DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Dé Máirt, 27 Bealtaine 2014

Tuesday, 27 May 2014

The Joint Committee met at 5.15 p.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Colm Burke,
Deputy Sandra McLellan,	Senator Jillian van Turnhout.
Deputy Dan Neville,	

In attendance: Deputy Liam Twomey.

DEPUTY CIARA CONWAY IN THE CHAIR.

Help us to Help More Campaign: Irish Medical Organisation

Vice Chairman: I must acknowledge many people are absent today given what is going on throughout the country. Many people are still at count centres and I apologise for the vacant seats. Apologies have been received from the Chairman, Deputy Jerry Buttimer, and from Deputies Peter Fitzpatrick, Mary Mitchell O'Connor and Caoimhghín Ó Caoláin.

I remind members, witnesses and those in the Public Gallery that mobile phones should be switched off completely for the duration of the meeting. The purpose of the meeting is to discuss with the Irish Medical Organisation its Help us to Help More campaign, which is designed to highlight the important role played by general practice in delivering health care. According to the IMO, every year more than 22 million clinical consultations take place between GPs and patients, making general practice the most frequently consulted part of the health system. Among the issues the campaign is trying to promote are a fivefold increase in the portion of the health budget spent on general practice with a corresponding plan for increased patient services, a commitment to ensuring the preservation of a community-based same day appointment service for general practice, and an agreed strategy for the development of general practice in the coming decade with a particular focus on extending the range of services provided through general practice.

I welcome Dr. Ray Walley, vice president and chair of the GP committee of the IMO; Dr. Illona Duffy, a member of the IMO GP committee; and Ms Vanessa Hetherington, assistant director of policy and international affairs. Witnesses are protected by absolute privilege in respect of their evidence to this 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 qualified privilege in respect of their evidence. Witnesses are further directed that only evidence connected with the subject matter of these proceedings is to be given and 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. 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. Ray Walley to make his opening statement.

Dr. Ray Walley: The Irish Medical Organisation thanks the Chairman and the Joint Committee on Health and Children for the invitation to present our resource general practice campaign, Help us to Help More. The IMO launched the campaign in November 2013 to highlight the potential for general practice to do more for the health care services and how we can do so with careful planning, adequate resources and meaningful negotiation. General practice can deliver 21st century care that is free at the point of access to all patients.

What is good about general practice? We have 2,414 GPs delivering care to almost 2 million General Medical Services patients. A total of 24 million clinical consultations take place every year with 1 million out-of-hours consultations also taking place. A total of 95% of all consultations are dealt with by a GP without the need for referral to secondary care. We are there when patients need us. We deliver a same-day service, 24-7, 365 days a year. GPs are committed to change and development.

A number of issues arise with general practice. The workload has increased while resources

have been savagely cut. The number of patients with medical cards and GP visit cards has increased by 500,000 over the past six years while resources have been cut by €160 million per year, which is a cumulative total of €434 million. This is a reduction of 38% in funding to general practice, compared with an 18% reduction in other parts of the health care service. The Government spends just 2.3% on general practice out of total health expenditure, public and private, compared with 9% in the UK. Practices are struggling financially and in terms of capacity. GPs are frustrated with an out-of-date 40 year old contract. Since the Competition Authority intervened in 2006, general practice has stagnated and there have been no new initiatives or developments. There has been no engagement. Morale among GPs is at an all-time low. There is a serious manpower crisis. Young GPs choose to emigrate while older GPs see no viable future.

I have included a number of quotes from a professor of general practice and primary health care in the US, Barbara Starfield. She stated that evidence-based studies show that primary care, in contrast to specialty care, is associated with a more equitable distribution of health in populations, a finding that holds in cross-national and in-national studies. She also stated:

> The supply of primary care physicians was significantly associated with lower all-cause mortality, whereas a greater supply of specialty physicians was associated with higher mortality. When the supply of primary care physicians was disaggregated into family physicians, general internists, and paediatricians, only the supply of family physicians showed a significant relationship to lower mortality.

The term "primary care physicians" is from the US and our equivalent is "general practitioners".

General practice is at the centre of strong health care systems, such as those in the UK, the Netherlands and Denmark, where access to GP services is provided on an equitable basis across the population and where a greater proportion of the health care budget is spent on GP services and ancillary primary care services. The Government's goal is to deliver GP care which is free at the point of access to the total population. The IMO is in the vanguard of supporting this, but it requires careful planning, appropriate resourcing and meaningful negotiation.

Planning for the provision of GP services free at the point of access requires careful analysis of demographics trends. Ireland has an ageing population and, by 2021, there will be an extra 200,000 people over 65 years of age. It also requires careful analysis of manpower needs, including the required number of GPs and other practice staff per 1,000 population. Priorities based on medical evidence must be established. Clinical service and visitation rates must be defined. Visitation rates are higher among older people and those with long-term conditions. In addition, visitation rates increase when access to GP care does not require out-of-pocket expenses. The ancillary workload must be defined. Realistic timelines for implementation must be developed with appropriate cost analysis.

Appropriate resources for general practice are required to ensure sufficient manpower levels. Ireland is facing a shortage of GPs. Approximately 240 GPs, or one in eight, in the country are 64 years or older. More than 4,000 doctors are registered in the United Kingdom and the majority are general practitioners. Over the past four years, 1,049 Irish-trained GPs have taken up general practitioner principal posts in the National Health Service. We need appropriate levels of medical, nursing and practice support staff. Successive cuts under the Financial Emergency Measures in the Public Interest, FEMPI, Act have led to cuts in employment hours of practice staff. We need access to allied health and social services in primary care. At present, waiting lists apply to access to all allied health and social services in primary care for

GMS patients, and many of these services are simply not available for those without a medical card. We need appropriate infrastructure. Premises, medical and diagnostic equipment and IT requirements must be fit for purpose. The real and specific needs of rural and deprived areas must be provided for. Allowances should be made for opt-in to enhanced services as many GPs have training in other specialist areas.

Free GP care requires real negotiation. Since the inception of the GMS in 1972, the IMO has negotiated with Department of Health and the HSE publicly funded contracts which have stood the test of time. These include the GMS contract, the mother and infant scheme, GP visit cards and out-of hours co-operatives which have delivered value for money to the State, quality services for patients and a service that works. GP services have a 97% patient satisfaction rate.

Negotiation benefits all parties. The Department of Health will acquire GP knowledge and expertise as to what can work in general practice. It ensures GPs can deliver care in a safe, effective and sustainable way, patients remain at the centre of care, legitimacy is enhanced, implementation is smooth and delivers a standard and equitable service to all patients, and both parties have an interest in making it work and ensuring success.

The Government is fully aware that legal proceedings are being initiated by the Competition Authority against the IMO. The position is that the IMO is a registered trade union with a negotiating licence and, therefore, is entitled to fully represent its members in all aspects of negotiation. The position of the Competition Authority and the Government is that the IMO cannot negotiate on behalf of its members on price. A former Attorney General, Mr. Paul Gallagher, stated the following in 2012:

> I believe that the Competition Authority's position is wrong as a matter of law and that this stance has created significant uncertainty on the part of the representative bodies with regard to what they can and cannot do and has created significant difficulties for Government in implementing the necessary changes. … GPs were all charging the same fees to the Government for the medical card services and therefore the idea that they were somehow combining on price by entering into negotiations is difficult to understand. There was never any prospect of the Government being able to negotiate independently with GPs to achieve differential pricing.

That shows that there is no impediment to negotiation and it is in the interest of all parties.

The IMO calls on the Government to do the following: agree a strategy for the development of general practice services for the whole population with a focus on extending the range of services provided, provide adequate resources to support the strategy, and agree an action plan to address the manpower needs in general practice.

The importance of general practice is evidenced in Holland which has invested in general practice for 30 years. That underpins the provision of universal care in Holland and acts as an appropriate gatekeeper. The international belief is that the system works but needs resources.

Vice Chairman: As nobody from Fianna Fáil is present, I call Deputy McLellan.

Deputy Sandra McLellan: I thank the delegation for its presentation. I apologise on behalf of Deputy Ó Caoláin who cannot attend today.

We commend the campaign and are totally supportive of the guiding principle that general practice can deliver 21st century care that is free at the point of access to all patients. The Second Stage of the Bill that provides free GP care for children under six will be debated. Do

the witnesses care to comment on the current level of engagement between the IMO and the Minister of State? Sinn Féin supports the extension of free GP care but has been critical of the way the measure is being introduced, especially the level of consultations. Has the situation improved for the IMO?

There has been much discussion about children aged under six as well as check-ups, as part of the new legislation. In principle I support both initiatives. Rather than constantly being a curing system we could have a preventative system. Does the IMO see this type of role extension as appropriate if adequate support and resources are provided? Are there bottlenecks in the system that can be readily addressed, for example, diagnostics and access to hospital services? If so, it would allow GPs to relieve pressure on the emergency departments.

The delegation stated that Ireland is facing a shortage of GPs. Why are trained GPs leaving Ireland? Have we sufficient training posts for GPs? What duties, if any, could GPs offload to pharmacists and nurses?

Senator Jillian van Turnhout: I, too, welcome the delegation. It is great to have this discussion. I read the presentation and want to understand more by asking one or two questions. First, Dr. Walley stated in his presentation that GP care is provided 24-7, 365 days a year. However, a continuum and continuity of care is very often provided by a different GP or an out-of-hours GP. I have lived in Belgium which has a system of more medical practices and they retain a person's file, thus providing a continuum of care. I have had some bad experiences where somebody was seen by a person who had no idea of the patient. I found the line "We deliver ... 24-7, 365 days a year" interesting and I want to understand more about the system.

Dr. Walley talked about being at full capacity, which I appreciate. What should be done to develop GP services? He said that one in eight GPs are 64 years or older. What steps can be put in place to encourage the development of a proper GP service? Dr. Walley continued by talking about investment in premises and that infrastructure "must be fit for purpose". Is the IMO looking for the State to bring GPs together? Perhaps everybody else knows that information. Is there a scheme to facilitate the infrastructural investment and where it is to come from? Is Dr. Walley talking about primary care centres? Does the IMO want greater involvement by GPs in that type of system? Dr. Walley's answers will inform me and help me understand more about the sector.

I love statistics but was impressed with Dr. Walley's statement that "GP services have a 97% patient satisfaction rate". What is the basis of that statistic? What were the patients satisfied with? We have often heard at this committee that everybody is very satisfied once they get the care, but problems can occur with access to care and getting answers. I am surprised the figure is so high. GPs do a fabulous job but many times people have been left seeking a prognosis or answer. GPs do not have a magic wand so cannot always answer their questions. I want to understand a little bit more about the 97% satisfaction rate.

Senator Colm Burke: I thank Dr. Walley for his presentation. I fully support what was said about the Competition Authority's decision being incorrect. Is the pending legal challenge likely to be heard and dealt with before the end of this year? We need the matter to be clarified. I do not agree with the decision and it has caused a lot of frustration.

I want to touch on the cost of health care. In excess of €3 billion has been taken out of the health budget over recent years. A lot of pressure was created by the level of taxation being collected, especially from 2010 onwards, and meant that a lot of budgets were cut such as edu-

cation. The budget ha been substantially increased due to the fact that the cost of medications was left unchecked. Over a period of ten years the cost increased from €560 million to more than €2 billion a year. This year the budget will not be much under €2 billion. If we want to increase the funding provided for GP services, we will have to make savings elsewhere. One of the areas where we must make savings is on the cost of drugs, particularly when some medications are four to five times more expensive here than in other EU countries. We have brought in the long overdue legislation on generic drugs. From the point of view of practitioners, what else can we do to make savings in terms of the cost of medication? Any savings could be given to members of the IMO and would improve practices. How does the IMO see the matter developing over the next few years?

Deputy Dan Neville: I welcome the delegation. Some of my questions have been asked so I can save time and thus speed up the debate. Some of us are under pressure to go elsewhere but I do not mean soon, just within half an hour.

As a former industrial relations practitioner, I do not understand the Competition Authority's decision. I have questioned its decision but did not receive an answer. I spent 20 years dealing with trade unions in a former life. There is no problem with IBEC being a trade union and negotiating as an employers' organisation. Why is the IMO treated differently?

There have been improvements in general practice but there are concerns about the treatment and identification of people with mental health issues. Can the IMO comment on the matter? The training of GPs has improved significantly. I know that a GP cannot give the time to fully explore a difficulty if a person has a mental health issue because of the busy nature of the practice. Perhaps the witnesses would comment on that and on how an improvement could take place in that area?

Vice Chairman: Does Deputy Catherine Byrne wish to contribute?

Deputy Catherine Byrne: I will wait for a while until I hear some of the replies.

Vice Chairman: I will return to our guests. Who would like to speak?

Dr. Ray Walley: As there is an element of *à la carte* we will all make a contribution. What I am going to say in regard to our engagement with the Minister is quite terse. Basically, we are in discussion with the Minister of State at the Department of Health, Deputy Alex White, and our agreed comment on it has been that we have had useful talks and that the process continues. I do not want to jeopardise that in any way, but the talks continue.

In regard to a preventative role, one area where general practitioners feel constrained is in providing preventative medicine. We have time-bombs in regard to the development of diabetes and obesity and other health care issues. Certainly, it is part of our training as hospital doctors coming through the system and going into general practice. General practice training in this country continues for four years and involves medicine and other areas of paediatrics, obstetrics and so on but the problem is that within the current contract we cannot use those skill-sets. Pilots have been conducted in Ireland on, for example, diabetes shared care and these have been progressed considerably to the point where they are almost at contract level. The evidence with the pilots is that not only do we provide better care and better statistics in regard to mobility and mortality than the hospitals - that is not to dismiss what the hospitals do as they do not have the resources either - but there is no reason the majority of this work cannot be done in communities. General practitioners work in each community throughout the country and there

is no reason people have to travel to a hospital for the majority of diabetic care.

Savings can be made in diabetic care. Given that renal dialysis costs €100,000 per year and that the most common cause of renal failure is diabetes, if one was to delay its progression by six months that is a saving of €50,000. The most common cause of blindness is also diabetes. The social benefit of reducing the progression of blindness is phenomenal, not to mention the monetary cost. Those are issues on which we wish to use our skillsets but there are many other areas where we could do that, such as in cardiovascular health, mental health and so on. As there is an explosion of elderly people coming down the line we want to be involved in dealing with stroke prevention, dementia prevention and so on which can be dealt with in general practice.

An issue mentioned was bottlenecks in access to diagnostics. Due to the withdrawal of resources, many general practitioners do not have access to 24 hour blood pressure machines. For example, in my local area - I refer to Beaumont Hospital - there is a four-month waiting time for that, which is extending. If a person was to purchase such a machine in private health care it will cost in the order of €180. Hypertension is very common and a risk factor for stroke, diabetes in conjunction with other illnesses, and dementia, therefore it is important that we have access to it.

On the issue of the shortage of general practitioners, recently the committee may have read that for the first time ever the number of general practice posts applied for in training was deficient in numbers. We have 157 training posts for general practitioners. These are four-year contracts. They are contracts where a person knows where he or she will be for the next four years. For the first time ever we have only 150 suitably trained applicants for those 157 posts. We are haemorrhaging young doctors. Not only are they leaving when they qualify, they are not even willing to stay to do their raining here because they are being sourced by locum agencies throughout the English speaking world to go to Australia, Canada and the UK. Of more concern is that for the first time we are losing middle-aged general practitioners. A couple of weeks ago 25 general practitioners left for Qatar. We are aware of that because there was a large group of individuals involved but three, four and five people in their mid-fifties are leaving for places such as Canada. The average age of a general practitioner here is 52 years.

We have got to ensure we retain our existing general practitioners, of whom there are 2,414. We need to retain the one in eight GPs, who is over 64 years of age because most of them want to work. However, they want to work without having to deal with all the difficulties in the system. The committee will have read of all the difficulties in the UK and there are similar difficulties here. There are difficulties with burn-out because of the workload implications. People are working 12-hour days. People are arriving at work before their staff and leaving after their staff. It is not an attractive job but it is a job we all love and do and we all want to work in our communities. Putting more training posts in place will not resolve the position. We need to ensure we can retain the existing general practitioners. This issue has been looked in the McCraith report into which the IMO has had an imput.

With regard to the GPs who are applying for the training posts, the most common reason given for not wishing to take up a GP training post here was the uncertainty for the future. The present generation travels easier, are more confident to travel, and are more likely to stay where they go. The majority are trained by the time they arrive. They get into the workforce early, find their feet, have a family and after four or five years they want to get citizenship for their children. After they remain for seven or eight years they are less likely to come back. I know that as I was one of those individuals who emigrated in 1990. The difference was I emigrated

for my training. Nowadays, the majority who emigrate are trained and are less likely to come back. That is a very expensive loss of a resource besides the fact that one would expect the community to stay and look after its own community.

On the issue of off-loading workload, a high proportion of us work in teams with practice nurses and secretaries. Secretaries do the work of secretaries and nurses do the work of nurses while GPs do the work of GPs. We have always worked in teams. In recent years, the HSE has realised that primary care teams exist. We have always dealt with them and we have all embraced changed. All our CME is done outside of our working hours, between 5 p.m. and 9 a.m. We are engaged in education all the time. General practice here is of a high quality and we want to continue to prove that. We want to work in teams within our general practice and within primary care but both must be funded. In these systems of work, 10% goes to general practice and 10% goes to primary care teams. Anything outside the hospital and outside the GP surgery is primary care. All of it, general practice and primary care, adds up to community care. There is a need to resource the public health nurses, social workers, occupational therapists and speech therapists because if they are not available they come back to the general practice. We can only do our own job.

In regard to continuity of care, I was a founding chairperson of the D-Doc out of hours service. I brought my skillset from the UK where I was one of the individuals who set up Brightdoc in Brighton. The majority of shifts in D-Doc, which is the same as other co-operatives throughout the country, are done by general practitioners where, through economies of scale, we cover a population of 0.5 million people. We have a visiting service for those who cannot come to the surgery and as a result, the majority of the care is provided by GPs local to the community. Certainly, we do not have the manpower to do all those hours. We no longer want people working 24 hours. If one is working those hours, one is more likely to make a mistake. Those reports are faxed back to the individual GP who looks at it. I had a lady one night recently who had a problem. The GP who was seeing it thought it was acute but to me, who knows the lady, I was able to engage with somebody else to say this is a repeated problem which we need to deal with elsewhere. In that way the person concerned got more appropriate care. All of that amounts to continuity of care with appropriate use of IT technology. That is not to say one cannot improve.

In regard to the 97% satisfaction rate, I am pleased to say that comes from a State organisation, the Medical Council. It is similar to the previous study which showed a 93% satisfaction rate the previous year. When the HSE conducts its studies, they are also over 80%. The last one they did was three or four years ago, and it was in the order of 84%. They are coming from State organisations that we do not influence.

Senator Jillian van Turnhout: Is that with one's GP?

Dr. Ray Walley: It is with one's general practitioner.

We have a capacity problem because, for example, there are next to no locum general practitioners. Not only are the general practitioners who are trained moving on, but they are going to more attractive areas, such as the United Kingdom, Australia and Canada, and as a result we have lost the spare capacity in general practice. It has become an unattractive job because of a withdrawal of resources. As I stated, we are on 2.3% of the State's spend whereas the equivalent is 9% in the United Kingdom, 10% in Holland and 10% in Australia.

In regard to premises, many general practitioners over the years have invested in premises,

many of which are high quality and fit for purpose. We agree that one needs to invest in premises where the need is there, but we want to scotch this view that we can do cardiac surgery, appendicectomies and all of those procedures that patients still need to go to hospital for. We can only provide general practice care. One will still have patients attending in casualty. A recent study in the *British Medical Journal* within the past week looked at the appropriateness of referral to casualty and the accident and emergency physicians who would like to be saying they are getting the wrong patients presented in casualty. However, it was found that the appropriate patients are being referred to casualty. I would say in the majority of cases that is so in Ireland as well, but the problem is, because general practice is starting to fray at the edges, many of the issues that should be going to casualty could be dealt with in general practices where we had the resources. That is something that we can improve on.

The majority of premises are fit for purpose. Where investment is needed it should occur in conjunction with talking to the local general practitioner to ascertain whether he or she has the ability to invest or whatever. They are the practitioners based in their own community.

In regard to drug savings, much of the pricing of medicines is not in our control. It is dealt with between the pharmacy lobby, be it the pharmaceutical companies and the pharmacists, and the Department of Health. We see, as part of chronic care, that one can have integrated heath care models whereby one can ensure that there is more appropriate prescribing, but that is all part of chronic care regimes. For example, one has this in the United Kingdom. Moneys have been invested back into general practice in regard to savings where there is a recognition - this is something recognised by the troika - that there are incentives to ensure that general practitioners are willing to meet the workload. As was stated earlier, we only have a ten minute consultation and at times that is reducing, and there is an insatiable appetite for health care. We can provide so much in a consultation but we must ensure that we prioritise what is most appropriate at the time and within our resources.

In regard to mental health, there is a pilot in the United Kingdom in regard to general practice being a more engaged area of mental health. It is something that we are not averse to. All of those prescriptions are still coming from the general practitioner and much of the reviews, physically, are coming from the general practitioner, but what we would like is a more integrated chronic care model to ensure that we can improve on that. Whatever we are doing, we can do better but we need more resources for it. I will ask Dr. Duffy to come in here.

Dr. Ilona Duffy: Deputy McLellan mentioned the check-ups. I suppose check-ups were one of the matters that were part of the contract for those aged under six. There is very little evidence to support the view that they will help. The big issue we must be careful of is that we do not end up filling up the time-slots and the face-to-face GP and patient time with box-ticking exercises. That, to an extent, is what has happened in the United Kingdom where one cannot be seen with a sore throat but one's baby will be seen in order to have its weight and length measured. We cannot let it happen there. We also have all of that work being done in the public health system through the public health nurses and through the public health doctors. At present, that is the least of our worries.

Bottlenecks, the congestion the Deputy mentioned and diagnostics are huge issues around the country. We are seeing difficulties in access to diagnostics. With simple diagnostics, such as ultrasound, where a general practitioner has somebody with tummy pain and wants to check whether the patient has gallstones, one cannot merely refer the patient in many areas of the country to get an ultrasound done. The patient must be referred to a surgical clinic. In many areas, the patient may wait nine to 12 months to get to that clinic when all he or she needs is

an ultrasound for the general practitioner to make the diagnosis and then, appropriately, send the patient to see whether he or she needs surgery done. We are clogging up the system by not letting us have access to those systems.

As to why GPs are leaving, it is, as Dr. Walley stated, about stability and security. That is what they are not being provided with in Ireland at present. The impact of that is already hitting. I work in Monaghan where two GP practices have GP partners about to go on maternity leave - one in July and one in August. One of the practices is a two-doctor practice and that means it will lose a doctor. The other is a six-doctor practice and it will lose a doctor. They cannot find a doctor to do the maternity cover in those practices. Already, they are saying that they cannot tell the doctor she cannot take maternity leave. The doctors will go on maternity leave. What they will have to do is reduce access of service to patients. It will mean, especially in the case of the two-doctor practice, that they will be down to half-doctor time and that is not sustainable in the long term. This is the first time we are seeing this hitting home. Up until now, it has been that GPs merely have not taken holidays because they cannot get somebody to replace them but now, when we are seeing instances of maternity leave and sick leave, what is going to happen and where is that going to lead to?

I understand completely where Senator van Turnhout is coming from on out-of-hours cover and continuity, but, as Dr. Walley stated, we must get to a stage where it is safe for GPs to be working day time and night time, and we cannot have them doing both. My dad was a GP and I grew up with him working through the night, etc.

Senator Jillian van Turnhout: I do not expect both. I was referring to their statement of what GPs provide.

Dr. Ilona Duffy: We provide the out-of-hours cover. The position has improved. The big improvement with the out-of-hours services being more organised now is that it is GPs providing the service. It is not merely locum agencies, where it is hospital doctors or doctors flying in from abroad to do weekend sessions, which is what is happening in the United Kingdom. In the United Kingdom, one does not know whether one is seeing a GP; one is seeing a doctor. There is a huge difference between a parent with a sick child seeing a doctor who specialises in obstetrics and gynaecology, and them seeing a GP who recognises a sore throat and realises the child does not need to be admitted for intravenous antibiotics.

It is important that we develop and protect the out-of-hours cover. However, we are struggling with that. As the day-time work becomes busier and GPs are having to work longer and later, they are not in a position to do as many shifts. We are struggling with that.

Dr. Walley covered infrastructure. On the 97% satisfaction rate, one of the big reasons we have that is we provide choice. One can choose who one's GP is here. If one lives in the United Kingdom, one does not have that same choice; one is allocated to a practice. I have a sister and a brother who have been in the United Kingdom and my sister was four months on a waiting list to get a GP practice. She was told the practice she must join, which was in her catchment area. However, they said that they did not have space on it yet and they would let her know when they do. Any time she got sick, she was told to go to accident and emergency. We do not want that to happen here. This is a big issue, be it one person with a medical card or a private patient. Patients must have the ability to move around and choose a GP who is to one's liking and with whom one gets on.

Senator Colm Burke raised the cost of health care and the medication. Professor Michael

Barry, who is professor of pharmacoeconomics in Trinity, has been working on the preferred drug prescribing scheme with the HSE. One of his tasks has been to go around the country. One of my roles is in medical education for the GPs, as Dr. Walley mentioned already. Professor Barry has been all over the country meeting GPs, talking about this and asking how can we get drug costs down. It is clear that we have a finite budget. We are aware of that. New developments and new medication are always more expensive. If we can save money in medications that are coming off patent and will become generic drugs, that is all to our benefit because it will mean we can have more drugs for the cancer patients, MS patients, etc. The difficult is, as the Senator stated, that prices have been arranged, and that needs to be looked at. Why can one go to Spain and get six months' supply of medication for the same cost as a month's here? Why can my patients in Monaghan ask me to give them a prescription so that they can go across the Border rather than buying it here? That needs to be addressed. However, GPs are wholeheartedly engaging in that and have been meeting with Professor Barry to look at it throughout the country.

Hospitals must become responsible with prescribing. We all are fully aware that there is one particular stomach tablet that is prescribed by most of the hospitals, and there are reasons for that. However, that means every time one refers a patient he or she comes home with one brand of medication only. It is difficult for us in the community to try breaking that, yet it has cost implications.

Finally, in response to Deputy Neville, mental health takes time. We are the first port of call for many patients. We conducted a study in our practice to look at how many patients who were on antidepressants were attending psychiatry as well and 80% of those on antidepressants in our practice only see us. We are managing them. One of the reasons that has improved for us, and why we are able to hold on to those patients and look after them, was the introduction of primary care access to psychology services. Something that started out as a fantastic resource for us, now has a waiting list of 15 months. That is happening because of cuts and moratoriums on the hiring or rehiring of staff who are on leave, including sick leave. We now find that we cannot get access to those services which we know will work to help the patient and also help us to manage them in a primary care setting.

Dr. Ray Walley: We also need to learn lessons from the United Kingdom where they have a nine-to-five contract. All their funding, 10% of the budget, goes to a nine-to-five contract. Ours goes to a 24-7 contract. In the UK the problem is that when general practitioners gave up the out of hours service, they lost control of the out of hours system so there was no continuity. As a result of that, two thirds of all out of hours consultations are done by people flying in to do shifts. We still have continuity care.

One of the findings from the Francis report in Mid Staffordshire Hospital about two years ago, was an estimate - the sad thing is that it is an estimate, because they cannot even be specific - that up to 1,500 people passed away in terrible, atrocious conditions where the care was substandard. As a result of that they brought in a system whereby one would have a named GP for everybody over 75. We still have a named GP system here, whereby matters come out to a specific GP. Even though we are getting a quarter to one fifth of the resources, the level of care we are providing is as good, but we want a modern contract.

A professor of general practice recently came from the UK to take up a job in Cork. He complimented without qualification the general practice in this country because the strength of it is the personalised continuity of care. It needs to be resourced, however, or else we will lose it. The young will not take the abuse that other doctors have had over the years. They will walk

away and will not stay.

Vice Chairman: May I ask what Dr. Walley means by "abuse"?

Dr. Ray Walley: The lack of resourcing, the abuse within the service and the fact that we are being expected to provide a service without the necessary resources. The service needs to be resourced at the appropriate level. We need a modern day contract, not one that is 40 years old. We need appropriate engagement to do that, which involves scoping and appropriate assessment in regard to the use of statistics. The statistics we are using are different from those used by the Department of Health. For example, one of the studies they are using states that when one gets a free card, one will only make one extra visit. Give me a break. If it was not so serious it would be laughable.

Vice Chairman: Dr. Walley is making the point that the Department of Health is using statistics to say that if one has a GP card, one will only make one visit.

Dr. Ray Walley: Yes.

Vice Chairman: Is Dr. Walley saying he has different statistics?

Dr. Ray Walley: The statistics we have are based on a study and are identical to the statistics in Northern Ireland and identical to QResearch's in the UK. However, they are researched based on looking at computer databases that exist in general practice surgeries. The majority of general practitioners in this country are computerised and their statistics are identical to those of QResearch in the UK. They show that if one ends up having free provision of care at the point of delivery, people will understandably want to access the general practitioner. As a result of that, one can have a capacity problem depending on what group of people will be coming. They may be young, fit and healthy but scarce resources mean that one will not have the necessary resources to see the people who may require more health care provision.

Dr. Ilona Duffy: Although it must be said that, at all times, we welcome anything that will provide free GP care to all patients at the point of access. It is something we have agitated for and campaigned for over the years, but it must be done in a planned approach so that there are enough staff of all sorts, not only GPs but also practice and public health nurses. It is something we want because we want everybody to be able to come to us. We can do so much more and we know we can do it well because the evidence is there, but it must be planned and resourced.

Vice Chairman: Does Deputy Byrne want to come in?

Deputy Catherine Byrne: Yes. I do not know whether I have questions or comments, but I will make them anyway, although the witnesses may not like some of them. I am one of the 95% of patients who express a high satisfaction rating with their GP. I have been going to the same GP for the last 37 years, and I am not 37 so people can do the calculations. Since I moved house I have been with the same GP. I have been very satisfied with that GP and so have the rest of my family who attend him. I would give him 100%.

General practice does not always offer a same day service, so people may have to make an appointment. They do not turn up in their GP's practice, whether it is public or private, and have immediate access. I receive complaints from people who may have a sore throat or whose baby is unwell, but who are offered a doctor's appointment in three days time. I would not specifically agree with the statistics mentioned earlier.

Only 2% of the health budget is allocated to general practice. We cannot compare the UK to Ireland which is a smaller country with a smaller population. Some 60 million people live in Britain, so it is not practical to compare 2% of our budget to 9% of the UK's.

It was stated that doctors only get €10 per month for GP card patients. I am not sure how many medical card applicants GPs are allowed to have. Is it 100, 200, 300 or 600? I am not too sure. I would imagine the more one has, the more money one takes in. It is like any business. When more money is taken in, it is up to business people to allocate it to what they think is more important.

We should all remember that health in this country is dismal because people themselves make it dismal. There is no proper health promotion. People are being diagnosed with different things, particularly young people who are suffering from obesity. That needs to be identified and dealt with because that is where a young person's health begins.

From the time my children were born they had their dinner at the table. They never sat with a plate on their knees watching television. They were never allowed to bring their dinner to the bedroom. They always sat at the table. To this day, we still use that practice at home. In a busy working day, the only time a family can be together is at dinner time.

The way we use our resources makes us healthy. I grew up in a home where we had dinner at the dining table. It is very important but a lot of children do not grow up in homes like that now. Many children are eating much more fast food than ever before, so we should be promoting healthier eating. That would help to combat the rise in the number of people having to bring their children to GPs.

In recent weeks, while canvassing, I met a lady who was very critical of the Government and many aspects of the health service. She did say, however, that once one gets into the system, one is well looked after. I have to agree with that. It is because we have a wealth of expertise in accident and emergency units and elsewhere in the health system. That expertise also includes general practitioners. That lady told me she had been in hospital for a couple of weeks. Before she went into hospital she was on 40 tablets but she left the hospital only taking 20, having been analysed medically there. When writing prescriptions for their patients, GPs have a responsibility to try to limit the amount of medication. It is tough on older people with medical cards who have to pay a €2.50 prescription charge for each item. If doctors properly identified the required prescriptions, there would be no need for some people to be on the amount of medication they take. That point came across to me on the doorsteps when we were canvassing.

Why do young GPs leave the country? A fairly good friend of mine is leaving the country the week after next. He is going to work in Australia. He is a young doctor who has come through the system, but he is going away because he said his chances of ever being promoted in this country, particularly in the hospital ethos, are slim because of consultants. Consultants have things wrapped up for themselves in a nice tight little bow, and they do not want to encourage young doctors to get on. The young doctor said that if he goes away, there will be a great opportunity for him to climb the ladder more quickly. That is a sad reflection on us as a society. It is also a sad reflection on how our health service is run.

Can anybody tell me the average earnings of a GP? I have been trying to find this out for months but I cannot discover it. I am not too sure whether the witnesses can answer that question. I am bewildered by the whole episode. I would have loved if my children could have had medical cards when they were growing up, when they were under five years of age. In my view,

children need to see the doctor because they are frequently sick in the period from birth until they are in primary school. If the under-six GP medical card is introduced we must ensure it is used well because there is a need for it. I wonder why GPs are so much opposed to the scheme and I would like to hear the reason.

Senator Colm Burke: I wish to come back to the cost of drugs. In the entire period 2000-10, when the cost of drugs increased by more than 230% to 240%, no one flagged this increase, not the medical profession, nor the Department or politicians. Everyone gave the impression that this could continue forever. We are now trying to back-track on it. We have to work on this area. On the discussion about the prescribing of drugs in hospitals, I have met hospital doctors and they have advised me of their continuing concerns that patients are presenting in hospital who are on unnecessary medication, a situation which makes it more difficult for hospital doctors who are dealing with a more serious condition in many cases.

The issue of budgets keeps arising. I refer to the increase in the cost of drugs in the ten-year period. Are there other areas which have not been flagged and where savings could be made? I believe there are other issues about wasting of resources of which I am not aware but which general practitioners may know about. Could those resources be made available to the GP care to which the witnesses referred? We are all in this together. I agree with the percentage of the average spend on GP care being lower than in other EU countries. I acknowledge we need to do more but we need to start making savings in other areas in order to do that. Can we work together to identify and tackle the wastage?

Vice Chairman: Like Senator Burke I have a few questions about medical cards and prescribing patterns. Dr. Duffy referred to a road-show with regard to the move to educating GPs about prescribing generic medicines. The issue of medical cards has been to the fore in public discussion in recent months. I am acutely aware that the drugs budget and the medical card budget come from the one pot. I am concerned that people are being over-prescribed or where regular reviews of their medication are not being carried out. For example, my 92 year-old grandmother had two kitchen presses full of medication. I am not a doctor but I am not sure that her medication was ever reviewed. For a number of years we used to collect the two shopping bags full of medication. Is the IMO satisfied that the current policy of educating GPs about the prescribing of generic medication and medication in general is sufficient? Could we be doing more?

We attended a meeting in the PCRS, primary care reimbursement service, with Paddy Burke, last week. He indicated to us that GPs have the power to activate or re-activate medical cards. He told us categorically that there is a system in place whereby GPs can prolong the life of a medical card up to three months in emergency situations and where there are extenuating social circumstances, for up to one year. I ask the delegation to comment. People are coming to constituency offices in a panic. If that power and discretion is available to GPs, why is not being used?

Dr. Ray Walley: I will deal with the last question first. It is completely incorrect to say that we can re-ignite a medical card that has been cancelled.

Vice Chairman: I did not say that. I asked about extending a card.

Dr. Ray Walley: Senator Burke has said that. The IMO appeared before the health committee four years ago in March 2010. We spent a year and a half advising there was a problem with medical cards and we found it very difficult to get engagement but thankfully, the Oireachtas

committee invited us to come to a meeting. We had a 17-point plan much of which was applied and improved. The HSE-PCRS envisaged that we would replace them in registering medical card-holders. If we are doing their job we cannot do our own job. We are a scare resource. In the case of children, because we were finding that it was constraining us in immunising children as children in deprived areas were not being registered, we were able to register the child but we informed the HSE-PCRS that we would only do so with the minority of children rather than the majority because, ultimately, that is the role of the HSE-PCRS, the reason it exists and it is its job. We asked for certain other things, such as that there would be a responsible service for the homeless and more responsible provision of services for cognitively impaired persons.

I note that one of the promises - we will see if the promise is maintained - is that there will be possibly a named person to deal with a cognitively impaired person. That did not happen four years ago. If we are aware that somebody is being assessed we can certainly extend the medical card. Many of these people who are cognitively impaired are aged over 70 and they are on income assessments. We are not necessarily aware whether this is the case. However, our job is to address the position of the minority and the seriously compromised individual. It is not a small number as it is happening in the case of tens of thousands of people. We have asked that the HSE-PCRS err on the side of safety whereby it asks the GP - this formed part of our submission four years ago - whether there is any reason the person should not lose his or her medical card, having made its decision that the person should lose the card. However, they did not do that. There is no reason that this cannot be done.

We do not have the resources to monitor what the HSE-PCRS does. I returned from the UK in 1998. Sixteen years later, the difficulties with medical cards have not been resolved because ultimately, I am afraid, it is like trying to nail down a cat - one cannot get an answer as to what is happening. The system for registration of medical cards has always been flawed because it is not patient-centred. Those administering the system do not err on the side of safety. A number of years ago I had six patients who were cognitively impaired. I had to threaten to report them to the elder abuse officer because I was fed up with the fact that they were losing their cards. Unfortunately, that worked and those people were given extended medical cards.

Vice Chairman: Dr. Walley is saying that he was not in a position-----

Dr. Ray Walley: We are not necessarily aware of it.

Vice Chairman: If I may ask the question first, please. Those are very difficult cases which Dr. Walley describes. I agree that patient safety is of the utmost concern. Dr. Walley maintains he was not able to roll over those medical cards for three months.

Dr. Ray Walley: We are not necessarily aware that those patients' cards will be stopped. Therefore, as a result, we are not able to roll over the cards. Generally we find out-----

Vice Chairman: Is there is no system in place to inform doctors?

Dr. Ray Walley: We do not have the resources to monitor the HSE-PCRS computer, to know what they are doing. They are supposed to err on the side of safety and caution. Generally, we find out that a person has lost his or her card when it has happened. The system should be designed to inform doctors so that we can then extend the card. There is no fail-safe mechanism in place and such a policy in the system would make sense. However, the problem is we are not aware before a patient has lost the card.

Vice Chairman: There is no named liaison person.

Dr. Ray Walley: There are ten people assigned to the Oireachtas. We have asked repeatedly for a number of people to be assigned to general practitioners but this has been refused.

Dr. Illona Duffy: On the numbers involved, it is not the case that only a few medical cards are being removed from each general practitioner's list. Feedback from general practitioners nationwide indicates that between 8% and 10% of medical cards have been removed from the General Medical Services, GMS, list. This figure amounts to thousands of medical cards.

Vice Chairman: I would like to see the figures.

Dr. Illona Duffy: Approximately 10% of the medical cards on my list have been removed.

Vice Chairman: It would be interesting to have information on that issue as the figure cited by Dr. Duffy seems especially high.

Dr. Illona Duffy: Deputies and Senators must be aware of the issue from constituents calling to their doors. We are aware of it from our patients.

Senator Colm Burke: The 10% figure would correspond to a reduction of 190,000 medical cards. That has not occurred.

Dr. Illona Duffy: Large numbers of cards are being removed. While some of them are reinstated within a couple of months, the problem is that patients may not have a medical card for three or four months.

Senator Colm Burke: Let us be clear on this matter. The figure of 10% corresponds to 190,000 medical cards. It is not the case that 10% of medical cards have been withdrawn.

Dr. Illona Duffy: I am reporting to the joint committee the information that is being reported to us.

Senator Colm Burke: I ask Dr. Duffy to stop circulating incorrect information. As of 1 March 2014, there were 1,951,000 medical cards. It is totally inaccurate and untrue to claim that 10% of medical cards have been withdrawn. Dr. Duffy should stop alarming people unnecessarily.

Vice Chairman: Dr. Walley wishes to respond.

Dr. Ray Walley: There are certainly practices in more affluent areas where people have returned to the workforce and lost their medical cards. While the number involved is substantial, I cannot say whether the average corresponds with the figure cited because the only entity that has control of the relevant data is the primary care reimbursement service of the HSE. The PCRS has shown itself to be an opaque organisation when we seek data from it. While we want to engage-----

Senator Colm Burke: It is important to ensure members of the public are not fed incorrect information. It was alleged that 10% of medical cards had been withdrawn. This figure is incorrect. As of 1 March, 1,951,000 medical cards were in place and the number has increased by 12.5% since January 2011.

Dr. Illona Duffy: I am simply reporting the information that is being reported to us from general practitioners around the country. I hate to think the Senator is trying to imply that I am making up these figures. That is not the case as this is what we are seeing on the ground. This

is not about scoring points but about what is good for patients. Every day, patients are presenting - specifically elderly people who are not cognitively impaired - who would fill in and return forms if they knew their medical cards were due for renewal. That is the problem and it is one of the issues we are trying to highlight. We need to protect these patients, which is also what members are trying to do.

Vice Chairman: Senator Colm Burke is making the valid point that we do not want incorrect information to be imparted.

Dr. Illona Duffy: General practitioners also want accurate information. We need the correct data.

Vice Chairman: I appreciate that. However, the statement that approximately 10% of medical cards have been withdrawn is not true or borne out by the facts.

Dr. Illona Duffy: The Vice Chairman should not state it is not true. She should instead seek clarification in order that we all have open and transparent data.

Senator Colm Burke: I will provide clarification. The joint committee received figures showing that approximately 1,733,000 cards were in place on 1 January 2011 and as of 1 March 2014, this figure had increased to 1,951,000. These are accurate figures. In case there is any dispute, I fully accept that general practitioners have done a major job, far beyond the call of duty, in assisting people who seek to retain medical cards. When I contact GPs they are extremely helpful. They have fought cases hard and do a fantastic job. They should not have to do this work and I fully accept Dr. Duffy's comments in that regard.

Dr. Ray Walley: The Vice Chairman made an excellent suggestion. Four years ago, at a meeting in these committee rooms, we asked-----

Vice Chairman: That was before my time.

Dr. Ray Walley: The joint committee should use its good office and ask the PCRS, through its computer system, to inform general practitioners when someone loses a medical card on a short-term basis in order that we could take action for a three month period, during which the PCRS could reassess whether its decision was correct. This would help to ensure we have a more patient-centred and safe focus.

Vice Chairman: With the agreement of members, I suggest the joint committee write to Mr. Burke and make the point Dr. Walley raises.

Senator Colm Burke: It is a very important point. This should have been done.

Vice Chairman: I was struck by this issue when we met Mr. Burke. I thank Dr. Walley for his input on the issue, on which the joint committee will be happy to follow up.

Senator Colm Burke: At the meeting with the PCRS, we also asked that every person who submits an application for a medical card be given the right to designate a person to whom correspondence would be copied. This is especially necessary for elderly people.

Dr. Ray Walley: On a point of clarification, I work in the north inner city of Dublin, an area with significant literacy problems where there is still no system in place to help people with literacy difficulties. The nearest office to my practice is in Ballymun, which is not exactly a walk around the corner for people living on the North Strand or Amiens Street. There is no local

service to ensure that individuals with literacy problems can be supported. The same applies in respect of the cognitively impaired being able to nominate someone. Many of those who are cognitively impaired reside in nursing homes. These homes could be nominated as the entity to which correspondence would be sent. The only way to have a more patient-centred and safe approach would be to extend eligibility for a period of approximately three months during which the application could be reassessed to ensure the decision of the PCRS was correct.

Vice Chairman: Does Deputy Twomey wish to comment?

Deputy Liam Twomey: I was at a meeting on global taxation when I overheard some of the discussion. The primary care reimbursement service is not working as it should work. Senator Colm Burke indicated he had received figures from the PCRS, while Dr. Walley and Dr. Duffy stated they are seeing a reduction in the number of people with medical cards. There has been a significant reduction in the number of people who are obtaining medical cards. People applying for medical cards are being turned down or informed that information has been lost. They are constantly resubmitting information. My constituency office is scanning and photocopying every item of information being submitted to the primary care reimbursement scheme, yet material is still being lost by the PCRS.

Deputy Sandra McLellan: I agree.

Vice Chairman: We made all those points to Mr. Burke when we visited the PCRS office two weeks ago.

Deputy Liam Twomey: Comments have been made to the PCRS for some time. If the committee wishes to get involved in this issue, it should take a more robust approach. For example, members should visit the PCRS office regularly to ask why issues are not being addressed. I have been dealing with the primary care reimbursement scheme since it was established. The medical card process has become more chaotic for patients since it was centralised. The issue that arises is not how it affects doctors or politicians but how chaotic the process has become for patients. It verges on the ridiculous that 80 year old ladies with medical cards are being asked to produce P60 and P45 documents. Will they be required to submit copies of the deeds of their homes? The joint committee should take a more robust approach to the PCRS.

Senator Colm Burke: Another problem that arises is when comprehensive medical reports are submitted to the PCRS and it subsequently asks general practitioners to fill out additional forms. This practice is totally unfair on doctors who have enough to do.

Vice Chairman: I thank the witnesses for their informative and interactive presentation.

The joint committee adjourned at 6.40 p.m. until 9.30 a.m. on Thursday, 29 May 2014.