IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Solving the Chronic Disease Problem

through General Practice

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The role of the IMO is to represent doctors in Ireland and to provide them with all relevant services.

It is committed to the development of a caring, efficient and effective Health Service.

Introduction

Dr Padraig McGarry

Ireland is facing a very predicable health challenge over the coming years. As our population ages there will be an exponential rise in the incidence of Chronic Disease and it is imperative that we radically reform the manner in which we deliver services to those suffering from Chronic Disease.

For many decades the proportion of the Irish population that was over the age of 65 remained static but this has now begun to change and the pace of that change will accelerate rapidly in the years ahead. In simple terms an additional 20,000 people each year will reach the age of 65 and as life expectancy increases the number of those over 80 will double. Unfortunately, as we age health issues arise and the challenge for us as a society is to manage those health issues so as to allow citizens to lead quality lives which are well supported by the health system.

Healthcare costs money but as doctors we want to see that money spent in a way that best benefits our patients. The IMO is proposing a solution to the problem of Chronic Disease and our ageing population that will improve the patient experience, improve outcomes and deliver services in a more cost effective manner.

The current model for managing Chronic Disease is fragmented and is focused on the acute hospital system, a system which is overburdened and underfunded with 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.

There is a better way and the solution is through General Practice. General Practice is currently under resourced following many years of cuts and unless we do something now to build up capacity, infrastructure and services we will not have the much valued GP system we currently cherish. All politicians, commentators and economists have acknowledged that care is best delivered in a setting closest to the patient and the appropriate setting is General Practice, with the support of community health professionals. Just saying this is not enough, we must invest in and resource GPs to deliver a modern GP service to patients in Ireland.

We can solve the problem of Chronic Disease through General Practice but we need commitment and investment to do so. It is not acceptable to stand idly by in the knowledge that doing nothing gives tacit support to a health system which fails to deliver optimum care to patients and maintains the status quo will eventually bankrupt the country.

Yet, we continue to follow failed policies, ignore medical evidence and decimate our public health services.

We can and must do better.

Dr Padraig McGarry

Chair
National GP Committee
Irish Medical Organisation

Presentations

An Overview of Ireland's Healthcare need. The next 25 years...

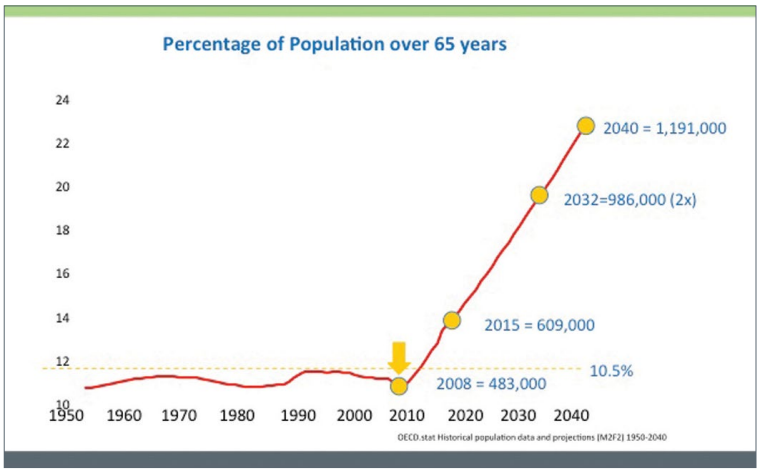
Dr Austin Byrne

Dr Austin Byrne

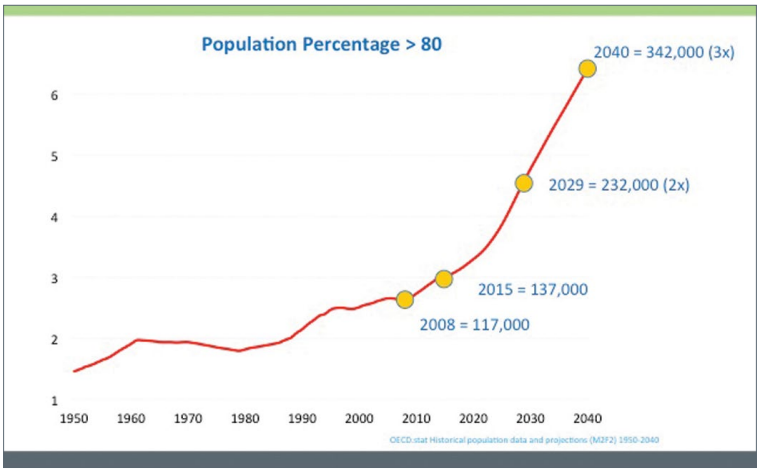
Dr Austin Byrne is a partner in Tramore Medical Clinic, a three doctor modern GP practice in Tramore, Co Waterford. He is a member of the IMO GP committee.

Originally from Dublin, he graduated from Trinity College Dublin in 2003. He completed his medical membership exams in 2006 and graduated from the South East GP training programme in 2010. He is involved in undergraduate medical training.

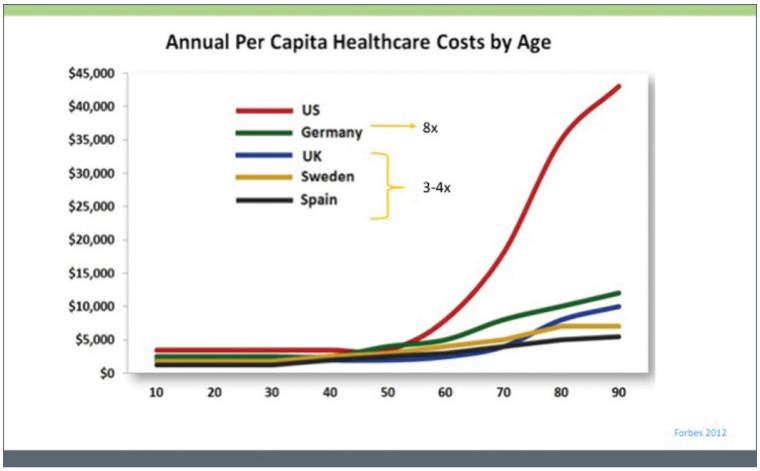
He lives with his wife and three daughters in Tramore and enjoys building sandcastles and flying aircraft.



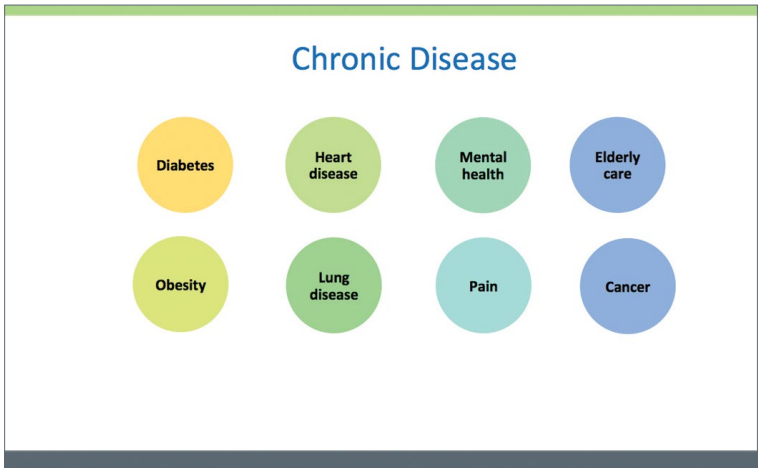
- The above graph shows Ireland's over 65s as a percentage of the whole population since 1950.
- Over 65s have always made up only 10-11% of the total population. Unique internationally
- This balanced the number of older, sicker people relative to younger, working age, average healthier people.
- In 2008 there began a sudden transition and in just over 20 years, the number of people over 65 will have more than doubled as approximately 20,000 older people are added to our population year on year.
- **We will go from 1 in 10 to 1 in 5 of our population being aged 65 or over.** Shortly beyond 2040 we will have 1 in 4 over 65.
- The year after this rise began, 2009 saw the peak of Irish healthcare spending. Since then we have been facing unprecedented cuts in health spending.
- Our older people also live longer than ever before and as we see more of these **old and especially the older old** we see a vast change in the need for healthcare. We see a massive demand in providing for chronic disease management.
- **Without resourced, GP led, chronic disease management our overwhelmed hospital system will fail completely in the very near future.**



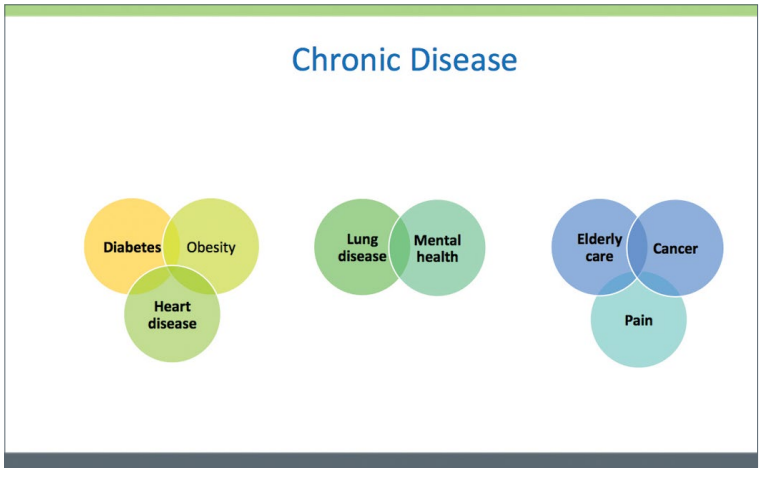
- We see the same sort of dynamic in the over 80s with a doubling time for the population of 20 years.
- While the absolute numbers are smaller when compared with over 65s, the over 80s treble by 2040 compared to the 2008 reference point.
- The age profile of the population matters hugely to the healthcare system as there is a year on year increase in healthcare expenditure per person as they age due to increased health needs.



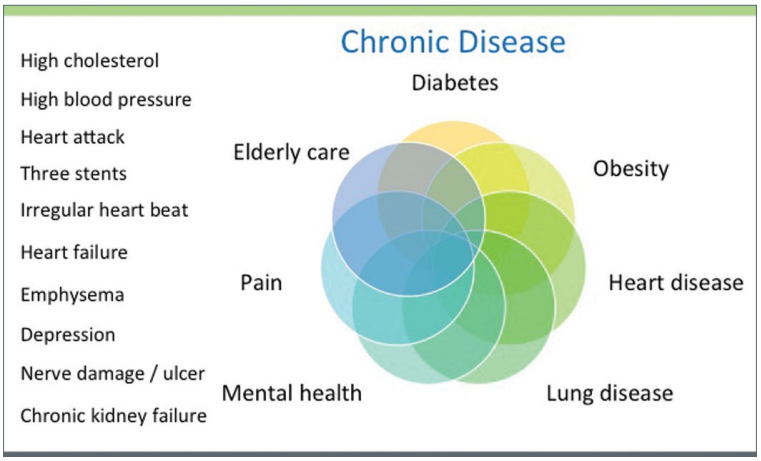
- The above slide shows the increased healthcare costs associated with increased age.
- What aging populations mean in reality is: higher doctor attendances, higher hospital admission rates, higher medicines costs and ultimately a dramatically higher overall healthcare bill.
- The above graph was published in Forbes in 2012 and makes two points really well:
  1) As we age it gets far more expensive to care for us.
  2) The Americans do care for the elderly the really expensive way with an 800% rise from age 40-80.
- The higher cost per capita in the U.S. is a direct result of **fragmentation of healthcare**.
- In the USA, patients' various illnesses are divided up and sub-contracted to various providers **with the focus removed from general practice**. This insurance based system rewards activity, medicalising patients and rewards busy providers.
- **We desperately need to avoid the fragmented US model** and implement chronic care delivered largely by the GP and subcontracted out briefly, in a measured and controlled manner to specialist centres.



- Chronic Disease is the driver of the increased cost associated with ageing patients
- A chronic disease is one lasting three months or more. Chronic diseases are diseases that generally cannot be cured by medication or prevented by vaccines.
- Most are preventable or the risk of developing them is dramatically reduced by preventative interventions such as lifestyle or dietary modifications.
- Prevention saves illness, suffering and resulting healthcare costs.
- Management reduces the rate of deterioration and further episodes of illness, it reduces the suffering and the economic cost.
- Preventative management is the only way to lower the cost of chronic disease yet many of these conditions are not adequately managed.
- There is no capacity in the hospital sector with overbooked clinics and GPs are not resourced or contracted to manage them in the community.



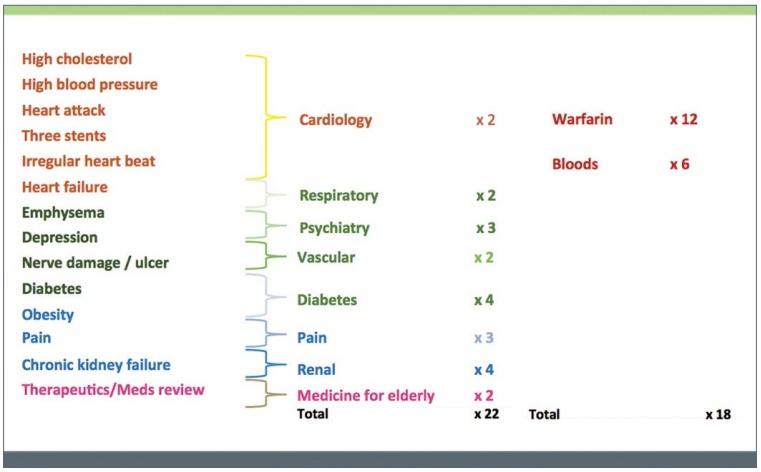
- The reality of chronic disease is that they tend to overlap. As patients age there are significant co-morbidities which present as per the above slide.
- For example a patient may suffer from obesity, diabetes and heart disease. This patient probably also has high blood pressure, high cholesterol and other illness present.



- Often we see such overlap that its hard to see where one disease starts and another stops. This is the land in which more than any other the GP is key.
- This is a worked example of a 68 year old gentleman with multiple chronic diseases. Dr Byrne has at least 300 patients with this degree of illness in his three doctor practice.

The patient has diabetes.

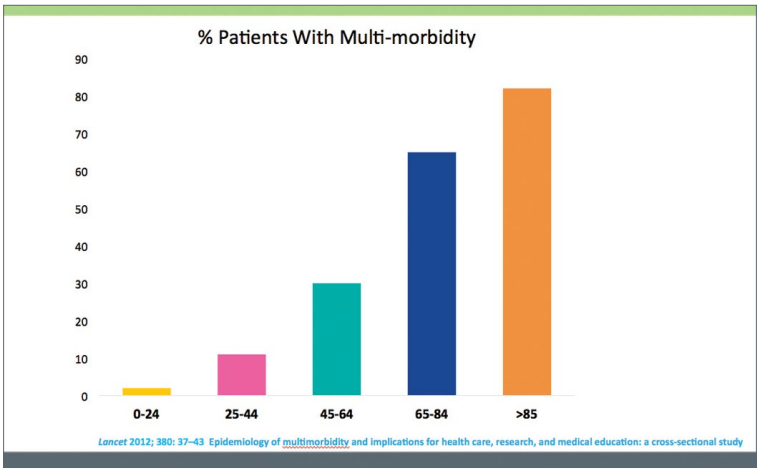
- Due to his diabetes and obesity he has high cholesterol and high blood pressure. This has led to heart disease, he now has three stents after a heart attack. He also has an irregular heart beat and needs life long blood thinners.
- He has borderline lung function or emphysema from smoking like many of his peers. His mental health is affected by depression, about 70% of people with this degree of chronic disease are so affected. He suffers chronic pain from worn out nerves from diabetes. He also has chronic kidney disease from his diabetes.
- So this man has huge care needs and sees Dr Byrne on average 18 times a year plus house calls. His care needs will increase into the future.
- He makes 18 visits a year at present, his care is not formally structured but is reactive and demand driven. Chronic disease is not covered by the medical card contract, and there is no structured programme for such patients to be treated in the community by their GP.



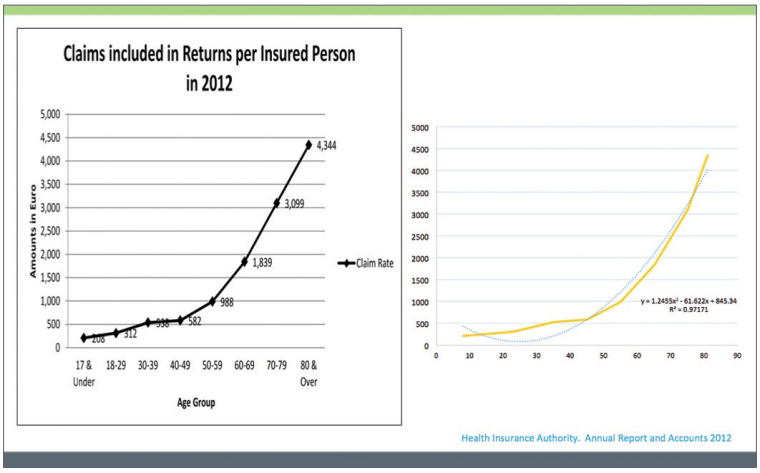
The above graph shows the patients diseases burdens on the left and his average number of required hospital visits in the middle.

Off to the right, he needs 12 warfarin checks a year and six additional sets of bloods.

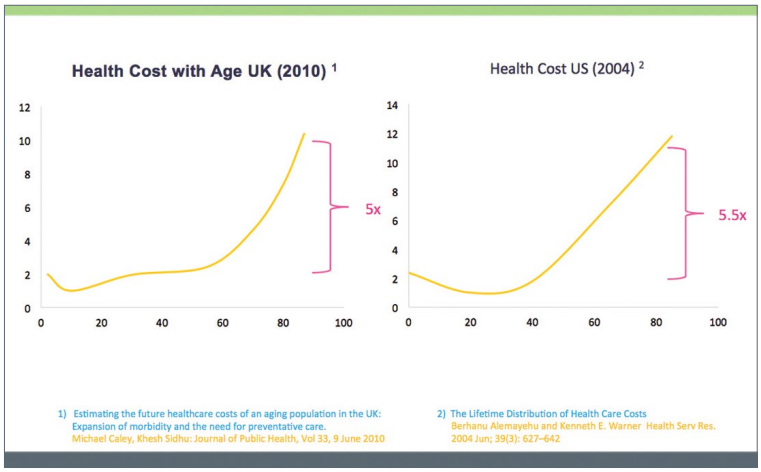
- OPD = €167 x 22 visits = €3,674 for OPD visits
- €900 for bloods
- He'll cost in excess of €6,000 per annum for hospitalisations per year on average, in reality it's likely twice this level for him.
- So we're looking at a conservative cost of €10,574 and then there's additional radiology costs and various extras.
- A GP is currently funded to €129 per annum to manage all his acute care needs. But we are not optimally managing henry.
- GPs are qualified and experienced to manage 95% of Henry's OPD needs but are not contracted or resourced to do so.
- Treatment in general practice could prevent over half of his hospital admissions and nearly all of his €4,574 worth of hospital OPD/blood visits. Treatment in a general practice setting could save €3,000 per annum on admissions and €3,000 on OPD. That's €6,000 in spend deferred.
- When this level of saving is extrapolated out across the increasing and aging population we see that managing chronic care in the general practice setting is the only way in which we can hope to combat the increased demand which the aging population will place on our healthcare system.



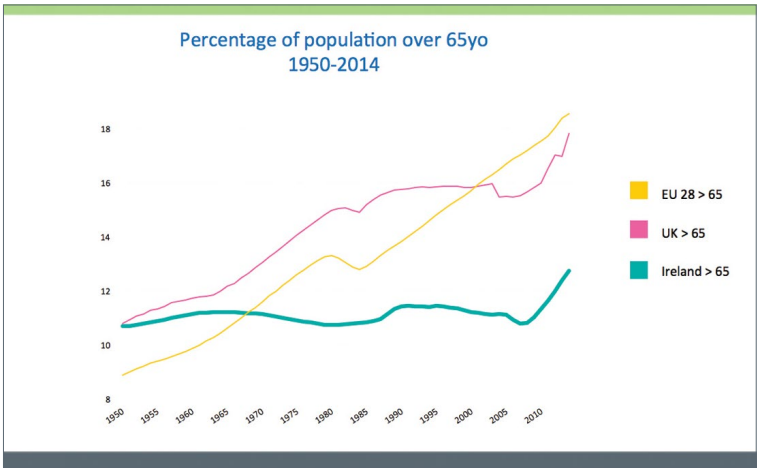
- This slide looks at rates of multi morbidity, two or more chronic diseases present by age group for example diabetes, heart failure, lung disease.
- Published in the lancet 2012, this is a comprehensive study of 1.75 million patients in Scotland.
- 42% of patients had one or more condition at any age.
- By age 50, half of the population had at least one morbidity, and by age 65 years 65% of patients have two or more significant chronic diseases
- The cost of providing healthcare needs relates directly to comorbidity,
- The main determinant of comorbidity is age.
- Social demographics can shift the age curve by 10-15 years from a chronic disease point of view, meaning we see the emergence of chronic diseases at earlier ages in deprived areas.



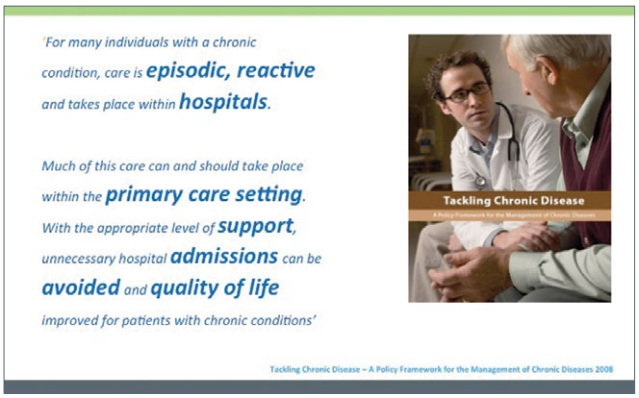
- Here is a graph from the Health Insurance Authority from 2012 looking at the cost of care with age via insurance claims data. (document states it may under-report the true cost by up to 20%)
- The left is the original. The right is the same with a simple model applied for ages > 40. We can calculate to within 3% the actual average cost for a patient over the age of 40 per annum.
- Again we see the same basic pattern of exponential rise in cost with age.
- In Ireland, care costs rise gradually for the first 40 years of life before taking off on an exponential rise from middle age onwards.
- From age 40, costs quadruple by age 65, are 5-fold higher at 70 and 8-fold by age 80.
- This is Irish data from fragmented, specialist delivered care.
- It shows the same pattern of increase as the US trend, an 8-fold increase from age 40 to 80.
- Ireland cannot afford to allow this model of care to become the future



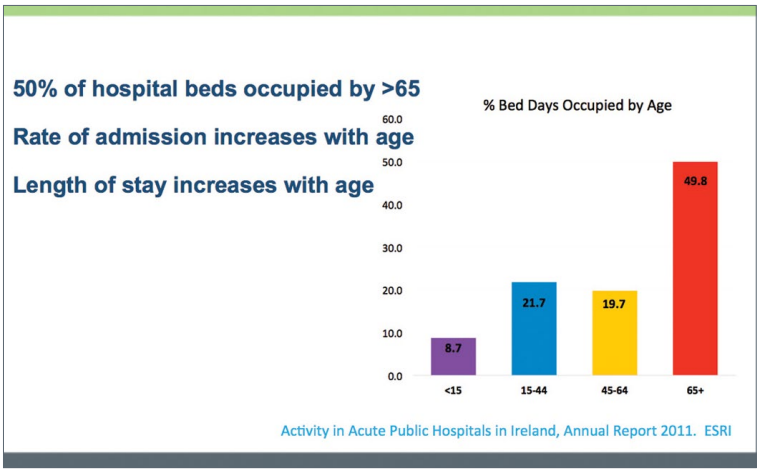
- We see the same pattern everywhere: be it private or public system.



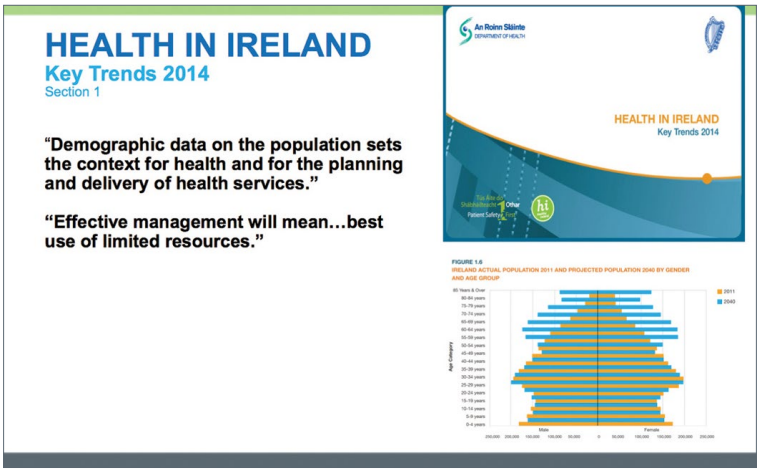
- Caring for an aging population is nothing new. It has happened all over Europe. But Ireland is fundamentally different, let's see how.
- Here's the first slide again, this time cut short at 2015 and with UK and Europe overlaid. Ireland is in green on the bottom.
- This time we're looking backwards and can see the stability of our older age.
- We've trundled along at 10.5% or less of population aged 65 or over.
- We still struggle to deal with these older people today as patients. These are the main contributors to the population of so called "bed blockers".
- You'll notice our nearest neighbours the UK in red started their transition back in the 1950s and their elderly population slowly grew to current levels of 18%. They have had 65 years to evolve elderly and chronic care services.
- This is the main reason Ireland is not at the ready. The demand simply didn't rise anywhere near as rapidly pre-2008. We have a health service that has always behaved in a reactive manner, deciding which problem to solve as it occurs, rather than having a long term population based health care strategy.
- Successive governments have failed to prepare for our demographic shift.



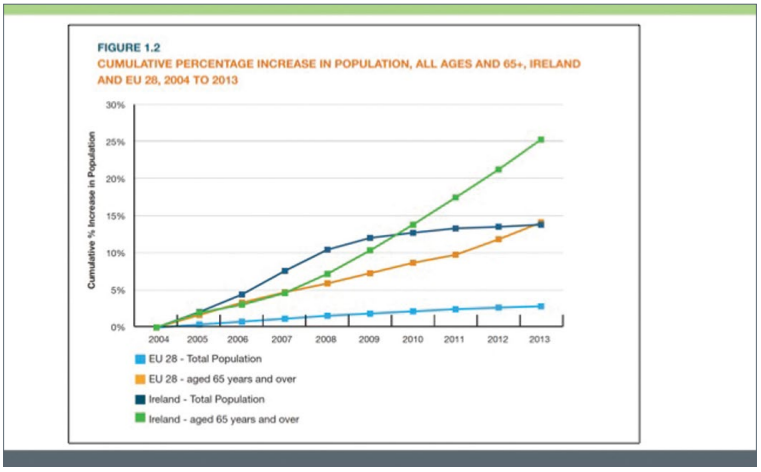
- Our pattern of reactive behaviour has long been acknowledged.
- This is an excerpt from the Chronic Disease Management Framework of 2004.
- The problem is seen and reports are written but no actual change has taken place.
- The current medical card contract still does not cover chronic disease and GPs are not resourced to provide such care.
- This leads to increased pressures and demands on the secondary care system and has a huge effect on bed capacity.

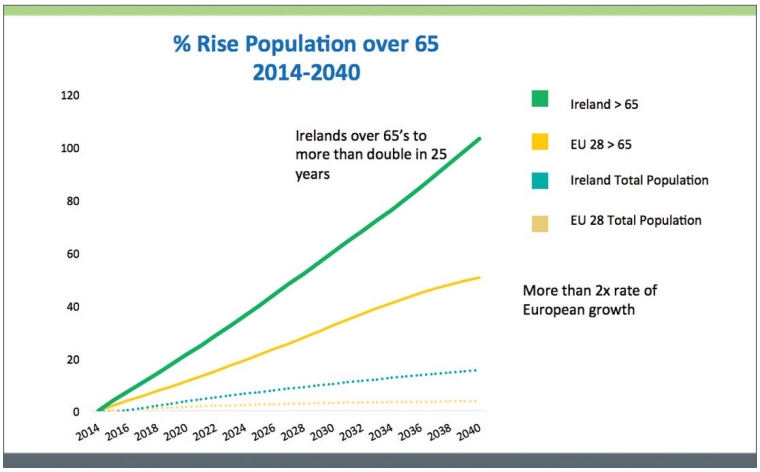


- Hospital beds are largely a fixed capacity situation.
- When demand exceeds supply, the first indicator is trolleys backing up in A&Es.
- A&E trolleys are there not because A&E can't see patients fast enough, they are there because patients need to advance to ward level.
- We know that in 2011 50% of beds were occupied by the over 65s.
- 10% of the population therefore use 50% of the beds.
- Bearing in mind 20% of bed capacity is day case beds, the actual occupancy rates by age in acute care beds are even higher.
- Currently, bed blockers, as they are known, occupy 5% of beds or so, down from near 10% in recent years. In other words, this is mostly an age related demand and not a nursing home in the hospital type situation any more.
- We had 800 beds blocked, now we have 500, those 300 freed beds have allowed us to tread water for a year, but elective surgery lists have grown. We have in fact fallen behind despite this freeing of capacity.
- We clearly need well in excess of an additional 400 beds a year to stay static. The problem is that this applies year on year for the next 25 years.
- The current system is not sustainable.

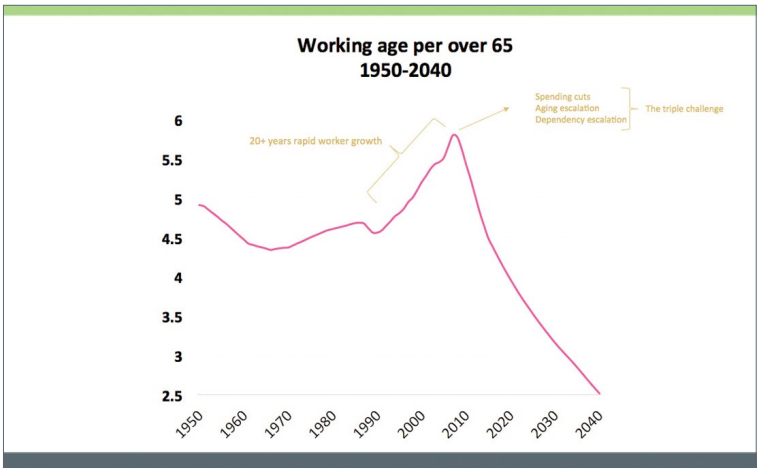


- The challenge of caring for an aging population has long been recognised by the Department of Health.
- In its Health in Ireland document 2014, the first line of section one starts with the above quote.
- In fact the 2013 document has the same cover and starts with the same line. That's not said in criticism, the content is really excellent and should be reiterated.
  - 2012 – same line, same page
  - 2011 – same line, same page
  - 2010 "Demographic data on the population sets the context for health and for the planning and delivery of health services."
- But yet we are not acting.
- It's all too easy to gloss over the details by looking at population pyramids and the document goes on to give a relative account of aging in quite an astute fashion. However they have not projected beyond 2015 yet.



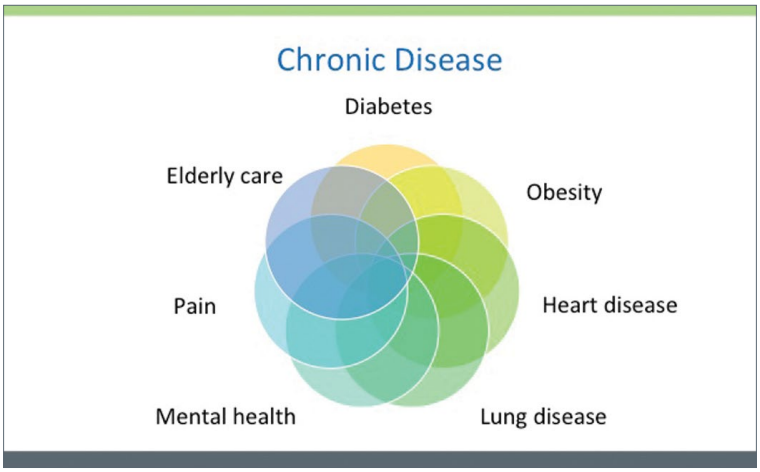


- So let's look forward from 2014 at European population trends.
- Population over the age of 65 will double in the next 25 years.
- This is really serious. Think of where the main backlogs are in the health system today Orthopaedic waiting lists, cataract operation lists, so called prolonged stay patients or bed blockers, patients on trolleys. Patients with frequent admissions. These are extensively populated from the over 65 group.
- **We are facing a health crisis of unprecedented magnitude in the years to come**. This crisis is somewhat similar to the looming pension time bomb we keep hearing about in that its driver is mainly population aging. This dwarfs the pension issue however and will ultimately cost the taxpayer more and result in huge patient suffering.
- **Unlike pension shortfalls, the looming healthcare shortage will affect citizens of all ages in the public health system in much the same way.**
- Younger, working age individuals will have increased need to derive benefit from PHI due to increased levels of in-access in the public system. **The private public divide will shortly become even more age based further widening the gap.**
- If we fail to realise and act upon this challenge we will have no excuses for our inaction. This change has been recognised for years now but has not been acted upon by decision makers. We have failed for several decades now to make the necessary structural and funding alterations to deal with the impending demographic change.

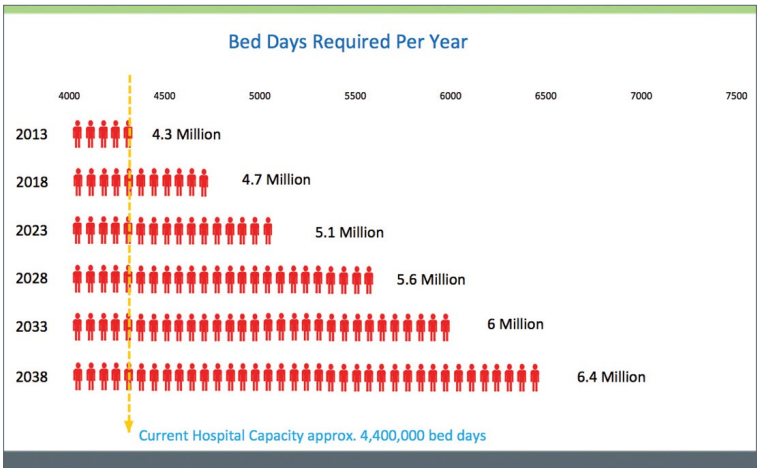


- This chart looks at the number of workers for every non worker over the age of 65.
- We really had an easy time in healthcare funding for the last two decades. Until 2008, for 20 years, we experienced a rapid growth in the ratio of younger working individuals to older dependants. During this time the over 65s remained static.
- We then went from 4.5 to almost 6 workers per older dependant person. A rise of 30% in the number of contributors towards heathcare costs.
- You'll notice a **peak in 2008** when we near 6 people working and contributing taxes for every older resident in the state.
- **By 2035 we will have under half as many tax payers per older person than we do at present.**
- The burden of heathcare taxation per working age individual taken from general taxation will double. This is before health inflation.
- At present we spend on average **€3,000 per person** annually on healthcare. That's €3,000 per year for each our **4.6 million population**. As discussed the amount spent varies greatly with age. That money all comes from **direct taxation**. So we need workers to support our health service.

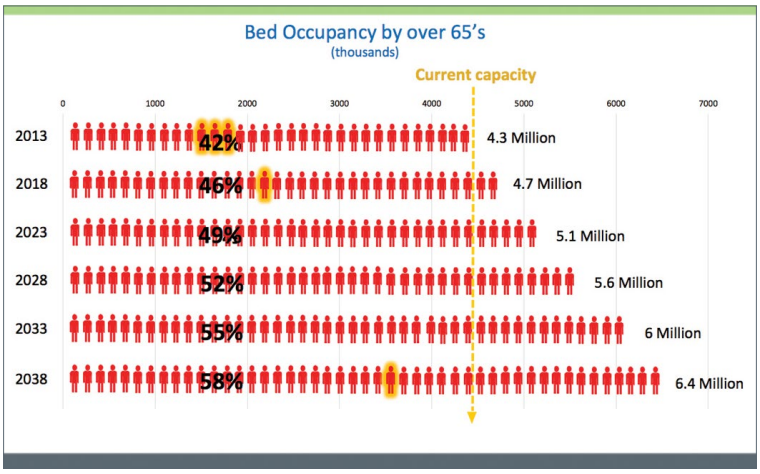
This is if we stick with current modes of care. We cannot afford not to change.



- Our 68 year old man from the start of this presentation attends 18 times per year. He attends for blood pressure checks, disease surveillance, mental health care, respiratory tract infections.
- He's on medication for blood thinning, cholesterol, three blood pressure meds, and an anti depressant as well as a prostate relaxer. He doesn't need a huge degree of resource to tie this all together with structured care protocols.
- He is currently been treated reactively.
- We need to start structuring his care and proactively meeting his care needs in the community rather than hospital setting.
- His hospital cost would be greatly reduced we've seen, by well over €6,000 per annum.
- He is on 11 medications in total, dispensed monthly. And gets an additional 20 issues of one off medications for various infections and aches.
- He gets his medications from 12 repeat prescriptions that require monthly processing and five phone consultations per annum. He receives two home visits.
- At present this GPs are funded €129 per annum or €10.75 per month for this patient.
- The GP is not resourced nor contracted to cover the patient's chronic care needs.
- Instead this ends up being done, more expensively, in a combination of settings but mainly the secondary or hospital setting.
- Just like the US system, where care costs several times what it should. We need change.



- We currently have about 4.4 million bed days in the system. Or 12,000 beds including day wards.
- We are over capacity with 97% bed occupancy at any one time and lists of patients who cannot access the system.
- Bear in mind we have hugely increased the number of day case procedures in recent years to the point where we are really efficient with hospital procedures and bed turnover.
- For the past decade, rather than finding beds, we have been finding ways of extracting the maximum possible efficiency from the beds we have. Now we've done that there are only two options:
- We can either provide more beds or avert their use in the first instance by funding out of hospital care to prevent admissions and manage pre admission situations.
- A bed is more than a bed. Each clutch of beds needs doctors, nurses, porters, administration, meals and more. Each bed is a significant cost.
- If we continue refusing to manage disease in the community we will need an extra 90,000 bed days per year or about 250 beds per year.
- In order to address this problem we must free up capacity in the hospital system by resourcing general practice to deal with patients with chronic care needs.



The Evidence for Improving the Irish 'Healthcare Value Curve' Supports resourcing General Practice.

Dr William Behan

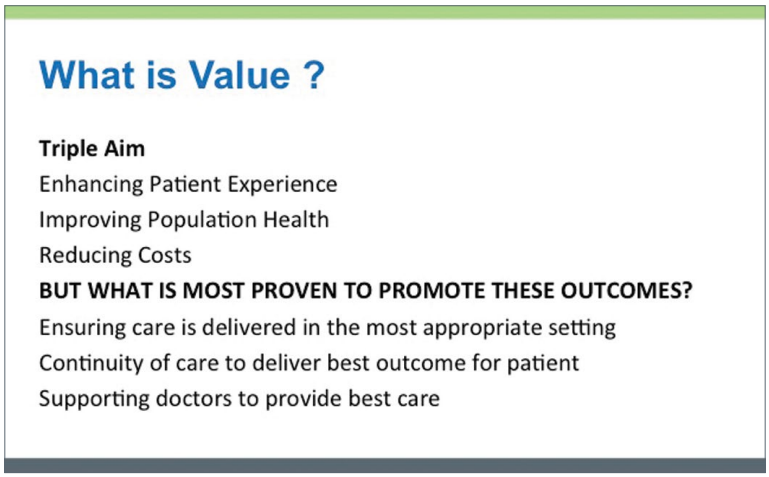
Dr William Behan

William Behan qualified from the Royal College of Surgeons and completed the South Eastern GP Training Scheme in 2008. He spent a year in Australia working as a GP and an Emergency Department Registrar before he returned to Dublin where he has been working as a GP ever since. He is a principal in a two partner practice in Dublin 12 for the last 15 years, was the local GP representative on the HSE Primary Care Team Implementation Group since its inception and is now a trainer on the TCD/HSE Specialist Training Programme in General Practice for the last three years.

Dr Behan's comments on health policy have been published by the online versions of the British Medical Journal and New England Journal of Medicine. In 2015, he was a key note speaker at the European Vasco Da Gama meeting hosted by the Irish College of General Practitioners.

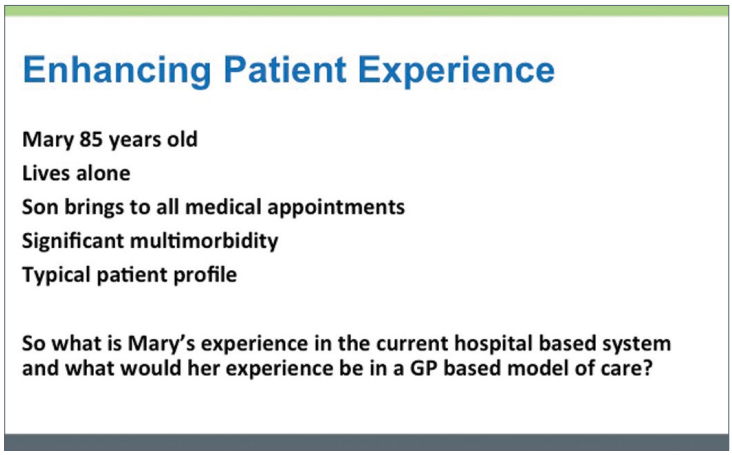
Economists refer to influences that effect healthcare costs as "bending the healthcare cost curve".

This presentation is an analysis of how, if certain policies are implemented, we can bend the healthcare curve and reduce costs while at the same time increase health outcomes and patient experiences.

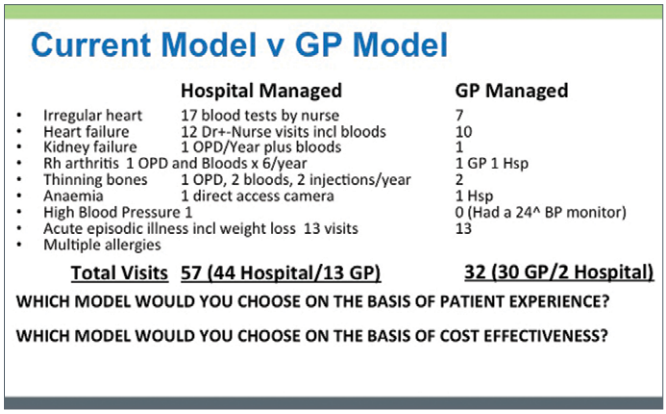


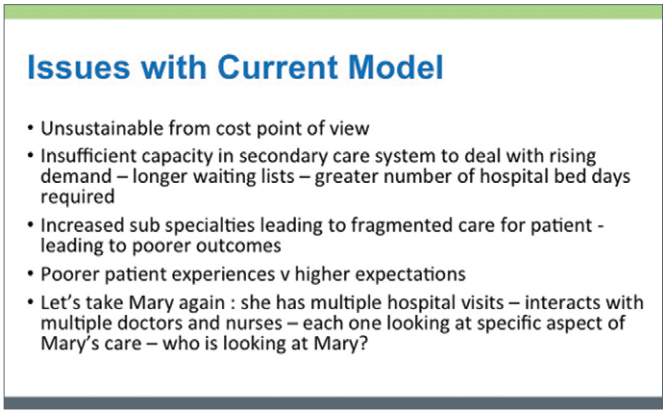
In fundamental economic terms the cost is what it takes to deliver the service, the value in healthcare is however more complex. In assessing Value in Healthcare there are a number of factors that need to be taken into account including patient experience, population health outcomes and costs.

We have in Ireland too many examples of decisions made that may reduce costs in the short term but do not provide value in the immediate, medium or long term. In terms of looking at value in healthcare we must consider where care is delivered, continuity of care and how best to support doctors and other health professionals to deliver that care.



Mary is a real patient but this is not her real name. Mary is typical of many elderly patients who either live alone or rely upon a relative to attend with them to hospital or GP appointments. She is also typical of the patient profile of this age cohort and suffers from significant multi morbidity. Under the current system Mary's problems are in fact exacerbated and she is effectively forced to engage with too many health specialists, too many hospital visits and finds this a burden on both herself and her son. On the face of it this may seem that Mary is getting the best care, but that is not the case and Mary's care can be compromised in such a system.

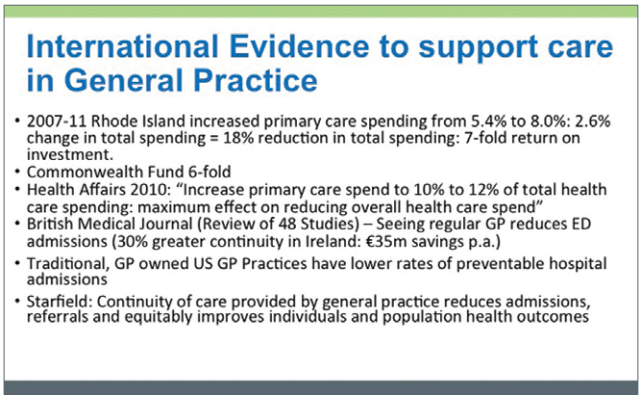


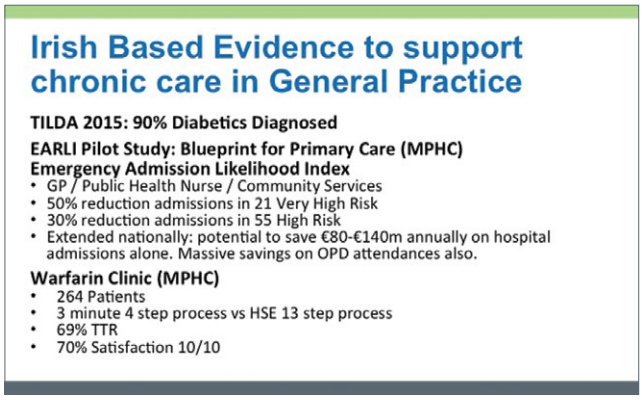


Let us examine Mary's experience under the current model and what might be her experience under a GP Chronic Care Management System. It is not that Mary will never require hospital care under a GP managed model, but the number of visits can be significantly reduced thus reducing the burden on Mary, her son and indeed on the hospital.

Mary will be treated by her primary carer – the GP and will not be subjected to fragmented care. This can only enhance Mary's patient experience of the health service, give her more confidence, manage her health better and as far as the State's responsibility for the provision of healthcare the GP system will cost less.

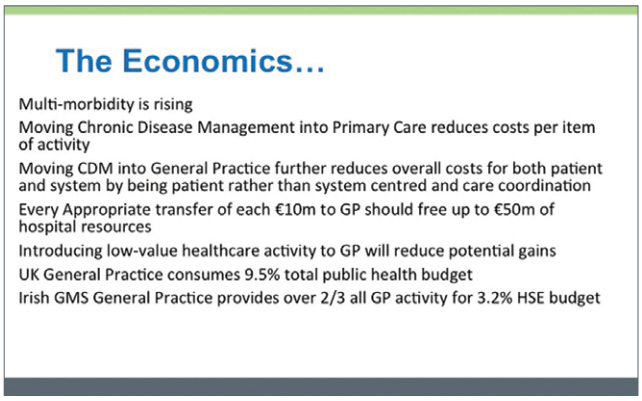
There are significant problems with the current system including unsustainable rising costs, insufficient capacity in terms of outpatient waiting times and beds for admission, fragmented care leading to poorer outcomes. This is not patient centred care.

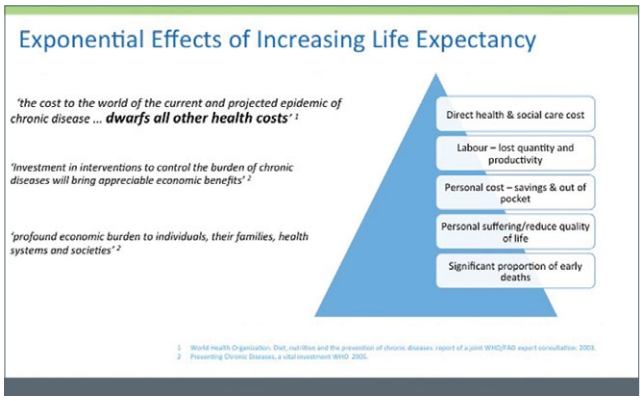




The international and Irish research evidence points to a number of facts:

- Continuity of care at GP level improves individual and population health outcomes – reduces admissions and referrals to hospitals.
- Investment in General Practice yields a 7-fold return.
- Increasing spend in General Practice to 10%-12% of total health care spending would result in the maximum effect on reducing overall healthcare spend.
- Corporate style practices increase spend and increase unnecessary admissions, referrals and costs despite on paper appearing to perform better than traditional, GP owned practices.
- Capacity in hospital system is improved with ease of burden from ED to outpatients to bed days required. This will lead to more patients being treated in appropriate settings and in a timely manner. It will follow that equity and access will improve.

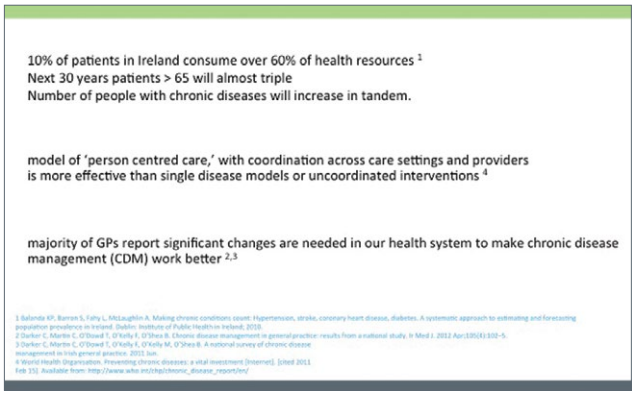


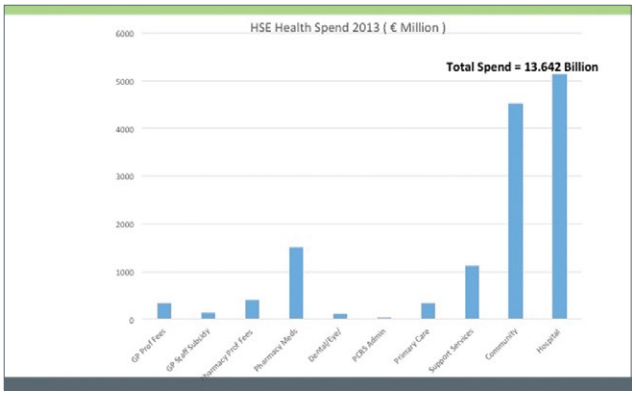


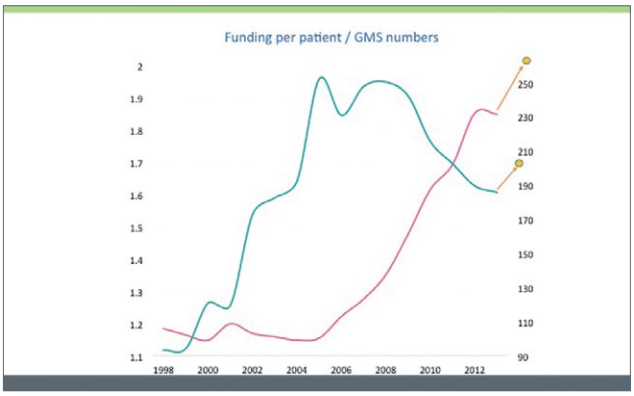
The economics of our changing demographics and the incidence of chronic disease are stark. We can reduce the economic curve which is predicted by the World Health Organisation to "dwarf all other health costs". In terms of the economics of healthcare we must focus our resources and investment in areas of high value – low value healthcare spending will reduce any potential gains we can make. This will require a significant change in policy which should focus on what the evidence tells us – increased ageing population, longer life expectancy and the challenges of multiple chronic care. There is of course a need for preventative measures which can again be best managed in General Practice in terms of structured programmes for Chronic Care with the aim to stabilise patients, thus reducing need for more invasive and expensive care into the future.

The World Health Organisation states that "investment in interventions to control the burden of chronic disease will bring appreciable economic benefits". To achieve such benefits we must act now. Our current economic model of allocating the lowest amount to General Practice in our healthcare spend does not make economic sense. If we increase the investment in General Practice we know that for every €10 million investment there will be a consequential freeing up of up to €50 million in the hospital system.

This is not a saving – this is to allow our hospital systems to treat cases of greater acuity in a timely manner. Something that is not currently happening as elective surgeries are being cancelled on a daily basis which forms part of the vicious circle of increased ED attendances, poor outcomes and greater costs.

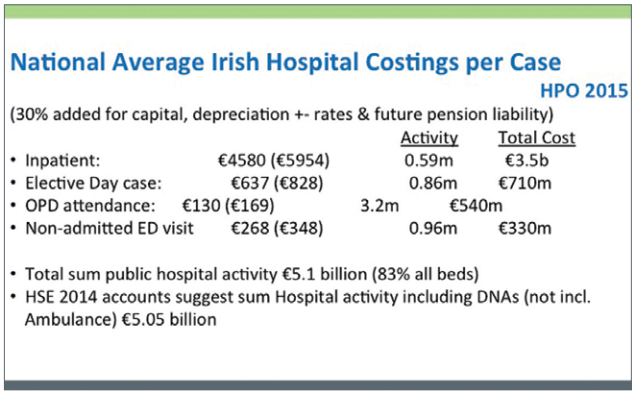


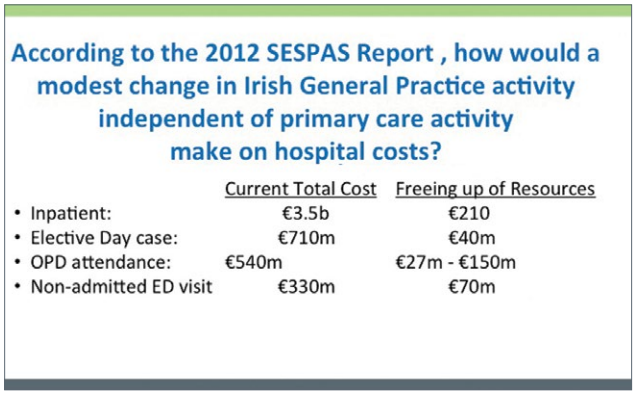




The current health spend is not delivering. In the Irish context, General Practice receives the lowest level of funding and yet the hospital system continues to struggle with inadequate funding. The cycle of cuts over recent years has led to a situation where:

- Patient numbers in General Practice have increased yet the amount allocated to deal with each patient has decreased
- Fragmentation and disease centred care has led to increased drug and pharmacy costs
- Hospitals have insufficient capacity to deal with acute demand some of which could be better managed in General Practice
- Health funding must increase with a significant and sustained investment in General Practice

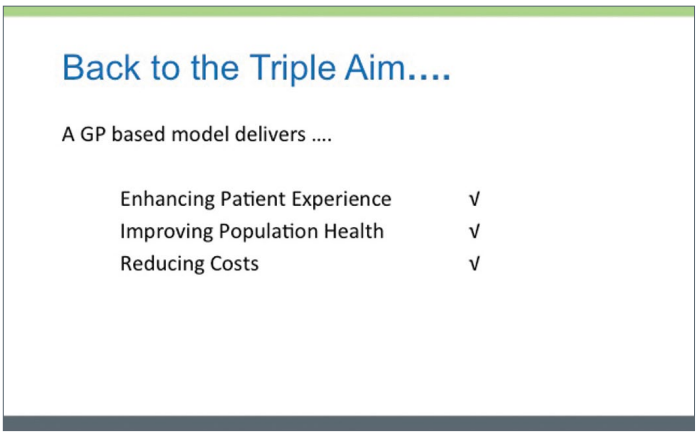




Healthcare costs. The challenge is to deliver that care in the most appropriate setting which is not necessarily either the most expensive or the cheapest setting, but must always be the most appropriate setting.

However, when we examine the costs of hospital care we can see that some services are not best managed in this costly environment. Such acute environments should and must be used to treat patients who present with greater levels of acuity and medical need which cannot be managed safely in the community.

The economic model we must follow is to transfer appropriate tasks and programmes from the acute to the GP setting. The current crisis we see in our health services on a daily basis are as a direct result of not following medical evidence, not planning investment programmes and failing to take account of sound economic models.



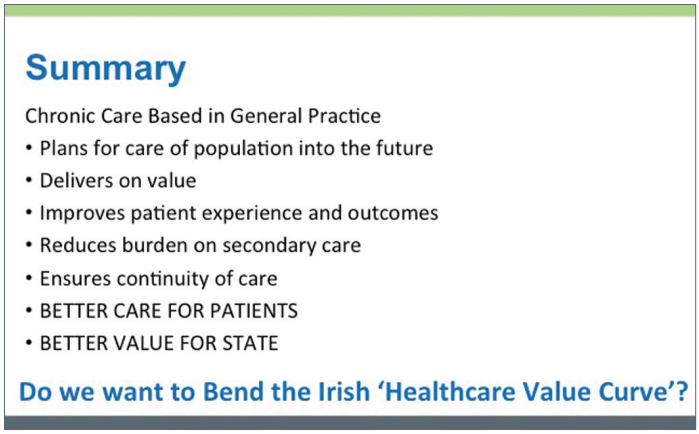
So what is Value – if we invest in General Practice can we deliver on the Triple Aim?

The answer is yes we can deliver on:

- Enhancing Patient Experience – Improving Population Health – Reducing Costs

In addition we can

- Provide continuity of care
- Ensure patients are seen in appropriate settings
- Support doctors to deliver care



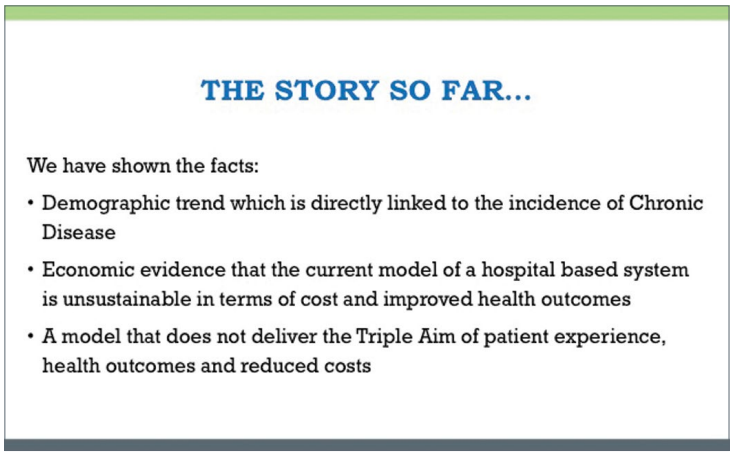
Are we prepared to bend the Irish Healthcare Value Curve?

The Solution is Chronic Care Programmes in General Practice

Dr Tadhg Crowley

Dr Tadhg Crowley

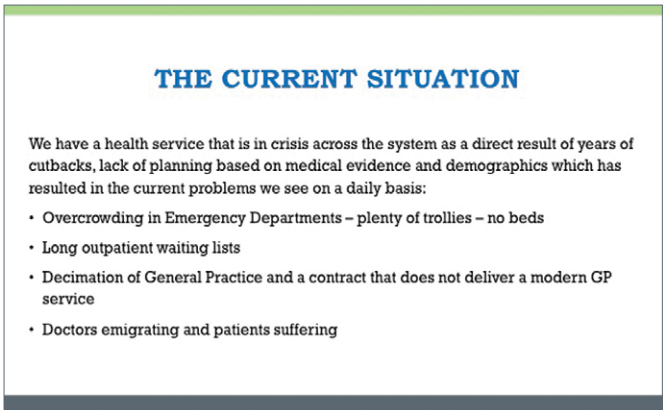
Dr Crowley has worked in the practice since 1997. He trained in UCD and completed his general practice training on the mid-western scheme. His area of interest includes childhood asthma, general allergy as well as sports and exercise medicine. After completing his general practice training he completed post graduate diplomas in paediatrics, psychiatry and in occupational medicine in London. He has worked with the Kilkenny hurling team for 10 years and also served nationally on the GAA scientific and player welfare committee. He has overseen a number of national projects on behalf of the GAA including injury prevention and cardiac screening. He has a keen interest in primary care teams and their role within the community. He has served on a number of task forces nationally within the HSE in relation to primary care. Dr Crowley has been an IMO subcommittee member for five years.



The demographic picture for Ireland into the coming decades clearly shows a rise in our elderly population with the inevitable health issues associated with the incidence of one or more chronic diseases. Our current health policy, which relies on a hospital based system to deal with chronic disease, will be unable to cope either in terms of capacity or cost.

- The current model is incapable of improving patient experiences.
- Incapable of improving health outcomes.
- From a financial point of view is unsustainable.

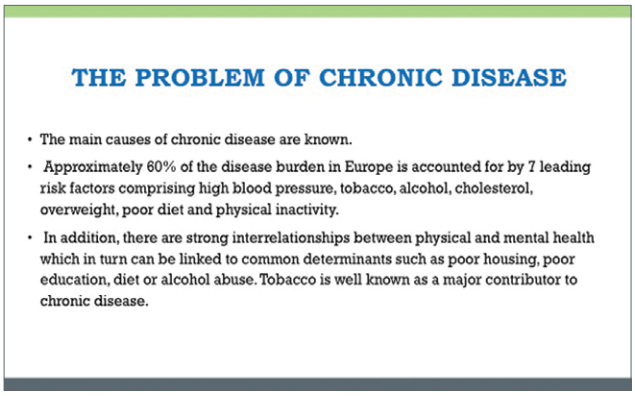
Using this model health costs will dwarf all other spending.

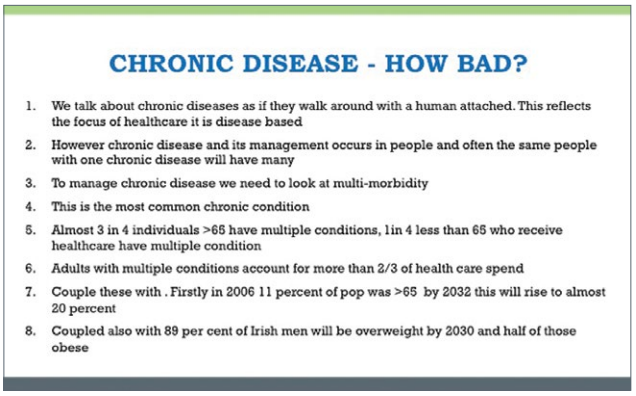


Current health services are in crisis.

- Overcrowding in our Emergency Departments is a manifestation of problems across the health system.
- Insufficient beds in hospitals and nursing homes.
- We have unsafe long waiting lists for outpatients.
- Lack of capacity and resources in general practice.
- Doctors are emigrating.

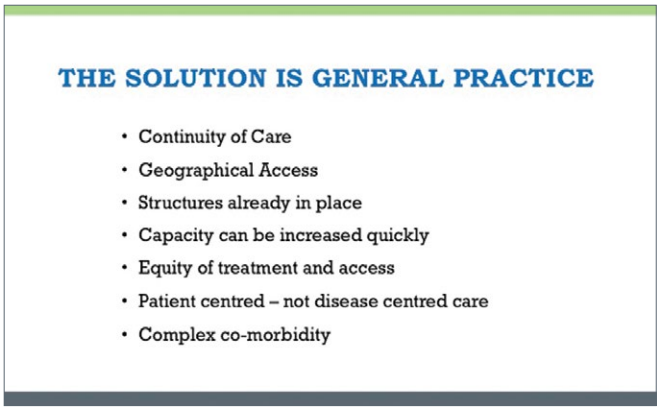
The key problem is that successive Governments have chosen to develop health policy based on election soundbites rather than based on demographics or medical evidence. Organisational reform in Ireland has focused on one sole objective – saving money. We are now paying the price for short term economic decisions of recent years.





The real irony of the current situation is that we are dealing with an entirely predictable issue. The main causes of Chronic Disease are known, the treatment and management protocols have already been identified, the current and rising incidence is calculable.

Yet we continue to operate a system which will do nothing more than deliver the same problems but we do have a solution. A solution that does not require massive organisational reform, does not require reams of reports from management consultants, does not require years of planning and a solution that can deliver.



General Practice can provide a real solution to the problems of Chronic Disease.

Continuity of Care: Within the hospital system care by the very nature of the hospital is fragmented with each team or specialist dealing with only one aspect of the patients care.

All studies show that continuity of care has the most positive influence in terms of health outcomes. The GP and support team can offer this continuity of care.

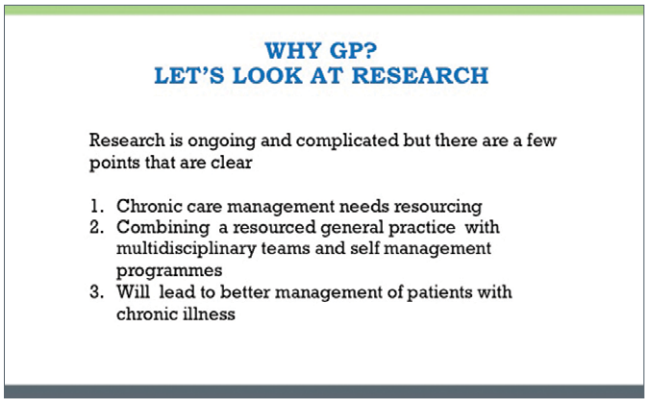
Geographical Access and Structures: Hospital based care is not evenly distributed throughout the country which leads to issues of inequality and inequity in terms of access to care. General Practice is here, in every town in Ireland which means the core infrastructure required is in place and just needs developing to the next level. Individual GPs have been to the forefront in developing structures, both physical structures and staffing structures with GP led teams of practice nurses and support teams. With proper resources these structures can be supported so that they can deliver high quality, accessible and cost effective chronic care programmes in the community.

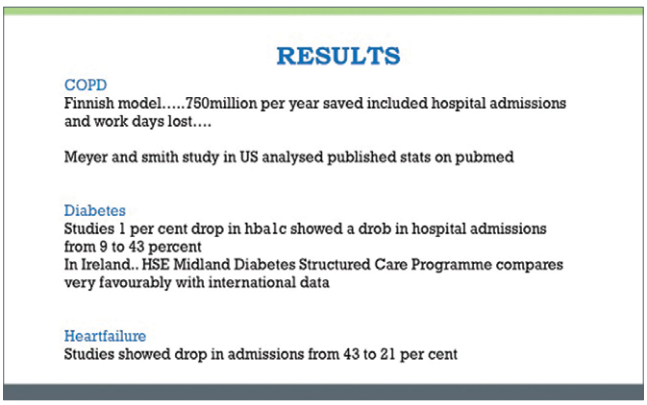
Capacity: There is evidence of a significant undersupply of GPs in Ireland and the predicted trend is that this shortage will grow. The current situation is that General Practice is already overstretched in terms of capacity and workload and there are insufficient allied health professionals such as public health nurses, physiotherapists, speech and language therapists, counselling supports available to GPs in the community. However capacity in General Practice can be developed and built up much more rapidly than in other areas of the health sector. Some immediate steps include:

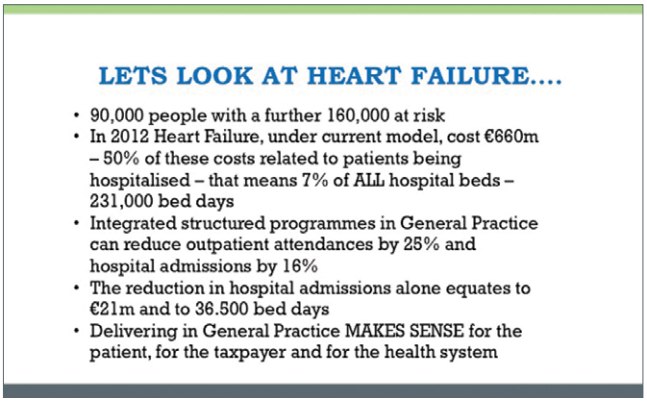
- Increase the number of GP training places in tandem with recruitment and retention policies as otherwise we are simply training GPs for emigration.
- Resource the provision of additional practice nurses and support staff in GP surgeries.
- Ensure sufficient numbers of allied health professionals are in place to meet the patient demand.
- Investment in integrated IT systems to allow for better care pathways and communication with secondary care system.
- Increased access to diagnostics by GPs.

Equity of Treatment and Access that is Patient Centred: Uniquely within the Irish health system General Practice offers equity of access to all patients. In order for this to be maintained we must ensure that the most vulnerable and needy of patients receive a modern GP service and not just the acute service as is provided under the current system. As the primary carer, it is the GP that can treat the patient and move away from fragmented care, from multiple health teams and services. It is only in a GP based system that the patient can truly be at the centre of care and treated accordingly as a person with illness as opposed to treatment of a disease.

Complex Co Morbidity: GPs are specialists and when resourced and allowed to provide patient centred care, General Practice is the most effective way to deal with medical complexity and uncertainty. The GP when dealing with patients with complex co morbidities, which is the vast majority of chronic care and elderly patients, KNOWS THE PATIENT AND MANAGES ACCORDINGLY.







The Chronic Care problem is not unique to Ireland and there is much research from both Europe and America to support the premise that Chronic Care when dealt with in General Practice is better for the patient and more cost effective in terms of healthcare costs. While we have to accept that we as healthcare professionals will always operate in an environment of limited resources we would at the very least expect that those resources be spent in areas that will achieve the best medical benefit to our patients.

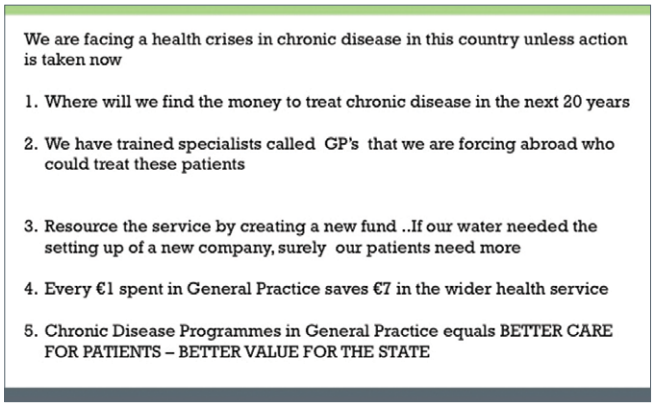
Some of the key research has been done in areas of COPD, Diabetes and Heart Failure. Not only does the research conclude that General Practice and associated continuity of care delivers best outcomes, there are significant added benefits:

- Hospital outpatient visits are reduced
- Hospital admissions are reduced

This is critically important, particularly in the context of the Irish system where lists are out of control and each target for reduction in waiting times is missed. We must remember these are not just numbers on a waiting list, these are patients who, during the interminable wait for an initial appointment, have to be managed by their GP or present in the Emergency Departments.

If we just take Heart Failure as an example we can see that investment in General Practice to manage heart failure can reduce outpatient visits by 25% and hospital admissions by 16%.

In real terms this frees up 36,500 beds – let's think again about all the elective surgeries being cancelled at the moment and what that number could do to alleviate the problem in the secondary care system.



There is a problem with Chronic Care – it can be solved through General Practice.

- It is better for the patients.
- It is better for the State.
- General Practice is offering a real, viable and sustainable solution.

We need to invest now or the current crisis will be nothing compared to what we are planning for future generations.

Notes

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