could be implemented. We have not yet really seen a recognition of the resources that are required for that. All of these things can be done if the resources are acquired. Unfortunately, the budget provides that just €25 million will be made available for primary care in 2018. If those who are negotiating feel there is no genuine interest in going forward, it knocks the heart out of them. Realistic resources need to be made available. I do

not doubt that an indication that realistic resources are to be allocated would result in many of these issues coming together. They cannot be done in isolation.

I would like to make a point about one aspect of rural practice. Many people have indicated that they do not want to commit to rural practice.

Deputy Bernard J. Durkan: Why?

Dr. Pádraig McGarry: I think there are many reasons. Money is one issue. Isolation is another. Maybe people just do not want to commit to a particular rural area in isolation. There is a flexible contract that allows two or three people to take on a practice, perhaps working in a 40-60 split. Many people now want to work with flexible hours. This issue has not really been addressed. The practice itself has to be viable. The potential exists for two people to run a practice. I do not think this issue has been addressed as well as it could be. I think a great deal of traction could be gained in this regard.

Deputy Bernard J. Durkan: Can I ask a quick question in response to that?

Chairman: We have two other groups to come in.

Deputy Bernard J. Durkan: I know that.

Chairman: After the Deputy has asked his question, I will give the representatives of the ICGP and the IMO a minute to sum up their wish list for Sláintecare or for the future. Sláintecare, which is not a perfect document, sets out the direction we feel we need to go in. I will ask the witnesses to sum up after Deputy Durkan has put his question.

Deputy Bernard J. Durkan: A rumour that a rural practice is going to close has an immediate knock-on effect on anyone who is considering applying to that practice. Somebody might wish to go into that practice, but he or she will be reluctant to do so as long as the rumour persists. It is quite common for rural practices to receive no applications or just one application. To my mind, that sounds the death knell for rural practices. We have to find some other means of supporting them. Ireland is not at the lower end of the table of OECD countries in terms of health expenditure generally. We are well up in the middle. We are competing with our near neighbours to a great extent. While we may need more resources, we must realise that better organisation is needed as well. If we do not put the money we are spending to good use for effective, efficient and rapid progress, we will be criticised.

Dr. Pádraig McGarry: On the Deputy's overall question, the Irish Medical Organisation welcomes the Sláintecare report. It is very ambitious. As the Deputy said, there can be issues that need to be addressed. If they are addressed correctly, we can go forward to develop the type of health care system we want. We need to be realistic about the resourcing for general practice. What this needs to be has been well aired but there has to be an upfront commitment that it is going to happen rather than just rhetoric. Unfortunately, we have listened to this for far too long. One loses the will to live when it is heard again and again and nothing actually happens. I would love to see it happen and I am hopeful that it will because I am of the view that we have no alternative. To do otherwise would be reckless. It would almost be seen as reckless trading if it were a business.

Dr. Ray Walley: I would again take cognisance of the Dutch health care system - the best in the world - which has been developed over the course of 30 years. Ireland is further in to that 30 years but five years is too ambitious. As the committee has heard from the Irish College of

General Practitioners, there is a morale problem within general practice whereby people feel they have a heavy workload. Aside from that, the focus of the next generation of GPs is on work-life balance. If we are saying that we will build a mountain of work when we do not have the resources in place, the industrial action of emigration will increase. We need an appropriate timeframe. Five years is too ambitious.

Ms Vanessa Hetherington: I would like to see a phased development of general practice over a ten-year period as capacity allows. Five years is too ambitious. We need to reverse the cuts that happened over the past ten years and begin to build general practice for a proper 21st century service.

Dr. Brendan O'Shea: I will not repeat the excellent points that have been made by the Irish Medical Organisation. The points are both valid and extremely relevant. I have 47 seconds left in which to speak so I will say this - we need a contract that will actually ensure the recruitment and retention of adequate numbers of general practitioners and practice nurses. I would like to focus, in my final 30 seconds of speaking time, on practice nurses. The position of the practice nurse in the Irish primary care system is a major cause of concern. These nurses are paid a significantly lower rate than their hospital colleagues. They get no maternity or educational leave, no support and no pensions. That is Victorian. We understand that there are approximately 3,700 GPs and 1,700 practice nurses. We need to move rapidly towards having 5,000 GPs and 5,000 practice nurses. This brings us to an important metric - the number of GPs per 100,000 of population. In County Kildare, there are 41 GPs per 100,000 people. On average, there are 63 GPs per 100,000 people throughout the State. In Scotland, the figure is close to 90 per 100,000. We need a contract that would be sufficiently attractive. I put it to the members that practice nurses are very enfranchised - they have high levels of job satisfaction and their involvement is greatly appreciated. They will particularly contribute to the capacity we need to make a start on chronic disease management. We need the contract that will actually deliver this. I thank the committee for listening.

Chairman: On behalf of the committee, I sincerely thank Ms Hetherington, Dr. McGarry, Dr. Murphy, Dr. O'Shea and Dr. Walley for coming before us to give their views.

Sitting suspended at 11.15 a.m. and resumed at 11.25 a.m.

Deputy Louise O'Reilly took the Chair.

Vice Chairman: Good morning to everyone. On behalf of the committee, I welcome Dr. Emmet Kerin, Dr. Ronan Fawsitt, Dr. Mary Flynn and Dr. Maitiú Ó Tuathail of the National Association of General Practitioners, NAGP.

I draw the witnesses' attention to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. If they are directed by it to cease giving evidence on a particular matter and continue to so do, 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, persons or entity by name or in such a way as to make him, her or it identifiable. I also advise the witnesses that any opening statements they have made to the committee may be published on the committee's website after this meeting. Members are reminded of the long-standing parliamentary practice to the effect that members should not comment on, criticise or make charges against a person outside the House

or an official either by name or in such a way as to make him or her identifiable.

Dr. Emmet Kerin: We wish to thank the committee for inviting us here this morning to discuss primary care expansion as recommended in the Sláintecare report. I am the president of the NAGP. I am also a Limerick-based, full-time GP. I am joined by Dr. Ronan Fawsitt, a Kilkenny-based GP, and Dr. Mary Flynn, who is based in Wicklow, who are members of our executive. I am also joined by Dr. Maitiú Ó Tuathail who represents GP trainees within our organisation. Those trainees are effectively the future of our profession.

Some time has passed since we last met in February. At that point, we were addressing capacity and manpower in general practice. We had a very valuable interaction with the committee in conjunction with the Irish College of General Practitioners, ICGP, and our sister union, the Irish Medical Organisation, IMO. I wish to acknowledge the committee's work at that time to support the introduction of a new GP contract through its request to the Minister of Health, Deputy Harris, to have parity of process in contract negotiations for all the representative bodies. There is great synergy to be had in all three organisations working together. It is the stated position of the NAGP to be inclusive of all bodies in this process.

Based on our earlier presentation and the supporting documents we have submitted, particularly the document submitted from the perspective of GP trainees, the committee is pretty well informed now of what the issues in general practice are and what we continue to face. We need to retain young graduates and restore functionality. It has become very clear to the committee that functionality needs to be restored in general practice. We clearly need a solid foundation if we are going to make any transitions in health reform. This view was confirmed by the HSE-commissioned report, A Future Together, compiled by Trinity College Dublin. In that report, Professor Tom O'Dowd says:

> Providing long-term illness care, improved diagnostic services, increased practice based staff and modern IT requires additional funding. Primary care and general practice, as now structured, will be unable to cope with additional workload. Transitional funding spread over a number of years is needed ...

That is becoming more and more clear as we have these discussions. Today we really want to focus on what the key enablers for primary care are and also to reflect on the Sláintecare report itself. The NAGP's position at the time of the launch of Sláintecare was to support the core principles within the report. We continue to hold that position. We can all agree the report is certainly visionary and outlines a paradigm shift in how we deliver health care in this country. However, until such time as general practice is adequately resourced and has a totally new contract, this will unfortunately remain only a report. General practice, through the contract, underpins an effective primary care service.

The recent report to which I refer places the general practice service as one of the key enablers in the move to a primary care model. This report and other bodies use the term "GP-led primary care", a term which has been one of our core principles over a number of years and which is our message in the conversation on health care reform. For clarity, the GP-led aspect does not make general practitioners superior to other members of the community team. It identifies a leadership role in the team with responsibility and accountability for delivering care to the patient. This is called governance.

There are many existing team-based models of care in the world that demonstrate GP-led primary care, leading to better health outcomes for populations and greater return on health care

spend. Examples are the patient-centred home care model seen in the United States, the New Zealand primary care health system, or the rapidly emerging primary care home model in the UK. The NAGP recently led a delegation to Plymouth to study the principles of such a model. These models are not directly transferable to Ireland but the core principles certainly are.

Data are driving change across the world in health care delivery. Ireland has recently made good progress through Health Atlas Ireland, which can now map local population demographics and health needs. This is very important for population health planning. Similarly, the national quality assurance and improvement system is leading change in the hospitals. It drives investment and service delivery for local populations, building integration and support through GP-led primary care.

This is a lot of change. With change comes fear of change, and with that the potential for misinformation. We have experienced that ourselves while discussing these models. The reality is that GP-led, team-based care, involving personalised care for a defined population, is a culture change that comes from grass-roots level and not by diktat. It is informed by international experience but does not seek to copy it, merely to learn what works and apply this, if appropriate, to the Irish system in an agreed, resourced and beneficial way.

The Sláintecare report has recommended an impact study on the effect of separating private practice from public practice at secondary care level. It is only logical to have the same approach to considering the implementation of free GP care. The Minister for Health has acknowledged the GP service is put to the pin of its collar and pointed out there are lessons to be learnt from our experience with the introduction of free care to the population under six. We have already seen from the under-sixes provision the effects of what we call "service-induced demand" on a GP system that lacks capacity for the increased activity that free GP care has brought.

The Government-funded and Government-partnered ESRI study Growing Up in Ireland shows there was a 25% increase in daytime activity with free GP care. That predates the introduction of the under-sixes initiative. With free care for the under-sixes, we have seen an increase of up to 40% at peak times in our out-of-hours service. I am from the mid-west, in Limerick. The Shannondoc out-of-hours service crashed owing to the volume of calls over the winter. It is interesting to note that. The knock-on effect has been increased waiting times for all patients and reduced access for the frail elderly in general practice, with increased attendances at emergency departments. Therefore, there are consequences.

We suggest that we hit pause on introducing further free GP care based on age cohorts and start to make general practice functional again as a foundation for delivering real health care reform. We suggest that for primary care to expand into population health, as outlined in Sláintecare, general practice must first be stabilised and enhanced through positive State actions in the areas I shall mention. There is a lot of overlap but I will run through the areas again.

We need to reverse FEMPI. This must be in line with health care workers. This must not be delayed until 2019 to seek more return because there is already a stretched service.

I touched on the contract. It has to be totally new, not one with a bolted-on element. It should not be delivered in incremental phases. We need a new contract and a new way of delivering health care. We need to move from a sickness model to a wellness contract. That is the big difference here.

We have touched on capacity from a trainee's perspective. Dr. Ó Tuathail will refer to this later. We need to increase capacity, including through novel ways to utilise practice nurses and other allied health professionals in the community, with the general practitioners driving the change.

With regard to data and ICT, funding is absolutely necessary. General practice does have fairly good practice-based systems but we need to have connectivity to bring us together. Diagnostics was well covered. We can agree on that. Funding needs to be front-loaded, ring-fenced transitional funding, underpinned by legislation over a ten-year window to support primary care development. We must spend if we are to save in the long term. On implementation, general practice should have a role in the Sláintecare implementation body.

All these measures require funding and a strategy. Most of all, and important to those in this room, we need the political commitment to drive the change. We suggest all this needs to be underpinned by legislation, facilitated in the Oireachtas.

Deputy Michael Harty resumed the Chair.

Chairman: I thank Dr. Kerin and apologise for missing the first part of his presentation. I thank him for attending.

To contextualise what we are doing this morning, we are, as I said to the other groups, very concerned about the slow response to the Sláintecare report. It has been out for six months now and we are concerned that the Government is moving too slowly on examining and implementing it. Perhaps the delegates will outline their attitude to the report and how they believe its recommendations could be implemented more quickly. What are the positive aspects? Are there negative aspects? We accept it is not a perfect report but it is sending the health service in the right direction.

A number of members who were present earlier have gone but they may return. I will invite the members present to ask questions. If there are questions that have not been addressed but were asked to the first group, I will introduce them myself.

Deputy Louise O'Reilly: I thank the witnesses for making a presentation. When we hear from people involved in health care delivery in particular, we understand they are taking time out from a very busy schedule to come here to inform us. That is very much appreciated by us.

A couple of issues arise. We have heard already that the management of chronic diseases within the hospital is expensive and cumbersome. The approach is probably not the best.

There is a recruitment and retention crisis. Activity that may or may not be described as industrial action has been discussed and aired in the media. It is an expression of the frustration staff feel at the coalface. When we ask questions about capacity, recruitment, retention and the manner in which these issues might be addressed, we are told continually they will be addressed once the GP contract is sorted. We are told it will be very long, broad-ranging and detailed and that it will possibly fix every single problem in the health service. Perhaps the delegation will talk to us about how we can, even in the short term, address the issue of capacity.

My next question is on the fee structure. What is the breakdown regarding the fee, wages and income of a general practitioner? How is the income divided between the practice nurse and the general practitioner where the two are working together? We have already heard the conditions of the practice nurses described as Victorian. They are working under a very out-

dated model, with no access to maternity leave and all that goes along with that. I refer to how the work is divided in respect of GMS and private patients and how the income is split. The delegates might talk to us a little about that.

I am interested in hearing the delegates' views on what constitutes a properly fit-for-purpose primary care team. What management do they envisage? Who would be the paymaster and who would schedule the appointments? Who would manage the allied health professionals in that context? How many do we need per head of population? How can we move towards a more fit-for-purpose model?

On the GP contract and the capacity issues, there is a problem not too far from my area owing to medical card patients being turned away and advised they cannot be seen on a Saturday. I am pretty sure that is not an appropriate way to treat patients and that the delegates would not stand over it; nevertheless, it happened. Is that a manifestation of the capacity problems we are having? In light of capacity problems of that nature, perhaps the delegates have a view on how limited capacity is to be managed. If the approach of shutting the doors to certain categories of patients at certain times of the week is the view of even one general practitioner, it is not necessarily appropriate. In Balbriggan, which is in my constituency, there are general practitioners who say they cannot take any more under-sixes. This all comes back to the same issue, that of capacity.

We might hear from the representative of GP trainees as to the mood among that cohort. I am conscious that sometimes when we talk in this room, we are sending a message to people in college that the health service is not an ideal place to work. Clearly, we want general practitioners. They are the brightest and best and they are wanted all over the globe. We know that. They are much sought after. We want to be able to send out a very positive message. Perhaps the representative could talk to us about how we could do that.

Senator Colm Burke: I thank the delegates for taking time out of their busy schedules and for the work they are doing for general practitioners throughout the country and for their own patients.

On the contract negotiations, there is always a golden rule that if one wants to delay something, particularly if one is the person writing the cheque, one should create a division between the negotiators. Is there some level of co-operation between the medical organisations that would help remove the excuses from the Department about trying to exclude these negotiations? I raised a question earlier about identifying an area that we could fast-track and the reply was that this has to be taken in an overall context. However, we need to prioritise ensuring that we can retain our current practices while also growing them in areas where we need them. The lack of support for practice nurses within the current contract arises. Could that issue be fast-tracked to assist the organisations? They may have identified other areas but that area arose earlier in the discussion.

Another issue concerns access to diagnostic services. Given that this is not really part of the contract negotiations, although it is in an overall context, has there been any negotiation with the HSE at local level, whether in Cork, Limerick, Waterford, Dublin or elsewhere, about trying to make information relating to diagnostic services available more speedily? Are individual discussions taking place? Could such discussions take place? It would be of assistance to GPs when dealing with their patients and would provide a far more comprehensive and faster service.

Deputy Bernard J. Durkan: I thank our guests for attending this morning. What issue do they consider most important to improve the service they provide to their patients in the community, whether in urban or rural settings? Apart from what we heard in the opening statement, what are the most immediate changes needed? We must recognise, however, that we do not have an open cheque book and have to keep an eye on comparisons with other countries in the OECD. That is a fact of life. I know that everyone will say, as we say ourselves, that that is okay but we are in a particular situation now from whence we have to extricate ourselves. However, we must remain within reasonable comparisons.

When a patient cannot get access to a service that a GP refers to, what are the causes of the delay? We have thousands of people on waiting lists. I am a former member of one of the health boards and I cannot understand why we have lists at all. That is the first question. What is the cause of a waiting list? If a waiting list is six months long, why not have it three months, two months, three weeks or something like that? Why can we not identify the extent of the problems? From the witnesses' perspective, what are the contributory factors to the huge amount of stress to patients all over the country? I have no doubt they cause a huge amount of distress to the witnesses also. When we table a parliamentary question asking that someone receives a service after waiting for two or three years, and there have been longer periods, we are told to get a letter from the GP if it is urgent. Everything becomes urgent after a while. If the patient waits long enough without receiving treatment, the patient will no longer be a patient. That is the sad part of it. To what extent have the witnesses found frustration and annoyance at this kind of thing?

Apart from Sláintecare, we have done our own research. We also have anecdotal evidence as to what every branch of the health service, including GPs, consultants and junior hospital doctors, sees as a problem. There are numerous problems. If the witnesses were to select the three most important items to improve the service to the patients they serve and to get a reasonable degree of reliance, job satisfaction and improvement in the service delivery to the patient, what would they be?

Deputy Billy Kelleher: I welcome the witnesses and apologise for missing their opening statements. We should establish a committee to investigate the development of bi-locatory powers. It might help many members. Some of us have been engaged in a detailed exercise in completing the Sláintecare report. We met with many expert groups, those of the witnesses included, who contributed to that process. Out of it has come a reinforcement of the view that primary care is the right way to go. It is the bulwark of the delivery of medicine and health care in general in the community setting. Of course, we were not reinventing the wheel when the Sláintecare report came up with that particular recommendation. It has been widely recognised internationally as the way to deliver health care in the least complex areas, that is, in GP surgeries in the community setting and the home-base setting.

A number of problems arise in that we do not have enough capacity, a shortage of GPs and an ageing profile of GPs. We can see from the fact that GPs are leaving that it is not remuneratively attractive. Therefore, we all accept that unwinding FEMPI is critically important. It is an issue that has caused difficulties for GPs throughout the country. In that context, even with the unwinding of FEMPI, are the witnesses completely wedded to the independent contractor model or do they see any role for salaried GPs in the delivery of health care for the public health system?

Consider the difficulties associated with the hospital-centric model, which are evident. All the resources are piled into the hospital and the patients follow the resources. This creates its

own difficulties in that there is overcrowding and continual difficulties in trying to get patients seamlessly through the hospital system, either through the emergency departments or scheduled processes. Is there any relationship between GPs, consultants and hospitals? I know the St. Luke's model in Kilkenny is held up as a good example. However, why is there no capability within the health system to have more meaningful relationships between hospitals, consultants and GPs? Sometimes we forget that a GP is a specialist and we end up with specialists referring patients to be seen by a junior doctor who then has to go through the whole process again, although a specialist has already referred them to that point in the health system. We could be forever talking about the grand plans but there are also the small things that mean patients end up in waiting rooms, with junior doctors then referring them off elsewhere. Given a specialist, namely a GP, has already made a referral, there seems to be a consistent delay in moving the patient seamlessly through the process.

Given that we have an ageing profile of GPs, do we need to amend our training programmes to deal with the whole issue of chronic disease and illnesses in the community or are the training programmes which are in place good enough but lacking capacity in terms of throughput? On practice nurses and nurse specialists in the delivery of treatment for chronic disease and illnesses in the primary care centre, how do the witnesses see that evolving in the years ahead?

Without putting a tooth in it, in the context of the ongoing negotiations on the GP contract, the witnesses are outside looking in the window. I had and have a view that they should be inside. We are led to believe that there are some forms of informal discussion but I do not know if that continues. However, I would much prefer them to be inside given their organisations represent more GPs than those who are inside. Having said that, will the contract only be finalised when everything is finalised? I assume this contract should be negotiated on a continuing basis. There is this idea that we would wait for it to be completed and then park it up for another 20 years. Does the witness see any flexibility in that area for picking out quick wins for GPs and, more important, for patients and for the health services? Can those issues which are more difficult to resolve be separated out from it so that we can start the process of implementing Sláintecare's recommendations, primarily in terms of primary care and treatment of the patient in the community care setting?

The witnesses may have seen the "Prime Time Investigates" programme, and the famous letters that GPs write which say "urgent" or "clinically urgent" which are now deemed meaningless by the system. Where does that leave the witnesses in terms of their clinical competence being questioned by the administration? A GP does not put the word "urgent" on a letter lightly. If there are two patients in his surgery and he knows that only one CT scan is available he will obviously give it to the person who requires it most. Have those issues been raised, through the National Association of General Practitioners, NAGP, with the Irish college, to inform the administrative side of the health services that it is questioning clinical and ethical independence?

Dr. Ronan Fawsitt: We support the principles of the Sláintecare report, which is a coherent statement by the body politic to say that we need to develop a different health system based on primary care in collaboration with secondary care. There is no question about that. The argument has been won, and I congratulate our politicians for that. Uniting the body politic behind that vision and allowing ten years for it to happen is a very good thing. However, we cannot wait ten years to deliver the recommendations in the report. It just will not happen. In our presentation we provided a graph outlining the reasons why it would not happen. The reason is demographics. In the next 30 years our population is going to grow substantially. In particular, there will be more people in the over 65, over 75 and over 85 categories. Most of those people

are going to get chronic disease. Some 65% of people over 65 have two or more chronic diseases. How will they be managed? Most of them are going to end up in hospital if we continue the current model where chronic disease is managed by hospitals. That means that the number of bed admissions is going to go up very dramatically in the next five, ten or 15 years, and it is scary that bed usage is going to go up by 120% in the next 25 years. We do not have the capacity in our hospitals or in the community at present to manage that increase. It would involve building six 1,000 bed hospitals the size of Croke Park and manning them with doctors, nurses and staff. It cannot be done. We have to make a change and start managing chronic disease in the community in a better way.

The Deputy rightly asked about the capacity. I had a conversation with a very senior person in the acute hospital division a year ago, and he said to me that our acute system has two winters left. We all know what happened last winter. Flu is coming.

Deputy Durkan asked what we can do to reverse things immediately and create a sense of confidence about general practice. The reversal of the Financial Emergency Measures in the Public Interest, FEMPI, legislation would help at this moment, or a commitment to reverse it without precondition.

He also asked about fees. It is a thorny question. We have a Victorian system where our nurses, who are our most valued asset in our practice, are not valued financially in the same way because we do not have the resources in general practice to do so. Some 4.6% of the health budget is allocated to general practice. In Scotland it is 6.5%. In England it is close to 8%. Other systems are way above that. We do not have the resources and we are chronically under-funded.

Someone asked how many teams we need. The primary care report recommended 400 to 600.

The question of turning away patients on a Saturday was mentioned. That is based on the contract, and it is mad. It should never happen. Patients should be seen when they need to be seen.

A Deputy asked why we struggle. I have 40 slots a day to allocate to my patients, and those slots are full. My practice nurse has 35 slots and they are full. We have 0.3 nurses per average list. It cannot be done. How can we take on chronic disease management within the current budget? It cannot be done. We need to front-load funding into primary care, by legislation, and into general practice-led teams. This is not about putting money into my pocket. It is about putting money into practice nursing, into the allied health professionals, into administration, IT and everything that is needed to provide a modern health system fit for the 21st century.

Senator Colm Burke asked about building co-operation. We must build co-operation between the representative bodies. There is no difference between the NAGP, our sister organisation, the Irish Medical Organisation, IMO, or the Irish College of General Practitioners, ICGP, on the way forward, but we need to fast-track this triangular system where we are all in different rooms. Deputy Kelleher asked me, when I presented on the Sláintecare presentation on integrated care, who would do the governance and what is really needed for primary care. I believe the ICGP is well placed and should be part of the contract negotiations in an advisory capacity. It is able, has the insights and has the confidence of all GPs. They need to be involved formally in the process in some way to build confidence going forward.

Deputy Durkan asked what three things are needed immediately. I like a man who goes to

the point. What do we need immediately? After a decision to reverse FEMPI, which would create confidence for young GPs to stay here - and Maitiú will talk about that shortly - we need access to diagnostics. It is a disgrace that an intern in a hospital can access an MRI or CT scan and I cannot. I could not even access a brain natriuretic peptide, BNP, test, which is a heart failure blood test, until we negotiated through the local integrated care committee, LICC, in Carlow and Kilkenny and made that happen. Diagnostics need to be streamlined.

Our practice nurses need to be developed and increased. The idea of putting 900 community nurses out there into another silo in the community is mad. They are great people. Please, give them to general practice. We will use them well, make them feel good and connect them in an integrated system.

We also need rapid access to consultant advice and treatment when we need it without the hassle involved. I am a senior decision maker with 30 years experience. I know when an appendix is an appendix. I should not have to send a patient into the emergency department to be triaged by a junior nurse or doctor. It is mad. We have an integrated service in Carlow-Kilkenny which is called the acute floor. We have negotiated direct access for GPs to the acute floor so that patients are screened for medicine, surgery, paediatrics, observation, psychiatric care or whatever else they might need. It is a no-brainer, and it could be developed everywhere. We need direct access to consultant advice, both in the acute system and in scheduled care. In Ireland East we have the same vision. We need to develop services in the community for chronic disease, and one of the things we have worked on in the last year is a virtual clinic for heart failure. This is being developed in Carlow-Kilkenny and in Ireland East with Mary Day and Ken McDonald. In the first 270 consultations which were referred 90% were heading for the acute floor or outpatient departments, OPDs, whereas 90% are now managed in primary care without ever having to go near the acute floor or the OPDs. This involves a culture change, with the GP, the senior decision maker, being involved with the consultants in a process, along with the diagnostics, access to echo and a community nurse who can come in to assist us, and we can build the services from the ground up. Those three things are what are immediately required. Most of them are culturally wrong.

Dr. Emmet Kerin: I will start with the contract process as it stands at the moment which Deputy Kelleher asked about. There is no big bang where we have to wait for the contract to be absolutely completed before we get to the point where we can start delivering GP-led health care. We can certainly start now. I cannot go into details about what was discussed in the room, but we have brought up over 30 issues we can immediately deliver on. Those issues range from end of life care to crises management and other areas. We can immediately effect those measures and we have put together pathways to do so. It needs to be supported but it is something we can definitely get moving on.

The relationships between the organisations in the process is something we are looking to build on. We have been doing it by back channelling and making representations. We need to all be in the same room, which the Minister could facilitate. The Sláintecare report recognised that the Taoiseach's office needs to be involved in the implementation of the report. The Minister needs to be in the room with us. In the Scottish contract that has just been negotiated, there were senior organisations and representation from the Minister involved. The Minister can facilitate getting us into a room together and getting the organisations working together. At individual level there is a huge amount of respect. Old histories and cultures might be slightly different but at grassroots level we are all GPs. The committee has heard a huge amount of repetition in the earlier sessions and this one. We are looking for the same things but we just

need the enablers and the Minister's involvement would be helpful.

Dr. Ronan Fawsitt: I echo that. Why do we have mad waiting lists? We have 600,000 people waiting to see a specialist. Our population is less than 5 million so it is absolutely mad. A lot of those people on that waiting list could have services delivered in primary care. They do not need to see a specialist or the specialist needs to come to them. Of the beds occupied in acute hospitals, 40% are occupied by people with chronic disease; 55% of hospital costs are a result of chronic disease; and 80% of GP consults are for chronic disease. We are spending the money in the wrong place and in the wrong way and we need to shift a lot of that care for things such as COPD and heart failure. It needs to come out of the hospital, empires and silos and into general practice-led primary care teams. Many models around the world have developed the concept of a team. It is GP-led and includes a practice nurse, a nurse physician assistant and an administration person. In the US, they have shown that the primary care medical home model - which will not translate here although there are aspects of it that make sense - can reduce referrals, get better outcomes and better care, has lower costs and results in better satisfaction among providers. The biggest threat to providers is not money, it is about hope and a feeling that one's work as a junior doctor or nurse matters. We have had a lack of that hope for some time. The model of team-based care scaled for our practice population is the way forward. That is the international model that has worked. In the UK, 11% of GP practices have embraced that medical home model within two years and 14% of the NHS is now covered by a medical home model, which is team-based care involving people working to the top of their licence. It has reduced referrals to hospital, increased satisfaction among GPs and their staff and led to the retention of GPs in areas where GPs were falling off the cliff. An example is the Plymouth place we visited. In that practice, seven GPs were recruited whereas the neighbouring practices had begun to lose their partners. The concept of a GP-led team is very good for patients, GPs and hospitals. It would be good to the State as well because it will reduce costs and make health care systems sustainable.

Dr. Mary Flynn: I will address Deputy O'Reilly's question on patients being turned away. The concept of a medical card patient being turned away as opposed to another patient is something that is alien to most of us. I am 22 years in the clinic where I work. In general practice, we pride ourselves on the fact that GMS patients and private patients are treated 100% the same way. There are no different investigations or waiting times. It is completely equitable. However, GP lists close. We are a six-doctor practice and there are occasions when we have to say we are not taking new patients because we have reached a safe capacity. Our college sets superb standards for the treatment of our patients. If we are going to treat our patients to those standards we cannot take on more than we can safely manage. If we did, we would leave ourselves and the patients exposed to missing something or to litigation, for example. There is limited capacity and that is why in lots of towns around the country patients are being told there is no capacity. It is a travesty that that is the situation because they go from one practice to the next and finally somebody takes them on. This is where capacity is so critical. Dr. Ó Tuathail will address the fact that keeping our trainees is what we need to do to address the capacity.

Deputy Louise O'Reilly: Perhaps I have misunderstood Dr. Flynn's answer. She is saying there would not be any scenario in which that would happen. I have spoken to the people directly involved and they were told the practices did not see medical card patients on a Saturday. That will be dealt with separately. In a scenario in which the practice's list is closed and there is no more capacity, it would be closed to everybody. There would not be a scenario whereby a GP practice would say it has closed its list to medical card patients but is still open for private patients. That simply would not happen and should not happen.

Dr. Mary Flynn: No, absolutely not.

Deputy Louise O'Reilly: Obviously it would be dealt with if it is the case that it is happening.

Dr. Mary Flynn: Yes, there should be a complaint made in a situation where that arises. We would not stand over it. Saturday visits are covered mainly by an out-of-hours service so there should have been no question of that happening. It is difficult to understand how that happened.

Deputy Kelleher mentioned that remuneration was a big issue for GPs and that remuneration abroad was more attractive but it is not the only issue. How we practise day-to-day and our job satisfaction is dictated to a large extent by the other services we can access. When I have somebody in front of me who is suffering psychological distress and I want to refer that person to a psychologist, I have no access whatsoever if that patient cannot afford to pay. If I want physiotherapy for somebody with acute back pain who is holding down a job and who I want to get back to work quickly, I have no hope of getting it because our current waiting list in Wicklow is six months. Our job is made increasingly difficult by not having timely access to services. There is no uniformity across the country. In terms of diagnostics, I work in an area where we are extremely lucky. Global diagnostics is based in a primary care centre in Arklow. We have one-week access to chest X-rays and we have ultrasound in two to three weeks. There are GP friends of mine who work in other areas of the country who just cannot imagine having a service like that. There is absolutely no uniformity which is really very unfair to patients. I do not know why that service cannot be replicated in other areas. It is a very simple thing and it would make a huge difference to what patients can access in their local communities and to the job satisfaction for GPs.

Dr. Maitiú Ó Tuathail: I thank the committee for allowing the voice of trainees to be heard for the first time. I thank Deputy O'Reilly for describing us as the best and brightest. It is nice to have that acknowledged sometimes. No students enter medicine with the dream of emigrating but it is a fact that a proportion of us are leaving. We have data on this. The ICGP does a survey every two years on the career intentions of graduates and graduates who have recently qualified. What they found is that 20% have emigrated; 20% are seriously considering emigrating and 10% do not see themselves working as GPs in five years. Theoretically that is 50% of the workforce gone.

The report highlighted four reasons GPs leave and the committee has touched on those in various ways so I will be able to answer some questions by going through them one by one. The first is their own personal professional satisfaction as doctors. Deputy Kelleher is right that GPs feel helpless. I studied medicine to help people but the health service I work in makes it really difficult to do that. I am tired of opening consultations daily by saying "I am sorry you are waiting two years for the MRI", or "I am sorry you are waiting two years for that hip". As people are waiting they are deteriorating. They are not just waiting; they are coming back to the GP again and again. As Senator Burke said, they are told to tell their GPs to write another urgent letter. I am writing three or four urgent letters a day. It does not make a difference because what happens at that stage is that every letter becomes an urgent letter. It is extremely difficult, demanding and emotionally draining to work in an environment in which there is nothing to do but wait and write more letters. It makes us, as doctors, feel helpless. I do not want to have the weekly conversation I have with patients when I tell them that they have two options - wait two years for an MRI or pay €300 and have it done tomorrow. Many of them are pensioners and cannot afford to pay that amount. It is a very difficult conversation and, frankly, embarrassing. It strains our relationship with patients. I am embarrassed to be part of a health service that

cannot provide access to basic investigations for patients.

Deputy Billy Kelleher is right - we do not feel valued as doctors. Many trainees feel they are unable to do what they spent ten years training to do, at tremendous cost to the taxpayer. We are highly qualified and skilled and assets to the health service, but we will be wasted if we are not utilised. Once I qualify I cannot access basic tests, as Dr. Fawsitt mentioned. If I were to order a chest X-ray today for Senator Colm Burke, it would take two weeks to get an appointment and one month to receive the report, a total of six weeks. I cannot order MRI or CT scans. I have to refer patients to hospital where they must wait to see a consultant, which might take six months or one year. The consultant will say the GP was right, that the patients need a CT scan and they will then be put on the waiting list which will take another six months, all to order the scan that I knew was needed in the first place.

Sláintecare deals with the management of chronic conditions in the community. As Deputy Billy Kelleher pointed out, GPs are skilled and specialised. We have the knowledge and skill to do this work and know our patients. What we do not have is the support and resources of the health service to enable us to do it. As a GP in 21st century Ireland I cannot access the most basic tests. Patients must sometimes be referred to emergency departments because where I am the waiting time for an ultrasound is four months. Sometimes a patient will deteriorate in that time and all we can do is send him or her to the emergency department, which is both very frustrating and embarrassing. We want to achieve our potential as doctors and do what we are capable of doing, but many GPs and trainees believe the system does not allow us to do that. The systems in place in Canada, Australia and New Zealand do. They are functioning health services that allow GPs to reach their potential as doctors. It is very little for which to ask.

As Deputy Louise O'Reilly said, we are very concerned about the future viability of general practice. When we are training, we work with senior GPs and see them struggling. They took a 40% reduction in income as a result of the financial emergency measures in the public interest, FEMPI, legislation. It was coupled with a genuinely dramatic increase in workload since the introduction of free GP care for those younger than six years and older than 70. In the out-of-hours service in which I worked over Christmas appointments continued until 5 a.m. This happens when someone rings the doctor to say his or her child needs to be seen. The GP will say the next appointment is at 5.30 a.m. We are coming near to full capacity. The system is at breaking point.

We do not know what the future has in store for us. The FEMPI legislation due to pass through the Oireachtas this week will allow the Minister for Health to alter the fees paid to general practitioners as he sees fit. Since the introduction of free GP care for those younger than six years, banks are far less likely to lend newly qualified GPs like me money to buy a premises because they know that our income can be controlled and reduced by the State. That is a serious problem. Trainees are not willing to commit to taking on a list in Ireland when they cannot plan for the future, given the uncertainty created. Much of the talk is about remuneration, but my generation wants quality of life. An improved work-life balance is something GPs of all ages value, but in order to encourage us to stay, that work-life balance needs to be attained. I know GPs who have not been able to take time off in 18 months. They are technically entitled to annual leave, but they cannot find locums to replace them or to cover for someone on sick leave or maternity leave. In Australia they can.

I am from Leitir Móir on the west coast. When I was young, there were five GPs there and the system worked well. We did not even have an ambulance service when I was growing up. Last year one GP took early retirement because she had to take a required period of absence

and could not find a locum to replace her. Incredibly, she was replaced by a young, enthusiastic doctor who recently wrote a letter to *The Irish Times* stating one night on call, 72 hours into a shift, he was called to see a man who was unwell. He waited for an hour on the side of the road for an ambulance to come and nearly ran out of oxygen. He was genuinely worried that the patient would die. I do not want to have a conversation like that with a patient telling him or her that there is nothing I can do but wait for an ambulance when he or she could die. As of 2 August, a second GP had resigned, not retired, because the workload was becoming unmanageable and unsafe. It sends an incredibly powerful message when someone who for years was the lifeline for the community no longer believes he or she can do his or her job safely because of the incredible demands placed on him or her. The post remains unfilled. From December it is likely a third GP will take early retirement too because of the impossible demands placed on him.

Doctors are resilient. We endure six years of struggle in college and work all of the hours God gives to help our patients. We are not afraid of hard work and it is rare that we give up. When we do, it should cause serious concern that primary care services are on the verge of collapse. I studied medicine because I hoped to replace my GP on his retirement. Last week he worked 120 hours. He works a one-in-four rota, meaning that every three or four days he will do a 36 hour shift. He works 48 hours every fourth weekend. I am not ashamed to say I do not know if I am physically or mentally able to do that job and face the demands it would place on me. I am in my 20s; he is in his 60s. No amount of money in the world would attract doctors to these jobs. It is not a question of money but increasingly the impossible conditions GPs face. Would any committee member tell his or her son to take up a job in an organisation from which three people have resigned because they believed the workload was unsustainable, unsafe and possibly posed a threat to their health? They would not.

Financial prospects are better abroad. The United Kingdom is approximately ten years ahead of us in dealing with its general practice crisis. There is a huge shortage of GPs in the United Kingdom and they will come looking for GP trainees. We, therefore, need to address this problem now. General practice has changed in that it is attracting graduates. These are ones who have taken out massive loans to become doctors and they are in debt to the tune of approximately €150,000 or €200,000. They need to pay back these loans. They are not being greedy; they just want to pay off their loans in order that they can start a family and have a life during training. They took out the loans to become doctors. That is a complex matter and I acknowledge that Senator Colm Burke is working very hard on the issue of graduate debt. I am not sure what the answer is, but I know that he is working on it. It is a huge problem.

There are four reasons GPs are leaving: they want to be able to work to their full capabilities; they want to reach their potential as doctors; they need access to basic services and diagnostics and they need to be paid for what they do. We are not sure if the specialty is viable. The first step in providing that reassurance would be the reversal of the FEMPI legislation. If we were to be given a new contract which reflected the day-to-day workings of 21st century practice in Ireland. it would be a huge step for us. We do not want much. We want to be able to take time off. I want to be able to take one or two weeks off when I need to for my own physical and mental health. I know that in many posts such as the one in the place I am from there might be a period of two years in which I would not be able to take a single day off. There are not many reasonable people who would be willing to do that. Some of us are heavily indebted and cannot afford to stay in Ireland and know that we will be able to pay back the loans and have a life in moving abroad.

Chairman: I am sorry to interrupt Dr. Ó Tuathail in mid-stream, but in respect of the Sláintecare report, the reason we are here, what is the main issue Dr. Kerin believes needs to be addressed first? The report refers to capacity, an issue about which Dr. Ó Tuathail is speaking. Dr. Fawsitt referred to integration, on which subject there is a substantial chapter in the report. The final chapter, however, is devoted to implementation, to which we have devoted a lot of time. Regrettably, that is where the blockage seems to be. Will Dr. Kerin give us his views on the issue of implementation?

Dr. Emmet Kerin: We have all touched on the question of what we can do immediately to get things moving. Dr. Fawsitt, rightly, pointed out that we are putting nurses into the wrong area in the community and that there is no relationship with general practice. If we could have that changed, it would be an immediate win.

We have to redefine how general practice is run. When we studied the GP home care model in Plymouth, we found that they had changed the ethos completely. They had pooled practices through the use of information and communications technology to create an alliance between GPs and practices and shared resources. They had drawn on the voluntary and National Health Service structure, particularly on the voluntary side. In Ireland there are many voluntary groups, including patient advocacy groups, meals on wheels and social care services.

One brings that into one's practice and one then pulls back on the workload. Much of my workload includes counselling, which is not in my contract, dealing with depression, anxiety and social situations. I write letters relating to the housing crisis and everything in that range of things, so social work is interplaying with general practice. If we create that alliance together, we would achieve an immediate win. We must redefine what our practice nurses do in general practice. They are a significant asset particularly in chronic disease management. GPs are senior decision makers and need to be at the level of senior decision making for complex disease polymorbidity. That is what our role is. We need to move back from signing forms and writing ever stronger letters to argue that a case is more urgent than the last letter that said it was urgent, and start enabling. We can do that ahead of implementation and the big bang of a new contract but I strongly believe that we now have a sickness model.

Deputy O'Reilly asked about the fee structure and was interested in the split. We operate on a capitation model. The public is not aware of this. In my consultation, I do not tell my patients that I get paid X amount a year for their care, which is an open-ended system and I receive a dead-end payment. That has a huge ramification because the GP is trying to pick up the slack of what is not being done in secondary care and is becoming overwhelmed, which means that inversion happens. After subsidies, the average payment for a medical card is just in excess of €10 monthly per head coming to the GP. How can someone run a business like that? One cannot. It depends on an individual's outlook. In my practice, I augment my income by doing work outside general practice, in occupational medicine, procedures, lecturing and research and I put it all in the pot to deliver for my patients. Many GP practices do that. If one is only getting the State payment on GMS alone, it is not enough. It will end in a situation of getting less for less. We must get down to the issues. There has to be immediate resourcing and goodwill. The budget this year was a huge disappointment, no meaningful transformation fund was put in place. GPs are hanging on by their fingernails and are looking for that support but it is not forthcoming.

Returning to the level of public funding in the country, less than €500 million was put into funding the service. Some €17.5 billion is spent in the health service with 90% of interactions happening in general practice. It does not add up. These are my immediate comments on

implementation.

Dr. Ronan Fawsitt: I would like to come in on that because it is critical. Professor Tom O'Dowd's TCD study said that 90% of patients were happy with their last GP consultation. Imagine if the politicians here were getting a 90% satisfaction rating. We are coming from a good base. We are trusted and valued. That voice needs to be in the implementation team. We are looking for GP representation and involvement in the implementation team because GPs are entrepreneurs. We get things done. We have a powerful impetus to make thing happen.

I echo Mr. Tony O'Brien's observation that we need €500 million annually over ten years for primary care development. We need to front-load transitional funding into primary care. Politicians have to take a punt that general practice can do this. We know we can, our patients - 90% of them - trust us to do this but the State has to invest in it. It has been done in other jurisdictions, such as Vermont and New Zealand where there has been legislation-led change. The people on this committee do not know how powerful they are. We cannot deliver the change that is needed without the support of the body politic. That is why Sláintecare, whether right, wrong or indifferent, is brilliant for having brought together the body politic and given us a vision for how to go forward. The body politic now needs to get people into that team and we are willing to put our hands up and get involved.

We need to develop a sense of population health. My population is my practice. I want to look after my practice. I know where my patients are, I know the sick people, the frail people, the COPD patients, the heart failure patients and mental health patients, but I do not yet have the team to manage them. The State has a population of those over 70 years and it could incentivise better care in the community. They are already State-funded through the over 70 years medical card. A start could be made with that population, and we could develop services around chronic disease in the community and manage them appropriately but the nonsense of the doctor visit card has to be stopped, which turns patients into second-class citizens without access to a public health nurse, occupational therapy or other things, because they have a second-class card. I would ask that they please be given a full medical card. Starting now, with a stroke of a pen, full GMS entitlement could be brought in for those over 70 years which would allow them to access whatever supports are already there in the community. Then GPs can be incentivised to provide more structured care. I will give one example of where we have made a proposal. We know that 70% of hospital work is medicine. Many patients are discharged after medical admission, and 12% of those over 70s are readmitted within 30 days. There is evidence that if those patients who were discharged after pneumonia, a stroke or whatever are seen by their primary care physician within seven days, the readmission rates are reduced by between 12% and 24%. That is joined-up care, joined-up thinking and is better for patients and for general practice. If we were resourced to do that extra care, it would cost very little but the reward is considerable and this is for a population whose care is already covered by the State. That is the kind of intervention and joined-up care that we need to promote, the idea that we have a population that we are responsible for, and we should put in the structures that can help them to stay well and out of hospital. International systems have shown that this works. That is what we should do.

Dr. Mary Flynn: I will reiterate Dr. Fawsitt's comment. A question was asked about how Sláintecare can be implemented. We only know the primary care part. We need the Department of Health and the HSE to embrace it and then for the general practice bodies, namely, the ICGP, the NAGP and the IMO to be involved. This cannot be implemented by HSE managers or anyone else. This has to be done in partnership with the people on the ground who know the

system and how it works. It is really important for the general practice professional and representative bodies to be involved with the Department of Health and the HSE in making a start on this. A contract is essential and it must be negotiated with all representative bodies. If the bulk of GPs are to be brought along with wherever we are going with the contract, the GPs must feel they have been represented in the process. It must be a contract that has been negotiated by both bodies. While we cannot have a big bang and something set out in stone on day one, we still need a rough guide as to where it is going in order to keep Dr. Ó Tuathail and his generation here. The problem is one of uncertainty. There is massive uncertainty over what is happening. Will there be free GP care for all? Will we be nationalised? There is a total lack of understanding among this generation of newly qualified GPs as to what their life will be like in ten years' time. We need a contract, or the basis of a contract, that will give some clue about that.

The aspiration of Sláintecare is free access to primary care and general practice for all patients. While that is a very admirable end point, perhaps "free" is the wrong word, and maybe it should be in some way limited. We are very far from being anywhere close to ready for that unless we can get the Department, the HSE and the bodies in the room to get talking about the contract and how that will evolve. That will get the GPs who are qualifying interested in getting involved and staying. Until we do that, we will not get anywhere with Sláintecare.

Chairman: I have a question for Dr. Ó Tuathail. The matter of corporate entities coming into general practice versus independent contractor status versus salaried GPs in certain key locations, rural practice and private urban areas, was raised at a previous session. As a trainee, what is Dr. Ó Tuathail's view on the corporatisation of general practice, which is beginning to develop because it is an exit strategy for GPs who have no other exit strategy to retire?

Dr. Maitiú Ó Tuathail: I believe the independent practitioner model works at the moment. We have no GP waiting list. The problem with the hospital is that there are loads of managers, but general practice is made up of just front-line staff. I believe the independent practitioner model needs to remain. Potentially in exceptional circumstances salaried GPs could be brought in. I believe the solution is to improve the terms and conditions for all so that independent contractors can work throughout the country. The jobs could be salaried and let in some more, but I do not think anybody would take them.

I do not believe the corporate model is a good idea. We should continue to work as independent practitioners. The increased popularity of the corporate model is a reflection of the fact that many GPs are struggling and, as the Chairman rightly describes, it provides them with a way out. While I cannot speak on behalf of all trainees, I personally feel we should continue with the current model of independent practitioners.

Deputy Kelleher asked if we thought our training would suffice in allowing us to manage chronic care. We are very well trained; we spend ten years in college. We can absolutely manage anything that can be thrown at us. We can manage all the chronic diseases we are required to manage, but not in its current guise. We need to be given access to the resources we need first and then the care can be transferred out. There is no urgency when these patients are being looked after in secondary care as is. We should focus and try to do it right for once. We should transfer the resources first and the patients afterwards. We are more than adequately skilled to be able to manage chronic care as per Sláintecare.

Chairman: Senator Swanick did not get in earlier. Perhaps he might like to make some brief comments.

Senator Keith Swanick: I apologise for coming and going in order to attend a Commencement debate and the Order of Business in the Seanad. I welcome all the witnesses. Considering all the negatives and pressures on the sector, let me say that, as a GP, I believe that general practice works, and that is solely down to the professionalism of doctors. It is important to acknowledge that. We still have access within 24 hours, unlike our colleagues in the UK.

I totally agree with everything Dr. Flynn said about uncertainty in the sector. There is a perceived dichotomy between the GP seeing patients in his or her surgery and the decision makers, be they politicians or representative bodies. We need to address that perception. I frequently speak to young GPs and medical students; my niece will qualify from the University of Limerick this year. Even though she likes general practice, her main reason for not going into general practice is the uncertainty about funding and the contractual uncertainties. As I have said previously, I fundamentally believe we will not get a good contract without equal status for all negotiating bodies around the table. The NAGP needs to have equal status with the IMO. It is not one organisation against the other; it is about working together.

Our colleagues who appeared earlier today spoke about IT. General practice is so far ahead of the secondary care system in IT. We get blood and radiology test results online. We do referrals online. Much can be learnt from general practice. There is considerable time wasting in the secondary care system. Dr. Ó Tuathail hit the nail on the head. Some outpatient departments are operating with juvenile inexperienced doctors. While we all have to learn, at the end of the day we have to call a spade a spade. People are being brought back to outpatient departments every six months because of the indecision and incapability of a young doctor to make a call. There is a safety net in bringing the patient back six months later. The doctors will have moved on to another job. Those looking at the patient can determine things are not too bad and not much has been missed. That model does not work and will never work. That is why the funding needs to go into primary care where we have senior decision makers who are not afraid to make a call on things and they know their patients very well.

I wish to talk about diagnostics in primary care. Primary care centres are not about the bricks and mortar, but about the activity within those centres. There is no funding model for diagnostics in primary care. I have a DEXA scanner, but the HSE does not pay for medical card patients to have a scan. I have ultrasound and spirometry equipment. It is up to the doctor to provide these services. We need a funding model for diagnostics if we are serious about providing these services for patients in the community.

General practice is a small or medium-sized business with many staff members making up the team, including practice nurses. How would the experts feel about having practice nurses directly employed by the HSE? What about having a different model of funding, involving phlebotomists, for example? We are all doing jobs we should not be doing. Nurses could be doing more productive duties than taking blood.

The drugs saving scheme had ceased before my time as a general practitioner. Would there be any merit in reintroducing that scheme and having a finite spend model whereby the savings incurred would be monitored by the HSE or another overseeing group to prevent it being exploited? I know that scheme was discontinued some time ago, but I would be interested to hear the witnesses' views on it.

Chairman: I am conscious that another group from the Irish Congress of Trade Unions is scheduled to come in. The Joint Committee on the Eighth Amendment of the Constitution will be using this room at 1.30 p.m. I ask for a one-minute summary from each of the witnesses,

including taking Senator Swanick's comments on board.

Dr. Emmet Kerin: I completely agree with Senator Swanick that professionalism is at the core of general practice and it is what keeps the whole thing going. I thank him for that acknowledgement. We touched on a few areas before he arrived. I will focus on the things we did not discuss; there is some overlap with what Senator Colm Burke said. I totally agree that we need to get diagnostics to work. Arising from this meeting the committee should call for a funding model to make this a reality in primary care.

In the mid-west, we now have the HSE-led ultrasound service in St. Camillus's Hospital in Limerick which is accessible to GPs. I book ultrasound scans through the software I pay for. I can get ultrasound scans for my patients within two to three weeks. It is absolutely fantastic and I praise the local HSE. That came from a sustained lobby at a local level, but has not been translated. Those of us sitting at this table have completely different access to diagnostics, but this is an example of something that is working really well in Limerick. Why is it in Limerick and not in other parts of the country? That is absolutely ridiculous. That is an early win and we can drive that. I hope that will come out of today's meeting.

Dr. Ronan Fawsitt: My passion is integrated care, which represents the future of our health system; we need to learn to work together. I will conclude with a quote from Allison Williams who presented at the NQAIS launch at the RCPI last month. She is CEO of a trust in Wales which is in the top three of the most deprived areas in the UK. She had a totally dysfunctional health system with ambulances queuing up at one end of a hospital and trying to get out at the other. She changed it around and did it through integration. She made this comment about population health. We need to embrace this concept which is in Sláintecare. She said:

> I have 792 frequent flyers in my hospital. I know who they are. I know where they live. I know their GPs... I don't have 1,000 beds in my trust. I have 360,000 beds in my trust; they are the patients' homes. I use their beds... I don't give my GPs money; the state does that. I give my GPs what they ask for, which is diagnostics, nurses, access to my consultants and services.

That is the mindset that we need to embrace. That is what general practice can do if it is properly resourced. We can turn this around if the Government gives us the capacity to do it.

Dr. Mary Flynn: I feel that we are talking into the sky unless we get the Minister of Health, the Department of Health, the HSE and the GP representative and professional bodies together on the same sheet to progress this, otherwise we are talking to ourselves.

Dr. Maitiú O'Tuathail: Very briefly, what I feel we need is a contract that deals with this uncertainty that is driving trainees away; makes general practice viable; makes it possible to take a break from time to time; gives us access to the tests we need; and as I have already said, gives us the ability to reach our potential and to do the job that we are actually paid to do.

Chairman: On behalf of the committee, I thank Dr. Kerin, Dr. Fawsitt, Dr. Flynn and Dr. O'Tuathail for taking the time to come in this morning. I am sure this is a matter we will return to again in the not too distant future. I thank the witnesses very much for their time.

Sitting suspended at 12.41 p.m. and resumed at 12.46 p.m.

Chairman: I apologise for keeping our witnesses so long. We had three sessions this morning. Quite often it does not work that well because people like to talk so I thank our witnesses

for their patience. On behalf of the committee, I would like to welcome the representatives of the Irish Congress of Trade Unions, ICTU, Mr. Liam Doran, Mr. Liam Berney, Mr. Paul Bell and Mr. Eamonn Donnelly.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a 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 they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I also wish to advise the witnesses that any opening statements that they have made to the committee will be published on the committee's website after this meeting.

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

I will now ask the witnesses to make their opening statement.

Mr. Liam Doran: On behalf of the Irish Congress of Trade Unions, ICTU, I wish to begin this submission by formally thanking the Chairman, Deputy Harty, and members of the committee for their invitation to participate in this discussion with regard to the Sláintecare report and the expansion of primary care.

ICTU, which represents over 700,000 citizens and their families, has welcomed the Sláintecare report, which recommends the introduction of a single-tiered, universally accessible and quality assured public health service. It is our view that this Sláintecare report, which enjoys almost universal political consensus about how our public health services should be structured, funded and maintained, offers a real opportunity for radical reform of the current inequitable two-tiered health system, leading to a properly resourced public health service, which is a fundamental social good in any society. As an indication of our support for the report, the health committee of the Irish Congress of Trade Unions is currently meeting with the health spokespersons of all political parties. We are satisfied that, to date, these engagements have been positive and all political parties have reaffirmed their commitment while recognising the challenges and scale of change involved.

Primary care expansion, as detailed within the report, is undoubtedly a cornerstone of the reform programme. ICTU fully supports, and will actively work towards achieving, the delivery of health care in the community as near as possible to the home of the patient or client. In that regard, we note that the report identifies all critical areas to be reformed and expanded, including universal access to primary care; universal GP care; expansion of diagnostics; expansion of home care and palliative care; and additional services for citizens with disabilities. In working towards implementing all of the report's recommendations, we remind the committee of the recent report, from the Economic and Social Research Institute, ESRI, which measured the increasing demand upon the health service between now and 2030.

In a further confirmation of the scale of the challenge facing our health system, the report states that demand for home help hours will increase by between 38% and 54%, demand for practice nurse visits is to increase by between 26% and 32% and demand for GP visits to in-

crease by between 20% and 27%. It should be noted that, in addition to these very significant increases in primary care based services, the report also states that the demand for inpatient bed days will increase by between 32% and 37% for the same period. We believe this highlights two critical facts in relation to our public health service. First, the expansion of our primary care services, faced with this level of measured increased demand, is absolutely critical and cannot be ignored. Second, even with major expansion of our primary care services, the nature of our demographics will still result in a significant increase in demand for inpatient bed days; in other words, the demand for acute care will continue, even while we are expanding primary care services, and this has resource implications which must be accepted by all political parties.

Turning to the issue of universal GP and primary care access, it is self-evident that any expansion of primary care, as recommended in the report, requires a seismic shift in the eligibility of citizens to access all services outside the hospital setting. In that regard, the Sláintecare report correctly identifies the need for the expansion of, and universal access to, GP services and primary care services. From the Irish Congress of Trade Unions, ICTU, perspective we believe the expansion of these services should, in the context of universal access, be integrated. In other words, universal access to GP and primary care services should be seamless and delivered by a primary care team of health professionals who can directly receive self-referred patients, refer patients and clients to other health professionals within the team and refer on to other specialist or sub-specialist services as required. In that context, the GP is an integral member of this team but so, equally, are all other health professionals. This seamless approach, by fully utilising the skills of all, is the most effective way of dealing with growing demand including the management of chronic disease in a quality assured way.

It remains the view of ICTU that the most efficient and effective way of delivering universal access to all primary care services, including GP services, is that they should be provided by directly employed health professionals. The ongoing discussions, with regard to a revision of the GP contract, should be wholly informed by, and against the background of, a requirement that in future all new GPs should be directly employed by the public service. They should be rostered, particularly in urban areas, on a seven over seven basis, as should other key health professionals, and all members of the team paid a competitive salary reflecting their role and experience. This would ensure recruitment and retention.

With regard to the steps to implementation and ensuring delivery of the reform programme, ICTU believes that a critical first step is the establishment of an implementation office in the Department of the Taoiseach. This will ensure a whole-of-Government approach to implementation. In the absence of this initial oversight step, ICTU is already very concerned at the failure in budget 2018 to provide earmarked funding to prepare for the reform programme including the absence of a dedicated capital building programme, with regard to primary care centres with comprehensive diagnostic services to deliver the required community based infrastructure. There has also been no engagement on the necessary funded workforce plan required to deliver universal access, which the report states are 900 general nurses to expand the child health and well-being programmes; 1,917 health care assistants to expand home care and other services; 1,296 allied health professionals to delivery universal access to primary care; and 2,021 nurses of various grades to also deliver universal access.

In the context of the current recruitment and retention difficulties, facing grades within the health system, no expansion can take place without these additional staff. The reality is these additional staff will not be recruited without a properly structured and funded workforce plan covering the numbers of training places, clarity on the autonomy of roles within each team

fully utilising all available skills and improved pay and conditions of employment. The report also recommends expansion of such critical services as the child and family health, community based child, adolescent and adult mental health services, expansion of palliative care services, and expansion of home care and disability services.

The report states that in the transition period, lasting up to ten years with many developments delivered within five years, expansion of these services should begin in year one. The report is correct when its states that all of these service expansions, while taking place on a phased basis, should be developed through an integrated model of care. This means that we must have simultaneous developments within all these strands of services so that the user, who will often have more than one need, can enjoy the benefits of a seamless expanding service. Against the background of the foregoing, we are already required to ask when the implementation will start. Is this year one or ten? Why was there not greater clarity about the funding in budget 2018?

A very broad overview of the additional funding requirement, arising from the expansion of services listed under primary care, identifies a cost of some €1.297 billion. This is separate from the capital build, essential to develop primary care centres, which will be the hub of the provision of seven over seven services required as part of the reform programme. Recognising the additional funding required, it is necessary for all political parties in the context of their support for Sláintecare to be forthright in saying in their policy statements that reducing overall taxation levels is not compatible with delivering a single tiered, equitable and universally accessible public health service capable of meeting future demand.

Regarding health care and social economic good, in 2001 the then Government defined primary care in its primary care strategy as:

> ...an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.

Almost two decades later, despite the excellence of effort by health service staff and significant expenditure by the Government, it has to be said we have not achieved this goal in the interest of all citizens. There are many reasons for this, with some related to funding and others related to ideology and an acceptance that a two tiered health system was somehow acceptable. The Sláintecare report provides the opportunity and solid platform for this State as a society to address the glaring inequality that is inevitable when money can ensure faster access to senior clinicians, diagnostics and, ultimately, treatment. We now have the opportunity by working together at political, organisational and societal level to address this inequality informed by this report and the expansion of primary care services is a cornerstone of this transitional journey. ICTU fully supports this report and the recommendations detailing how we expand our primary care services. We commit, on behalf of all of our members and their families, to work with all parties in delivering the transformational change now available to us.

I thank the members for their time and attention and we look forward to discussing this submission and the relevant elements of the report with the committee.

Chairman: I thank Mr. Doran. We will now take some questions.

Deputy Louise O'Reilly: The witnesses, all of whom I know, are very welcome. It is very

heartening to hear ICTU's support not just as the representatives of health care professionals, but also as representatives for workers outside the health sector who depend hugely on the public health service. ICTU's support in this regard is very welcome. I am hopeful that this support might nudge some of my colleagues into being a little more vocal. We need the political will to implement Sláintecare. We do not lack research findings and a plan. Sadly, we do lack the political will to follow through.

I welcome ICTU's statement on the incompatibility of building decent public services, including health services, with tax cuts. I am sorry that there are not more of my colleagues present to hear and understand that message.

I want to ask a few questions that I asked earlier today. The ICGP has described the terms and conditions and pay structure for practice nurses as Victorian and inflexible. I know that practice nurses are flexible. How can we ensure we are getting the best value for money? Before we adopt an expanded primary care model, we need to move forward in achieving good value for money, respecting patients and workers and building the best foundations to broaden the services provided. I asked the previous delegates to outline how money reached the GP through the operation of the small business model? How is money passed on to those who work as part of that cohort? If someone is paid on a fee per item basis, is it always paid on the assumption that it is the GP who will provide the service or are there others who can provide it? If it is the latter, how are they remunerated? Is there scope for the use of advanced nurse practitioners to form part of a primary care team?

I am sure we all agree that having primary care teams in the community is a good idea. Will the delegates outline what they consider to be a fully staffed fit for purpose primary care team? A GP often leads the primary care team. What is the working relationship like between the GP and the primary care team? Do the delegates envisage a GP being the employer in an expanded service? Do they envisage the entire primary care team being employed by the one person and working together in providing an expanded service? The small business model of general practice seems to be quite limited. Such a model will not be expanded without the addition of allied health professionals and others who would form part of a primary care team.

I am a massive fan of home helps and anyone who knows me will not be surprised by my next question. Will the delegates talk about the expansion of the home help service? The committee has met representatives of home care providers and the HSE and they painted a picture that it was sometimes difficult to find home helps to work, specifically in the evenings. As a result, people were forced to access services from the private sector. I doubt if much has changed since the last time I represented them, but I have always found the home help service to be one of the most flexible and responsive in the HSE. According to the Department of Public Expenditure and Reform, the average cost of a home help is €24.20 an hour. Some global multinationals charge up to €42 an hour. In the context of an expanded service and what constitutes value for money which is always paramount, will the delegates comment on from where the figure of €42 an hour stems. Is the service capable of being expanded? I believe it is; therefore, it is unnecessary to source home helps from multinational corporations. Many of the independent and directly employed home helps are capable of providing the service. Will the delegates confirm that for us?

Chairman: In the two earlier sessions we met representatives of the IMO, the ICGP and the NAGP. They were adamant that the independent contractor model would best serve the health service. They believed the resourcing of the small business model was broken and that, therefore, general practice was unsustainable. Are the delegates aware of a model that employs sala-

ried GPs outside the independent contractor model? If so, where does it happen? If one were to have salaried GPs working on a roster seven days a week, how many additional GPs would the health service require? Let us remember that salaried GPs would be subject to the EU working time directive. Many GPs work in excess of 48 hours a week. An additional number of GPs would be required to man the service under the EU working time directive. How would the delegates propose to recruit and retain and maintain capacity and increase the capacity of the health service if we were to move to such a model?

Contract negotiations are taking place. There is a proposal in Sláintecare to have salaried GPs in certain areas in which it has been hard to recruit doctors, including rural and deprived urban areas.

Perhaps the delegates might also refer to access to hospital services. Last week a "Prime Time" programme drew attention to the fact that there were many unsavoury practices in hospitals. It appears that there was a lack of management to ensure hospital doctors worked the full hours in their contracts, which had a knock-on effect on public outpatient and inpatient waiting lists.

Will the delegates refer to the growing trend for corporate entities to enter general practice? Companies have taken over practices. Many GPs cannot see a way out of their practice other than by becoming involved with a corporate entity.

Deputy Louise O'Reilly referred to practice nurses. Should they be directly employed or should they be employed using the small business model?

Like the delegates, we believe implementation of Sláintecare has been slow. Will they identify short-term measures that would kickstart it?

I apologise for asking so many questions.

Mr. Liam Doran: It is a little like the Chinese proverb: "If I wanted to go there, then I would not start from here". Let me be clear: we cannot and will not deliver Sláintecare and a universal accessible primary care system under which all health professions will be utilised if we approach it with the current model. ICTU's view differs from those of the other contributors that the committee has heard today. We have a system under which some people are entitled to care paid for by the State, while others pay for it, but we are trying to introduce universal access. Why would one have independent contractors in a small business model providing a universal accessible primary care system? What profit would be generated by it?

As we stated in our original submissions, it will take more than ten years to implement Sláintecare. A massive political and societal buy-in is required because Sláintecare is a completely different way of allowing the health service to touch people when they need help. I will try to go through the points as best I can but my colleagues will bail me out if I leave some out. Mr. Paul Bell will address the questions on home helps.

Practice nurses for GP practices have been needed for years and we are fully supportive of their role. They should be directly employed by the State. There is no salary scale for practice nurses. Under the present model, the GP receives a grant to employ a practice nurse, but he or she may not necessarily pay the nurse that amount of money. They have an individual employment relationship and this can lead to argy-bargy. On top of that, the practice nurse performs services in the clinical area for which the GP gets another fee, whether for the flu vaccine, the cervical smear test or whatever. The State is paying for the service twice.

A couple of years ago we conducted a survey and in one practice, our members estimated that they generated income from private patients' fees of €112,000, outside of the GMS income for the practice, based on the tasks they did in the previous 12 months. Our view is that practice nurses should be directly employed by the State and should be entitled to be eligible for superannuation. We agree that their role should be broad so that they have a seamless connection with the community-based nursing services. At present, there is this wall behind which the practice nurse stays. Patient A goes to the public health nurse or the community general nurse. That is not a seamless service. If one is intelligent enough to navigate it, one might get out of it but if not, it creates a problem. The practice nurse should be directly employed by the State, as all people in the system should be. They should be allowed to expand their practice. The current model of grant aid to the GP, which is not reflected in the salary paid to the practice nurse or the revenue that the practice nurse generates for the practice from private patients is neither fair, reasonable nor sustainable.

The fundament point about primary care is that one is not always dealing with sick people, one is trying to keep them healthy or trying to continue the model of treatment that is there. It is not all short-term episodic interventions, rediagnosing and reclassifying, although that is a part of it. What we are trying to do is manage the care of the individual and keep him or her healthy. The advanced nursing practice will have to be the bedrock, particularly in chronic disease management. In general practice in any jurisdiction, the GP will not be intimately involved in the twice or three times a week management of the care of a person with a chronic disease. That is the team's role and that is where the advanced nursing practitioner comes in. The community midwife has a similar role, as the does the community intellectual disability nurse, the community pharmacist, the radiographer, the physiotherapist and the dietician. These health professionals have equal and vital roles to play in a primary care team that is embedded in and serving the community. No one service is greater than the other and they all should be able to take self referred people. The advance nursing practice is part of that service.

The primary care team is the key, but it must be fit for purpose and have good working relationships. Let us fast forward ten years when we will see the impact of the changing demographics on health services. The ESRI has projected an increase in demand of 20% to 32% for services, but not all for acute interventions. The ESRI projects that the demand for home help services will increase by 54%. That is a massive increase. The primary care team has to be modelled, staffed and resourced to deal with the demand on a seven over seven basis.

The Chairman raised the issue of rostering. We would have a fairly strong view on this. The current GP model has the GP providing a service from 9 a.m. to 5 p.m. Monday to Friday and after that one goes into the out-of-hours on-call system and so on. We are very concerned that the development of the out-of-hours on-call system has had a hand in glove impact on the number of people being referred to the emergency departments, who might be treated otherwise in a more collective team-based way. At weekends, in particular, people are being referred because they are seeing a different GP who is a completely new point of contact and there is no continuity of care. That applies to public health nursing and community general nursing services as well. They too are structured on a 9 a.m. to 5 p.m. Monday to Friday service with essential calls only at weekends. We are saying that they should span the seven days as well. If one is truly interested in keeping people out of hospitals then one has to provide a service in the community seven days a week. That is labour intensive but it is the only way. The GP is an integral part of that transition. We are saying that with the changing demographics, modes of treatment and increase in chronic disease management the team must comprise a group of health professionals with no one specialty having supremacy over the other and no one being a gatekeeper of the

other, all referring from one to the other in a much more mature and adult way which does not have as its core a medical model of care that is shaped, directed and conducted by a doctor. That is not the health service of the future.

The health service of the future is different and the team will be central to the care of the individual. We should model the employment relationship as follows. There is no chance that many of the current GP cohort would move to be directly employed by the State. They have their business models, and have mortgages and debts. The only way we will successfully move to a new model is that new GP contracts should be for directly salaried doctors and over a generation one will build up the critical mass of people who will be employed directly. It is the same for consultants. What was disclosed last week in the hospital setting is a direct result of the incentives for practice. One cannot fault people for following the money trail. People are all the same. How long ago did somebody say that people of the same profession never gather without money being discussed. Consultants are no different. We will only get to a directly employed universal health care in hospital or primary care by accepting that the current cohort have a certain contract and as people retire and leave, they are replaced by staff who have been offered a direct public only contract so that in 15 years' time, we have a critical mass of people working completely differently with no delineation between the private and public patients. That is what will be required if we are to deliver Sláintecare, whether in primary care or in the hospital. That is a big ask, but it is the only way this will be done.

Chairman: I am sorry but I must interrupt Mr. Doran. We must vacate the committee room now as another committee is due to meet here at 1.30 p.m. Undoubtedly we will come back to the topic again. When we discuss this topic, the witnesses will be the first group to appear before us. I will allow each one of the witnesses a minute to sum up their views.

Mr. Paul Bell: I thank the Chairman. Deputy Louise O'Reilly raised a very important point about community care, especially in the area of home helps. In the ICTU document, we seek that the HSE or the statutory provider of health care is the employer of choice so that people will want to have a career in the delivery of public health services. Unfortunately, time does not permit me to develop this further, except to say that the WHO has made it clear that by the year 2030, there will be a shortage of 40 million health professionals throughout the globe. That will obviously affect Ireland on the basis of the demographics.

A point I wanted to expand on, but disappointingly it is not possible, is the unsavoury practice to which the Chairman referred whereby there are various issues arising from contracts of public and private provision. We have a concern about the development of radiography services in the community, as we would have seen in Athlone, where there is a HSE facility. We are concerned that advantage is being taken of the difficulties experienced by public health services in trying to recruit health professionals or fund the capital expenditure.

I will now defer to my colleague, Mr. Eamonn Donnelly.

Mr. Eamonn Donnelly: I concur with everything Mr. Doran has presented. I emphasise the issue of self-referral among allied health professionals. Until we get this, we will always have to have the public jumping through hoops and an unwieldy health service. Mr. Doran is right. We cannot picture the model now and try to make the journey from here. The committee must also decide what model of health care will be provided, because the notion of the current configuration of seven hospital groups and nine community health care organisations is not sustainable. We need to talk about an integrated health care model. Primary care, along with hospital care, is the key cornerstone of an integrated health care model. Somebody needs to

grasp that nettle sooner rather than later.

Deputy Louise O'Reilly: I suggest we schedule another hearing on this if time permits because there are many issues and the time ran away from us this morning, which is no fault of anyone except possibly some of the people asking questions, and I will hold my hand up in this regard. It is a topic we should come back to because if we do not get the perspectives of all of the people delivering the service, we really are at nothing.

Mr. Liam Doran: On behalf of congress, I would like an early return.

Chairman: I understand the frustration of the witnesses and I apologise again. On behalf of the committee, I thank Mr. Doran, Mr. Berney, Mr. Bell and Mr. Donnelly for coming before us. I apologise for the short time available but we will bring them back on a future date.

The joint committee adjourned at 1.20 p.m. until 9 a.m. on Wednesday, 6 December 2017.