

Oifig an Stiúrthóra Cúnta Náisiúnta Clár Cúraim Pobail Feabhsaithe & Conarthaí Príomhchúraim Feidhmeannacht na Seirbhíse Sláinte Urlár 2, Páirc Ghnó Bhóthar na Modhfheirme, Floor 2, Model Business Park,

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Health Service Executive

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Deputy Padraig Rice, Dáil Eireann. Leinster House, Dublin 2.

27th July, 2025

PQ: 34487/25

To ask the Minister for Health the number of patients who have received appointments and the condition for which they were treated under the HSE's chronic disease management Programme in each of the last four years, and to date in 2025; and if she will make a statement on the matter.

PQ: 34488/25

To ask the Minister for Health the annual costs associated with the implementation of the chronic disease management programme in each of the last four years, and to date in 2025; and if she will make a statement on the matter.

Dear Deputy Rice,

I refer to your parliamentary questions above, which were passed to the HSE for response.

The GP Agreement 2019 provided for the introduction of an integrated model of a structured Chronic Disease Management (CDM) Programme. The GP Agreement (2019) provided €80m for new developments including roll out of the CDM Programme. The CDM Programme was launched in 2020 and has been rolled out on a phased basis (2020 - 2023). The aim of the Programme is to prevent and manage patients' chronic diseases using a population-approach. The Programme identifies and manages GMS and GP visit card patients at risk of chronic disease or who have been diagnosed with one or more specified chronic diseases.

The Programme improves the health and wellbeing of patients living with certain chronic diseases. Its goals are to minimize symptoms, improve quality of life, and prevent unnecessary hospitalisations. In May 2025, the third report into the implementation of the Chronic Disease Management (CDM) Treatment Programme in General Practice was published and can be accessed here https://www.hse.ie/eng/services/publications/primary/third-chronic-disease-report.pdf

As set out in the third report, overall the CDM data to date suggests an effective Programme which is well supported by GPs and patients and achieves good lifestyle behaviour and clinical results. Analysis from HIPE and from the ICGP audit indicates a reduction in health service usage for this cohort after a period in the CDM Programme, similar programmes elsewhere have shown these risk factor reductions and health service utilisation and reductions also. Significant return on investments have been calculated for these types of programmes.

The Treatment Programme is open to all adults who have a General Medical Services /Doctor Visit Card/Health Amendment Act Card (GMS/DVC/HAA) and who have been diagnosed with at least one of the following chronic diseases;

- Type 2 diabetes mellitus
- Ischaemic heart disease
- Atrial fibrillation
- Heart failure
- Cerebrovascular accident (CVA)
- Transient ischaemic attack (TIA)



- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma

To support patients in managing their chronic condition(s) there are two scheduled Treatment Programme reviews in a 12 month period as set out in the GP Agreement (2019). Each of the two scheduled reviews provides for a GP visit and a Practice Nurse visit.

As at May, 2025 there are 2,402 GMS GPs signed up to provide the CDM Programme. This represents 97% of GMS General Practitioner contract holders. Patient figure's include 499,136 patients registered on the Treatment Programme; 203,264 patients registered on the Prevention Programme and 262,854 patients who have received an Opportunistic Case Finding Assessment since the inception of the programme.

The cost of managing the patients on the overall Structured Chronic Disease Management Programme was €16.53m in 2020; €33.38m in 2021; €56.74m in 2022; €83.52m in 2023; €101.68m in 2024 and €41.64m from January to May, 2025.

CDM Phase 3

As part of the 2023 GP Agreement Phase 3 of the CDM Programme provided for an expansion of the Programme (addition of Hypertension Stage 1 and Gestational Diabetes & Pre-Eclampsia in the Prevention Programme and inclusion of HAA Cardholders) as well as enhancement of existing and additional functionality in the CDM ICT Module.

I trust this is of assistance.

Yours sincerely,

Geraldine Crowley, Assistant National Director, Enhanced Community Care Programme & Primary Care Contracts