Irish College of General Practitioners

ICGP Submission to the Joint Committee on Health on Prescribing Pattern Monitoring and the Audit of Usage and Effectiveness Trends for Prescribed Medications

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About the Irish College of General Practitioners

The Irish College General Practitioners (ICGP) is the professional body for general practice in Ireland. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.
The College is the recognised body for the accreditation of specialist training in general practice in Ireland and is recognised by the Medical Council as the representative academic body for the specialty of general practice.

There are 3,724 members and associates in the college, comprising over 85% of practising GPs in the Republic of Ireland. There are 205 members in Northern Ireland, the United Kingdom, Canada and other overseas locations, and 690 GP trainees.

ICGP representatives:

Dr John O'Brien	ICGP Vice President & Incoming College President
Dr Mark Murphy	Chair of Communications & Member of the Board

ICGP Opening Statement

The ICGP thanks the Chair and Members of the Joint Committee on Health for the invitation to discuss prescription pattern monitoring and the audit of usage and effectiveness trends for prescribed medications.

Prescribing is a key professional activity for General Practitioners. It is estimated that a prescription is generated in two out of every three consultations. It is GPs who reconcile and coordinate patient's medications as they transition between different healthcare interfaces. It is GPs who issue repeat prescriptions for the Irish population. It is GPs who are best placed to share decisions with patients on medications, factoring their preferences on the possible benefits the possible harms. Monitoring the usage, the effectiveness and trends for prescribed medications are essential, for a high quality healthcare system. This submission is composed of four sections.

The first section outlines the context to prescribing trends in the Irish healthcare system. The prevalence of chronic diseases and multimorbidity is increasing in Irish society, though is not reflected in a modern GP contract. Rising prevalence of chronic diseases and an ageing population has resulted in a rise in the dispensing and costs of medications in the annual health budget. Our submission outlines our expenditure on pharmaceutical products, but in summary we spend approximately €2 billion on medications, which is taken from the community budget.

In contrast to the drug budget, Irish General Practice is extremely poorly resourced. We spend <4.5% of our overall healthcare budget on General Practice. At a time when GP-led, community-orientated healthcare should have happened, we have seen a massive retraction in GP funding. FEMPI cuts are still imposed on General Practice, which limit time for patient care.

We work off a 40 year-old out-dated contract. We have severe capacity restraints, with 6.2 GPs per 10,000 populations (lowest in Europe) and an exodus of our GP graduates.

GPs coordinate and facilitate high-quality repeat prescribing for patients. GPs issue a 'repeat-script' every three to six months, but this can be more frequent if there is a clinical need. Whilst the GP takes the responsibility and assumes the risk for prescribing, often GPs are not the original doctor who starts a medication. If a drug is initiated in hospital, the GP would issue the prescription on a GMS script for a GMS-eligible patient the cost then comes from the community budget.

The ICGP supports evidence-based and cost-effective treatments in the Irish healthcare setting (including prescribing). The ICGP also supports initiatives from the Medicines Management Programme to support effective prescribing. Opportunity costs are evidence throughout the healthcare system, where we spend money on low value products (with limited benefit and excessive costs), which results in other areas of our public healthcare system being under-funded.

The second section outlines the evidence for trends in prescribing. Evidence from large, population-based studies have shown that prescribing of 10 of more drugs (called '*excessive polypharmacy*'), in over-65s, has increased from 2% in 1997 to 22% in 2012.Whilst prescribing has increased, the odds of *potentially inappropriate prescribing* in 2012 (versus 1997) having controlled for age and level of polypharmacy was 60% less. GPs and hospitals are prescribing more medications for an ageing and more multimorbid population, but are doing a better job at prescribing.

The submission also looks at research from Irish cohort studies, including TILDA. One report has shown that in an older population reporting polypharmacy, using a system of reference pricing based on groups of similar drugs could potentially save up to €152.4 million per year. The submission then addresses trends in the prescribing of certain drug classes, including benzodiazepines, anti-depressants, opioids and antibiotics.

We can discuss the prescribing trends in more detail in the questions and answers session, but we might anti-depressant prescribing now. In 2016, the State spent €40.07 million on anti-depressant medications for GMS eligible patients and €4.29 million on the Drug Payment Scheme. In contrast, we spent ~€10 million on Counselling in Primary Care was only. All evidence suggests that GPs prescribe extremely appropriately in the context of a severe capacity shortage in General Practice and Primary Care. Prescribing rates of anti-depressants reflect a lack of psychological therapies and a lack of social therapies and resources in society (including fragmented communities, isolation and austerity).

The third section discusses some opportunities and challenges in relation to audit and data monitoring. We outline how it is pivotal that GPs are provided with sufficient time and resources to enable shared discussion on medicines management. When savings are made, it is of paramount importance, that savings are directed in appropriately funding Irish general practice.

We need to address the challenge of medicines reconciliation across healthcare interfaces and promote electronic discharges, to reduce error and improve quality. The role of clinical pharmacists in the general practice team (or in the nursing home setting) should be explored, but as part of a new GP contract. Monitoring and audit of prescribing, if done

correctly, has the potential to be an extremely powerful tool for GPs in their on-going efforts to deliver the very best care for their patients. Research and audit needs to be actively supported and promoted at the highest level. We need to be careful, when using this data or when comparing raw prescribing data from individuals and comparing it to national standards. We need to take account of confounders such as poverty and deprivation, or conditions such as multimorbidity and depression. Continuous medical education has seen a curtailment in funding, which needs to be reversed.

Pharmaceutical advertising (in the national media) indirectly promoting certain products has been an unwelcome development in recent years. This should come under legislative control as GPs are encountering demand for drugs and services, which have dubious cost-benefit.

Lastly, the submission finishes with some recommendations. GPs need time to deal with complex cases. This will require a modern GP contract which facilitates the management of chronic conditions and medication management. Before this, there is need for the urgent reversal of FEMPI, which has curtailed the ability of general practices to grow, at a time when GP services should expand. We also need to retain our brightest and best GPs who see other healthcare systems as a preferable career option. ICGP is becoming increasingly frustrated with the lack of government action on these key matters.

We need to direct any savings in drug prescribing back into General Practice to reinforce a cycle, which is to the benefit of the patient and of the health system more widely. A medicines management programme, led by GPs, needs to be created as part of a new contract.

This committee should endorse a recommendation to ban non-governmental healthcare advertising, especially the indirect promotion of drugs in the media. The ICGP is willing to continue to work and collaborate with the HSE and educational bodies to promote cost-effective, evidence-based prescribing. Sometimes collaboration has not happened (e.g. such as through online requirements for issuing certain drugs or for phased prescribing), which has disenfranchised and increased frustration with GPs.

Prescribing trends can only be identified through research and audit. Academic career structures for GPs have not been sufficiently facilitated by the HSE or the Department of Health. Similarly research on our electronic health records, such as that through the Irish Primary Care Research Network, is underdeveloped in the Irish setting, which will require an expansion and State funding. This will deliver savings in the future.

Section 1: Context to Prescribing Trends

1.1. Rising Prevalence of Chronic Diseases

Ireland has a rising prevalence of chronic illnesses, explained partly due to an ageing population. Approximately 10% of the Irish population is over 65, which will increase to over 25% by 20401. Examples of chronic conditions include chronic respiratory conditions (e.g. COPD and asthma), cardiovascular illnesses, mental health conditions, arthritis and dementia.

Multimorbidity is a medical term defined as an individual having two or more chronic illnesses. 65% of those aged more than 65 years and almost 82% of those aged 85 years or more have two or more chronic conditions. Patients with multimorbidity include one third of consultations in general practice[2]. Chronic illnesses should be managed with community services, led by GPs. This is a key but yet unrealised policy objective of successive governments[3].

Patients often expect medication solutions to medical problems. However, often psychological or social or lifestyle options, including conservative management, is the most effective option. It is estimated that two out of every three consultations result in a prescription[4]. Prescribing for both acute conditions and repeat prescribing for chronic conditions informs the majority of our working day.

Table 1: An example of a typical patient in General Practice [5]

70 year old female patient with five 'chronic diseases':	Drug burden
• COPD • Diabetes • Hypertension • Arthritis • Osteoporosis	• 19 doses of 12 different medications • Taken at five times during the day • 10 different possibilities for drug-drug or drug-disease interactions Also, 14 non-drug activities recommended

1.2. Increased Prescribing/Dispensing of Medications in the Community

The 2016 PCRS Annual Report outlines the large costs and dispensing data for all drugs, which come from the community PCRS budget (whether prescribed in the community or not)[6].

- €1,003.29 million was spent by the State on medications for GMS-eligible patients
- High Tech medications, paid from the community budget, cost €631.23 million. Hospital drugs, from oncology, Hepatitis C and outpatient parenteral antimicrobial therapy amounted to €68.5million.
- €153.67 million was spent on the Drug Payment Scheme (DPS)
- €207.45 million was spent on the Long Term Illness (LTI) Scheme

Figure 1: The Top 10 Most Commonly Prescribed Products reimbursed by the GMS

	Prescribing frequency (million)	Cost (euro) (million)
1. Aspirin	2.1	2.8
2. Atorvastatin	1.8	7.2
3. Thyroid hormone	1.7	2.8
4. Paracetamol	1.4	2.3
5. Esomeprazole	1.2	8.7
6. Bisoprolol	1.2	2.7
7. Salbutamol	1.1	5.0
8. Calcium (combinations)	1.1	5.8
9. Lansoprazole	0.9	4.8
10. Codeine analgesics	0.6	6.2

Figure 2: The Top 10 Products by Ingredient Cost reimbursed by the GMS

	Cost (euro) (million)	Prescribing frequency (million)
1. Clinical Nutritional Products	45.4	0.6
2. Pregabalin	24.8	0.7
3. Salmeterol inhalers	23.7	0.5
4. Lidocaine	21.6	0.3
5. Ostomy requisites	16.1	0.2
6. Formoterol inhalers	13.1	0.3
7. Tiotropium inhalers	13.0	0.3
8. Rivaroxaban	10.8	0.2
9. Urinary requisites	9.9	0.1
10. Denosumab	9.8	0.04

In comparison, in 1998, for 1.18 million eligible GMS patient, drugs fees were as follows 6:

- GMS pharmacy claims £203.15 million
- DPS £47.2 million
- LTI £23.2 million
- High Tech Drugs Scheme £2.1 million
- Methadone £1.5 million

1.3. Context of Irish General Practice

Macro-economic picture: Compared to the ~€2 billion drug spend, which comes from the community budget, in 2016 we spent €394.8 million on GP fees (and €148.33 million on GP expenses). The total expenditure in Irish General Practice- including private fees- comes to < 4.5% of the total healthcare budget. This compares to > 7-11% in other countries7.

Out-dated contract and under-funded: General Practitioners work off a 40-year-old contract. FEMPI has also taken 38% from most GP's GMS income, which has curtailed the services able to be provided to patients.

Capacity restraints: Ireland has 6.2 GPs per 10,000 population7. 20% of recent GP graduates have immigrated to countries which prioritise a GP-led system8. At a time when GP-led, community orientated healthcare should have happened, we have seen a massive retraction in GP funding, when pharmaceutical spending has massively increased.

Primary care: Prompt access to our colleagues in primary care can enable the promotion of non-drug treatment options. As an example, if a patient does not have access to a physiotherapist or a psychologist (or counsellor) it removes non-drug options from a management plan and can promote prescribing.

1.4. Repeat Prescribing in the Irish Healthcare System

Typically GPs issue a 'repeat-script' every three-six months, but this can be more frequently if there is a clinical need. Coordinating and facilitating high-quality and safe repeat prescribing for patients is a professional responsibility of the GP.

For GMS-eligible patients, when prescribed a medication in a hospital setting, the medication needs to be transcribed by the GP onto a GMS prescription, after reconciling and confirming the script is accurate. Therefore, whilst the GP has ultimate responsibility to prescribe the medication, often GPs are not the original doctor who started the medication. So when a drug is initiated in hospital, then subsequently prescribed by the GP to make it GMS-eligible, the cost then comes from the community budget. Example could include complex pain medications, which may come from rheumatology, orthopedics, palliative care pain clinics etc.; or benzodiazepines and anti- depressants, which may be started in psychiatry clinics.

The ICGP has a comprehensive guidance document to advice our Members on the best practice principles when issuing repeat scripts. Issues with GPs consider include drug-disease interactions, drug-drug interactions and drug monitoring.

1.5. Cost-Effective Prescribing

ICGP supports evidence-based, cost-effective prescribing. A key principle in the discipline of pharmaco-economics includes the concept of opportunity cost. This is evident throughout the healthcare system where we spend money on low value products (with limited benefit and excessive costs), which results in other areas of our public healthcare system being under-funded.

The ICGP supports the input Medicine Management Programme of the HSE in the preferred prescribing information and their Tips and Tools guidelines. This information can help GPs deliver more informed prescribing us with relevant pharmaco-economic information.

Section 2: Evidence on Prescribing Trends

Raw dispensing data is important, but does not tell us about the underlying complexities of prescribing. It does not factor important variables such as degree of morbidity, age of the patient, deprivation etc. It also does not tell us whether a prescription is appropriate or not. We are lucky in Ireland, despite difficulties accessing data for researchers, that analysis of PCRS data and specific research studies have helped shed light on prescribing trends.

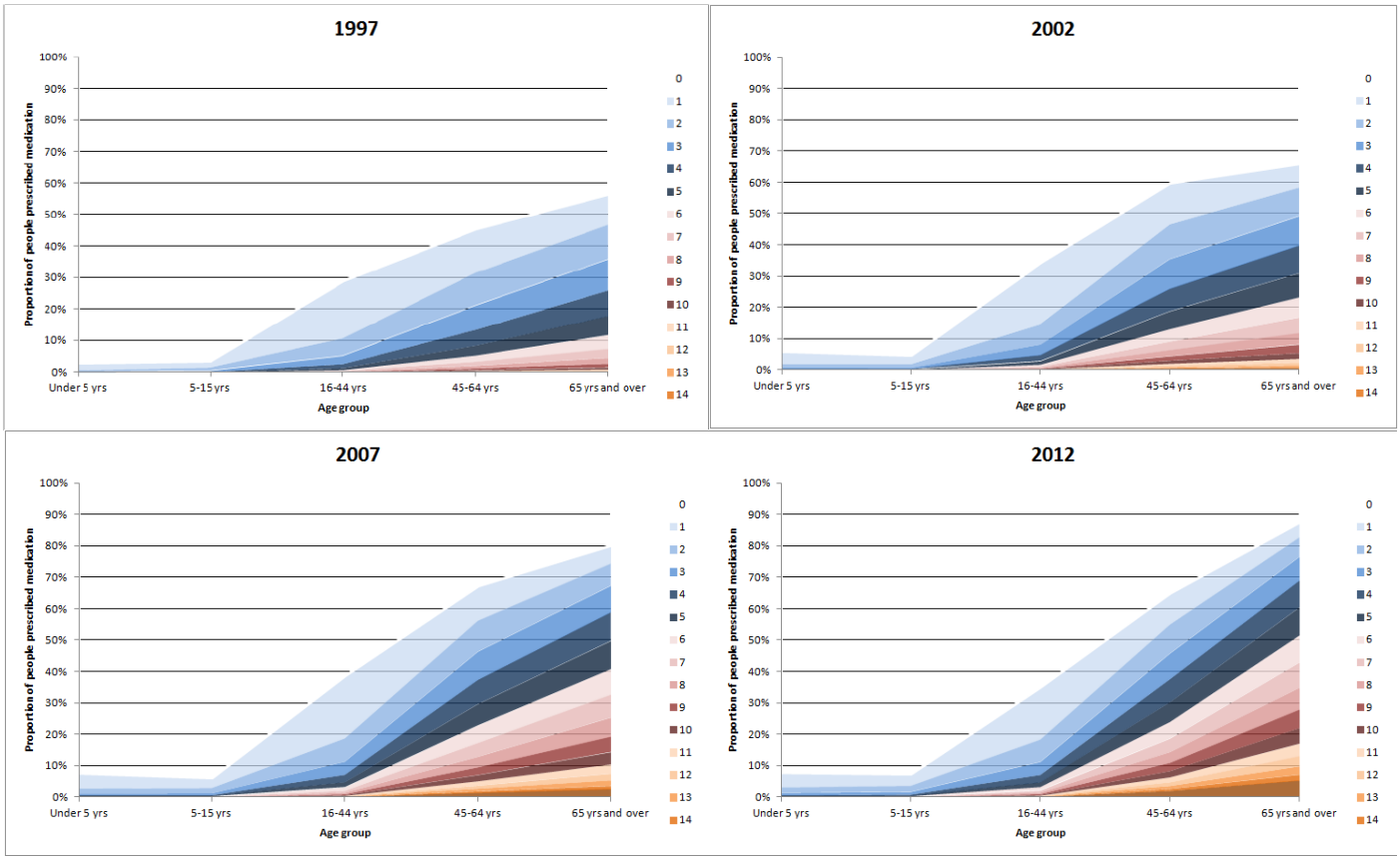
The HRB Centre for Primary Care Research, since 2008, has looked at trends of prescribing. One paper by Frank Moriarty et al. (published in BMJ Open in 2015) looked at trends in prescribing - specifically 'potentially inappropriate prescribing'- from 1998 to 20129.

Overall prescribing has increased year on year from 1997 to 2012, explained by an older population with more chronic disease:

- In over-65s, prescribing of 5 of more drugs (called 'polypharmacy') in over 65s increased from 18% in 1997 to 60% in 2012.
- In over-65s, prescribing of 10 of more drugs (called 'excessive polypharmacy') increased from 2 to 22%.

The odds of '*potentially inappropriate prescribing*' in 2012 (versus 1997), having controlled for age and level of polypharmacy, was 60% less. This would suggest that GPs and hospitals are prescribing more medications for an ageing and more multimorbid population, but are doing a better job at prescribing.

Figure 3: Percentage of Eligible Population by Number of Regular Medicines for the Years 1997-2012[9]



A cohort study, the Irish Longitudinal Study on Ageing (TILDA), has delivered important information on prescribing trends in older adults in Ireland[1]:

- Medications used to treat cardiovascular conditions (mainly high blood pressure and heart disease) are the most common medications contributing to polypharmacy.
- Currently one in five medicines used by those reporting polypharmacy is a generic, 15% being a branded generic and 6% a pure generic. The report sound that increasing the use of generic medicines could potentially save up to €29.5 million per year.
- In the older population reporting polypharmacy, using a system of reference pricing based on groups of similar drugs could potentially save up to €152.4 million per year.

Another cohort study[11], developed by Dr Emma Wallace et al. in the HRB Centre for Primary Care Research, has shown that older community-dwelling people, prescribed ≥2 potentially inappropriate medications are more likely to report adverse drug events, poorer health related quality of life and attend the emergency department over a two-year follow-up.

2.1 Anti-Depressants:

The majority of mental health conditions are managed within General Practice. GPs and psychiatrists manage depression and anxiety in accordance with evidence-based guidelines. All mental health conditions require a bio-psych-social approach to their management; whilst psychosocial options are arguably the most important component of managing any condition, drug options have a definite evidence base for certain conditions.

It is worth considering the overall context and costs. In 2016, the State spent €40.07 million on anti-depressant medications for GMS eligible patients and €4.29 million on the Drug Payment Scheme. In contrast, the spend on counselling in primary care was only ~€10 million[6]. Prescribing rates of anti-depressants reflect a lack of psychological therapies and a lack of social therapies and resources in society (including fragmented communities, isolation and austerity). Limited public (free) access to psychosocial services disproportionately affects those without ability to pay and forces an increased use of medication options.

There is no evidence GPs are over-prescribing anti-depressants, but the failure to resource psychological services may increase the likelihood of prescribing medications, as mental health conditions can worsen. This is not an issue for GPs to manage in isolation. Enhanced HSE psychological supports would greatly improve options for GPs in the area of mental health management. Anecdotal feedback on the experiences of GPs with the HSE community counselling service is that it is difficult to access, waiting times are too long and there are a lot of exclusion criteria.

2.2 Benzodiazepines and Z-Drugs:

The most recent data suggests that benzodiazepine prescribing has stabilised but remains higher than desired. On the other hand prescribing of "z" hypnotics has been increasing. Chronic benzodiazepine prescribing (> 8 weeks) has been reducing over the past 15 years. The continuation of chronic benzodiazepine prescribing is largely related to legacy prescribing, in which patients are on these medications for over ten years and have developed a tolerance to these medications.

There needs to be a consistent approach to this issue across the healthcare system as this is not simply an issue for primary care- it is recognised that prescribing of these medications is initiated in hospitals and psychiatry units also.

The ICGP was closely involved in the development of the new benzodiazepine receptor agonist guidelines (BZRA), issued recently by the HSE Medicine Management Unit. All GPs will be issued with summary of these guidelines, which offers doctors tips and tools for reducing long term BZRA use. There is greater awareness of the issues related to prescribing BZRA medications for long- term use. Through education and greater awareness particularly during GP training, we would anticipate that appropriate prescribing in keeping with the guidelines can be achieved.

2.3 Opiates:

ICGP is aware of the opiate crisis in the US and all efforts should be made to avoid a similar experience in Ireland. But like the medications addressed above, GPs are at the front line and it is difficult when a patient is sitting in front of the GP, disabled with intractable pain, possibly waiting years for an orthopedic or a pain clinic appointment.

Prescribing guidelines for the appropriate use of opiates in pain are in discussion. The ICGP is represented in the Faculty of Pain Management of the College of Anesthetists. Education for all GPs and GP Trainees is being enhanced on the area of pain management.

Evidence does not support the use of opiates for non-cancer pain. We must be aware of the strong influence of pharmaceutical marketing, which promote an increasing array of opioid medications offering solutions for chronic pain. Increasing awareness of at risk patient groups and encouraging closer collaboration with specialist pain services so that at risk patient can be identified prior to prescribing opiates is desirable.

2.4 Antibiotic stewardship:

The MMU has produced prescribing data, information and guidelines for appropriate antibiotic prescribing. The ICGP supports the HSE initiatives such as the patient information campaign "*Under the Weather*" which reinforces the message that most minor illnesses are viral and can be managed safely without the use of antibiotics.

Antibiotic stewardship involves ensuring a doctor is prescribing the right antibiotic for the

right patients, with the right dose, route and duration, causing the least harm to the patient. A core focus of antibiotic stewardship involves limiting the development of antibiotic resistance. Irish data has shown that nursing home prescribing. Barriers to effective antibiotic stewardship have been outlined as[12]:

- Lack of true community resistance data
- Lack of accurate antibiotic data
- Lack of access to diagnostics laboratory and near patient e.g. CRP
- Lack of access to experts in microbiology/ care of the elderly etc. for complex cases
- Lack of leadership and governance
- Lack of time

Section 3: Challenges for Audit and Prescription Monitoring

3.1 Challenges Facing Irish General Practice, Particularly Time

The introduction of FEMPI, the extension of the GMS to cover under 6 and over 70 years along with a manpower crisis contribute to GPs having less time to give to individual patients with complex problems. It takes time to prescribe effectively, efficiently and safely, to follow guidelines and to reconcile medications.

It cannot be over-emphasised and FEMPI and a lack of support for general practice has reduced the time for GPs to share decisions with patients. Also, there is no specific medicines management programme in our current contract.

Medicines management involves a quantum of time and workload, which has not been reflected by the HSE or DoH. An example would be the online requirements for GPs to permit phased prescribing or to prescribe a certain drug which was not initiated in General Practice (e.g. lidocaine patches). This workload needs to be resourced. This lack of collaboration has only heightened the frustration amongst GPs.

3.2 Where Should Savings be Directed?

Any savings in the drug budget, generated by GPs, need to be fed back in to General Practice to reinforce a cycle, which is to the benefit of the patient and of the health system more widely.

3.3 Medicines Reconciliation between Healthcare Interfaces

One of the biggest risks to patient safety is when patients cross boundaries of care. This is especially true on discharge from secondary care to General Practice. Redmond et al. demonstrated that 80% of GPs and pharmacists recall a prescribing error following a transition of care, in the preceding six months[13]. Audits have shown >30% of paper hospital discharges do not have accurate information on prescriptions.

The ICGP Quality in Practice programme and GP-IT group has supported initiatives to improve safety and reduce risk at these transitions. E-referrals to hospitals have facilitated accurate information arriving at hospitals. However, E-discharges have largely been neglected. Discharge letters from secondary care settings- such as outpatients, Emergency Departments and post admission need to be standardized. It is common for a GP and patient to be unsure of what is written on a prescription, what medications were started, what medications were stopped and to be unable to read the name or bleep number of the prescriber in the secondary care setting. This is an unacceptable breech in patient safety. Standardised discharges, ideally through e-Discharges, would improve safety, efficiency and deliver clarity and accountability. Ideally an electronic pro forma to include a medication-list, plus comments on any changes made to the admission medications.

3.4 Role of Pharmacists in Repeat Prescribing and Data Monitoring

The community pharmacist is an essential and extremely valued member of the primary care team. The current role of the community pharmacist, with the GP as the prescriber, promotes safety for patients through a prescriber-dispenser split.

Rationalisation of medications and de-prescribing is a major challenge. The role of practice-based pharmacists (not community pharmacists) has an emerging evidence base- especially looking at at-risk groups such as nursing home residents and patients with excessive polypharmacy. HSE pilots are underway. Pending a review of this evidence, ICGP would like to collaborate on recommendations on how pharmacists could be integrated into the primary care teams, or even practice based teams, but needs to be considered in terms of overall GP contract.

3.5 Use of Data to Monitor Prescribing and for Self-Audit

Monitoring and audit of prescribing, if done correctly, has the potential to be an extremely powerful tool for GPs in their on-going efforts to deliver the very best care for their patients.

When comparing individual performance to national norms, we need to take account of confounders such as poverty and deprivation. Prescribing patterns are likely to be affected by consultation times most especially in the areas of multimorbidity and depression. The use of data to develop a centrally-controlled, regimented prescribing pattern without reference to individual clinical judgement is a risk. For an individual patient, the cheapest prescribing may not be developing the best result with possible relapse and a need for further hospital care. The risk is that the state will only see the price and not the clinical outcome.

Research:

The ICGP supports research on prescribing trends, through collaboration with university departments, funding higher degrees for GPs interested in research and development of research networks. One research network is called the Irish Primary Care Research Network. It is a powerful tool, which has the potential to support rapid analysis of prescribing trends (for research purposes only, iPCRN and research).

Research costs money and funding, e.g. for the IPCRN, needs to be State funded. Looking at datasets in abroad (e.g. CPRD in the UK) highlights what a lost opportunity we have in Ireland, due to the lack of funding of this research.

Audit:

Audit involves comparing current clinical practice against best practice, with a view to improving quality. ICGP supports GPs, as part of their annual professional competence cycle, to perform an audit on prescribing data. Use of the IPCRN facilitates this.

The ICGP welcomes the prescribing feedback they receive from the Primary Care Reimbursement Service of the HSE. This allows individual GPs to reflect on their prescribing of benzodiazepines and to see where there prescribing levels are in comparison to their peers. The limitation of this process is that it only captures GMS prescribing and the data on private scripts is not captured.

3.6 Pharmaceutical Advertising

The advertising for medical services from commercial companies in the national media has been an unwelcome development in recent years. This follows an American model where such advertising involves very extensive advertising of drugs with an exhortation to discuss them with the doctor. Unless this practice comes under legislative control it is likely that patient pressure driven by marketing will result in GPs encountering demand for drugs and services with dubious cost benefit.

Conclusion

Medicine is unrecognisable now compared to twenty years ago. More patients are living with chronic conditions. More patients are prescribed multiple, expensive medications. It is GPs who generate and/ or coordinate the prescribing of these medications, but funding for Irish General Practice has been cut and is behind all other developed countries. When our health services should have moved towards a GP-led, community orientated system, funding for General Practice has retracted and GPs have less time.

ICGP wishes to make the following recommendations to the Joint Committee on Health:

- GPs need time to deal with complex cases. This will require a modern GP contract which facilitates the management of chronic conditions and medication management. Before this, there is need for the urgent reversal of FEMPI, which has curtailed the ability of General Practices to grow, at a time when GP services should expand. We also need to retain our brightest and best GPs who see other healthcare systems as a preferable career option. ICGP is becoming increasingly frustrated with the lack of government action on these key matters.
- We need to direct any savings in drug prescribing back into General Practice to reinforce a cycle, which is to the benefit of the patient and of the health system more widely.
- A medicines management programme, led by GPs, needs to be created as part of a new contract.
- This committee should endorse a recommendation to ban non-governmental healthcare advertising, especially the indirect promotion of drugs in the media.
- The ICGP is willing to continue to work and collaborate with the HSE and educational bodies to promote cost-effective, evidence-based prescribing. Sometimes collaboration has not happened (e.g. such as through online requirements for issuing certain drugs or for phased prescribing), which has disenfranchised and increased frustration with GPs.
- Prescribing trends can only be identified through research and audit. Academic career structures for GPs have not been sufficiently facilitated by the HSE or the Department of Health. Similarly research on our electronic health records- such as that through the Irish Primary Care Research Network- is underdeveloped in the Irish setting, which will require an expansion and State funding. This will deliver savings in the future.

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